

The impact of devolution

Long-term care provision in the UK

David Bell

January 2010

A review of the evolution of long-term care policy during the first decade of devolved government in the UK.

Devolution has given the constituent nations of the UK greater freedom to pursue different long-term care strategies. After ten years of devolution, this report looks at why, and how, long-term care policies have diverged in England, Scotland, Wales and Northern Ireland. It found:

- Population ageing is common to all parts of the UK.
- Levels of disability are somewhat higher in Wales and Northern Ireland than in Scotland and England.
- There is a dual system of support for those with long-term conditions. One branch is largely run by local authorities and health authorities, funded by the devolved administrations. The other operates through the Department for Work and Pensions. There is little interaction between these.
- In relation to the demand for long-term care, differences within UK countries are much greater than differences between them.
- Levels of support for long-term care differ partly because of differences in funding. Those more generously treated by the Barnett Formula can afford to provide better services.
- But, in reality, the devolved authorities cannot follow radically different long-term care policies. They are constrained by the UK structure of taxes and benefits, where power is 'reserved' to Westminster.
- So far, UK nations have not been good at learning lessons from each others' experiences of long-term care policies.
- Scotland, Wales and Northern Ireland are at a disadvantage to England because they do not have the resources to conduct large-scale evaluations of policy effectiveness.
- Much of the legislation that influences long-term care provision was passed before devolution. Changing this legislation to permit greater policy differentiation is not high on the legislative agenda.

Contents

Executive summary	2
1 Introduction	4
2 Devolution: politics and finance	5
3 The demand for long-term care across the UK	11
4 Ability to pay	17
5 Care provision in the UK	20
6 Long-term care policy since devolution	24
7 Long-term care policies across the UK	32
8 Conclusions and recommendations	34
Notes	37
Related reports	38
References	39
Acknowledgements	42
About the author	42

Executive summary

This report reviews the development of long-term care policy for older people in the UK, in the decade since the introduction of devolution in 1999.

Key findings include:

- The challenges which different parts of the United Kingdom face in terms of population ageing and the demand for long-term care are not hugely different: the proportion of the population aged 65 plus will increase rapidly over the next few decades throughout the UK; levels of disability are slightly higher in Wales and Northern Ireland than in England and Scotland; the ability to pay for care privately is higher in England than in the devolved territories; there appears to have been some convergence in rates of unpaid care provision across the UK in recent years. The differences in the demand for care across the constituent parts of the UK are not large by international standards. Nevertheless, if the devolved bodies have different views about equity, or different capacities to deliver care efficiently, one might expect to see some variation in long-term care policy across the UK nations.
- It is widely assumed that policies for the long-term care of older people are entirely under the control of the devolved administrations in Scotland, Wales and Northern Ireland. The financial and political importance of the ‘secondary’ social care system, which is funded by DWP benefits which are determined at Westminster, is often overlooked.
- It is also important to understand that the ‘primary’ care system, which is in the hands of the devolved bodies, is ultimately funded through the Departmental Expenditure Limits (DEL) system, while the secondary care system is funded through Annually Managed Expenditure (AME). Annual budget constraints are binding on DEL, but less so on AME. This implies that social care provided by the devolved authorities is more likely to be rationed than is the case for the care provided by DWP.
- The delivery of long-term care is largely in the hands of local authorities, with the exception of Northern Ireland. There is a wide divergence in needs, ability to pay and provision across local authorities throughout the UK. Both the devolved administrations and the Westminster Government face a political dilemma in determining the relative role of centralised direction and local autonomy over long-term care policy.
- While devolution may have restructured political power within the United Kingdom, it did not fundamentally change the system for funding Scotland, Wales and Northern Ireland. As a result, there continue to be significant differences in the amount of public resources allocated to long-term care in the different parts of the UK.
- The devolved territories cannot pursue long-term care policies that are independent of the UK Government. This is partly because of the secondary care system comprising Attendance Allowance, Disability Living Allowance and Carers Allowance, which are funded by the Department for Work and Pensions in London. Any changes to these benefits are likely to be driven by English concerns, but will have knock-on effects in the devolved territories. Politicians in Scotland, Wales and Northern Ireland cannot afford to ignore the possibility of such change in

designing their own long-term care policies. The ability to influence what may happen to DWP benefits is at present very limited because of the weakness of the system of intergovernmental relations, such as the Joint Ministerial Committees which were supposedly an important component of the devolution arrangements.

- It is not clear, therefore, that the devolved territories have the capability to pursue a radically different strategic vision for long-term care from that in England. Scotland and Wales have produced older people's strategies, but these cannot carry the weight of documents like *Putting People First*, which outlines a vision for the future of adult social care in England. They tend to have fewer resources to devote to strategic development and, crucially, they cannot sign up stakeholders that have responsibility for 'reserved' issues, as is possible with policy development in England.
- One of the benefits of devolution may be that it does help policy-makers compare the effects of policy changes in different parts of the UK. Certainly other parts of the UK have learned from Scotland's experience of free personal care. But without formal intergovernmental mechanisms for knowledge exchange, such knowledge has mostly been collected and disseminated as a result of the activities of researchers and interested organisations, including the Joseph Rowntree Foundation. Policy-makers therefore tend to learn at second hand about policy changes elsewhere in the UK. This may lead to misunderstanding of what is going on elsewhere. Again there is a clear need to improve interaction between policy-makers in London, Cardiff, Belfast and Edinburgh.
- In developing long-term care policy, the devolved administrations are at a disadvantage compared with England. This is because they do not have the resources to conduct and assess large-scale evaluations. An example is the piloting of individual budgets in 13 local authorities in England by the Independent

Budgets Evaluation Network (IBSEN). Additionally, the devolved authorities do not tend to work with the Department for Work and Pensions in developing policy initiatives for care for older people. An example is the Streamlined Assessment Project (StAP), which integrates assessment procedures for Attendance Allowance and local authority care. A further consequence is that the devolved nations do not build up the capacity to analyse large-scale evaluations. In England, individual universities, or groups of universities, are capable of high-quality policy evaluations.

- Much of the legislation which sets the framework under which long-term care is provided pre-dates devolution. This inhibits the devolved nations from instigating radical change because the unravelling of this legislation would be problematic and time-consuming. Integral to this is the role given by such legislation to local authorities for the delivery of social care. As a result, social care policy is partly a product of the way that local government interacts with the devolved administrations and with the Department of Health in England.
- Whether devolution has benefited care clients is difficult to assess. In the last decade, there has been a substantial increase in the resources allocated to health and care provision throughout the UK, which will not be repeated for the foreseeable future. Over this period, opportunities for co-operation or co-ordination of social care policy across the UK have rarely been taken. The need to understand successful policy interventions in different parts of the UK will be much more acute in the next decade.

1 Introduction

The UK has long struggled with the problem of designing an effective and fair long-term care policy for older people. In the last decade, with the advent of devolution, the context for the development of such policy has changed substantially. As a result of the establishment of the Scottish Parliament and the Welsh and Northern Ireland Assemblies, the constituent parts of the UK (the devolved nations) were given greater freedom to design and implement their own long-term care policies. As a result, there has been increasing policy diversity across the UK. But the development of policy also reflects variations in the finances available to the devolved bodies, the demand for long-term care by older people and the ability to pay for such care. Such policies also have to take account of the wide variations in demand and in ability to pay that exist *within* each part of the UK.

This report looks at the role of devolution in the development of long-term care policy in the last decade. It considers how far such policy in the devolved nations is constrained by policies controlled from Westminster. Next, it examines diversity in long-term care provision both within and between the nations that comprise the UK. Finally, it discusses how devolution affects the political and financial context within which long-term care policy is framed in the UK.

2 Devolution: politics and finance

Politics

Devolution in the UK celebrated its tenth birthday in 2009. On 1 July 1999, powers were transferred from Westminster to the Scottish Parliament and to the Welsh Assembly. In Northern Ireland, the transfer took place on 2 December 1999. The Northern Ireland Assembly has not sat continuously since then: its most recent spell began on 26 March 2007.

While many powers were transferred to the new Parliament and Assemblies, others were 'reserved' to Westminster. Reserved powers include social security, defence and macroeconomic policy. Areas such as health, housing and local government came under the control of the devolved bodies. The devolved institutions enable the people of Scotland, Wales and Northern Ireland to exert greater control and scrutiny over a range of important public services. As a consequence, policy differences have emerged.

One area where such divergence has increased is the provision of long-term care to older people. The Department of Health in England and the devolved nations provide resources for local authorities and health boards. These resources, in turn, support services for older people requiring long-term care. Services which the local authority funds may be provided by the private sector, by the voluntary sector or directly by themselves. In the remainder of this report, this set of local authority-based activities is described as the primary care system. Its key feature is that the devolved nations and England have some latitude to design and implement their own long-term care policies in the primary care sector. These differences emerge partly because of institutional differences in delivery mechanisms for long-term care in different parts of the UK.

Thus, in Wales, Scotland and England, local authorities are primarily responsible for delivering care for older people, liaising with relevant health

boards. In Wales, health boards and local authority boundaries are coincident. In Northern Ireland care is delivered by Health and Social Care Trusts (HSCs). The Minister of Health, Social Services and Public Safety appoints the chairman and the non-executive directors of the HSCs. Thus, in Northern Ireland, social care policy does not have a local democratic input. There are positive and negative aspects of the Northern Irish structure. It is easier to ensure uniformity in assessment, provision and charging when there are no local political inputs. On the other hand, local care clients might wish to differentiate provision from that in other parts of the Province. This issue of uniformity versus local discretion arises in many different guises in the debate on long-term care policy in the UK.

There is another care system which is funded by the public sector, but is entirely independent of the devolved bodies. The secondary care system, which is administered by the Department for Work and Pensions (DWP), provides direct cash benefits to the disabled, carers and those with care needs. These benefits comprise Attendance Allowance (AA) and Disability Living Allowance (Care Component) (DLA) and Carers Allowance (CA). AA and DLA are non-means-tested cash benefits. Older clients can use the cash as they see fit. Their assessment procedures differ from those used by the primary system.

AA is payable to those aged 65 and over who need help with their personal care because of an illness or disability. Similarly, DLA provides for those aged under 65 with personal care needs. But if the claim was made before age 65 and the disability has persisted, the benefit will continue to be paid after the client reaches 65. Thus, DLA claimants tend to be drawn from the 'young' old, while AA claims are typically made by the 'oldest' old.

AA is paid at two rates depending on the level of disability. The current higher rate is £70.35 and the lower rate is £47.10. DLA (Care Component)

is payable at three weekly rates, £70.35, £47.10 and £18.65. In November 2008, there were 0.98 million individuals aged 65+ receiving DLA and 1.63 million receiving AA. The secondary care system supports more than 2.6 million individuals throughout the UK. In 2008/9 the total cost of AA was £4.7 billion. Assuming that the amount paid through DLA is on average the same irrespective of age then a further £2.7 billion can be added to the DWP bill to support long-term care. This implies that the average annual payment to

claimants through the secondary care system in support of personal care needs is around £2,800 per client.

Thus, the process of devolution has naturally resulted in a focus on the primary system of care provision because the devolved bodies can form their own policies for its delivery. But this has perhaps resulted in a failure to appreciate the important contribution made by the secondary system in supporting older people with care needs on a uniform basis throughout the UK. There was

Box 1: Attendance Allowance payments to care home clients in Scotland

Prior to 2001, care home residents could be charged for nursing care, subject to a means test. After the report of the Royal Commission in 1999, the principle of free nursing care was accepted throughout the UK. But from July 2002 the Scottish Parliament agreed to provide free personal care as well as nursing care for both care home clients and those receiving care at home. Weekly payments for nursing care and personal care were set at £65 and £145 respectively. Payments were to be made by the local authority. AA is specifically intended to help 'people aged 65 or over who have an illness or disability and need help with personal care'. DWP rules prevent payment of AA when a local authority is already contributing towards the client's personal care costs. Hence AA was withdrawn from clients in Scottish care homes who were receiving free personal care. Payments for nursing care, which form part of health care and so are within the scope of the NHS, are not affected by this rule. In contrast, those who now receive free personal care at home in Scotland, who might have previously paid for this care, continue to receive AA.

England, Wales and Northern Ireland adopted more generous allowances for nursing care than did Scotland. The current position is that the allowance for nursing care in Scotland is £69 per week; in England there are two

bands with a lower rate of £103.80 and higher rate of £142.80; in Wales there is a single band of £119.66; and in Northern Ireland the contribution is 'up to' £100 per week.

AA is payable at £70.35 at the higher rate and £47.10 at the lower rate. This means that a care home client in England could potentially receive up to £213.15 per week from nursing care and AA, while in Scotland the maximum payable for both nursing and personal care is £222 per week – based on the current personal care allowance of £153 per week. The numbers of clients eligible for such allowances in both countries depend on many factors including assessment procedures. But the difference in the maximum contribution between Scotland and England is less than £9 per week even though the headlines around 'free personal care' suggest that the Scottish policy is much more generous. One important distinction is that all of the payments in Scotland come from the Scottish budget, whereas in England they are funded in part by the Department of Health and in part by the Department for Work and Pensions.

The introduction of free personal care in Scotland has 'saved' DWP over £200 million in AA since 2002. Scottish politicians and media have felt that this was unjust. Lord Sutherland's recent review of free personal care also suggested that this was an anomaly. It is unclear whether any radical change in the structure of disability benefits will follow from the recent Green Paper. Until there is some radical change in AA, the status quo is likely to prevail.

one important difference of opinion as to whether its application has always been uniform – the payment of AA to care home clients in Scotland who were receiving free personal care. This proved an extremely controversial issue (see Box 1).

The primary and secondary care systems do not serve identical groups of clients, largely due to differences in their assessment procedures. This can be illustrated with data from Scotland. The Scottish Government collects data on those being provided with free personal care at home by local authorities. These clients are in the primary care system. As shown in Box 1, AA is only paid to those living at home in Scotland: care home clients are excluded. Thus, one might expect a large overlap between those receiving personal care at home from their local authority (primary system) and those receiving AA (secondary system). But the populations served by the two systems differ substantially in size. The number of personal care clients being supported in the primary system is around one-third of the number being supported in the secondary system. If one adds those receiving at least the lower care component of DLA who are aged 65 and over, the share receiving care from the primary sector falls to 21 per cent. Thus, for older clients living at home, the secondary care system, which is entirely independent of the devolved institutions, serves almost *five times* as many clients as the primary system.

