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Funding social care for older people: The implications of extending the current means-test

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Contents

Introduction	2
Methods.....	4
Results	4
Costs	4
Outcomes.....	6
Asset depletion.....	6
Quality of life.....	10
Concluding points.....	13
References	14

Introduction

In addition to its core recommendation of introducing a cap on the costs of care that any person would face, the Dilnot Commission also recommended an increase in the upper capital limit (UCL) of the current means test from £23250 to £100,000 [1]. The UCL determines whether or not a person is eligible for a public subsidy towards the cost of their care. However, the size of this subsidy depends crucially on their assessable income and in this respect changes to the lower capital limit (LCL) will have a potentially greater impact. In this paper we consider the cost and benefit implications of funding reform based current means-testing system but where the LCL and UCL are merged and where the capital limit is raised significantly above its current level. We might call this alternative system *means-testing plus* (MTP).

The Dilnot Commission proposed a ‘capped risk’ model that would limit the total amount a person would have to pay towards the cost of their care. It would work by adding up the total (notional) cost of a person’s care to date (as benchmarked by what level of care and support would be assessed by local authorities). Anyone whose costs exceeded a given threshold – the Commission suggested £35000 – would have the full costs of their care met by the state. Although people’s liability would be measured in terms of the care they need and not according to how much they actually spend, the underlying principle is to protect the total private contribution any person would have to make. The idea, in other words, is to protect care recipients against possible *catastrophic costs* (for the minority of people that would otherwise incur them under the current system).

There are well-understood benefits in giving people an opportunity to insure against potential catastrophic costs of care. The Dilnot proposals protect people by limiting the total amount that any person would have to spend; however, the current system also has a limited liability mechanism of a kind in that it ensures that people always retain a given amount of their assets/capital. In the current

system there is an upper capital limit (presently set at £23,250) below which people are entitled to some state support towards the cost of their care. Their capital is completely protected if it falls below the lower capital limit (currently £14,250). People are still expected to contribute part of their income, but for people in care homes this is largely used to cover the costs of the housing element of their care.

The current system is not often regarded in this light because the capital thresholds are set at a low level and only protect a small residual amount of people's assets in many cases. The lower capital limit is only just above the median level of non-housing wealth/savings held by 65 year olds and considerably below the mean level. This protection feature of the currently system would become more significant if the capital thresholds were increased. This is an option considered in this paper.

The Dilnot Commission suggested increasing the upper capital limit to £100,000, but with no change to the lower capital limit. It is the lower limit, however, that fully protects people's assets, precluding the need for any person to draw on their assets to pay for care once they fall to this level. Increasing the lower capital limit to £100,000 would make a significant difference to most self-payers. It would mean that no person would have to use their savings to pay for care if this would leave them with less than £100,000. Unlike the capped risk model, this option would not limit the total amount that a person would have to spend, but it would ensure that no-one was left with less than £100,000 of assets. It therefore insures people against the loss of residual wealth rather than against the cost of care.

An advantage compared to the capped risk model is the ease at which this reform could be implemented practically. Any means-testing arrangement implies a significant pro-poor focus of public resources but a version with a much higher asset threshold implies less re-distribution than the current arrangements. Whether achieving a flatter income gradient is considered an advantage or otherwise is a political judgement. It is clear, nonetheless, that the current model is least advantageous to the middle of the wealth distribution. The alternative funding models considered here would help to reduce this imbalance.

This means-testing plus option would protect *assets* and not (the use of) income and so will create incentives, and sometimes perverse incentives, for people to keep their wealth in savings and capital, and not draw-down an income from those assets. Problems would also remain as concerns the differential treatment of assets between those receiving home care and those people in care homes. For example, take the not unusual case of a home-owner living alone who needs either a care home placement or an equivalent high-intensity home care package. In the current system they would receive no help with the cost of the care home but could have the whole of their home care cost covered by the public purse.

The aim of this report is to assess the implications of a change in the LCL from its current level of £14,250. Following a change in the LCL, the analysis considers the implications for the individual older person and also the overall public cost of social care; the benefits in terms of any changes in outcome that result; and the distributional effect on service users (i.e. who would gain or lose).

The analysis considers the effects of a change in the LCL to:

- £25,000
- £50,000
- £75,000
- £100,000
- £150,000
- £200,000

In each case, as these thresholds exceed the current level of the upper capital limit, this is increased to the same value as the lower capital limit.

