advice and support for older age
Independent Age

Institute and Faculty of Actuaries

Will the cap fit?

What the government should consider before introducing a cap on social care costs

Contents

Executive summary

The social care available to England's ageing population has rarely ever felt so crucial an issue. The challenges facing older people with care needs continue to grow. However, the UK government has taken little action since it promised a Green Paper at its 2017 Spring Budget.

The government has said it plans to make the adult social care system sustainable and that it wants to place care and support services on a firmer financial footing. It has also set out plans to introduce a lifetime limit on individuals' care costs.

The additional £2 billion announced at the Spring Budget represented welcome new funding for local authorities involved in delivering care. However fundamental questions remain about longer-term reforms to social care including how, if at all, the government intends to place a cap on what adults spend on their own social care.

A debate about a more equitable approach to funding social care in England has taken place over a number of decades, with multiple reviews and panels set up to consider fairer and more affordable ways of sharing care costs. But since the 2011 recommendations of the Commission on Funding of Care and Support, led by Sir Andrew Dilnot, the idea of a lifetime cap on care costs has drawn perhaps the most attention.

Independent Age and the Institute and Faculty of Actuaries believe that introducing a limit on the amount individuals have to contribute towards their own care is the right way forward.

It introduces an element of social insurance where previously none has existed. A cap on care costs, designed in the right way, could bring much needed clarity and simplicity to the care and support system. Set at the right level, it could even help families to plan for later life with greater certainty and be clear about their own responsibilities to save and pay for care.

The 2017 General Election appears to have paved the way for new debate about the precise way in which that cap, combined with a means-test, could be designed. This report aims to further facilitate that debate. Specifically, it presents new insights on the impacts that different approaches to introducing a cap, and changing the means-test in England's publicly-funded system of social care, could have on pensioner households who need care.

We have modelled different levels for the cap and our analysis specifically focuses on:

- a £35,000 cap, based on the Dilnot Report;
- a £72,000 cap, contained in the Care Act; and
- our proposed all-inclusive £100,000 cap that includes the local authority rate, daily living costs and 'excess' top-up fees based on average care costs. Our intention is to show the impact that each of these care cap levels will have on cumulative care costs.

We also applied different means-test thresholds/capital limits, including:

- the current £23,250 upper capital limit for state-funded care;
- the £118,000 upper capital limit in the Care Act and originally intended to be introduced in 2016; and
- a new capital limit of £100,000 as proposed in the Conservative Party's 2017 General Election manifesto.

Key findings

- **A £72,000 care cap, which is the cap legislated for under the Care Act 2014, would only be of limited value because it would only see 1 in 10 who pay for their care costs benefiting from the cap.**
- **Compared with a £35,000 cap, which was the level first recommended by the Commission on Funding of Care and Support, the planned for cap of £72,000 would see pensioner households spending more money, and taking longer, to genuinely reach a position where all their care costs are 'capped'.**
- **Under the Care Act plan, it would typically take a pensioner over six years to reach a care cap, which is roughly double the average life expectancy for someone in residential or nursing care.**
- **A £35,000 cap covering care fees, or a cap that covers all care costs and set at £100,000 (including daily living costs and 'excess' top-up fees) would be reached in approximately three years, and benefit around 4 in 10 who pay for their care costs.**
- **In all models except a £100,000 all-inclusive cap that covers all costs, accumulated care costs rise above £150,000 by year 6 and £300,000 by year 10. Without an all-inclusive cap, individuals with the highest care needs will continue to see their costs rise to well over £100,000.**
- **The cap model is unlikely to benefit those with low domiciliary care needs, even if they are chronic and experienced over a long time.**

Recommendations

The proposed cap of £72,000, legislated for in the Care Act 2014, should be:

- **Reset to a level where individuals can plan for an average length of care with high need, with the government supporting any further cost.**
- **Reframed to include all costs so that individuals know the total amount they are likely to spend on care, even if they become eligible for some state support.**

Under the original Care Act proposals, only the local authority rate for eligible care needs counts towards the cap and is paid by the government once the cap is reached. Any excess above the local authority rate, including £12,000 per year towards daily living costs, are uncapped and the individual will continue to pay for these costs.

Only a small minority of those who enter care are likely to benefit from the legislated £72,000 care cap – even if their care needs are high. Our analysis shows that the original cap of £35,000 proposed by the Commission on Funding of Care and Support would:

- benefit more people
- be likely to be reached within three to four years for those individuals with high care needs, which is broadly the average life expectancy for someone in residential care.

Setting the cap at a level that benefits individuals with high care needs once they live longer than average life expectancy, has a number of advantages. It could allow the state to ask individuals with the means to be able to do so to plan for and pay for an average length of high care need themselves. The state would then agree to meet any further costs.

However, there would still be the risk that individuals misunderstand the nature of a cap that covers the local authority rate for care fees alone.

To reduce this risk of misunderstanding we recommend that the government introduces a higher cap of £100,000, but that this is inclusive of the local authority rate, daily living costs and any top-up, or what we refer to as 'excess' costs. Our analysis shows that this would kick in at around the same time as the Commission on Funding Care and Support's proposed £35,000 cap. This would help those who experience high care needs beyond average life expectancy, and we believe it would reduce complexity within the system by creating a 'truer' cap on costs.

Working together: Independent Age and the Institute and Faculty of Actuaries

Independent Age has partnered with the Institute and Faculty of Actuaries (the IFoA) to provide a report on social care funding, mapping out some of the current challenges and how they may be addressed to provide a fairer future for those that need and pay for social care in later life.

Following the June 2017 General Election, debate has continued about the need to change the way that social care is funded in England. We hope that by working together, we can help identify a way forward that will help the government address some of the challenges ahead of the proposed Green Paper.

Introduction

The care and support older people receive has been in the spotlight this year. The 2017 General Election saw funding of social care in England climb up the political agenda. The public response to the Conservative Party's proposed care reforms and the fallout which followed is even credited with having an impact on the election result.

In many ways, the election debate illustrated problems characteristic of England's social care system. It is complex, often controversial and politicians often promise to reform it. In the end little changes, but demand continues to grow and costs continue to soar.

Few people understand that, unlike the NHS, social care is means-tested so large numbers of people have to draw on their own resources to pay for it[1]. Access to state support to cover these care costs is tightly controlled with what has been described as "the most pernicious means-test in the whole of the British welfare state"[2].

England remains one of the few major advanced economies not to have undertaken funding reform for long-term care in response to its ageing population.

This made it difficult to propose, what felt to many at the election, like a radical redrawing of the state's responsibilities to pay for care.

Social care at a tipping point

The social care system in England has been described by regulators to be close to reaching a tipping point[3], both in terms of the funding available and its capacity to manage increased demand. As the population ages and people live for longer with multiple and costly care needs, there are new strains being felt. These are felt both inside local authorities and across the millions of families who find they have to organise, and pay for their own care.

There is universal acceptance that something needs to change[4]. The question is what, and how fast those changes will take place.

One of the key areas in need of reform – as recognised by all the major political parties – is social care finance. That is the balance between:

- state contributions for those who can't afford to pay; and
- individuals' own responsibility to make provision for, and meet private care costs where the state deems they can afford to pay.

1 Gregory S., *Attitudes to health and social care: Review of existing research*, Commission on the Future of Health and Social Care in England Background Paper, 2014.

2 Sir Andrew Dilnot, Everlasting Care: Lecture to the Resolution Foundation on a lasting solution to the social care crisis, April 2017.

3 Care Quality Commission, *The state of adult social care services 2014-2017: Findings from CQC's initial programme of comprehensive inspections in adult social care,* August 2017.

4 See for example the letter to the Prime Minister regarding health and social care from Chairs of the Communities and Local Government, Health and Public Accounts Select Committees, 6 January 2017. Also see the open letter to the Prime Minister on Health and Social Care signed by 75 leading health and care organisations, January 2017.

Focus on a care cap

In the run-up to the election, there were reports the government was going to refresh its commitment to a lifetime cap on individuals' care costs. This means that even where people have to pay for their own care needs, there will be a cap on how much they have to pay. As explained later, the government's position on a 'care cap' came under great scrutiny. As a result, the Prime Minister used a speech to confirm there would be an "absolute limit" on how much any individual would have to pay for social care, regardless of income or wealth[5].

At present, individuals who do not meet the means-test for state-funded social care do not have a limit on the amount they could be required to pay for their own care. To provide some reassurance, the government has now reaffirmed a commitment to introduce a cap on care costs.

We believe that introducing a limit on the amount individuals have to contribute towards their own care is the right way forward.

It introduces an element of social insurance where previously none existed beyond the means-test. A cap, designed in the right way, could bring much needed clarity and simplicity to the care and support system.

Set at the right level, it could even help families to plan for later life with greater certainty and be clear about their own responsibilities to save and pay for care.

Introducing a level of social insurance

There are different forms of social insurance. In this context, it means providing a state guarantee that any eligible adult will be insured against paying excessive care fees, beyond a defined level.

In this report, we set out how the funding model for care should include a degree of social insurance that:

- protects individuals who have the highest need
- makes it clear which costs are covered by the state and which are not.

If the government agrees to cap care costs, so that those individuals who face the highest costs receive support from the state, it could help many more individuals to plan for their care needs. However, this will be dependent on the contract between individuals and the state being clear and the cap being set at an appropriate level.

Who pays for what?

The government is appraising a number of options on who pays for what for social care. This report makes clear that if a cap is to go ahead, the government should include all significant costs in the cap, including daily living costs and any 'excess' top up fees. We conclude that of the various options available to the government, an all-inclusive cap of £100,000 which covers all these core care costs, is the most effective approach.

5 Speech by Prime Minister Theresa May, 22 May 2017.

Why we are looking at this

There is a growing focus on the state of social care. As the ideas of a care cap and a new means-test were such key features of the 2017 General Election campaign, this report specifically looks to present new analysis on how the combination of a cap and improved means-test might stand to affect typical pensioner households in England.

More people are funding their own care than ever before. More than half of those living in a residential care home in the UK fund their own care in some way[6] (they are 'self-payers' or sometimes referred to as 'self-funders'). Specifically:

- 44% pay for all their care (ie around 172,000 people)
- 12% contribute towards their care through a third party top-up contribution
- On the other hand, 44% of those living in a care home are fully state-funded (through local authorities and the NHS)[7].

The cost of social care can often be very high. It can be especially high for those self-funders who end up requiring care for extended periods. The average length of stay for those in care varies significantly depending on the care setting and who is funding the care, but it is in the range of 16 to 42 months[8]. And there are a significant number of people who live far longer than this (20% live longer than five years, based on a female aged 85 entering residential care).

It is these individuals who have the potential to face incredibly high care costs, well in excess of anything they anticipated and can reasonably be saved or planned for.

A cap on care was due to be implemented in 2016 as part of the reforms of the Care Act. However, its postponement until April 2020 was announced with its future left in a somewhat precarious position. This has significant implications both for those planning for care costs and for those in care now who have no clear limit on the care fees they might be expected to pay.

Independent Age has identified a distinct lack of confidence about what happens next across many parts of the social care sector, not least in local government. In a January 2017 joint survey with MJ, the magazine for local government, Independent Age reported that 9 out of 10 local authorities who responded were "not confident" that a cap on care costs would be introduced in their area by the planned-for 2020 deadline[9].

In many ways, the 2017 General Election served to confuse, rather than clarify the situation. What level will the care cap be set at and when will it be introduced? How many people will it benefit? What will it cost? To all these and many other questions, older people and their families are waiting for answers.

6 As at March 2016, LaingBuisson, *Care of Older People: UK Market Report*, 28th edition, May 2017, p.xxiii.

7 Ibid., p.xxiv.

8 LaingBuisson, *Care of Older People: UK Market Report,* 28th edition, May 2017, p. xxi and Institute and Faculty of Actuaries analysis of Forder, J. and Fernandez, J-L., *Length of stay in care homes*, report commissioned by Bupa Care Services, PSSRU Discussion Paper 2769, 2011.

9 Peters, D., *Lack of confidence in adult social care strategy exposed*, Municipal Journal, 24 January 2017.

What is clear is that the current system is not working. It is widely perceived as unfair and under-resourced, meaning many don't receive the care and support they need[10].

