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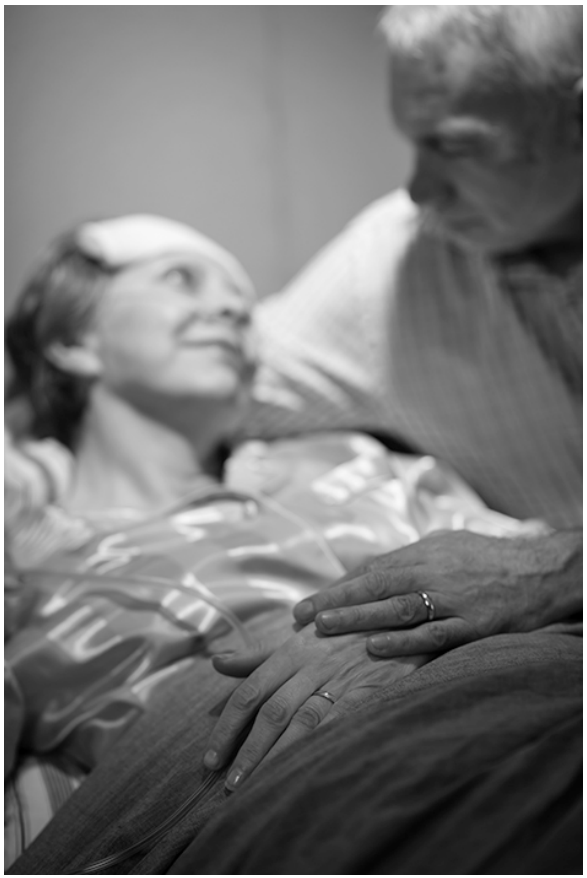
Healthcare intelligence

# PERSONAL ASSET PROTECTION GUARANTEE

A mechanism for sharing the costs of long term care between older property owners and the state



SOCIAL CARE WHITE PAPER No. 3

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## Healthcare Intelligence

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## Policy context and White Paper objective

Over the last two decades, successive governments have struggled to arrive at a comprehensive new settlement for sharing long term care costs between individuals and the state. To date, attempts in England have been fruitless. Following postponement of the Dilnot reforms in 2015, a fresh Green Paper was expected in the autumn of 2017, but has now been put back to summer of 2018.

The Dilnot proposals will once again be on the table, together with the variations on the basic concepts of an asset threshold and a lifetime care cost cap, as proposed by the Conservative party during the 2017 general election.

This White Paper proposes a novel mechanism, in the form of a Personal Asset Protection Guarantee (PAPG), for sharing the costs between individual older care service users and the state. It is argued that PAPGs would more equitably and efficiently achieve the same policy objectives as a combination of threshold extension and care cost cap.

As a starting point, some equity and efficiency downsides of the Dilnot solution are identified, before building on Dilnot by proposing PAPGs as a variation which goes some way to resolving these issues.

## Equity and efficiency downsides of Dilnot

While the Dilnot Commission's solution to sharing long term care costs between individuals and the state is an elegant one, it poses a number of challenges:

a) Geographically inequitable distribution of benefits;

b) Threat to the stability of the care home sector, especially in less affluent areas of England;

c) Complexity and cost of administering the lifetime care cost cap.

## The Personal Asset Protection Guarantee (PAPG) concept as an alternative to the threshold and cap

During the course of work commissioned by Alzheimer's Society on the impact of Conservative party proposals for long term care funding put forward in the 2017 general election, and overlapping work for the County Councils Network, it became apparent to LaingBuisson that the policy objectives of both the threshold and the cap could be achieved in what is arguably a simpler and more equitable way, by defining individuals' eligibility for council support for residential care in terms of the percentage of each individual's assets (including owner-occupied property) which has been spent down since being assessed as needing care.

The concept of a Personal Asset Protection Guarantee (PAPG) can be outlined as follows.

a) The baseline for the value of each individual's assets is crystallised at the time when that individual seeks an assessment from his or her local council and is found to need care, followed by an assessment of means (no difference in principle from the current regime);

b) The individual is guaranteed that once X% of his or her baseline assets have been spent down (other than through inappropriate divestment, which is already defined in CRAG rules) he or she will be eligible for financial support from the council in the usual way, subject to income related user charges;

c) The individual may seek a further assessment at any time (as now). If care is still needed and assets have been depleted by X% or more, the individual will be eligible for council support (note that the council will have a record of the prior value of any property at the time of the initial assessment, which will make any re-valuation easier).

The attractiveness of PAPGs, as a complete and self-contained alternative to combinations of threshold and cap, will of course depend on the value of 'X'. We have used the spreadsheet model developed by LaingBuisson on behalf of Alzheimer's Society and the County Councils Network to calculate 'X' at 27%, to deliver similar policy objectives, more equitably, at the same public expenditure cost of a single threshold of £100,000 and a care cost cap of £72,000.

Another way of expressing this is that individuals would be guaranteed to keep 73% of their assets.

Thus, an individual with baseline assets of £500,000 would be guaranteed to retain £365,000, while an individual with baseline assets of £100,000 would be guaranteed to retain £73,000, and subsequently have their fees paid by their council, subject to income related charges only.

To illustrate a range of possibilities, from generous to restrictive, **Table 2A** shows the net public expenditure cost of additional services that the state would pay for under different combinations of threshold and cap, and **Table 2B** shows what PAPG rate would give rise to an equivalent net public expenditure cost.

**The examples cited illustrate the principal effect of a PAPG arrangement, which is to give some financial benefit (or peace of mind) to the full range of property owners (who make up over 70% of the older population at risk of entry into care homes) rather than concentrating the benefits on property owners of modest means (around £100,000 in assets) or a small minority of the care home population which survives for several years[1].**

[1] Using these examples, an individual with assets of £500,000, who wished to pass on his or her wealth to several grandchildren, would gain much more peace of mind from a PAPG at 73% than an asset threshold of £100,000. His or her benefit would be paid for by requiring the individual with modest assets of (say) £100,000 to spend down £27,000 of it before being eligible for council support. These are the trade-offs which need to be considered to determine which of the policies on offer is the fairer and more desirable

In summary, the advantages of PAPGs, as a complete alternative to any combination of threshold or cap, are:

a) The concept is simple to understand;

b) It delivers benefits (in terms of peace of mind) to the full range of property owners, not just those in 'spending down' sight of any feasible threshold;

c) Minimal change to the current means testing regime and no need to track actual spending on care services;

d) The geographical distribution of benefits from PAPGs would be more equitable than under a threshold extension (see **Figure 1**) and a care cost cap (see **Figure 2**);

e) The propensity of individuals and their financial advisors to 'game' PAPGs by divesting property assets would be no greater than the current incentive to divest property assets to circumvent the £23,250 upper threshold;

f) The opportunities for developing new long term care insurance products around PAPG entitlements are at least as great as building them around combinations of threshold and cap, and probably greater;

g) The 'payor shift' threat to the stability of the commercial care home sector in less affluent areas of the country would be diluted (though it would not disappear)[2];

h) Without any need to monitor individuals' care costs, the assessment, care management and administrative costs of PAPGs would be lower than for any combination of cap and threshold.

