Should the planned cap on liability to meet care costs be uniform across England?

Care and State Pension Reform (CASPeR) a collaborative project between the Pensions Policy Institute (PPI), the University of East Anglia (UEA) and the London School of Economics and Political Science (LSE), funded over two years by the Nuffield Foundation, investigating the long-term impacts of both long term care and state pension reforms and their potential interactions.

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October 2016
http://www.pensionspolicyinstitute.org.uk/casper

Long-term care financing - Should the planned cap on liability to meet care costs be uniform across England or vary across the country?

Summary

This report presents data on regional variations in a range of relevant variables to inform discussion about whether there is a case for the planned cap on liability to meet care costs to vary in value between regions or areas of England.

Care home fees are generally higher in more affluent areas, reflecting higher wages and higher property prices. This means that a higher proportion of service users will reach the cap, and will reach it more rapidly in London and much of southern England, than in northern England.

The proportion of older households comprising an older home owner living alone – the group most likely to need to fund their own residential care - varies between regions, being highest in London and lowest in the East of England and East Midlands. This means that, other factors equal, Londoners are more likely to need to self-fund their residential care and hence more likely to benefit from the cap on liability for care costs. Moreover home owners in London and the South East have higher average housing wealth than home owners in the rest of the country.

Average net weekly income before housing costs for single pensioners – and most care home residents are single, mostly widowed – vary between regions, being highest in London. Other factors equal, service users funding their own care in regions with higher incomes can make a larger contribution to its costs from their income and use less of their savings than those in regions with lower incomes.

There are different dimensions of equity that could be considered relevant to the choice between a uniform cap across the country or a cap which varies by region or local area. Much depends on which dimension of equity is considered more important.

Introduction

Under the current system for financing adult social care in England, people with savings exceeding an upper capital limit (currently £23,250) are ineligible for publicly funded social care (with limited exceptions). This means that they need to meet the full costs of their care from their income and savings unless and until their savings drop below this capital limit. Since the value of a person's house is generally treated as part of their savings if they enter a care home, this means for many home owners requiring residential care that they need to sell their home to fund their care.

The Government plans to introduce in 2020 substantial reforms to this system of funding long-term care in England, as discussed in our previous overview report[1] and briefing notes[2,3]. The key change is the introduction of a lifetime cap on an individual's liability to pay towards their care costs on the lines recommended by the Commission on the Funding of Care and Support[4]. To benefit from the lifetime cap, a person will have to be assessed by a local authority (LA) as having eligible care needs. The LA will then calculate the weekly costs of meeting those needs and keep track of the cumulative amount of those costs through the

person's 'Care Account'. Until their Care Account reaches the cap, the LA will still apply a means test to determine how much the person must pay towards the cost of their assessed needs. Once the cap is reached, the state will meet the cost of their eligible care needs without a means test. The daily living (or 'hotel') costs component of care home fees will continue to be means-tested. The reforms will also increase substantially the upper capital limit in residential care for all except home owners where the value of their home is disregarded.

The Government propose that the cap on liability to meet care costs will be of uniform value across England and the upper capital limit will also continue to be uniform across the country If the reforms had been implemented in 2016 as the Government originally planned prior to postponement to 2020, the cap would have been £72,000 and the upper capital limit would have been £118,000 for residential care and £27,000 for home care.

The Institute and Faculty of Actuaries have estimated the probability of reaching the cap for a person entering a care home with nursing at age 85 and the number of years elapsed between care home admission and reaching the cap. Both of these vary considerably by region.[5] The probability of reaching the cap is 22% in the South East, 18% in London and 17% in the South West but only 7% in the North West and West Midlands and 6% in Yorkshire and Humber. The average years elapsed before reaching the cap is 6.4 in Yorkshire and Humber and 6.1 in the North West but only 4.0 in the South West, 3.9 in London and 3.4 in the South East. These differences reflect mainly regional differences in average care home fees.