Methods

The PSSRU dynamic microsimulation model (DMS) is used for this analysis. The standard assumptions are used:

- The central measure of disability in the model that drives care needs is the inability to perform basic activities of daily living (ADLs), such as washing, feeding, dressing etc. Age and household composition (informal caring) are also factors in determining overall care need. The base case scenario assumes constant age-sex prevalence of ADL disability over time.
- Mortality is modelled to conform to the over 65 population projections made by GAD/ONS. Mortality rates for people in care homes are adjusted to be in line with estimates for England (with average lengths of stay of around 2.5 years).
- At baseline (2010), for care home placements unit costs are £560 p.w. For community care, each hour of care is assumed to cost £15.65
- All costs are up-rated in real terms on an annual basis. Initially in the base case scenario we assume a 1.5% per annum real terms increase in unit costs and then after 2017, unit costs increase by 2% in real terms.
- New cohorts of 65 year olds joining the over 65 population have both income and assets that are 2% higher in real terms than 65 year olds from the year before.
- Otherwise, people in the over 65 population earn interest on savings and have housing assets increase in value in real terms at 2% p.a.
- State pension income is assumed to increase in line with earnings (at 2% p.a.) but other income does not increase in real terms.

In each scenario we assess cost and benefits as though the reform option (i.e. the increase in the corresponding threshold) was implemented in 2010/11, the base year of the model.

Results

Costs

Table 1 reports the annual net public cost of care services for older people for the various levels of the lower capital limit. Net public cost is defined as gross expenditure on services less any charge

income to the council. It does not include the costs of care management or other central/strategic costs.

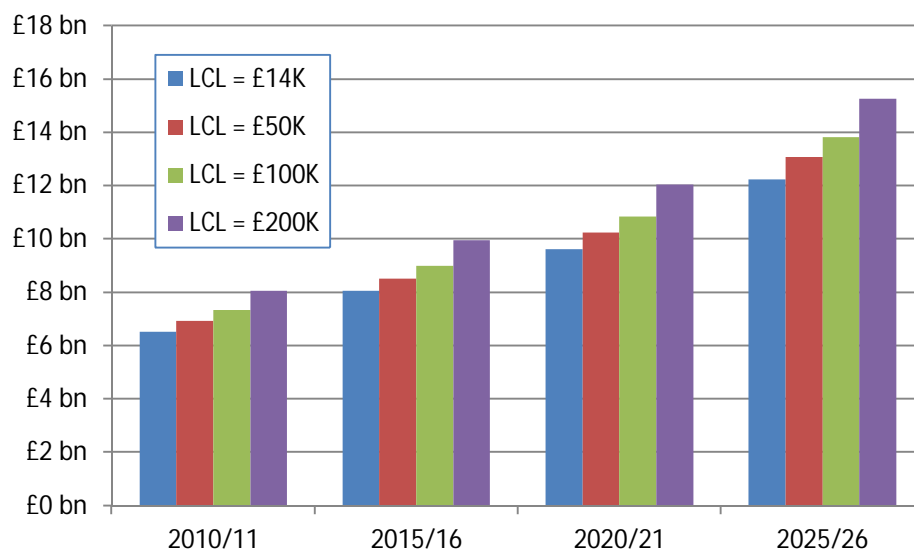
The central projection from the PSSRU DMS for the current system – i.e. with a lower capital limit of £14250 and an upper capital limit of £23150 – is given in the first column of the table. It projects that net public cost will increase from £6.53 bn in 2010/11 to £12.23 bn in 2025/6.

Table 1. Net public costs (£bn p.a.), various lower capital limits

	Lower capital limit						
	£14250	£25000	£50000	£75000	£100000	£150000	£200000
2010/11	6.53	6.60	6.94	7.13	7.33	7.76	8.07
2015/16	8.05	8.14	8.53	8.77	9.01	9.52	9.96
2020/21	9.62	9.72	10.24	10.54	10.85	11.51	12.06
2025/26	12.23	12.35	13.08	13.48	13.82	14.56	15.26

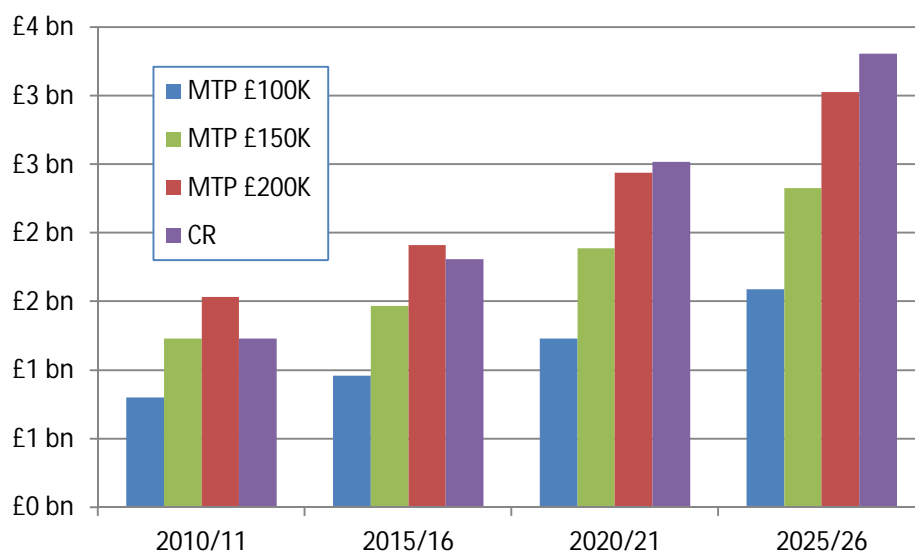
Figure 1 displays these costs and shows that the underlying upward trend in costs in all scenarios between 2010 and 2025 exceeds the extra cost within year that an increase in the LCL would require.