[2] To eradicate the 'payor shift' threat to care homes, particularly in less affluent areas, it would be necessary substantially to reduce the 40% plus gap between privately paid fees and the fee levels that councils are able and willing to pay

# 1. POLICY CONTEXT AND WHITE PAPER OBJECTIVE

The current debate on social care funding in England revolves around two linked but distinct questions:

1. How much should central and local government commit to spending on social care to deliver a good public service for older people with care needs and without adequate means of their own to pay?

2. How should the cost of long term care be divided between the state and those individuals (mainly property owners) with care needs who do have the resources to pay for themselves?

This White Paper deals only with the second question. It proposes a novel mechanism, in the form of a Personal Asset Protection Guarantee (PAPG), for sharing the costs between individual older care service users and the state. It is argued that PAPGs would more equitably and efficiently achieve the same policy objectives as a combination of asset threshold extension and lifetime care cost cap.

## 1.1 Summary of policy options proposed by government over the last two decades

For the last 20 years and more, policy makers have been searching for a comprehensive new settlement for long term care funding, thus far without success.

The Royal Commission set up by the 1997 Labour government led to the introduction of what is now called NHS Funded Nursing Care (NHS FNC), but left other matters unresolved.

In 2009 the Labour government's Green Paper, *Shaping the Future of Care Together*, was published. It returned to the question of the balance between public and private funding of long term care for older people, which the government's response to the Royal Commission had failed to settle. Of the three principal funding options presented by the Green Paper the first was 'Partnership', in which everyone who qualified for care and support from the state would be entitled to have a set proportion – for example a quarter or a third – of basic care and support costs paid for by the state. The second was 'Insurance' in which older people would be helped to insure against the catastrophic costs of long term care through a state-sponsored insurance plan based on the value of older people's housing assets. The third option was 'Comprehensive' under which all care costs (but *not* hotel costs) would be paid for by the state. This was the option adopted by the Labour government, following a consultation, but the government fell in 2010 fell before the policy could be implemented,

In 2010 the Coalition government set up a new Commission on Funding of Care and Support, chaired by Andrew Dilnot, to look at the issues afresh. The Commission reported in 2011 with an elegant solution to the means testing 'cliff edge' for care home residents (which still exists today) where those with up to £23,500 in non-disregarded assets (the upper threshold) receive financial support for residential care and those with more receive nothing. The Coalition government accepted Dilnot's recommendations in principle, including a substantial extension to the upper asset threshold and the parallel introduction of a lifetime care cost cap, though in the interests of economy the care cost cap was set at a higher level than that proposed initially by Dilnot. The revised Dilnot reforms were incorporated in the Care Act 2014, with implementation planned for April 2016. In the summer of 2015, however, implementation of the Dilnot reforms was 'postponed'. The reason for

postponement was believed to be partly cost and partly fears that the reforms would destabilise the care home sector at a time (April 2016) when care homes would also have to deal with the challenge of the National Living Wage.

The most recent indication of government intentions (which in the light of the general election result may not be carried out) is contained within the proposals made by the Conservative party during the 2017 general election campaign (before and after the Manifesto). These can be summarised as follows:

- **A 'single threshold' of £100,000**, meaning that the first £100,000 of an individual's reckonable capital will be disregarded when determining eligibility for council financial support for social care services. Since the £100,000 is described as a single threshold, by implication the intention was to abandon the distinction between a lower capital threshold (currently £14,250) and an upper capital threshold (currently £23,250). By the same token, the intention was presumably to end the current arrangements for charging tariff income on the difference between the lower and upper capital thresholds;
- **Removal of the automatic disregard of the value of owner-occupied property when determining eligibility for council support for care at home services** meaning that, for the first time, users of non-residential care services would have to spend down their capital until it reaches a threshold (£100,000) at which they will be eligible for council financial support;
- **Extension of Deferred Payments to care at home services**, to allow property owning service users to pay for their current care costs by taking an 'advance' from the value of their estates;
- **A 'Lifetime care cost cap'**, at a level to be determined – in the Manifesto, the cap on care costs was ruled out, but was subsequently brought back on the agenda.

The position at the time of writing (October 2017) is that a weakened Conservative administration, reliant on support from the Democratic Unionist Party of Northern Ireland, is unlikely to seek to legislate in the near future on long term care funding, given that any new 'shared funding' proposals are likely to be opposed by those who favour the 'comprehensive' social insurance plan proposed by the former Labour government. Nevertheless, it is expected that a Green Paper will be published or a consultation will take place in the summer of 2018 (originally the autumn of 2017) on the future of social care funding in England.

This LaingBuisson White Paper is intended to feed into the ensuing debate on policy options.

## 2. CHALLENGES POSED BY THE THRESHOLD AND CAP APPROACH

While the Dilnot Commission's solution to sharing long term care costs between individuals and the state is an elegant one, it poses a number of challenges:

1. Geographically inequitable distribution of benefits;
2. The 'payor shift' threat to the stability of the care home sector, especially in less affluent areas of England;
3. Complexity and cost of administering the lifetime care cost cap.

This section describes each of these challenges in turn, and **Section 3** outlines an alternative approach to the threshold and cap, in the form of a Personal Asset Protection Guarantee (PAPG).

### 1. Geographically inequitable distribution of benefits

#### i. Threshold extension

Most of the benefits from the threshold extension, whether the Care Act's £118,000 or the 2017 Conservative manifesto's £100,000, would be concentrated among care service users in less affluent areas of England.

In order to demonstrate this, we have used a spreadsheet model developed by LaingBuisson as part of two consultancy projects undertaken in 2017, one commissioned by Alzheimer's Society and the other by the County Councils Network, both of which sought to project the impact of the long term care reforms proposed by the Conservative party in its 2017 election campaign. At the heart of the model is Land Registry data on around 1 million residential property transactions in England. Owner occupied property is by far the most important source of personal wealth and, after adjusting for financial wealth[3], it is possible to calculate asset distributions down to highly granular geographic areas. Further details of the methodology are provided in **Appendix 1**.

