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Care in later life: incentives to use assets to pay for care

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- Extend and encourage research and debate on policy on pensions and retirement provision
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Care in Later Life: Incentives to Use Assets to Pay for Care

Executive Summary

The care funding system in England is widely perceived to be in need of an overhaul. The ageing population means there are more people than ever reaching older ages and increasing the need for care. The Association of British Insurers (ABI) asked the PPI to investigate a selection of incentivised proposals that could encourage and assist people to use their existing savings and assets to fund their care in an efficient manner.

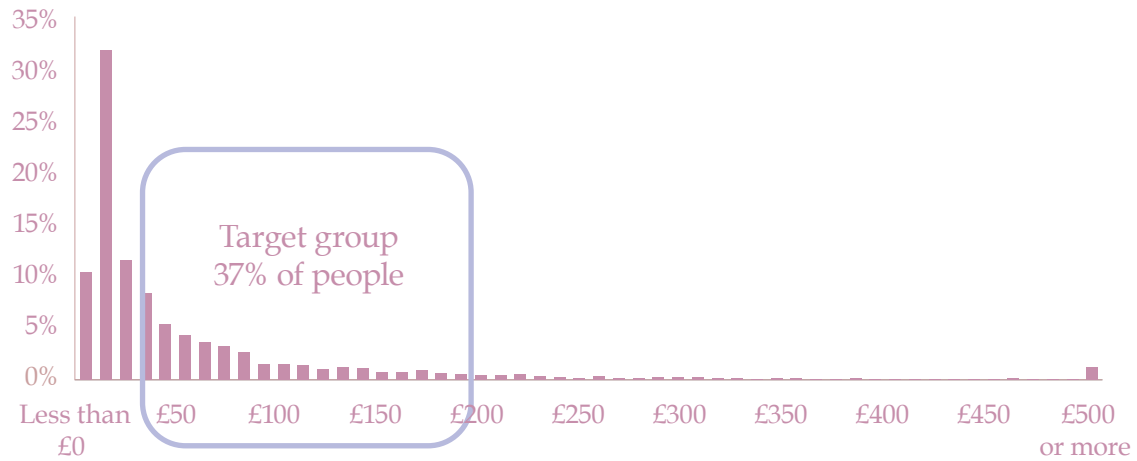
The state provides care services for people with assets below a threshold level, others with very high levels of assets may be able to pay for care without specifically needing to put money aside. But there is a middle group, who are unable to claim support from the state, yet do not have adequate finances that the cost of care would not impact their financial well-being. This group may benefit from some way of preparing, or being able to efficiently use currently owned assets to meet care costs if, following reform, they are required to self-fund.

We have considered a target group to be people who have savings and assets, excluding their house value, of more than the threshold for losing state support (£23,250), but less than £200,000. The target group makes up approximately 37% of people in England aged over 50 (Chart Ex1).

Chart Ex1

The target group of people for care funding is around 37% of people

Distribution of savings levels among people in England aged over 50 (excluding pension and housing wealth). Target group is those with between £23,250 and £200,000 of savings.



There is unlikely to be a single solution that works for all people. Financial product providers may be able to offer products that can help people prepare for care as part of a range of solutions. 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. The report considers five possible proposals that have been raised within the financial industry:

- Income from a pension scheme is used to pay for care, exempt from income tax. Payments from pensions which are made to care providers would be exempt from income tax. Around two thirds of those in the target group who are currently aged over 65 have a pension in payment that may be a means to pay for care. For those with a care need, tax relief on their care spending could give them a significant increase in purchasing power.

  There is a cost to government in terms of the tax relief given on pension income used to pay for care. This tax cost is ongoing during the period that such pension payments are being used to pay for care.

- Use tax exempt pension withdrawals to secure an insurance product that covers care costs. Premiums for an insurance product to pay for care could be taken tax free from a pension, the insurance company then pays off future care needs if they should arise during the period of cover.

  The number of people within the target group who are between ages 55-59 and who have some un-accessed Defined Contribution pension is around 29%. The premium value for full cover may be more than that which most people with pension savings could afford from their pension scheme.

- The introduction of a Care ISA with no Inheritance Tax paid on residual amounts at death. This would use people's propensity to save in ISAs to fund care by introducing a Care ISA which would provide a fund earmarked to pay for care, with the funds invested tax free and any left-over money free of Inheritance Tax upon death. Saving in an ISA is very common among the target group, around 85% of whom have ISAs. The median savings level in ISAs for members of the target group is around £35,000.

  The popularity of ISAs may mean that the Care ISA is a product that people feel they understand and are therefore attracted to. However, Inheritance Tax relief may not be a large incentive to save in a Care ISA as only around 4% of deaths in the UK are subject to Inheritance Tax.

- Releasing equity from a property to secure an insurance product that covers care costs. In the case that an insurance market for care cover develops, the current older generation could pay for care insurance by releasing equity in their home. The policy would leverage the high incidence of home ownership amongst older people. Essentially the proposal is simply using equity release to pay for care insurance. With no government intervention required through tax incentives, it may be possible that this proposal could be offered by providers now.

  Home ownership is very high. Among the target group, over 90% of people aged between 65 and 79 own their own home with the median house value being around £300,000. The use of housing equity release does not tangibly affect day to day income, so may be more attractive than other forms of using assets to pay for care.

- Pledging equity from a property to cover care costs in return for a corresponding government pledge. A government incentivised scheme to encourage people to pledge that a proportion of the equity in their home would be made available to cover care costs if, following reform, they are required to self-fund. The government incentive would be to make a notional corresponding pledge of a proportion of the amount that the person pledged. Both pledges are notional until a care need arises.

  Like the proposal where insurance is purchased through releasing equity, the pledge aims to utilise the high levels of home ownership among the target group. The pledge may also be attractive because it is not an immediate financial transaction, so it may be seen to be even less tangible than using equity release to purchase insurance.

These proposals, provided by the ABI, are intended to represent a selection of the types of products and/or fiscal regime changes that could be adopted to create an environment that enables people to efficiently pay for, or prepare for, care costs. In analysing these proposals the Pensions Policy Institute is not endorsing them.

Introduction

The growth in the older population as the baby-boom generation retires, coupled with improvements in life expectancy are increasing the number of retired people at older ages.[1] This in turn leads to an increase in the number of people requiring social care, which increases the need for funding of social care and the need for solutions.

The social care system in the UK is devolved to the individual countries. This paper concerns the system in England. In England, social care is not covered by social insurance in the same way as the NHS, and it is not free at the point of use. Instead, there is some government support such as Attendance Allowance and Funded Nursing Care, beyond that people have to pay for their own care but may receive means tested support from their Local Authority which could partially or fully cover the cost.

In 2010, the Government set up the Commission on Funding of Care and Support, chaired by Sir Andrew Dilnot, subsequently known as the Dilnot Commission. The Commission was tasked with recommending a sustainable approach to care funding that would best "meet the costs of care and support as a partnership between individuals and the state", while helping people to "choose to protect their assets, especially their homes". The Dilnot Commission reported in July 2011 with a set of recommendations, including a care spending cap for individuals, which would limit the amount that any individual had to pay toward care costs (excluding "hotel costs" associated with residential care), and an increase to the allowable savings in the means test for people in residential care.[2]

While provision was made for a care spending cap in the Care Act 2014, implementation was delayed until 2020, but in 2017 the Government announced that plans for introducing the care cap had been scrapped.[3] Similarly, the Government announced it would increase the savings allowance in the means test, but also delayed implementation. In the March 2017 Budget, the Conservative Government said that it would publish a Green Paper on social care, in order to allow a public consultation to be held.[4] The Government has said that the proposals in

1. There are around 4.8 million people aged 75 and over in England in 2019, this is projected to increase to around 6.4 million by 2030: *2016-based National Population Projections* Office for National Statistics
2. Commission on Funding of Care and Support (2011)
3. https://www.bbc.co.uk/news/uk-politics-42266076
4. HMT (2017)

the Green Paper will "put the social care system on a more secure and sustainable long-term footing". The publication of the Green Paper has been delayed several times, but is expected in 2019.

There is currently only a very small market in financial products designed to prepare for an individual's care needs. This could be due to a lack of demand resulting from individuals not recognising the need to pay for care, a mental avoidance of the issue of future care needs, or a belief that the state is responsible for paying for care. Without a significant public interest in care products, insurance companies have had little incentive to develop them.

The Association of British Insurers (ABI) has asked the PPI to examine a selection of five proposals to help individuals fund their care. This is not intended to represent an exhaustive list of potential options.

None of the proposals has been suggested as a single solution. Rather, in order to try to enable individuals to find the best solution for themselves it is likely that a wide range of options could be developed under a care funding framework.

The proposals examined in this paper are intended to represent a selection of the types of products and/or fiscal regime changes that could be adopted to create an environment that enables people to efficiently pay for, or prepare for, care costs. In analysing these proposals the Pensions Policy Institute is not endorsing them.

The structure of the report is three background chapters which set the scene:

- Description of care provision in England (Chapter 1)
- Difficulties with engaging individuals and defining the target group of people for care funding proposals (Chapter 2)
- Outlining the broad concepts in approaches to care funding (Chapter 3)

and then five chapters examining a selection of individual funding proposals:

- Offering tax relief on pension payments made directly to care providers (Chapter 4)
- Use pension withdrawals to secure an insurance product that covers care costs (Chapter 5)
- Introduction of a Care ISA with no Inheritance Tax paid on residual funds at death (Chapter 6)
- Releasing equity from a property to secure an insurance product that covers care costs (Chapter 7)
- Pledging equity from a property to cover care costs (Chapter 8)

Chapter One: Care Provision in England

Current Care provision

Social care involves the provision of various services that support "people of all ages with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines" that help "people sustain employment in paid or unpaid work, education, learning, leisure and other social support systems".[5]

Care is provided on either a formal or informal basis. Informal care is generally provided by friends and family who, while dedicated and diligent, are not professional carers, for example, those looking after an elderly relative. Formal care is undertaken within the care system by professional carers. The funding of formal care is the focus of this report.

