Institute and Faculty of Actuaries

Inquiry on long-term funding of adult social care

IFoA response to Communities and Local Government and Health Committees

7 March 2018

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The Institute and Faculty of Actuaries is the chartered professional body for actuaries in the United Kingdom. A rigorous examination system is supported by a programme of continuous professional development and a professional code of conduct supports high standards, reflecting the significant role of the Profession in society.

Actuaries' training is founded on mathematical and statistical techniques used in insurance, pension fund management and investment and then builds the management skills associated with the application of these techniques. The training includes the derivation and application of 'mortality tables' used to assess probabilities of death or survival. It also includes the financial mathematics of interest and risk associated with different investment vehicles – from simple deposits through to complex stock market derivatives.

Actuaries provide commercial, financial and prudential advice on the management of a business' assets and liabilities, especially where long term management and planning are critical to the success of any business venture. A majority of actuaries work for insurance companies or pension funds – either as their direct employees or in firms which undertake work on a consultancy basis – but they also advise individuals and offer comment on social and public interest issues. Members of the profession have a statutory role in the supervision of pension funds and life insurance companies as well as a statutory role to provide actuarial opinions for managing agents at Lloyd's.

Institute and Faculty of Actuaries

Rt Hon Clive Betts MP and Rt Hon Sarah Wollaston MP
Communities and Local Government and Health Committees
House of Commons
London
SW1A 0AA

7 March 2018

Dear Mr Betts and Dr Wollaston

IFoA response to Communities and Local Government Committee and Health Committee's long term funding of adult social care Inquiry

1. The Institute and Faculty of Actuaries (IFoA) is the UK's only chartered professional body dedicated to educating, developing and regulating actuaries. Quantifying health and long term care risks is a growing area for actuarial work. The evolution of models for health provision to meet changing needs is a feature of both public and private sector work and actuaries work with other health professionals to find appropriate solutions for private medical insurance, income protection, critical illness, and long-term care insurance.

2. The IFoA's members have produced a number of research reports on the sustainability of adult social care funding. In particular, analysing the costs for self-funders and the balance between State and personal funding. Our members are working on further analysis as we hope to continue to assist the Government as it looks for ways to meet the changing needs, demands and expectations of the health and care system as a result of changing demographics.

3. We are encouraged that the Department of Health became the Department of Health and Social Care at the start of 2018. A comprehensive and holistic approach to health and social care will be required to meet the needs of an ageing population. The health and care systems are already under strain as a result of population ageing and this is set to increase as the population continues to age. In order to ensure that the proportion of the population with unmet care needs does not continue to increase it is crucial that the Government responds to this increased demand.

4. The potential integration of health and care creates an opportunity for debate about the disparity that exists between State provision and self-funding. For any real progress to be made we will need cross-party consensus on the fundamental principle of whether the State should cover all health and care costs, or whether those who can afford to contribute towards their needs should, and if so how much.

5. We have focused our response on how the Government might strike a balance between Government and individual funding to meet health and care needs within a sustainable framework, as this best aligns with the options being openly considered by Government (e.g. in the Care Act and Conservative Manifesto). For this reason

we have focused on insurance solutions and risk pooling, as well as solutions that allow people to use their accumulated wealth and assets. Again, a clear steer from Government on which approach it will take will best enable us to conduct further research. Therefore, our response to the Committees is based on the premise that a balance has to be struck between:

- State contributions for those who cannot afford to pay for care; and
- individual responsibility to make provision for, and meet care costs, where it is deemed they can afford to pay, for at least some, if not all, of their care costs.

It is important to note that in order to divide responsibility between individuals, the State and any insurance involved will need a consistent definition of a care claim.

6. We recommend that a combination of approaches might be necessary for a truly long-term funding model - one for those already in retirement, or with care needs, and one for the working population with potential future care needs. For example:
    a. A solution that enables people with care needs, or who are already in retirement, to use some of the value in their homes to fund their care costs, without having to move out of their home.
    b. A pre-funded model, whereby the working age population takes action now that means, where they can afford to, they are better able to meet potential future care costs.

7. For any approach to be successful it will be crucial that in the first instance the Government raises awareness of the current system. Consensus on future reform is not necessary to do this and so it should be an immediate priority. This would mean the public is able to make a better informed view of any future Government proposal and could avoid the misconceptions that became apparent (and hit the headlines) during the 2017 General Election.

