Financial care models in Scotland and the UK

David Bell and Alison Bowes

A review of the introduction of free personal care for older people in Scotland

Scotland is the only part of the UK to introduce free personal care for older people both in care homes and in domiciliary settings. In this report the authors provide a case study of the provision of free personal care which has implications for other parts of the UK.

The study begins by outlining current care policy for older people in the UK, and the development and context of free personal care in Scotland. It then explores the Scottish situation and finds that the similarities are sufficiently strong to argue that Scotland is a good exemplar for social care policies elsewhere in Great Britain. The practical problems encountered in Scotland during its introduction are assessed in detail, from the point of view of both the suppliers of care, and the older people themselves. Looking forward, the authors identify key threats to the sustainability of the Scottish policy and conclude by reviewing the wider lessons for the UK as a whole in designing policies to care for older people.

This study will be of interest to anyone working to develop and deliver care for older people, in particular those in the voluntary sector working with older people, civil servants, local authority staff and all those with an interest in the development of sustainable solutions to care issues.

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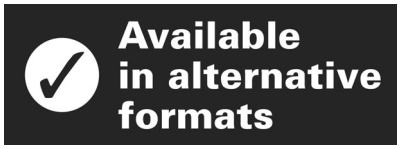

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Foreword

Evaluation of free personal care in Scotland

How has the provision of free personal care worked out in Scotland? Are there lessons for the rest of the UK?

These were the questions we wanted David Bell and his team at the University of Stirling to answer in their evaluation of the story so far. As this report demonstrates, the exercise has proved fascinating with some real insights for the way in which funding for long term care could be re-engineered for England, Wales and the rest of the UK.

First, the changes in Scotland have been popular. There were worries that many would be disappointed. The popular perception was that the full costs of going into residential care would be covered by the State: in fact, those concerned still face a means test for more than half the costs because their 'board and lodging'/'hotel' costs are not covered by the new system. But individuals do get substantial help – currently with a maximum of £145 for personal care and another £65 for nursing costs if needed. And the help with no means test, for home care – the preferred choice for so many older people – has been very well received.

Second, the fear that free home care would mean a dramatic reduction in informal care by family and friends has not materialised. Nor has there been an explosion in the numbers of people receiving free personal care at home. Informal carers are continuing to put in similar hours as before, but there has been a constructive switch in the way that care is provided from the more mundane and more intrusive tasks (such as washing and dressing) to social interaction such as outings.

Third, expenditure has proved rather greater than expected – £107m was set aside for 2002/03 – actual expenditure was £127m. But the extra costs have not been frightening and have stayed within a global figure of around 0.2% of Scottish GDP. They are set to rise because of demographic change and real cost increases mean they could have tripled by 2035. But there may be ways of moderating this rise through switching between residential care and home care and targeting other potential savings.

Fourth, the expected public sector cost differentials between Scotland and England have been much smaller than have been popularly assumed. This is mostly because

those in residential care in Scotland lose entitlement to Attendance Allowance (of around £60 per week) unlike those in the rest of the UK; and the payment for nursing care in Scotland – fixed at £65 – is much lower than the highest rate currently payable in England, at nearly £130 per week. So although the funding is arranged differently, the outcome is not so marked: and the gap may narrow if there is a delay in up-rating payments in Scotland.

Finally, free personal and nursing care have improved equity and fairness, particularly for those of modest means and those with conditions such as dementia which are now accepted as triggering personal care payments with no need for a means test. The artificial boundaries between health and personal care have become more blurred.

A direct transplant of the Scottish experience into other, equally complex systems is not a simple matter since the introduction of free personal care would have implications for other components of care provision. Nevertheless the Scottish example could well provide important lessons for the ways in which the English White Paper, *Your health, your care, your say*, can lead to reforms which better fit the aspirations and the sense of fairness of those affected.

We are very grateful to David Bell and Alison Bowes for this report and commend it to the policy makers throughout the UK.

Richard Best/Chris Kelly
December 2005

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Executive summary

Aims of the study

This study focused on considering:

- practical problems encountered in Scotland during the introduction of free personal care for older people
- looking forward, key threats to the sustainability of the Scottish policy
- the wider lessons for the UK as a whole in designing policies to care for older people.

Care policy for older people in the UK

The common features of care and support for older people in the UK derive from the responsibilities of Westminster departments for taxation, state benefits and the largely shared economic, social and cultural heritage.

In 1998, the Royal Commission on Long-term Care proposed that personal and nursing care be provided free to older people in the UK. Between then and 2002, all parts of the UK introduced free nursing care for older people in care homes. However, Scotland is the only part of the UK to introduce free personal care for older people both in care homes and in domiciliary settings. Throughout the UK, including Scotland, older people still pay their 'hotel' charges in care homes, provided they have the means to do so.

Assessing the specific impact of free personal care in Scotland is complicated by the environment of wider changes in a range of care policies. Supporting People, Direct Payments, shared assessment processes and shifts in the balance of care have all developed alongside the implementation of free personal care.

The Scottish example?

Scotland, England, Wales and Northern Ireland have similar projected growth patterns for their older populations over the next 50 years, with the population aged 85 and over growing most quickly.

For older people, Scotland as a whole is broadly comparable with other areas of the UK in respect of income, wealth and social security levels. However, these broad similarities mask great variations at the sub-country and regional level. These variations are particularly noticeable in Scotland.

The difference in the costs of nursing and personal care between Scotland and the rest of the UK is smaller than public debate has suggested.

The report therefore provides a case study of the provision of free personal care, which has implications for other parts of the UK.

Implementing free personal care: views from the suppliers

From the supplier point of view, free personal care has sharpened debate on the need for a holistic approach to funding long-term care for older people. This is because free personal care was introduced into arrangements for long-term care that are not only very complex but were also in the process of being radically changed as a result of a stream of government policies.

At the operational interface between staff and clients, experience was variable, though local authorities had been central to implementation. Issues for the voluntary and private sectors had received little consideration. There was a perceived need for better understanding and more effective co-operation between sectors.

Implementing free personal care: older people's perspectives

Older people who participated in focus group discussions for the research had strong and clear views on the need for a holistic method to meet older people's care and support needs. They did not differentiate personal care from other types of care and

support, and emphasised the importance of good quality services, which were person-centred and sensitive. There was continuing confusion and lack of clear knowledge about free personal care.

Informal carers' dedication, commitment and crucial role were emphasised. There was no real evidence of 'substitution' following the introduction of free personal care. In fact, free personal care could support carers to carry on longer, and to devote their time to caring tasks other than personal ones if this was preferable from the point of view of the older person and the carer. This finding, that there is no evidence of reduction in informal caring after the introduction of free personal care, is an important outcome of our work. The Scottish Executive set aside a budget of £8m to pay for increased provision of formal care to offset an expected reduction in informal caring. There is no evidence, as yet, of any such switch.

The financial effects of free personal care

Free personal care does not increase the costs of care to society as a whole – it shifts the balance between payment by individuals and payment from the public purse. The Scottish Executive has incurred an annual charge that is currently around £140m, to be met within a fixed budget. However, the total budget of the Scottish Executive exceeds £25bn and therefore any negative effects of free personal care on other expenditure priorities have been small. For clients, the main impact has been felt in care homes. However, higher charges in care homes have meant that individuals themselves have not benefited by the full amount allocated to cover personal care. The considerable increase in care home fees since 2001 is only partly a consequence of free personal care. Other policies, such as Care Standards, have also placed upward pressure on fees. Although local authority social care budgets are not ring-fenced, local authority spending on care for older people increased sharply from 2001 onwards, particularly for intensive home care packages.

England, Wales and Northern Ireland provide higher levels of support for nursing care than does Scotland. Local authorities in these areas also frequently charge less than the full cost of personal care for those receiving care at home. As a result, the difference in the aggregate costs of nursing and personal care between Scotland and the rest of the UK is smaller than public debate has suggested.

Sustainability in Scotland and the UK

Simulations show that the costs of free personal and nursing care expressed as a share of national output depend on underlying demographic change, but are also sensitive to:

- the balance of care provision – a shift to more care at home reduces costs
- healthy life expectancy
- changes in the costs of care
- the rate of economic growth
- changes in the proportion of self-funders in the population, particularly due to changing rates of home ownership.

If other influences do not change, demographic pressure alone will lead to substantial increases in costs during the next 50 years. But there are policy actions that can be taken to control costs. These include changing the balance of care towards more care at home, trying to enhance healthy life expectancy and closely examining the operation of charging policy. In addition to these issues, the free personal care policy will be sustainable only if there is sufficient political will within the Scottish Parliament and sufficient economic resources available to support the Parliament's spending plans.

Simulated application of the Scottish policy of free personal and nursing care to the rest of the UK shows that costs would evolve very similarly throughout the UK, because of the close correspondence in demography and economic circumstances. Hence, similar arguments about the actions that can be taken to moderate cost increases are likely to apply.

Wider lessons

A number of wider lessons can be drawn from the study.

- Free personal care has the capacity to support clients' wishes for person-centred, sensitive services without boundaries.

- Shifts in the balance of care can moderate costs – it is important that projections of future trends do not merely reproduce existing models of the balance of care.

- A new approach to costing care packages which avoids boundaries problematic classifications of tasks and their allocation to different budgets could address many difficulties, both for individuals and for the delivery and costs of service provision.

- Equity issues remain, as people of modest means – especially women – and people with conditions such as Alzheimer's disease may be charged inappropriately, where the care they need is not free at the point of delivery.

Conclusions

Practical problems

- The consequences of interactions with other policies and the complexity of the systems.

- A range of implementation issues for local authorities focused on resources and regulatory demands.

- Less than effective partnerships between service providers.

- Client confusion and lack of knowledge about free personal care, coupled with a desire to participate actively in constructing holistic care packages.

Key threats to sustainability

- The need to maintain relatively high levels of public spending in Scotland.