Figure 1. Net public costs (£bn p.a.), various lower capital limits (LCL)



The additional costs required (as compared to the current system) can also be plotted directly – see Figure 2. For comparison the graph also includes the additional public costs of the capped risk (CR) model (with a £35,000 capping threshold and an increase in the upper capital limit of £100,000 in residential care). Three of the means-test plus options are also included in the chart: where the lower (and upper) capital limits are increased to £100,000, £150,000 and £200,000 for both residential and non-residential care.

Figure 2. Increase in net public costs (£bn p.a.) compared to net public costs of the current system – capped risk (CR) model and various MTP options



Raising the LCL to £150,000 would require extra costs that are broadly in line with the extra costs of the CR model in 2010/11. Under the MTP options, costs increase at a slower rate than for CR for two main reasons: (a) in line with unit cost growth, the capping threshold of £35,000 is increased in real terms over the period, and (b), the projected increase in life expectancy of older people disproportionately affects the costs of the capped risk model.

Outcomes

The outcome implications of funding reform can be assessed in a number of ways. We begin by looking at how quickly people would deplete their assets to pay for care. We then consider the effects of reform on their social care-related quality of life.

Asset depletion

Asset depletion is the lifetime amount that people have to draw on assets to pay for (assessed) care services. To assess the scale of asset use, we first calculate *residual income*:

$$\begin{aligned}
 \text{Residual income} = & \text{total income (all sources)} \\
 & \text{less} \\
 & \text{cost of living amount} \\
 & \text{less} \\
 & \text{the charge for assessed care package} \\
 & \text{(including accommodation costs in residential care)}
 \end{aligned}$$

If residual income is negative – i.e. if care charges and costs of living costs exceed a person's income – then they are required to draw on their savings. In other words, any negative residual income is the amount at which people deplete their assets. We can calculate this amount each year for service users and add it up over the person's lifetime to give an indication of lifetime asset depletion.

We are only interested in this analysis in people that have negative residual income (as a result of paying care charges). Those service users with sufficiently high incomes to cover all costs have zero asset depletion, although of course they may still end up paying a large amount in charges.

Since we subtract an *average* cost-of-living amount from everyone (based on the amount of the minimum income guarantee in Pension Credit), these asset depletion figures may not correspond to people's actual use of their assets. Rather, this might be considered as the minimum amount that people would need to draw on assets. More importantly, it gives a consistent basis for comparing the impact on assets of different funding options.

In the figures given below we take all new service users from 2010 and track their asset depletion over their remaining lifetime. Asset depletion is expressed as the percentage of total (household) housing and non-housing assets in 2010 that people would have needed to use.

Figure 3 shows lifetime asset depletion for the worst affected residential care service user in each quintiles of the income distribution.¹ Under the current system the worst affected person would have lost 84% of her 2010 total household assets – in Box 1 we describe this person's situation and there financial experience.

Although wealthier people pay higher charges for their care in almost all funding systems, the high level of their starting wealth means that they can end up paying a lower proportion than people in lower income quintiles. For example under the CR system, the worst affected care home resident in quintile 5 loses just under a quarter of their assets. The worst affected person in quintile 1 loses over half of their starting assets.

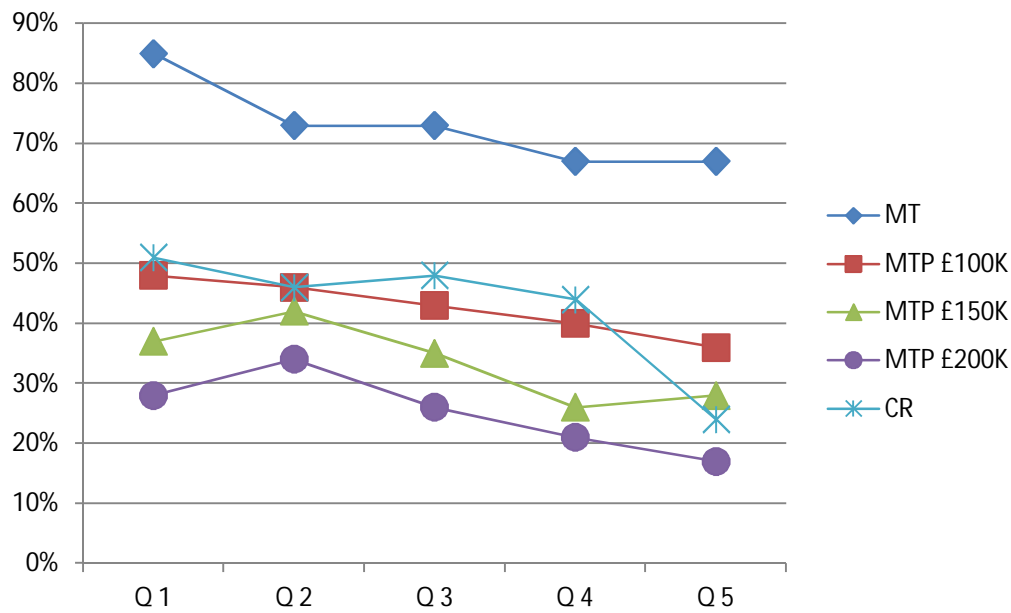
The situation is slightly different if we look at the rates at the 75th percentile of the asset depletion distribution rather than the 100th percentile as above. The asset depletion rates in this case are presented in Figure 4.

