



Institute for Fiscal Studies

IFS Briefing Note BN339

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Does the cap fit? Analysing the government's proposed amendment to the English social care charging system



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Copy-edited by Judith Payne

Published by **The Institute for Fiscal Studies**

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ISBN 978-1-80103-067-0

This project was funded by the Health Foundation. David Sturrock also gratefully acknowledges the support of the ESRC Centre for the Microeconomic Analysis of Public Policy (ES/T014334/1). The English Longitudinal Study of Ageing was developed by a team of researchers based at University College London, NatCen Social Research and the Institute for Fiscal Studies. The data were collected by NatCen Social Research. The funding is currently provided by the National Institute of Aging (R01AG017644), and a consortium of UK government departments coordinated by the National Institute for Health Research.

Executive summary

In September 2021, the government announced that a cap on lifetime social care costs would be operationalised in England from October 2023, set at a level of £86,000. When the possibility of a cap was first legislated for in the 2014 Care Act, that legislation set out that total personal care costs incurred (including those covered by means-tested council funding for those with low assets or income) would count towards the cap. However, in November 2021, the government proposed to amend the Care Act so that an individual will reach the social care cost cap when the amount they have spent themselves (excluding any means-tested support from their council) reaches £86,000. The government estimates that this amendment will save £900 million per year from 2027–28, reducing the cost of the social care cap by around a fifth.¹

This briefing note considers the effects of the government's proposed amendment to the Care Act, which would mean that means-tested support does not count for an individual's progress towards the social care cost cap. Our analysis does not compare the government's proposed system with the existing system (which does not include a cap). Rather, we compare the government's proposed system with how the new system (including the cap) would work without the proposed amendment to the Care Act.

We present analysis of which groups of older people would be affected by the proposed amendment, looking at differences between those with different levels of wealth and income and those living in different parts of England. To do this, we use information on the assets and income levels of different groups of older people and calculate the proportion of assets that they would be required to contribute towards their care costs under a number of different care journeys, both with and without the government's proposed amendment to the Care Act.

¹ Cabinet Office, DHSC and Prime Minister's Office, 2022b. This figure includes Barnett consequential and is expressed in 2027–28 prices. Excluding Barnett consequential and expressed in 2021–22 prices, this corresponds to a reduction in the reported cost of the cap of around a fifth.

How the effects of the amendment would depend on income, wealth and care received

- 1 **The majority of care journeys are unlikely to be affected by the government's proposed amendment to the cap because most people would not reach the care cost cap or would not receive means-tested support, even under the cap as currently legislated. However, the proposed amendment to how the cap will work would significantly reduce the protection against large costs – one of the main motivations for introducing the cap – for those who might draw on means-tested support, relative to plans set out in existing legislation.** Given the unpredictability of future care need, this would reduce the benefits of the cap in terms of helping people plan and have peace of mind around future care costs.
- 2 **The government's proposed amendment would mean that those with moderate income or assets, and who receive means-tested support to help them with care costs, would take longer to reach the cap, or never reach it.** Without the government's amendment, someone needing residential care costing £700 per week would reach the cap after 3 years and 4 months, regardless of their levels of income and assets. With the amendment, someone with that care need who has annual income of £16,000 and assets of £100,000 would take almost 6½ years to reach the cap.
- 3 **As a result, those experiencing costly care journeys, and who would be eligible for means-tested support, would make contributions for longer, and spend more on their care, under the government's plans, compared with how the cap is currently legislated for.** Under a 'worst case' cost scenario of a decade spent in residential care, someone with £106,000 in assets and annual income of £11,800 would be most affected. Under the government's plans, their contribution towards their care would be £76,000, or 71% of their initial assets, compared with £44,000, or 41% of their assets, under existing legislation (a rise of £32,000, or 30% of their assets). In this scenario, those with assets of over £186,000 would be unaffected.
- 4 **Those who spend an extended period requiring domiciliary care and subsequently enter residential care would face particularly large impacts of the proposed amendment to the cap.** Under a scenario of 5 years

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receiving domiciliary care and then 5 years in residential care, someone with annual income of £12,000, housing wealth of £75,000 and other assets of £25,000 would see their assets depleted by £52,000 under the government's proposed amendment, compared with £12,000 under current legislation, an increase of £40,000, or 40% of their initial assets.

5 Those with large amounts of total wealth, but less than £186,000 of non-housing wealth, can be affected by the proposed amendment to the cap.

This is because they could be eligible for mean-tested support if receiving domiciliary care and this support would not count towards the cap under the government's plans. Under a scenario of 2½ years spent in receipt of domiciliary care and then 2½ years in residential care, someone with annual income of £12,000 and wealth of £250,000 (with three-quarters in the form of housing wealth) would see their assets depleted by an additional 5% (£12,500) under the government's plans.

6 Working-age adults with modest income and significant care costs could be significantly affected by the government's proposed reform.

They would be required to use any income they have above the minimum income guarantee (£91.40 for someone aged between 25 and pension credit age) to pay for their care until they hit the cap. Their income could be limited to this level for years longer as a result of the government's proposed amendment.

How the amendment would affect protection against high care costs for different groups of older people

7 Under the government's plans, those in the second wealth quintile of those aged 65 and older (wealth per person of between £83,000 and £183,000) would face the biggest loss of protection against high care costs, relative to the system under existing legislation.

The government's plans would mean that a 10-year residential care journey would consume an additional 10% of assets or around £12,000, on average, for those in the second quintile. This compares with 1%, or £2,300, for the fourth quintile and a negligible effect for the top quintile. A care journey consisting of 5 years of domiciliary care followed by 5 years of residential care would deplete an additional 21% of assets, or £27,500, for those in the second quintile, on average.

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8 Levels of wealth vary substantially across England and this would feed through to different impacts of the proposed amendment across regions.

Average wealth among the population aged 65 and over in the North East is around £150,000, compared with an average of around £490,000 in London.

9 Those in the North East, Yorkshire and the Humber, and the Midlands would see the biggest erosion of their protection against large care costs, as a result of the proposed amendment.

If they were to spend 10 years in residential care, one in four individuals in the North East would have to contribute an additional 10% of their initial assets to cover their care costs, as a result of the amendment. This compares with just one in forty of those in London. If they were to spend 5 years in receipt of domiciliary care followed by 5 years in residential care, the government's plans would mean those in the North East would have to contribute an additional 12% of their assets towards their care costs, on average, compared with an additional 5% for those in London.

10 For shorter care journeys, those in parts of the country where care costs are higher are more likely to be affected by the proposed amendment.

Those in high-cost areas such as the South and East of England would hit the cap faster under the unamended system than those in lower-cost areas such as the North West and Midlands. Under a care journey of 2½ years receiving domiciliary care and then 2½ years in residential care, we estimate that those in the North West would not hit the cost cap with or without the proposed amendment, and so are unaffected. By contrast, those in the South East would have to contribute an additional 3% of their assets to their care if the proposed amendment to the cap is implemented.

11 The government's proposed amendment would not substantially increase the number of people at risk of having to use their housing wealth to pay for a long period of residential care, other than in the case where they first spent significant time receiving care at home. This is because most individuals who would receive means-tested support and have some housing wealth would have to draw on it even under the system without the amendment.

1. Introduction

In September 2021, the government announced changes to the social care charging system, including an £86,000 lifetime cap on care costs and an increase in the upper capital limit, the highest level of assets at which someone can receive government support for their care costs, to £100,000. These changes represent a significant expansion of state support for social care costs and would be funded by the new health and social care levy.

The changes announced in September 2021 were structurally consistent with the 2011 Dilnot Commission recommendations, legislated for in the 2014 Care Act. However, in November 2021, the government announced that it was proposing changes to the way that care costs would be counted towards the cap. Making such a change requires an amendment to primary legislation.

The amendment was brought to the House of Commons in November but there was no government assessment of the impact of the proposed policy change before the vote. This was criticised at the time by the Treasury Committee. The amendment passed and is now in the Lords to be voted on in February.

On 4 January 2022, the government published an Impact Assessment of its proposals. This considered the costs and benefits of the government's full set of social care charging reforms, when compared with the current system (i.e. it compared the system under the government's plans and the system with no lifetime cap on care costs and without the expansion of means-tested support). However, Parliament is being asked to vote on the amendment which relates only to the way that care costs count (or meter) towards the cap. The Impact Assessment that was released does not show the effect of this amendment – in terms of the cost savings and impact on individuals – in isolation.

This analysis therefore attempts to fill this gap with information about the impacts of the government's proposed amendment to the 2014 Care Act on individuals with different levels of wealth and income, and in different parts of the country.

2. The current system and the reform proposals

The current system

There is great uncertainty about the costs of the social care that individuals may face in later life. The Department of Health and Social Care (DHSC) estimates that one in seven of those aged 65 and over will face costs of more than £100,000 over their lifetime (DHSC, 2022a). Younger adults with a care need may face large costs that accumulate over many years. Under the current social care charging system, individuals who have chargeable assets² worth more than £23,250 (the 'upper capital limit') are responsible for paying for any social care they need.

Uncertainty about future care needs and the potential for extremely large care costs is one of the main reasons why the current system of social care charging was perceived as in need of reform. Unlike in many other areas of life, individuals have very limited ways of insuring themselves against the risks of very high care costs. The only form of insurance products available on the market are immediate needs annuities, bought at the point of developing a care need. As a consequence, individuals with even modest levels of wealth face the risk of care costs that could consume a large fraction of their wealth. Even for those who do not in the end experience catastrophic care costs, the risk that they might has the potential to be a source of concern and to impair their ability to plan.

The current system of social care charging can lead to inefficiencies in the face of high costs. One possibility is that individuals will seek to save enough to cover the depletion of their assets that would result if they have high care needs. As most individuals will not in the end experience very high costs, such saving will, in most cases, turn out to be unnecessary and come at the cost of reduced ability to spend and a lower quality of life than would otherwise be possible. A second possibility is that, faced with the prospect of their assets being greatly depleted by social care costs, some may judge it not worthwhile to save for their older age in the first place. This would leave them with a reduced standard of living in older age and more reliant on state

² DHSC Care and Support Statutory Guidance (CASS; DHSC, 2022b) describes chargeable assets as 'financial resources available for use and tends to be from sources that are considered more durable than money in the sense that they can generate a return'. CASS gives examples of chargeable assets, including buildings, land, stocks and shares, bank and building society accounts, and trust funds. Certain assets are not counted as chargeable assets, including the surrender value of life insurance policies and annuities. An individual's house is included within the capital test unless disregarded for certain reasons, including if the individual or their partner is resident there.

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support for their income and the costs of any care needs that they develop. While these responses make sense from the perspective of an individual faced with the current system, at a societal level they represent an undesirable outcome. Saving decisions are distorted, and resources are less well used – and societal welfare is lower – than they could be if the risk of large care costs was not present or was properly insured.

The current system also leads to perceived unfairness. Most individuals face the risk of catastrophic care costs but only a minority will actually experience them. Those who, most likely through no fault of their own, end up with the highest care needs – such as those who need dementia care for a number of years – end up paying the most. This is in contrast to other areas of life where insurance, purchased in private markets or administered by the state, allows the cost of risks to be shared to a greater degree.

The Dilnot Commission's recommendations

In its 2011 report, the Commission on Funding of Care and Support ('the Dilnot Commission') highlighted the above problems with the current system and identified that the fundamental problem was the lack of any form of risk pooling. Risk pooling – for example, through insurance – has the potential to improve welfare by removing or reducing the inefficiencies and perceived inequities described above, as well as the anxieties and strains that they can bring.

The Commission concluded that, in this area, there was no prospect of a private sector solution. It judged that risks around longevity, care cost growth and technological developments in the care sector were not ones that the insurance sector was willing to bear at a price that individuals would be willing to pay. It recommended that the government provide a form of social insurance against very high care costs by capping individuals' lifetime care costs. This would mean that individuals would be responsible for their care costs up to the cap, after which the state would cover the full costs of their remaining care. For those deemed not able to meet their costs up to the cap, means-tested support would be available.