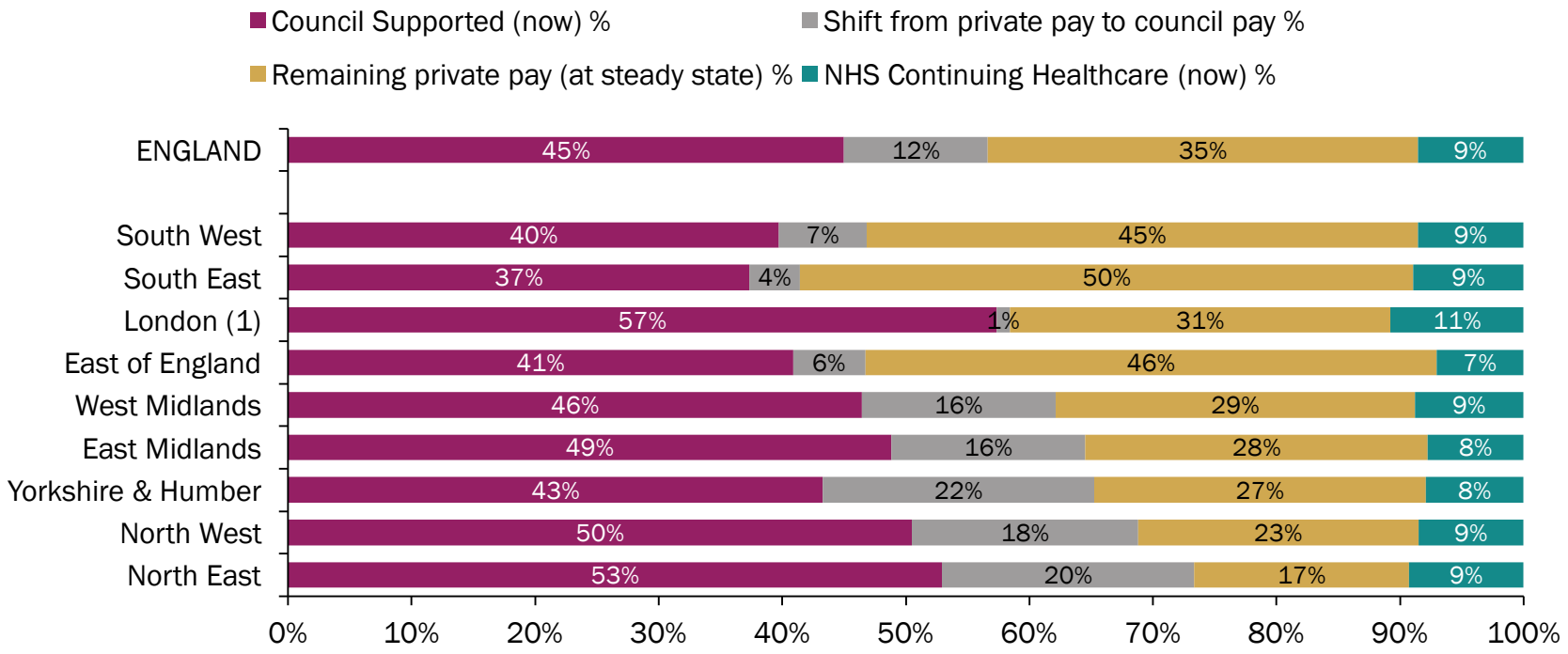
Residential property values vary widely across England, with the lowest values north of a line from The Wash to the Bristol Channel and the highest values to the South. In many areas of the North the modal point of the property value distribution lies close to the proposed threshold extension level of £100,000 and a large proportion of property owning service users in those areas would either qualify for council financial support on entry into a care home or be within spending down distance of doing so. Conversely, only a small proportion of property owning service users in the affluent South would be within spending down sight of £100,000.

[3] Both physical and pension wealth are disregarded in local authority means tests for eligibility for social care support

Striking regional disparities are illustrated, in **Figure 1**, in the share of care home residents projected to benefit from a single threshold of £100,000 at 'steady state' (that is, within a future care home population when the reform would have fully worked its way through the system, in about four years' time). The term 'payor shift' is used to represent the share of care home residents (excluding those qualifying for NHS funded continuing healthcare) who would otherwise have been private payers but would become eligible for council support following an extension of the asset threshold (to £100,000 from the current, 2017, upper threshold level of £23,250). Payor shifts calculated through the spreadsheet model vary from 15% to 22% in relatively non-affluent regions to the north of a line from The Wash to the Bristol Channel, compared with between 1% and 7% in more affluent regions to the South. Geographical disparities are much higher when the analysis is taken down to 1st or 2nd tier local authority level, or below.

Figure 1

*Projected payor shift from private pay to council support following a capital threshold uplift to £100,000, England residential and nursing care for older people (65+)*



**BOX 1 'Steady State' projections**

In order to simplify calculations for the purposes of this White Paper, the spreadsheet model developed by LaingBuisson makes no allowance for either inflation or changes in demand for social care, whether driven by demographic pressure or other factors. The projections, therefore, are at 2016/17 prices and 2017 levels of demand.

The model projects changes in the net public sector cost of social care services for older people at a 'steady state', which would not be reached until several years after funding reforms had been implemented. In the case of an extension to the asset threshold, 'steady state' would be approached in about four years because of the relatively short average length of stay in care homes. For the lifetime care costs cap, on the other hand, costs would accrue slowly over several years and 'steady state' would not be approached in much less than a decade, depending on the value at which the cap were set.

'Steady state' is a concept which relates to an overall population of care service users at a snapshot in time. The model projects the average 'payor shift' for the population – i.e. the proportion of service users who would qualify for council support as a result of each of the proposed funding reforms at a point of time, after the reforms had fully worked their way through the system, and the resulting transfer of costs from individuals to the state.

For example, **Figure 1** indicates a payor shift (from private pay to council pay) of 12% of the population of older care home residents in England, following implementation of a single threshold of £100,000, thus reducing the private pay share from the current (2017) 47% of the population of older care home residents to 35% at 'steady state'. The annual cost to the state of the payor shift can then be calculated by multiplying the additional number of service users who have become a charge on councils by their annual unit costs, and deducting the Attendance Allowance clawback by central government.

It is important to be clear that the model does *not* measure the proportion of service users who would qualify for council support by the time they die. That proportion would be higher than the proportion in a population snapshot at a point of time, since the snapshot will include many privately paying service users who are only part way through their period of care and would continue to spend down their assets to reach the threshold, or continue to accrue costs towards the cap, before they die.