Box 1. Mrs A

This married woman has £124300 of assets in 2010, almost all of which is the family home. Her assessable income is low which puts her in quintile 1. In 2014 she is projected as going into residential care. At that time, being still married, she is eligible for public support towards the cost of her care, and is being charged less than £100 p.w., paid for out of income i.e. no asset depletion. However, in this example her husband dies in 2017 and she inherits the proceeds from the sale of the family house (at the time worth £145,000 in 2010 prices, having gained in value). With this money in the bank, the council are now able to charge her the full cost of her care (over £620 p.w.). Her modest income means that her assets are now being depleted at over £500 p.w. or £26000 per year. This situation continues until her assets are depleted down to near the upper capital limit of £23250 (in 2010 prices) by 2020 and again the council now pay the majority of the cost of the care home placement. The woman dies in the following year having used £105,000 of her assets, or 84% of their 2010 value of £124,300. Because the housing asset accrued real capital gains over the period, the estate was valued at over £23,250 at her death.

¹ The definition of income in this case includes income from all sources and also an estimated return on liquid assets, according to the definition used for Pension Credit determination.

Figure 3. Percentage of assets depleted in lifetime – person with the highest asset depletion in the sample - % of 2010 total assets, residential care service users in 2010 by wealth quintile



Rates of asset depletion are substantially lower at the 75th percentile overall, as expected. If we rank all service users according to how much they deplete their assets, then this analysis is looking at the person three quarters up the distribution i.e. there are a quarter of people with higher rates of depletion. In this case (the 75th percentile), people in income quintile 1 will experience lower depletion rates than their counterparts in higher income groups. The median rates of asset depletion are zero for all funding systems except for people in quintile 5 where rates are just a few per cent. Asset depletion rates are lower in the three alternative funding systems as compared to the current system.

Figure 4. Percentage of assets depleted in lifetime – person at 75th percentile of the distribution - % of 2010 total assets, residential care service users in 2010 by wealth quintile

