Caring for our future:

progress report on funding reform

HM Government

Caring for our future: progress report on funding reform

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

July 2012

Cm 8381

£16.00

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This publication is available for download at www.official-documents.gov.uk and from our website at www.dh.gov.uk.

ISBN: 9780101838122

Printed in the UK for The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID P002498466 07/12

Printed on paper containing 75% recycled fibre content minimum

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1. Introduction and summary

Care and support is something that everyone in this country will experience and be part of at some point in their lives. Some people have impairments from birth, or develop an impairment or mental health condition during their working life, and use care and support to maintain active and independent lives. Many, as they become older, become more frail and rely on care and support from others. As the Prime Minister's Challenge on Dementia has already shown, we are committed to improving the lives of people with care needs. This report, and the White Paper and draft Care and Support Bill published alongside this report, are about how we provide high quality care and support for all.

In the White Paper, we have set out a new vision for a modernised care and support system which will empower communities, families and individuals to plan and prepare for their future, to reach out to those around them who may need support, and to choose the care and support that best enables them to meet their goals and aspirations. This will result in higher standards of care, tailored to the needs of individuals and their carers.

On coming into Government, the Coalition recognised the need for reform of the way in which care and support is paid for and quickly established the Commission on Funding of Care and Support, chaired by Andrew Dilnot.

In his letter to the Government in September 2010, ahead of the last Spending Review, Andrew Dilnot urged the Government to prioritise resources in the short term to support the current system as much as possible over the next few years. The Government responded quickly and with purpose. In the Spending Review, we recognised the pressures on the adult care and support system within a challenging settlement for local government, and took the decision to **prioritise adult care and support by allocating an additional £7.2 billion** to the system over the four years to 2014/15 to support local authorities in delivering care and support. Since then, we have allocated an additional £300 million, and the White Paper promises further support in the two years ahead.

The Commission published its recommendations on how to share costs between the state and individuals in July 2011. Since then the Government has engaged with a wide range of people – service users, their families and carers, local authorities, charities, providers of care services and the financial services sector – to get views on the Commission's proposals.

The Government welcomes the work of the Commission. The Commission made two key proposals for reforming the way in which people pay for their care and support:

- the Government should put a cap on the lifetime care costs that people face, and raise the threshold at which people lose means-tested support; and
- there should be universal access to deferred payments for people in residential care.

The Government supports the principles on which the capped cost model is based. Protecting people against very high care costs would provide peace of mind and enable them to plan and prepare for their future care needs. **The Government agrees that the principles of the Commission's model would be the right basis for any new funding model –**

financial protection through capped costs and an extended means test.

Whilst we support the principles of the approach recommended by the Commission, and it is our intention to base a new funding model on them if a way to pay for it can be found, there remain a number of important questions and trade-offs to be considered about how those principles could be applied to any reformed system. Given the size of the structural deficit and the economic situation we face, we are unable to commit to introducing the new system at this stage. The Government will work with stakeholders and the Official Opposition to consider the various options for what shape a reformed system, based on the principles of the Commission's model, could take before coming to a final view in the next Spending Review. Taking a decision in the Spending Review will allow the Government to take a broad view of all priorities and spending pressures.

Some of the key questions about how to apply the principles include:

- the level of cap: some people have argued for a cap within the range suggested by the Commission, and others have argued that a higher cap would deliver the same peace of mind benefits. This question also includes how the cap rises over time, what is and is not counted in the cap, and the contribution to general living costs that people are expected to make; and
- who benefits and who should pay: many commentators have suggested that those who benefit most from reform should be asked to meet the cost of reform. One way of doing this is through a voluntary or opt-in funding system, where people have a choice to pay a specified amount to receive financial protection from the state.

The Government will explore these issues further, alongside others as set out in this detailed report, engaging with stakeholders to ensure we are in the right place to make final decisions at the next Spending Review. We welcome and strongly encourage stakeholders to contribute to the debate and bring forward their own ideas about applying these principles.

Whilst we continue to work with stakeholders on the options for these elements of funding reform, we will take definitive steps now to take forward a number of important recommendations made by the Commission, which will support individuals and their families and will deliver real improvement for individuals.

- We recognise the stress and anxiety that people face when they move into residential care and have to sell their homes. To address this, we will introduce a **universal system of deferred payments for residential care,** as recommended by the Commission. This will mean that no-one will be forced to sell their house in their lifetime to pay for care. The draft Care and Support Bill, published today, includes the necessary powers to implement this policy in England. Universal deferred payments will be introduced from April 2015.
- We will introduce for the first time a **national eligibility threshold for adult care and support** in England, as set out in the accompanying White Paper. This will address an unfairness in the current system, where eligibility for care and support can depend on where someone lives and will support the Commission's principles, by providing improved clarity on entitlements. The draft Care and Support Bill includes the necessary powers to set a national eligibility threshold. The national threshold will be introduced in April 2015.
- We will improve the information available to support people who have care needs. We have committed to providing, for the first time, a **clear, universal and authoritative source of national information about the health and care and support system.** This will include information on how the care and support system works, who might be eligible for financial support from the state, and how much care costs.

  We are also legislating in the draft Care and Support Bill to ensure that people get information on how the care and support system works locally and how people can access care and support, regardless of who pays for their care.

- We will set up a working group with financial services and the care sector to ensure the right information is available to **help people plan ahead for later life** and we will **clarify the tax treatment of disability-linked annuities**.
- We will legislate to transform the support for carers, by **extending the right to a carer's assessment** and provide **an entitlement to public support** for the first time.
- We will publish a framework for **improved integration** between health and care, co-produced with our key partners. We will make available an additional £300 million over 2013/14 and 2014/15 to support local areas to further develop innovative, integrated services that support care and support and benefit people's health and wellbeing.

This progress report sets out Government's analysis of the Commission's recommendations, and maps out the way forward as we continue to work towards further funding reform. Following this report, the Government will continue to engage with the sector, with users and carers, and with the Official Opposition on the detail underpinning the principles of the capped cost model. The content of this report reflects the analysis and further development of the Commission's report, as reflected in the cross-party talks in which Ministers and Official Opposition spokespeople have participated.

2. The need for funding reform

2.1 Care and support in England

Care and support affects most people in England at some point in their lives. More than eight out of ten people aged 65 or over will need some care and support in their later years. 670,000 people in England are affected by dementia today. Even if we don't need care ourselves, most of us will know a family member or friend who does. Almost five million people in England care for a friend or family member – some for more than 50 hours per week.

As healthcare and living standards in our society improve, we are living longer lives and the number of older people in our society is increasing. The Office for National Statistics estimates that by 2030 the number of people aged over 85 will have doubled. As we get older, we are more likely to need care and support. Medical advances also mean that it is now possible for people who develop care needs at a younger age to live long and fulfilling lives.

The number of people who need care and support is therefore growing. We currently spend around 1.1% of our GDP on publicly funded adult care and support. If the system remains unchanged, we would expect this to rise as a result of demographic change: by 2025/26 we would need to spend around 1.25% of our GDP on adult care and support to maintain current levels of access and quality.[1]

This means that it is more important than ever that we have a system that is user-focused, fair and delivers high quality services. One important aspect of the system is the way in which care and support is paid for and how costs are shared between the individual and the state.

2.2 How care and support is currently paid for

The Government currently provides support to care users on a means-tested basis. People who are able to, pay for their own care; others receive financial support from local authorities. The means test looks at the income and assets of individuals.

People with assets of less than £14,250 are not expected to use their assets to pay for care. They pay what they can from income (once the amount of money they need to live on has been taken into account) and their local authority pays the remaining cost.

Those with assets between £14,250 and £23,250 are required to make some contribution beyond their income, but only up to a 'tariff income' based on their wealth. These levels are known as the lower and upper capital limits. Those with assets above £23,250 (including their home for people in residential care) are 'self-funders' and are required to meet all of their own care and support costs. This can mean that they have to use their assets and, in some cases, sell their home to pay for residential care.

1 Estimates based on analysis by the Personal Social Services Research Unit (PSSRU) (DP 2811/2, DP 2800/3); these estimates are on a different basis to those presented in the Office for Budget Responsibility's Fiscal Sustainability Report.

As shown in figure 1, more than half of all care users currently receive some local authority support – although many of these people will also be paying part of the cost themselves. As rates of home ownership among older people are increasing, we would expect a greater proportion to be funding their own care in the future.

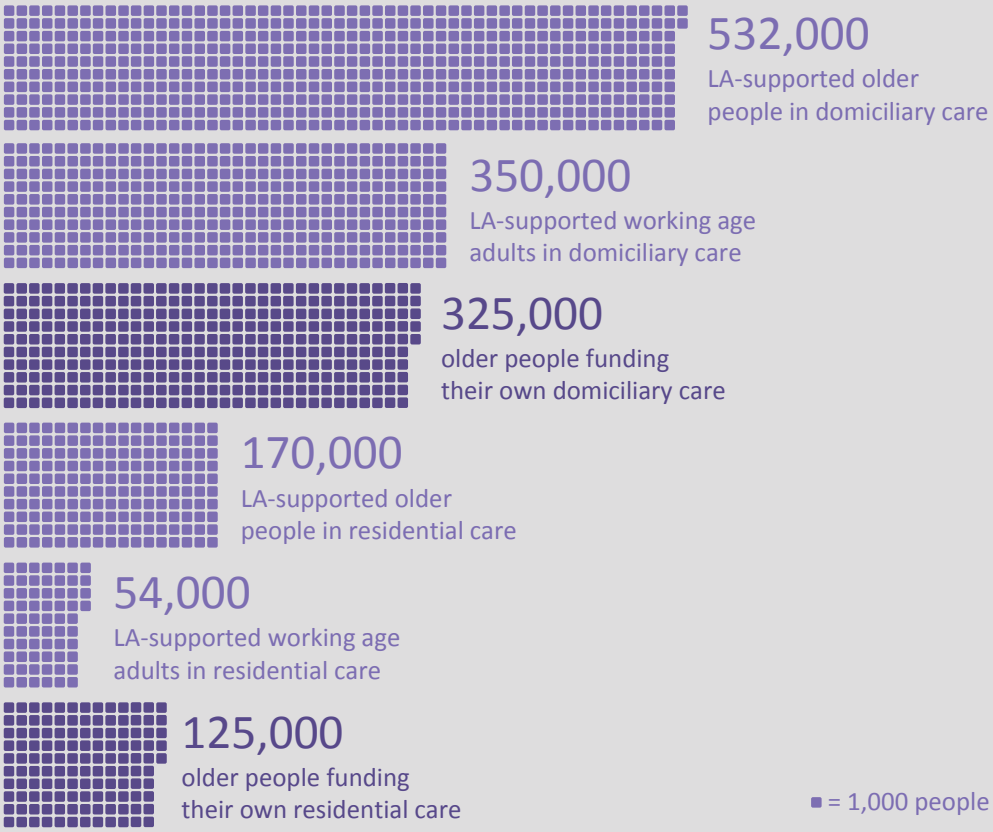
2.3 Why the Commission on Funding of Care and Support was established

Providing support to those who cannot pay for themselves is an essential part of the Government's role in care and support. It is right that our current system aims to ensure that nobody goes without care due to an inability to pay.