1.2 million people in England are estimated to experience some level of unmet care need[11]. Furthermore, a recent report from Ipsos MORI suggests that on two principal measures of care need (namely difficulties with daily living or mobility) over half of all older people in England have an unmet need for support with at least some of their difficulties[12]. Even where they do receive care and support, the costs are so prohibitive and potentially so catastrophic, social care can lead to huge pressures on family finances.

With a consultation promised, we believe now is the right time to focus on some of the more notable policies proposed on social care reform during the 2017 General Election campaign: namely a lifetime cap on care costs, and an improved means-test for those accessing state-funded care.

The context: Dilnot and the background of the cap

The cost of social care, particularly the need to rethink how care is provided and funded as the population ages, has been a preoccupation of policymakers for many years now. In England at least, we have not seen any firm action or 'game changers' – no blueprint for reform that has yet translated into a fairer share of responsibility for funding care between state and citizen.

Many recommendations have been made, but few of these have led to any change in government policy or reined in the costs to care recipients and their families.

As the King's Fund and Nuffield Trust assert, successive governments have failed to make it clear to the public that paying and arranging for care is largely the responsibility of the individual and their families. Public funding for social care is reserved only for those with the lowest means and highest care needs[13].

Every independent review, spanning almost 20 years, has recommended social care needs should be funded from a fairer mix of public and private resources, rather than see the burden fall on care recipients' own shoulders. This would bring the future funding model more in line with healthcare, which is non-means-tested and "free at the point of use". Most reviews agree that it is unrealistic for individuals to predict whether or not they'll need care in the future, the length of time they'll need care and the level of their care needs if in fact they do end up requiring support, before even considering what the cost of that care is likely to be[14].

The independent Commission on Funding of Care and Support carried out the review that led to the idea of a 'care cap' and was chaired by Sir Andrew Dilnot. It published its recommendations in 2011[15].

10 See Humphries, R., Thorlby, R., Holder, H., Hall, P., Charles, A., *Social care for older people: home truths*, The King's Fund and Nuffield Trust, September 2016 and Care Quality Commission, *The state of adult social care services 2014-2017,* August 2017.

11 *1.2 million older people don't get the social care they need,* Age UK, 17 November 2016.

12 Blake, M., Lambert, C., Siganporia, Z., Unmet need for care, Independent Research funded by NIHR School for Social Care Research, Final Report, July 2017.

13 Humphries, R., et al, *Social Care for Older People,* pp. 78-79.

14 Ibid, pp. 80-81.

15 Throughout the rest of this report we have referred to the Commission on Funding of Care and Support as the Dilnot Report.

A 'capped costs' model was legislated for by the government in 2014, albeit based on a cap set at more than double the level that the Dilnot Report recommended (£72,000 versus £35,000). The Care Act 2014 sets out how a cap would operate. Self-payers would only benefit if they had 'eligible needs' and engaged with their local authority to receive an Independent Personal Budget. This would be used to calculate an individual's eligible care costs. This system would be introduced together with a change in the means-test, including a new upper capital limit set in the Care Act at £118,000.

The care cap as currently legislated contains the following:

- **A limit of £72,000 on the assessed, eligible lifetime care costs that adults are expected to meet, rising with inflation.**
- **Increases in the lower and upper capital thresholds for residential care including a change in the upper threshold from £23,250 to £118,000 for people living in a care home where their property has not been disregarded.**
- **People continue to pay for care costs in excess of what their local authority is willing to pay (thereby causing variation across councils).**
- **People continue to be liable to pay daily living costs or 'hotel costs' of £12,000 per annum once the cap is reached.**
- **The introduction of national eligibility criteria for qualifying for state support and a 'universal' deferred payment scheme.**

The funding reforms were scheduled for April 2016, yet in July 2015 it was announced that part two of the Care Act (which would have introduced a cap on care costs and changed the means-test) would be postponed until April 2020. The then care minister wrote to the Local Government Association at the time, citing the need for continued restraint on spending and a concern that the private insurance market hadn't yet developed complementary pre-funded insurance solutions. However, as the Strategic Society Centre noted, these same factors are still likely to be an issue in 2020[16].

The revised 2020 deadline for implementing the cap has not been confirmed since the 2017 General Election, raising the question – again – as to when a care cap will be implemented, if indeed it ever gets implemented at all.

The social care system is under immense pressure and so too are many of the self-payers who contribute so much of the money that goes into it. While local authorities have absorbed a reduction of more than £5 billion in social care budgets over the five-year period from 2011 to 2016, at least 26% fewer older people are receiving assistance and both the expectations on unpaid carers and levels of unmet need appear to be increasing[17].

While the Care Act provided a widely welcomed and much needed update to the legal framework governing care, it actually does little to reform how the system as a whole is funded.

It is also notable that while £2 billion in extra funding was announced for social care at the Spring 2017 Budget, none of this was intended to limit the care costs faced by self-payers. Indeed, there are separate questions about whether the funding announced in March 2017 was even sufficient to fix the many significant problems in England's system of publicly-funded care.

16 Lloyd, J., *Rebooting the cap: improving protection from catastrophic care costs,* The Strategic Society Centre, June 2016, pp. 5, 11.

17 Humphries, R., et al, *Social Care for Older People*, p. 75.

Continued reliance on private funding will prove neither adequate, nor equitable unless households have complete clarity about what they are expected to pay for, and where the state's own contributions kick in. A longer-term strategy is now badly needed to meet the needs of the ageing population in England.

There have been previous attempts to explore the question of long-term reform to care funding and some of these looked more broadly at the health and care system as a whole. The Barker Commission of 2014 called for an approach that integrates health and care around the needs of the individual. It recommended that public spending on this combined approach be increased to 11–12% of GDP by 2025 (specifically 9.1% on health and 2.2% on social care), citing that additional private insurance and funding options would be insufficient and inequitable[18].

As noted by the King's Fund and Nuffield Trust, a mechanism is also needed to secure cross-party consensus so that whatever reforms are introduced can lead to a lasting settlement that endures for many parliaments to come[19]. Encouragingly, polling from Independent Age has shown that 86% of MPs in England agree[20]. The main opposition parties also headed into the 2017 General Election with commitments of their own to introduce a lifetime limit on care costs. However in the case of the Labour Party, like the Conservatives, a specific level of cap has not been confirmed.

Is there room to change the proposed cap model?

As our analysis shows, the cap in its current legislated form – to place a lifetime limit on costs over £72,000 – has limited value as only 1 in 10 are likely to benefit.

Even once the cap is reached, the overall reduction in care costs is less significant than one might expect because the cap only applies to the local authority's view as to which costs it deems 'eligible' care costs. To be clear, there can be a significant difference between a fee a local authority will pay for social care – what a local authority deems to be 'eligible' costs – and the private fees paid by individuals responsible for funding their own care.

In addition, daily living costs or so-called 'hotel costs' and any 'excess' fees paid over-and-above what a local authority considers 'eligible' costs are not capped.

In short, the cap does not in fact cap all costs.

The delay in implementation from 2016 to 2020 means that those currently receiving care are missing out on any sort of protection on the amount they may end up spending on care. Even before the Conservative Party's 2017 General Election commitment, its 2015 manifesto pledged to introduce a cap, but care recipients are still waiting for its introduction.

18 Barker, K., Alltimes, G., Bichard, L., Greengross, S., Le Grand, L. *A new settlement for health and social care*, Commission on the Future of Health and Social Care in England, 2014, p 22.

19 Humphries, R., et al, *Social Care for Older People*.

20 Independent Age, Parliamentary Audit, polling conducted by Com Res, July 2017, available at: www.independentage.org/sites/default/files/2017-08/Independent%20Age_MPs_Parliamentary_Audit_Social_Care.pdf.

It should be noted that it has been argued by Sir Andrew Dilnot and others that catastrophic fees are those in excess of £100,000. However, for those living on lower incomes (but with assets, including housing assets, in excess of £23,250) what they determine as 'catastrophic' can in fact be far lower. Those receiving care (and their families who are often left to pay the bill) can be left in situations where what they are paying far outstrips what they deem affordable and sustainable.

"You're penalised for getting on in the world," summed up one individual Independent Age interviewed in preparation for this report. We imagine this is a sentiment shared by many self-payers of residential care, who aren't always able to determine the extra value they receive from paying more.

Private fees are typically 40% higher for like-for-like services[21], which has important implications for self-funders and their experience of reaching a cap. With a cap only covering what the particular local authority pays, or would pay, towards an individual's costs, a significant portion of self-funders will continue to pay substantial amounts of money beyond the £35,000 or £72,000 they have nominally spent or indeed whatever level the cap is set at. It could come as a nasty surprise to some that this 'top-up excess'[22] won't be capped and that what local authorities are willing to cap is far below the actual fees charged in a number of care homes.

If, however, an all-inclusive care cap is implemented (where all care costs are included in the cap) then this issue is eliminated.

21 LaingBuisson, *Care of Older People: UK Market Report*, p. 50.

22 It is important to clarify by 'top-up excess' we are not referring to third party top-up fees, which are sometimes paid to cover some of the care fees of individuals eligible for state-funded care. By 'top-up excess' we are referring to the balance between the rate a local authority pays fees to a care provider, and the actual (often higher) rate a self-funder pays fees.

Our approach

Independent Age and the Institute and Faculty of Actuaries have worked together to investigate different caps and means-testing thresholds. We have considered a range of caps and means-tests in anticipation of a Green Paper from the government.

Our analysis is based on a number of assumptions about the government's plans, largely based on the proposals put forward during the 2017 General Election campaign and the plans previously legislated for in the Care Act 2014.

Our aims are:

- to explore whether it could be possible to reduce complexity within the social care funding system to facilitate greater public understanding;
- to see if this could be achieved whilst ensuring that the cap kicks in once an individual who is paying for high care needs lives longer than the average life expectancy for individuals in care; and
- to assess the impact of varying the means-test threshold, or a capital limit on asset depletion, as this will be particularly important for those with lower financial means of paying for their care.

To do this, for each of our typical pensioner household scenarios, we modelled different levels for the cap and our analysis focuses on:

- a £35,000 cap, based on the Dilnot Report;
- a £72,000 cap, contained in the Care Act; and
- our proposed all-inclusive £100,000 cap that includes the local authority rate, daily living costs and 'excess' top-up fees based on average care costs.

Our intention is to show the impact that each of these care cap levels will have on cumulative care costs.

We also applied different means-test thresholds/capital limits, including:

- the current £23,250 upper capital limit for state-funded care;
- the £118,000 upper capital limit in the Care Act which was originally intended to be introduced in 2016; and
- a new capital limit of £100,000 as proposed in the Conservative Party's 2017 General Election manifesto.

The scenarios we modelled to investigate the impact of different caps and means-testing thresholds are based on a range of typical pensioner households. We have varied gender, age, which region in England the household lives in, and their level of assets and income on starting to pay for care. We have used these scenarios and variables to demonstrate the different impacts on individuals' overall care costs and the likelihood of them benefiting from a cap or means-test.

Figure 1: Domiciliary care needs

Level	Days per week	Hours per day	Cost per hour	Weekly total with regional weightings
Domiciliary Low	7	1	£12.60	£88.20
Domiciliary Medium	7	3	£14.73	£309.33
Domiciliary High	7	6	£16.86	£708.12

We used the English Longitudinal Study on Ageing (ELSA) dataset to obtain an estimate of individuals' income and assets, based on English averages.

We have defined the different levels of domiciliary care needs in **Figure 1**.

The figures are based on 2016 values obtained from LaingBuisson's latest reports on *Care of Older People: UK Market Report*[23] released in May 2017 and their Annual Survey of Local Authority Usual Costs[24] as well as the UK Home Care Association's 2016 *Overview of the Domiciliary Care Market in the United Kingdom*[25].

We have modelled all components of care costs (ie the local authority rate, plus the daily living costs and where appropriate any 'excess' top-up fees) and allowances (Attendance Allowance, NHS-funded nursing care and Personal Expense Allowance) used in the assessment of an individual's care needs.

The model projects these costs and allowances over a 10-year period and an annual rate of inflation is assumed for all components.

We have included survival rates over the 10-year period allowing for the probability of survival for each year. This enables us to determine people's prospects of living long enough to benefit from the cap. A 10-year projection was used as the probability of survival at 10 years is around 3% and therefore the probability of living longer than this is very low.