8. One particular headline that showed a lack of understanding of the care system amongst politicians and the public was the 'dementia tax'. Our analysis and recommendations are based on the current system whereby many individuals have to pay towards their care, but the State meets their health needs. However, we do not necessarily think that this is the most appropriate approach and would encourage the Government to consider integration of health and care as it could reduce complexity, provide individuals with greater continuity of care and create greater parity between physiological and cognitive diseases. A large proportion of the care received by someone with dementia is social care (such as help with washing, dressing and eating) and this is means-tested, meaning the individual pays. With many other conditions, the individual will receive the majority of their care through the NHS, which is free at the point of use.[1] It is important that we at least acknowledge and raise awareness of this imbalance, if not take steps to address it, as the number of people with dementia in England is projected to reach one million by 2025 and to have doubled to two million by 2050.[2]

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[1] Alzheimer's Society (2018) *Did someone say dementia tax?* [Available online: https://blog.alzheimers.org.uk/campaigns/dementia-tax/]

[2] Dementia Statistics Hub : https://www.dementiastatistics.org/statistics-about-dementia/prevalence/ [Accessed 19.02.2018]

9. This disparity between physiological and cognitive diseases also highlights the need for the sustainability of funding to be considered within the broader context of likely future disease prevalence and the impact this could have on the delivery methods for care now and in the future. Without including these considerations it is impossible to ascertain what the most appropriate funding mechanism will be – both funding and provision must be considered within the sustainability question.

How to fund social care sustainably for the long term (beyond 2020), bearing in mind in particular the interdependence of the health and social care systems.

10. We have broken this down into two sections:
    a. Meeting the needs of those already in retirement whether they have care needs now, or at a later stage in their retirement
    b. Meeting the needs of the working age population without any current care needs

Meeting the needs of those already in retirement

11. More people are funding at least some, if not all of, their care than previously. For example, half of individuals living in residential care homes fund their own care in some way and it is estimated that 26% of people who receive domiciliary care privately fund it in the UK.[3] [4] The costs of care can be significant, particularly for those who require care for extended periods – 20% of those who enter residential care remain in care for longer than five years.[5] This is further exacerbated by cross-subsidy, with one report estimating that self-funders pay, on average, between £603 and £827 a week for a care home placement depending on the area, compared to councils paying between £421 and £624 a week.[6] For these individuals it is likely that the costs they will face are well in excess of anything they could reasonably be expected to anticipate, and therefore make provisions to meet.

12. The system must establish what would be a reasonable amount for any one individual to have to pay towards their care – this could be achieved by a combination of placing a cap on care costs alongside the means test. The second question is how those individuals who are deemed able to afford to, can contribute towards their care costs using the equity in their home, without having to sell their home. Those who have care needs that could be met at home could also use their housing equity to adapt their home without having to move out of their home.

13. The Care Act already contains legislation that would go some way to addressing these issues, namely via the 'Care Cap', increased means testing thresholds and the Universal Deferred Payment Scheme (UDPS).

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[3] LaingBuisson (2017) *Care of Older People: UK Market Report, 28th Edition*
[4] Based on 2014/15 data UKHCA (2016) *An Overview of the Domiciliary Care Market in the United Kingdom*
[5] IFoA analysis of Forder, J. and Fernandez, J-L. (2011) *Length of stay in care homes. Report commissioned by BUPA Care Services, PSSRU Discussion Paper 2769.*
[6] LaingBUisson (2015) *Stabilising the care home sector and preparing for implementation of part 2 of the Care Act in 2020*

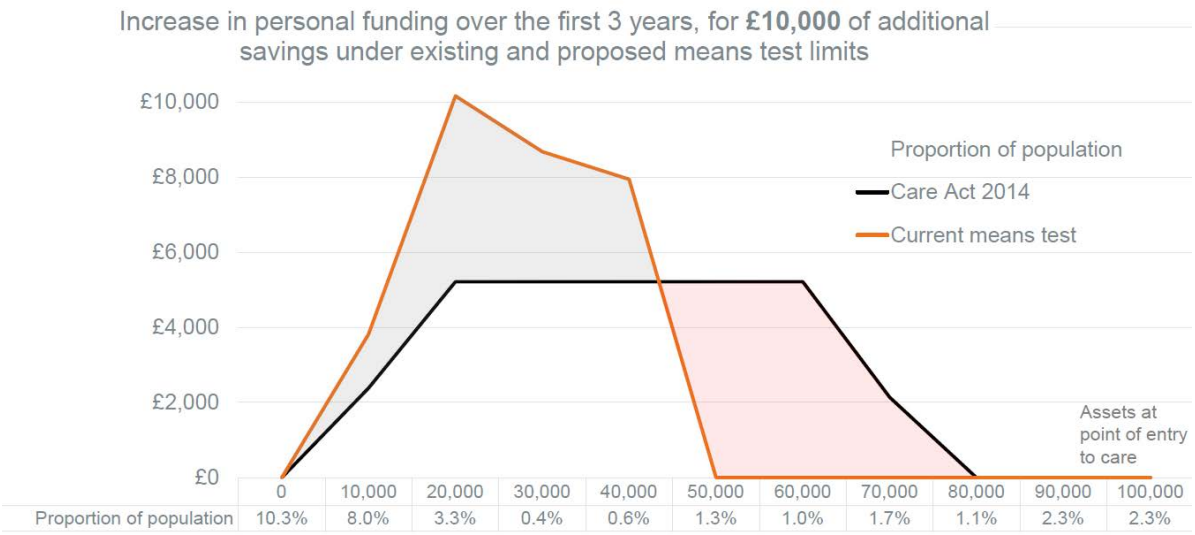
14. We would prefer that the Government makes changes to the Care Act's Cap ('the Cap') and means testing thresholds before these are implemented, but we would be supportive of phase two of the Care Act being implemented, if the alternative is a significant delay to any policy reform.

