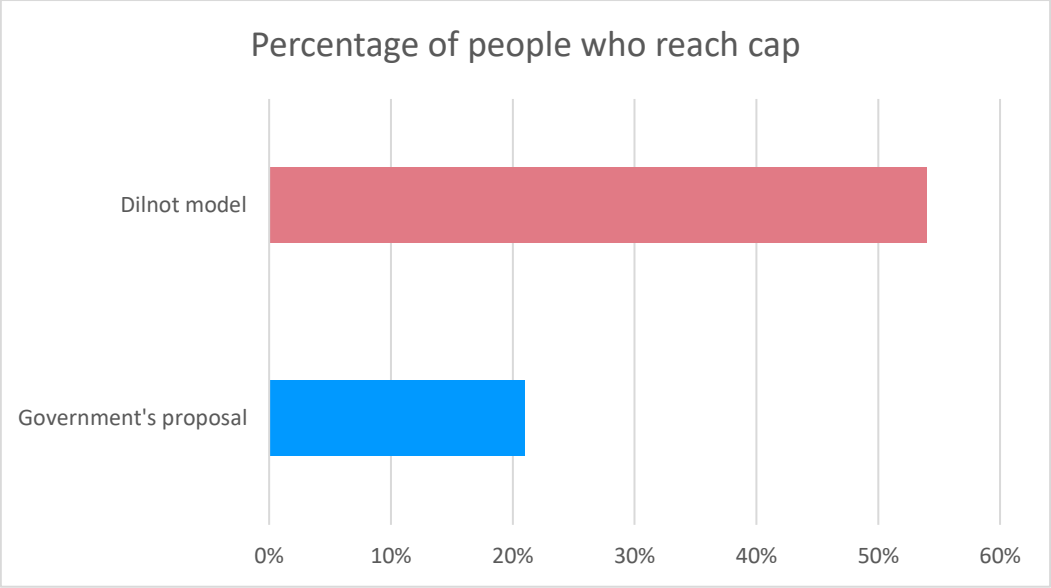
Cap on care costs data

1. Percentage of people with dementia and care starting in 2023 who would reach the cap under respective policy options:

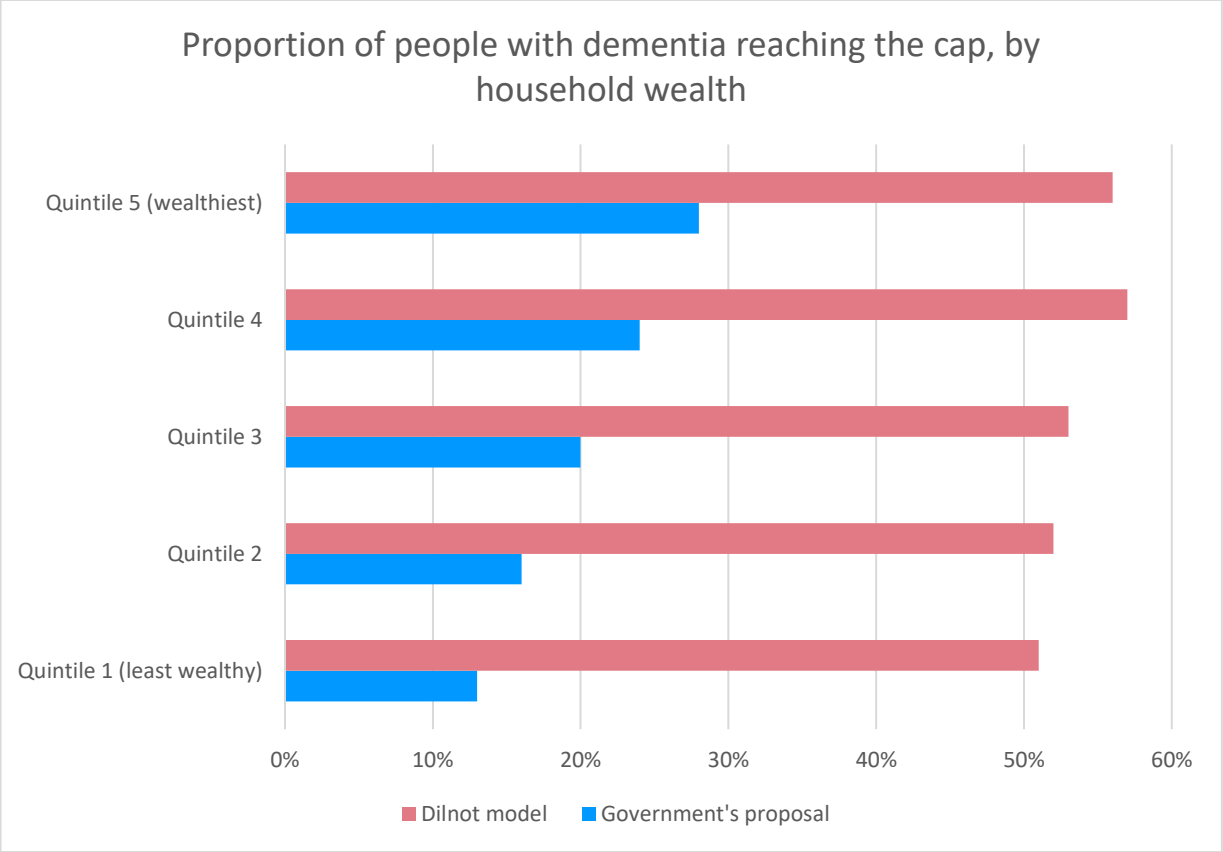
Policy	Percentage of people who reach cap
Government's proposal	21%
Dilnot model	54%