However, many people believe that more should be done to help those who fall outside the current means test criteria. Such people have assets that they can use to pay for care, but in some cases this can result in people spending all of their savings and having to sell their home.

The Government has recognised the importance of this issue. The Coalition's programme for government set out the urgency of reforming the system of care and support to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face.[2]

Figure 1: Numbers of local authority (LA)-supported and privately funded older people (65+) and working age adults (18-64) in domiciliary and residential care



Sources: NHS Information Centre, Laing and Buisson; numbers correct at 31 March 2011
* Numbers of privately-funded users are estimates; there are very few working age adults using care and support who do not receive some local authority support

2 HMG, The Coalition: our programme for government, 2010.

In July 2010, the Government established the Commission on Funding of Care and Support to make recommendations on how to achieve an affordable and sustainable funding system for care and support for adults in England.

The Commission was asked to make recommendations on:

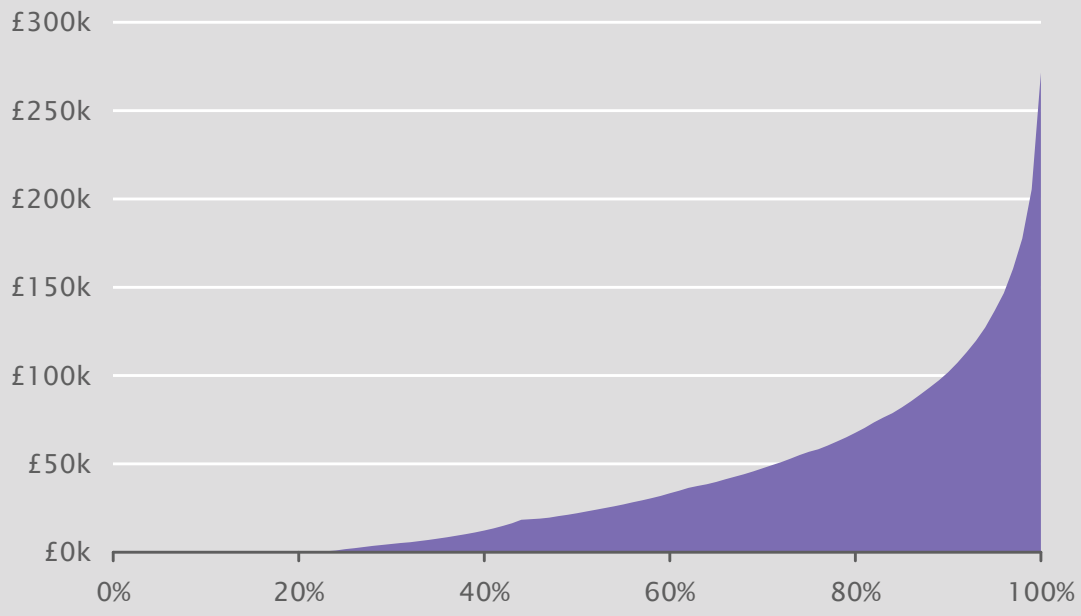
- how best to meet the costs of care and support as a partnership between individuals and the state;
- how people could choose to protect their assets, especially their homes, against the costs of care;
- how, both now and in the future, public funding for the care and support system can be best used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

2.4 The Commission's case for change

The Commission reported in July 2011, setting out its view of the problems with the current care and support funding system and proposing a set of reforms to address these issues.[3]

The Commission viewed the current system as confusing and unfair. It identified the central problem in how people pay for their care and support as a failure of the insurance market, which leaves people facing a potentially catastrophic financial risk against which they cannot insure themselves. This section outlines the main arguments made by the Commission in support of reform.

Figure 2: Percentile distribution of expected lifetime care costs for people currently aged 65 (2009/10 prices)



Source: Fairer Care Funding: Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support

Care costs are unpredictable and can be very high

Care costs vary considerably between individuals. Around a quarter of people will have to spend very little on care, while one in ten will have costs of over £100,000. It is not possible for people to predict what their lifetime costs will be, leaving people facing a significant financial risk. A healthy 65 year old cannot know whether they will go on to develop a mental or physical disability that requires a significant amount of care. Even people with care needs find it difficult to predict whether these will be relatively short or long term.

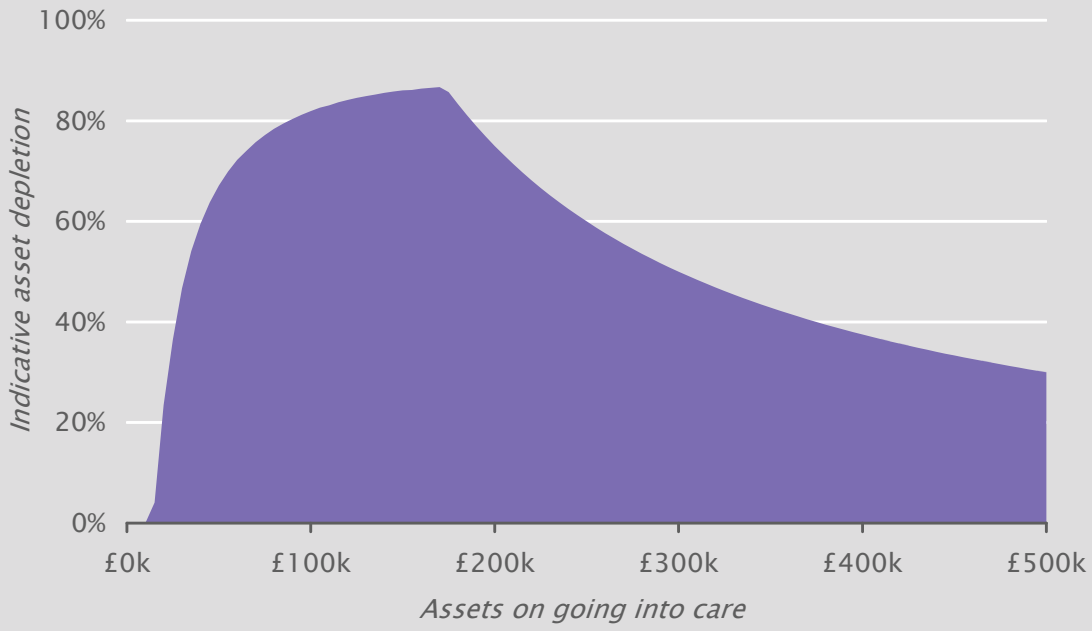
Figure 2 is reproduced from the Commission's report. Based on modelling carried out for the Commission, it shows the distribution of care costs that people currently aged 65 can expect over their lifetimes.

Those with modest assets who go into residential care may have to use the majority of their assets to pay for care

The Commission assessed the financial risk that people face in the current system by looking at the proportion of assets that people could use to pay for care in a hypothetical worst case scenario.

Figure 3, reproduced from the Commission's report, shows the proportion of a person's assets that would be depleted after a long stay (around eight years) in residential care. These costs are manageable for the wealthiest people, while the poorest are protected by the means test; but those with modest assets are at risk of having to spend most of their wealth on care costs. The Commission argued that it is this group that are most in need of protection against high care costs.

Figure 3: Indicative proportion of assets depleted under the current system for someone with very high residential care costs, by initial level of assets on going into care[4]



Source: Fairer Care Funding: Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support

4 This analysis is based on around eight years in residential care, assuming that people buy care at the local authority rate and can pay £10,000 per annum from their income. People who have more expensive care or lower income might deplete a greater proportion of their assets.

Most people who need residential care have limited income and savings, and some have to sell their homes to pay for care. Many people find this inconvenient and distressing to arrange when they use care.

The situation for most people in domiciliary care is different, because costs are not usually as high and people are not expected to use the value of their home to pay for care. However, those in domiciliary care still face the possibility that their needs will increase to the point that they need residential care – so they are still exposed to a significant financial risk.

People cannot protect themselves financially

The Commission argued that in most areas of life where we face a large financial risk we can insure ourselves against it. Healthcare costs can be very high, but we are insured against them by the NHS. Few people could afford to replace their house and possessions in the unlikely event of a serious fire, so we buy insurance to cover the risk. However, the options for someone wishing to protect themselves against the risk of high care and support costs are very limited.

This financial risk may lead to distress, excessive saving or disengagement

The Commission suggested the prospect of high care costs and limited sources of protection is something people find distressing. Many people are unable to protect themselves against these costs and so worry about how they will manage when they develop care needs in later life.

Some people may wish to plan for the worst case. In the absence of insurance, this means trying to save large amounts of money. This could compete with other demands on individuals' resources and lead to a reduction in spending on other things, including low-level care needs, prevention and home adaptations. These arguments are in line with standard economic theory, but there is a lack of empirical evidence about the extent to which people behave like this, and some people may not be sufficiently aware of the risk for this effect to be significant.

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 can either cause people to worry, or to disengage with the issue and fail to plan appropriately.

Public opinion research by Ipsos Mori raises this as a concern for some people. For example, 43% of Londoners are concerned about who will look after them when they are older.[5] However, it also pointed out that many people are unaware of how care and support is funded, or do not think about long-term care at all: "concern about the future is an issue of low salience among the general public".

We know information about what care and support is and how to plan for it is often poor. This could mean that some people worry less about care and support costs, but will also leave them less prepared if they do need care and support.

The current system is inconsistent, complex and difficult to understand

The Commission identified a number of other issues with the system:

- it said there is 'unacceptable variation' in eligibility for services across the country, and noted that different people with similar needs can receive very different levels of support from their local authorities;
- it found that provision of information and advice is poor, that people are unaware of the support and services available to them, and they struggle to find financial information and advice; and,
- it found that the wider care and support system (care and support, the NHS, disability and housing benefits) is not sufficiently joined up, although there are examples of good practice. This can mean some people have a disjointed experience and it can make the system harder to understand.