15. In 2017, we published a joint report with the charity Independent Age. In this paper we recognised the value of a capped model, but raised concerns that the Cap within the Care Act does not cap all care costs, and therefore, there is a risk that the public will misunderstand the Cap and this could lead to confusion and mistrust in the system. We propose a cap of £100,000 – this is higher than the Dilnot Commission's proposal and the £72,000 in the Care Act, but it would cover Daily Living Costs and excess top-up fees in addition to the Local Authority Rate that is covered by the Cap. It would be an 'all-inclusive' cap.

16. Our key arguments are:
    a. An all-inclusive cap is an easier concept for the public to grapple with because it is a complete cap.
    b. It would kick in at roughly the same time as Dilnot's original proposal i.e. once the individual has been in care for around 3 years. This is the average length of stay in residential care and so provides protection to those who live longer than we might reasonably expect them to anticipate they could have care needs. Additionally 59% of those with high domiciliary care needs could stand to benefit from this model, compared to 35% if the Cap is implemented. As we stated above, care at home is significantly more popular than entering into care.
    c. It drastically reduces regional variation in the amount spent before the cap is reached in comparison to the Cap.

17. Further information can be found in our 2017 report 'Will the cap fit? What the government should consider before introducing a cap on social care costs'. We are currently considering the steps that would need to be taken to cost our proposal and we would welcome the opportunity to share this with your Committees upon completion.

18. In 2016, the IFoA produced a report 'The Future of Social Care – Who Pays?'. A key part of this report compares the potential incentive to save, or lack thereof, between the current means test thresholds and those proposed in the Care Act.
    a. Our modelling shows that the means testing thresholds in the Care Act provide a greater level of reward for savers than the existing thresholds, and may increase the level of saving for care, but they could still act as a barrier.
    b. As with any means test there will be 'winners and losers'. The current means test has a significant impact on the incentive to save for those individuals with assets of £110,000 or less at the point of entering care. If these individuals try to save more to pay for their care, it will mean that they end up paying more for their care without those extra savings being available to improve the type and quality of care they receive.



c. The figure above shows the impact of the current and Care Act means test on the incentive to save. It shows that under the current system if individuals with between £20,000 and £40,000 in assets save an additional £10,000 to contribute towards their care costs, they can expect to see their personal care costs increase by £10,000 to £8,000. This means the individual will lose means tested benefits worth somewhere between the entire value of their extra savings, to 80p for every extra £1 saved by the time they have been in care for three years (the average length of stay in residential care). They therefore only have between £0 and £2,000 to spend on improving the type and quality of care they receive from their additional £10,000 saving.
d. The increase in personal care costs for those individuals close to the upper means testing threshold would reduce under the Care Act to a maximum of 50p for every extra £1 saved being lost in means tested benefits. This would mean that, under the Care Act, if individuals with assets between £20,000 and £60,000 save an additional £10,000, their personal care costs will increase by £5,000 and they will have £5,000 remaining to improve the standard of care received.
e. It is only for individuals with assets above £80k where additional savings do not directly replace Local Authority funding. This is the point at which no means tested support is received over a three year period. Above this level of assets the extra savings are fully available to be used for other reasons such as improving the standard of care received or leaving a larger inheritance.

19. This report also explored potential financial product solutions. One product where the market is already rapidly growing, and where the regulatory framework is already taking steps to adapt to growing demand, is equity release. There is a sizeable group of older people on low income for whom moving house would be impractical but for whom a higher income could significantly help improve their day-to-day life and wellbeing – particularly older retirees who live alone and may have current or impending care needs. Equity release mortgages enable a residential property owner to release part of the value of their property without having to sell the home immediately and they can continue to live there until they die or go into residential

care. The released equity in the property could be used to fund social care costs, or pay for improvements that enable people to live independently in their home for longer.

20. We are working on a further report that explores different means testing thresholds and are overlaying our results against population data to identify who would be affected by changes to the means test.