More information on the data and assumptions underpinning the research can be found in Appendix A and the comprehensive data sets produced for each scenario can be found in Appendix B.

23 LaingBuisson, *Care of Older People: UK Market Report*.

24 LaingBuisson, *Annual Survey of UK Local Authority Usual Costs 2016/17,* Community Care Market News, July 2016.

25 Holmes, J., *Overview of the Domiciliary Care Market in the United Kingdom*, Version 35, May 2016.

The key findings

The cap

In a typical scenario where the individual enters **residential care**, either with or without nursing:

- Only the £35,000 cap and the all-inclusive £100,000 cap will provide protection to those who live longer than expected in residential care.
- In all models except the £100,000 all-inclusive cap, the costs rise well above £100,000 by year 6 to £157,669 for the £35,000 cap and £241,818 where there is no cap, or the cap is set at £72,000.
- Without a cap, or where the cap is set at £72,000, the care costs reach over £300,000 by year 10 and over £200,000 when the cap is set at £35,000.
- The all-inclusive cap reduces the variation in care costs between regions. This effect becomes greater the longer an individual has care needs. At year six, the Care Act proposals based on a £72,000 cap see a regional variation of £133,703 between the North East where the costs are lowest and the South East where the costs are highest. The £100,000 all-inclusive cap reduces this variation to £2,063.
- Only the proposed all-inclusive cap, or a £100,000 capital floor prevents assets from depleting to well below £100,000. However, the all-inclusive cap results in an increase in assets over time as the individual's care needs are being met and they continue to receive age-related state benefits, such as the State Pension. We understand the government might wish to examine this further, as it presents questions about the future treatment of income as a contribution to care costs once an individual has reached the care cap.

In a typical scenario where an individual requires **domiciliary care**:

- If the cap were set at either £35,000 or £100,000 all-inclusive, over half of those (59%) with high domiciliary care needs could stand to benefit from the cap, compared to the legislated for £72,000 system where approximately a third (35%) are likely to live for long enough until they reach the cap.
- The cap model is unlikely to benefit those with low domiciliary care needs, even if their care needs are chronic and experienced over a long time.

Only the £35,000 cap and the all-inclusive £100,000 cap will provide protection to those who live longer than expected in residential care.

Figure 2: Impact of different care cap levels on accumulated care costs and probability of surviving to end of year^

Care cap	Year 1	Year 3	Year 6	Year 10	Years to reach cap
No cap	£37,479	£115,728	£241,818	£331,994	N/A
£35k	£37,479	£115,728	£157,669	£217,177	3.1
£72k	£37,479	£115,728	£241,818	£309,882	6.3
£100k all-inclusive	£37,479	£104,797	£104,797	£104,797	2.8
Survival probability	63%	36%	13%	3%	

^Based on Scenario 1 in Appendix B. The upper means-testing threshold of £118,000 contained in the Care Act has been used for each of these calculations.

Accumulated costs

Figure 2 sets out the care costs an individual would accumulate over a 10 year period, in a typical scenario, varied by the level of cap that is set[26]. Figure 2 shows that it is only our proposed all-inclusive £100,000 cap that gets reached by year 3 and begins to reduce care costs for individuals. Under our proposed cap, accumulated care costs total £104,797 and stop at year 3. This is slightly above £100,000 as we have assumed the cap increases with inflation each year. Our modelling shows that if there is no cap on care costs, or the cap is set at £35,000 or £72,000, but only incorporates the local authority rate, then the accumulated cost of care at year 3 is £115,728.

Unless the cap is all-inclusive, or set at £35,000, accumulated care costs continue to rise to over £200,000 by year 6 and £300,000 by year 10.

We begin to see greater variance between the different caps by year 6. Under the £100,000 all-inclusive cap, no further costs accumulate after year 3 and total care costs remain at £104,797. Yet costs continue to rise under all other models. Under the £72,000 cap in the Care Act, or where there is no cap, costs reach £241,818 by year 6. The £35,000 cap is reached by year 6 and as a result care costs total £157,669.

The difference is even more stark by year 10, remaining at £104,797 for our proposed model, compared to £217,177 for the £35,000 cap proposed by Dilnot, £309,882 for the £72,000 cap and £331,994 if there is no cap.

It is worth reiterating that this analysis is based on the more generous means-test limits legislated for in the Care Act. Without implementation of the more generous means-test, costs will be even higher.

26 For the full results see Scenario 1 in Appendix B.

In Appendix B, we have set out the 20 scenarios that we modelled to assess variation in care costs and the subsequent impact of different caps based on:

- type of care – residential with and without nursing, as well as high, medium and low domiciliary care
- gender
- where in England the individual lives – average cost of care varies by region
- the individual's level of assets and income upon entry into care.

Figure 3 (overleaf) demonstrates how an individual's cumulative care costs change dependent on the type of care they are receiving (where all other variables remain the same).

Without an all-inclusive cap individuals with the highest care needs will continue to see their costs rise to well over £100,000.

It is clear from Figure 3 that any cap is preferred to no cap at all. Without the implementation of a cap by year 6, those with **high care needs** (residential with and without nursing, and high domiciliary care needs) will face £200,000 to £250,000 in care costs, with this rising to £330,000 to £340,000 by year 10. We can also see from Figure 3 that for these individuals with the highest care needs, the £100,000 all-inclusive cap is generally by far the most generous across most scenarios.

For those with **medium domiciliary care needs,** the £35,000 cap is the only cap to reduce care costs at year 3. However, at year 6 and year 10 the £100,000 all-inclusive cap is the most generous.

A typical individual with medium domiciliary care needs can expect to face almost £160,000 of care costs by year 6 under a system with no cap and the proposed system in the Care Act. By year 10, the costs would rise to £278,596 where there is no cap and £216,185 where there is a cap of £72,000. Even with a £35,000 cap, the costs will reach £173,634 by year 10 for someone with medium domiciliary care needs. Whereas, under the all-inclusive £100,000 cap, costs cap at £107,700 and the individual does not make any further contributions between years 6 and 10.

For those with **low domiciliary care needs,** the various caps have no effect on care costs until after year 6. By year 10, in all other models the costs approach £200,000, but remain close to £100,000 for the all-inclusive cap.

These results suggest that the effect of any cap, other than the all-inclusive cap, is limited for those with medium to low domiciliary care needs until they reach year 10[27].

27 We have not modelled people moving between care types eg from domiciliary care to residential care, and recognise that a cap will have different impacts on people who move between care types if their care needs and costs increase over time.

Figure 3: Cumulative care costs varied by care need and the level of cap^

	Year 1				Year 3				Year 6				Year 10			
	No cap	£35k cap	£72k cap	£100k cap all-inclusive	No cap	£35k cap	£72k cap	£100k cap all-inclusive	No cap	£35k cap	£72k cap	£100k cap all-inclusive	No cap	£35k cap	£72k cap	£100k cap all-inclusive
Residential care with nursing	£37,479	£37,479	£37,479	£37,479	£115,728	£115,728	£115,728	£104,797	£241,818	£157,669	£241,818	£104,797	£331,994	£217,177	£309,882	£104,797
Residential care (without nursing)	£32,065	£32,065	£32,065	£32,065	£99,012	£96,372	£99,012	£99,012	£206,891	£136,744	£205,519	£106,111	£337,851	£196,253	£265,027	£106,111
High domiciliary care needs	£36,950	£36,950	£36,950	£36,950	£114,095	£110,812	£114,095	£104,813	£238,407	£151,184	£236,700	£104,813	£330,276	£210,692	£296,209	£104,813
Medium domiciliary care needs	£24,414	£24,414	£24,414	£24,414	£75,387	£73,754	£75,387	£75,387	£157,525	£114,126	£156,676	£107,700	£278,596	£173,634	£216,185	£107,700
Low domiciliary care needs	£16,602	£16,602	£16,602	£16,602	£51,265	£51,265	£51,265	£51,265	£107,121	£107,121	£107,121	£107,121	£189,452	£176,603	£189,452	£110,912

^Based on Scenarios 1-5 in Appendix B. The upper means-testing threshold of £118,000 contained in the Care Act has been used for each of these calculations.

Time taken to reach the cap

Figure 4 highlights how long it will take individuals to reach the various caps dependent on their care need.

Figure 4 demonstrates that where the individual enters residential care, either with or without nursing, it is only the £35,000 cap, or the all-inclusive £100,000 cap that would be triggered around year 3.

Whereas the £72,000 cap would not be triggered until the individual approaches or has just passed year 6. This is roughly twice the life expectancy of someone entering residential care.

This pattern remains true for high domiciliary care needs where the probability of survival to the end of year 3 is 59%, but this reduces to 35% by year 6. The proposals in the Care Act would only come into effect just before year 6, meaning only 35% of people with high domiciliary care needs are likely to benefit from those reforms.

If the cap were set at either £35,000 or £100,000 all-inclusive, over half of those (59%) with high domiciliary care needs could stand to benefit from the cap. This compares to the legislated for £72,000 system where approximately a third (35%) are likely to survive until they reach the cap.

For those with medium domiciliary care needs the £35,000 cap would take effect before either the Care Act proposals or the all-inclusive £100,000 cap. The £100,000 all-inclusive cap is met in 4.2 years – this is approximately the average life expectancy for those with this type of care need.

For those with low domiciliary care needs the Care Act proposals would mean that the individual does not reach the cap by year 10. In addition, those with low domiciliary care needs wouldn't reach either the £35,000 or the £100,000 all-inclusive cap until above average life expectancy for those with care needs.

Figure 4: Years taken to reach the cap varied by care need and the level of cap^

Care cap	£35k cap	£72k cap	£100k all-inclusive cap
Residential care with nursing	3.1	6.3	2.8
Residential care (without nursing)	2.9	5.9	3.3
High domiciliary care needs	2.9	5.9	2.8
Medium domiciliary care needs	2.9	5.9	4.2
Low domiciliary care needs	7.8	n/a	6.2

^Based on Scenarios 1-5 in Appendix B. The upper means-testing threshold of £118,000 contained in the Care Act has been used for each of these calculations.

This suggests the cap model is unlikely to benefit those with low domiciliary care needs, even if they are chronic and experienced over a long time.

Gender and regional effects

The above analysis is based on female life expectancy data, as there is a greater proportion of females in care than males, though the gender gap is narrowing. When we compare the likelihood of males and females reaching the cap, we find that fewer males live long enough to reach it. The trajectory in costs, and therefore the years taken to reach the cap, remain consistent across genders. This difference is caused by shorter life expectancy among males with care needs.

A previous IFoA report found that there is significant variation in the time taken to reach the cap and the amount likely to be spent on care, depending on the region in England where an individual lives. This is due to regional variation in care costs. In scenarios 6 to 14, we have modelled different regions in England to assess whether any of the caps may go some way to alleviate this regional variation in care costs. This analysis is based on an 85-year-old female, with average assets and income, entering residential care with nursing (**Figure 5 overleaf**).

Figure 5 shows that at year 3, the cost of care varies with a:

- **£35,000 cap** from £82,306 in the North East to £140,819 in the South East, a range of £58,513.
- **£72,000 cap** from £82,306 in the North East to £144,421 in the South East, a range of £62,115.
- **£100,000 all-inclusive cap** from £82,306 in the North East to £104,849 in the West Midlands, a range of £22,543.

The all-inclusive cap reduces the variation in care costs between regions. This effect becomes greater the longer an individual has care needs.

Figure 6 shows that, at year 6, the cost of care varies with a:

- **£35,000 cap** from £130,499 in the North East to £178,724 in the East of England, a range of £48,225.
- **£72,000 cap** from £154,429 in the North East to £288,132 in the South East, a range of £133,703.
- **£100,000 all-inclusive cap** from £104,528 in the South East to £106,591 in the North East, a range of £2,063.

The regional variation is vastly reduced and to a large degree minimised by the £100,000 all-inclusive cap. Although, it is important to note that individuals living in areas where the cost of care is higher reach the cap sooner, and their overall cost of care over time may therefore be lower.