- Demographic pressure for the next 35 years at least.

- Potential failure to shift the balance of care away from more expensive forms of provision.

- Care homes capturing the free personal care 'dividend'.

Lessons for transferability

Making comparisons

- Scotland a good exemplar for the rest of the UK, though the public sector is relatively more significant.
- Much more variation between local authority areas in Scotland than between countries in the UK.
- The need for balance between nationally agreed priorities and local authority autonomy. Lack of ring-fenced budgets increases LA autonomy.

The nature of the free personal care policy

- Complex policies to support care for older people are difficult for both suppliers and older people themselves to understand.
- Free personal care added to this complexity. It is frequently misunderstood and is sometimes taken to mean ‘free care’.
- Free personal care does not increase costs to society as a whole– it shifts the balance between payment by individuals and payment from the public purse.

The balance of care

- We found no evidence of a reduction in informal care after the introduction of the policy.
- Free personal care may have supported increases in care at home.
- A need to understand much more clearly the operation of the private market for providing personal care and domestic care at home. Its scale is very much larger in England than in Scotland and this is one of the few major differences in care provision.

The costs of care

- Differences between Scotland and the rest of the UK in public sector support for self-funding care clients are significantly smaller than is commonly assumed.
- Costs of personal care in Scotland will rise because of increases in home ownership.
- The costs of care – or more precisely costs relative to the economic activity needed to support these costs – are not driven simply by demography. They are also affected by the balance of care, costs changes, the rate of economic growth and changes in proportions of potential self-funders.
- These factors can be influenced by public policy, given the political will.
- Accurate recording of the costs and benefits of free personal care is essential for effective evaluation.

Equity and fairness

- People with conditions such as dementia and people of modest means have been the main beneficiaries of the free personal care policy.
- On average, self-funding care home residents in Scotland now pay for approximately half of the costs of their care – this is much fairer to those on modest incomes.
- A clear need for greater equity in the rules governing Attendance Allowance.
- Imprecise boundaries defining care create difficulties allocating budgets and may promote disputes over assessment outcomes.
- National policy needs to provide equity and fairness to all, affluent and deprived, urban and rural, majority and minority ethnic.
- Policies designed to assist older people's financial problems may potentially be derailed by care homes increasing their fees.

Consumer perspectives

- Clients and carers' holistic view of the care and support needs of older people, which does not differentiate personal care from other care, is a key issue for those designing policy.

- Clients are keen to be active participants in the process of obtaining and using care and support.

- Clients focus on the quality of services and debate issues of payment accordingly.

- Free personal care promotes more 'joined-up' approaches, reduces means-testing and money worries, and enables informal carers to continue caring. Thus, it can improve clients' quality of life.

Overall transferability of the Scottish policy

- Changes since 2001 in funding of nursing care throughout the UK and for personal care in Scotland have caused the funding of the care systems in different parts of the UK to diverge. This increases the difficulties of transferring the Scottish model of free personal and nursing care to the rest of the UK.

- If introduced in other parts of the UK, free nursing and personal care would probably incur higher costs than would have been the case if the decision to proceed had been taken in 2001.

- More radical solutions might need changes to the boundaries within care provision that influence resource allocation. Such change would probably require intervention from the Department of Work and Pensions, which would be problematic because of the devolved nature of social care policy.

- Many of the lessons learned in Scotland about the application of the policy, its funding and reception by clients and providers will have parallels for the effective delivery of personal care in other parts of the UK. All parts of the country will face increases in demand for personal care in the next few decades, posing a challenge to all seeking to improve the outcomes for frail older people.

1 Introduction

In 1998, the Royal Commission on Long-term Care proposed that personal care be provided free to older people in the UK. England, Wales and Northern Ireland chose not to follow its recommendation. In contrast, Scotland chose to implement free personal care. Scotland's experience provides many lessons for the rest of the UK, particularly at a time when Government intends to make radical changes to further modernise care services for vulnerable people.

It took Scotland four years to implement its policy. Thus it was not until 2002 that the Scottish Parliament introduced free nursing and personal care (free personal care) for those aged 65 and over living in their own home or in a care home. This policy has now been in existence for three years. This research project attempts an initial evaluation of its effects. Its three specific objectives are to consider:

1 practical problems encountered in Scotland during the introduction of free personal care

2 looking forward, the key threats to the sustainability of the Scottish policy

3 the wider lessons for the UK as a whole in designing policies to care for older people.

In exploring these areas, we consider a set of key questions about the policy, its implementation, its sustainability and its implications. These questions include the following.

- Whether the funding model is sustainable? What are its strengths and limitations, and what external factors (e.g. financial or political) threaten its survival?

- Has there been a shift in the provision of care as a consequence of the changes to the care funding model? For example, has it affected the balance between formal and informal care provision? What is the effect on the overall demand for care?

- What is the cost of various funding models in the UK? What is the balance of funding between State and individuals?

- Has the overall cost of care risen since the introduction of free personal and nursing care in Scotland and free nursing care in England and Wales? If so, how have the respective funding systems contributed towards this?

- What issues of equity and fairness arise in relation to paying for care and support for older people?

- Is there any evidence that changes to the funding models have affected consumer attitudes to care provision? For example, does the availability of free personal care discourage older people from living more independently? If the costs of personal care are being met, what impact does this have on the ability to pay and willingness of relatives to provide informal care?

- How transferable is the Scottish funding model to England and Wales? What costs would be involved?

The report is structured as follows:

1 In Chapter 2, we describe the different policy regimes for caring for older people that now exist across Great Britain.

2 Chapter 3 follows with an explanation of the development of free personal care policy in Scotland and the place that it occupies within the wider context of social care policy.

3 Chapter 4 examines how Scotland compares with the rest of Great Britain in terms of the characteristics of older people. We also show that contrasts within Scotland are very important in understanding the differing impacts of free personal care that we subsequently describe.

4 In Chapters 5 and 6, we consider the effects of the policy. We include discussion of its effect on service providers and on informal carers, but most importantly we describe its effects for service users.

5 Chapter 7 explores the financial impact of the policy, which is highly complex. We consider some issues around the true resource costs of free personal care.

6 Chapter 8 discusses the issue of sustainability. If the policy is to have resonance beyond Scotland, then it must be sustainable.

7 Chapter 9 considers the wider policy lessons for the rest of Great Britain from the introduction of free personal care.

8 In Chapter 10, we return to the key issues of practical problems, sustainability and wider lessons of the free personal care policy.

The methods used to conduct the research are described in the Appendix.

We argue that Scotland is a good test bed for the introduction of new social care policies elsewhere in the UK. But, in terms of the funding of care, what has happened in Scotland represents incremental change. It has slightly shifted the balance of costs rather than the fundamental change that would be involved if the UK adopted the kinds of approach to funding long-term care that have been developed, for example, in Japan and Germany. Free personal care was introduced in Scotland without changes in taxes, social security benefits or in the market for long-term care insurance: instead it was based on an increase in public funding and concomitant decline in private expenditure. The value of this transfer was around 0.2 per cent of GDP in the year it was introduced.

We also show that care provision within Scotland in particular and the UK in general is extremely complex. These systems have followed different paths since devolution in 1999. Therefore a direct transplant of free personal care from Scotland into other, equally complex, systems is not a simple matter, since free personal care would have implications for other components of care provision. For example, how would the more generous allowances for nursing care in England, Wales and Northern Ireland be affected by the introduction of free personal care?

Nevertheless, the free personal care policy in Scotland does offer some wider lessons to other parts of the UK. These include its affordability in relation to overall public spending, its role as a catalyst in altering the balance of care towards care at home, its relationship to the benefits system and, fundamentally, its impact on clients, particularly those of modest means.

2 Care policy for older people in the UK

Key points

1 The common features of care and support for older people in the UK derive from the responsibilities of Westminster departments for taxation and state benefits, and the largely shared economic, social and cultural heritage.

2 Since 2002, all of the countries of the UK have supported free nursing care for older people in care homes, though at different levels. The lowest weekly payments are in Scotland and the highest in England.

3 Since 2002, Scotland has supported free personal care for older people both in care homes and in domiciliary settings.

4 In all cases, older people who are assessed as having the means to do so pay for 'hotel' charges in care homes and for non-personal care at home.

5 Assessing the specific impact of free personal care in Scotland is complicated by the environment of wider changes in a range of care policies.

Care and support for older people in the UK involve a multitude of agencies. These include bodies with local responsibilities such as health boards, housing agencies and local authorities, devolved regional government – the Scottish Parliament and the Welsh Assembly – and bodies whose remit covers the whole of the UK such as the Department for Work and Pensions.

With a multitude of agencies responsible for its delivery, it is not surprising that there are a plethora of care policies. Nevertheless they tend to share common features. These derive largely from:

1 the overarching responsibilities of Westminster departments in areas such as taxation and benefits

2 a largely shared economic, cultural and social heritage.

Since the advent of devolution, Wales and particularly Scotland have had greater freedom to design and implement new policies to enhance the quality and increase the volume of care for frail older people. New developments in Northern Ireland have

been impeded by the collapse of the power-sharing agreement. But, as a result of the transfer of powers relating to community care policy to the Welsh Assembly and the Scottish Parliament in 1999, there has been a significant divergence of policy relating to the care of older people within the UK.

In particular, unlike England and Wales, Scotland followed the recommendation of the Royal Commission for Long-term Care (1999) that:

> The costs of long-term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation: the rest should be subject to a co-payment according to means.
> (Royal Commission on Long-term Care, 1999)

The Scottish Parliament passed the Health and Community Care Act (2002), which funds those living in care homes and aged 65+ at £145 per week to meet the cost of personal care. Those aged 65+ receiving care at home are entitled to receive free personal care funded by the local authority, subject to the assessment of their needs, but irrespective of their means.