### ii. Lifetime care cost cap

Whereas the threshold extension would mainly benefit people in less affluent areas, the converse is the case for the care cost cap, where people in affluent areas of the South and East are more likely to benefit than people in the less affluent areas of the North and Midlands. The reason is that councils' 'usual costs' (the fees they will usually pay to care services) are more tightly constrained in non-affluent areas and, after deducting a nationally determined sum for board and lodging[4], the balance of 'care' costs in care homes which is left to count towards the lifetime care cost cap would typically be less than in affluent areas, where councils' 'usual costs' are typically less tightly constrained.

[4] Assuming board and lodging costs would be set at a national rate, as per the Dilnot reforms incorporated into the subsequently postponed sections of the Care Act

Figure 2

*Share of eligible care service users who would have reached a lifetime care cost cap of £72,000 at a 'steady state' point of time (in up to ten years), England by region*

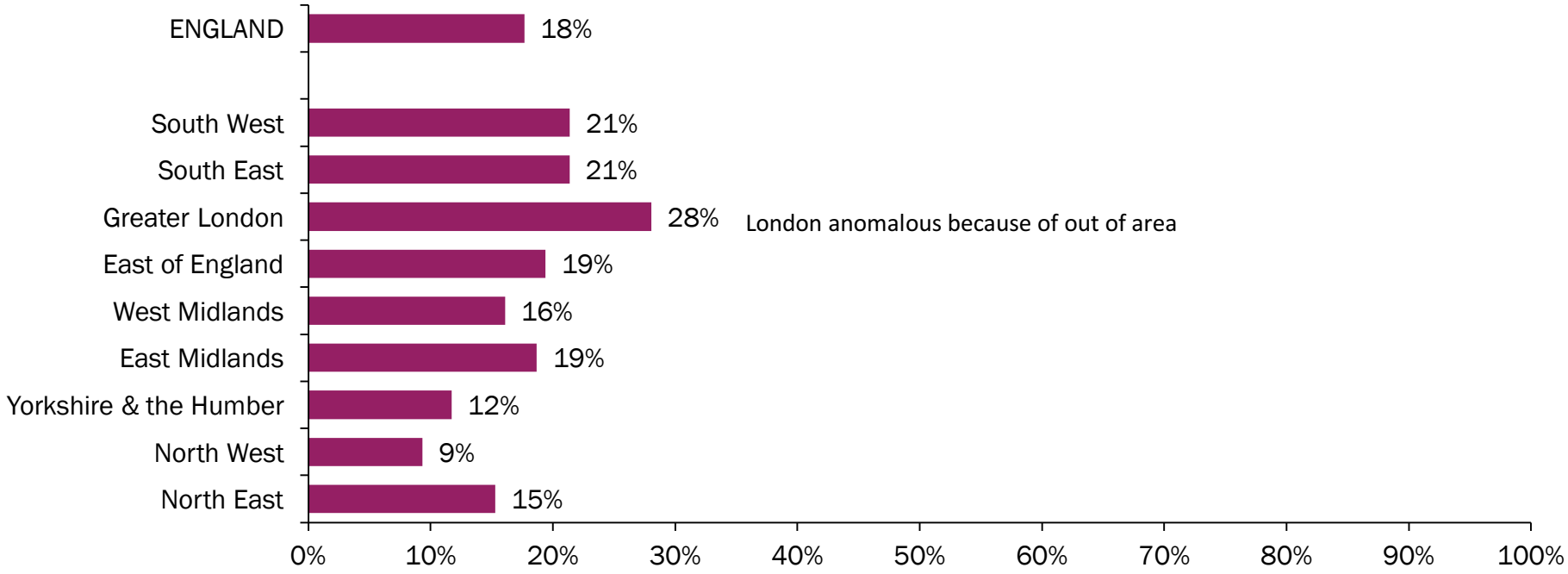



**Figure 2** illustrates the regional variances in the proportion of care home residents who would have reached a care cost cap of £72,000 at steady state, in up to ten years' time. Care service users in the more affluent regions would be most likely to have reached the cap by the time the scheme reached maturity, headed by the South East and South West at 21% (ignoring London, which is anomalous), while those in less affluent regions are least likely, with the North West at the foot at 9%.

### iii. Can regional disparities be eliminated?

The regional disparities in shares of people reaching the lifetime care cost cap (**Figure 2**) could be greatly diminished quite easily by changing the rules under which spending on care counts towards the cap. One obvious way of doing so would be to allow local variation of the allowance for board and lodging costs, so that more of usual fee rates paid by councils would count towards the 'care' costs being added to each individual's account.

On the other hand, the regional disparities in 'payor shift' arising from a threshold extension are not amenable to administrative modification, because they are tied to residential property values (as the principal source of personal wealth) which are driven by market factors largely outside government control. Any feasible level of threshold is bound to focus benefits on owners of modest properties in less affluent areas of England.

## 2. The 'payor shift' threat to the stability of the care home sector, especially in less affluent areas of England

The beneficiaries of 'payor shift' as a result of an asset threshold extension are individuals who no longer have to pay their care home fees privately, and instead qualify for council support.

The other side of this coin is that care homes will have fewer private payers at premium fee rates. This is a problem because of a type of market failure which is peculiar to the care home sector, in the form of endemic cross subsidisation. It has developed into a structural feature of the care home market in the two decades since implementation of the community care reforms in 1993, which gave Councils with Adult Social Services Responsibilities (CASSRs) the principal role in arranging state-funded long term care. Most CASSRs have never had sufficient funding to pay fees at an economic level, i.e. that is sufficient to attract and sustain investment from independent sector care providers, which now account for 90% of long term care capacity. In response, care homes (most of which have mixed privately and publicly funded clientele) have tended to push up private-pay fees in compensation. As a result, LaingBuisson found – in work commissioned by the County Councils Network in 2015 – that private payers on average pay over 40% more than councils for the same room type, and in all probability the same level of care, (**Table 1**).