Figure 5: Regional variation in cumulative care costs at year 3 dependent on the cap

	£35k cap	£72k cap	£100k all-inclusive cap
North East	£82,306	£82,306	£82,306
North West	£100,469	£100,469	£100,469
Yorkshire and Humber	£96,788	£96,788	£96,788
East Midlands	£92,100	£92,100	£92,100
West Midlands	£110,199	£110,199	£104,849
East of England	£136,057	£136,057	£104,606
London	£114,333	£129,122	£104,671
South East	£140,819	£144,421	£104,528
South West	£125,875	£125,875	£104,702

^Based on Scenarios 6-14 in Appendix B. The upper means-testing threshold of £118,000 contained in the Care Act has been used for each of these calculations.

Figure 6: Regional variation in cumulative care costs at year 6 dependent on the cap

	£35k cap	£72k cap	£100k all-inclusive cap
North East	£130,499	£154,429	£106,591
North West	£166,641	£209,934	£106,069
Yorkshire and Humber	£157,781	£172,121	£106,175
East Midlands	£139,493	£192,446	£106,310
West Midlands	£171,029	£230,266	£104,849
East of England	£178,724	£284,298	£104,606
London	£142,986	£216,720	£104,671
South East	£175,192	£288,132	£104,528
South West	£169,014	£263,021	£104,702

^Based on Scenarios 6-14 in Appendix B. The upper means-testing threshold of £118,000 contained in the Care Act has been used for each of these calculations.

Combining the impact of varying means-test and cap

One of the main pillars of the social care funding regime in England is the means-test that governs access to state-funded care. In fact, the Care Act 2014 created a new upper capital limit for residential care, set at £118,000 for those without a property disregard. However, to date, this more generous means-test has not been enacted. It also remains unclear whether the government intends to stick with this planned-for £118,000 capital limit.

Our means-test analysis covers the current upper capital limit for residential care of £23,250, the means-test legislated in the Care Act and the £100,000 capital floor proposed in the Conservative Party's 2017 General Election manifesto.

Figure 7 and **Figure 8** show the care costs and assets individuals would have with the various levels of means-test and care cap used in the analysis. There are six different projections which are colour-coded in these charts and also in Appendix B where all the 20 scenarios are documented.

The six projections are based on the means-test and care cap set out in the colour-coded table below. Note that we have assumed that the property has not been disregarded in the financial assessment.

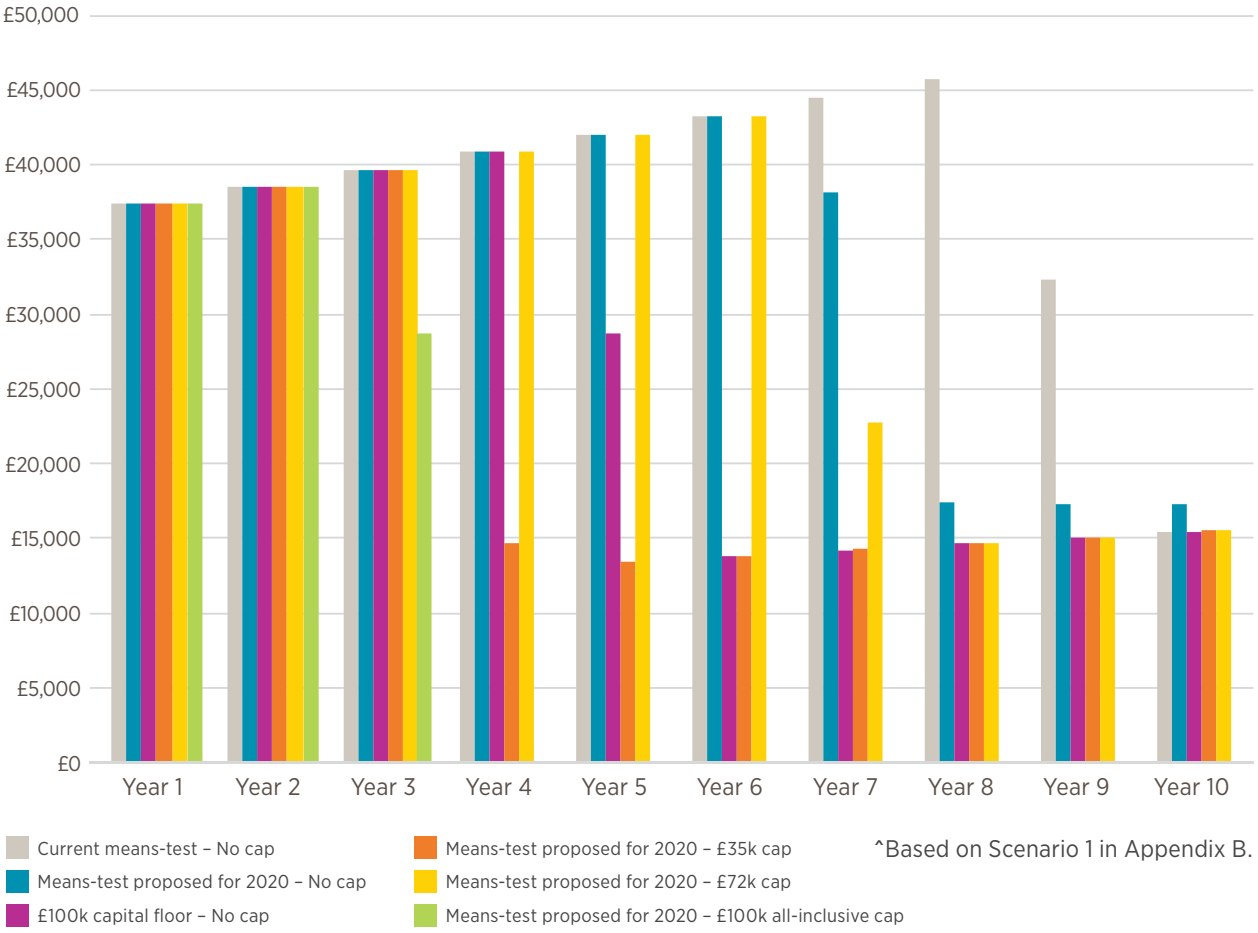
	Current means-test	**No cap**
	Means-test proposed for 2020	**No cap**
	£100k capital floor	**No cap**
	Means-test proposed for 2020	**£35k cap**
	Means-test proposed for 2020	**£72k cap**
	Means-test proposed for 2020	**£100k all-inclusive cap**

The yellow bar demonstrates the combined effect of both the cap and means-test set out in the Care Act. If you compare this with the results for the means-test proposed for 2020, but with no cap, you can see that the cap starts to take effect in year 7, reducing the costs by comparison.

If we compare the Care Act proposals (yellow bars), with the proposal in the Conservative Party's 2017 General Election manifesto of a £100,000 capital floor (purple bars), we see that the manifesto commitment reduces care fees sooner than the Care Act proposals.

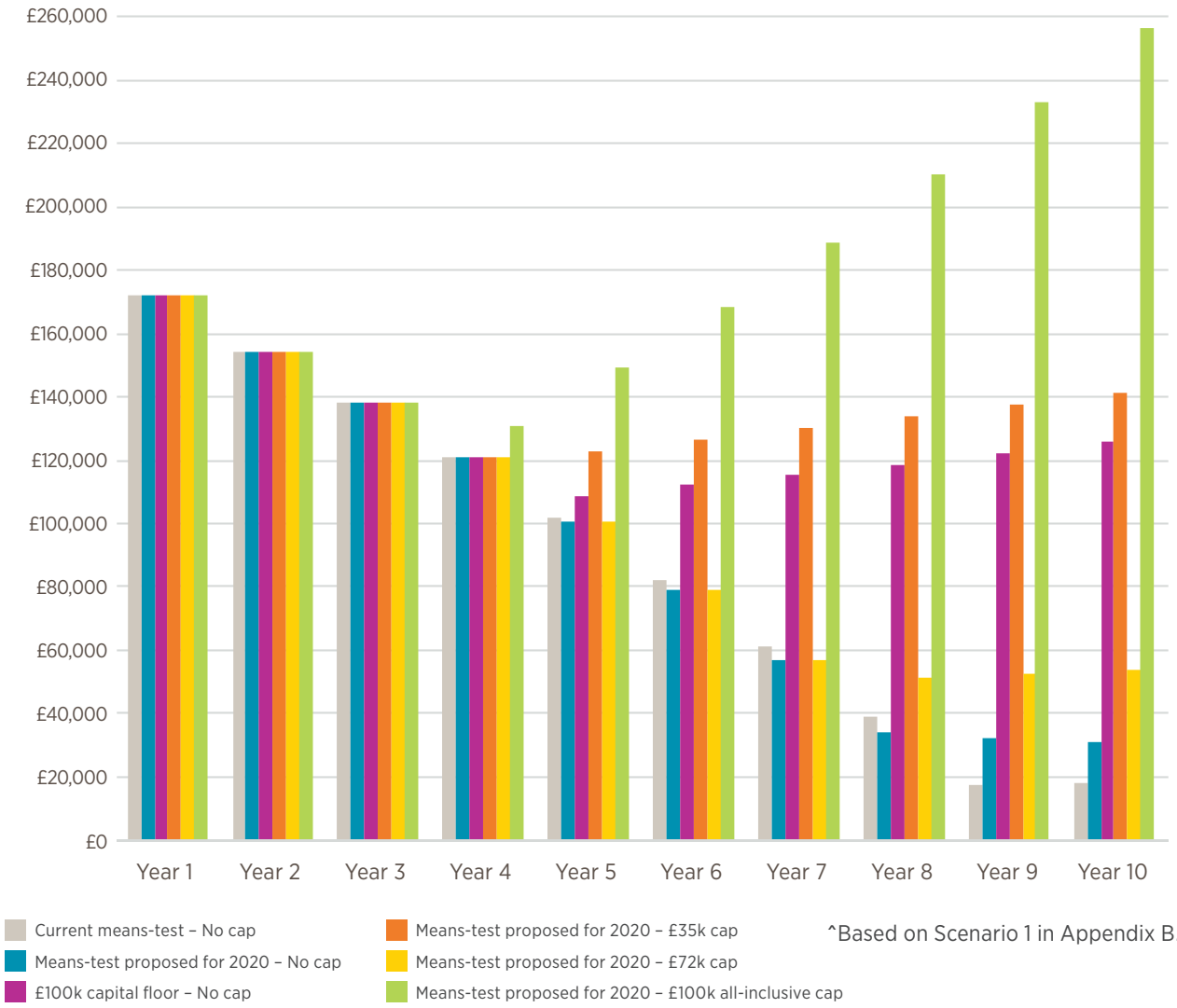
The £35,000 cap reduces costs in year 4, which is sooner than the other scenarios, except for our proposed all-inclusive £100,000 cap, which reduces care costs by year 3 and means that there are no further care costs from year 4.

Figure 7: Care fee projections for varying care cap and means-test^



^Based on Scenario 1 in Appendix B.

Figure 8: Levels of assets for varying cap and means-test^



^Based on Scenario 1 in Appendix B.

Figure 8 shows for the same individual the impact on the level of assets under the various projections.

Figure 8 shows that an individual's assets will reduce to well below £100,000 under the current system and the system proposed in the Care Act. However, assets of above £100,000 would be maintained if any of the £100,000 capital floor, £35,000 cap or the all-inclusive £100,000 cap are introduced.

One perhaps surprising result is that assets continue to rise, quite significantly, under the all-inclusive cap. This is because whilst the individual no longer has to contribute towards their care costs, they will still be in receipt of the State Pension.

The government might want to address the issue that assets continue to rise under the all-inclusive cap.

Discussion

Truly a cap?

Under the Care Act proposals, only the local authority rate for care counts towards the cap and is paid by the government once the cap is reached. The care needs themselves also need to be deemed as eligible by the local authority, so it is not simply the case that someone privately paying for care is automatically contributing towards a cap. They must have a needs assessment conducted to ensure that their needs are eligible. Additionally, any 'excess' top-up above the local authority rate – including £12,000 per year towards daily living costs – are uncapped and the individual will continue to pay for these costs.

As the legislated-for £72,000 cap is not a cap across all care costs, we suggest the government uses the opportunity of a new consultation on social care in England to examine from fresh principles what it wants a cap to achieve. Simply put, Independent Age and the IFoA think government should use this period of postponement and policy analysis to reframe the cap.