Under usual NHS rules, nursing care is provided free to those in hospital or at home. Prior to 2001, care home residents were liable to be charged for nursing care, subject to a means test. England, Scotland and Wales took steps to remove this anomaly. In Scotland, the Health and Community Care Act (2002) provided those requiring nursing care in care homes with an allowance of £65 per week to meet these costs. The English system allows for three bands of nursing care – low, medium and high – depending on the needs of the individual. These were initially valued at £35, £70 and £110 per week respectively. The Welsh Assembly Government, like Scotland, adopted a single-banded payment for nursing care, which is currently valued at £107.63 per week. Northern Ireland introduced free nursing care in October 2002 with a value of up to £100 per week.

In Scotland, the weekly allowances of £145 for personal care and £65 for nursing care for care home residents have not been changed since they were introduced. Between 2001 and 2005, the weekly payments for nursing care in England had been increased to £40, £80 and £129 per week.

Following the elections in 2003, the Welsh Assembly made a commitment to the provision of free ‘domiciliary’ care. This policy has not yet been implemented and several important issues have emerged in its design. These include how eligibility is to be determined and whether the definition of ‘domiciliary’ care will be broader or

narrower than that of personal care. Nevertheless, one feature that is clearly distinctive about this policy is that the commitment is to the provision of free domiciliary care to all ages – not just to those aged 65+ as currently in Scotland.

Unlike the Scottish Parliament, the Welsh Assembly does not have the power to pass primary legislation. Therefore it cannot compel local authorities to deliver free domiciliary care. It must persuade them to implement the policy by offering to transfer sufficient resources to cover at least the additional costs that these authorities may face.

In Northern Ireland, while several of the political parties are committed to free personal care, no progress towards this ambition has been possible because of the political impasse in the province.[1]

Scotland, Northern Ireland, England and Wales each decided to support free nursing care in care homes (see Table 1). In addition, Scotland now provides free personal care to those aged 65 and over both in care homes and in a domiciliary setting. But this does not mean that *all* forms of care are free in *any* part of the United Kingdom to those who are capable of contributing to the cost of care.

Care home residents throughout Great Britain are still expected to meet their 'hotel' costs where their notional income is above specified limits. These 'hotel' costs broadly cover the charges made for accommodation and food. These charges are substantial. In Scotland in 2004, care home fees averaged £427 per week. Thus, even after the introduction of a £210 allowance to meet the costs of nursing (£65) and personal (£145) care, self-funding care home residents in Scotland still have to meet more than half of their weekly charges from their own resources. Similarly, housing support services are charged following means testing and, since levels of support vary according to assessed individual needs, the charges are variable.

Table 1 Charges to individuals for publicly provided care

	Charging for care and support			
	Personal care	**Nursing care**	**Housing support**	**'Hotel' costs in care homes**
Scotland	Free	Free	Not free (means-tested)	Not free (means-tested)
England	Not free (means-tested)	Free	Not free (means-tested)	Not free (means-tested)
Wales	Not free (means-tested)	Free	Not free (means-tested)	Not free (means-tested)
Northern Ireland	Not free (means-tested)	Free	Not free (means-tested)	Not free (means-tested)

Our research focuses on the implications of the divergence in care policies that we have described. Such diversity provides an opportunity to learn what works and what doesn't work elsewhere. In particular, the introduction of free personal care in Scotland might be seen as an 'experiment' in care policy, from which other parts of the UK can learn.

However, while free personal care has been controversial and very much in the public eye, other policies for the provision of care for older people in Scotland have also been in a state of flux. It is difficult to isolate the impact of one specific policy when many changes are taking place together. The simultaneous dynamics of a number of care policies complicate the assessment of the impact of free personal care.

Against this background, we now consider the development and context of free nursing and personal care in Scotland.

3 Development and context of free personal and nursing care

Key points

1 Free personal and nursing care was introduced at a time of considerable flux in other aspects of social care policy. These included:
   - a drive to shift the balance of care away from long-stay hospital care towards domiciliary care
   - encouragement of joint working between health boards and local authorities
   - increasing regulation of care provision
   - the introduction of Direct Payments and Supporting People.

2 The Department for Work and Pensions (DWP) benefits framework remained largely static, but had important implications for the delivery of free personal care.

3 Inevitably, these policies were bound to interact with free personal care, increasing the complexity of identifying the precise impacts of the policy.

The main driver behind the introduction of free personal care in Scotland was the recommendation of the Royal Commission on Long-term Care in 1998 that personal care should be provided free. There was concern among politicians that such a policy would particularly benefit more affluent care recipients. This was because personal care was effectively free throughout the UK to those who did not have sufficient means to pay for its provision. Thus, the main beneficiaries of free personal care would be those who both require care *and* pay for some or all of the costs of care from their own resources.

The Royal Commission's estimate was that free personal care would cost £1.1bn for the UK as a whole. In their 'memorandum of dissent', Joel Joffe and David Lipsey argued that free personal care would be unaffordable in the long term because of demographic change and increased costs. This argument was very influential in the decision not to go ahead with free personal care in England and Wales.

When Henry McLeish took over as First Minister in Scotland in late 2000, he decided to move quickly to introduce free personal care. By February 2001, the Care Development Group (CDG) had been set up with a remit 'to bring forward proposals

for the implementation of free personal care for all, along with an analysis of the costs and implications of so doing'. The recommendations of the Care Development Group in its July 2001 report were fully accepted by the Scottish Executive. Provision of free nursing care for care home residents was viewed as an integral part of the changes necessary to provide more equitable treatment for frail older people. Thus, though the policy is often referred to as free 'personal' care, free nursing care was always seen as an integral part of the policy both by the CDG and the Scottish Executive. We shall subsequently discover that the integration of nursing and personal care does pose some challenges for the transferability of the policy. Free personal and nursing care became a reality in July 2002 following the passing of the Community Care and Health (Scotland) Act 2002 in March 2002.

While nursing care was defined as interventions requiring a registered nurse, the definition of personal care used in the 2002 Act was derived from the Regulation of Care (Scotland) Act (2001). The precise wording was:

> … 'personal care' means care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without prejudice to that generality, to remembering to eat and wash).
> (Regulation of Care [Scotland] Act [2001])

The 2002 Act prohibited local authorities from charging for any service that fell within this definition: they were not prevented from charging for other services. There was confusion over this issue. Some clients believed that *all* care was to be provided free, whereas in fact means tests were still carried out for payments towards 'hotel' costs – the costs of food and accommodation, etc. associated with normal living. For care home residents, these costs are generally substantial.

Free personal and nursing care was not introduced in a static policy environment. Many other policy changes for care and support for older people had been and were being implemented at the same time as free personal care was being introduced. These interacted with personal care policy in a variety of expected and unexpected ways.

Some of the key policies were the following.

In 1998, the Scottish Office (predecessor of the Scottish Executive) published a report entitled *Modernising Community Care: An Action Plan*. This proposed a strategy for the development of care services in Scotland. It was driven by a desire

to improve care standards for frail older people and by a desire to moderate the growth in the costs of care. Key aspects of this strategy were:

- shifting the balance of care so that more people are cared for at home
- an emphasis on working better in localities
- developing more flexible services.

After devolution, the new Scottish Executive accepted the principles underlying *Modernising Community Care* but felt that, in practice, implementation had been patchy and, in some respects, such as changing the balance of care, little if any progress had been made. This was partly because the Executive did not want to ring-fence local authority budgets and therefore constrain the way they were spent. Nor did it wish to legislate to ensure that relevant agencies delivered real progress towards meeting the *Modernising Community Care* agenda. Instead it relied on political pressure and on providing modest incentives to local authorities who could demonstrate real progress in taking the policy agenda forward.[1]

To accelerate progress, the Executive set up the Joint Future Group – to make the existing policies work better. In its 2000 report (Scottish Executive, 2000), the Group made a number of specific suggestions including:

- introduction of a Single Shared Assessment procedure
- development of a single assessment tool for older people and people with dementia
- sharing of information between agencies, with client approval
- local authorities, health boards and trusts and Scottish Homes[2] to draw up local partnership agreements, including a clear programme for local joint resourcing and joint management of community care services
- local authorities jointly to develop guidance on charging policies to reduce inconsistencies in home care charging.

These proposals were largely accepted by the Scottish Executive, which then increased the pressure on local authorities and health boards to deliver change by setting up the Joint Future Unit,[3] a small team responsible for promoting joint working between relevant agencies to improve care services. The Single Shared Assessment

agenda was taken forward and an assessment tool developed – the Single Shared Assessment Index of Relative Need (SSA-IoRN).

'Joint community care plans' were introduced before free personal care and have continued to be rolled forward since its introduction. These three-year plans involved health boards and local authorities, and were intended to adopt a client-focused approach to improving care for frail older people involving joint working between all relevant agencies. A related development was the transfer of resources from health boards to local authorities following the reduction of geriatric long-stay beds and increased care provision by local authorities.

In 2001, the Regulation of Care (Scotland) Act 2001 altered the system of care regulation in Scotland. It established the Scottish Commission for the Regulation of Care. This body is responsible for the registration, inspection, complaint investigation and enforcement of Care Standards under the Act. Imposition of Care Standards inevitably led to upward pressure on care costs.

There were also significant changes in the way that housing support was resourced. Housing support was no longer paid directly by DWP though it remains the ultimate source of funding. Local authorities have responsibility for delivery of housing benefit on behalf of the DWP. And, since 2003, the Supporting People Programme has provided a new framework for funding housing support services aimed at providing good quality services, focused on the needs of users, to enable vulnerable people to live independently in the community, in all types of accommodation and tenure. While this is a UK-wide policy, there are differences in delivery across the UK to take account of differences in local authority and housing support structures. In Scotland, the Scottish Executive[4] has responsibility for its implementation. As we shall see subsequently, Supporting People has interacted significantly with free personal care. The annual Scottish budget for Supporting People is around £400m. Around 30 per cent of this budget (£120m) is spent by local authorities to improve older people's housing services. This policy was introduced in 2003.

