

Progressive Title: Social Care Charging Reform Impact Assessment IA No: 9583 RPC Reference No: RPC-DHSC-5133(1) Lead department or agency: Department of Health and Social Care Other departments or agencies: N/A	Impact Assessment (IA)			
	Date: 05/01/2022			
	Stage: Development/Options			
	Source of intervention: Domestic			
	Type of measure: Primary legislation			
Contact for enquiries: chargingreformconsultation@dhsc.gov.uk				
Summary: Intervention & Options			RPC Opinion: Not Applicable	

Cost of Preferred (or more likely) Option (in 2019/20 prices)			
Total Net Present Social Value	Business Net Present Value	Net cost to business per year	Business Impact Target Status
£1.94 billion	N/A	N/A	Not a regulatory provision

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

Currently individuals face the risk of unpredictable and unlimited social care costs - one in seven individuals over 65 will face care costs above £100,000 and roughly one in ten individuals will face care costs above £120,000 over their lifetime. Most people are unable to protect themselves against these risks as affordable financial products are unavailable, which impacts their wellbeing and represents a market failure. Government intervention is therefore required to protect people from the risk of unlimited care costs.

What are the policy objectives of the action or intervention and the intended effects?

The primary objective of the policy is to provide people with financial protection from unlimited care costs and, as a result, give them the peace of mind from knowing that they do not face unlimited care costs. The reforms also aim to increase the protection of those with lower wealth and incomes, expanding eligibility for means tested support by increasing the upper capital limit (UCL). Secondary objectives of the reforms include encouraging people to take responsibility for planning and preparing for their care needs in later life, and contributing to wider objectives of the care and support system, as set out in the government's white paper *People at the Heart of Care*, including supporting sustainable care markets and fairness in terms of rates paid by self-funders and those who fall under the means-test.

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 (2011). The then 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 a new charging reform policy, as announced in September 2021, with a cap on the amount people will have to spend on their personal care and an extended means test.

The policy will be reviewed after 5 years as per <u>Section 71(1) of the Care Act 2014</u> . Review Date: October 2028				
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?		Micro Yes	Small Yes	Medium Yes
What is the CO ₂ equivalent change in greenhouse gas emissions? N/A (Million tonnes CO ₂ equivalent)		Traded: N/A		Non-traded: N/A

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:  Date: 04/01/2022

Summary: Analysis & Evidence Policy Option 1 (Do nothing)

Description:

FULL ECONOMIC ASSESSMENT

Price Base	PV Base	Time	Net Benefit (Present Value (PV)) (£m) n/a		
2021-22	2020	10 years	Low: n/a	High: n/a	Best Estimate: n/a

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate	n/a		n/a	n/a

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

There are no costs or benefits associated with this option. This is the baseline against which all other options are appraised.

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

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Low		Low	Low
High	High		High	High
Best Estimate	n/a		n/a	n/a

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

There are no costs or benefits associated with this option. This is the baseline against which all other options are appraised.

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

Key assumptions/sensitivities/risks	N/A

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m: N/A
Costs: N/A	Benefits: N/A	Net: N/A	

Summary: Analysis & Evidence Policy Option 2 (Preferred)

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period	Net Benefit (Present Value (PV)) (£bn)		
			Low: Optional	High: Optional	Best Estimate: £2.02bn
2021-22	2020	10 years			

COSTS (£bn)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate	£0.18 billion		£2.68 billion	£23.25 billion

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

All the costs listed below fall upon the government.

- Costs of charging reform for all adults (Net Present Value £15.93 billion).
- Cost of implementation of reform and additional costs for trailblazers (Net Present Value £0.31 billion).
- Indicative costs to local authorities from moving towards a Fair Cost of Care (Net Present Value of £7.01bn).

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

- Familiarisation costs to businesses such as the time and administrative costs involved in understanding changes to the charging system and moving local authorities towards a Fair Cost of Care.

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		£2.94 billion	£25.27 billion

Description and scale of key monetised benefits by ‘main affected groups’ <ul style="list-style-type: none"> Financial benefits to all adults receiving additional support (Net Present Value £12.10 billion). The costs to local authorities from moving towards a Fair Cost of Care results in a transfer to providers via higher fee rates resulting in a benefit of having more funding to enable Section 18(3) of the Care Act (Net Present Value £6.69bn). Financial benefits to government due to a reduction in benefits allowances payable (Net Present Value £1.28 billion) as some benefits, such as Attendance Allowance, are only available when not receiving state support. Peace of mind to everyone from knowing that they will not face unlimited care costs (Net Present Value £5.20 billion). 	
Other key non-monetised benefits by ‘main affected groups’ <ul style="list-style-type: none"> People planning and preparing for their care and support needs in later life. Space for financial services products to emerge onto the market that enable people to plan/prepare and further pool risk. 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
<ul style="list-style-type: none"> Demand for formal care follows projections produced by CPEC We assume that the cost of care rise in line with unit cost/wage growth, as set out by CPEC modelling. 80% of eligible self-funders will take up the charging reform offer to move towards the cap LAs use additional funding to make genuine progress towards more sustainable fee rates, as appropriate to local circumstances. Estimates on peace of mind benefits is based on data on loss ratios from long-term care insurance markets in the USA. As a result, there is a risk of overstating these benefits as the context may be less applicable in the UK. This approach also risks overstating the peace of mind benefits to state supported users as they will already receive some peace of mind from this support. We will work with stakeholders to test our key assumptions, including any additional costs for local authorities. 	

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m: N/A
Costs: N/A	Benefits: N/A	Net: N/A	

Contents

SUMMARY: INTERVENTION & OPTIONS	1
<i>Summary: Analysis & Evidence Policy Option 1 (Do nothing)</i>	2
<i>Summary: Analysis & Evidence Policy Option 2 (Preferred)</i>	3
CONTENTS	5
EVIDENCE BASE	7
PROBLEM UNDER CONSIDERATION AND RATIONALE FOR INTERVENTION	8
<i>The problem under consideration</i>	8
<i>Why is government best placed to intervene?</i>	11
<i>Scope of this impact assessment</i>	12
<i>Rationale and evidence to justify the level of analysis used (proportionality approach)</i>	13
DESCRIPTION OF OPTIONS CONSIDERED	14
<i>Option 1: Do nothing (the current system)</i>	14
<i>Option 2: A capped cost model with an extended means test implemented in October 2023</i>	14
<i>Fair Cost of Care (FCC) and full implementation of Section 18(3)</i>	18
<i>Other options considered</i>	19
POLICY OBJECTIVE.....	23
<i>Objectives of the reforms</i>	23
<i>How the policy will work in practice and meet its stated objectives</i>	24
PREFERRED OPTION WITH DESCRIPTION OF IMPLEMENTATION.....	27
<i>Implementation plan</i>	27
<i>Legislation</i>	28
MONETISED AND NON-MONETISED COSTS & BENEFITS OF OPTION 1	30
<i>Impact appraisal of option 1 (“Do nothing”)</i>	30
MONETISED AND NON-MONETISED COSTS OF OPTION 2 (INCLUDING ADMINISTRATIVE BURDEN) 30	
<i>The cap and extended means test</i>	30
<i>Moving LAs towards a fair cost of care (FCC)</i>	36
<i>Costs of option 2</i>	37
<i>Implementation costs</i>	72
<i>Total costs of charging reform</i>	72
<i>Impact appraisal of Fair Cost of Care (FCC) and Section 18(3)</i>	73
<i>Trailblazer costs</i>	90
<i>Summary of costs</i>	90
MONETISED AND NON-MONETISED BENEFITS OF OPTION 2	92
<i>Benefits for people who draw on care and support</i>	92
<i>Benefits associated with the Fair Cost of Care (FCC)</i>	95
<i>Peace of mind benefits</i>	96
<i>Summary of monetised benefits</i>	98
<i>Non-monetised Benefits</i>	99
DIRECT COSTS AND BENEFITS TO BUSINESS CALCULATIONS	100
RISKS AND ASSUMPTIONS	102
<i>Charging reform: Older adults</i>	102
<i>Charging reform: Adults aged under 65</i>	103
<i>Section 18(3) and Fair Cost of Care</i>	104
IMPACT ON SMALL AND MICRO BUSINESSES	107
WIDER IMPACTS.....	108
<i>Effects of charging reform on the wider economy</i>	108
<i>Effects on local authority processes and systems</i>	108

<i>Impact of charging reform on public health</i>	109
SPECIFIC IMPACT TESTS.....	110
<i>Equalities</i>	110
<i>Socio-economic status</i>	110
<i>Marital Status</i>	115
<i>Regional Impact</i>	115
<i>Competition</i>	118
<i>Environmental and sustainability impacts</i>	118
<i>Human rights</i>	119
<i>Justice system impacts</i>	119
<i>Rural proofing</i>	119
<i>Trade implications</i>	119
MONITORING AND EVALUATION.....	120
ANNEX A: OVERVIEW OF DHSC SOCIAL CARE CHARGING MODEL FOR OVER 65S.....	121
<i>Introduction</i>	121
<i>Model Structure</i>	122
<i>Overview of data and assumptions</i>	130
<i>Other assumptions and future trends</i>	136
<i>Model Validation and Quality Assurance</i>	137
ANNEX B: PEACE OF MIND METHODOLOGY.....	138

Evidence Base

Table 1: Net Present Value of preferred option, £ billions, 2021-22 prices

	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32	<i>Discounted Total (2020 Base Year)</i>
COSTS											
Charging Reform - 86k Cap, 20k LCL, 100k UCL Older Adults	0.00	0.57	1.27	1.34	2.03	2.68	2.97	3.17	3.35	3.60	15.93
Older Adults	0.00	0.41	0.89	0.87	1.51	2.15	2.42	2.60	2.76	2.92	12.48
Adults under 65	0.00	0.17	0.38	0.46	0.52	0.54	0.56	0.57	0.59	0.69	3.45
Total FCC and MMF	0.57	0.63	0.69	0.70	0.95	1.06	1.03	1.06	1.09	1.13	7.01
FCC	0.54 ¹	0.56	0.57	0.59	0.61	0.63	0.65	0.68	0.70	0.73	4.99
Interaction of FCC with Charging Reform	0.00	0.04	0.07	0.07	0.30	0.39	0.33	0.34	0.35	0.36	1.70
Market Management Function	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.31
Implementation Costs	0.03	0.17	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.18
Trailblazer Costs	0.01	0.05	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.13
Total Care and Support Costs	0.62	1.42	2.04	2.04	2.98	3.74	4.00	4.23	4.44	4.74	23.25
BENEFITS											
Financial transfers to the care population	0.00	0.47	0.91	0.98	1.53	2.04	2.27	2.42	2.56	2.77	12.10
Financial transfers to older people	0.00	0.30	0.54	0.52	1.02	1.51	1.72	1.86	1.98	2.10	8.72
Financial transfers to adults under 65	0.00	0.17	0.37	0.46	0.51	0.53	0.54	0.56	0.58	0.68	3.38
Impact of FCC on providers	0.54	0.59	0.65	0.66	0.91	1.02	0.99	1.02	1.05	1.09	6.69
Reduction in AA, DLA and PIP payable	0.00	0.05	0.10	0.10	0.17	0.23	0.24	0.25	0.26	0.27	1.28
Peace of mind benefits	0.00	0.20	0.39	0.42	0.66	0.88	0.97	1.04	1.10	1.19	5.20
Total benefits	0.54	1.31	2.05	2.16	3.27	4.17	4.47	4.73	4.97	5.33	25.27
NPV											2.02

Note: numbers may not add due to rounding.

¹ This analysis assumes underpayment is addressed in full. However, the policy intent is that there should be movement towards LAs paying a fair cost of care over the first three years, as appropriate to local circumstances to sustain markets. The expected cost is lower (particularly in the first two years), but we are not able to estimate at this stage.

Problem under consideration and rationale for intervention

The problem under consideration

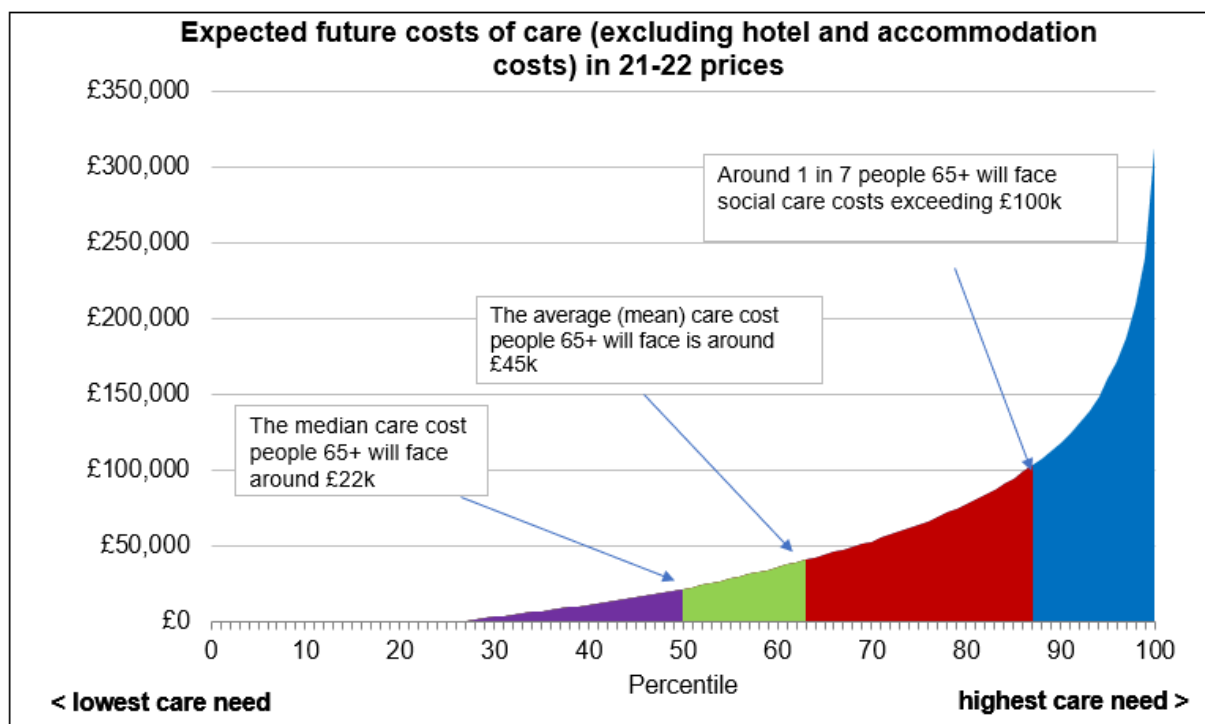
1. The way people pay for their social care has changed very little since 1948 and, as a result, no longer reflects the realities of today's society, particularly in terms of the ageing population or definitions of wealth. Social care is devolved across the UK. Under the current system in England, people face the risk of unlimited and unpredictable care costs. This is widely regarded as unfair as people have little (if any) control over whether they will draw on care or support at some point in their life. For those who develop more intensive care needs, the costs can be significant, quickly eroding their accumulated wealth. At the same time, people have limited options available to protect themselves.
2. Research over the past decade, including by the Commission on Funding of Care and Support² as well as "Caring for our Future: progress report on funding reform"³, set out in detail how catastrophic care costs create practical difficulties and distress for people receiving care and support.
3. People who need care and support for a long period, such as those with long-term health conditions such as dementia or are disabled, face these high care costs whilst others do not ever develop significant care needs and therefore spend very little, if anything, on care. DHSC estimates suggest that around three out of four adults over the age of 65 will face care costs in their lifetime. People are unable to predict what their future needs might be and therefore what level of costs they may face. This means they can have no degree of certainty to plan and prepare.
4. Figure 1 shows the estimated distribution of future lifetime care costs that people aged 65 currently face, updated from the analysis conducted for the Commission on Funding of Care and Support⁴ due to rising care costs. Around one in seven people aged 65 are expected to experience lifetime care costs exceeding £100,000 (excluding hotel and accommodation costs) and around one in ten are expected to experience costs exceeding £120,000. The median lifetime cost of care for over-65s is approximately £22,000 and the average (mean) is around £45,000 (excluding 'hotel' and accommodation costs).

² <http://www.dilnotcommission.dh.gov.uk/>

³ <https://www.gov.uk/government/publications/government-publishes-progress-report-on-social-care-funding-reform>

⁴ Commission on Funding of Care and Support (2011). Fairer care funding. The Report of the Commission on Funding of Care and Support. [online] HMSO, p.12.

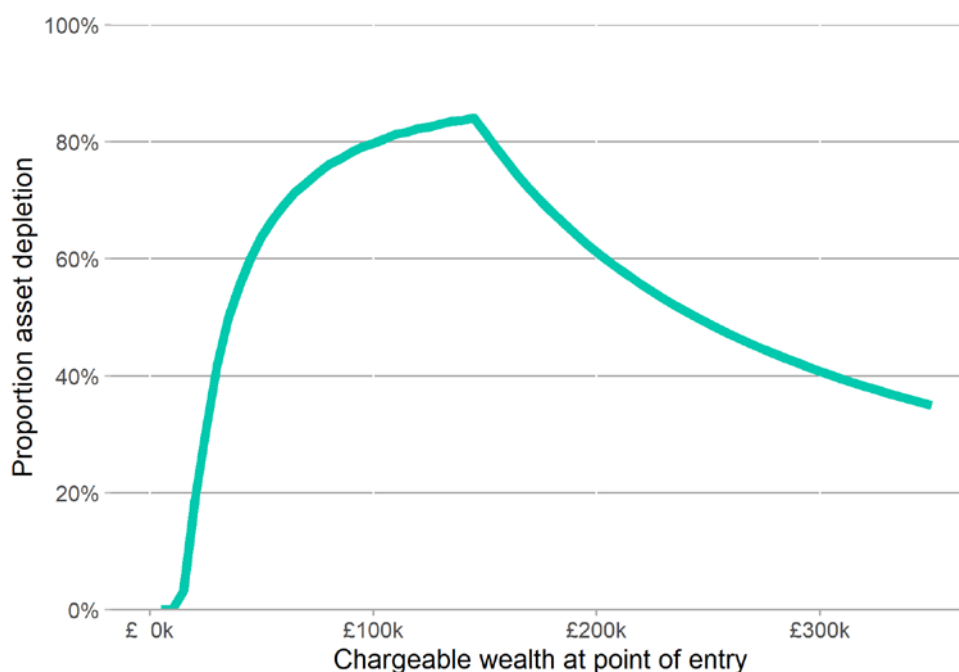
Figure 1: Expected future lifetime costs of care for people aged 65 in 2010-11, by percentile (2010-11) in 21-22 prices – DHSC analysis based on CPEC modelling



5. At present, there is state support available for those who would have difficulty paying for the costs of their care, but only if their assets are below £23,250. This means that anyone who owns their own home, and lives in it on their own, is usually excluded from any form of state funded support when moving into residential care, such as a care home or nursing home.
6. This means that people with even moderate levels of assets are at risk of having to run down their assets to £23,250 to pay for their care, and even then, are still required to make a contribution from their assets until they reach the lower capital limit of £14,250 (after which they only contribute from their income).
7. Even if somebody's assets are such that they receive state support, they are expected to contribute from their income towards the cost of their care. They must be left with a certain amount of income, called the social care allowances, which is different depending on the care setting:
8. In residential care, those within the means-test must be left with the Personal Expense Allowance (PEA), which is currently £24.90 per week.
9. In domiciliary or community care, those within the means-test must be left with the Minimum Income Guarantee (MIG). This varies depending on circumstances (e.g., if a person has a child under 18) and can be an accumulation of the standard rate, which ranges from £71.80 for a person in a couple aged 18-64 and £189.00 for a single person who has reached pension credit age.

10. Around one in eight people who enter a care home have lengths of stay more than 5 years⁵. Figure 2 illustrates how much someone might deplete their assets if they stay in a care home for 5 years under the existing system.
11. Those who are most at risk in this scenario have assets between £80,000 and £160,000, below the median housing wealth. These individuals face the possibility of spending around 80% of their assets paying for their care and are least able to manage high costs in the current system. These people are most in need of protection.

Figure 2: Asset depletion under the current system for an individual following 5 years of residential care, under different levels of chargeable wealth at point of entry



Source: Based on DHSC modelling of an individual with an average weekly income for older adults of £239 per week at the average local authority rate of £683 per week and 5 years in residential care, by initial level of chargeable wealth (2021-22 prices).

12. Given the uncertainty, a risk-averse person might want to plan for the worst-case scenario. The Commission on Funding of Care and Support suggested that this leads to highly inefficient outcomes: Individuals may be unwilling to release the value from their assets, for example by downsizing their home, to invest in preventative services, for fear of facing unpredictable and unlimited care costs in later life (even though they might not need their savings by the end of their care journey). This may have a detrimental impact on their health and wellbeing and, perversely, means that those people are likely to have to pay more should they develop care and support needs. Those who cannot easily afford to cover what they perceive to be the worst-case scenario from their wealth will want – and will benefit from – protection from unlimited care costs.

⁵ DHSC analysis based on Length of Stay in Care Homes. Forder, Julien and Fernández, José-Luis 2011 : <http://eprints.lse.ac.uk/33895/>

Why is government best placed to intervene?

13. In other areas of our life, when faced with the risk of high costs, people are protected through insurance – either provided by the state (for example, the NHS) or purchased privately (for example, house insurance). Insurance is a way of “risk pooling”, i.e., sharing the cost of care amongst the population. It is well-evidenced in economic theory⁶ that pooling risks via insurance 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. It thereby reduces the inefficiency of asset hoarding discussed above.
14. However, due to the degree of uncertainty of developing care needs, a market-based solution to protect against unlimited and unpredictable care costs does not exist. In England, it is not currently possible to buy products which fully pool the risk of long-term care costs. A small market for pre-funded long-term care insurance grew in the 1990s but products were withdrawn in the 2000s, with insurers citing both supply side and demand side difficulties.
15. Past research explored the barriers to a fully private insurance system for social care costs; identifying adverse selection, uncertainty about future care needs and costs as key supply side barriers; and the high cost and poor affordability of care insurance as key demand side barriers⁷. In addition, there is a low level of knowledge of how adult social care works in the general population⁸.
16. The only risk-pooling products currently available are immediate needs annuities (INAs). These products are typically sold to people entering a care home, who make a one-off payment in return for which they usually have their care home costs covered until they die. They allow people going into residential care to pool their longevity risk, but not the risk of going into a care home in the first place.
17. The absence of a pre-insurance market is a market failure which leads to unfairness and inefficiency as people have no influence over their lifetime care costs, yet can do little to protect themselves against them. People who are unable to save sufficiently to cover a worst-case scenario cannot prepare and save for their probabilistic care costs. This can either cause significant worry or disengagement with the issue. It will also mean that when these people come to drawing on care, they may have less flexibility to make optimal choices about their care.
18. Due to supply and demand side barriers, there is a case for Government intervention to provide that risk pooling. The current means-tested system ensures a basic level of provision for all who meet the eligibility criteria, but the absence of

⁶ Several economic papers demonstrate this. An example is Malani and Jaffe 2018 “The Welfare Implications of Health Insurance” <https://www.nber.org/papers/w24851>

⁷ 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, Raphael Wittenberg and Joshua M. Wiener, Printed in the LSE Companion to Health Policy, Edward Elgar, 2012.

⁸ <https://www.local.gov.uk/about/news/majority-people-unprepared-adult-social-care-costs-ipsos-mori-care-homes-consumer-research.pdf> (publishing.service.gov.uk)

any cap on costs means that individuals are still exposed to the risk of unlimited care costs.

Scope of this impact assessment

19. In 2010, the cross-party Commission on Funding of Care and Support was tasked with leading an independent investigation to recommend improvements to the funding of care and support in England. The commission recommended ‘capping the lifetime contribution to adult social care costs’ to ensure that no-one paid over a certain amount towards their care; thus protecting against extreme costs and implementing a ‘significant increase in the threshold at which mean-tested support is taken away, so that extra protection is given to those with the lowest incomes and wealth.’
20. The approach to reforming the charging system, as set out in this IA, has been shaped by two key principles of the Commission’s recommendations – a cap on care costs and an extended means test, which together address unlimited costs and improves support to those with lower levels of wealth and income.
21. A cap on care costs can only be successfully implemented in a market for social care with transparent and more sustainable fee rates, and where self-funders can access local authority-commissioned rates of care by being able to ask their local authority to meet their needs under section 18(3) of the Care Act 2014. If people were able to meter towards the cap at a rate above what a local authority would spend, then there would be nothing to prevent them paying well above a fair rate of care, hitting the cap more quickly, and leaving the state to pick up their ongoing costs. If people are unable to access the local authority commissioned rate for care, then the amount counted towards the cap, and the amount they may have needed to pay for their personal care may be substantially different.
22. Stakeholder responses during previous consultations indicated that at the time the wider market for social care was not sufficiently prepared for the reforms to be implemented. Therefore, given the intention to commence the provisions in Section 18(3), further funding is being made available to ensure local authorities better sustain their local care markets in anticipation of the changes that charging reform will bring; and by supporting them to move towards paying providers a fair cost of care.
23. The implementation of a more generous means testing regime, a cap on personal care costs, and enabling individuals to benefit from the same rates that local authority funded citizens do; aims to address the issue of unlimited costs and unfairness in the system. However, there are wider issues in the provision of support for people who draw on care, which are not addressed through the reform of the charging system. These include steps to help improve the quality of care, and the skills of the people who provide it. These steps are set out separately in People at the Heart of Care⁹ which was published in December 2021.

⁹ DHSC (2021): People at the Heart of Care: adult social care reform white paper - GOV.UK (www.gov.uk)

24. The Health and Social Care Levy is also out of scope here.
25. This impact assessment is concerned with the implementation of charging reform following the principles of the Commission's recommendations, through:
 - i. Implementation of a lifetime cap on personal care costs
 - ii. Raising the means-test for receiving state funded care
 - iii. Unfreezing the social care allowances for people receiving local authority support
 - iv. Implementation of Section 18(3) of the Care Act 2014, which will allow people funding their own care to access the same rates as those funded by local authorities, with further funding to help local authorities to sustain their local markets.

Rationale and evidence to justify the level of analysis used (proportionality approach)

26. The impacts outlined in this assessment are primarily based on DHSC's internal charging reform cost models which have been developed over several years, taking into account feedback from previous consultations and external stakeholders. The models have undergone internal and external quality assurance, including the Government Actuary's Department and the Institute for Fiscal Studies. This analysis, with sensitivities, represents the best available evidence to date, and we have a high level of confidence in it. However, it should be noted that the rollout of reform will need to be closely monitored; a model is not an exact replica of the real world and cannot perfectly predict the future.
27. Where the analysis is very sensitive to underlying assumptions, we explain this explicitly throughout the document and have included sensitivity analysis where appropriate. Key remaining risks, assumptions and uncertainties are also summarised at the end of this Impact Assessment.

Description of options considered

Option 1: Do nothing (the current system)

28. This would leave the current system as it is, broadly unchanged since 1948. Currently, people are liable for their own care costs, although there is means-tested support. Whether or not a person qualifies for any financial support towards their care costs depends on their chargeable capital assets as follows:
 - a. Anyone who has chargeable assets above the upper capital limit (£23,250) are expected to meet the full cost of their care.
 - b. Anyone who has chargeable assets below the lower capital limit (£14,250) pays what they can afford from income only.
 - c. Anyone between the two limits pays what they can afford from their income plus a contribution from their chargeable assets. The contribution from chargeable assets is determined by a tariff income of £1 per week for every £250 between the limits.
29. A financial assessment considers income and assets to determine if someone falls within the means test. However, there are certain types of income and wealth disregarded from the assessment, and housing wealth is only considered in certain circumstances.
30. Under the do-nothing option, people would remain unable to protect themselves from the risk of unlimited care costs, and the system would not be suitable for 21st century demographic challenges. The protection provided by the means test would continue to be low, meaning state support would only be provided once a person's chargeable wealth or assets drop below £23,250.
31. If additional funding was not provided to support LAs to move towards paying providers a fair cost of care, this would result in a continuation of widespread underpayment and an unsustainable provider market, with insufficient investment in buildings and innovation, and poor workforce practices. If Section 18(3) is not implemented alongside this then self-funding individuals would continue to be exposed to higher costs, paying more than an LA would for equivalent care in order to make up for the widespread underpayment which currently exists.

Option 2: A capped cost model with an extended means test implemented in October 2023

32. A capped-cost model – to be implemented in October 2023 – is based on some of the principles set out by the 2011 Commission on Funding of Care and Support. The government's proposal includes a cap of £86,000 to meet their eligible care and support needs for adults who reside in England. This is in line with the cap of £72,000, which was the basis for the 2015 IA^[1], when uprated with average earnings.

^[1] [Social Care Funding Reform IA FINAL v2.pdf \(publishing.service.gov.uk\)](#)

33. Individuals in residential care will also pay 'daily living costs' (DLCs), including 'hotel and accommodation' costs, of £200 a week, which will not count towards the cap. An individual will meter towards the cap at the rate they personally contribute towards meeting their eligible care needs, minus DLCs.
34. After reaching the cap, individuals in residential care who ask their local authority to meet their needs will remain responsible for a contribution towards their DLCs of £200 per week. Means-tested support will be available on the same basis as for care costs, such that these individuals will contribute what they can from their income and assets based on a financial assessment. They will also remain responsible for any agreed top-ups.
35. Self-funders who do not utilise Section 18(3) but who have an Independent Personal Budget via which they meter towards the cap will ask their local authority to meet their eligible care needs once they hit the £86,000 cap. If they have chosen to top up their care for a premium accommodation, they will continue to pay these costs themselves.
36. Subject to Parliamentary approval, people will meter towards the cap at the rate they contribute towards their eligible care costs, but the metering rate has a maximum limit of the rate the local authority would spend on their care as set out in their Personal Budget (PB) or Independent Personal Budget (IPB), depending on who is responsible for meeting their eligible care needs.
37. The proposals also include:
 - a. An "extended means test" - upper capital threshold (UCL) of £100,000 and increased lower capital limit (LCL) threshold of £20,000.
 - b. A tariff income (£1 per week for every £250) continues to be applied to those with assets between the lower and upper capital limits.
 - c. The level of the cap will be uprated in line with a measure of average earnings. Decisions on the uprating of other parameters will be taken annually.
 - d. The minimum income guarantee (MIG) in domiciliary and community care and the personal expenses allowance (PEA) for local authority supported care home residents is increased by inflation from April 2022. For current rates, please see "[Social care –charging for care and support](#)". The exact trajectory after this point will be determined at the relevant Spending Review, with the intention to incrementally increase the allowances over time.
38. Funding to support the delivery of charging reforms will be allocated to local authorities based on a formula.
39. The government has laid a clause in the Health and Care Bill to amend Section 15 of the Care Act 2014 so that individual contributions made by those with eligible care needs meter towards the cap at a local authority determined rate. This change will mean that costs paid by the LA towards an individual's care would not be included in the accrued costs. The change will not impact the other areas of

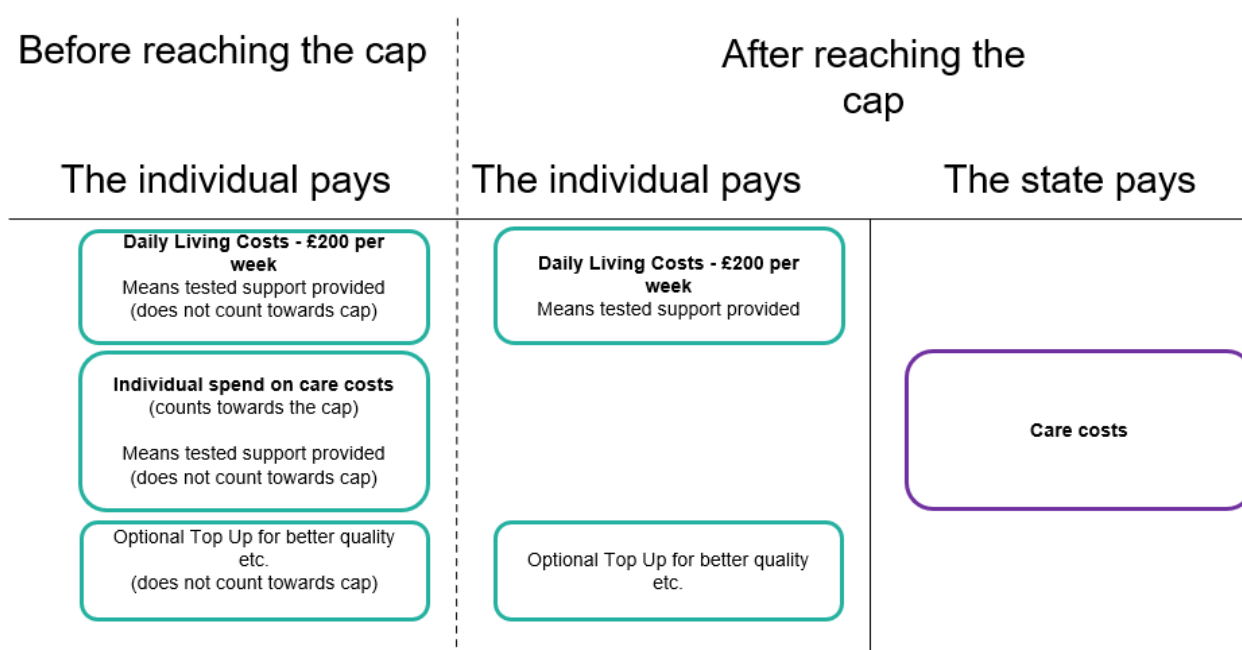
reform and the cap will continue to interact with the benefits received from the means test.

40. When considered as part of a package of charging reforms, the government believes this change makes the system fairer: two people starting with the same level of wealth and contributing the same amount towards their eligible care needs each week will hit the cap at the same time; under the previous formulation they could reach the cap at very different times, depending on the level that the LA was contributing towards the cost of their care. People with modest means are primarily supported through the more generous means testing regime, which makes it very unlikely they will deplete a large proportion of their assets rather than the cap. The government has chosen to set DLCs in residential care at a level that will be affordable to people on average incomes so they do not have to continue to use their assets after reaching the cap; to have done otherwise would denigrate one of the aims of the cap, which is to provide some protection of assets. Finally, the Government has chosen to set the upper capital limit at the same level no matter what setting a person draws on care from. This supports more people to stay in their own homes for longer, which is an ambition set out in our white paper, *People at the Heart of Care*.
41. In comparison to previous proposals for charging reform, these plans mean that more people receive more support right from the start of their care journey. However, this has meant difficult choices elsewhere; we have needed to balance the longer term costs of charging reform (and what proportion of the future Health and Social Care Levy revenues we want to earmark for that purpose), with wider investment in adult social care reform to make the system more sustainable.
42. Rules around how the home is treated in the assessment of assets will remain the same. The only circumstances where people will need to draw on their housing wealth to help pay for their care is if they enter residential care and they don't have a spouse or other eligible adult still living in their house.
43. If the value of someone's home is considered in their assessment and they need to draw on that wealth, then at some point they need to release the equity in it. Many individuals and their families choose to sell the house of somebody who's entered residential care quickly, because they are no longer living in it and are unlikely to return.
44. However, some people may prefer to wait before selling the home, either until they have had chance to get their finances in order, because it needs some renovation, or because an emotional attachment means that they do not want to sell it until the person drawing on residential care has died. In these circumstances, people can take out a deferred payment agreement (DPA). A DPA is an agreement between the individual and the local authority to defer care payments in exchange for equity in their property. It is effectively a not for profit equity release scheme for the purpose of meeting care costs, administered by local authorities.

How the cap will operate in residential care

45. Figure 3 illustrates how the cap will work in residential care and highlights the additional state contribution to cap people's eligible care costs.
46. Before reaching the cap, the person will pay for their personal care costs and DLCs. These costs will be means tested, therefore they may receive state support with both costs.
47. Subject to Parliamentary approval, people meter at the rate they contribute to the cost of meeting their eligible care needs (so long as this does not exceed the amount it would have cost the local authority to meet their eligible care needs), minus their DLCs of £200 per week and any additional top-ups for enhanced or additional services. For people whose needs are being met by the local authority, this is set out in their Personal Budget and for self-funders this is set out in their Independent Personal Budget.
48. After reaching the cap, individuals in residential care who ask their local authority to meet their needs will no longer be responsible for their eligible care costs, but will remain responsible for their DLCs of £200 per week (as they would remain responsible for the cost of their housing and food at home if they were in receipt of domiciliary care), with means-tested support provided for those who cannot afford to pay for them from their income or their remaining chargeable assets.

Figure 3: How the cap will work in care homes (note that the cap interacts with the means test, which is not demonstrated here).



49. Please note that those who are receiving care and support through NHS Continuing Health Care (CHC) or Funded Nursing Care (FNC) will not be affected by the changes unless they cease being eligible for CHC or FNC.

Fair Cost of Care (FCC) and full implementation of Section 18(3)

50. To deliver the objectives of the cap on personal care costs, self-funders need to have the option to pay the same price as the local authority would pay to meet their needs, as this is the rate which is used on their behalf to meter them towards the cap. Access to the local authority-commissioned rate for care could in theory be achieved through market mechanisms, e.g., a code of practice with providers or price transparency measures. These measures would not deliver the necessary outcomes at the point people begin metering towards the cap because it would take some time for such mechanisms to result in providers offering lower rates to self-funders. This poses two issues which undermine the success of the policy without further action to counter.
51. Firstly, many self-funders currently pay significantly more for care than local authorities. For example, the CMA found in 2017 that self-funders pay an average of 40% more than local authorities, due in part to councils' monopsony power and lack of consumer empowerment.¹⁰ More recent evidence on the difference between self-funder and local authority fees is limited, stakeholders and sector experts suggest a "gap" remains. This means self-funders will therefore spend significantly more on their care than the cap limit unless they can pay the same lower rate paid by local authorities. This means the cap would not limit care costs at the publicly-stated amount. Commencing Section 18(3) would achieve this purpose. This part of the Care Act 2014 is already in force for home care, but not for residential care. Once Section 18(3) is fully in force, it will allow an individual with assets above the means-test threshold to ask their local authority to meet their eligible needs and their local authority will be under a duty to do so by commissioning care on that person's behalf. The local authority determines the adult's eligibility for care and support via a needs assessment and then commissions their eligible care at the local authority-commissioned rate. Self-funders reimburse the local authority, or pay the provider directly at the commissioned rate, and can pay separately for extra services, 'top-ups', if desired.
52. Secondly, under the Care Act 2014, LAs should be paying rates that allow providers to provide safe, compliant, good quality care whilst investing to improve in future. DHSC analysis suggests, however, that many local authorities pay providers less than it costs to deliver the care provided. This means that the rate used to meter towards the cap is artificially low and doesn't reflect true costs of care. Allowing self-funders – who represent c.50% of the market and pay more on average than the LA rate – to pay currently unsustainable local authority rates would seriously destabilise the already fragile care provider market. The Government wants to support the delivery of a sustainable and fairer system, therefore it is providing funding and guidance to help local authorities better support their local markets and move towards paying providers a fair cost of care.