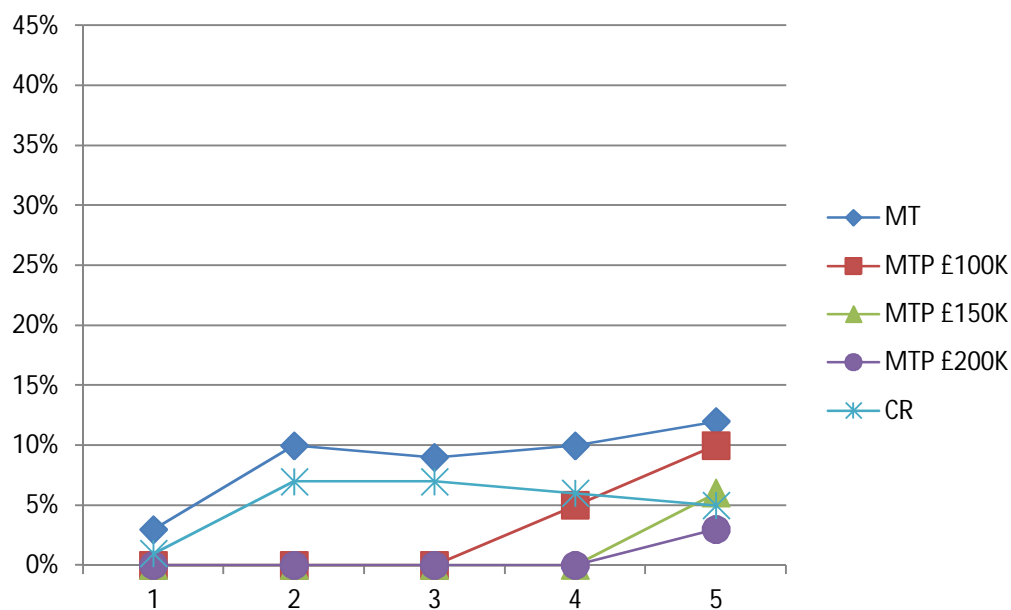
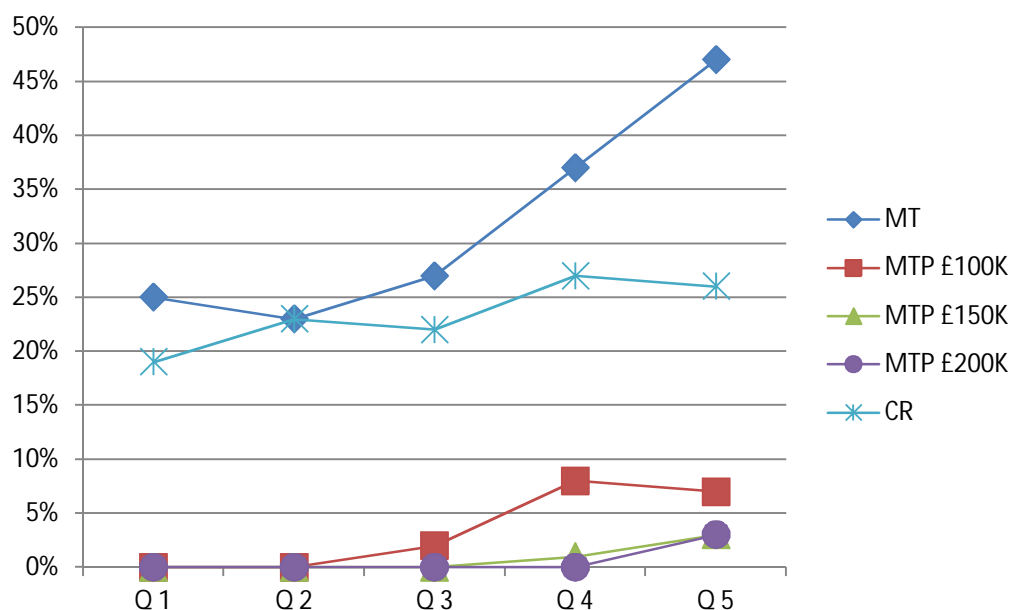


Figure 5 has assets depletion figures for people using community-based services. In particular, these figures concern those service users with high levels of need (an average of two or more ADL problems over their remaining lifetime)². In this case the two means-testing plus options produce much lower rates of depletion than under the current system, as does the capped risk option. Under the capped risk model, the worst-affected person is projected to lose 27% of their 2010 assets – see Box 2 for this person's experience.

Figure 5. Percentage of assets depleted in lifetime – person at 100th percentile of the distribution - % of 2010 total assets, community-based care service users (high need) in 2010 by wealth quintile



Box 2. Mrs B

This single woman has £97,700 of non-housing assets, and no housing assets, in 2010. Her regular income is low but her assessable income is relatively high as a result of the return on her savings. She is income quintile 4. In 2018 she takes up community care services at the age of 80 after a fall. At that time she has assessable assets of £67,500 and so would not be eligible for public support. Initially her needs are relatively low and she purchases only a low level of care services (under £20 p.w.) using her savings to finance this purchase (after living costs). After two further years her need deteriorates and she buys a bigger care package. Now her income increases somewhat as a result of her getting Attendance Allowance and Pension Credit (now qualifying for severe disability premium), but with the extra costs associated with her high level of need, most of the care package is financed from savings. She is now using her savings at a rapid rate but also adding care costs towards the £35,000 capped risk threshold. In 2024 her assets have fallen to below £23,250 and she now becomes eligible for council support. Her charges fall to zero at this point (due to her low regular income) and so has no further asset depletion, but she is still just under the £35,000 cap. In the following year she reaches the capped risk threshold but is already paying a zero charge so her situation is unaffected. By this time she has used around £26,000 of her savings to pay for care – lifetime asset depletion is therefore 27%.

² Low-need service users have negligible rates of asset depletion

Quality of life

The use of social care services by people with care needs generally improves their quality of life (compared to the situation where no services are available). Using research on outcomes in social care [2; 4] it is possible to estimate the degree to which services impact on people's social care-related quality of life (SCRQoL), using a standard scale³. Moreover, a monetary value can be attached to any improvement on this scale by applying the same methodology as used by National Institute of Health and Clinical Excellence (NICE) [3]. In this way, assuming that the value of a quality of life-adjusted year of service receipt is £30,000 per service user (as used by NICE), the total value of social care services provided each year in England can be estimated. We put a value on the actual amount of care people use but only as long as this amount does not exceed their assessed need for care:

$$\text{Value of care} = \text{SCRQOL gain (intensity and type of care)} \times \text{£30,000}$$