In effect, a cap on care costs provides social insurance with an excess. Compared with full social insurance which fully covers individuals' care costs (a zero cap), it reduces the costs to the state by targeting protection on those with the highest care needs.

The Dilnot Commission recommended a lifetime cap on care costs of £25,000–50,000 with a central recommendation of £35,000. The Dilnot Commission also recommended an increase in the upper capital limit for those in residential care from £23,250 to £100,000, making means-tested support available to a much wider range of people. Costs towards the cap would be on the basis of 'accumulated need' – that is, the number of weeks of care weighted by the weekly costs of care (on the basis of the amount the local authority would pay for care). For adults of working age (younger than 65), the Commission recommended that anyone entering adulthood with a

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care need, or developing a care need at or before the age of 40, would receive free care. The cap would increase gradually for those developing care needs between the ages of 40 and 65.

Those in residential care would be expected to contribute towards 'daily living costs', just as they would were they living in their own home. This was set at £190 per week.

The 2014 Care Act

In 2013, the coalition government announced that it would introduce Dilnot-style reforms from April 2016 with a cap of £72,000 and an upper capital limit of £118,000. The legislation to enable a Dilnot-style cap to be implemented, including the way in which costs counted towards the cap, was enshrined in the 2014 Care Act. The level of the cap and the upper capital limits were not set in primary legislation but were, instead, prescribed in regulations. However, how the cap would be adjusted each year was set out in the Act – it would rise in line with average earnings. Implementation was delayed in July 2015 by the newly elected Conservative government, and then postponed indefinitely.

Current proposals

In September 2021, the government announced that it would implement the relevant sections of the Care Act and introduce Dilnot-style reforms to the social care charging system, funded by the new health and social care levy.

These changes would be introduced in October 2023 and would include:

- An £86,000 cap on lifetime care costs.
- An increase in the upper capital limit to £100,000 and in the lower capital limit to £20,000.
- The change to the upper as well as lower capital limits would apply to those in residential care and those receiving care in their own homes. This is more generous than the Dilnot Commission recommendations and the 2014 proposals. The earlier proposals only raised the upper capital limit for those in residential care, on the basis that those receiving home care already had the benefit of having housing assets disregarded from the means test.
- 'Daily living costs' charge of £200 per week.

The policy would apply to younger adults (those under 65) and older people in the same way.

In addition, the policy proposals include triggering section 18(3) of the Care Act 2014, which gives self-funders the right to ask their local authority to commission care for them at the local authority rate. Currently, self-funders can find it difficult to buy care at the rate paid by local authorities (which is the rate at which individuals 'meter' towards the cap). This is partly because local authorities have the power to negotiate lower rates than individuals are able to find. The consequence of this is that self-funders could pay more than the amount of the cap on

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their care. Triggering section 18(3) of the act requires funding to allow local authorities to pay a 'fair cost of care', closer to the rate self-funders can find.

For those aged under 40, the system announced is a significant departure from the Dilnot Commission recommendations of free care. For those at older ages, the changes to the cap announced in September were consistent in structure with the 2011 Dilnot Commission recommendations, legislated for in the 2014 Care Act, albeit with different levels of generosity for some key parameters. However, in November, the government announced that it was proposing changes to the way that care costs would be counted towards the cap. This would require an amendment to primary legislation.

The broad effect of the amendment, for a given level of cap and means-test thresholds, is to lower the cost of the reform, with savings coming from those with high lifetime care needs and receiving some means-tested support for their care costs. Much of the remainder of this briefing note looks at the effects of the amendment.

Summary and comparison of the proposals

Table 2.1 compares the government's proposals, the care charging system recommended by the Dilnot Commission and the one set out by the 2014 Care Act. This comparison shows that the government's current proposals are more generous than the Dilnot Commission's recommendations in relation to daily living costs and the upper capital limit for domiciliary care. But they are less generous in relation to the cap, the upper capital limit for people in residential care, adults entering adulthood with a care need or developing a care need under the age of 40, and how care costs are metered towards the cap.

Costs and benefits of the government's proposals

The government has published analysis of its proposals and an assessment of its costs and benefits (DHSC, 2022a). The Impact Assessment compares the proposed reforms with a 'do nothing' option, i.e. maintaining the current system. It does not include assessment of other options, although it does say that the government has considered a number of these.

Costs of the government's proposals

Table 2.2 shows the costs of the reforms (in 2021–22 prices) using the numbers from the government's Impact Assessment. These include the costs of introducing the cap and means-test reforms, the new assessment costs and the reduction in benefits paid by the Department for Work and Pensions (DWP). Benefits savings arise because those who receive state support in residential care are not entitled to attendance allowance (AA), disability living allowance (DLA) or the daily living component of personal independence payment (PIP), and under the reforms there will be greater numbers of people in residential care receiving state support.

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Table 2.1. Comparison of social care charging systems under the Dilnot Commission recommendations, 2014 Care Act and 2021 government proposals

	Dilnot Commission	Care Act 2014	2021 proposals
Key parameters and date of introduction	£25–50k cap (central recommendation £35k). £100k upper capital limit. £14,250 lower capital limit. £190 per week daily living costs. All parameters for system introduced in 2011.	£72k cap in April 2016. £118k upper capital limit for those in residential care only. £17k lower capital limit. £230 per week daily living costs.	£86k cap in Oct 2023. £100k upper capital limit for residential and domiciliary care. £20k lower capital limit. £200 per week daily living costs.
Metering towards the cap	Based on total eligible care costs, as assessed by the local authority.	Based on total eligible care costs, as assessed by the local authority.	Based on individual contribution towards eligible care costs.
How parameters would change over time	Parameters expected to rise in line with basic state pension. (Figures below based on 3.0% annual rise in state pension 2011–23.)	Cap to rise in line with earnings. Other parameters determined annually, but DHSC Impact Assessment models these rising in line with cap. (Figures below based on 2.6% annual earnings growth 2016–23.)	Cap would rise in line with earnings. Other parameters determined annually, but DHSC Impact Assessment models these rising in line with cap.
Value of parameters in Oct 2023 prices			
Value of cap	£36–71k, £50k central	£86k	£86k
Upper capital limit for residential care	£143k	£141k	£100k
Upper capital limit for domiciliary and community care	£33k	£27k	£100k
Lower capital limit	£20k	£20k	£20k
Daily living costs	£270 per week	£270 per week	£200 per week
Younger adults	Zero cap for those born with care needs or developing needs up to age 40. Cap rising between 40 and 65.	Zero cap for people born with care needs or developing needs up to age 25. Above age 25, cap as for older people.	The system would be the same for younger adults and older people.

Source: Authors' calculations using Commission on Funding of Care and Support (2011), DH (2013), DHSC (2022a) and average weekly earnings, 2011 to 2021 (from the Office for National Statistics).

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Table 2.2. Presentation of government's estimated exchequer costs of its proposed reforms (2021–22 prices)

£bn	2022– 23	2023– 24	2024– 25	2025– 26	2026– 27	2027– 28	2028– 29	2029– 30	2030– 31	2031– 32
Charging reform										
Cost of cap and means-test reforms										
Older people (65+)	0.00	0.41	0.74	0.71	1.36	2.00	2.27	2.44	2.60	2.75
Adults under 65	0.00	0.17	0.37	0.45	0.51	0.53	0.55	0.56	0.58	0.68
Assessment costs										
Older people (65+)	0.00	0.00	0.15	0.16	0.15	0.15	0.15	0.16	0.16	0.17
Adults under 65	0.00	0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Total: charging reform	0.00	0.57	1.27	1.34	2.03	2.68	2.97	3.17	3.35	3.60
<i>DWP benefits savings</i>	0.00	–0.05	–0.10	–0.10	–0.17	–0.23	–0.24	–0.25	–0.26	–0.27
Total: charging reform and DWP benefits savings	0.00	0.52	1.17	1.24	1.86	2.45	2.73	2.92	3.09	3.33
Provider market reforms										
Fair Cost of Care	0.54	0.56	0.57	0.59	0.61	0.63	0.65	0.68	0.70	0.73
Interaction with charging reform	0.00	0.04	0.07	0.07	0.30	0.39	0.33	0.34	0.35	0.36
Market management	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
Total: market reforms	0.57	0.63	0.69	0.70	0.95	1.06	1.03	1.06	1.09	1.13
Implementation	0.03	0.17	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Piloting	0.01	0.05	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total: all costs	0.61	1.37	1.94	1.94	2.81	3.51	3.76	3.98	4.18	4.46

Source: Impact Assessment (DHSC, 2022a) and authors' calculations.

Costs of the cap and expanded means test are low in the early years but increase quickly as increasing numbers of people reach the cap. By 2028–29, the system has reached a 'steady state' and in subsequent years cost increases are driven by increasing numbers of older people and rising care costs. In 2028–29, the total costs of the cap and changes to the means test (net of DWP benefits savings) is around £3 billion. This represents around 11% of what the current system would cost in 2028–29. These costs assume that 80% of eligible self-funders take up the charging reform offer to meter towards the cap.

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Table 2.2 also shows the costs of enabling local authorities to increase the prices that they pay for care, to create a more sustainable provider market and to enable self-funders to find care at the same rates that local authorities pay. These are costs associated with section 18(3) of the Care Act, described above. Finally, the table includes implementation and piloting costs.

Benefits of the government's proposals

The proposed changes significantly reduce exposure to catastrophic costs, especially for those with larger amounts of wealth, as will be shown in more detail in the next section.

The Impact Assessment estimates a monetary value of the 'peace of mind benefits' of the insurance provided through a cap and expansion of means-tested support. These are estimated as £0.97 billion in 2028–29, 43% of the increased net financial transfers to individuals, reported as £2.27 billion in 2028–29. The 43% is based on studies of the amount that individuals in the US are prepared to pay for care cost insurance. For each pound of long-term care risk transferred to the state, an individual over 65 is assumed to be willing to pay around £1.43.

The costs and benefits set out in the Impact Assessment are compared with the current system. The Impact Assessment does not include an assessment of costs and impacts of the proposals without the change to metering in the proposed amendment. Therefore, the Impact Assessment does not give information on the cost savings from the latest amendment and its impact on different groups. This is crucial information for the change that Parliament is being asked to vote on. Our analysis seeks to help fill this gap.

3. Care Act amendment impact analysis

This section sets out an analysis of the impact of the proposed amendment to the Care Act. We consider the effects on individuals, including outcomes such as the time taken to hit the cap, care spending as a proportion of the assets held at the start of a care journey, and whether people would be required to use their housing wealth to pay for care. We also consider the effects of the amendment on the proportion of people's care costs that would be paid for by the state.

We first show how effects on these outcomes vary by individuals' assets and income and the care journey they experience. We then use data on the older population in England to show how different groups of people would be affected by the proposed amendment when faced with various care journeys. We examine differences by position in the wealth and income distribution and by region. All figures are in October 2023 prices.

The effect of the amendment on those with different levels of assets and income and experiencing different care journeys

The amendment would mean that those receiving means-tested support take longer to hit the cap, or never reach it

The government proposes to amend the Care Act so that means-tested support that covers care costs (i.e. the portion covered by the local council, not the individual) does not count towards an individual's progression towards the social care cost cap. Without the amendment, people who follow the same journey and whose care had the same weekly cost hit the cap at the same time. Under the amendment, how long it takes someone to hit the cap depends on how much of their care costs were met by their personal contributions. Under the amendment, for a given care journey, those receiving means-tested support for care costs before they have hit the cap would take longer to hit the cap, or may never hit the cap.