5 Ipsos Mori Public opinion research on care and support funding, 2011.

3. Stakeholder views on reform

Since the publication of the Commission on Funding of Care and Support's report, the Government has been engaging with stakeholders to understand their views on the priorities for reform and the Commission's proposals. Most notably, the Government conducted the *Caring for our future* engagement from 15 September until 2 December 2011, involving those who receive care services, their carers, local authorities, the care and support sector and financial services. This chapter summarises the stakeholder views we have heard about funding reform since publication.

The *Caring for our future* engagement also looked at the whole range of priorities for reform of care and support. The Government's plans for reform in other areas are set out in the White Paper.

Support for the idea of a cap

The majority of those involved in the engagement supported the Commission's proposals for a cap. For example, The MS Society said:

> *At present people with MS can lose all of their savings and assets in paying for the care and support they rely on to go about their daily lives – the Commission's cap and extended means test would provide a degree of financial protection for people with MS.*

As well as giving people protection against high care costs, stakeholders thought that the cap could have other significant benefits, including helping people to plan and prepare for care and support needs and encouraging prevention.

There was a clear message about the urgency of reforming the system. Groups, such as Mencap, Age UK and the Local Government Association have all commented that the momentum for change should not be ignored, and that this is the opportunity for reform.

Being realistic about what the cap can achieve

However, stakeholders highlighted that it was important to be realistic about what the cap would and would not achieve.

There was a broad consensus that the cap deals convincingly with the issue of high and unpredictable care and support costs. It could help people to understand their responsibilities and plan for future care needs – provided there is also information on how the system works. A cap could also lead to significant behaviour change, such as increasing prevention, but it was recognised that behavioural effects are hard to predict.

However, stakeholders were clear that the cap was not a 'magic wand' for care and support. Though it would bring many benefits, it should not be expected to solve all of the issues with the system, such as variable access to and quality of care, poor access to information and a lack of clear entitlements to support for carers. Many of

these issues were highlighted in the Commission's report.

Stakeholders said that it is important that any reform to the funding system be accompanied by a wider package of reforms. The Care and Support White Paper and draft Care and Support Bill set out the Government's actions to address these wider problems with the system, building on the Prime Minister's Challenge on Dementia launched in March 2012.

The level of the cap

During the engagement stakeholders discussed the appropriate level for a cap. It was generally felt that the bottom of the Commission's range (£25,000) was unrealistic in the current fiscal environment, and that the cap could be set at the top of the Commission's range without undermining the benefits of the system.

The financial services industry said that the level of the cap could be important in creating the right environment for them to offer new products to help people with their care costs. The industry thought that a cap at the top end of the recommended range or higher would be appropriate.

Other stakeholders have suggested that even higher levels of cap (e.g. £75,000) should be considered, recognising that it may be necessary to reduce the cost of reform in order to get a cap in place, which they see as the ultimate goal.

Some stakeholders have also suggested that the system would be fairer if the cap varied depending on a person's wealth, or which part of the country they live in.

Ensuring fairness of reform

Stakeholders recognised the value of the Commission's proposal for the extension to the means test as a way of ensuring that those homeowners with modest wealth get greatest protection. This maintains the current system's focus on the poorest in society.

In spite of this, stakeholders also highlighted that the cap in particular increases spending on the better-off, as public funds are used to protect more of their wealth than under current arrangements. Therefore, it has been suggested that those who gain the most from reform should be asked to pay the most.

Ensuring the system is adequately funded

Stakeholders highlighted that one of the most important priorities for care and support should be to ensure that the system is adequately funded so that it can continue to meet people's needs despite demographic pressure. Parkinson's UK was one of many organisations that noted:

> *Additional funding from the Government is required to sustain care and support in the future in order to meet the needs of an ageing population.*

There was a strong message that, whatever funding system the Government chooses to implement, it is essential that it is properly funded.

Universal deferred payments

Stakeholders agreed that universal deferred payments would give people additional choices and flexibility in meeting their care costs and there was strong support for this policy.

Creating a market for financial services

One strand of the engagement focused on the financial services industry, since the Commission suggested that its model would lead to increased involvement from this sector. The group looking at financial services in the engagement supported this view and felt that the introduction of a cap would provide an opportunity to offer a range of

products to help people to plan for their share of costs before they reach the cap, or top up the local authority package afterwards. They reported:

> *There is strong support for capping care costs. This would provide a major opportunity for behaviour change and to inform a[illegible] people. It would facilitate [illegible] of financial products.*

4. The Commission's recommendations and how the Government is responding

The Commission made a number of proposals for reforming the way in which people pay for their care and support, and on how the system supports people to use services and to plan and prepare.

The Government is committing to implement many of the Commission's recommendations and has already taken action.

- We have allocated an additional £7.2 billion to adult care and support over this Spending Review period.
- We will introduce universal deferred payments from April 2015, so that nobody will be forced to sell their home in their (or their spouse's) lifetime.
- We will introduce a national minimum eligibility threshold to help remove variation in access to care depending on where people live.
- The reforms announced in the White Paper include legislating to address portability, and for improved support for carers and integration of services.
- We will help people to plan and prepare, and remove barriers to financial services.

4.1 A capped cost scheme and extended means test

The Commission recommended that the Government should provide people with protection against the risk of high care costs through a combination of capping the amount that people have to spend on care in their lifetimes, and extending the means test threshold for residential care so that more people can benefit from means-tested support. This included the principle that people should pay 'living costs' in residential care.

We agree that the principles of the Commission's model – financial protection through capped costs and an extended means test – would be the right basis for any new funding model.

Chapter 5 of this report discusses these recommendations in more detail, analyses their costs and benefits, and discusses some of the key considerations.

4.2 Additional resources for care and support

In this letter to the Government in September 2010, ahead of the last Spending Review, Andrew Dilnot urged the Government to reprioritise resources in the short-term to support the current system as much as possible over the next few years.

The Government responded quickly and with purpose. In the Spending Review, we recognised the pressures on the adult care and support system within a challenging settlement for local government, and took the decision to **prioritise adult care and support by allocating an additional £7.2 billion** to the system over the four years to 2014/15 to support local authorities in delivering care.

Since then, we have allocated an additional £300 million over two years and the White Paper announces further support in the years ahead.

4.3 Universal deferred payments for residential care

The Commission recommended that deferred payments should be available to anyone who is unable to afford care charges without selling their home.

Around 40,000 people sell their homes to pay for care each year.[6] The majority of sales involve people with insufficient income and savings to fund their care without using housing assets.

For the first 12-week period when someone enters residential care, housing wealth is disregarded from means testing.[7] This protects housing wealth during transition into care and allows people to commence selling the home. However, a sale can be difficult to arrange in this timeframe. It can also be stressful when people are vulnerable and adapting to a change in lifestyle. Furthermore, many people would prefer to keep their home for practical, financial or emotional reasons.

Deferred payments are available in some local authorities and allow people to defer their fees, paying either on their death or once they sell the home. However, we know there are parts of the country where people face difficult decisions because their authority does not offer deferred payments, or they are hard to obtain.

The Commission therefore recommended extending the current discretionary system to a full national offer.

We accept this recommendation. Deferred payments will be available in all local authorities from April 2015 and the necessary powers are included in the draft Care and Support Bill, published today.

What this means

No one will have to sell their home in their own (or spouse's) lifetime to pay for residential care. People that cannot afford reasonable residential care charges without selling their home will have the choice to defer the fees until they are ready to sell.

We think this will have a range of benefits, preventing 'distressed' housing sales and providing convenience, choice and peace of mind.

We will introduce a universal scheme, available in all authorities from April 2015, using new powers set out in the draft Care and Support Bill, subject to parliamentary agreement. This will mean that deferred payments come into force as part of the new care and support statute.

The Commission recommended deferred payments should be run on a cost-neutral basis to the Government, by charging interest so that authorities can recover their costs. Currently authorities cannot do this, making it harder for them to offer deferred payments. We agree that interest or charges should apply and the draft Bill will allow this.

In 2013 and 2014, we will work with the care sector on how the scheme would work, including exactly when someone should be eligible and what interest or charges would be appropriate. We will fund local authorities for this new requirement.

6 There is uncertainty around the number of people who sell their homes to pay for care; however, evidence from Hamnett (1995, 1997) and Department of Health (2005) suggests this figure may be between 30,000 and 40,000 people per year. Henwood (2006) summarises a number of sources and notes that *"it would seem reasonable to conclude that the number of homes sold each year to pay for care probably is somewhere in the region of 40,000"*.

7 Only housing wealth is exempt; people still use income and savings over £23,250 to pay for care. From the 13th week, housing wealth is also taken into account.

4.4 Eligibility and assessment

The Commission recommended that the level of need at which people become eligible for care and support should be set nationally to create a clearer, fairer and more coherent system for the public.

We accept this recommendation. The White Paper announces that for the first time, the Government will introduce a **national minimum eligibility threshold** to help remove variation in access to care depending on where people live. The draft Care and Support Bill provides for this. The White Paper makes clear that, given the commitment to a national threshold, and the funding in this Spending Review, there should be no need for local authorities to tighten current eligibility thresholds. The national minimum threshold will be in place from April 2015.

The Commission also recommended **improving the assessment process** that identifies people's level of need and eligibility for services. It notes that people in very similar circumstances can be treated very differently and that this can seem unfair and confusing.

We are committing to undertake work to develop and test options for a potential new assessment and eligibility framework. This will look at the role of assessment in the system to develop options which will seek to provide both local authorities and individuals with a clear view of the skills, talents and goals of people seeking to access support.

During the *Caring for our future* engagement, the financial services industry also made clear that the national eligibility threshold announced in the White Paper will make it easier for people to plan and prepare.

4.5 Helping people plan and prepare

The Commission argued that people need better information and support to understand the care and support system and the options available to them, and to plan and prepare for their care costs. It recommended that the Government develop a major new information and advice strategy to help when care needs arise.

We accept this recommendation. The White Paper sets out how we will take this forward by developing a new information offer for care and support.

This incorporates the Commission's proposals in this area. We have committed to providing, for the first time, a **clear, universal and authoritative source of national information about the health, care and support system.** We are also legislating to ensure that people get information on how the care and support system works locally and how people can access care and support, regardless of who pays for their care in the draft Care and Support Bill.

The Commission made a number of related recommendations to remove barriers that currently make it difficult for the financial services industry to offer products that help people with their care costs.