In reframing the cap, the cap should be set so that the core care costs are included. We suggest that at a minimum daily living costs and 'excess' top-up care costs should be counted towards the cap. This would make the cap a true cap on costs making the system much easier for individuals to understand and prepare for.

The government will need to look more closely, however, at how they cap any excess fees that self-funders pay over and above the fee a local authority would ordinarily arrange for a resident's care.

One possible approach would be to cap these excess costs, but within a set limit or at an agreed percentage above all personal care costs and daily living costs. Alternatively the government could clarify that local authorities are only expected to cap care costs that are paid in local authority-approved homes. These would meet certain agreed criteria in terms of quality or how high their charges reach above ordinary local authority fees.

To ensure the cost of care received by the individual is reasonable, there would need to be a mechanism for controlling how 'excess' top-up fees self-funders pay are monitored and ultimately capped, which we have not considered in detail here. We also appreciate including 'excess' top-up costs within an all-inclusive cap could have a series of effects on the care market, which again, we have not examined but we understand they would need addressing before such a cap could be implemented.

However, we recognise that to keep the system as simple to administer as possible, there will need to be a balance struck between keeping the cap straightforward for the public (capping all core costs) and keeping it relatively straightforward and economic for local authorities to manage as well.

Crucially, the capped costs model in the Care Act is clearly limited and the term 'cap' ends up being misleading. The original £72,000 cap is incredibly complex, and coupled with one's inability to predict the likelihood of needing care, and the years they will spend receiving it, in its current form it represents a limited tool in allowing people to plan for their potential future care needs.

Once its implications are truly understood by residents and their relatives, it's unlikely to truly offer 'peace of mind' to older people and their families. We believe a reframed, all-inclusive cap would address this concern.

Regional impacts

Access to care increasingly depends on what people can afford and what local authority they live in rather than what they require to meet their care needs as they age.

The amount people are paying for residential nursing care varies quite considerably across England. As a result, the time taken to reach the care cap similarly varies. We have looked at the variations in average incomes and assets across England. In doing so, we have analysed the length of time it would take someone to reach a cap set at the various levels as well as the amount someone is likely to spend, both before and after.

Taking the primary scenario of a woman entering residential care with nursing at the age of 85:

- at the legislated cap of £72,000, it would take 6.3 years for her to reach the cap were she to live in the East of England;
- if she resided in the North West, it would take 8.5 years for her to reach the cap; and
- if she were a resident of London, the cap would be reached after 4.4 years.

While the variations in prices paid can reflect the differences in labour and property costs, as well as general cost of living, this difference is potentially viewed as unfair by consumers, particularly when variations in care quality are factored in.

The North West scenario provides a case in point. Under the proposed system in the Care Act, an 85-year-old woman living in nursing care in the North West will have paid £209,933 in accumulated care fees by her sixth year in the home.

Yet looking at the Care Quality Commission ratings care homes across England, the North West is of particular concern with 33.6% of homes – or 1 in 3 – being rated 'inadequate' or 'requires improvement', far higher than the national average[30]. The same person living in the East Midlands will have paid £192,448 yet have a lower chance of living in a home with these lower ratings, with 24.2% of homes being rated 'inadequate' or 'requires improvement'.

Similarly, the percentage of self-payers by region has significant variations. Within affluent regions, more than 60% of residents are paying for their care in certain local authorities.

The regional breakdown of care recipients who are self-paying is as follows[31]:

North East	21.9%
North West	39.0%
Yorkshire and the Humber	40.3%
East Midlands	49.5%
West Midlands	41.4%
East of England	45.5%
Greater London	45.6%
South East	61.9%
South West	49.8%
UK	43.8%

30 Independent Age, *Care home performance across England,* as of January 2017, March 2017, available at: www.independentage.org/policy-research/research-reports/care-home-performance-across-england.

31 LaingBuisson, *Care of Older People: UK Market Report.*

As a result, the areas of the country that look set to benefit most from a cap varies considerably, with the proportions of self-funders not evenly spread across the nation. Going forward, not only does this leave councils in lower income areas paying for the care of a higher proportion of residents, it also has the potential to skew the nature of the private care market.

Areas where individuals are more likely to be able to self-fund more of their care costs may well end up in a situation where more choice is provided to them, potentially at the expense of those living in less affluent areas with a higher proportion of local authority funded residents.

This bifurcation of the care market, disadvantaging people who live in areas with proportionately fewer self-payers, is something that the government should actively guard against. Local authorities have duties to shape local care markets, but if care providers cannot provide care at the rates councils are paying, then they could leave the local authority-funded market to concentrate on self-payers, particularly in areas where there are higher concentrations of self-funders.

The Competition and Markets Authority has highlighted some of the unique challenges facing care providers, particularly those concentrated on the local authority market. These pressures could intensify without careful oversight. More work needs to be done to tackle variation in care, not just in terms of the fees that self-payers find they have to pay, but also in terms of quality from area-to-area, too. The government's promised Green Paper represents an opportunity to properly address these issues[32].

The way forward

Without decisive and bold reform to tackle the future funding of care, older people throughout England face an uncertain future.

While the focus of this report is of course self-payers, the sector as a whole should not be overlooked. In addition to the savings they have had to make, local authorities have faced increased obligations since the introduction of the Care Act 2014.

Only 29% of adult social care directors are fully confident they can meet their statutory obligations in 2017/18 and this falls to 3% for 2019/20[33].

The care market is in a fragile state and without increased certainty and adequate funding, it will be those in need of care who will lose out most. According to their latest Budget Survey, the Association of Directors of Adult Social Services (ADASS) has found that provider failure has faced 69% of local authorities over the last six months, affecting thousands of people[34].

The care cap alone will not solve all of the problems in the care and support system – we are under no false illusions of this.

We acknowledge the concerns expressed by those who argue that the restraint on public spending poses serious questions about a cap during a period where social care still has scarce resources.

32 Competition and Markets Authority Care homes market study: Update Paper, June 2017.

33 The Association of Directors of Adult Social Care, ADASS Budget Survey, 2017, p. 14.

34 Ibid, p. 25.

It is certainly clear that implementing a £72,000 cap on personal care fees alone, whilst protecting the small minority of people who spend an extended period of time in care, does little in the way of offering protection to the majority of people who self-fund their care costs.

Importantly, whilst the legislated for cap should protect the small minority of people who will spend more than £72,000 on their care fees post 2020, it won't do anything to help the hundreds of thousands of older people who have already been rationed out of receiving any care.

It will also have no impact on the large numbers who have never, and will never, have incomes or assets that would enable them to self-pay. The Dilnot Report rightly argues that an essential pillar of any capped costs reforms would be a more generous means-test to benefit families with a modest amount of wealth. Since the upper capital limit is so low at £23,250, many fall foul of the existing cliff-edge.

What a cap could potentially encourage, if the system was structured differently, is more people prepared to make provision for and access care earlier. A cap on care could also facilitate earlier interactions between self-payers and their local authority as importantly only 'eligible' care needs contribute towards a cap. Earlier interaction could be beneficial to ensure older people and their families are signposted to relevant services and receive advice.

If people knew that the care that they paid for went towards a cap, people may be more likely to access care sooner when they need it rather than trying to hold off for as long as possible due to financial concerns or constraints. This could have important positive implications for people accessing early interventions and potentially mean they are more able to remain independent, within the community, for longer – thereby staying out of hospital.

Yet the current system does not facilitate or encourage such behaviours or life decisions. If reform continues to stall, people who pay for care privately will continue to go without a local authority assessment of their care needs and will never see their spending contributing towards a cap.

The government needs to prioritise this issue and it now needs to act. As the system stands, there is far too much uncertainty and no meaningful way in which future and current care recipients and their families and carers can plan for their potential care costs.

There is a need for cross-party cooperation in order to ensure that substantial and lasting reform can take place by the end of this parliament. Social care, and the people who need it, cannot wait any longer.

Moving towards a solution

Our analysis has made it clear that for self-funders, a cap that does not include all care costs, would have a limited impact on the total cost they go on to face in residential care.

Reframing the cap

Currently framed, so that it only contains local authority rates for care, a £35,000 cap has a real prospect of benefiting meaningful numbers of older people and insuring them against the tail-risk they face in terms of 'catastrophic costs' of £100,000 or above. In practice, they will go on to pay just over £100,000 after three years of living in residential care, but the overall costs that accumulate over time would climb higher still if the original cap of £72,000 was introduced.

While strongly supportive of the capped cost model, it is clear to us that a cap on local authority rates for care alone, even when combined with the more generous means-test set out in the Care Act, does little to curb costs for self-payers. That is manifestly the case when a cap is set at £72,000 or higher.

As a result, we believe that a cap on all costs should be investigated. In other words, the cap on care should be reframed so that it is all-inclusive.

Fundamentally, it is only this approach that has the potential to truly curb fees in a sense the public is likely to understand. It is only this approach that truly creates simplicity and prevents catastrophic costs. The £100,000 all-inclusive cap that we propose could have the effect of creating certainty, making it clear to consumers how much they would be spending on all care costs, by including daily living costs and any 'excess' top-ups. Individuals would know in advance everything a local authority is willing to cover on care fees and allow people to plan accordingly.

We recognise that such an approach has its limitations and is neither pain-free for the government nor care recipients. It will cost the government considerably more than a cap that is narrowly framed.

Notably, it has the potential to benefit those who are able to pay the most first. We do not however believe this would act as a perverse incentive, particularly as people are more likely to wish to stay in their own homes for as long as they can.

While our focus has been a cap on care costs, we are clear that the government's planned consultation would also do well to identify and examine other funding mechanisms, including other approaches to social insurance. These may also warrant further investigation.

Ultimately, whatever funding solutions are consulted on, the government will need to set out how they meet the needs of all those receiving care today, and all those likely to end up needing care in the future.

Other cost-limiting measures that could be examined might include:

- capping the total number of years of self-paying for care; and
- capping costs that care providers are able to charge for providing care.

Resetting the cap

In addition to reframing the cap so that it is all-inclusive, we also propose that it is reset at £100,000.

Since individuals will typically find themselves paying a total sum of £100,000 or more for their care if they survive for longer than average in residential or nursing care, a £100,000 cap would kick in at the stage people with high needs survive for three years, but no less. We believe this represents a fair contract between the state, which has to manage increased demand as the population ages, and individuals who experience significantly greater than average care costs.

An all-inclusive £100,000 total cap would mean individuals with the assets and incomes to meet their own care costs need to cover the first £100,000. Thereafter they would expect future care costs to get covered, as these represent 'catastrophic' and exceptional costs that should be covered through social insurance.

Combining the impact of varying the means-test and cap

The role of the means-test must not be overlooked and the increases outlined in the Care Act should be implemented as soon as possible as it reduces care costs for a greater proportion of individuals than the cap.

There are different approaches the government could adopt, and our analysis has of course concentrated on a legislated-for £118,000 upper capital limit or a £100,000 capital floor. Either way, the current means-test has to be changed to make it less stringent.

Policy recommendations

1 There is a definite need for clarity around what care costs the state will cover in later life, and what individuals must contribute to meet their own care needs. It is critical the government provides this clarity soon and sets out the main options on social care finance as part of its promised consultation on care and support in England.

2 Considering the two main proposals for a care cap we have seen to date, from the Dilnot Report on the Funding of Care and Support and the cap legislated for in the Care Act 2014, we are clear that a care cap of £72,000 is less beneficial – and to fewer people – than a £35,000 cap on care costs. If the choice is between these two limits then the £35,000 cap proposed by the Dilnot Report would be more meaningful in curtailing costs. However, the Care Act proposals would still be preferable to no cap at all, or to a further delay in introducing a care cap model.

3 An immediate next step for the government should be to introduce a more generous means-test to widen access to the state-funded system of care and support for pensioner households with modest assets and wealth.

4 A raised capital floor of £100,000 is beneficial, compared with the £23,250 upper capital limit for residential care that exists today, but to have a stronger impact still it should be applied in conjunction with a cap.

5 Ultimately, we believe the most effective approach would be for government to reframe and reset the cap to an all-inclusive £100,000. This should be considered because it would remove the risk that the public misunderstand what costs are capped and it would represent a fair contract between the state and individuals facing 'catastrophic' costs.