NB. These figures relate to self-funders. Those who would reach the cap would begin to receive state assistance for their care costs. Those who don't reach the cap would be required to pay for their own care.

2. Percentage of individuals with dementia entering care in 2023 that would reach the cap specified under each proposal, by quintile of household wealth among over-65s:

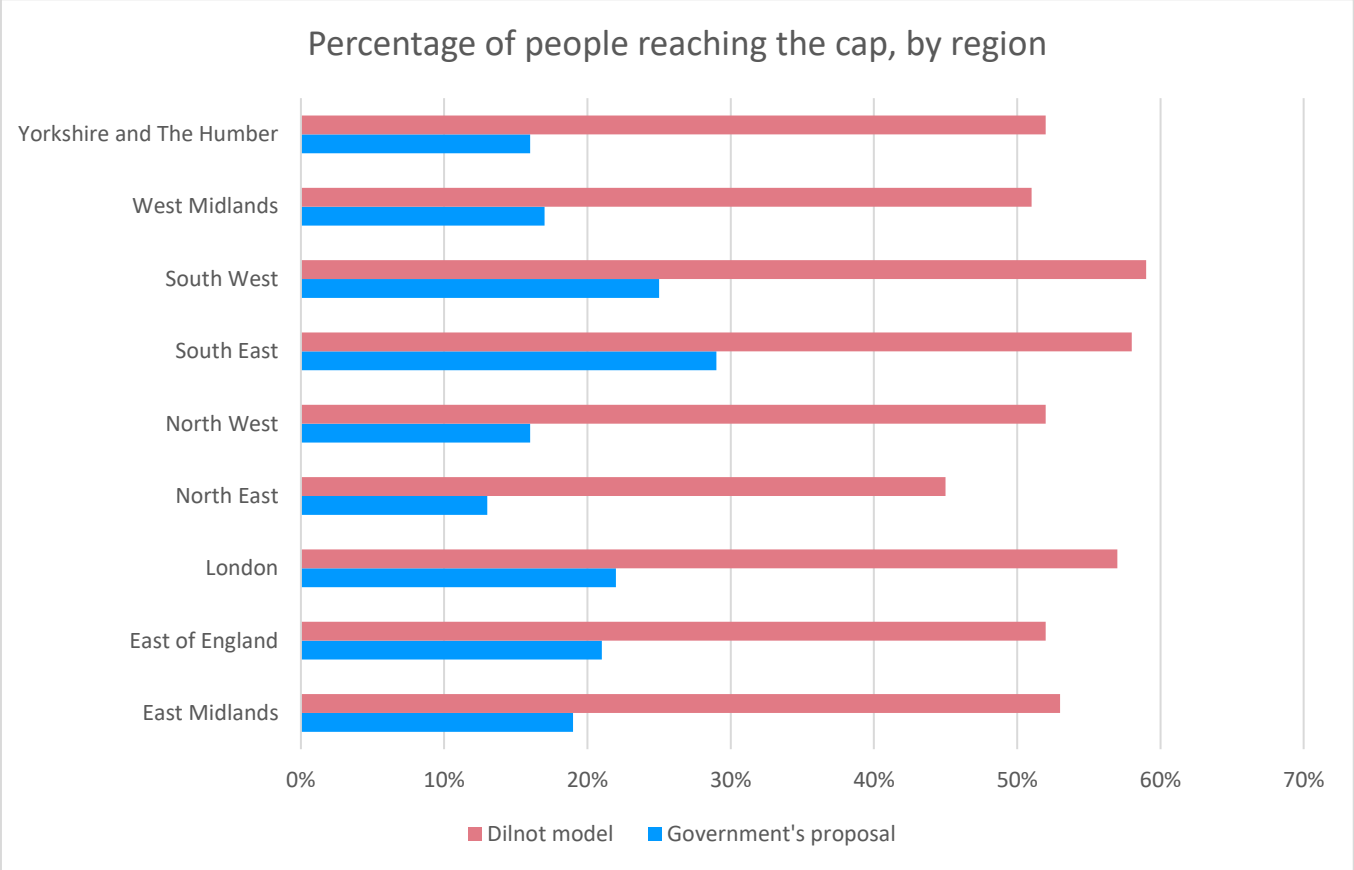
	Quintile 1 (least wealthy)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (wealthiest)
Government's proposal	13%	16%	20%	24%	28%
Dilnot model	51%	52%	53%	57%	56%