Table 1

*Evidence of fee differentials between private payers and council funded care home residents in homes for older people and dementia (65+) owned by a sample of care home groups operating in 12 English counties in 2015*

| **Analysis of fee differentials in 'unique room sets' (i.e. groups of rooms of similar or identical specification, where it was possible to compare private and council paid fee rates on a like-for-like basis)** | | | | |
|---|---|---|---|---|
| | Number of unique room sets | Number of private payers in unique room sets | Weighted average ratio of private to council paid fees within unique room sets | Percentage of cases in which privately paid fees were higher than council paid fees for like-for-like services |
| Nursing homes | 147 | 776 | 1.41 | 94.6% |
| Residential homes | 304 | 2,663 | 1.46 | 96.7% |
| All homes | 451 | 3,439 | 1.43 | 96.0% |

Source: County Care Markets: Market Sustainability & The Care Act
http://www.laingbuisson.co.uk/MarketReports/LatestMarketReports/tabid/570/ProductID/661/Default.aspx

Consequently, other things being equal, payor shift as a result of a threshold extension can be expected to cause a reduction in average fees and a fall in operating margins. How threatening this might be depends on the existing level of margins and on the extent of payor shift. Both of these risk factors are at their highest in less affluent areas of the country[5]. In the North East, according to **Figure 1**, it is projected that the private pay share of care home residents would fall from 38% (now) to just 17% (at 'steady state') as a result of a £100,000 asset threshold for eligibility for council funding for care home services. In some geographic areas within the North and other less affluent regions, the impact would be even greater. In contrast, payor shift would hardly dent the private pay market in affluent areas like Surrey, because very few property owners have assets which are as low as, or within spending down distance of, the proposed £100,000 single threshold.

## 3. Complexity and cost of administering the lifetime care cost cap

The official impact assessment for the Care Act projected substantial costs of administering the long term care funding reforms. Additional costs attributable to the lifetime care cost cap were not separately identified, but since nearly all service users would be incentivised to register, the volumes of assessments and maintenance of care accounts would be greater than current staffing levels could cope with.

Moreover, the unit cost per person reaching the cap would be very substantial since because most care recipients would be incentivised to set off down the road of counting care costs towards the cap but relatively few would survive long enough to reach the destination (a projected 18% in England, **Figure 2**).

[5] Care of Older People UK Market Report, 28th edition (www.laingbuisson.com/shop/care-older-people_28th-edition

## 3. THE PAPG ALTERNATIVE TO A THRESHOLD AND CAP

During the course of work commissioned by Alzheimer's Society on the impact of Conservative party proposals for long term care funding put forward during the 2017 general election, and overlapping work for the County Councils Network, it became apparent that the policy objectives of both the threshold and the cap could be achieved in what is arguably a simpler and more equitable way, by defining individuals' eligibility for council support for residential care in terms of the percentage of each individual's assets (including owner-occupied property) which has been spent down since being assessed as needing care.

The concept of a Personal Asset Protection Guarantee (PAPG) can be outlined as follows:

a) The baseline for the value of each individual's assets is crystallised at the time when that individual seeks an assessment from his/her local council and is found to need care, followed by an assessment of means (no difference in principle from the current regime);

b) The individual is guaranteed that once X% of his or her baseline assets have been spent down (other than through inappropriate divestment, which is already defined in CRAG rules) he/she will be eligible for financial support from the council in the usual way, subject to income related user charges;

c) The individual may seek a further assessment at any time (as now). If care is still needed and assets have been depleted by X% or more, the individual will be eligible for council support (note that the council will have a record of the prior value of any property at the time of the initial assessment, which will make any re-valuation easier).

The attractiveness of PAPGs, as a complete and self-contained alternative to combinations of threshold and cap, will of course depend on the value of 'X'. We have used the spreadsheet model developed by LaingBuisson on behalf of Alzheimer's Society and the County Councils Network to calculate 'X' at 27%, to deliver similar policy objectives, more equitably, at the same public expenditure cost of a single threshold of £100,000 and a care cost cap of £72,000.

Another way of expressing this is that individuals would be guaranteed to keep 73% of their assets.

Thus, an individual with baseline assets of £500,000 would be guaranteed to retain £365,000, while an individual with baseline assets of £100,000 would be guaranteed to retain £73,000, and subsequently have their fees paid by their council, subject to income related charges only.

The more generous the threshold and cap, the more generous the PAPG could be, if the aim were to deliver an equivalent quantum of cash transfers (though differently distributed) from the state to service users.

To illustrate a range of possibilities, from generous to restrictive, **Table 2A** shows the net public expenditure cost of additional services that the state would pay for under different combinations of threshold and cap, and **Table 2B** shows what PAPG rate would give rise to an equivalent net public expenditure cost.

At the generous end of the spectrum, the projected steady state net public expenditure cost[6] of a lifetime care cost cap of £50,000 and a single threshold of £200,000 is £1,860 million a year at 2017 prices and levels of demand (**Table 2A**). The PAPG rate which gives rise of an equivalent cost is 88% (**Table 2B**). In other words, once an individual's assets had been depleted by 12% the individual would be entitled to CASSR financial support, subject to normal income related charges.

At the restrictive end of the spectrum, the projected steady state net public expenditure cost[7] of a lifetime care cost cap of £120,000 and a single threshold of £80,000 is £350 million a year at 2017 prices and levels of demand (**Table 2A**). The PAPG rate which gives rise of an equivalent cost is 54% (**Table 2B**). In other words, once an individual's assets had been depleted by 46% the individual would be entitled to CASSR financial support, subject to normal income related charges.

**The examples given above illustrate the principal effect of a PAPG arrangement, which is to give some financial benefit (or peace of mind) to the full range of property owners (who make up over 70% of the older population at risk of entry into care homes) rather than concentrating the benefits on property owners of modest means (around £100,000 in assets) or a small minority of the care home population which survives for several years[8].**

In summary, the advantages of PAPGs, as a complete alternative to any combination of threshold or cap, are:

a) The concept is simple to understand;

b) It delivers benefits (in terms of peace of mind) to the full range of property owners, not just those in 'spending down' sight of any feasible threshold;

c) Minimal change to the current means testing regime and no need to track actual spending on care services;

d) The geographical distribution of benefits from PAPGs would be more equitable than under a threshold extension (see **Figure 1**) and a care cost cap (see **Figure 2**);

e) The propensity of individuals and their financial advisors to 'game' PAPGs by divesting property assets would be no greater than the current incentive to divest property assets to circumvent the £23,250 upper threshold;

f) The opportunities for developing new long term care insurance products around PAPG entitlements are at least as great as building them around combinations of threshold and cap, and probably greater;

[6] Net of clawback of Attendance Allowance which ceases to be payable to recipients if they are supported by councils in residential care. Cost is for services only. Additional administrative, assessment and case management costs are excluded

[7] See note 6

[8] Using these examples, an individual with assets of £500,000, who wished to pass on his/her wealth to several grandchildren, would gain much more peace of mind from a PAPG at 73% than an asset threshold of £100,000. His/her benefit would be paid for by requiring the individual with modest assets of (say) £100,000 to spend down to £27,000 of it before being eligible for council support. These are the trade-offs which need to be considered to determine which of the policies on offer is the fairer and more desirable

g) The 'payor shift' threat to the stability of the commercial care home sector in less affluent areas of the country would be diluted (though it would not disappear)[9];

h) Without any need to monitor individuals' care costs, the assessment, care management and administrative costs of PAPGs would be lower than for any combination of cap and threshold.

