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Reforming the funding of adult social care:
Costs and impacts of the government's proposal

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The analysis set out in this report is the responsibility of the authors and the views expressed are those of the authors and not necessarily those of the Nuffield Foundation, NIHR or the Department of Health and Social Care.

Glossary

Daily living costs (DLC): an allowance for the costs of accommodation, heating, food etc supplied in care homes, which are covered by the care home fees but do not count as care costs for the purposes of a cap on care costs.

Cap (on care costs): lifetime limit on the liability of service users to meet the costs of their care, such that their care is publicly funded after the cap has been reached.

Capital limits: limits relating to savings which are set out for the purposes of the means test, where savings above the upper capital limit render the person ineligible for local authority support and savings below the lower capital limit are disregarded in the means test. In residential care, savings include housing wealth (see below) unless the care home resident has a partner or other qualifying relative who continues to live in the family home.

Continuing health care (CHC): Care in a nursing home or in the community which is fully funded by the NHS for people with 'long-term complex health need'.

Disability benefits: social security benefits comprising Attendance Allowance (AA), Disability Living Allowance (DLA) and Personal Independence Payment (PIP) and any related additions to means-tested benefits.

Eligible care costs: the costs of the social care which the local authority assesses the person to require under the terms of their needs-based eligibility criteria.

Free personal care: care for personal care needs such as dressing and feeding but not help with domestic tasks such as shopping and laundry.

Funded Nursing Care (FNC): NHS contribution to the costs of nursing home care for people assessed as needing care from a registered nurse but not eligible for NHS continuing health care.

Housing wealth: the value of the person's home (minus any outstanding mortgage) if they own it, or the person's former home if the person has sold it, or their share of the value of the home if it is jointly owned.

Income: the person's individual income, net of taxes, and after housing costs for those living in the community.

Minimum Income Guarantee (MIG): the minimum weekly disposable income which local authority funded community care users must be allowed to retain under the terms of the means test.

Personal expenses allowance (PEA): the minimum weekly disposable income which local authority funded care home residents must be allowed to retain under the terms of the means test.

Savings: the person's total financial savings plus (generally) their housing wealth if living in a care home but excluding pension wealth (but including pension lump sums already received).

Self-funder: Person who funds their own long-term care without any contribution from their local authority (but who may receive NHS Funded Nursing Care or a disability benefit).

Note: This glossary indicates the definitions in general terms but for brevity and simplicity does not cover all the details. In particular, some sources of incomes and savings are disregarded in the means test.

Executive summary

This paper presents projections of the public costs and the distributional effects for older people of the Government's recently announced reforms to the funding of Long-term Care in England, compared with the reforms planned by the Coalition Government of 2010-2015. Both sets of plans would introduce a lifetime cap (at differing levels) on the amount people need to contribute to the costs of their care and to raise the threshold (again by different amounts) above which people are ineligible to receive publicly funded care. The projections were produced using the Care Policy and Evaluation Centre's (CPEC) aggregate long-term care projections models and the CARESIM microsimulation model.

Under the current system:

- Around 700,000 older people in England were receiving long-term care in 2018, of whom about half lived in care homes and half used community care[2]. 55% received financial support from local authorities (LAs), 41% were self-funded, and 4% were NHS funded.
- Total expenditure on long-term care is estimated to be almost £20 billion in 2018 at 2018 prices. This includes £7.4 billion in net local authority expenditure, £2.4 billion funded by the NHS, £0.75 billion paid in disability benefits to self-funding care home residents and £9.4 billion paid by users (self-funders and local authority supported).
- Single non-homeowners received 55% of LA-funded expenditure on long-term care, and people in the lowest income quintile received 38% of LA-funded expenditure in 2018.
- LA-funded care home residents made an average weekly contribution of £170 to £200 to their fees in 2018. Self-funded residents on average paid £793 to £796 per week in care home fees. Sixty-five per cent of LA-funded care home residents contributed to daily living costs only, paying nothing towards the care component of their fees.
- Public spending on long-term care for older people is projected to rise from £10.5 billion in 2018 to £20.8 billion in 2038.

Under the government's latest plan and using pre-pandemic Office for Budget Responsibility economic forecasts:

- Public spending is projected to be £2.3 billion higher in 2028 and £3.2 billion higher in 2038 than under the current system. This is more generous than the plans of the Coalition Government.
- Care home residents in 2028 are projected to be £60 a week better off than under the current system, which compares to weekly gains of £43 under the plans of the Coalition Government. Home care users in 2028 are projected to be £20 a week better off on average than under the current system.
- The average gain for homeowners is projected to be £64 per week in 2028, in contrast to £5 per week for non-homeowners.
- The average gain for people in the highest income quintile is projected to be £72 per week in 2028, whereas for people in the lowest income quintile it is projected to be £21 per week.
- If current government plans were amended to measure progress towards the cap in the way proposed by the Coalition Government, we project this would add £0.4 billion in 2028 and £0.5 billion in 2038 to the public cost of the reforms, bringing the additional cost to £2.7 billion and £3.7 billion in 2028 and 2038 respectively.

[2] We use the terms community care and home care interchangeably to refer to social care provided to people who are living in their own homes as opposed to in communal facilities i.e. care homes.

These findings are based on a set of assumptions about future socioeconomic and demographic trends. They do not allow for the potential impact of rising expectations or other behavioural changes. Moreover, the findings are based on numbers of service users and social care unit costs prior to the covid-19 pandemic and use Office for Budgetary Responsibility economic forecasts which pre-date the pandemic. They thus do not take into account the short-term transient effects of covid-19 such as sharp movements in measured earnings growth and productivity nor the potentially important, but as yet uncertain, longer-term impacts of the pandemic.

Introduction

In the UK, help with long-term personal care, whether for people living in their own homes or in care homes, is mostly provided by the private and voluntary sectors. Much of it is commissioned and paid for by the public sector, through local government, working within national policy guidelines. Eligibility for state help with the cost of long-term care is determined by an assessment of the need for care and through the application of a means test. This is in contrast to health care which is mainly provided through the public sector and is largely free at the point of use.

There have been a substantial number of proposals over the last 25 years for reforming the financing of long-term care in England[3]. They have been motivated among other factors by concern about the current means test for eligibility to receive publicly funded care. It takes account of service users' incomes and savings, usually including, in the case of residential care, the value of their home. A Royal Commission set up by the Labour Government in 1997 recommended that user charges for personal care should be removed and free personal care implemented (Royal Commission on Long Term Care 1999). Their recommendation was implemented in Scotland but not in England. A review established by the King's Fund and led by Sir Derek Wanless recommended a form of partnership arrangement under which all those whose care needs meet the local eligibility criteria would receive at least some contribution to their care costs rather than free personal care (Wanless 2006). The Coalition Government of 2010-2015 set up a Commission on the Funding of Care and Support (CFCS) which recommended that a life-time cap be introduced on individuals' liability to meet the costs of their care (CFCS 2011). The Government accepted this recommendation, and the necessary legislation was included in the Care Act 2014, but a lifetime cap has not yet been introduced. The current Conservative Government announced in September 2021 that it plans to introduce a cap in October 2023 (HMG 2021).

The aim of this paper is to present an analysis of the costs and impacts of the current Government's proposal for reforming the English means test for eligibility for public support for care costs, including a lifetime cap of £86,000 on service users' liability to meet their care costs. Our focus here is on people aged 65+. Although the reforms will also affect younger adults, the issues that arise for them are a little different and much of the debate has concerned the impacts for older people who form a large majority of users of adult social care. The analysis includes a comparison with the costs and impacts of the 2010-2015 Coalition Government's similar proposal. The UK Department of Health and Social Care (DHSC) has published some analysis of the currently planned reforms (DHSC, 2022). Our analysis provides similar and additional analysis, including comparisons with the Coalition Government's proposals, using independently developed simulation methods. The next section outlines the current long-term care funding system in England and the planned reforms to it. This is followed by sections describing methods, results and then a discussion and conclusions section. Supplementary analysis is contained in the Appendix.

[3] In the UK, health and social care policy are devolved functions so the systems differ across the constituent countries of the UK.

The current funding system and planned reforms

In England a small proportion of older care home residents with complex health needs have their fees met in full by the NHS ('Continuing Health Care'). For others who have been assessed as needing long-term care, their Local Authority (LA) applies a means test to establish how much they must pay towards the cost of that care. Those with capital above an upper limit, currently £23,250, have to meet all of their care costs and where care is provided in a care home, the value of a person's home is included in their capital unless a qualifying relative continues to live in it. If their capital is below this threshold their income is taken into account in assessing their contribution to the cost of their care. Where the person has capital below the upper capital limit, but more than the lower capital limit (currently £14,250), £1 per week for every £250 of capital between the two limits is added to their assessable income. Care home residents who have to contribute to their care home's fee from their income must be left with a weekly personal expenses allowance (currently £24.90) while those contributing to care at home must be left with a minimum weekly disposable income, currently £189 for a single person, after contributing to their care costs. The values of these parameters have been unchanged since 2015. People assessed as needing nursing care in a care home, but not entitled to Continuing Health Care (CHC), are eligible for a non means tested contribution (£158.16 per week in England in 2018/19) from the NHS to their care home fees known as Funded Nursing Care (FNC). Box 1 details the key features of the current long-term care means tests in England.

Box 1: Key features of the current long-term care means test

Capital test:

A person with capital above the **upper capital limit (£23,250)** is not eligible for any financial help from their Local Authority (LA). Capital below a l**ower capital limit (£14,250)** is completely ignored; capital between the lower and upper limits is treated as generating a notional income which is counted in the income test (see below). Housing wealth is not included in assessable capital for home care but is for permanent residential care after the first 12 weeks unless a qualifying relative (such as a spouse) continues to live in the property.

Income test:

For residential care, most* income except a small **Personal Expenses Allowance (£24.90 pw)** must be used towards the cost of a care home's fees. The LA meets any shortfall between this income and the care home's fee. The NHS makes a non means-tested contribution (**£158.16 pw in 2018)** to assessed nursing care needs in a care home.

For home care, most* disposable income above a **Minimum Income Guarantee (£189 pw)** must be used towards the cost of home care, with any shortfall met by the LA. Disposable income excludes certain costs such as housing costs. An allowance for disability related costs must be deducted from assessable income if the LA includes income from disability benefits (see below) in assessable income.

Disability Benefits:

People with care needs may also be eligible for one of two non means-tested cash disability benefits paid through the national social security system – **Attendance Allowance (AA)** or **Disability Living Allowance (DLA)/Personal Independence Payment (PIP)**. Receipt of these benefits can also trigger increases in means-tested social security Benefits (Pension Credit, Housing Benefit and Council Tax Support) through a **Severe Disability Addition**. If someone receives help with care home fees from their LA, payments of these disability-related benefits cease. Reforms which expand eligibility for state-funded residential care can therefore lead to some savings in these benefits.

*Small disregards apply to some sources of income e.g. through a 'savings disregard'. Any income from employment is ignored.

There are two general issues which arise when considering potential reforms to the long-term care funding system. The first stems from the fact that currently, people who are not entitled to any help with their care costs under the means test are typically charged higher prices – at least for care provided in care homes – than those receiving publicly funded care (Competition and Markets Authority, 2017). Reforms which extend eligibility for LA help with care costs could increase the proportion of care recipients for whom providers receive lower prices, with consequent effects on their revenues (and hence the supply of care) unless prices paid by remaining self-funders rise, or LAs increase the prices they pay for users who have LA funding (Hancock et al. 2013). It is important therefore to state clearly what assumptions are being made about such prices under a reformed system. Secondly, care home fees cover not only the cost of providing personal, and possibly nursing care to residents but also 'daily living costs' such as accommodation, heating and food. Currently the means test that applies in residential care relates to the total fee including both care and daily living costs. Under most suggested reforms, state support with the daily living costs in care homes would continue to be means-tested, even when the care component is met by the state without a means test. Under such reforms, care home fees have to be split into daily living and care costs. For those receiving care in their own homes, any state support for daily living costs is provided via the social security system, the care means test relates only to the cost of care and there is no equivalent to the daily living cost component of care home fees.