Going further, we can put a total monetary value on services that people are assessed as needing and compare that with the (monetary value) of the services they actually use:

$$\text{Shortfall} = \text{Value of care needed (assessed)} - \text{Value of care used}$$

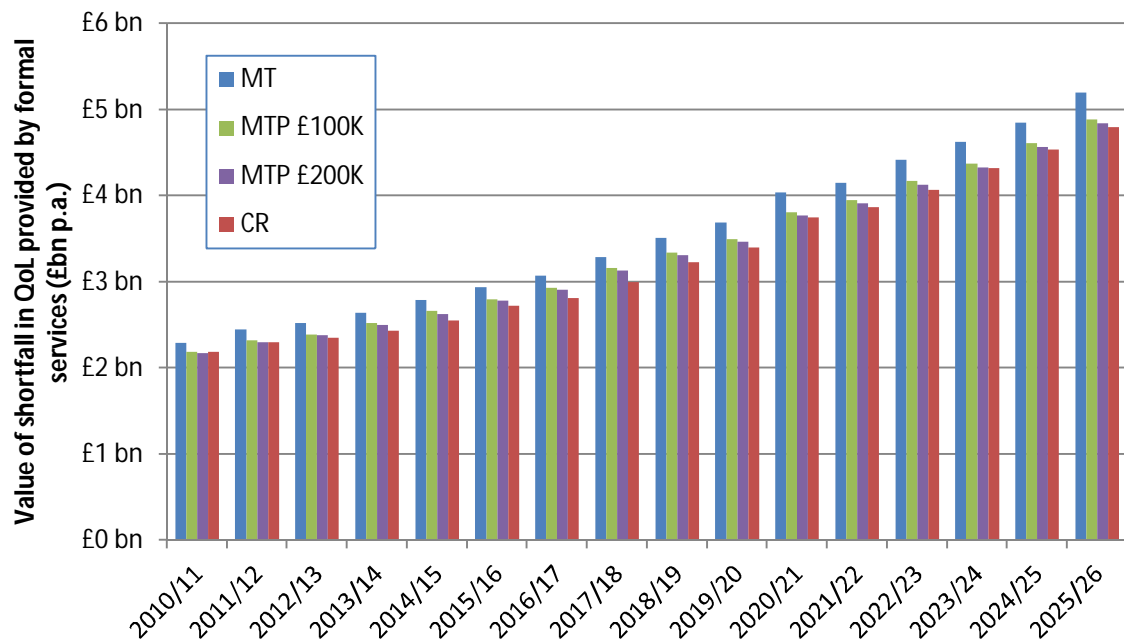
A shortfall can occur because services come with a cost and therefore actual demand can be different from assessed need. Moreover, the prevailing funding arrangements determine the charges that people face and so affect the size of this shortfall. Changing the funding system will therefore impact on the size of this shortfall.

Figure 6 has the results. In this case the shortfall in SCRQoL is between assessed support need and the amount formal services deliver (we exclude informal care at this time). The chart shows the shortfall under the current system and the alternative arrangements. It can be seen that the alternatives all result in a reduced shortfall, but that the reduction is relatively modest in scale. Most of the reduction in the shortfall is due to people facing lower average charges/fees for their care and therefore expressing a higher demand.⁴

³ SCQOL is derived from the ASCOT measure (see www.pssru.ac.uk/ascot), taking a rating of 1 for full social care-related quality of life and 0 for a state that is so bad as being no better than death. Given the very high level of need of people in care homes, the gain in SCQOL is estimated at 0.8. Non-residential care produces a gain in outcome according to the intensity (weekly amount in £s) of care received, but at a diminishing rate.

⁴ Since the actual size of demand effects are difficult to estimate very accurately, the demand assumptions in the base case of the PSSRU model are relatively conservative. In other words, the differences could be greater in reality.

Figure 6. Value of shortfall in social care-related quality of life (SCRQoL) provided by formal services (£bn p.a.), different funding options



Another useful concept for assessing the impact of each funding system is the *net benefit* of care received. This figure accounts for both the value of care people use and the amount that they pay for it directly in charges:

$$\text{Net benefit (NB)} = \text{Value of care (£s)} - \text{Charge for care (£s)}$$

Net benefit can be calculated for each year and summed over the person's lifetime to get a lifetime total net benefit, $\sum_t \text{NB}$.