Table 2A

*Net additional annual public expenditure cost of care services[1] in England of different combinations of single asset threshold and lifetime care cost cap at 'steady state' several years in the future, older people (65+) in England at 2016/17 prices and 2017 level of demand*

| | Single asset threshold | | | | | | |
|---|---|---|---|---|---|---|---|
| | **£80,000** | **£100,000** | **£120,000** | **£140,000** | **£160,000** | **£180,000** | **£200,000** |
| **Lifetime care cost cap** | £ million | £ million | £ million | £ million | £ million | £ million | £ million |
| **£50,000** | 1,480 | 1,550 | 1,630 | 1,690 | 1,760 | 1,810 | 1,860 |
| **£60,000** | 1,150 | 1,230 | 1,310 | 1,380 | 1,460 | 1,510 | 1,570 |
| **£70,000** | 890 | 980 | 1,070 | 1,150 | 1,230 | 1,290 | 1,350 |
| **£72,000** | 860 | 940 | 1,030 | 1,110 | 1,190 | 1,250 | 1,310 |
| **£80,000** | 700 | 790 | 890 | 970 | 1,050 | 1,110 | 1,180 |
| **£90,000** | 560 | 660 | 750 | 840 | 920 | 990 | 1,050 |
| **£100,000** | 470 | 560 | 660 | 750 | 830 | 900 | 970 |
| **£110,000** | 400 | 500 | 590 | 680 | 770 | 840 | 910 |
| **£120,000** | 350 | 450 | 550 | 640 | 730 | 800 | 870 |

**Notes 1** Net of clawback of Attendance Allowance which ceases to be payable to recipients if they are supported by councils in residential care. Includes costs of services only. Additional administrative, assessment and case management costs are excluded.

[9] To eradicate the 'payor shift' threat to care homes, particularly in less affluent areas, it would be necessary substantially to reduce the 40% plus gap between privately paid fees and the fee levels that councils are able and willing to pay

Table 2B

*The PAPG rate (being the percentage of personal assets that individuals are guaranteed to keep) that gives rise to equivalent public expenditure costs for the same combinations of cap and threshold*

| | Single asset threshold | | | | | | |
|---|---|---|---|---|---|---|---|
| | **£80,000** | **£100,000** | **£120,000** | **£140,000** | **£160,000** | **£180,000** | **£200,000** |
| **Lifetime care cost cap** | £ million | £ million | £ million | £ million | £ million | £ million | £ million |
| **£50,000** | 83% | 84% | 86% | 87% | 88% | 88% | 89% |
| **£60,000** | 77% | 79% | 80% | 81% | 83% | 84% | 85% |
| **£70,000** | 72% | 74% | 76% | 77% | 79% | 80% | 81% |
| **£72,000** | 71% | 73% | 75% | 76% | 78% | 79% | 80% |
| **£80,000** | 67% | 69% | 72% | 74% | 75% | 76% | 78% |
| **£90,000** | 63% | 66% | 68% | 70% | 72% | 74% | 75% |
| **£100,000** | 60% | 63% | 66% | 68% | 70% | 72% | 74% |
| **£110,000** | 57% | 61% | 64% | 66% | 69% | 70% | 72% |
| **£120,000** | 54% | 59% | 63% | 65% | 68% | 69% | 71% |

## 4. THE 'DEMENTIA TAX' – END OF AUTOMATIC DISREGARD OF FAMILY HOME

The most controversial element of the entire Conservative manifesto in 2017 was the proposal to remove the automatic disregard of the value of owner-occupied property when determining eligibility for council support for care at home. Condemned by Alzheimer's Society as a 'Dementia Tax', it was made no more palatable by the assurance that soft loans would be made available through extended Deferred Payments schemes to give older care at home service users (many of whom are asset rich but income poor) the liquidity to continue paying for day to day care needs, before recouping the cash from their estates after death.

The proposal is a radical one in terms of both the number of people who would lose support and the scale of the cash transfer from individuals to the state. LaingBuisson estimates that:

- Between 55% and 62% of current council supported, older, non-residential care recipients would lose financial support from their councils (other than through Deferred Payments advances)[10];
- Between £1.2 to £1.3 billion would be transferred from individuals to the state;
- If implemented, therefore, the policy could pay for the entirety of the asset threshold extension to £100,000 and a care cost cap at £60,000, see **Table 2A**.

We have not brought this proposal into the analysis of equivalence between PAPGs and threshold/cap combinations, because it seems unlikely to be implemented, but in principle there is nothing to prevent the PAPG concept being extended to people in receipt of non-residential care as well as those in receipt of residential are.

[10] Basic data limitations make it difficult to project the impact of this particular Conservative manifesto proposal on numbers of older people eligible for and taking up council financial support for non-residential care needs, and the costs. The methodology for deriving the range of estimates cited here is described in a report prepared for the Alzheimer's Society by LaingBuisson

## APPENDIX: METHODOLOGY

A simple spreadsheet model has been developed to answer the key questions posed by the Conservative party proposals in 2017, including a single asset threshold of £100,000 and a lifetime care cost cap at a value yet to be determined.

- How many gainers and losers will there be?
- How are they distributed geographically?
- What are the costs and savings to the taxpayer?

### Single asset threshold of £100,000

At the heart of the model is data on the distribution of personal wealth, nationally and regionally, which is sufficiently granular to allow estimates to be made of the proportion of care service users who have non-disregarded assets of £100,000, or are within 'spending-down' sight of that figure.

Having considered a number of official and non-official data sets, we considered that the best source of personal wealth distribution was the Land Registry, because of its granularity and very extensive coverage (over 1 million residential property transactions across England). Official data from the ONS *Wealth in Great Britain* series[11] confirms that residential property is by far the dominant source of personal wealth, and while the 'property wealth' data subset within the broader ONS data lacked the granularity to be useful for the specific purpose of calculating how many people have assets of up to £100,000, it did provide evidence on the relative scale of property and financial wealth, which could be used to adjust the Land Registry property value distribution to take account of the financial wealth factor[12].