This illustrates one of the main paradoxes of devolution and long-term care in the UK. There are two quite distinct systems: one is supported by DWP, while the other is provided by local authorities that are responsible to their respective administrations. Provision by the devolved authorities through the primary system is strictly cash-limited, while that provided through the secondary system is not subject to such stringent financial controls.

The secondary care system is subject to less stringent financial control than the primary system because social security benefits form part of Annually Managed Expenditure (AME). AME is not directly cash-limited by HM Treasury since it is difficult to precisely predict large elements of social security spending. Rather, the Treasury estimates the likely path of AME and determines

its other spending plans based on these estimates. In particular, it determines a Departmental Expenditure Limit (DEL) for each spending ministry and for each of the devolved bodies. The Department of Health and the devolved bodies must stay within the DEL that they have been assigned. To stay within these limits, the devolved bodies assign fixed budgets to their local authorities and health boards.

At the level of the individual client requiring care, this means that local authority social work departments will be working within budgets that they cannot breach, while the opportunity cost of providing Attendance Allowance or Disability Living Allowance is much more nebulous. Assessing an additional client as eligible for Attendance Allowance does not appear to reduce the budget of any other part of the public sector. Of course, in the long run, there is an equivalent cost to government, irrespective of whether the funding has come from the primary or secondary care system, but to those making the decisions about whether to provide local authority-funded care services on the one hand, or social security benefits on the other, this equivalence may not be at all clear.

There is also a 'tertiary' system of care support comprising unpaid care by friends and relatives and privately purchased care. It is not directly dependent on the public sector for funding, though the supply of care by this route does interact with public provision. In the UK, there are around five million relatives, friends and volunteers in the UK who provide unpaid care to older people. Not much is known about this sector in the sense that survey and administrative data on private care provision tends to be limited for a variety of reasons. Compared to the widespread availability of data on publicly provided health care, the data on social care in the UK is much less complete, particularly that involving the tertiary sector where the public sector may have no role in assessment, commissioning or provision. Even where data is available, it is often collected in different ways in England, Wales, Scotland and Northern Ireland, making comparisons difficult. UK-wide data tends to be only available from commercial organisations such as the UK Home Care Association and Laing & Buisson, who collect data on care homes.

As we have just seen, the primary and secondary systems do not serve the same set of clients. DWP benefits are not means-tested, while at least in England and Wales, local authority personal care provision is subject to means-testing. And this affects the tertiary care sector, since clients who feel they receive inadequate publicly funded support may seek care elsewhere. This may come from family, friends or charities, or it may be purchased from the private sector, provided that the client has the required resources.

Long-term care policy and devolution were linked by one important coincidence. For the incoming Labour administration in 1997, both devolution and long-term care policy were close to the top of the 'to do' list. There were manifesto commitments in both policy areas. Thus the Royal Commission on Long-Term Care was established in 1997 with Sir Stewart Sutherland as chairman. Its report was published on 1 March 1999, only a few months before the establishment of the devolved bodies.

A key recommendation in its report, supported by a majority of the commissioners, was that 'personal care should be available after an assessment, according to need and paid for from general taxation' (HMSO, 1999a.). But in a formal note of dissent, two of the commissioners argued that this proposal was unaffordable. The devolved bodies were thus established just as the report of the Royal Commission was stimulating an intense debate on the future of long-term care.

Powers to influence long-term care varied across the devolved bodies. This was because devolution was 'asymmetric': though they were responsible for largely the same policy areas, the devolved bodies did not have the same powers to legislate. For example, the Welsh Assembly did not have the power to introduce primary legislation: it could only build on existing Acts of the UK Parliament. This was partly responsible for the decision of the Welsh Assembly not to go ahead with the policy of free domiciliary care (see Box 2).

Box 2: Domiciliary care charges: the importance of the legislative framework

The Welsh Assembly only had secondary legislative powers when it was set up. It therefore had to work within the framework of UK statute. For non-residential care, this was provided by the National Assistance Act 1948, which makes local authorities responsible for the provision of non-residential social services. In addition, the Health and Social Services and Social Security Adjudication Act 1983 gives local authorities discretionary power to recover charges for care services, including personal care.

The Labour Party made a manifesto commitment in 2003 to provide free domiciliary care to all adults (not just those aged 65+). But the Welsh Assembly could not pass a law to prevent local authorities charging for these services. This was because it only had secondary legislative competence. It could try to persuade local authorities to stop charging by compensating them for the loss in income,

but it did not have the powers to guarantee an end to charges. In contrast, with its primary legislative powers, the Scottish Government could, and did, force local authorities to stop charging for personal care services delivered at home to those aged 65+.

The Government of Wales Act 2006 enhanced the legislative powers of the Welsh National Assembly. It can now bring forward a Legislative Competence Order (LCO) that transfers powers from the UK Parliament to the Welsh Assembly. This gives the Assembly the ability to introduce primary legislation, though by a much more convoluted procedure than is required in Scotland. LCOs have to be approved by the Assembly, the Secretary of State for Wales and both Houses of the UK Parliament. In 2008, the Assembly successfully introduced an LCO to 'create a more level playing field in relation to charges for domiciliary care services' (WAG, 2009). During 2009, it consulted on how this objective would best be taken forward, before introducing the necessary legislation to effect a more uniform structure of home care charges throughout Wales.

In Northern Ireland, there are ‘excepted’ powers over which the Assembly has no control and ‘reserved’ ones where legislation requires the consent of the Secretary of State. The Assembly has powers to pass primary legislation in other matters and therefore could have introduced free personal care to Northern Ireland.

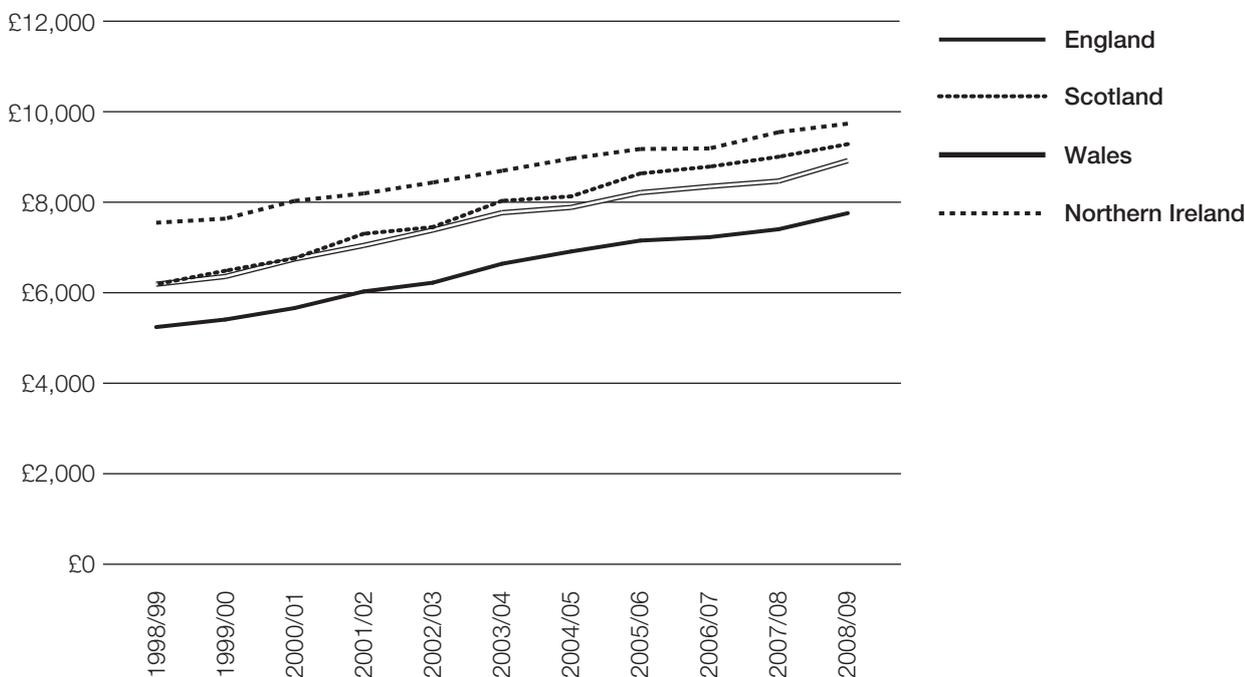
Aside from the differences in the powers of the devolved bodies, another set of contrasts existed because of the different ways in which long-term care policy had evolved across the UK, even within a common legislative framework. Thus, for example, in 1999 more than 50 per cent of contact hours purchased or provided by local authorities in England were supplied by the independent sector; in contrast, in Scotland, only 8 per cent of hours were not supplied exclusively by local authorities. Some local authorities in Scotland had already effectively introduced free personal care before 1999. As we shall see, this was one of the reasons why there was so much variation across Scottish local authorities in the costs of free personal care.

Finance

Devolution introduced new legal frameworks within which long-term care policy operated in different parts of the UK. But this was not the only reason why long-term care policy evolved in different ways: resources also played a key part. There have been significant differences in government spending per head in different parts of the UK for many decades. These partly reflect varying levels of need: where unemployment is high, per capita payments on unemployment benefits will be high. But differences in spending power between the devolved governments are largely driven by the Barnett formula, an arcane distribution formula devised in 1978 by Joel Barnett, then Chief Secretary to the Treasury. Its outcomes are largely driven by past history rather than by differences in need.

The Barnett formula passed unscathed through the devolution process. While the UK Government was willing to concede additional political powers to Wales, Northern Ireland and

Figure 1: Real public expenditure per head by country 1998/9 to 2008/9 (2007/8 prices)



Source: Public Expenditure Statistical Analysis, HM Treasury

Scotland, it was unwilling to extend additional financial powers.¹ As we shall see later, proposals for changes to the funding system have recently been made in both Scotland and Wales. Thus, while devolution increased the ability to exert political control over long-term care policy, it did not significantly increase the ability of the devolved bodies to control the financial resources available to them.

Figure 1 illustrates spending per head in real terms (2007/8 prices) in the devolved nations over the period 1998/9 to 2008/9.² The trends are almost parallel, implying that there have been minimal changes in *relative* public spending per head between England, Scotland, Wales and Northern Ireland since devolution was introduced. Thus, for example, public spending per head in Scotland was 16 per cent above that in the UK as a whole in 1998/9; in 2008/9, it was still 16 per cent above the UK average.

Figure 1 also illustrates a second major coincidence that affected both devolution and long-term care policy in the last decade. Over this period, there has been a period of unprecedented *real* increases in public spending. In the UK as a whole, the real value of public spending per head grew by 55 per cent between 1998/9 and 2008/9 – 3.6 per cent per annum – and well in excess of the real growth of the UK economy. This meant a general loosening of budget constraints.

Many of the differences in long-term care policy among the devolved nations and England that have emerged since 1999 can be more easily interpreted in the light of the differences in their respective financial settlements rather than as a result of devolution itself. The UK may have become a ‘policy laboratory’ as a result of devolution. This might help explain the differences in long-term care policy that have emerged since 1998/9. But it is vital to bear in mind that the freedom to pursue new policies within this laboratory is constrained by available resources. And, as we have just seen, devolution did not significantly affect the distribution of public finance among the different parts of the UK. But, while resource availability may constrain policy variation, differences in care provision may reflect differences in the demand for care across the UK. In the next chapter, we examine the extent to which such contrasts exist.

3 The demand for long-term care across the UK

Long-term care policy may have evolved differently in Scotland, Wales and Northern Ireland because of variations in the level and nature of demand for long-term care. The purpose of this chapter is to investigate differences in demand for long-term care across the UK.

A good starting point is to look at differences in the proportions of the population aged 65 and over. These are shown in Table 1 for various years. There has clearly not been any ‘devolution’ effect that influenced the age structure of the population in the devolved nations during this short period. Table 1 shows that Northern Ireland’s population is somewhat younger than elsewhere. Thus, relative to its total population, the demand for long-term care in Northern Ireland is lower than in the rest of the UK. But the proportion of those aged 65+ in Northern Ireland (and Scotland and Wales) grew more rapidly than in England between 1981 and 2007. This is partly the outcome of higher rates of immigration from overseas by younger people into England, which will keep its population relatively young.

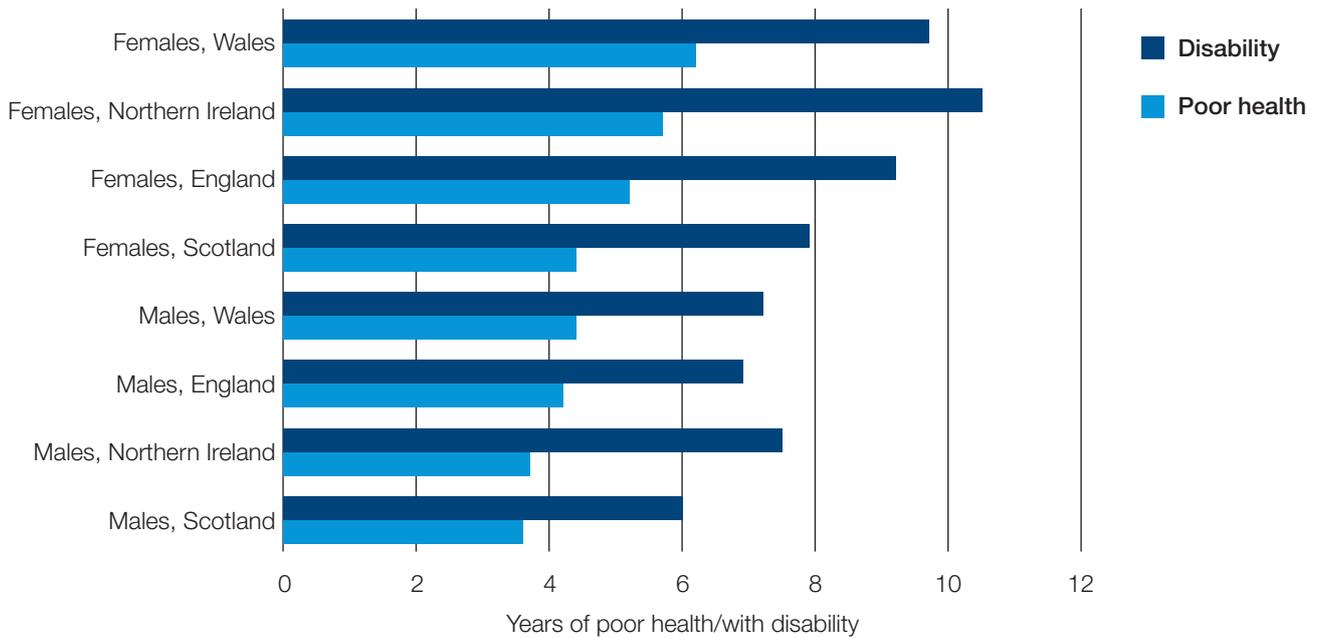
The demand for long-term care depends not only on the size of the older population, but also on its health. One way to analyse this is to look at the difference between overall life expectancy and ‘healthy’ or ‘disability free’ life expectancy. The Office of National Statistics has analysed responses to questions on health and disability in the General Household Survey in Great Britain and the Continuous Household Survey in Northern Ireland. Figure 2 shows the number of years in poor health or with disability that someone aged 65 can expect in different parts of the UK. Thus Welsh females will, on average, experience the longest period of poor health – 6.2 years. Scottish males aged 65 can expect a much shorter period of poor health, 2.7 years, mainly reflecting their shorter life expectancy. The disability data is broadly consistent with that on poor health, though both males and females in Northern Ireland experience longer periods of disability than males and females elsewhere in the UK. This finding has to be treated with care, given that the Northern Ireland data is drawn from a different survey.