6 The introduction of a care cap would be a welcome safety net, but individuals would need to make financial plans so that they only need to pay for costs up to the cap. To help more individuals to make this level of provision, government needs to clarify which households in future can access deferred payment agreements to help them meet what still represent very significant costs. Greater clarity also needs to be given on what costs are capped. A widespread public information campaign is needed in the way Sir Andrew Dilnot's Commission on Funding of Care and Support recommended.

7 Local authorities must be adequately resourced to administer any new changes that get introduced and they also need to have sustainable funding to provide social care to those who require it and have insufficient incomes and assets to pay for their own care. There should be greater integration between health and social care to ensure better outcomes for individuals.

8 The government's promised consultation on social care should take place urgently, with a wide call for evidence. It should provide clarity on the future care costs of all adults with social care needs, including working age adults. This should lead to a broad and comprehensive appraisal of all relevant options to deliver an improved settlement on social care funding. The consultation must then lead to firm action, ideally with cross-party backing, and it should lead to a final plan enacted by no later than the end of this parliament.

Longer-term, the government may want to look at age-related spending as a whole. They could examine whether, as part of an improved social contract sharing out responsibility for meeting care costs, state benefits could be better targeted to match need.

Conclusion

Substantial changes to the care funding system are urgently needed and without real consensus on the way forward, any reforms are unlikely to pass parliament.

There is clearly an appetite for reform. The 2017 General Election saw social care funding feature as a key debate topic, a status not afforded to it in the past. Yet since then there has been very little information on what changes to social care will be consulted on in the government's promised Green Paper, let alone enacted. There is also uncertainty around whether a cap set at £72,000 and the increased means-test thresholds in the Care Act will be implemented in 2020. What is clear is that the risk of abandoning the principle of a lifetime cap on social care would be a significant step in the wrong direction.

Independent Age and the Institute and Faculty of Actuaries are also clear that a cap on care costs isn't a panacea and won't solve all the problems in England's social care system. Other changes also need to take place – principally a change to the current stringent means-test which heavily restricts access to local authority-funded care.

As the government prepares for its consultation, it should use this period of policy development to consider reframing and resetting the care cap so that it is truly a cap on all care costs. The cap should also be set at a level that means people with high care needs would have a reasonable prospect of benefiting from the cap. That means setting the cap at a level that would kick-in when a typical pensioner in residential or nursing care reaches the average life expectancy for those with high care needs.

We recommend the cap is 'all-inclusive' of all care costs, including accommodation costs. Individuals who pay for their own care, and have the means, would need to make provision for the first £100,000 of their care, but their total costs beyond this level should be 'pooled' collectively by the state.

Ultimately, we need to find a fair and responsible way of preparing for millions more people living well into old age and living for greater periods of old age in need of formal, paid, care and support. We hope the government will confront the challenge and present a comprehensive solution in the coming months.

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Glossary

Attendance Allowance: a non-means-tested, tax-free benefit paid to those aged 65 and over who have a physical or mental disability and require assistance with personal care.

All-inclusive cap: We have defined this as a cap on care spending which includes care fees, daily living costs and 'excess' top-up fees.

Capital floor: An asset threshold. In this context it refers to the £100,000 asset threshold proposed in the Conservative Party manifesto where one would only pay for their own social care costs until their assets met or fell below this level.

Catastrophic care costs: We have defined this as self-paying more than £100,000 on meeting an individual's care needs.

Daily living costs: Residents of care homes pay a contribution of about £12,000 per year towards general living expenses such as food and accommodation. These are also known as 'hotel costs'.

Deferred payment agreements: An arrangement with the local authority that allows eligible people to use the value of their home to postpone paying their residential care costs. The local authority covers the cost of their care and this is repaid, along with administrative fees and interest, upon the sale of the home, or once the person has died. Since April 2015 deferred payment agreements have been required to be offered by all English local authorities. The Conservative 2017 manifesto highlighted that deferred payment agreements could also be made available in future to people needing domiciliary care, so they in effect can take out a loan against the home they need to stay in for their own care.

Dilnot Report: The 2011 Commission on Funding of Care and Support.

Domiciliary care: Also known as 'home care', this refers to personal care provided within one's own home.

'Excess' top-up: The difference between the (higher) fee paid by a self-funder for their care and what a local authority would be expected or willing to pay for a residential care placement.

Hotel costs: See 'daily living costs'.

Local authority rate: The assessment by the local authority of the weekly or hourly cost of meeting someone's long term care needs.

NHS Continuing Healthcare: A non-means-tested package of care arranged and fully funded by the NHS. To qualify, a person must be assessed as having a 'primary health need' where their nursing and care needs are deemed beyond what a local authority could be expected to provide.

NHS-funded nursing care: A flat-rate contribution paid directly to a care home towards the cost of providing registered nursing care.

Personal Expense Allowance: A weekly amount that people whose care is being fully funded by the local authority are allowed to retain from their income for personal use.

Property disregard: A local authority must ignore the value of a person's home for the first 12 weeks of their time in residential care.

Residential care without nursing: Commonly referred to as a 'care home'.

Residential care with nursing: Also known as a 'nursing home', a care home which provides higher levels of care to people with higher care needs, and staffed by registered nurses.

Self-payer: Also known as 'self-funders'. An individual who pays for their own care costs (rather than being funded by the local authority).

Third party top-up: A fee paid by a third party (usually a relative) towards the residential care of a local authority funded resident above their personal budget.

Appendix A

Survival rates

The survival rates for residential care were based on Table 15 in the PSSRU/BUPA Report on Length of Stay in Nursing Homes in England (Forder and Fernandez, 2011). The survey had a mean age of entry to a care home of 85. The survival rates for varying gender, age and type of care home have been extrapolated linearly from the survival rates shown in Table 15 and Figure 1 in the PSSRU/BUPA Report. This gives an indication of the impact of gender, age and type of care on the probability of reaching the cap.

The survival rates have been adjusted for longevity improvements of 1% per annum. There is uncertainty about what is the correct level of longevity improvements to apply for people over 80, but it was felt that this was a reasonable assumption.

We are not aware of any studies on survival rates for domiciliary care. We decided to use the average of the survival rates determined for residential care (as set out above) and the survival rates determined from population mortality in the latest English Life Tables (ELT17) with a view that domiciliary survival rates will fall within the rates experienced by the general population and the residential care home population.

The ELT17 rates have been adjusted for longevity improvements of 1% per annum, there is similar uncertainty over the correct improvement rate to apply. However, in both cases it is not a material assumption given the short life expectancy – we have also run a sensitivity of 0.5% per annum and 1.5% per annum to assess the range of result.

Appendix B shows the survival rates used for each of the 20 scenarios.

Care costs

The key assumption throughout is the current and projected care costs.

The residential care costs (with and without nursing) are derived from LaingBuisson Reports for 2016/17.

- For residential care in 'for profit' homes without nursing we have used Table 8.2 of the LaingBuisson report of average weekly fees by region – for older people and dementia (65+), UK 2016/17 (public and private payers combined).

- For residential care in 'for-profit' homes with nursing we have used the regional local authority usual costs for frail older people set out in the LaingBuisson *Community Care Market News* July 2016-17 including Annual Survey of Local Authority Usual Costs.

The domiciliary care costs were derived from the UKHCA survey of rates per hour in April 2016 with regional weightings based on NHS Digital 2015-16[35]. The level of domiciliary care needs were modelled at three levels.

Income and assets

The scenarios are based on a single homeowner with assets (including the value of their property) and income based on the median values of the equivalised income and assets from the English Longitudinal Study of Ageing (ELSA) wave 7 (2014/15). These values are based on the region in England where the individual lives. The median values for England as a whole are £172,000 for assets and £13,266 per annum for income.

35 Source: ASC-FR Collection 2015/16, NHS Digital – see table 16 in Reference Data Tables.

Inflation

The rate of inflation applied to all components of care costs, the care cap, means-test limits, income and assets and all allowances has been determined in the same way as the Care Act 2014 Impact Assessment. This used the projected rate of increase in average earnings based on the Office for Budget Responsibility Economic and Fiscal Outlook for the following five years at that time and averaged the values. We have used the same approach using the Office for Budget Responsibility's Fiscal Outlook for March 2017, which was 2.9%.

'Excess' top-ups

For the all-inclusive cap we have assumed that all 'excess' top-ups cease once the cap is reached. The costs would be met by the government from this point forward, meaning that it is likely that they pay the local authority rate rather than the higher fee paid by self-funders.

Attendance Allowance

Throughout the scenarios we have assumed that Attendance Allowance is not paid for the first 6 months because a person normally needs to have satisfied the eligibility criteria for this length of time before they qualify, or should be eligible for NHS Continuing Healthcare if their care needs are for a short period of time. There are exemptions to this waiting period for people who are terminally ill under 'special rules' which have not been considered in our analysis.

Personal Expenses Allowance

We have assumed that once an individual reaches the cap that the personal allowance is spent. This is only applicable where the individual also becomes eligible for the means-test.

Modelling limitations

Although it is highly likely that individuals will transition from lower to higher care needs, we have not modelled people moving between care types, for example, from domiciliary care to residential care or residential to nursing care.

We have not modelled deferred payment agreements explicitly. However, we have assumed that the individuals are able to release equity from their property to fund their care. The cost of doing this has not been modelled, for example, interest on loans and any associated fees.

We have not modelled the property disregard explicitly. However, the impact of this can be understood by looking at asset levels that roughly equal assets net of property wealth.

The IFoA is looking to address these model limitations in a later piece of research.

The data and analysis in this paper has been peer reviewed in line with the Actuaries Code. However, the information in this paper is not actuarial advice or advice of any nature and should not be treated as a substitute for advice.

Appendix B:

IFoA care cost scenarios – details of model inputs and outputs

Scenario 1				YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME										Expected value of care fees	Years before cap is reached
Gender	F	Means-test limits	Care cap	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10		
Type of care	Nursing	Current	None	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£44,491	£45,782	£32,264	£15,478	£108,850	N/A
Age at entry to care	85	Proposed 2020	None	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£38,101	£17,409	£17,323	£17,343	£105,100	N/A
Care region	England	£100k capital floor	None	£37,479	£38,565	£39,684	£40,835	£28,778	£13,806	£14,206	£14,618	£15,042	£15,478	£94,250	N/A
Continue full costs after cap reached	Y	Proposed 2020	£35k	£37,479	£38,565	£39,684	£14,644	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£82,700	3.1
Assets at entry to care	£172,000	Proposed 2020	£72k	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£22,801	£14,659	£15,084	£15,521	£102,900	6.3
Income at entry to care	£13,266	Proposed 2020	£85k	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£38,101	£19,545	£15,084	£15,521	£105,050	7.4
		Proposed 2020	all-inclusive £100k	£37,479	£38,565	£28,753	£0	£0	£0	£0	£0	£0	£0	£64,050	2.8
PSSRU/BUPA Survival Rates for Nursing care		Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

Scenario 2

Gender	F
Type of Care	Residential
Age at entry to care	85
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
PSSRU/BUPA Survival Rates for Nursing care	

		YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME										Expected value of care fees	Years before cap is reached
Means-test limits	Care cap	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10		
Current	None	£32,065	£32,995	£33,952	£34,937	£35,950	£36,992	£38,065	£39,169	£40,305	£41,474	£101,200	N/A
Proposed 2020	None	£32,065	£32,995	£33,952	£34,937	£35,950	£36,992	£38,065	£39,169	£33,257	£20,469	£99,850	N/A
£100k capital floor	None	£32,065	£32,995	£33,952	£34,937	£35,950	£22,632	£14,206	£14,618	£15,042	£15,478	£90,800	N/A
Proposed 2020	£35k	£32,065	£32,995	£31,312	£13,075	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£75,050	2.9
Proposed 2020	£72k	£32,065	£32,995	£33,952	£34,937	£35,950	£35,620	£14,245	£14,659	£15,084	£15,521	£93,100	5.9
Proposed 2020	£85k	£32,065	£32,995	£33,952	£34,937	£35,950	£36,992	£38,065	£15,744	£15,084	£15,521	£96,450	7.0
Proposed 2020	all-inclusive £100k	£32,065	£32,995	£33,952	£7,099	£0	£0	£0	£0	£0	£0	£63,750	3.3
Probability of surviving to end of year		66%	51%	40%	29%	21%	15%	10%	7%	5%	4%		