This note presents data on regional variations in a range of relevant variables to inform discussion about whether there is a case for the cap or the upper capital limit to vary in value between regions or areas. Our aim is not to argue that because there are regional differences in older people's incomes and savings and in average care homes it necessarily follows that the cap or capital limit should vary between regions rather than be uniform across the country. Our aim is to present relevant data to inform discussion.

We present and discuss data on regional variations in life expectancy and disability free life expectancy at age 65, regional variations in the resources of older people and regional variations in care home fees met by local authorities. We are not arguing that, if the level of the cap varied across England, it should necessarily be set at regional rather than more local level. There may be a case for variation within some or all regions. We present regional data because that is the level at which all the data are available.

The variations between regions in the variables we consider are likely to reflect differences in the socioeconomic characteristics of their older populations or in the case of care home fees in their local labour markets and property markets. These are factors outside the control of local authorities and also outside the control of older people themselves by the age at which they may need care and support.

The cap will apply to both home-based and residential care. If a person receives first home-based care and then residential care, for example, the costs of both types of care will be included in their Care Account and count toward the cap. We focus our discussion on residential care simply because large spend-down of savings to fund care arises more frequently for residential care.

Life expectancy and healthy life expectancy

There are marked variations by region in overall life expectancy at age 65, disability-free life expectancy at age 65 and expectation of life with disability at age 65 (Table 1). For both men and women the average age of onset of disability and the expected number of years lived with disability varies between regions. The average age of onset is higher in the South East than in the North East, by 2.1 years for men and 2.5 years for women. The average number of years lived with disability varies for men from 7.9 years in the South West and 8.0 years in the South East to 8.9 years in London and the East Midlands and for women from 9.6 years in the South East to 11.0 years in London. This suggests that average duration of disability is shorter in the South East

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Table 1: Life expectancy (LE) and disability-free life expectancy (DFLE) at age 65, by region[6]

English region	Men				Women			
	LE (Years)	DFLE (Years)	Disability LE (Years)	Age at Onset	LE (Years)	DFLE (Years)	Disability LE (Years)	Age at Onset
South East	19.3	11.3	8.0	76.3	21.7	12.1	9.6	77.1
South West	19.3	11.4	7.9	76.4	21.8	11.8	10.0	76.8
East of England	19.3	11.0	8.3	76.0	21.6	11.4	10.2	76.4
London	19.2	10.3	8.9	75.3	21.9	10.9	11.0	75.9
East Midlands	18.6	9.7	8.9	74.7	21.1	10.2	10.9	75.2
West Midlands	18.5	10.0	8.5	75.0	21.1	10.3	10.8	75.3
Yorkshire and The Humber	18.2	9.7	8.5	74.7	20.6	10.4	10.2	75.4
North West	18.0	9.4	8.6	74.4	20.3	9.7	10.6	74.7
North East	17.9	9.2	8.7	74.2	20.0	9.6	10.4	74.6
England	**18.8**	**10.3**	**8.5**	**75.3**	**21.2**	**10.9**	**10.3**	**75.9**

and South West than in London and the East Midlands.

It is important to note that the measure used in the calculation of these data on disability-free life expectancy at age 65 relates to self-reported limiting long-standing illness. This is a wider definition than limitation in ability to perform personal care tasks, which is relevant for long-term care. Nevertheless, regional variation in expectation of life with disability seems likely to be associated with regional variation in rates of difficulty conducting personal care tasks. On this basis, because of their shorter average duration of life with disability, other factors equal, a lower proportion of older people starting to receive intensive home care or residential care in the South East are likely to reach the cap than in the North East or London.

Care home fees

There are large differences between regions in average care home fees met by local authorities. Average fees met for users whose support reason is physical support are substantially higher in London, the East of England and the South West and lower in the North East, Yorkshire and Humberside and the North West than the national average (Table 2). The pattern is similar for users whose support reason is memory and cognition. This means that a higher proportion of service users will reach the cap, and will reach it more rapidly, in London and much of southern England than in northern England.