Table 1: Share of older people (aged 65+) in total population (%)

Year	England	Scotland	Wales	Northern Ireland
1981	23.5	22.1	24.6	11.8
1991	24.3	23.0	27.0	12.9
2001	24.2	24.1	27.3	13.1
2007	24.0	24.5	27.5	13.7

Source: NOMIS (www.nomis.co.uk) and Northern Ireland Statistics and Research Agency (NISRA)

Figure 2: Expected years with poor health/disability, 2004–06



Source: Health Statistics Quarterly No 40, Winter 2008, Office of National Statistics

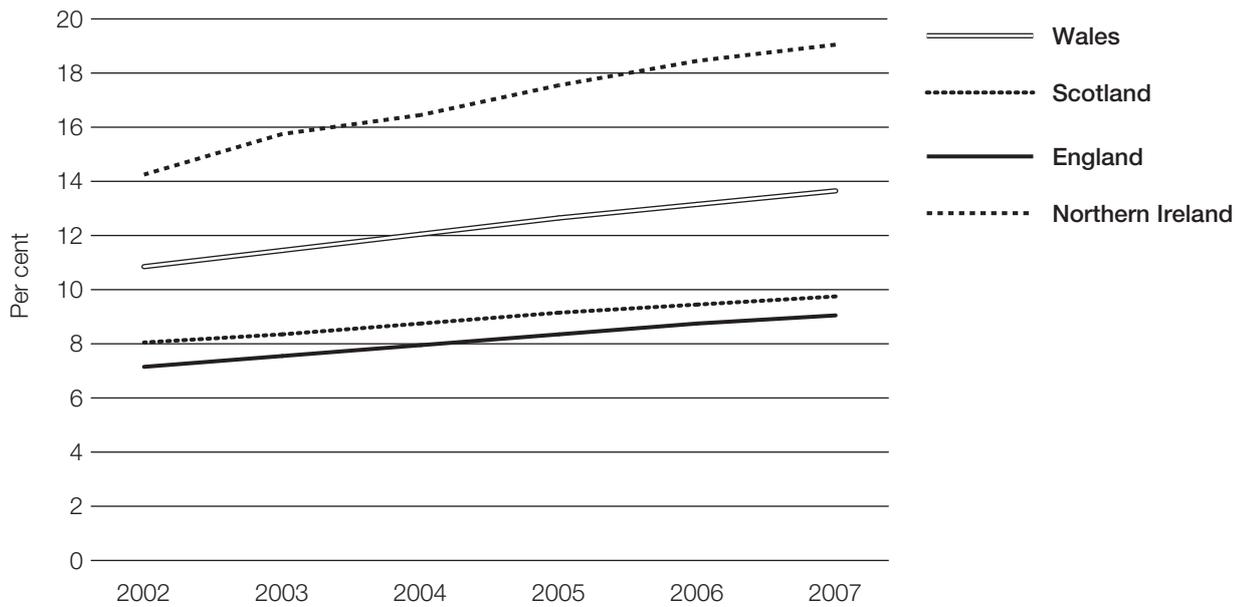
Taken together, this data suggests shorter periods of poor health and disability in Scotland, both for males and females. At the other end of the spectrum, it appears that older people in Wales and Northern Ireland experience longer periods of poor health and disability. These differences are clearly influential in determining demand for long-term care.

Another way to review the demand for long-term care across the UK is to analyse claims for disability-related benefits among those aged 65 and over. Figures 3 and 4 show the proportion of those aged over 65 receiving AA and DLA, respectively, across the UK since 2002.¹ They show some distinct trends. First, in line with the data on poor health and disability, the share of older people receiving DLA and AA is significantly higher in Wales and Northern Ireland than in either Scotland or England. Second, DLA claims by those over 65 are increasing much more rapidly than AA claims. This reflects increasing numbers of those below pension age receiving DLA, which then continues beyond retirement age. Between 2002 and 2008, there was a 14 per cent increase in the number of DLA claimants aged 50–64 and a 34 per cent increase, to 2.1 million, in the number of claims that had lasted at least five years.

The share of the older population receiving AA is more stable. As with DLA, among those aged over 65, a slightly larger share of older people in Scotland than in England claim AA. But this is a relatively small difference compared with the much higher rate of claims for both AA and DLA in Wales and Northern Ireland. In Wales more than 20 per cent of those aged 65+ now claim AA and this share is increasing, while in Northern Ireland, where almost 30 per cent of older people were AA claimants in 2002, the share has recently fallen to just over 25 per cent.

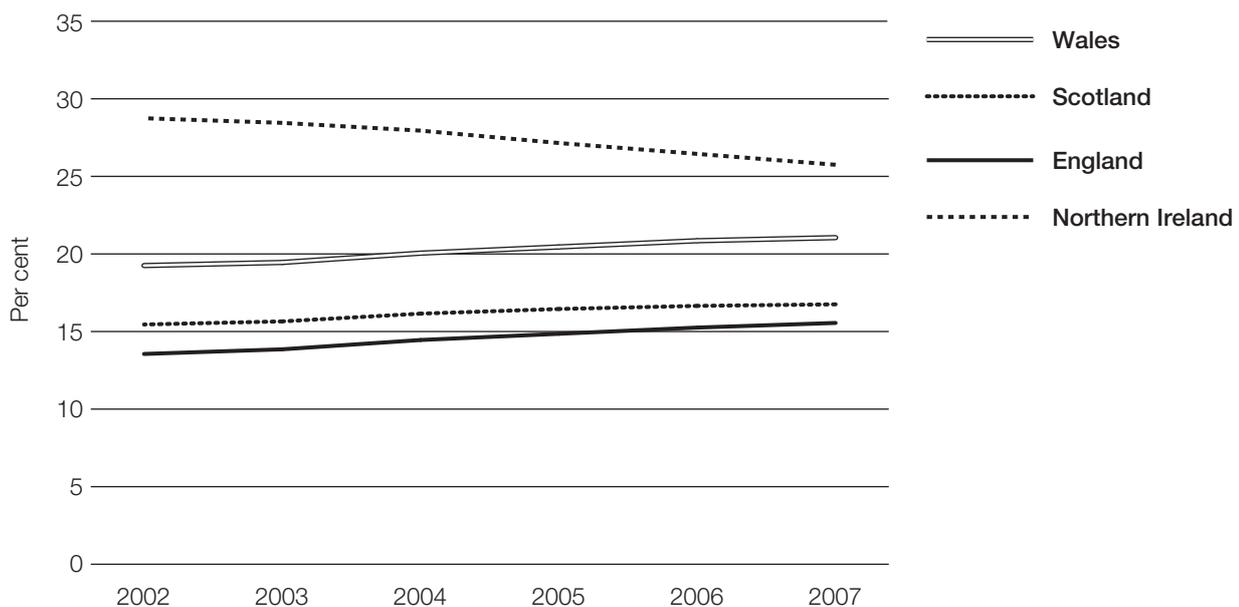
The data on AA and DLA suggests significant variation *between* the devolved nations. But they conceal much greater variation *within* their boundaries. Figure 5 maps the proportion of those aged 65+ receiving AA by local authority across the UK. This share varies between 4 per cent and 37 per cent – much greater than the variation *between* the devolved nations. If benefit take-up is an objective indicator of long-term care needs, then each part of the UK experiences wide variation in the demand for long-term care within its boundaries. Local authorities and health boards in the devolved nations have widely differing resource needs if they are to provide a uniform level of support for long-term care clients.

Figure 3: Proportion of over 65s receiving Disability Living Allowance, 2002–07



Source: Department for Work and Pensions and Social Security Agency, Northern Ireland

Figure 4: Proportion of over 65s receiving AA, 2002–07

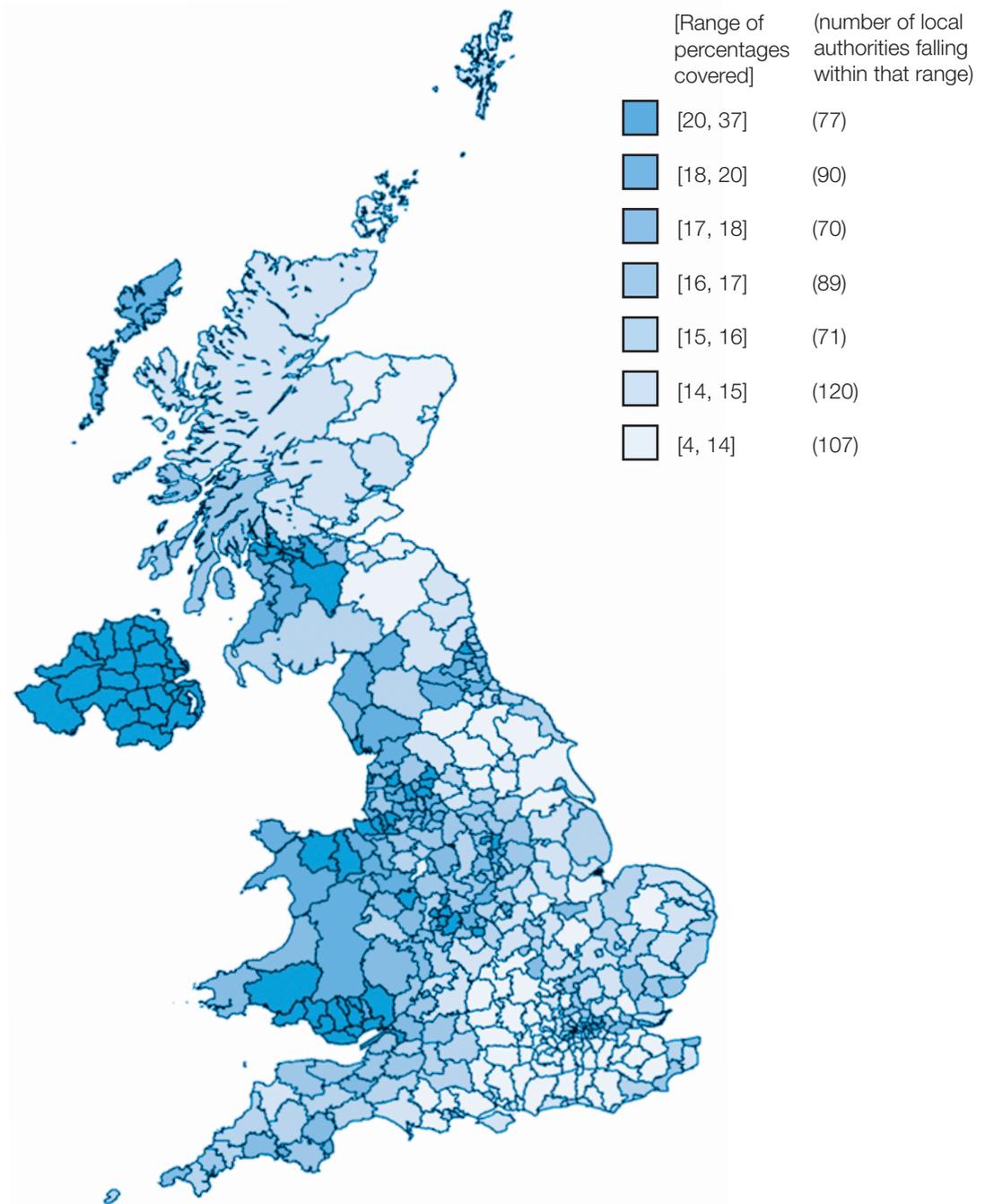


Source: Department for Work and Pensions and Social Security Agency, Northern Ireland

These benefit statistics may not be unbiased measures of the demand for long-term care. There may be differential take-up of AA and DLA across regions. Some regions may have more effective systems to assist claimants, as indicated by the House of Commons Work and Pensions Committee (2009) in its recent report on pensioner

poverty. But while there is evidence of low take-up of some types of benefit, particularly by older people, there is little evidence of regional variation in low take-up. Given that eligibility criteria are the same throughout the UK, it is difficult to explain the variation shown in Figures 3, 4 and 5 unless there is a corresponding variation in disability rates.

Figure 5: Proportion of over 65s receiving Attendance Allowance by local authority (November 2008)



David Bell, University of Stirling
Source: NOMIS

The overall picture of the demand for long-term care across the countries of the UK is complex. Northern Ireland has a younger population than the rest of the UK. Levels of disability are higher in Wales and Northern Ireland. Years of unhealthy life expectancy are shortest in Scotland. There are some variations in levels of disability within the devolved nations. But by international standards, these differences are

relatively small. Further, there is much greater variation in disability rates between local authorities than between the constituent parts of the UK as a whole. And the secondary care system has a much larger client base than its primary equivalent.