Scenario 3

Gender	F
Type of care	Domiciliary High
Age at entry to care	85
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
Average of ELT17 & PSSRU/BUPA Survival Rates for Residential care	

		YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME										Expected value of care fees	Years before cap is reached
Means-test limits	Care cap	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10		
Current	None	£36,950	£38,021	£39,124	£40,259	£41,426	£42,627	£43,864	£45,136	£31,356	£15,478	£178,350	N/A
Proposed 2020	None	£36,950	£38,021	£39,124	£40,259	£41,426	£42,627	£37,491	£18,336	£18,080	£17,961	£166,850	N/A
£100k capital floor	None	£36,950	£38,021	£39,124	£40,259	£27,471	£13,806	£14,206	£14,618	£15,042	£15,478	£140,050	N/A
Proposed 2020	£35k	£36,950	£38,021	£35,841	£13,075	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£116,900	2.9
Proposed 2020	£72k	£36,950	£38,021	£39,124	£40,259	£41,426	£40,921	£14,245	£14,659	£15,084	£15,521	£156,750	5.9
Proposed 2020	£85k	£36,950	£38,021	£39,124	£40,259	£41,426	£42,627	£37,491	£15,330	£15,084	£15,521	£165,000	7.0
Proposed 2020	all-inclusive £100k	£36,950	£38,021	£29,842	£0	£0	£0	£0	£0	£0	£0	£80,250	2.8
Probability of surviving to end of year		79%	68%	59%	50%	42%	35%	29%	24%	19%	15%		

Scenario 4

Gender	F
Type of care	Domiciliary Medium
Age at entry to care	85
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
Average of ELT17 & PSSRU/BUPA Survival Rates for Residential care	

		YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME										Expected value of care fees	Years before cap is reached
Means-test limits	Care cap	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10		
Current	None	£24,414	£25,122	£25,851	£26,600	£27,372	£28,166	£28,982	£29,823	£30,688	£31,578	£123,700	N/A
Proposed 2020	None	£24,414	£25,122	£25,851	£26,600	£27,372	£28,166	£28,982	£29,823	£30,688	£31,578	£123,700	N/A
£100k capital floor	None	£24,414	£25,122	£25,851	£26,600	£27,372	£28,166	£28,982	£29,823	£30,688	£31,578	£123,700	N/A
Proposed 2020	£35k	£24,414	£25,122	£24,217	£13,075	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£88,700	2.9
Proposed 2020	£72k	£24,414	£25,122	£25,851	£26,600	£27,372	£27,317	£14,245	£14,659	£15,084	£15,521	£108,550	5.9
Proposed 2020	£85k	£24,414	£25,122	£25,851	£26,600	£27,372	£28,166	£28,982	£15,330	£15,084	£15,521	£113,750	7.0
Proposed 2020	all-inclusive £100k	£24,414	£25,122	£25,851	£26,600	£5,713	£0	£0	£0	£0	£0	£73,950	4.2
Probability of surviving to end of year		79%	68%	59%	50%	42%	35%	29%	24%	19%	15%		

Scenario 5

Gender	F
Type of care	Domiciliary Low
Age at entry to care	85
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
Average of ELT17 & PSSRU/BUPA Survival Rates for Residential care	

		YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME										Expected value of care fees	Years before cap is reached
Means-test limits	Care cap	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10		
Current	None	£16,602	£17,084	£17,579	£18,089	£18,614	£19,153	£19,709	£20,280	£20,869	£21,474	£84,150	N/A
Proposed 2020	None	£16,602	£17,084	£17,579	£18,089	£18,614	£19,153	£19,709	£20,280	£20,869	£21,474	£84,150	N/A
£100k capital floor	None	£16,602	£17,084	£17,579	£18,089	£18,614	£19,153	£19,709	£20,280	£20,869	£21,474	£84,150	N/A
Proposed 2020	£35k	£16,602	£17,084	£17,579	£18,089	£18,614	£19,153	£19,709	£19,168	£15,084	£15,521	£81,550	7.8
Proposed 2020	£72k	£16,602	£17,084	£17,579	£18,089	£18,614	£19,153	£19,709	£20,280	£20,869	£21,474	£84,150	N/A
Proposed 2020	£85k	£16,602	£17,084	£17,579	£18,089	£18,614	£19,153	£19,709	£20,280	£20,869	£21,474	£84,150	N/A
Proposed 2020	all-inclusive £100k	£16,602	£17,084	£17,579	£18,089	£18,614	£19,153	£3,791	£0	£0	£0	£65,500	6.2
Probability of surviving to end of year		79%	68%	59%	50%	42%	35%	29%	24%	19%	15%		

Scenario 6

Gender	F
Type of Care	Nursing
Age at entry to care	85
Care region	North East
Continue full costs after cap reached	Y
Assets at entry to care	£103,800
Income at entry to care	£11,628
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£26,655	£27,428	£28,223	£29,042	£29,884	£30,751	£31,642	£32,560	£19,061	£13,359	£77,300	N/A
Proposed 2020	None	£26,655	£27,428	£28,223	£29,042	£25,136	£17,946	£17,190	£16,645	£16,275	£16,050	£71,200	N/A
£100k capital floor	None	£26,655	£15,132	£10,937	£11,254	£11,580	£11,916	£12,261	£12,617	£12,983	£13,359	£46,400	N/A
Proposed 2020	£35k	£26,655	£27,428	£28,223	£20,896	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£64,800	3.5
Proposed 2020	£72k	£26,655	£27,428	£28,223	£29,042	£25,136	£17,946	£17,190	£17,200	£15,084	£15,521	£71,150	7.2
Proposed 2020	£85k	£26,655	£27,428	£28,223	£29,042	£25,136	£17,946	£17,190	£16,645	£18,899	£15,521	£71,300	8.5
Proposed 2020	all-inclusive £100k	£26,655	£27,428	£28,223	£24,285	£0	£0	£0	£0	£0	£0	£56,350	3.9
Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

Scenario 7

Gender	F
Type of care	Nursing
Age at entry to care	85
Care region	North West
Continue full costs after cap reached	Y
Assets at entry to care	£121,350
Income at entry to care	£13,401
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£32,537	£33,480	£34,451	£35,450	£36,479	£37,536	£38,625	£29,799	£15,211	£15,653	£93,100	N/A
Proposed 2020	None	£32,537	£33,480	£34,451	£35,450	£36,479	£37,536	£30,336	£14,783	£15,211	£15,653	£90,900	N/A
£100k capital floor	None	£32,537	£33,480	£25,377	£13,185	£13,568	£13,961	£14,366	£14,783	£15,211	£15,653	£69,450	N/A
Proposed 2020	£35k	£32,537	£33,480	£34,451	£35,450	£16,878	£13,844	£14,245	£14,659	£15,084	£15,521	£80,850	4.1
Proposed 2020	£72k	£32,537	£33,480	£34,451	£35,450	£36,479	£37,536	£30,336	£14,783	£15,211	£15,521	£90,900	8.5
Proposed 2020	£85k	£32,537	£33,480	£34,451	£35,450	£36,479	£37,536	£30,336	£14,783	£15,211	£15,653	£90,900	N/A
Proposed 2020	all-inclusive £100k	£32,537	£33,480	£34,451	£5,601	£0	£0	£0	£0	£0	£0	£61,300	3.2
Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

Scenario 8

Gender	F
Type of care	Nursing
Age at entry to care	85
Care region	Yorkshire and Humber
Continue full costs after cap reached	Y
Assets at entry to care	£111,040
Income at entry to care	£11,021

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£31,345	£32,254	£33,189	£34,152	£35,142	£36,161	£23,835	£11,876	£12,220	£12,574	£86,550	N/A
Proposed 2020	None	£31,345	£32,254	£33,189	£34,152	£27,966	£13,216	£13,176	£13,212	£13,312	£13,467	£80,250	N/A
£100k capital floor	None	£31,345	£20,660	£10,294	£10,592	£10,899	£11,216	£11,541	£11,876	£12,220	£12,574	£52,350	N/A
Proposed 2020	£35k	£31,345	£32,254	£33,189	£33,696	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£77,350	4.0
Proposed 2020	£72k	£31,345	£32,254	£33,189	£34,152	£27,966	£13,216	£13,176	£13,212	£14,560	£13,467	£80,300	8.2
Proposed 2020	£85k	£31,345	£32,254	£33,189	£34,152	£27,966	£13,216	£13,176	£13,212	£13,312	£13,467	£80,250	9.7
Proposed 2020	all-inclusive £100k	£31,345	£32,254	£33,189	£9,387	£0	£0	£0	£0	£0	£0	£60,300	3.4
Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

PSSRU/BUPA Survival Rates for Nursing care

Scenario 9

Gender	F
Type of care	Nursing
Age at entry to care	85
Care region	East Midlands
Continue full costs after cap reached	Y
Assets at entry to care	£175,000
Income at entry to care	£12,964

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£29,827	£30,692	£31,582	£32,497	£33,440	£34,410	£35,407	£36,434	£37,491	£38,578	£88,350	N/A
Proposed 2020	None	£29,827	£30,692	£31,582	£32,497	£33,440	£34,410	£35,407	£36,434	£37,491	£38,578	£88,350	N/A
£100k capital floor	None	£29,827	£30,692	£31,582	£32,497	£33,440	£34,410	£22,330	£14,249	£14,662	£15,087	£82,850	N/A
Proposed 2020	£35k	£29,827	£30,692	£31,582	£20,096	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£70,350	3.4
Proposed 2020	£72k	£29,827	£30,692	£31,582	£32,497	£33,440	£34,410	£33,509	£14,659	£15,084	£15,521	£84,200	6.9
Proposed 2020	£85k	£29,827	£30,692	£31,582	£32,497	£33,440	£34,410	£35,407	£36,434	£19,202	£15,521	£86,400	8.2
Proposed 2020	all-inclusive £100k	£29,827	£30,692	£31,582	£14,210	£0	£0	£0	£0	£0	£0	£59,050	3.5
Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

PSSRU/BUPA Survival Rates for Nursing care

Scenario 10

Gender	F
Type of care	Nursing
Age at entry to care	85
Care region	West Midlands
Continue full costs after cap reached	Y
Assets at entry to care	£147,500
Income at entry to care	£13,266
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME										Expected value of care fees	Years before cap is reached
		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10		
Current	None	£35,688	£36,723	£37,788	£38,884	£40,012	£41,172	£42,366	£33,433	£15,042	£15,478	£102,000	N/A
Proposed 2020	None	£35,688	£36,723	£37,788	£38,884	£40,012	£41,172	£34,987	£14,618	£15,042	£15,478	£99,650	N/A
£100k capital floor	None	£35,688	£36,723	£37,788	£28,564	£13,416	£13,806	£14,206	£14,618	£15,042	£15,478	£83,700	N/A
Proposed 2020	£35k	£35,688	£36,723	£37,788	£33,532	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£85,250	3.8
Proposed 2020	£72k	£35,688	£36,723	£37,788	£38,884	£40,012	£41,172	£34,987	£14,618	£15,042	£15,478	£99,650	7.8
Proposed 2020	£85k	£35,688	£36,723	£37,788	£38,884	£40,012	£41,172	£34,987	£14,618	£15,042	£16,890	£99,700	9.3
Proposed 2020	all-inclusive £100k	£35,688	£36,723	£32,438	£0	£0	£0	£0	£0	£0	£0	£63,100	2.9
Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

Scenario 11

Gender	F
Type of care	Nursing
Age at entry to care	85
Care region	East of England
Continue full costs after cap reached	Y
Assets at entry to care	£185,500
Income at entry to care	£15,727
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME										Expected value of care fees	Years before cap is reached
		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10		
Current	None	£44,062	£45,340	£46,655	£48,008	£49,400	£50,833	£52,307	£43,141	£18,135	£18,661	£126,050	N/A
Proposed 2020	None	£44,062	£45,340	£46,655	£48,008	£49,400	£50,833	£46,184	£17,624	£18,135	£18,661	£123,300	N/A
£100k capital floor	None	£44,062	£45,340	£46,655	£48,008	£38,959	£16,645	£17,127	£17,624	£18,135	£18,661	£112,150	N/A
Proposed 2020	£35k	£44,062	£45,340	£46,655	£15,369	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£94,950	3.1
Proposed 2020	£72k	£44,062	£45,340	£46,655	£48,008	£49,400	£50,833	£25,730	£14,659	£15,084	£15,521	£120,400	6.3
Proposed 2020	£85k	£44,062	£45,340	£46,655	£48,008	£49,400	£50,833	£46,184	£19,875	£15,084	£15,521	£123,150	7.4
Proposed 2020	all-inclusive £100k	£44,062	£45,340	£15,204	£0	£0	£0	£0	£0	£0	£0	£67,500	2.5
Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