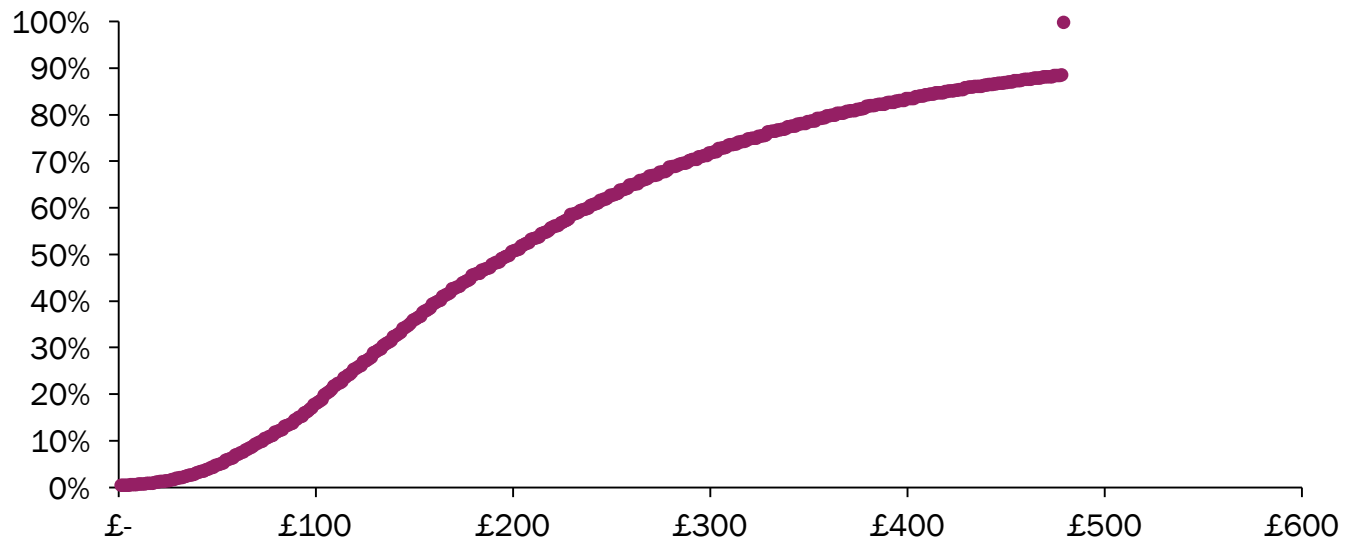
Note that under current arrangements (and we are assuming by default future arrangements as well) both physical wealth (jewellery, furniture, etc.) and pension wealth are disregarded in the means tests that councils use to determine eligibility for financial support for care services. Wealth profiles vary widely from region to region, mainly due to property prices, and the financial impact of the threshold extension varies equally widely, as indicated in the findings in the body of the report.

[11] Wealth in Great Britain Wave 3, 2010 – 2012, www.ons.gov.uk/ons/rel/was/wealth-in-great-britain-wave-3/2010-2012/index.html

[12] The adjustment was made by shifting the entire residential property value distribution upwards by a factor equal to: aggregate financial wealth divided by aggregate property wealth, derived from the ONS Wealth in Britain series. This in turn implicitly assumes that the distribution of financial wealth is not greatly dissimilar to the distribution of property wealth. This may not be the case, but it is believed that the crude adjustment does not compromise the results in order magnitude terms

Figure A1.1

*Distribution of residential property prices, England 2016, truncated at £500,000*




Source: Land Registry

The adjusted personal wealth distribution, combining property and financial wealth, provides us with a reasonable proxy for the distribution of non-disregarded assets of people at risk of entering a care home. However, what we are seeking to measure is the asset distribution of the care home population at steady state, some years in the future, when the £100,000 single threshold has worked its way through the system. This must take account of asset depletion as a result of care service consumption by those service users who do not yet qualify for council support. We do this in two ways:

- **Estimating private pay spend-down in care home fees:** this makes use of the fact that, unless the rate of decay of any given cohort of care home entrants is highly skewed, the average length of stay of *in situ* care home residents at a point of time will be approximately half the expected length of stay at discharge or death, making use of reasonably reliable, though imperfect, publicly available data on expected length of stay in care homes, as summarised in Section 6

of LaingBuisson's annual report on the older person's care home market[13]. For example, if expected length of stay is twenty-four months, then on average private payers in situ in a care home at a given point of time will have spent down 12 months' worth of fees.

- **Estimating private pay spend-down on care at home, prior to care home admission:** our best estimate, based on fragmentary data, is that, on average, privately paying care home residents will have spent about one and a half years receiving and paying for care at home services at full cost prior to care home admission. This estimate takes account of some residents who will have been admitted into a care home without any preceding care at home and also those whose care at home was fully or partly paid by the council, thus limiting asset depletion.

When these asset depletion factors are taken into account, the share of *in situ* care home residents whose non-disregarded assets are less than or equal to £100,000 is nearer to the share of the general (pre-admission) population whose non-disregarded assets are less than or equal to around £150,000, subject to significant regional variation.

One further significant factor must be taken into account when estimating the *additional* care home residents who will quality for council support as a result of an extension of the asset threshold from £23,250 (now) to £100,000. This is the fact that the proportion of older care home residents who qualify for council support (excluding NHS-funded continuing healthcare) is, at 49%, higher than might be expected from the statistic that non-owner occupiers make up only about 30% of the older population at risk of care home entry, in all regions, even though property ownership usually bars an individual from council support. Part of this apparent discrepancy is accounted for by spend-down. Another part is explained by disregard of property owned by a care home entrant which is occupied by his/her spouse or former carer. Another part of the explanation must lie in intentional divestment of property, though by its nature this is impossible to quantify. The model deals with these factors by assuming that all of the 49% of social care residents who are currently financially supported by their councils will continue to be so, and that *additional* supported residents resulting from a £100,000 single threshold would all come from residents who would otherwise be private payers (under the current, £23,250, upper threshold limit), based on the assumption that the adjusted personal property and financial wealth distribution (as described above) is a good proxy for the wealth distribution of the remaining 51% of (non-NHS-funded) care home residents.

Region-specific wealth distributions, as described above, allow the calculation of the number of additional residents who would be subject to 'payor shift' from private pay to council pay.

The annual gross cost of 'payor shift' to councils can be calculated by multiplying the additional number of 'enfranchised' residents by the average fee rates paid by councils. The annual net cost to councils can then be calculated by deducting user charges. Latest NHS Digital statistics indicate that user charges amount to 34% of gross costs. User charges for the newly enfranchised residents would certainly be higher, since nearly all of them would be property owners with higher than average incomes. In the absence of any hard data, we have assumed that their user charges would average 55%. This is set at a parameter in the model (see parameter list below), modification of which will cascade down into the model results.

The net cost to the public sector as a whole is lower, since Attendance Allowance payable to private payers would no longer be payable to those residents who qualified for council support. But the savings would accrue to central government (the social security account) not to councils.