To complete the picture of the demand for long-term care for older people across the UK, we finally focus on the tertiary care system – where

Figure 6: Trends in care receiving across the UK, 1997/8 to 2007/8

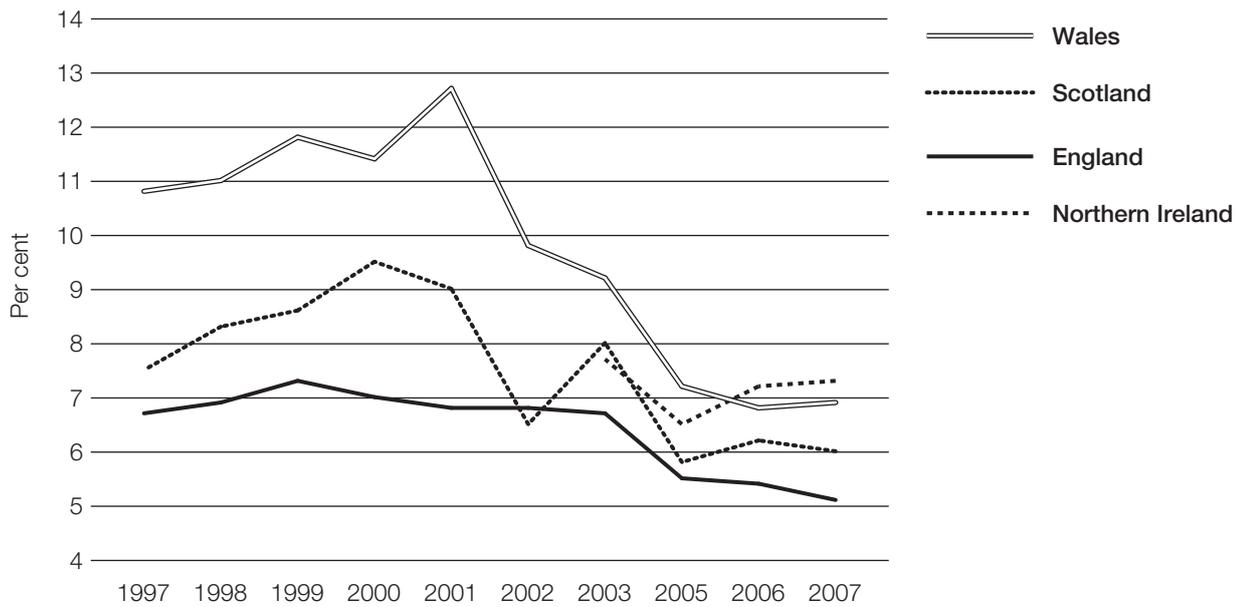
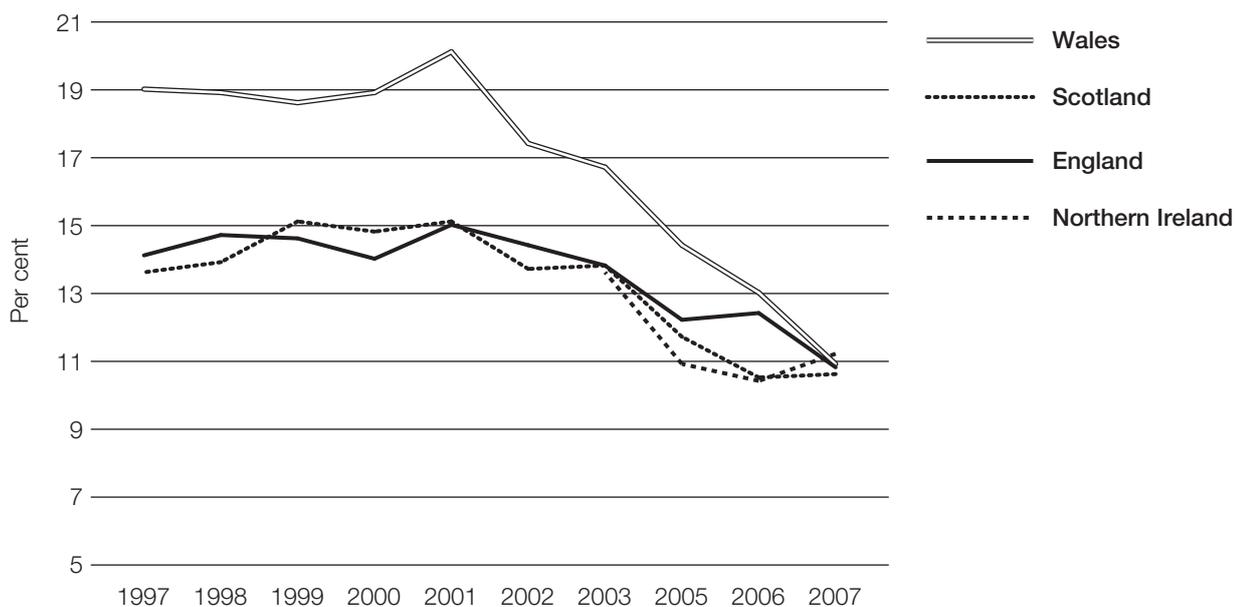


Figure 7: Trends in care giving across the UK, 1997/8 to 2007/8



paid and unpaid care is provided by friends, family, charities and private providers. As already mentioned, much of this activity is not well measured.

One way to examine the unpaid care component is to look at UK-wide household surveys which include questions on voluntary care provision. The Family Resources Survey is a regular survey of representative households that

has been conducted each year since the mid 1990s. Unfortunately data from Northern Ireland is only available since 2003. Figures 6 and 7 show the proportion of adults receiving care at home and the proportion of adults giving care, either in the home or outside the home, respectively. Figure 7 shows differences in levels of disability across the UK. England has the lowest share of older people receiving care, while Northern Ireland

has the highest proportion. These rankings are consistent with the findings from the AA data. The downward trend evident in the proportion receiving care in Figure 6 and the simultaneous upward trend in the number of clients receiving AA and DLA may suggest that there is a shift away from tertiary care to secondary care – from friends and relatives to reliance on cash benefits from DWP to purchase care services.

There is a higher proportion of adults giving care than receiving care. This is because some care clients receive care from more than one individual. Thus the proportion of the adult population giving care in Figure 7 is significantly higher than the proportion receiving care as shown in Figure 6. In line with the general decline in the receipt of care, Figure 7 also shows a reduction in the share of adults giving care to friends and relatives in the ten years prior to 2007/8. The downward trend seems common to all parts of the UK: in fact, there appears to be some convergence, with around 11 per cent of adults in each part of the UK providing care to other adults in 2007/8. There is no evidence of diverging trends in unpaid care provision that might be associated with differences in long-term care policy across the UK.

4 Ability to pay

Older people's ability to pay for long-term care services varies substantially throughout the UK. There are three factors that affect the capacity to direct purchase care services:

- 1 Pensions – for those aged 65+, pensions are the main source of income. Private pensions depend on contributions to pension schemes during working life, while state pension is dependent on the history of National Insurance contributions. High earners who have been employed for most of their adult life are likely to have a higher pension than those who have been periodically outside the workforce for reasons such as unemployment, care-giving or bringing up a family.
- 2 Savings and investments – which reflect income and consumption patterns. Those who have consumed a large proportion of their income or have supported others with cash transfers may not have assets that can easily be liquidated to pay for care.
- 3 Housing equity – by international standards, the UK has a high proportion of home ownership. Thus, large numbers of UK citizens have significant proportions of their wealth in the form of housing equity rather than in financial assets. Older people generally find the process of reducing their housing equity to pay for care distressing.

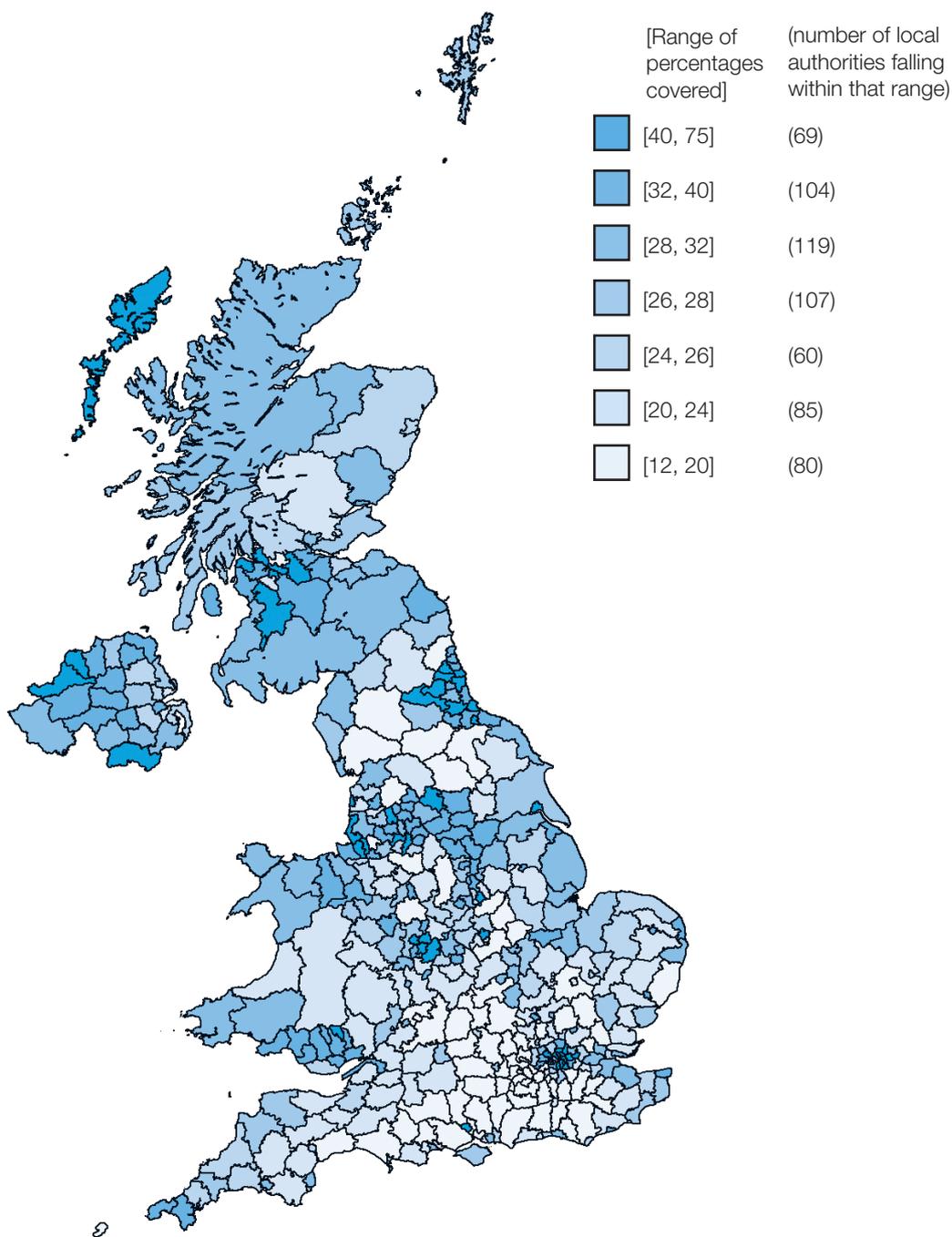
Each of these components of pensioner wealth varies across the constituent parts of the UK. Table 2 shows data for weekly household income and non-housing capital which is drawn from the Family Resources Survey 2007/8. Smaller samples in Wales and Northern Ireland mean that results for these areas must be treated with caution. Nevertheless a consistent pattern emerges. For households where the head is aged 65 or above, household income is highest in England and lowest in Scotland. For working-age households, income in Scotland is generally higher than in either Wales or Northern Ireland. For those of pension age, household incomes in Wales and

Table 2: Ability to pay

	England	Wales	Scotland	Northern Ireland
Average weekly household income aged 65+	£375.6	£391.1	£346.7	£363.3
Households with > £23,000 non-housing capital (%)	28.89	22.96	22.15	11.54
Owner-occupiers 1991 (%)	68.1	70.7	52.4	65.6
Owner-occupiers 2008 (%)	71.1	77.0	77.9	88.5
Average house price 2008	£237,112	£169,948	£168,593	£218,282

Source: Family Resources Survey 2007/8 and Department of Communities and Local Government

Figure 8: Proportion of over 65s receiving Pension Credit by local authority (November 2008)



David Bell, University of Stirling
Source: NOMIS

Northern Ireland are higher than those in Scotland. This is because higher rates of disability in Wales and Northern Ireland result in higher contributions from AA, DLA and other social security benefits to weekly household income. For the UK as a whole, pensioner household incomes are higher when someone in the household receives care. But higher household incomes in England also reflect higher lifetime earnings, and therefore higher pensions.

A higher proportion of pensioner households in England have more than £23,000 in financial assets. This limit is important because care clients whose savings and investments exceed £23,000 are normally expected to meet all of their care charges. Scotland and Wales both have around 22 per cent of households in this category, almost twice the share in Northern Ireland, though the latter figure should be treated with caution.

Housing tenure varies across different parts of the UK. Currently, Scotland has the lowest share of owner-occupiers, though the share of owner-occupiers grew more rapidly in Scotland between 1991 and 2007 than in other parts of the UK. Nevertheless, this means that a higher proportion of those entering residential care in Scotland cannot use housing equity to pay for care. The Care Development Group (2001) argued that the increasing proportion of home ownership in Scotland would offset the costs of free personal care because an increasing share of those entering residential care would have access to housing equity and therefore would be able to contribute towards their accommodation costs.

House prices are good indicators of housing equity, particularly for older people who have typically fully repaid their mortgage. Table 2 shows that house prices are highest in England, while those in Wales and Scotland are around 30 per cent lower. House prices in Northern Ireland in 2008 were above those in Scotland and Wales but below those in England. Recent experience with the housing market shows that house prices can be extremely volatile, suggesting that housing equity is not a low-risk method of funding long-term care.

Household income, financial assets and housing assets can all be used to fund long-term care. Clearly these vary between England and other parts of the UK. Devolution is not the cause of these differences: they are largely historical or reflect changes in economic circumstances since devolution. Differences in ability to pay may elicit differences in policy response across the devolved institutions. In areas where pensioner income and assets are relatively low, one might expect greater reliance on state provision of care and vice versa. But this will result in more affluent clients in poorer areas gaining while poorer clients in affluent areas lose in terms of state support for care provision.