¹⁰ CMA Care homes market Study 2017 – It should be noted that the data used in the CMA report is now over five years old (before significant additions of new funding into adult social care) and relates to a sample of larger care providers.

53. The Market Sustainability and Fair Cost of Care funding the government is providing in 2022-23 will support LAs to build and plan for sustainable markets, in preparation for reform, particularly Section 18(3). In 2022/23, the focus will be on making genuine progress towards more sustainable fee rates and building strong foundations. As a condition of receiving funding, we will expect LAs to conduct cost of care exercises, set out their plans for driving market sustainability, including progress towards a fair cost of care, and to report to DHSC on how funding is being used. The Department will use this information to monitor progress and provide public assurance that local markets are being managed successfully. In 2023/24 and 2024/25, funding will increase to £600m in each year. We will expect local authorities to execute their strategy, including by making substantial movement towards paying provider the fair cost of care, where they are currently not doing so. The funding profile allows for sensible implementation that is deliverable, whilst also reflecting the timelines for charging reform.

Other options considered

54. Alternatives to a state funded cap on lifetime cost of care were considered but not progressed, as they fail to meet the overarching policy objective of providing individuals with protection against unpredictable and unlimited care costs:
- a. **Private voluntary insurance:** due to the uncertainty involved for the financial sector in providing insurance against either the full cost of care or unpredictable care costs, the sector has struggled to design affordable and attractive products.
 - b. **State-backed voluntary insurance against catastrophic cost:** alternative to insurance provided by the private sector, state-backed insurance products, such as insurance to provide a cap, and provided on an opt-in basis, were considered. Whilst it would have addressed supply-side issues around voluntary insurance, it would have risked low take-up, in turn magnifying issues such as adverse selection and increased administration costs relative to overall costs. It would also have carried high economic and set up cost.
 - c. **Full social insurance:** in 2011, the Commission on Funding of Care and Support also examined the case for a full social insurance scheme, prevalent in other OECD countries, such as Japan or France. Full social insurance would provide everyone with full protection from any care costs not just from incurring unpredictable care costs. However, as noted at the time, it would require a much larger increase in public expenditure and leave little scope for future flexibility in costs, and on this basis was ruled out as an option for reform.
 - d. **Free personal care instead of a cap on care cost:** This was recommended by the Lords Economic Affairs Committee¹¹ in 2019, with free personal care, defined as support with essential daily tasks, such as washing, cooking, mobility or dressing. Delivered through a defined state contribution for those in residential care, in

¹¹ <https://publications.parliament.uk/pa/ld201719/ldselect/ldeconaf/392/392.pdf> House of Lords Economic Affairs Committee - *Social care funding: time to end a national scandal* (4 July 2019)

addition to free care to those in domiciliary or community care, this model has been in operation in Scotland since 2002. While this would provide a degree of universal protection for everyone and is easy to understand, it would not provide protection from unpredictable and unlimited care costs for those with long care journeys. The cost to the state would exceed that of introducing a cap on care costs and an extended means test.

- e. **Increase in the UCL only and including the home in the means test in domiciliary care:** an alternative considered was to only increase the UCL to £100,000 alongside starting to include a person's home in the means-test if they are still living in it and drawing on care at home. Whilst this proposal would have benefited some people living in residential care whose housing wealth is currently considered in the financial assessment (as the UCL would be more generous than the current system), it would have disadvantaged people drawing on care at home and those in residential care who currently had their housing wealth disregarded from the financial assessment. Also, it would not have provided any protection to unpredictable and unlimited care costs.
- f. **Co-payment model:** Everyone would contribute to their care costs (with the means test still in place) but is left with a certain percentage of their income each week and a certain percentage of the wealth each year. While this model would provide assurance that weekly costs would be capped at a certain level despite needs, it did not resolve the issue of lifetime unpredictable and unlimited care costs.

55. The following variations to a cap on care costs of £86,000 and an extended means test (£20,000 LCL and £100,000 UCL) as set out in this IA were considered:

- a. **Cap on total weekly expenditure:** e.g. in Wales there is a weekly cap of £100 per week in domiciliary care. This was ruled as not effective in protecting those with long care journeys from high and unpredictable care costs.
- b. **Regional cap:** e.g. a set cap in the North East and higher cap in the South East on the basis of relative levels of wealth. This was not thought to be a viable option. Levels of wealth vary substantially within regions, as they do between regions. It was not considered fair, for example, for those living in Harrogate to have a lower cap on care costs than those living in Hastings, simply on the basis of the region in which they were located. In addition, there would be wide-ranging fee rates across local authorities. Given the complexity of the policy to both implement and understand, it was not pursued.
- c. **A time-based cap:** e.g., no one drawing on care would pay for care for more than a set number of years (potentially with some differentiation between domiciliary and residential care). We considered a time cap to address regional inequalities. However, whilst a time cap would introduce less regional inequality in the proportion of users hitting a cap, it would increase inequality between people with different intensities of domiciliary care. Moreover, a time cap would still carry a level of uncertainty for individuals as to the maximum cost individuals may be subject to.

- d. **A cap based on percentage of wealth:** This option would require LAs to assess the value of everybody's assets rather than just those at the means test thresholds, placing a high administrative burden on LAs. The value of people's assets changes over time. This can be overcome by locking in the value of assets at a point in time, however, this creates practical problems. Doing so is likely to increase the number of disputes, attempt to hide or offload assets and that a level of uncertainty will remain in how much they will be required to pay for their care before their care journey, impacting their ability to plan.
- e. **Banded cap:** e.g. people with less than a set amount in chargeable assets will have a fixed cap, and those with higher wealth will have a higher cap. While this method will ensure those with less wealth will have a lower cap, it presents a cliff edge for those nearing the different band(s). Also, people's wealth could change significantly for reasons unrelated to their care, making it difficult to set the point someone's cap is determined – the cap could not fluctuate with someone's wealth as this would potentially make the cap unattainable. This may undermine the principle of helping people to plan financially for their care needs, or risk leaving people with less protection than promised.

Alternative levels of the cap and UCL

- 56. **Alternative levels for UCLs** were considered, for instance a £50,000 UCL. However, a higher UCL of £100,000 ensures more people will be captured by the means test and eligible for state support, and also that a higher proportion of a person's wealth, and in particular of those with lower housing wealth, is protected.
- 57. The Commission on Funding of Care and Support recommended a differential UCL depending on whether housing wealth was disregarded; a higher UCL for people with housing wealth included in the financial assessment and a lower UCL for people with housing wealth not included. The Government decided to provide a universal UCL in order to protect more wealth for people in domiciliary care, therefore encouraging more people to receive care in their own home.
- 58. **Different levels of the cap considered.** Setting the cap affects both the costs and benefits of the policy. It is necessary to strike a balance between competing government spending pressures, especially as the country recovers from the pandemic. The government believes that setting the cap at £86,000 provides people with protection from unlimited care costs and ensures that the policy is sustainable in the long term.
- 59. The major considerations in setting the cap were:
 - a. **The Commission on Funding of Care and Support recommended** that an appropriate level of cap in 2010-11 should be £25,000 to £50,000, recommending £35,000 as a central option. It also said the cap should inflate over time so that every generation gets a fair deal.

- b. **Cost of the policy.** The amount of resource spent on the cap needed to be balanced against potential other uses for those funds and the government's fiscal objectives.
- c. **The level of protection provided.** A lower cap provides greater protection from unlimited care costs but increases the overall costs of the reforms risking potential sustainability issues. Assume steady state, with 2021-22 demand, an £86,000 cap alone would be benefitting around 60,000 over 65s who draw on care and support out of a population of 700,000.

Previous challenge to the policy

60. A cap and more generous means test have been discussed as a potential reform since the Commission on Funding of Care and Support and was consulted on in 2013. There have been challenges to the policy which have informed our policy development. These have included:
- a. Daily living costs (DLCs) being unaffordable for those on lower incomes. This concern has been addressed by reducing the rate of DLCs from £258 (in 2021-22 prices) in the previous DHSC Impact Assessment to £200 (in 2021-22 prices, £10,400 per year). The Commission on Funding of Care and Support recommended DLCs were set between £7,000 and £10,000 (£8,640 and £12,343 when inflated to 21/22 prices¹²).
 - b. The social care allowances have reduced in real terms since 2016 when they were last updated. The MIG and PEA will be raised with inflation from April 2022, with the intention that they will continue to rise with inflation.
 - c. A relative disadvantage for those who do not benefit from the housing wealth disregard in domiciliary care versus those who do. The extension of the means-test to £100,000 will benefit those in domiciliary care who are not benefitting from a housing disregard.

¹² Original figures from the 2011 Dilnot Commission (Fair Care Finding – July 2011) updated from 2010/11 to 2021/22 prices by using the CPI index at the beginning of the financial year

Policy objective

Objectives of the reforms

61. The primary objective of the policy reform package is to address the risk individuals face due to unlimited care costs. The reforms should provide people – whatever their age - with financial protection from unlimited costs should they need to draw on care and support. This protection will give peace of mind to both people who draw on care and to the general public. The reforms also aim to increase the protection of those with lower wealth and incomes who fall under the means test.
62. There are also secondary objectives, namely:
- a. the system encourages people to plan responsibly and prepare for their care needs in later life;
 - b. the system contributes to fairness in terms of rates paid between self-funders and those who fall within the means test;
 - c. any reforms should be financially 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; and
 - d. the system should support the wider objectives for the care and support system including supporting a sustainable social care market, investment in preventative services and the provision of information and advice to enable people to make informed choices about their care and support.

Success indicators

63. Key indicators of success will include the following:

Objective	Key indicator of success
Primary objectives	
The reforms should provide people of all ages with financial protection from unlimited care costs.	<p>A reduction in lifetime cost of care across people who draw on care and support, including by income and wealth deciles.</p> <p>An increase in relevant measures of financial health of people who draw on care, e.g., wealth/assets and income retained by care users.</p>
This protection will give peace of mind to both care users and to the general public.	An increase in measures of satisfaction and wellbeing of people who draw on care and the general public in relation to social care costs.

The reforms also aim to increase the protection of those with lower wealth and incomes who fall under the means test.	An increase in the number of people with lower income and wealth who benefit from state support towards the cost of their care from the extended means test.
Secondary objectives	
The system encourages people to take responsibility and to plan and prepare for their care in later life.	Individuals are incentivised to save for future care. Excess spend is released into the economy, including on preventative care services.
The system contributes to fairness in terms of rates paid between self-funders and those who fall within the means test.	The gap between LA rates and self-funder rates narrows.
Any reforms should be financially 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.	Demand and cost models indicate that the level of funding in the system is appropriate to sustain the reforms.
The system should support the wider objectives for the care and support system including supporting a sustainable social care market, investment in preventative services and the provision of information and advice to enable people to make effective choices about their care and support.	Local authorities moving towards paying a fair cost of care where necessary, strengthening data and contract management, and strategically securing their markets in response to change. People who draw on care and the general public are able to access and understand appropriate advice People who draw on care and the general public report good understanding of the care system and reforms

64. Monitoring and evaluation plans will be developed against these key indicators. In some cases, alternative metrics or composite / proxy measures may be identified as plans for data collection progress in line with implementation plans.

How the policy will work in practice and meet its stated objectives

65. Around half of all older adults in care receive some state support for their care costs under the current system. This rises to roughly two thirds under these new proposals. In principle, the introduction of a cap on care costs provides additional peace of mind to all individuals through unlimited care costs.

Lifetime cap on care cost

66. A lifetime cap on care costs of £86,000 provides a partial risk pool for those whose care costs exceed the cap, protecting individuals from unpredictable and unlimited care costs. By introducing an £86,000 cap, no one will need to pay more than £86,000 for their eligible care in their lifetime.
67. To make sure the system is fair, through full commencement of Section 18(3) of the Care Act 2014, everybody would be entitled to ask their local authority to meet their eligible needs, and therefore access care at the same rate that the local authority would pay for a similarly-placed individual who does not fund their own care. It is the rate the local authority does or would (if asked) pay to meet an individual's eligible needs that would be used to calculate how much a person had needed to pay towards their own eligible care (i.e. count towards the cap), and once this totalled £86k, the local authority would (if asked) have a duty to meet that person's eligible care needs and would not be able to charge them for that.
68. Individuals can pay additional top-up fees for more expensive provision but any money they spend over and above what the local authority would commission, will not count towards the cap. This stops individuals from choosing more expensive care options in order to reach the cap more rapidly and would mean that once the cap has been met, everyone receives the same support from the LA.
69. Individuals in residential care are still responsible for DLCs, including accommodation costs, just as they would be at home. This will be an amount specified in Regulations of £200. Whilst the cap ensures no one will need to pay over £86,000 in personal care costs to meet their eligible needs, DLCs are not included. Some individuals will therefore end up spending more than £86,000 across their care journey once accommodation and other living costs have also been paid for. To make sure that no one is subject to high living costs, we will set the DLCs at a fixed national rate that is affordable. Individuals may wish to pay additional top-up fees for more expensive care homes, rooms or services.
70. Once the cap has been met, people will have a choice of how they purchase their care. They can:
 - a. request that the LA arranges their care, making payment to the provider directly, with the opportunity to pay an additional top-up if they are able and willing; or
 - b. request a direct payment, providing flexibility in the care they receive and making it simpler to top-up. Direct Payments will continue for people receiving care at home.

Raised upper capital limit

71. The second component of the reforms to provide protection against unpredictable and unlimited care costs is an extension of the means test through an increase in the Upper Capital Limit (UCL) from £23,250 to £100,000. By raising the UCL more people will become eligible for state support towards the cost of their care. The raised means-test is the most important form of protection for people with

chargeable assets under £100,000. This means they will contribute a much smaller proportion of their assets than they would otherwise have done. It also means that it is very unlikely they will spend as much money towards their care as people who are better off. They are less likely to reach the cap that better off people because means-tested support means they are spending far less throughout their care journey.

Raised lower capital limit

72. The third component of the reforms to provide protection against unpredictable costs is an extension of the means test through an increase in the Lower Capital Limit (UCL) from £14,250 to £20,000. By raising the LCL more people will be protected from using their assets below this level towards the cost of their care.

Unfreezing of the MIG and PEA

73. Unpredictable costs are typically perceived as loss of assets. The fundamental principal of the cap on care costs is that an individual has had the opportunity to accrue savings and a cap will help protect these assets.
74. However, as individuals who fall within the means-test contribute to their care from their income, for those that have been unable to accrue wealth, particularly adults under 65 (some of whom will have been in receipt of care their whole life) and those already supported by the means test, the cap offers very little protection against the loss of income once they fall within the means-test.
75. Income is taken into account when calculating a person's contribution towards their care. There are exceptions; some benefits are disregarded from the financial assessment, such as the mobility component of Personal Independent Payments. Notably, earnings from employment are also disregarded so as not to disincentivise people into work where they can, which aligns with Government's National Disability Strategy to provide more support for disabled people to start and stay in work.
76. If Housing Benefit is paid to the person, this should be disregarded as they will still be responsible for meeting any costs associated with their main or only home. The local authority should also disregard any other payment the person receives in order to meet the cost of their housing and/or to support independent living.
77. A local authority must also ensure that in addition to the minimum guaranteed income or personal expenses allowance, people retain enough of their benefits to pay for things to meet those needs not being met by the local authority.
78. People supported by the means test must be left with a certain amount of income – the social care allowances. The levels of income people must be left with are different depending on the setting.
79. Where an individual is drawing on care in their own home, charging should not reduce an individual's income below the Minimum Income Guarantee (MIG). This must be after any housing costs such as rent and council tax net of any benefits provided to support these costs. The Personal Expense Allowance is the minimum income residents of a care home must be left with.

80. The unfreezing of the social care allowances will help re-align the minimum income that those in receipt of care are left with after care costs each year.

Movement towards a fair cost of care in support of full implementation of Section 18(3) of the Care Act 2014

81. LAs paying more sustainable fee rates is critical to ensuring the government delivers on its objective of capping care costs. A key element to making this align with a cap is to fully implement Section 18(3) of the Care Act 2014, which allows those with assets over the means-test threshold to request the LA to commission their care. This will ensure everyone will have access to the LA-commissioned rate.
82. As previously stated, it is therefore important that users can access care at the rate that the LA would pay to meet their needs to have their costs effectively capped at £86,000.
83. However, the market currently operates on the basis of a cross-subsidy from self-funded to LA-funded clients. The Competition and Markets Authority market study¹³ in 2017 found that self-funder clients pay around 41% more than LA-funded clients in the same care home.
84. If self-funded care users are to be given a right to access the LA-commissioned rate through Section 18(3), this will increase the share of users on the (often unsustainably low) LA-commissioned rate. The LA will need to strategically plan and support providers to adjust to this shift in the market and where necessary fee rates will need to increase to a more sustainable level to help offset a portion of the revenue impact of having more users on the local authority-commissioned rate. Otherwise, the care home market will be worse off at the time of reform (see cost benefit section below).
85. Although some cross-subsidy will be lost as individuals move onto LA commissioned rates, first-party top-ups will be permitted under the new system, allowing private-funding to continue to flow into the system even from Section 18(3) users. The Government is providing funding and guidance to help LAs better support their local markets and move towards paying providers a fair cost of care. This will ensure local care markets can respond to the changes reform will bring.

Preferred option with description of implementation

Implementation plan

Legislation and implementation dates

86. Implementation dates:
- The unfreezing of the MIG and the PEA will begin in April 2022.
 - The increases to the LCL and the UCL will come into force in October 2023
 - Individuals will start metering towards the cap in October 2023.

¹³ [Care homes market study - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/research-data-and-analysis/publications/care-homes-market-study)

87. To support the commencement of Section 18(3), funding to LAs to aid the move towards a Fair Cost of Care will be made available in 2022-23 and 2023-24.
88. The Government will work closely with relevant stakeholders on implementation of the reforms, including implementation issues and mitigation of risks. Guidance for LAs will be co-produced to ensure it is clear and specific, meeting the needs of the sector to implement the changes to the timescales set out above.
89. The implementation period will allow for LAs to prepare for the changes, specifically having in place:
 - a. the required technology
 - b. capability to enable metering towards and tracking of the cap;
 - c. additional workforce to carry out the required additional assessments in preparation for the cap; and
 - d. new processes and procedures as required, supplemented by workforce training. In particular, there will be a process to carry out early assessments in preparation for the cap.

Learning from early adopters of the policy - Trailblazers.

90. Our charging reform implementation plan includes a small number of 'trailblazer' LAs that will implement charging reform earlier than others. The purpose of trailblazers will be to test key charging reform policy and implementation hypotheses, as well as to identify any unforeseen implementation issues that we can mitigate before other LAs replicate them when implementing charging reform. Data will be collected during the trailblazer period that will be used to inform wider implementation roll out.

Legislation

91. The unfreezing of the MIG and the PEA to increase with inflation in April 2022 will be given effect by a Statutory Instrument laid under negative procedure.
92. The Care Act 2014 already legislated for the introduction of a lifetime cost of care. However, as referred to above (in Description of options considered), a clause to amend Section 15 of the Care Act has been laid in the Health and Care Bill.
93. The clause laid in the Health and Care Bill also aims to make technical amendments to the Care Act to ensure the policy intention of Personal Budgets and Independent Personal Budgets are reflected in legislation. The legislation will specify the information which must be included when creating a Personal Budget to ensure that all contributions made by the individual which ought to, in line with the policy intention, count towards the cap at the LA-determined rate, are recorded in the Personal Budget. They also ensure that Personal Budgets and Independent Personal Budgets work as they were originally intended when being used in conjunction with the cap.

94. Otherwise, primary legislation related to the cap will be commenced and the level of the cap and DLCs will be set through Statutory Instrument by affirmative procedure. The extension of the means-test will be given effect by a Statutory Instrument laid under the negative procedure.
95. The cap and UCL statutory instruments, as well as supporting guidance, will be laid and published with sufficient lead time for LAs to prepare for implementation in October 2023. The Government currently expects legislation to be laid in March 2022, before coming into force in October 2023.

Monetised and non-monetised costs & benefits of option 1

Impact appraisal of option 1 (“Do nothing”)

96. Under the ‘do nothing’ proposal, there would be no planned additional government expenditure compared to the status quo. Costs would simply rise in line with rising care costs and demographic pressures and people would still face unlimited care costs. With the aging population more people would be forced to deplete their assets to pay for care, placing increased strain on families, friends, and local communities. Additionally, capital limits of the social care means-test have not been updated since 2010, so gradually fewer and fewer people will be eligible for state support each year due to inflation.

Costs and Benefits of Option 1

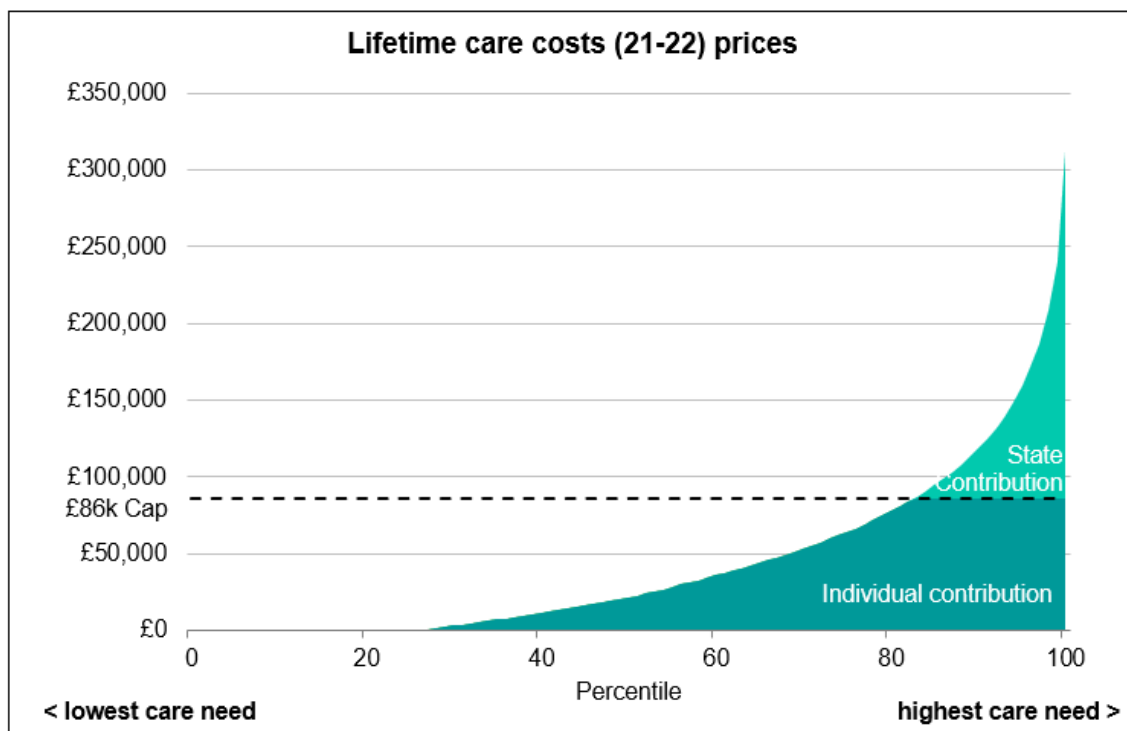
97. There are no costs or benefits associated with this option. This is the baseline against which all other options are appraised.

Monetised and non-monetised costs of option 2 (including administrative burden)

The cap and extended means test

98. 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 until the cap, but if they have higher care needs, they will not face unlimited costs.
99. The cap acts to protect people from costs above £86,000. As shown by Figure 4, it truncates the distribution of care costs borne by individuals and ensures that they are protected from lifetime costs above a certain amount.

Figure 4: Lifetime care costs met by the individual and the state under a £86,000 cap, for people entering care, by percentile in 2021-22 prices – CPEC modelling updated to 2021-22



100. Figure 4 shows how with the £86,000 cap the individual's contribution to eligible care costs stop once they have reached the cap, whereas in the current system they are at risk of unlimited care costs.
101. This removes the risk of individuals needing to pay care costs above this amount and makes it feasible for other financial products to support covering the individual's contribution. Everyone benefits from the peace of mind of knowing that they will not face unlimited care costs, not just the people who enter care or benefit financially from the cap.
102. The time to reach the cap is dependent on several factors which include:
 - a. the local authority residential home rates and any prior community care;
 - b. the amount of chargeable assets of an individual; and
 - c. the level of chargeable income of an individual.
103. Individuals meter to the cap from their personal contributions towards care costs, local authority contributions towards care costs are not part of the metering and therefore those who benefit from state support will take longer to reach the cap for the same care journey.
104. Table 2 showcases the time to cap for individuals when they have variations in their care journey and fee rates, showing how both of those factors can impact how long they receive care before reaching the cap. This is specifically for self-funders who do not receive state support prior to reaching the cap. For example, a self-funder, with chargeable income of £239 per week who has received one year of community

care before moving into a residential home with a rate of £650 will reach the cap after three years and three months of residential care, whereas the same person facing a residential home rate of £850 per week would reach a cap after only two years and three months of residential care due to their higher spend per week on care costs.

Table 2: Time to reach the cap in care home for older adults at different levels of local authority care home rates and prior years in community care

Time in care home to reach cap	No prior time in eligible community care	1 year in prior eligible community care	2 years in prior eligible community care
Residential Care Fee Rates			
£650	3 years and 8 months	3 years and 3 months	2 years and 9 months
£750	3 years	2 years and 8 months	2 years and 3 months
£850	2 years and 6 months	2 years and 3 months	1 year and 11 months

Note: DHSC Analysis – assumes community care costs of £200 per week

105. Table 3 shows how income can also play a factor in the time to reach the cap, particularly for those with chargeable assets below £186,000. We observe that for low income, as the user benefits from state support earlier in their care journey, they would take a long time to reach the cap due to lower personal contributions. However, if an individual has high enough income, they could be solely contributing from their income and assets without any state support until they reach the cap in 3 years and 5 months as seen with the £400 income for someone in the scenario outlined.

Table 3: Time to reach the cap in care home for older adults at different levels of income

Weekly income	Time in care home to reach cap	State Support until cap is reached
£200	5 years, 7 months	£54,000
£250	4 years, 4 months	£24,000
£300	3 years, 10 months	£10,000
£350	3 years, 7 months	£3,000
£400	3 years, 5 months	£0

Note: DHSC Analysis assumes daily living costs of £200 per week, residential care fee rates of £683 per week and an initial chargeable wealth of £150k.

106. Table 4 shows the time taken for individuals to reach the cap if we vary their initial wealth. We observe that for lower levels of wealth, as the user benefits from state support earlier, they would take a very long time to reach the cap. But in that time, they receive a lot of state support to slow down their asset depletion. However, for an individual with higher assets and therefore without (or with very little) state support, they will reach the cap much faster.

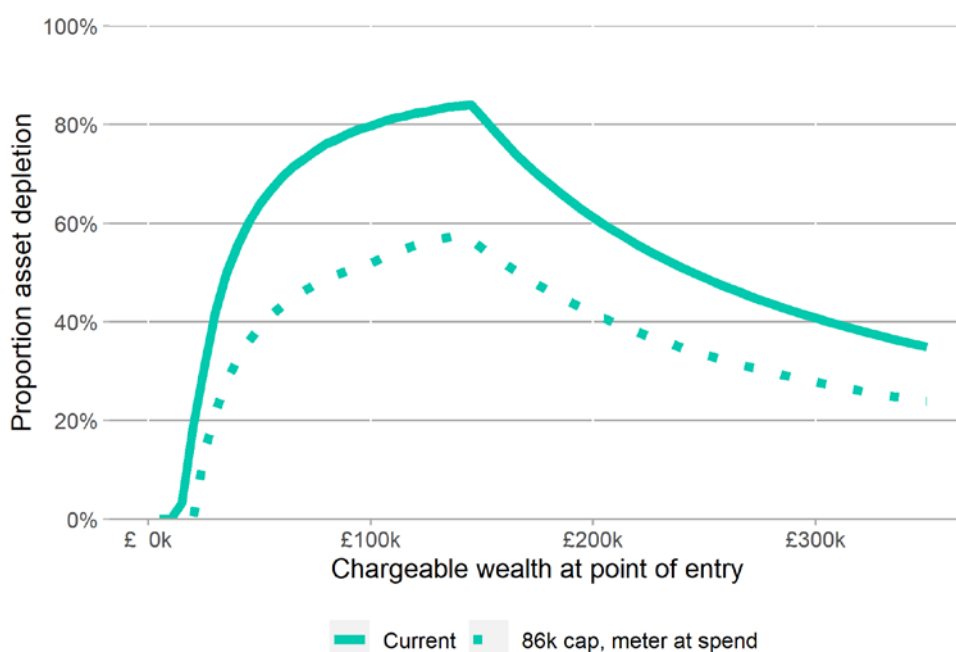
Table 4: Time to reach the cap in care home for older adults at different levels of wealth

Total initial wealth	Time in care home to reach cap	State Support until cap is reached
£100,000	13 years, 9 months	£260,000
£120,000	7 years, 6 months	£102,000
£140,000	5 years, 2 months	£44,000
£160,000	4 years, 1 months	£16,000
£180,000	3 years, 6 months	£1,000
£200,000	3 years, 5 months	£0

Note: DHSC Analysis assumes daily living costs of £200 per week, residential care fee rates of £683 per week and weekly income of £239 per week

107. In the current system it is those of modest wealth (around £80,000 - £160,000 of chargeable wealth) who face the risk of spending the highest proportion of their assets to meet their care and support needs. For example, under the current system, someone with chargeable wealth of £150,000 would have to self-fund their care until they have depleted their assets down to the current upper capital limit of £23,250 before receiving any state support. It is for these people that the cap and extended means test provides the greatest protection.

Figure 5: Possible asset depletion for people who spend 5 years in a care home with local authority care home rate of £683 per week under the current and proposed systems.



Source: Based on DHSC modelling of an individual with an average weekly income for older adults of around £239 per week at the average local authority rate of around £683 per week and 5 years in residential care, by initial level of chargeable wealth (2021-22 prices).

108. For example, at the peak of the chart above, someone with moderate levels of assets of £145,000 and median income of £239 per week could deplete around 84% of their assets over 5 years in residential care with care fees of £683 per week. Under the reforms this same individual would deplete around 57% over the same

care journey and deplete around £40,000 less from their assets. This is the difference seen in Figure 5 at the £145,000 point.

Table 5: Asset depletion for individual with moderate wealth

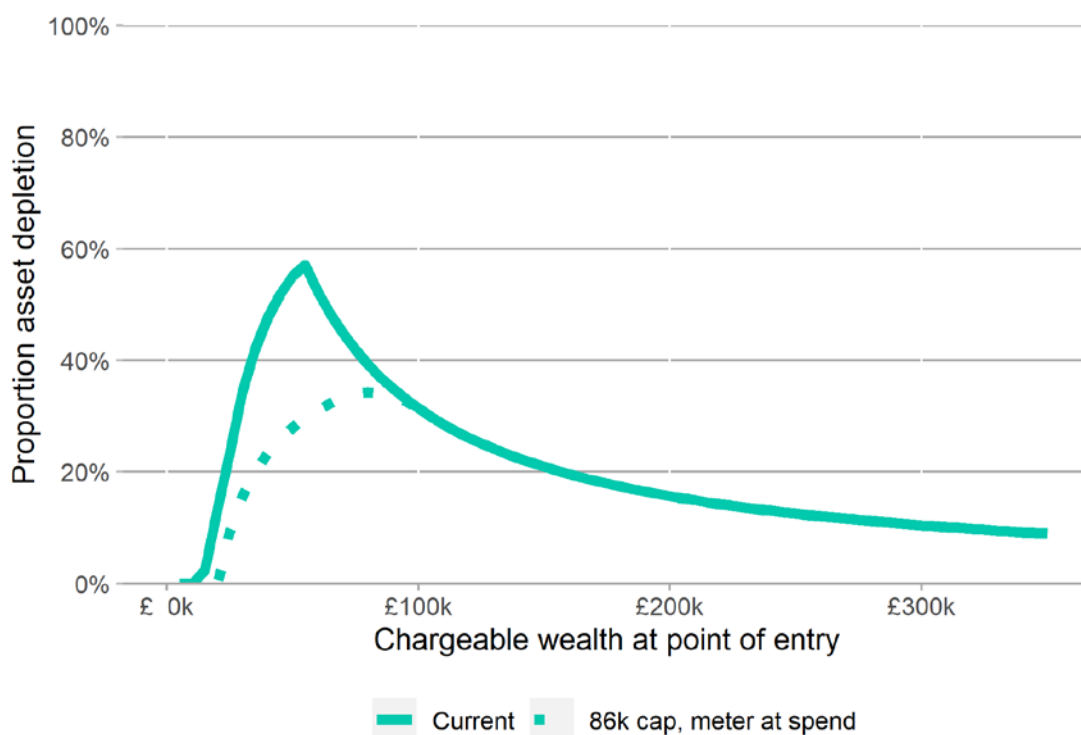
Assets depleted under the current system and the reforms for an individual with assets of £145,000 when entering a residential care home and staying for 5 years.

	Current	Reform
% of assets depleted	84%	57%
Assets depleted (£)	£122,000	£82,000
Difference (£)		-£40,000

Source: based on DHSC modelling of an individual with an average weekly income for older adults of around £239 per week at the average local authority rate of around £683 per week and 5 years in residential care, by initial level of chargeable wealth (2021-22 prices)

109. While many adults in domiciliary care are less likely to see any benefit from the lifetime cap due to care fees in domiciliary care generally being substantially lower, the adults can benefit substantially from the more generous means test.

Figure 6: Possible asset depletion for people who spend 3 years receiving care in their home at a rate of £250 per week under the current and proposed systems.



Source: Based on DHSC modelling of an individual with an average weekly income for older adults of around £239 per week receiving domiciliary care of £250 per week and 3 years in domiciliary care, by initial level of chargeable wealth (2021-22 prices).

110. At the peak of Figure 6, someone with initial chargeable wealth of £55,000 and median income of £239 per week will deplete around 57% of their assets over 3 years in domiciliary care with fees of £250 per week. Under our proposals, this same individual would deplete around 30% over the same care journey, depleting around £15,000 less from their assets. This difference is seen in Figure 6 at the £55,000 point. These people benefit the most in this example.

Table 6: Asset depletion for individual with moderate wealth

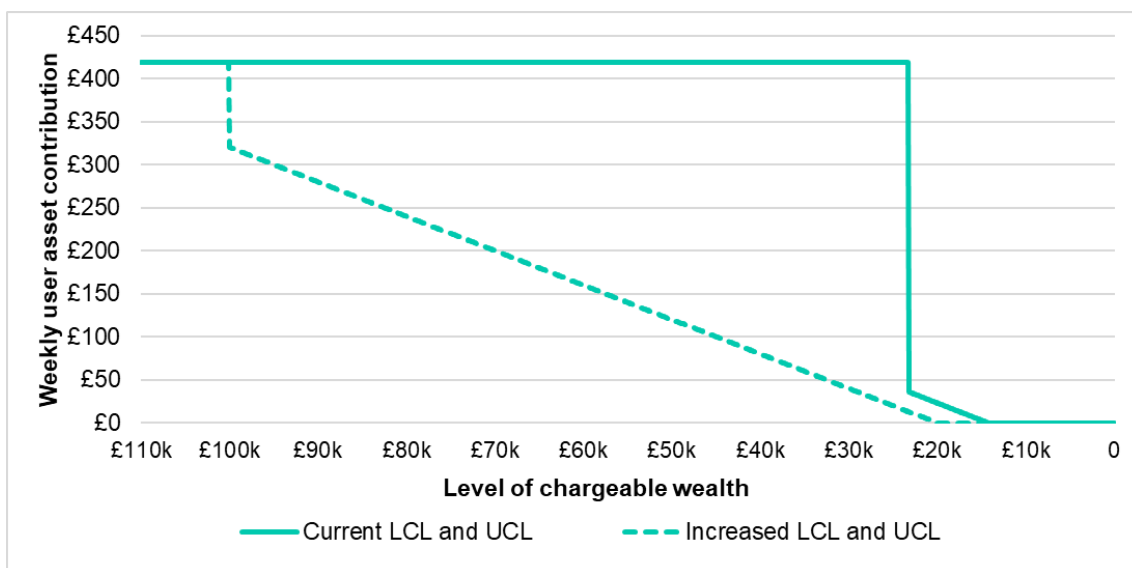
Assets depleted under the current system and the reforms for an individual with chargeable assets of £55,000 when starting to receive care in their home and receiving care for 3 years.

	Current	Reform
% of assets depleted	57%	30%
Assets depleted (£)	£31,000	£16,000
Difference (£)		-£15,000

Source: based on DHSC modelling of an individual with an average weekly income for older adults of around £239 per week receiving domiciliary care of £250 per week and 3 years in domiciliary care, by initial level of chargeable wealth (2021-22 prices).

111. The combination of the cap and the extended means-test protects people with any level of assets from unlimited care costs and defines a new partnership between the individual and the state. People will no longer face an unknown and unlimited future cost for care. A greater number of people than now will have a greater level of wealth protected, and the ability to plan ahead.
112. A person receiving domiciliary care in their home, or receiving residential care while a spouse or qualifying relative lives in their home, will benefit from the housing disregard. This means that the value of their primary home will not contribute towards the means test. Some people who do not benefit from the housing disregard may need to use some of their housing wealth to pay for their personal care costs. Although the reform protects against unlimited costs, care users are still expected to contribute to DLCs throughout their care journeys and their income and non-housing wealth may not always be sufficient to meet these DLCs. Of the users that do need to use some housing assets to pay for care, a higher proportion are protected through the more generous means test under reform. Additionally, Deferred Payment Agreements exist to ensure that no one must sell their home during their lifetime. To further support these reforms, we will work with partners to review the existing Deferred Payment scheme in order to provide more flexibility for people to defer their care payments.
113. The extended means-test also provides immediate additional state support to those with low and moderate wealth. It makes the taper more generous, where people with assets above £23,250 receive no state support and those with £23,250 receive significant levels of state support. Instead, the proposals result in a means-test that gradually increases the state financial support as people deplete their assets.
114. In practice, this means that those who meet the eligibility criteria for the new means-test will benefit from help earlier; when they have up to £100,000 in chargeable assets instead of £23,250 and therefore their weekly contribution is lower as seen in Figure 7.