For a given care journey, the amendment can affect people in one of three broad ways, as follows:

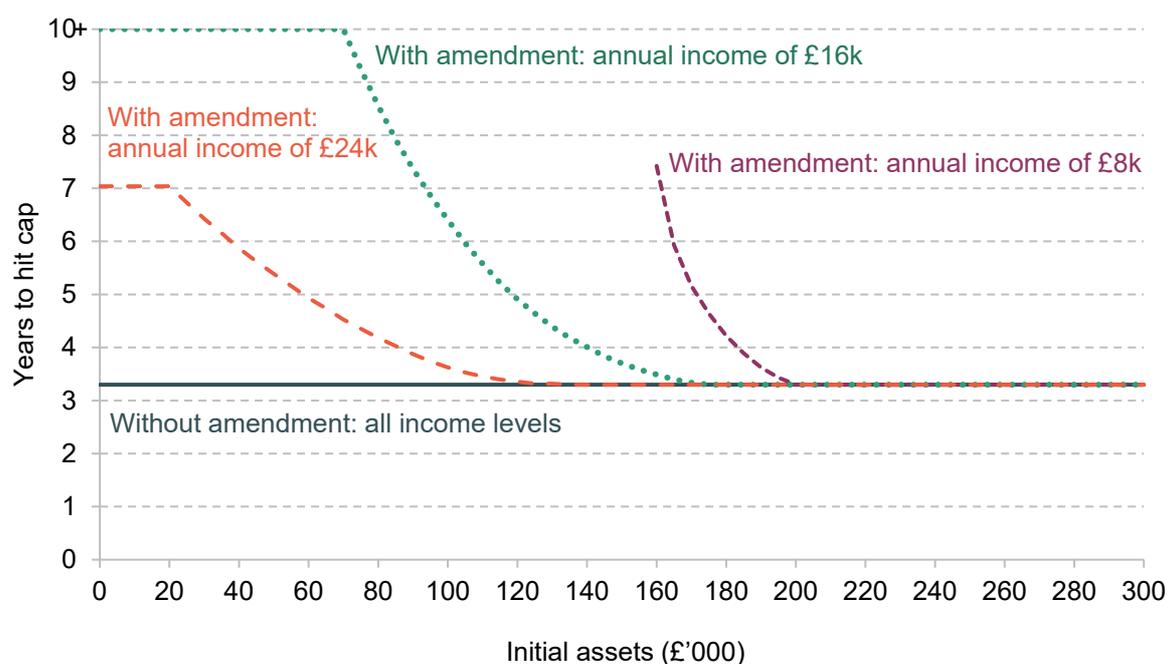
- **Those who would reach the cost cap without receiving any means-tested support are not directly affected by the amendment.**
- **Those who make some contribution towards their care costs, receive some means-tested support, and would reach the cap under the unamended system would, as a**

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result of the amendment, have to continue making contributions to their care costs for longer. Instead of the requirement to contribute ceasing when the total cost of their care reaches £86,000, those individuals would have to contribute until either their private contributions total £86,000 or their income and assets become low enough that they no longer have to contribute. They would contribute for longer and contribute more to their care overall.

- **Those whose income and assets are sufficiently low that they would stop having to make contributions before their total care costs reach the level of the cap, *even under the unamended system*, would be unaffected by the amendment.** They will stop being required to make contributions at the same point under the amended system. They would *never* hit the cap under the amended system but the amendment would make no difference to the contributions they must pay towards their care costs.

Figure 3.1. Number of years taken to hit the care cost cap given £700 total costs per week, under the unamended system and for selected income levels under the amended system, by initial asset level



Note: Assumes a residential care journey costing £700 per week, of which £200 is the daily living cost charge. The maximum value shown on the graph is 10 years or more ('10+'). Those with income of £8,000 and assets less than £160,000 would never hit the cap under the proposed amendment, so no values are shown.

Source: Authors' calculations.

Figure 3.1 shows the number of years that people with some example levels of income and assets would take to hit the cap, under the unamended system and the amended system, when they have care costs of £700 per week (including £200 per week on 'daily living costs'). Without the amendment, people would hit the cap after 3 years and 4 months, regardless of their levels of

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income and assets. With the amendment, those with lower levels of income and assets – who would receive means-tested support – take longer to hit the cap. For example, those with annual income of £16,000 and assets of £100,000 would take almost 6½ years to hit the cap. Those with annual income of £16,000 and less than £70,000 in assets would take more than a decade to hit the cap, as higher means-tested support means they make lower private payments each week. By contrast, someone with annual income of £16,000 but assets of £175,000 or more would still hit the cap after 3 years and 4 months.

Protection against the 'worst case'

What are the implications of the fact that it would take some people much longer to hit the care cap under the proposed amendment? What does this mean for how much of people's assets would have to be contributed towards their care in a 'worst case' scenario?

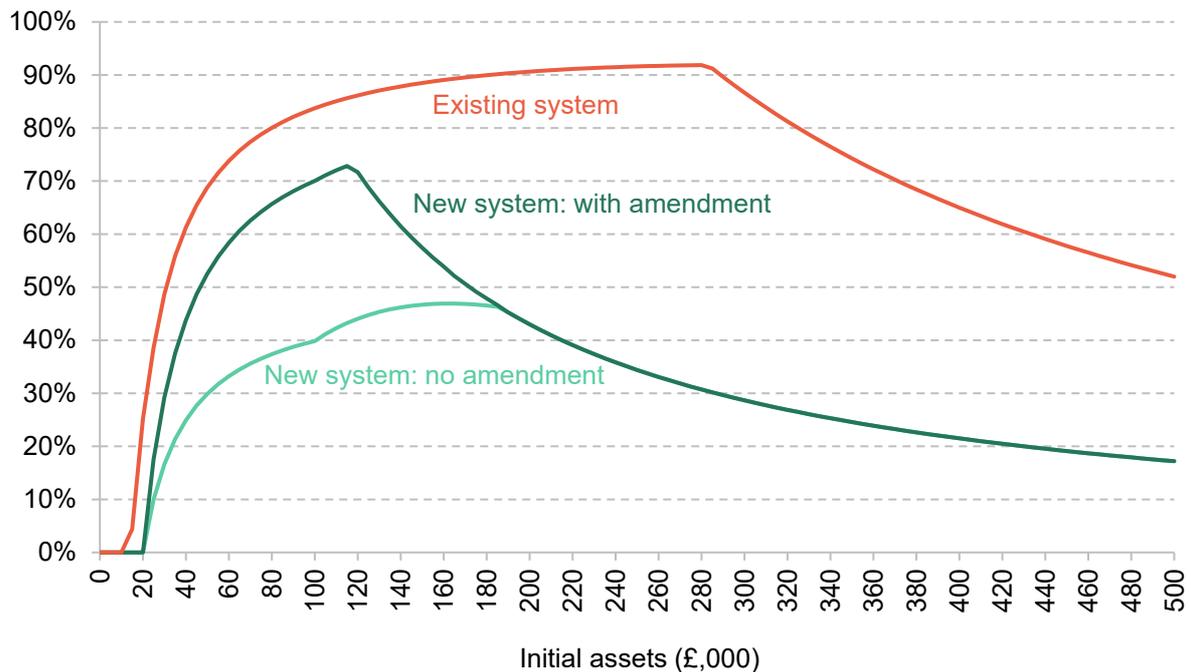
In principle, under the amendment, someone making contributions towards their care only from their assets would only have to stop doing so once they have contributed £86,000 or their assets have fallen to £20,000. The result is that someone with £110,000 in assets could lose up to 78% of their wealth whereas someone with £500,000 could lose just 17%. However, as we have seen, for some levels of income and assets, it would take a very long time to reach the cap.

In order to consider a realistic 'worst case' scenario, Figure 3.2 shows care cost spending as a percentage of starting assets, for individuals who spend 10 years in residential care at a total cost of £700 per week. It is assumed that their weekly income is equal to the £200 'daily living costs' charge plus the personal expenses allowance of £26.67. This implies an annual income of £11,800 and means their income is sufficient to cover their living costs but not to make any contribution to the £500 per week of care costs. The £500 per week care costs are met from a combination of contributions from the individual's assets and means-tested support, according to the system being illustrated.

As has been pointed out by a number of commentators, the government's proposed amendment reduces the protection against a 'worst case' care cost scenario for those with assets between £20,000 and £186,000. There are significant reductions in protection against a 'worst case' scenario for those in the middle of this range. Those with annual income of £11,800 and starting assets of £106,000 see the largest impact in percentage terms. Under the unamended system, they would see their assets reduced by 41% in this 'worst case' scenario, but this rises to 71% under the amendment, an increase of 30 percentage points or just under £32,000.

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Figure 3.2. Care cost spend as a percentage of initial assets, under 'worst case' scenario, for existing system, and new system with and without amendment to the Care Act



Note: Assumes a 10-year residential care journey costing £700 per week. Of this £700 weekly cost, £200 per week living costs are assumed to be met from income and the remaining cost is assumed to be met from assets or means-tested support, as per the relevant system rules.

Source: Authors' calculations.

Figure 3.3. Depletion in assets for a 10-year residential care journey, under the new system with and without the amendment, by level of income and initial assets

(a) Without amendment						(b) With amendment						(c) Difference, as a percentage of initial assets					
Annual income (£,000)	Wealth (£,000)					Annual income (£,000)	Wealth (£,000)					Annual income (£,000)	Wealth (£,000)				
	50	75	100	150	250		50	75	100	150	250		50	75	100	150	250
8	53%	63%	65%	66%	50%	8	53%	64%	70%	77%	50%	8	0%	1%	5%	12%	0%
12	30%	37%	40%	47%	34%	12	53%	64%	70%	57%	34%	12	23%	28%	30%	10%	0%
15	30%	37%	40%	44%	30%	15	53%	64%	63%	49%	30%	15	23%	28%	23%	5%	0%
20	30%	37%	40%	39%	24%	20	48%	51%	49%	39%	24%	20	18%	15%	9%	1%	0%
25	30%	37%	38%	28%	17%	25	39%	42%	40%	28%	17%	25	9%	6%	2%	0%	0%

Note: Assumes a 10-year residential care journey costing £700 per week. Of this £700 weekly cost, £200 is assumed to be living costs. Costs are assumed to be first met from income and any remaining cost is assumed to be met from assets or means-tested support, as per the relevant system rules. Panel c shows the increase in asset depletion, as a percentage of initial assets, as a consequence of the amendment.

Source: Authors' calculations.

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The additional depletion in assets that results from the government's proposed amendment varies not only according to the individual's initial level of assets but also by the individual's level of income. In Figure 3.3, we show the asset depletion under the 'worst case' scenario for a range of combinations of income and starting assets. We compare the new system with and without the amendment.

We see in Figure 3.3 that, when looking at incomes above the amount that covers daily living costs after expenses are allowed for (over £11,800 per year), a higher income is associated with a smaller effect of the amendment. This happens because any income above the level required to cover the living costs charge must be contributed towards care costs and so counts towards the cap.³ A higher level of income above this threshold therefore results in the individual hitting the cap faster, facing fewer weeks when charges are levied on their assets, and the amendment having a smaller effect on the depletion of their assets.

If someone has an income that is lower than that required to meet the daily living costs charge, however, a *lower* income leads to a smaller impact of the amendment on their asset depletion. This is because part, or all, of the capital charge they must pay goes towards meeting their daily living costs. Contributions to daily living costs must be made even once the cap has been hit, with or without the amendment. The greater is the share of an individual's assets charge that is going towards daily living costs rather than care costs, the less affected is the individual by the amendment. Consequently, we see that for those with income less than the amount that covers daily living costs after expenses are allowed for (i.e. less than £11,800 per year), the effect of the amendment is smaller.