Table 2: Care home fees met by local authorities, by region[7]

English Region	Support Reason	
	Physical Support	Memory & Cognition
North East	495	467
North West	470	457
Yorkshire and The Humber	483	422
East Midlands	513	503
West Midlands	510	505
East of England	612	486
London	616	692
South East	571	578
South West	601	549
England	**540**	**517**

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Care home fees clearly cover both hotel costs and care costs. The cap however will relate to care costs only and will not extend to hotel costs in care homes, for which only means tested support will be available. The level of hotel costs will be set at a uniform notional level and will not depend on actual costs of individual care homes. This suggests that the variation in care home fees is relevant not only for decisions on the level of the cap but also for decisions on the level of notional hotel costs.

Housing tenure and prices

The value of a service user's home is always disregarded in the means test for home-based care but is usually taken into account as part of the person's savings in the means test for residential care. An exception is when the person's spouse or other dependent relative or older disabled person continues to live in the house. This means that the group most likely to have to fund their own care if they need residential care is home owners who live alone. People with substantial financial (non-housing) savings or incomes may need to fund their own care or meet a considerable proportion of its costs through user charges.

The proportion of older households comprising an older home owner living alone varies somewhat between regions (Table 3). It is highest in London at 51.4% and lowest in the East of England at 45.8% and East Midlands at 45.9%. This means that, other factors equal, Londoners are more likely to need to self-fund their residential care, if they should need to enter a care home, and hence more likely to benefit from the cap on liability for care costs.

Moreover home owners in London and the South East have higher average housing wealth than home owners in the rest of the country (Table 3). Average house prices vary from below £125,000 in the North East (close to the planned value of the new raised upper capital limit for residential care) to around £440,000 in London (nearly four times the new upper capital limit). It could be argued that for this reason the cap should be higher in London, the East and the South East, and lower in the North East, North West and Yorkshire and Humber. Service users in these regions will on average spend-down a lower proportion of their housing wealth before reaching the cap than those in the rest of the country.

Table 3: Tenure and house prices, by region[8,9]

English Region	Proportion of older home owners living alone	Average house prices (£'000s September 2015)
North East	49.9%	123.3
North West	49.1%	142.8
Yorkshire and The Humber	48.3%	144.6
East Midlands	45.9%	162.2
West Midlands	46.5%	167.6
East of England	45.8%	247.3
London	51.4%	439.7
South East	46.7%	284.4
South West	46.4%	224.4
England		**216.4**

Income

The average income of pensioners also varies between regions (table 4). Since most care home residents no longer meet ordinary housing costs, the most relevant measure of income is net income before housing costs. For pensioner couples,

Table 4: Average net weekly pensioner income before housing costs (£s), by region[10]

English Region	Pensioner Couples	Single pensioners
North East	496	275
North West	504	278
Yorkshire and The Humber	487	261
East Midlands	514	264
West Midlands	489	265
East of England	563	288
London	612	306
South East	649	294
South West	566	273
England	**522**	**280**

average net weekly income before housing costs in 2013/4 ranged from £487 in Yorkshire and Humber to £649 in the South East. For single pensioners – and most care home residents are single, mostly widowed - average net weekly income before housing costs ranged from £261 in in Yorkshire and Humber to £306 in London. The relevance of this regional variation in incomes is that, other factors equal, service users funding their own care in regions with higher incomes can make a larger contribution to its costs from their income and use less of their savings than those in regions with lower incomes.

Savings

Wealth also varies very considerably between regions. Median household net financial wealth, that is excluding housing and pension wealth, was over twice the national figure in the South East and less than half the national figure in the North East in July 2012 to June 2014 (Table 5). Although this data relates to all households and not just pensioner households, there seems likely to be similar substantial variation in net financial wealth among pensioner households. The relevance of this regional variation in financial wealth is that, other factors equal, service users funding their own care in regions with higher financial wealth can make a larger contribution to its costs from their financial savings and use less of their housing wealth than those in regions with lower financial wealth.