What the data in Table 2 fails to reflect is the huge variation in incomes and assets that exists *within* each part of the UK. This can be illustrated with measures of inequality. There is a class of such measures which can be used to allocate the overall inequality in pensioners' household income in the UK to that which arises *between* England, Scotland, Wales and Northern Ireland and that

which is due to variation *within* these areas. Using a measure devised by Frick *et al.* (2006) in combination with the 2007/8 Family Resources Survey, one can show that over 99 per cent of the inequality in pensioner household income in the UK is due to differences *within* the nations, while less than 1 per cent of this inequality is due to differences *between* average pensioner household income in England, Scotland, Wales and Northern Ireland. To reinforce the message that variation within is much more important than variation between, Figure 8 shows the proportion of pensioners receiving Pension Credit by local authority across the UK at the end of 2008. The share varies massively. Across UK local authorities, a minimum of 12 per cent and a maximum of 75 per cent of pensioners receive Pension Credit. The south of England has generally lower proportions of pensioners receiving Pension Credit, but it is also striking that there is a great deal of variation in this share both within England and within the devolved nations.

The conclusion from the analysis of ability to pay is that though there are significant differences in older people's ability to contribute towards the costs of long-term care *between* the component parts of the UK, these are much less significant than the differences *within* each part. Further, the differences in incomes, financial assets and the value of housing between the devolved nations are not themselves the result of devolution, but largely reflect past political and economic decisions.

5 Care provision in the UK

In the UK, care is provided in a number of settings, including long-stay hospitals, care homes, various forms of intermediate housing and clients' homes. Of these, the most important settings in terms of numbers of clients are care homes and care at home. The balance of care between these different forms of provision tends to change slowly because of the organisational and staffing costs associated with change.

Another dimension to care provision is the issue of the ownership of the organisations supplying care. There is an ideological divide between those who believe that care should be delivered by the state and those who favour private sector provision. The arguments of those who favour state provision generally emphasise equity and quality, while those who support private provision argue that this form of provision maximises efficiency and client choice.

Different parts of the UK had different policy positions with respect to these dimensions of care prior to devolution. There have been some changes since 1999, particularly in Scotland, but the changing role of the private sector and increased personalisation are mainly attributable to policies developed at Westminster for England. For example, the debate between private and public sector provision has become less stark. The Blair Government moved towards increased private sector delivery in England, aiming to combine private sector efficiency with the public sector acting as regulator and commissioner of services. Rather than focusing on an exclusively public sector or private sector system, the debate refocused on the respective roles of the private and public sectors within that system. Increased commissioning of private sector providers by local authorities underlies the rapid increase in private sector delivery of home care services by local authorities in England. Westminster has also promoted consumer choice by extending clients' rights to choose between service providers. This approach is aligned with the general preference of

frail older people for care services to be delivered at home. It also provides a rationale for the extension of direct payments, self-directed care, and personal and individual budgets.

The enthusiasm for extending consumer choice was not shared to the same extent by the devolved administrations, even those that were Labour-dominated. Thus, as we shall see, the implementation of consumer choice in care services varies considerably across the UK. For a variety of reasons the extension of client control over care packages has been more limited in the devolved administrations than in England.

But ideological differences at the national level are not the only source of variance: social care policy is delivered by local authorities, which have their own policy agenda. They have always had some choice over the range and quality of services that they provide to older people. Even if the resources provided to local authorities by the devolved authorities to support older people are 'ring-fenced', they could decide to provide additional services to older people by increasing their spending above the ring-fenced level.

Another aspect of policy in recent years has been a drive to remove so-called 'postcode lotteries' in the provision of public services. Political parties have willingly or unwillingly been forced to increase pressure on local service deliverers to conform to national standards. It is most clearly exemplified by the use of Performance Indicators, particularly in England, to ensure that public bodies follow the policy objectives set by government. This was another component of the New Labour philosophy and was applied widely and rigorously in the early part of this decade. Recently, there has been some retreat from strong central direction from Westminster. One signal of this has been the decision to remove ring-fencing from Supporting People – the £1.7 billion programme aimed at supporting vulnerable people in their own homes.

Older care clients living at home were among the main beneficiaries from this programme.

For long-term care, the Department of Health and devolved administrations have tried to introduce a more uniform charging structure within their jurisdictions. This reduces local authorities' freedom to design their own charging policies which was granted to them under the 1948 National Assistance Act. To illustrate how these ideological and practical differences across the administrations have real effects, Table 3 shows some recent data on the structure of care in different parts of the UK. The statistics should be interpreted as being broadly indicative rather than precise because of differences in the way that care statistics are collected across England, Scotland, Wales and Northern Ireland. In particular, the different approaches taken to measuring home care provision make the interpretation of data relating to this topic problematic.

The first row of Table 3 shows that a very high proportion of care home places are provided by the independent (private and voluntary) sector throughout the UK. Northern Ireland has the highest proportion of independent care homes, while Wales has the lowest share. There has been

a general policy preference towards a 'hotel' model of residential care, and an acceptance that this implied increased scale – with around 40 clients widely perceived as an appropriate size. The private sector has easier access to capital and has therefore been in a better position to build homes that provide attractive environments and meet regulatory requirements. Therefore the balance has shifted towards care homes owned by the private sector.

Northern Ireland also has the highest share of care home places per thousand population aged 65+. This may reflect its higher level of per capita funding, higher levels of disability and current or historic preferences over care provision. England has by far the largest number of domiciliary care clients aged 65+ whose cases have been reviewed by local authorities. This simply reflects its much greater population: 83 per cent of all UK citizens aged 65+ live in England. On a per capita basis, Northern Ireland has the largest number of older clients receiving local authority home care, followed by Scotland, Wales and finally England. This does not tell the whole story: in Northern Ireland, residential care is more commonly used for clients with personal care needs. Of the 21,400 clients receiving

Table 3: Balance of care

	England	Scotland	Wales	Northern Ireland
Share of independent sector (care home places) (%)	83.0	81.0	77.4	93.0
Care home places per 1,000, population 65+	43	44	46	49
Number of older LA domiciliary care clients	471,000	68,759	41,496	21,420
LA home care per 1,000 aged 65+	58	81	78	88
Total home care per 1,000 aged 65+	70			
Direct payments hourly rate	£8.87	£9.70	£6.74	£7.82
Private purchases of domiciliary care (£m)	1,460	34		
% of LA home care contracted out to independent sector	81	36	52	51

domiciliary care in Northern Ireland, only 5,600 are receiving intensive home care. Compare that with Scotland: following the introduction of free personal care in 2002, there has been a significant shift away from care home provision towards greater provision in clients' own homes. Thus, for each older person receiving personal care in a care home in Scotland at the start of 2009, there were 4.7 individuals receiving personal care at home. When the policy was introduced at the beginning of 2002 there were only 3.4 individuals receiving personal care at home for each care home client receiving personal care. This is a very significant shift in the balance of care. But the Scottish legislation that introduced free personal care merely prohibited local authorities from charging; it said nothing about the balance of care. The impetus towards changing the balance of care towards care at home began before devolution, but was carried forward by the Care Development Group, which was commissioned by the Scottish Executive after devolution to consider the feasibility of introducing free personal care.

The definition of what constitutes a care package differs between Scotland and Northern Ireland. But in both, a high proportion of clients receive personal care and there is therefore a significant overlap between the types of client. The data therefore suggests a substantial difference in the balance of care between care homes and domiciliary settings between Scotland and Northern Ireland, with a greater proportion of personal care being delivered at home in Scotland.

Northern Ireland also has an extensive home help service. In 2006/7, 19,600 older clients received a home help service. Such services have largely disappeared in Great Britain, with local authorities tending to provide services only to those with substantial or critical needs. In England, around 73 per cent of councils only offer home care services to those with 'substantial' or 'critical' care needs (UKHCA, 2009). In Scotland, the total number of local authority social care clients fell by more than 3,000 between 2004 and 2009. In 2004 at least 50 per cent of this group were receiving personal care; by 2009 this share had risen to 69 per cent.¹

The proportion of those aged 65+ receiving home care services is slightly lower in Wales than in Scotland and considerably lower in England. This does not tell the whole story, however. While 471,000 clients received home care packages in England in 2007/8, just over one million of those aged 65+ had some interaction with community-based services such as day care, meals and equipment and adaptations. Because statistics are not collected on the same basis in the rest of the UK, it is not possible to make direct comparisons.

Nevertheless, the lower proportion of those aged 65+ receiving home care packages from local authorities, shown in Table 3, may explain the substantial expansion of the private home care market in England. The Commission for Social Care Inspection (2009) estimated that 150,000 clients in England buy domiciliary care privately, slightly more than the 146,000 who pay their care home fees privately. Little is known about private purchasers of home care in Wales, Scotland and Northern Ireland. UKHCA (2004) estimates suggested that in Scotland in 2004, 16,000 weekly care hours were purchased independently by clients, accounting for only 3 per cent of total care hours purchased that year. As in England, these hours may be used to replace services which local authorities are no longer prepared to provide. But the scale is much larger in England. If private clients in Scotland purchased care packages half as large as those being given to the average Scottish local authority home care client receiving personal care, there would only be 2,800 such clients – less than 2 per cent of the number in England. While there is no data on expenditure of clients in Wales and Northern Ireland, Wales has fewer than half as many independent home care providers as Scotland has, while Northern Ireland has less than 13 per cent of the Scottish total. This suggests that the market for private purchases of home care for older people is much more developed in England than in Scotland, Wales or Northern Ireland. This may reflect greater ability to pay in England, as already discussed. It might also reflect stronger preferences for home care in England. Finally, it may be a reflection of the differences in government funding to the constituent parts of

the UK, with less pressure on local authorities in areas that are generously funded to withdraw from non-critical home care.

The last row in Table 3 shows the proportion of home care commissioned by local authorities which is contracted out to independent suppliers – charities and private providers. Again, there is a substantial contrast between England and the rest of the UK. Voluntary and private providers now supply 81 per cent of publicly funded home care in England, compared with 5 per cent in 1993. This is a much higher proportion than in Wales and Northern Ireland, where independent suppliers provide just over 52 per cent of state-funded home care. In Scotland the share of independent provision is even lower, with only 36 per cent of home care supplied by independent providers in 2008, while a further 11 per cent of provision involved combined working by local authorities and the voluntary or private sectors. The low proportion of independent provision in Scotland may be indicative of political and staff resistance to private sector care provision at home.

The evidence thus suggests that there are significant differences in the primary care system in different parts of the UK.

Key differences include:

- the balance between home care and care home provision;
- the ability of clients to design their own care packages;
- the balance between care provided by the public sector on the one hand and the independent sector on the other.

In the next chapter, we discover how some of these differences have emerged in relation to care policies that have been introduced in different parts of the UK.

6 Long-term care policy since devolution

In this chapter we examine a number of cross-cutting themes in relation to long-term care for older people and devolution. The first of these is free personal care, which has not only had major significance for the care of older people, but has also been one of the major policy divergences resulting from the first decade of devolution.

Free personal care

The Royal Commission on Long-Term Care recommended that personal care should be free to those assessed as in need of such care. Its recommendation coincided with the establishment of devolution. Since social care policy came under the control of the devolved bodies, each of these had to determine whether to take this proposal forward. As we shall see, the results are quite diverse: though politically appealing, free personal care has only been introduced in Scotland. In this section, we examine the history of this policy in each part of the UK. We start with Scotland.

Scotland

Free personal care for those aged 65+ was introduced in Scotland in July 2002 through an Act which prevented local authorities from charging for personal care. It had the support of all of the major political parties and was strongly supported by older people's advocacy groups. Its history has been somewhat troubled, but it has had a major impact on care provision in Scotland. It has also had a number of unintended consequences, some of which provide useful lessons for other parts of the UK. It has been the subject of a major review (Scottish Government, 2008), led by Lord Sutherland. It now has almost unanimous political support within Scotland. This may partly be because free personal care is not only valued in its own right, but it is also perceived as one of the best examples of how devolution has 'made a difference'. Prior to its introduction, the support of the Labour Party was more

equivocal. Its eventual support for the policy was partly driven by the need to maintain its coalition with the Liberal Democrats who were strongly committed to free personal care. We now examine some aspects of the policy, including its unintended consequences, having already dealt with the issue of Attendance Allowance in Box 1.

Understanding of the policy

Throughout its existence, understanding of the free personal care policy has been limited. This is true of the media, clients and carers. The misapprehension has extended throughout the UK. Its most extreme version is that all social care for older people in Scotland is free. In reality, accommodation charges are still charged in care homes, using broadly the same means test that applies in the rest of the UK. Therefore, those on medium or high household incomes may have to reduce their financial assets or housing equity to pay for care. Non-personal care provided at home is charged for, again using charging regimes that differ little from those in the rest of the UK.

Allocations to local authorities

England, Wales and Scotland have complex mechanisms to distribute funding from central government or the devolved bodies to local authorities. In Northern Ireland, the range of local authority functions is more limited, and therefore the allocation mechanism is simpler. Local authorities were compensated by the Scottish Executive for loss of charge income when free personal care was introduced. But calculation of this loss was complex. Allocation mechanisms tend to be weighted towards extra provision in areas of deprivation or in very rural areas. But the introduction of free personal care meant that local authority income fell most in relatively affluent areas. In poorer areas, funding had already been increased to pay for those who were unable to contribute towards their care costs and therefore did not benefit from free personal care. Thus the

allocation mechanism should have been biased towards higher-income authorities. Initially no separate calculation for free personal care at home was made, leaving some more affluent local authorities arguing that the policy was underfunded (see, for example, East Renfrewshire, 2007).

Some local authorities had already moved towards free personal care before 2002 by reducing or eliminating charges. These authorities thus had already absorbed the costs of the policy before it was introduced and therefore found it relatively easy to implement. Others had made no move in this direction and found it much more difficult to fund.

Variations in costs

The estimates of costs produced by the Scottish Executive showed huge variation across local authorities. Audit Scotland's review of free personal care (2008) argued that local authorities had been given insufficient guidance to accurately cost free personal care. Estimates of the per capita annual cost of free personal care at home vary widely across local authorities. Audit Scotland's revised cost estimates and the quarterly monitoring data collected by the Scottish Government suggest that in 2005/6, per head costs varied by a factor of six across local authorities. Argyll and Bute's annual cost was £6,650 while that in Angus was £1,100. The average for Scotland as a whole was £2,800. This is a huge variation in costs and well beyond what one might expect from, say, variations in transport costs. Given that service delivery is in the hands of the local authorities, the Scottish Government has limited powers to reduce cost variation. It has, however, set up the Joint Improvement Team (2009), which is charged with improving joint working between local health and social care partnerships and so indirectly should exert downward pressure on costs.