Yet another piece of the policy background was the introduction of Direct Payments for care services in 2001. Although take-up has been modest, these allow those in need of care to directly purchase services from local providers. They have a symbolic value in establishing the rights of clients to influence the services they receive. However, Direct Payments have been unpopular with local authorities, partly because of a concern that independent providers might compete with local authority services and threaten their viability.

Direct Payments have been implemented much more slowly in Scotland than in England. In 2003, only 534 Scottish adults received Direct Payments for care, whereas in England 8,700 received such payments.[5] Only 30 per cent of these were aged over 65. Many of the large local authorities in West Central Scotland make fewer than two Direct Payments per 10,000 people, whereas, in England in 2002/03, 18 payments per 10,000 people were being made.

A much larger source of funding than Direct Payments for social care in the UK is social security benefits. Benefits policy is 'reserved' – meaning that the devolved institutions cannot change either the rates of benefit or the rules that determine their coverage. The DWP sets the levels of these benefits for the whole of the UK. For social care, not only are old age pensions (including Pension Credit with its additions for severe disability) of importance in providing general support for older people, but also Attendance Allowance and Carer's Allowance help provide resources where specific forms of care are required. In particular, Attendance Allowance is intended to meet the extra costs of disability. The assessment, however, is based on the needs that people have for care or supervision (they may not necessarily be receiving that care or supervision, or it may be provided by friends and relatives rather than social services). It is likely that anyone who is assessed by social services as being in need of personal care should also be in receipt of Attendance Allowance, but many more people than meet the strict eligibility criteria for social-services-provided care, meet the eligibility criteria for Attendance Allowance.

The lack of flexibility in the benefits system affected the cost of free personal care in Scotland. Because the Scottish Executive could not persuade DWP to change its rules on Attendance Allowance, self-funding care home residents lost their rights to claim this benefit, adding an additional £22m to the costs of the policy.

A final essential component of the context in which free personal care was introduced was the public expenditure environment. After exercising considerable restraint during its early years in office, the Labour Government expanded public spending rapidly from 2000/01. Increased spending was concentrated in health and education, which in turn resulted in large increases in the grant to the Scottish Parliament from Westminster through the operation of the Barnett Formula.

To summarise, free personal and nursing care was introduced at a time when there was substantial pressure from the Scottish Executive on health boards, local authorities and housing agencies to work together towards a client-based approach to the provision of health and social care for older people. In addition, some uniformity was being imposed on assessment procedures both to facilitate this joint working and to provide more uniform service provision for comparable levels of

need. In addition, changes to the framework for the regulation of care were intended to improve conditions under which frail older people (and indeed all users of services) were cared for. This had clear benefits, but it also imposed additional costs, such as those associated with additional training or for the upgrade of buildings to meet new standards. Direct Payments were introduced in 2001, allowing disabled people greater freedom to control their care, but this policy has not yet had a substantive effect. Take-up in Scotland has been much slower than in England.

One aspect of funding that did not change over the period of introduction of free personal care was the structure of DWP benefits for older people. Nevertheless, these had important implications for its delivery and costs. The other policy shifts were also bound to interact with free personal care, making it difficult to identify the precise impacts of the policy. We discuss these interactions in future chapters. In the next chapter, we examine whether Scotland is sufficiently similar to other parts of the UK to offer useful insights into the effects of free personal care.

4 The Scottish example?

Key points

1 All the countries of the UK have similar projected growth patterns for their older populations over the next 50 years.

2 The population aged 85 and over will grow most quickly.

3 Variability in respect of income, wealth and levels of receipt of state benefits within Scotland, England and Wales is greater than variability between the countries.

4 This variability creates differential effects on financial support for care home residents and difficulties of calculating resources required to support older people, as well as ensuring that resources are spent as intended.

5 The availability of informal care is similar throughout the UK, and statistics suggest there is no evidence of decline in informal caring in Scotland as compared with England and Wales since 2002. Indeed, the availability of informal care has increased in recent years.

6 Therefore, Scotland provides a good exemplar for social care policies elsewhere in the UK.

This chapter focuses on the characteristics of older people in Scotland and the rest of the UK. It argues that the similarities are sufficiently strong to suggest that Scotland is a good exemplar for social care policies elsewhere in Great Britain. Clearly there is a scale difference: Scotland's population in 2003 was 10.1 per cent of that in England, and 9.5 per cent of that in England and Wales. But, aside from scale, the similarities are much greater than the differences. We begin by focusing on demography and go on to discuss illness, affluence, the balance of care and informal caring.

Demography

Scotland comprises a relatively small share of the British population. Nevertheless, there are close similarities in the expected *changes* in population during the next half-century. In particular, the Scottish population will age at broadly the same rate as is expected in other parts of the UK. Table 2 shows the expected growth in the population of Scotland and the UK by selected age groups from 2003 based on the

projections of the Government Actuary. Note that a great deal of uncertainty attaches to population forecasts in the distant future. This is because of uncertainty about changes in birth and death rates and in the impact of migration. Nevertheless, the consensus view is that growth rates in the 85+ age group will be more rapid than in the 65+ age group in both Scotland and the UK as a whole. The rapid growth in the number of 'oldest old' is a worldwide phenomenon, which has caused demographers to seriously examine their preconceptions about the upper limits of life expectancy. By 2058, it is expected that the size of the 85+ group will have almost tripled compared with 2003 in both Scotland and the UK as a whole. The 'younger' old population will grow more slowly in Scotland, particularly towards the middle of this century because of the slower overall growth in the Scottish population. This is evident from the decline in the numbers aged 65+ after 2038. It is also evident that, in the early part of the period, the growth rate in all age groups is slightly more rapid in Scotland than in the UK as a whole. Nevertheless, the key long-term message of the projections is that the growth in the 'older old' – those most likely to require care – will be similar in Scotland to that in the UK over the next 50 years.

Table 2 Growth from 2003 in population by selected age groups (per cent)

Age group	Area	2008	2018	2028	2038	2048	2058
65+	Scotland	4.6	25.0	48.7	64.5	56.3	51.1
	UK	3.7	23.0	42.9	59.9	64.1	69.5
75+	Scotland	5.3	26.0	53.1	74.5	74.6	64.5
	UK	5.4	24.1	62.8	86.3	121.2	119.9
85+	Scotland	16.7	55.6	110.5	181.3	249.1	275.0
	UK	19.0	50.7	100.4	170.2	218.8	288.1

Source: Government Actuary's Department.

Health status

Another comparison with implications for the costs of care is in older people's health status. For this, we can call on the 2001 Census, which asked questions on limiting long-term illness and on health status. Table 3 shows that England has the lowest percentage of those 65 and over who claim to have a long-term limiting illness. While Scotland has fewer sufferers from long-term limiting illness than either Wales or Northern Ireland, its rate is 4 per cent higher than that in England. On the other hand, older Scots are slightly more likely than either the Welsh, English or Northern Irish to describe themselves as being in good health. Again, while there are some differences in the health status of older people between Scotland and other parts of the UK, these are not very large.

Table 3 Health and long-term limiting illness among over 65s

	Per cent of over 65s suffering from long-term limiting illness	Per cent of over 65s describing their health as 'good'
England	51	35
Scotland	55	36
Wales	58	31
Northern Ireland	57	33

Source: 2001 Census, Sample of Anonymised Records.

Estimates of Healthy Life Expectancy (HLE) have been calculated by the Office of National Statistics for England and for Scotland by Clark *et al*. (2004). Table 4 compares estimates of life expectancy and healthy life expectancy (based on absence of long-term illness) in Scotland and England for males and females from birth and at age 65.

It shows that, among the over 65s, average spells of long-term limiting illness (as measured by the difference between life expectancy and healthy life expectancy) are generally longer in England than in Scotland. This is likely to result from lower overall life expectancy in Scotland and from the higher incidence of acute illness, such as heart disease, in Scotland.

These differences will tend to result in higher costs of care in England. However, there is no consensus, either national or international, as to whether the difference between life expectancy and healthy life expectancy will increase or decrease in the future.

Table 4 Life expectancy and healthy life expectancy in Scotland and England

		At birth			At age 65		
		LE	HLE (LLI)	LE-HLE (LLI)	LE	HLE (LLI)	LE-HLE (LLI)
Females	Scotland	78.7	62.6	16	17.9	9.6	8
	England	80.6	62.9	18	19.2	10.2	9
Males	Scotland	73.3	58.9	14	14.8	9.3	6
	England	76.0	60.8	15	16.1	8.9	7

Source: Clark et al. *(2004) and OPCS (2004). Data for Scotland are for 2000 and for England 2001. Both are based on a definition of healthy life expectancy implied by absence of long-term limiting illness (LLI).*

Affluence

Are older Scots less affluent than older people elsewhere in Great Britain and so less able to contribute to the costs of care? It is difficult to find reliable estimates of financial, and more particularly housing, assets, but one quick way to check on relative affluence is to examine the proportion of households in which at least one person receives Council Tax Benefit, Income Support/Minimum Income Guarantee or Housing Benefit. Table 5 shows the proportion of households in which at least one person is aged over 65 that receive *none* of these state benefits and the proportion that receive *all* of them. Results are shown for England, Scotland and Wales, and for some local authority areas within Scotland.[1] From these, it is clear that older people in Scotland are more reliant on state benefits than is the case in England.

Table 5 Receipt of benefits among the over 65s – regional comparisons (percentages)

Area	No benefits	Housing Benefit, Council Tax Benefit and Income Support/ Minimum Income Guarantee
Glasgow	37	18
Fife, Central, Lothian	59	13
Scotland	59	13
Strathclyde ex. Glasgow	59	12
Borders, Dumfries & Galloway	61	15
North of the Caledonian Canal	63	9
England	65	10
Wales	66	10
Highland, Grampian, Tayside	73	12

Source: Family Resources Survey 2002/03.

