ADULT SOCIAL CARE: POTENTIAL WIDER IMPACTS OF SOCIAL CARE CHARGING REFORMS

Final Report for the DHSC

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Confidential

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This research was commissioned under the previous administration (11th May 2010 to 5th July 2024) and therefore does not reflect the policies of the current government. The views expressed are the authors' and do not necessarily reflect those of the government.

EXECUTIVE SUMMARY

Introduction and context

Care costs for individuals entering adult social care in England are highly variable, and highly uncertain. This has significant implications for those in care, those entering care and for the wider population (who may one day need to access care). In 2011, the Commission on Funding of Care and Support ("the Commission") completed a major report to look at these issues and suggest a package of reforms. The key financial elements of the proposed reforms included:

- introducing a **lifetime cap on individuals' total contribution to adult social care costs**; and
- increasing the **threshold for assets held by an individual (upper capital limit), above which that individual is required to fund their own residential care** (subject to the cap) without support from their local authority.

The Commission argued that its proposed reforms would have several potential direct benefits for individuals, particularly around fairness. The Commission also argued that its reforms would support long-term sustainability of the sector, greater opportunity for public and private sector joint-working, and greater freedom of choice for individuals.

More recently, the Department of Health and Social Care (DHSC) has considered whether the reforms could also lead to several **potential wider benefits**:

- Discouraging 'excessive saving' amongst individuals, which may currently occur as a precaution against uncertain future care costs.

Stimulating new care products and services, due to potential willingness of individuals to buy these (from released excessive savings).

- Encouraging innovation and investment in the care sector, due to expected greater long-term sustainability of the sector, and to support the development of new products and services.
- Stimulating the wider economy, due to individuals spending some of their released excessive savings.

The DHSC commissioned Frontier Economics (working with LaingBuisson) to provide a brief review and assessment of these issues, focusing specifically on the potential wider benefits of the announced care costs cap and increased upper capital limit for those entering adult residential social care. The work was carried out over a 12-week period in 2021.

We note that since undertaking our analysis, but prior to publication of this report, the Government announced its proposed package of social care charging reforms.[1] These are similar, but not identical, to those analysed in this report. Most notably, the Government announced that the Lower Capital Limit will increase from £14,250 to £20,000, which was not considered by our analysis. However, we believe that the conclusions drawn from this analysis would not be substantially different had we considered this announced change.

[1] DHSC (2021a)

Framework

These charging reforms would create the following main benefits to individuals:

- **Reducing actual care costs for some individuals.** For those individuals who end up requiring a substantial amount of care – and make a significant contribution to the costs of this care – both the costs cap and the higher upper capital limit serve to reduce the total cost that they will pay over their lifetime.
- **Reducing uncertainty over future costs for all individuals.** The announced cap on costs would remove the risk of costs above this level for all individuals.
- **Reducing expected future care costs for all individuals.** The reduction in actual care costs for some individuals creates a reduction in expected future care costs for everyone. Before their individual care needs develop, an individual does not know what their future costs might be, including the possibility of very high care costs.

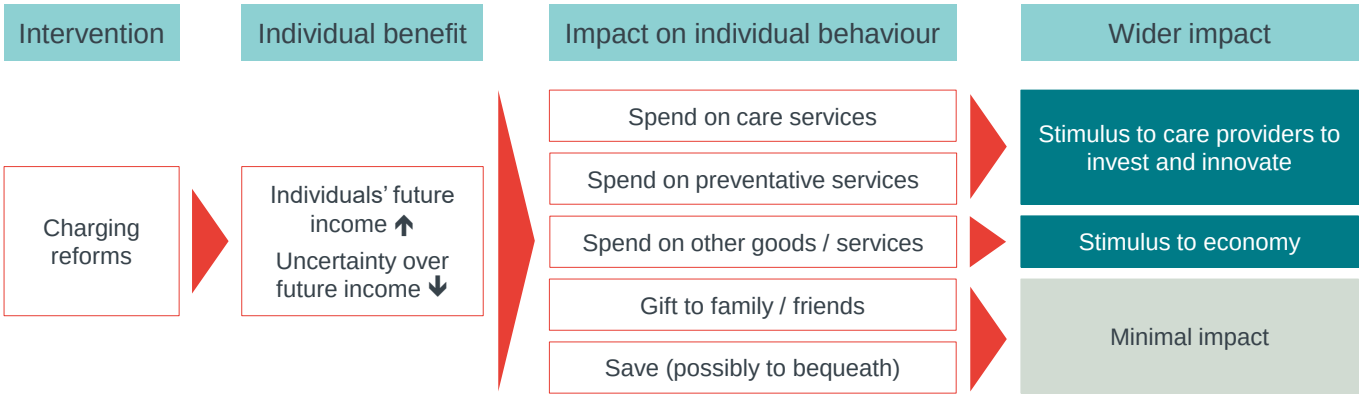
There are several possible responses by individuals to these changes:

- They may choose to spend more on care or elsewhere.
- They may choose to 'gift' additional savings to their family and friends.
- They may choose nevertheless to continue saving as before, with no change to their spending behaviour (possibly with the intention to bequeath any additional wealth).
- They may see the care costs cap as a 'savings target' and choose to save more than previously.

If individuals choose to spend more on their current care services, this will directly benefit the social care sector. Some individuals may choose to spend more on preventative services, which are aimed at keeping them at home and living independently. The Commission argued that the above impacts would **support the social care market in becoming more sustainable, more innovative and higher-quality**.

Some individuals may choose to spend in the wider economy. In this case, the impact of the reforms would be an injection in the economy, although the beneficiaries of this spending could be diffuse and difficult to identify.

Figure 1 Potential impacts of charging reforms



Source: Frontier Economics

Testing whether all or parts of this framework are likely to be borne out in practice requires answering the following key questions:

By how much will individuals' future income be affected by the reforms?

How will individuals respond to reduced care cost uncertainty and expected reduced care costs?

If they choose to spend more…

… how much might be spent on care services?

… how much might be spent on preventative services?

… how much might be spent in the wider economy?

If individuals spend more in the social care market, will providers become more sustainable, more innovative or higher-quality?

We answered these questions using a combination of existing evidence and new analysis.

Literature review

Our review of academic and grey literature suggests the following key messages.

The response of individuals to reduced uncertainty in care costs is difficult to predict:

- Behavioural theories predict that people do not plan for social care in the first place because they underestimate the possibility of needing it later in life.
- However, precautionary savings theories argue that people tend to over-save out of precaution given uncertainty on future health.

Evidence shows that in practice the population divides into a minority over-saving and a majority under-saving.

The effect of the charging reforms will be stronger for those in retirement who are more likely to over-save. It will be strongest for those that are already in care given they may face less uncertainty of future needs. It will be close to zero for the working-age population who are more likely to under-save.

To affect the working-age group requires significant improvements in their financial awareness of social care costs.

The literature presents a wide range of estimates of how consumption changes following an income shock. Taken as a whole, it suggests:

- Retired people will spend up to about 30% of potential savings in the economy.
- Retired people will spend up to about 55% of this extra consumption on care services.

Social care markets are highly localised, and the impact of the reforms on social care providers is likely to vary across the country, depending upon local characteristics.

The social care market is unlikely to become more sustainable solely as a *direct* consequence of the reforms. The market may become more innovative and offer some new or higher-quality services. These developments are likely to be targeted at self-funded residents.

Data analysis

We estimate the expected future financial benefit to individuals in residential care from the reforms. We analyse the impact of the care costs cap and the increased upper capital limit separately. We further look at differential effects based on individuals' income and wealth and their current working and care status.

Our analysis suggests that the potential impact of the increased upper capital limit and the cap on care costs is likely to vary by people's working and care status as well as their wealth and income.

Table 1 below shows the estimated number of residents in England segmented according to their working and care status and their wealth. We assume only individuals with asset wealth above £23,250 (i.e. those in the top two wealth brackets) would benefit from the increased upper capital limit or the cap on care costs.

Table 1 Population segmentation for England

Segment	<£23,250	£23,250-£100,000	>£100,000	Total
Working age	16,000,000	7,630,000	12,280,000	**35,900,000**
Retirement age, not in care home	1,100,000	870,000	7,770,000	**9,740,000**
Retirement age, in care home	70,000	50,000	215,000	**335,000**
Total	**17,170,000**	**8,550,000**	**20,270,000**	**46,000,000**

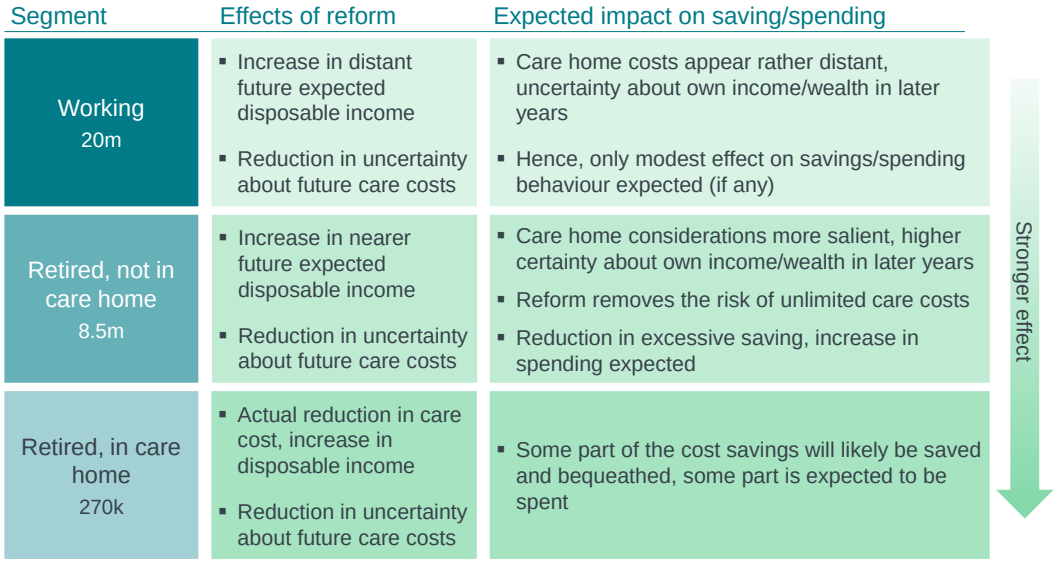
Source: *Frontier analysis based on ONS Wealth and Asset Survey (2016-2018); ONS National Population Projections (2018); LaingBuisson (2021).*

Note: *Wealth only includes financial and property wealth (excl. physical or private pension wealth). Presented numbers are for England. They are corrected to account for aggregate wealth holdings and rounded.*

We expect the reform to produce additional spending from retired people in care and from those not in care. We estimate insignificant effects for working-age individuals who are not in care.

Figure 2 below shows the estimated number of people in each population segment with high enough wealth (assets greater than £23,250) so that they could benefit from the reform. It also summarises the effects of the reforms which we have modelled in our data analysis.

Figure 2 Potential impact of reform on different population segments



Source: Frontier illustration

Note: The numbers of people in each segment only include those with asset wealth greater than £23,250. Therefore, they differ from the total number of people in each segment presented in Table 1.

Our analysis suggests large aggregate future cost savings for the current group of retired people, yet the individual per-person expected savings are more limited.

Our estimates of the likely financial benefit to individuals in the three population segments are set out in Table 2. We note that all figures in this report are in 2021 prices and not estimated at the time of policy implementation.

Table 2 Aggregate impact of future cost savings by population segment

Segment	Potential savings
Working age	Potential savings too distant
Retirement age, not in care home	£5.1-8.7 billion from increased upper capital limit; £4.0-25.3 billion from costs cap
Retirement age, in care home	£1.5-2.5 billion from increased upper capital limit; £0.6-3.5 billion from costs cap

Source: Frontier calculations based on various data sources.

Note: The estimated per-person savings for working-age individuals would be equal to those for retirement-age individuals who are not in a care home. However, these potential savings are very distant and uncertain and are thus likely to lead to little behavioural changes.

Our indicative estimates of the possible change in individuals' spending behaviours as a result of these expected care cost savings are described in Table 3.

Table 3 Potential additional annual spending due to reforms by population segment

Segment	Potential additional spending
Working age	No significant additional spending
Retirement age, not in care home	£65-240 million; of which on care services: £20-65 million
Retirement age, in care home	£280-840 million; of which on care services: £150-460 million
Overall	**£350 million – 1.1 billion;** **of which on care services: £170-520 million**

Source: Frontier calculations based on several data sources

Note: The presented figures are based on various assumptions (see Chapter 5 and Annex A) and are subject to a high degree of uncertainty. Hence, they should be read as indicative estimates only.

The above approach does not consider whether some parts of wealth held by individuals are 'earmarked' for care costs, and might be released following the reforms. Depending on how much money is earmarked for this purpose, the reform could release significantly more consumer spending than currently estimated.

Overall, the results should be regarded as indicative as there is a high degree of uncertainty and variation around the potential impact.

Conclusions

There is justification for the announced reforms on the grounds of fairness alone: ensuring individuals do not face unpredictable and unlimited care costs. However, in this report, we've focused on the potential wider impacts of reducing care cost uncertainty.

Our analysis has drawn upon the best available evidence, however we note that this evidence is limited and therefore our conclusions should be treated with caution. Figure 3 summarises our relative level of confidence in each area of the analysis. We have relatively high confidence in the analysis of expected savings. We have moderate confidence in our estimates of individuals' spending behaviour, but slightly lower confidence in whether this spending will be on care and preventative services. Consequently, we also have lower confidence in the likely impact on the social care market due to the reforms.

Figure 3 Relative level of confidence in each area of analysis

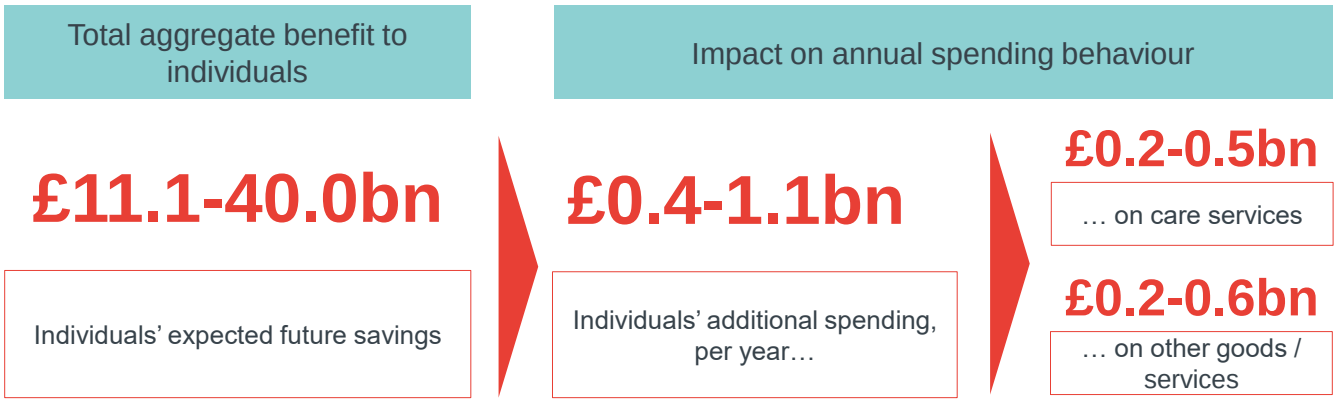
Area of analysis	Relative level of confidence	
Expected savings due to charging reforms	Higher	We have modelled expected future cost savings using several data sources such as the Wealth and Asset Survey, ONS population projections and data from LaingBuisson. The estimation relies on calculations carried out on the latest data available. Ranges for estimates are also presented.
Individuals' overall saving / spending behaviour	Medium	In order to estimate how individual spending would change, we have drawn upon an extensive literature on impacts of income shocks on consumption. However, the literature does not allow us to estimate precisely the extent to which people might spend now because of a greater – but uncertain – likelihood that they will face lower care costs in future.
Individuals' spending on care and preventative services	Lower	There exists some (although limited) evidence in the literature on willingness to spend on long-term care services, which we have used for our modelling. However, the evidence on willingness to spend on preventative services is almost non-existent.
Impact on social care market	Lower	The social care market is large and diverse, e.g., including providers of different sizes and ownership, serving self-funded and local authority-funded individuals. There is little evidence on likely innovations or competitive developments within the sector in response to the proposed reforms.