Care can either be provided to people who reside in their own home, or in specialist residential care homes and nursing homes. In care homes, the residents face both "care costs" associated with the care they receive, and "hotel costs" covering accommodation and food.

What is the current situation for individuals in terms of paying for care?

Provision of social care is the responsibility of Local Authorities. When a care need arises, the Local Authority will undertake an assessment of the care requirement. They will also undertake a financial assessment of the individual to establish how much of the care costs fall on the individual.

NHS data suggests that 565,000 people aged over 65 accessed long-term care support in England during 2017/18. This is around 5.6% of the over 65 population. Current spending on care to support people aged over 65 by Local Authorities was around £7.1 billion in 2017/18, of which around £2.2 billion came from payments by the individuals themselves.[6]

In addition, there are people who fund care privately without Local Authority support. The National Audit Office (NAO) estimated that £10.9 billion was spent on privately bought care in 2016/17 for adults aged 18 and over.[7]

5. Commission on Funding of Care and Support (2011)
6. NHS Digital (2018)
7. NAO (2018)

Informal care, which is provided by unpaid carers, such as family members, neighbours and friends, does not have a spending cost in the same sense as formal care. However, the NAO estimated that in 2016/17 the value of informal care was much larger than formal care. They estimated the value of informal care as being up to £100 billion and that if informal care were not available, the cost of the care that would fall on the state might be around £59 billion, for adults aged 18 and over.[8]

The care means test

After assessing a care need, the Local Authority will carry out a means test to determine the financial responsibility on the Local Authority and the individual in paying for the care.

Eligibility

The individual's savings and assets are measured against an asset threshold currently set at £23,250. If they have savings and assets over that value they are not eligible for means tested support and must pay for the care themselves.

If the individual is receiving care in their home, the value of their home is not included in the asset calculation. If the individual is receiving care permanently in a residential care home, then the value of a property owned by them may be included if they do not have a partner or child still living in the property.

Amount of support provided

Once an individual is eligible for receiving means tested support, the Local Authority will calculate how much support is provided. The amount of support is reduced by taking into account:

- savings of between £14,250 and £23,250
- eligible income, including pensions, earnings and some benefits

People over State Pension age who do not receive means tested care support from the Local Authority may still receive some money from the government that is used to pay for care. The main benefit targeted to those who need care is Attendance Allowance which is at £58.70 or £87.65 a week in 2019, depending on level of need. The new State Pension is £168.60 a week, so with full new State Pension and in receipt of the higher amount of Attendance Allowance, the government may be support the care needs of an individual who is ineligible for means tested payment through Social Security by £256.25 a week.

Addressing the problem of care funding

Dilnot Commission

In 2010, the Government set up the Commission on Funding of Care and Support, ("the Dilnot Commission"), tasked with recommending a sustainable approach to care funding that would best "meet the costs of care and support as a partnership between individuals and the state", while helping people to "choose to protect their assets, especially their homes".[9]

The Dilnot Commission reported in July 2011. They found that the current system was deficient in a number of areas:

- People are exposed to very high care costs with no meaningful way to protect against the risk.
- The current system offers inconsistent services across the country.
- People find the current system confusing and are often unaware of the financial liabilities, believing that the government will provide free care.
- There is inadequate information and advice available to people entering the care system.
- It was reported that an increasing demand for care services was not matched by an increase in the funding for care, potentially leading to a reduction in the quality of services.

The Commission concluded that it was very difficult for people to adequately plan or provide for their care needs.

The Dilnot Commission made a set of recommendations to try to address the deficiencies of the current system. These were:

- A cap on lifetime contributions to adult social care costs that any individual would face. They suggested a figure of around £35,000 (in 2011 terms) uprated in line with the increase in the State Pension. The cap covers care costs only, not hotel costs for people in residential care, meaning a significant cost could still remain in the presence of a cap.
- Continuing the means tested support for people with lower means, but increasing the asset threshold to £100,000 (in 2011 terms).

8. NAO (2018)
9. Commission on Funding of Care and Support (2011)

- Care and support to be free for individuals who develop care needs before adulthood.
- Alignment of the social care funding system and Attendance Allowance.
- A standardised contribution by people to cover general living costs in residential care of between £7,000 and £10,000 (in 2011 terms).
- An objective eligibility and assessment framework which produces consistent, standardised assessments across England.
- An awareness campaign to encourage people to plan ahead for their later life, including possible care needs.
- The Government to develop an information and advice strategy to help when care needs arise.
- Support offered to carers to ensure that the impact of caring is manageable and sustainable.
- Review the place of care in the wider care and support system, particularly to improve integration with health services.

Government response

The Care Act 2014 set out measures that addressed some of the Dilnot recommendations. Among other things the Care Act 2014 included:

- a framework of duties on Local Authorities;
- assessing and meeting the needs of carers;
- promoting wellbeing of people in care, and carers;
- powers to delegate functions;
- the care cap on social care charges of £72,000 to be introduced in 2016 but subsequently delayed indefinitely; and
- more generous means test upper threshold on people entering residential care, to be introduced in 2016 but subsequently delayed indefinitely.

In the March 2017 Budget, the Conservative Government said that it would publish a Green Paper on social care, in order to allow a public consultation to be held. This followed the decision in July 2015 to postpone the introduction of a cap on lifetime social care charges and the more generous means test that had been proposed by the Dilnot Commission and accepted in principle by the then Coalition Government.

During the subsequent 2017 General Election campaign, the Conservative Party made a manifesto commitment to introduce the Green Paper. The publication of the Green Paper continues to be delayed and in December 2017 the Government announced that plans for introducing the care cap had been scrapped. In June 2018, the Health and Social Care Secretary announced a further delay to the "autumn" of 2018 following the announcement that a ten-year plan for the NHS would be developed. The Green Paper was then pushed back to April 2019, but did not emerge. The current position is that publication of the Green Paper will be "at the earliest opportunity".

The Government has said that the proposals in the Green Paper will "put the social care system on a more secure and sustainable long-term footing".[10] During the General Election campaign, the Prime Minister said that the proposals in the Green Paper would include a lifetime "absolute limit" (i.e. cap) on what people pay for social care, and the Conservative Party's manifesto also proposed changes to the means test. Topics that the Government have said will be covered include integration with health and other services, carers, workforce, and technological developments, among others. The Government will also consider domestic and international comparisons as part of the preparation for the Green Paper.

The care cap

The care cap was recommended by the Dilnot Commission to limit individuals' exposure to care costs. The care cap would cover care costs but not hotel costs and general living expenses.

Methodology: As set out in the Dilnot report, the Local Authority would, as part of the care assessment, calculate care costs, based on a typical Local Authority package for the appropriate level of care in that area. They then work out a timescale of when costs would reach the care cap. Care costs up to that date would be met by the individual (with means tested support as appropriate), all care costs after the calculated date would be covered by the government. Any change in care circumstances would necessitate a revision of the calculation.

In the Dilnot report, the care cap system was characterised as a social insurance model with a significant excess.

There are significant arguments in favour of a care cap, particularly to the individual, however there are some considerations to be made when designing or implementing a cap.

10. HMT (2017)

THE CARE CAP PROS:

- It gives people a known limit on the amount of money they will be expected to spend on care costs,
- This knowledge may enable and encourage them to save or take some form of protection against care costs,
- And may encourage financial product development,
  - To meet the needs of an emerging market,
  - In the knowledge that liability is limited to the care cap.

THE CARE CAP CONS:

- The introduction of a care cap would come with a cost to the government as the costs above the cap are taken on by the government.[11]
- It may be difficult to create a care cap that is easy to understand, particularly as the cap may not reflect actual money spent, but representative costs of care.
- The care cap is supposed to protect individuals from the extreme costs of care, this means that the majority of people who receive care will not receive any benefit from the cap, which could undermine it in the public's eye.
- Excluding hotel costs from the care cap means that there remains a potentially very large cost for the individual in residential care which is not capped.
- Regional differences in cost of care could lead to a perception of unfairness.
- There could be significant infrastructure and admin costs of recording and overseeing the care payments made by individuals to care providers.
- There is a political risk of a future Government abolishing the care cap:
  - Even with a care cap in place, the risk of it being abolished could put people off relying on it.
  - Financial providers may also be wary of issuing products if the abolition of the cap could leave them exposed to higher pay-outs, or costs falling back on policyholders who then feel unfairly under-insured.

Industry Response

Currently, insurers and long-term savings providers offer several products to help fund care, which includes the growing equity release market, retirement income products, immediate needs annuities, life insurance with care riders and long-term care products in payment.

The insurance industry has responded to the care funding discussion by considering the role of incentives that could try to tackle the issue. These include innovative insurance-based models and mechanisms for releasing savings in a way that attracts government incentives discussed in this report. None of the proposals explored in this report are all encompassing solutions, as it is recognised that a range of potential solutions may be required in order to best meet different individuals' needs.

11. The Casper project estimated a care cap set at £72,000, the level announced by the Chancellor of the Exchequer in 2013, would represent a cost to the government of £2 billion a year by 2035 (in 2015 prices)

Chapter Two: Individuals and the cost of care

Disengagement from care funding

The Dilnot report highlighted that, for various reasons, individuals are not engaged with funding for care.

Many people are unaware of the roles of the individual, government, and Local Authorities in paying for care. There is an assumption that social care is part of the NHS and many people only come to realise the financial responsibility of the individual at the point at which they have to interact with the care system either because of their own care need or for a family member.

The care system can be complex even for those people who do have awareness of the roles of the state and the individual in paying for care. The system of benefits available for care is somewhat disjointed with some of the benefits used to pay for care coming from a Local Authority and some from government. The Dilnot report suggested that the name of the Attendance Allowance may be unclear and that may itself lead to a lower take-up rate.

People may also face a mental block toward considering the possibility of future care needs. It can be unpleasant to think about requiring help to do tasks which can currently be easily performed. There may also be a fear of feeling helpless, or of being a burden.

The combination of a lack of awareness, the complexity of the system, and a mental block on thinking about care means that there is no culture of preparing for care needs. It is not part of the generally accepted financial life course. And without the culture of preparing for care, there is little demand for products that are specifically designed to save for, or insure against, the cost of care needs.