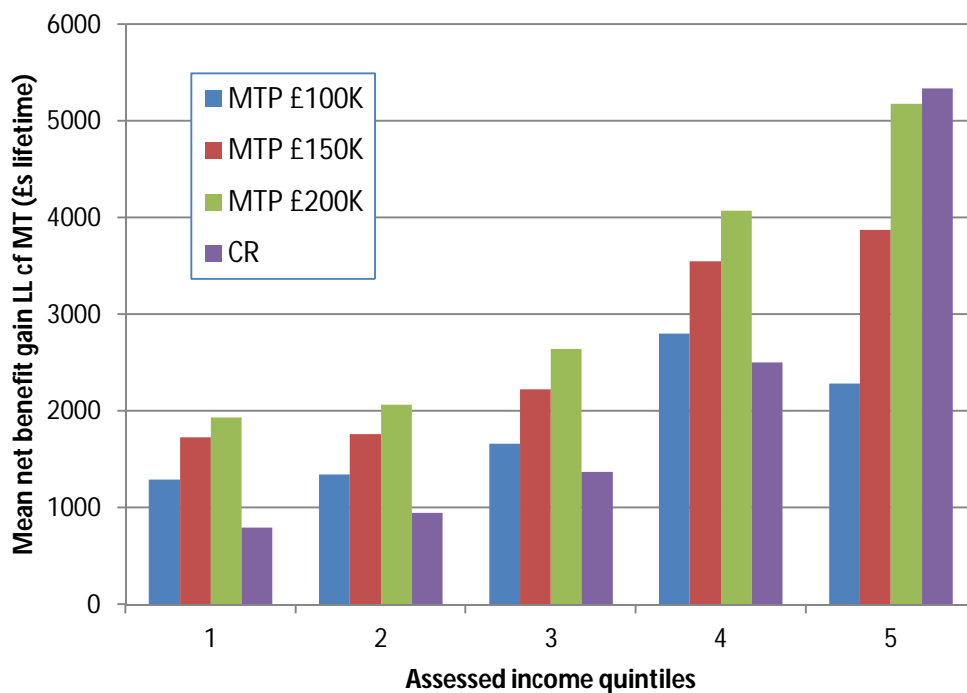
This indicator can be used to compare different funding systems. By and large, people will pay different charges and may use different intensities and types of care under different funding arrangements. As such the net benefit they receive under the current means-tested system (which we denote $\sum_t \text{NB}^{\text{MT}}$) can differ from the net benefit they would receive under the capped risk or means-testing plus systems. In fact, both these reform options result in reductions in care charges for some people and increases in service uptake. Net benefit from capped risk or means-testing plus will be higher than net benefit from means-testing i.e. net benefit *gain* from capped risk or means-testing plus will be positive: $\Delta \sum_t \text{NB}^{\text{CR}} = \sum_t \text{NB}^{\text{CR}} - \sum_t \text{NB}^{\text{MT}} > 0$ and also $\Delta \sum_t \text{NB}^{\text{MTP}} = \sum_t \text{NB}^{\text{MTP}} - \sum_t \text{NB}^{\text{MT}} > 0$.

Figure 7 shows the net benefit gain from implementing the capped risk or means-testing plus for new service users over their lifetime. The results are presented for each assessed income quintile. This analysis takes any person with a care need at 2010 or at any point up to 6 years later. It considers those people that would be in the same care setting under the new funding option as they would under the current system. This assumption is made to improve comparability. Nonetheless, because the numbers of people included in each analysis can differ slightly, comparison of the results between MTP options and CR options should be taken as indicative. Indeed, the main

intention of this analysis is to compare the distribution of net benefits between assessed income groups for each funding option.

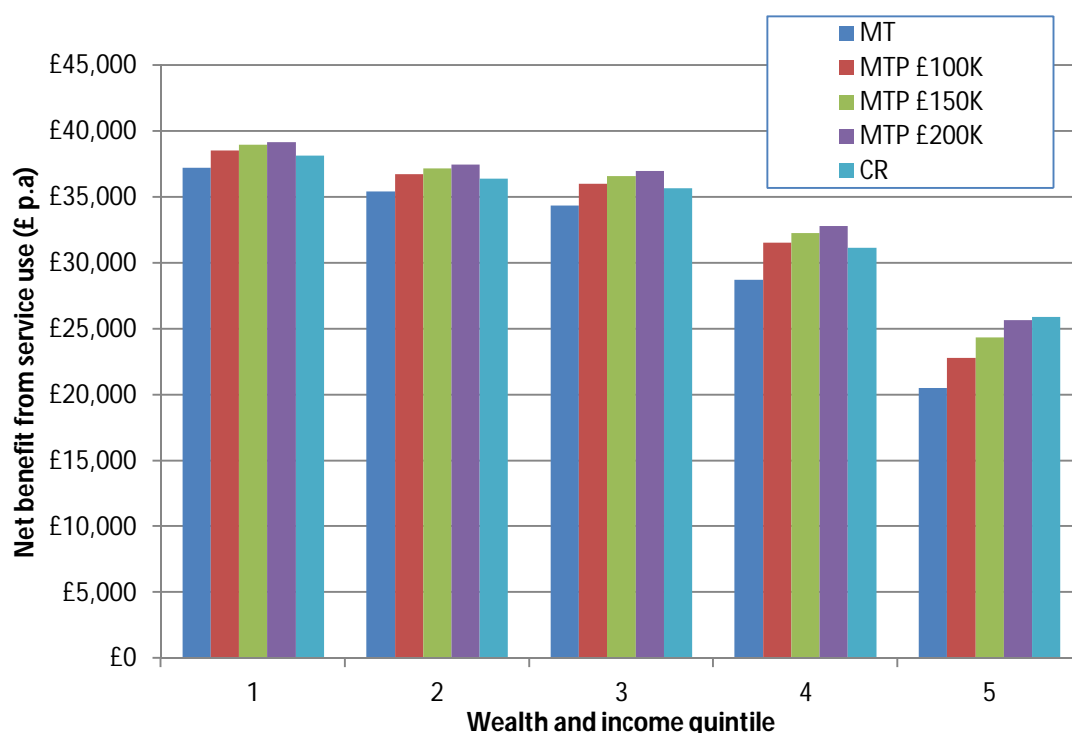
For the base-case capped risk (CR) option, the highest income group gains the most. For the means-testing plus option with a £200,000 LCL, it is also the wealthiest who gain the most, although the difference in gain from highest to lowest income groups is less pronounced in this case. However, for the means-testing plus option with a £100,000 LCL it is people in the fourth income quintile that gain the most and the gradient between income groups is much flatter than the other reform options. As regards the MTP option with £150,000, the gain in quintiles 4 and 5 is very similar.