NB. These figures relate to self-funders. Those who would reach the cap would begin to receive state assistance for their care costs. Those who don't reach the cap would be required to pay for their own care.

3. Percentage of individuals with dementia entering care reaching the cap, by region:

	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire and The Humber
Government's proposal	19%	21%	22%	13%	16%	29%	25%	17%	16%
Dilnot model	53%	52%	57%	45%	52%	58%	59%	51%	52%



NB. These figures relate to self-funders. Those who would reach the cap would begin to receive state assistance for their care costs. Those who don't reach the cap would be required to pay for their own care.

Methodology note

Qualifying Income and Assets

To undertake the research, we first obtained data from the English Longitudinal Study of Ageing (ELSA). ELSA collects information from people aged over 50 across a range of topics such as physical and mental health, wellbeing, and attitudes.

For our analysis we utilised detailed variables on the wealth and income of each individual from Wave 9 (2018/19) of ELSA, to calculate the qualifying income and capital for each of the 5,300 individuals in our sample. That is the total income and assets for each individual that is considered for inclusion by the current means test. This qualifying income and assets are the same under each of our modelling scenarios.

For qualifying income, we followed Government guidance, including benefits income (such as state pension) as applicable, and disregarding any earnings and the savings credit (according to a Care Act formula). Some simplification of other elements of the calculation was required due to data limitations in the source survey.

For qualifying capital, we followed Government guidance: we excluded the value of primary residence for those receiving care at home (domiciliary care), as well as for those identified in the survey as living with a partner, assuming that their partner continues to live in their primary residence, meaning that it must be disregarded. Primary residence value was included in qualifying capital for those entering residential care and without a partner expected to continue living in the residence. For other assets, where the data was only available at benefit unit (family) level, we assume these are split equally between the partners if a study member is living in a couple.

In addition to data on income and assets we also kept some basic data on the individuals in the sample, including data on the region in which they live. We filter the ELSA sample to only those aged 65 and above.