Single Outcome Agreements

There is no ring-fencing of funding associated with the free personal care policy. Instead local authorities and the Scottish Government now individually agree Single Outcome Agreements (SOAs). These commit the local authority to actions that support the Scottish Government's

overall strategy, but are the outcome of bilateral negotiations. Thus, in some agreements, older people's issues may play a central part, while in others such issues are peripheral. This contrasts with the more target-led culture in English local authorities which embody much more central direction. The design of the SOAs naturally leads to concerns that older people's issues will play only a minor role in local authority priorities because the National Performance Framework on which the SOAs are based only includes two aspirations in relation to older people. These are to reduce the number of emergency inpatient admissions and to increase the proportion with complex care needs who are cared for at home.

Unmet need

There was a substantial increase in demand for personal care shortly after the policy was introduced. This was not anticipated by the Care Development Group. The number receiving free personal care at home rose from 26,000 in 2002 to 44,000 in 2008. But the overall number of home care clients drifted slightly downwards to 66,000 over the same period. Thus, many fewer clients now receive non-personal care from Scottish local authorities. Clients who would previously have received non-personal care from the local authority may now be purchasing such care elsewhere. There are many unsubstantiated reports of clients asking for their free personal care from the relevant local authority, while purchasing other components of their care from the private sector.

Local authority provision of personal care at home and AA/DLA are both addressed at clients with personal care needs. We have shown that the AA/DLA client base is around five times larger than the local authority client base, and that AA/DLA claims in all parts of the UK, including Scotland, have increased somewhat during this decade. But the growth has been slower than the increase in demand for free personal care at home in Scotland provided by local authorities. The increase in home care clients in Scotland seems to be a response to previously unmet need from clients who were assessed as requiring personal care by local authorities. Although there was not a similar proportionate rise in AA claimants, the

increase in local authority provision may have occurred because some clients who were receiving AA but not local authority personal care were given assessments which indicated that they were entitled to receive local authority care. This illustrates the importance of the assessment mechanism in determining eligibility for services that are free at the point of delivery.

Care boundaries

Whenever a service is provided free, disputes are likely to arise both over the definition of the service and over eligibility for free provision. With Scotland, the key issue turned out to be food preparation. Local authorities claimed that Scottish Executive guidance on the circumstances in which food preparation constituted personal care was unclear, and they did not wish to risk litigation by taking a narrow view of eligibility. Following recommendations in the Sutherland Review of 2008, discussions between the Scottish Government and the Convention of Scottish Local Authorities (COSLA) resulted in the passing of a regulation (Scottish Statutory Instruments, 2009) which precisely specifies the nature of food preparation. Devolution has provided powers not only to legislate in Scotland, but also to amend legislation relatively easily.

Treatment of those aged under 65

Eligibility for free personal care in Scotland is age-dependent. Those aged under 65 who are assessed as being able to contribute to the costs of care continue to be charged. Only those aged 65+ receive free personal care. This has yet to be challenged in the courts on the grounds of age discrimination. If it were successfully challenged, there would be significant cost implications for the Scottish Government. Evidence from Wales suggests that those aged under 65 tend to have more complex care needs and are less able to fund their care.

Wales

The Welsh Assembly initially took a cautious approach to free personal care. But in 2003, the Labour Party manifesto for the Welsh Assembly pledged to introduce free domiciliary care services for disabled people in Wales. Following this

commitment, in 2004, an expert group – the Free Home Care for Disabled People Task and Finish Work Group (FHCTG) – was convened to consider options for implementation. This group examined the definitions of disability and types of service that might be eligible under the scheme. The definition of domiciliary care was closely aligned to the definition of personal care used in Scotland. Following this report, the Minister for Health and Social Services announced that a final scheme would be released in 2006/7.

Local authorities in Wales have a statutory right to charge for domiciliary care. Until recently, the Welsh Assembly Government did not have the legislative powers necessary to set aside this right except for the first six weeks. It could, however, try to persuade local authorities to stop charging by reimbursing them for loss of charge income.

Research commissioned by the Assembly Government (Bell, 2006) provided estimates of future costs of free domiciliary care in Wales. These costings reflected higher levels of disability in Wales and the additional costs of providing free care for those aged under 65. Wales is not as generously funded in relation to its level of need through the Barnett formula as is Scotland. The additional costs thus provided a significant challenge to the Welsh Assembly's budget. These costs were forecast to increase substantially over time as a result of demographic change.

The Assembly Government therefore investigated alternative ways of reducing charges to personal care clients in Wales. In 2006, it proposed an alternative scheme (Welsh Assembly Government, 2006), which was specifically targeted at those on modest incomes. Specifically, it increased the 'buffer' above Income Support levels from 25 per cent to 35 per cent before charges are made. This allowed those on incomes just above Income Support levels to retain a greater share of this income. More affluent care clients would be unaffected by this measure and would therefore continue to pay charges. The full package included additional support for carers, greater provision of equipment and expansion of telecare.

The Welsh experience is therefore quite different from that in Scotland. Concerns over costs and scarcity of resources led to a quite

different policy from that envisaged by the Royal Commission. Rather than treating personal care as equivalent to NHS provision, i.e. free at the point of delivery, the Welsh Assembly focused assistance on those of modest means who pay a much larger proportion of their income in charges than more affluent clients.

Northern Ireland

Prior to devolution, care home clients in Northern Ireland were expected to contribute to the costs of personal care, subject to a means test. Those receiving care at home did not have to pay for their personal care; this was a more generous provision than elsewhere in the UK. But, as we have already seen, numbers receiving domiciliary care in Northern Ireland were relatively low.

In 2001, the Northern Ireland Executive commissioned a group to examine the costs of introducing free personal care. The Assembly was suspended before the analysis was complete. Ministers were unwilling to take a decision during the period of direct rule, arguing that such a decision should be taken by a locally elected Executive.

The Northern Ireland Assembly voted in favour of providing free personal care in 2007. Following this vote, it set up a review of the costs and benefits of introducing free personal care in Northern Ireland. The review argued that a relatively small number of clients would benefit from free personal care. This is partly because the care needs of 70 per cent of care home clients in Northern Ireland are fully funded by the state, reflecting the relatively low incomes of Northern Irish pensioners, as mentioned previously. Accommodation charges are means-tested as in the rest of the UK. Data on residents in private care homes is not collected systematically in Northern Ireland. But the review estimated that there were around 1,600 such residents and a further 1,900 self-funding residents that were known to the HSCs. However, based on estimates of the weekly costs of personal care in care homes, which were close to the estimates used in Scotland, the review estimated that 1,900 self-funders and 230 residents who are part-funded by the Northern Ireland Executive would benefit financially from the introduction of free personal

care. Just over a quarter of care home residents in Northern Ireland would be better off as a result of the introduction of free personal care.

The review concluded that the relatively small number of beneficiaries made it difficult to justify the estimated initial cost of £30 million, which would rise to £45 million by 2026. In May 2009, the Northern Ireland Health Minister, Michael McGimpsey, announced that he would not be able to introduce free personal care in Northern Ireland for cost reasons.

Thus, both in Wales and Northern Ireland, initial political support for free personal care was eroded when the cost implications of the policy were analysed. This does illustrate that, even with a fixed budget, devolution has made local politicians accountable for the choices they make. In both areas, organisations that support the needs of the disabled have made their disappointment very clear to the politicians who decided not to proceed with free personal care.

England

In its response to the Royal Commission on Long-Term Care, the Department of Health (2000) argued that making personal care free for everyone would carry a very substantial cost and that it does not help the least well-off. They therefore rejected its recommendation that personal care should be free, subject to assessment of need. Unlike in Scotland, Wales and Northern Ireland, the policy of free personal care never commanded sufficient support in the major political parties to make its introduction in England likely.

Nevertheless, in all recent evaluations of long-term care funding in England, free personal care is invariably one of the options considered. For example, the Wanless Review (King's Fund, 2006) analysed current and potential future costs of free personal care alongside the 'partnership' model which provides people with a free minimum guaranteed amount of care set at around two-thirds of a benchmark care package. Individuals can then contribute towards the cost of their package with match-funding from the Government until the benchmark care package is achieved. Those on low incomes who could not contribute would receive state funding to pay for the benchmark package. The partnership model is

preferred to free personal care in the Wanless Review, largely on the grounds of cost. With free personal care, the state has to provide 78 per cent of total costs compared with just over 71 per cent in the partnership model.

The report also argues that both the partnership and free personal care models undermine the logic of AA and DLA, and that these benefits might largely be discontinued. Clearly, should this come about, there would be significant implications for the devolved nations, who might wish to implement a different mechanism for funding long-term care. They might be forced to accept changes in the secondary care system as a result of the introduction of, say, the partnership model. This could undermine the funding basis of their long-term care policies, thus questioning the ability of the devolved nations to follow a radically different approach to that in England.

A final aspect of the process of examining the costs and benefits of free personal care is the relative size of the resources that each part of the UK has devoted to its evaluation. England's relative size means that it can absorb the fixed cost of large-scale policy evaluations relatively easily. Scotland, Wales and Northern Ireland have to design policy based on much more meagre analytical resources. The same disparity in analytical power has been evident in the next topic that we discuss – the drive towards giving clients greater control over the care they receive.

Personalisation

In recent years, many industrialised countries have given disabled people greater control over the services that they use. In the UK, direct payments (also described as self-directed care) have increased client control over care provision by allowing them to choose among care providers. The move towards personalisation began before devolution with the 1996 Community Care (Direct Payments) Act which allowed local authorities throughout the UK to offer direct payments instead of services. The devolved bodies have therefore been able to control the rate at which personalisation was introduced: they could influence local authorities' priorities and provide resources to meet implementation costs such as

training and arrangements for monitoring and management. These costs are relatively greater in Scotland, Wales and Northern Ireland because of their smaller scale than England.

In England there has been a sharp increase in the number of clients receiving direct payments since 1997. But take-up in the devolved nations has been much slower. This cannot be easily explained by differences in the regulatory framework. In April 2003 regulations were put in place requiring councils in England to offer direct payments to *all* people using community care services.

Similar guidance was introduced in Scotland in 2003, and then updated in 2007. The legislative competence for this guidance came from the Social Work (Scotland) Act 1968. Another important input into the 2007 regulations was the report of the Scottish Parliament Health Committee (2006) which stated that:

The Committee supports the concept of direct payments as a means of increasing the autonomy of those who receive them as well as enabling care packages to be tailored more closely to their needs. Whilst not a solution for everyone, they have the potential to improve the care available to many and the Committee wishes to encourage the increase in their take-up.

The report also stressed the need for the guidance to encourage clear commitments from local authorities to improve take-up. Thus, partly as a result of this report, the 2007 guidance proposed that local authorities should fund:

- independent, user-led, local support services;
- training for individuals making use of self-directed support, including personal assistants;
- appointment of self-directed support lead officers within each local authority;
- training on self-directed support for care managers, finance managers and local authority directors.

In England, Putting People First (Department of Health, 2007) marked a new commitment to personalisation of adult social services. It embodied a new vision for the future of care services:

The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focused on prevention, early intervention, enablement, and high quality personally tailored services. In the future, we want people to have maximum choice, control and power over the support services they receive.

(Department of Health, 2007, p.2)

Putting People First introduced the concept of personal budgets, which could be taken in the form of a direct payment or by asking the local council to commission the service. A further extension was the introduction of individual budgets, which cover a larger group of funding streams such as Supporting People, Independent Living Funds etc. First proposed in 2005, these were piloted across 13 councils in England by the Individual Budgets Evaluation Network (IBSEN), which was based at five leading universities. A key finding of the evaluation was that, though some groups reacted positively to individual budgets, older people were more likely to suggest that taking control of their support was burdensome.

One aspect of this approach to policy formation is that it helps develop policy evaluation capacity in English universities. With a less well-resourced approach to policy formation, universities in the devolved nations are unable to provide such high quality policy analysis.

In Scotland, regulations for direct payments were introduced in June 2003. The duty to offer direct payments was extended to all persons aged 65+ assessed as needing a community care service because of infirmity or old age. Unlike in the rest of the UK, carers in Scotland were not offered direct payments for their own services (Carers UK, 2009). In Wales, similar measures were established in March 2005 (Welsh Assembly Government, 2004). In Northern Ireland, the Carers and Direct Payments Act (Northern Ireland) 2000 extended direct payments.

The extension of personalisation has been very uneven across the UK. This was illustrated by Riddell *et al.* (2006), who conclude that by 2003 the take-up of direct payments in England was twice as high as in other parts of the UK. They provide a number of explanations, including the effectiveness of local disability advocates, funding for policy development, political culture, the supply of social care and the appropriateness of infrastructure.

Before mandatory duties were placed on local authorities, local interpretations of policy were an important influence on direct payment provision (Priestley *et al.*, 2006). Some local authorities lacked the capacity to implement national policies. The smaller scale of the local authorities in the devolved nations may have impeded their ability to implement new policy initiatives. But also there was local resistance to direct payments, particularly in Scotland. This may have come from local politicians, managers or front-line staff (Priestley *et al.*, 2007) and may stem from a greater commitment to collectivism and loyalty to the welfare state in Scotland (Keating, 2003).

The resources and training allocated to personalisation inevitably affect take-up. Smaller local authorities have more difficulty in absorbing the fixed costs of implementation. Resources allocated to training varied widely across local authorities. Training was vital given the novelty of the service and the large number of issues that had to be resolved before an effective and efficient service could be delivered. There is also evidence of wide variation in the effectiveness of this training (Davey *et al.*, 2007).

Recent data from Scotland and England shows a marked increase in take-up in recent years. Between 2004 and 2009 the number of self-directed support payments in Scotland more than doubled. However, this data covers all adults, rather than those aged 65+. Similarly, Wales and Northern Ireland do not publish data on those direct payments that are specifically directed at those aged 65+. Only England publishes data on direct payments by age group.

Personalisation posed a different challenge than did free personal care to the devolved administrations. Though it represented a major change in the philosophy of care provision, it did

not require legislative change. Rather, the issue was the willingness of the administrations and local authorities to prioritise personalisation. The 2007 manifestos of the Labour Party, Liberal Democrats and Conservatives in Wales and Scotland did not highlight personalisation. Only the Scottish National Party alluded to this issue, with a commitment to introduce individual budgets. The general impression is that politicians in the devolved bodies are lukewarm to the personalisation agenda and that this has impeded its relatively slow extension compared with England.