Scotland has a substantially lower proportion of those aged 65 and over receiving no state benefits and a higher proportion receiving all of the benefits than is the case for either England or Wales. But within Scotland there is huge variation in these rates. Glaswegians over 65 are more than twice as likely to receive some state benefit than those living in the Highlands, Grampian and Tayside. Table 6 shows the proportion of this age group receiving both Housing and Council Tax Benefit based on the much larger sample in the Scottish Household Survey.

The receipt of benefits in Scotland is higher than that in England or Wales, but this outcome is largely driven by high levels of deprivation in West Central Scotland. This suggests that there are larger contrasts *within* Scotland than exist *between* the *average* financial resources of older people in Scotland, England and Wales.

Table 6 Receipt of benefits among the over 65s – Scottish comparisons (percentages)

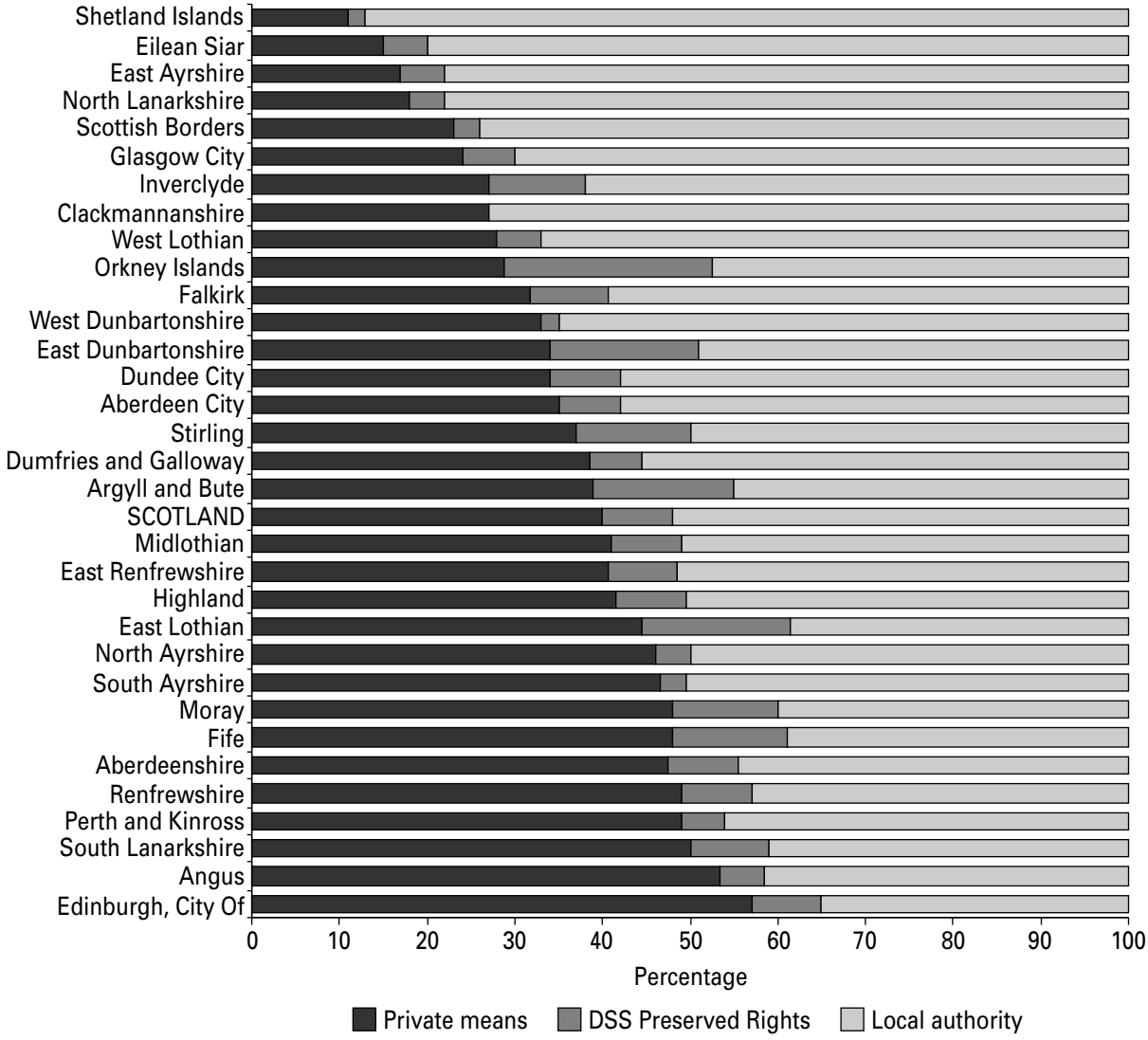
Local authority grouping	Both Housing and Council Tax Benefit
Highlands and Islands	6
Southern	10
Edinburgh	10
Tayside	12
Grampian	14
Lothian	15
Fife	17
Scotland	17
Central	18
South Lanarkshire	18
Renfrewshire and Inverclyde	20
Ayrshire	21
Dunbartonshire	24
North Lanarkshire	27
Glasgow	31

Source: Scottish Household Survey 2002.

If there are large variations in the affluence of older people living in households, then these differences are likely to be replicated for the population living in care homes. This is demonstrated in Figure 1, which gives the source of financial support for residents of care homes in 2002 by local authority.[2] The differences in the proportions of self-funding residents between local authorities are large: from 11 per cent in Shetland to 57 per cent in Edinburgh. The trend in the number of self-funders in Scotland has risen in recent years, from 33 per cent in 1999 to 40 per cent in 2003.[3]

The variation in shares of self-funders also has significant implications for the funding of personal care. Large authorities such as East Ayrshire, North Lanarkshire and Glasgow City do not have many self-funding residents who are entitled to £145 (£210) per week to compensate for the costs of personal (personal and nursing) care. Such authorities may be able to expand their domiciliary care facilities more rapidly than areas such as Edinburgh, Angus and South Lanarkshire. These have significant populations of self-funders and their budgets would tend to be biased towards compensating their relatively large populations of care home residents.

Figure 1 Financial support of residents in care homes, 2002



Source: Community Care Statistics 2002, Scottish Executive.

Similar variations in funding requirements would be repeated across local authorities in England and Wales if Scottish free personal care policy was extended to the rest of Great Britain. The Scottish arrangements, based on local authority funding, have two disadvantages for older people.

1 Estimates of the funding required to compensate individuals for the costs of care are difficult to put in place. These may also be subsumed within more general arguments about the spatial distribution of local authority funding. This has been historically a highly contentious and politically charged debate, which involves, for example, arguments about the relative costs of providing local authority services in deprived inner cities as against affluent suburbs or remote rural areas.

2 While there are political arguments to do with preserving local autonomy in favour of not ring-fencing the free personal care budget, the danger of not ring-fencing it is that resources are diverted to other local authority priorities.

Note that the diminishing number of those with Department of Social Security (DSS)[4] preserved rights have come within local authority funding arrangements since 2002. Local authorities carried out means tests on this group and have expected those with high income to contribute towards their costs.

Informal care

How does the provision of informal care differ between Scotland, England and Wales? Table 7 shows that the number of informal carers has been *increasing* in England, Wales and Scotland since 1996 and that its gender composition has been fairly stable. Thus, at a time when there has been increasing provision of local authority subsidised home care, the number of informal carers has nevertheless been rising. The number of informal carers in Scotland tends to be just less than 10 per cent of those in England, which is perhaps explained by the slightly lower life expectancy in Scotland. But the difference from population shares is too small to suggest significant differences in caring behaviour. In addition, the gender composition of informal carers is both stable and differs little between England, Scotland and Wales. Note, finally, that the number of informal carers in Scotland actually increased in 2002 and 2003, when free personal care was introduced. This may be a result of the shift towards domiciliary care. Once individuals are moved to a care home, the carer may no longer describe themselves as such. But, as more and more people are staying at home, there is still a large residual caring role for those around the person receiving personal care, such as dealing with what happens if the formal carer does not turn up, doing other tasks and being at the other end of the phone for emergencies. These people will still describe themselves as carers, as they still feel responsible for the older person in some way. Our statistical analysis confirms that there has been no decline in informal caring in Scotland compared with England and Wales since the introduction of free personal care. We discuss further the activities of informal carers in our analysis of the views of older people and informal carers in Chapter 6.

Table 7 Informal carers total and by gender, 1996–2003 (thousands)

	England		Wales		Scotland	
Year	Total	% female	Total	% female	Total	% female
1996	3,465	61	266	66	352	65
1997	3,584	62	261	63	344	70
1998	3,818	63	287	60	342	62
1999	3,842	62	301	62	365	68
2000	3,676	63	298	62	388	61
2001	4,101	60	295	59	380	66
2002	3,976	62	282	63	387	62
2003	3,902	61	276	62	384	64

Source: Family Resources Survey 1996–2003.

The balance of care

The delivery of care and its costs are fundamentally determined by the modes in which it is delivered and the relative sizes of these forms of delivery. We describe this distribution of modes of delivery as the 'balance of care'. In this section, we compare the balance of care in England, Scotland and Wales. How does the balance of care in Scotland compare with that elsewhere?

As mentioned previously, the main providers and modes of delivery are:

1 the health care system – usually in the form of geriatric care

2 local authorities that supply residential homes of various kinds and that provide or organise home care

3 independent providers, who operate principally in the nursing home sector, but also provide home care.

Finding comparable statistics on the balance of care is challenging: the way in which statistics are collected by the relevant statistical offices across the UK tends to differ and, in some areas, such as private home care, there is a real paucity of reliable data.

Table 8 shows how the balance of care in England, Scotland and Wales differs. Data on population size and shares of those aged 65+ are provided by the Government Actuary. These show that 85.6 per cent of all those aged 65 and over in Great Britain live in England, 8.8 per cent in Scotland and 5.5 per cent in Wales. The remaining rows of the table show how the main forms of care are distributed in these areas.