The impact of the cap for a range of care journeys

While protection against the 'worst case' scenario is one of the key motivations behind the introduction of a cap on social care costs, and may bring important 'peace of mind' benefits even if this scenario will not actually materialise for many people, most care journeys will be much shorter and less costly than this example and may involve domiciliary as well as residential care. The extent of additional depletion of assets as a result of the amendment varies according to the length, cost and type of care journey. Figure 3.4 therefore shows the additional asset depletion as a result of the amendment for a number of example care journeys. These journeys are:

1. 10 years in residential care (i.e. the 'worst case' discussed above);
2. 10 years in high-intensity domiciliary care;
3. 5 years in medium-intensity domiciliary care followed by 5 years in residential care;
4. 2½ years in medium-intensity domiciliary care followed by 2½ years in residential care.

³ The nature of what income is chargeable and what allowances are made is described more fully in the appendix.

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In each of our care journeys, we assume the following weekly costs of care:

- £700 for residential care;
- £400 for high-intensity domiciliary care;
- £250 for medium-intensity domiciliary care.

These care costs are illustrative but are similar to the values used in the examples in the DHSC Impact Assessment and, in the case of residential care, close to the DHSC projection for average care costs for older adults in residential care in 2023.

When an individual is receiving domiciliary care, their housing wealth is disregarded in the calculation of their assets, for the purposes of the means test. We assume that 75% of individuals' wealth is held as housing wealth and so disregarded for the means test when the individual is receiving domiciliary care. This share is in line with that in the elderly population.

Figure 3.4 shows that it is those who experience long residential care journeys and have modest assets or income, or those who have long care journeys involving both domiciliary and residential care, who would face the greatest impacts of the amendment. Journeys involving just domiciliary care or that are not as long have less dramatic – though still substantive – impacts and have larger impacts, in percentage terms, for those with relatively higher levels of wealth. For example, someone with £250,000 of wealth (and therefore £62,500 of chargeable assets under our assumptions) and income of £12,000, and needing high-intensity domiciliary care at a cost of £400 per week for 10 years, would see their assets depleted by an additional 5%, or £12,500, as a result of the amendment. For the shorter journey of 2½ years in domiciliary care followed by 2½ years in residential care, the effects are more modest than in panels a and c because those individuals who would hit the cap under the unamended system do so closer to the end of their care journey. There can only be a small impact, in terms of additional weeks of contributions, of delaying how long it takes them to hit the cap.

As there is no daily living cost charge in the case of domiciliary care, once someone has hit the cap they will no longer make any contributions from their assets no matter how low their income is. This means that, unlike in the case of residential care, among those facing long periods of domiciliary care, those on the very lowest incomes would be amongst the most affected by the amendment, in terms of the loss of protection to their assets.

The fact that the value of the house in which someone is living is not counted towards chargeable assets when they are receiving domiciliary care leads to important implications of the amendment for those who move from domiciliary to residential care. We see very large impacts of the amendment for those spending 5 years receiving domiciliary care and then 5 years in residential care. The amendment leads to £40,000 additional depletion of assets (rising from £12,000 to £52,000) for someone with income of £12,000 and total assets of £100,000. Furthermore, even

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Figure 3.4. Additional depletion in assets due to the amendment, by level of income and initial assets, for various care journeys



Source: Authors' calculations.

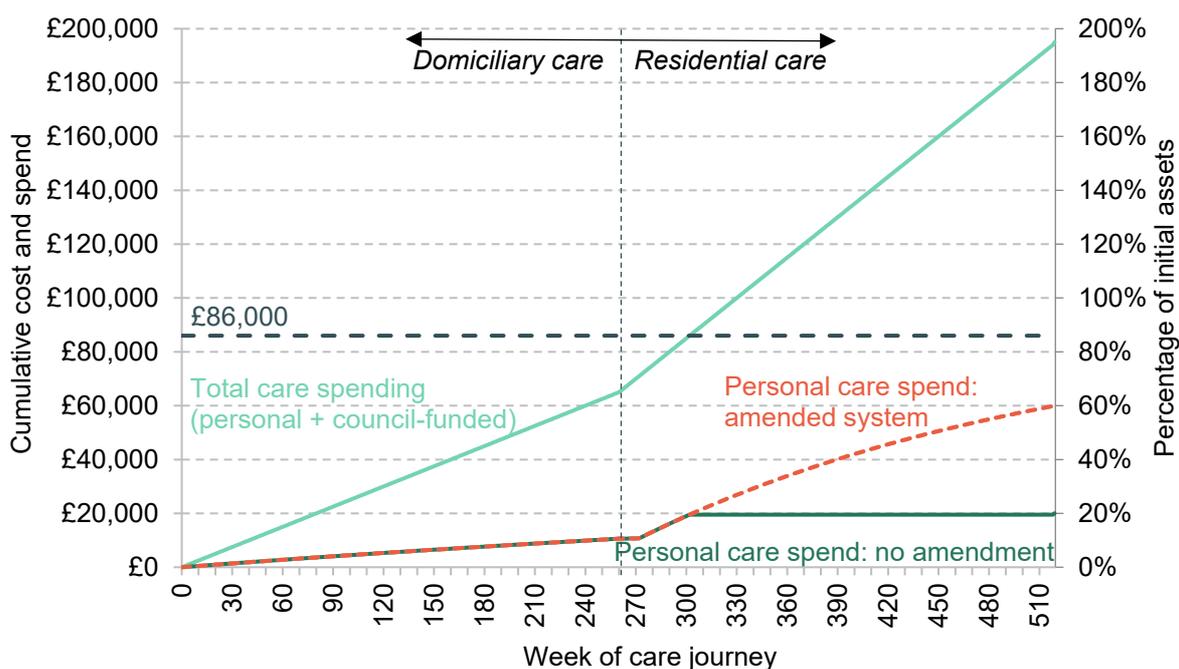
those with levels of total assets in excess of £186,000 can be significantly affected by the amendment under mixed care journeys.

The reason that the amendment has such a large effect on those who have a period receiving domiciliary care followed by a period in residential care is as follows. When non-housing assets are a relatively small part of total wealth, a larger proportion of people will be eligible for some

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means-tested support on the basis of low assets when receiving domiciliary care than when in residential care (because housing assets are disregarded for the former but not the latter). As a result, there is a range of assets levels where individuals would make substantial progress towards hitting the cap due to their domiciliary care under the unamended system. But these people will make much less progress towards the cap under the amended system as their low non-housing wealth results in them qualifying for means-tested support while in domiciliary care. On moving into residential care, housing wealth becomes chargeable. When housing is a relatively large amount of people's wealth, there is a large range of total assets levels for which moving into residential care means losing means-tested support and charges on wealth recommencing. If an individual is much further from the cap at that point than they would have been without the amendment, they will face much larger asset charges on their housing wealth as a result.

Figure 3.5. Cumulative care spending and cumulative personal care spending, with and without amendment to the Care Act, for an individual with £100,000 assets and £12,000 annual income and requiring 5 years of domiciliary care followed by 5 years in residential care



Note: Assumes a care journey of 5 years in medium-intensity domiciliary care, at a cost of £250 per week, followed by 5 years in residential care at a cost of £700 per week (including £200 living costs). The individual is assumed to initially hold £75,000 of housing assets and £25,000 of non-housing assets.

Source: Authors' calculations.

Figure 3.5 shows the pathway of care spending for an individual on a care journey of 5 years' domiciliary care followed by 5 years' residential care. Cumulative total care spending on this person (light green line) grows over time, growing more quickly in the second half of their journey, after they enter residential care. We show the contributions that someone with £100,000

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in assets (three-quarters of which is assumed to be housing wealth) and £12,000 annual income would have to pay towards their care under the unamended system and under the amended system. Such a person receives a significant amount of means-tested support in the period they are receiving domiciliary care because they only have £25,000 of chargeable assets initially. Under the unamended system, they meter towards the cap at the rate of their total care spending (the light green line) and hit the £86,000 cap shortly after entering residential care. Under the amended system, they meter at the rate of their own contributions, which reach less than £11,000 by the time they enter residential care. At this point, contributions pick up as housing wealth becomes chargeable. Under the amended system, these higher contributions are paid for longer. The individual never reaches the cap under the amendment and must contribute an additional £40,000 towards their care while in residential care.

It is important to note that the care journeys illustrated here are relatively long ones. For shorter journeys, the amendment makes a smaller or no difference to asset depletion rates. This is because an individual will only lose out due to the amendment if they would have hit the cap in its absence. In the absence of the amendment, it would take 3 years and 4 months to hit the cap given care costs of £500 per week, 4 years and 2 months to hit the cap given care costs of £400 per week, and 6 years and 7 months to hit the cap given costs of £250 per week. Evidence from a Personal Social Service Research Unit study of the length of stays in Bupa care homes estimated that half of care home residents had a stay of 1 year and 7 months or less, while a quarter had stays of 3 years and 7 months or more, and one in ten had a stay of 6 years and 2 months or more. The mean length of stay was estimated at 2 years and 6 months (Forder and Fernandez, 2011). On this evidence, the majority of care home stays are short enough that, assuming no prior or subsequent case use, they would not be affected by the amendment. However, there is a sizeable minority of care journeys that would be affected. And of course, given the fact that people do not know in advance how long they will spend in care, many more may be affected in terms of lost 'peace of mind' benefit.

We have analysed care costs and time spent in care in the context of the older population. The situations and care journeys for many younger adults may be different. For example, many of those with learning disabilities will have lower assets and low incomes and require care and support for many years. While we are not able to analyse the financial situations of working-age adults who have care needs, the effect of the amendment may be to significantly increase the length of time that this group must contribute their income towards care costs. To give one example, suppose that an individual has care needs of £500 a week and assume that they have no assets but income of £50 per week (£2,600 a year) above the minimum income guarantee. Under the system under current legislation, they would contribute the £50 from their income for 172 weeks, or 3 years and 4 months. After this time, they would keep their whole income. Under the government's proposed amendment, they would contribute £50 a week until they had personally contributed £86,000. This would take 1,720 weeks, or 33 years. They would be living on the

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minimum income guarantee, and be £50 a week worse off, for nearly 30 years longer as a result of the government's proposed amendment.

We have considered the effects of the amendment through the lens of its impacts on people's assets. It should be noted that the amendment would also have impacts on the total amount that people receiving means-tested support pay out of their income towards their care, above and beyond any impact on assets. Again, this happens because people would take longer to hit the cap and so have to make contributions from their income for longer.

The effect on state support for care costs

The following set of figures shows the reduction in the percentage of care costs covered by public spending as a result of the amendment. Again, we first show this outcome under the unamended system, the amended system and the difference between the two (in percentage point terms) for a 10-year residential care journey – see Figure 3.6. This tells us that 89% of care costs are covered under the unamended system for someone with income of £12,000 and wealth of £75,000 and this falls to 81% under the amendment, a reduction of 9 percentage points. All individuals are assumed to have the same care costs so the percentage point reductions in state coverage are comparable across those with different assets and income.