We will set up an **expert working group** involving the Government, the financial services sector, local authorities and the care sector to support development of the information offer. The group will explore how the sector as a whole can contribute, and make links with pensions, benefits, wider services and specialist financial advice to ensure the offer is comprehensive.

We will clarify the **tax treatment of disability-linked annuities** as the Commission and some in the financial services sector felt that it is currently unclear. HMRC has worked with the Association of British Insurers to clarify the rules and will publish an update to its guidance by September.

4.6 Reforming care and support

The Commission made recommendations about how to improve the care and support system more generally. We have considered these as part of our wider programme of reform for care and support, and the White Paper, published alongside this report, takes forward these recommendations in three key areas.

Portability: The Commission recommended care assessments should be portable so that people can move more easily between local authorities. The White Paper announces that when people move local authority area, for instance to take up work or move closer to their family, they will have continuity in their care and support. The draft Care and Support Bill provides for a duty on local authorities to ensure this. A duty will also be placed on local authorities to ensure that they share information to make the move as seamless as possible. This will break down the major barrier to portability.

Carers: The Commission recommended that the Government take forward the recommendations that the Law Commission made to extend and increase the legal rights of carers. We accept these recommendations, and the White Paper sets out how we will take this forward, to give carers the rights that they deserve.

Integration: The Commission recommended that the Government review the scope for improving the integration of adult care and support with other services in the wider care and support system. The Care and Support White Paper sets out the steps we are taking in this area. This includes clear duties in the Health and Social Care Act and the draft Care and Support Bill requiring the NHS and local authorities to co-operate and provide integrated services.

5. The principles of funding reform

5.1 Key principles of the Commission's capped cost model

The Commission's central proposals for funding reform are based on three key principles.

A cap on care costs

The Commission characterised care and support funding as an insurance problem: many people have low or no care costs, while a few have very high costs; and the costs can be high enough that some people use up nearly all of their assets paying for care. These costs are unpredictable.

An important principle of the Commission's recommendations is that the most efficient way to address this issue is to cap people's care costs. Under the Commission's proposals, local authorities would assess everyone's care needs and work out how much it would cost to meet those needs at the local authority rate. Once these needs had reached a cumulative value of £25,000-£50,000 for older people, or a lower level for people who develop a care need before the age of 65, people would become eligible for state support.

So, people with wealth – including housing assets – would be responsible for paying for their care, as now. But that responsibility would no longer be unlimited, as the cap would protect people from the risk of very high costs.

As discussed earlier in this report, stakeholders support the idea of a cap. There was discussion of the level of the cap, with some people suggesting that a cap could be set at the top of the Commission's range – or even slightly higher (e.g. at £75,000) – without undermining the principles of the system.

An extended means test for residential care

A second important principle of the Commission's recommendations is that the current means-tested system should be retained and extended, to ensure that those who are less able to afford to fund their own care get additional support.

As described earlier in this report, the current means test offers support to people with assets of less than £23,250; the Commission recommended that this should be extended to £100,000 for people in residential care. As now, the maximum that an individual would contribute would depend on their income (minus what they need to live on) and a 'tariff income' based on their assets. This would mean that many more people of low and moderate wealth would have access to the means test and have some of their care costs met by the state. Less wealthy people would therefore spend less than the full value of the cap over their lifetimes (as illustrated in figure 4).

Figure 4: Indicative lifetime spend on care under the current system and different levels of cap (with extended means test) for someone with very high residential care costs, by initial level of assets on going into care[8]

Initial assets	Current System	Level of cap £25,000	£35,000	£50,000	£75,000	£100,000
£200,000	£150,000	£25,000	£35,000	£50,000	£75,000	£100,000
£150,000	£129,000	£25,000	£35,000	£50,000	£72,000	£88,000
£100,000	£82,000	£22,000	£28,000	£38,000	£50,000	£59,000
£70,000	£53,000	£14,000	£18,000	£25,000	£32,000	£38,000
£50,000	£34,000	£9,000	£12,000	£16,000	£21,000	£25,000
£40,000	£24,000	£7,000	£9,000	£11,000	£15,000	£18,000
£14,250 or less	£0	£0	£0	£0	£0	£0

Source: Department of Health analysis.

People in residential care should make a contribution towards their living costs

The Commission recommended that the cap should exclude 'general living costs' for people in residential care, to reflect the costs that people would have to meet if they were living at home (such as food and accommodation). This principle is important to create a level playing field between care settings and prevent people who reach the cap having a financial incentive to go into residential care. The Commission proposed that people be asked to make a fixed contribution towards these costs of between £7,000 and £10,000 each year.

The upper end of this range was based on the median income for older people. This means that, depending on the level at which the contribution towards living costs is set, up to half of all older people will be unable to meet these from income alone and may have to deplete savings or other assets as a result. Alternative approaches could be considered to avoid this, but these may have an additional cost to the Government.

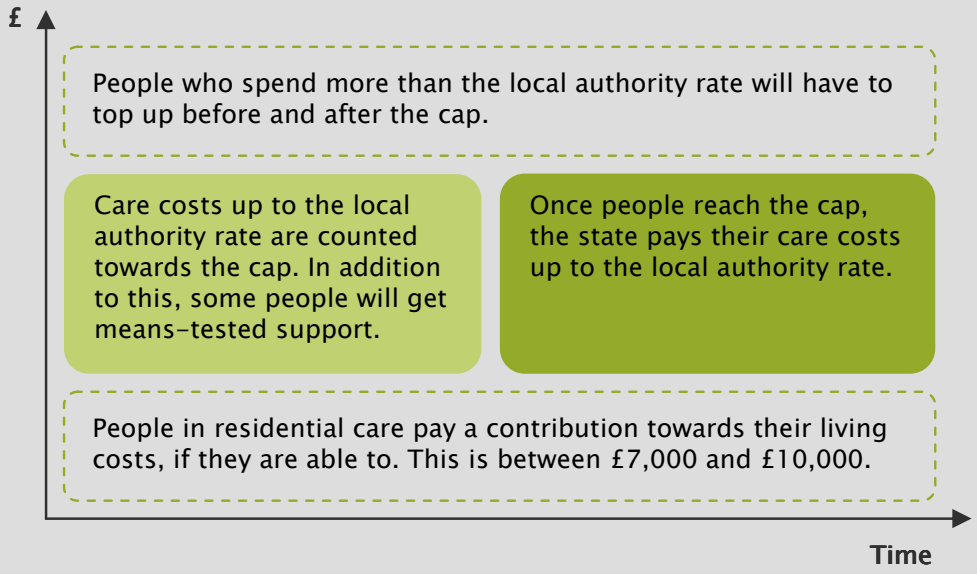
8 This analysis is based on around eight years in residential care, costing £150,000 (plus £10,000 per annum general living costs). It assumes that people buy their care at the local authority rate – someone paying a higher rate for their care could spend more over their lifetime; and that they can pay £10,000 per annum living costs from their income – estimates would be different for people with higher or lower income.

What the cap does and does not cover

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

Figure 5 illustrates which costs are covered by the cap and which are not, for someone in residential care. The cap covers care costs, but excludes a contribution towards living costs of £7,000-£10,000 for those in residential care, and any spending above the local authority rate.

Figure 5: Costs included and excluded from the cap



5.2 How these principles could be implemented

The Government agrees that these principles would be the right basis for any new funding model. Whilst we support the principles of the approach recommended by the Commission, and it is our intention to base a new funding model on them if a way to pay for this can be found, there remain a number of important questions and trade-offs to be considered about how those principles could be applied to any reformed system. These have particular significance given the size of the structural deficit and the economic situation we face. The Government will work with stakeholders and the Official Opposition to consider the various options for what shape a reformed system could take, based on the principles of the Commission's model, before coming to a final view in the next Spending Review.

There are a number of areas that require further work before a final decision can be made on funding reform. The most important of these are outlined below, and some are explored in more detail in the next chapter of this report.

Implementing the principles in an affordable and sustainable way

Given the fiscal situation, it is important the Government can apply the principles in a way that is consistent with public expenditure constraints. Therefore, as well as exploring the range of options within the parameters set out in the Commission's report, the Government believes that further options should be explored. We will look at how reform consistent with the principles of the Commission's model can be implemented, but at a lower cost to the public purse. Options could include setting a cap higher than the range proposed by the Commission, and options that allow people to make a choice about whether to have financial protection, so they could themselves weigh up the benefit against the cost. We would welcome the views of stakeholders on these or other options.

The level of the cap

The Commission recommended that people care costs should be capped at a level between £25,000 and £50,000. They also recommended the cap for working age adults should be lower than the level set for older adults and those turning 18 with care needs should receive free care. The Commission believed that a cap within the given range would make the scheme affordable to the Government, give people a realistic amount to plan for and allow the financial services industry to offer products to help people with this planning.

However, some stakeholders and commentators have suggested that a cap set at a higher level could deliver similar benefits. For example, through the *Caring for our future* engagement, the financial services industry told us that the most appropriate level for the cap would be at the top of the Commission's range or slightly higher. Others recognised, given the fiscal circumstances, that a higher cap could provide a more affordable way to implement reform consistent with the principles of the Commission's model.

We will continue to work with stakeholders to consider what the most appropriate level for a cap would be – balancing financial protection for care users, the cost of reform and creating a space for financial services.

The Commission recommended that people who enter adulthood with eligible care needs should be entitled to state support, and that other working age adults with care needs should have a lower cap than older people. However, the Commission did not make specific recommendations about the level of the cap for working age adults. Further work is required to determine the most appropriate level for people of different ages.

The level of the means test threshold

The Commission recommended that the upper threshold of the current means test for residential care should be raised to £100,000 to give more support to less wealthy people. However, it would be possible to set this threshold at a different level. This would affect the level of protection that less wealthy people get, and the cost of the scheme.

Opt-in and opt-out approaches

Many of the people that we spoke to throughout the engagement highlighted the importance of the people who gain the most from the cap meeting the cost – particularly as it will increase public spending on wealthier older people. One approach would be to implement a voluntary scheme which people could opt into or out of. People could individually make the choice to be protected by the capped cost scheme – and only people that opt in would pay the cost. We will work with stakeholders to investigate voluntary as well as universal approaches.

Implementing the principles in a clear and fair way

There are a number of other important questions that have a significant bearing on how well the offer is understood, how the system would operate, how much it would cost and how it would be implemented at transition.