Table 8 The balance of care in Scotland, England and Wales

	Scotland	Share (%)	England	Share (%)	Wales	Share (%)
Population aged 65+	0.819m		7.947m		0.514m	
Geriatric beds	4,089	3.8	27,431	3.6	1,660	3.3
Care home places	37,977	35.6	371,328	49.2	26,841	52.7
Local authority home care	55,513	52.1	134,080	17.8	22,424	44.0
Total home care	64,546	60.5	355,630	47.1	n/a	n/a

Sources: 2001 Census, Office of Population Censuses and Surveys, Health Care Costs Report (2001), Information Services Division, Scottish Executive, Community Care Statistics (2002) Scottish Executive, Digest of Welsh Statistics (2003), Community Care Statistics England (2004), Care Homes for Older People in the UK (2005), Office of Fair Trading.

The percentages in the 'Share' column show the proportion of the population receiving care in the various care settings.[5]

First, consider geriatric long-stay beds. With 3.8 per cent of clients in geriatric care, Scotland has a slightly higher share of this care setting than either England or Wales. This may reflect a history of higher spending on health care in Scotland than in the rest of the UK, Nevertheless, the number of geriatric long-stay beds in Scotland has fallen sharply from a peak of 9,300 in 1990.

Data on availability of care home places in Table 8 are drawn from the recent Office of Fair Trading (2005) report on care home prices, which should provide reasonable comparability across Great Britain. It is apparent that England and Wales are much more reliant on the care home sector to provide care than Scotland. Around half of care is provided in care homes in England and Wales, while the Scottish share is only 36 per cent. This inevitably means that debates about how to finance care home fees acquire greater significance in England and Wales than in Scotland.

For England, the greater reliance on care homes is largely driven by much lower availability of local authority home care. While Welsh local authorities meet 44 per cent of the demand for care, and those in Scotland 52 per cent, only 18 per cent of the demand for care in England is met by local authorities. This is partly compensated by a larger private home care market in England, which meets almost 30 per cent of demand compared with only 8 per cent in Scotland. The high levels of local authority provision of home care in Scotland and Wales compared with England perhaps reflect a more culturally ingrained public sector ethos and less well developed private sector supply. As we shall see, in Scotland, it may also reflect a greater impetus to moving the balance of care towards home care. Even within home care funded by the local authority in England, there has been a significant move towards local authorities acting as facilitators with much of the provision coming from private sector firms or voluntary organisations.

Now consider how the balance of care has changed in Scotland. Between 1980 and 2002, the mean length of stay in geriatric wards in Scotland declined by a factor of four – from 170 days to just over 40. And the average number of beds occupied fell from around 10,000 to just over 3,000. In 2001, such beds cost around £820 per week, more than twice the cost of nursing homes. By 2004, the cost had risen to £1,163 per week.[6]

Transfers from geriatric long stay to care homes were actively promoted in Scotland during the 1990s. To resource this change, the NHS transferred significant amounts of cash to local authorities. There was a 56.5 per cent increase in 'resource transfer' from the NHS to local authorities to provide nursing home places for frail older people between 1999/00 and 2003/04, when it totalled £67m. Spending on geriatric care (including resource transfer) increased by 14.7 per cent between 1999/00 and 2003/04.

The value of the 2003/04 resource transfer would buy around 1,100 patient years of geriatric care in NHS hospitals and around 3,000 patient years of care in care homes, because of their lower average costs. These payments for 'continuing care' pay the costs of care for about 7.7 per cent of the Scottish care home population. The growth in spending on continuing care has been less rapid than that on health care as a whole in Scotland. Between 1999/00 and 2003/04, the growth in funds to support continuing care services was only 37 per cent as fast as the general increase in the overall NHS budget for Scotland. This implies that responsibility for care for older people in Scotland is moving significantly away from the health service and towards local authorities. For a given volume of clients, this is likely to restrain cost increases.

Continuing care appears to be less contentious in Scotland than in England. Since February 2003, over 4,000 disputes relating to continuing care in England have been taken to the Health Service Ombudsman. A majority of these relate to the refusal of the NHS to fund nursing home costs of older people whose needs are primarily for health care. In Scotland, such disputes are relatively rare. The Health Service Ombudsman has reviewed over 12,000 cases in England and in 20 per cent of cases financial repayment has been made. The Scottish Public Services Ombudsman has not dealt with any cases The Department of Health estimates that some £180m will be required to repay those who have contributed to care home fees when their care should have been free. In March 2004, 20,000 individuals were receiving continuing care in England.

Comparative costs of care

We now consider how the costs of care have evolved in the UK. The way in which frail older people were supported financially in Scotland, England, Wales and Northern Ireland diverged substantially in 2002, four years after the publication of the Royal Commission's report into long-term care. Key to these changes were the differing ways of dealing with (a) nursing care and (b) personal care. We deal with these in turn.

Nursing care

Following the Royal Commission's report, all parts of the UK accepted that charging for nursing care in care homes was unfair when those in hospital or those being cared for at home received free nursing care. Further, since nursing care was accepted as a form of medical care, it was inconsistent with the principles of the NHS that medical services should be free at the point of delivery.

However, while the principle that nursing care should not be charged was accepted, the levels of support for this care differed widely.

- In England, nursing care was assigned to one of three levels – low, medium and high. Financial support increased with the level of care provided. In 2005, the weekly payments rates were £40, £80 and £129 per week respectively.

- In Wales, a flat-rate contribution for nursing care was adopted and is currently £107.63 per week.

- In Northern Ireland, the weekly payment was set at £100.

- In Scotland, the CDG recommended a single-banded payment of £65 per week for nursing care. This was accepted by the Scottish Executive and, like the payment for personal care, its value has not been adjusted since 2002.

From these levels of support, it is clear that the Scottish payments for nursing care are least generous. The high level of nursing support in England is almost twice as costly as that in Scotland. The costs of nursing care in England have grown dramatically. In 2003/04, the Department of Health (DoH) allocated £584m to meet the total costs of nursing care for 130,000 self-funding and local authority clients.[7] This implies an *average* weekly payment of £86. Thus, though the highest level of

nursing care in England exceeds that in either Wales or Northern Ireland, the average payment is less than the fixed payments that they use.

From the 130,000 clients receiving nursing care, there were 41,600 self-funding clients in 2003.[8] In Scotland, the equivalent total was 5,100 – 12.2 per cent of the English total. Scotland thus has somewhat more than its population share of self-funding clients receiving nursing care, but the average weekly cost of nursing care is £65, which is 25 per cent lower than the average weekly payment in England.

Personal care

There are two types of payment for personal care in Scotland. The first is a fixed weekly payment of £145 per week (£7,540 per year) made to care home residents who contribute to the cost of their care. The alternative is an open-ended payment to meet the costs of personal care at home. Average expenditure per home care client receiving free personal care in 2002/03 was £3,000. The average number of clients in 2002/03 was 32,000 and the total cost in this financial year approximately £95m.

In both cases, the payment is made by the local authority on the client's behalf. The client has little control over how the money is used. This may partly explain our subsequent finding that clients are keen to exert greater control over the design of their care packages.

Another important issue arises from the differences between personal care costs in care homes and care at home. It is that the *total* costs of personal care will be heavily influenced by the distribution of clients between care homes and care at home. At one extreme, if all clients could be cared for at home at current average costs, the costs of funding personal care would be approximately three-sevenths of the costs of personal care if all clients were in care homes. Thus, the balance of care is vitally important to understanding the costs of care. In Scotland, an integral part of the free personal and nursing care policy was a drive to increase the capacity to provide care at home. Given the calculation of the relative costs of personal care in care homes and care at home, this will have exerted a downward pressure on the public costs of personal care.

Attendance Allowance

There is one further important divergence between payments for personal care across the UK. 'Attendance Allowance is a tax-free benefit for people aged 65 or over who have an illness or disability and need help with carrying out a range of daily living tasks'[9] – they do not have to require personal care. There are upper and lower rates of payment for Attendance Allowance (AA), which are currently set at £60.60 per week (£3,150 per year) for higher rate AA and £40.55 per week (£2,100 per year) for the lower rate. Eligibility for the different rates depends on whether help is needed during the day or at night and on the extent of disability.

Clients being provided with personal care in care homes in Scotland no longer receive AA, since DWP rules preclude its payment when a local authority is contributing towards the client's care costs. This means that DWP retains the payments that would previously have been made to these clients. In contrast, those receiving free personal care at home, who previously paid for this care, continue to receive AA.

There is a general lack of co-ordination of the respective roles of DWP and local authorities in respect of personal care. This is highlighted by the situation now pertaining in Scotland. Any comprehensive assessment of the anomalies thrown up by provision of free personal care should involve DWP: yet the structure of its benefits has remained largely intact throughout recent policy changes. The payments that it makes are extremely large: the total cost of AA in Great Britain in 2003–04 was £3.4bn[10] and, of this, around £340m was spent in Scotland. This is more than double the annual budget allocated by the Scottish Executive for free personal care.

Subsidised personal care

Local authorities across the UK have different charging regimes for providing care services, including personal care. The Welsh Assembly, Department of Health in England and the Scottish Executive have each issued guidance about 'fairer charging'.[11] Yet there are still divergences between authorities. These concern issues such as the income or benefits that may be 'disregarded' in means tests, the capital limits that are used to impute an income from an individual's assets, the maximum weekly charge that may be levied for service provision and the hourly charge for services.

And, while there are divergences between authorities, it is also true that, as a result of the operation of these rules, local authorities subsidise the costs of home care services to all users, including those who might be capable of paying the full costs. In England in 2003–04, local authority gross expenditure was £1.52bn, while net expenditure was £1.36bn – implying that charges raised only 10.8 per cent of home care costs. These data do not differentiate between different forms of care, nor do they distinguish between self-funders and those low-income clients who receive free care. Nevertheless, given that self-funders comprise approximately 40 per cent of the care home population, it is surprising that a much lower proportion of home care is not purchased by clients.