Charging

All UK local authorities have the legal right to set charges for long-term care under the 1948 National Assistance Act. Differences in charges between local authorities are criticised on the grounds of both complexity and equity. The Department of Health in England and the devolved administrations can issue guidelines to ensure consistency of charging.

The broad principles of charging are common to most local authorities, but details may differ significantly. Thus, charges are generally based on ability to pay rather than cost. The charging process must therefore be based on an assessment of clients' financial circumstances. The assessment of capital has an important role in determining whether charges are levied at all.

If capital exceeds some limit, charges are set so that a client retains a minimum level of income. For those living at home, this minimum may reflect the value of Income Support. To this is usually added a 'buffer', set at a percentage of these minimum income levels. This is 'guaranteed' income. The person's 'assessable income' would be any income that exceeds the guaranteed income. Charges are only levied against the 'assessable' component of this income.

Charging for care is highly complex. For many years, local authorities determined charges without reference to national guidance. But as the costs and volume of care increased, the desire of the devolved authorities and the UK Government to have greater consistency has led to more pressure being put on local authorities to align their charging policies.

For example, the Welsh Assembly Government issued statutory guidance on charging policy in July 2002. *Fairer Charging Policies for Home Care and Other Non-Residential Social Services* (WAG, 2002) sets out a framework for 'reasonable' charging policies. It considered issues such as maximum charges, buffers, minimum residual income and savings limits. When the Welsh Assembly decided not to go ahead with the policy of free personal care, it partly offset the negative impact of this decision by increasing its grant to local authorities to allow them to reduce charges to domiciliary clients. Specifically, it increased the 'buffer' so that a substantial number of less affluent clients would no longer have to pay charges.

In Scotland, guidance tends to come from COSLA. Thus, in January 2006, COSLA sent a circular letter to local authorities which was careful not to be seen to be interfering with local authorities' power to determine charges. It stated that:

The Guidance does not take the form of national prescription. It provides a framework that aims to maintain local accountability and discretion while encouraging councils to demonstrate that in arriving at charges they have followed best practice.

Although personal care is free at home in Scotland, councils can and do charge for day care, lunch clubs, domiciliary services, including meals on wheels, wardens in sheltered housing, community alarms, laundry services, aids and adaptations. As council budgets have tightened, these charges have tended to increase significantly. This has been understandably unpopular with clients. For example, the increase in charges for such services in Fife from £4 to £11 per hour in 2008 was credited with having an impact on the Glenrothes by-election (*The Courier*, 2008).

In Northern Ireland, care is primarily delivered by HSCs. No charges are made for domiciliary care. As mentioned earlier, the balance of care in Northern Ireland is weighted more towards care homes than in other parts of the UK. Care home charges are determined in a similar way to other parts of the UK. Savings limits in Northern Ireland are the same as those in England.

In England care charges are set by local councils, but should comply with the *Fairer Charging* guidelines (Department of Health, 2003). As in the rest of Great Britain, local authorities in England have some autonomy to set their own charges. There are ongoing concerns over differential charges across local authorities. Differences in policy priorities and views about how progressive charging should be, may partly explain some of these differentials, but they also reflect differences in local authorities' financial situations. These partly indicate the extent to which central government grants accurately reflect local needs in each authority across all categories of spending. Unexpected overspends in other parts of the local authority budget, including social services, may force local authorities to increase care charges to older people.

Across the whole of the UK, care charges to older clients are determined by an uneasy mixture of local autonomy and central direction. Care charges are widely perceived to be unfair in that they fall most heavily on those of modest means who are unlucky enough to require complex packages of care, either at home or in a residential setting. The two major impacts of devolution have been the removal of charges for personal care in Scotland and the changes to the structure of charges in Wales as compensation for not introducing free personal care.

While there has been pressure to reduce the variability of charges across local authorities, there is no enthusiasm for taking responsibility for charging away from local authorities in either Scotland or Wales. This may be a political calculation, given the unpopularity of care charges. But it would also remove local authority freedom to adjust charges in the light of their own financial circumstances and so would further weaken the accountability of local government.

Relationship between local authorities and devolved bodies

As implied by the previous discussion, the relationship between local authorities, devolution and long-term care for older people is highly complex. This stems from (1) the legislative duty on local authorities to provide social care and

from (2) the tension between national uniformity and local autonomy in assessment, delivery and charging.

Devolution has added a new layer to this complexity. Devolved authorities can establish a different working relationship with their local authorities from that which exists between English local authorities and Westminster. For example, as mentioned previously, the SNP introduced an outcomes-based governance model, the National Performance Framework, in 2007 (Scottish Government, 2009a). Its constituent parts are a single government Purpose, five Strategic Objectives, 15 National Outcomes and 45 National Indicators designed to track progress. Performance against these in relation to older people is calibrated on the 'Scotland Performs' website (Scottish Government, 2009b), and the SOAs 'set out how each will work in the future towards improving national outcomes for the local people in a way that reflects local circumstances and priorities'.

The effectiveness of joint working between health authorities and local government is also important for long-term care delivery. Health authorities are typically not elected. They have less democratic legitimacy and therefore are less able to contest policy initiatives from the devolved bodies. This is important in Northern Ireland, where local authority powers are much more limited than in the rest of the United Kingdom and long-term care for older people is delivered by HSCs.

Laffin *et al.* (2002) argue that the establishment of the Welsh Assembly has not restricted local government autonomy in Wales. As with its equivalent, COSLA in Scotland, the Welsh Association of Local Government (WLGA) has developed new policy networks as a result of the establishment of the Assembly. Such networks could potentially improve long-term care delivery. This reflects the benefits of the relative smallness of the devolved authorities: it is easier to agree policy innovations when there are a small number of parties involved. It is much more difficult in England where there are not only a large number of local authorities but a complex structure involving metropolitan districts, shire counties and unitary authorities as well as the London boroughs.

7 Long-term care policies across the UK

This chapter looks at the extent to which changes in long-term care policy are constrained or enhanced by the creation of the devolved administrations.

Social security

The UK has two care systems that are largely funded by the state. The primary system is largely funded by local government; the secondary system is paid for by DWP. In the devolved nations, local government is the responsibility of the respective administrations. Suppose that a UK government wished to instigate a major reform of welfare benefits, including AA and DLA. This would result in significant political difficulties under the current structure, because changes to welfare benefits might have implications for care provision via local government. Clearly this would involve some mechanism for co-operation across the UK. Such a mechanism does in theory exist. The Joint Ministerial Council was set up in 1999 'for the devolved administrations to be involved by the UK Government at ministerial level when they consider reserved matters which impinge on devolved responsibilities' (Scottish Executive, 1999). In practice, meetings of this committee have been relatively rare though they were revived in 2008. As yet, none of them have focused on social care, which clearly constitutes one of the most important interactions between devolved and reserved matters in terms of both social welfare and fiscal sustainability.

Thus, for example, the Streamlined Assessment Project (StAP) approach arose out of UK government policy to 'meet the challenges of ageing in the 21st century' (Hilton, 2008). It involves joint assessment of eligibility for AA and for local authority social care. In the interests of efficiency, it is sensible to streamline assessment procedures. All of the pilots for this project have been carried out in England. Assessment

procedures for the primary care system are different in Scotland, Wales and Northern Ireland.

Funding mechanisms

The first decade of devolution has coincided with a benign public expenditure climate. While there has been some dissatisfaction with levels of funding in the devolved nations, the decade has in fact witnessed an unprecedented increase in the real value of public expenditure across the UK. However, it has been clear for some time that the financial arrangements that currently underpin devolution are difficult to justify on grounds of equity and have no international parallels.

Thus, and for different reasons, Wales and Scotland have separately set up commissions to investigate the existing funding structure and suggest alternatives. The Independent Commission on Funding & Finance for Wales (the Holtham Commission) recently reported on the advantages and disadvantages of the Barnett formula to Wales, and on possible alternative funding mechanisms, including tax varying and borrowing powers (Independent Commission on Funding & Finance for Wales, 2009). Similarly, the Commission on Scottish Devolution (the Calman Commission) examined the provisions of the Scotland Act 1998 to determine if there was a way to improve the financial accountability of the Scottish Parliament within the United Kingdom. Developments such as these suggest that devolution should be regarded as a process, rather than an event. It is unclear where this process may go, and at what speed.

Changes in the powers of the devolved administrations will mean further changes to relationships with Westminster ministries. Their success will therefore be contingent on goodwill in Westminster, which has not always been present, perhaps partly because these Westminster departments are not compensated for the costs of dealing with the devolved administrations.

Both commissions emphasise autonomy, equity and accountability as desirable features of any revised funding arrangements. One mechanism for increasing autonomy and accountability would be to confer tax powers from London to Edinburgh and Cardiff. The Calman Commission has proposed that the Scottish Parliament retains around half of income tax revenue and makes an explicit decision about the income tax rate required to generate this revenue. (Commission on Scottish Devolution, 2009). In terms of long-term care, this would open opportunities to use either general or hypothecated taxes to fund long-term care, as is the case in Germany and Japan.

However, the Calman Commission accepted that social security would continue to be available on a uniform UK-wide basis. Thus, even if Scotland used additional tax-raising powers to fund long-term care, state support for care for older people would still be partly provided by Westminster through AA and DLA. Since neither the Holtham nor the Calman Commission appears willing to contemplate devolving social security, it seems likely that, for the foreseeable future, the primary and secondary sources of support for long-term care will continue to exist. Inevitably this raises questions around whether this is an efficient use of public resources when the two systems have very limited joint communication. While general principles of equity suggest that the social security system should be uniform across the UK, these efficiency arguments are perhaps too readily dismissed and might well be worth revisiting.

Our analysis of the structure of long-term care provision in different parts of the UK suggests that there are relative differences in the demand for care. These stem from differences in age structure, healthy life expectancy and unpaid care provision etc. But the Barnett formula, as we have previously described, is not responsive to differences in need. In Wales, England and Scotland, allocation mechanisms for funding local authorities and health authorities do respond to indicators such as numbers of older people. But the mechanism which determines the overall grant by the Treasury to Scotland, Wales and Northern Ireland does not respond to differences in need. The Holtham Commission is likely to recommend

that a needs assessment should be undertaken, while the Calman Commission has accepted that such an assessment may be necessary, though this may well have negative effects on funding in Scotland and Northern Ireland.

Political constraints

The UK has a very open and efficient media environment. Differences in the volume and quality of public services across the UK are easily communicated. This creates difficulties for politicians who wish to emphasise constructing policy around local needs and aspirations, and having local accountability for these choices.

Similarly, aside from the nationalist parties, the political structure of the UK is organised around three major UK-wide parties, each of which is represented at the different levels of government. This inevitably causes tensions if a party wishes to follow different policies at different levels of government. Thus, for example, the Labour Party in Scotland has consistently supported free personal care since its introduction, whereas the UK Labour Party has argued that it is too costly, and also not sufficiently targeted at the poor.

These centralising forces make it difficult for the devolved governments to introduce radical policy initiatives. This is particularly true where there are significant funding consequences, given their almost complete dependence on a block grant from the UK Government. Aside from the issues that we have already discussed, such as the UK-wide social security system, the importance of pre-devolution legislation and the policy role of local authorities, the constraints associated with funding and the political culture also inhibit the development of truly radical approaches to long-term care provision in the devolved nations.

8 Conclusions and recommendations

This report has looked at several different aspects of the interaction between devolution and long-term care for older people in the last decade. It is evident that devolution has made a system that the public, politicians and clients found difficult to comprehend even more complex. One of the principal reasons for confusion is the multiplicity of agencies involved. The devolved institutions are responsible for long-term care insofar as they largely fund local authorities or, in the case of Northern Ireland, the Health and Social Care Trusts. These bodies provide the primary social care system that assesses and manages care for those with assessed need. However, there is a parallel secondary system which provides cash to those with care needs. They are assessed by a different mechanism and the client base is around five times larger than that of the primary system. The secondary system is funded by DWP and is independent of the devolved bodies. Finally, there is a tertiary system associated with those who cannot, or do not wish to, access publicly provided care. In this system, clients, their relatives or friends pay for care privately or make informal arrangements to supply care. These three systems interact, but these interactions are not well understood. Their interdependence means that it is impossible to change the rules by which one of them operates without having effects, sometimes unintended, on the others.

This poses a particular problem for devolution because social care is one of the areas which is not reserved to Westminster. But the social security system is reserved even though it includes payments to compensate for care needs – Attendance Allowance and Disability Living Allowance. And because of the interdependence between the two systems, it is difficult to see how these benefits could be altered without affecting the funding of social care policy in the devolved nations. Indeed, this argument is implicitly acknowledged, albeit weakly, in the recent Green Paper on social care (HM Government, 2009).

In a paper of 132 pages, there is only one mention of the devolved administrations. This is in relation to the possibility that moving funding from the secondary to the primary system would affect publicly funded care provision in the devolved nations. According to the Green Paper, the devolved administrations may ‘choose to adopt the new care and support system’ (p.104) that will be implemented in England. Such treatment of the devolved administrations tends to reinforce stereotypes held in Scotland, Wales and Northern Ireland that some of the Westminster ministries are unwilling to engage with the intricacies of the devolution settlements.

The Green Paper is somewhat vague on what this system might be. But it does suggest that there will be further extension of client choice through mechanisms such as personal budgets. As we have seen, there has been much less enthusiasm for this approach in the devolved nations than in England. Indeed, the whole point of devolution was to allow different parts of the UK to formulate their own policies for a limited set of policy areas, including social care. The sentiments of the Green Paper seem at odds with this. It does not reflect the possibility that the devolved authorities may have distanced their social care policy from that in England as a point of principle – to demonstrate that devolution is able to provide different policies from those in England.

The Green Paper makes it abundantly clear that changes in the structure of the secondary care system will be driven by the English policy agenda. This makes it difficult for the devolved administrations to embark on radical changes to their own funding mechanisms. It is therefore not clear that the devolved nations can really pursue a wholly independent long-term care policy. Politicians in Scotland, Wales and Northern Ireland cannot afford to ignore the possibility of such change in designing long-term care policy.

For example, even if the devolved administrations are granted tax-raising powers,

it would be difficult to conceive how a Scottish administration might operate its own long-term care tax or insurance scheme unless it had greater control over AA and DLA. But the Calman Commission has explicitly ruled out the possibility of varying the social security system across the UK. Paradoxically, it may be that the UK Government will be willing to consider such variation. This could happen if the implication of the Green Paper that greater alignment of the primary and secondary care systems would be desirable in England becomes part of UK government policy.