How the cap would rise over time

In order that each generation gets an equal offer from the state, the Commission suggested that a cap on care costs would have to rise over time. This is for three reasons: firstly, inflation means that if the cap were held constant in cash terms it would reduce (and become more generous) in real terms; secondly, the population generally becomes wealthier over time, so it is reasonable to expect people to pay more; and thirdly, it is essential to ensure that the system is financially sustainable, particularly with an ageing population. It is important that individuals understand that the cap will rise, so that they are aware of how much of the cost of their care and support is their responsibility and can plan accordingly.

The Commission recommended that the cap rise in line with the state pension, which is currently protected by a triple-lock: it will increase in line with earnings, prices or at 2.5% per annum – whichever is the highest. This would broadly keep an older person's share of care costs equally affordable over time. As care and support costs consist largely of wages, which would rise at a similar rate, the amount of care and support that an individual is responsible for funding would also remain roughly constant.

By the same rationale, the Commission assumed the other parameters of the care and support system, such as the means test capital limits and general living costs for those in residential care, would rise at the same rate. This is illustrated in figure 6.

The Commission's modelling – and the modelling in this report – has assumed that the cap would continue to rise for people who have made some progress towards it. The amount that they had left to pay before they reach the cap would increase in line with the state pension, so that the *proportional* progress that people had made towards the cap would stay the same. There are advantages and disadvantages to this approach.

Uprating the amount that people have left to pay ensures that the cap is equally affordable to people who accrue costs at a different rate. If this remainder were not uprated, people who accrue costs more slowly would benefit as their remaining liability devalued over time and their income increased, while those who accrued costs faster would not.

However, this makes the system more complicated for people to understand and they will not know the exact value of their responsibility when they start paying for care. The greater simplicity of setting the cap in cash terms when people enter care would need to be weighed against the greater fairness of allowing it to rise. It should also be noted that fixing the cap when people enter care would increase costs above those presented in the next section.

Figure 6: Nominal value of a £35,000 cap over time, and related income and expenditure amounts, assuming that it rises in line with the state pension[9]

	Basic state pension per week	Residential care cost per week	Cap	Equivalent weeks in a care home	Equivalent weeks of state pension	Lower capital limit	Upper capital limit	Living costs in res care
2010/11	£102	£350	£35,000	100	343	£14,250	£100,000	£10,000
2015/16	£116	£398	£39,797	100	343	£16,203	£113,705	£11,371
2020/21	£145	£496	£49,594	100	343	£20,192	£141,697	£14,170
2025/26	£180	£618	£61,803	100	343	£25,163	£176,580	£17,658

Source: Department of Health analysis.

9 This analysis uses the latest HM Treasury GDP deflator figures and assumes a long-term inflation rate of 2.5%; care costs and the state pension are assumed to remain constant in real terms until 2014/15, then rise at 2% real per annum.

Transition to the new system

When the scheme is introduced, a particular transition issue is whether it should look back at the care people have already received and count this towards the cap. Alternatively, the system could only count care from introduction of the scheme. There is rationale for either choice.

Retrospectively counting care costs might be seen as fairer to those who have spent money on care before the cap was introduced. However, it would be difficult to count this accurately, and where someone has been receiving care outside the local authority system, it would be difficult to determine retrospectively whether this care was eligible according to local authority criteria. This could undermine the perception of fairness. Moreover, this would be a difficult and bureaucratic exercise.

Starting counting from zero at implementation would be a far simpler approach. Although it might seem unfair on those who have already spent £25,000-£50,000 on care to ask them to start again from zero, it would ensure that care costs were counted consistently for everyone and avoid significant extra bureaucratic work.

Other issues

There will also be a number of other important issues to resolve in relation to how a system based on the principles of the Commission would work. For example, there will be cross-border issues for people who move between England and Scotland, Wales or Northern Ireland, where the systems will be different. We will need to consider whether and how a capped cost system could follow an individual from England to another devolved administration.

6. The benefits and costs of the Commission's model

6.1 The benefits of a capped cost model

The benefits of insurance and peace of mind

The benefits of insurance are well established in economic theory.[10] When people face a large financial risk, they will want to do something to protect themselves. For most people, it is not possible to save enough money to cover a large financial risk such as the cost of care and support, so they will benefit from being able to pool this risk with others – either through private insurance or via the state.

This theory is borne out in practice. Typically, insurance costs more than it is expected to pay out, because premiums also need to cover administration costs, profits and the accumulation of reserves. The fact that people are still willing to buy insurance in many areas of their lives indicates that they are deriving an additional benefit over and above the payout that they expect. This benefit is often thought of as peace of mind.

Asset protection

A capped cost model allows people to pool the risk of high care and support costs via the state. It places a limit on the amount that an individual will spend on care over their lifetime, if they buy their care at the local authority rate and can afford living costs from their income. This significantly reduces the financial risk that people face. The Commission estimated that, while under the current system people who go into residential care for a long time could see up to 85% of their assets spent on care costs, a cap of £25,000-£50,000 limits this to 20%-40%. Figure 7, reproduced from the Commission's report, illustrates the effect of a cap within the Commission's recommended range, with the means test upper capital limit extended to £100,000.

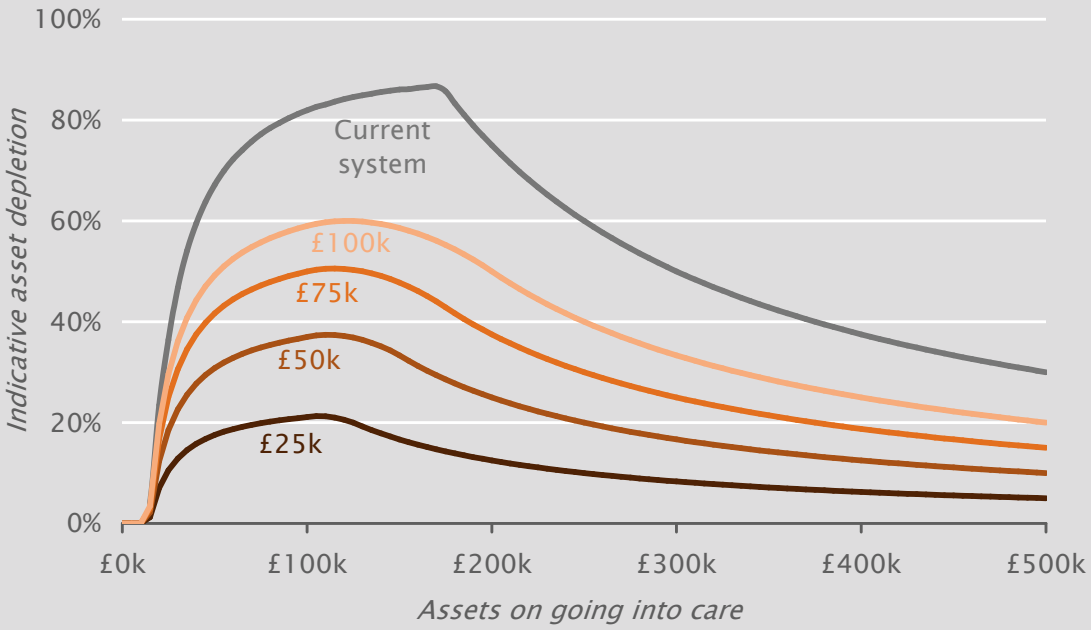
The level of asset protection that people get from this type of scheme will depend on the level of the cap: the lower the cap, the greater the protection. Figure 8 shows the indicative level of asset protection that people have under different levels of the cap as recommended by the Commission compared to the current system. For cap levels up to around £75,000, people will not have to use more than 50% of their assets paying for residential care, provided they buy care at the local authority rate and pay living costs from their income.

The limits of asset protection

This analysis does not count any expenditure by individuals beyond the care package recommended by the local authority. People who spend more than the agreed amount could deplete their assets further than set out above. However, it is not reasonable for the state to cover all of a person's expenditure without some limit or conditions, so this caveat will apply to any scheme.

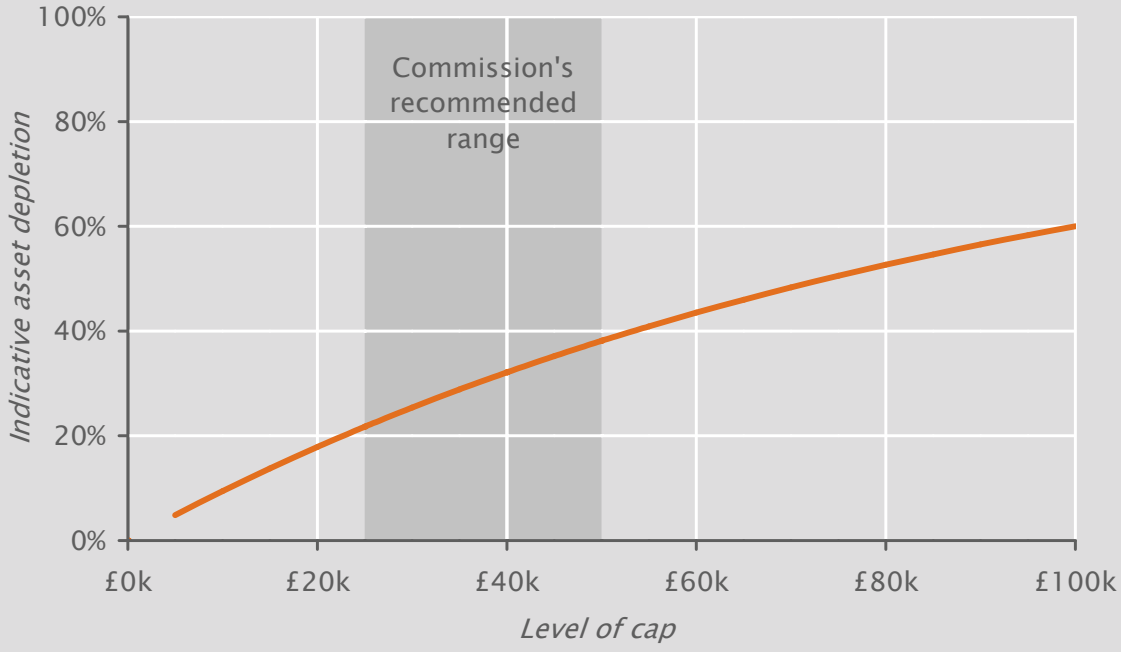
10 For a summary see Barr. N, Economics of the Welfare State, 2004.

Figure 7: Indicative proportion of assets depleted under the current system and different levels of cap (with extended means test) for someone with very high residential care costs, by initial level of assets on going into care[11]



Source: Department of Health analysis.