One way to characterise the Scottish home care position is that the subsidy to personal care is now a uniform 100 per cent in all local authorities. This contrasts with the situation in other UK local authorities where there is a variable rate of subsidy, which may be quite high.

Scottish local authorities still charge for components of home care that are not described as personal care. In 2002/03, local authorities raised £28m in charges to older people for non-personal domiciliary care.

Differences in costs of care between Scotland and the rest of the UK

What are the major differences from the client's perspective in the costs of care for older people between Scotland and other parts of the United Kingdom? Clearly, payments for nursing care in Scotland are less generous than in the rest of the UK. Average nursing care payments are £1,040 per year higher in England, £2,215 per year higher in Wales and £1,820 per year higher in Northern Ireland.

Scotland provides £7,540 per year for personal care in care homes, but clients do not receive the AA payment of £3,120 (higher rate) or £2,180 (lower rate), which the great majority of care home residents in England, Wales and Northern Ireland would normally receive.

Scottish home care clients receive a 100 per cent subsidy on personal care costs: they may still be charged for other care services. Potentially, self-funding clients in other parts of the UK receive subsidised personal care, but the level of subsidy varies between local authorities and cannot be easily extracted from local authority accounts since personal care is not distinguished. Nevertheless, the low level of charge income relative to costs in England suggests that the subsidy may be

considerable. AA is payable to home care clients throughout the UK irrespective of any help that they may be receiving providing that they meet the relevant criteria.

It is clear from this discussion that the difference in the costs of care for older people between Scotland and other parts of the UK is not as large as often assumed. In terms of the net cost to the public sector the increased costs of free personal care are offset by:

- the non-payment of AA to care home clients in Scotland
- lower nursing care costs in Scotland
- the subsidy to the costs of personal care that is being paid in other parts of the UK because local authorities charge less than the full economic cost of the personal care services they provide.

Our general argument suggests that the general assumption that Scotland has substantially higher *public* costs associated with care for frail older people than other parts of the UK must be carefully qualified. There are some areas of uncertainty, notably private domiciliary care and the local authority subsidy to personal home care. The assertion by Stephen Ladyman (2004), Parliamentary Under-Secretary for Community Care, that England is spending resources in a more targeted manner 'to provide a better range of services and increased choices for older people; and carers' is at least questionable.

Private domiciliary care

Switching now from public to private sector costs, we consider the private market for domiciliary care, which covers a wide range of services from housekeeping to nursing care. It is an extremely diverse market, which is characterised by private arrangements between clients and suppliers of services. It is important because individuals currently paying entirely for their own care might wish to take advantage of freely provided personal care, should it become available.

Unfortunately, the private domiciliary care market is not well calibrated. For example, estimates of the size of the home care market in Scotland have varied widely. The UK Home Care Association, in research commissioned by the CDG, (Matthew and Rimmer, 2001) estimated that 37,500 hours of care were purchased each year in Scotland at a cost of £10m. More recent estimates by the Scottish Executive, based on the Scottish Household Survey, suggest a substantially higher cost of £160m per

annum (Scottish Executive, 2004a). This seems extremely high, given that Laing & Buisson (2003), suggested that 27 million hours of domiciliary care were purchased privately in England in 2003. At an hourly cost of £7, this would cost £189m. Assuming that all clients currently buying private care would wish to change to publicly provided care if free personal care became available, this cost would have to be included in estimates of the cost of introducing free personal care in England.

Estimates of the size of the domiciliary care market in other parts of the UK are not generally available. It is likely that the provision of private domiciliary care is less extensive in Scotland, Northern Ireland and Wales because of lower levels of affluence in these areas.

Conclusion

Differences in the average circumstances of older people between the constituent parts of the UK are smaller than differences within England, Scotland, Wales and Northern Ireland. Differences in demographic structure, health and informal caring are relatively small. The trend in informal care has recently tended upward in Wales, Scotland and England, even though formal provision has followed a different path in England compared with Scotland and Wales.

There are differences in the income and wealth of older people across the UK. High rates of deprivation, for example in some parts of Scotland, result in a greater dependency on state benefits in Scotland than in England, which has important implications for the provision of free personal care.

1 The greater reliance on state rather than private provision of care in Scotland has had an effect on the policy culture, where public provision rather than market provision tends to be the received wisdom. Given that the Scottish version of free personal care has been conceived as a policy that relies on local authority delivery, it has little power to inform the rest of the UK about private sector solutions to providing personal care.

2 Differences in affluence do have one important implication in relation to the cost of free personal care. This cost is often taken to mean the cost of provision of *all* personal care. This is incorrect in the UK context. The cost of free personal care is actually the cost of providing personal care *to those who would otherwise have been expected to contribute towards these costs*. If the population is too poor to contribute, then the ‘cost’ of free personal care is zero because personal care is

being provided entirely by the public sector anyway. Thus, free personal care is typically less costly in poorer areas. The *overall* resource cost of providing personal care does not change – free personal care affects only the distribution of the overall resource cost between the private and public sectors.

There are also important differences between parts of the UK in respect of care provision.

- The private sector plays a much more prominent role in providing care at home in England than in Scotland, Wales or Northern Ireland.
- Nevertheless, home care provision (publicly provided) is substantially more common in Scotland than in the rest of the UK.
- But Scotland also has a relatively larger number of geriatric beds compared with England and Wales.
- Disputes associated with continuing care and its funding are more prevalent in England than in Scotland or other parts of the UK.
- Differences between Scotland and the rest of Great Britain in the costs of personal and nursing care are often exaggerated. There are substantial offsets to the higher costs caused by the provision of free personal care in Scotland.

5 Implementing free personal care: views from the suppliers

Key points

The tactical interviews involved civil servants with a general overview of the policy and its implementation, and others with expertise in issues such as housing and workforce.

1 Respondents emphasised the context of free personal care, commenting on a range of issues about the care and support of older people and the need for an improved approach.

2 Change in recent years had been complex and piecemeal, and policy developments – including Supporting People, Single Shared Assessment, Care Standards, Direct Payments and benefits such as Attendance Allowance – interacted significantly.

3 While the consequences of free personal care were not easily to isolate, they were felt to include:
- a sharper focus of debate about issues of long-term care for older people
- no clear evidence of substitution of formal for informal care
- indications that free personal care could support informal carers to continue their caring
- a continuing and heightened debate about care home fees
- a stronger focus by service users on quality of care at home, with limited evidence of more complaints
- demand for a larger, better trained workforce, as the nature of work was changing.

The operational interviews involved local authority social work managers and their equivalents in the voluntary and private sectors who were able to comment on the implementation of the policy.

1 Local authority experience was variable, with some early difficulties including resourcing, confusion about contracts, extra work for staff in classifying tasks and conducting assessments, and difficulties posed by the interaction of policies.

Continued

2 Local authorities had been central to the implementation of free personal care. As a consequence, issues for the voluntary and private sectors had received little consideration.

3 While the voluntary sector had theoretically not been directly affected by the introduction of free personal care, pressure on resources had come from increased volume of enquiries, reflecting uncertainty on the part of service users.

4 The role of the private sector in delivering care and support for older people – including much free personal care in care homes – had been rather neglected, and there was a view that more effective partnerships between sectors could be forged, with each contributing particular expertise.

5 Overall, the main beneficiaries of the free personal care policy were felt to be people with conditions such as dementia and people of modest means, who had previously found charges particularly burdensome.

Introduction

In this chapter, we examine the experiences and views of people involved in implementing the policy of free personal care at tactical and operational levels. By tactical we mean those operating at a level of some authority and with an influence on how the policy is implemented. The operational level concerns social workers and others who are actually charged with making decisions about what the policy means for individual clients.

We consider the issues that were faced over the implementation period and the emerging understandings of the impact of free personal care, as well as ways in which free personal care fitted into the broader universe of care and support for older people. In general, we found that free personal care had sharpened the focus on care and support for older people, raising the profile of a number of developments already under way and, among these respondents at least, promoting critical thinking about the whole area.

Tactical interviews

Overall, the interviews with civil servants and others with a general overview of aspects of the policy emphasised strongly the difficulty of considering the policy of

free personal care in isolation, and ways in which other policies might interact with it. Often, influences were mutual, with the discussion of free personal care bringing out wider issues perhaps more sharply. There are indications in these interviews that free personal care may have catalysed wider tactical thinking on the care of older people, and emphasised the need for a more holistic overview and strategy. For example, it was widely perceived that capacity to implement and evaluate free personal care was limited by factors such as the lack of good information systems and continuing weaknesses in 'joined-up' working and thinking. Interviewees took a broad overview of the policy, as well as commenting on their specific areas of expertise. We present their views and experiences under headings that reflect their own assessments of important issues and areas for discussion.

The context of free personal care

Without exception, the respondents saw free personal care as being linked with a wide range of issues concerned with the care and support of older people, and with some already existing challenges in providing these. They reflected the view we presented previously that free personal care could not be considered in isolation from the wider universe of care and support for older people in Scotland and the UK. These contextual issues were discussed as follows.

- There is continuing need for improvement in good quality care management and good quality care. This reflected a widespread view that services for older people were less than ideal, and that there were continuing problems with the processes of ascertaining needs and supplying services to meet them.

- Difficulties presented by the quantity of recent changes were highlighted. As we discussed previously, free personal care was only one of a raft of policies changing the provision of care and support for older people, and there was a perception of overload in terms of continually implementing further change.

- Linked with the assessment of overload, respondents suggested that principles and priorities needed to be clearer, instead of the more 'piecemeal' approach that recent policy changes appeared to reflect. In particular, a lack of clarity about the roles of the private and voluntary sectors was perceived, since so much policy debate and change had been focused on local authorities.