Source: Frontier Economics

Our headline results are summarised in Figure 4 below. We estimate that in aggregate across all currently retired individuals, expected future savings due to the reforms are £11.1-40.0 billion. We estimate that this will lead to additional spending of £350 million – 1.1 billion per year, of which £170-520 million will be on care services, with the remaining £180-560 million on other goods and services. We have not been able to estimate the likely additional spending on preventative services.

The wide range around these estimates reflects a relatively high degree of uncertainty in the impact. This should be borne in mind when interpreting or using the results from this analysis.

Figure 4 Headline results



Source: Frontier Economics

The impacts are likely to be greatest amongst older people, and particularly those already in care. For working-age individuals not currently drawing on care and support, although the potential savings are (in aggregate) quite large, these would likely be considered too distant and too uncertain to drive a significant change in individuals' behaviours. Overall, this suggests a relatively weak short-run 'financial' effect from the reforms.

The impact on the social care market may therefore also be relatively limited, at least initially. Social care markets are highly localised, and the impact of the reforms is likely to vary across the country, depending upon local characteristics.

The social care market is unlikely to become more sustainable solely as a direct consequence of the reforms. The market may become more innovative and offer some new or higher-quality services. These developments are likely to be targeted at self-funded residents.

The chances of realising the financial and economic benefits set out above would be improved if the focus of reform were not solely on charging. In addition to introducing the care costs cap and the upper capital limit, reforms have a better chance of success where they include:

- Better information about future care costs – and the limits on those costs – to raise awareness amongst individuals which may make them more responsive to changes.
- A stronger financial base for the social care sector would enable greater investment and innovation.
- Regulation (e.g. to improve understanding of quality and cost of different types of care, of entry and exit) to foster a more dynamic and competitive market, particularly within the self-funded part of the market.

INTRODUCTION AND CONTEXT

The adult social care system in England is imperfect. It is virtually impossible for people or providers to know the cost of care for someone entering the social care system. For some people those costs are, unpredictably, very high. At the same time, on the supply side, many providers of social care services operate on thin profit margins and the market exhibits relatively low levels of investment and innovation.[2] On the demand side, many adults are poorly informed regarding social care services.

Repeated efforts by governments over the years to place the sector on a more sustainable footing and to manage the uncertainty facing individuals have been unsuccessful.

In 2011, the Commission on Funding of Care and Support ("the Commission") completed a major report to look at these issues and suggest a package of reforms. The key financial elements of the proposed reforms included:

- introducing a lifetime cap on individuals' total contribution to adult social care costs; and
- increasing the threshold for assets held by an individual (upper capital limit), above which that individual is required to fund their own residential care (subject to the cap) without support from their local authority.

For a variety of reasons, a decade later these reforms have still not been implemented.

The Department of Health and Social Care (DHSC) commissioned Frontier Economics (working with LaingBuisson) to provide a brief review and assessment of these issues. Frontier's work was carried out over a 12-week period in 2021.

We note that since undertaking our analysis, but prior to publication of this report, the Government announced its proposed package of social care charging reforms.[3] These are similar, but not identical, to those analysed in this report. Most notably, the Government announced that the Lower Capital Limit will increase from £14,250 to £20,000, which was not considered by our analysis. However, we believe that the conclusions drawn from this analysis would not be substantially different had we considered this announced change.

The scope of our work **focused on residential social care for older people**. The social care system also provides important support to other groups (e.g. adults of any age drawing on care in their own home or community settings, younger people drawing on care and support in residential care). The Commission discussed these other groups. They need consideration as part of a wider impact analysis of social care reform.

[2] Competition and Markets Authority (2017).

[3] https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/adult-social-care-charging-reform-further-details

Current charging rules and planned reforms

Residential care costs vary across the country and across individuals, depending upon need. Average fees are around £680 per week for residential care (see Table 4).[4]

Fees paid by self-funded individuals tend to be higher than fees paid by local authorities. There is variation across regions, but on average self-funded fees are around 40% higher than local authority-funded fees.[5]

Table 4 Average residential care weekly fees by region

Region	Weekly fees
North East	£582
North West	£562
Yorkshire and the Humber	£622
East Midlands	£656
West Midlands	£627
East of England	£659
London	£767
South East	£840
South West	£740
England	**£681**

Source: *LaingBuisson (2021)*

Note: *Average weekly fees (public and private payers combined) – for-profit homes for older people and dementia (65+), 2019-20*

Current charging rules

Below we set out a very simple summary of the current charging rules. This does not explore all the nuances within the system, which can be quite complex, and can vary across locations and individual circumstances.

Individuals entering residential care can request a needs and means assessment from their local authority. The means assessment considers both the individual's assets and their income.

Individuals' contribution to care costs from assets

In very simple terms, if the individual's assets exceed £23,250, they will receive no financial support from the local authority, and we consider them as **self-funded**, at least upon entering care.[6] They will usually arrange their own care directly with their chosen provider and will pay the provider directly.

4 LaingBuisson (2021).

5 LaingBuisson (2021).

6 As the individual's circumstances change (and in particular, as they use their assets to fund their care), their 'self-funded' status may change.

If the individual's assets amount to £23,250 or below, they will normally receive some financial support from their local authority.[7] Even though the local authority will rarely pay all the costs, we refer to these individuals as **local authority-funded**. Their care will be arranged on their behalf by the local authority, who will pay the provider, with the individual making payments instead to the local authority.

If an individual's assets amount to £14,250 or below, they make no contribution to care costs from their assets (although they will usually contribute from their income, see below).

Table 5 summarises these 'asset thresholds'.

Table 5 Individual contribution to care costs from assets

Level of assets held by individual	Individual contribution from assets
Assets above £23,250	Care paid for entirely by individual
Assets between £14,250 and £23,250	Tapered contribution from assets (£1/week for every £250 of assets above £14,250)
Assets below £14,250	No contribution from assets

Source: DHSC (2021b)

For individuals with assets between £14,250 and £23,250, the 'tapered contribution' is calculated as £1 per week for every £250 of assets above £14,250. For someone with assets of £23,250, this implies a payment of £36 per week. As their assets decline due to these costs, so too will their contribution from assets. The weekly contribution is £18 per week for someone with assets of £18,750, and falls to £0 for someone with assets of only £14,250 remaining.

Individuals' contribution to care costs from income

As well as contributing from their assets, individuals contribute to care costs from their income.

Individuals entering residential care are expected to **contribute most of their income above the Personal Expenses Allowance (PEA)**. The PEA is set at £24.90 per week in England in 2020-21.[8]

Table 6 provides some examples of the individual contribution from income, for care fess of £650 per week. In each case, the individual only keeps the PEA of £24.90 per week.

Table 6 Individual contribution to care costs from income – examples

Individual's income	Individual contribution from income
£500 per week	£475.10 per week
£330 per week (UK retirement average)	£305.10 per week
£173.75 per week (pension credit)	£148.85 per week

Source: Frontier Economics, DWP (2021)

[7] This may not be the case if they have sufficiently high income to cover their care costs.

[8] DHSC (2020).

Individuals' contribution to care costs – illustrative examples

To illustrate how the current charging rules are applied, the figures below describe the contribution to care costs made by three fictional individuals.

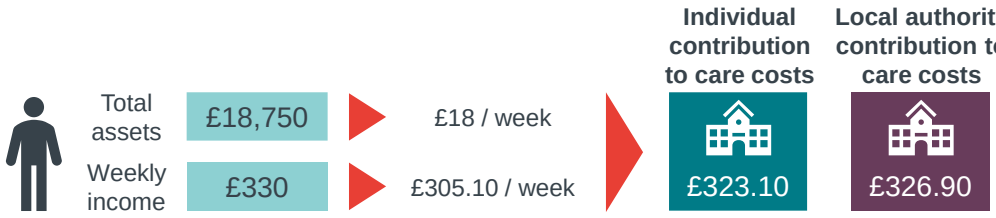
In each case, the care costs are assumed to be £650 per week (£33,800 per year), irrespective of whether they are paid by the individual or the local authority.[9] Depending upon the individuals' assets and income, they contribute a different proportion of these costs. The figures show the weekly contributions made by the individual and the local authority, upon entering residential care.[10]

Figure 5 Individuals' contribution to care costs – illustrative example 1

Source: Frontier Economics

The individual in Figure 5 has eligible assets of £200,000 and weekly net income of £500 per week. Because their assets exceed the £23,250 upper capital limit, this individual must pay for the full costs of care, £650 per week, either from their assets or from their income. The local authority makes no contribution to care costs.

Figure 6 Individuals' contribution to care costs – illustrative example 2



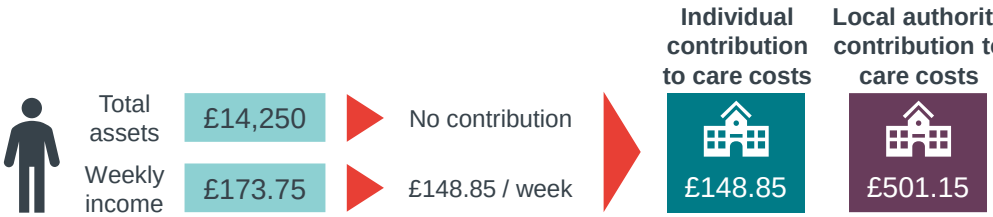
Source: Frontier Economics

The individual in Figure 6 has eligible assets of £18,750 and weekly net income of £330 per week. Their assets fall between the £14,250 lower capital limit and £23,250 upper capital limit. They therefore contribute from their assets, £1 per week for every £250 of assets above £14,250 (see Table 5). In this case, this means a starting contribution of £18 per week from assets. In addition, they must contribute £305.10 per week from their income (see Table 6). The individual's total starting contribution is therefore £323.10 per week. The local authority contributes the remaining £326.90 towards the care costs.

[9] In practice, fees paid by local authorities tend to be lower than fees paid by self-funders.

[10] Note that the costs and contributions of the individual and local authority can change over time in line with changing needs or means.

Figure 7 Individuals' contribution to care costs – illustrative example 3



Source: Frontier Economics

The individual in Figure 7 has assets of £14,250 and weekly net income of £173.75 per week (the pension credit level[11]). Because their assets are at the £14,250 lower capital limit, this individual makes no contribution from their assets. However, they must contribute £148.85 per week from their income (see Table 6 above). The local authority contributes the remaining £501.15 towards the care costs.

Proposed Commission reforms

The Commission argued that the existing charging rules are unfair. According to the Commission, the key underlying issue is that **care costs are**:

- **highly variable**: in 2011, one in 10 individuals faced care costs in excess of £100,000, while half could expect care costs below £20,000;[12] and
- **highly uncertain**: in advance, any one individual does not know what their future care costs will be.

As well as being unfair to individuals, the Commission suggested that this has damaging consequences for the social care market. These issues are discussed in more detail in Chapter 0.

In response to these issues, the Commission proposed the following two main changes to the charging rules:[13]

Cap on care costs (excluding general living costs)

First, the Commission proposed a cap on care costs. Once the overall cost of their care, excluding any top-ups, reached this cap, the local authority would then meet all care costs for that individual. The proposed level of this cap was £35,000, which uprated in line with inflation is equivalent to around £44,000 in 2021.[14]

11 https://www.gov.uk/government/publications/benefit-and-pension-rates-2020-to-2021/benefit-and-pension-rates-2020-to-2021

12 Commission (2011).

13 We note that these remain recommendations only and are not official DHSC policy.

14 https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator

WHY CAP CARE COSTS?

The Commission concluded that it was unfair that a small proportion of individuals would face 'catastrophic' care costs. They also concluded that it was inefficient to expose everyone to this care costs risk, encouraging them to save more (or hold on to assets) 'just in case'.

In addition to excluding any "top-ups" that individuals chose to pay, the cap on care costs would **exclude a notional amount for general living costs** (e.g. accommodation, food etc.), which individuals would be expected to pay for themselves. Currently, the cost of residential care includes these living costs as well as the costs of care, although care home pricing does not usually explicitly separate them. The Commission proposed a figure in the range of £7,000 to £10,000 for general living costs in 2011.

WHY EXCLUDE GENERAL LIVING COSTS FROM THE CAP?

The Commission suggested that it would be unfair if those entering residential care were to have their living costs contribute to the total cap on care costs, whereas those receiving other forms of care (e.g. domiciliary care) were not to benefit from including their living costs in the total cap on care costs. It might also create a perverse incentive to choose residential over domiciliary care.

Illustrative example: For a residential care home costing £650 per week, the annual fees amount to £33,800 per year. If general living costs notionally accounted for £10,000 of these fees, then the annual care costs – which would count towards the costs cap – would amount to £23,800 per year. In this case, a self-funded individual paying these fees without any local authority contribution would reach cap proposed by the Commission in around 2 years. After this point, under the proposed reforms, the local authority would pay for all care costs, excluding general living costs.

The cap on care costs proposed by the Commission would be **calculated on the basis of the costs 'as if' the local authority were paying** for the care, as follows:

The cap on care costs proposed by the Commission would be administered by local authorities. For individuals seeking local authority-funded care, local authorities already determine – based on a needs and means assessment – what care an individual requires and whether the local authority will contribute to the costs. In cases where the local authority does contribute to the costs, they would then arrange for care and agree the rate which is paid to the provider. Introducing the cap on care costs would require the local authority to undertake a similar process for all individuals who wish to have their care costs capped. Specifically, the local authority would determine eligibility of individuals for receiving care, based upon their needs assessment. The local authority would also determine the rate that the authority would expect to pay for such care. This rate would be used to 'meter' the individual towards the cap on care costs, after accounting for general

living costs. If the individual chooses to buy care which is more expensive than this rate, then any spend in excess of the rate is not counted towards the cap.[15]

Illustrative example: According to the local authority's needs and means assessment, an individual is eligible for social care but not for local authority funding. The local authority determines that it could purchase care for that individual at a rate of £500 per week (after subtracting their general living costs), and therefore will 'meter' the individual towards the cap at a rate of £500 per week. If the individual chooses to purchase care (excluding general living costs) at £500 per week, their actual costs will correspond with the local authority's meter towards the cap. If instead, the individual chooses to purchase care at £600 per week, their actual costs will exceed the meter. After 1 year, the individual would have paid £31,200 (£600 x 52 weeks) but will have only metered £26,000 (£500 x 52 weeks) towards the cap.