Figure 7: Weekly user asset contribution with the extended means-test compared to the current system for an individual in a care home with fee rate of £683 per week and income of £239 per week at different levels of chargeable wealth (2021-22 prices)



115. For example, an individual with £80,000 of assets and income of £239 when they enter a residential home will receive around £45,000 of state support through the extended means-test and new cap, compared to receiving only £15,000 state support in the current system by the end of a 3 year stay.

Table 7: State support from local authorities and disability benefits for an individual with £80,000 of assets and £239 per week income over a 3 year stay in a care home (residential care fees of £683)

2021-22 prices	Cumulative state support		Cumulative user spend		Total care costs (incl. DLCs)	
	Current	Reform	Current	Reform	Current	Reform
End of year 1	£0	£13,000	£36,000	£22,000	£36,000	£36,000
End of year 2	£0	£28,000	£71,000	£43,000	£71,000	£71,000
End of year 3	£15,000	£45,000	£92,000	£61,000	£107,000	£107,000

Moving LAs towards a fair cost of care (FCC)

- 116. The full commencement of Section 18(3) of the Care Act 2014 will allow people funding their own care to access the same rates as those funded by local authorities.
- 117. If a significant fraction of people who would self-fund their care under the do-nothing option do choose to commission their services through the local authority, this implementation risks reducing provider income and posing a risk to market sustainability.
- 118. From 2022, Government will be providing funding to enable LAs to better sustain their local care markets and move towards paying providers a fair cost of care. This will help offset some of the lost income providers will face due to the full implementation of Section 18(3). However, we expect local authorities (as part of their strategic planning) to plan for and support this adjustment and to facilitate

different types of care where more appropriate. Providers who face potentially reduced demand from care users may want to consider how best to respond to the more transparent market, and how best to steer their best business.

119. An increase in fee rates also has an impact on the costs for Charging Reform, as state-supported people will meter towards the cap at a higher rate and will therefore reach the cap at an earlier point in time.

Costs of option 2

120. There are different costs that result from the implementation of the reforms for all adults over 18 years:
- Care costs for people eligible for financial support due to the extended means test and cap.
 - Care costs associated with an increase in personal allowances.
 - Administrative costs for LAs to assess whether people are eligible for state support and how they are metering towards the cap.
121. The ongoing costs of higher fee rates as a result of fair cost of care (FCC):
- Costs associated with LA capacity for implementing FCC, including strengthened data and contract management.
 - The interaction of FCC with charging reform.
 - Exchequer costs to provide support for LAs to develop robust strategic plans to sustain their market in anticipation of reform.
 - Exchequer costs to implement robust assurance and oversight of LA ability and progress towards sustaining their market and fair cost of care.
 - Exchequer costs to enhance LAs commissioning and contract management functions to enable them to improve market management.
122. One-off costs to government for implementing the proposed reforms, including:
- Costs to LAs support planning and preparation for implementation of the second phase of the reforms.
 - Costs to LAs to carry out early assessments that are due to the initially high number of new self-funders individuals entering the system. Their ongoing costs are included in the administrative costs for charging reform.
 - Costs to government for implementing trailblazers ahead of the official enforcement of the reforms.

Cost of the cap and extended means-test for older adults

123. This section explains the amount of money that the state will spend on older adults to protect them from unlimited care costs and increase the support from the state through the extension to the means test and the introduction of the cap.

Overview of the modelling

124. The cost projections are estimated using the DHSC social care charging reform microsimulation model. The model is designed to estimate the impact of different charging reform options in comparison to the current system, in particular to estimate the public spend on older adult social care and the distributional impact of the different reforms. The model has been externally reviewed on several occasions:
- The Institute of Fiscal Studies (IFS)¹⁴ review gave the model a positive assessment in 2018 and several the recommendations made were implemented.
 - Further reviews were undertaken in 2020, including working collaboratively with Sir Andrew Dilnot.
 - A review by the Government Actuarial Department (GAD) concluded that the model is appropriate for estimating the cost of charging reform. Furthermore, GAD's own modelling of the cost of reform using a different method produced similar results.
125. The model is a cross-sectional model that simulates the uncompleted care journeys of a representative cross-section of people who draw on care and support at a given point in time. It independently models each year from 2022-23 to 2031-32. For each year modelled, the cross-sectional population, who have varying care journeys, have their care journey modelled up to that point in time. Their contribution and the state's contribution at that point in time is determined by previous interactions with different charging rules. Repeating this across the whole model population gives the cost to state of a given charging system at a given point in time.
126. The model uses a base sample from wave 9 of the English Longitudinal Study of Ageing (ELSA)¹⁵ population filtered for older adults in England who need assistance with one or more Activity of Daily Living (+ 1ADL). There are around 1,000 people in wave 9 meeting these criteria, the most recent wave of the survey. It models six care settings separately: nursing homes, residential homes and four levels of domiciliary care (low, medium, high and very high intensity). The base sample provides the individual wealth and income characteristics used in the model, as well as some other key characteristics for determining interaction with charging rules (marital status and homeownership status).
127. The base sample is reweighted using weightings derived from projections from the CPEC (Care Policy and Evaluation Centre¹⁶, formerly PSSRU - Personal Social Services Research Unit¹⁷) long-term care projections aggregate model of the number and characteristics of care users in future.

¹⁴ Institute of Fiscal Studies (2018): [R151.pdf \(ifs.org.uk\)](https://ifs.org.uk)

¹⁵ <https://www.elsa-project.ac.uk/wave-reports>

¹⁶ <https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf>

¹⁷ [http://www.pssru.ac.uk/-](http://www.pssru.ac.uk/)

128. For each care setting the model runs a representative sample (through weighting the base sample) through an individual care pathway model.
129. Each individual in the sample is assigned a random care pathway from a derived distribution of all uncompleted care pathways using PSSRU survey data. The individual care pathway model computes the state and private spend for each month of the care pathway, this is dependent on the individual's characteristics (income, wealth, household type, housing tenure) and the funding system being modelled. The quantities of the cross-sectional point are aggregated using the weights to produce population level estimates.
130. The model is useful to compare the impact of a reform compared to the current system. However, it does not directly align with the current and projected costs of the current system. This is because it captures the spend that could be faced by a person but does not capture system wide costs which the state / local authorities face to maintain a social care system.
131. To align with the costs of the current system, both the cost of reform and the current system are proportionally uplifted to align with the state costs that will change under a reform. The costs that will change with reform will be the costs to the state for individuals in different care settings and other local authority costs such as that of assessments and reviews, taken from the DHSC Long-Term Demand Model.
132. The results produced are not definitive costs of reform but are sensitive to different assumptions used and are better interpreted as a central estimate of the cost to state of different reform options. More details of the modelling are provided in Annex B: Peace of Mind Methodology.

Projected costs

133. The model for older adults is run with £86,000 cap, £20,000 LCL and £100,000 UCL implemented in October 2023, MIG and PEA increasing with inflation from April 2022.
134. With the central set of assumptions, we project the charging reform costs for older adults increasing from just over £0.41 billion in 2023-24 to around £2.92 billion in 2031-32, as can be seen in Table 7. This includes the opportunity cost of LA time spent on additional assessments for state-supported individuals, as well as the financial cost to them of supporting more individuals who now fall under the more generous means-test or hit the cap. The latter effect represents the shift in burden of paying for care costs from individuals to the state and is therefore a transfer rather than an economic cost.
135. The costs can be understood as follows:
136. The proposals begin in October 2023 and so costs are lowest in 2023-24.
137. Most do not reach the cap for several years, and therefore the initial years only include the costs of the means-test and administrative costs that are increased for the state supported population. The costs between 2024-25 and 2025-26 are steady

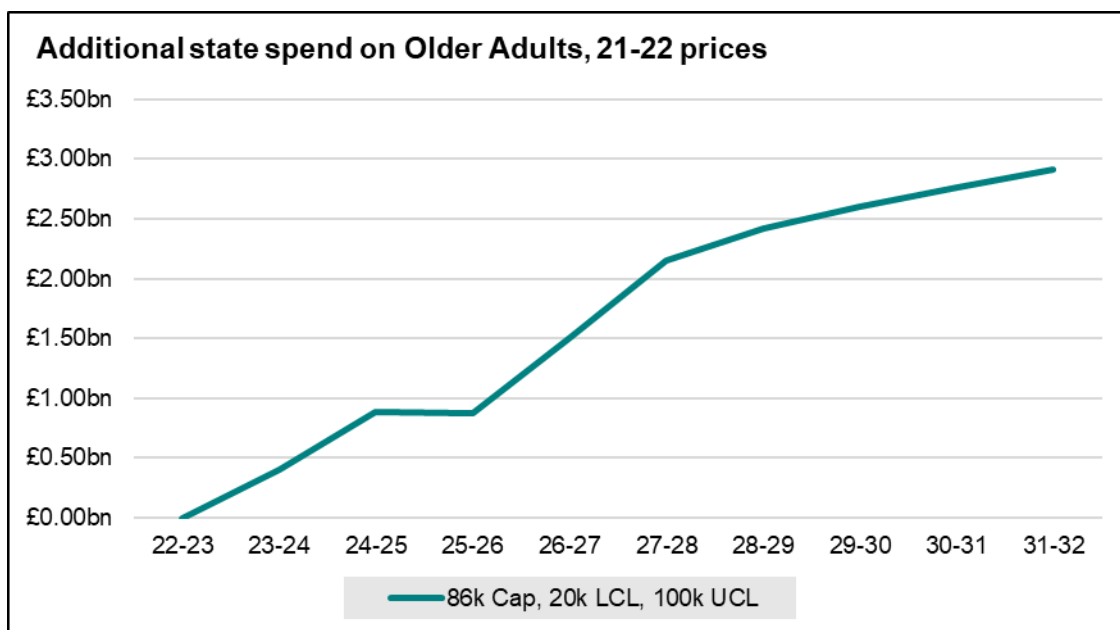
as they reflect the system still only being impacted by users benefitting from the means tests.

138. In the first year, many immediately benefit from having assets between £23,250 and £100,000. Under the current system some of these users would have benefited from full state support after a few years by reaching the LCL. Under the reform, those that start on the taper at £100,000 do not reach the LCL as fast and we see the effect of this in year 25-26 where the additional costs of reform drop very slightly.
139. The costs from the cap are observed from 2026-27 in our modelling where a lot of the self-funder population start hitting the cap. Care users will reach the cap at different points as seen from the time to cap analysis above. The variation of care home fees across the country and the different characteristics of individuals explains the gradual increase in costs as different users hit the cap.
140. While the costs of the reform will increase annually post 2031-32, this is due to an increase in projected underlying demand rather than reform, and so we have chosen a standard ten-year appraisal period. Due to the nature of the cap and that all care users begin with their meter at zero, the state does not incur additional costs from the cap immediately. Roughly four years after implementation (2027-28), the majority of those who will hit the cap do so and the cost of those who have not reached the cap yet after 2027-28 is minimal. Therefore, steady state is reached approximately 4 years after implementation. From that moment onwards, the drivers of increased costs are an increase in projected demand in line with the underlying CPEC projections; increase in the unit cost of care; and the proportion of the population that are likely to be self-funders. The CPEC user projections go as far as 2038 and project an average increase in the total care population of 2% per year from 2031-32 to 2038-39. This increase in demand increases the cost to the state from social care in both the current and a reform system, however the projections have increasing uncertainty further into the future.

Table 8: Projected additional state spend relating to older adults for charging reform, £ billion, 2021-22 prices

<i>Financial Year</i>	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Older Adults										
86k Cap, 20k LCL, 100k UCL	0.00	0.41	0.89	0.87	1.51	2.15	2.42	2.60	2.76	2.92

Figure 8: Projected additional state spend relating to older adults for charging reform, £ billion, 2021-22 prices

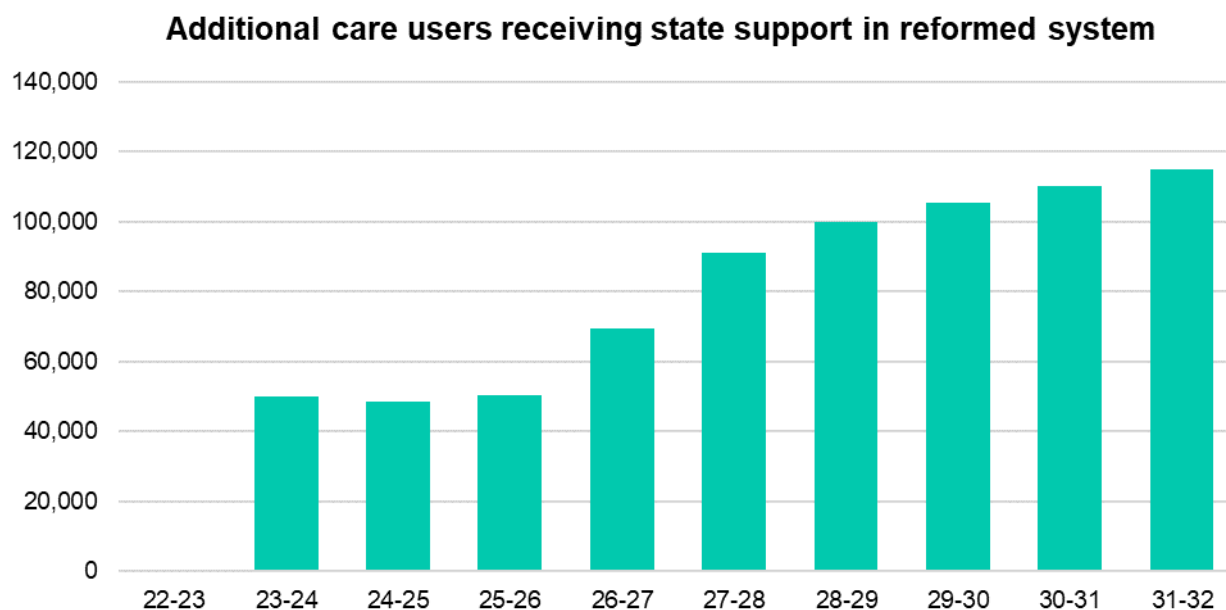


141. By the end of 2025-26, very few benefit from the cap. The main additional beneficiaries in those early years are those who get to support through the increased upper capital limit. By 2031-32 around 115,000 additional people would be receiving state support with their care costs when considering the care population at any one time, 74,000 of whom would have reached the cap.

Table 9: Projected number of additional older adults receiving state support and number of care users reaching the cap at any one in time

	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Additional people supported	0	50,000	49,000	51,000	70,000	91,000	100,000	105,000	110,000	115,000
Number reaching the cap	0	0	0	1,000	21,000	47,000	59,000	65,000	70,000	74,000

Figure 9: Projected number of additional older adults who draw on care receiving state support at any one time



Source: DHSC modelling

142. State support is extended to these additional individuals through a combination of the cap and the means-test. As the cap provides a universal element to a means-tested system, the additional spend goes towards those in the high wealth groups (as the lower wealth groups already receive state support). The overall system remains progressive.

Assessment costs

143. The assessment process is an important intervention. It is the first step in ensuring that the care and support system is personalised as it identifies the person’s strengths and the network that supports them. It helps people understand and think about their own requirements, as well identifying what those are and what outcomes the person wants to achieve. It can also identify the impact on other people, e.g. an unpaid carer, which could result in their carer being offered a carers assessment, for instance.
144. The reform will likely lead to an increase of administrative costs for local authorities to assess whether people are eligible with regards to their care needs and financial needs for state support and how they are metering towards the cap. Care users receive a needs eligibility where their care needs are assessed by the local authority to decide a care package, and also a financial assessment to determine their level of income and wealth that is chargeable as per the criteria to receive the right level of state support.
145. These assessment costs can broadly be divided into two different categories: costs for state-supported people, and costs for self-funders.
146. Assessment costs for state-supported people are reflected in the above costings as part of the re-alignment to the future costs of the current system. This is because

the costs to local authorities of assessing, supporting, and administering the care system is included within the DHSC Long term Demand Model projections.

147. Assessment costs for self-funders arise so that people can begin to meter towards the cap. This is a change from what currently happens and is therefore not included in the Long Term Demand Model baseline and needs to be calculated separately. These assessments include checking if the person meets a care needs threshold and should be reviewed at least annually, with additional reviews occurring if needs change.
148. The three assessments are appropriate for different types of people:
- i. full assessments are for new self-funders who wish to start metering towards the cap;
 - ii. reviews are for existing self-funders who are metering towards the cap; and
 - iii. case management is for self-funders who receive high intensity domiciliary care.

Table 10: Unit costs of assessments and reviews, in 2021-22 prices

	Costs (2021-22 prices)
Full Assessment	£616
Review	£308
Case Management	£1,120

149. The unit costs of assessments, reviews, and case management above are based on the previous impact assessment published in 2015 as it involved extensive engagement and joint working with local authorities¹⁸.
150. For older adults, we combine the unit costs of assessments with user number projections from DHSC modelling of the central reform scenario. The projections below do not include the years 2022-23 and 2023-24 as due to the implementation during this period the figures are slightly different. The additional costs relating to those years is provided in the implementation costs section. The user number projections are as follows.

Table 11: Projected number of self-funding older adults in care each year for charging reform

	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Existing self-funder	–	–	140,000	144,000	139,000	132,000	132,000	136,000	139,000	144,000
New self-funder	–	–	136,000	140,000	136,000	131,000	131,000	135,000	139,000	143,000
High intensity domiciliary care self-funder	–	–	14,000	14,000	15,000	15,000	15,000	15,000	15,000	16,000

¹⁸ [Response to the consultation on funding formulae for implementation of the Care Act in 2015/16 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/444444/response-to-the-consultation-on-funding-formulae-for-implementation-of-the-care-act-in-2015-16.pdf)

151. We have then applied the unit costs to the user number projections with the following assumptions:
- 80% of eligible self-funders come forward for metering. This figure is based on the same assumptions as the take-up assumption discussed previously.
 - 16% extra ineligible people come forwards for an assessment and receive one at full cost.
 - The average number of reviews per year is 1.2, as some individuals will have more than one assessment in the year due to changing needs.
 - All self-funders receiving high-intensity domiciliary care opt for case management. This is a conservative assumption, as there is limited data to base uptake assumptions on.

Table 12: Projected costs of additional assessments, reviews and care management, £m, 2021-22 prices

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Central estimate	0	0	150	160	150	150	150	160	160	170

Key assumptions and uncertainty (older adults)

Unit cost of care and future projection

152. In the modelling we make assumptions on the local authority unit cost of care in the year of implementation and then project this forward with inflation. The outturn data we have used is from NHS Digital's ASC-FR 2019-20 returns, shows the average local authority unit costs for residential care to be £662¹⁹. We have used this to ensure we are not misrepresenting due to COVID-19 related impacts which exist in the latest data.

Table 13: Unit costs of care for older adults in cash prices – NHS Digital ASC-FR

£ per week	2015-16	2016-17	2017-18	2018-19	2019-20
Nursing	563	606	638	678	715
Residential	549	565	604	636	662

153. Care costs are assumed to increase in line with average earnings due to the labour-intensive nature of care and support. This assumption makes no requirement for efficiency gains in the provision of social care services. Care costs have risen over the past five years, driven, in part, due to rises in the National Minimum Wage. ASC-FR fee rates for 2020-21 have been released in October 2021 but were not used in the modelling.

¹⁹ <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20>

Table 14: Unit Cost Increase Assumption

% increase	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25 >
Average Earnings Index (2019-20 to 2021-22)	3.0%	0.7%	2.4%	1.7%	1.7%	1.3%
CPEC Unit Cost Growth (2022-23 onwards)						

154. There is uncertainty around the projection of care costs. We believe a short-term assumption of increasing in line with average earnings, balances the risk between further below trend increases and pressures to catch up following the recent trend of costs remaining flat.

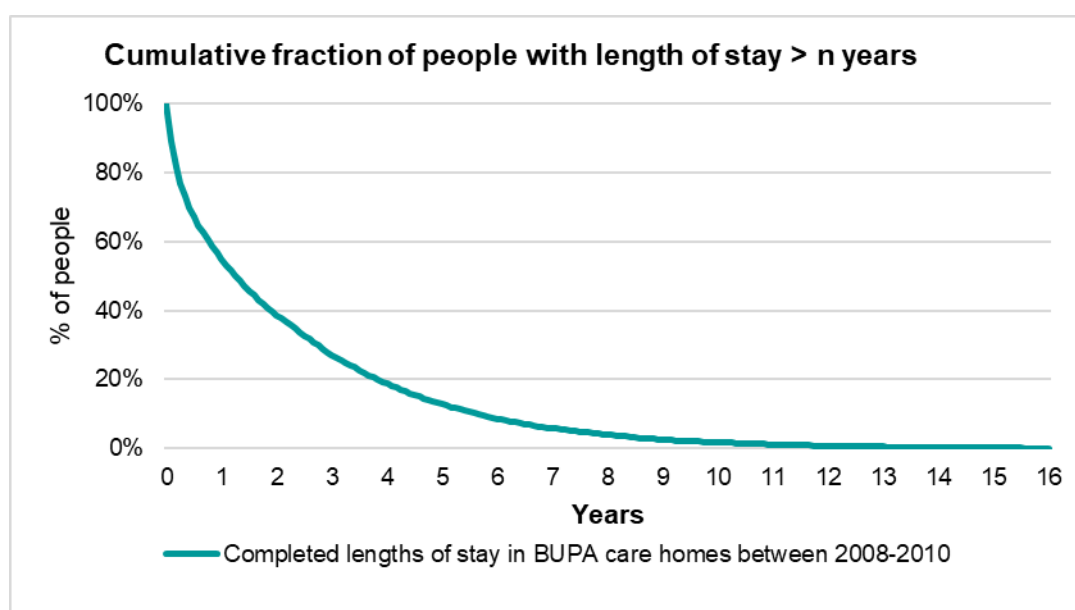
Table 15: Projected average care costs for older adults 2019-20 to 2024-25, 2021-22 prices

	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Nursing (per week)	£715	£720	£737	£750	£762	£772
Residential (per week)	£662	£667	£683	£694	£706	£715
Home Care (per hour)	£17.78	£17.90	£18.34	£18.64	£18.95	£19.20

Lengths of stay in care

155. We use the distribution of lengths of stay from the PSSRU study of BUPA care homes²⁰. The sample had a mean completed length of stay of 27 months and a median length of 15 months.

Figure 10: Completed lengths of stay (BUPA-PSSRU)



156. As our central assumption we assume that lengths of stay remain constant in the future.

157. We recognise that the availability of analysis and data regarding the lengths of stay is somewhat limited and there is uncertainty around the lengths of stay. DHSC has explored more recent data sources, however the datasets we have had access to have had limitations such as being specific to certain regions or local authorities.

²⁰PSSRU, Lengths of stay in care homes <http://eprints.lse.ac.uk/33895/1/dp2769.pdf>

They did not suggest a substantial difference in length of stay and DHSC continues to engage with stakeholders such as CPEC to learn from new sources of evidence.

Demand projections for formal care and support

158. The modelling assumes the demand for formal care and support grows according to the CPEC long term demand modelling which projects social care demand from demographic trends, including the number of self-funders. The key assumptions are the 2019 ONS based population projections (low migration variant as used by the Office of Budget Responsibility in their central projections) and that care and support need prevalence by age and gender band remains constant in the future. Various publications provide further details of the projections and the methodology and assumptions used²¹. We assume that these projections are not significantly affected by the implementation of the reforms (other than moving self-funded care users in the current system to being state supported in a reform system). Implicit assumptions around some of the criteria that could affect demand projections are explained in further detail below.
159. To achieve sensitivity analysis around a scenario where the care population was larger than projected, we could simply multiply additional state spend from reform by the proportional difference between projected and actual size of care population. We have not provided this analysis due to a lack of meaningful insights that could be derived from it. For example, if user numbers were 5% higher than currently estimated, the additional cost to government would also increase by 5%.

Life expectancy

160. There is uncertainty in whether changes in older adult health and healthcare provision will see fewer or more people drawing on care, and whether their care needs will be more or less intense. We have assumed that the distribution of care journeys and intensities will not change for the care population but have assumed that the overall size of the care population will increase in future.

COVID-19 Impact

161. All key data sources used are based on pre-COVID-19 data collections and therefore this analysis does not take into any impacts from COVID-19.
162. Although the latest data on demand for social care – which include the higher mortality observed in 2020 during the COVID-19 pandemic – suggest a decrease in life expectancy for the period 2018-2020, it is too early to say what will be the impact of this on long-term trends in life expectancy. It is too early to understand what, if any, impact COVID-19 will have on long-term demand.
163. More recent ASCFR data for 2020-21 has now been published, but as noted in other sections, they are affected by COVID-19 impacts, and the most appropriate way to estimate future costs is thought to be to project forward from 2019-20 data.

²¹ http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/121203_care_for_older_people_1.pdf

Eligibility criteria

164. The modelling is based upon estimates of current social care eligibility; this is consistent with the implementation of the national minimum eligibility criteria in April 2015.
165. We assume that 100% of individuals who received LA support under the current system will also be eligible for state supported care under the reform.
166. In practice, not everyone self-funding their care would meet the LA eligibility criteria for receiving state support – whether because they self-fund an intensity of care higher than their eligibility or because they would not be eligible for any social care. We assume that 89% of individuals who are self-funders in community care would meet the criteria based on analysis of the Health Survey for England data from 2015 to 2018²². This was estimated to be around 3% of the modelled cost of a reform for self-funded users in domiciliary care who would benefit from a reform based on their financial assessment but would not be eligible based on their care needs as assessed by their LA.

Uptake of the reforms

167. Our modelling assumes that reform will not cause a change in the take-up of state-support for individuals who are already eligible to receive state support under the current system.
168. An important consideration when introducing a more generous offer for adult social care is the extent to which individuals who are not currently receiving state-supported services will take up support. These could be individuals who currently a) pay for care themselves, i.e. self-funders, b) individuals who receive unpaid care and c) people who receive no care at all (e.g. ‘unmet need’). These groups could include those who would already be eligible for support, due to a rising in awareness of how the system works. It is difficult to predict the potential further increase in demand as it is based on their anticipated reaction to the introduction of the policy. The paragraphs below set out what assumptions we have made for these groups of individuals.

Assessment costs

169. There is uncertainty around the current costs of assessment, around how assessments for the cap will be conducted compared to traditional assessments. We will be engaging and working with Local Authorities to better understand the additional costs they may face.

Self-funders

170. We assume that 80% of individuals who were self-funders under the current system and who are eligible to receive support after reform, will come forward to be part of the charging reform system. We assume that the 20% who do not take up reform

²² <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018>

are those who financially benefit the least from reform in our modelling. They account for 9% of reform expenditure.

171. The 80% uptake assumption is a central estimate and was informed by the uptake rates of other state benefits. There is evidence that uptake of cash benefits where the benefit to the individual is immediate is similar to this level. For example, take up of the guarantee credit element of pension credit is 70% of families and 77% by expenditure (total amount of benefits that could have been claimed and was claimed). The relatively higher expenditure figure suggests that the individuals who would benefit the least are the most likely to choose not to take up the benefit. Take up of housing benefit by pensioners is 86% by caseload and 90% by expenditure²³.
172. Assuming that not all eligible people will take up the cap is in line with the economic concept of time preference, which suggests that people prefer value now rather than later. Not all people will therefore see a significant benefit in receiving a cap on care costs that comes into effect at an uncertain point in the future, as they take into account the likelihood that it will never come to that event in the first place, and that the actual costs might be less than £86,000. The actual (time) costs associated with the initial assessment process, in combination with a low level of risk aversion, might offset the perceived benefits of the cap. In addition, potential care users will need to pass the LA assessment tests based on care and financial needs, and whether informal support is available. This will reduce the incentive to take up the cap or the ongoing support available to those below the UCL.
173. If anything, we believe that the 80% assumption is an upper estimate, because it does not take into account the administrative burden and associated time cost for people to take up the cap, nor the fact that potential benefits from a cap in the future provide much weaker incentives to participate compared with the cash benefits upon which the central uptake assumption is based.
174. We also recognise that there is uncertainty on the proportion of self-funders there will be in the care system in the future. Our model is based on the long-term user projections provided by CPEC which provides a forecast of the split of state-supported and self-funders in the current system.

The number of unpaid carers in England

175. Unpaid carers make a vital contribution supporting people with care needs. The reported that there were 5.4 million people providing unpaid care at time of the census, 5.3 million of these were over the age of 16.²⁴ Alongside the Census other data sources exist that provide us with rich information about the provision of unpaid care in England, including the Family Resources Survey and Health Survey for England. For example, using 2019 Health Survey for England data²⁵, ONS

²³ [Income-related benefits: estimates of take-up: financial year 2018 to 2019 - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

²⁴ [QS301EW \(Provision of unpaid care\) - Nomis - Official Labour Market Statistics \(nomisweb.co.uk\)](https://nomisweb.co.uk)

²⁵ [HSE19-Carers-rep.pdf \(digital.nhs.uk\)](https://digital.nhs.uk)

population projections²⁶ and CPEC ASC projections²⁷, we can estimate that in 2021, there were approx. 7.7 million unpaid carers over the age of 16 in England.

176. It should be noted that all data sources which provide estimates of the number of carers and information about their characteristics will have limitations, including people not recognising themselves as unpaid carers. In addition, there exists some variation across data sources in question wording asking about the provision of unpaid care.

Impact of reform on unpaid carers

177. Robust evidence on whether a more generous charging system will increase the number of individuals in the formal care system is limited. We might expect to see a switch from unpaid care to formal care as a result of charging reform if individuals are currently under-consuming formal care services due to financial reasons. In other words, where unpaid care recipients have chosen not to take up formal care because doing so is too costly.
178. Bell et al (2007) found that the introduction of free personal and nursing care in Scotland led to no significant change in the total number of unpaid carers. But it did lead to a decrease in the proportion of unpaid carers that provide a very high intensity of care to someone they live with (100+ hours per week) from 46% to 27%²⁸. This was corresponded by an increase in the proportion of unpaid carers providing less intensive care (between 0-19 hours per week) to someone they live with. This suggests that when presented with free personal care, unpaid carers - particularly those who are providing very high intensity care to someone they live with - might partially substitute a portion of the unpaid care they provide with formal care, and may change the type of care provided (e.g. providing less intensive caring activities themselves but commissioning formal carers for other tasks i.e. personal care).
179. The findings from Scotland (above) are broadly consistent with more recent research examining the degree of substitutability between formal and informal care from Nizalova et al (2019) who found a negative relationship between formal and informal care within the household, suggesting a degree of substitutability between the two modes of care. This relationship was not significant for those providing care outside of the home²⁹.
180. We believe that the extent to which adult social care charging reform will lead to an impact on the amount or type care provided by unpaid carers will be small and limited. This is due to the following reasons:
- a. We would expect any impact of charging reform on the behaviour of unpaid carers to be significantly less than what was observed in Scotland as a result of the introduction of free personal care. This is because of the large differences

²⁶ [National population projections: 2018-based, 10-year migration variant for Wales - Office for National Statistics](#)

²⁷ [Projections of Adult Social Care Demand and Expenditure 2018 to 2038 \(lse.ac.uk\)](#).

²⁸ [Bell et al \(2007\): Did the Introduction of Free Personal Care in Scotland Result in a Reduction of Informal Care?](#)

²⁹ [Nizalova et al: The impact of formal care on informal care for people over 75 in England](#)

between the two systems which mean that the financial incentives to reduce unpaid care in England are less than what they were in Scotland.

- b. The decision for unpaid carers to provide care may be driven by non-financial incentives. What we know about the behaviour of unpaid carers, including common motivations (e.g. altruistic behaviour, and a sense of duty), suggests that financial incentives are not the main driver for the decision to provide unpaid care, so a more generous charging reform system might have little impact on the decision to provide unpaid care. Only a third of all unpaid carers indicate that the decision to provide care included some form of financial motivation, compared to four fifths of carers who indicated the decision to care was free choice³⁰.
 - c. The primary objective of the proposed reform is to provide more state support for those already receiving formal care and protecting them from unlimited care costs.
 - d. Where any behavioural impact is observed, we would primarily expect to see this change in behaviour amongst individuals who benefit from the extended means test as opposed to the cap. This is because A) individuals need to accumulate high social care costs to benefit from the cap and it is not possible for individuals to know early in their care journey whether they will ever reach the cap; and B) benefitting from the cap will take several years, at which point the decision about whether to provide unpaid care or to purchase formal care might already have been made.
181. Overall, our central assumption is that we believe that the impact of charging reform on people who provide unpaid care will be limited. We have tested this assumption in our sensitivity analysis and we will carefully monitor the impact of these reforms on demand for formal care using data returns from local authorities.

Deliberate asset deprivation

182. Under the current charging system, some individuals that interact with the care system may have an incentive to engage in deliberate asset deprivation. Individuals may behave in this way to decrease the amount they are asked to pay towards their care costs. This may be more likely for those just above the upper capital limit.
183. This is a feature of the current system, and local authorities conduct investigations if they suspect that deprivation of assets has occurred. Annex E of the care and support statutory guidance details guidance on how LAs should respond if they suspect this³¹.
184. It is difficult to estimate whether reform would increase or decrease incentives to participate in deliberate asset deprivation. This is due to a lack of evidence on the prevalence of this behaviour in the current system. However, we do not expect reform to lead to a significant change in the prevalence of this behaviour.

³⁰ <https://pubmed.ncbi.nlm.nih.gov/28401583>

³¹ [Care and support statutory guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/674423/care-and-support-statutory-guidance.pdf)

Sensitivity analysis (older adults)

185. This section focuses on analysing how the costs of reform could change if our assumptions were to be optimistic. We focus on a plausible downside scenario, relative to the baseline reform scenario presented above, to see what the impact on costs from the changes would be.
186. Our sensitivity analysis of the older adult costings focuses on a plausible downside scenario that encompasses the following changes with respect to the baseline reform scenario:
 - a. User wealth and income 10% higher - fewer state supported users under no reform and more newly state supported users under reform
 - b. Length of stay increase of 5% - users are in care for longer
 - c. Changes to assumption of escalating intensity of care in domiciliary care - users now spend at least half their domiciliary care journey in their highest intensity of domiciliary care (under the baseline scenario reform option they spend equal proportions of time in each domiciliary care setting they experience);
 - d. Behavioural impacts – increase in domiciliary care population of 9% from users coming forward who would now get some state protection from the means test.
187. This scenario was selected as it characterises areas where there is uncertainty in our assumptions and data, and where changes in those assumptions would have a significant impact on reform costings.
188. For the first three changes (a), (b), and (c) we are able to apply the required changes to both the existing and reform systems in the Microsimulation model in order to determine the impact they will have on state spend. It should be noted that all three of these changes would impact the existing baseline population of the current system and their characteristics.
189. We have taken the figure of 10% for income and wealth as the ELSA data is sourced from individuals who are receiving care at home or no formal care but have stated they have 1+ADL. Therefore, there is some uncertainty in the data as it is from survey data and does not directly reflect the care population. It is also based on 2018-19 data. Nevertheless, we still expect this to be an upper estimate of income and wealth as the ELSA 1+ADL population (which we use) is likely to have higher wealth levels than those in care.
190. Higher income and wealth for care users than the central estimates will mean that the costs will be lower in early years and higher as less users will benefit from the means test due to financial eligibility. However, the costs relating to the cap in later years will be higher as with more income and wealth, users contribute and meter to the cap faster, increasing those costs.

191. We have used an estimate of 5% for length of stay as although the source data is older, more recent evidence from CPEC amongst other stakeholders suggests that length of stay of care users has been consistent over time.
192. The length of stay change has an impact as users spending longer in care means that they can have a longer portion of their care journey in which they are state supported.
193. Assessing likely behavioural change and outcome for local authority services as a result of the reforms is challenging for several reasons. Eligibility for publicly funded support depends on a number of factors, including level of care need, how care needs impact on an individual's quality of life, the extent to which the individual's needs are already met through for instance support provided by their family and the financial situation of the potential care recipient.³²
194. We have carried out illustrative analysis of a change in domiciliary care demand from adults who receive unpaid care only. First, we compare the proportion of adults who receive unpaid care only amongst individuals with wealth below and above the current means test. Using CPEC (2021) research on need and unmet need among older people in the community³³, we estimate that under the current system around 85% of older adults with needs comparable to those receiving local authority funded domiciliary care and whose capital is above the UCL receive unpaid care only. This compares to around 59% for those with capital below the UCL.
195. We assume that individuals with capital between £23,250-£50,000 will have an increased incentive to take up formal care support after reform due to receiving state support under the increased UCL. These individuals would have assets below the new UCL after reform. We could assume that the proportion we observe after reform would be the same as the proportion we observed before reform (i.e. that 59% of all people with assets below the UCL would take up unpaid care only). However, we do not think this is realistic, because on average people who fall under the UCL under the reformed system will have higher wealth compared to those who previously fell under the UCL and state support for people with higher assets (e.g. £80,000) is less generous than for those with lower assets (e.g. £20,000).³⁴ They will therefore have less of an incentive to switch to formal care. We therefore assume that for this cohort of people, 81% of all care receivers would receive formal care. This is the midpoint between 85% (proportion for those above UCL in the current system) and 76% (proportion for those below UCL and above LCL in the current system).
196. We also assume that individuals with capital between £14,250-£20,000 will have an increased incentive to take up formal care support after reform. We assume that for

³² Eligible care needs, which are identified purely in terms of the impact of the inability of individuals to carry out key activities of daily living on their wellbeing, do not always translate into eligibility for care services. This depends on whether the person's strengths (including their access to unpaid care support) offset the impact of their disability on their wellbeing.

³³ https://83ef4ee1-4515-4f78-ba01-32c025e0c0a2.filesusr.com/ugd/442c21_40fb3ce426a24956b41bfb07e301f6d2.pdf

³⁴ This is because, state support becomes less generous the more chargeable assets someone has above the LCL and below the UCL. Individuals with chargeable assets between the lower and upper capital limits pay what they can afford from their income and contribute £1 per week for every £250 of assets between the limits. The more assets you have above the LCL the more you can be charged from your assets. For example, if an individual has £1,000 above the LCL they can only be charged £4 per week from their assets. If an individual has £2,000 above the LCL they can be charged £8 per week.

this cohort, 56% of care users would receive unpaid care only under reform. Under the current system we assume that this would have been 76%. This change is due to the LCL being raised from £14,250 to £20,000.