Figure 3.6. Reduction in state coverage of care costs under a 10-year residential care journey, under the new system with and without the amendment, by level of income and initial assets

(a) Without amendment						(b) With amendment						(c) Difference, as a percentage of total care costs					
Annual income (£,000)	Wealth (£,000)					Annual income (£,000)	Wealth (£,000)					Annual income (£,000)	Wealth (£,000)				
	50	75	100	150	250		50	75	100	150	250		50	75	100	150	250
8	99%	94%	89%	77%	67%	8	99%	94%	87%	70%	67%	8	0%	1%	3%	7%	0%
12	94%	89%	84%	73%	67%	12	89%	81%	72%	67%	67%	12	5%	9%	12%	6%	0%
15	90%	85%	81%	70%	67%	15	78%	69%	67%	67%	67%	15	13%	16%	14%	3%	0%
20	84%	79%	74%	67%	67%	20	67%	67%	67%	67%	67%	20	17%	12%	7%	1%	0%
25	77%	73%	68%	67%	67%	25	67%	67%	67%	67%	67%	25	11%	6%	2%	0%	0%

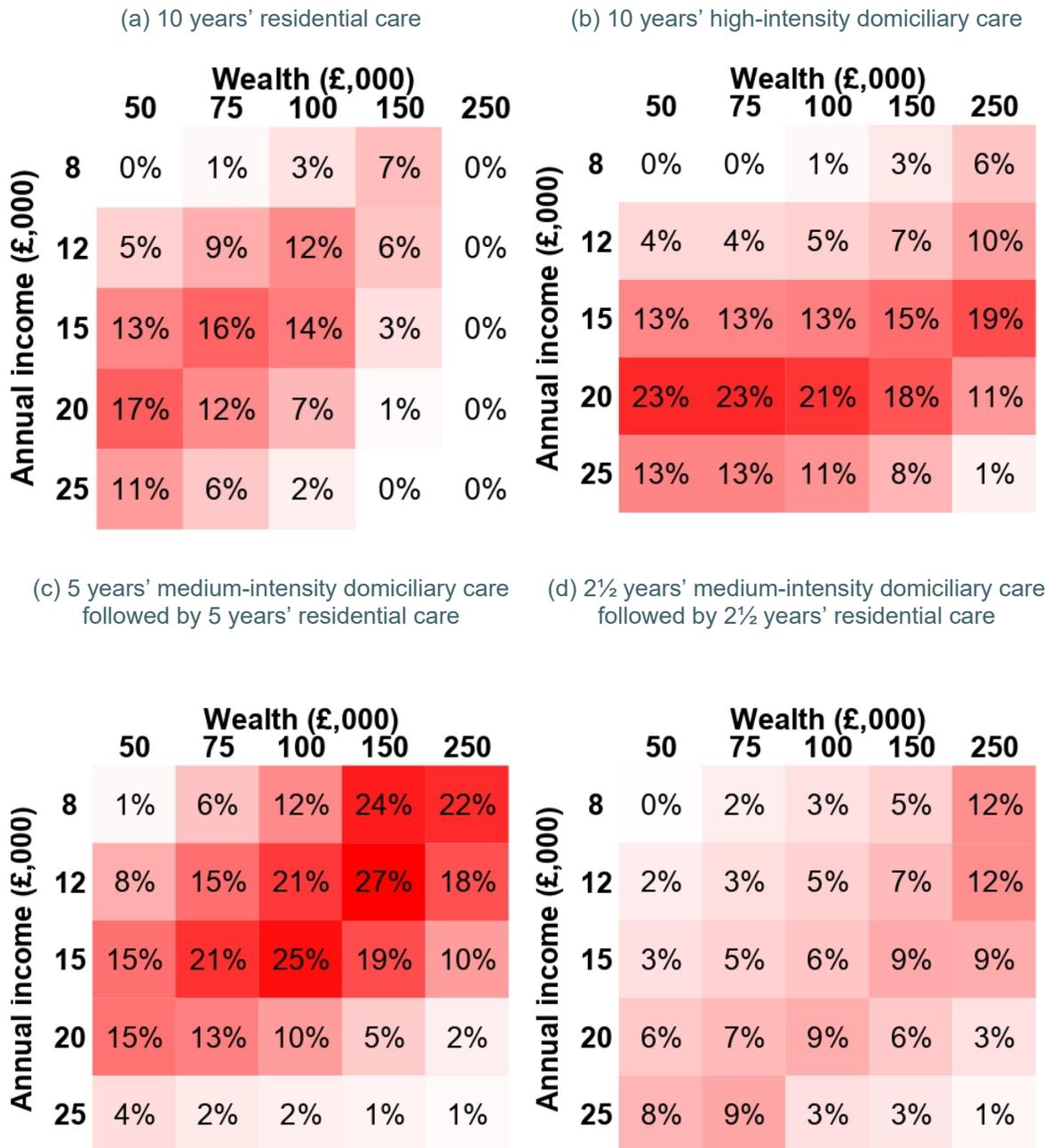
Source: Authors' calculations.

We can see that the largest savings in terms of state spending come from those with modest assets but also those with low assets and higher income. For example, the state coverage of costs is reduced by 17 percentage points for those with £50,000 in assets and £20,000 annual income. Savings come from those with low assets but higher income because the amendment means that contributions made from income will be made for longer by those who would receive some

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means-tested support. While this does not appear as a reduction in assets for these sorts of individuals, it nevertheless represents a shift of spending from the state and towards them.

Figure 3.7. Reduction in state coverage of care costs, as a result of the amendment, by level of income and initial assets, for various care journeys



Source: Authors' calculations.

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Figure 3.7 illustrates the impact of the amendment on state coverage of costs for a larger set of care journeys. For those receiving domiciliary care, how much is saved varies more by income than by assets. This is because while all of someone's income (above an allowance for costs of living) must be contributed towards care costs until they have reached the cap, only contributions from non-housing assets are made. Non-housing assets have to be very large in order for significant contributions to be made from assets. For journeys that combine domiciliary and residential care, significant savings are made from those with higher assets, higher income or modest assets and income. This is because those with high assets and high income would not receive much means-tested support (and those with low assets and low income would not contribute to their care with or without the amendment) but those with moderate overall resources would receive means-tested support and so pay out of income or assets for longer as a result of the amendment, shifting costs from the state to the individual.

Impact by income and wealth quintile of the older population

The previous subsection explained how the amendment affects people based on their income and wealth level. We now turn to say what this means for the population of older people.

To consider the impact of the reform on particular groups in the elderly population, we take survey data from the English Longitudinal Study of Ageing (ELSA), which give us information about the wealth, income and other relevant characteristics (such as marital status and sources and types of income and wealth) of a representative sample of the population aged 65 and over in England.

Our approach is as follows. For each individual in the data, we calculate the percentage of their assets that would be depleted under each of the care journeys set out in the previous subsection. We do this for systems with and without the proposed amendment to metering. We take into account the different types of assets held by those in our sample and the conditions under which certain assets and income sources are, or are not, required to be used to meet care costs. We also account for regional differences in average costs of care. There are a number of assumptions in our methodology, set out in the appendix.

Only a minority of the older population will actually experience care journeys like those we illustrate. However, all individuals have a risk, to varying degrees, of having high care needs in future. Our results are intended to show the impact of the amendment on the degree of protection against the *risk* of facing these costs of care.

Levels of wealth and income in the elderly population

The key determinants of how much someone would be affected by the amendment are their levels of wealth and income. Tables 3.1 and 3.2 show the cut-offs for each of the quintiles of income and wealth in the 65-and-older population. Our measures are income per person and

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wealth per person meaning that, for couples, we divide their combined income and wealth by two. This is because for most people in a couple, their chargeable income and wealth will be half of the income and wealth they have jointly with their partner. The income and assets measures that we use are described in the appendix.

Table 3.1 tells us that the lowest-income fifth of the elderly population have annual income per person of £11,200 or less. A further 20% have income of between £11,200 and £14,700. The highest-income fifth have income per person over £25,400. Those with some disabilities limiting their ability to conduct 'activities of daily living' (ADLs) such as dressing, washing and preparing a meal for themselves are more likely to need care in the more immediate future. We therefore show equivalent figures for all individuals in the elderly population who report difficulties with one or more such activity, in order to give a sense of the income levels of those more likely to need care. The income levels of this group are slightly lower than those for the elderly population as a whole.

Table 3.1. Selected percentiles of annual income per person

Population	Annual income per person			
	20 th percentile	40 th percentile	60 th percentile	80 th percentile
All 65+	£11,200	£14,700	£18,700	£25,400
65+ and at least one ADL problem	£10,800	£13,900	£17,300	£22,500

Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

Table 3.2. Selected percentiles of wealth per person

Population	Wealth per person			
	20 th percentile	40 th percentile	60 th percentile	80 th percentile
All 65+	£83,000	£183,000	£298,000	£482,000
65+ and at least one ADL problem	£10,000	£113,000	£219,000	£380,000
65+, inherits spouse's wealth	£134,000	£302,000	£482,000	£805,000

Note: Wealth includes net housing wealth, financial assets such as savings accounts, ISAs, holding of stocks and bonds, and a number of other smaller categories. For a full description, see the appendix.

Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

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Table 3.2 shows equivalent information for wealth. We see that 20% of the elderly population have £83,000 or less in assets and a further 20% have between £83,000 and £183,000 in assets. For those reporting problems with at least one ADL, wealth levels are substantially lower. 20% of this group have less than £10,000 in wealth and 40% have £113,000 or less. In couples, entry into residential care is more common after the death of a partner. We therefore show the percentiles of the wealth distribution in the situation where individuals will inherit their partner's wealth.

Impact of different care journeys by income and wealth quintile

We now combine the information from ELSA about the distribution of income and assets in the elderly population with the illustrative care journeys set out earlier in this section to show the impacts of the amendment on asset depletion for different income and wealth quintiles. We show the effects on asset depletion in the case where each member of the 65-and-older population begins each of our care journeys with their current levels of income and assets. Again, this is not because such a scenario is likely, but because it is informative about how far different groups of people are protected against the risk of developing extensive care needs.

Figure 3.8 shows the average depletion rates under a 10-year stay in residential care by each combination of quintiles of income per person and wealth per person in the elderly population. Again, we assume a weekly cost of £700, including £200 of living costs. Panel a shows the average rate of asset depletion under the unamended system, panel b shows asset depletion under the system with the amendment and panel c shows the additional asset depletion that would result from the amendment (i.e. the difference between the other two panels).

Figure 3.8. Average asset depletion under 10-year residential care journey, by income and wealth quintile of the 65-and-older population

		(a) Without amendment					(b) With amendment					(c) Difference, as a percentage of initial assets				
		Per-person wealth quintile					Per-person wealth quintile					Per-person wealth quintile				
		Bottom	2	3	4	Top	Bottom	2	3	4	Top	Bottom	2	3	4	Top
Equivalent income quintile	Bottom	11%	61%	48%	28%	17%	11%	70%	51%	29%	17%	1%	9%	2%	1%	0%
	2	12%	51%	38%	23%	14%	16%	63%	40%	24%	14%	3%	12%	2%	1%	0%
	3	15%	45%	33%	20%	10%	21%	57%	35%	21%	11%	6%	12%	2%	1%	0%
	4	16%	42%	28%	17%	9%	22%	50%	29%	17%	9%	6%	8%	1%	0%	0%
	Top	17%	31%	17%	12%	4%	20%	35%	18%	12%	4%	3%	5%	0%	0%	0%

Note: Asset depletion rates are calculated using the assumptions set out in the appendix. Income quintiles are based on income of the individual and their partner, equivalised using the OECD modified scale.

Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

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Those in the second wealth quintile (i.e. with per-person wealth of between £83,000 and £183,000) and the second and third income quintiles (i.e. with income between £11,200 and £18,700) would be most strongly affected by the amendment. Their asset depletion in this 10-year residential care scenario would increase by 12 percentage points as a result of the amendment. In other words, about an eighth more of their initial wealth would be used to pay for care.

Figure 3.9 shows the effect that the amendment would have on average asset depletion for our full set of care journeys. On average, the 10-year residential care journey would deplete an additional 10% of assets, or £12,000, of those in the second quintile under the amended system. This compares with 1%, or £2,300, for the fourth quintile and essentially no effect for the top quintile. The impact on asset depletion under the combination of 5 years in domiciliary care followed by 5 years in residential care is much larger and extends up the wealth distribution. This is for the reasons set out earlier in this section and highlights an important interaction between the types of assets that people hold and the way these are treated for the purposes of the means test. Those in the second quintile would see an additional fifth of their assets, equivalent to £27,500, consumed by care costs, as a consequence of the amendment, if they experienced this journey. For those in the third quintile, the equivalent figure is a tenth.