WHY CALCULATE COSTS 'AS IF' THE LOCAL AUTHORITY WERE PAYING?

This is intended to ensure fairness within the system. A self-funded individual only benefits from the cap if the local authority deems that they are eligible for social care. They also cannot reach the cap 'early' – and receive free care thereafter – by choosing an expensive social care package, which exceeds their needs. This restricts the potential for 'moral hazard' in the system, and limits public expenditure to that which is necessary to meet individuals' needs.

The Commission also proposed that the **costs cap should be 'tiered'** depending upon an individual's age, with a lower cap for younger people requiring care. The Commission suggested a cap of £0 (i.e. no individual contribution to care costs) for those under 40, a cap of £10,000 for those aged 40-49, £20,000 for those aged 50-59 and £30,000 for those aged 60-64. The full £35,000 cap would apply to individuals aged 65 and over.

Increased upper capital limit

Second, the Commission proposed an increased upper capital limit. They proposed increasing the upper capital limit from £23,250 to £100,000 for those in residential care irrespective of whether their housing wealth had been disregarded from their assets. The existing 'tapered contribution' (£1 per week for every £250 of assets above the lower capital limit) would continue to apply for those holding assets between the lower and upper limits.

[15] It is possible that the rate available to a self-funder may be higher than the rate available to the local authority, for the same package of care. To avoid individuals in this situation having to 'overpay' and incurring costs above the cap, Section 18(3) of the Care Act 2014 allows for any individual to request that their local authority arranges care on their behalf.

WHY INCREASE THE UPPER CAPITAL LIMIT?

The Commission argued that someone holding assets of £23,250 should be considered as having relatively low means. Under the current rules, anyone holding assets at this level or greater receives no local authority support for their care costs. Raising the upper capital limit means a greater number of (relatively less well-off) individuals could benefit from some financial support.

Illustrative examples: For an individual with assets over £100,000, the new upper capital limit makes no difference. They will pay all their own care costs, with no local authority contribution.[16] Similarly for individuals with assets at or below £23,250, the new upper limit makes no difference.

For an individual with assets in the range of £23,250 to £100,000, the new upper limit will reduce the amount they contribute to their care costs from assets. Table 7 illustrates the weekly contribution from assets for various individuals.

Table 7 Individual contribution to care costs from assets – new upper capital limit – examples

Level of assets held by individual	Individual contribution from assets	
	Current upper capital limit (£23,250)	Announced upper capital limit (£100,000)
£150,000	Care paid for entirely by individual	
£100,000	Care paid for entirely by individual	£343 per week
£50,000		£143 per week
£23,250	£36 per week	

Source: Frontier Economics based upon Commission on Funding of Care and Support (2011)

Potential benefits of the reforms

The Commission argued that these charging reforms would have several **potential direct benefits** for individuals, particularly around fairness:

- Avoiding the current situation for small numbers of individuals who face very high care costs, instead targeting support on those with the greatest lifetime need (via the proposed costs cap).
- Reducing costs for individuals with relatively low housing wealth (via the increased upper capital limit).
- Reducing costs for younger people with care needs (via the proposed tiered approach to the costs cap).[17]

The Commission also argued the reforms would support long-term sustainability of the sector, greater opportunity for public and private sector joint-working, and greater freedom of choice for individuals.

[16] Note that if the individual's assets fall below £100,000, the local authority would start to contribute.

[17] Note that the proposed tiered approach to the costs cap is not considered in this report.

More recently, the DHSC has considered whether the reforms could also lead to several **potential wider benefits**:

- Discouraging 'excessive saving' amongst individuals, which may currently occur as a precaution against uncertain future care costs.
- Stimulating new care products and services, due to potential willingness of individuals to buy these (from released excessive savings).
- Encouraging innovation and investment in the care sector, due to expected greater long-term sustainability of the sector, and to support the development of new products and services.
- Stimulating the wider economy, due to individuals spending some of their released excessive savings.

Scope of this report

The DHSC asked us to consider the **potential wider benefits** of a care costs cap and increased upper capital limit. We were asked to consider whether these wider benefits are likely to occur, and their possible magnitude. We were asked to focus on the impacts for the residential social care market (both individuals and providers) in England.

This report does not assess the potential direct benefits from the reforms, or the cost of implementing the reforms. We have not considered in detail the impacts upon non-residential care services. We have drawn upon existing evidence and have not undertaken any new evidence collection.

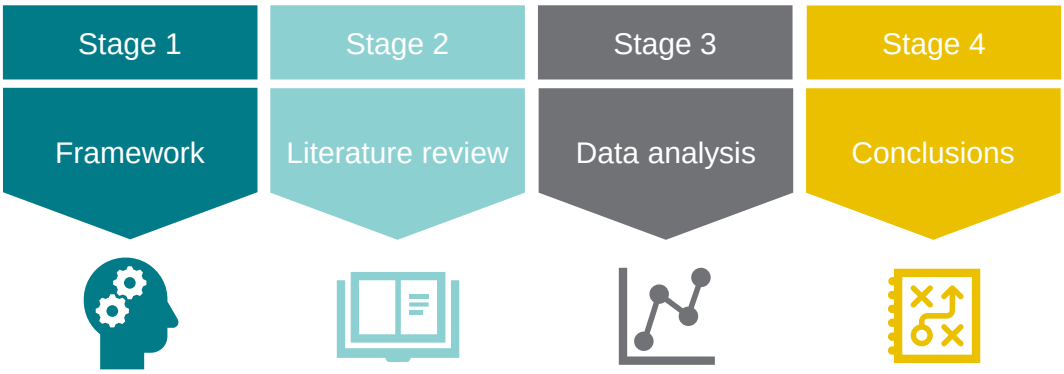
Our findings are intended to provide useful insight on our specific research questions, and thereby to help to provide context for the wider policy debate in this area.

Our work was supported by information and expertise provided by the DHSC. However, the conclusions and views in this report represent those of Frontier Economics and not necessarily those of the DHSC.

APPROACH

Frontier's work was undertaken in the following stages:

Figure 8 Stages of work



Source: Frontier Economics

- **Stage 1.** We considered the potential wider benefits of the charging reforms from a theoretical perspective. We identified the mechanisms through which the reforms may lead to the proposed impacts. This provided a framework to guide the rest of the work. This framework is described in more detail in Chapter 0.
- **Stage 2**. Based upon our framework, we reviewed relevant academic and grey literature. We gathered evidence related to the current retirement planning of individuals, and the characteristics of the social care market. We then gathered evidence on the possible responses of both individuals and social care providers, in response to any changes in charging rules. The results of our literature review are described in Chapter 0.
- **Stage 3.** Based upon our framework, we carried out our own data analysis. This analysis focused upon the size of the potential financial benefit to individuals – depending upon their age, financial status, and social care needs – and their possible saving and spending responses. Our data analysis is described in Chapter 0.
- **Stage 4**. Based upon all of the above evidence and analysis, we developed our conclusions. These conclusions are presented in Chapter 0.

Our work was supported throughout by information and insight provided by the DHSC. However, the conclusions and views in this report represent solely those of Frontier Economics.

FRAMEWORK

In this chapter we consider the potential wider benefits of the charging reforms from a theoretical perspective. Sections 4 and 5 then discuss the evidence and provide some quantitative estimates of the effects described in this framework.

We start by identifying current issues in the social care market. We then describe the mechanisms through which we might expect the charging reforms to affect these issues. This provides a framework for analysing the reforms.

The framework is necessarily a simplification of complex decisions often taking place over years or decades. Further, it characterises the drivers of decisions more precisely than is true in reality: often people may be unable to articulate precisely why they have chosen particular social care arrangements or make decisions when forced to do so by circumstances and without much advance thought. The framework is intended to help organise complex drivers into categories and help decide whether action in one area is likely, on balance, to improve outcomes.

Current issues in the social care market

As discussed in Chapter 0, the Commission argued that the existing social care charging arrangements led to several issues. In this report we do not consider the potential direct benefits of the reforms, which address underlying issues of **fairness** in the current system. This report instead focuses upon the potential wider benefits of the reforms, which relate to the issue of **uncertainty** over care costs. This issue currently affects both individuals and the wider social care market.

Individuals

Individuals cannot predict their future care needs.[18] Under the current charging arrangements, they do not know their future care costs. Some individuals will face very high care costs, with relatively little government support unless they have both low income and low wealth.

The unpredictability of future care costs means that individuals may be incentivised to build up **excessive savings** as a precaution against these costs. Individuals' saving and spending behaviour may depend upon their age and circumstances:

- Working individuals may save excessively in expectation of future care costs.
- Retired individuals not receiving care may hold on to savings or other assets, not spending as much as they otherwise would, in expectation of future care costs.
- Individuals already receiving care may similarly hold on to savings or other assets, and in particular may spend less on their current care package than

[18] Throughout this report we focus on older people who access care. It is important to note that other groups (e.g. people with disabilities) also access the care system. Some of these people use require care throughout their lives. The Commission discusses those groups as well. Considering these other groups in detail was beyond the scope of this work but any reforms will need to consider the impacts on other groups and how to modify this framework to incorporate current and future impacts on them.

they might otherwise, because they do not know how long they will need to continue paying for care.

Social care market

The social care market may also be affected by the uncertainty over individuals' care costs, both directly and indirectly. We identify two hypotheses that could be tested to understand whether they are true.

Directly, the uncertain nature of costs makes it **more difficult to offer long-term products and services to individuals at fixed prices**. In particular, the Commission identified an under-developed insurance market. They argued that the large variation in potential care costs – costs which are incurred over a long time period – means that a pre-funded insurance policy is extremely difficult to price at the individual level.

Indirectly, providers may be affected by care cost uncertainty, because of the potential impact upon individuals' saving and spending behaviour identified above. If individuals in care choose to spend less on their care package as a result of uncertainty, this may **weaken the incentive for providers to offer higher-quality or more innovative care services**, because the demand for such services is constrained. Additionally, there may be a **relatively under-developed market for preventative services**, e.g. for older people seeking to maintain independence in their own home, and to avoid further care needs (and costs).

Potential impacts of charging reforms

More recently, the DHSC has considered whether the reforms could also lead to several **potential wider benefits**.

First, the reforms would create the following main benefits to **individuals**:

- **Reducing actual care costs for some individuals.** For those individuals who end up requiring a substantial amount of care – and make a significant contribution to the costs of this care – both the costs cap and the higher upper capital limit serve to reduce the total cost that they will pay over their lifetime.
- **Reducing uncertainty over future costs for all individuals**. The cap on costs would remove the risk of costs above this level for all individuals. Although actual costs would remain unpredictable, reducing the uncertainty may discourage individuals from saving 'excessively' as a precaution against future costs.
- **Reducing expected future care costs for all individuals.** The reduction in actual care costs for some individuals creates a reduction in expected future care costs for everyone. Before their individual care needs develop, an individual does not know what their future costs might be, including the possibility of very high care costs. Due to reduced estimated future costs (on average), individuals may immediately feel more affluent.

There are several possible responses by individuals to these changes:

- They may choose to spend more on care or elsewhere.
- They may choose to 'gift' additional savings to their family and friends.

- They may choose nevertheless to continue saving as before, with no change to their spending behaviour (possibly with the intention to bequeath any additional wealth).
- They may see the care costs cap as a 'savings target' and choose to save more than previously.

If individuals choose to save as before and/or intend to bequeath any additional wealth to their family or friends, this behaviour would lead to no wider impact from the reforms. If they choose to save more, this may lead to a reduction in spending in the economy. If they choose to make financial gifts to their family or friends, this might lead to a secondary impact of spending in the economy.

If individuals choose to spend more, the impact will depend upon what they choose to spend on.

If individuals choose to **spend more on care services**, which is perhaps most likely for those already receiving care services, this will directly benefit the social care sector. These individuals may choose to 'top up' their existing care packages with additional services to improve their quality of life. The Commission suggested this might lead to greater personalisation and quality of care.

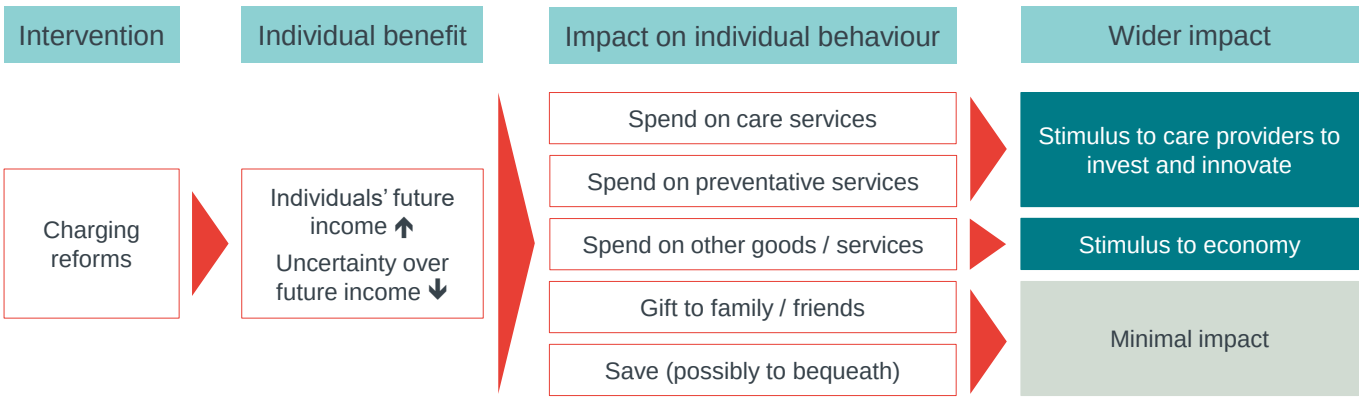
Some individuals may choose to **spend more on preventative services**, which are aimed at keeping them at home and living independently. This may delay, reduce or even prevent the need for additional care. Spending on such services is perhaps most likely for older people who are not yet receiving care. Any such spending may benefit the social care sector if providers are able to offer such services to individuals. The Commission suggested this might lead to a wider offering of services, including a greater uptake of new technologies amongst social care providers.

The Commission argued that the above impacts would support the social care market in becoming more sustainable, more innovative and higher-quality.

Finally, some individuals may choose to **spend in the wider economy**. In this case, the impact of the reforms would be an injection in the economy, although the beneficiaries of this spending could be diffuse and difficult to identify.

These potential impacts are summarised in Figure 9 below.

Figure 9 Potential impacts of charging reforms



Source: Frontier Economics

Testing whether all or parts of this framework are likely to be borne out in practice requires answering the following key questions:

By how much will individuals' future financial position be affected by the reforms?

How will individuals respond to reduced care cost uncertainty and expected reduced care costs?

If they choose to spend more…

- … how much might be spent on care services?
- … how much might be spent on preventative services?
- … how much might be spent in the wider economy?

If individuals spend more in the social care market, will providers become more sustainable, more innovative or higher-quality?

In the following chapters, we explore the evidence for each of these potential impacts.