Scenario 12

Gender	F
Type of care	Nursing
Age at entry to care	85
Care region	London
Continue full costs after cap reached	Y
Assets at entry to care	£297,832
Income at entry to care	£13,834
PSSRU/BUPA Survival Rates for Nursing care	

		YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME											
Means-test limits	Care cap	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£41,816	£43,029	£44,277	£45,561	£46,882	£48,242	£49,641	£51,080	£52,562	£54,086	£123,850	N/A
Proposed 2020	None	£41,816	£43,029	£44,277	£45,561	£46,882	£48,242	£49,641	£51,080	£52,562	£54,086	£123,850	N/A
£100k capital floor	None	£41,816	£43,029	£44,277	£45,561	£46,882	£48,242	£49,641	£51,080	£52,562	£33,261	£123,050	N/A
Proposed 2020	£35k	£41,816	£43,029	£17,768	£13,075	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£79,000	2.2
Proposed 2020	£72k	£41,816	£43,029	£44,277	£45,561	£28,192	£13,844	£14,245	£14,659	£15,084	£15,521	£103,550	4.4
Proposed 2020	£85k	£41,816	£43,029	£44,277	£45,561	£46,882	£22,463	£14,245	£14,659	£15,084	£15,521	£109,100	5.3
Proposed 2020	all-inclusive £100k	£41,816	£43,029	£19,826	£0	£0	£0	£0	£0	£0	£0	£66,300	2.5
Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

Scenario 13

Gender	F
Type of care	Nursing
Age at entry to care	85
Care region	South East
Continue full costs after cap reached	Y
Assets at entry to care	£280,667
Income at entry to care	£13,232
PSSRU/BUPA Survival Rates for Nursing care	

		YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME											
Means-test limits	Care cap	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£46,771	£48,127	£49,523	£50,959	£52,437	£53,958	£55,522	£57,132	£58,789	£44,657	£137,900	N/A
Proposed 2020	None	£46,771	£48,127	£49,523	£50,959	£52,437	£53,958	£55,522	£57,132	£49,589	£15,604	£136,250	N/A
£100k capital floor	None	£46,771	£48,127	£49,523	£50,959	£52,437	£53,958	£55,522	£41,114	£14,999	£15,434	£133,000	N/A
Proposed 2020	£35k	£46,771	£48,127	£39,922	£13,075	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£95,200	2.7
Proposed 2020	£72k	£46,771	£48,127	£49,523	£50,959	£52,437	£40,316	£14,245	£14,659	£15,084	£15,521	£123,950	5.7
Proposed 2020	£85k	£46,771	£48,127	£49,523	£50,959	£52,437	£53,958	£42,503	£14,659	£15,084	£15,521	£129,400	6.7
Proposed 2020	all-inclusive £100k	£46,771	£48,127	£9,630	£0	£0	£0	£0	£0	£0	£0	£68,900	2.3
Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

Scenario 14

Gender	F
Type of care	Nursing
Age at entry to care	85
Care region	South West
Continue full costs after cap reached	Y
Assets at entry to care	£201,150
Income at entry to care	£13,908
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£40,765	£41,947	£43,163	£44,415	£45,703	£47,028	£48,392	£49,796	£38,999	£16,308	£118,600	N/A
Proposed 2020	None	£40,765	£41,947	£43,163	£44,415	£45,703	£47,028	£48,392	£41,910	£16,003	£16,435	£116,700	N/A
£100k capital floor	None	£40,765	£41,947	£43,163	£44,415	£45,703	£34,288	£14,968	£15,402	£15,849	£16,308	£108,700	N/A
Proposed 2020	£35k	£40,765	£41,947	£43,163	£15,842	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£89,050	3.1
Proposed 2020	£72k	£40,765	£41,947	£43,163	£44,415	£45,703	£47,028	£26,136	£14,659	£15,084	£15,521	£111,850	6.3
Proposed 2020	£85k	£40,765	£41,947	£43,163	£44,415	£45,703	£47,028	£48,392	£31,949	£15,084	£15,521	£115,800	7.5
Proposed 2020	all-inclusive £100k	£40,765	£41,947	£21,991	£0	£0	£0	£0	£0	£0	£0	£65,750	2.6
Probability of surviving to end of year		63%	48%	36%	26%	19%	13%	9%	7%	5%	3%		

Scenario 15

Gender	F
Type of care	Nursing
Age at entry to care	80
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£44,491	£45,782	£32,264	£15,478	£123,550	N/A
Proposed 2020	None	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£38,101	£17,409	£17,323	£17,343	£119,000	N/A
£100k capital floor	None	£37,479	£38,565	£39,684	£40,835	£28,778	£13,806	£14,206	£14,618	£15,042	£15,478	£105,950	N/A
Proposed 2020	£35k	£37,479	£38,565	£39,684	£14,644	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£92,050	3.1
Proposed 2020	£72k	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£22,801	£14,659	£15,084	£15,521	£116,400	6.3
Proposed 2020	£85k	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£38,101	£19,545	£15,084	£15,521	£119,000	7.4
Proposed 2020	all-inclusive £100k	£37,479	£38,565	£28,753	£0	£0	£0	£0	£0	£0	£0	£69,800	2.8
Probability of surviving to end of year		69%	55%	43%	31%	23%	16%	11%	8%	6%	4%		

Scenario 16

Gender	M
Type of care	Nursing
Age at entry to care	85
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£44,491	£45,782	£32,264	£15,478	£80,300	N/A
Proposed 2020	None	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£38,101	£17,409	£17,323	£17,343	£77,950	N/A
£100k capital floor	None	£37,479	£38,565	£39,684	£40,835	£28,778	£13,806	£14,206	£14,618	£15,042	£15,478	£71,300	N/A
Proposed 2020	£35k	£37,479	£38,565	£39,684	£14,644	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£64,250	3.1
Proposed 2020	£72k	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£22,801	£14,659	£15,084	£15,521	£76,650	6.3
Proposed 2020	£85k	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£38,101	£19,545	£15,084	£15,521	£77,950	7.4
Proposed 2020	all-inclusive £100k	£37,479	£38,565	£28,753	£0	£0	£0	£0	£0	£0	£0	£52,550	2.8
Probability of surviving to end of year		51%	34%	22%	16%	11%	8%	6%	4%	3%	2%		

Scenario 17

Gender	M
Type of care	Residential
Age at entry to care	85
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£32,065	£32,995	£33,952	£34,937	£35,950	£36,992	£38,065	£39,169	£40,305	£41,474	£73,700	N/A
Proposed 2020	None	£32,065	£32,995	£33,952	£34,937	£35,950	£36,992	£38,065	£39,169	£33,257	£20,469	£72,850	N/A
£100k capital floor	None	£32,065	£32,995	£33,952	£34,937	£35,950	£22,632	£14,206	£14,618	£15,042	£15,478	£67,350	N/A
Proposed 2020	£35k	£32,065	£32,995	£31,312	£13,075	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£57,700	2.9
Proposed 2020	£72k	£32,065	£32,995	£33,952	£34,937	£35,950	£35,620	£14,245	£14,659	£15,084	£15,521	£68,750	5.9
Proposed 2020	£85k	£32,065	£32,995	£33,952	£34,937	£35,950	£36,992	£38,065	£15,744	£15,084	£15,521	£70,800	7.0
Proposed 2020	all-inclusive £100k	£32,065	£32,995	£33,952	£7,099	£0	£0	£0	£0	£0	£0	£50,850	3.3
Probability of surviving to end of year		53%	36%	24%	18%	13%	9%	6%	4%	3%	2%		

Scenario 18

Gender	M
Type of care	Domiciliary High
Age at entry to care	85
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£36,950	£38,021	£39,124	£40,259	£41,426	£42,627	£43,864	£45,136	£31,356	£15,478	£153,050	N/A
Proposed 2020	None	£36,950	£38,021	£39,124	£40,259	£41,426	£42,627	£37,491	£18,336	£18,080	£17,961	£143,750	N/A
£100k capital floor	None	£36,950	£38,021	£39,124	£40,259	£27,471	£13,806	£14,206	£14,618	£15,042	£15,478	£121,850	N/A
Proposed 2020	£35k	£36,950	£38,021	£35,841	£13,075	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£102,700	2.9
Proposed 2020	£72k	£36,950	£38,021	£39,124	£40,259	£41,426	£40,921	£14,245	£14,659	£15,084	£15,521	£135,550	5.9
Proposed 2020	£85k	£36,950	£38,021	£39,124	£40,259	£41,426	£42,627	£37,491	£15,330	£15,084	£15,521	£142,250	7.0
Proposed 2020	all-inclusive £100k	£36,950	£38,021	£29,842	£0	£0	£0	£0	£0	£0	£0	£72,700	2.8
Probability of surviving to end of year		72%	59%	49%	41%	34%	28%	23%	19%	15%	12%		

Scenario 19

Gender	M
Type of care	Domiciliary Medium
Age at entry to care	85
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
PSSRU/BUPA Survival Rates for Nursing care	

Means-test limits	Care cap	YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME: Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£24,414	£25,122	£25,851	£26,600	£27,372	£28,166	£28,982	£29,823	£30,688	£31,578	£105,800	N/A
Proposed 2020	None	£24,414	£25,122	£25,851	£26,600	£27,372	£28,166	£28,982	£29,823	£30,688	£31,578	£105,800	N/A
£100k capital floor	None	£24,414	£25,122	£25,851	£26,600	£27,372	£28,166	£28,982	£29,823	£30,688	£31,578	£105,800	N/A
Proposed 2020	£35k	£24,414	£25,122	£24,217	£13,075	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£77,250	2.9
Proposed 2020	£72k	£24,414	£25,122	£25,851	£26,600	£27,372	£27,317	£14,245	£14,659	£15,084	£15,521	£93,600	5.9
Proposed 2020	£85k	£24,414	£25,122	£25,851	£26,600	£27,372	£28,166	£28,982	£15,330	£15,084	£15,521	£97,800	7.0
Proposed 2020	all-inclusive £100k	£24,414	£25,122	£25,851	£26,600	£5,713	£0	£0	£0	£0	£0	£65,350	4.2
Probability of surviving to end of year		72%	59%	49%	41%	34%	28%	23%	19%	15%	12%		

Scenario 20

Gender	M
Type of care	Nursing
Age at entry to care	80
Care region	England
Continue full costs after cap reached	Y
Assets at entry to care	£172,000
Income at entry to care	£13,266
PSSRU/BUPA Survival Rates for Nursing care	

		YEAR BY YEAR CARE FEES AFTER ENTRY TO CARE HOME											
Means-test limits	Care cap	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Expected value of care fees	Years before cap is reached
Current	None	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£44,491	£45,782	£32,264	£15,478	£89,500	N/A
Proposed 2020	None	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£38,101	£17,409	£17,323	£17,343	£86,700	N/A
£100k capital floor	None	£37,479	£38,565	£39,684	£40,835	£28,778	£13,806	£14,206	£14,618	£15,042	£15,478	£78,800	N/A
Proposed 2020	£35k	£37,479	£38,565	£39,684	£14,644	£13,454	£13,844	£14,245	£14,659	£15,084	£15,521	£70,350	3.1
Proposed 2020	£72k	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£22,801	£14,659	£15,084	£15,521	£85,150	6.3
Proposed 2020	£85k	£37,479	£38,565	£39,684	£40,835	£42,019	£43,237	£38,101	£19,545	£15,084	£15,521	£86,700	7.4
Proposed 2020	all-inclusive £100k	£37,479	£38,565	£28,753	£0	£0	£0	£0	£0	£0	£0	£56,500	2.8
Probability of surviving to end of year		55%	38%	26%	19%	14%	10%	7%	5%	3%	2%		

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