Figure 3.9. Increase in average depletion rate of assets for those aged 65 and older, as a result of amendment, by initial wealth quintile, for a range of care journeys

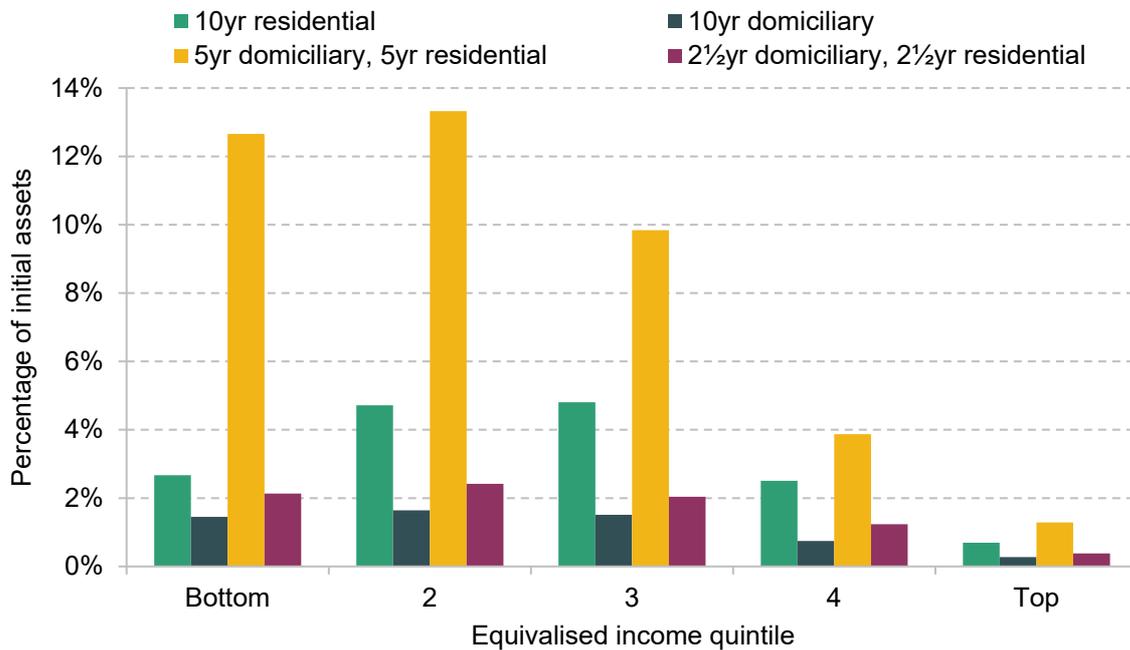


Note: Asset depletion rates are calculated using the assumptions set out in the appendix.

Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

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Figure 3.10. Increase in average depletion rate of assets for those aged 65 and older, as a result of the amendment, by equivalised income quintile, for a range of care journeys



Note: Asset depletion rates are calculated using the assumptions set out in the appendix. Income quintiles are based on income of the individual and their partner, equivalised using the OECD modified scale.

Source: Authors’ calculations using the English Longitudinal Study of Ageing, wave 9.

Those who are further up the wealth distribution are affected by the amendment even though their assets exceed £186,000 – the threshold above which people are unaffected by the reform under a number of simplifying assumptions. This is because if they or their partner are resident in their home then their housing wealth is disregarded for the purposes of the means test. Our analysis shows that there are some people in all wealth quintiles who have non-housing wealth which is low enough to make them eligible for means-tested support in this case. The fact that this means-tested support would not bring them closer to meeting the cap increases the contributions they would be required to make in these care journeys.

Figure 3.10 shows an equivalent analysis but now splitting by equivalised income quintile. The effect of the amendment does not differ as starkly by income as it does by wealth. The impacts of the amendment given our illustrative care journeys would generally be largest in the bottom three income quintiles.

An outcome that is often discussed in relation to social care costs is whether people need to sell their home to pay for care. As housing assets are disregarded for the assessment for means-tested support when an individual or their partner is still living in their home, no one should have to sell a home that they or their partner are living in to pay for care. Those in residential care may have to use their housing wealth to pay for care but can do this by agreeing that the proceeds of

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the sale of their house following their death be used to repay their care costs. Nevertheless, whether or not someone may have to use their housing wealth in this way is a salient issue, perhaps because it affects how much can be bequeathed.

Figure 3.11. Increase in the percentage of individuals using some of their primary housing wealth to pay for care, for those aged 65 and older, as a result of the amendment, by per-person wealth quintile, for a range of care journeys



Note: The percentage using housing wealth to pay for care is calculated using the assumptions set out in the appendix.

Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

Figure 3.11 shows estimates of the increase in the percentage of older individuals in each wealth quintile who would have to draw on the value of their main home to pay for residential care, as a result of the amendment, for our three care journeys that involve some residential care. The increases are relatively small for the 10 years of residential care scenario and for the 2½ years of domiciliary care followed by 2½ years of residential care scenario. This is because almost all individuals who would receive means-tested support and have some housing wealth would have to draw on it even under the system without the amendment. There is therefore only a small number of people who could be made to draw on their housing wealth who would not already have to. For the 5 years of domiciliary care followed by 5 years of residential care scenario, there are large effects. The increase is largest for the second quintile, with one in four people who would not otherwise have had to having to use some of the value of their main home to pay for care. The reason that there is an impact in this case is due to the significant proportion of homeowners who would reach the cap *before* entering residential care under the unamended

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system (and so whose housing wealth is, as a result, never chargeable) but who would no longer hit the cap before entering residential care under the proposed amendment.

The scenarios that we have illustrated have taken as given individuals’ levels of wealth in the ELSA data and assumed that, were they to start receiving care, they would do so with that level of wealth. Those at older ages tend not to draw down their wealth substantially as they age (Crawford, 2018). However, one significant way in which wealth *per person* would change is when one member of a couple dies. Under the assumption that the surviving spouse inherits their partner’s wealth, their wealth, for the purposes of means testing, will roughly double at this time. This is an important sensitivity to consider, on the basis that care is more likely to be received by individuals without a partner.

Figure 3.12 shows an alternative set of results where we assume that each individual inherits their partner’s wealth (in most cases, this will be a share of jointly held wealth). As shown in Table 3.2, in this case, the sample becomes wealthier in terms of assets per person. Consequently, the effects of the amendment are more modest.

Figure 3.12. Increase in average depletion rate of assets for those aged 65 and older, as a result of amendment, by initial wealth quintile, for a range of care journeys, assuming those in couples inherit their spouse’s wealth before entering care

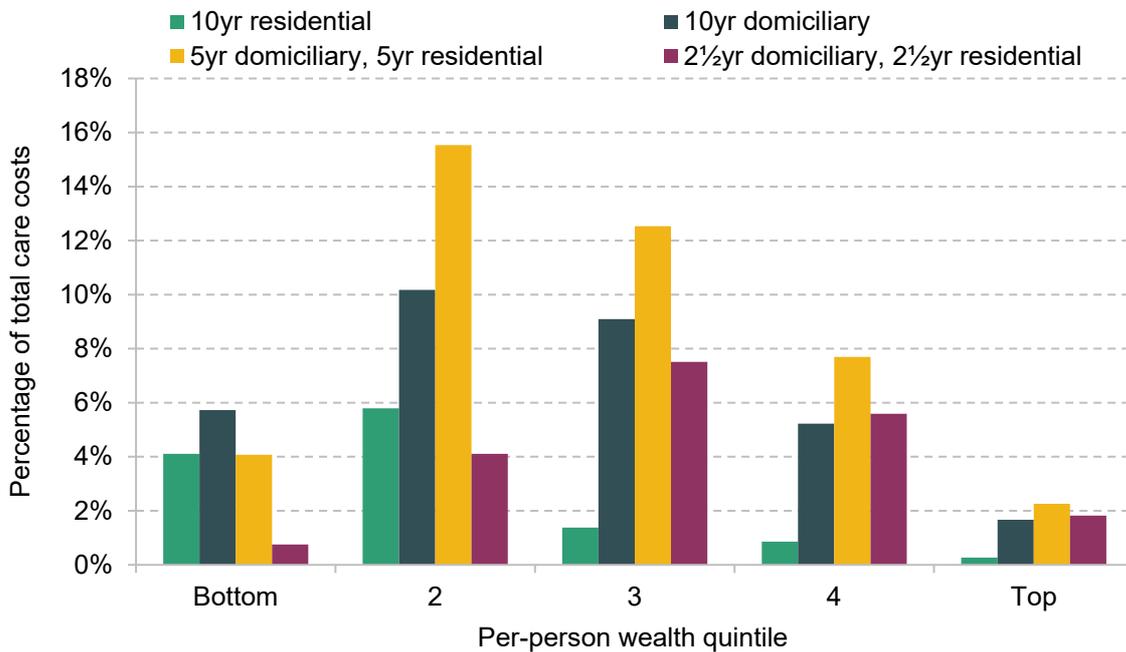


Note: Asset depletion rates are calculated using the assumptions set out in the appendix.

Source: Authors’ calculations using the English Longitudinal Study of Ageing, wave 9.

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Figure 3.13. Reduction in state coverage of care costs, for those aged 65 and older, as a result of amendment, by initial wealth quintile, for a range of care journeys



Note: State coverage of costs is calculated using the assumptions set out in the appendix.

Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

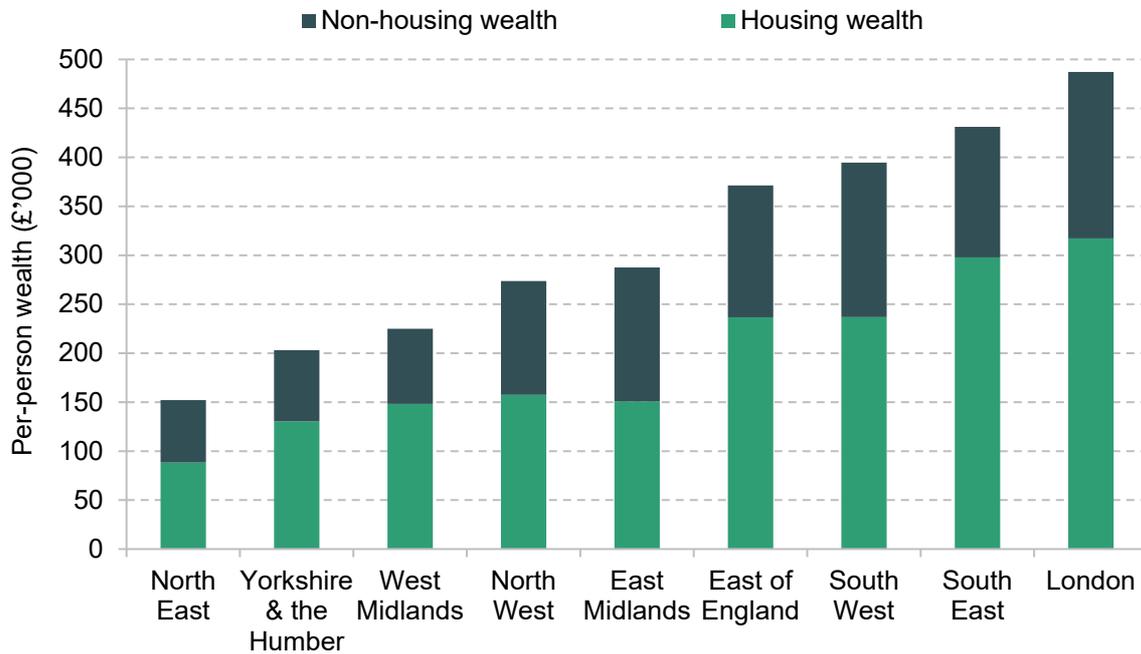
Finally, we look at from which parts of the wealth distribution there are the largest state savings in terms of the reduction in the share of care costs covered by the state (Figure 3.13). This can differ from the impact on assets both because a reduction in state spend can be met by higher contributions from income and because a given percentage of assets is a larger sum, and larger share of total costs, for those with higher levels of assets. For most journeys, savings are largest for those in the second decile. There are significant savings from those in the third (and fourth) deciles too because these groups would make higher contributions from their income as a result of the amendment.