197. Additionally, we assume that individuals with capital between £20,000-£23,250 will have an increased incentive to take up formal care and support after reform. We assume that for this cohort, 72% of care users would receive unpaid care under reform. Under the current system we assume that this would have been 76%. 72% was derived by applying a 5% reduction to 76% (the unpaid care proportion for those with asset below the UCL and above the LCL in the current system). We assume that there will be no change for those with assets exceeding £50,000. This is because the charging system becomes less generous the more chargeable assets someone has.
198. In total, we estimate an increase of 9% in older adults receiving state supported domiciliary care (per year). We model this by increasing the weights given to self-funders in domiciliary care to produce an overall 9% increase in the number of domiciliary care users in the model. Please note that this analysis is purely illustrative, and highly dependent on various assumptions we make around behavioural changes of individuals and should therefore be interpreted as indicative only.
199. Once we have increased their weights, we calculate the impact of this increased weight on the additional costs compared to the existing system costs (where no change from unpaid care is expected)
200. This is done for the year 2031-32 to look at the steady state effect but the proportional increase in costs is applied to all years of the time series
201. The combined costs of the plausible downside scenario by 2031-32 would be 13% higher than under the baseline reform scenario for older adults as seen below.

Figure 11: Cost of reform package on older adults in central and plausible downside scenario – (a), (b), (c) and (d) combined scenario, £ billion, 2021-22 prices

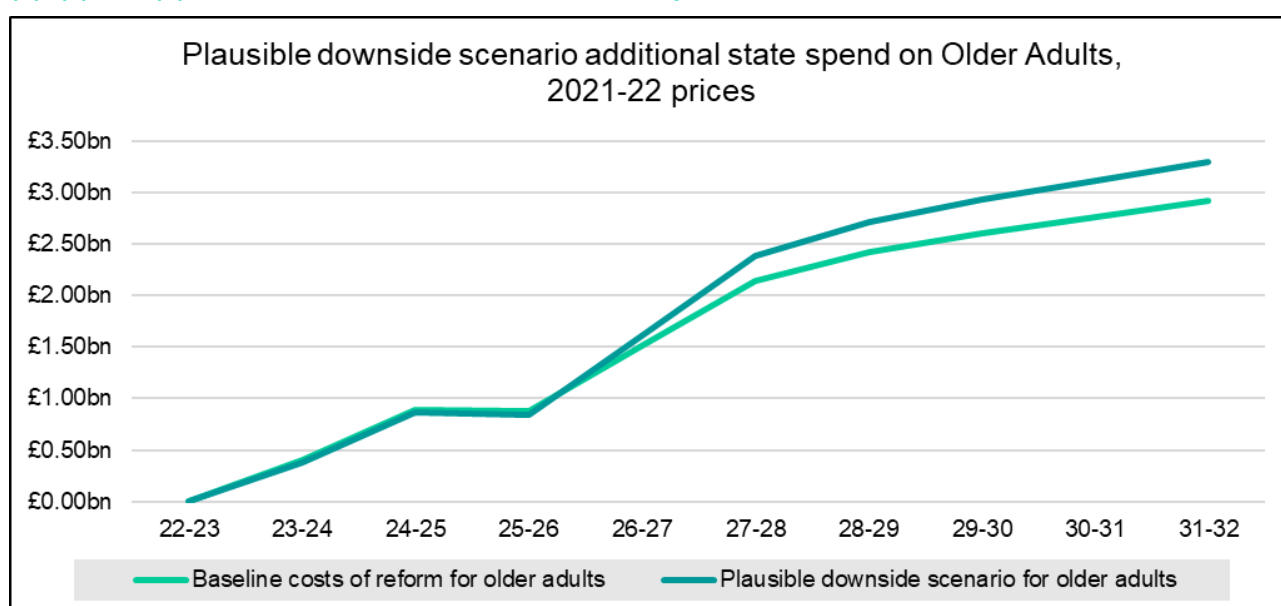


Table 16: Difference between additional cost of baseline reform and plausible downside scenario on the reform in £bn, 2021-22 prices

£ billions, 2021-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Additional Cost in £bn (Baseline reform)	0.00	0.41	0.89	0.87	1.51	2.15	2.42	2.60	2.76	2.92
Additional costs in £bn (Plausible Downside Scenario reform)	0.00	0.38	0.86	0.84	1.61	2.38	2.71	2.93	3.12	3.29
Absolute Difference	0.00	-0.02	-0.03	-0.03	0.10	0.23	0.29	0.33	0.35	0.38
Percentage Difference	0%	-6%	-3%	-3%	7%	11%	12%	13%	13%	13%

202. It should be noted that the sensitivity scenario represents an unlikely and pessimistic scenario. Further, uncertainty around current/future parameters could equally lead to lower additional state spend from a reform. As such, while the sensitivity scenario could be seen as an upper estimate on what reform might cost, our central scenario should not be read as the lower bound of what it could cost. In fact, the lower estimate of what the reform might cost could be substantially lower than our central scenario. This lower cost could emerge if we have over-estimated lengths of stay as compared to real-world care users for example or the estimate of the take up of cap is higher than expected.
203. Under the sensitivity scenario, which considers an increase in lengths of stay, income and wealth of users, increasing domiciliary care intensity and some uptake of reform from unpaid care, charging reform for older adults costs an additional £0.4bn in 2031-32.

Cost of the cap and extended means-test for adults under 65

204. This is the amount of money that the state will spend on adults aged under 65 to protect them from unlimited care costs and to increase the support from the state through the extension to the means test and the introduction of the cap. We have assumed that when a child turns 18 they become part of the cohort 'adults aged under 65'.

Overview of the modelling

205. We take a different modelling approach to that of older people, primarily due to the lack of high-quality data on adults aged under 65. The model was externally reviewed in early 2021 by the Department for Work and Pensions. Unlike the data sources available for older adults modelling, we have been unable to access robust data on care journeys or individual level income and wealth for adults aged under 65. We therefore have used an Excel based model which estimates the average state spend per individual on care and the average user spend on care (user contribution). The model multiplies projected volumes of users who will benefit from the reform by average state spend per individual, to estimate a relative increase in state spend compared to base expenditure. Base expenditure is taken from the

CPEC long-term care projections aggregate model of care users³⁵ as this provides projections split by care setting and care support categories specific to those aged under 65 including clients requiring: learning disability support, physical or sensory support and mental health support (including memory and cognition support). However, as the CPEC expenditure projection is not directly attributable to the system wide costs which the state / local authorities face to maintain the social care system, we take the relative increase in spend and apply this to proportionally uplift the base system cost from the DHSC Long-Term Demand Model³⁶. This provides an estimate of reform costs relative to the DHSC baseline spend on Adult Social care for adults aged under 65.

206. The results produced are sensitive to different assumptions used and should therefore be interpreted as a central estimate of the cost to state of different reform options.

User Demand

207. In terms of volumes of users, the analysis splits under 65 adult care users into three different funding categories: LA funded individuals, self-funded individuals who have care arranged via LAs, and self-funded individuals who arrange their own care.
208. Volumes of LA funded care-users to 2031-32 are derived from the CPEC aggregate model of long-term care projections in England³⁷. The CPEC model produces projections based on assumptions about future trends in the key drivers of demand for long-term care³⁸. The number of people by age and gender changes in line with the Office for National Statistics (ONS) 2018 principal population projections. However, assuming the number of service users will increase in line with this projection for the younger adult population would ignore any expected change in the incidence of disability. Therefore in the CPEC model the prevalence of learning disability by age and gender and of physical disability at ages 18 to 30 changes in line with Emerson et al. (2012) projections³⁹; and prevalence rates of physical disability at ages 31 to 64 and of mental illness are assumed to remain constant by age and gender. These assumptions will impact projected costs of the current system as well as reform, and the user projections have increasing uncertainty further into the future.
209. The number of self-funders is a key driver of the cost of reform. Base volumes of self-funded individuals who have care arranged via LAs and are aged under 65 are based on data from the NHS Digital ASC-FR 2019-20 return⁴⁰. Future years have been modelled based on the trends forecast in the social care demand projections from the CPEC aggregate model.

³⁵ [Projections of demand and expenditure on Adult Social Care. Wittenberg, R, Hu, B & Hancock, R, 2018, PSSRU.](#)

³⁶ [DHSC Long-Term Demand for Adult Social Care Model, 2020.](#)

³⁷ [Projections of demand and expenditure on Adult Social Care. Wittenberg, R, Hu, B & Hancock, R, 2018, PSSRU.](#)

³⁸ [Projections of Adult Social Care Demand and Expenditure 2018 to 2038 \(lse.ac.uk\)](#)

³⁹ [Estimating the Need for Social Care Services for Adults with Disabilities in England 2012-2030 - Lancaster EPrints \(lancs.ac.uk\)](#)

⁴⁰ [Adult Social Care Activity and Finance Report, England - 2019-20 - NHS Digital.](#)

210. The number of self-funded individuals who arrange their own care and are aged under 65 has been more challenging to estimate as there is no robust published estimate for community care. To estimate the number of self-funded individuals who arrange their own care in the community, we worked with a number of domiciliary care providers to review the prevalence of genuine self-funders vs. state funded individuals, in a sample of their client bases. We grossed this estimate up to get a total community self-funder estimate for England using the NHS Digital ASC-FR 2019-20 return.
211. For self-funding in residential and nursing homes, we assumed approximately 1% of adults under 65 in these care settings will be self-funders based on evidence from the LaingBuisson Adult Specialist Care UK Market Research Report⁴¹.
212. Self-funder projections for future years have been modelled based on the trends forecast in the social care demand projections from the CPEC aggregate model by care setting and care support category.

Eligibility Criteria and uptake of reform

213. We use a consistent approach to the older adults modelling for assumptions on eligibility for social care. We assume that 100% of individuals who received LA support under the current system will also be eligible for state supported care under the reform. Then for self-funders, we assume that 89% of individuals who are self-funders in community care under the current system would be eligible to receive state support after reform.
214. Our assumptions on reform take-up are also in line with the methodology for the older adults modelling. We assume that reform will not cause a change in the take-up of state-support for individuals who are already eligible to receive state support under the current system. We assume that 80% of individuals who were self-funders under the current system and who are eligible to receive support after reform, will come forward to be part of the charging reform system. The 80% uptake assumption is a central estimate and was informed by the uptake rates of other state benefits.
215. We apply take-up and eligibility assumptions to the number of self-funders to ascertain demand for support under the social care reform. Table 17 shows our estimate of the number of self-funders (both who have care arranged via LAs or who arrange their own care) who are eligible for and likely to take up the social care reform, in all care settings.

Table 17: Number of self-funders aged 18 to 64 years (applying 89% eligibility criteria and 80% take up assumptions)

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Self-funders	19,900	20,100	20,400	20,700	21,000	21,400	21,700	22,000	22,200	22,500

⁴¹ [Adult Specialist Care UK Market Report. Laing, W, 2019, 3rd ed, LaingBuisson.](#)

Cost Method

216. CPEC's modelling provides annual projections on public expenditure and user spend related to care costs in the community⁴². Projected gross public expenditure is divided by projected volumes of community care users, to give a gross community care unit cost as shown in Table 18.

Table 18: Gross Unit costs of community care per week for adults aged under 65

19-20	Community care
Unit costs (£)	595

217. Unit costs of care for residential and nursing care for adults aged under 65 are taken directly from NHS Digital's ASC-FR 2019-20 return as shown in Table 19. We have used data from 2019-20 to ensure we are not misrepresenting costs due to COVID-19 related impacts in the latest data. The unit costs of care are projected forward with inflation, based on assumptions which are consistent with older adults modelling. As our central assumption, we assume that unit costs increase in line with average earnings from 2019-20 to 2021-22 due to the labour-intensive nature of care. In the years after this, we assume the costs increase with CPEC unit cost growth.

Table 19: Unit costs of Nursing and Residential care per week for adults aged under 65 – NHS Digital ASC-FR⁴³

2019-20	Nursing	Residential care
Unit costs per week (£)	996	1,373

218. Table 19 shows that the unit costs for Residential care are higher than Nursing care which can be explained as i) users with Learning Disabilities have complex needs that will not necessarily be met by nursing care ii) the ASC-FR data is based on the cost to LAs and so excludes for example Funded Nursing Care (FNC) for users with Physical Disabilities and requiring Mental Health support which would increase the total nursing care unit cost.
219. For costing both the enhanced means test and the £86,000 cap, the model estimates the number of self-funders and state supported users who would benefit in each year based on the average rate users spend on their care costs. A key determinant of the rate users spend on their care costs is their wealth and income. We use data from the Wealth and Assets Survey⁴⁴ (WAS) to estimate wealth and income for self-funding adults aged under 65 in need of care as shown in Table 20. The WAS is a longitudinal survey conducted by the Office for National Statistics

⁴² Projections of demand and expenditure on Adult Social Care. Wittenberg, R, Hu, B & Hancock, R, 2018, PSSRU

⁴³ Adult Social Care Activity and Finance Report, England - 2019-20 - NHS Digital.

⁴⁴ Analysis of wealth and assets by disability, age, income, Great Britain, July 2012 to June 2016 and April 2014 to March 2018 - Office for National Statistics (ons.gov.uk)

(ONS) which measures individual's assets, savings, debt, and income. The data is based on self-reported disability and the survey identifies disabled individuals as those who report any physical or mental health condition or illness that lasts or is expected to last 12 months or more.

220. The model uses 2012-2014 WAS data in modelling the central estimate. In the WAS data sample sizes below 30 have been suppressed, shown as “..” in Table 20. This suppression particularly impacts the data for individuals with learning and memory disability, and so we have assumed data for individuals with a physical disability could be used as a proxy for the population in need of social care under the central estimate.

Table 20: Wealth and Assets Survey- Counts by financial and property wealth, personal gross annual income, disability and age, Great Britain, July 2012-2014

Age	Population Group	Annual Gross Income	Financial + Property Wealth (£)				
			Zero or negative	Greater than £0 less than £14,250	£14,250 but less than £23,250	£23,250 but less than £100,000	£100,000 or more
18-44	All	less than £10,000	2,733,000	3,362,000	657,000	3,273,000	1,742,000
		£10,000 or more	1,628,000	2,342,000	921,000	3,919,000	1,756,000
	Physical Disability	less than £10,000	500,000	498,000	56,000	193,000	73,000
		£10,000 or more	111,000	126,000	..	174,000	73,000
	Learning and Memory Disability	less than £10,000	178,000	147,000	..	..	..
		£10,000 or more	..	..	..	..	..
45-64	All	less than £10,000	1,215,000	1,403,000	235,000	2,358,000	3,369,000
		£10,000 or more	430,000	884,000	292,000	2,894,000	2,787,000
	Physical Disability	less than £10,000	642,000	643,000	70,000	629,000	540,000
		£10,000 or more	78,000	112,000	41,000	274,000	262,000
	Learning and Memory Disability	less than £10,000	215,000	193,000	..	113,000	79,000
		£10,000 or more	..	..	..	..	..
65+	All	less than £10,000	403,000	1,705,000	165,000	2,181,000	6,137,000
		£10,000 or more	..	..	..	67,000	166,000
	Physical Disability	less than £10,000	241,000	924,000	79,000	942,000	1,950,000
		£10,000 or more	..	..	..	..	..
	Learning and Memory Disability	less than £10,000	40,000	168,000	..	146,000	293,000
		£10,000 or more	..	..	..	..	..

221. The income and wealth distribution in the WAS data is used to estimate the proportion of the care population in each income and wealth band. For example, based on Table 20, 25% of the aged 18 to 64 Physical Disability population have Financial + Property Wealth greater than ‘£23,250 but less than £100,000’ and could benefit from the enhanced UCL of £100,000. We therefore assume an

equivalent proportion of our estimated self-funder population could benefit from the enhanced UCL of £100,000.

222. The grouped WAS data is limited in comparison to the ELSA data used for the older adults modelling which provides wealth and income at the individual level. We have therefore had to make several simplifying assumptions in using the WAS data for our central estimate modelling:
- a. We are assuming that all wealth reported in the survey is eligible for inclusion in wealth assessments. In reality, there are more complex rules on which assets are eligible for inclusion in wealth assessments for LA funding and how assets are apportioned between household members.
 - b. When calculating the contribution of users, we assume users do not make contributions to their care from their income and assume all contributions are from user assets. In reality, whilst income from employment is excluded from the means test, income from some benefits would be included.
 - c. We assume that weekly user contributions are constant, representative for this group of users and do not decrease over time. In reality, individual user contributions would decline as assets deplete.
223. We next calculate the average rate users spend on their care costs with wealth '£23,250 but less than £100,000'. As we do not know the distribution of wealth within this bracket, we assume a uniform distribution and that all users have average wealth by taking the mid-point value of £61,625. Applying the user contribution of £1 per week for every £250 of wealth between the lower and upper capital limits, to the mid-point wealth value of £61,625 gives a weekly taper contribution of approximately £10,000 per year in the first year. We have modelled this as an average ongoing contribution for this group of users. However, in reality subsequent user contributions will be dependent on individual asset depletion and whether asset levels reach the lower capital limit, when individuals would continue to pay from their income until they reach the cap. As a consequence of taking an average ongoing contribution rate, it will take just on average just over 8 years for this group to hit the cap but our central estimate costs may be an underestimation.
224. The average contribution of a partly state supported user is estimated to be approximately £2,000 per year. This is based on average client contributions across primary support reasons and care settings according to CPEC expenditure projections⁴⁵. Similarly, we have modelled this as an average ongoing contribution for this group of users.
225. The cost to the state for a group of users is calculated as total costs of care minus the average rate users spend on their care costs. The state incurs these costs for a group of users until when, on average, the group hit the cap and the state incurs the full cost of care.

⁴⁵ Projections of demand and expenditure on Adult Social Care. Wittenberg, R, Hu, B & Hancock, R, 2018, PSSRU

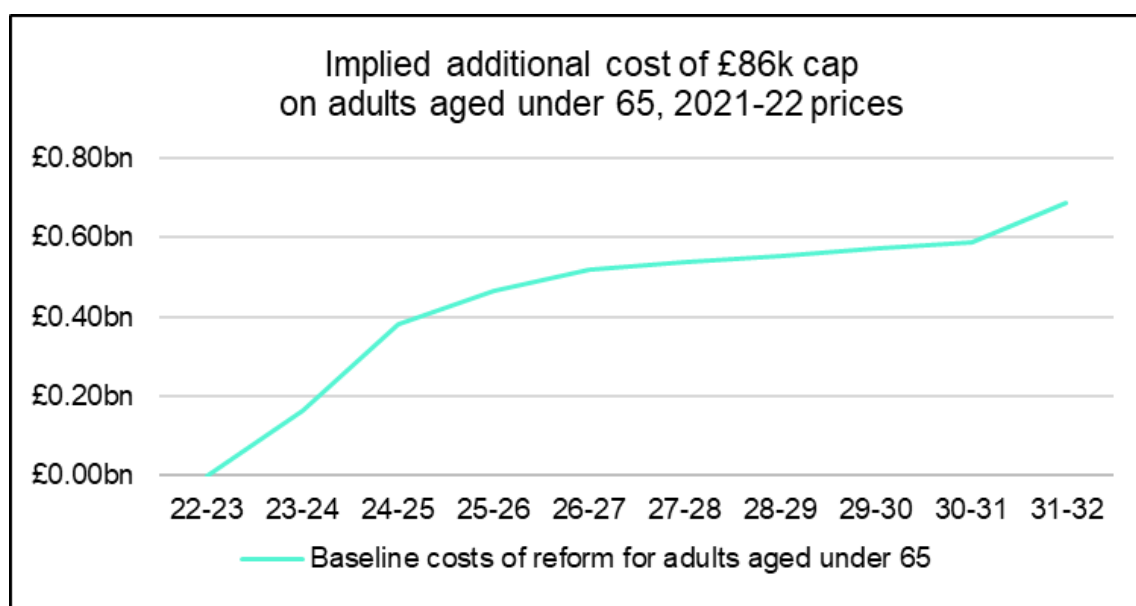
Projected costs

226. The projected costs of reform for adults aged under 65 with a £86,000 cap, £20,000 LCL and £100,000 UCL implemented in October 2023, start at £0.2 billion in 2023-24 rising to £0.7 billion in 2031-32 (in 2021-22 prices). The cost profile can be seen in Table 21 and Figure 12: Implied additional costs for adults under 65 of reform, £ billion, 2021-22 prices.
227. Overall, the costs are substantially lower than for the older adult age group since we estimate there are fewer younger adults currently self-funding their own care. The costs increase from 2023-24 with the first year having lower costs due to the charging reforms beginning in October 2023. The costs in the initial years to 2025-26 are predominantly driven by the enhanced means-test as few in this age group reach the cap by then. However, from 2026-27 we estimate that a significant number of self-funders paying for their own care costs (i.e. with assets or income above the means test), would on average be reaching the cap. We see a more stable period of costs at this point up-to 2030-31. In 2031-32 there is an approximately 20% increase in cost as we estimate that self-funders who benefit from the enhanced means test (i.e. have assets between £23,000 to £100,000) will on average, start to reach the cap.

Table 21: Projected costs for adults under 65, £ billion, 21-22 prices

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
86k Cap	£0.00	£0.17	£0.38	£0.46	£0.52	£0.54	£0.56	£0.57	£0.59	£0.69

Figure 12: Implied additional costs for adults under 65 of reform, £ billion, 2021-22 prices



Assessment Costs

228. The projected costs for adults under 65 include assessment costs. We use the CPEC user demand projections to estimate the current number of care users and future care users requiring assessments out to 2031-32. We assume that the cost of a full assessment for current care-users will be covered by implementation costs, but that this group then require ongoing reviews. We assume new self-funding individuals will require a full assessment, then ongoing reviews. The estimated projections are set out below.

Table 22: Profile of adults needing assessments for adults aged under 65

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Ongoing self-funder (reviews only)	17,100*	17,300*	17,600	17,900	18,100	18,400	18,700	18,900	19,200	19,400
New self-funders (full assessments)	4,000*	4,000*	4,100	4,100	4,200	4,300	4,300	4,400	4,400	4,500

* Assessment costs for the years 2022-23 & 2023-24 are covered under implementation costs.

229. The following key assumptions have been made in estimating assessment costs for adults aged under 65:

- a. The unit costs of reviews are consistent with those in older adults' assessment costs.
- b. 11% extra ineligible community care self-funders, and 20% extra ineligible residential care self-funders come forward for an assessment and receive one at full cost. This assumption is in line with the assessment costs in older adults modelling, and the impact of the assumption will be marginal if incorrect.
- c. The average number of reviews per year for these extra users is 1.2 as some individuals will have more than one assessment in the year due to changing needs. This assumption is of reasonable quality, however, given a degree of uncertainty we have completed a sensitivity scenario which doubles the average number of reviews per year for extra users to 2.4. Doubling the number of assessments to an average of 2.4 increases costs by less than 1% of total under 65 reform costs.
- d. The review and full assessment costs are inflated every year from 2021-22 using CPEC unit cost growth.
- e. We are only estimating the additional assessment cost for self-funders, because the state is already currently funding assessments for state-supported and LA-arranged self-funding users in the current system.

- f. We do not have data available on the split of domiciliary care by intensity for under 65 users. Therefore, case management costs, which apply to self-funders who receive high intensity domiciliary care, have not been included in our central estimate modelling. If we were to assume all new community self-funders require high intensity domiciliary care and so incur case management costs, this increases costs by up-to £5 million per year from 2024-25, which is less than 1% of total under 65 reform costs.

230. Table 23 sets out the total assessment and review costs for adults aged under 65, ranging from £10-£12 million between 2024-25 and 2031-32 in 2021-22 prices. There are nil costs shown in year 1 and 2 as we have assumed these are covered under the implementation costs.

Table 23: Assessment and review costs for Under 65s, £m, 2021-22 prices

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Assessment cost	£0	£0	£10	£10	£10	£11	£11	£11	£12	£12

231. There is uncertainty around the current costs of assessment and around how assessments for the cap will be conducted compared to traditional assessments. We will be engaging and working with Local Authorities to better understand the additional costs they face.

Who benefits

232. ASC-FR data⁴⁶ shows that in 2020-21 approximately 256,100 adults aged under 65 received long-term care support compared to 359,900 older adults. Net public expenditure on adult social care was £20.7 billion in 2020-21⁴⁷ in England. Currently net state spend is broadly even between adults aged under 65 and older adults⁴⁸ which indicates a higher average spend per care user on adults aged under 65 compared to those over 65.
233. Based on the estimates of self-funders used in our modelling for 2020-21, we estimate approximately 90% of care users aged 18-64 are already currently state supported. This compares to approximately 55% of care users aged over 65 being state supported. This suggests that under the current system, a significant proportion of adults aged under 65 are already benefitting from state support compared to older adults. The following table and figure summarise our estimate of additional care users aged under 65 who will benefit under the proposed reforms from the enhanced means test or cap.

⁴⁶ Adult Social Care Activity and Finance Report, England – 2020-21 - NHS Digital.

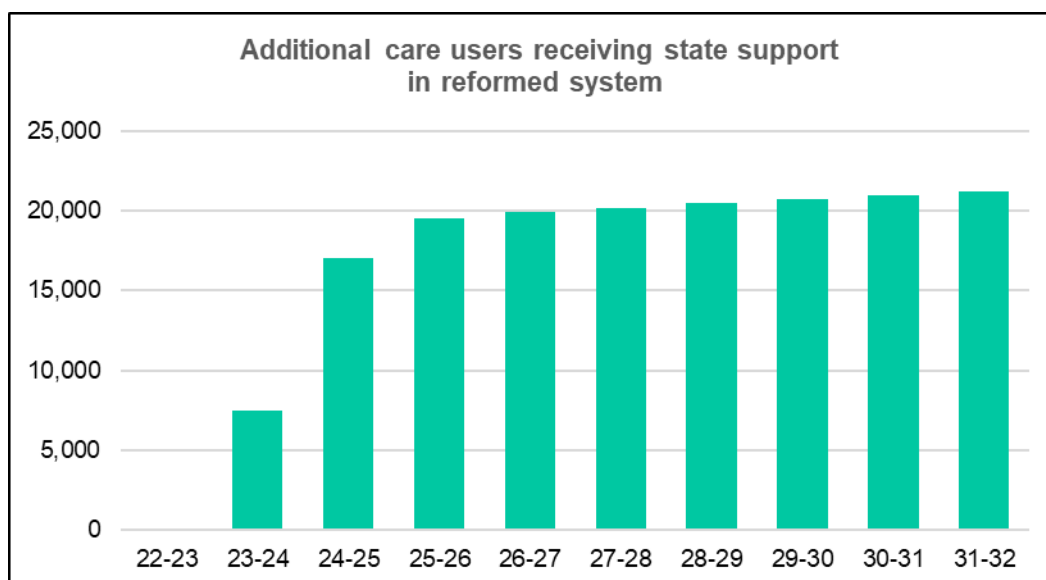
⁴⁷ <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2020-21/appendix-b>

⁴⁸ <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2020-21/4.-long-term-care>

Table 24: Projected number of additional adults aged under 65 receiving state support at any one time

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Additional people supported	0	7,500	17,000	19,500	19,900	20,200	20,500	20,700	21,000	21,200

Figure 13: Projected number of additional adults aged under 65 receiving state support at any one time



234. The following three tables are mutually exclusive and show the number of people we estimate benefit from each of the cap, increased UCL and increased LCL.
235. In the Table 25 below, we show the estimated number of eligible self-funders (both who have care arranged via LAs or who arrange their own care) that will take up the reform and will benefit from hitting the cap in each year. We estimate that, on average, users that are currently partially state funded are less likely to hit the cap by 2031-32 as their contribution to their care is low. They may however benefit from the enhanced LCL as shown in Table 27.
236. Up-to 2026-27 we see an increasing number of self-funders with assets or income above the means test, who are paying for their own care costs, reaching the cap. We see the next significant increase in beneficiaries in 2031-32 when we estimate that self-funders who benefit from the enhanced means test (i.e. have assets between £23k to £100k) and become state supported will, on average, start to reach the cap.

Table 25: Projected users who will benefit from £86,000 cap at any one time

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Self-funders who have hit the cap	0	2,400	6,600	8,900	9,200	9,300	9,400	9,600	9,700	19,900

237. In Table 26, we show the estimated number of eligible self-funders (both who have care arranged via LAs or who arrange their own care) who are likely to benefit from

the enhanced means test in each financial year under the reform. There is an immediate benefit from implementation in October 23 from the enhanced means test and there is a stable population of beneficiaries until 2031-32 when on average this group start to reach the cap.

Table 26: Projected users who will benefit from UCL at any one time

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Self-funders who benefit from increase in UCL £23k-£100k	0	10,200	10,400	10,600	10,700	10,900	11,100	11,200	11,300	1,300

238. In Table 27 we show the estimated number of eligible care users who are likely to benefit from the enhanced means test under the reform due to the increase in the Lower Capital Limit. In our modelling state supported users who benefit from the LCL include both those who are fully and part LA funded. These two groups cannot be distinguished due to data limitations, and so this may overestimate the number of state supported users who benefit from the increase in the LCL.

Table 27: Projected users who will benefit from the increase in LCL

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Fully and part LA supported users who may benefit from increase in LCL £14k to £20k	0	8,800	9,000	9,100	9,300	9,400	9,600	9,700	9,800	9,900

Key assumptions and uncertainty (under 65s)

Demand

239. Our modelling estimates the cost of the £86,000 cap, £20,000 LCL and £100,000 UCL as £0.7 billion by 2031-32 (in 2021-22 prices). As a comparison point CPEC estimated the cost of free care to be £0.5 billion in 2011⁴⁹.
240. One of the key drivers of the reform costs is the number of self-funding adults aged under 65. In particular, there is a lack of high-quality data on the number of self-funded adults aged under 65 who arrange their own care. While anecdotal evidence from local authorities suggests that this number of self-funders is low, we have been unable to conclusively verify this with a nationally-representative study.
241. To estimate the number of community care self-funders for this analysis, we worked with a number of domiciliary care providers to review the prevalence of self-funders vs. state funded individuals, in a sample of their client bases. We grossed this estimate up to get a total self-funder estimate for England using the NHS Digital ASC-FR 2019-20 return. Whilst this is the best available data, we recognise that this

⁴⁹ Projections of demand and expenditure on Adult Social Care. Wittenberg, R, Hu, B & Hancock, R, 2018, PSSRU.

estimate is only based on a sample of around 500 care users from four domiciliary care providers and so we have tested this assumption via sensitivity analysis.

242. We assume approximately 1% of adults aged under 65 in residential homes will be self-funders. This assumption is based on published evidence from LaingBuisson⁵⁰, which suggests the proportions to be between 0% and 3%; with a central estimate being 1%. This assumption will have minimal impact on total costs as there are only a small number of self-funders in residential homes.
243. Given the overall uncertainty around the self-funder numbers we have included two related sensitivity analysis scenarios in Table 28 which reflects:
- An increase in self-funder community, nursing, and residential user numbers by 10%
 - A decrease in self-funder community, nursing, and residential user numbers by 10%

Table 28: Change to self-funder user numbers by ±10%. Cost of £86,000 cap reform package on under 65s in central and sensitivity scenarios, £ billion, 2021-22 prices

£ billions, 2021-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Central scenario	£0.00	£0.17	£0.38	£0.46	£0.52	£0.54	£0.56	£0.57	£0.59	£0.69
Sensitivity Scenario (+10%)	£0.00	£0.18	£0.41	£0.50	£0.56	£0.58	£0.59	£0.61	£0.63	£0.73
Absolute Difference (+10%)	£0.00	£0.01	£0.02	£0.03	£0.04	£0.04	£0.04	£0.04	£0.04	£0.05
Proportional Increase (+10%)	0%	7%	7%	7%	7%	7%	7%	7%	7%	7%
Sensitivity Scenario (-10%)	£0.00	£0.15	£0.36	£0.43	£0.48	£0.50	£0.52	£0.53	£0.55	£0.64
Absolute Difference (-10%)	£0.00	-£0.01	-£0.03	-£0.03	-£0.04	-£0.04	-£0.04	-£0.04	-£0.04	-£0.05
Proportional Decrease (-10%)	0%	-7%	-7%	-7%	-7%	-7%	-7%	-7%	-7%	-7%

244. Table 28 shows that a 10% increase in community, residential and nursing self-funders increases costs by £10-£50 million per year in 21-22 prices over a 10-year period. Alternatively, a 10% decrease in community, residential and nursing self-funders decreases costs by £10-£50 million per year in 21-22 prices over a 10-year period. It should be noted that with more accurate self-funder data, we expect our self-funder estimate would reduce. We therefore consider the 10% decrease scenario would be more likely than an increase.

245. There is one published study by LaingBuisson⁵¹ which estimates the number of privately funded homecare and supported living users aged under 65 at 11,000 in 2017-18. However, due to the small sample size and low response rate of the

⁵⁰ Adult Specialist Care UK Market Report. Laing, W, 2019, 3rd ed. LaingBuisson.

⁵¹ Adult Specialist Care UK Market Report. Laing, W, 2019, 3rd ed. LaingBuisson.

underlying surveys we have not used this as a central estimate. We have included an additional sensitivity analysis scenario to reflect this in Table 28.

246. Table 29 shows a proportional decrease in costs of approximately 40% against our central estimate when the number of under 65s self-funders is considered to be 11,000; this corresponds to a difference of between £60-£240 million per year in 2021-22 prices over a ten-year period. We consider this to be a key area for data collection going forward.

Table 29: 11k self-funders- cost of £86,000 cap reform package on under 65s in central and sensitivity scenarios, £ billion, 2021-22 prices.

£ billions, 2021-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Central scenario	£0.00	£0.17	£0.38	£0.46	£0.52	£0.54	£0.56	£0.57	£0.59	£0.69
Sensitivity Scenario 11k Self-funders	£0.00	£0.11	£0.25	£0.30	£0.33	£0.34	£0.36	£0.37	£0.38	£0.45
Absolute Difference	£0.00	-£0.06	-£0.13	-£0.16	-£0.19	-£0.19	-£0.20	-£0.21	-£0.21	-£0.24
Proportional Change	0%	-36%	-34%	-34%	-36%	-36%	-36%	-36%	-36%	-35%

Eligibility and take up

247. We assume 100% of LA arranged full cost clients will be eligible for care under the reform. We assume that LA arranged clients will have a needs assessment before the LA agrees to arrange care therefore this group is eligible for care under a reform. This is a reasonable assumption made in line with the Care Act, and will likely have a modest impact on total costs as there are only a small number of LA full costs clients.
248. We assume 89% of community care self-funders will be eligible for LA funded care when calculating the £86,000 cap costs and assessment costs. This assumption results from internal analysis on the proportion of older users who are eligible for care and we have been unable to access data specifically for adults under 65. It is also assumed that the proportion of community self-funders that meet the eligibility criteria does not change over time. Sensitivity analysis in Table 30 indicates that increasing the eligibility assumption by a 5 percentage point uplift would result in a 5% increase to the central estimate and approx. £10-30 million difference in costs.

Table 30: Change to Eligibility +5% - Cost of £86k cap reform package on under 65s in central and sensitivity scenarios, £bn, 2021-22 prices

£ billions, 2021-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Central scenario	£0.00	£0.17	£0.38	£0.46	£0.52	£0.54	£0.56	£0.57	£0.59	£0.69
Sensitivity Scenario (Eligibility +5%)	£0.00	£0.17	£0.40	£0.49	£0.55	£0.56	£0.58	£0.60	£0.62	£0.72
Absolute Difference (Eligibility +5%)	£0.00	£0.01	£0.02	£0.02	£0.03	£0.03	£0.03	£0.03	£0.03	£0.03
Proportional Change (Eligibility +5%)		5%	5%	5%	5%	5%	5%	5%	5%	5%

249. We have assumed an 80% take up of the reform for fully self-funded users when calculating the central estimate, in line with older adults modelling. We have assumed that the 20% who do not take up the reform are uniformly distributed by need. For users who are already being funded (fully or partly) by the LA we have assumed 100% take up. The 80% take up assumption for self-funders is based on evidence from benefits take-up however there is variation across benefit types. For example, take up of housing benefit by non-pensioners was 79% by caseload and 87% by expenditure in 2019, compared to take up by all adults of Income Support/Employment and Support Allowance at 90% by caseload and 94% by expenditure⁵².
250. Table 31 indicates that increasing the assumed 80% take up of the reform by a 5-percentage point uplift would result in a 7% increase to the central estimate and approx. £10-50 million difference in costs.

Table 31: Change to Take-up +5% - Cost of £86k cap reform package on under 65s in central and sensitivity scenarios, £bn, 2021-22 prices

£ billions, 21-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Central scenario	£0.00	£0.17	£0.38	£0.46	£0.52	£0.54	£0.56	£0.57	£0.59	£0.69
Sensitivity Scenario (Take up +5%)	£0.00	£0.18	£0.41	£0.50	£0.56	£0.57	£0.59	£0.61	£0.63	£0.74
Absolute Difference (Take up +5%)	£0.00	£0.01	£0.03	£0.03	£0.04	£0.04	£0.04	£0.04	£0.04	£0.05
Proportional Change (Take up +5%)		6%	7%	7%	7%	7%	7%	7%	7%	7%

User contributions

251. With regards to how the contributions from users' wealth/assets are modelled, we assume that users with wealth between £23,250-£99,999 are affected by the UCL increase to £100,000 and that all users have average wealth by taking the mid-point value of £61,625. Applying the user contribution of £1 per week for every £250 of wealth between the lower and upper capital limits to the mid-point wealth value of £61,625 gives a taper contribution of approximately £10,000 per year. This assumption brings uncertainty as some users could have wealth value closer to the LCL and some users closer to the UCL and this could have a substantial effect on costs as discussed below.
252. Table 32 shows the effects of all users having wealth of £23,250 (just over the LCL) with estimated taper contributions of approximately £2,000 per year. In this scenario, assuming average user contributions for the group remain constant, it would take the users over 40 years to hit the cap. This would mean an additional cost of £10-80 million to the state. The high cost increase in years 2023-2031 is due to the user contributions being approximately £8,000 lower than the estimate for the central scenario, which means that the state will have to cover the difference. In

⁵² Income-related benefits: estimates of take-up: financial year 2018 to 2019 - GOV.UK (www.gov.uk)

year 2031-32 in the central scenario, the self-funder clients in the taper will start hitting the cap and the state will start covering the full costs of care for this population, which makes the difference with the sensitivity scenario narrower.