LITERATURE REVIEW

KEY MESSAGES

- The response of individuals to reduced uncertainty in care costs is difficult to predict:
  - Behavioural theories predict that people do not plan for social care in the first place because they underestimate the possibility of needing it later in life.
  - However, precautionary savings theories argue that people tend to over-save out of precaution given uncertainty on future health.
- Evidence shows that in practice the population divides into a minority over-saving and a majority under-saving.
- The effect of the charging reforms will be stronger for those in retirement who are more likely to over-save. It will be strongest for those that are already in care, given they may face less uncertainty of future needs. It will be close to zero for the working-age population who are more likely to under-save.
- To affect the working-age group's behaviour requires significant improvements in their financial awareness of social care costs.
- The literature presents a wide range of estimates of how consumption changes following an income shock. Taken as a whole, it suggests:
  - Retired people will spend up to about 30% of potential savings in the economy.
  - Retired people will spend up to about 55% of this extra consumption on care services.
- Social care markets are highly localised, and the impact of the reforms on social care providers is likely to vary across the country, depending upon local characteristics.
- The social care market is unlikely to become more sustainable solely as a *direct* consequence of the charging reforms. The market may become more innovative and offer some new or higher-quality services. These developments are likely to be targeted at self-funded residents.

By how much will individuals' future financial position be affected by the reforms?

Building upon the framework developed in Chapter 0, this section presents our review of existing literature. We address each of the key questions identified in Chapter 0 in turn, except for the first question. The first question – by how much

will individuals' future financial position be affected by the reforms? – we address quantitatively in Chapter 0.

How will individuals respond to reduced care cost uncertainty and expected reduced care costs?

The charging reforms, and especially the cap on care costs, will lead to reduced uncertainty in expected care costs. The response of individuals to reduced uncertainty is difficult to predict. We have reviewed the literature to understand how the population affected by the reforms might respond.

Individuals face uncertainty about whether they will need long-term care or not. Behavioural economics theory advocates that people suffer from a downward bias when estimating the probability of occurrence of negative events in life.[19] Individuals are therefore likely to underestimate the probability of needing long-term care in the future so they might not save adequately for the event. Those individuals will not be affected by the reforms as they are not planning for long-term care in the first place.

On the other hand, a different strand of the literature observes an opposite behaviour. Individuals do not spread all assets over their life (as standard economic theory would predict[20]) and still possess a significant amount of assets when they pass away. In other words, they over-save out of precaution. One of the drivers for these 'precautionary savings' mentioned in the literature is uncertainty about future care needs.

Even though it is difficult to examine the effect of health uncertainty on savings,[21] some authors have found evidence of this phenomenon both in the UK and internationally. Merrigan and Normandin (1996) found evidence from the UK that the precautionary motive is a driver of savings behaviour. Kotlikoff (1986), with a stylised model, observed that saving for uncertain health expenditures might explain saving rates to a large extent in the US. Palumbo (1999) found similar results, building a more sophisticated model applied to the US.

The ambiguous effect of uncertainty on saving behaviours makes it difficult to predict how individuals will respond to the reduced uncertainty driven by the reforms. The overall effect might be relatively weak.

Will individuals save less and spend more?

As seen in the previous section, a strand of the literature reports that older people hold excessive savings for several reasons. But is this true in practice?

In broad terms, the population appears to divide into two groups: a significant minority with savings outside of their primary residence and pension that could contribute to care costs and the majority who do not have such savings.

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19 Pestieau et al. (2012).

20 The basic life-cycle hypothesis introduced by Modigliani and Brumberg in 1954 predicts that individuals spread their consumption over their lifetime by saving cash for periods with low income, as in retirement.

21 Because it is hard to quantify the monetary value of the probability that someone would be met by a negative shock.

In a study published in 2020, the IFS[22] shows that only around half of the UK population believes they are saving enough for their retirement. Half of the individuals do not believe they understand enough to make savings and retirement decisions. Only around half of people have savings outside of pensions which might in theory be put towards their future care costs.

Similarly, an analysis in 2013 by the Department for Work and Pensions[23] revealed that around 40% of individuals in the UK do not save enough for retirement. This excludes housing wealth and does not address the large variability in care costs they might face.

A 2016 IFS paper[24] analyses the Wealth and Asset Survey (WAS). It finds that around half of adults in the UK have wealth in excess of £100,000 but financial wealth (i.e. excluding property and pension wealth) is typically less than 10%, therefore less than £10,000 per person. This means that the financial wealth for the average person would fall well below the announced care costs cap.

Lastly, Advani et al. (2020) show that about 40% of the population has assets and wealth above £250,000 and some considerably more, but around 70% of it is tied up in housing and pensions.[25]

These findings seem to indicate that the 'excessive savings' behaviour only applies to a small subset of the population. This subset is large if property wealth is included within the definition of 'excessive saving'. If we exclude property, we find that people actually under-save, underestimating the importance of retirement income. Only a minority of individuals could then be considered to have 'excessive savings' that might be released due to the reforms.

Who is included in this minority? We can safely assume that, to the extent there is an effect on released savings from the reforms, it will be stronger for those in retirement who possess high income and wealth. The retired not yet in care are more likely to better estimate the probability of entering a care home than those of working age and, as a consequence, to hold excessive savings. The impact is strongest for the retired people already in care, who may face less uncertainty on future needs.The working-age population is likely to under-save and is likely to not be affected by the released savings from the reforms.

However, there may be a relatively imperfect mechanism through which working-age individuals could respond to charging reforms.

International evidence generally supports the idea that most individuals fail to save sufficiently – but better-informed and wealthier individuals do adjust their saving behaviour in response to incentives.

Lusardi and Mitchell (2011) present evidence from the US suggesting individuals are typically not very financially literate, individuals tend to over-estimate their understanding of financial matters, and that more financially-literate individuals are more likely to plan for retirement. Bottazzi et al. (2006) give evidence from Italy suggesting individuals respond to pension reforms by changing their saving

22 Crawford et al. (2020).

23 DWP (2013).

24 Crawford et al. (2016).

25 ONS wealth data for 2016-2017.

behaviours as would be expected by economic theory. This is more pronounced for individuals who are better informed about their pension wealth.

Evidence from the UK shows that individuals do not typically consider care costs, not only because they do not understand them but also because they do not want to engage with the topic. Price (2014) ran a survey on financial planning practices in the UK. He found that "end-of-life planning for domiciliary or residential care was virtually non-existent across all socio-economic groups, and couples employed a range of techniques to avoid making these discussions 'real'".

Several surveys have shown that the UK population has limited understanding of how social care is funded. Polling conducted on behalf of Deloitte in 2017[26] showed that 63% of people think the NHS provides social care services and 47% believe that social care is free at the point of need.

This evidence tells us that better public information (as suggested by the Commission) is likely to be necessary to educate the population, in order to see a significant response in individuals' behaviours.

More affluent individuals who are better informed and aware (or can afford better financial advice), may be likely to respond first to the reforms to charging rules. It may take longer for other individuals to adjust their behaviour. However, we still prefer to conservatively assume that the effect on the working-age population will be small/non-existent. In fact, we do not know to what extent the reforms will be effective in increase public awareness and if this will be enough to overcome the downward bias and reluctance to plan of the whole population.

How much will they spend, and on what?

The quantitative analysis described in Chapter 5 gives us an idea of how much disposable income could be released by different groups due to the reforms. We have reviewed literature on consumption behaviour to understand how much of this they might choose to spend:

- in the economy in general;
- on long-term care services; and
- on preventative services;

Spending in the economy

Existing literature has explored how much people are willing to spend when given extra disposable income in the context of testing the validity of the life-cycle/permanent-income hypothesis (LCPIH).

The LCPIH states that households maximise utility over a lifetime and assumes that they can smooth consumption through personal savings or credit markets. Given this assumption, a household should change its consumption plans in response to permanent shocks to income and react far less in terms of consumption if there is uncertainty. At the other extreme, when the shock is

[26] https://www.ipsos.com/ipsos-mori/en-uk/public-perceptions-austerity-social-care-and-personal-data

predictable, the household should be able fully insure against any shocks, so its consumption should not react to either permanent or transitory income shocks.[27]

However, most of the literature shows that the LCPIH does not hold in real life: when facing an income shock, both expected and unexpected, households tend to adjust their spending afterwards.

Many authors have tried to quantify by how much consumption changes after a shock, by calculating the Marginal Propensity to Consume (MPC). This is the proportion of an increase in disposable income that consumers spend on the consumption of goods and services, as opposed to saving it.[28]

A detailed list of all the studies we have reviewed together with the estimated MPCs reported can be found in Annex A. Estimates from different studies can differ widely. This is due to several reasons: the size of the sample, the type of shock (unexpected, predictable or transitory), the basket of goods used to identify consumption (durables, non-durables or all goods) and the state of the economy at the time of the study.

Many studies have also found that different households respond differently to income changes, therefore we can have several MPCs for the same shock. In particular, most of the studies find that richer households have lower MPCs. This may be true for several reasons: richer households have better access to credit markets, so they are not liquidity-constrained; they might be more prudent and set aside precautionary savings; and if bequests are 'luxury' goods, rich individuals consume a smaller fraction of their lifetime resources.[29]

Consequently, several papers present a range of MPCs and not a single estimate. We have taken an average across them and identified a lower bound and upper bound of the average range, which are 28% and 41% respectively.

Given most of the evidence shows that wealthier households have lower MPCs, we have decided to only use the lower bound of this range (28%) in the quantification of the extra consumption due to the reforms presented in Chapter 0. In fact, the analysis focusses only on those 'richer' individuals that are affected by the reform (i.e. that have wealth greater than £23,250).

In the analysis presented in Chapter 0, we apply the 28% lower bound to the released savings of those that are already retired and in care. People in this category face lower uncertainty about their future health needs, as they are already in care and most are likely to remain in care in the foreseeable future. Depending upon their income and wealth, they are likely to benefit from the reforms.

Amongst retired individuals who are not in care, we believe there will be a lower propensity to consume, given that these savings are more distant and less certain. However, the literature does not provide evidence to allow us to estimate robustly these individuals' MPC (i.e. the extent to which people might spend now because of a greater – but uncertain – likelihood that they will face lower care costs in future). Conservatively, we apply half of the first group's MPC (i.e. 14%) to the potential savings of those retired and not yet in care.

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27 Fisher et al. (2020).

28 https://www.investopedia.com/terms/m/marginalpropensitytoconsume.asp

29 We have found only two studies that claim the opposite, therefore we have excluded them from the sample.

In principle, the MPC amongst this group could be even lower, perhaps as low as 0% (i.e. no change in spending as a consequence of potential future care cost savings). Individuals' propensity to spend will depend on many factors, including the extent to which they are aware of and understand the reforms, their attitude to financial risk and the probability they attach to needing social care in the future. These are elements that widely differ from individual to individual. In Chapter 0 we discuss the impact on our modelling results if the MPC were zero for those who are retired and not in a care home.

Amongst individuals of working age, we apply a '0%' MPC. This is because the evidence reviewed has shown low awareness/planning for social care for most of the population, which will greatly reduce the impact on their willingness to spend potential savings released far in the future. As mentioned in the previous sections, the impact of released savings from the reforms will likely be zero for this group.

A summary of the MPCs we assume for the three categories (working age, retired not in care and retired in care) is presented in Table 8.

Table 8 MPC assumptions for the quantitative analysis

	Working age	Retired not in care	Retired in care
Assumed MPCs	0%	14%	28%

Source: Frontier Economics

Spending on long-term care services

Once we have estimated how much people are willing to spend in the economy after an income increase, we want to know how much of this money people will want to spend on long-term care.

This is a difficult exercise, as we cannot rely on a body of literature that has looked at this question specifically. However, we can rely on studies that have tried to understand why older people often hold on to savings, rather than spending, before their death.

As explained in section 0, according to the LCPIH, older people should spend all the money they have accumulated during their life as they get closer to death. However, this is not observed in practice. The literature explains that this happens for two reasons:

- uncertainty around future health and related expenses, that brings people to save more than necessary out of precaution;[30] or
- willingness to leave bequests.[31]

Some papers that have tried to quantify what the ideal split between long-term care and bequests is by asking people 'strategical questions'. Ameriks et al. (2011) and

[30] Yaari, (1965); Davies (1981).

[31] Barro (1974).

Havinga (2016) asked survey participants (over 55) to imagine that they had won a cash prize of $250,000[32] which they had to divide between a 'bequest box' and a 'long-term care box'. As shown in Table 9, the studies find very similar answers: 51% and 57%, respectively. Taking an average between the two studies, the percentage of the cash prize that people are willing to put in the long-term care box is 54%. Thanks to this evidence we can indicatively assume that older people would be willing to use up to 54% of their extra spending to fund longer-term care.

Table 9 Literature disentangling long-term care and bequest motives

Authors and date	Content	Average % put into longer-term care
Ameriks et al. (2011)	Both studies use 'strategical questionnaires' to disentangle what drives precautionary savings, if long-term care or bequests motives. They ask participants (who are older than 55) to divide $250,000 / €250,000 into two cash boxes: one for long-term care and one for retirement.	51%
Havinga (2016)		57%

Source: Frontier Economics

Another way to corroborate these findings is by considering how much older people who are retired but not in need of care, are willing to spend to improve their quality of life. In 2005 the Joseph Rowntree Foundation published a survey on attitudes towards spending and inheritance in the UK.[33] In the survey those respondents that reported having released equity from their home were asked how they used the money. Some 39% reported using it for property repairs/improvements and 11% reported using it on non-essentials (e.g. holidays).[34] We could interpret this as up to 50% of the extra money coming from equity release being spent on improvement of quality of life in old age.[35] The other main uses for the money were reported as paying bills/debt (28%) or spending on essential items of daily living (23%).

This percentage is consistent with the findings of the studies described above. For our estimation purposes we will then assume that up to 54% of the extra money spent due to the reform will be spent on improvement of quality of life/long-term care services.

In the data analysis presented in Chapter 0 we treat this as the upper bound of money that could be spent on long-term care services. Older people that are already in care will not be able to spend on much else than long-term care services, therefore such a high percentage seems likely for them. However, the willingness

[32] €250,000 in Havinga (2016).

[33] Rowlingson and McKay (2005).

[34] The answers were not mutually exclusive, therefore there might be some overlap between the two.

[35] We note a limitation that the paper reported only the proportion of people spending on particular categories, not how much they spent within these categories. Also, the survey was run on the whole population, not only on older people, but the majority of respondents that reported having released equity from their home were over 55.

to spend on social care of older people not yet in care might be much lower, given the evidence outlined in the previous sections that people do not sufficiently plan for care.

Another reason why the 54% should be considered as an upper bound is that precaution may also extend to unwillingness to pay for care costs even when such spending would generate benefits. Demos (2014), Oldman and Quilgars (1999), Campbell-Enns et al (2020) argue that individuals exhibit an unwillingness to spend on care. Entering residential care is often seen as a 'last resort', even though some evidence[36] suggests that residential care can improve quality of life.

Moreover, when they are forced to pay for care, people are price-sensitive. Saloniki et al (2019), Zigante et al (2020) find that formal and informal care are relatively strong substitutes, meaning that if the price of formal care increases, the demand for informal care will likely increase.

This may suggest an unwillingness to pay for care to the optimal level – partly out of precaution and partly out of the imagined consequences of entering a more formal care setting (such as a care home).

We therefore assume indicatively that people in retirement but not in care will be willing to spend half as much as those in care, i.e. 27% of their expected savings.

Spending on preventative services

Preventative care helps detect or prevent serious diseases and medical problems before they can become major. Spending on preventative care can in principle reduce the probability of needing NHS services and eventually entering a care home.