The 2011 Commission on Funding Care and Support (CFCS) recommended a lifetime cap on the eligible care costs that individuals would have to meet (CFCS, 2011). Daily living costs in care homes would not count towards the cap and would continue to be means tested even after reaching the cap. There would also be an increase in the residential care upper capital threshold, above which no state help is provided. The Commission recommended a lifetime cap of around £35,000 (2011 prices). Following the 2014 Care Act, the Coalition Government of 2010 to 2015 planned a cap of £72,000 and daily living costs in residential care set at £12,000 a year. There were also to be increases in the upper capital limit to £118,000 for care home residents who have housing wealth that is being taken into account in the means test, and to £27,000 for other care home residents and those receiving home care; and an increase to £17,000 in the lower capital limit, all in 2016 prices (Jarrett, 2015). However these planned changes were not implemented. In September 2021 the current Government announced its intention to introduce in October 2023 a lifetime cap on care costs of £86,000, with daily living costs of £10,400 a year (£200 per week)[4]. The upper capital limit is to be increased in 2023 to £100,000 in both residential and domiciliary care, whether or not a person's housing wealth is included in the means test. The lower limit will be increased to £20,000[5]. Under the Coalition Government's plans, individuals' progress towards the cap was to have been measured by the cost of the care they were receiving (subject to a maximum equal to the cost the LA would normally meet) irrespective of how much they themselves paid towards their care. For this purpose the value of care in a care home was expected to be the difference between the care home fee that the LA would pay and the allowance for daily living costs, while for home care it would be the cost (at LA rates) of the package of care the individual was assessed as needing. Under the latest reform plans, progress towards the cap will be measured by the amount users contribute to their care costs. This can range from zero (care home residents who under the means test contribute only to the daily living costs component of their care home fees) to the full cost (self-funders). Note, however, that those who pay nothing towards their care under the current system, do not benefit from a cap on care costs however progress towards it is measured, because their care costs are already met in full by the state. The effects of different ways of measuring progress towards the cap are illustrated for three vignettes in Boxes 2a to 2c.

[4] In March 2022 it was clarified that the amount for daily living costs had been quoted in 2021 prices and would therefore be a little higher in 2023 than this figure implies and indeed than we have assumed (see https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/adult-social-care-charging-reform-further-details Updated 8 March 2022)

[5] https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/adult-social-care-charging-reform-further-details Updated 17 November 2021

Box 2: Examples of progress towards the cap [6]

a) Recipient of community care, savings below the current lower capital limit

Mr Black is assessed as eligible for a personal budget of £100 per week for community-based care. Because of his income he is assessed to meet a user charge of £40 per week. Under the Coalition Government's proposal his progress toward the lifetime cap would have been £100 per week. Under the current government's plan, his progress toward the cap will be £40 per week. This means that, under the current plan, it would take him over 40 years to reach the £86,000 cap, instead of 16.5 years under the earlier proposal. If, as is likely, his care needs rose over time, which would lead to an increased personal budget but not an increased user charge, he would reach the cap in less than 16.5 years under the earlier proposal, but it would make no difference to the time taken to reach the cap under the current plan.

b) Recipient of residential care, savings below the current lower capital limit

Mrs Green is assessed as eligible for a personal budget of £700 per week for residential care. Because of her income she is assessed to meet a user charge of £300 per week. Under the Coalition Government's proposal her progress toward the lifetime cap would have been around £500 per week, the £700 personal budget minus around £200 for daily living costs. Under the current government's plan, her progress toward the cap will be only around £100 per week (£300 minus £200 daily living costs). This means that, while it would take her around 16.5 years to reach the £86,000 cap under the current plan, it would have taken her 3.3 years under the earlier proposal. However, if Mrs Green had savings well above the planned new upper capital limit such that she was not eligible for any local authority support, she would reach the cap after 3.3 years under the current plan as well as under the earlier proposal.

[6] These vignettes assume that the lifetime cap and personal budgets rise at the same rate over time and that the daily living cost element of care home costs, that is the element that is not care costs and does not count toward the cap, is around £200 per week, although under the Coalition Government plans it would have been around £285 per week by 2023 if uprated by average earnings.

c) Recipient of residential care, savings of £125,000

Mrs Smith enters a care home providing personal care because she has a high level of care needs but does not need nursing care. She has savings of £125,000 and a weekly pension income of £250. Since her savings exceed the current upper capital limit of £23,250 and the planned new capital limit of £100,000, she needs to self-fund her care under the current system and would need to do so under the planned new system. She needs to meet the care home's fee for self-funders of £750 per week without any local authority (LA) support until her savings have fallen to the capital limit.

Under the current system Mrs Smith would pay the full care home fee for nearly 4 years before she spends down to the capital limit of £23,250 and starts to be eligible for LA support. Under the current government's plans, she would need to meet the full care home fee for only just under 1 year before she spends down to the capital limit of £100,000 and starts to be eligible for LA support. By this time she will have spent £27,500 on the care component of her fees which will count toward the new lifetime cap of £86,000 and £10,000 on daily living costs which will not count toward the cap.

Mrs Smith's remaining savings of £100,000 will be deemed to produce a notional income of £320 per week (calculated at the rate of £1 per week per £250 of savings above the new lower capital limit of £20,000) to add to her weekly pension income. She will therefore receive LA support of £180 per week and need to contribute £570 per week (£370 toward care costs and £200 toward daily living costs). As she continues to spend down her savings, at an initial rate of £320 per week (£750 fee - £180 LA support - £250 payment from pension income), her notional income will fall, her LA support will rise, and her contribution to the costs of care will fall. How quickly she reaches the cap of £86,000 depends on how frequently the LA re-assesses her notional income as her savings reduce, but it would be at least 4 years from her care home admission. After she reaches the cap, she would need to contribute only £200 per week, for the daily living costs element of the care home fee, and the LA would fund the care costs element. She would then no longer need to draw on her remaining savings, which would by then be somewhat less than £50,000.

(This vignette ignores inflation, interest on invested savings and the fact that as a self-funder her care home fee could be higher than when receiving some means-tested LA help with her fees. The analysis assumes for simplicity that the resident uses all their income toward the costs of their care, but in practice they would likely need some of their income for goods or services that are not covered by care home fees (e.g. hairdressing, gifts)).

When considering the practical implementation of a lifetime cap on care costs, two important issues arise in relation to residential care. The first is how to determine initially the care component of care home fees which will count towards the cap, once the daily living cost has been set, and how to uprate the two components for inflation thereafter. Different approaches to setting them will have different implications for how much of the care home fee remains means-tested and therefore for the cost of the reforms to the public purse and the benefits to residents. Under plans by the Coalition Government to introduce a cap on care costs, the daily living allowance would be uprated in line with average earnings from an initial amount of £12,000 per year in 2016 prices (Jarrett, 2015). It was proposed that eligible care costs counting towards the cap would be the difference between fee rates for publicly funded residents and this daily living allowance[7]. This difference could differ between those needing and not needing nursing care in addition to personal care. In our analysis we assume that this is how eligible care costs and the daily living allowance

[7] See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/400757/2903104_Care_Act_Consultation_Accessible_All.pdf p. 21

would be determined with the latter uprated each year by the growth in average earnings. Under the current Government plans, we assume that the costs that count towards the cap for care home residents would be the minimum of eligible care costs and the resident's contribution towards them. The latter would be the excess, if any, of their total contribution over the daily living costs. We contrast this, however, with a scenario in which the costs that count towards the cap are calculated in the same way as under the Coalition Government's plans.

The second issue concerns whether a care home resident who receives only the non-means-tested contribution from the state, meeting all the daily living costs themselves, would face the self-funder care home fee (as under the current system) or the lower rate applicable to residents receiving a means tested contribution from the state. Our modelling assumes that care homes receive the LA fee for all residents who receive any means-tested support from their LA. Under reforms which increase the number of such residents (e.g. by raising capital limits), care homes' incomes fall as a result. However, if care homes receive the lower publicly funded fee rate for all care home residents receiving any state help with their care including those who are eligible for some public funded only because they have reached the cap, care homes' incomes could fall quite substantially, unless fees for publicly funded residents were increased. Previous analysis of proposals for a lifetime cap, assumed that people who were initially self-funders would start and remain on the self-funder fee rate even once they reached the cap (Wittenberg et al. 2011). We follow this approach but note that the Government has indicated it plans to 'ensure that self-funders are able to ask their Local Authority to arrange their care for them so they can find better value care' (HM Government 2021, para 40, p.16). In the White Paper published by the Department of Health and Social Care (2021), the government stated that it aims to 'ensure that self-funders can access the same rates for care costs in care homes that local authorities pay' (p.21).

Details of the reforms we examine are contained in Box 3. To aid understanding of their effects we examine the lifetime cap options with and without the associated increase in capital limits but present some of the resulting extra detail only in the Appendix.

Box 3: Reform Scenarios

'Build Back Better'

1. The equivalent in 2018 prices to a lifetime cap of £86,000 and daily living costs of £10,400 a year in 2023 prices, progress towards the cap based on the minimum of eligible care costs and the user's contribution towards them.
2. As 1. combined with universal upper and lower capital limits which in 2018 prices are the equivalents of £100,000 and £20,000, in 2023 prices.

We refer to these as **Build Back Better lifetime cap** (with/without increases in capital limits)

Coalition Government

3. The equivalents in 2018 prices, of a lifetime cap of £72,000 and daily living costs in residential care of £12,000 per year in 2016 prices, progress towards cap based on eligible care costs.
4. As 3. combined with 2018 equivalents of an upper capital limit of the £100,000 for those whose housing wealth is taken into account in residential care, £27,000 for all others and a lower limit of £17,000 in 2016 prices.

We refer to these as a **Coalition Government lifetime cap** (with/without raised capital limits)

'Build Back Better' with care cost based cap

5. As 1. above but progress towards cap based on eligible care costs.
6. As 2. above but progress towards cap based on eligible care costs.

We refer to these as a **Build Back Better care cost-based** lifetime cap, (with/without raised capital limits)

For all scenarios we assume that all those newly eligible for LA funding take-up their entitlement and that as under the current system, care home residents who receive any funding from their LA towards their fees, cease to receive Attendance Allowance or Disability Living Allowance/ Personal Independence Payment after four weeks. This generates a saving in public expenditure to be offset against the cost of the extended eligibility for LA funding.

Lifetime caps and daily living costs are converted to 2018 prices (the base year for our projections) according to movements in average earnings. The higher upper and lower capital limits, expressed in 2016 or 2023 prices, are converted to 2018 prices using the GDP deflator.

The government has announced that the minimum income guarantee and personal expenses allowance within the home and residential care means tests, which have been frozen in recent years, will be unfrozen from April 2022. We therefore assume that under the pre-reform system these allowances and the capital limits are unfrozen from that date and re-linked to price inflation from that point.

Key parameter values in 2018 prices

	Build Back Better	Coalition Government
Cap on care costs	£73,260	£76,310
Daily living cost component of care home fee	£174 pw	£245 pw
Upper capital limit, care homes	£90,400	£122,530 if housing wealth is being taken into account, £28,620 otherwise
Upper capital limit, community care	£90,400	£28,620
Lower capital limit	£18,080	£17,650

The 2018 values of key parameters of the Build Back Better and Coalition Government reforms presented in Box 3 show that the former are mainly more generous than the latter. The Build Back Better lifetime cap is the lower, meaning it is the more generous since it would be reached more quickly than under the Coalition Governments plans. The daily living cost component of care home fees is also lower meaning more of the fee counts towards the cap, which is again therefore reached sooner. The lower capital limit below which all capital is ignored in the means test is higher under the Build Back Better reforms and the upper capital limit for community care is considerably higher (over £90,000 compared with around £28,000) under the Build Back Better reforms. The upper capital limit in care homes is higher under the Coalition Government's plans but only where housing wealth is being taken into account in the means test. The recent clarification that the announced £200 per week allowance for daily living costs was in 2021 rather than 2023 prices means that the gap between the Build Back better and Coalition Government values for daily living costs is smaller than we have assumed but it is still substantial[8], meaning that a greater proportion of a care home's fees will count towards the cap under the Build Back Better plans.

These comparisons are sensitive to the assumed level of earnings growth used to convert the 2023 parameters to 2018 prices. We have used the March 2020 OBR economic data and assumptions (OBR 2020a) for average earnings to deflate to 2018 prices the proposed cap of £86,000 in October 2023 and to inflate to 2018 prices the Coalition Government's proposed cap of £72,000 in April 2016. The cap of £86,000 in 2023 was first announced in September 2021 when the most recent medium term OBR forecasts were those published in March 2021 (OBR 2021). Using those forecasts, £72,000 in March 2016 inflates to almost £86,000 in October 2023. This is consistent with the Impact Assessment statement that *"The government's proposal includes a cap of £86,000 …….. . This is in line with the cap of £72,000, which was the basis for the 2015 IA[1], when uprated with average earnings."* (Department of Health and Social Care, 2022, para 32). Using the March 2022 OBR assumptions (OBR, 2022), £72,000 in 2016 would be equivalent to a cap in excess of £90,000 in October 2023. The relative generosity of the two cap levels will thus remain uncertain until earnings growth over the relevant period is confirmed.