Table 32: User contributions scenario A £23k - Cost of £86k cap reform package on under 65s in central and sensitivity scenarios, £bn, 2021-22 prices

£ billions, 2021-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Central scenario	£0.00	£0.17	£0.38	£0.46	£0.52	£0.54	£0.56	£0.57	£0.59	£0.69
Sensitivity Scenario User contributions £23,250	£0.00	£0.20	£0.45	£0.54	£0.60	£0.61	£0.63	£0.65	£0.67	£0.69
Absolute Difference	£0.00	£0.03	£0.07	£0.07	£0.07	£0.08	£0.08	£0.08	£0.08	£0.01
Proportional Change	0%	20%	18%	15%	14%	14%	14%	14%	14%	1%

253. Table 33 shows the effects of users having wealth of £99,999 (just under the UCL) with estimated user contributions of approximately £18,000 per year. In this scenario, assuming average user contributions for the group remain constant, it would take the users around 5 years to hit the cap. During these first 5 years, the costs to the state would be reduced due to the user contributions being approximately £8,000 higher than in the central scenario. In the sensitivity scenario the clients would hit the cap in year 2028-29 and the state would be covering the full costs of care from then on which reflects as an increase of £170-190 million in years 2028-31. In the central scenario, the clients would be hitting the cap in year 2031-32 which makes the difference with the sensitivity scenario narrower.

Table 33: User contributions scenario B £99k - Cost of £86k cap reform package on under 65s in central and sensitivity scenarios, £bn, 2021-22 prices

£ billions, 2021-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Central scenario	0	£0.17	£0.38	£0.46	£0.52	£0.54	£0.56	£0.57	£0.59	£0.69
Sensitivity Scenario User contributions £99,000	£0.00	£0.13	£0.31	£0.39	£0.45	£0.46	£0.73	£0.76	£0.78	£0.80
Absolute Difference	0	£0.03	£0.07	£0.07	£0.07	£0.08	£0.17	£0.18	£0.19	£0.11
Proportional Change	0%	-20%	-18%	-15%	-14%	-14%	31%	32%	32%	17%

WAS 2016/18

254. The model estimates the number of self-funders and state supported users who hit the cap each year based on the average rate of spend on care costs. Average wealth and income for these populations is based on data from the Wealth and Asset Survey. The model uses 2012-2014 WAS data as the best available data during the development of the central estimate, however updated 2016-2018 data

has recently been published⁵³. There has been change in the wealth and income distribution in the under 65 population between the 2012-2014 WAS data used in the model and the 2016-2018 WAS data, therefore we have included a sensitivity analysis scenario using the 2016-2018 WAS data.

255. Table 34 shows when 2016-2018 WAS data is used there is an initial decrease in the costs in the first years of reform until 2025-26, due to an increase in the proportion of self-funders and a decrease in the proportion of users with wealth 'greater than £23,250 but less than £100,000' compared to the 2012-2014 WAS data. This results in lower costs in the initial years after reform due to a decrease in the proportion on users on the taper. Costs are shown to increase from 2026-27 driven by the cost of self-funders hitting the cap. There is a small decrease in costs in year 2031-32 due to the decrease in the proportion of users with wealth 'greater than £23,250 but less than £100,000' that are on the taper, who will on average hit the cap later than fully self-funders. Overall, this corresponds to a total increase in the cost of reform of approximately £5 million over a ten-year period.

Table 34: Cost of £86k cap reform package on under 65s in central and sensitivity scenario, £bn, 2021-22 prices

£ billions, 21-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Central Scenario	£0.00	£0.17	£0.38	£0.46	£0.52	£0.54	£0.56	£0.57	£0.59	£0.69
Sensitivity Scenario (WAS 2016-2018)	£0.00	£0.14	£0.34	£0.46	£0.54	£0.55	£0.57	£0.59	£0.61	£0.68
Absolute Difference (WAS 16/18)	£0.00	-£0.03	-£0.04	£0.00	£0.01	£0.02	£0.02	£0.02	£0.02	-£0.01
Proportional Change (WAS 16/18)	0%	-17%	-10%	-1%	3%	3%	3%	3%	3%	-1%

Under 65s unpaid care impact (sensitivity analysis)

256. In our central modelling, we have assumed that individuals who receive unpaid care (under the current system) will not substitute unpaid care with formal care due to reform. This assumption is based on the same evidence that is detailed earlier on 'Impact of reform on unpaid carers and the people they support'. We anticipate that a behavioural change from these individuals is likely to be limited to a small number of cases.
257. However, we have conducted sensitivity analysis to estimate a potential increase in domiciliary care users from adults aged under 65 that would receive unpaid care under the current system. We anticipate that individuals who receive unpaid care would be most likely to substitute to domiciliary care under a reform.
258. We take the 9% uplift in domiciliary care estimated for the older adults, and then apply a downward adjustment, based on the number of unpaid care recipients aged under 65 as a percentage of all individuals receiving either unpaid or community care (Table 35). We assume, that a higher proportion of unpaid care recipients

⁵³ [Analysis of wealth and assets by disability, age, income, Great Britain, July 2012 to June 2016 and April 2014 to March 2018 - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

translates to a larger cohort of individuals that may have an incentive to switch to domiciliary care. This proportion is lower for under 65s when compared to over 65s. Therefore, we anticipate that there will be a lower proportion of under 65s with an incentive to switch to domiciliary care. For this reason, the estimated percentage increase in the total domiciliary care population is marginally lower for under 65s (8%) when compared to older adults (9%).

Table 35: shows the unpaid care recipients as a percentage of individuals receiving unpaid/community care^{54 55}:

Adult age group	Unpaid care recipients as a percentage of all individuals that receive unpaid or community care
Under 65	66%
Over 65	74%

Note: We estimate that all individuals included in these percentages have needs that either meet/exceed the care needs criteria to be eligible for LA support.

259. In total, we estimate that an additional 8% formal domiciliary care users (per year) would increase the cost to government by up-to £0.05bn per year (2021-22 prices).

Plausible downside scenario for adults aged under 65

260. The plausible downside scenario was determined to be when three conditions considered to be the most likely metrics of uncertainty overlap:

- a. Take up is increased by 5%. As shown previously the effect of reasonable uncertainty in this assumption could have an individual effect of £10-50 million on costs.
- b. 8% users switching from unpaid care to formal care for adults aged under 65. As shown previously the effect of reasonable uncertainty in this assumption could have an individual effect of £10-50 million.
- c. The application of the Wealth and Assets data from 2016-18. As shown previously the effect of reasonable uncertainty in this assumption could have an individual effect of £10-20 million additional cost after an initial saving (up to 2025-26) of £30-40 million.

261. The overall effect of these three conditions occurring together is shown in Figure 14 and Table 36. These show an initial reduction to the costs of approximately £10 million in 2023-24 (due to the impact of the WAS 2016-18 data) followed by an increase of up-to £110 million in the years out to 2031-32.

⁵⁴ This has been estimated using CPEC analysis of the Health Survey For England dataset (2015-17).

⁵⁵ We also used data from the NHS Digital [Survey of Carers in Households 2009/10](#) (table 6.1). This is used to derive the percentage of unpaid care receivers who are aged under and over 65.

Figure 14: Cost of reform package for adults aged under 65 in central and plausible downside scenario, £bn, 2021-22 prices

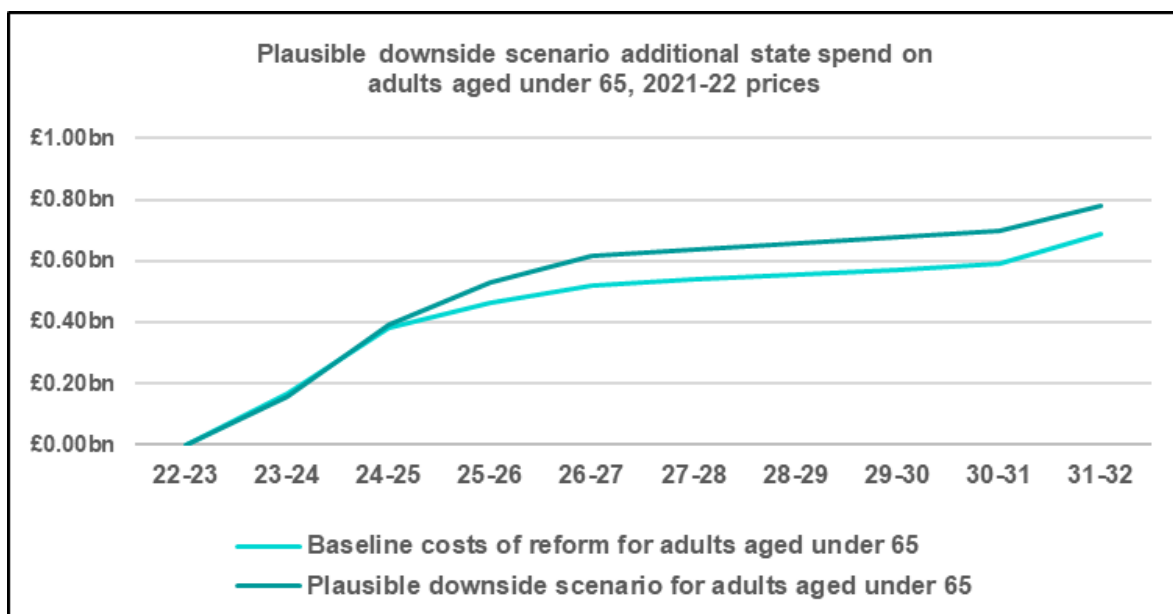


Table 36: Difference between cost of reform package for adults aged under 65 central and plausible downside scenario, £bn, 2021-22 prices

£ billions, 21-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Central scenario	£0.00	£0.17	£0.38	£0.46	£0.52	£0.54	£0.56	£0.57	£0.59	£0.69
Sensitivity Scenario (Unpaid care +8% Take up +5% WAS-IW 2016-18)	£0.00	£0.16	£0.39	£0.53	£0.62	£0.64	£0.66	£0.68	£0.70	£0.78
Absolute Difference (Unpaid care +8% Take up +5% WAS-IW 2016-18)	£0.00	-£0.01	£0.01	£0.07	£0.10	£0.10	£0.10	£0.11	£0.11	£0.09
Proportional Change (Unpaid care +8% Take up +5% WAS-IW 2016-18)		-5%	3%	14%	19%	19%	19%	19%	19%	14%

Plausible downside scenario – for all adults

262. The sensitivity analysis suggests that for the combination of costs for Over 65s and Under 65s, the plausible downside scenario increase in costs could be an increase of up to 13% on the central projections. It should be noted that the sensitivity scenario represents a pessimistic scenario, but that there is also a wider range of uncertainty around future cost of social care – both for the current system as well as costs arising from the reform. Multiple economic, demographic and technological factors could drive changes in future demand and supply for care which means there will be significant uncertainty about the future under any social care reform system.

Implementation costs

263. The costs in this section cover the implementation costs under charging reform for all adults. The implementation costs for 2022-23 and 2023-24 include funding for early assessments, and planning & preparation costs. Funding will be made available specifically to support local authorities to prepare for the 2023-24 reforms. This includes:

- a. £34 million to support planning and preparation for implementation of charging reform. This funding is in the first year to support the LA implementation period and is expected to enable resources required for implementation of reforms to be put in place locally, including recruitment, training, and new IT systems capability, and is subject to review. DHSC and NHSX will confirm the required technology capability and recommended approach to implementation.
- b. £168 million to enable local authorities to undertake early assessments towards the cap during 2023-24 to manage capacity demands. This funding is calculated by taking the cost of a full assessment multiplied by the number of self-funders who we assume will want to meter towards a cap. Funding is based upon 50% of these self-funder assessments being conducted in the six months prior to implementation, and the remaining 50% in the six months after implementation.

Table 37: Total implementation costs (all adults), £m, 2021-22 prices

	22-23	23-24
Total Implementation Costs (£m)	34	168
Early assessments (£m)	-	168
Planning and preparation (£m)	34	-

Total costs of charging reform

Table 38: Total additional costs to state of charging reform including implementation costs, in £bn, 2021-22 prices

Charging Reform - 86k Cap, 20k LCL, 100k UCL	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32	Discounted Total (2020 Base Year)
Older Adults	0.00	0.41	0.89	0.87	1.51	2.15	2.42	2.60	2.76	2.92	12.48
Adults under 65	0.00	0.17	0.38	0.46	0.52	0.54	0.56	0.57	0.59	0.69	3.45
Implementation Costs	0.03	0.17	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.18
Total	0.03	0.74	1.27	1.34	2.03	2.68	2.97	3.17	3.35	3.60	16.12

Impact appraisal of Fair Cost of Care (FCC) and Section 18(3)

264. The Government wishes to introduce two policy changes in the market for care:
- a. The Fair Cost of Care (FCC) which aims to support LAs to move towards paying a fair cost for the local area. A fair cost of care is based on evidence of local costs (for example through a cost of care exercise) and reflects a reasonable rate of return on capital.
 - b. Further commence Section 18(3) of the Care Act 2014, which requires LAs to arrange care when requested to do so by someone who does not qualify for financial support, allowing them to benefit from the expert help of an LA, both in navigating the complex care market, and in obtaining a fair price. This section of the Care Act 2014 was commenced in relation to domiciliary care in 2015. Local Authorities are therefore already required to meet the eligible needs of individuals requiring domiciliary care when requested.

Rationale

265. There are two market failures in the provision of adult social care in England:
- a. People buying care for themselves or a relative are at a competitive disadvantage compared with the care provider, as they often know little about the quality and price of care services, about the range of providers available, and even about care needs, and appropriate services. As a result, it is easy to end up buying more services than wanted and paying a higher price.
 - b. Local Authorities buy care for people who are not financially able to pay for care themselves, and because they hold a relatively large portion of demand (almost 50% across the country) they can obtain fee rates that are low, and often lower than the cost of providing care. This leads to care providers having low resilience to cope with changes such as fluctuations in demand, cost increases, and other factors such as worker shortages. A further consequence of these low fee rates is that providers end up failing to carry out long term investments. Providers may also respond by compromising on the quality of care or applying downward pressure on workers wages or conditions.
266. Evidence of these problems includes:
- a. A CMA study of larger care home providers⁵⁶ estimates that a self-funder will on average pay around 40% more than a state-supported person in the same care home. This is partly due to cross-subsidy as providers seek to charge self-funders to cover overheads that LAs do not fully fund for the clients they place.
 - b. Some of the cross-subsidy may be justified by economies of scale that providers might attain from contracting out beds to Local Authority commissioned clients.

⁵⁶ CMA Care homes market study 2017- It should be noted that the data used in the CMA report is now over five years old (before significant additions of new funding into adult social care) and relates to a sample of larger care providers.

However, a large part will also be due to Local authorities using Monopsony Power to drive down fee rates.

- c. Local Authorities pay fee rates that are below what are estimated to be a fair cost of care: among residential care providers, around 70% are estimated to pay below a fair cost, and 54% pay a rate that is 5% or more below a fair cost⁵⁷. Among nursing care providers around 46% are estimated to pay below a fair cost, and 35% pay a rate that is 5% or more below a fair cost.
- d. The CQC reports⁵⁸, based on their oversight responsibility for the care market, that the market is fragile because of the low income received due to under occupancy, increased costs and difficulty recruiting and retaining staff.

267. In addition, the introduction of the Fair Cost of Care and Section 18(3) is intended to address the market failures (and their consequences) described above and to make a reality of the cap on care costs. The introduction of charging reform, the main subject of this Impact Assessment, is premised on the fact that individuals can access the fee rate at which they meter towards the cap on care costs. Without this, the integrity of the cap will be limited as it will not reflect the actual costs of care to individuals. Commencing Section 18(3) supports the integrity of the cap by allowing individuals to access LA commissioned rates, and basing progress towards the cap on those rates. The only policy alternative which would retain the integrity of the cap would be to allow individuals to meter towards the cap at the rate at which they pay for care on the open market, which would be a much more costly policy and would not address the market failures described above.

Finances of a care home

- 268. The issue arises partly from finances for a care home, with property cost being a substantial proportion of the total. If the property is owned outright, then that together with a few other elements of cost (eg maintenance, return on operations) can be deferred for a time, possibly a few years, to enable the home to survive with a fee rate that covers regular payments but is less than a full fair cost.
- 269. To take a simplistic example, suppose total cost per person is 100, with 55 being deferrable and 45 needing regular payment (as they cover ongoing non-deferable costs). A payment of 85 by the LA for say half the beds in the care home covers all regular costs for those individuals and makes a substantial contribution to deferrable. If the self-funders pay 115 each for the other half of places the home breaks even (with the modest profit included in the overall cost of 100). The self-funders are cross-subsidising the state supported clients by paying 35% more (= 115/85).

⁵⁷ Based on internal modelling of fair rates. Methodology for calculating fair rates is described in the section Fair Cost of Care

⁵⁸ The state of health care and adult social care in England 2020/21 – CQC publication October 21
https://www.cqc.org.uk/sites/default/files/20211021_stateofcare2021_print.pdf

270. Where property costs are covered by regular payments such as lease or rent or debt repayments, then the ongoing costs will be nearer to 85 or 90 of the 100 total cost. The LA rate might then just cover ongoing payments, or even not quite that, leaving the care home to rely on self-funder cross-subsidy even for regular payments, or needing to cut costs that are not reasonable, such as low or no pay for the owner and family, or pushing staff to work more than paid hours.
271. Even where LAs cover all regular costs, but still pay less than a fair cost, care homes with a lot of state funded clients will struggle to break-even, and are likely to deteriorate (in the property and in service level), and be vulnerable to financial or other problems. This is likely to be the way in which the fragile market observed by CQC arises.
272. In some cases, providers may remain viable in the short term (as they can just about cover day to day operating costs) but be unable to carry out lump sum investments required to ensure long term sustainability. For example, a provider may find themselves unable to carry out a long term repair to their property as a result of precariously low revenues.
273. The aim of Government is to support LAs to move towards paying a fair cost of care, so that self-funders are then able to obtain a fair price in the market, not dissimilar to that paid by the council, even if they choose to arrange it for themselves (as some would prefer to do, for a variety of reasons).
274. This aim and the FCC policy applies as much to care at home (domiciliary) as to residential and nursing care in care homes. With little capital cost, and a much lower level of deferrable and fixed costs, the LA rate does not need to be much below a fair cost for a domiciliary care provider that relies on LA funded clients to be in difficulty. It is also the case that Section 18(3) already applies to the arrangement of care at home, so self-funders can already access the LA rate for care, meaning that providers are less able to make up any difference through cross-subsidy. This seems to be reflected in a greater fragility of the domiciliary care sector even than care homes. According to the spring survey by the Association of Directors of Adult Social Service (ADASS) 82% of directors reported that they were concerned about the sustainability of their home care providers as opposed to 77% about their care home providers⁵⁹.
275. The remainder of this section focuses on the impact on providers and LAs of Section 18(3) and the Fair Cost of Care.

Section 18(3) and Fair Cost of Care policy overview

276. From April 2022, Government will provide funding and take steps to enable LAs to better sustain their local care markets to deal with the problems of a fragile market, and the consequent problems that causes for the workforce and care quality. By ensuring LAs move towards a fair cost of care and supporting them to strengthen

⁵⁹ The state of health care and adult social care in England 2020/21 – CQC publication October 21
https://www.cqc.org.uk/sites/default/files/20211021_stateofcare2021_print.pdf

data and contract management, LAs will be able to steer their markets as appropriate to local circumstances.

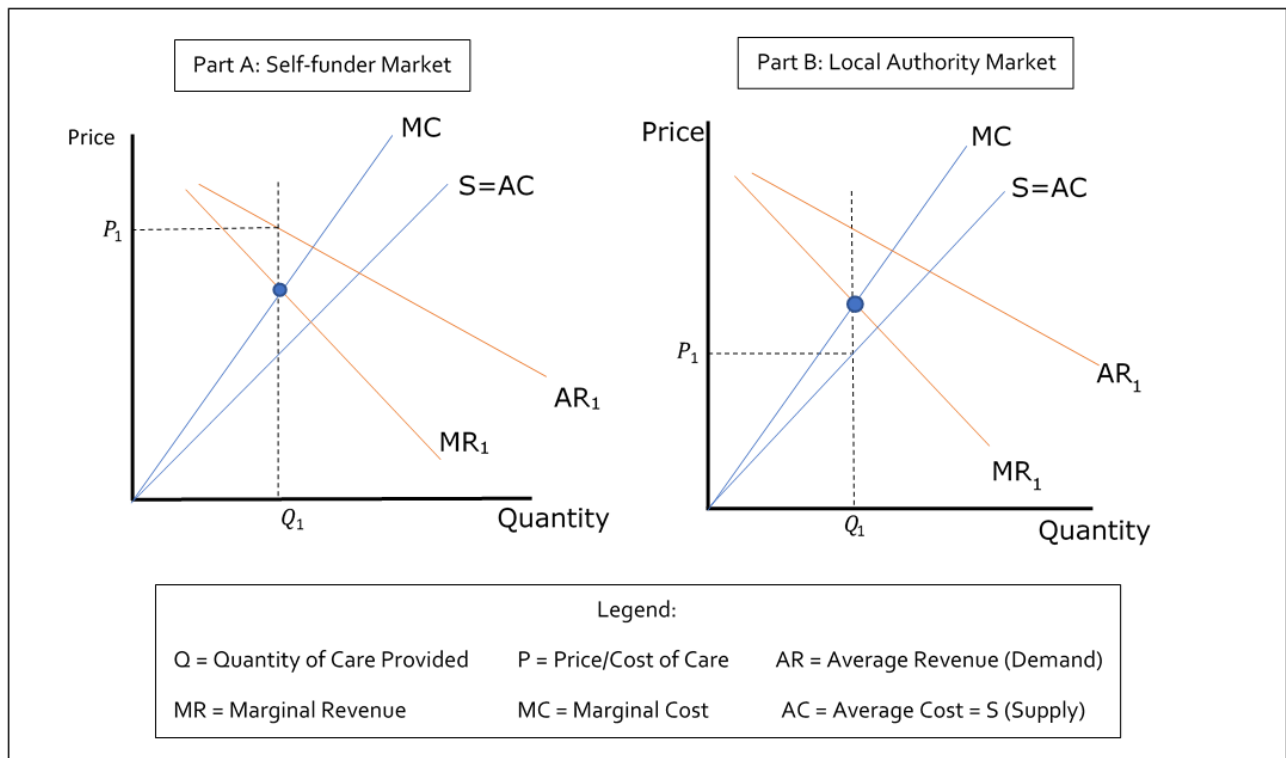
277. The analysis in this Impact Assessment assumes that Section 18(3) of the Care Act 2014 will be fully commenced alongside the cap on care costs in 2023.
278. In this section, we examine the effect of fully implementing Section 18(3) alongside a fair cost of care and provide estimates for the cost to government of introducing a market sustainability and fair cost of care policy. We also set out the impacts, benefits and costs for private providers and for the supply of care in an area as a result of the changes.

Impact on providers and LAs – Economic Theory

279. We begin by outlining the economic theory behind the impact of implementing Section 18(3) in a scenario where self-funders pay higher fee rates than LA commissioned clients. We then expand upon why such a scenario could occur and explain the conditions under which the implementation of Section 18(3) will affect providers and explain how the impact might vary depending on key demographic and market conditions. We continue by outlining how Section 18(3) could affect LAs. We also provide hypothetical case studies to demonstrate the impact of introducing Section 18(3) for residential care at the same time as introducing a fair cost of care. Finally, we outline estimates for the cost impact from moving towards a fair cost for care.
280. First, we use a microeconomic framework to provide an example of an interaction between self-funders, a local authority, and a residential care provider in Figure 15⁶⁰ below. We outline aggregate demand and supply curves for hypothetical self-funders and LA-commissioned clients. Prior to the introduction of Section 18(3), in both markets the level of service is provided at the points where the marginal revenue curves (MR_1) intersect the marginal cost curve (MC). However, in the market for local authority commissioned clients, the local authority is able use its market power to drive down fee rates to a lower point (we provide an illustrative “lower point” in the diagram).

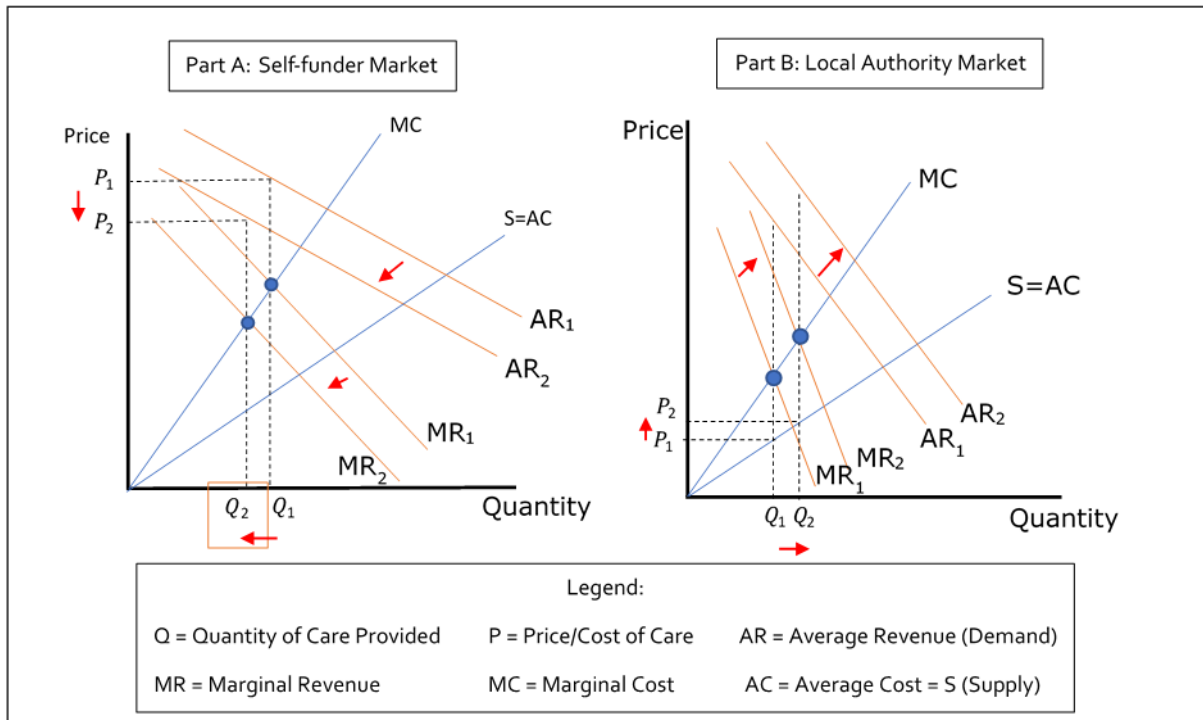
⁶⁰ The chart shows an example of a market as outlined in any standard microeconomic theory textbook – eg Microeconomics by Jeffery M. Perloff 2018

Figure 15: Fee imbalance between Self-funder and Local Authority Markets



281. In this market, the potential impact of introducing Section 18(3) is shown in Figure 16. As Section 18(3) is introduced, some self-funders decide to request the LA to commission care on their behalf. The result is a shift in demand from the self-funder market (shown on the left of Figure 16) to the market for LA-commissioned clients (shown on the right). This is demonstrated by a fall in the Average and Marginal Revenue curves in the market for self-funders and an increase in the Average and Marginal Revenue curves in the market for local authority commissioned clients (from AR_1 and AR_2 to MR_1 and MR_2). The result is a fall in the self-funder rate and increase in the rate that providers will expect from LAs (to maintain the same level of care for LA-commissioned clients).
282. In theory, the transition of a portion of the self-funder market to LA-commissioned rates will reduce the cross-subsidy provided by self-funders, although the scale, distribution, and consequences of this reduction are difficult to predict. If high levels of uptake occur in areas where the provider market and LA are less able to respond to these changes (for example by increasing LA rates to offset the fall in self-funders), market stability could be affected.

Figure 16: Fee imbalance between Self-Funder and Local Authority Markets



283. It should be noted that the example above applies to a single residential care provider. However, in reality, a single local authority will deal with multiple providers with varying degrees of market power. Therefore, it is possible that if one provider raises fee rates due to increased demand, local authorities will switch to another where they are able to keep fee rates down.
284. Furthermore, even where fee rate differentials exist between self-funders and LA commissioned clients, any impacts will depend on numbers of self-funders and uptake of Section 18(3). The simplistic model above also doesn't consider that users who take up Section 18(3) could pay higher rates for additional services via top-ups.

Characteristics of providers and their implications for the impact of FCC and Section 18(3)

285. The Fair Cost of Care policy is expected to have a positive effect on providers, enabling them to receive a fair price for state funded clients, cover their overheads appropriately, and be less fragile in the face of uncertain times with fluctuating demand from Covid, NHS pressures, and trends in council commissioning (a decline in the number of long term care users).
286. It is possible that some councils who appear to already pay more than a fair cost may adjust their rates (in order to negotiate a cheaper arrangement for their clients), but are expected to do so in discussion with providers and to a reasonable timescale.
287. The effect of Section 18(3), on the other hand, will be to reduce provider income in certain cases. Depending on the circumstances of the individual provider the effect of this reduction and any accompanying mitigations will differ.

When LAs pay a fair cost of care

288. We start this analysis on the basis that councils will be paying a fair cost of care following the introduction of Section 18(3) (analysis of Section 18(3) when the council is paying a lower rate is considered in the following section).
289. It is worth noting that the effect of Section 18(3) is not on providers directly but is to re-balance the market operation so that self-funders can better obtain the service they want at a fair price for that service. Providers will be affected indirectly if they find themselves less able to attract custom at previous prices, as a result of 'customers' choosing to pay less, either at the provider being considered, if the lower price is available, or if not then elsewhere.

Reasons for high self-funder rates

290. There are a number of reasons why current self-funder prices might be higher than the fair cost:
- a. Cross-subsidy: where the provider charged higher prices previously in order to cover overheads where there is under-payment by LAs.
 - After the introduction of a fair cost for care this should no longer be a factor in the setting of prices by providers as if the council pays a fair cost and there is no longer any need for this increase in price (to cover overheads).
 - b. Extra services with variable cost: where the provider wants to offer a higher standard of say activities or food or entertainment, and charges accordingly.
 - Self-funders who use Section 18(3) will still have the option to pay for these services via top-ups. However, if, following Section 18(3), it becomes apparent that there are fewer self-funders willing to pay for such extra services, the provider will have to consider its position, with one of the options being to reduce costs and services for clients.
 - c. Extra services with less variable cost: for example, if the capital cost is high, e.g. being a luxury home or in a high cost area, and where a reduction in cost might require a move of care home or similar radical change.
 - Where the provider finds that their business is less viable once customers can choose cheaper services, it will have to consider options, including but not limited to seeking self-funders from elsewhere, reducing the size of home or transferring elsewhere. The LA may need to play a role in ensuring that the safety and care of existing care users is managed appropriately.
 - Note that where the provider has lower cost providers nearby, and users choose the provider despite that, then Section 18(3) is not likely to have an adverse effect, as in this case users would have deliberately chosen the high cost provider. It is only really where there is little choice in the area other than a high fixed cost provider where this issue arises. This is because, such a provider may have self-funders that are paying for extra services due to a lack of cheaper alternatives. If that is the case, the council would ideally work with these providers as part of their market

shaping responsibilities, to help them understand the likely impacts of Section 18(3) so that they can reduce their cost base where possible. The LA may also offer transitional support to providers where this is essential to maintain market stability and services, or may encourage more fair cost provision within the market, and may want to do so urgently recognising the possible demand for Section 18(3).

d. Excess profit, i.e. profit much higher than expected for the type of market.

- If excess profit comes from an efficient provider who is able to squeeze costs without reducing quality of care or workforce conditions, then there will be no impact from the introduction of Section 18(3) in the context of the LA paying a fair cost for care.
- However, if the excess profit comes from charging users more than the fair cost, the provider may find that they need to reduce prices to a fair cost or else lose users who opt for cheaper providers that are available.

291. Those providers that fall into bullets a, b or d above would seem likely to be able to manage their situation even though there will be some disruption in doing so.

292. It is the third category with high fixed costs that will pose more of a challenge to the provider themselves and, depending on circumstances, to the council too. Depending on how fast the change happens, and how widespread it is within the local area, the situation might be quite challenging for the system including the LA to manage.

293. Where providers, with high fixed costs, are unable to reduce costs or raise revenues local authorities may need to help manage market transition to avoid care users being at risk of disruption.

294. In such cases, local authorities may want to take steps to facilitate an increase in fair cost provision, whether from existing providers or new entrants into the market.

If LAs do not pay a fair cost and continue to pay below that

295. For the reasons explained above, the overall cost impact of fully introducing Section 18(3) remains uncertain. Whilst we have identified the market conditions and characteristics that determine which providers will be affected, we cannot robustly determine the numbers affected. Ultimately, it will be the responsibility of local authorities to ensure market sustainability. As part of the implementation of a fair cost of care, local authorities will be asked to submit plans on how they are going to sustain their markets. As part of these plans, LA's are likely to identify those providers that have high fixed costs and are likely to have a higher take up of Section 18(3). This will help build a clearer picture on areas in the country where Section 18(3) is likely to have the greatest impact. Early assessments, undertaken in advance of the full implementation of the reforms, will also give an indication of potential take-up rates, as will the findings from the Trailblazer local authorities which will implement the changes in advance of the broader national rollout. Recent estimates by the ONS on the numbers of self-funders will also help provide greater insight into different LAs' exposure to Section 18(3).

296. The above analysis shows that while many providers will face a degree of disruption following the introduction of Section 18(3) in the context of LAs moving towards paying a fair cost of care, it is mainly those with high fixed costs which will have the greater challenge in responding to market demand once self-funders can ask LAs to commission care on their behalf. This is in the context of LAs paying a fair cost when they arrange care either for state supported clients or for self-funders under Section 18(3). If in fact the LA is paying below a fair cost, then more providers will face difficulty, as their profit at least will be squeezed, reducing resilience, and depending on the gap, sustainability as well as profits could be at risk. This will put additional pressure on councils to pay a fair cost.
297. The proportion of self-funders within a provider or an area will also affect the impact of Section 18(3) on providers in areas where the LA does not pay a fair cost of care. Providers with few self-funders will see little impact from Section 18(3), even if their LA continues to pay less than a fair cost of care, as it will not be possible for revenue rates to change significantly as a result of Section 18(3) take-up. Similarly, at LA level, the impact of introducing Section 18(3) will be significantly less if self-funders represent a small minority of care users. Conversely, high levels of self-funders will put additional pressure on councils to pay a fair cost.
298. Whilst further evidence is oncoming, we have produced some hypothetical case studies to illustrate how the economic impact would differ between different types of providers. The examples provided below are of care providers where there is sufficient uptake of Section 18(3) and a sufficient differential in the LA and self-funder rate for Section 18(3) to have an impact on the provider's revenue.
299. There are significant assumptions underpinning these examples; the most significant being the Section 18(3) take-up rate and LA responses to Section 18(3) regarding fee rates. It also simplifies the setting of fee rates, which can be complex, and excludes consideration of first-party top-ups, which will be permitted under the reformed system, and which will allow providers to maintain additional self-funded revenue. Furthermore, in the real-world fee rate contracts are agreed between providers and their clients in advance meaning that LAs would have limited scope to renegotiate fee rates.
300. However, these hypothetical examples are still useful to demonstrate, in principle, how Section 18(3), could affect different providers differently when introduced alongside a fair cost for care.

Table 39: Illustrative impact of fair cost of care and Section 18(3) on a hypothetical provider

	Pre 18(3)		Post 18(3) and with FCC		
	Typical Care Home 40 bed	Higher-End Care Home	Typical Care Home 40 bed	Higher-End Care Home 40 bed	Higher-End Care Home 40 bed
Group 1	£596 LA	£596 LA	Group 1	£647 LA	£647 LA
Group 2	£596 LA	£596 LA	Group 2	£647 LA	£647 LA
Group 3	£596 LA	£596 LA	Group 3	£647 LA	£647 LA
Group 4	£596 LA	£776 SF	Group 4	£647 LA	£647 LA (changed from SF to LA)
Group 5	£596 LA	£776 SF	Group 5	£647 LA	£647 LA (changed from SF to LA)
Group 6	£596 LA	£776 SF	Group 6	£647 LA	£647 LA (changed from SF to LA)
Group 7	£776 SF	£776 SF	Group 7	£647 LA (changed from SF to LA)	£776 SF
Group 8	£776 SF	£776 SF	Group 8	£647 LA (changed from SF to LA)	£776 SF
Group 9	£776 SF	£776 SF	Group 9	£776 SF	£776 SF
Group 10	£776 SF	£776 SF	Group 10	£776 SF	£776 SF

301. In Table 39 we have depicted two hypothetical residential care providers, each with a capacity of 40 beds, divided into 10 ‘groups’ of 4 beds. The first represents a ‘typical’ care home, with 40% of its beds occupied by self-funders. The second care home is catered towards the self-funder (or higher-end) market with 70% of its beds occupied by self-funders⁶¹.
302. On the left-hand side we show that prior to full implementation of Section 18(3), LA clients pay £596 per week, and self-funders £776. These are typical fee rates for residential care state supported users and self-funders in 2019-20 according to a LangBuisson study⁶². We use this study as it provides us with the best possible estimate for a typical self-funder rate.
303. On the right-hand side of table 28 we show implementation of Section 18(3), the proportion of LA-commissioned clients rises from 60% to 80% for the typical care home, and 30% to 60% for the higher-end home. This occurs because some self-funders will choose to take up Section 18(3) and commission their care through their LA.
304. At the same time, the local authority pays the fair cost of care. We assume that a fair cost of care lies in between the local authority and self-funder rate. As an illustrative example we apply a fair cost of £647 a week.
305. The right-hand side shows a scenario where the fair cost of care has been fully implemented. This is a hypothetical example where the clients on the right-hand side can be considered as brand-new clients rather than the existing clients on the

⁶¹ The two types of care homes are not necessarily representative of the actual provider market. However, we have modelled them based on evidence as much as possible: According to the CMA report, the average number of beds in a care home is 40 and the current self-funder rate across the UK is 41%. The proportion of self-funders in the high-end care home is hypothetical. See <https://www.gov.uk/cma-cases/care-homes-market-study#final-report>

⁶² Care homes for Older People UK Market Report – LaingBuisson 2021.

left-hand side. The example essentially shows the impact of Section 18(3) and fair cost of care on providers several years after implementation, however for the sake of simplicity we assume there are no changes to fee rates due to inflation, wage increases or fluctuating demand.