Figure 8: Indicative proportion of assets depleted under different levels of cap (with extended means test) for someone with very high residential care costs[12]



Source: Department of Health analysis.

11 This analysis is based on around eight years in residential care, costing £150,000 (plus £10,000 per annum general living costs). It assumes that people buy their care at the local authority rate – someone paying a higher rate for their care could spend more over their lifetime; and that they can pay £10,000 per annum living costs from their income – estimates would be different for people with higher or lower income.

12 Ibid.

The analysis also assumes that care home residents can afford to make their contribution towards living costs from their income. However, depending on the chosen level for general living costs, many people might not be able to fund them from income alone and so could end up depleting a greater proportion of their assets. Further work is needed to establish how big an impact this could have, and to identify alternative approaches to mitigate this impact if necessary.

Quantifying the benefit

Insurance benefits are difficult to quantify. It is hard to say how much peace of mind people get from moving from a situation where they might have to use 85% of their assets on care to one where they will not have to use more than 30%, 40% or 50%.

We can broadly identify the groups that would benefit the most from a cap and the increased peace of mind that would accompany it. These include women, since they have a higher than average life-time cost of care than men, and people with long-term conditions developed before late old age who also face above average life-time care costs.

The other group most likely to benefit is those for whom high care costs have the greatest impact in the current system. The Commission's analysis, shown in figure 7, shows that people with assets of between £50,000 and £200,000 can end up using the highest proportion of their assets for care in the current system, and see the greatest improvement in this risk when the cap is introduced. This is the wealth group most in need of insurance, so we expect this group to gain the most in terms of peace of mind.

Behavioural effects

The Commission argued that there could be a number of positive behavioural effects associated with introducing a cap.

- *Reducing unmet need*
  A cap on care costs may encourage people to start spending on their care when they need it, since they do not fear having to use all of their assets to pay for care.
- *Increased preventive action*
  Similarly, if people are willing to start spending earlier, they are more likely to use preventive services. Better information and advice, resulting from more people coming into contact with their local authority, would also make people more aware of their options and the benefits of preventing a care and support need from worsening.
- *Better planning and preparing*
  Individuals currently have limited opportunities to financially plan for care costs, because costs can be very high, there are few options for them to protect themselves and some people believe that care and support is free, like the NHS. The Commission argued that by giving people a realistic amount to plan for, and better information and advice about their responsibilities and options, we can incentivise people to make better preparations for care and support needs.
- *Reduced gaming of the system*
  There are large incentives in the current system for people who would otherwise fall outside the means test to hide their assets to gain access to state support. Limiting the amount that people have to spend on care costs would reduce this incentive and make it more likely that people will pay their fair share of their care costs.

These benefits are supported by economic theory, and stakeholders involved in the *Caring for our future* engagement supported the Commission's view that they could be important. However, as stakeholders recognised, there is significant uncertainty around behavioural effects and little evidence about the extent to which they would occur.

A market for financial services

The capped cost model would leave a significant proportion of costs as the responsibility of the individual. People who can afford to would have to pay all of their costs before the cap and continue to pay living costs after the cap. Those spending more on care than the local authority rate will also need to top up the state package afterwards. The Commission argued that its

model would encourage the growth of a market in financial services to help people pay their share of the costs.

This claim has been tested with the financial services sector through the Government's *Caring for our future* engagement. The sector supported the idea of a cap and thought that, if it were implemented, new types of pensions, insurance and equity release products could emerge.

The sector thought that the level of cap would be important in terms of implications for the market. A cap of £50,000 or slightly higher would leave people with a realistic amount to plan for while creating incentives to save and demand for financial products.

The sector also made it clear that it would also be essential that people understood what the state would cover and what they would be responsible for. In particular, they would need to understand that living costs in residential care and any costs above the local authority rate would be their responsibility, and something for which they should plan.

The assessment and process of monitoring when people reach the cap would also bring self-funders into contact with the care and support system. The sector thought that this would create opportunities to inform people about their financial options and encourage planning and preparing.

Better information and advice

Although the current system gives everyone a right to a local authority assessment of their care needs, many people with care and support needs, who are not eligible for financial support do not make contact with their local authority. The introduction of a cap would provide a significant incentive for people to come forward and be assessed, as this would allow their care to count towards the cap.

This would increase the opportunities for local authorities to provide information and advice to individuals who are currently outside of the support network. More informed care users should make better choices about their care, leading to better outcomes for them and driving improvements in the care market.

6.2 The cost of reform

The Commission provided estimates that its proposals would cost £2.2 billion in 2015/16, and that demographic pressure would mean that this would increase to £3.6 billion by 2025/26 (2010/11 prices).

This estimate relates to the Commission's base case, which comprises:

- a cap set at £35,000 for older people;
- a contribution of £10,000 per annum towards general living costs by people in residential care;
- an extended means test for residential care, with the upper capital limit raised to £100,000; and
- free care for those who develop a care need before the age of 40, and a lower cap for those developing a care need aged 40-64.

These cost estimates include the additional cost of services, the cost of providing an increased number of assessments and the savings generated through reduced disability benefit payments, since people receiving state-funded residential care are not eligible for some disability benefits. The Commission used the cost of free care as an upper bound for the cost of working age adults' services, as more detailed modelling was not available.

This section looks in more detail at the costs of the Commission's recommendations. It looks at the overall cost of different packages of reform within the Commission's recommended ranges; how these costs change over time; different options for implementing the system; and the effect of changing system parameters. Finally, it analyses the distributional impact of the capped cost scheme.

Our assessment of the costs of reform

How we have modelled these costs

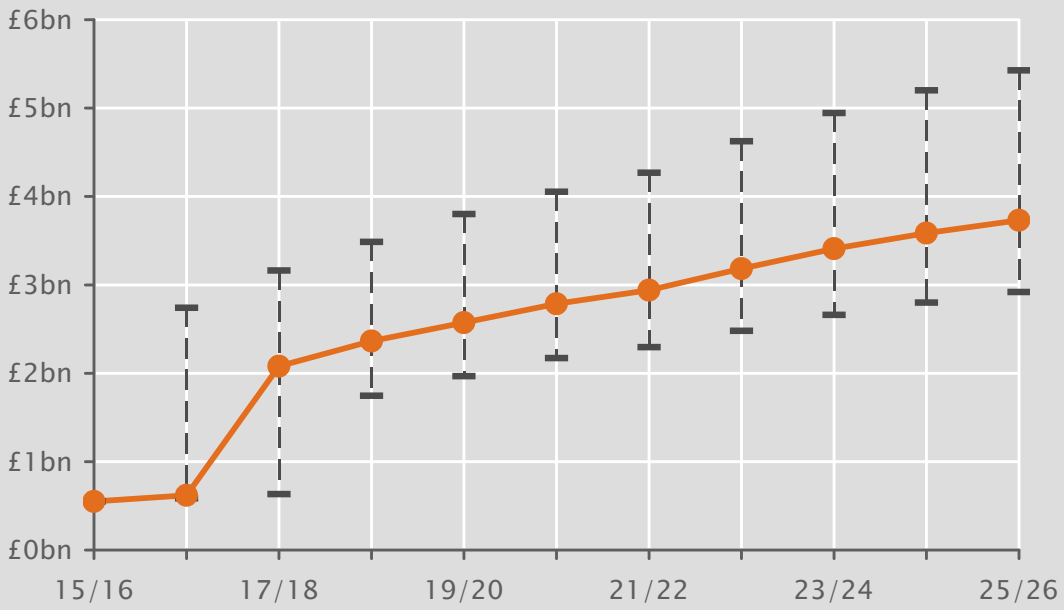
The costs presented here have been produced by the Department of Health, using a micro-simulation model developed internally. This is not the same model used by the Commission, so results will not match exactly those in the Commission's report.[13]

There are also some other difference in the analysis and assumptions used, including:

- a different baseline for projecting future costs – we have used the latest baseline estimates published by PSSRU;[14]
- we have used 2012/13 prices – although for simplicity we have still referred to a '£25,000-£50,000 cap', which is in 2010/11 prices;
- we have produced revised estimates for working age adults, assessment costs and disability benefit savings; and
- we have used a different methodology for the distributional analysis, looking at a cross-section of the population rather than lifetime costs.

For illustrative purposes, we have assumed that a capped cost model would be implemented in 2015/16.

Figure 9: Costs of central Commission proposal, and most and least expensive variants within its recommended range (2012/13 prices)[15]



Sources: Department of Health analysis; PSSRU modelling of working age adults costs
Central variant based on a £35,000 cap with £10,000 living costs; lower variant based on a £50,000 cap with £10,000 living costs; upper variant based on a £25,000 cap with £7,000 living costs. All include £100,000 upper capital limit.

13 The DH model uses data from the English Longitudinal Survey of Ageing and data from the Information Centre for Health and Social Care. While it has been produced using good data and detailed methods, and thoroughly quality assured against other models of the care and support system, its findings should be treated with some caution. It is impossible to be certain about future care pathways and future durations of receipt of different care packages, so there is some uncertainty in all projections of future care and support costs.

14 Personal Social Services Research Unit Discussion papers 2811/2 and 2800/3.

15 These estimates – and all other cost estimates in this paper – assume that the cap is uprated in line with the state pension, as discussed in section 5.2. Costs include care and support for older people and working age adults, the cost of providing additional assessments and savings to disability benefits.

Headline costs

Figure 9 shows our estimates of the cost of the capped cost scheme according to the Commission's proposals, and how these costs change over time, for the central Commission proposal and the most and least expensive variants within the Commission's recommended range.

These costs are for both older people and working age adults, and include the cost of additional assessments and savings from reduced disability benefit payments.