Taking a narrow definition of preventative services, for example focusing upon specific healthcare interventions, the evidence on willingness to spend on preventative services is almost non-existent, as most of the preventative care services are provided by the NHS (e.g. annual check-ups, immunisations and flu shots). Therefore, it is hard to quantify how much of the released savings from the charging reforms would be spent on preventative services.

However, considering preventative services a little more broadly, there is some evidence to suggest that people are willing to spend on preventative services. For example, in the last few years Retirement Communities have gained popularity.[37] These are groups of self-contained accommodations reserved for older people that enable residents to take advantage of personal care administered by staff, only if they need it.

Residents of these communities are less likely to enter hospital and to need NHS services, reducing NHS costs. Moreover, people in Retirement Communities are half as likely to enter institutional residential care homes. [38]

Retirement Communities can be therefore seen as a type of preventative care for older people. Currently about 75,000 people live in Retirement Communities, this

[36] Forder et al. (2017).

[37] Associated Retirement Community Operators (2021).

[38] Associated Retirement Community Operators (2021).

represents 0.6% of people over 65 in the UK. The number is expected to double over the next 10 years. Providers plan to invest up to £40 billion to accommodate increased demand by 2030.[39]

This means that it is likely that part of the savings released by the reforms will be spent on some type of preventative services. We cannot include a precise estimate in our calculations due to the difficulties explained above, however we can safely assume that this percentage is positive and due to increase over time.

If individuals spend more in the social care market, will providers become more sustainable, more innovative or higher-quality?

If individuals choose to save, gift, or spend in the wider economy, there is likely to be little or no impact on social care providers. However, there are two ways in which providers might be affected if individuals' care cost uncertainty and expected care costs are reduced:

- if individuals choose to spend more on care services; and/or
- if greater certainty encourages related markets (e.g. insurance) to develop.

The likely impact depends upon the characteristics of the social care market, which we discuss below. We then return to each of the two possible impacts above.

Characteristics of the social care market

The social care market is large (estimated value of £17.3 billion in 2020) and diverse (including local authority, NHS and independent sector homes, varying widely in size, offering a range of types of care to self-funded and local authority-funded individuals).[40] The impact of the reforms is therefore difficult to predict. However, the following market characteristics will be important in determining the impact:

- the geographical size of social care markets;
- the relative size of the self-funded and local authority-funded parts of the market;
- level of competition between providers, including the ability of new providers to enter the market, or existing providers to exit;
- the ability and incentive for providers to innovate and invest in services.

The above characteristics are closely related to each other.

Geographical size of social care markets

The geography of a market determines which providers are actually in competition with one another. This influences whether we should expect to observe different impacts in different locations.

[39] Associated RetirementmerdOperators (2021).

[40] LaingBuisson (2021).

Social care markets are highly localised. According to LaingBuisson (2021), typical catchments are based on a 5-10 minute drive time, whereas the CMA (2017) suggested that local markets might be defined by 15-20 minute drive times.

This evidence suggests that the impact of the reforms may vary across locations, depending upon the nature of each local market, including the factors presented in the following sub-sections.

Relative size of self-funded and local authority-funded parts of the market

Social care markets operate quite differently between the self-funded and local authority-funded parts of the market. These parts of the market are approximately equal in size. Table 10 shows the variation by region.

Table 10 Self-pay percentages of residents by region

Region	%
North East	25%
North West	38%
Yorkshire and the Humber	43%
East Midlands	45%
West Midlands	41%
East of England	51%
Greater London	45%
South East	61%
South West	55%
England	**48%**

Source: *LaingBuisson (2021)*

Note: *Self-pay percentages of residents in independent sector care homes for older people and dementia (65+), March 2020*

Level of competition between providers

The level of competition determines the strength of the incentive for providers to respond to reforms. The level of competition is determined by a range of factors, including:

- buyer information, i.e. whether individuals or local authorities are able to choose between providers based on good information, e.g. about quality; and
- barriers to entry and exit, i.e. whether poor-performing providers can be effectively replaced by newer, higher-performing entrants.

Overall, the social care market is considered to be relatively competitive. Based on the geographical market definitions above, LaingBuisson (2021) note that around 15% of local areas would be defined as monopolistic under the CMA's threshold (35% market share for a single provider). The CMA itself reported slightly different statistics – 90% of postcode districts had at least three different care homes within 15 minutes – but also concluded that local social care markets are typically competitive.

The CMA (2017) did find, however, that the self-funded part of the market is less competitive, and that residents are very unlikely to move to a different home, indicating high switching costs. Self-funders tend to have relatively poor information at the point of purchase and are often making decisions at a difficult emotional time in their lives.[41] Many individuals will therefore not be able to make informed decisions.[42]

By contrast, local authorities are well-informed about available care providers, have contracts with many local providers, and have a responsibility for shaping their local market over time. They also have a significant amount of 'buyer power', as the local authority is solely responsible for buying care on behalf of a large proportion (on average, around half) of the market.[43]

Because of these differences, the fee rates paid in different parts of the market vary significantly. The average local authority-funded fees for residential care were £596 in 2020, compared with £776 for self-funders.[44]

These fees are typically not driven by differences in the services received, or the costs of providing those services.[45] Consequently, the profitability achieved in each part of the market also differs. LaingBuisson (2021) report that EBITDAR[46] as a percentage of revenue ranges from mid-teens for 'groups with high exposure to public pay' to around 30% for groups 'with a private pay focus'.

There is some evidence that new entry could be further stimulated. Barriers to entry are relatively low, primarily requiring some initial capital expenditure (e.g. around £5 million for a new-build 50-bed care home[47]) plus the ability to recruit a suitable workforce. Regulatory approvals are also not significant barriers and there are no powerful brands with more recognition than others. There have been some exits from the market for financial reasons, but also around 100 (typically larger) new homes entering the market, including some larger groups, over the last 10 years.[48]

Ability and incentive for providers to innovate and invest in services

Providers have a stronger incentive to innovate when markets are more competitive. However, innovation often requires investment, which is only possible if providers make sufficient profits to be able to invest, or if future returns are sufficiently certain they can borrow against future revenue. Economic theory suggests therefore, that for a market to innovate and invest, it requires sufficient competition to give providers the incentive, but not so much competition that they lack the ability to do so.[49]

41 Baxter et al. (2020).

42 Competition and Markets Authority (2017).

43 LaingBuisson (2021).

44 LaingBuisson (2021).

45 LaingBuisson (2021) note that "it is common knowledge within the care home sector that private payers pay more than local authority-funded residents in the same home for the same level of amenity and service."

46 Earnings before interest, taxes, depreciation, amortization, and restructuring.

47 LaingBuisson (2021).

48 LaingBuisson (2021).

49 Hart (1980).

The CMA (2017) found that investment is deterred by uncertainty and low profit margins. Evidence from LaingBuisson (2021) is more mixed, suggesting investment and innovation is already taking place, however this has often focused on refurbishment of older estate, and is weak in comparison to more dynamic markets. They note that independent-sector care home providers continue to attract investment, albeit this is focused on the self-funded segment of the market.

LaingBuisson (2021) report that providers varying care services in response to different needs is relatively rare. Most providers have not developed additional products or services to meet particular needs or serve individuals with particular conditions (with dementia care being the most notable exception). Better use of technology (e.g. for administration, remote monitoring, coordination with NHS) could be made across the sector but adoption is very slow. Innovation has focused upon the development of more specialist dementia care, new housing-with care models at the premium end, and some new intermediate care services. Overall, they conclude that the market is not very innovative, and likely to look very similar in 10 years' time.

Further considerations

The evidence above is based upon the existing characteristics of the social care market. Possible future reforms may alter these characteristics.

For example, implementing section 18(3) of the Care Act 2014 may lead to a significant number of self-funders choosing to ask their local authority to arrange care on their behalf, thereby accessing the lower fee rates paid by the local authority. This would have uncertain consequences, but these may include:

- a reduction in income for providers due to self-funders securing reduced fee rates, perhaps followed by an increase in the fee rates paid by local authorities to reduce the possibility of providers exiting the market;
- local authority buyer power increasing, if they now arrange care for an even larger proportion of the market; and
- more alignment between the self-funded and local authority-funded parts of the market, reducing some of the differences highlighted above.

These factors might significantly influence the competitive dynamics of the social care market in future.

Additional spending on care services

If individuals choose to spend more on care services, this might either take the form of additional or new services, or buying a higher quality for their existing services.

The financial benefits of the charging reforms – in particular the costs cap – will accrue primarily to self-funded individuals. As noted above, the self-funded part of the market is less competitive and more profitable than the local authority-funded part of the market. And development of new services, or increases in quality, are therefore most likely to be focused upon more affluent self-funders, both because of their ability to afford them, and since it is amongst this group that the reforms may lead to a financial benefit.

Providers' financial sustainability will likely benefit from any spending on care services, although this may be most relevant for providers with a significant proportion of self-funded residents. Also, in many locations, the competitiveness of the care market may mean that any 'excess profits' would be quickly competed away.

The above points suggest again that the impact of the reforms may vary between locations, depending upon the relative size of the self-funder part of the market. Locations and individual care providers with a greater proportion of self-funders are likely to have a stronger ability to innovate and invest in services. By contrast, providers who rely more heavily upon local authority-funded residents may be constrained by a lack of available funds.

Given the relatively low levels of innovation amongst current providers, this might suggest that new entry, or partnerships between incumbents and other organisations (e.g. from the technology, housing or financial services sectors) might be a bigger driver of future innovation in the sector. The incentive to innovate is likely to be strongest in the more affluent, self-funded part of the market, where customers' demand curves are relatively less elastic than the local authority-funded part of the market.

Development of related markets

As noted above, innovation may not be driven by incumbents, or even new social care providers entering the market, but instead by partnerships with new organisations. The Commission suggested that the financial services industry, in particular, might be expected to develop new care-related products in response to a cap on care costs.

Existing financial services related to social care

Financial service providers currently offer only a limited set of products to help fund care. This could be due to a lack of demand resulting from: individuals not recognising the need to pay for care; a psychological avoidance of the issue of future care needs; or a belief that the state is responsible for paying for care. Insurance companies claim that they have had little incentive in developing products because of a lack of public interest in care.[50]

The Association of British Insurers (ABI), reports the following products are available in the industry to fund long-term care:[51]

- Pensions: particularly following the pension freedoms in 2014, many individuals look to their long-term savings to fund social care needs.[52]
- Equity release: some insurers provide equity release products, allowing individuals to release some funds tied up in their home to provide either a lump sum, a regular income or both, to meet care costs, especially care at home.

[50] Pensions Policy Institute (2019).

[51] https://www.abi.org.uk/products-and-issues/topics-and-issues/social-care/

[52] Consumer polling run by ABI found that 38% of individuals would expect use of private and workplace savings to pay for care.

- Immediate needs annuity: some insurers offer a product called Immediate Needs Annuity, which pays out a guaranteed income for life to help cover the cost of a customer's care fees in exchange for a one-off lump-sum payment.
- Life insurance triggering on death or care needs: Some life insurance products provide customers with lifelong care cover that pays out on death, or crucially, if they suffer an illness which leaves them permanently incapable of looking after themselves.

However, take-up of these products amongst the population is low. Just Group (2020) polling shows that only 2% of respondents think that they would use insurance to pay for residential care in case they needed it in the future. This might also be due to the fact that many products are typically only available to people with existing medical needs, or they are linked to life insurance and cannot be bought as standalone products.

Possible market developments facilitated by the reforms

The economic theory predicts that capital market reforms, such as pension system liberalisation, can promote the efficiency of financial markets by making them deeper, more liquid and more competitive.[53] The effect of these reforms on aggregate savings is still ambiguous. Evidence from the UK pension reforms shows that, even though the liberalisation has increased privately funded pension savings, the increase might have been offset by a decrease in other forms of savings.[54] Limited evidence from other countries such as Chile show a positive effect on aggregate domestic savings.[55]

The literature does not explore whether financial services providers have become more innovative or developed new products.

In 2014, the then Department of Health organised working groups with financial industry representatives to conduct a review of the market products to fund care and understand which opportunities for development might stem from charging reforms. The key messages from the review were that:[56]

- The financial industry has welcomed the government's reform on social care and especially the collaboration between state and private sector.
- The opportunities of product development build more on the markets that already exist for retirement products, rather than new ones (such as annuities, equity release products and saving vehicles).
- There is scope to explore the possibility of bringing back products that were previously available, such as disability-linked annuities which start as normal annuities but increase the individual's income when a triggering care need arises.
- In contrast, stand-alone care products bought early in life are unlikely to be in demand and are not likely to be developed.

[53] Holzmann (1997); Orszag and Stiglitz (2001).
[54] Granville and Mallick (2003).
[55] Holzmann (1997).
[56] DHSC (2014).

- Understanding of care costs and funding choices is vital for the development of a market. Regulated financial advice could be a way to solve the information gap.

Possible further action required to spur innovation

In 2019 the Pensions Policy Institute (PPI), commissioned by ABI, published further research on the way the government could help the private insurance market for care through incentives such as tax reliefs on specific insurance products.[57]

The research suggested that with specific tax incentives from the government, new products could develop. The research proposed, for example, the introduction of a Care ISA with no inheritance tax paid on residual amounts upon death. This product would provide a pot earmarked for care so people will be incentivised to not accessing it before the needs appear without the fear of family and friends having to pay sizeable inheritance taxes upon their death.

This research also directly considers the pros and cons of a cap on care costs. It suggested that the cap could encourage financial products development given that the liability would be limited to the cap amount. However, the authors highlight several potential problems with the proposals, including that:

- the benefits would be focused on a subset of the population;
- the risk of the cap being lifted might put financial providers off from developing products relying on it.

Overall, it appears that the financial services sector would not expect the reforms to enable – at least on their own – the effective development of the long-term insurance market. They suggest that targeted government incentives, such as tax relief on care spending or preparation, may help encourage people to use their money efficiently to pay for care.

[57] Pensions Policy Institute (2019).

DATA ANALYSIS

KEY MESSAGES

- The potential impact of the increased upper capital limit and the cap on care costs is likely to vary by people's working and care status as well as their wealth and income.
- We expect the reform to produce additional spending from retired people in care and from those not in care. We estimate insignificant effects for working-age individuals who are not in care.
- Our analysis suggests large aggregate savings for the current group of retired people, yet the individual per-person expected savings are more limited.
- The results should be regarded as indicative as there is a high degree of uncertainty and variation around the potential impact.

In this section we estimate the potential financial benefit to individuals from the announced reforms. For the purposes of our analysis, we have modelled:

- a cap on care costs of £86,000;
- an increase in the upper capital limit from £23,250 to £100,000;
- general living costs of £10,400.

We analyse the impact of the care costs cap and the increased upper capital limit separately. We further look at differential effects based on individuals' income and wealth and their current working and care status.

We note that all figures in this report are in 2021 prices and not estimated at the time of policy implementation.

Potential benefit to individuals – overview of analysis

To model the impact of the announced reforms, we estimate the reduction in future care costs from which an individual would benefit. As explained in Chapter 0, economic theory suggests that when individuals expect some financial gain in the future, this may lead them to feel wealthier today, and to increase current spending. We estimate individuals' expected future gain – allowing for the fact that this will vary depending upon their current care status and their level of wealth and income – and we use this to estimate the likely impact upon spending on care services and in the wider economy.