What is clear is that there has been little joint learning of social care policy lessons in the last decade. Although one could think of the UK now being a 'policy laboratory', there do not seem to be proper mechanisms where ideas and experience can be transferred. Most importantly, the Joint Ministerial Committee mechanism does not seem to be functioning adequately. None of its relatively rare meetings have addressed the issue of social care, one of the most pressing policy issues currently facing the UK.

At a lower level, governmental evaluation and assessment of social care policy in the different parts of the UK generally focus on England, Scotland, Wales and Northern Ireland separately. It is only charities, such as the Joseph Rowntree Foundation, that attempt to take a wider perspective. Understandably, the resources allocated to policy evaluation in England substantially exceed those deployed in the rest of the UK. This means that there is much less evaluation capacity in the devolved nations. There is possibly a role for the Economic and Social Research Council, which has significantly more resources than the charitable research organisations, to take a lead in enhancing knowledge exchange and capacity-building in relation to social care policy across the UK.

Our research has indicated that there are differences in the demand for long-term care by older people in different parts of the UK. These reflect differences in life expectancy, the prevalence of disability and the willingness of unpaid carers to supply care, though rates of unpaid care provision seem to be converging across the UK. What is clear is that variations in

the demand for long-term care *between* the component parts of the UK are much smaller than are the variations *within* each of these parts. Similarly, the ability to pay for care appears to vary more within than between England, Scotland, Wales and Northern Ireland. Variations in the demand for long-term care for older people and in ability to pay between the component parts of the UK are relatively small in international terms.

While devolution may have restructured political power within the United Kingdom, it did not fundamentally change the funding mechanisms in Scotland, Wales and Northern Ireland. As a result, there continue to be significant differences in the amount of public resources allocated to long-term care in the different parts of the UK. In consequence, the tertiary sector, where people pay for their own care, is much more developed in England than in the devolved nations. Unfortunately, information on this sector is relatively poor, and, given that it is likely to expand throughout the UK in the future because of the severe constraints on government spending that are likely to apply for at least the next decade, there should be a priority to improve our understanding of its operation.

As mentioned above, in Great Britain, the 'primary' long-term care system is administered by local authorities. This is partly because much of the legislation which sets the framework under which long-term care is provided pre-dates devolution. This inhibits the devolved authorities from instigating radical change because the unravelling of this legislation would be problematic and time-consuming. Thus local authorities in Great Britain tend to be responsible for assessment, charging and, in some cases, provision. Clearly they have democratic legitimacy, and therefore the devolved administrations and the Department of Health in England have to take care not to interfere with legally established local authority powers. However, the devolved administrations can legitimately influence the autonomy of local authorities by adjusting their ability to allocate funding towards their own priorities or towards those of the devolved administration. The Scottish Government has taken a quite different approach to this issue to that of the Westminster Government. However,

both the devolved administrations and the Westminster Government face a political dilemma in determining the relative role of centralised direction and local autonomy in long-term care policy.

Health boards are not generally elected, but they have an important interaction with local authorities in supporting frail older people. There is therefore a complex political interaction in Scotland and Wales between the devolved administration, health boards and local authorities. In Northern Ireland, local authorities do not have a significant social care role. Nevertheless, all parts of the UK are introducing policy changes to improve the joint working of the relevant public agencies, including pooled budgeting. There must be lessons that can be learned from other jurisdictions in seeking to effect these efficiency improvements, yet again there seems to be no appetite for joint evaluations in this area.

Ultimately, the key question is whether devolution has benefited care clients. This is not easy to answer. The last decade has seen an unprecedented increase in public spending, which has significantly increased the amount of resources allocated to health and care provision throughout the UK. This will not be repeated in the next decade. It has been possible for the devolved administrations and the UK Government to improve services, at least for some clients, without experiencing a significant political cost. They have done this without much co-operation or co-ordination across the UK. The need to learn from each other, even if policies differ somewhat, will become much more acute in the next decade.

Notes

Chapter 2

- 1 The Scottish Parliament was given the power to vary income tax by 3p in the pound but this power has never been exercised.
- 2 Data is taken from various volumes of Public Expenditure Statistical Analysis (PESA), HM Treasury and chain-linked back to 1998/9.

Chapter 3

- 1 2002 is the first year for which consistent data is available.

Chapter 5

- 1 We do not have data on those aged under 65 who receive personal care. Therefore these percentages represent lower bounds on the share of clients receiving personal care.

Related reports

Adamson, D. (2010) *The Impact of Devolution: Area-based Regeneration Policies in the UK*

Bivand, P., Bell, L., Vaid, L., Whitehurst, D. and Wan, K. (2010) *The Impact of Devolution: Employment and Employability*

Palmer, G. (2010) *The Impact of Devolution: Indicators of Poverty and Social Exclusion*

Wilcox, S. and Fitzpatrick, S. (2010) *The Impact of Devolution: Housing and Homelessness*

References

- Audit Scotland (2008) *A Review of Free Personal and Nursing Care*. Available at www.audit-scotland.gov.uk/utilities/search_report.php?id=230 (accessed August 2009)
- Bell, D.N.F. (2006) *Estimating the Cost of Free Home Care for Disabled People in Wales*. Cardiff: Welsh Assembly Government
- Care Development Group (2001) *Fair Care for Older People: Report*. Available at www.scotland.gov.uk/Publications/2001/09/10069/File-1 (accessed August 2009)
- Carers UK (2009) 'What are direct payments?' Available at www.carersuk.org/Information/Directpayments/Whataredirectpayments (accessed August 2009)
- Commission for Social Care Inspection (2009) *The State of Social Care in England 2007/8*. Available at www.cqc.org.uk/_db/_documents/SOSC08%20Report%2008_Web.pdf (accessed August 2009)
- Commission on Scottish Devolution (2009) *Serving Scotland Better: Scotland and the United Kingdom in the 21st Century*, Final Report. Available at www.commissiononscottishdevolution.org.uk/uploads/2009-06-12-csd-final-report-2009bookmarked.pdf (accessed August 2009)
- Davey, V., Fernández, J., Knapp, M., Vick, N., Jolly, D., Swift, P., Tobin, R. Kendall, J., Ferrie, J., Pearson, C., Mercer, G. and Priestley, M. (2007) *Direct payments: a national survey of direct payments policy and practice*. London: Personal Social Services Research Unit
- Department of Health (2000) 'The NHS Plan, The Government's response to the Royal Commission on Long Term Care', Cm 4818-II, July. Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082154.pdf (accessed November 2009)
- Department of Health (2003) *Fairer Charging Policies for Home Care and Other Non-residential Social Services: Guidance for Councils with Social Services Responsibilities*. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4117930 (accessed August 2009)
- Department of Health (2007) *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118 (accessed August 2009)
- East Renfrewshire (2007) Letter from the Director of Finance to Lord Sutherland's Review of Free Personal Care. Available at www.scotland.gov.uk/Resource/Doc/924/0056697.pdf (accessed August 2009)
- Frick, J.R., Goebel, J., Schechtman, E., Wagner, G.G. and Yitzhaki, S. (2006) 'Using Analysis of Gini (ANoGi) for detecting whether two sub-samples represent the same universe: the German Socio-Economic Panel Study (SOEP) experience', *Sociological Methods & Research*, Vol. 34, No. 4, pp. 427–68
- Hilton, J. (2008) *Streamlining the Assessment of Attendance Allowance Applications with Social Care Assessment: An Evaluation of Two London Pilots*, Department for Work and Pensions Research Report No. 534. London: DWP

- HM Government (2009) *Shaping the Future of Care Together*, Cm 7673. Available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102732.pdf (accessed August 2009)
- HMSO (1999a) *With Respect to Old Age: Long Term Care – Rights and Responsibilities, A Report by The Royal Commission on Long Term Care*, Cm 4192-I. London: The Stationery Office
- House of Commons, Work and Pensions Committee (2009) *Tackling Pensioner Poverty, Fifth Report of Session 2008–09*. London: The Stationery Office
- Independent Commission on Funding & Finance for Wales (2009) *Funding Devolved Government in Wales: Barnett & Beyond, First Report*. Available at <http://wales.gov.uk/docs/icffw/report/090708barnettfullen.pdf> (accessed August 2009)
- Joint Improvement Team (2009) *What is JIT?* Available at www.jitscotland.org.uk/about/what-is-jit/ (accessed August 2009)
- Keating, M. (2003) 'Social Inclusion, Devolution and Policy Divergence', *The Political Quarterly*, 74.4, pp.429–30
- King's Fund (2006) *Securing Good Care for Older People: The Wanless Review of Social Care*. Available at www.kingsfund.org.uk/research/publications/securing_good.html (accessed August 2009)
- Laffin, M., Taylor, G. and Thomas, A. (2002) *The National Assembly for Wales and Local Government*. York: Joseph Rowntree Foundation
- Priestley, M., Jolly, D., Pearson, C., Riddell, S., Barnes, C. and Mercer, G. (2006) 'Direct payments and disabled people in the UK: supply, demand and devolution'. *British Journal of Social Work*, July
- Riddell, S., Priestley, M., Pearson, C., Mercer, G., Barnes, C., Jolly, D. and Williams, V. (2006) *Direct Payments: A UK Comparative Study*, ESRC End Of Award Report, RES-000-23-0263. Available at www.leeds.ac.uk/disability-studies/projects/UKdirectpayments/UKDPfinal.pdf (accessed August 2009)
- Scottish Executive (1999) 'Concordat Between the Scottish Executive and the Lord Chancellor's Department', December. Available at <http://www.scotland.gov.uk/Publications/1999/12/lcd> (accessed November 2009)
- Scottish Government (2008) *Independent Review of Free Personal and Nursing Care in Scotland, A Report by Lord Sutherland*. Available at www.scotland.gov.uk/Publications/2008/04/25105036/0 (accessed August 2009)
- Scottish Government (2009a) *Scotland Performs*. Available at www.scotland.gov.uk/About/scotPerforms (accessed August 2009)
- Scottish Government (2009b) *Scotland Performs Indicators relating to older people*. Available at www.scotland.gov.uk/About/scotPerforms/indicators/CareAtHome (accessed August 2009)
- Scottish Parliament Health Committee (2006) *Care Inquiry Final Report*, 10th Report (Session 2), Vol. 2. Available at www.scottish.parliament.uk/business/committees/health/reports-06/her06-10-vol01-01.htm#CaR5 (accessed August 2009)
- Scottish Statutory Instruments (2009) No. 137, *Social Care, The Community Care and Health (Scotland) Act 2002 (Amendment to schedule 1) Order*. Available at www.opsi.gov.uk/legislation/scotland/ssi2009/ssi_20090137_en_1 (accessed August 2009)
- The Courier* (2008) 'Parties reflect as dust settles'. Available at www.thecourier.co.uk/output/2008/11/07/newsstory12209428t0.asp (accessed August 2009)

UKHCA (United Kingdom Home Care Association)
(2004) *Who Cares Now?* Available at
www.ukhca.co.uk/pdfs/whocaresnowscotland.pdf
(accessed August 2009)

UKHCA (United Kingdom Home Care Association)
(2009) *An Overview of the UK Domiciliary Care Sector*. Available at www.ukhca.co.uk/pdfs/domiciliarycaresectoroverview.pdf
(accessed August 2009)

Welsh Assembly Government (2002) *Fairer Charging Policies for Home Care and other non-residential Social Services: Guidance for Local Authorities*, July Available at <http://wales.gov.uk/topics/health/publications/socialcare/guidance/2002/fairercharging?lang=en>
(accessed November 2009)

Welsh Assembly Government (2004) *Direct Payments Guidance: Community Care, Services for Carers and Children's Services (Direct Payments) Guidance Wales 2004*. Available at wales.gov.uk/docrepos/40382/dhss/socialservices/reportsenglish/Direct_Payments_2004-e.pdf?lang=en (accessed August 2009)

Welsh Assembly Government (2006) *Free Homecare for Disabled People*, Cabinet Statement by Brian Gibbons, Minister for Health and Social Services. Available at wales.gov.uk/about/cabinet/cabinetstatements/2006/950641/?lang=en (accessed August 2009)

Welsh Assembly Government (2009) *Assembly Measure on Charging for Non-residential Social Care Task & Finish Group*. Available at <http://wales.gov.uk/docs/dhss/report/090507taskgroupreporten.pdf>
(accessed November 2009)

Acknowledgements

The author would like to thank Richard Humphries at King's Fund, Dean Looney, Elderly and Community Care Unit, Department of Health, Social Services and Public Safety, Northern Ireland Assembly and Gareth Griffiths, Older People and Long Term Care Policy Directorate, Health & Social Services Department, Welsh Assembly Government.

About the author

David Bell is Professor of Economics at the University of Stirling. He is also Budget Adviser to the Finance Committee of the Scottish Parliament.

He was a member of the Care Development Group which considered the policy of free personal care in Scotland, the Joseph Rowntree Foundation Policy and Practice Group on Long-Term Care and Lord Sutherland's Independent Review of Free Personal Care.

During 2009 he jointly authored a JRF *Viewpoint* with Professor Caroline Glendinning (University of York) entitled *Rethinking social care and support: What can England learn from other countries?* and another *Viewpoint* with Professor Justin Keen (Leeds) entitled *Identifying a fairer system for funding adult social care*.

When not researching social care, David's current research is mainly on unemployment. In 2009 he co-authored two papers with Professor David Blanchflower (Stirling and Dartmouth College) entitled *What should be done about unemployment in the UK?* and *What should be done about unemployment in the OECD?*

The Joseph Rowntree Foundation has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy-makers, practitioners and service users. The facts presented and views expressed in this report are, however, those of the authors and not necessarily those of the Foundation.

Joseph Rowntree Foundation
The Homestead
40 Water End
York YO30 6WP
www.jrf.org.uk

This report, or any other JRF publication, can be downloaded free from the JRF website (www.jrf.org.uk/publications/).

A CIP catalogue record for this report is available from the British Library.

© University of Stirling 2010

First published 2010 by the Joseph Rowntree Foundation

All rights reserved.
Reproduction of this report by photocopying or electronic means for non-commercial purposes is permitted. Otherwise, no part of this report may be reproduced, adapted, stored in a retrieval system or transmitted by any means, electronic, mechanical, photocopying, or otherwise without the prior written permission of the Joseph Rowntree Foundation.

ISBN: 978-1-85935-726-2 (pdf)