Implementation options

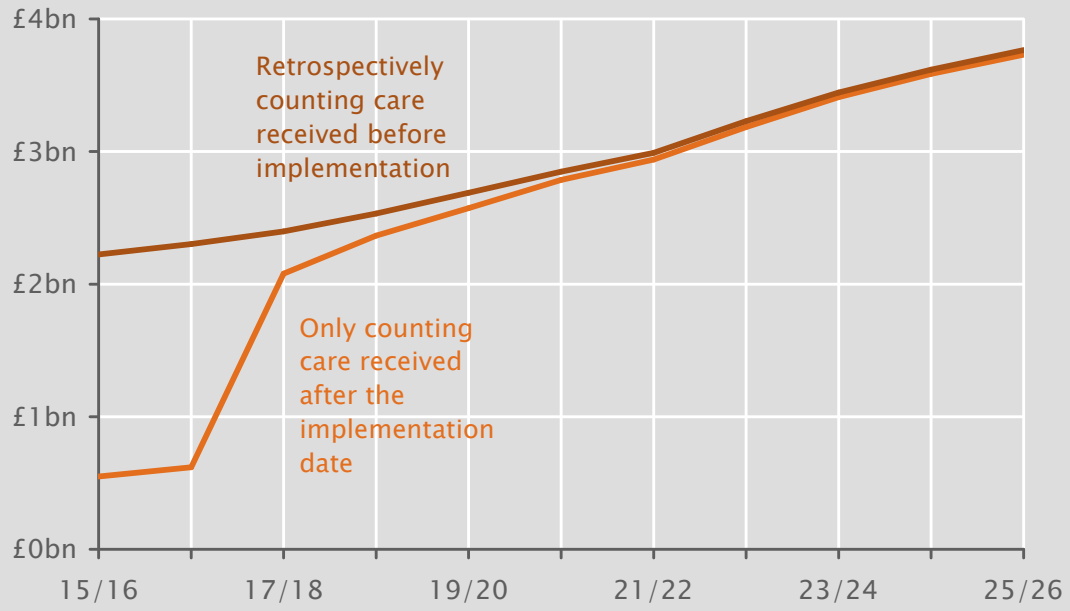
The costs presented in figure 9 assume that the scheme is implemented in April 2015 and that care received before this date is not counted towards the cap. This means that the cost of the scheme is relatively low in the first few years after implementation. As discussed in section 5.2, it would also be possible to include these costs retrospectively. Figure 10 illustrates that this approach would increase costs in the first few years of implementation.

It would, however, be technically difficult to count care costs retrospectively, and hard to do so accurately and fairly. Therefore, the costs elsewhere in this report assume that only care received after the implementation date would count towards the cap.

The impact of changing the level of the cap and general living costs

Figure 9 looks at the costs of a cap within the Commission's recommended range. However, as discussed above, some stakeholders and commentators have suggested that a cap set at a higher level could deliver similar benefits while being more affordable to the Government.

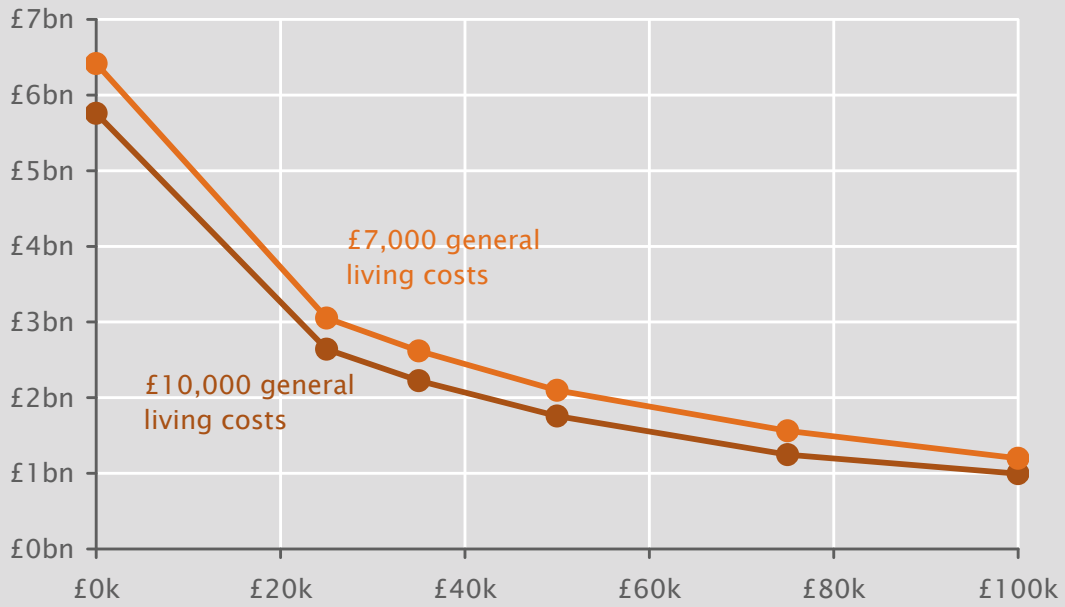
Figure 10: The cost of a £35,000 cap and £100,000 upper capital limit with £10,000 living costs, under different implementation assumptions (2012/13 prices)[16]



Source: Department of Health analysis; PSSRU modelling of working age adults

16 Costs include care and support for older people and working age adults, the cost of providing additional assessments and savings to disability benefits.

Figure 11: The effect of changing the level of the cap and general living costs on the cost to the Government of reform in 2015/16 (2012/13 prices, steady state estimates)[17]



Sources: Department of Health analysis; PSSRU modelling of working age adults costs
Costs are for a scheme that is fully implemented in 2015/16 and include raising the upper capital limit to £100,000.

Figure 11 shows how the level of the cap and the contribution that people in residential care are asked to make towards their general living costs affect the cost to the Government of reform. As would be expected, a higher cap or a higher contribution towards living costs make reform less expensive to the Government – and increase the proportion of costs that individuals have to meet themselves.

Detailed breakdown of costs

Figure 12 gives a detailed breakdown of the cost of reform across the Commission's recommended range of parameters, and for higher levels of the cap.

As set out in section 2.1, we currently spend around 1.1% of our GDP on publicly funded adult care and support.[18] In the absence of funding reform, this would rise to around 1.25% by 2025/26.

The Commission's proposals could increase public expenditure on care and support in 2025/26 by between around 0.15% and 0.30% of GDP, depending on the parameters chosen and how the costs are met.[19]

Given the increase in the costs of the current system and the necessity of eliminating the public sector deficit, it is essential that a decision about how to implement the Commission's recommendations is made in a Spending Review to allow the Government to take a broad view of all priorities and spending pressures.

17 To make a fair comparison between models, each needs to be in a steady state. As such, these costs assume that retrospective care costs are counted, although this is unlikely to be feasible in practice. All estimates assume that the upper capital limit is raised to £100,000.
18 Estimates based on PSSRU analysis (DP 2811/2, DP 2800/3).
19 For example, the above costs do not include Barnett consequentials for the devolved administrations, which may arise if there was additional spending by the Government. However, taking account of Barnett consequentials would not affect the percentages of GDP shown, as our calculations are based on England-only GDP.

Figure 12: Detailed cost breakdown for different variants of the Commission's proposals, (£billion 2012/13 prices)[20]

£25,000 cap package, with £7,000 general living costs

	15/16	*16/17*	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*
Older people											
£25,000 cap	0.0	2.6	2.9	3.2	3.5	3.7	3.9	4.3	4.6	4.8	5.1
£100,000 means test[21]	0.4	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
Assessment costs	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3
Working age adults											
All costs	0.1	0.2	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5
Total care and support cost for all	**0.7**	**3.1**	**3.6**	**3.9**	**4.3**	**4.5**	**4.8**	**5.2**	**5.5**	**5.8**	**6.0**
Savings to benefits	**-0.1**	**-0.4**	**-0.4**	**-0.4**	**-0.5**	**-0.5**	**-0.5**	**-0.5**	**-0.6**	**-0.6**	**-0.6**

£35,000 cap package, with £10,000 general living costs

	15/16	*16/17*	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*
Older people											
£35,000 cap	0.0	0.0	1.7	1.9	2.1	2.3	2.5	2.7	2.9	3.1	3.2
£100,000 means test	0.4	0.4	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3
Assessment costs	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3
Working age adults											
All costs	0.1	0.2	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5
Total care and support cost for all	**0.7**	**0.8**	**2.4**	**2.7**	**3.0**	**3.2**	**3.4**	**3.6**	**3.9**	**4.1**	**4.2**
Savings to benefits	**-0.1**	**-0.1**	**-0.3**	**-0.4**	**-0.4**	**-0.4**	**-0.4**	**-0.4**	**-0.5**	**-0.5**	**-0.5**

20 These costs are given in constant 2012/13 prices – with the effect of inflation adjusted out – to allow comparisons to be made between years. In the Spending Review, the Government will need to assess these costs in nominal (cash) terms. The additional costs to care and support – and the savings to disability benefits – are set out in nominal prices for the most and least expensive variants in the table below, for the first five years of the reformed system.

Additional costs and savings for the most and least expensive variants shown in figure 12 (£billion, nominal prices).

		15/16	*16/17*	*17/18*	*18/19*	*19/20*
Most expensive	Additional social care costs	0.7	3.5	4.1	4.6	5.1
	Disability benefit savings	-0.1	-0.4	-0.5	-0.5	-0.6
Least expensive	Additional social care costs	0.7	0.8	0.9	2.4	2.7
	Disability benefit savings	-0.1	-0.1	-0.2	-0.3	-0.4

21 The costs of the £100,000 extended means test threshold are the additional costs once a cap is in place. Once a cap is in place the cost of raising the threshold becomes less.

Figure 12 continued

£50,000 cap package, with £10,000 general living costs

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Older people											
£50,000 cap	0.0	0.0	0.0	1.3	1.5	1.6	1.7	1.9	2.0	2.1	2.3
£100,000 means test	0.4	0.4	0.4	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
Assessment costs	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3
Working age adults											
All costs	0.1	0.1	0.2	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4
Total care and support cost for all	**0.7**	**0.7**	**0.8**	**2.0**	**2.3**	**2.5**	**2.6**	**2.8**	**3.0**	**3.2**	**3.3**
Savings to benefits	**-0.1**	**-0.1**	**-0.1**	**-0.3**	**-0.3**	**-0.3**	**-0.3**	**-0.4**	**-0.4**	**-0.4**	**-0.4**

£75,000 cap package, with £10,000 general living costs

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Older people											
£75,000 cap	0.0	0.0	0.0	0.0	0.7	0.8	0.9	1.0	1.1	1.1	1.2
£100,000 means test	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.4	0.4	0.4
Assessment costs	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3
Working age adults											
All costs	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.4	0.4	0.4	0.4
Total care and support cost for all	**0.7**	**0.7**	**0.7**	**0.8**	**1.4**	**1.6**	**1.8**	**2.0**	**2.1**	**2.3**	**2.3**
Savings to benefits	**-0.1**	**-0.1**	**-0.1**	**-0.1**	**-0.2**	**-0.2**	**-0.3**	**-0.3**	**-0.3**	**-0.3**	**-0.3**

£100,000 cap package, with £10,000 general living costs

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Older people											
£100,000 cap	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.5	0.6	0.6	0.7
£100,000 means test	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5	0.5
Assessment costs	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3
Working age adults											
All costs	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.4	0.4
Total care and support cost for all	**0.7**	**0.7**	**0.7**	**0.8**	**0.8**	**0.9**	**1.4**	**1.5**	**1.6**	**1.8**	**1.8**
Savings to benefits	**-0.1**	**-0.1**	**-0.1**	**-0.1**	**-0.2**	**-0.2**	**-0.2**	**-0.2**	**-0.2**	**-0.2**	**-0.3**

Source: Department of Health analysis.