Alternative approaches were considered but ultimately rejected, including:

- calculating only 'actual' savings, amongst those receiving care, including savings due to the costs cap only at the point at which those individuals actually reach the cap; and

- estimating existing levels of 'excessive saving' amongst individuals, seeking to identify the particular parts of financial wealth held by individuals which were 'earmarked' for care costs, which might then be released following the reforms.

The approach taken in this report is imperfect. As explained in Chapter 0, in reality people cannot accurately predict their future care costs. The small probability of very high care costs poses a risk that is unlikely to be considered rationally by an individual. Some people might ignore it altogether while others might overestimate its magnitude and save excessively to be able to cover the chance of substantial care costs. However, this effect is difficult to precisely quantify and will vary significantly across individuals. Amongst other factors, it will be driven by their personal degree of risk aversion and their level of information about the cost of home care.

Furthermore, this analysis is based upon current average costs of care. Any package of reforms implemented in the social care sector may lead to changes in these costs, which would alter the magnitude of the impacts estimated here. For example, section 18(3) of the Care Act 2014 allows for self-funders to request that their local authority arrange care on their behalf, which would enable self-funders to access the lower fee rates which are currently paid by local authorities. In this case their overall expected costs of care would be lower, and the 'cost saving' due to the reforms would also be lower. Other elements of the reforms might similarly decrease or indeed increase fee rates. We have not sought to estimate the impact of any resulting change in fee rates; however, we note that this is a limitation of our analysis.

Given the above limitations, the numbers presented below should be read as indicative estimates with a high degree of uncertainty and individual variation around them.

Segmentation of the population

The increase of the upper capital limit from £23,250 to £100,000 and the introduction of a cap on individual care costs of £86,000 as part of the implementation of the announced reforms are likely to affect different parts of the population in different ways.

We expect the reform's impact to differ mainly across two dimensions: (i) by working and care status and (ii) by wealth and income bracket. For this reason, we divide the English population into the relevant segments. Specifically, in terms of working/care status, we split the population into three groups:

- working-age individuals;[58]
- retirement-age individuals who are not in a care home; and
- retirement-age individuals in a care home.

In terms of asset wealth, we divide the population into the following three brackets:

- those with asset wealth below £23,250;
- those with asset wealth between £23,250 and £100,000; and

[58] This comprises individuals aged 16 up the State Pension Age (currently 66).

- those with asset wealth above £100,000.

These dimensions taken together result in nine distinct population segments.

We combine different data sources to estimate the number of people in each segment.[59]

Table 11 below shows the estimated number of residents in England in each of these segments. We assume only individuals with asset wealth above £23,250 (i.e. those in the top two wealth brackets) would benefit from the increased upper capital limit or the cap on care costs.

Table 11 Population segmentation for England

Segment	<£23,250	£23,250-£100,000	>£100,000	Total
Working age	16,000,000	7,630,000	12,280,000	**35,900,000**
Retirement age, not in care home	1,100,000	870,000	7,770,000	**9,740,000**
Retirement age, in care home	70,000	50,000	215,000	**335,000**
Total	**17,170,000**	**8,550,000**	**20,270,000**	**46,000,000**

Source: *Frontier analysis based on ONS Wealth and Asset Survey (2016-2018); ONS National Population Projections (2018); LaingBuisson (2021).*

Note: *Wealth only includes financial and property wealth (excl. physical or private pension wealth). Presented numbers are for England. They are corrected to account for aggregate wealth holdings and rounded.*

Impact by population segment

Working-age and not receiving care

For working-age individuals, the reform leads to an increase in distant future expected disposable income and a reduction in uncertainty about future care costs. However, care costs appear rather distant and related considerations are thus unlikely to be made at this stage in life. Additionally, there is considerable uncertainty about one's own income and wealth when older. As mentioned in Chapter 0, we therefore assume only a very modest effect on spending and saving behaviour from the reform, if any.

Retirement-age not in a care home

For retirement-age individuals, the reform leads to an increase in future expected disposable income and a reduction in uncertainty about future care costs. Care home cost considerations are likely to be more salient at this point in life and there is a higher degree of certainty about one's own income and wealth when older. As the introduction of the cap on care cost removes the risk of unlimited care costs, a reduction in excessive saving and an increase in spending are expected.

[59] In particular, we use data from the ONS Wealth and Asset Survey (2016-2018), the ONS National Population Projections (2018), ONS Average household income, UK: financial year 2020, and from LaingBuisson (2021). As most of these data sources cover the whole of the UK, we scale the numbers down to obtain estimates for England only.

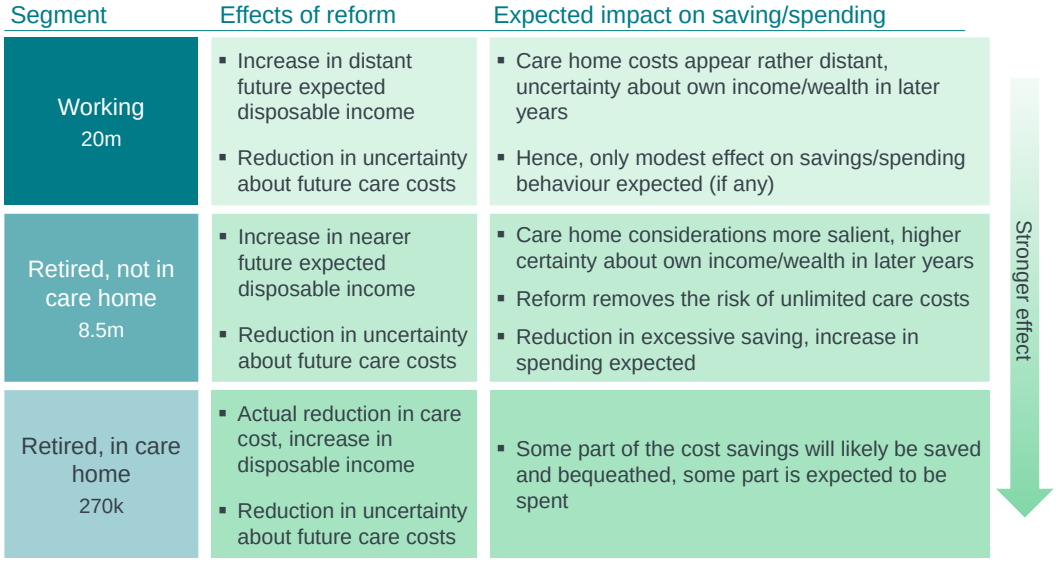
Retirement-age in a care home

For older people in a care home who fall within the relevant wealth brackets, the reform leads to an actual reduction in care costs and an increase in disposable income. The costs cap also reduces uncertainty about future care costs. Some part of the cost savings will likely be saved and bequeathed while some part is expected to be spent on care services or in the wider economy.

Summary

Figure 10 below summarises the above and shows the estimated number of people in each population segment with high enough wealth (assets greater than £23,250) so that they could benefit from the reform.

Figure 10 Potential impact of reform on different population segments



Source: Frontier illustration

Note: The numbers of people in each segment only include those with asset wealth greater than £23,250. Therefore, they differ from the total number of people in each segment presented in Table 11.

In the following section, we analyse and estimate the potential benefits from the increased upper capital limit and the cap on care cost separately.

Potential savings from the increased upper capital limit

To estimate expected cost savings due to the increase in the upper capital limit from currently £23,250 to £100,000, we distinguish between retired people not (yet) drawing on care and support in a care home and those already in a care home. As argued above, the latter group is likely to enjoy more direct and thus greater benefits. For both groups, only individuals with assets between the current and the prospective upper capital limit are expected to gain from the reform.

Retirement-age people not in a care home with asset wealth between £23,250 and £100,000

As shown in Table 11 above, we estimate for England around 870,000 retired people not drawing on care and support in a care home with assets such that they would potentially benefit from the increase of the upper capital limit from £23,250 to £100,000.

Of those 870,000 people, we assume 20% (i.e. around 174,000) do draw on care and support in care home at some point in their life[60] and an average length of stay of 2 years.[61] We further assume the 20% affected people to be split equally across all wealth and income percentiles within the relevant wealth bracket.

Because of the high degree of variation in care cost by type of care, location and funding arrangement,[62] we calculate the potential cost savings for two different levels of average weekly care home fees: £675 and £875. This allows us to obtain a range a potential cost savings.

In both cases, we assume a weekly Personal Expenses Allowance of £24.90.[63]

Estimating the expected individual care home contributions for different levels of wealth and an assumed average weekly disposable income of £225[64] under the current and the announced system results in average weekly cost savings between £280 (weekly fees of £675) and £480 (weekly fees of £875) per care home resident due to the increase in the upper capital limit. This is equivalent to total savings of £29,100-£49,900[65] per person in a care home or, as only 20% are assumed to enter a care home, expected 'ex ante' savings of £5,820-£9,980 for each individual in that segment.

On aggregate, these individual savings add up to a total reduction in individual contributions of £5.1-£8.7 billion for that group of retirement-age people not drawing on care and support in a care home.

Retirement-age people in a care home with asset wealth between £23,250 and £100,000

As shown in Table 11 above, we estimate for England around 50,000 older people in a care home with assets such that they would benefit from the increase in the upper capital limit.

Using the assumptions and the range of weekly care home fees stated above,[66] we again estimate average weekly savings of £280-£480 per care home resident

60 Crawford (2018).

61 This represents the weighted average length of stay for residential and nursing care residents. See LaingBuisson (2021).

62 See, e.g., Table 1.22 and Figures 1.29a, 1.29b and 1.30 in LaingBuisson (2021).

63 DHSC (2020).

64 This implies a chargeable income of around £200 per week after deducting the Personal Expenses Allowance of £24.90. The assumed average chargeable income of retired people in this wealth bracket stems from information provided by the DHSC, based on ELSA data for 2018/19.

65 This results from £280 to £480 per week multiplied by 104 weeks (2 years).

66 We do not apply the assumption that 20% of people enter a care home at some point in their life. This additional condition is not needed here as we analyse a group of people that already are in a care home.

and total savings of £29,100-£49,900. **This adds up to an aggregate reduction in individual contributions between £1.5 and £2.5 billion for that group of older people drawing on care and support in a care home.**

Potential savings from an £86,000 cap on care costs

In the estimation of expected cost savings due to the introduction of a cap on individual care costs, we need to distinguish between those people who fully bear their own cost of care and those who receive a partial contribution from their local authority.

Estimated savings for full self-funders (asset wealth above £100,000)

In a first step, we estimate the expected individual cost savings as a result of the £86,000 cap on care costs for those people that are assumed to fully bear their cost of care themselves (i.e. no contribution from the local authority). These are individuals with high income and/or asset wealth in excess of £100,000.

To be able to estimate the expected reduction in individual care home contributions, we need to make a few further assumptions. Specifically, we assume that, on average, people have spent £12,500 on previous care services at the time that they enter a care home.[67] We further assume annual living costs in care homes of £10,400 (£200 per week) that do not count towards the costs cap.[68]

Similarly to above, we again estimate potential cost savings for two different levels of weekly care home costs. Specifically, we apply local authority fee rates of £500 and £700.[69]

For illustrative purposes, we present calculations for assumed weekly fee rates of £700 (i.e. £36,400 yearly) in the following.

Assuming that care costs are borne entirely by the individual, this would imply a duration of 2.83 years until a care home resident's individual expenditure reaches the costs cap.

Based on the distribution of the length of stay in a care home,[70] it follows that 34.7% of all people entering a care home stay in care long enough to reach that cap. Conditional on staying in a care home long enough to reach the costs cap, the average length of stay is 4.63 years. This leads to total care costs of £168,700, of which £48,200 cover living costs and thus do not count towards the cap.

Consequently, considering previous care expenditure of £12,500, the reform leads to expected cost savings of £47,000 for each person reaching the costs cap.

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67 PSSRU (2011a). For 2011, the paper assumes previous care costs of £10,000. Uprated for inflation, this gives around £12,500 in 2020.

68 Assumption provided by the DHSC.

69 For self-funding residents, these local authority-metred rates may differ from effective individual payments. This is why we use a different range at this point than for the estimation of the impact of the increased upper capital limit above.

70 PSSRU (2011b). See Table 1.

As 6.9%[71] of all people are expected to reach the cap, this implies 'ex ante' expected cost savings of £3,260 for any person who is not in a care home and is expected to bear the full cost of care themselves.

For fully self-funding individuals already in a care home, the expected per-person savings amount to £16,300.[72]

Assuming weekly fee rates of £700, the total expected savings in individual care home contributions amount to £25 billion on aggregate for the current group of retired people not (yet) in a care home in England with asset wealth above £100,000.[73] For a weekly fee rate of £500, analogous computations result in aggregate expected savings of around £4 billion.

For the current group of retired people in a care home in England within that wealth bracket, we estimate total expected savings in individual care home contributions between £550 million (for fee rates of £500) and £3.5 billion (for fee rates of £700) on aggregate.[74]

Estimated savings for partial self-funders (asset wealth between £23,250 and £100,000)

Depending on their individual income and wealth, large parts of the population are likely to be partly self-funding their care and partly supported by the local authority.

People with lower income and assets (asset wealth below £23,250) are unlikely to individually spend enough on care home costs to reach the £86,000 costs cap. We thus focus on individuals with asset holdings between £23,250 and £100,000. The personal contribution of this group of people is likely to be large enough so that they might realistically benefit from the costs cap.

Using the same assumptions as above, we calculate the average share of individual contributions versus local authority contributions for this segment. Across different wealth levels within this wealth bracket and assuming an average weekly disposable income of £225, the individual is estimated to self-fund 51% of their care costs (including living costs), on average.[75]

Again, we illustrate the following calculations for assumed weekly fee rates of £700.

Assuming that 51% of care costs are borne by the individual, this would imply a duration of 9.0 years until a care home resident's individual expenditure reaches the costs cap.[76]

Based on the distribution of the length of stay in a care home,[77] it follows that only around 3% of all people entering a care home stay in care long enough to reach

[71] This results from 20% entering a care home, of which 34.7% are estimated to stay long enough to reach the cap.

[72] As 34.7% of them are expected to reach the cap.

[73] This results from 7.8 million people expected to save £3,260 each over the course of their lives.

[74] This results from 215,000 people expected to save between £2,600 and £16,300 each.

[75] This number is based on assuming weekly care home fees of £775 (midway in the £675-£875 range applied above).

[76] Only individual contributions less payments towards living costs are counted towards the cap.

[77] PSSRU (2011b). See Table 1.

that cap. Conditional on staying in a care home long enough to reach the costs cap, we assume the average additional length of stay to be one more year. This leads to total individual care contributions of £185,700, of which £104,000 cover living costs and thus do not count towards the cap.

Therefore, considering previous care expenditure of £12,500, the reform leads to expected cost savings of £8,200 for each person reaching the costs cap.

As only 0.6%[78] of all people are expected to reach the cap, this implies 'ex ante' expected cost savings of only £50 for any person who is not already drawing on care and support in a care home.