306. Furthermore, in reality, we are also likely to see a fall in the self-funder rate and a reduction in the gap between the local authority and self-funder fee rate post Section 18(3). However, for the purpose of this example the self-funder rate is kept the same.
307. With the introduction of the fair cost of care, and implementation of Section 18(3), the typical care home's baseline weekly revenue slightly increases from £26,720 to £26,912, a rise of £192 per week, if we assume a capacity of 40 beds, distributed as in the figure above. More significantly the typical care home's 'minimum' revenue (where every bed is filled by LA clients) rises from £23,840 to £25,880 (i.e. the point where providers cover operating costs and make reasonable profits), a rise of £2,040 per week.
308. For the "Higher-End" care home, with an increased number of local authority clients due to Section 18(3), its revenue falls by £936 per week (£28,880 to £27,944). However, its minimum revenue also rises by £2,040. While the higher-end care home sees a drop in its baseline revenue, with the fair cost of care, local authority clients are less costly for them to fill their beds with. Any potential drop in revenue will be partially offset by the decreased revenue volatility brought about by introducing the fair cost of care. It has not been possible at this stage to estimate the value to providers (willingness to pay) of this reduced volatility, but we expect this to be substantial for some providers.
309. This example demonstrates that introducing a fair cost of care in concurrence with Section 18(3) will partially or fully mitigate any impact on provider revenues. The extent to which this happens will vary by provider and region and depend on several of the market conditions listed earlier (e.g. number of self-funders, fee rate differentials, uptake etc). As mentioned earlier, whilst the overall impact on providers is currently uncertain, we will take steps to engage with local authorities and identify how different types of providers are affected.

Costs of Fair Cost of Care

310. Funding for local authorities to move towards a fair cost of care will be introduced from 2022. Below we outline an estimate for the cost impact of this policy.
311. Local authorities will be expected to develop a plan to strategically sustain their local market and conduct cost of care exercises to determine the sustainable rate. The funding provided will help LAs move towards paying providers a fair cost of care as an outcome of these exercises, where necessary. As a result, this funding will also partially mitigate the income reduction some providers may face as a result of Section 18(3) implementation, as LAs move towards paying a fair cost of care.
312. Some providers may choose to respond by adjusting their business models in line with the changes that charging reform, and specifically full Section 18(3)

implementation will bring. We will also expect local authorities to plan and support for this adjustment as part of their strategic planning and facilitate different types of care where appropriate.

313. The outcome of cost of care exercises will depend on local market conditions. Different local factors such as property rental costs, differing care intensities and labour market conditions will mean that fair cost of care will vary by local authority.
314. Whilst local authorities will retain the autonomy to determine local rates, Central Government will publish guidance on cost of care exercises and will engage with local authorities to shape the best possible implementation of the fair cost of care.
315. Since cost of care exercises are not yet universal and not available to DHSC, we need a separate approach for estimating a potential increase in cost from local authorities if they are to adopt the outcome of cost of care exercises. We have explored a range of evidence, some of it confidential, and judge that a close proxy can be constructed by using area cost and other adjustments to a base rate derived from Scottish LA rates for residential/nursing care users and the minimum price suggested by Mears Care for domiciliary care users.
316. The calculations presented below aim to estimate what the individual LA cost of care exercises might arrive at, but this cannot be known perfectly in advance, so a range is presented for the most uncertain and locally varying element of the exercises (care home return on capital).
317. When using these rates as a benchmark we need to take two factors in to account:
 - a. Firstly, we note that property rental costs are higher on average in England than in Scotland. 1-bedroom Local Housing Allowance rates are a potential proxy for measuring this, and for adjusting the rate across English LAs to reflect differences in property costs. Taking an unweighted average of all the broad rental market areas in each country, the English average rate of £129.58 is £35.29 higher than the Scottish rate of £94.29.
 - b. Secondly, we also account for local variation in market conditions and out-of-area placements, as an LA with high local costs may place more clients elsewhere.
318. Therefore, we calculate an estimate for a sustainable 65+ residential and nursing care rate for each local authority as [The Scottish Rate] + [premium as above to reflect higher property costs in England] – [England average 1-bed Local Housing Allowance] + [LA's average 1-bed Local Housing Allowance], with NHS funded nursing care paid where appropriate]. We then weight the results using 2009 Collecting Regulatory Information at Local Level (CRILL) data on out-of-area placements.
319. We compare the average fee rate for each LA as taken from their iBCF return (Improved Better Care Fund) 2019-20 age 65+ residential care and nursing care fee

rate⁶³ against the benchmark and multiply by the number of care home users in NHS digital data.⁶⁴

320. The two main options for fee rate data in Adult Social care are the NHS Digital Adult Social Care Finance Return (ASC-FR) and the iBCF rates. We use iBCF data as it is more timely and is also reported directly by local authorities (whereas NHS digital reported fee rates are compiled through information that local authorities send to NHS digital).
321. To illustrate the impact of variation in care home return on capital, benchmark rates are adjusted upwards or downwards by 10% to obtain a range.
322. For domiciliary care, we start with the rate proposed by Mears Group⁶⁵ From assessment of a range of sources, this has been taken as a good proxy for a fair rate. We use the independent sector Skills for Care-based Adult Social Care Pay and Prices Index to inflate the Mears proposed rate, and get a benchmark rate of £17.64 in 2019-20.
323. We compare each local authority's iBCF 2019-20 domiciliary care fee rate against the benchmark rate and estimate each local authority's purchased number of hours by dividing their reported annual home care spend by their reported external provider unit cost, both from NHS Digital data.
324. As a result, we obtain an estimate for each local authority of the extent to which they pay below the benchmark. We sum the negative values to obtain an England-level uplift for 2019-20 which we inflate in line with average earnings projections to our Charging Reform Model's baseline year (2021-22). We use CPEC projections of demand and unit cost increases to project forward this figure up till 2034-35. Table 40 summarises the illustrative cost of introducing fair cost of care based on the rates described above. Table 41 and Table 42 demonstrate the range from adjusting benchmark rates upwards and downwards by 10%. The range also enables us to account for any risks that Scottish rates are insufficient.
325. The costs provide an indicative impact rather than point estimates as actual costs faced by local authorities will depend on precise local market circumstances at the point of implementation.
326. Furthermore, while illustrative costs of fully implementing fair cost of care are shown from 2022-23 onward, in 2022-23 funding would aim to move towards fair cost of care, with a higher quantum in 2023-24 to align with the implementation of Section 18(3). The extent to which local authorities move towards the fee rate increases presented by the illustrative costs presented below, from 2023-24 onward, will also depend on local factors that affect provider sustainability including but not limited to: the take up of Section 18(3), provider business model adjustments and the use of 'top-ups'.

⁶³ <https://www.gov.uk/government/publications/improved-better-care-fund-provider-fee-reporting-quarter-2-2019-20> .

⁶⁴ <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20> , Reference Data Table T38

⁶⁵ Paying for it The human cost of cut-price care https://www.basw.co.uk/system/files/resources/basw_44005-1_0.pdf

327. The costs shown below do not include familiarisation costs such as the time and administrative costs involved to local authorities in implementing a fair rate for care. These costs are included as part of the wider implementation costs mentioned above in the “Implementation Costs” section.

Table 40: Illustrative Cost impact from introducing Fair Cost of Care (central)

	Cost of Fair Cost of Care Central Scenario (£ millions) – in 2021-22 prices									
Care setting	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Residential/Nursing	365	378	390	403	417	430	445	460	477	494
Domiciliary	172	178	184	190	196	203	210	217	225	233
Total Cost	537	556	574	593	613	633	654	677	701	726

Table 41: Illustrative Cost impact from introducing Fair Cost of Care (lower)

	Cost of Fair Cost of Care Lower Bound (£ millions) – in 2021-22 prices									
Care setting	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Residential/Nursing	103	107	110	114	118	121	125	130	134	139
Domiciliary	172	178	184	190	196	203	210	217	225	233
Total Cost	275	285	294	304	314	324	335	347	359	372

Table 42: Illustrative Cost impact from introducing Fair Cost of Care (upper)

	Cost of Fair Cost of Care Upper Bound (£ millions) – in 2021-22 prices									
Care setting	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Residential/Nursing	744	770	795	821	849	877	906	938	971	1,006
Domiciliary	172	178	184	190	196	203	210	217	225	233
Total Cost	916	948	979	1,012	1,045	1,080	1,116	1,155	1,196	1,238

Market Management Function

328. LA capacity and capability in regard to managing the market is variable and there are some specific gaps, for example, the capacity for LAs to carry out detailed financial monitoring of the provider market. We are therefore planning to enable LAs to use FCC funding to build the capacity and capability needed to effectively manage the change reform will bring to ensure sustainability.

329. We estimate that such additional activities will require funding of between £36 million and £43 million annually.

330. These costs have been estimated as follows. Using CQC data for July 2021, we identify the number of home care locations (in total) and of care home locations

(serving older people and/or dementia care) at local authority level. We then identify the mean wage rate for the ‘manager’ category of local authority staff in Skills for Care data at local authority level, which has a mean wage across all LAs of £50,500. We additionally assume nonwage costs of an additional 20%, a working week of 37.5 hours per week, and real terms pay growth of 2% per annum.

331. For the monitoring of provider (location level) finances, we assume that the monitoring will require on average one week (37.5 hours) of staff time per location as defined above. This may vary by location. Some local authorities may have multiple locations run by the same provider, which may reduce the time needed per location.
332. For quality improvement support, we assume an additional three weeks (112.5 hours) of staff time on average for all locations as defined above with a rating of Requires Improvement or Inadequate. Again, this may vary by location.
333. We calculate the results at local authority level and then sum to England level.

Table 43: Total costs for market management function, £ million, 2021-22 prices

	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Market Management Function	36	37	37	38	39	40	40	41	42	43

Interaction of Fair Cost of Care with Charging Reform

334. Should LAs move towards a fair cost of care, this will likely cause an increase in the costs of charging reform as the rate at which individuals meter towards the cap will change. The number of individuals getting means-test support will increase too as a higher fee rate means, some additional care users will not be able to contribute solely from income and wealth in the taper.
335. The costs relating to the interaction with the two policies has been modelled by using the fee rate increases from the Cost of Fair Cost of Care exercise and applying that to increase the fee rates used in the micro-simulation modelling proportionally. We run the timeseries to look at the costs of reform with increased LA fee rates.
336. This gives us the following estimates for the interaction between the policies.

Table 44: Illustrative impact of the fair cost of care on charging reform

	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Impact of FCC on Charging Reform⁶⁶ (£m)	0	37	74	67	301	387	332	343	349	363

⁶⁶ For illustrative purposes these costs are based on our central scenario for fair cost of care cost impacts. There may be a slight decrease/increase to these costs under the low and high scenarios however this should lead to a significant change to the estimates.

337. Summing our range for the impact of fair cost of care with the impact of fair cost of care on charging reform and the costs for market management function gives us the following total cost.

Table 45: Total Illustrative Cost Range of FCC and Market Management Function

	22-23*	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Total Illustrative Cost of FCC low scenario and MMF (£m)	311	358	405	409	654	751	708	731	750	778
Total Illustrative Cost of FCC central scenario and MMF (£m)	573	630	686	698	953	1,060	1,027	1,062	1,093	1,132
Total Illustrative Cost of FCC high scenario and MMF (£m)	952	1,021	1,091	1,117	1,385	1,506	1,488	1,539	1,587	1,644

Note: numbers may not add due to rounding

* While illustrative costs of fully implementing fair cost of care are shown from 2022-23 onward, in 2022-23 funding would aim to move towards fair cost of care so that the policy can fully kick in in 2023-24 at the same time that Section 18(3) is introduced.

338. The costs detailed in the table above for fair cost of care are illustrative and are an estimation for the sector as a whole. The actual costs to each Local Authority will vary dependent on their local market circumstances. We also expect some providers will adapt their business models in light of reform changes.
339. This means that the progress that LAs make in moving towards paying a fair cost of care will vary between local authorities, dependent on local factors. For example, the number of self-funders, the amount of Section 18(3) take-up in each locality as well as the extent to which top-ups are available/utilised
340. In 2022-23, the focus for the Market Sustainability and Fair Cost of Care Fund will be on making genuine progress towards more sustainable fee rates and building strong foundations. As a condition of receiving funding, we will expect LAs to conduct cost of care exercises, set out their plans for driving market sustainability, including progress towards a fair cost of care, and to report to DHSC on how funding is being used. The Department will use this information to monitor progress and provide public assurance that local markets are being managed successfully. In 2023/24 and 2024/25, funding will increase to £600m in each year. We will expect local authorities to execute their strategy, including by making substantial movement towards paying provider the fair cost of care, where they are currently not doing so. The funding profile allows for sensible implementation that is deliverable, whilst also reflecting the timelines for charging reform. The costs in the table reflect the hypothetical costs to reach this in totality.
341. The costs of moving towards a fair cost of care will be different for each LA. If more funding was provided to allow every LA to reach a fair cost of care immediately, this would inevitably translate into over-payment in some areas, which would be poor

value for money. The funding set out for 2022-23 will ensure progress towards a fair cost of care in all local authorities and allows for monitoring of the impact of the funding provided by central government.

342. We will work closely with Local Government to determine appropriate grant conditions, national guidance and distribution mechanisms for funding allocations in 2023-24 and 2024-25.
343. Both elements above will be vital to ensure a smooth start to the new system and to manage both the flow of people contacting their local authority and expectations. This note builds on previous advice and sets out the intended purpose of those funds.

Table 46: Fair cost of care and market management function costs [central scenario]

Total FCC and MMF	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32	Discounted Total (2020 Base Year)
FCC Central Scenario	0.54	0.56	0.57	0.59	0.61	0.63	0.65	0.68	0.70	0.73	4.99
Interaction of FCC with Charging Reform	0.00	0.04	0.07	0.07	0.30	0.39	0.33	0.34	0.35	0.36	1.70
Market Management Function	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.31
Total	0.57	0.63	0.69	0.70	0.95	1.06	1.03	1.06	1.09	1.13	7.01

Note: numbers may not add due to rounding

Table 47: Fair cost of care and market management function costs [low scenario]

Total FCC and MMF	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32	Discounted Total (2020 Base Year)
FCC Low Scenario	0.28	0.28	0.29	0.30	0.31	0.32	0.34	0.35	0.36	0.37	2.55
Interaction of FCC with Charging Reform	0.00	0.04	0.07	0.07	0.30	0.39	0.33	0.34	0.35	0.36	1.70
Market Management Function	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.31
Total	0.31	0.36	0.41	0.41	0.65	0.75	0.71	0.73	0.75	0.78	4.57

Note: numbers may not add due to rounding

Table 48: Fair cost of care and market management function costs [high scenario]

Total FCC and MMF	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32	Discounted Total (2020 Base Year)
FCC High Scenario	0.92	0.95	0.98	1.01	1.05	1.08	1.12	1.16	1.20	1.24	8.50
Interaction of FCC with Charging Reform	0.00	0.04	0.07	0.07	0.30	0.39	0.33	0.34	0.35	0.36	1.70
Market Management Function	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.31
Total	0.95	1.02	1.09	1.12	1.38	1.51	1.49	1.54	1.59	1.64	10.52

Note: numbers may not add due to rounding

Trailblazer costs

344. We have estimated the costs of the trailblazer initiative to be an additional £142 million between 2022-23 to 2024-25 in 2021-22 prices.
345. This estimate is based on modelling the costs of 6 local authorities of differing sizes and demographics going live with charging reform earlier than other local authorities. These are costs the state would face anyway, but they are brought forward to support trailblazer testing and rollout. These estimates were based on a sample of local authorities that will not necessarily be the LAs that become trailblazers. The trailblazers are assumed to begin 6 months prior to the go-live date of October 2023.

Table 49: Total costs for trailblazers, £ million, 2021-22 prices

Financial Year (2021-22 prices) (in £m)	22-23	23-24	24-25
Charging reform (additional costs due to trailblazers)	8	50	84

Summary of costs

346. As our central estimate, we project the total care and support costs of the policy to increase from around £0.61 billion in 2022-23 to around £4.74 billion in 2031-32 with the total costs being £30.24bn in 2021-22 prices and the NPV with a 2020 base is £23.25 billion. The majority of the costs result from the costs of the policy for older adults. All costs would fall on government.

Table 50: Monetised costs to government of preferred option, in £ billion, 2021-22 prices

	22- 23	23- 24	24- 25	25- 26	26- 27	27- 28	28- 29	29- 30	30- 31	31- 32	<i>Discounted Total (2020 Base Year)</i>
COSTS											
Charging Reform - 86k Cap, 20k LCL, 100k UCL	0.00	0.57	1.27	1.34	2.03	2.68	2.97	3.17	3.35	3.60	15.93
Older Adults	0.00	0.41	0.89	0.87	1.51	2.15	2.42	2.60	2.76	2.92	12.48
Adults under 65	0.00	0.17	0.38	0.46	0.52	0.54	0.56	0.57	0.59	0.69	3.45
Total FCC and MMF	0.57	0.63	0.69	0.70	0.95	1.06	1.03	1.06	1.09	1.13	7.01
FCC	0.54	0.56	0.57	0.59	0.61	0.63	0.65	0.68	0.70	0.73	4.99
Interaction of FCC with Charging Reform	0.00	0.04	0.07	0.07	0.30	0.39	0.33	0.34	0.35	0.36	1.70
Market Management Function	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.31
Implementation Costs	0.03	0.17	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.18
Trailblazer Costs	0.01	0.05	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.13
Total Care and Support Costs	0.62	1.42	2.04	2.04	2.98	3.74	4.00	4.23	4.44	4.74	23.25

Note: numbers may not sum due to rounding

Monetised and non-monetised benefits of option 2

347. The monetised benefits of the reforms include:

- I. Financial benefits to both older people and adults under 65 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.
- II. Financial benefits to social care providers and care users due to the FCC.
- III. Reduction in DWP benefits payable due to more people receiving state support for social care.
- IV. 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 which accrues even to individuals who do not encounter unlimited care costs.

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

- I. Encouraging people to plan and prepare for their care needs in later life.
- II. Creating a space for financial services products which enable people to further mitigate their risks and gain additional peace of mind benefits.
- III. Wider benefits from supporting other objectives for the care and support system including supporting preventative services and the provision of information and advice.

Benefits for people who draw on care and support

349. The majority of the costs incurred by Government to provide additional social care services will be of benefit to receivers of social care services who are entitled to more state support under the preferred option compared to the status quo. The total cost to Government associated with the introduction of a cap, the increase to the LCL, the increase to the UCL of the means test and the unfreezing of the MIG and PEA will be transfers to users of social care.

350. Table 51 shows the direct benefits to older people and adults under 65 as financial transfers. It removes the additional costs faced by local authorities from the total costs and also accounts for the reduction in some benefits for older adults (which is outlined in the next section).

Table 51: Financial benefits to care receivers as a result of charging reform, in £ billion, 2021-22 prices

£bn, 2021-22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
Financial transfers to older people	0.00	0.30	0.54	0.52	1.02	1.51	1.72	1.86	1.98	2.10
Financial transfers to adults under 65	0.00	0.17	0.37	0.46	0.51	0.53	0.54	0.56	0.58	0.68

351. It should be noted that, while the cost of the care system could be interpreted as a transfer from government to social care users, the type of services received by care users are likely to change in some instances. It is therefore not a direct transfer in the economic sense, where financial resources for the same good are exchanged. For example, some self-funders might previously have opted to pay higher rates for services that are not included in the services provided by local authorities.
352. However, as it will remain a voluntary decision for receivers of care to pay for additional services, we assume that, where the decision is made to take up additional state support, the welfare gains at least offset the cost of receiving lower-priced services commission care themselves but might now commission care via a local authority. This could have positive impacts on the opportunity cost incurred by care receivers to organise social care but could also have positive or negative impacts as the type and quality of services they receive changes.
353. There are also possible financial transfers from fully implementing Section 18(3) as self-funders will be able to have local authorities arrange their care at a lower rate. The financial transfers from this have not been quantified due to the uncertainty on take-up and how Section 18(3) will pan out in practice.

Reduction in the total costs of Attendance Allowance (AA), Disability Living Allowance (DLA) and Personal Independence Payment (PIP) for people aged over 65

354. AA, DLA and PIP are benefits available to those who have a physical or mental disability and need assistance with activities of daily living. They are not means tested and are therefore available to anyone who can show they require assistance. Uptake of these benefits compared to those who would be eligible is currently difficult to accurately quantify, but it is not believed that there is 100% take up among those eligible for the benefits⁶⁷.
355. Take up is likely to be higher amongst those who have higher needs and contact with their local authority. This is because the local authority will want to support people to maximise their income to support their wellbeing and enable them to access the care and support they need.

⁶⁷ The take-up rate of Disability Living Allowance and Attendance Allowance: Feasibility study (DWP) http://niesr.ac.uk/sites/default/files/publications/021007_143834.pdf

356. Care home residents who receive local authority support will have payment of their AA, or the care component of DLA, or the daily living component of PIP discontinued after 28 days of stay under current practice.
357. There are two counter acting factors that impact on the number of people receiving disability benefits due to reforms.
358. The reforms result in more care home residents receiving local authority support through the extended means test and cap on care costs. This therefore is offset by a reduction in the numbers for whom AA, DLA or PIP is payable. Note, that this has been assumed to apply only to older adults. This seems a reasonable assumption as the number of self-funders in care homes in adult population under 65 is expected to be very low.
359. The implementation of the reforms and the increased contact between self-funders and local authorities mean that there is potential for an increase in the take up of AA.

Reduction in AA, DLA and PIP payable

360. The table below shows the estimates of expected number of people for whom AA, DLA or PIP would no longer be payable.

Table 52: Estimates of number of people for whom AA, DLA or PIP would no longer be payable

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
upper bound	-	22,000	43,000	45,000	76,000	102,000	106,000	111,000	116,000	120,000
central	-	19,000	38,000	40,000	67,000	90,000	94,000	98,000	102,000	106,000
lower bound	-	17,000	33,000	34,000	58,000	78,000	81,000	85,000	88,000	92,000

361. Internal estimates from ongoing discussions with DWP suggest that the savings to disability benefits would increase from around £40-60 million in 2023-24 to £240-310 million in 2031-32. DHSC will continue to work with DWP to understand these impacts on disability benefits further.

Table 53: Savings to disability benefits from reduction in AA, DLA and PIP payable, £m, 2021-22 prices

£millions, 21/22 prices	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32
upper bound	-	60	110	120	200	260	270	290	300	310
central	-	50	100	100	170	230	240	250	260	270
lower bound	-	40	90	90	150	200	210	220	230	240

Increase in take up of AA (of those not claiming but would be eligible)

362. Although not increasing eligibility, there is always a risk of increased take up that could occur due to implementation raising the profile of the benefits. A potential increase in the take up will depend on:
- the current take-up of self-funders in care homes and the community; and

- b. the proportion of those who are not currently claiming who due to contact with local authority do so.
363. In this case, we do not expect an increase in take up from increased interaction between self-funders and local authorities partly based on the limited capacity for in-depth interaction.
364. As with any change dependent on behaviour there is large uncertainty around the potential increase in take up of AA. DHSC will continue to work with DWP to understand any potential impact.
365. There are also potentially smaller monetised benefits to DWP on other benefits however our discussions to date with DWP suggest that these would be smaller and more difficult to quantify due to uncertainties.

Benefits associated with the Fair Cost of Care (FCC)

366. The introduction of a fair cost of care is expected to generate various benefits:
- a. FCC will enable local authorities to ensure local care markets can respond to the changes reform will bring; address under-investment and poor workforce practices; and provide a stable base for reform of adult social care.
 - b. In addition, moving towards fair rates will help to improve market sustainability and ensure that the cap on care costs delivers on its objective of capping care costs/
367. Without moving towards fair rates, granting people the right to commission at the (currently in most cases unsustainably low) local authority-commissioned rate would increase the share of users on that rate and reduce care provider revenue. Fair cost of care funding will help LAs to support providers through charging reform, including partially mitigating effects on income due to Section 18(3).
368. This presents an opportunity for local authorities to achieve greater oversight of their local care markets, improving information on people who fund their own care which can be used to strengthen their strategic planning.
369. The key beneficiaries are:
- a. LAs, as this provides an opportunity to enhance their market power (as they become responsible for securing care for a greater portion of over-65s), enabling them to be more strategic about their markets.
 - b. Recipients of care who would previously have paid for their care themselves and who may now face lower fees
 - c. Social care providers who would benefit from a reduction in the uncertainty of their minimum revenue from care clients, and for those who are commissioned by local authorities, as their revenue might increase due to higher fees.
370. As stated above, first order benefits to providers are any reductions in uncertainty in minimum revenue or potential revenue increases. However, there are several

secondary benefits from this to both providers themselves as well as other key stakeholders:

371. Additional revenues for providers may lead to higher profits. This would particularly be the case for providers that have a large proportion of local authority commissioned clients. Among providers with a large proportion of self-funders, the additional revenues may just mitigate any revenue shortfalls from Section 18(3) (see earlier discussion on the impact of Section 18(3)).
372. Higher profits or reduced uncertainty around revenues can enable providers to carry out longer term investments in their properties or in the quality of their services. Care recipients could therefore benefit from improvements in the quality of their care. Whilst investments in capital such as property are more likely to benefit residential care clients, all clients will benefit from investments to staff training or basic services provided.
373. Additional revenues may also be passed on to staff in the form of better pay or conditions. As an example, for staff in domiciliary care, better terms could mean that staff receive greater compensation for travel time between appointments.
374. However, the benefits of these reforms go beyond the cost of implementing those changes. Promoting transparency within the market and prices which better reflect the true costs of care for all individuals should increase allocative efficiency within the market by promoting a more appropriate use of resources. In particular, if local authorities are currently paying prices below the cost of providing care, this may encourage them to place too many people in residential settings potentially to the detriment of the welfare of these individuals and the efficiency of the care and support system.
375. The policy also contributes to the benefits and non-monetised benefits associated with the cap on care costs as it is an important enabler of the proposed reform.

Peace of mind benefits

376. Funding reform is a type of social insurance and people generally value insurance more highly than the value of the expected pay-out. 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.
377. 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.
378. A capped cost system will lead to a net welfare gain for the population since risk-averse people would be willing to pay premiums exceeding the costs.
379. 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.

380. 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 B: Peace of Mind Methodology.
381. There are several assumptions in this work, most notably it assumes constant risk aversion and that the USA data is applicable to the UK. Since we do not have data for adults under the age of 65, we have assumed that this figure is applicable to individuals of all ages.
382. This means there are peace of mind benefits of 43% above the value of the state support provided to individuals drawing on care and support.

Table 54: Peace of Mind Benefits from proposed reform, in £ billion, 2021-22 prices

Financial Year	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32	Total
Financial transfers to older people	0.00	0.30	0.54	0.52	1.02	1.51	1.72	1.86	1.98	2.10	11.56
Financial transfers to working age adults	0.00	0.17	0.37	0.46	0.51	0.53	0.54	0.56	0.58	0.68	4.39
Additional Peace of mind	0.00	0.20	0.39	0.42	0.66	0.88	0.97	1.04	1.10	1.19	6.86

383. There are several potential sensitivities that could affect the value of peace of mind benefits. These could either reduce or increase the peace of mind benefits.

Reducing peace of mind benefits:

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

Increasing peace of mind benefits:

386. 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.
387. 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 2023. This would tend to increase the effect as people value benefits now more than future ones.
388. This approach may also overstate peace of mind benefits as it doesn't account for the fact that under the existing system individuals will already have some peace of mind from the state support provided to those who can't pay for care out of their income and wealth.

389. Therefore, since this is a relatively uncertain value, we have tested the various values for peace of mind benefits. As long as the benefits are 28% or greater 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.
390. For the purposes of this impact assessment we have assumed that all peace of mind benefits occurs when funds are spent. This is the most conservative assumption we could make – any proposals which spread the benefits over a longer time period (and therefore with the benefits occurring before the costs) will increase the merit of these proposals.
391. 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.
392. In this view the entire net present value of the policy would occur in 2023-24 (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 in societies at large, then these two different views would not affect the overall NPV of the policy.

Summary of monetised benefits

393. In total, we estimate that the benefits of reform are approximately £33 billion over a ten-year appraisal period in 2021-22 prices with a NPV of £25.27 billion in 2020 base year.

Table 55: Total monetised benefits of preferred option, £ billion, 2021-22 prices

BENEFITS	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31	31-32	Discounted Total (2020 Base Year)
Financial transfers to the care population	0.00	0.47	0.91	0.98	1.53	2.04	2.27	2.42	2.56	2.77	12.10
Older Adults	0.00	0.30	0.54	0.52	1.02	1.51	1.72	1.86	1.98	2.10	8.72
Adults under 65	0.00	0.17	0.37	0.46	0.51	0.53	0.54	0.56	0.58	0.68	3.38
Impact of FCC on providers	0.54	0.59	0.65	0.66	0.91	1.02	0.99	1.02	1.05	1.09	6.69
Reduction in AA, DLA and PIP payable	0.00	0.05	0.10	0.10	0.17	0.23	0.24	0.25	0.26	0.27	1.28
Peace of mind benefits	0.00	0.20	0.39	0.42	0.66	0.88	0.97	1.04	1.10	1.19	5.20
Total benefits	0.54	1.31	2.05	2.16	3.27	4.17	4.47	4.73	4.97	5.33	25.27

Note: numbers may not add due to rounding

Non-monetised Benefits

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

394. Through providing protection from unlimited care costs the proposals provide people with greater certainty and 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 face.
395. 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 the person's best interests.

Support for wider government objectives around planning, preparation and prevention

396. 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 charging reform could make a particularly significant contribution are around prevention and intervention.
397. In the current system, many people funding their own care will have very little contact, if any, with their local authority. The introduction of a cap on care costs will encourage people to make contact and provide an opportunity for them to access information and advice from their local authority and to make choices about the care services available in their local area.
398. While the proposals create no direct benefits in this area, they may support other government policies to enable people to access information and advice around their care operate more effectively, making effective use of this additional contact individuals have with local authorities.

Space for financial services products

399. 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 limit on people's care costs should provide greater incentives for the financial services industry to provide relevant products that people see the benefit of purchasing.
400. 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.

Direct costs and benefits to business calculations

401. We do not expect any direct impact on businesses as a result of the core charging reform. There could, however, be indirect impacts on providers of financial insurance products as the introduction of a cap on care costs generates the opportunity to supply social care insurance products.
402. We note that the full implementation of Section 18(3) of the Social Care Act and the introduction of a FCC could have a direct impact on social care providers. However, as explained below, the scale of these impacts is uncertain.
403. Firstly, as local authorities move towards paying a fair cost of care, likely by increasing fee rates appropriate towards their locality, providers will see an increase in revenues from their local authority commissioned clients.
404. Secondly, as a result of Section 18(3), self-funders will be entitled to commission social care services at the lower, Local Authority commissioned rate which could reduce revenues for those social care providers who are primarily commissioned by self-funders.
405. The benefits from aforementioned impact on provider revenues from introducing a fair cost of care are presented in Table 1 and in the Benefits section of this document, where we note that of the £7bn (NPV over a 10 year period) of illustrative costs to local authorities from fair cost of care and market management functions, £6.7bn (NPV over a 10 year period) will be transferred to providers through higher fee rates.
406. In theory this additional revenue should result in first order benefits to businesses through increased profits or reduced uncertainty around income. However, it may also be the case that any additional revenues from local authority commissioned clients, are just used to offset any potential losses in revenues from self-funder clients that take up Section 18(3). Among providers where a substantial fee rate gap exists between self-funders and local authority clients (where self-funders effectively cross subsidise local authority commissioned clients) the additional revenues may also be used to finance a reduction in self-funder rates and thereby reduce or partially eliminate this fee rate gap.
407. Furthermore, in practice, even where providers are able see net increases to their revenue, this may only lead to indirect benefits to staff or care recipients. This is because any benefits higher profits or reduced income uncertainties may be partially or fully passed on to staff and care residents through investment in the quality of service provision or in workforce wages and conditions.
408. Therefore, whilst spending by local authorities to increase fee rates will be passed on to providers through higher revenues from LA commissioned clients, any direct benefits are unclear and currently not quantifiable.
409. We would also expect wider indirect benefits to providers as a result of Section 18(3), as the reform would increase price transparency and reduce volatility of

prices, which is expected to lead to a better functioning market overall in which prices accurately reflect costs.

410. As stated in earlier sections on Section 18(3) and the fair cost of care, the scale of these potential impacts will depend on a variety of conditions and market factors and how they interact with each other. For now, we are unable to quantify these impacts. However, in the section on the cost of Section 18(3), we also noted that a clearer picture of the impact would emerge as we gather more evidence via steps such as early assessments and trailblazers. This will also shed a greater light on whether there are any direct or indirect benefits to businesses and other stakeholders, from Section 18(3) and the fair cost of care, as well as the potential scale of these benefits.

Risks and assumptions

411. The costs and benefits within this impact assessment represent the most likely effects 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. The most critical assumptions we have made are outlined below, and more detail is available in the annex.
412. We will be seeking views on the assumptions and data used in this impact assessment as part of the consultation process.

Charging reform: Older adults

413. The model is a cross-sectional model that retrospectively simulates the uncompleted care journeys of a representative cross section of care users in the time period of interest. For each financial year, it models all users up to a randomly assigned day in that financial year to assess how their assets would deplete and how they would interact with different charging systems.
414. The model uses a base sample of respondents from the English Longitudinal Study of Aging (ELSA) wave 9 who need assistance with one or more activities of daily living (1+ADL) to get a distribution of wealth, income, and other key variables at point of entry into care⁶⁸.
415. The main part of the model is the individual pathway model that simulates the care pathway for the individuals in the model. Each individual in the model is assigned a random un-completed care pathway. For residential care and nursing care they are assigned a completed spell in domiciliary care (or no previous domiciliary care) and then an uncompleted spell in residential care. For domiciliary care they are assigned an uncompleted spell in domiciliary care. The distributions from which the random un-completed pathways are selected are constructed using the 2011 BUPA Survey, PSSRU (now CPEC) Admissions to care homes survey 2005, and the User Experience Survey 2006.
416. As our central assumption we assume that lengths of stay remain constant in the future, where we use the distribution of lengths of stay from the PSSRU study of BUPA care homes⁶⁹, showing a mean completed length of stay of 27 months and a median length of 15 months.
417. For costs of care, we use data from the NHS Digital ASC-FR 2019-20 return; this is data from returns completed by each Local Authority. The unit cost data is derived from returns on the level of activity and spend. In the long run you would expect unit costs in social care to increase approximately in line with wage inflation, due to the dominance of staffing costs in the costs of delivering social care. Although new data were released in October 2021, given they are affected by Covid-19 effects, we consider the better way to estimate future costs is to base projections on 2019-20 data.

⁶⁸ <http://www.ifs.org.uk/ELSA>

⁶⁹ PSSRU, Lengths of stay in care homes <http://eprints.lse.ac.uk/33895/1/dp2769.pdf>

418. There are simplifying assumptions around the inflation of different financial quantities. We assume that all individual financial quantities and all financial parameters uprate in line with average earnings after reforms are implemented. These include the:
- a. level of cap and general living costs;
 - b. means test thresholds and income allowances;
 - c. wealth of the older population, including home ownership proportions;
 - d. income of older population; and
 - e. cost of care.
419. The base sample is reweighted using weightings derived from demand projections from the Care Policy Evaluation Centre (CPEC⁷⁰ - formerly the PSSRU - Personal Social Services Research Unit⁷¹) aggregate model of the number and characteristics of care users in year in question.
420. The CPEC model is a cell-based model that projects the:
- a. number of older people with disabilities;
 - b. number of people who use formal social care services;
 - c. number of people who qualify for state support; and
 - d. cost to the state.
421. The details of the CPEC long term demand and the data and assumptions it is based on is provided in Annex A: Overview of DHSC social care charging model for over 65s. There are many different academic papers documenting the CPEC model, which provides reports on the projections and documents the model structure^{72, 73}.
422. The central assumption regarding the uptake of the reformed system is that 80% of self-funders will come forward to be part of the charging reform system.

Charging reform: Adults aged under 65

423. The central assumption regarding the uptake of the reformed system is that 80% of self-funders will come forward to be part of the charging reform system.
424. There is no robust published estimate of the number of under 65 self-funded individuals who arrange their own care in the community. To estimate the number of self-funded individuals who arrange their own care in the community we worked with a number of domiciliary care providers to review the prevalence of genuine self-funders versus state funded individuals, in a sample of their client bases. We

⁷⁰ <https://www.lse.ac.uk/cpec>

⁷¹ <http://www.pssru.ac.uk/>

⁷² http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/121203_care_for_older_people_1.pdf

⁷³ <https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf>

grossed this estimate up to get a total community self-funder estimate for England using the NHS Digital ASC-FR 2019-20 return⁷⁴.

425. To calculate the proportion of self-funders and full cost clients who will be affected by the enhanced means test, we use Wealth and Asset survey⁷⁵ (WAS) data (2012-2014). This is data on the income and wealth of those under 65 with physical disabilities, as a proxy for the income and wealth of all under 65 care users. We assume the distribution of wealth for under 65 users with physical disabilities is similar to the distribution of wealth for all under 65 care users.
426. The WAS data does not include a breakdown of wealth for under 65 care users between £23,250-£99,999, who are affected by the UCL increase to £100k. Therefore, we assume a uniform distribution and that all care users have an average wealth by taking the mid-point value of £61,625.
427. The under 65 model assumes the proportion of community self-funders that meet the eligibility criteria is 89% when calculating the £86,000 cap costs and assessment costs. We have a significant degree of uncertainty for this assumption as we are unable to access data specifically for adults under 65, therefore this assumption results from internal analysis on the proportion of older users who are eligible for care. It also assumes that the proportion of community self-funders that meet the eligibility criteria does not change over time.
428. Demand projections of LA funded care-users in the under 65 model are derived from the CPEC aggregate model of long-term care projections in England⁷⁶. The CPEC model produces projections based on assumptions about future trends in the key drivers of demand for long-term care. The number of people by age and gender changes in line with the Office for National Statistics (ONS) 2018 principal population projections. Further detail on CPEC model assumptions is included in the annex.