Increasing engagement

The Dilnot report suggested that the government mount an awareness campaign for the public on "the cost of care and support and the new funding system" to encourage people to plan for their future care needs. It also suggested that the government "encourage saving for social care as part of [the Government's] wider agenda to encourage savings for retirement".

Develop a culture of thinking about care needs

In a system where care funding requirements fall on individuals, a change in the public attitude to thinking about care may be a required first step in any discussion about care funding. Without a substantial shift in the public perception of care there is no incentive for financial providers to develop products that could help meet care needs.

In its series of reports on consumer engagement within the pension system, the PPI found that when engaging with individuals it is important to do so at a "teachable moment", that is a time when they are willing and able to take decisive action.[12] Interventions wrongly timed, such as when people are incapable of absorbing and acting on information may be ineffective. Teachable moments can occur during life transitions or during other times when people are making financial decisions such as buying other financial products, for example when they retire and are making decisions about their pension fund.

The Behavioural Insights Team concludes that if interventions are Easy, Attractive, Social and Timely (EAST) then they are more likely to motivate action. This aligns with the theory of teachable moments in that:

Any follow up action must be straightforward (easy).

People are more likely to take action if they feel others would approve and/or are doing the same thing (social).

Messages must be personalised and relate to the achievement of current goals (attractive and timely).[13]

In the case of care funding, these teachable moments might occur at times when people are thinking about saving for their future in a pension, helping a friend or family member who has a care need, or upon reaching retirement.

Policy levers that influence outcomes

The PPI previously identified six potential policy levers in the context of promoting good pension provision which can also be used to provide context for policy interventions in care funding.[14]

Box 1: Policy levers involved in promoting good outcomes

Compulsion - options that people must take whether they wish to make an active choice or not.

Defaults - an option given to people who do not wish to or are unable to make an active choice.

Safety nets - policy mechanisms designed to help those in financial hardship.

Consumer protection - legal and regulatory measures which protect people from fraud or poor governance (including high charges).

Behavioural interventions - policies aimed at encouraging people to make decisions (or not make decisions) which result in better financial outcomes.

Freedoms - policies which extend freedom to individuals, such as the removal of tax regulations which may prevent people from using their money as they wish.

12. PPI (2017)
13. Behavioural Insights Team (2014)
14. PPI (2017)

The policy levers describe the type of role that a policy takes, or the way in which it tries to influence the stakeholders to achieve the policy goal.

Many of the policies considered in this report are behavioural interventions. For example offering tax relief when using money to provide for care is trying to encourage individuals to change their behaviour with the hope of a better outcome.

They may go hand in hand with consumer protection policies requiring qualified advice or guidance. As potential new products are developed that use substantial amounts of an individual's money or asset wealth, it is important that they are fully informed of the potential consequences of each alternative action so that they can make appropriate decisions.

Target group

Not all individuals are likely have the same financial issues when a care need arises. Some people are likely to be eligible for government support under the means test, while others may be wealthy enough that they would be able to pay for a care need as it arises from their savings without the need for specific care planning.

The target group for solutions to fund care are the people in the middle. The ones who have savings above the means test threshold, but not enough to be able to comfortably self-fund care.

It is difficult to define precisely what amount of savings allows for self-funding without care planning. For the sake of this report we have chosen those with £200,000 of assets as representing the upper end of our target group. Housing assets and pension wealth are excluded, because they are not taken into account for the means test for care at home. So the target group consists of people with net assets, excluding the value of their home, of between £23,250 (the upper threshold of eligibility for means tested) and £200,000. This group is around 37% of the people in England over age 50 (Chart 1), which is around 7.6 million people.[15]

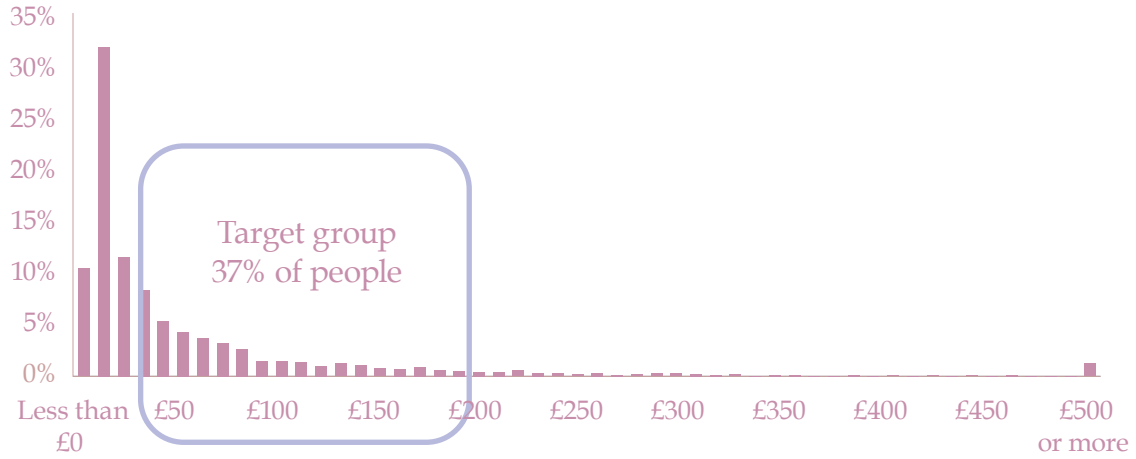
Chart 1[16]

The target group of people for care funding is around 37% of people

Distribution of savings levels among people in England aged over 50 (excluding pension and housing wealth). Target group is those with between £23,250 and £200,000 of savings.

Around 57% of people have net assets of less than the means tested threshold, and would therefore be eligible to receive Local Authority support when paying for care, and 6% of people have net assets of more than £200,000.

There may also be some homeowners and pension holders with no other savings who may still benefit from the proposals in this report, or who would need to use their home to pay for residential care.



15. PPI analysis of English Longitudinal Study of Ageing Wave 8 data
16. PPI analysis of English Longitudinal Study of Ageing Wave 8 data

Chapter Three: Possible approaches to individual care funding

Many of the proposals for trying to solve the problem of funding for social care in older age use existing savings and wealth. The proposals made fall in two categories of either being;

Insurance based, where the individual is buying an insurance product that will cover some or all of the costs of care as they fall due, or

Individual funding, where the person is being offered a way to use their own money to efficiently pay for care if and when required.

Individual funding approach to care funding

The proposals in this paper that are referred to as individuals funding their own care, are where individuals pay for care as it falls due, with payments made from their own assets or income. They use wealth that individuals already have, that would not necessarily be used for providing care, such as their ISA savings, or home equity.

The proposals that use this approach tend to encourage the government to offer tax relief on payments toward care, and to improve individuals' ability to access money that may otherwise be difficult to use. People do not tend to anticipate and save specifically for care, with many either assuming that the government pays for care[17] or that they will not be affected.

However, they may have other assets or savings such as property or an ISA, which they had no fixed plan for using for any other financial need. It may therefore be a welcome approach for some individuals to be able to use specifically designed products that are responsive to care needs and/or to receive some form of government incentive in using assets to pay for care.

For an individual, they don't necessarily have to make any prior arrangements, instead using the product at the point at which they have the care need. Also, they will only have to make payments for care if the need actually arises, in the case of having no care need, they suffer no financial detriment. However, in the case that they do have a care need, they may face very large costs which might substantially deplete their assets.

17. Commission on Funding of Care and Support (2011)

Insurance approach to care funding

Individuals pay a premium, or series of premiums, to an insurance company and in return receive money when a (pre-defined) care need occurs, which covers some or all of the cost for which they are responsible.

An insurance market needs the following in order to exist:

Insurance companies who are willing to insure against a risk happening, and

A customer base that is keen to protect themselves from the risk.

In order for a risk to be insurable, insurance companies may require that there is a limit to the amount that they may be required to pay out in a claim. Currently there is no limit on the potential cost of care needs while they are required, however the introduction of a cost cap could provide a limit. This may provide greater certainty for insurance providers depending on how it is designed. In the absence of a cap the insurer could make use of reinsurance arrangements, where the insurer itself takes out insurance against the more extreme costs.

Also required is a customer base of people who are keen to protect themselves from the financial implications of care. There is no significant demand for care insurance products, possibly because it is something that people mistakenly think the government pays for as part of the NHS, or they do not like to think about the possibility that they might need care and the costs that would come with it. The Dilnot Commission suggested a campaign to raise awareness of the implications of care.[18]

Care insurance may require a large premium to purchase, industry estimates are around £30,000[19] to cover care up to £100,000. However, reducing the coverage amount could also reduce the cost. This is a lot of money and even those who are attracted to care insurance may find it difficult to access that amount of money. The insurance-based proposals in this paper attempt to address this issue by providing ways to access large value assets, such as pension funds or housing wealth, to pay for insurance and some form of government incentive, for example tax relief on the insurance premium(s).

Duration of insurance

Insurance could be offered to cover either a specific period of time ("term insurance"), or for the rest of the customer's life ("whole life insurance").

Term insurance:

- is likely to be less expensive than whole life insurance because it covers a shorter period of time, but this may not be the case for the total cost, if the customer keeps renewing insurance contracts for the rest of their life;
- may also give insurers the opportunity to review the conditions of insuring someone more regularly, perhaps in light of changing economic or political circumstances within the care funding world;
- but it could lead to people who see themselves having a more likely immediate need for care taking out a policy. This could make the pool of customers unrepresentative of the general population and require a corresponding increase in the premiums.

Whole life insurance:

- offers the customer peace of mind that they have protection for the rest of their life;
- may be less prone to people taking out insurance with knowledge or belief about an impending care need;
- however, it is likely to have a higher upfront cost than term assurance, making it less appealing to some customers.

18. Commission on Funding of Care and Support (2011)
19. This £30,000 figure is purely indicative, in a competitive market prices may change.

Structure of premiums

Premiums to the insurance company can either be paid as a series of premiums throughout the term of the insurance up until care is required ("regular premiums") or as a single upfront lump sum ("single premium"). There are pros and cons to the individual and to the insurer of each approach.