For partly self-funding individuals already drawing on care and support in a care home, the expected per-person savings amount to £250.[79]

Assuming weekly fee rates of £700, the total expected savings in individual care home contributions amount to £43 million in aggregate, for this group of retired people not (yet) in a care home in England with asset wealth between £23,250 and £100,000.[80,81]

For older people drawing on care and support in a care home in England with asset wealth between £23,250 and £100,000, we estimate total expected savings in individual contributions towards the cost of care in a care home of up to £12 million (for fee rates of £700).[82]

Potential total savings due to the reforms

Combining the estimates from sections 0 and 0, we estimate the following total expected future savings for the current group of retired people:

- £9.1-34.0 billion for retired individuals not drawing on care and support in a care home.
- £2.0-6.0 billion for retired individuals drawing on care and support in a care home.
- £11.1-40.0 billion across all retired individuals.

Additional detail is provided in Annex A.

Potential additional spending due to future cost savings

As a result of these future expected cost savings, we assume that many individuals will choose to spend more today, or at least in advance of actually realising those cost savings. This response to changes in future income is well-established by

78 This results from 20% entering a care home, of which 3% are estimated to stay long enough to reach the cap.

79 As 3% of them are expected to reach the cap.

80 This results from 870,000 people expected to save £50 each over the course of their lives.

81 Assuming (instead) weekly fee rates of £500, the expected savings would be minimal as the necessary length of stay to reach the cap would be very long (more than 25 years) and therefore the number of people benefitting from the cap would be very small.

82 This is the result of 50,000 people expected to save up to £250 each.

economic evidence, as discussed in Chapter 0. The proportion of additional income (in this case additional expected future income due to lower care costs) which is spent is known as the Marginal Propensity to Consume (MPC).

As described in Chapter 0, we assume an MPC of 14% for those retired individuals who are not in a care home, and an MPC of 28% for those retired individuals who are in a care home.

Retirement-age not in a care home

For any retirement-age individual not (yet) drawing on care and support in a care home, the potential cost savings are highly uncertain and might only occur many years in the future. Therefore, we consider it likely that the behavioural reaction to these savings would be smaller compared to a situation where the individual's lifetime income would increase by a specific amount with certainty.

As described in Chapter 0, we assume that:

- retirement-age people who are not in care would spend up to 14% of their expected future cost savings and save or gift the rest; and
- of the proportion spent, we assume them to spend 27% on care services.

This translates into an indicative range of additional total spending of £1.3-4.8 billion by retirement-age individuals not in care. Of this spending, £340 million – 1.3 billion would potentially be spent on care services.

Retirement-age in a care home

For older people drawing on care and support in a care home, the decrease in care home costs is more certain and more direct. We therefore assume a stronger behavioural response to the reforms. As described in Chapter 0, we assume that this group of people would spend 28% of their expected future cost savings in the economy, of which they would spend 54% on care services.

This would suggest an additional total spending of £0.6-1.7 billion by older people in care homes in England. Of this spending, £300-900 million would potentially be spent on care services.

We note that in future years, individuals in the in-care group will likely have previously been part of the retired not-in-care group. For these individuals, it is possible that they will already have responded to the expected future cost savings, and we would risk double-counting the impact of the reforms by assuming a further behavioural response. While we note this issue, we think it is relatively minor for three reasons. First, at the point of implementation of the reforms, the impact will be 'new' for all individuals in the in-care group and there is no risk of double-counting. Second, even amongst individuals moving into care, their expected savings increase significantly at the point of moving into care (because the uncertainty over whether they may need to draw on care and support has disappeared). Third, we expect a more significant behavioural response – we assume their propensity to consume doubles from 14% to 28% – amongst this group. Therefore, any additional spending amongst the not-in-care group could be

considered a relatively modest 'bringing forward' of their total additional spending in response to the reforms. These issues are also discussed in Annex A.

Summary

These results are summarised in Table 12. This provides an overview of the estimated total additional spending for the current population within different segments.

Table 12 Potential total additional spending due to future cost savings, for currently retired individuals, by population segment

Segment	Aggregate savings	Marginal Propensity to Consume	Potential additional spending
Working age	Too distant	Insignificant	No significant additional spending
Retirement age, not in care home	£9.1-34.0 billion	14%	£1.3-4.8 billion; of which 27% on care services: £0.3-1.3 billion
Retirement age, in care home	£2.0-6.0 billion	28%	£0.6-1.7 billion; of which 54% on care services: £0.3-0.9 billion
Overall	**£11.1-40.0 billion**	**-**	**£1.8-6.4 billion; of which on care services: £0.6-2.2 billion**

Source: Frontier calculations based on various data sources.

Annual estimates of additional spending in the economy and on care services

The estimated total additional spending figures outlined above represent aggregates for the entire current groups of retired people in care and not in care, respectively.

The timing of this additional spending is hard to predict. Some individuals may immediately feel better-off following the implementation of the reforms, while others may initially feel unaffected, or may simply be unaware of any future benefit. Conservatively, we assume that individuals' responses will occur over many years, as they become more engaged in care planning or gain a greater understanding of their potential savings due to the reforms.

Additionally, over time new individuals will move into these groups, for example as they retire or as they move into care. To reflect both these factors we have converted our aggregate savings figures above into estimated annual figures. More details are also provided in Annex A.

Retirement-age not in a care home

Based on the conditional life expectancy of people reaching retirement age, we assume that individuals remain in the group of retired people who are not in care for 20 years on average.[83] Conservatively, we model that the total aggregate spending for the retired not-in-care group is distributed over a period of 20 years – we effectively assume that each year, a greater proportion of this group become aware of their expected future savings and choose to spend as a result. Every 20 years, the current group is expected to be fully replaced by a new group and the total aggregate spending identified above would thus occur again.[84]

Based upon these assumptions, this suggests an indicative range of additional annual spending of £60-240 million by retirement-age individuals not in care. Of this spending, £20-65 million would potentially be spent on care services each year.

Retirement-age in a care home

Based on the average length of stay in a care home, we assume people to be part of the group who are retired and in care for 2 years.[85]

Using the same approach as for the not-in-care group, our model assumes that every year, half of the estimated aggregate spending for this group is actually spent by individuals. Every 2 years, the current group is expected to be fully replaced by a new group and the total aggregate spending identified above would thus occur again.

Based upon these assumptions, this suggests an indicative range of additional annual spending of £280-840 million by individuals in care homes in England. Of this spending, £150-460 million would potentially be spent on care services each year.

Alternative calculation approaches

We have considered alternative approaches to estimating the additional spend in the economy, which were ultimately rejected, including:

- calculating only 'actual' savings, amongst those receiving care, including savings due to the costs cap only at the point at which those individuals actually reach the cap; and
- estimating existing levels of 'excessive saving' amongst individuals, seeking to identify the particular parts of financial wealth held by individuals which were 'earmarked' for care costs, which might then be released following the reforms.

[83] Specifically, at age 66 (current State Pension age), women in the UK can expect to live for another 21 years, while the conditional life expectancy at that point is an additional 19 years for men. This yields an average of 20 years. See the ONS life expectancy calculator, available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/articles/lifeexpectancycalculator/2019-06-07.

[84] For simplicity, this ignores price increases due to inflation and discounting of future values.

[85] See LaingBuisson (2021).

We determined that considering only 'actual' savings was overly restrictive, since the immediate impact of future potential gains is relatively well-established (see Chapter 4) and this is the basis on which 'released excessive savings' might be expected to create a wider benefit from the reforms.

Considering the possibility of 'released excessive savings', we note that significant wealth is held by people of retirement age in England: around £1.2 trillion in non-property wealth. If even a small part of this wealth were released as a consequence of the reforms, this would constitute a very significant increase in consumer spending. To illustrate the size of this potential effect:

- If we assume that the first £300,000 of non-property wealth held by all people is held as a precaution against care costs, an £86,000 costs cap will 'release' up to £214,000 of wealth for these people.
- Across all individuals of retirement age, this amounts to around £370 billion in wealth 'released'.[86]
- If just 1% of this were spent per year, as a result of the costs cap, this would amount to £3.7 billion in additional spending per year.

These figures indicate the magnitude of impact a cap could have but are not an estimate of how much would actually be spent. This is extremely difficult to predict, for several reasons. First, the above illustration assumes that the 'first £300,000' of all non-property wealth health is being saved for social care, which is unlikely. Second, the above illustration assumes 1% of released wealth is spent, however a figure of 0.1% or 10% may well be more appropriate. Third, the timing of any spending would also be uncertain. For all of these reasons, we have not used the above approach to estimate the impact of the reforms. Nevertheless, these figures demonstrate at least the potential for a significant impact upon consumer spending.

Summary

Table 13 below summarises these results and presents indicative ranges of the additional annual spending potentially generated due to the reforms.

[86] DHSC analysis of ELSA Wave 9 data suggests that approximately 3.1 million individuals aged 65+ hold more than £86,000 in non-housing wealth, totalling £1 trillion. Counting up to the first £300,000 of this wealth per individual gives a total of £640 billion. If each individual were to continue holding £86,000 as a precaution against care costs, this would total £270 billion retained. This leaves around £370 billion 'excessive savings' which could be released.

Table 13 Potential additional annual spending due to reforms by population segment

Segment	Potential total additional spending	Potential annual additional spending
Working age	No significant additional spending	No significant additional spending
Retirement age, not in care home	£1.3-4.8 billion; of which 27% on care services: £0.3-1.3 billion	£65-240 million; of which on care services: £20-65 million
Retirement age, in care home	£0.6-1.7 billion; of which 54% on care services: £0.3-0.9 billion	£280-840 million; of which on care services: £150-460 million
Overall	**£1.8-6.4 billion;** of which on care services: £0.6-2.2 billion	**£350 million – 1.1 billion;** **of which on care services:** **£170-520 million**

Source: Frontier calculations based on several data sources

Note: The presented figures are based on various assumptions and are subject to a high degree of uncertainty. Hence, they should be read as indicative estimates only.

Our headline estimates are that **total additional annual spending might be £350 million – 1.1 billion per year, of which £170-520 million might be on care services**.

We noted in Chapter 4 that the response of individuals who are not yet in care is particularly difficult to estimate. It is possible that individuals in this group would not change their spending behaviour at all. This would imply a marginal propensity to consume of 0% (instead of 14%) for this group. In this case, the total additional spending across all population segments would simply be equal to the additional spending amongst retired individuals who are in a care home. Specifically, estimated total additional spending would be £0.6-1.7 billion, of which £0.3-0.9 billion might be on care services.

We note that all of these estimates are based on various assumptions and are subject to a high degree of individual variation and uncertainty. Therefore, they should be regarded as indicative.

CONCLUSIONS

There is justification for the announced reforms on the grounds of fairness alone: ensuring individuals do not face unpredictable and unlimited care costs. However, in this report, we've focused on the potential wider impacts of reducing care cost uncertainty.

Our analysis has drawn upon the best available evidence, however we note that this evidence is limited and therefore our conclusions should be treated with caution. Figure 11 summarises our relative level of confidence in each area of the analysis. We have relatively high confidence in the analysis of expected savings. We have moderate confidence in our estimates of individuals' spending behaviour, but slightly lower confidence in whether this spending will be on care and preventative services. Consequently, we also have lower confidence in the likely impact on the social care market due to the reforms.

Figure 11 Relative level of confidence in each area of analysis

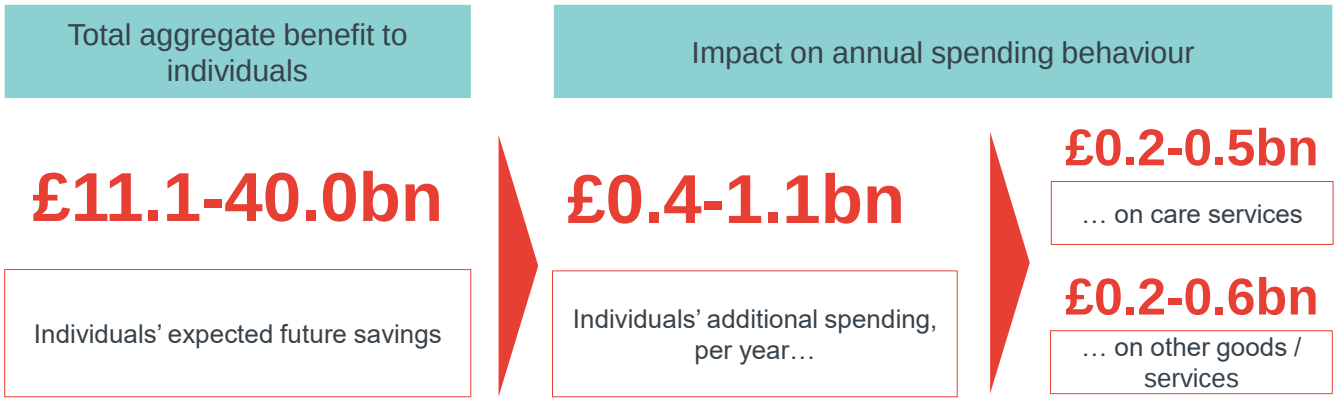
Area of analysis	Relative level of confidence	
Expected savings due to charging reforms	Higher	We have modelled expected future cost savings using several data sources such as the Wealth and Asset Survey, ONS population projections and data from LaingBuisson. The estimation relies on calculations carried out on the latest data available. Ranges for estimates are also presented.
Individuals' overall saving / spending behaviour	Medium	In order to estimate how individual spending would change, we have drawn upon an extensive literature on impacts of income shocks on consumption. However, the literature does not allow us to estimate precisely the extent to which people might spend now because of a greater – but uncertain – likelihood that they will face lower care costs in future.
Individuals' spending on care and preventative services	Lower	There exists some (although limited) evidence in the literature on willingness to spend on long-term care services, which we have used for our modelling. However, the evidence on willingness to spend on preventative services is almost non-existent.
Impact on social care market	Lower	The social care market is large and diverse, e.g., including providers of different sizes and ownership, serving self-funded and local authority-funded individuals. There is little evidence on likely innovations or competitive developments within the sector in response to the proposed reforms.

Source: Frontier Economics

Our headline results are summarised in Figure 12 below. We estimate that in aggregate across all currently retired individuals, expected future savings due to the reforms are £11.1-40.0 billion. We estimate that this will lead to additional spending of £350 million – 1.1 billion per year, of which £170-520 million will be on care services, with the remaining £180-560 million on other goods and services. We have not been able to estimate the likely additional spending on preventative services.

The wide range around these estimates reflects a relatively high degree of uncertainty in the impact. This should be borne in mind when interpreting or using the results from this analysis.

Figure 12 Headline results



Source: Frontier Economics

The impacts are likely to be greatest amongst older people, and particularly those already in care. For working-age individuals not receiving care, although the potential savings are (in aggregate) quite large, these would likely be considered too distant and too uncertain to drive a significant change in individuals' behaviours. Overall, this suggests a relatively weak short-run 'financial' effect from the reforms.

Our estimates of the likely financial benefit to the individuals in the three population segments are set out in Table 14.

Table 14 Aggregate impact of future cost savings by population segment

Segment	Potential savings
Working age	Potential savings too distant
Retirement age, not in care home	£5.1-8.7 billion from increased upper capital limit; £4.0-25.3 billion from costs cap
Retirement age, in care home	£1.5-2.5 billion from increased upper capital limit; £0.6-3.5 billion from costs cap

Source: Frontier calculations based on various data sources.

Note: The estimated per-person savings for working-age individuals would be equal to those for retirement-age individuals who are not in a care home. However, these potential savings are very distant and uncertain and are thus likely to lead to little behavioural changes.