Section 18(3) and Fair Cost of Care

429. In preceding sections, we've set out potential impacts on providers and local authorities that arise from the implementation of Section 18(3). We also identified the characteristics and market conditions that would see providers affected by Section 18(3). The critical assumption behind our analysis is that from 2022 Local Authorities will move towards a more sustainable rate for care.
430. For those local authorities that fail to move towards a fair cost of care, we could see larger than expected impact on providers. This is because, where a fair cost of care is introduced, it should be sufficient for modest and efficiently run care homes to operate without charging self-funders a higher rate. Concerns regarding provider viability should therefore be limited to those providers who need to charge self-funders above the fair cost of care to stay afloat.

⁷⁴ Adult Social Care Activity and Finance Report, England - 2019-20 - NHS Digital.

⁷⁵ Analysis of wealth and assets by disability, age, income, Great Britain, July 2012 to June 2016 and April 2014 to March 2018 - Office for National Statistics (ons.gov.uk)

⁷⁶ Projections of demand and expenditure on Adult Social Care. Wittenberg, R, Hu, B & Hancock, R, 2018, PSSRU.

431. If the impact of Section 18(3) on providers is larger than anticipated, there will be additional risks to individuals and local authorities. In local authorities where the LA rate is below the fair cost of care, fewer providers will be able to offer lower rates to self-funder clients that take-up Section 18(3). As a result, individual choice could be restricted. Furthermore, LAs could face higher transition costs as they would have to dedicate greater resource to either manage the transition of clients away from providers who are unable to offer lower rates (to those who take up Section 18(3)) or to facilitate new entrants to the market.
432. Risks on the assumptions that lead to uncertainty in the cost projections are commented on in the costs section and covered in the sensitivity analysis presented throughout the cost section and in Annex A: Overview of DHSC social care charging model for over 65s.
433. The majority of the risks in implementing charging reform are medium to long-term; materialising in the main implementation period. The key themes to the risks are:
- i. **Significant financial risk** – there remains an amount of uncertainty around the cost of charging reform and the associated impact across central government, Local Authorities and providers. This risk will be managed by the early implementation of trailblazer local authorities to guide an understanding of the financial requirements, as well as by early and continuous engagement with a range of provider organisations.
 - ii. **Complex operational delivery risk** – there are several delivery risks to consider in the implementation of this programme of work. The top programme risks are:
 - iii. **Technology** – we need to ensure LAs have the required technical solution in place, specifically the new metering capability. Where possible, we will seek to ensure IT solutions can support broader efficiency objectives (to help manage increased demand for assessments) and broader local government digital transformation objectives. DHSC are working jointly with NHSX and involving industry experts.
 - iv. **Workforce** – the policy implies additional demand for Local Authority assessments and commissioned care. This will have implications for a range of workforce groups in LAs this may include social workers, financial assessment officers, business support staff and commissioners, amongst others. We are analysing risk and working with the sector to understand the scale of the workforce challenge and alternative workforce and assessment models to mitigate these.
 - v. **Market stability** – there is a risk that delivery of reforms impacts on market sustainability. Switching on Section 18(3), giving the right for individuals to request that their LA meet their eligible care needs, will impact upon the provider market; potentially shifting the pattern of demand in some local authorities. Local authorities will need to manage their markets to remain sustainable through this

shift. Local authorities moving towards a fair cost of care will be an essential supporting and mitigating factor.

434. It is important to acknowledge that a number of assumptions about future demand pressures on adult social care under the reform system have been made. However, these will be kept under review and demand will be tested with trailblazer local authorities.
435. There are also risk to the policy. Amending s15 of the Care Act 2014 is dependent on the clause in the Health and Care Bill successfully passing through Parliament.

Impact on small and micro businesses

436. A net reduction in revenue could be incurred by those providers who primarily service self-funders, as they might experience a reduction in revenues and possibly profits and a change in services demanded as more self-funders commission services via local authorities at a lower rate under the full implementation of Section 18(3). A net increase in revenue could be incurred by providers primarily commissioned via Local Authorities. Additional benefits include an expected increase in allocative efficiency within the market by promoting a more appropriate use of resources and more transparency and less volatility in care prices. There could therefore be varying impacts on small and micro businesses.
437. Defining small and micro providers as having fewer than 50 employees and using a ratio of 1.5 employees per bed^[1], small and micro care providers can be defined as those having fewer than 33 beds in total. We define a provider using the provider ID field in the CQC care directory, and count brands as a single provider even if they have multiple provider IDs. There are 3,785 such care home providers out of 6,485 in England, although they only represent 68,737 beds out of an England total of 458,955. However, some will not in fact be small and micro providers if they have a higher staffing ratio than 1.5 or if they have activity in other markets. It should be noted that the smaller providers are disproportionately likely to serve younger adults, where self-funder numbers are substantially lower, so will be less affected by the reforms. These numbers therefore represent an upper bound of the number of small and micro businesses affected by the reforms.
438. Furthermore, as mentioned in earlier sections on the impacts of introducing Section 18(3), the policy is likely to affect a particular type of provider. Notably, those providers that have (among other characteristics): a large proportion of self-funders a proportional of their overall client base, have larger take-ups, who are in areas where local authorities do not already pay sustainable rates or are less able to move towards sustainable rates for care. Providers that currently see greater fee differentials between local authority clients and self-funders will also be particularly impacted. We are unable to identify the size of providers that will be particularly affected. However we note that the 2017 CMA care market study stated that fee differentials (between LA commissioned clients and self-funders) could be significant noting that “we understand that fee differentials for smaller providers are slightly lower (compared to larger providers) but still significant.”
439. The charging reform could also generate new opportunities for the market of financial products, however, this market exclusively consists of larger businesses.

^[1] Skills for care report 680,000 residential staff. Table 6, <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2020.pdf>. CQC data for April 2021 show 458,955 registered care home beds, see the care directory with filters at <https://www.cqc.org.uk/about-us/transparency/using-cqc-data>.

Wider impacts

Effects of charging reform on the wider economy

440. There are potential wider benefits, beyond removing the unpredictable risk of extremely high costs, from the charging reforms, to individuals, the social care sector, and the wider economy. DHSC has commissioned work from Frontier Economics to examine some of these wider impacts, including if reform could discourage excessive savings and therefore encourage innovation and investment in the care sector and wider economy.
441. Early findings suggest that those we expect to benefit financially 'directly' are those who are already receiving care services. These people may choose to spend some of these savings on wider care services (potentially driving innovation in the sector) or on other services (potentially supporting local economies) because of the reforms.
442. Those not yet receiving care will benefit more 'indirectly' through the possibility of future cost savings, though these will be less certain and would materialise further into the future. Those who internalise these future savings may also choose to spend more now.
443. We would also expect additional welfare gains from this additional spend, as spending in preventative services or on other goods is likely to increase individuals' utility compared to holding excessive savings.
444. Compared to total direct savings of £16 billion (based on financial transfers in the ten year appraisal period), and also not taking into account expected savings from individuals who have not received care, the impact on the social care market may be relatively limited, at least initially. Social care markets are highly localised, and the impact of the reforms is likely to vary across the country, depending upon local characteristics.
445. The social care market is unlikely to become more sustainable solely as a direct consequence of the proposed reforms. However, the market may become more innovative and offer some new or higher-quality services if people choose to spend some of their actual or perceived savings on other care services. These developments are likely to be targeted at more affluent, self-funded residents.

Effects on local authority processes and systems

446. The reforms will bring many more people into contact with local authorities and this may create challenges as well as opportunities. DHSC will work collaboratively with the LGA, ADASS, and wider stakeholders on implementation issues and mitigation of risks.
447. Implementation of this reform will require structural and system changes within local authorities, including new business processes and operating models. LAs will also need to make amendments to their IT systems to ensure that systems are capable of capturing and calculating costed eligible care needs which will count towards the

cap. Additional social workers and back-office staff will also be required to meet an increased number of assessments, the cost of which have been included above.

Impact of charging reform on public health

448. Where the state provides public services at no cost to the consumer, such as the provision of health in the UK, there exists a risk of moral hazard, i.e., incentives to minimise risky behaviour or take preventative actions to avoid negative health outcomes in the future are reduced when people know they will not have to pay for those future health care services.
449. A similar argument could be applied to the introduction of a cap on social care costs and the extension of the means test under which more people would have the assurance that they would not need to pay for their social care services later on, or would have to do so to a lesser extent. This could therefore have negative impacts on public health and on resources for the NHS and providers of social care.
450. However, we do not believe that such impacts would be significant due to the following:
 - a. Most individuals will still have to pay for the care costs up to the cap of £86,000 and continue to pay their DLCs and accommodation costs beyond this level (neither of which are cheap). We believe that for the majority of people this provides a sufficient incentive to invest in preventative action they otherwise would have taken without the cap.
 - b. Second, the value of keeping one's independence and good health is likely going to be higher for most individuals than the cost of receiving social care support. The additional benefit of wellbeing and quality of life is another incentive to take preventative actions to avoid being dependent on social care at any point in one's life.
 - c. Third, the uncertainty around the length and cost of future social care needs under the current system could lead to excessive savings by individuals prior to developing a care need, and therefore reduce their consumption of (and spending on) other services, including health care. The Commission on Funding of Care and Support put forward the argument that introducing a cap reduces this uncertainty and may encourage individuals to spend money they would have otherwise saved in a precautionary manner, which could include preventative services or simply an increase in uptake of social care services.
451. For the reasons above, we do not foresee any negative impact on public health. If anything, it could be argued that the incentive to commission social care services, and therefore improving general quality of life and health outcomes, could increase under the proposed reform.

Specific Impact Tests

Equalities

452. The policy has undergone a full equalities assessment as set out in the Statutory Equality Duties Guidance⁷⁷.

Socio-economic status

453. 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 level of wealth and income.

454. The reform offers two forms of protection – the financial cap, which provides certainty and protection for those with higher income and assets when entering care; and the increased LCL and UCL, which provides more protection for those who enter care at lower levels of wealth. Around half of all older adults in care receive some state support for their care costs under the current system. This rises to roughly two thirds under Option 2.

DHSC modelling indicates that the older adult care population is generally poorer than the total older adult population, with more care users concentrated in lower wealth and income groups than higher ones (see

455. Table 57). This is supported by a range of evidence which suggests that poorer people have worse health outcomes and spend more time needing support. ONS research suggests that people in the most deprived decile of the population in England and Wales spend almost twice as long living in poor health on average than those in the least deprived decile. Also, ELSA respondents who require no assistance with activities of daily living are wealthier than respondents who need assistance with one or more activities of daily living.⁷⁸

Table 56: Wealth and income quintile breaks of the older adult population from ELSA wave 9, in 2021-22 prices

Quintile	1	2	3	4	5
Wealth (total)	<£70,883	<£162,063	<£267,083	<£440,668	>£440,688
Income per week	<£144	<£208	<£289	<£404	>£404

⁷⁷ DHSC (2021): [Adult social care charging reform: public sector equalities duty impact assessment](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/96442/adult-social-care-charging-reform-public-sector-equalities-duty-impact-assessment.pdf) - GOV.UK (www.gov.uk)

⁷⁸ Health state life expectancies by national deprivation deciles, England and Wales: 2015 to 2017: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2015to2017#life-expectancy-and-healthy-life-expectancy-in-england-by-the-index-of-multiple-deprivation-2015-imd15-2015-to-2017>

Table 57: Proportion of 2021-22 care population in each wealth and income group based on total older adult population quintile breaks

		Wealth					Income Proportions
		1	2	3	4	5	
Income	1	8%	4%	3%	3%	2%	19%
	2	13%	5%	3%	5%	1%	28%
	3	10%	4%	5%	4%	2%	26%
	4	5%	3%	3%	3%	3%	18%
	5	3%	2%	2%	2%	2%	10%
Wealth Proportions		39%	17%	17%	17%	10%	100%

456. All income and wealth groups benefit from the reform and the state continues to spend the most on the poorest older adults. In a reform system, total social care spend on older adults with less than around £71,000 of assets when entering care - the least wealthy 20% of older adults – would be £4.42bn in a 2021-22 steady state. This is compared to £0.51bn on the wealthiest 20% of older adults. Therefore, those in the lowest quintile continue to receive the most state support.
457. The concentration of state spend on less wealthy older adults is driven by two factors – the first is that less wealthy adults are more likely to get state support when paying for social care as they are more likely to benefit from the means test; the second is that there is a greater number of relatively less wealthy care users as compared to the rest of the population – DHSC modelling suggests 39% of older adult care users are in the least wealthy 20% of all older adults.

Figure 17: State spend on older adults’ social care by wealth quintile under reform in 21/22 steady-state

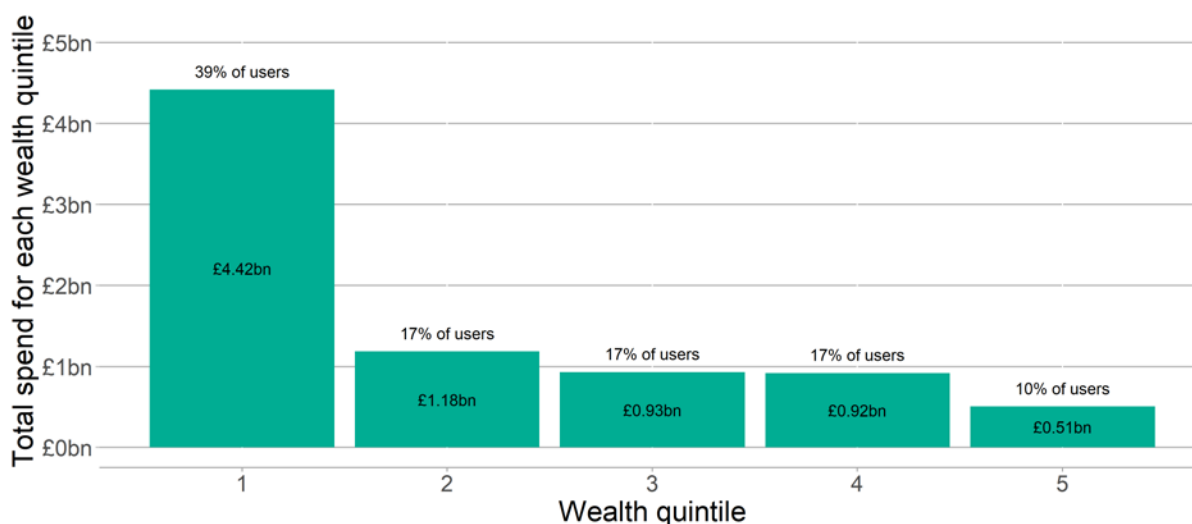
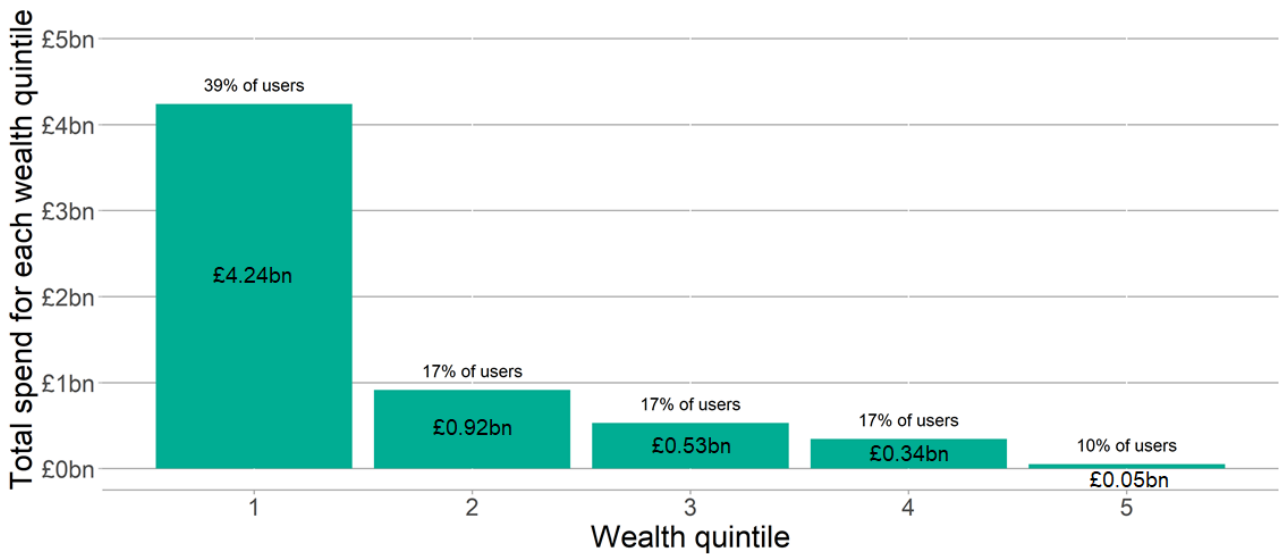


Figure 18: State spend on older adults' social care by wealth quintile under current (no reform) system in 21/22 steady-state



Note: Wealth and income quintiles are based on quintile breaks for the entire older adult population, taken from ELSA wave 9. Our model care population, derived from the ELSA +1ADL population and reweighting to known ratios of state-supported to self-funded care users from CPEC user projections, is generally poorer than the total older adult population. This means that, while the income and wealth breaks are based on quintile breaks for the entire older adult population, the older adult care population has 39% falling into wealth quintile 1, and only 10% falling into wealth quintile 5 (see Table 57). Also note, this is state spend on care user's care costs, and does not cover other costs to state of maintaining a social care system.

458. When looking at the distribution of state spend by income group, the lower income groups still receive more state support than higher income groups (note that there are fewer adults receiving care in the bottom income quintile at 19%, compared to 39% of adults in the bottom wealth quintile, see Table 57).

Figure 19: State spend on older adults' social care by income quintile under reform in 21/22 steady state

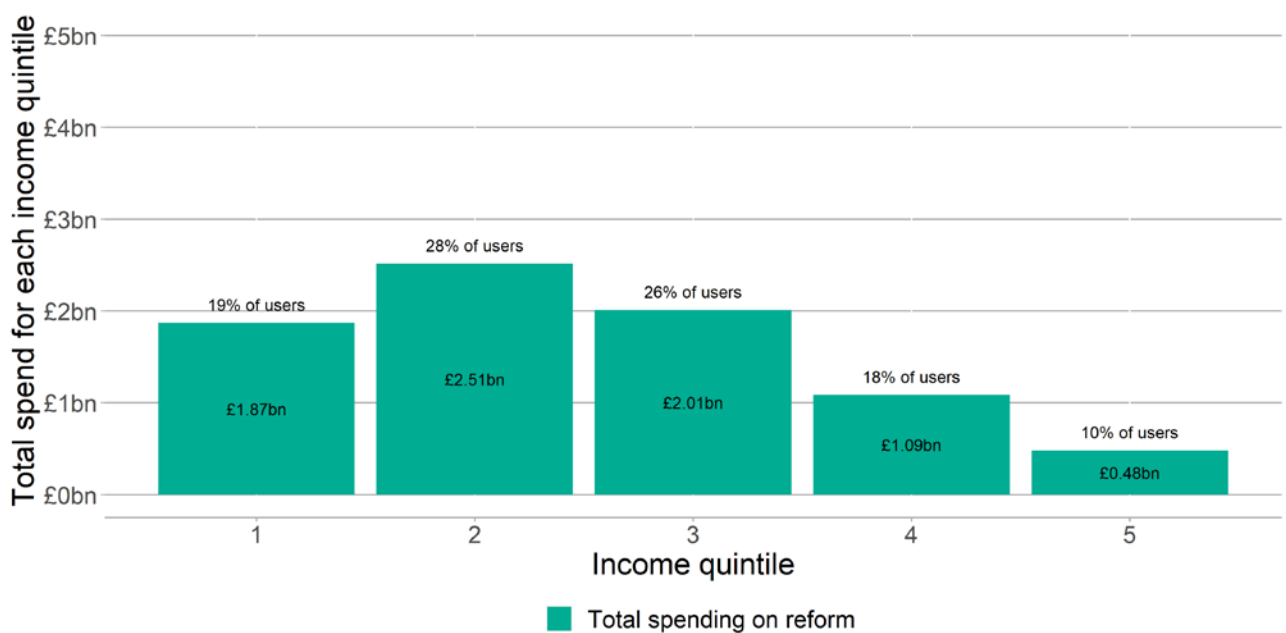
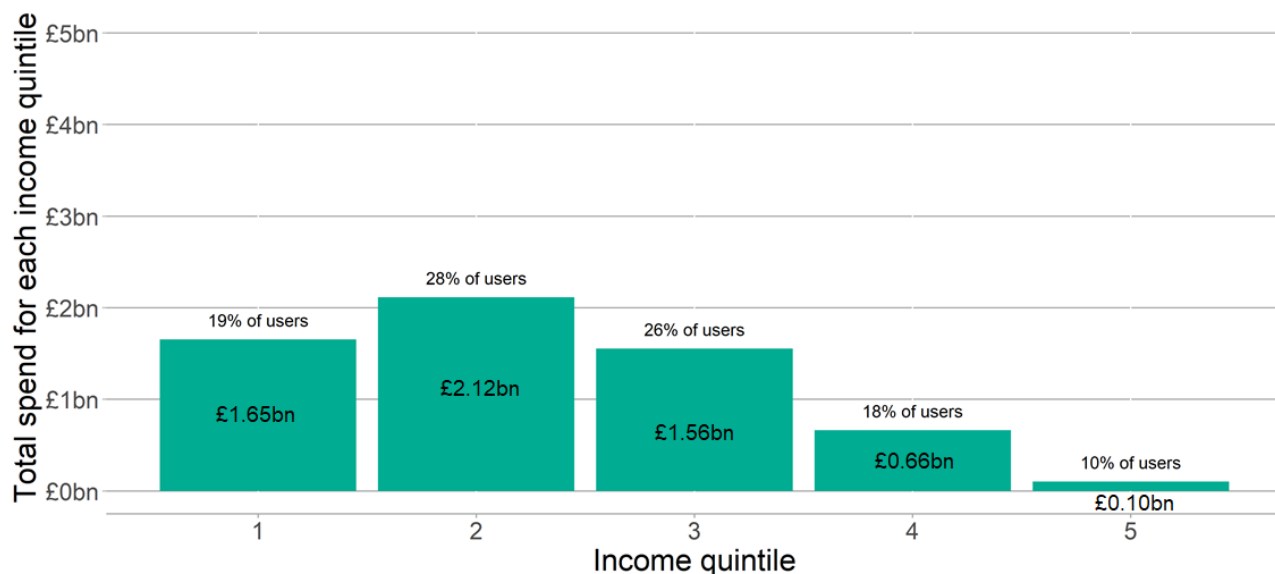


Figure 20: State spend on older adults' social care by income quintile under current (no reform) system in 21/22 steady-state



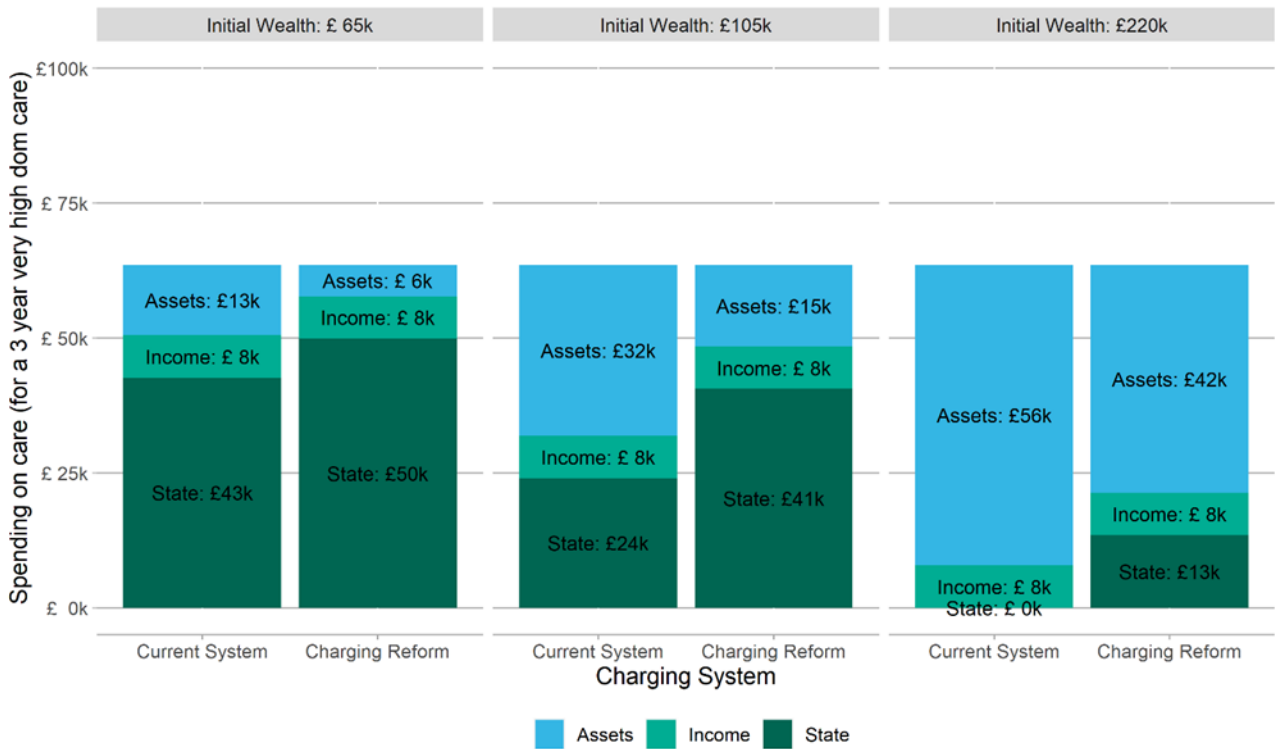
Note: Wealth and income quintiles are based on quintile breaks for the entire older adult population, taken from ELSA wave 9. Our model care population, derived from the ELSA +1ADL population and reweighting to known ratios of state-supported to self-funded care users from CPEC user projections, is generally poorer than the total older adult population. This means that, while the income and wealth breaks are based on quintile breaks for the entire older adult population (see Table 57). Also note, this is state spend on care user's care costs, and does not cover other costs to state of maintaining a social care system.

459. This analysis could not be repeated for the younger adults because we do not have robust data on their income and wealth at a granular level.

Illustrative example of breakdown of spend

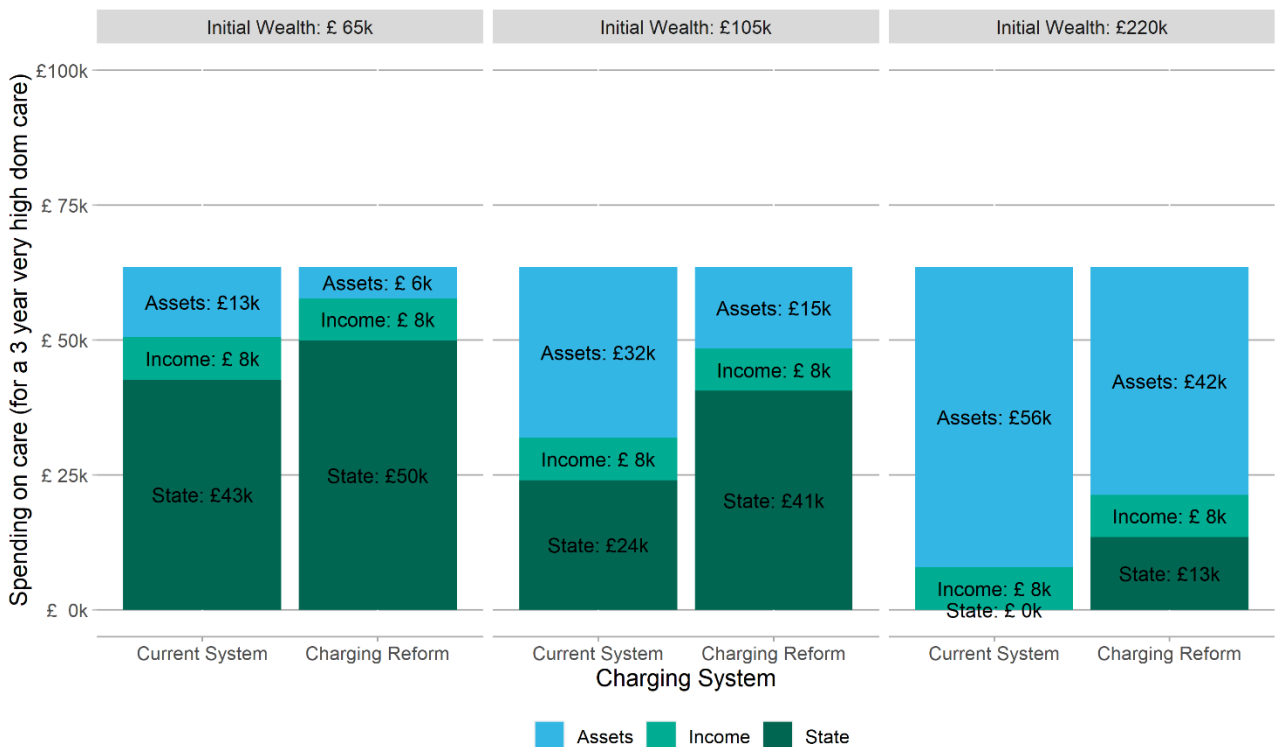
460. The following charts show the breakdown of spend for the current and reform system from assets, income and state contributions for different levels of starting wealth. Figure 21 shows a single older adult with very high domiciliary care for 3 years, and Figure 22 shows a single older adult with a median residential journey of 97 weeks. In both figures, we can see that state support is progressive with more support provided under the new system for those with lower levels of starting wealth.

Figure 21: The split of spend from income, assets and state on costs for a 3 year very high needs domiciliary care journey for a single older adult for different levels of initial chargeable assets



Source: DHSC modelling assumes income of £239, care package of £413 per week for the domiciliary care journey.

Figure 22: The split of spend from income, assets and state contributions for a single adult with a median length residential care journey (97 weeks) care journey across different initial wealth levels



Source: DHSC modelling assumes income of £239, fee rates of £683 per week for the residential care journey

Marital Status

461. The current system provides more protection to users in a couple than to single users. This is largely due to users in a couple benefitting from the housing disregard when one of them is receiving care in a care home.⁷⁹
462. The reforms announced will close the gap in state support between users in a couple and single users. The proportion of single older adults who receive no state support will decrease by 30%, while the proportion of older adults in a couple who receive no state support will decrease by 20%.

Regional Impact

463. All individuals will benefit from the reform regardless of where they live. Individuals are either more or less likely to benefit from reforms based on their income and wealth and care journeys, rather than where they live. Therefore, while on average there will be variation between regions in terms of how they will be benefit from the different aspects of the reform, there will be considerable variation within regions. Comparably less wealthy regions will likely have fewer users benefiting from the cap, whilst having more users benefit from the more generous means test, than comparably wealthier regions.
464. Detailed regional analysis is restricted by a lack of data on how care journeys and the social care population vary by region. However, some inferences can be drawn by looking at differences in fee rates and wealth and income profiles in different regions.
465. The regions which are likely to have more users reaching the financial cap are those with higher fee rates. This is because users facing higher fee rates will meter towards a financial cap quicker. Assuming that chargeable income and care journeys are consistent across different regions, this will mean more users will hit the cap in regions with higher fee rates.
466. Figure 23 and Figure 24 show the average (mean) Local Authority fee rates for residential and nursing care by regions in England. These show the variation between different regions in England, with regions in the south of England generally having higher fee rates than in the North. The average older adult in residential care in London, the South East, the South West and the East of England face residential fees of above £700 per week. Meanwhile in the North East, the North West, Yorkshire and the Humber, the East Midlands and the West Midlands, the average residential fee rate is below £700 per week. Similar differences are seen for adults under the age of 65, with London, the South East, the South West and the East of England having average residential fee rates over £1,400 per week, while all other regions have average rates below £1,400.

⁷⁹ “users in a couple” refers to any married care user as well as care users with some other qualifying adult, including partners, former partners, and civil partners, except when they are estranged.

Figure 23: Average (mean) residential and nursing care fee rates by region in England, older adults, 2021-22 prices.

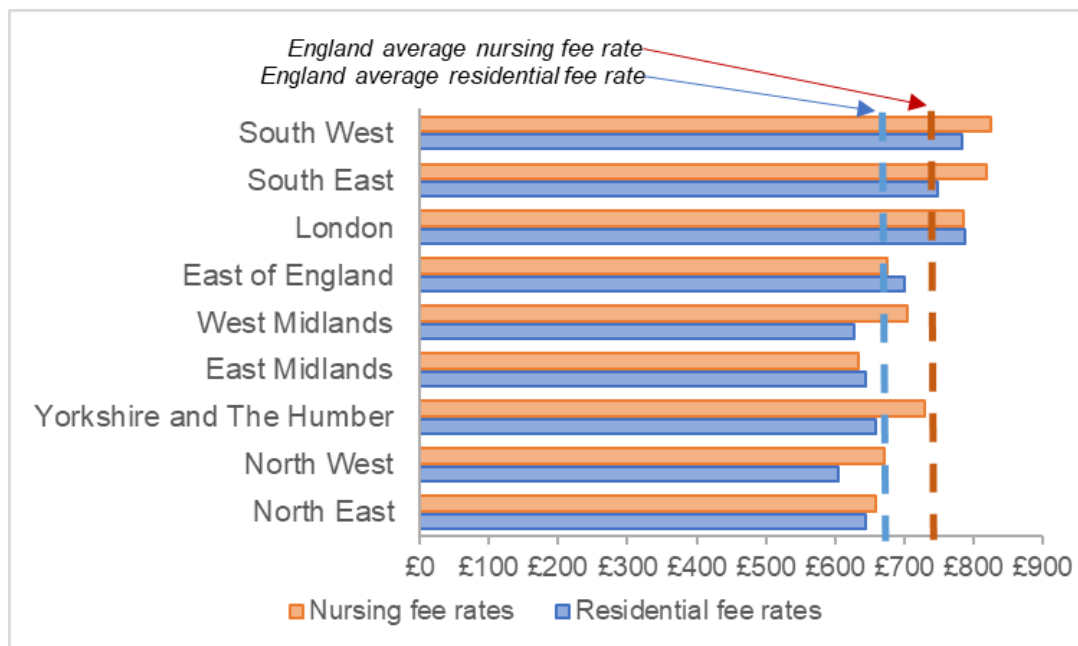
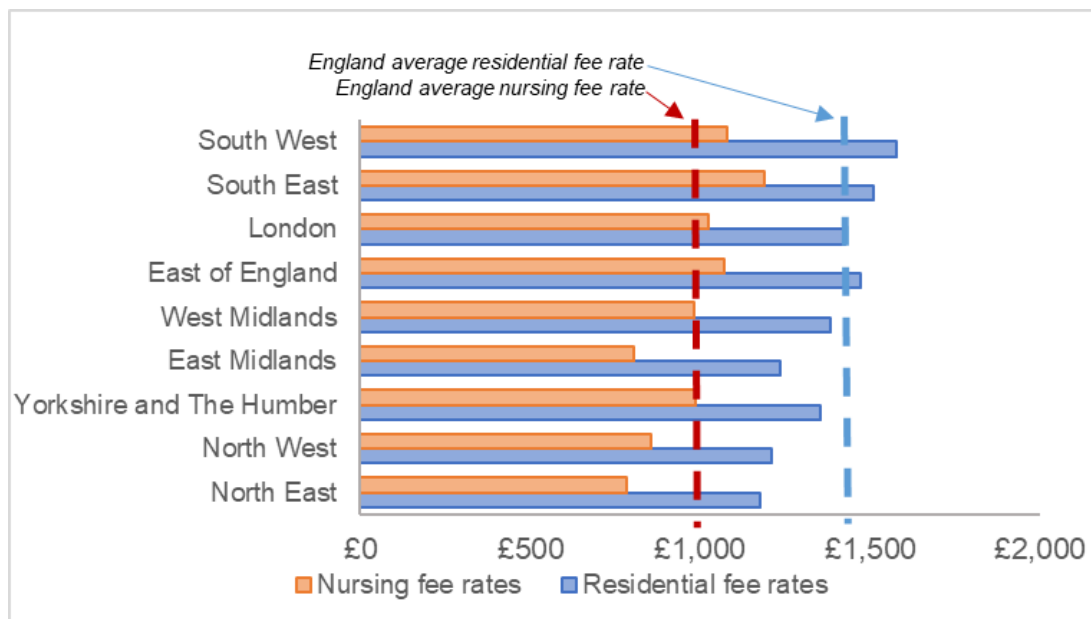


Figure 24: Average (mean) residential and nursing care fee rates by region in England, adults under the age of 65, 2021-22 prices.



467. Note, fee rates are taken from ASC-FR data for 2019-20 with fee rates uplifted to 2021-22 prices using average earnings index. This is to keep fee rates seen here comparable to fee rates used in modelling of the cost of reform. Means and medians are weighted to account for differences in the total provision of residential / nursing care in different Local Authorities in each region.
468. These variations in fee rates impact how long a self-funded adult would take to hit the cap in different regions. Due to the variation in fee rates, self-funded care users in London are likely to hit the cap sooner than care users in the North West.
469. There is, however, substantial variation in fee rates within regions. For example, the lowest older adult residential fee rate in London is £631, which is lower than the

average in the North East. Similarly, the lowest adult under the age of 65 residential fee rate in London is £976 – lower than the average for any region.

470. It is difficult to know how these varying fee rates will interact with variations in wealth and income between different regions as there is little data on how the care wealth, income, home ownership status and marital status vary by region (all factors that impact how likely users are to benefit from either the more generous means test or the financial cap).
471. Looking at the current expenditure on social care by region in England, we can see that there is a smaller variation in spend on adult social care between regions than there is between fee rates. This is because there are counter-acting pressures which push costs up and down for relatively wealthier regions. On the one hand, a more affluent population means care users are less likely to receive support, and can pay more of their own costs out of income when receiving some support. On the other hand, higher fee rates mean that the state pays more for users who are state supported. The region which has the highest expenditure is the South West, due to having relatively higher fee rates with relatively lower wealth and income as compared to other regions.