Table 5: Median household net financial wealth, by region: Great Britain, July 2012 [11]

English Region	£
North East	2,600
North West	3,500
Yorkshire and The Humber	3,900
East Midlands	5,400
West Midlands	4,000
East of England	8,500
London	6,200
South East	13,800
South West	11,700
England	**6,300**

Discussion

The case for introducing a cap on liability to meet care costs is mainly one of efficiency. Where people are risk averse, pooling of risks through insurance is generally more efficient than each person bearing their own risk. The Commission on the Funding of Care and Support (CFCS) (2011)[4] argued that, since lifetime costs of care vary greatly between individuals and are very substantial for a minority (over £100,000), and since private insurance for long-term care is not available in England, the state should meet the costs of care after the service user had, subject to their resources, met a substantial excess. The cap is in effect an excess. While the case for introducing a cap rests mainly on efficiency, the question of whether the cap should be uniform across the country or variable between regions or areas raises issues of equity.

There are different dimensions of equity that could be considered relevant. These include:

A. each person should be assured that however high their lifetime care costs, they will be left with a minimum level of savings;
B. each person should be assured that whatever their resources, they will be required to spend no more on their care than a specified amount which is equal for all;
C. each person should be assured that whatever their resources and however high their annual care costs, they will not be required to fund their own care for more than a specified number of years which is equal for everyone.

Dimension A may be regarded as the case for a uniform capital limit across the country but it may seem less relevant for the cap than for the capital limit. The cap will operate alongside the capital limit. Service users who fund their own care will become eligible for public support when their care account reaches the cap or when their remaining savings fall below the upper capital limit, whichever occurs first.

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Dimension B may be considered a justification for a cap on eligible care costs which is uniform across the country regardless of regional variations in average care home fees, the resources of the service user or any other variable.

Dimension C may be regarded as the case for the system operating in the New York State Partnership for Long Term Care. The Commission for the Funding of Care and Support however recommended a uniform lifetime liability to meet care costs in terms of amount of spending rather than number of years of spending.

The variation in care home fees presents a case for regional or even local variation in the cap on grounds of equity in average time elapsed between assessment of eligible care needs and reaching the cap, a form of equity dimension C. Whether this should be regarded as more equitable than a uniform cap across the country however is open to debate. The case for a uniform national level of cap is that equity across the country in the amount of spend-down (dimension B) is more important than equity in the duration of care before the cap is reached and care costs are met without means test (dimension C).

A case could be made for arguing that it is not so much the cap as the notional level of hotel costs which should be set at a higher level in London, and possibly other parts of the South and East, than in the rest of the country. The variation in care home fees is likely to reflect partly differences in wages but also partly differences in property prices across the country. It is for this reason that a case could be made for geographical variation in the notional level of hotel costs. The former Residential Allowance in Income Support for care home residents which was phased out in 2002/03 was set at a higher rate in London than elsewhere.

The different factors considered in this note tend to be linked. In London, the combined effect of relatively higher average incomes and savings, higher care home fees and longer length of life with disability contributes to a greater likelihood of being required to meet the full costs of care and a greater likelihood of reaching the cap. This contrasts with the North East where the combined effect of relatively lower average incomes and savings, lower care home fees and lower length of life with disability contributes to a smaller likelihood of being required to meet the full costs of care and a smaller likelihood of reaching the cap.

In summary, the case for a lower cap in more deprived and a higher cap in more affluent areas is that:

- Differences in expectation of life with disability suggest that residents of more deprived areas may need care for longer periods toward the end of life,
- Differences in care home fees mean that people in more affluent areas reach the cap more rapidly than people in less affluent areas,
- Differences in older people's incomes and savings mean that people in more deprived areas will in general spend-down a higher proportion of their savings before reaching the cap than residents of more affluent areas.

The case for a single uniform cap across the country is that:

- A cap which varies by area would be complex to administer if people move area while receiving care,
- Uniformity across the country in the level of expenditure on care required to be met by the care user before reaching the cap may be regarded as more important than uniformity in duration of care before meeting the cap or in spend-down of savings.

The choice between a uniform cap across the country or a cap which varies by region or local area depends on which dimension of equity is considered more important.

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