Methods

We use two simulation models (see for example, Adams et al. 2016). The first is the CPEC cell-based (macrosimulation) model[9]. This model makes projections of the future numbers of older disabled people, the associated likely level of demand for long-term care services and disability benefits, and the private and public costs of meeting this demand. The projections are made for population sub groups (cells) defined by personal characteristics such as age, gender, marital status, housing tenure, educational level and limitations in activities of daily living. The CPEC model draws on a range of data to establish the number of people in each cell and to estimate relationships between, for example, the demand for care services and these personal characteristics. Residents of residential and nursing homes and users of community services are divided between privately and publicly funded users based on administrative and survey data. For future years, we apply to the 2018 data the projected split between LA funded and privately funded service users from the CARESIM modelling described below, and we assume that the proportion of nursing home residents who are NHS fully funded remains constant.

The model consists of five main parts. The first part estimates the numbers of older people with different levels of disability by age group, gender, household composition, education and housing tenure. The second part estimates the levels of long-term care services required, by attaching a probability of receiving

[8] Using March 2020 OBR forecasts for earnings growth, £200 per week in 2021/22 corresponds to around £182 in 2018 prices, compared with the figure of £174 that we have used i.e. about 74% of the corresponding Coalition Government figure, rather than 71%.

[9] In addition to projections for older people (used here), CPEC models also make projections for younger adults and the social care workforce needed to meet projected demand.

health and social care services to each subgroup (cell), defined by these characteristics. It divides the older population between people receiving no care, unpaid care, formal community-based care, unpaid and formal community-based care, and residential care. The third part of the model estimates total health and social care expenditure, applying unit costs of formal care to the volume of services projected in the second part of the model. The unit costs are derived from local authority data. In the fourth part, total expenditure is allocated to the various sources of funding: NHS, social services and service users. A fifth part of the model relates to the social care workforce required to provide the projected volume of social services.

The CPEC model draws on a range of data to establish the number of people in each cell and to estimate relationships between, for example, the demand for care services and these personal characteristics. The version of the CPEC model used to make the projections in this paper utilises official 2018-based population (Office for National Statistics (ONS), 2019) and indicative 2011-based marital status and living arrangements projections (ONS, 2018), data from the Health Survey for England for 2011 to 2017, the 2005 PSSRU survey of older care home admissions (Darton et al., 2006), the Laing & Buisson survey of care home market (Laing, 2018), March 2019 data on residential care and home-based care, expenditure data for 2018/19 and unit costs adjusted to 2018/19 prices (NHS Digital, 2019). To apportion care 2018 home residents between publicly and privately funded we use data from NHS Digital Short and Long-term Support (SALT) statistics for local authority funded residents[10] and from an industry survey (Laing, 2018) for NHS fully funded and privately funded residents. For the corresponding apportionment of 2018 community service users, we use data from the Health Survey for England.

The second model, CARESIM, is a microsimulation model used to assess the distributional effects of reforms to the social care means tests and how such reforms are likely to affect the private-public split of care costs. CARESIM's projections of the latter by population sub-group are used in the CPEC model to derive the division of care costs between services users and the public purse. CARESIM is based on a representative sample of the older population (aged 65+ in the base year) drawn from the Family Resources Survey (FRS) (see for example, Department for Work and Pensions, 2021). Using information on the income, wealth and other relevant characteristics of sample members, CARESIM calculates what each sample member would be required to pay towards the cost of a range of types of care services, should they need such care. Liability to contribute to care home fees is calculated allowing for asset depletion to have taken place during an assigned time in a care home. In effect for each projection year, this mimics the observation of a cross-section of care home residents, producing results which can be used with the CPEC model. A similar approach is used for home care. CARESIM does not predict which sample members will need care. Instead, it applies weights or grossing-up factors from the CPEC model such that the sample is made representative in terms of age, gender, housing tenure, marital status and for community care, educational level. of the population projected by the CPEC model to be receiving different types of care, in a base year and in future years.

For future years, CARESIM 'ages' the sample simulating death, widowhood and the evolution of income and wealth of sample members. The CARESIM sample is refreshed with individuals from the FRS who are below the age of 65 in the base year. The future pension incomes of such individuals below the age of 65 in the base year are derived from the Pension Policy Institute's dynamic microsimulation model. That model projects the future pension incomes of a sample of individuals taken from the English Longitudinal Study of Ageing[11] . The resulting projections of different types of future pension income are statistically matched to FRS sample members who are aged 50-64 in the base year (see Adams et al. 2016 for details).

The models do not make forecasts about the future. They make projections on the basis of specific assumptions about trends in such variables as future mortality rates, disability rates and unit costs of care,

[10] https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19

[11] http://www.elsa-project.ac.uk/

as well as legislation and recent policy and practice on how key monetary parameters within the long term care and pension system are adjusted for inflation over time. Details of such assumptions used in this paper are contained in Box 4. The base year for our projections is 2018. Thus the numbers of service users and social care unit costs pre-date the covid-19 pandemic as do the Office for Budget Responsibility's economic medium and long-term forecasts that we use (OBR, 2020a, 2020b). This avoids the short-term transient effects of covid-19 such as sharp movements in measured earnings growth and productivity but does not take account of the potentially important, but as yet uncertain, longer-term impacts of the pandemic. OBR have yet to produce post-pandemic long-term (beyond 2027) economic forecasts compatible with their post-pandemic medium-term forecasts.

Box 4: Economic, demographic and uprating assumptions

- The number of people by age and gender changes in line with the Office for National Statistics (ONS) 2018-based principal population projections.
- Marital status rates change in line with the indicative 2011-based living arrangements projections for those aged 65 and over in England (ONS, 2018).
- There is a constant ratio of single people living alone to single people living with their children or with others and of married people living with their partner only to married people living with their partner and others.
- Prevalence rates of disability in old age by age group (65-69, 70-74, 75-79, 80-84, 85+) and gender remain unchanged, as reported in the Health Survey for England 2011 to 2014.
- The proportions of people receiving unpaid care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, disability and other needs-related characteristics.
- The new State Pension for those reaching state pension age from April 2016 and basic State Pension for those who reached state pension age before that are uprated by the 'triple lock' (the highest of price inflation, average earnings growth or 2.5%) indefinitely.
- State Second Pension/State Earnings Related Pension for those who reached State Pension age before April 2016 is uprated by prices.
- Under the current long-term care system most monetary parameters within the long-term care system are uprated by prices. Exceptions are: the NHS contribution to nursing care in nursing homes is linked to earnings; parameters that have not been changed since 2015 which are assumed to be held constant in nominal term until 2022 (e.g. capital thresholds, the personal expenses allowance in residential care, the income threshold in the home care means test). The income threshold in the home care means test is linked to earnings from 2022.
- Under long-term care reform scenarios, lifetime caps and daily living costs are uprated each year in line with average earnings as had been indicated would happen under the previously planned reforms. The enhanced upper capital/single capital limit is uprated by prices.
- Health and social care unit costs rise in real terms in line with the March (short-term) and July (long-term) 2020 Office for Budget Responsibility assumptions for future trends in productivity (OBR, 2020a, 2020b), with an uplift for the years to 2020 to take account of the planned rises in the national living wage (except that non-labour non-capital costs remain constant in real terms).
- Real Gross Domestic Product rises in line with 2020 OBR projections (OBR 2020a, 2020b)
- The supply of formal care will adjust to match demand and demand will be no more constrained by supply in the future than in the base year.
- The Guarantee Credit within Pension Credit and associated thresholds for means-tested help with rent and council tax are uprated by rises in average earnings. Capital thresholds in means-tested benefits are held constant in nominal terms until 2022 and then price linked.
- Disability benefits for older people are uprated by prices.

While the focus of the models is on making projections for the future and examining potential reforms to the long-term care funding system, they also provide useful estimates, mostly not available elsewhere, of the base year composition of older recipients of long-term care and the associated public and private expenditure. In the next section we provide such estimates, examining the composition in 2018 of older people resident in care homes or receiving care in their own homes, in terms of whether they were funding themselves or had funding from a Local Authority, whether they own(ed) their homes and were single or partnered. Also shown is private and public expenditure on long-term care in the base year. For the former we distinguish expenditure by self-funders and user contributions from LA-funded older people. Public expenditure is divided into LA spending (net of user charges), NHS expenditure and social security expenditure on disability benefits paid to self-funding care home residents. We also present the base year distribution of LA net public expenditure on long-term care according to the recipient's partnership and home-ownership status and position in the distribution of income for people aged 65+. For this purpose, income is measured without deducting housing cost but excludes disability benefits, following previous practice when considering the targeting of public support for people with disabilities (Hancock et al. 2019). Also presented are projections to 2038 of the numbers of older people receiving care, by funding status and the associated costs, assuming that the current funding system remains in place.

To aid understanding of the impact of the reform scenarios, supplementary analysis in the Appendix examines, for the base year, the association between income, housing and other wealth, the extent to which LA-funded care home residents' contributions to the care home fee exceeds a daily living component of £174 per week in 2018 prices, and also how far care home residents draw on their income, housing and other wealth to fund the daily living and care components of the care home fee. For this purpose, we assume that care home residents first use their income, apart from the weekly personal expenses allowance, towards their contribution to the care home fees, followed by their non-housing wealth and subsequently any housing wealth that is being taken into account in the means test.

The subsequent section of the paper presents our estimates of the effects of the reform scenarios. We begin with projections of the net effect on public expenditure and then present average gains to individuals according to type of care received (residential or home care), home-ownership and position in the income distribution. In the main text these estimates are presented as charts showing average weekly amounts. The Appendix contains some corresponding charts where weekly amounts have been expressed as a proportion of each person's net income and then averaged.

We assume that expenditure by social care users incurred before the currently planned reforms are implemented will not count as progress toward the cap. Since these reforms are due to be introduced in October 2023 and the effects of the cap will not be felt immediately, we start our projections of the effects of the reforms in 2028, by when the system will be largely mature.

Results: current policy

Base year (2018)

Table 1 presents our estimates of the number and funding source of older recipients of care for our base year, 2018. We estimate that nearly 700,000 older people were receiving care on any given day in 2018, split roughly equally between those receiving care in a care home and those remaining in their own homes (community care users). Overall, we estimate that 55% receive some financial support from a Local Authority and 4% are fully funded by the NHS in a care home, leaving 41% funding themselves in full. Two-thirds of community care recipients receive some financial support from their LA compared with 43% for care home residents. This difference in part reflects the inclusion of the value of the home in the means test for residential care but not for community care. A higher proportion (52%) of care home residents receiving nursing care are self-funders than is the case for residents not receiving nursing care (46%).

Table 1: Estimated numbers of older (65+) long-term care recipients by funding source, England 2018

	Care home residents – not nursing care	Care home residents – nursing care	All care home residents	Care home residents excluding fully NHS funded	Community care users	All long-term care recipients
LA supported	54%	30%	43%	47%	67%	55%
Self-funded	46%	52%	49%	53%	33%	41%
NHS funded (Continuing Health Care)	-	18%	8%	-	-	4%
Total	188,100 (100%)	158,500 (100%)	346,600 (100%)	317,700 (100%)	346,200 (100%)	692,700 (100%)

Source: CPEC and CARESIM models

Note: Numbers of care home residents rounded to nearest 100.

Our estimates of expenditure on long-term care for older people in England in 2018 are presented in Table 2. The combined total of private, Local Authority, NHS expenditure and disability benefits paid to self-funding care home residents amounts to just under £20 billion, of which around 36% is paid by people who receive no LA or NHS funding, 12% comes from charges paid by LA-funded users, 12% is funded through the NHS (CHC and FNC in care homes), 4% from disability benefits paid to self-funding care home residents and the remainder, 37%, is funded from LA budgets. Private expenditure including user charges represents a higher proportion of residential than community care spending (51% compared with 33%).