21. The Government has its own form of equity release. Since implementation of the Care Act 2014, councils have been obliged to offer deferred payment agreements as part of the UDPS to those who would otherwise have to sell their home to fund residential care. However, take-up rates have remained low. Experimental data collected by NHS Digital found that out of 55 local authorities in England, just 1,300 agreements were written in 2015 /16 – the first financial year the scheme was in force. [7] This is significantly less than was anticipated. Increasing eligibility and awareness of this scheme could increase take-up. In particular:
    a. this scheme does not help those who wish to receive care at home, despite evidence that around 9 out of 10 people would prefer to receive care in their own home – private providers do allow equity release to meet these needs;[8] and
    b. the value of your savings and investments must be below £23,250 (not including the value of your home and pension). This raises questions around fairness for example:
        i. an individual who's home is worth £500,000 and their savings and investments are worth £20,000 is eligible for UDPS; but
        ii. an individuals who's home is worth £120,000, yet their savings and investments are worth £25,000 is not eligible for UDPS, despite their overall level of wealth being significantly lower.

22. An alternative to equity release is downsizing. There are numerous barriers to this being an appealing option such as emotional attachments to the home and the desire to pass it on as inheritance, the availability of housing and the costs associated with buying and selling property. If the Government wants people to use their housing wealth to pay for care further work is needed to encourage downsizing or accessing the equity in their house without needing to sell it.

23. One further debate on the balance between individual responsibility and the State that is often overlooked, is the huge amount of care already provided by family and friends, both practically and financially. The contribution of family and friends is estimated to be worth £132 billion per year in the UK – this is roughly equivalent to the NHS budget. Evidence from Carers UK shows that the contribution of those providing unpaid care are not appropriately valued – the Carer's Allowance is the lowest paid benefit of its kind. This means carers are unable to protect their financial security in either the short or long term. We support Carers UK recommendations of

[7] Reform (2017) *Funding social care: The role of deferred payment agreements, March 2017*
[8] UKHCA (2014) *People prefer care at home media statement, 12.06.2014*

increasing the Carer's Allowance to at least to the same level as the Job Seeker's Allowance; introducing a right to paid leave for carers in work akin to maternity / paternity leave; and to auto-enrol carers in to a Carer's Pension to ensure carers do not face financial hardship in later life as a result of taking on caring responsibilities.[9]

Meeting the needs of the working age population

24. There is uncertainty around whether younger generations will have the same level of income in retirement and the same levels of housing equity as the Baby Boomer generation. Therefore a different approach may be needed to create a truly long-term solution, which is sustainable not just for the next generation, but for generations to come.

25. Germany and Japan are two of a number of countries that have national insurance programs that could provide examples for a long-term solution here in England.
    a. In Germany, there is a mixture of social and private insurance schemes. Compulsory social insurance was introduced in 1995. However, those with higher incomes, civil servants and the self-employed may opt for private insurance instead of the social insurance. Contributions to social insurance are split between the individual and the employer. This structure enables both public and private systems to sit alongside one another.
    b. In 2000, Japan created a care social insurance programme. This programme covers domiciliary and residential care and the benefits are set nationally. It is compulsory for those over 40 years of age to contribute and it offers access to social care for those aged over 65. The level of contribution is dependent on income, but the benefit is dependent on need, as opposed to being means-tested.

26. For a pre-funded model to work, whether that be insurance-based or through a savings approach incentives, strong nudges or some form of compulsion will likely be required to achieve a high level of take-up. Our members have expertise in designing private medical insurance products, long-term care products (both pre-funded and at the point of need products), as well as long-term saving products (pensions). We would be delighted to meet with you to discuss the merits of both approaches if it would be helpful to the Committees' inquiry.

27. Finally, we might also look to France where the Government has managed to significantly increase the amount of private provision for care through a Government-led public awareness campaign. In the Care Act 2014, for the first time the UK Government legislated for changes to the current system with the aim of encouraging innovation in this market. The lack of market response was cited as one of the reasons for the deferral of these reforms to 2020. If the Government genuinely wants people to be aware that they may have to fund care needs themselves and to make provisions then we believe the following needs to happen:

[9] Carers UK (2017) *State of acring 2017*

a. Widespread public engagement is needed to create the scale of demand required for any financial product solutions to develop that are commercially viable.
b. Savers must be incentivised, not penalised.

The mechanism for reaching political and public consensus on a solution

28. Others will be better placed to provide detailed commentary. However, we reiterate our view that, for any approach to be successful, it will be crucial for the Government to raise awareness of the current system. Consensus on future reform is not necessary to do this and so it should be an immediate priority. This would mean the public is able to make a better informed view of any future Government proposal and could avoid the misconceptions that we have seen in the past.

29. We would again like to take this opportunity to commend the collaborative approach being taken in this inquiry as we strongly agree that political consensus is crucial to the delivery of a long-term solution for social care.

Should you wish to discuss our response any further please contact Rebecca Deegan, Head of Policy, on rebecca.deegan@actuaries.org.uk.

Yours sincerely,

Jules Constantinou
President-elect, Institute and Faculty of Actuaries