Figure 7. Gain in lifetime net benefits (£s), CR and MTP compared to MT



Although it is wealthier service users that gain the most from these funding reforms, this improvement is from the position of being the least well served under the current means-testing arrangements. Figure 8 shows total net benefits (value less charges) under each funding system. Under the current means-testing system (MT in the chart) poorer people experience far greater net benefit over their lifetime than richer people; for example, net benefit for new service users in income quintile 1 averages £35,200 over their lifetime but is £20,500 for people in quintile 5. The latter are far more likely to be self-funders than the former and so pay much more out-of-pocket. The funding reforms measures considered here – capped risk and means-testing plus – would reduce the gradient in net benefits between poorer and richer people.

Figure 8. Total lifetime net benefits



Concluding points

A range of reform options for the funding of social care have been put forward. The Government is currently considering the proposals of the Dilnot Commission. This paper has sought to contribute to the funding debate by considering the implications of adjusting the current model. In particular, the PSSRU dynamic microsimulation model has been used to assess the consequences of a series of increases in the lower capital limit, where also, the upper and lower capital limits are merged into a single limit. These reform options were termed 'means-testing plus' in the analysis. The lower capital limit in a means-test system acts to protect any care recipient's *residual* assets after meeting care costs. It therefore embodies a limited liability provision of sorts that would constrain asset depletion.

The above analyses show that the capital limit could be raised to over £150,000 and have comparable public cost implications as the Dilnot proposals. At that level, maximum rates of asset depletion in the care recipient population would fall significantly from their current rates. Moreover, the analysis shows that maximum rates of asset depletion can be below those rates projected for the capped risk model in some cases.

An obvious advantage of the means-testing plus model is the ease at which it could be implemented practically in order to enhance asset protection and also to extend state support further up the income distribution, particularly giving more help to middle income groups. Nonetheless, a range of problems still remain. There are still strong incentives for people to divest of assets, particularly non-housing assets, in order to qualify for state support. Clearly, with a lower capital limit at, say, £150,000 only relatively wealthy people would be affected. There is also the related problem of the differential treatment of housing and non-housing assets according to the setting in which people receive care (i.e. as between their own home or a care home). A 'levelling down' policy of including housing assets in the home care means-test is politically sensitive, although setting a capital limit at

£150,000 or more might help to mitigate this problem somewhat. 'Levelling up' by excluding all housing assets from any means-test would be very expensive on the public purse and risk creating perverse incentives for older people to invest in high-value homes, rather than hold liquid assets. Furthermore, this option only protects people's assets – it would not help people that were income-rich but asset poor (although this is a relatively rare combination).

Finally, increasing the lower capital limit does not specifically protect people in terms of the absolute amount they spend. For example, a wealthy person with £800,000 of assets might deplete £200,000 of those assets. Whether or not £200,000 or, in relative terms, 25% of their assets is regarded as 'catastrophic' is a political judgement.

The Dilnot Commission identified the importance of providing catastrophic cost insurance for older people. The Commission's recommended capped risk model was designed to address the failings of the current system in that regard. Although a means-testing plus model is not set up to tackle this problem, the analysis shows that in practice rates of asset depletion can be reduced. Nonetheless, there are other serious problems with the means-testing system as it currently operates in social care, which will not be mitigated by changes to the capital limits. There remains, as there has been since the Royal Commission in 1999, a strong case for root-and-branch reform of social care funding.

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