Table 2: Estimated private and public expenditure on long-term care for older (65+) people, England 2018 (£s million 2018 prices)

	Residential care		Community Care		Total	
Private expenditure:	(£m, 2018 prices)	% of total	(£m, 2018 prices)	% of total	(£m, 2018 prices)	% of total
Self-funder expenditure, less disability benefits paid to self-funding care home residents	6,200	40%	850	19%	7,100	36%
Charges paid by LA-funded users	1,700	11%	630	14%	2,300	12%
Total private expenditure	7,900	51%	1,500	33%	9,400	47%
Public expenditure						
LA expenditure net of user charges	4,400	29%	3,000	66%	7,400	37%
NHS expenditure (FNC and CHC in care homes)	2,400	16%			2,400	12%
Disability benefits paid to self-funding care home residents	750	5%			750	4%
Total public expenditure	7,600	49%	3,000	66%	10,500	53%
Private plus public expenditure	15,500	100%	4,400	100%	19,900	100%

Source: CPEC and CARESIM models

Note: Figures exclude short-term support and the small amount of supported accommodation funded by LAs[12]. Percentages may not sum to 100 due to rounding.

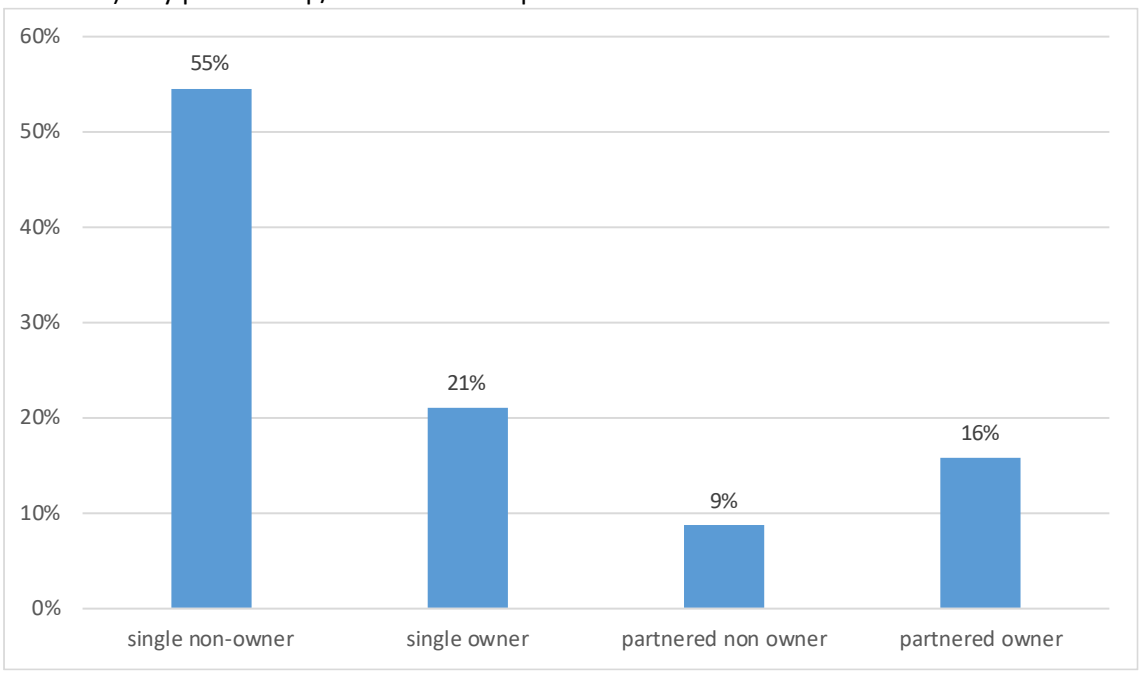
As Table 2 shows, the majority of public expenditure on long-term care for older people is channelled through LAs. Figure 1 shows how LA spending, net of user charges, is currently distributed by tenure/partnership (panel a) and income quintile (panel b) of care recipients. LA net expenditure is highly concentrated on single non homeowners who we estimate receive 56% of net expenditure (Figure 1, panel

[12] Adding expenditure on these would bring the total LA expenditure to that reported in the Adult Social Care Finance Return for 2018-19. (https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19)

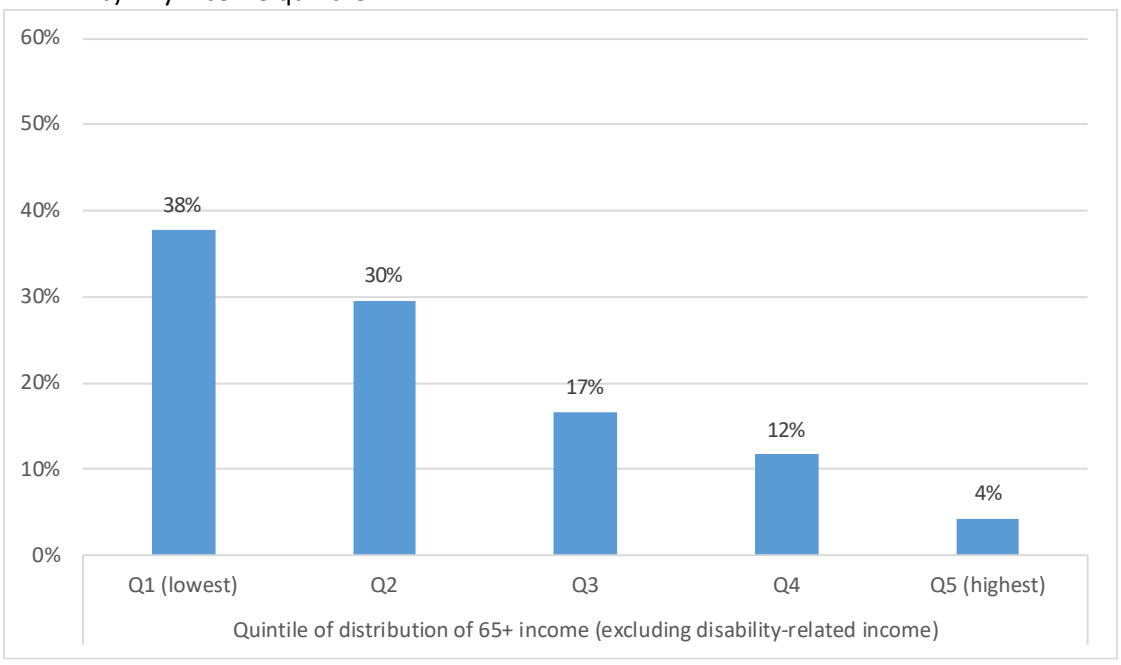
a). Spending is also highly targeted on those with lower incomes with 38% of net spending going to the lowest income quintile compared with just 4% received by the highest income quintile (panel b). The very strong income gradient may seem surprising given that the means test involves capital as well as income. However, as the analysis provided in Appendix 2 shows, there is a very strong correlation between income, home-ownership and whether savings are in excess of the (current) upper capital threshold. For example, we estimate that among care home residents (excluding those fully funded by the NHS) the proportion who owned their homes prior to care home entry rises from 40% in the lowest income quintile to 81% in the highest (Table A2). In the population aged 65+ as a whole we estimate that the proportion who have savings (excluding the value of their homes) in excess of the upper capital threshold is much higher amongst home-owners than those who do not own their homes and for home-owners rises strongly with income level (Table A4).

Figure 1: Distribution of net Local Authority expenditure on long-term care for people aged 65+ by income level and partnership/home-ownership status

a) By partnership/home-ownership



b) By income quintile



Source: CPEC and CARESIM models

Further supplementary analysis in Appendix, presents our model estimates under the current funding system, of the characteristics of older LA and self-funded care recipients in terms of home-ownership, income and whether they have a partner, compared with the general population of older people. Also provided are our estimates of the proportion of LA-funded care home residents who contribute towards the care component as well as the daily living cost component of their fees (Figure A1) and so under a system with a lifetime cap, would be affected by whether progress towards the cap is based on the total cost of care or on the user contribution to it. Also shown are the average contribution of each of income, housing wealth and other wealth to the daily living cost and care component of the fee (Figure A2). This

background information aids our understanding of the effects of the reforms. The key points that emerge from the supplementary analysis are:

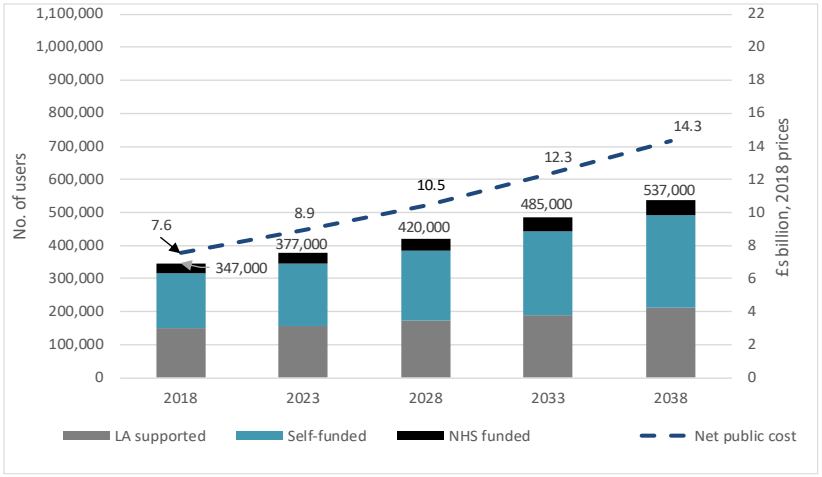
- The majority (66%) of LA-funded care home residents are unpartnered and were not home-owners before care home entry, 20% have a partner, split equally between home-owners and non home-owners and the rest are single home-owners who have depleted their capital and have become eligible for LA funding. In contrast, 88% of self-funding care home residents are unpartnered and were home-owners prior to care home entry.
- Even though housing wealth is not taken into account in the means test for community care, at 57%, the proportion of LA-funded community care users who are homeowners is considerably less than for self-funded community care users of whom 80% are home-owners. This is consistent with the strong positive association amongst home-ownership, income and non housing wealth. Home-owners who need social care are more likely than those who are not home-owners to have income and/or non financial wealth that disqualifies them from publicly funded social care.
- Assuming daily living costs of £200 per week, 65% of LA-funded care home residents currently contribute nothing towards the care component of their fees. so cannot benefit from a cap on care costs. For the remaining 35%, the method of measuring progress towards the cap will affect how much they benefit from a cap.
- On average, self-funding unpartnered care home residents pay around £795 a week (2018 prices) in care home fees and meet about 40% of the fee from their housing wealth.
- LA supported residents make an average weekly contribution of £166 to £195 to their care home fee, depending on whether they are single or partnered, home-owners or not. The average contribution is larger (£230 to £270 per week) where LA-funded residents are making a contribution towards the care as well as the daily living costs component of the fee but still less than half the cost met by self-funders.
- Single non-owners and partnered individuals who self-fund, make substantial contributions from their savings, but also make larger contributions from their income than LA-supported residents as a whole, confirming that income as well as wealth is associated with whether a care home resident is a self-funder.
- Where a LA-supported resident contributes to their care as well as daily living costs, the majority of that contribution comes from income.

Projections

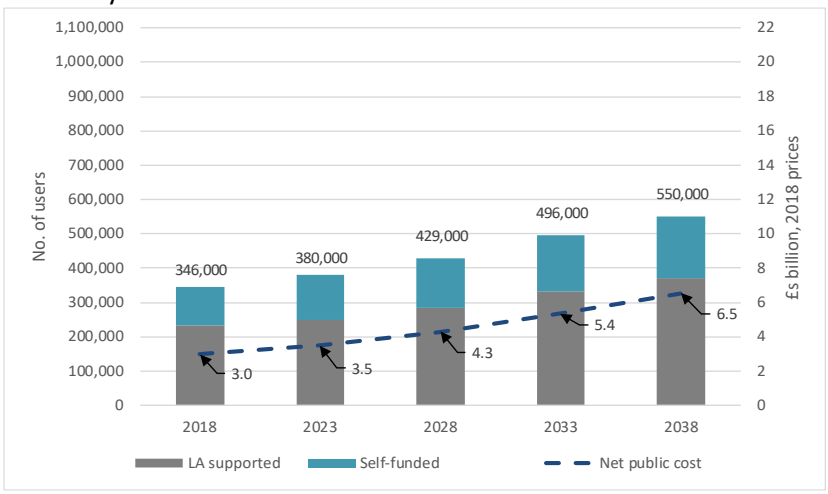
The projected number of older people receiving long-term care and projected expenditure according to care settings under the current funding system are shown in Figure 2. We project that the total number of care home residents will increase by 55%, from 347,000 in 2018 to 537,000 in 2038. Meanwhile, the associated net public expenditure is projected to rise from £7.6 billion in 2018 to £14.3 billion in 2038 (Figure 2a). We project that the total number of community care users will increase by 59%, from 346,000 in 2018 to 550,000 in 2038. The associated net public expenditure is projected to rise from £3.0 billion in 2018 to 6.5 billion in 2038 (Figure 2b). A total of 1.1 million older people is projected to receive long-term care in 2038, an increase of 57% in comparison to the number of care recipients (693,000 people) in 2018. The net public expenditure is projected to rise to £20.8 billion in 2038 (Figure 2c).