Table 58: Net current state expenditure on all adult social care per 100,000 users in 2020 – 2021, 2020-21 prices

Region	Net Current Expenditure (per 100,000 adults)
North East	£41,416
North West	£42,484
Yorkshire and the Humber	£40,943
East Midlands	£38,496
West Midlands	£39,267
East of England	£43,339
London	£38,003
South East	£41,704
South West	£45,660
England	£41,190

Note: Figures from ASC-FR⁸⁰

472. Table 59 shows median house prices by region in England. Homeowners in northern regions are more likely to get state support from the more generous means test if their chargeable assets reach £100,000 while in care. Meanwhile, homeowners in London and the south who do not benefit from the housing disregard are much less likely to get any state support towards their care until they hit the cap.

⁸⁰ [Adult Social Care Activity and Finance Report, England - 2020-21 - NHS Digital](#)

Table 59: Median house prices by region, 2021-22 prices

Region	Median House Price
North East	£141,250
North West	£168,750
Yorkshire and the Humber	£165,000
East Midlands	£196,000
West Midlands	£187,000
East of England	£294,000
London	£478,750
South East	£333,250
South West	£271,500
England	£247,500

Note: From ONS House price data up to end March 2020, uplifted to 2021-22 prices using Average Earnings Index and weighted by population in each LA.

473. In actuality, regional variation in benefit from this reform will be affected by a range of factors, not just larger variations in user wealth and fee rates than demonstrated here, but also variations in income, marital status, home ownership status, amongst others between regions. DHSC will continue to work with local authorities to better understand and monitor how the benefits from reform will be distributed between and within different regions.

Competition

474. Charging reform itself has no direct impact upon the operation of competition.

475. With regards to the market for financial services, we expect the changes in limiting care costs to £86,000 will help stimulate entry into the market, the creation of new products and greater competition. While the small existing market for INA's (Immediate Needs Annuity) 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.

476. There are no direct impacts upon the competition in the care sector since these reforms will affect how care is funded and the balance of costs between individuals and the state. See earlier "potential risks" section for a wider discussion.

477. Introducing a fair cost for care and Section 18(3) could have an impact on competition. The implementation of a fair cost of care is likely to ensure the long-term financial sustainability of providers, particularly those that have a large proportion of Local Authority commissioned clients. This could result in more competitive markets. Similarly, by allowing care users to access local authority commissioned care and rates, Section 18(3) providers users with greater choice. This should also lead to greater market competition.

Environmental and sustainability impacts

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

Human rights

479. There are no implications for human rights.

Justice system impacts

480. There are no implications for the justice system.

Rural proofing

481. Charging 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.

Trade implications

482. We do not foresee any impact on trade as a result of this change.

Monitoring and Evaluation

483. Charging reform will be reviewed and monitored and will be subject to robust process and impact evaluation. This would cover the impact on local authorities and providers implementing the reforms and also the impacts on users and carers, including whether the health and wellbeing benefits of the reforms are being realised. It will also cover unintended consequences as a result of the reform.
484. Data to monitor the reforms will be collected, including the number of people who take up Section 18(3), benefit from the extended means test and the number who reach the cap.
485. The evaluation programme will draw on both monitoring data and new primary research and data collection in order to assess both process and impact.
486. Impact will primarily be measured against the policy objectives and key success factors identified in this document. In some cases, alternative metrics or composite / proxy measures may be identified as plans for data collection progress in line with implementation plans.
487. We will commence Section 71 of the Care Act, which legislated for a five-yearly review by the Secretary of State. This will review the level of the cap, daily living costs and means test threshold. It must have regard to the financial burden of the state, local authorities, adults with needs for care and support and trends in healthy life expectancy. Data and evidence from the monitoring and evaluation programme will be used to inform this review.
488. The DHSC will provide implementation support to local authorities including assisting in preparation for charging reform in October 2023.
489. Trailblazers see a small number of local authorities implement charging reform earlier than all other local authorities which will allow us to collect the first set of data about the uptake of the cap among self-funders, the numbers of self-funders asking local authorities to commission care on their behalf, how well LAs can manage the demands of reform, and the response of the provider market to the higher number of LA-commissioned care packages. DHSC will also use trailblazers to collect data about other, unforeseen implementation issues.

Annex A: Overview of DHSC social care charging model for over 65s

Introduction

490. The DHSC social care charging reform for older adults is a microsimulation model. It is designed to estimate the impact of different charging reform options, in particular to estimate the public spend on older adult social care and the distributional impact of the different reforms.
491. The model is a cross-sectional model that retrospectively simulates the uncompleted care journeys of a representative cross section of care users in the time period of interest. For each financial year, it models all users up to a randomly assigned day in that financial year to assess how their assets would deplete and how they would interact with different charging systems.
492. The model uses a base sample of respondents from the English Longitudinal Study of Aging (ELSA) wave 9 who need assistance with one or more activities of daily living (1+ADL) to get a distribution of wealth, income, and other key variables at point of entry into care¹. It models 6 care settings separately: nursing homes, residential homes and 4 levels of domiciliary care (low, medium, high and very high intensity). The base sample provides the individual wealth, income, and other key characteristics used in the model (such as marital status and home ownership status).
493. This base sample is reweighted using weightings derived from projections from the Care Policy Evaluation Centre (CPEC² - formerly the PSSRU - Personal Social Services Research Unit³) aggregate model of the number and characteristics of care users in year in question.
494. For each care setting the model runs a representative sample (through weighting the base sample) through an individual care pathway model.
495. Each individual in the sample is assigned a random care pathway from a derived distribution of all uncompleted care pathways using CPEC survey data. 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 charging system being modelled. The quantities of the cross-sectional point are aggregated using the weights to produce population level estimates.
496. Multiple cloning of the input population before assigning random care journeys diminish the overall impact of the random distribution of care journeys and the modelled cost of reform, but the modelling is sensitive to certain assumptions underpinning it, such as the number of self-funders in future in the current system,

¹ <http://www.ifs.org.uk/ELSA>

² <https://www.lse.ac.uk/cpec>

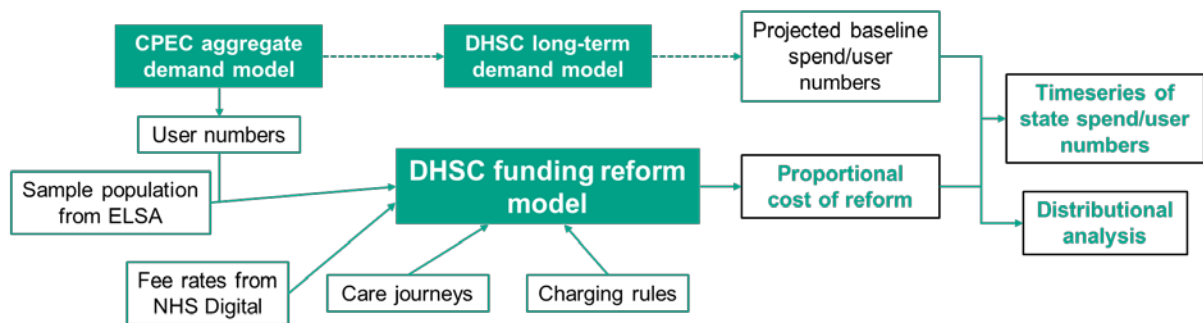
³ <http://www.pssru.ac.uk/>

and assumptions around the length and make-up of care journeys of the care population.

Model Structure

497. The schematic below illustrates the general structure of the model, and how it links with the CPEC aggregate model.
498. The CPEC model is a cell-based model that is recognised as the leading academic model to project the future demand for adult social care⁴. We use outputs from the CPEC model as inputs into the DHSC social care charging model to provide a projection of the care user population in future years, as well as key characteristics of care users in determining applicable charging rules such as marital status and home ownership status.
499. The DHSC social care charging reform microsimulation model uses assumptions on the make-up of older people’s care pathways, their wealth and income to model the impact of the reform options. The key outputs are the costs of the reforms, and the number of additional people who receive state support with their care and support costs.

Figure A1: Overview of DHSC social care charging model

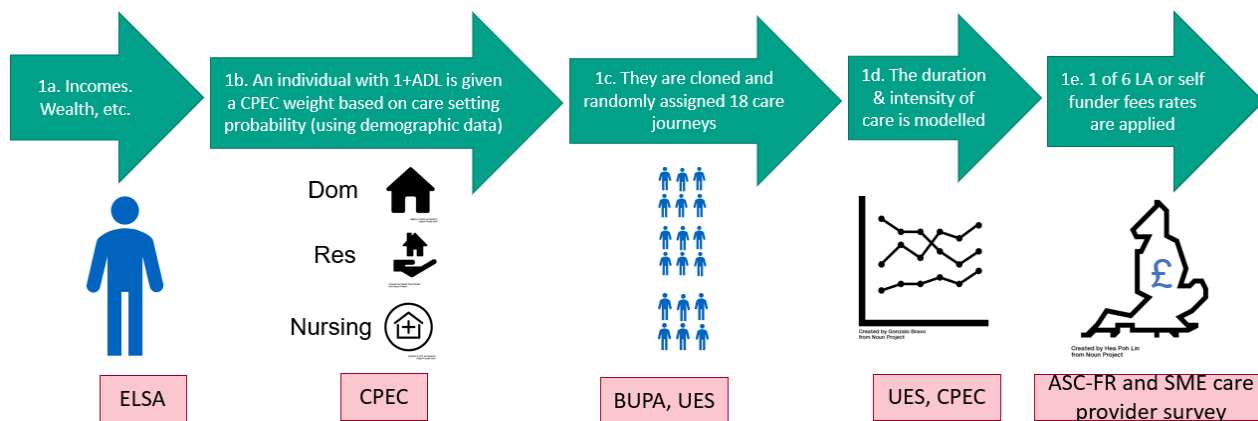


DHSC Social care charging reform microsimulation model construction

500. For each care setting the model runs a representative sample population through an individual care pathway model. The same base sample is used for each care setting. The representative sample is generated by weighting the sample for each year and care setting using weights derived from outputs from the CPEC aggregate model of the number and characteristics of care users. The results are then aggregated across on the individuals to produce to final outputs.

⁴ <https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf>

Figure A2: Creating the sample population



Acronyms: CPEC – Care Policy Evaluation Centre, UES (User Experience Survey of 2006), ELSA (English Longitudinal Study of Ageing), ASC-FR (Adult Social Care Financial Return)

501. Figure A3 shows the pipeline and the data sources for constructing the sample care population. The CPEC aggregate model projects the number of social care users in future years, and their characteristics. The base sample, as created above, is re-weighted using the characteristics of the projected care population for each of the years in the model, to produce a sample that represents the care population in that year. This sample is then run through the DHSC social care charging reform microsimulation model to model the costs of the current system and the reform options. This weighting and reweighting process is summarised in Figure A 3, and explained in more detail in the following section.

Figure A3: Overview of weighting and reweighting the sample population based on CPEC user projections



Re-weighting process

502. A weighting process is used in the modelling to produce a representative sample of care users.

ELSA base sample

503. The model includes a base sample of individuals from the ELSA (English Longitudinal Survey of Ageing) wave 9. We use the subsection of people in the survey who are: aged 65+, and report needing assistance with at least one ADL (activity of daily living). We use the ELSA cross-sectional weights, which are designed to correct for non-response bias. This dataset provides information on income, wealth, gender and marital status of this population.

Weighting to the care population

504. The ELSA base sample does not represent the care population. We use information on the characteristics of care users from outputs of the CPEC aggregate model⁵. The output provides the following disaggregation.

Table A1: Disaggregation in CPEC aggregate model (i.e. characteristics used to weight sample population to CPEC projections)

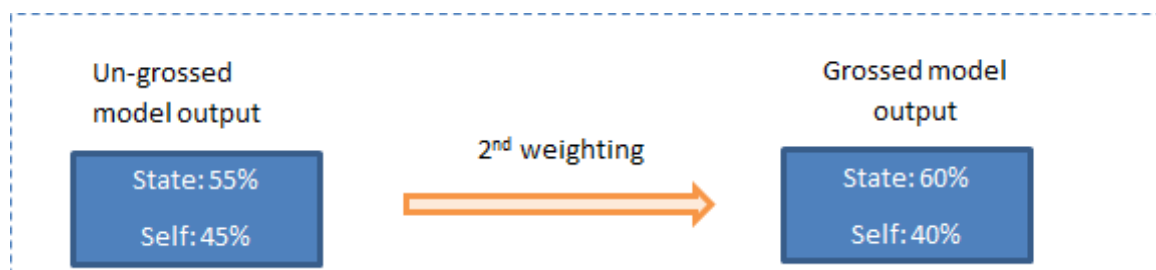
Year	Gender	Age	Marital Status	Home Ownership	Care Setting
2021 ->	Male	65-69	Single	Owner	Residential
	Female	70-74	Couple	Renter	Nursing
		75-79			Community
		80-84	care		
		85+	(by intensity)		

505. For each of the settings in the model, we use this information to re-weight the ELSA base sample for each care setting in the model.

Weighting to the projected number of state and self-funders

506. We run the model for the current funding system, for each individual in the base sample the model projects whether they are state funded or self-funded at the point of time in question. We then apply a second weighting so that the model output matches the projection of state and self-funders from the CPEC projections of the current system.

Figure A4: Example of second weighting



Projection assumptions

507. There are simplifying assumptions around the inflation of different financial quantities. We assume that all individual financial quantities and all financial parameters uprate in line with average earnings after reforms are implemented. These include the:

- level of cap and general living costs;
- means test thresholds and income allowances;
- wealth of the older population, including home ownership proportions;
- income of older population; and

⁵ <https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf>

e. cost of care.

508. To support this care costs are assumed to increase in line with average earnings, and the cap will be updated in line with average earnings. A review is scheduled every five years to assess the balance between state and individual spend and potential recalibration of inflation parameters of charging rules, amongst other things. These assumptions mean that the simulation part of the model is all run in 2019-20 care cost prices. The output is then simply updated by the care cost inflation assumption for each of the projected years.
509. The model outputs will be sensitive to more nuanced assumptions around how different inputs such as user incomes or fee rates, or different charging parameters such as capital limits and the cap, inflate and diverge over time. This impact will be small in the short/medium term but will produce a larger error term over a longer time scale.

Individual Pathway Model

510. The main part of the model is the individual pathway model that simulates the care pathway for the individuals in the model.
511. Each individual in the model is assigned a random un-completed care pathway. For residential care and nursing care they are assigned a completed spell in domiciliary care (or no previous domiciliary care) and then an uncompleted spell in residential care. For domiciliary care they are assigned an uncompleted spell in domiciliary care. The distributions from which the random un-completed pathways are selected are constructed using the 2011 BUPA Survey, PSSRU (now CPEC) Admissions to care homes survey 2005, and the User Experience Survey 2006.
512. The care pathways are different for residential and nursing care and dependent on the gender of the individual.
513. For example, when modelling 2021-22:
- a. the starting point is the projected number of social care users in April 2021. This comes from a linear interpolation of the CPEC aggregate model that projects in 5-year bands⁶;
 - b. the ELSA base sample is weighted to represent the care population;
 - c. each individual in the sample is assigned an uncompleted care pathway;
 - d. the DHSC social care charging reform microsimulation model then simulates the uncompleted care pathway back up to the point being modelled in the current system;
 - e. care users are reweighted based on whether they are self-funding or state supported at the point being modelled (based on CPEC projections); and

⁶ <https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf>

- f. this fully-weighted care population can now be run in a no reform and a reform(s) system to calculate the additional state spend from a reform

Re-grossing to the Long-Term Demand Model

514. The microsimulation model is useful in comparing the impact of a reform compared to the current system. However, it does not directly align with the current and projected costs of the current system. This is because it captures the spend that could be faced by the user but does not capture system wide costs which the state / local authorities face to maintain a social care system. This includes hourly wages paid to care providers when travelling between domiciliary care clients, provision of meals-on-wheels services, provision of day-care services etc.
515. In order to align with the costs of the current system, both the cost of reform and the current system from the microsimulation are proportionally uplifted to align with the state costs that will change under a reform. The costs that will change with reform will be the costs to the state for individuals in different care settings and also other local authority costs such as that of assessments and reviews, taken from the DHSC Long-Term Demand (LTD) Model. We call this process “regrossing”.
516. We do this because the LTD model is considered a better estimation of the future cost of the current system. It is a “top-down” model as it takes the current spend on adult social care and adjusts the spend in future by inflation parameters, population projections, and other parameters to model this cost into the future. The microsimulation model is a “bottom-up” model and is better suited to modelling a reform funding system as it can better capture how individual users will interact with different charging rules, something the LTD model cannot do.
517. Re-grossing happens in the following steps:
 - a. Spend in the LTD model is split into the components which are reform variable and reform fixed, and split by the care settings which have been modelled in the microsimulation model.
 - b. We calculate the proportional difference between the modelled state spend in the current (i.e. no reform system) in the microsimulation model, and the variable spend in the LTD model for each care setting.
 - c. We apply that same proportional uplift to the modelled state spend from any given reform option.
518. For example, imagine a simplified example where we model two care settings, residential care and domiciliary care, and all spend is reform variable. The microsimulation model models spend of £6 billion on residential care in the current system in a given year, but the LTD model has state spend of £6.6 billion on the same care setting. The grossing factor for care homes in that year is then 1.1.

Table A2: Worked example of deriving grossing factors

	Microsim modelled no reform	LTD	Grossing factor
Care Homes	£6.0 billion	£6.6billion	1.1
Dom Care	£4.0 billion	£5.0 billion	1.25

519. When we model a reform, the microsimulation model gives an additional spend of 50% in each care setting. We then apply the grossing factors above to our cost of reform to get our grossed cost of reform. This is the additional cost to state which we report.

Table A3: Worked example of applying grossing factors to reform costings

	Micro-sim modelled additional reform cost	Grossing factor	Grossed cost of reform
Care Homes	£3.0 billion	1.1	£3.3 billion
Dom Care	£2.0 billion	1.25	£2.5 billion
Total Cost of Reform	-	-	£5.8 billion

Overview of CPEC aggregate model

520. There are many different academic papers documenting the CPEC model, which provides reports on the projections and documents the model structure^{7, 8}.

521. The CPEC model is a cell-based model that projects:

- a. The number of older people with disabilities;
- b. The number of people who use formal social care services;
- c. The number of people who qualify for state support; and
- d. The cost to the state.

522. Eligibility for adult social care is assessed by judging whether people are unable or have difficulty in performing activities of daily living (ADLs), which include been able get dressed, bath yourself. Therefore, models that project demand for social care use the inability to perform ADLs as the measure of disability that affects how likely they will be eligible for social care. For example, the CPEC aggregate model uses 6 disability groups. These are:

- a. People able to perform ADL (personal care) tasks and IADL (domestic care) tasks without difficulty or need for help.
- b. People who need help to perform IADL tasks only.
- c. People who have difficulty performing ADL tasks.

⁷ http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/121203_care_for_older_people_1.pdf

⁸ <https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf>

- d. People who cannot perform one ADL task without help.
- e. People who cannot perform two ADL tasks without help.
- f. People who live in the community and cannot perform three or more ADL tasks without help, or people who are in care homes or long-stay hospital.

523. The diagram below shows the other characteristics that the CPEC aggregate model splits the population into:

- a. Age [5 groups]
- b. Gender [male / female]
- c. Disability [6 groups]
- d. Housing tenure [owner / renter]
- e. Education (leaving full time education below 15 yrs old/ above 16 yrs old)
- f. Household type / informal care [8 groups] – community
- g. Previous household type [married / single] – residential

Figure A5: Household/informal care groups in CPEC aggregate model

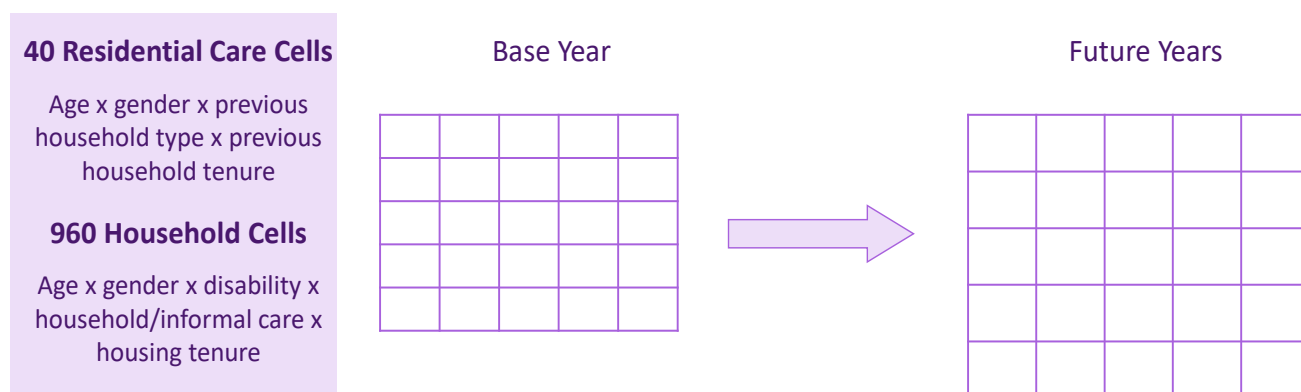
The eight different Household type/informal care classification used in the model are as follows:

1. Single, living alone, no informal care
2. Single, living alone, with informal care
3. Single, living with children
4. Single, living with others
5. Couple, living with partner only, no informal care
6. Couple, living with partner only, with informal care
7. Couple, living with partner only, with informal care from outside the household
8. Couple, living with partner and others

524. The household population includes all cells: $5 \times 2 \times 6 \times 2 \times 2 \times 8 = 1920$. The residential care population are assumed to be in the most disabled group and doesn't disaggregate by the 8 household type/informal care groups but 2 previous household types: $5 \times 2 \times 2 \times 2 = 40$.

525. The graphic below illustrates the structure of the model.

Figure A6: Schematic of structure of CPEC aggregate model



Residential Care

526. It estimates the proportion of disabled older people in residential care for each subgroup, using local authority data on number of supported residents and estimates of privately funded care home residents.

Non-residential care

- Estimates the probability of receipt of services for each cell (using GHS) data.
- Uses unit costs to calculate total expenditure on the services.
- Breaks down total expenditure by source of funding: NHS, LAs and services users.

527. The CPEC model includes key assumptions on the drivers of social care need and whether people would be eligible for state support, these include⁹:

- a. The number of people by age and gender changes in line with the Office for National Statistics (ONS) 2018-based principal population projections. The prevalence of disability in the older population, the central assumption is that age-gender prevalence of disability stays constant (defined by the number of ADLs/IADLs an individual reports). There is uncertainty around this assumption, analysis by DHSC strategy group concluded that the latest evidence suggests that we have seen a compression rather than an expansion of morbidity, while modelling from Carol Jagger (Newcastle University) suggest that the age-gender prevalence of social care need is likely to increase in the future due to increased obesity prevalence rates leading to increased dementia. Therefore, we are happy that constant age-gender prevalence is an appropriate central assumption.
- b. The proportion of care needs met informally stays constant in the future. However, there is other CPEC modelling that suggests the amount of care provided by grown up children may reduce due to the increase in childless older adults.
- c. The rate of home ownership of the older population. This is important in understanding the proportion of older people who would qualify for state support.

⁹ <https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf>

- d. The proportion of older people in couples. This is important both in determining the amount of informal care provided by spouses and also whether people would be eligible for the housing disregard in residential care.
- e. The eligibility for state services remains the same in future years.
- f. There is uncertainty around these assumptions which impact the projected number of people with a social care need in the future and the proportion of those will be supported by the state. CPEC have published sensitivity to the key assumptions.
- g. For the purpose of the modelling of the reforming it is important to remember that these assumptions impact the projected cost of the current system, as well as the costs of the reforms.

Overview of data and assumptions

Base sample

528. The base sample is made up of 990 people aged 65+ with 1+ ADL from wave 9 (2018-19) of ELSA. The sample provides the characteristics of the older people to run through the individual care pathway model. The characteristics used are:

Table A4: ELSA variables (some derived) used in the model

To weight the sample	Age
	Gender
	Marital status
	Housing tenure
For use in charging system	Housing assets
	Non-housing assets
	Income (exc. disability benefits)
	Gender
	Marital status

529. ELSA does have people in receipt of community services but not people in residential care, therefore the sample will underrepresent people with high levels of disability. We use the sample of 65+ in the survey who have 1+ ADL to give a representative sample of the financial status of older disabled people at point of entry into care. We clone these individuals multiple times, before assigning randomly distributed care journeys, with one clone in each domiciliary intensity and 6 clones in each of residential and nursing care (each assigned a different fee rate, see below). We make various assumptions in using the sample in this way:
530. We uprate the sample from 2018-19 to 2021-22 by assuming that wealth and income increases in line with average earnings.
531. We assume that the updated ELSA sample provides the financial status of older people at the cross section in the case when they did not require care and have therefore not spent down assets on care. We do no adjustment of assets for the people in the sample who report they are in receipt of care. We assume these people have not significantly spent down assets on care.

532. We then assume that this is their financial status when they start their care journey in the model (months or years in the past) and that their status does not change through their care journey apart from any assets spend down to pay for care. Therefore, we assume:

- The user’s income (excluding disability benefits) remains the same¹⁰ throughout their care journey.
- The user’s assets remain unchanged apart from any spend on assets for care.
- The user’s marital status remains unchanged through their care journey.

Projected characteristics of care users

533. The DHSC charging reform microsimulation model models 6 care settings:

- Nursing home
- Residential home
- Low intensity home care (less than 5 hours per week)
- Medium intensity home care (less than 10 hours per week)
- High intensity home care (more than 10 hours per week)
- Very high intensity home care (more than 20 hours per week)

534. We use projections from the CPEC aggregate model¹¹ of the characteristics of care users for future years (up to 2038). The projections give the proportion of users grouped by the following characteristics:

- Age [5 groups: 65-69, 70-74, 75-79, 80-84, 85+]
- Gender [male, female]
- Marital status [single, married]
- Housing tenure [renter, owner]

535. We needed to split by marital status (as the application of the funding rules depend on whether the care user has a spouse living with them, for this we use marital status as a proxy) and through analysis we determined the importance of the other variables, we constructed weights for the following 14 groups:

Table A5: Groups used for weighting

Male	Female
Single owner 65-74	Single owner 65-74
Single owner 75+	Single owner 75+
Single renter 65-74	Single renter 65-74
Single renter 75+	Single renter 75+
Married owner 65-74	Married owner 65-74

¹⁰ by remains the same we mean remains the same relative to all the financial parameters in the social care funding system

¹¹ [Projections of demand for and costs of social care for older people in England, 2010 to 2030, under current and alternative funding system \[PSSRU DP 2811/2 – December 2011\]](#)

Number of eligible self-funders in residential and nursing care

536. We use the CPEC estimate of the number of self-funders; which is based on registered Care Quality Commission (CQC) bed data, occupancy rates (Laing & Buisson survey), NHS Continuing Health Care residents, and LA supported residents (NHS Digital).

Wealth and Income of care users

537. The weighting of the base sample provides a sample of representative care users.

Economic Projections

538. The model uses OBR average earnings assumptions as used in the latest economic and fiscal outlook report, March 2021, to inflate and deflate inputs into the baseline year of 2021-22. The central assumption for care cost inflation is that, following 2021-22, it increases in line with the real terms growth in CPEC unit costs. CPEC unit costs are driven by earnings growth and National Living Wage projections.

Care cost data and assumptions

539. For our central assumption we use data from the NHS Digital ASC-FR 2019-20 return; this is data from returns completed by each Local Authority. The unit cost data is derived from returns on the level of activity and spend.

540. In the long run you would expect unit costs in social care to increase approximately in line with wage inflation, due to the dominance of staffing costs in the costs of delivering social care.

541. More recent ASCFR data for 2020-21 has now been published, but as noted in other sections, they are affected by COVID-19 impacts, and the most appropriate way to estimate future costs is thought to be to project forward from 2019-20 data.

542. As our central assumption, we assume that unit costs increase in line with average earnings from 2019-20 to 2021-22. In the years after this, we assume they increase with CPEC unit cost growth.

Table A6: Assumption on the inflation of care costs

% increase	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25 ->
Average Earnings Index (2019-20 to 2021-22)	3.0%	0.7%	2.4%	1.7%	1.7%	1.3%
CPEC Unit Cost Growth (2022-23 onwards)						

543. This produces the following trend in the national average care costs:

Table A7: Assumed average care costs

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Nursing (per week)	£715	£720	£737	£750	£762	£772
Residential (per week)	£662	£667	£683	£694	£706	£715
Home Care (per hour)	£17.78	£17.90	£18.34	£18.64	£18.95	£19.20

544. We calculate six differential fee rates, selecting the mid points from the 6-tiles for nursing and residential care. This is to capture the variation in care costs for different people in residential and nursing care

Table A8: Distribution of care home fees

2021-22	Nursing	Residential
Fee 1	£598	£539
Fee 2	£659	£611
Fee 3	£694	£652
Fee 4	£745	£702
Fee 5	£834	£740
Fee 6	£898	£851

Modelling Community Care

545. In reality people having their care and support need met in the community receive a variety of different services, including the traditional home care and day care services. With the introduction of direct payments, instead of the LA commissioning services for them people can choose to receive a direct payment (a cash payment equal to the monetary level of state support they are deemed eligible for) with which they self-commission services to meet their care and support needs.

546. To model community services, we use proportions of people receiving state support at different levels of intensity. The number of hours of service and unit costs for each of these levels is depicted below.

Table A9: Distribution of home care intensity

	2014-15	2015-16	2016-17	2017-18
Less than or equal to 2 hours	20.0%	12.3%	26.2%	21.7%
More than 10 hours inc overnight/lie in/24 hours	27.3%	38.5%	25.0%	28.3%
More than 2 hours and less than or equal to 5 hours	25.5%	23.1%	20.0%	25.0%
More than 5 hours and less than or equal to 10 hours	27.3%	26.2%	28.8%	25.0%

Source: Health Survey England

Table A10: Unit cost of community care included in the DHSC social care funding model

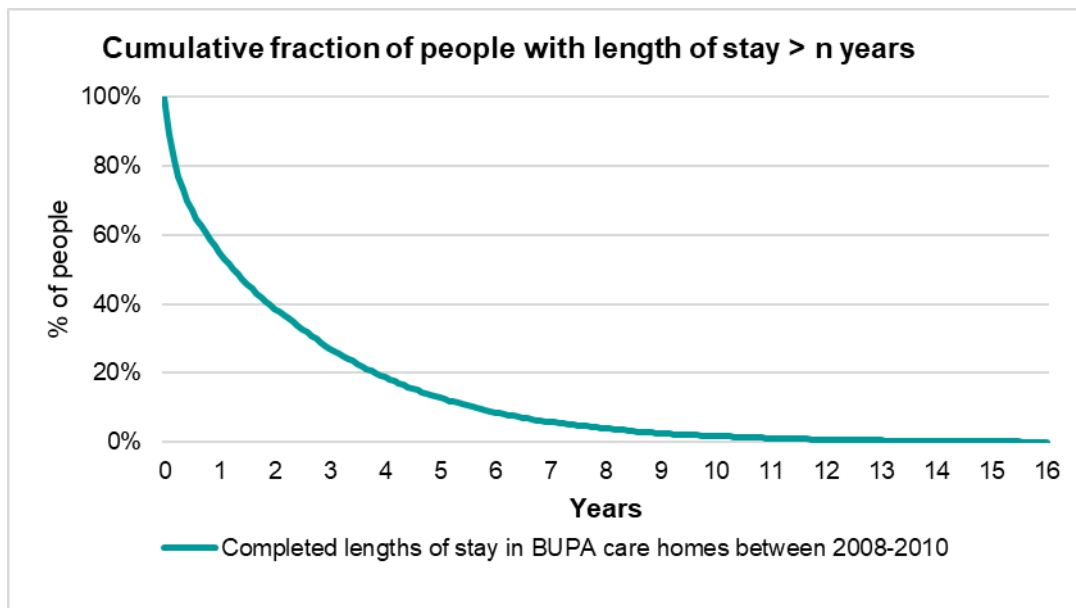
	Hours per week	2021-22
Hourly Rate	1	£18
Low	3.5	£64
Medium	7.5	£138
High	12.5	£229
Very High	22.5	£413

Care Pathway information

547. The DHSC funding model assigns random un-completed care pathways to each individual in each care setting. The random care pathways are selected from a

derived distribution of un-completed care pathways for the 6 care settings. We construct the distributions using survey data:

Figure A7: Lengths of stay in residential care (PSSRU)¹²



548. We convert the completed lengths of stay into uncompleted lengths of stay. To do this we make the following assumption that the lengths of stay distribution has not changed. We use separate distributions for residential care and nursing care, and for men and women. We adjust the overall distribution to account for the results of statistical analysis completed by PSSRU.

549. The analysis shows that:

- a. Men (residential), median length of stay is 13% lower than overall;
- b. Women residential), median length of stay is 73% higher;
- c. Men (nursing), median length of stay is 3% lower; and
- d. Women (nursing), median length of stay is 30% higher

550. We have not included dependence on age at this stage, partly due to the complexity of building this assumption into the model and also due to the difficulty of interpreting the statistical analysis. This is a factor that we intend to investigate in further updating of the model.

Admissions to care homes and home care survey 2005 (PSSRU)¹³

551. This survey gives the proportion of people who were previously receiving domiciliary care before their admission to a residential home.

¹² PSSRU DP 2769 – Jan 2011 – Commissioned by BUPA

¹³ PSSRU DP 2265/3 – July 2006

Table A11: Distribution of home care intensity

% receiving LA home care prior to care home		
	Frequency	Intensity
No	37%	
1 – 5 hours per week	10%	18.5%
6 – 10 hours per week	21%	36.4%
11 – 15 hours per week	13%	22.7%
16 – 20 hours per week	6%	9.9%
21 hours per week or more	7%	12.5%
Frequency not known	6%	
Any	63%	

2006 User Experience Survey

552. This survey gives the distribution of uncompleted length of stay in home care.

Table A12: Distribution of uncompleted lengths of stay in home care [UES 2006]

Weighted data	Frequency
< 6 months	10%
6 months to 1 year	17%
1 to 2 years	21%
2 to 5 years	30%
5+ years	22%

553. We make assumptions to disaggregate the distribution into one-month intervals and interpolate to generate the tail of the distribution. These three data sources are used to produce distributions of un-completed care journeys:

- Residential and nursing home: uncompleted length of stay in care home, whether they had previously received home care and, if so, the length of the home care
- Low, medium, high home care: uncompleted length of stay in home care

554. We randomly select a care pathway from the constructed distribution for each individual.

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

555. An input to the DHSC social care funding model is the projected number of self-funders under the current system from the CPEC 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.

556. Under the assumption that the features of self-funders, such as wealth or care journey, are unrelated to the level of their needs and, therefore, their eligibility, costs

of the reformed system are directly proportional and scale as a one-to-one ratio with the number of self-funders.

557. This means that if there were 10% more eligible self-funders than expected, the costs from the reforms would be 10% larger, with the opposite case also being true.

Unit costs of care

558. The central assumption for care cost inflation is that, following 2021-22, it increases in line with the real terms growth in CPEC unit costs. CPEC unit costs are driven by earnings growth and National Living Wage projections. This assumption applies to all components of care including residential, domiciliary, assessment, case management and review costs. This assumption feeds through from the CPEC modelling of projecting the costs of the current system.

Other assumptions and future trends

Prevalence of disability

559. In their modelling of the current system, CPEC assume that prevalence rates of disability remain constant by age group (e.g. 65-69, 70-74, etc.) and gender for those aged 65 and over. Variation around the central assumption may change either the number of older disabled people, the length of time they are disabled, or both.
560. Therefore, as an example, with increased prevalence of 10%, the smallest change to the reformed system, if it was purely numbers with a disability rather than length of time with a disability, would be a corresponding 10% increase in state costs. Increased prevalence could increase the lengths of time with a disability (of those who develop a disability), this would increase the costs by a different factor than 10%.

Trends in informal care

561. 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

562. 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

563. The modelling assumes that 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

564. The modelling assumes that the cap is uprated in line with the assumption for care costs.

Model Validation and Quality Assurance

565. The approach used in the charging reform model was the product of consultation with PSSRU (now CPEC) - the aim was to replace PSSRU's existing dynamic micro-simulation model, which was used to carry out analysis for the Dilnot Commission, with a more flexible and usable tool for estimating costs to the state of changes to the charging rules for older adults.
566. The methodology of the DHSC charging reform model was independently validated by GAD in 2015 and the IFS¹⁴ in 2018 (the latter published a comprehensive summary of how the model worked and the assumptions upon which it was based).
567. In 2019, DHSC worked with GAD to review the insurance version of the model, which shares many of the assumptions and data as this version of the model. In 2020, DHSC again worked with GAD to provide a review of the model and verify its method. GAD are currently in the process of a more in-depth quality assurance review, which includes a full line-by-line code review.
568. The model has been used extensively within DHSC for more than five years to cost universal reforms and revenue raisers and model outputs have been shared externally - for example with HMT to support spending review discussions and with Number 10, HMT and the Cabinet Office when discussing the cost and distributional impacts of reforms to the social care system

¹⁴ [R151.pdf \(ifs.org.uk\)](#)

Annex B: Peace of Mind Methodology

569. 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.
570. 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. An actuarially fair premium would be a price for insurance which equals the expected value paid out in claims, giving a very high loss ratio. The size of the loss ratio is a supply-side decision.
571. 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.
572. Using information from the USA, we estimate that between 40% and 60% of the total market premiums collected by LTC insurers is not paid out on claims. Our hypothesis is that, on average, those who buy LTCI pay between 40% and 60% 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.
573. Work from PSSRU on immediate needs annuities (INA) in the UK¹ suggests a similar premium where INA's cost around £100,000 but have an actuarially fair value of only around £70,000. This means those who buy INA's pay £30,000 for peace of mind, which is around 40% of the actuarially fair premium. This estimate supports the results from the US.

The Buyers of LTCI

574. 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

575. 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

¹ Forder 2011 Immediate Needs Annuities in England

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.

576. 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 market 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. The actuarially fair premium in this case would be 70% of the market premium. In turn, this means that on average the individual would be willing to pay 30 pence (or 43% of the actuarially fair premium) for the peace of mind that insurance brings (i.e. the POM ratio is 30%).

Caveats

Transferring Lessons from the USA

577. 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 to correlate with the limited evidence from the Immediate Needs Annuity Market in the UK.

Constant Risk Aversion

578. 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 with high loss risks to be of greater value to the individual than insurance that covers against lower cost but greater probability risks. We do not adjust for varying risk aversion, because we do not know the extent and pattern of the variation.

Sustainability of the Scheme

579. 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.
580. 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.