The pros and cons of regular premiums reflect the lower monetary amount that is paid in each instalment:

PROS OF REGULAR PREMIUMS:	CONS OF REGULAR PREMIUMS:
• More manageable cost for the individual, lower upfront cost and may match more closely with a regular income. • The provider may have some scope to adjust premiums to avoid inflation risk.	• Higher admin cost to the insurer because of the processing of the premiums, leading to higher required premiums. • There may be lapsed policies, where people fail to make premium payments. This creates uncertainty for the insurer, which, when taken into account in pricing the policy, will lead to higher required premiums. • The individuals who require care earlier pay fewer premiums than those who require care later, creating a cross-subsidy.

The pros and cons of a single premium are largely a mirror image of those for regular premiums:

PROS OF SINGLE PREMIUMS:	CONS OF SINGLE PREMIUMS:
• The total cost is paid upfront so there is certainty for the insurer, there will be no lapses so no need to include the risk of lapses in setting premiums. • A single payment requires less administration which doesn't require a corresponding increase to the premium. • The timing of when people require care doesn't affect the total amount of premium paid, removing the cross-subsidy present under the regular premium. • A single premium may be consistent with people using a one-time source of money to pay for it, for example a lump sum from a pension, or using equity release.	• The single premium may be seen to be expensive because the whole of the cost of cover is required at once. This could make it unattractive to the customer.

Framing the benefits of care insurance

The benefit of taking out a care insurance contract can be framed in more than one way. It could be presented as providing peace of mind that care costs (though perhaps not hotel costs) will be covered if required, or as protection against the erosion of assets in the case of a care need arising. For example, it has been suggested that care insurance might be characterised instead as inheritance insurance, a framing of the consequences of care costs which may serve to highlight the risks that care can present.[20]

In an insurance product, the interests of insurers and policyholders align in wishing to avoid circumstances that require care. Insurers have an incentive to help policyholders with preventative measures, such as regular check-ups, interventions at an earlier stage of need, and home adaptations, all designed to capture and halt burgeoning care needs. If the insurance company gets involved at an earlier time than care services otherwise would, people may get help sooner, in some cases avoiding or delaying the need for care. This could also mean lower Local Authority expenditure.

Care funding proposals considered in this paper

The following are a brief description of each of the proposals considered in this paper.

Proposal 1: Relief from income tax on pension income used to pay for care

The first proposal considered is to take the treatment of an existing product, the immediate needs annuity, and apply it to pension income. Payments from pensions, either through annuities, Defined Benefit income, or pension drawdown products that are made to care providers would be exempt from income tax.

Proposal 2: Use pension withdrawals to secure an insurance product that covers care costs.

The second proposal considered is to purchase a form of care insurance, using a drawdown fund. This could be either a single premium payment at retirement, or perhaps with regular premiums. The insurance company then pays off future care needs if they should arise during the period of cover. A premium (which is paid tax free out of the pension pot in a drawdown environment) might either buy whole of life cover or regular premiums which could be used to purchase a period of cover, for example one year of cover.

Proposal 3: The introduction of a Care ISA with no Inheritance Tax paid on residual amounts at death.

The third proposal considered is to use people's propensity to save in ISAs to fund care by introducing a Care ISA. The Care ISA would provide a fund earmarked for use to pay for care. This means it is identified within the individual's mind as being associated with care and there is some incentive to avoid accessing it until required to pay for care. The incentive for leaving the funds is that any left-over money in the Care ISA is free of Inheritance Tax upon death.

Proposal 4: Releasing equity from a property to secure an insurance product that covers care costs.

The fourth proposal considered is to release equity from a property to purchase a care insurance product. In the case that an insurance market for care cover develops, the cost of the insurance could be paid for differently by different generations. In particular, the current older generation could pay for care insurance by releasing equity in their home, either by downsizing or by an equity release product.

20. Royal London (2018)

Proposal 5: Pledging equity from a property to cover care costs.

The fifth proposal considered is for the government to incentivise people to pledge a proportion of the equity in their home to cover care costs should they arise. The pledge may take the form of a legal charge against their property, with the pledged amount appearing in a "care account", a record of assets pledged to pay care costs which is also used to establish the level of government incentive offered. Government incentives for this proposal could include a pledge to match a proportion of the individual's own pledge, or relief of Inheritance Tax on the pledged amount.

Subsequent chapters discuss each of these proposals in more detail. The structure of each chapter is:

- A description of the proposal;
- The impact on individuals;
- The impact on financial product providers;
- The impact on Government;
- Asset prevalence and value; and
- An illustrative case study.

The asset prevalence and value analysis uses the concept of the target group set out in Chapter 2. That is that the people analysed are those who may be most likely, from a financial point of view, to require care funding. The target group consists of those with assets over the means test threshold, but below £200,000.

Chapter Four: Proposal 1 - Relief from income tax on pension income used to pay for care

Proposal 1: Income from a pension scheme is used to pay for care, and is exempt from income tax.

Description of the proposal

The first proposal considered is to take the treatment of an existing product, the immediate needs annuity, and apply it to pension income. Payments from pensions, either through annuities, Defined Benefit income, or pension drawdown products, which are made to care providers would be exempt from income tax. This would relieve tax from pensions, in a similar way that they are for immediate needs annuities.

Currently, the income paid from an immediate needs annuity is not taxed where it is paid directly to a care home provider. It is a form of purchase life annuity, bought with money that has already been taxed – usually from existing savings or from sale of a home. As such, the tax incentive is modest. If someone wanted to use a pension to buy an immediate needs annuity, they would need to access their pension as a lump sum and therefore incur tax at their marginal rate. Given the cost of care, this would very likely mean that some of that withdrawn pension would be taxed at the higher rate of income tax.

At its most basic, this proposal would mean that an immediate needs annuity could be bought with a pension, and therefore no income tax would be paid on the annuity payments. This would create an incentive to leave money aside in a pension, so that an annuity can be bought later in life to guard against the risk of running out of money. If the need does not arise, the money can be passed on to a beneficiary within the pension wrapper.

The proposal could be extended so that a Defined Benefit pension is treated in the same way, although this would not have any incentive to leave money aside as the choices within a Defined Benefit pension are much more limited; or it could be extended to payments from drawdown, although there would be no risk pooling and the individual would still risk running out of money.

This proposal is largely a behavioural intervention, aimed at trying to get individuals to save more during their working life, or to be aware of the possible need for care in later life and adjust their pension withdrawal accordingly, in order to be in a better position should a care need arise.

Impact on individuals

This proposal does not generate a new source of personal income to pay for care, instead it enables current pensioners to use an existing income more tax efficiently. For people with pension income who may be paying for care out of that income, it would give them a significant boost in purchasing power.

This may therefore reduce their need to rely on other assets, for example reducing the need to sell assets or release equity from their home. This preserves their wealth and may in turn may allow them to leave a larger bequest on death.

For people in employment the proposal could benefit people of all income levels that have to make a payment for their own care and do so using pension income. This proposal may function both as an incentive to save in a pension scheme and also as a tax-efficient fall back for people with pension savings with no specific care savings, who have assets and savings which are over the means test threshold.

In addition to helping people currently receiving care, the knowledge that pension income could be an efficient way to save for care, as well as retirement income, could incentivise pension savings. As a result of incentivised additional saving, retirement outcomes could be increased for people whether or not they have a care need in later life.

Proposal 1 provides for payments from a pension scheme to be tax free. A pension scheme is already a tax advantaged savings vehicle, because the contributions made into the pension scheme are from tax free income, the investment returns are also tax free. Allowing tax relief on taking money from the pension scheme to pay for care essentially makes that payment completely exempt from tax.

The proposal aims to make care more affordable. More affordable formal care could lead to a shift from informal care to formal care. However, there is a risk that the proposal, which in effect subsidises spending on care, could lead to care providers simply increasing their prices to capture all or part of the subsidy, leaving the individuals no better off.

Impact on financial product providers

There is some certainty in annuity payments that may appear to make them a natural route to explore specific tax treatment, but the approach could equally be applied to drawdown income, increasing the reach to a wider audience.

If it were limited only to annuities, then the approach may be beneficial to the pension annuity market which, witnessed a reduction in the number of annuity providers as a result of reduced demand following the Freedom and Choice reforms.

Annuities are not the standard method of providing a retirement income now for people with Defined Contribution pension schemes, however this measure, if limited to annuities may make annuities more attractive. There could be an increase in administration costs if the tax treatment were to cause complications to the pension administration.

The measure would make pension saving more attractive if there is a culture of being engaged in care funding. There is not currently much engagement with care saving in England, so people may not take it into consideration when making decisions about their pension savings. Part of the problem with care funding, as identified by the Dilnot Commission, is that people don't think about care funding for themselves.[21]

Impact on government

There is a cost to government in terms of the tax relief given on pension income used to pay for care. This tax cost is ongoing during the period that such pension payments are being used to pay for care.

Under the current system, the contribution of individuals to care costs is around £2.2 billion a year. If, in an extreme case, tax relief at 20% could be claimed on all of that spend, then the cost to the government could be around

21. Commission on Funding of Care and Support (2011)

£440 million a year. This cost is very much an extreme and assumes that all the money spent on care by individuals would be eligible for tax relief. The actual amount eligible for tax relief would likely be lower, so the cost of the tax relief would also be proportionally lower.

Informal care is much more prevalent than formal care, so if the perception of formal care as being more affordable caused a shift from informal care to formal care, that cost could increase significantly.

There could be a long term saving to Local Authorities. The tax relief may make it less likely that assets will be depleted, which could otherwise have led to requiring Local Authority funding of care.

Asset prevalence and value

Annuities and Defined Benefit pension incomes

Annuities are guaranteed incomes for life purchased using the fund accumulated in a Defined Contribution pension pot. However, pension payments from Defined Benefit pension schemes also provide a guaranteed income for life in a very similar way. This suggests Defined Benefit pension incomes could also be used as a tax free source of income when paying care in the same way.