6.3 Distributional impacts

Where does the extra spending go?

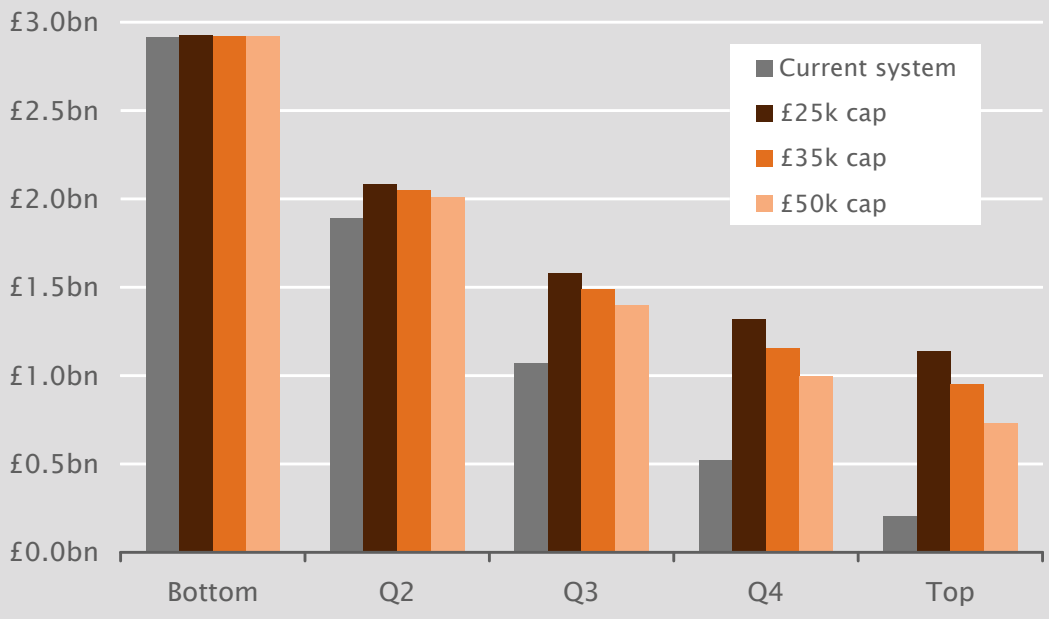
Figure 13 shows the distribution of public spending on older adults under the current care and support system and following introduction of a cap set at different levels (with an extended means test and general living costs set at £10,000).

As the chart shows, the care and support system is highly progressive. If we were to implement a cap and extended means test, the system would remain progressive, with the least wealthy still getting the most support. All but the bottom quintile (who already qualify for state support) benefit from a cap and extended means test; however – in cash terms – the wealthiest benefit the most and the poorest the least.

As the chart shows, the shape of the distributional impact remains broadly the same regardless of the level of the cap. This would also be the case for a cap slightly higher than the Commission's recommended range.

This is symptomatic of the nature of the problem that the Commission's model addresses, namely that some people currently suffer high care costs and have to sell their homes to pay for care. This problem, in general, affects only homeowners, who are in the middle and upper sections of the wealth distribution. Adding a universal element to a means-tested system will by definition lead to an increase on spending on wealthier people, since they currently get the least.

Figure 13: Public expenditure on care and support for older people in 2015/16 by wealth quintile of care users (2012/13 prices)[22]



Source: Department of Health analysis

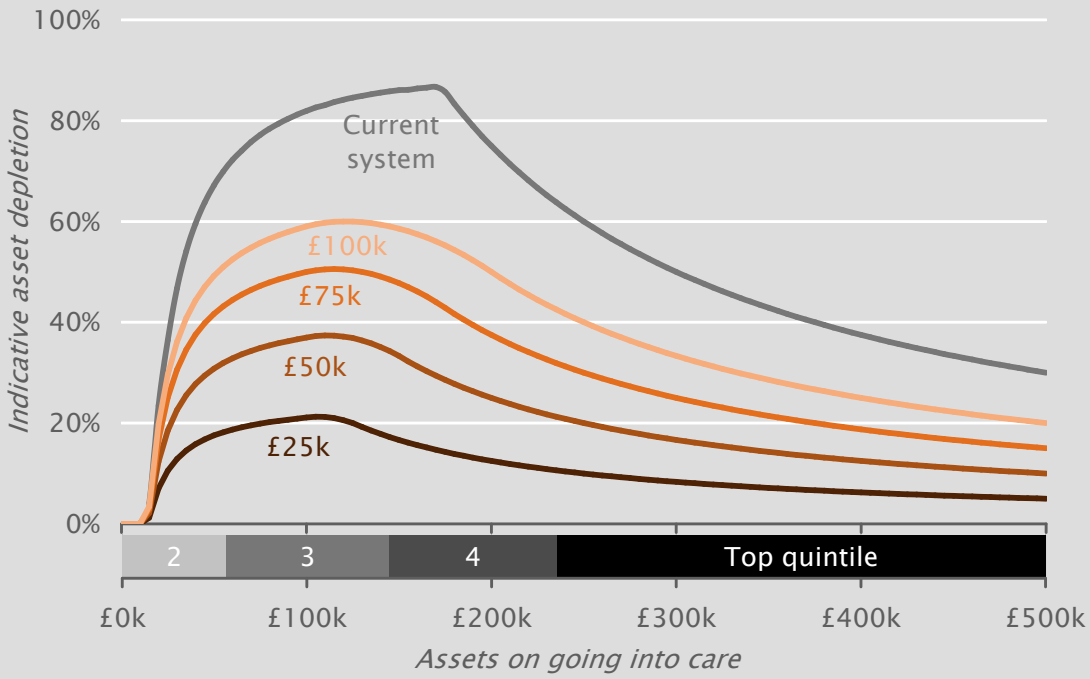
22 This analysis is for older people only, as there is not sufficient data to include working age adults (although we would expect spending on working age adults to also be focused on the less wealthy). Quintiles shown are of older people in care; and are based on income plus a 'tariff income' on assets, calculated at the same rate as in the current means test. To allow a comparison between models, these costs assume that retrospective care costs are counted, although this is unlikely to be feasible in practice

Who gains the most in terms of welfare?

Another way of assessing the distributional impact of the Commission's proposals is to look at how they affect the risks that people across the wealth distribution face. The Commission analysed the benefit of its proposals by looking at the worst case scenario that people face, in terms of the proportion of their assets that they could lose. Figure 14 replicates this analysis and compares it with wealth quintiles of care users.

While those that see the greatest increase in public spending are at the top of the wealth distribution, those who see the greatest improvement in outcomes (in terms of proportionate asset depletion) are the least wealthy homeowners, in the middle of the wealth distribution.

Figure 14: Indicative proportion of assets depleted under the current system and different levels of cap (with extended means test) for someone with very high residential care costs, by initial level of assets on going into care and wealth quintile[23]



Source: Department of Health analysis

23 Analysis is on the same basis as figure 7; wealth quintiles are as per figure 13. Since the analysis assumes that people can afford to pay £10,000 per annum general living costs from their income, the bottom quintile is excluded.

7. Conclusions and next steps

The Government agrees that the principles of the Commission's model – financial protection through capped costs and an extended means test – would be the right basis for any new funding model. Protecting people against very high costs would provide peace of mind and enable them to plan and prepare for their future care needs.

Whilst we support the principles of the approach recommended by the Commission on Funding of Care of Support, and it is our intention to base a new funding model on them if a way to pay for this can be found, there are important questions that need to be addressed about how those principles could be applied to any reformed system. Recognising the current economic situation, we are unable to commit to introducing the new system at this stage.

We are keen to work with stakeholders and the Official Opposition to consider the various options for what shape a reformed system could take, based on the principles of the Commission's model. For example, questions have been raised about the level of a cap. Some people suggested that a higher cap would reduce the cost to the Government, but still provide financial protection and create a greater space for financial services.

There have also been questions about the contribution to general living costs that people are expected to make after reaching the cap and about the level of the upper capital limit (which the Commission proposed is raised to £100,000).

Many of the people that we spoke to throughout the engagement suggested that those who gain the most from the cap should be asked to meet the cost of reform. One approach would be to implement a voluntary scheme which people could opt into or out of. People could individually make the choice to be protected by the capped cost scheme – and only people that opt in would pay the cost.

There are also other important issues to work through such as transitional and cross-border issues.

We will continue to engage with stakeholders and others with an interest on these questions and issues so that we have the right information to make a final decision in the Spending Review.

In the meantime we are taking steps towards a reformed funding system through:

- introducing a universal system of deferred payments for residential care from April 2015. We will engage with local authorities and other stakeholders on the design of a scheme so that no-one is forced to sell their home in their lifetime to pay for care;
- committing to a national minimum eligibility threshold from April 2015 to help bring greater clarity to the system, enabling people to better plan and prepare for their care needs; and
- improving the information available to support people who have care needs

This progress report also highlights the work we are taking forward on the other recommendations made by the Commission.

The table below sets out our timeline for reform.

July 2012	Publish draft Care and Support Bill with powers to introduce national eligibility and universal deferred payments.
2012	Parliament undertakes Pre Legislative Scrutiny of draft Care and Support Bill. Continue engagement with sector and Official Opposition on broad range of issues including the level of the cap, threshold and potential voluntary and opt-in models.
Autumn 2012	Establish a working group, including financial services and the care sector, to ensure people have access to the right information to help them financially plan for care needs.
Winter 2012	Publication of an integration framework, setting out how the modernisation of the NHS can be built upon to provide a more joined-up experience for older people.
2013	Introduce Care and Support Bill. Work with sector on designing final implementation of universal deferred payments, and consult with users.
Spending Review	Make decisions on capped cost model and extended means test threshold, alongside other funding priorities for the Government. Confirm level of eligibility for national threshold.
April 2015	Introduce universal deferred payments. Introduce national eligibility.

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