[13] See note 5

## Lifetime care cost cap

We have used a simplifying assumption, which is that very few social care service users will qualify for the cap while still living at home, using care at home services only. Nearly all who reach the care cap will do so when they are resident in care homes. This simplifying assumption allows us to avoid complex and unreliable simulations of care pathways and put in their place an estimated average of £15,400[14] accrued (through care at home costs over an average period of about a year and a half) towards the cap prior to admission to a care home, and then to calculate how much will be spent on the care element of care home fees using a life table for care home residents constructed from publicly available data on lengths of stay.

The pre-admission care at home period of a year and a half is estimated on the basis of fragmentary information. It is set at a parameter in the model (see parameter list below), modification of which will cascade down into the model results.

Service users would qualify for the care cost cap when the number of months of care multiplied by the cost of care per month reaches the care cost cap value. Costs per month are set as parameters (see parameter list below), extrapolated to 2016/17 from the latest available unit costs from NHS Digital for 2015/16. Unit costs are those usually paid by councils, not private pay fees.

In the absence of official or commercial data on claims experience, it is necessary to estimate rate of decay of populations in receipt of care in order to calculate the proportion of service users who would still be alive when the care cap is reached. We have estimated a suitable 'life table' for care home residents by constraining UK general population life tables for people of 85 and over such that, while relative rates of mortality by age remain unchanged as per the UK general population life table, absolute mortality rates are increased up to the point that expectation of life is the same as that experienced by care home populations, according to publicly available data.

Table A1.1

*List of parameters in the model (note that not all parameter values necessarily impact on the model's output*

| | |
|---|---|
| Share of residential care users in single person households | 0.75 |
| Share of non-residential care users in single person households | 0.5 |
| Financial wealth as a percentage of property wealth | 10.50% |
| Female share of residential care users | 0.75 |

[14] These costs are calculated at councils' 'usual cost' rates, in line with the principle adopted for Dilnot implementation which was, in effect, that the care cap should not underwrite individuals' care expenditure at private pay rates, and indeed should not underwrite individuals' expenditure on care services which fail to meet councils' needs criteria

| | |
|---|---|
| Female share of non-residential care users | 0.65 |
| Financial wealth multiplier | 10.50% |
| Privately paying care home residents with or without dementia, England 2017 | 161,449 |
| Average Length of Stay in care homes | 104 weeks |
| Average asset depletion period within a mature care home population (weeks) | 54.29 |
| Average asset depletion period for privately paying residents prior to admission - using homecare | 76 weeks |
| Private pay homecare premium | 1.15 |
| Estimated average asset depletion (£ per year) for privately paying residents prior to admission - using homecare | £17,700 |
| Gross council expenditure on 'community' (non-residential) social care services for people aged 65+ in England, 2015/16, source NHS Digital | £2,611,000,000 |
| Councils' income from client contributions for 'community' (non-residential) social care services for people aged 65+ in England, 2015/16, source NHS Digital | £441,000,000 |
| Client contributions as % gross expenditure 'community services' 2015/16 | 16.90% |
| Older people receiving council funded non-residential social care services at end year 2015/16, NHS Digital | 248,000 |
| Gross annual cost per older 'community' services user (gross of client contributions and SSMSS) | £10,528 |
| Gross council expenditure on residential care services for people aged 65+ in England, 2015/16, source NHS Digital | £4,649,923,527 |
| Councils' income from client contributions for residential care services for people aged 65+ in England, 2015/16, source NHS Digital | £1,565,990,018 |

| | |
|---|---|
| Client contributions as % gross expenditure on residential care services 2015/16 (from above) | 34% |
| Client contributions as % gross expenditure for residents enfranchised by £100k threshold or PAPG | 55% |
| Residential care budget inflation factor 2015/16 to 2016/17 | 1.03 |
| ENGLAND Unit costs of residential care to councils (gross of SSMSS, net of NHS FNC) 2015/16 | £559 |
| ENGLAND Unit costs of residential care to councils (gross of SSMSS, net of NHS FNC) 2017/18 | £563.50 |
| Social Service Management Support Services (SSMSS) as a percentage of Unit costs | 13% |
| Normalisation factor required to make weighted average fees net of SSMSS and NHS FNC by CASSR equivalent to England benchmark net of SSMSS and NHS FNC of £539 (2017/18) | 112% |
| Ratio of private paid to state paid non-residential care for older people, Table 2.4 of Care or Older People Market Syevey. Some private payers may not pass councils' needs assessments | 0.615036744 |
| Share of care home residents with dementia (Alzheimer's Society Estimates 69%) | 69% |
| Share of care at home recipients with dementia (Alzheimer's Society Estimates 60%) | 60% |
| Share of NHS continuing healthcare recipients in care homes with dementia | 69% |
| Share of non-residential NHS continuing healthcare recipients with dementia | 60% |
| Estimated persons over 65 receiving NHS funded continuing healthcare | 50,000 |
| Weighted average dementia fee premium (council pay) | £17 |

| | |
|---|---|
| Weighted average dementia fee premium (private pay) | £24 |
| England population aged 65+ | 10,063,000 |
| England care home residents excluding NHS continuing healthcare) | 317,700 |
| England council funded care home residents excluding full cost payers | 156,200 |
| England council funded care home residents including full cost payers | 165,200 |
| Share of care home private payers who would meet council needs assessment | 90% |
| Share of homecare private payers who would meet council needs assessment | 80% |
| ENGLAND PDA (People with Depletable Assets) stock in care homes at a point of time (2017) proxy = No. of Private Payers, including full cost payers | 111,435 |
| NHS FNC (free nursing care) 2017/18 | £155.05 |
| Hotel costs (weekly board and accommodation costs not counted towards the care cap) | £240 per week |
| Personal expenses allowance 2017/18 | £24.90 per week |
| Attendance allowance / DLA higher rate 2017/18 | £83.10 per week |
| Attendance allowance adjustment (to allow for 28-day grace period before it is taken into account as income for charging purposes) | £3.20 per week |

In addition to the parameters set out above, and data on the distribution of personal asset values, the spreadsheet model required data down to regional level or below on the following, all of which are believed to be reliable within a few percentage points:

- Bed capacity, from the Care Quality Commission
- Occupancy rates, from LaingBuisson surveys of care homes, in order to calculate numbers of residents
- Care home funding sources, from LaingBuisson surveys of care homes
- Private pay fee levels, which are necessary to calculate rates of spend-down from above the proposed single threshold of £100,000

- The number of older people placed by councils at financial year end, with ‘full cost payers’ classed as private payers since they receive no financial support from their councils. This information is available from NHS Digital, which collates data on personal social services activity and costs from all English councils in its annual Personal Social Services Activity and Expenditure and Unit Costs series

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