Figure 2: Projected number of older long-term care users, by funding source and associated net public expenditure, England, 2018-2038

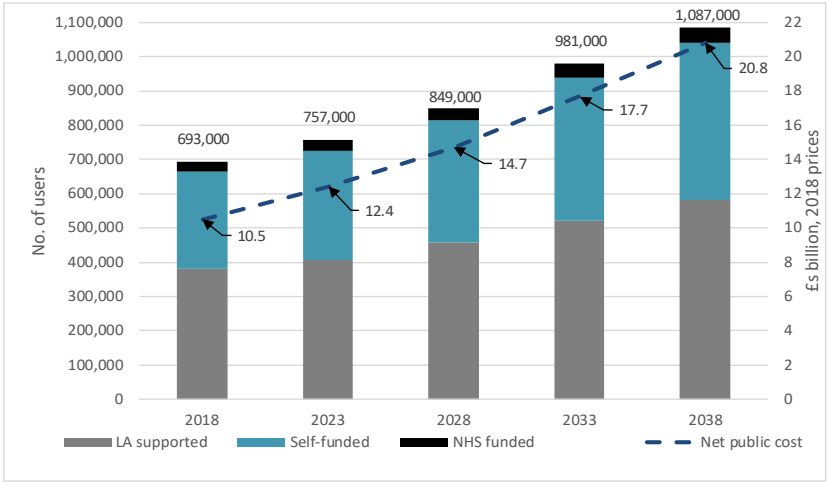
a) Residential



b) Community



c) Residential and community



Source: CPEC and CARESIM models

Note: Net public expenditure comprises LA expenditure on long-term care for older people net of user charges, NHS expenditure on CHC and FNC in care homes and disability benefits paid to self-funding care home residents.

Results: reform scenarios

Public expenditure effects

Figure 3 shows the effects of reforms on net public expenditure on long-term care (in 2018 prices). Figure 3a shows the effects of the current government's planned lifetime cap on care costs, with and without the planned increases in the means test capital limits. Including these increases in capital limits, public expenditure is projected to be £2.3 billion and £3.2 billion higher in 2028 and 2038, respectively, than under the current funding system. The extra spending amounts to about 18% of what is projected under the current system. Without raised capital limits, public expenditure is projected to be £2.0 billion and £2.9 billion higher in 2028 and 2038, respectively, than under the base case assumptions. Put differently, the net effect of the planned increase in capital limits is around £0.3 billion[13].

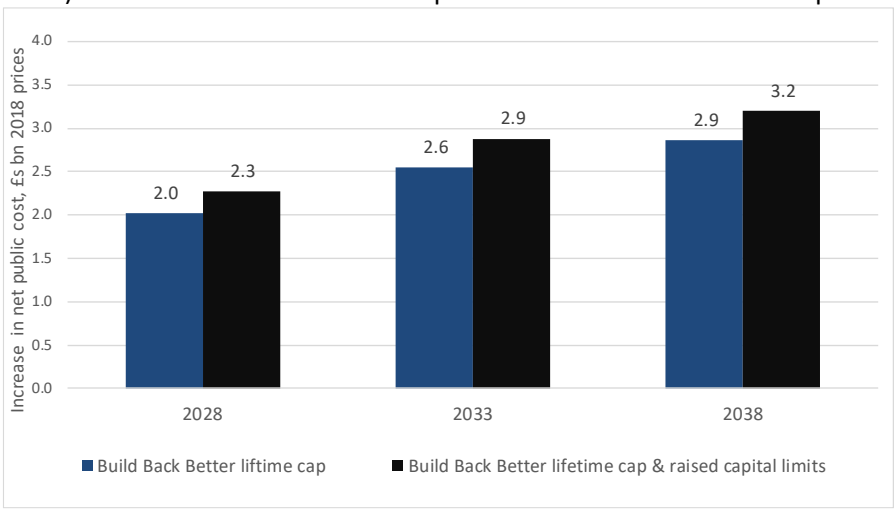
The latest government plans are more generous than the scenarios based on the lifetime cap proposed by the Coalition Government (Figure 3b). We project that public expenditure in 2038 would be £2.6 billion higher under the Coalition Government cap scenario, as opposed to £3.2 billion higher under the latest government plans.

The latest government plans are less generous than the equivalent scenarios where progress towards the cap is based on eligible care costs (Figure 3c.). Including the increases in capital limits, we project that the public expenditure in 2038 would be £3.7 billion higher in the eligible care cost-based cap scenario, compared with £3.2 billion when progress towards the cap is based on user contributions.

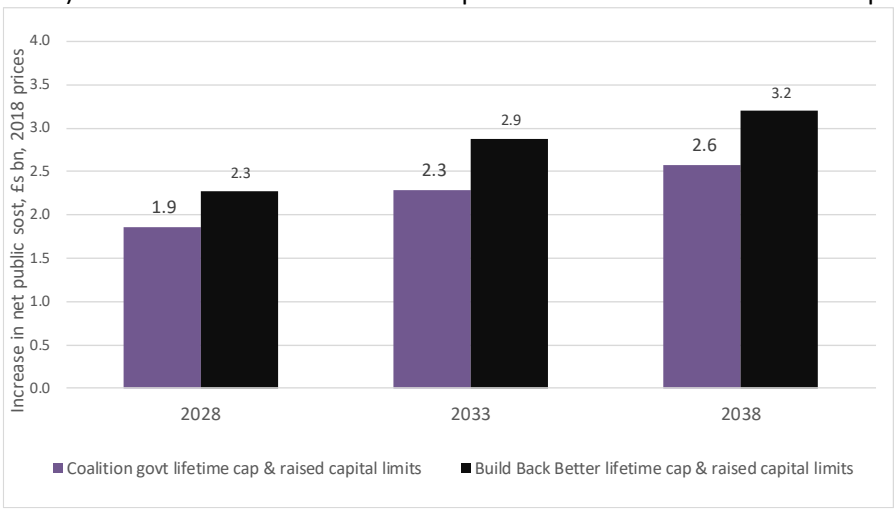
[13] Note that this is not the cost of the increased capital limits on their own because there are interactions between the cap and the increase in capital limits

Figure 3: Projected increases from reforms in net public cost of long-term care for older people, 2028-2038, England

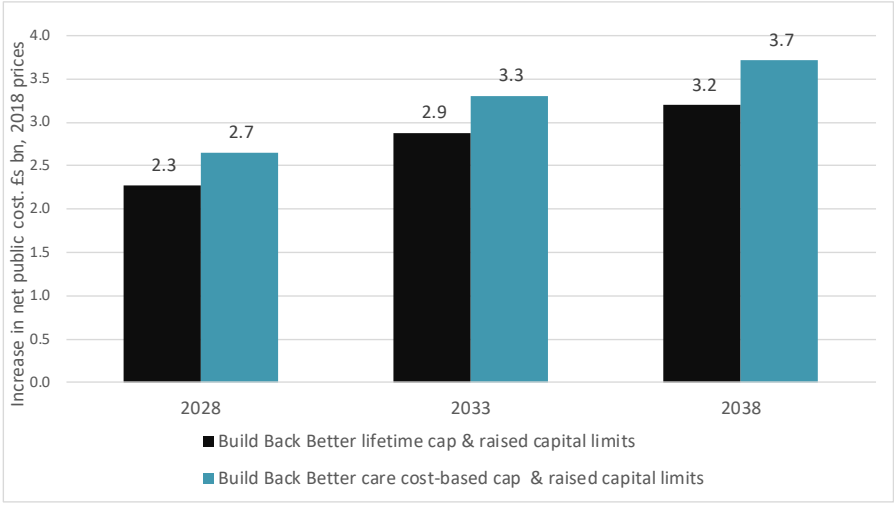
a) Build Back Better lifetime cap with and without increased capital limits



b) Build Back Better reforms compared with Coalition Government plans



c) Build Back Better reforms compared with cost-based progress towards cap



Source: CPEC and CARESIM models

Note: Net public expenditure comprises LA expenditure on long-term care for older people (less user charges), NHS expenditure on CHC and FNC in care homes and disability benefits used to fund residential care.

Distributional effects of reform scenarios

In this section we consider how the benefits of the funding reforms would vary across individuals receiving care according to whether those individuals are care home residents or receiving care in their own homes, whether they are (or were before care home entry) home-owners, and their position in the income distribution. Figure 4 shows our model estimates of the average weekly gains in 2028 that would result from each of the reform scenarios for care home residents and home care users. Corresponding results for care recipients who own(ed) their homes are contrasted with their non home-owning counterparts in Figure 5. As we have already noted there is a strong correlation between home-ownership, income and non-housing wealth and this correlation underlies some of the distributional impacts of the reforms.

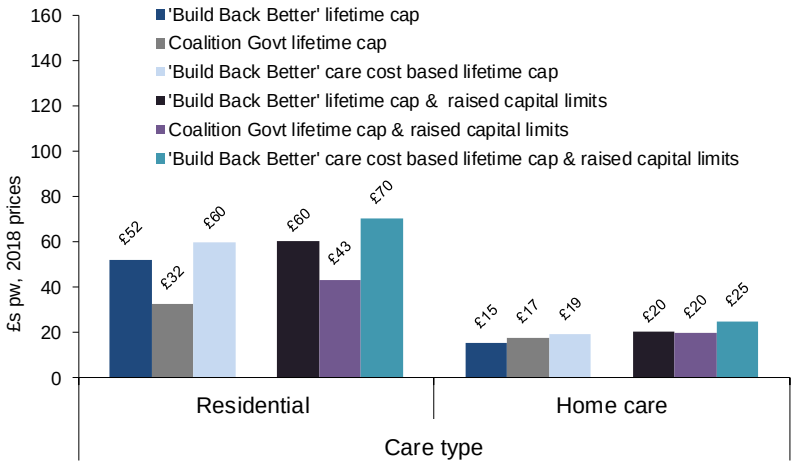
We estimate that in 2028, care home residents will be £60 a week (2018 prices) better off on average as a result of the current plans, including the raised capital limits. Gains for home care users are lower (although some will go on to become care home residents) at around £20 a week under the current plans. Home-owners stand to gain very much more than non home-owners – an average of £64 per week under the government's current plans compared with just £5 for non owners. This is unsurprising given that much of the rationale for a lifetime cap on care homes has been to avoid home-owners having to use all their housing wealth to pay for their care.

The average gain of £60 a week for care home residents under the current government plans compares with £43 a week under the Coalition Government plans. The equivalent comparison for home-owners is £64 per week from the current government plans compared with £48 a week from the Coalition Government's plans. For non home-owners and home care users average gains are very similar under the two sets of reforms.

The raised capital limits are important under all scenarios, as can be seen by comparing the effects of the caps on their own with the total reform packages. The raised capital limits benefit non home-owners least in absolute terms. We estimate that the average gain to non home-owners of the cap under current plans is just £3 per week, rising by £2 once the increases in capital limits are taken into account. The corresponding comparison for home-owners is £54 rising to £64. The implication is that the existing capital limits affect non-owners rather less than owners, because the former have relatively low levels of non housing wealth. For home care users, the more generous increase in capital limits under current plans compared with those of the Coalition Government, compensates for the less generous method of measuring progress towards the cap.