Our indicative estimates of the possible change in individuals' spending behaviours as a result of these expected care cost savings are described in Table 15.

Table 15 Potential additional annual spending due to reforms by population segment

Segment	Potential additional spending
Working age	No significant additional spending
Retirement age, not in care home	£65-240 million; of which on care services: £20-65 million
Retirement age, in care home	£280-840 million; of which on care services: £150-460 million
Overall	**£350 million – 1.1 billion;** **of which on care services: £170-520 million**

Source: Frontier calculations based on several data sources

Note: The presented figures are based on various assumptions and are subject to a high degree of uncertainty. Hence, they should be read as indicative estimates only.

The impact on the social care market may therefore also be relatively limited, at least initially. Social care markets are highly localised, and the impact of the reforms is likely to vary across the country, depending upon local characteristics.

The social care market is unlikely to become more sustainable solely as a direct consequence of the reforms. The market may become more innovative and offer some new or higher-quality services. These developments are likely to be targeted at more affluent, self-funded residents.

The chances of realising the financial and economic benefits set out above would be improved if the focus of reform were not solely on charging. In addition to introducing the cap and the upper capital limit, reforms have a better chance of success where they include:

- Better information about future care costs – and the limits on those costs – to raise awareness amongst individuals which may make them more responsive to changes.
- A stronger financial base for the social care sector would enable greater investment and innovation.
- Regulation (e.g. to improve understanding of quality and cost of different types of care, of entry and exit) to foster a more dynamic and competitive market, particularly within the self-funded part of the market.

ANNEX A ANNUAL SPENDING ESTIMATES: ADDITIONAL MODELLING METHODOLOGY DETAILS

Our analysis modelled the following reforms:

- a cap on care costs of £86,000;
- an increase in the upper capital limit from £23,250 to £100,000;
- general living costs of £10,400.

Our analysis provides indicative estimates of:

- the **total expected future savings** which could be anticipated by individuals, as a result of the reforms;
- the **total additional spending** which might be made by these individuals, as a consequence of anticipated future savings; and
- the **additional spending per year** which might occur as a consequence.

Our estimates are calculated for the existing 9.7 million individuals who are retired, but not receiving care, and a further 330,000 who are retired and in care.

We calculated each of the above estimates in turn, building upon the earlier results. Below we provide some additional detail for each of these steps.

Total expected future savings

As a result of the reforms, any of these individuals could potentially benefit financially from lower care costs in the future. At the point of implementation, the potential financial benefit to any given individual would be uncertain. This would depend upon the level of care they receive, the duration of the care, and the costs of the care.

As described in Chapter 0, accounting for these individuals' income and wealth, and a range of potential fee rates (which determine their future care costs), we estimate the following total expected future savings for the current group of retired people.

Table 16 Aggregate impact of future cost savings by population segment and wealth bracket

Segment	<£23,250	£23,250-£100,000	>£100,000
Working age	No savings expected	Potential savings too distant	Potential savings too distant
Retirement age, not in care home	No savings expected	£5.1-8.7 billion from increased upper capital limit; £0-45 million from costs cap	£4.0-25.3 billion from costs cap
Retirement age, in care home	No savings expected	£1.5-2.5 billion from increased upper capital limit; £0-12 million from costs cap	£0.6-3.5 billion from costs cap

Source: Frontier calculations based on various data sources.

Note: The estimated per-person savings for working-age individuals would be equal to those for retirement-age individuals who are not in a care home. However, these potential savings are very distant and uncertain and are thus likely to lead to little behavioural changes. See Figure 10 above.

Aggregated across the wealth brackets and the individual elements of the reforms, our analysis suggests total expected future cost savings of:

- £9.1-34.0 billion for retired individuals not drawing on care and support in a care home.
- £2.0-6.0 billion for retired individuals drawing on care and support in a care home.
- £11.1-40.0 billion across all retired individuals.

Total additional spending

As a result of these future expected cost savings, we assume that many individuals will choose to spend more today, or at least in advance of actually realising those cost savings. This response to changes in future income is well-established by economic evidence, as discussed in Chapter 0. The proportion of additional income (in this case additional expected future income due to lower care costs) which is spent is known as the Marginal Propensity to Consume (MPC).

As described in Chapters 0 and 0, we assume an MPC of 14% for those retired individuals who are not in a care home, and an MPC of 28% for those retired individuals who are in a care home. Applying these MPC rates, our analysis suggests total additional spending of:

- £1.3-4.8 billion for retired individuals not drawing on care and support in a care home.
- £0.6-1.7 billion for retired individuals drawing on care and support in a care home.
- £1.8-6.4 billion across all retired individuals.

Additional spending per year

It is possible that the additional spending identified above could all occur immediately following implementation of the reforms. However, we believe that it is more likely that this spending would occur gradually over time, since awareness and understanding of social care costs is low. This suggests a large direct post-implementation response is relatively unlikely. It is more plausible that over time, as individuals learn about the reforms, that the spending response of individuals is 'spread out'. In addition, for those who are not yet drawing on care and support, as they become older, and more likely to require care, they may be more likely to consider their future social care costs.

To provide an indicative annual estimate for additional spending, as a result of the above spending being 'spread out', we assumed the following:

- For retired individuals not in a care home, total additional spending will be evenly distributed over 20 years. This reflects the average life expectancy for individuals reaching retirement age.
- For retired individuals in a care home, total additional spending will be evenly distributed over 2 years. This reflects the average length of stay in a residential care home.

Based upon these assumptions, we estimate additional spending per year of:

- £65-240 million for retired individuals not drawing on care and support in a care home.
- £280-840 million for retired individuals drawing on care and support in a care home.
- £350 million – 1.1 billion across all retired individuals.

We believe these figures are a useful indicative guide. However, there are several reasons that these are imprecise.

- As noted above, the **timing of individuals' spending response** is difficult to predict. If awareness of the reforms is high, spending might occur earlier. If it is low, spending might occur later, or be significantly reduced.
  - For example, if all those drawing on care and support in a care home chose to spend immediately following implementation, the spending in year 1 would rise by a further £280-840 million, although it would be lower by the same amount in year 2.
- All of the above analysis is based upon the existing 10 million retired individuals (both in care and not in care). Over time, there will be a **flow of individuals joining and leaving the above groups**, including:
  - newly retired individuals;
  - retired individuals moving into a care home;
  - individuals moving out of a care home (although this is a relatively small proportion); and
  - individuals passing away.

Individuals moving into retirement or into a care home will increase the above estimates of spending, whereas those moving out of a care home or passing away will reduce the estimates.

- Within the 'retired in-care' group, on average every 2 years there will be a completely new group of individuals replacing the previous group (given the average length of stay). This means that the spending estimates for this group will be repeated for the new group of individuals. This indicates that the above annual estimates might also be a reasonable guide to the additional spending from 'year 3' post-implementation and over the medium term.
- Newly retired individuals joining the 'retired not-in-care' group will increase this group's size by around 5% each year, with a possible corresponding impact upon this group's spending. However, a similar number of individuals leave this group (either moving into a care home or passing away), which will likely reduce this group's spending by a similar amount. Again this indicates that the above annual estimates might be a reasonable guide over the medium term.

- In future years, **some individuals moving into a care home might already have responded to the expected future savings**, and this may reduce their spending response when moving into a care home. Based on our modelling, this effect is modest. If they have responded at all (noting that we estimate the response across the group is spread over 20 years), they would have 'brought forward' only around 10% of their spending, because:
  - their expected future savings before entering a care home are only 20% of the size of expected savings upon entering a care home (because they do not know that they will need to enter a care home at all[87]); and
  - their spending response (as we have modelled it) is only half the size of the response amongst those who are in a care home.[88]
- Over time, there are likely to be **changes to care home fee rates**. These are difficult to predict, but will directly affect all of the expected future savings estimated within our modelling.
- More widely, any **changes to social care policy or the social care market** which affect the number of individuals requiring residential care would significantly affect all of the above estimates.

For all of the above reasons, the amount of spending might vary quite considerably, and is very difficult to predict in advance of implementing the reforms. This uncertainty is partially reflected in the wide ranges of our estimates, but we also note that even higher or lower spending responses are possible.

[87] And we assume that probability to be 20%.

[88] Specifically, we assume an MPC of 14% compared with 28% for those in care.

ANNEX B LITERATURE REVIEW METHODOLOGY

We carried out a systematic review across several areas of interest in order to respond to the following questions:

- How will individuals respond to reduced care cost uncertainty and expected reduced care costs?
- To the extent they choose to spend more…
  - … how much might be spent on care services?
  - … how much might be spent on preventative services?
  - … how much might be spent in the wider economy?
- To the extent individuals spend more in the social care market, will providers become more sustainable, more innovative or higher-quality?

For each of the areas of interest we followed a three-stage approach:

1. Review of the theoretical economics literature.
2. Review of empirical evidence testing this theory, both in academic and grey literature.
3. Exclusion of those studies not relevant to our scope.

For stages 1 and 2, Google Scholar searches were carried out using the search terms presented in the tables below. Additional studies were then identified using a 'snowball method'.[89] Some studies present both theoretical models and empirical evidence so the two stages overlapped in some cases. The following sections present the search terms used in each of the areas of interest.

[89] Considering additional literature identified from citations in a relevant study.

How will individuals respond to reduced care costs uncertainty and expected reduced care costs?

Table 17 Search terms

Theoretical literature	Empirical literature
'uncertainty long-term care'	'savings patterns'
'economics of care'	'retirement savings'
'economics of long-term care'	'evidence on precautionary savings'
'life cycle savings'	'over-saving evidence'
'precautionary savings'	'under-saving evidence'
'uncertainty and savings'	'long term saving attitudes'
'theory of savings'	'wealth and assets'
'theory of health expenditure'	'household wealth'
	'wealth in retirement'
	'social care planning'
	'social care cost understanding'
	'social care survey'

Source: *Frontier Economics*

Note: *For the empirical evidence, we have focussed mainly on the literature based on UK and discarded most of the empirical studies concerning other countries.*

How much might individuals spend in the wider economy?

Table 18 Search terms

Theoretical literature	Empirical literature
'LCPIH'	'MPC'
'permanent income hypothesis'	'marginal propensity to consume'
'smoothing consumption'	'propensity to consume'
'lifecycle income smoothing'	'wealth and consumption'
'income uncertainty'	'income shocks and consumption'
'Modigliani'	'consumption changes'
'Euler equation'	'unpredictable income changes'
'precautionary savings'	'predictable income changes'
'precautionary motives'	'tax rebate consumption response'
	'pension reform consumption response'
	'consumption rich households'
	'uncertainty and MPC'
	'uncertain income shock and consumption'

Source: *Frontier Economics*

Note: *The starting point of the empirical literature review was a paper by Carroll et al. (2017) which presented a table of empirical estimates found between 1999 and 2016. The list of studies was then expanded to include more recent literature.*
The studies excluded because out of scope are a) studies that estimated elasticity and not MPCs and b) studies contradicting the prevalent economic theory for which wealthier households have a lower marginal propensity to consume.[90]

[90] Only two of them were found: Shapiro and Slemrod (2009) and Coronado, Lupton and Sheiner (2005)

How much might individuals spend on care services and preventative care?

Table 19 Search terms

Theoretical literature	Empirical literature
'health cost theory'	'willingness to spend older people'
'bequest motives'	'willingness to spend long term care'
'lifetime insurance theory'	'evidence bequests motives'
	'evidence precautionary motives'
	'retirement dissaving'
	'long term care spending survey'
	'preventative care spending UK'
	'retirement communities'
	'extra-care spending'

Source: Frontier Economics

Note: The theoretical literature review in this section was built on many of the concept explored in the previous section such as the LCPIH and precautionary savings.

Will providers become more sustainable, more innovative or higher quality?

Table 20 Search terms

Theoretical literature	Empirical literature
'care market competition dynamics'	'care market UK characteristics'
'social care markets'	'care market UK competition'
'barriers to entry care market'	'care market UK barriers to entry'
'long term care insurance theory'	'care market UK innovation'
'care market profitability'	'CMA care market'
	'care market UK incentives'
	'UK long-term insurance market'
	'ABI long-term care'
	'insurance products long-term care'
	'insurance market Dilnot reforms'
	'insurance developments after pension reforms'
	'financial products care market'

Source: Frontier Economics

ANNEX C LITERATURE ON THE MARGINAL PROPENSITY TO CONSUME

Table 21 shows a list of papers that have calculated MPCs with different methods and their correspondent estimates. Authors can calculate the MPCs in three ways:

- Using episodes in which income change as a natural experiment. Evaluating how consumption reacts to such changes (due for example to tax rebates, child benefits or others).
- Using data on income and consumption collected over several years (panel data) to study how income changes with consumption.[91]
- Asking people in surveys how they would react to hypothetical income changes.

Table 21 Literature estimating MPCs

Authors and year	Estimate or range	Relationship between consumption and income	Type of shock
Coulibaly and Li (2004)	0.24	Relationship not explored (durables only)	Homeowners paying off their mortgage (predictable income shock)
Agarwal and Qian (2014)	0.80	MPC is lower for wealthier households	Growth dividend program (unexpected income shock)
Browning and Collado (2011)	0	Relationship not explored	Bonus program (predictable income shock)
Jappelli and Pistaferri (2014)	0.48	MPC is lower for wealthier households (non-durables only)	2010 Italian Survey of Household Income and Wealth (transitory income shock)
Johnson, Parker and Soueleles (2009)	0.25	MPC is lower for wealthier households (non-durables only)	2003 child tax credit (transitory income shock)
Parker (1999)	0.20	Finds little evidence that people with liquidity constraints have lower propensity to save but caveats it saying that the sample of liquidity constraint individuals is small (non-durables only)	Social security tax withholdings (predictable income shock)
Sham, Shapiro and Slemrod (2010)	0.33	No evidence that MPC is higher for lower income households	2008 tax rebate (transitory income shock)

[91] Relying on a statistical decomposition of income shocks and the covariance restrictions imposed by the theory on the joint behaviour of income and consumption (Jappelli and Tagliaferri 2014).

Souleles (2002)	0.35-0.60	Liquidity constrained households have higher propensity to consume (non-durables only)	Income tax refunds (predictable)
Kaplan, Violante and Weidner (2014)	0.12-0.3	The upper value refers to 'wealthy hand-to-mouth' households and lowest value refers to no hand-to-mouth households	Survey data from several countries (unexpected income shock)
Hausman (2016)	0.6-0.75	Relationship not explored. Particularly high MPC due to economic circumstances.	1936 veteran bonus (transitory income shock)
Parker, Souleles, Johnson, and McClelland (2013)	0.12-0.9	MPC is lower for wealthier households (lower bound refers to non-durables, upper bound refers to total goods)	2008 tax rebate (transitory income shock)
Carroll (2017)	0.18-0.26	Lower bound for top 1% of income distribution, upper bound bottom 20% of income distribution	Theoretical model, announced stimulus check, transitory (unexpected)
Fisher et al (2020)	0-0.24	Upper bound refers to the bottom two wealth quintiles	PSDI data (predictable income shock)

Source: *Frontier Economics*

Note: *Studies looking at the LCPIH estimating elasticity of consumption and not MPC are left out of the analysis.*
Two studies found a higher MPC for wealthier households. They have been left out because they go against the common economic theory.

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