Table 1 shows the proportion of people over age 50 in England in the target group (Chapter 2) who have either an annuity or a Defined Benefit pension in payment by age. If the proposal was implemented and limited to annuity or Defined Benefit income then these are the people who may currently be able to make use of it, this is around 3.8 million people, of the 7.6 million people in the target group.[22]

Large proportions of pensioners have access to some income that could be used under Proposal 1 to make care payments on a tax-free basis. However most of these people would be able to do so through Defined Benefit pensions rather than annuities.

Table 2 brings both these two populations together, to set out the distribution of total guaranteed private pension income (either annuity or Defined Benefit income).

Table 1: Proportion of people over 50 in the target group with incomes from annuities or Defined Benefit pensions[23]

Age Group	Have annuity income	Have Defined Benefit income	Have either annuity or Defined Benefit	Have no guaranteed private pension
50 – 54	0%	11%	11%	89%
55 - 59	5%	22%	26%	74%
60 - 64	12%	43%	50%	50%
65 - 69	30%	48%	66%	34%
70 - 74	35%	51%	71%	29%
75 - 79	33%	44%	66%	34%
80 - 84	26%	46%	66%	34%
85 - 89	22%	44%	57%	43%
90 and over	16%	34%	44%	56%

22. PPI analysis of English Longitudinal Study of Ageing Wave 8
23. PPI analysis of English Longitudinal Study of Ageing Wave 8

Table 2: Total guaranteed private pension income of those with annuity or Defined Benefit pension income within the target group (£ a year)[24]

Age Group	10 percentile	25 percentile	Median	75 percentile	90 percentile
50 - 54	£8,200	£8,400	£15,700	£21,000	£31,200
55 - 59	£2,300	£4,900	£12,000	£19,900	£25,200
60 - 64	£1,300	£3,600	£9,600	£16,100	£21,600
65 - 69	£1,200	£3,200	£7,400	£15,500	£24,000
70 - 74	£1,200	£2,900	£7,400	£14,400	£23,100
75 - 79	£800	£2,400	£6,600	£12,800	£18,500
80 - 84	£1,400	£2,900	£6,800	£13,600	£19,600
85 - 89	£1,500	£3,700	£6,600	£11,700	£15,900
90 and over	£1,100	£2,800	£5,800	£13,000	£20,100

There is a wide range of income from private pensions, in payment, and the number of people who may be able to use the proposal depends on what limits the government puts on the type of pension that could be used. For many current pensioners their pension income comes from their former employer's Defined Benefit pension scheme. However, employers have tended to switch to Defined Contribution pension schemes for employees which, coupled with the increase in pension saving from automatic enrolment, will result in greater numbers of people retiring with Defined Contribution pension benefits.

People who are approaching retirement may be incentivised to take the tax relief on care payments into account when deciding how to access their pension fund. Around 25-30% of people aged between 50 and 59 in the target group have un-accessed pension savings. The levels of pension savings may not be enough to be able to live comfortably now, while also being careful about the size and timing of withdrawals such that a large chunk is set aside for future care needs (Table 3).

As younger generations, those currently aged 20–40, reach retirement, they are more likely to have pension savings. This is a result of automatic enrolment. However automatic enrolment minimum contributions are quite low, so the size of the pension pots at retirement may still not be enough for most people to set aside pension funds to pay for care.

Table 3: Distribution of un-accessed pension funds amongst people in the target group approaching retirement

Age Group	10 percentile	25 percentile	Median	75 percentile	90 percentile
50 - 54	£3,000	£16,000	£27,500	£87,500	£233,000
55 - 59	£5,000	£22,000	£50,000	£120,000	£220,000
60 - 64	£16,300	£23,000	£103,000	£230,000	£250,000

24. PPI analysis of English Longitudinal Study of Ageing Wave 8

Illustrative case study

For an illustrative pensioner couple, the effect of the policy could be to allow a greater purchase of care before needing to deplete assets to pay for care.

- An average pensioner couple has an income, after housing costs, around £560 per week.[25] This means that whoever has the higher income (driven by private pension income) is likely to be paying income tax at the basic rate of 20%.
- Typical expenditure after housing costs for a pensioner couple is around £500 per week.[26]
- This illustrative couple would therefore be able to save around £60 per week.

This couple are assumed to have savings and assets above the level of the asset threshold, so they are liable for home care costs.

The cost of home care is around £15 per hour,[27] so as things stand this couple would be able to afford around 4 hours of care per week before they need to start spending down their savings and assets.

Under the policy, the tax advantage would enable them to purchase an additional hour of home care each week without spending down their assets or making other economies.

If they needed two hours of care per day this would cost £11,000 per year. Without the policy in place they would have to spend £7,800 of their assets each year; this would be reduced to £5,600 with the tax break in place.

25. DWP (2018) Table 2.1
26. ONS (2019) Table A55
27. The Money advice service (2018)

Chapter Five: Proposal 2 - Using pension funds to purchase care insurance

Proposal 2: Use tax exempt pension withdrawals to secure an insurance product that covers care costs.

Description of the proposal

The second proposal suggests that premiums for an insurance product to pay for care could be taken tax free from a pension, the insurance company then pays off future care needs if they should arise during the period of cover.[28] The premiums could either come in the form of:

A single premium, which in this report is considered at £30,000 but may vary with age, need and the amount of cover required,

Regular premiums, which may also vary with age, need and the amount of cover.

At the time of a claim when a care need arises, which could be based on an assessment of activities of daily living, the benefit could be in the form of:

- A single lump-sum payment.
- Regular payments, which could go to either the individual or direct to the care provider.

This benefit could be:

- Capped, paying up to a set amount ('sum assured') for care costs.
- Unlimited, and meeting all future care costs for life.
- Unlimited costs for a set period of cover purchased. e.g. 1 year.

28. Royal London (2018)

The conception of the product is that this could be integrated into the drawdown pension product.

In order to consider care costs as an insurable risk, the insurance company could place a cap on the amount paid out. This could integrate well with a government set care cap on an individual's liability to care costs (though hotel costs in residential care are unlikely to be capped). In the absence of a government cap, the insurer would set a cap on the amount they would pay out, potentially leaving the individual open to the risk of meeting extreme costs over and above the level of the insured amount.

Proposal 2 is a behavioural intervention, it is the offer of an incentive of reduced tax on the pension scheme proceeds in order to encourage people to take out insurance against the costs associated with care.

Without a product it is not possible to say exactly what the cost would be, however for the purposes of this paper we consider an indicative on-time premium cost of £30,000 at retirement for cover up to £100,000 of care costs, this is purely indicative, in a competitive market prices may change. However, it may be possible for people to adjust the cover level for a correspondingly higher or lower premium.

Impact on individuals

Proposal 2 uses a drawdown product with an integrated insurance, so within the insurance part there is pooling of the risk across all the policyholders. In return for a premium, the individuals are protected from the risk of high costs in the event of expensive care needs.

As an insurance product, some people will pay for it but never receive a pay-out from their policy, this can make such products unattractive, so some form of minimal pay-out could be made on death without a claim. Such a guaranteed pay-out will add a small cost to the premium, causing a trade-off between the advantages of a small guaranteed pay-out or a lower premium.

The premium is tax free, which may serve as an incentive when comparing to other forms of care insurance without a tax incentive. Similarly to Proposal 1, Proposal 2 offers a further tax advantage on pension savings which are already tax advantaged, (being from tax-free contributions and tax-free investment return), essentially making the insurance premium completely exempt from tax.

It might be more attractive to potential clients if presented as inheritance insurance as opposed to care insurance. The product reduces the potential cost of care, resulting in money possibly being left as an inheritance.

The proposal uses a drawdown fund at the point of retirement, which could exclude people who don't have the type of pension fund that could be used in that way (for example, Defined Benefit pensioners or those who would prefer to buy an annuity).

There are increasing numbers of individuals who transfer Defined Benefit benefits into drawdown arrangements to take advantage of pension freedoms, who may then be able to buy a product containing the insurance. However, this would be a significant step, which would require careful consideration and financial advice. The people who have made these transfers may have significant reasons for doing so, for example, because they are in bad health and intend to pass money on. Therefore only some of the people who make these transfers might be in a position to take up care insurance.

Future cohorts may be more likely to have Defined Contribution pension schemes, so might be more likely to be in the market for pension drawdown.

In a fund that is being drawn down at 3.5% per annum of the initial fund, a reduction in the fund size of £30,000 would mean a reduction in the pension withdrawn of around £1,000 a year, £800 after basic rate tax.

It is also possible that other sources of funds could be used to pay for the insurance, however these would be separate from integrated drawdown pension products.

Impact on financial product providers

For insurers this would provide a new product market. A provider could take the opportunity to be the first to create an innovative product and gain early market leadership.

Providers may wish to offer a way of enabling people who are already in a drawdown product to switch to a drawdown product with integrated care insurance. This would open up the market to people who had taken drawdown before the policies are developed.

It would be expected that financial advice is required, explaining to potential clients; the nature of the product, the upfront cost and comparison to the potential costs of care in the absence of such insurance. The tax relief on the premium would allow advisors to favourably present the care insurance as an efficient means to prepare for care, or to protect against the high costs of uninsured care.

The interests of insurers and policyholders may align in wishing to avoid circumstances that require care. Insurers would have an incentive to help policyholders with preventative measures, this could be very beneficial to policyholders. If the insurance company gets involved at an earlier time than care services would otherwise, people could get help sooner, in some cases avoiding or delaying the need for care.

Impact on government

Allowing a tax-free payment to be made from the pension product incurs a cost to the government. The timing of the cost to the government depends on how the pension income drawn from the fund is affected.

The cost to the government also depends on how many people take up the policy. Around 600,000 people reach State Pension age in England each year, if 1% of those people chose to take out a policy based on Proposal 2 at a premium of £30,000, the cost of tax relief to the government would be around £36 million. (This is a purely indicative figure.)

If an individual chooses to drawdown their fund by taking the same pension as they would have done without the insurance add-on, the government receives the same tax revenue cashflows, until the reduced fund level affects the pension drawn. Hence the cost to the government is effectively deferred. If the pension drawn is reduced immediately, then there is an immediate cost to the government. However, the entire cost of the tax relief is essentially amortised over the length of the pension being drawn down.