Disease and care progression pathways

The next step of our modelling utilises a randomisation approach to project how individuals' care needs will develop over time. As just 3% survive for over ten years from the point of receiving care, we make a simplifying assumption and assume that after 10 years all individuals in our sample will have died.[1] Our cost modelling focusses just on those with dementia, so we assume that all individuals in our sample have mild dementia and are drawing upon either domiciliary or residential care in year 1. By using statistics on (1) disease progression (2) survival rates over a 10-year period and (3) assumptions about how those with changing disease severity progress from one type of care to another we are able to probabilistically simulate the type of care individuals are in, or whether they have died, for each year over a ten year period for each member of our sample.[2,3] We re-ran this simulation 3 times and averaged the results to reduce the role of outlier events.

From care pathways to costs

The modelling stages described above allow us to estimate the care needs, the qualifying income and assets at year 1, and the region of each individual. To estimate the cost of care for these individuals over our period we utilise the rules pertaining to each scenario together with regionally-variated estimates of care costs. To estimate the average cost of five types of care, across England's nine regions we utilise national estimates of the average annual cost of each type of care and adjust this using the relative regional variation observed in other estimates of care costs. [4,5,6] We then use these average figures to estimate regional care costs paid by local authorities and self-funders.

We differentiate between local authority rates and self-funder rates: those eligible for LA support after the means test are assumed to pay LA rates, while those not eligible are assumed to pay the higher self-funder rates.

For all scenarios we do exclude the 'hotel costs' – that is daily living costs in a residential care setting, set to be £200 per week, equivalent to £10,430 a year for all individuals– from individual contributions that count towards the cap, reflecting both the current Government policy as well as the future policy indication from the Government's 'Build Back Better' proposal. [7]

We also exclude 'excess top ups' that is additional costs faced by self-funders on top of local authority rates, from counting towards the cap in the Government proposals scenario. For all scenarios, the final results are weighted using the ELSA study weights, to account for variability in survey responses and to make the results a better representation of the overall population.

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[1] "Will the cap fit? What the Government should consider before introducing a cap on social care costs" Independent Age and Institute and Faculty of Actuaries (IFoA), (2017).
[2] Davis, Matthew et al. "Estimating Alzheimer's Disease Progression Rates from Normal Cognition Through Mild Cognitive Impairment and Stages of Dementia." Current Alzheimer research vol. 15,8 (2018): 777-788. doi:10.2174/1567205015666180119092427;
[3] Forder, Julien et al. "Length of stay in care homes" PSSRU Discussion Paper 2769 (2011). Available here: https://eprints.lse.ac.uk/33895/1/dp2769.pdf
[4] Namely: Low domiciliary care needs, Medium domiciliary care needs, High domiciliary care needs, Residential care without nursing, Residential care with nursing
[5] From "Will the cap fit? What the Government should consider before introducing a cap on social care costs" Independent Age and Institute and Faculty of Actuaries (IFoA), (2017)
[6] "Care home fees" from LaingBuisson "Care of Older People UK Market Report 31st edition" LaingBuisson (2020). Retrieved from: https://www.payingforcare.org/how-much-does-care-cost/.
[7] *As specified by the government (2022): Adult social care charging reform: further details . Retrieved from https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/adult-social-care-charging-reform-further-details#case-studies*

Policy option modelling

Having modelled the care pathways and potential costs for each individual's care type we then implement the payment rules for each scenario. This then allows us to calculate the amount the individual would pay for care that year from their wealth and income and the amount of wealth that is carried over into the following year. In the subsequent years the individual's updated financial position is accounted for alongside the probabilistically estimated progression in care needs, before estimating the cost paid that year. The total cost paid by each individual is estimated across the modelling period. Our analysis utilises the outputs of this modelling to appraise the policies against our four criteria.

Distributional results

We present the results across different breakdowns. Results by wealth quintile use benefit unit total net wealth quintile from the ELSA sample. Benefit unit (family) wealth is used rather than individual wealth (or 'qualifying' wealth) as it likely offers a better overall representation of one's overall material circumstances, and is more reflective of typical wealth statistics which consider family or household level wealth.