Impact on the older population by region

Figure 3.14 shows the average levels of wealth per person among the elderly population in each English region, split into housing and non-housing wealth. There are dramatic differences across regions. The average wealth held by an elderly individual living in the North East is around £150,000. This compares with almost half a million pounds of wealth held on average by an elderly person living in London.

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Figure 3.14. Average levels of housing and non-housing wealth per person by English region, for those aged 65 and older



Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

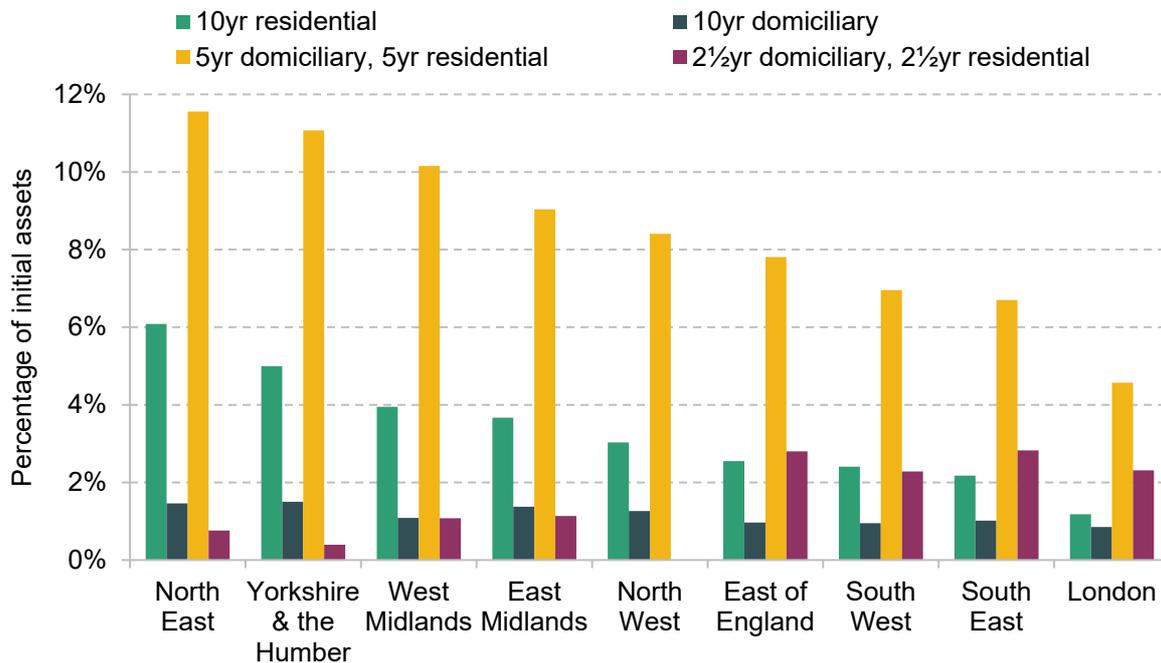
Wealth is the main determinant of whether and how much someone would be affected by the amendment if they experience high care costs. Differences in wealth across regions therefore translate into very different effects of the amendment across regions. An important component that also differs across regions is care costs. We draw on estimates of average weekly residential care costs by English region from 2017, reported by Age UK.⁴ We assume that the ratio of costs in each region to the English average will be the same in future years. Care costs reflect regional differences in wages and other factors and are lowest in the North West and highest in London.

Figure 3.15 shows that average depletion of assets would be 6 percentage points higher in the North East under a 10-year residential care journey as a result of the amendment. This is equivalent to an average increase in contribution of £5,700. The effect in the South East is to increase the average depletion rate by 2 percentage points and in London by 1 percentage point (equivalent to £3,800 and £2,800, respectively). There is a similar gradient by region in the effects of the 5-year domiciliary combined with 5-year residential journey. These differences are driven by the fact that more people in the North East, Yorkshire and the Humber, and the Midlands have wealth at the moderate levels that mean they are most affected by the amendment than do people in the South.

⁴ <https://www.ageuk.org.uk/information-advice/care/paying-for-care/paying-for-a-care-home/>.

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Figure 3.15. Increase in average depletion rate of assets, for those aged 65 and older, as a result of the amendment, by English region, under a range of care journeys



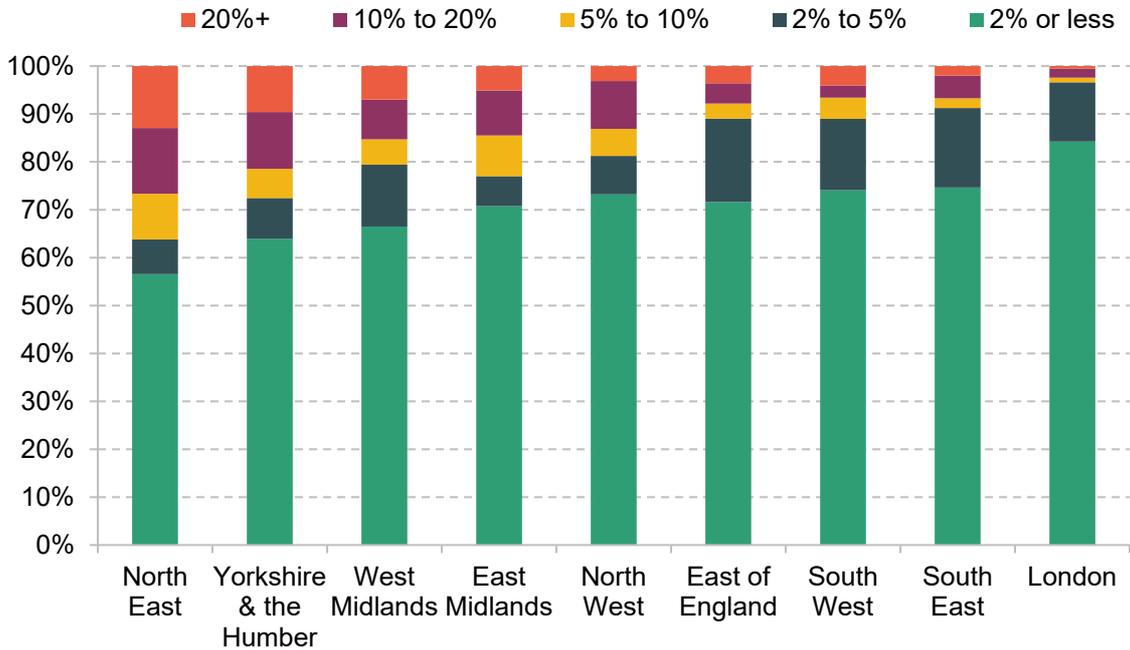
Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

For shorter care journeys, there is a potential for the amendment to have a greater impact on those in the South and East of England due to the higher weekly cost of care in those regions. The reason for this is that people are only affected by the amendment if their care costs would have reached £86,000 – and therefore triggered the cap – in the absence of the amendment. People pay more as a result of the amendment during the additional time it takes them to hit the cap. For some shorter journeys, the lower cost of care means that individuals would not accumulate £86,000 of care costs (or would reach that point later in time) in lower-cost regions such as the North and West of England, but would have accumulated that level of costs (or accumulated it earlier) in the South of England.

Figures 3.16 and 3.17 show the distribution of the effects of the amendment on the depletion rate of assets for the two scenarios with the largest average impacts. We can see, for example, that more than one in four individuals in the North East would see an increase in the amount of their assets going towards their care of 10 percentage points or more as a result of the amendment, if they were to spend 10 years in residential care. This compares with just one in forty of those in London.

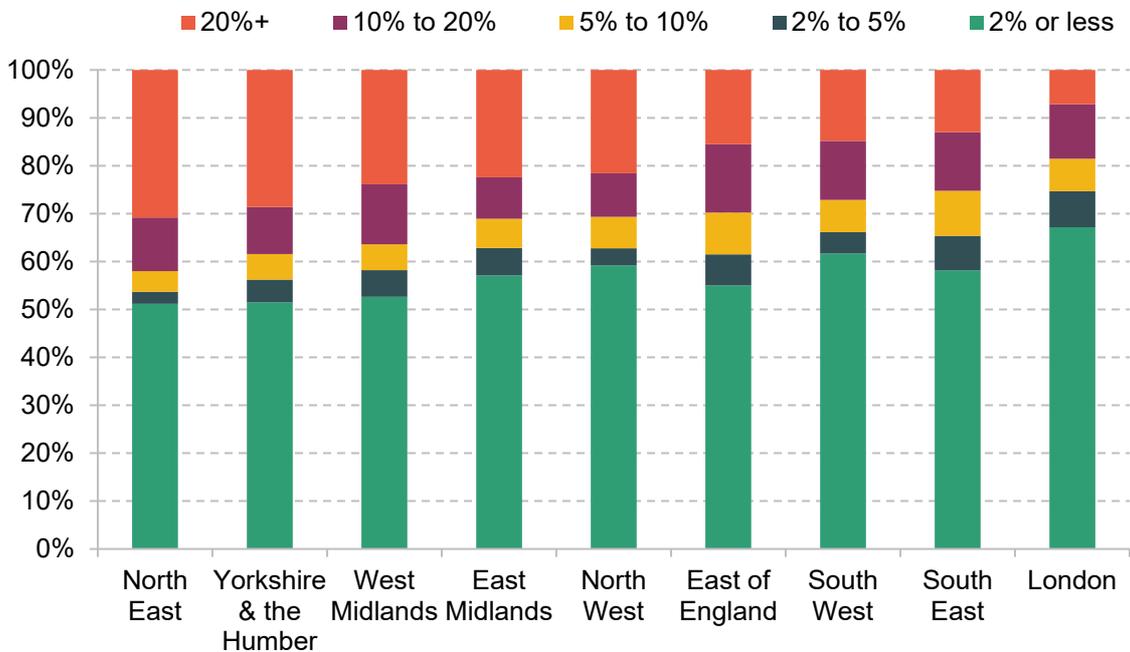
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Figure 3.16. Distribution of increase in asset depletion rates, for those aged 65 and older, by English region, given 10 years in residential care



Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

Figure 3.17. Distribution of increase in asset depletion rates, for those aged 65 and older, by English region, given 5 years in domiciliary care followed by 5 years in residential care