There could be a long-term saving to Local Authorities. Insurance cover makes it less likely that assets will be depleted, which could have otherwise led to requiring Local Authority funding of care. In addition, the incentive for the insurance company to provide preventative help may reduce the overall incidence or severity of care needs. With insurance there may be less call on Local Authority funds for care.

Asset prevalence and value

The proposal is aimed at people as they first access their pension and are making decisions about their future income needs and considering the possibility of requiring care in the future. The most representative age group data for people as they approach retirement may be the 55-59 group. The data in this age group is not affected by a significant proportion of people already having accessed their pension.

The number of people within the target group[29] between ages 55-59 who have some un-accessed Defined Contribution pension is around 29% (Table 4). However the coverage of pension savings is likely to increase when subsequent generations retire, as a result of automatic enrolment.

Table 4: Proportion of people in each age in the target group with undrawn pension[30]

Age Group	Have un-accessed pension
50 - 54	24%
55 - 59	29%
60 - 64	14%
65 - 69	4%
70 and over	0%

29. See Chapter 2

30. PPI analysis of English Longitudinal Study of Ageing Wave 7

Taking out care insurance, particularly with a lump sum would use up a sizeable amount of the pension fund for most people. Within the target group many people do not have enough un-accesssed pension to pay a £30,000 premium (Table 5).

Table 5: Distribution of un-accessed pension funds[31]

Age Group	10 percentile	25 percentile	Median	75 percentile	90 percentile
50 - 54	£3,000	£16,000	£27,500	£87,500	£233,000
55 - 59	£5,000	£22,000	£50,000	£120,000	£220,000
60 - 64	£16,300	£23,000	£103,000	£230,000	£250,000
65 - 69	£2,500	£2,500	£38,000	£38,000	£38,000
70 and over	£0	£0	£0	£0	£0

In the data for the 55-59 age group, the group that might be approaching retirement with most of their funds intact, the median un-accessed fund is £50,000 (Table 5). This is more than the illustrative cost of care insurance but if taken could significantly reduce the pension income available from the fund.

Those at the 75th percentile have £120,000, at retirement, taking the 25% tax free lump sum would leave around £90,000. Using the remaining £90,000 to provide a drawdown of 3.5% a year would give a private pension income, before tax, of around £3,100 a year. If £30,000 were paid as an insurance premium, the remaining £60,000 would provide a drawdown income of £2,100 a year. For the 90th percentile person, the difference on the same basis would be an income from the pension fund of £5,775 without the insurance, compared with £4,775 with the insurance.

While the pension fund at retirement is for many people a large pot of money, spending £30,000 of it at the point of retirement on an insurance premium would have a significant impact on the future income that could be drawn. This may be too much for many people, limiting the attraction of the proposal. Around 460,000 in the target group have more than £30,000 un-accessed money in their pension fund, of whom around 230,000 have more than £100,000.

The data pre-dates the pension freedoms which led to a surge of transfers from Defined Benefit pensions to Defined Contribution which may mean that these figures understate the number of people with access to large Defined Contribution pots. However, the reasons for the transfers should also be taken into account when analysing that data, it may be the case that transfers were selectively undertaken by people with a reduced life expectancy in order to maximise their bequest.

In the future, the prevalence of Defined Contribution pension savings will increase as a result of automatic enrolment. However, the size of the resulting pension funds will depend on the level of contributions, and asset returns.

31. PPI analysis of English Longitudinal Study of Ageing Wave 7

Illustrative case study

For an illustrative pensioner retiree with a Defined Contribution pension pot, the effect of the policy could be to protect their house and other assets in the case they need care.

- A typical Defined Contribution pension saver retiring around 2030 could have a pot worth £50,000, a small amount of Defined Benefit entitlement around £2,000 per year and entitlement to a full new State Pension around £8,500.[32]
- They own a house and have other financial assets which make them ineligible for care support.
- Drawing a sustainable rate of 3.5% plus CPI will give them an income of £12,300.

Purchasing insurance at, for example, £30,000 when they retire to protect them against £100,000 of care costs could pay for around three years of care home costs.[33] If there is a care cap of £100,000 implemented, this would ensure that they have no further liability to their care costs and they will be able to leave an inheritance.

After paying the insurance premium their income may be reduced from £12,300 to £11,300, but is covered for the costs of a care need arising up to £100,000. Without insurance they will be liable for £100,000 which will need to be met from their assets.

32. PPI (2018)
33. The Money advice service (2018)

Chapter Six: Proposal 3 - Care ISA

Proposal 3: The introduction of a Care ISA with no Inheritance Tax paid on residual amounts at death.

Description of the proposal

The third proposal is to use people's propensity to save in ISAs to fund care by introducing a Care ISA. The Care ISA would provide a fund earmarked to pay for care. This means it is identified within the individual's mind as being associated with care and there is some incentive to leave it alone unless required to pay for care. The incentive for leaving funds in the Care ISA is that the return on the funds invested is tax free and any left-over money is free of Inheritance Tax upon death.[34]

This approach may raise awareness for the need to provide for care in people who are currently in their 60s and 70s, and encourage them to keep some of the savings they have already built up. The Care ISA would, to some extent, either by branding or by some form of ring-fencing arrangement, be allocated to be exclusively for care purposes. Money could be transferred in from existing ISA savings, or from new savings.

The Care ISA is intended as a funding vehicle, to provide money in the event that a care need arises for the individual. This is to encourage people to put aside some of the savings they have already built up toward potential care costs. It is not an insurance policy, there is no pooling of risk.

Proposal 3 is a behavioural intervention, it is the offer of a tax incentive in order to encourage people to maintain a fund of assets specifically earmarked to pay for the costs associated with care.

Impact on individuals

ISAs are a popular savings vehicle that many people[35] have experience of saving with. This could make a Care ISA a product that people feel they understand and are therefore attracted to.

34. The Care ISA in this form was suggested by Ros Altmann. Altmann, Ros (2018)
35. PPI analysis of English Longitudinal Study of Ageing Wave 8 showed that around half of people over 50, and around three quarters of the target group have ISA savings.

The individual only benefits from the incentive (Inheritance Tax relief) if they would otherwise have been subject to Inheritance Tax. The majority of individuals are not subject to Inheritance Tax; data from 2015/16 indicated that only 4.2% of UK deaths were subject to Inheritance Tax,[36] this could limit how attractive the policy is to most people.

A potential drawback of the Care ISA is that it may be susceptible to abuse by people who are aware they are approaching death, but who try to use the Care ISA in order to avoid Inheritance Tax. This could be addressed somewhat by placing restrictions on the eligibility for tax relief, for example a minimum time period for money in the Care ISA.

The money within the Care ISA may be the money that people who end up requiring care would have been using to pay for the care irrespective of whether labelled a Care ISA or a regular ISA.

The possibility of reduced Inheritance Tax may not be a large enough incentive to encourage people to actively save into a Care ISA, but it may act as an incentive for people who already have an ISA to choose to allocate some toward care needs.

Impact on financial product providers

The impact on financial product providers is unclear. The introduction of a Care ISA would not necessarily bring more money into savings if people embrace the policy, it may just be a diversion of existing savings. However, this would not necessarily be a failure of the policy, which is intended to encourage an allocation of funds for care, rather than to necessarily increase saving.

The investment portfolio for a Care ISA might be different from the existing ISA, for example investment in liquid assets to enable fast cashing out when required. Allowing flexibility of moving money into or out of a Care ISA may be difficult, and it may be the case that providers choose to offer products with funds locked away instead.

The exemption from Inheritance Tax could increase regulatory oversight, leading to more expensive administration of the funds.

Impact on government

The government would face a cost resulting from the relief on Inheritance Tax. However, there is no up-front cost to the government on tax relief, the tax relief promise is only payable when people die.

The Government may also have to take steps to avoid people using the Care ISA simply as a tax avoidance vehicle. The risk of misuse arises because the tax benefit is payable on money that is not used to pay for care, so people who do not have a care need, but are aware that they don't have long to live could put money into the Care ISA in an attempt to protect themselves from Inheritance Tax. However, any government limitations to combat misuse which also impact on people who had a true care need, but died very soon after, could lead to negative publicity and mistrust of the Care ISA.

The cost to the government is in giving Inheritance Tax relief on the remaining amount in the Care ISA at death, so there is only a cost in the case of individuals who would otherwise have been subject to Inheritance Tax. Only around 4% of deaths in the UK result in any Inheritance Tax being due.[37] Assuming there is a cap on the level of assets in the Care ISA of £50,000 and that those who would be subject to Inheritance Tax keep the Care ISA topped up, then the cost to the exchequer could be around £350 million a year.[38]

Asset prevalence and value

ISA investment is quite prevalent among older people as a whole, with more than half of English Longitudinal Study of Ageing (ELSA) respondents having an ISA investment.[39] Among the target group it is even more prevalent, with around three quarters of the target group having ISAs in almost all age groups (Table 6).

36. HMRC (2018)
37. HMRC (2018) In 2015-16, 4.2% of UK deaths were liable to Inheritance Tax
38. PPI calculation
39. PPI analysis of English Longitudinal Study of Ageing Wave 8

Table 6: Proportion of the target group in each age group with ISA product[40]

Age Group	Have ISA	Do not have ISA
50 - 54	86%	14%
55 - 59	81%	19%
60 - 64	89%	11%
65 - 69	88%	12%
70 - 74	85%	15%
75 - 79	86%	14%
80 - 84	81%	19%
85 - 89	76%	24%
90 or over	70%	30%

The high proportion of people with ISA investment could mean that there are a large number of people who understand ISAs and might be readily able to extend that knowledge to the concept of a Care ISA. However it may also be the case that one of the things that they like about ISAs is the lack of complications.

ISA savings, while prevalent are skewed in the value that people hold, with most people in the target group having relatively modest levels of savings (Table 7). The median savings level for members of the target group is on average around £35,000 for each of the age groups.