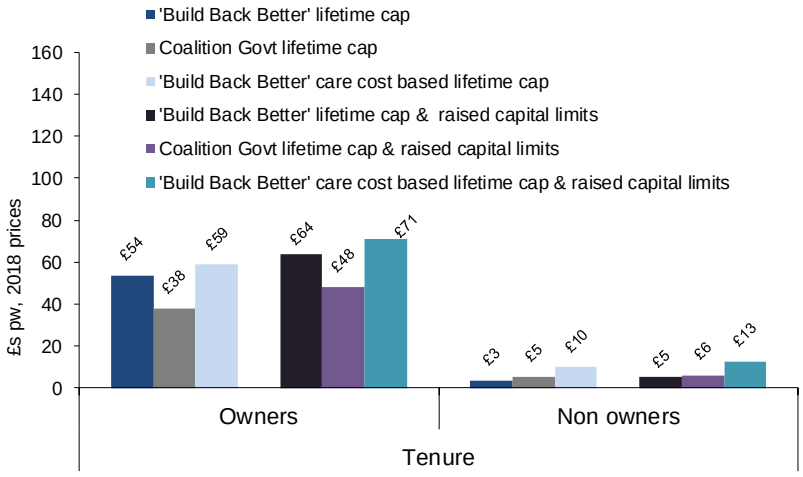
If progress towards the cap were to be based on care costs rather than user contributions and combined with the current plans for a lifetime cap and raised capital limits, the impact would be proportionately greater for home care users than for care home residents. The average gain would be £25 per week rather than £20. For residential care users the effect of progress towards the cap being based on total care costs would be to increase average gains from £60 to £70 per week. Although non-owners stand to gain much less than home-owners from both the current plans and those of the Coalition Government, the proportionate effect on their average gains from basing progress towards the cap on total care costs would be large, increasing the average weekly gain from £5 to £13 per week. The corresponding figures for home-owners are £64 and £71.

Figure 4: Average gains in 2028 from reform scenarios amongst care users aged 65+ by type of care, £s pw, 2018 prices



Source: CPEC and Caresim models

Figure 5: Average gains in 2028 from reform scenarios amongst care users aged 65+ by housing tenure, £s pw, 2018 prices



Source: CPEC and Caresim models

Figure 6 shows average weekly gains amongst care home residents and home care users according to their position in the income distribution for all older (65+) people. For simplicity we show only the combined effects of lifetime caps and raised capital limits. Equivalent charts showing separating the effects of the caps from the raised capital limits are given in Figure A3 in the Appendix. Panel a) of Figure 6 shows average gains across both care home residents and home care users. Panels b) and c) show gains separately for care home residents and home care users respectively. As has previously been shown (Adams et al., 2018), lifetime caps tend to benefit those on relatively high incomes. Taking all care recipients together (panel a), those in the highest quintile of the income distribution will, on our estimates, be £72 per week (in 2018 prices) better off in 2028 under the reforms planned for implementation in 2023, than they would be if the current system continued, compared with £21 a week for those in the lowest income quintile. The absolute and proportionate difference between the gains for the highest income group and lowest income

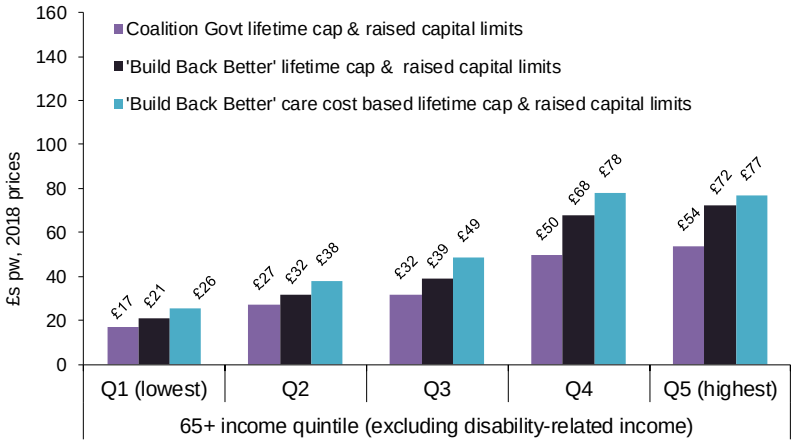
groups would be somewhat larger without the increased capital limits at £69 compared with £15 (Figure A3). The gradient across the income distribution is steeper for care home residents than for home care users. Again this is not surprising given the focus of the reforms on providing more help to people currently required to use their housing wealth towards their care.

If weekly gains from the scenarios are expressed as percentages of the user's income (Figure A4), the pattern across income groups is a little different. In general it is flatter, with average gains representing lower percentages of the income of higher income care users and higher percentages of the incomes of lower income users.

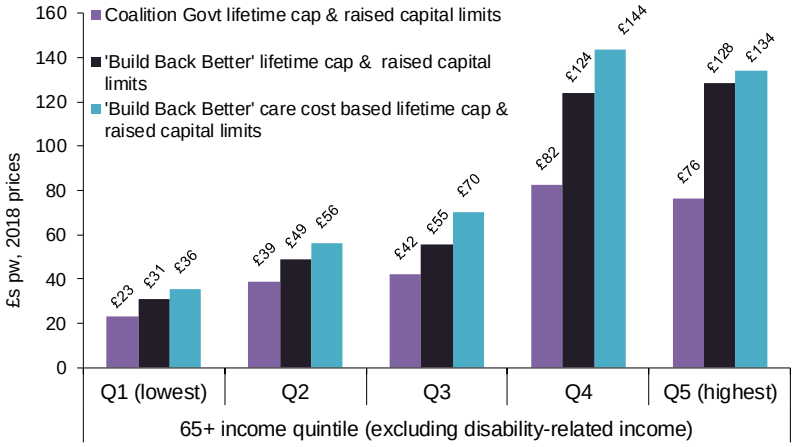
That absolute gains tend to be larger at higher income levels means that the reforms alter slightly the distribution by income level of net LA expenditure on long-term care for older people, with reduced shares being received by the lowest three incomes quintile and higher shares being received by the highest two quintiles under each reform scenario (Figure 7). However, LA expenditure remains highly concentrated on the lowest income groups under each reform scenarios.

Figure 6 : Average gains in 2028 from reform scenarios amongst care users aged 65+ by income, £s pw, 2018 prices

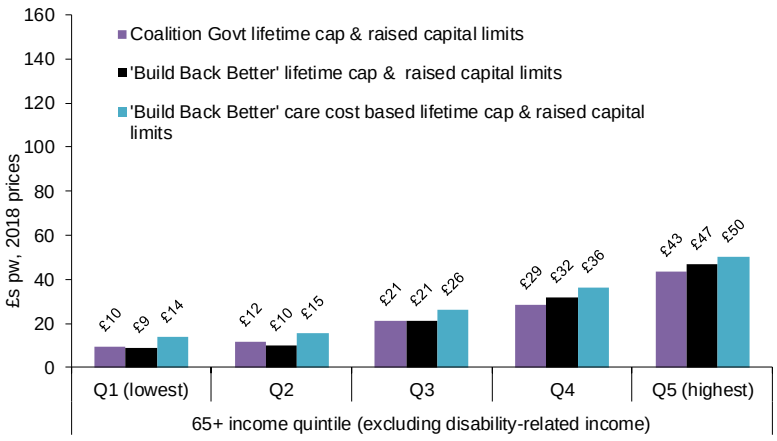
a) Care home residents and home care users combined



b) Care home residents

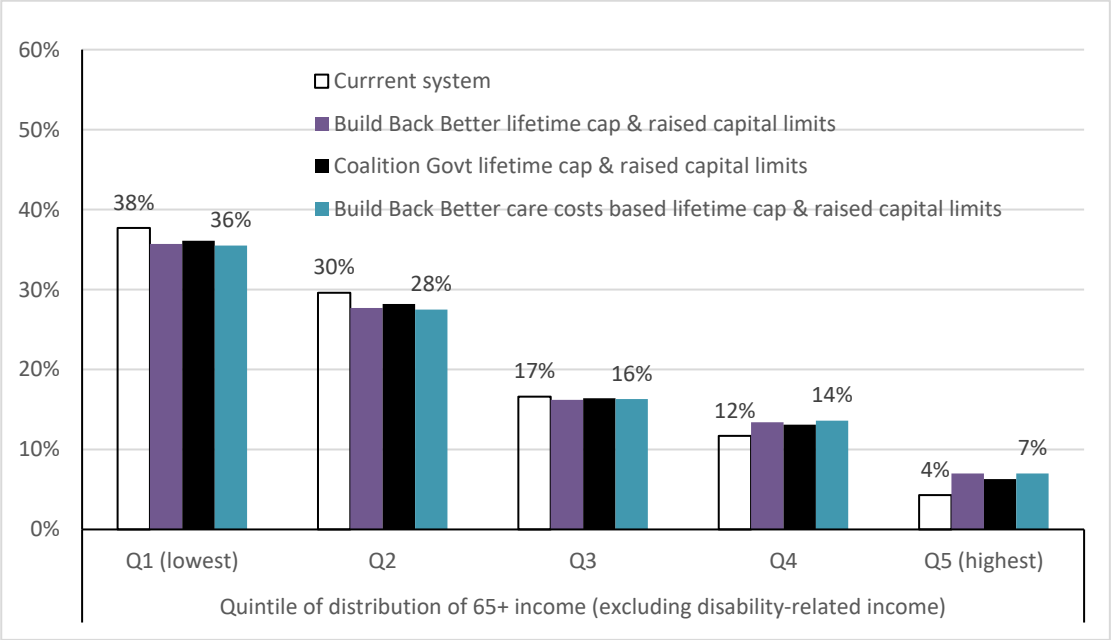


c) Home care users



Source: CPEC and Caresim models

Figure 7: Distribution of net Local Authority expenditure on long-term care for people aged 65+ by income level, current system and reform scenarios



Conclusion and discussion

This paper has presented projections of the public costs and the distributional effects of the latest plans set out by the government to reform the funding of long-term care in England. We estimate that around 700,000 older people aged 65 and over in England were receiving long-term care in 2018, of whom about half were living in care homes. At around 350,000 our estimate of the number of older people living in care homes in 2018 is similar to, if a little higher than, the recent ONS figure for 2019-20 of some 330,000 residents in care homes for older people or people with dementia[14] (ONS, 2021, Table 7). We estimate that 55% of the total of 700,000 older long-term care users in 2018, received financial support from local authorities. We know of no external estimate with which to compare this figure. Drawing on data reported by Laing (2018), we estimate that 49% of care home residents aged 65+ were self-funding residents in 2018. This compares with the somewhat lower recently published ONS (2021) figure of 41% for residents in care homes for older people or people with dementia in 2019-20.

Our analysis suggests that public spending on long-term care would increase from £10.5 billion in 2018 to £20.8 billion in 2038 at 2018 prices under the current funding system but the planned reforms will generate a further £2.3 billion of public expenditure in 2028 and £3.2 billion in 2038 (at 2018 prices), respectively. Official estimates put the net present value of the cost for older adults of the charging reforms in 2028 (discounted to 2020 and expressed in 2021 prices) at £2.42 billion with a savings on disability benefits of £0.24 billion (DHSC, 2022, Table 1). This produces a net cost which is close to our estimate, albeit that ours is not converted to a present value basis and is in 2018 prices.

We found that the government's latest Build Back Better plans are more generous than the previous plans proposed by the Coalition Government. This is despite the fact that the method of measuring progress towards the cap (based on user contributions) is less generous than if it is measured by eligible care costs. It is important to recognise that care recipients benefit from the 'whole package' of the proposed reforms, including the increases in capital limits. In practice, the relative generosity of the Build Back Better and Coalition Government plans will depend on movements in prices and earnings between now and October

[14] Recent estimates put the proportion of people with dementia in England who are aged 65+ at 96% (Wittenberg et al., 2019) meaning that residents in care homes for people with dementia are predominantly aged 65+.

2023 when the Build Back Better reforms are due to be implemented. Differences between sets of OBR forecasts produced over the last two years highlight the considerable uncertainty involved.

If progress towards the cap were to be based on care costs rather than user contributions, the impact would be proportionately greater for home care users than for care home residents. Many publicly funded care home residents are already paying nothing towards their care, contributing only to daily living costs, so do not benefit from a cap however progress towards it is measured. In contrast, all publicly funded home care users who contribute something towards the costs of their home care under the current system, stand to benefit from a cap. However, for them the method of measuring progress towards it can make a substantial difference, particularly where their own contribution is a small fraction of the cost of their care. Put another way, the choice of method of measuring progress towards the cap does not affect people who are not paying anything towards their care costs – including the majority of LA-funded care home residents who pay only towards daily living costs – or people who are paying the full cost of their care. It affects those paying a proportion of their care costs.