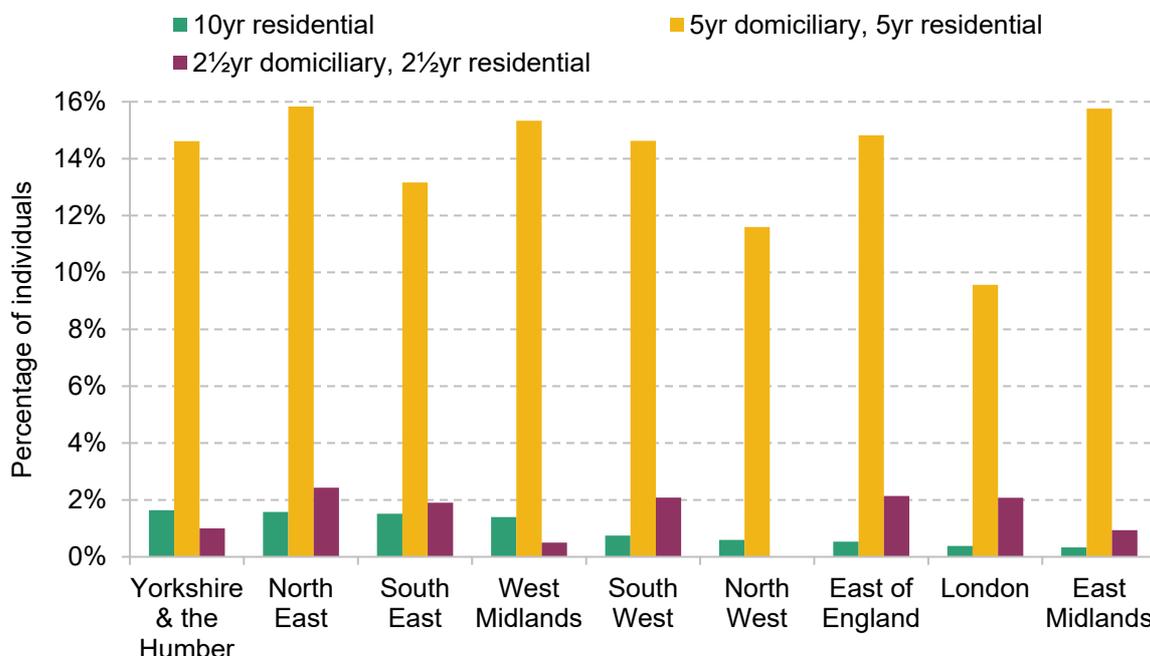


Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

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Figure 3.18 shows the increase in the percentage of individuals who would have to use some of the value of their main home to pay for care, as a result of the amendment, under those care scenarios involving some residential care. For the reasons discussed above, the additional share of individuals having to use housing wealth to pay for their care as a result of the amendment is only substantial in the 5 years of domiciliary care followed by 5 years of residential care scenario. We might expect that regions in the South would be less affected on this metric, in the same way that they are less affected in terms of the impact on asset depletion in this scenario, but this is not the case. In the South, despite people being wealthier on average, a higher share of wealth is held as housing and so there are more people for whom a given percentage increase in contributions from assets must be met from housing.

Figure 3.18. Increase in the percentage of individuals using some of their primary housing wealth to pay for care, for those aged 65 and older, as a result of the amendment, by English region, under a range of care journeys



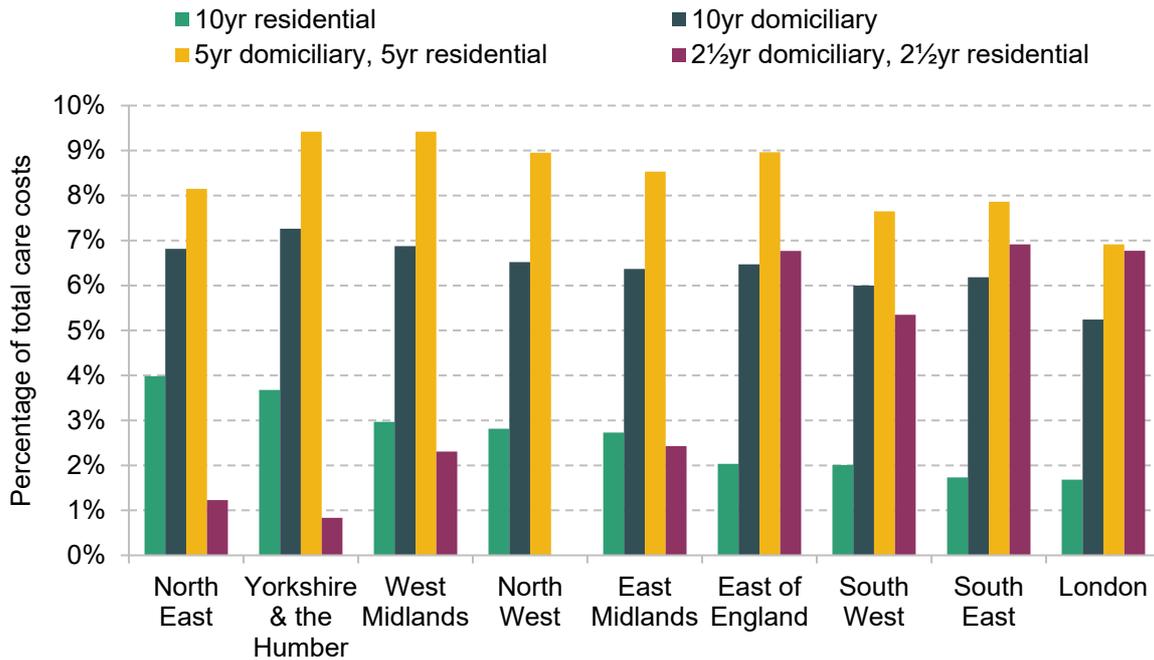
Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

Figure 3.19 shows the percentage point reduction in the share of care costs that are covered by state support, under different care journeys, as a result of the amendment. For example, the costs over a 10-year residential care journey that are covered by the state would fall by 4% of the total costs incurred over that period for those living in the North East, compared with under 2% for the South East, South West and London. For those having this care journey, it means twice as large a saving, per person, from those in the North East as from those in the South. The differences across regions in these savings are less stark than the differences in the effects on asset depletion, for two reasons. First, older people in the South have higher incomes than their counterparts in the North and so would make up more of the additional required contributions as

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a result of the amendment through their income rather than their assets. Second, the asset depletion effects are larger in percentage terms in the lower-wealth regions but there is less variation in absolute terms. The final point to note from this figure is that the largest savings in the case of the shorter, mixed domiciliary and residential journey come from those in the South and East of England, mirroring the differences across regions in the effect on asset depletion under this scenario.

Figure 3.19. Reduction in the share of care costs covered by the state, for those aged 65 and older, as a result of the amendment, by English region, under a range of care journeys



Source: Authors' calculations using the English Longitudinal Study of Ageing, wave 9.

4. Conclusion

The government's introduction of a cap on lifetime social care costs and expansion of means-tested support for care costs go a long way to limiting the risks of incurring large care costs that consume a significant proportion of wealth. The benefits of this insurance against high care costs not only accrue in the case when large care costs are incurred, but also come in the form of increased ability to plan for the future and the 'peace of mind' benefit this may bring.

In this briefing note, we have analysed the government's proposed change to the way that individuals progress towards the social care cost cap. This change would require an amendment to the 2014 Care Act which is currently being considered by Parliament. We have compared the new social care charging system – including the new cap and expansion of means-tested support – as it would operate with this amendment to the Care Act, and how the new system would operate under existing legislation.

Relative to the currently legislated system, the government's proposed amendment to the Care Act would unpick a substantial amount of the benefits of the new cap and expanded means test, in terms of protection against long and costly care journeys, for those with moderate assets and income.

The reduction in protection against the risk of high care costs will be most keenly felt by those with moderate assets. In the elderly population, this means those in the second wealth quintile (who have wealth per person of between £83,000 and £183,000). However, the fact that housing is not counted for the purposes of the means test when receiving care at home means that those in the third and fourth quintiles would also be substantively more exposed to the risk of high care costs for journeys that involve both domiciliary and residential care, as a result of the government's plans.

There is a clear geographical pattern to who would see a large reduction in their protection against high costs. Those living in the North East, Yorkshire and the Humber, and the Midlands are more likely to have the moderate levels of assets and income that mean they would be more exposed to care costs as a result of the amendment, whereas many in the South and East would see minimal or no change in protection, given their current level of wealth.

Appendix

This appendix describes the modelling approach used in Section 3.

Policy parameters and uprating

The following policy parameters are uprated from 2021–22 prices to October 2023 prices by assuming uprating for 2022–23 of 3.1% (September 2021 CPI) and 3.9% for 2023–24 (Office for Budget Responsibility's October 2021 forecast for year-on-year CPI inflation for Q3 2022):

- personal expenses allowance;
- minimum income guarantee for a single individual over pension credit age;
- minimum income guarantee for a member of a couple over pension credit age.

The levels of the care cost cap, the lower capital limit and the upper capital limit were announced by the government as levels to be introduced in October 2023. These are £86,000, £20,000 and £100,000, respectively. We assume that the daily living cost charge for residential care is £200 in October 2023 prices.

The capital charge tariff rate is £1 per week for each £250 of assets held over the lower capital limit (£20,000).

All policy parameters, asset prices and incomes are assumed to grow at the same rate after October 2023.

Behavioural assumptions

1. Individuals do not draw down on, or accumulate, their assets in the absence of care contributions.
 - a. One way of describing this is that income that is not spent on care (including the 'daily living cost' charge) is spent and asset prices rise in line with care costs and the policy parameters.
 - b. Note that this means, for example, that if some people make top-up payments on their care, this is assumed to come from their income.
2. Non-housing assets are sold to pay for care before housing assets.

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3. When one member of a couple starts receiving care, the couple splits their assets so that spending on care depletes only that member's assets and not those of their partner (and means-tested support is maximised).
4. When a single person enters residential care, they cease to have any housing costs and take advantage of the 12-week disregard for housing assets.
 - a. This is consistent with them immediately selling their home or stopping renting.
5. When an individual enters residential care, they cease any employment they are undertaking and lose any employment income.

Definition of wealth and income

We construct the measures of housing and non-housing wealth in ELSA using the IFS financial derived variables (downloadable from the UK Data Service) as follows:

1. Non-housing wealth is comprised of:
 - a. Savings
 - b. Premium bonds
 - c. National Savings products
 - d. Shares
 - e. Stocks and shares ISAs
 - f. Trusts
 - g. Bonds
 - h. Second homes (net of debts secured on them)
 - i. Business assets
 - j. Farm or business property
 - k. Other physical wealth (land/trust/antiques/jewellery etc.)
2. Note that antiques and jewellery are excluded from capital according to government guidance but are included here because ELSA asks for the combined value of other physical wealth. These are a small share of non-housing wealth.
3. Net primary housing wealth is defined as the corresponding IFS derived variable (i.e. value of main property net of any mortgages secured on it).
4. For wealth measures, we use the benefit-unit (i.e. individual if single or couple if has a partner) variable and divide by two for couples.
5. Net primary housing wealth is disregarded for individuals in a couple or those receiving domiciliary care when calculating means-tested support.
6. Housing wealth is uprated to October 2023 prices using regional house price growth from the month of observation until October 2021. Thereafter, we assume the level of annual house price inflation for the year to Q3 2022 and to Q3 2023 given by the OBR's October 2021 Economic and Fiscal Outlook (supplementary economy tables, chart 2.15).

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7. Non-housing wealth is uprated to October 2023 prices using CPI inflation from the month of observation until October 2021. Thereafter, we assume the level of annual CPI inflation for the year to Q3 2022 and to Q3 2023 given by the OBR's October 2021 Economic and Fiscal Outlook (supplementary economy tables, chart 2.29).

Income is defined using the IFS financial derived variables as follows:

1. Income is defined as benefit-unit total net non-employment income. For those in couples, 50% of the partner's private pension income is disregarded if the individual is in residential care (as per government rules that 50% of a partner's private pension income is disregarded if they are not living in the same care home). Housing costs (rent and mortgage payments) are also disregarded for those in domiciliary care or with a partner. For couples, the benefit-unit income is then divided by two.
2. Any benefit income (including disability living allowance, personal independence payment and attendance allowance) paid to the individual is assumed to cease on entry to residential care.
3. We winsorise the top and bottom 1% of income (this implies a minimum income in the sample of around £100 per week).
4. Income is uprated to October 2023 prices using CPI inflation from the month of observation until October 2021. Thereafter, we assume the level of annual CPI inflation for the year to Q3 2022 and to Q3 2023 given by the OBR's October 2021 Economic and Fiscal Outlook (supplementary economy tables, chart 2.29).

Care costs

We assume average care costs for England as set out in Section 3. We assume a ratio of costs in each English region, relative to the English average, equal to the ratios in the regional residential care cost data published by Age UK (<https://www.ageuk.org.uk/information-advice/care/paying-for-care/paying-for-a-care-home/>).

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