The distributions of savings is relatively consistent in each age group which might suggest that people don't tend to spend their ISA savings on pre-planned purchases.

Table 7: Distribution of ISA savings among the target group[41]

Age Group	10 percentile	25 percentile	Median	75 percentile	90 percentile
50 - 54	£6,000	£19,500	£39,000	£53,000	£90,000
55 - 59	£4,000	£15,300	£38,000	£60,000	£112,500
60 - 64	£6,000	£15,000	£31,500	£72,000	£122,000
65 - 69	£8,000	£20,000	£38,000	£73,000	£128,000
70 - 74	£10,000	£20,000	£36,000	£72,000	£115,000
75 - 79	£5,000	£14,000	£25,000	£55,000	£105,000
80 - 84	£6,000	£14,000	£29,000	£60,000	£124,000
85 - 89	£7,000	£15,000	£26,000	£46,000	£70,000
90 and over	£8,000	£20,000	£25,000	£50,000	£90,000

Around 2.3 million people in the target group have ISA savings of over £50,000, of whom around 900,000 people have ISA savings of more than £100,000.[42]

The important element in the appeal of the Care ISA may be whether the individual is likely to be liable for Inheritance Tax. Only around 4% of deaths are subject to Inheritance Tax[43] so it may only be people with the highest levels of saving that have an incentive to use a Care ISA.

Inheritance Tax is paid by people with an estate valued at over a threshold of £325,000 of assets (or £450,000 if the estate includes the value of a house). It is not paid when people leave their estate to their spouse, or civil partner. Widowed individuals can also inherit any unused portion of their late partner's allowance, which means the threshold for an individual can be up to £900,000. So the people liable to Inheritance Tax may not include many of our target group, and may also not be the people who are the focus of the Government's upcoming care Green Paper.

The low number of people who are subject to Inheritance Tax may mean that the Care ISA does not serve as an incentive to many people, however the size of the incentive could be significant to those who are likely to be liable to Inheritance Tax. If they are able to keep the Care ISA topped up at say, £50,000 then they could reduce their Inheritance Tax bill by £20,000.

40. PPI analysis of English Longitudinal Study of Ageing Wave 8, ISA products include cash ISAs, and stocks & share ISAs.
41. PPI analysis of English Longitudinal Study of Ageing Wave 8
42. PPI analysis of English Longitudinal Study of Ageing Wave 8
43. HMRC (2018)

Illustrative case study

For a pensioner with substantial financial and other assets they may choose to invest in a Care ISA.

- They have assets such that on death they would be liable to Inheritance Tax at 40%.
- Included in their assets is £50,000 invested in an ISA.
- They transfer the £50,000 of ISA savings into a Care ISA earmarked for future care needs.

At the point of needing care they have assets over the threshold level so will be ineligible for state support and will need to meet their own care costs. This will be the case whether they have used a Care ISA or not.

£50,000 may pay for several years of home care support, however it may only be enough to meet the cost of 18 months of residential care.[44] If they need a substantial amount of care they will have to spend down their wealth.

On death any money in the Care ISA will not be included in the value of the estate subject to Inheritance Tax. With £50,000 in a Care ISA (rather than any other form of ISA) their Inheritance Tax liability is reduced by £20,000 which can be passed on instead.

44. Average cost of residential care is between around £30k and £40k a year. Money advice service (2018)

Chapter Seven: Proposal 4 - Release equity to purchase care insurance

Proposal 4: Releasing equity from a property to secure an insurance product that covers care costs.

Description of the proposal

The fourth proposal is to release equity from a property to purchase a care insurance product. In the case that an insurance market for care cover develops, the current older generation could pay for care insurance by releasing equity in their home, either by downsizing or by an equity release product.[45]

The proposal would leverage the high incidence of home ownership amongst older people. And, being an insurance based proposal, limits the outgoings of the individual.

This is an insurance approach and in that way is, similar to Proposal 2, the main difference being the source of the money used to pay for the premium. As such the two proposals could co-exist.

Impact on individuals

This is an insurance approach, so there is risk pooling, making it cheaper for those who do require care but 'lost money' for those who do not. As an insurance product it would limit the impact of care costs to simply the premium. This could allow people who do not have a drawdown pension fund, but who do have property to be able to make the large one-time insurance premium of around £30,000 to pay for care.

In the case of a cohabiting couple, the housing wealth would have to be used to cover both lives. This could severely reduce their net housing wealth.

The focus of the proposal is on people with housing wealth, which is a large proportion of the older population.[46] However, around 20%

45. A proposal of Damian Green. Reform (2018)
46. PPI analysis of English Longitudinal Study of Ageing Wave 8

of older people in England do not have housing wealth, this emphasises the need for a range of solutions to the care funding question.

As formulated there isn't a tax incentive for individuals to purchase care insurance using their housing wealth. The suggestion of using housing wealth to pay for care has been unpopular in the past, especially if people feel it will reduce their ability to make a bequest. Similar to Proposal 2, the purchase of care insurance could be presented as using a portion of housing wealth to purchase insurance to reduce the potential spending of an individual on care, and protect the capacity to make a bequest, which could serve as an incentive.

However, equity release is a loan that is paid back out of the housing wealth from the estate of the borrower (or their spouse or civil partner if they are outlived) As such, using housing equity to pay for care insurance may be attractive as an affordable option because there is no tangible parting with assets, or any impact on current or future income until after death. In addition to the initial loan amount being paid back, there would also be an interest charge payable on death.

Impact on financial product providers

The impact on financial product providers is similar to that in Proposal 2. This would provide a potential new insurance product market. There could be the opportunity for product innovation and to obtain some advantage by being one of the first providers to offer the new type of insurance.

As in Proposal 2, it would be required that an appropriate financial advisor explain the product to potential clients, including the upfront cost, compared to the potential costs of care in the absence of any insurance.

The interests of insurers and policyholders align in wishing to avoid circumstances that require care. Insurers would have an incentive to help policyholders with preventative measures, this could be very beneficial to policyholders. If the insurance company gets involved at an earlier time than care services would otherwise, people could get help sooner, in some cases avoiding or delaying the need for care.

Proposal 4 is essentially simply using equity release to pay for care insurance. With no government intervention required through tax incentives, it may be possible that Proposal 4 could be offered by providers now.

Impact on government

There is not a cost to the Government associated with this proposal, because it doesn't have a tax incentive associated with it. In comparison with other tax advantaged options, a lack of tax incentive could limit the attraction to potential purchasers. There might be pressure on the government to offer some kind of tax incentive to encourage people to purchase care insurance in this manner.

Asset prevalence and value

Home ownership is prevalent among older people. Most people over age 60 own their home outright, after paying off their mortgage through their working life. Around 80% of all people in England over 50 own their own house, whether outright or with a mortgage. Home ownership is even higher among the target group, which is over 90% of people for those aged between 65 and 79 (Table 8).

Table 8: Home ownership among the target group by age group[47]

Age Group	Own Outright	Own with mortgage	Do not own
50 - 54	47%	43%	10%
55 - 59	67%	31%	2%
60 - 64	83%	14%	3%
65 - 69	90%	5%	5%
70 - 74	95%	3%	2%
75 - 79	94%	2%	4%
80 - 84	87%	3%	10%
85 - 89	81%	3%	16%
90 or over	87%	0%	13%

47. PPI analysis of English Longitudinal Study of Ageing Wave 8

Table 9: Distribution of house value of those in the target group who own their house outright[48]

Age Group	10 percentile	25 percentile	Median	75 percentile	90 percentile
50 - 54	£120,000	£170,000	£280,000	£350,000	£500,000
55 - 59	£170,000	£225,000	£350,000	£420,000	£650,000
60 - 64	£150,000	£200,000	£300,000	£425,000	£625,000
65 - 69	£150,000	£200,000	£300,000	£430,000	£625,000
70 - 74	£150,000	£200,000	£300,000	£450,000	£650,000
75 - 79	£130,000	£180,000	£290,000	£400,000	£700,000
80 - 84	£125,000	£180,000	£280,000	£400,000	£600,000
85 - 89	£130,000	£155,000	£250,000	£300,000	£450,000
90 or over	£100,000	£170,000	£245,000	£400,000	£500,000

The median house value for 65-69 year olds who own their house outright in the target group is £300,000 (Table 9) compared to £230,000 for those who have some outstanding debt on the house, after any debt amount.

The use of housing equity does not tangibly affect day to day income in the same way as using pension savings. This could make this proposal attractive to some of the people who fall in the gap of having enough assets to be over the means test threshold, but do not have enough pension savings to use the approach of Proposal 2.

Property is the highest value asset owned by most people in the target group, and most people have paid off their mortgage by the time they retire. Many people have housing wealth at substantial levels that might, under the right circumstances, be an appropriate source of funding for their care needs. Around 5.4 million people in the target group have housing wealth of over £200,000.

Over 80% of current pensioners in the target group own their home and the vast majority of those have housing wealth of more than the illustrative premium level of £30,000 (Table 9). If they were incentivised to buy care insurance, whether to protect against funding care costs or to protect an inheritance from being spent down, then using housing equity could be an attractive way for people to do so.

48. PPI analysis of English Longitudinal Study of Ageing Wave 8

Illustrative case study

For a home owning pensioner who may be liable for £100,000 of care costs up to a care cap they will be able to insure this by releasing equity from their home.

- They live in an average house worth around £230,000.[49] This would be taken into consideration when assessing care costs, so without insurance they may be liable for £100,000.
- Insurance can be purchased for a cost of £30,000 which could be met through equity release.
- For simplicity, the numbers are expressed in current house price terms and it is assumed that the interest rate on the equity release product is the same as the growth in house prices.

	Without insurance	With insurance
No care needs	House value to be bequeathed: £230,000. The house is passed on without further liability.	House value to be bequeathed: £200,000. Should there be a need for care costs these will be met through the insurance.
Care needs	House value to be bequeathed: £130,000. £100,000 will need to be raised, through equity release. This will take up over 40% of the house value reducing the size of the estate which can be passed on.	

Care needs are assumed to cost £100,000 to meet a cap.