A strong correlation between income, wealth and home-ownership of older people underlies our results on the costs and distributional effects of the reform packages that we have analysed. Our finding that older recipients of social care tend to have lower income and wealth than older people in general, is consistent with the picture that emerges from DHSC's impact assessment of the reforms (DHSC, 2022). Our distributional analyses indicate that the average gains for care recipients vary according to the care settings, home ownership, and levels of (pre disability-related) income. We project that care home residents in 2028 will be £60 a week better off and home care users will be £20 a week better off under the government's latest plans than under the current system. Average gains for homeowners are projected to be £64 per week in 2028, in contrast to average gains of £5 per week for non-homeowners. Average gains for people in the highest income quintile are projected to be £72 per week in 2028, whereas average gains for people in the lowest income quintile are projected to be £21 per week. This is consistent with the official analysis which demonstrates that although state spending on social care for older people will remain concentrated on lower income groups, it will rise most amongst higher income groups (DHSC, 2022, Figures 19 and 20).

While the correlation between income, home-ownership and non-housing wealth is a driver for these findings, we did find that, among people in the lowest income quintile, as many as 40% were homeowners. Under the current system low income care home residents who own their homes are likely to deplete their capital comparatively quickly because they have relatively little income to put towards care home fees, while being excluded from any LA funding. Both the cap and the increases in capital limits will be of benefit to them. However, the fact that progress towards the cap is to be measured on the basis of user contributions rather than total care costs means that, once users have depleted their capital to the new higher upper capital limit, their progress towards the cap will become slower as their contribution becomes smaller. This is an example of a more general issue of interactions between the two components of the package which is likely to particularly affect users whose care needs and eligible care costs are constant for a sustained period of time.

The plan to measure progress towards the cap on the basis of user contributions has been criticised because it reduces the benefits of a cap most for people with modest amounts of wealth (see for example, Tallack and Sturrock, 2022). Our analysis suggests that the additional cost of adopting the Coalition Government's method of measuring progress towards the cap on top of the current Build Back Better plans is likely to be around £0.4 billion in 2028 rising to £0.5 billion in 2038. These costs are similar to the additional expenditure required to implement the Build Back Better plans compared with the Coalition Government's plans. There is clearly therefore a balance to be struck between the more generous method of measuring progress towards the cap and other aspects of the current plans which are more generous than the Coalition Government's plans. These includes the lower level of daily living costs component of care home fees which is itself a key determinant of the speed of progress towards the cap.

The strengths of our study include the fact that we use simulation models which have been developed and refined over many years and are capable of producing a wide range of analyses of proposals for reform of

long-term care for older people. There is no single source of good data for England on the characteristics of social care users but the models draw on a range of national micro-level survey data and more aggregated administrative data to provide a comprehensive picture of care use and costs at the population level to form a basis for projections into the future and analyses of reforms. The CPEC and CARESIM models are based on different methodologies, with their respective strengths complementing each other.

Our findings are of course dependent on assumptions that have to be made about the future. In previous work we have shown that projected costs of long-term care for older people are sensitive to assumptions on the future path of social care costs (Hu et al. 2020). Our analysis assumes that (1) the unit costs of care, such as the labour and capital costs of an hour's home care, will rise in line with OBR projections for rises in average earnings, and (2) 62.5% of the care bill will be affected by planned rises in the national living wage (NLW) to 2024. There is scope for debate about whether wages in the care sector will rise in line with average earnings. In particular, a shortage of care staff may impose upwards pressure on wages. Since there is inevitable uncertainty about the exact impact of the increase in the NLW on wages in the sector, the planned NLW increase adds to uncertainty about future unit costs of care and projected future expenditure. Furthermore, although we allow for the care home fees to differ between nursing and residential care, and for varying intensities of home care packages and associated costs, we do not model regional variations in the unit costs of social care which will affect the regional distribution of benefits from the reforms (Wittenberg, 2016; Tallack and Sturrock, 2022).

Additionally, we have not attempted to account for the effects of the Covid-19 pandemic. Residents in care homes have to date experienced disproportionately high mortality from Covid-19 (Morciano et al., 2021), but there is a lack of evidence on the impacts of Covid-19 on home care users. The longer-term impacts on the number of social care users, productivity, earnings, price inflation and unit costs remain very uncertain. Similarly, our modelling does not account for the transient economic effects of the pandemic. However, to the extent that our focus is on *changes* resulting from the reforms, the consequences of the pandemic seem unlikely to alter the main conclusions of our analysis, for example on the costs and distribution of the benefits of the different reform scenarios compared with the current system.

Also, while our models capture the cross-sectional effects of reforms on social care users, they are more limited in analysing lifetime effects on individuals. Finally, our analysis does not take account of the Government's aim of moving towards a 'Fair Cost of Care' such that the differential in care home fees charged to self-funding and LA-funded residents is eliminated. This will have consequences for what residents pay for their care in addition to the effects of the means test reforms, and it may also affect the care home market more widely. However, the way in which this aim will be pursued has not yet been detailed by the Government.

The Build Back Better plan (HM Government 2021) and the White Paper (Department of Health and Social Care 2021) both state that it will be the key missions of the government to create a fairer and more equitable social care system. Our distributional analyses provide some evidence on the extent to which the planned reforms do this. However, debate in this area is hampered by the absence of an agreed framework for assessing the equity of the social care system. Criteria are sometimes implicit rather than explicit. For example the decision to base progress towards the cap on user contributions rather than care costs has been criticised because it can lead to those with lower capital having to use a higher proportion of it to pay for care than those with higher capital, implying that the proportion of capital used to pay for care should be similar for rich and poor (Health Foundation, 2021; Tallack and Sturrock, 2022). While the proportion of capital that individuals contribute to their care may be one aspect of fairness, it has been recognised (Wanless, 2006) that fairness in social care funding is multi-dimensional, concerning factors such as degree of need for care, ability to pay, dignity, and responsibility. The extent to which average gains in care recipients are unequal in our analysis depends on how they are compared. Inequality may be larger when average gains are compared in absolute than relative (percentage of income) terms, or vice versa. Unless

there is an agreed and explicit definition of equity in the social care system, it will remain useful to consider a range of measures.

Finally, our analyses have focused on the distribution of cash benefits amongst current and future users of care. One of the central objectives of a lifetime cap on the amount individuals must contribute towards their care, should they need it, is to provide 'peace of mind' from knowing that they will not need to meet in full the potentially 'catastrophic costs' of care. This benefits everyone who could have to pay for their care for a long time. However, capturing the benefits of this insurance by placing a monetary value on 'peace of mind' is not straightforward.

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Appendix: Supplementary analyses

Table A1: Distribution of older recipients and non-recipients of care by whether partnered and home ownership, 2018

	Single, non home-owner	Single, home-owner	Partnered, non home-owner	Partnered, home-owner
			%	
Not receiving care	12	24	8	56
Care home residents	45	40	7	9
Community care recipients	27	46	3	25
All care recipients	36	43	5	17
All aged 65+	13	26	8	53

Source: CPEC and Caresim models. Note: Care home residents exclude those fully funded by the NHS

Table A2: Distribution of older recipients and non-recipients of care by quintile of the 65+ income distribution, 2018

	Income quintile Q1 (low)	Q2	Q3	Q4	Q5 (high)
			%		
Not receiving care	20	20	20	20	20
Care home residents	33	26	17	15	9
Community care recipients	27	19	16	18	20
All care recipients	30	23	16	17	14
All aged 65+	20	20	20	20	20

Source: CPEC and Caresim models. Note: Care home residents exclude those fully funded by the NHS

Table A3: Home-ownership rates among older recipients and non-recipients of care by quintile of the 65+ income distribution

	Income quintile Q1 (low)	Q2	Q3	Q4	Q5 (high)	All
			% who own(ed) their home			
Not receiving care	64	70	81	90	96	80
Care home residents	40	37	50	62	81	48
Community care recipients	56	60	72	80	89	70
All care recipients	47	47	61	72	87	59
All aged 65+	63	68	80	89	95	79

Source: CPEC and Caresim models. Note: Care home residents exclude those fully funded by the NHS. For care home residents, home-ownership status is prior to care home entry

Table A4:Whether has savings (excluding housing wealth) > current upper capital limit by quintile of the 65+ income distribution

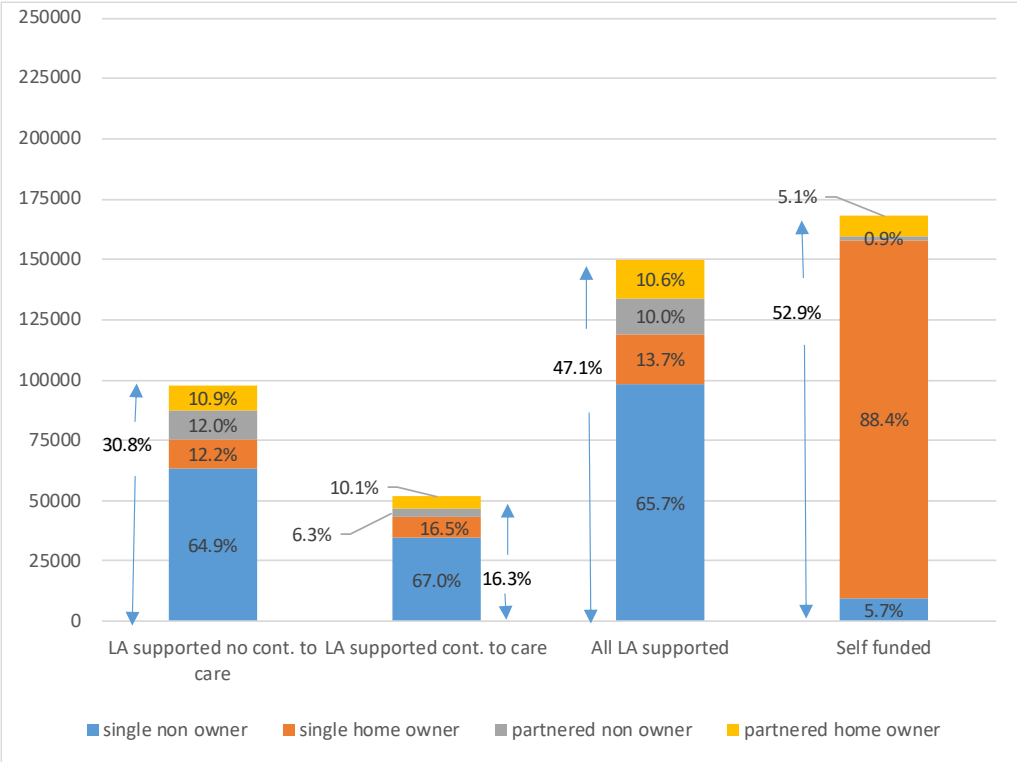
	Income quintile					
	Q1 (low)	Q2	Q3	Q4	Q5	All
				%		
Single non home-owner	6	3	13	23	*	8
Single home-owner	19	19	25	41	64	33
Partnered non home-owner	3	6	2	20	*	7
Partnered home-owner	24	18	27	43	65	40
All aged 65+	15	14	23	43	63	32

Source: CPEC and Caresim models.