If insurance is taken out, then the individual can make a bequest of £200,000 regardless of whether they face care costs. Without insurance, they may be able to bequeath the entire value of the house, but in the case of having care needs the bequest is reduced to £130,000 after money is released to pay for care.

This proposal is, therefore, about protecting the size of the legacy they can pass on. To be able to protect a larger legacy the purchase of insurance through releasing equity will ensure that most of the value of the house can be passed on.

49. HM Land Registry (2018)

Chapter Eight: Proposal 5 - Pledge portion of housing equity to fund care

Proposal 5: Pledging equity from a property into a care account to cover care costs in return for a corresponding government pledge.

Description of the proposal

The fifth proposal involves the government incentivising people to pledge a proportion of the equity in their home to cover care costs should they arise. The pledge may take the form of an irreversible (but transferable) legal charge against their property, with the pledged amount appearing in a "care account", a Government held record of assets pledged to pay care costs. The care account assets are reserved specifically for paying for care costs and are accessed following a Local Authority care assessment.[50]

The government could incentivise people to make a pledge by:

- Making a government pledge into the care account at a given proportion of the value pledged by the individual. The government pledge would be notional money at the time the pledge is made, only being paid if a care need arises, or
- Offering Inheritance Tax relief on any pledged amount that has not been used for care by the time of the individual's death.

50. The 'home equity pledge' concept has been developed by Just Group, a variant of which was explored in Demos (2014)

The money pledged to the care account would be called upon to provide the individual's contribution to the care costs. If there is no call on the care account at the time of death the legal charge is removed with no reduction in the house value on bequest, and the government pledge would be cancelled.

Proposal 5 is a behavioural intervention, it is the offer of a monetary incentive in order to encourage people to maintain a fund of assets specifically earmarked to pay for the costs associated with care.

Impact on individuals

This is an individual funding approach rather than insurance. The individual pays for their own care if a care need arises. However, if the individual does not require care they suffer no cost and can bequeath their property wealth intact.

The target market would therefore be individuals who have housing wealth.

In the case of a couple who both take a property pledge, the couple may be required to place two ring-fenced pledges on their property, which could be a sizable proportion of the value of their home.

The legal charge on the property would be transferable, but might limit the individual's ability to downsize. If the amount pledged is greater than the value of the downsized property, then the full pledge cannot be transferred. In this case the balance of the pledged amount may need to be taken from the proceeds of selling the larger property and deposited in the care account. This could be an unpopular restriction for people whose circumstances change, for example if they wish to join family or a support network in another part of the country.

Impact on financial product providers

At the point of a care need, money from the pledged amount needs to be accessed from the equity of the house. This could increase the market for equity release products, and it could encourage providers to develop innovative deferred equity release products, for example with flexible drawdown to meet care needs as they fall due.

This policy relies on equity being released when care is required. In this case, unlike in insurance-based solutions, the providers do not have incentives for care prevention, the sooner a product is purchased, the better for the equity release provider.

This is a complex proposal and may be very difficult for individuals to understand the full implications, it would require qualified financial advice.

Impact on government

With a notional government pledge incentive, the Government would not face an upfront cost as a result of the pledge, they would only be liable if care is required.

But the size of the means tested payments may be lower, because the individuals have resources specifically set aside for paying for their care, and have not used those assets for other purposes in the interim.

The level of the pledge proportion offered on funds pledged for care would be set by the government with reference to the likely cost, behavioural impact and might possibly be age related to encourage people to make pledges at younger ages.

Care funding and assessments are provided by Local Authorities. Portability of the care pledge would be eased with joined up services between Local Authorities, or for the care pledges to be centrally monitored.

If the government offered an Inheritance Tax incentive on pledged funds they would have a similar range of impacts as under the Care ISA proposal (Proposal 3). In particular:

- There is a cost resulting from relief on Inheritance Tax, however that cost is not an up-front cost, it is incurred at the death of the individual.
- The Government may need to take steps to avoid people misusing the pledge in order to avoid Inheritance Tax.
- Inheritance tax is only payable on around 4% of deaths in the UK so the incentive may not have great reach among the target population.

Asset prevalence and value

The assets used for funding care under Proposal 5 is the same as under Proposal 4, therefore, for ease of reference the tables from Proposal 4 are reproduced here.

Home ownership is very prevalent among older people. With most people over age 60 owning their home outright, after paying off their mortgage through their working life. Generally, around 80% of the ELSA respondents own their own house, whether outright or with a mortgage, however the figure is around 90% of those in the target group (Table 10).

Table 10: Home ownership among the target group by age group[51]

Age Group	Own Outright	Own with mortgage	Do not own
50 - 54	47%	43%	10%
55 - 59	67%	31%	2%
60 - 64	83%	14%	3%
65 - 69	90%	5%	5%
70 - 74	95%	3%	2%
75 - 79	94%	2%	4%
80 - 84	87%	3%	10%
85 - 89	81%	3%	16%
90 or over	87%	0%	13%

Table 11 sets out the distribution of house values of those in the target group who own their homes outright.

Table 11: Distribution of house value of those in the target group who own their house outright[52]

Age Group	10 percentile	25 percentile	Median	75 percentile	90 percentile
50 – 54	£120,000	£170,000	£280,000	£350,000	£500,000
55 – 59	£170,000	£225,000	£350,000	£420,000	£650,000
60 – 64	£150,000	£200,000	£300,000	£425,000	£625,000
65 – 69	£150,000	£200,000	£300,000	£430,000	£625,000
70 – 74	£150,000	£200,000	£300,000	£450,000	£650,000
75 – 79	£130,000	£180,000	£290,000	£400,000	£700,000
80 – 84	£125,000	£180,000	£280,000	£400,000	£600,000
85 – 89	£130,000	£155,000	£250,000	£300,000	£450,000
90 or over	£100,000	£170,000	£245,000	£400,000	£500,000

Many people have housing wealth at substantial levels that might under the right circumstances be an appropriate source of funding for their care needs (Table 11). Around 5.4 million people in the target group have housing wealth of over £200,000.

As noted in Chapter 7 (Proposal 4), the use of housing equity release does not tangibly affect day to day income in the same way as using pension savings, so may be more attractive. The pledge may also be seen to be less immediate and less tangible than using equity release to purchase insurance, because while it is a commitment to take action at some point in the future if the need arises, it is not an immediate financial transaction.

51. PPI analysis of English Longitudinal Study of Ageing Wave 8
52. PPI analysis of English Longitudinal Study of Ageing Wave 8

The high levels of home ownership and the distribution of house values, suggests that many people might have the housing wealth to enable them to make the pledge. Whether or not it is attractive to them is likely to depend on the individual's level of awareness and engagement with care funding, their attitude to wishing to pass on a bequest, and the level of government incentive.

Illustrative case study

For a person who:

- Owns their house, worth £230,000.[53]
- Pledges £40,000 of housing wealth towards care provision.
- The government makes a notional pledge of 25% of the person's pledge - £10,000.
- They have non-housing assets of £70,000 making them ineligible for means tested care benefits.

The total amount pledged is £50,000 towards care.

On a care need arising, the individual uses an equity release product to pay for care, either releasing the pledged amount all at once or by using a product that allows regular incremental withdrawal.

The government fulfils their pledge by making payments towards the individual's care based on the proportional split (in this case 25% of the individual's contributions to care costs).

If the person dies before the pledged amounts are exhausted, their pledge is cancelled and the money remains with their estate, and the government's remaining pledge is cancelled. The person's estate does not receive the government's remaining pledged amount.

If the pledged amounts are exhausted and they still require further care then they would have to fund their care themself however they choose, from either their non-housing assets or continuing the equity release product, but would not receive proportional matching payments from the government beyond the pledged amount.

If no care need arises before they die, the pledges are cancelled. No housing equity is released and the government pledge is cancelled without having to be fulfilled.

53. Average house price in the UK, HM Land Registry (2018)

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PENSIONS POLICY INSTITUTE

PPI

Our history and why we exist

The Pension Provision Group, chaired by **Tom Ross OBE,** was asked in 1997 by the then Secretary of State to assess the likely trends in pensions provisions. They concluded that there was a need for "An organisation, independent of government, to have lead responsibility for accumulating, analysing and publishing information about current and future pension provision and its implication for pension policy."

Following these recommendations in 2001 the PPI was founded by the members of the Pensions Provision Group, so that a permanent expert organisation would undertake rigorous research from an independent, long-term perspective. This is helping all those interested to achieve a better, wider understanding of retirement provision issues. We achieve this in a number of ways.

Research reports

Describe, analyse and model all areas of pensions policy in depth to produce fact-based reports. Our reports are almost always sponsored by at least one organisation.

Briefing Notes

Provide short summaries and clarify topical pension policy issues. Briefing Notes are included in **core work**, though some are sponsored.

Modelling

PPI have developed a suite of economic models that allow modelling of the hypothetical individuals, aggregate costs and distributional implications or various pension policies.

The Pensions Primer

Contains a detailed description of the UK pensions system and is an invaluable reference tool. The Primer is part of the PPI's **core work**.

Pension Facts

Brings together the most up to date information and statistics on pensions and demographic data. Pension Facts is part of the PPI's **core work**.

Consultation responses

Respond to consultations and calls for evidence within the pensions and retirement area, and provide oral evidence when requested. Responses are part of the PPI's **core work**.

Knowledge Sharing Seminars

Training seminars held by the PPI to provide a basic overview of the pensions system and pensions policy.

Events

Our events include research launch events, roundtables, exhibitor stands at trade conferences, the annual House of Lords Dinner, Party Conference fringe events and members events.

Supporting Members

As a charity, the PPI rely on annual donations from Members to fund the **core work**. Without Supporting Members, the PPI would not exist.

Media engagement

The PPI produce press releases for research, write articles for trade press and appear on TV and radio to discuss pensions policy.

Speaking engagements

PPI staff speak at many external events to provide impartial, fact-based commentary on selected topics.

Industry engagement

Continuous communication on a range of topics with other organisations within the field. All organisations are eligible to sponsor research as long as it fits within the charitable objective.

Est. since 2001

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