* sample size < 100

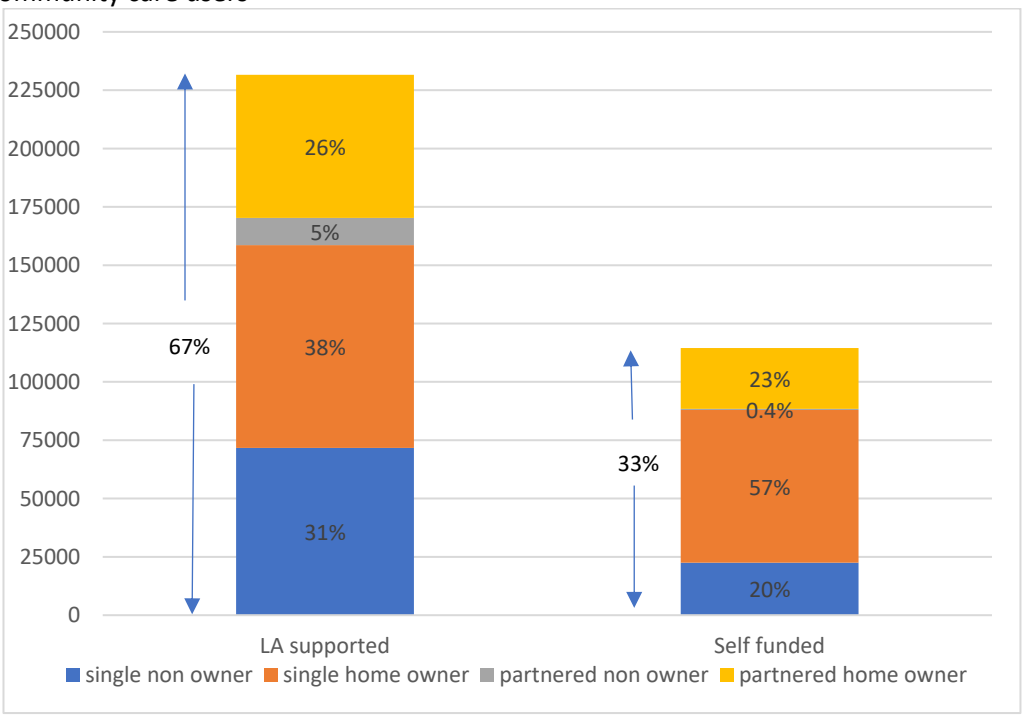
Figure A1: Long-term care users aged 65+ by home-ownership, whether partnered and for residential care, whether they contribute to the care component of care home fees, 2018

a) Care home residents



Note: Excludes fully NHS-funded residents

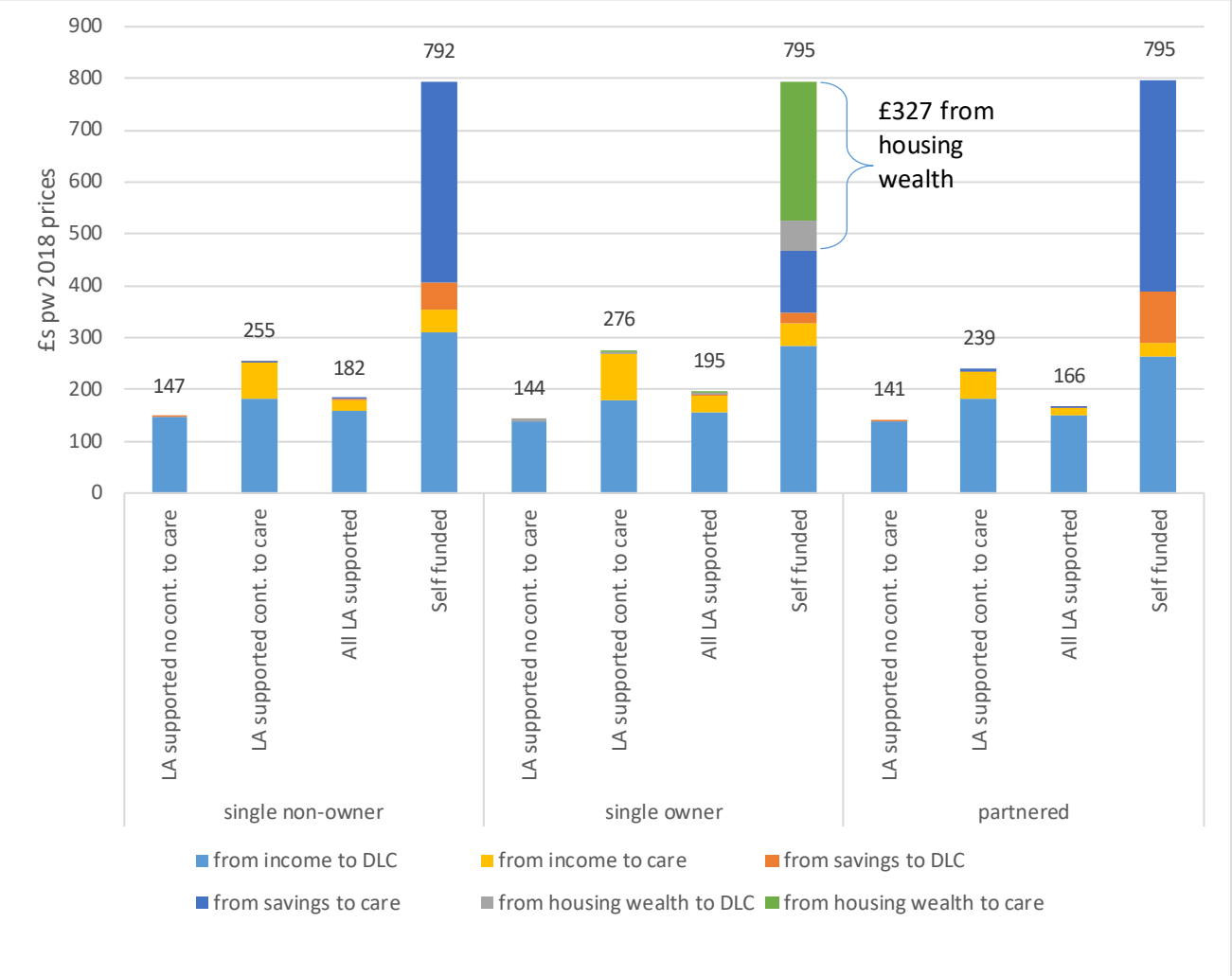
b) Community care users



Source: CPEC and CARESIM models

Daily living costs are assumed to be £174 per week in 2018 prices.

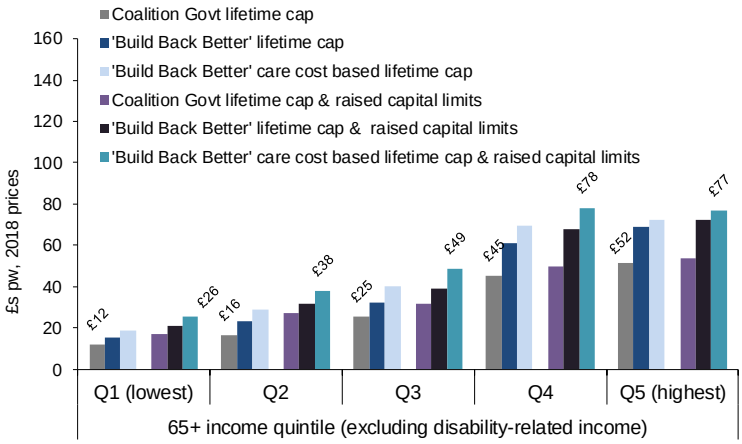
Figure A2: Estimated average weekly user contribution to care home fees from income, savings and housing wealth, care home residents aged 65+, 2018



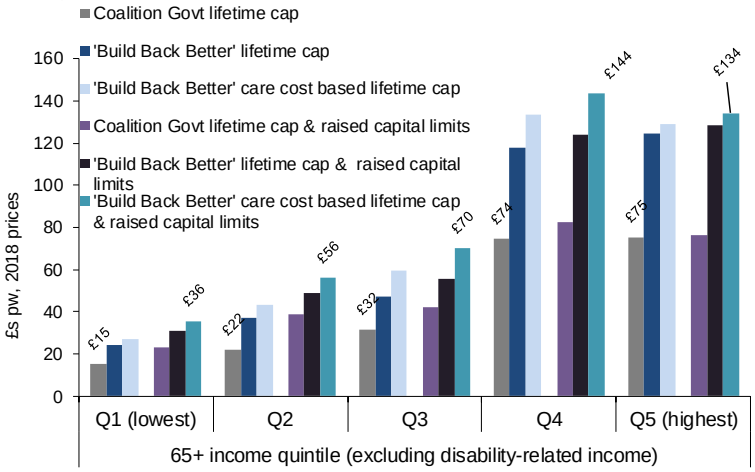
Source: CPEC and CARESIM models
Daily living costs are assumed to be £174 per week in 2018 prices.
'DLC'= daily living costs; 'Savings' = non-housing wealth.

Figure A3: Average gains in 2028 from reform scenarios amongst care users aged 65+ by income, £s pw, 2018 prices

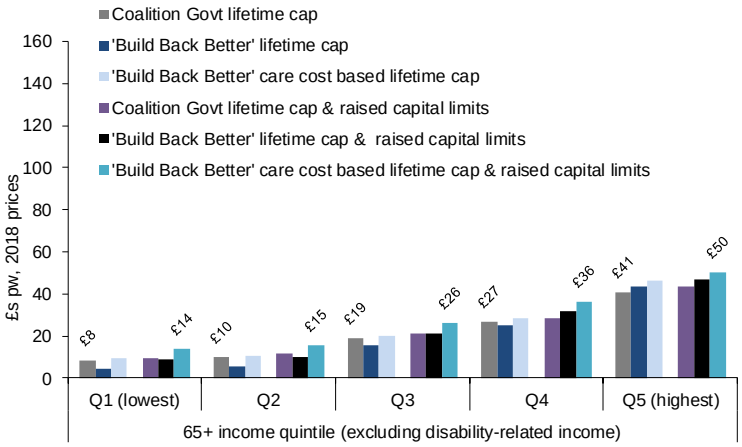
a) Care home residents and home care users combined



b) Care home residents



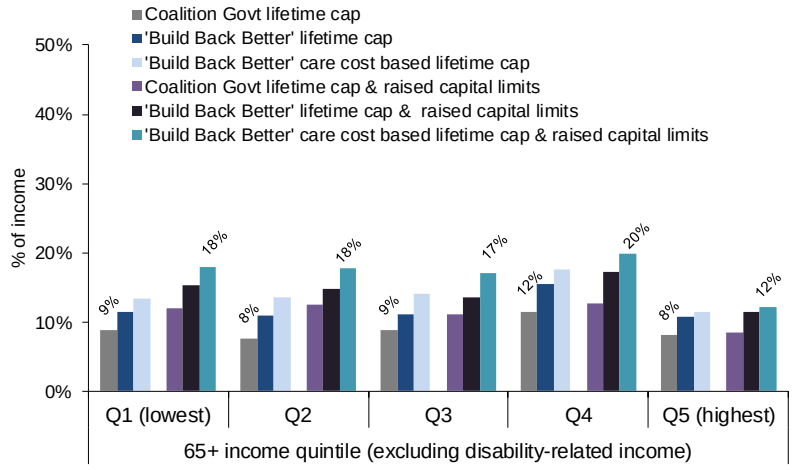
c) Home care users



Source: CPEC and Caresim models

Figure A4: Average gains in 2028 from reform scenarios amongst care users aged 65+, expressed as percentages of the user's income, by income.

a) Care home residents and home care users combined



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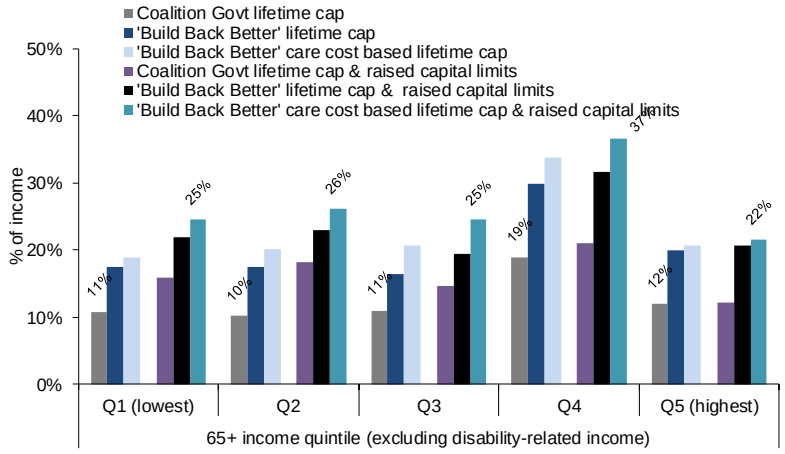
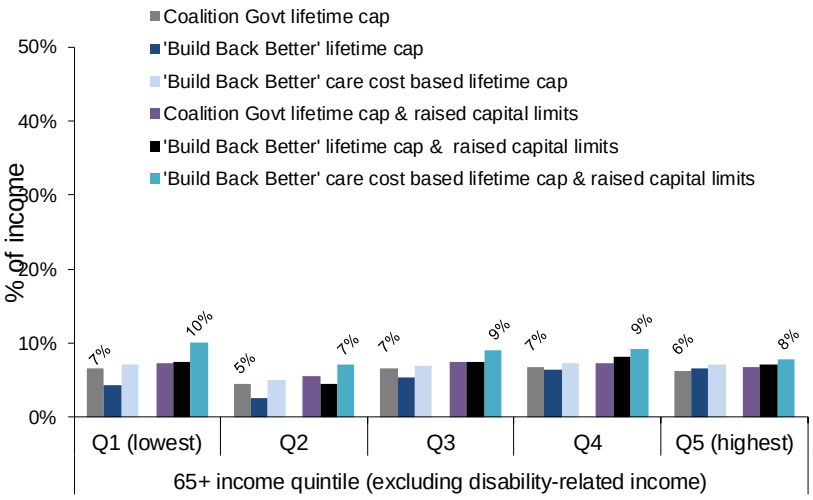


c) Home care users



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