- Respondents felt that 'doomsday' scenarios about older people in the future needed to be countered with better demographic data and appreciation of the potential of new care models (such as housing with care or the use of new

technology). Housing solutions were particularly noted, and there is a need to include these in official data collection and analysis. This has relevance for the way in which costings were done.

- Poor quality of community care data and lack of effective recording systems in many local authorities reduce efficiency and consequently increase both difficulties of implementation and costs. In particular, statistics on care at home were noted to be of rather poor quality. The recent Kerr report (Scottish Executive, 2005) recommends improvements in NHS records – this might usefully be linked with improvements in social care recording. Poor quality data from local authorities has reduced the ability of the Scottish Executive to generate accurate estimates of the impacts of free personal care in the period since implementation. It may be that the speed of implementation of free personal care made it difficult for local authorities to implement data gathering at that time.

- There was still a need for a more 'joined-up' approach to policy development and delivery. In particular, the health sector had not been effectively involved in the process of delivering free personal care, as the process had been 'driven' by social work.[1] Budgets had been an area of difficulty, where there was a risk of service users falling between systems and therefore not receiving the services they needed.

Despite all these contextual issues, however, respondents agreed that the general support in Scotland for state provision of services promoted government commitment to the policy. And, throughout the period of the research, ministers made repeated public assurances to the effect that this was a 'flagship' policy to which they remained firmly committed. Towards the end of the period of fieldwork, a debate was starting on the possibility of extending the policy to people under 65. Typically, there are many fewer clients aged less than 65, but their care needs are more extensive. Hence, extension to this age group would require a further extensive commitment of resources. A commitment to disabled people of all ages has been made in respect of home care by the Welsh Assembly Government, which is currently evaluating how the costs can be met.

The discussion of this wide range of issues suggests that, for our interviewees at least, free personal care had focused debate on more general issues of care for older people in ways that might not otherwise have occurred.

Interactions between free personal care and other policies

We have already noted that the respondents saw the quantity of change on policies regarding care for older people as having presented some tactical issues. They went on to highlight some specific interactions that were of particular significance.

- The policy most often discussed was Supporting People. In principle, the policies of free personal care and Supporting People should have been quite distinct. In practice, this was not the case. The main issue was the difficulty of distinguishing between different care tasks and allocating them correctly. During the course of the research, one of the main problem areas – that of meal preparation, feeding and clearing up afterwards – was resolved by a directive from the Executive clarifying that all these tasks could be classified as personal care. This clarification did not, however, prevent respondents from continuing to raise these ambiguities as an issue. We noted earlier that meal preparation was outside the original definition of personal care proposed by the Royal Commission. We show subsequently that expenditure on free personal care considerably exceeded the Care Development Group estimate and suspect that meal preparation may be an element of this. However, there is no convincing statistical evidence of this as yet.

- There had been difficulties attached to the implementation of Single Shared Assessment, despite the length of time since this was first mooted (Scottish Executive, 2000). In particular, health was perceived not to be integrated with social work, and less so with housing. Thus, respondents implied, processes of assessment were not operating as well as they might, and this affected receipt of personal care.

- Inspection regimes attached to the National Care Standards (Scottish Executive, 2004b) were seen as having the potential to improve quality of services. However, there was seen to be a risk that they might also restrict availability, as the quantity of provision might be adversely affected because of higher costs. Therefore, it might prove difficult to satisfy demand for personal care, whether or not this increased.

- Direct Payments, it was reported, had been seen as a potential threat to services in that, for example, clients might withdraw from local authority provision and make services unviable, but this had not occurred as far as respondents knew. Indeed, take-up of Direct Payments by older people had to date been limited, possibly because of the paucity of information from unenthusiastic local authorities[2] and the relatively recent inclusion of older people in the groups

eligible to receive them. The potential impact of an increase in Direct Payments on the receipt and delivery of personal care, therefore, remained to emerge.

- Some respondents noted that, with the introduction of free personal care, Attendance Allowance had been withdrawn from care home residents. The withdrawal of Attendance Allowance from care home residents in Scotland offsets the £145 per week that they receive for free personal care, and thus reduces the difference between Scotland and England in care home costs for self-funders.

Our respondents thus perceived the introduction of free personal care as interacting with a number of other recent policy changes and emphasised for us a need to explore these interactions carefully. It is also clear that the potential effects of these interactions may not yet be fully worked out and that they have implications for the implementation of all the areas of provision identified.

The consequences of free personal care

Since they saw the recent policy measures for older people as mutually influential, respondents found it difficult to isolate developments that had been specifically brought about by the implementation of free personal care, and they tended to be reluctant to identify cause and effect. In this, they bear out the arguments we have made previously about the difficulty of isolating the effects of this policy alone.

Nevertheless, a number of specific consequences were suggested, often with caveats.

- The Scottish Executive anticipated that provision of free personal care would result in a substitution away from informal caring and greater dependence on formal care. It made an initial allowance of £8m to cover these costs and anticipated that these might rise through time. In practice, respondents felt that some substitution of free personal care for informal care had been observed, but no one was able to quantify this. As we will discuss in the section on user views, there are reasons to suggest that increased demand for free personal care from those who have informal carers may represent a need for these informal carers to be supported to continue caring, rather than their withdrawal from care in favour of services from outside the home. The statistical analysis, which we discuss subsequently shows no significant change in informal caring after the introduction of free personal care. There is thus a sense in which free personal care supports informal carers to continue caring.

- It was widely noted that care home charges had increased over the period since the introduction of free personal care and, for a minority of respondents, this represented care homes cashing in on the extra resources now available to people who no longer had to pay for personal care. However, others noted the more general underfunding in the care home sector and took the view that charges would have had to rise anyway, without the introduction of free personal care. Again, we address this issue subsequently in our analysis of care home fees.

- Respondents reported increasing numbers of complaints about care at home – but it is not clear that free personal care *per se* has influenced this. The route for complaints provided by the Care Commission is relatively new and numbers of people receiving care at home are increasing – these factors alone may well have had the effect of increasing complaints. In the section on older people's own views, we will explore the variation in attitudes towards free services and people's assessments of their quality, which may also affect numbers of complaints. As our respondents recognised, this is a complex issue.

- The introduction of free personal care was seen as having particular benefits for middle-income groups, 'people of modest means', for whom, it was believed, charges had previously been particularly burdensome.

Several respondents identified workforce issues, which they linked partly with the introduction of free personal care, but also with other policy developments.

- They noted that the policy emphasis on increased care at home would require a better trained and supported workforce. One positive measure in this regard was the registration of the social care workforce under the Regulation of Care (Scotland) Act (2001), which was seen as having the potential to improve the quality of service. However, the workforce would increasingly be faced with providing personal care at home, involving a new set of tasks that had not necessarily been part of their work before. If generic working were to increase, registration issues would become more complex.

- For social workers, free personal care had reinforced the process of bureaucratisation, by increasing the burden of assessment – this is discussed subsequently in the section on local authorities.

- These discussions about the workforce thus identified a balance of forces. On the one hand, people felt that demand for labour would increase. On the other, they felt that registration issues and the changing nature of social work might restrict supply.

It was notable that these interviewees were broadly supportive of the policy. They felt that the difficulties they outlined were challenges that could be met.

Operational interviews

The issues raised in the operational interviews with social work managers and their equivalents in the private and voluntary sectors varied considerably, and we present these accordingly. Again, in examining respondents' views, we aim to represent their own priorities and perceptions.

Local authority perspectives

The most striking finding to emerge from the interviews with local authority representatives is that the *experience of local authorities was variable*. This reflects the findings from our quantitative analysis showing that variation in the population requiring care within Scotland is much more marked than variation between Scotland and the rest of the UK. Variations that emerged in the interviews depended on a number of factors, including the local population structure in terms of proportions of older people and the socio-economic composition of the area as a whole as well as the older population. Also influential were the former methods of delivering personal care. In some authorities, personal care at home had been offered as a free service prior to the introduction of the policy; in others, there had been different charging regimes, usually involving means testing and sometimes higher charges for the more wealthy, which were used to support wider service provision in the area. And the local strategy for older people was also a source of variation, as authorities differed in the balance of care they offered and in their patterns of investment. Some general issues did emerge.

1 All felt that there had been a shortage of funds for implementation. The early months had been difficult, as the implementation timetable was very fast. There was variation in the difficulties experienced, depending particularly on the previous arrangements for paying for personal care. Importantly, some respondents felt that the formula used to decide on resource allocation to authorities was flawed.

2 There was much discussion of the contracts between users, providers of contracted out services (especially residential care) and local authorities – there had been confusion in this area, but it appeared to have been resolved in most

cases. There was considerable technical complexity in this area and coming to grips with the issues was identified as one of the implementation costs. One outstanding issue concerned self-funders in residential care who, some respondents felt, might have slipped through the whole system and consequently have been vulnerable to overcharging or unreasonable contractual conditions.

3 For local authority staff, there had been extra work, both in the initial implementation period and subsequently. This included the following.
   - New processes for classifying care. The boundaries of personal care and other forms of support had not always been clear and work had been done to guide this process, for example by producing local guidance for staff. The difficulties however appeared to have persisted. This may reflect a more general difficulty of dividing a perceived need for care and support into categories, which is discussed further in the section on user perspectives.
   - Assessments had increased in number. Some of this was an implementation issue, where support packages had to be reclassified under new budget headings, but it also emerged that reviews were increasing in number. This seems to have been partly due to a fear that people would not voluntarily relinquish a free service if they no longer needed it.
   - The interaction of free personal care with other policies had made staff's work more complex.

4 Interaction with other policies was particularly highlighted in two cases at this level.
   - Supporting People (housing support) was the main area of difficulty, and respondents repeatedly mentioned the example of food preparation and feeding, despite the apparent resolution of this issue mentioned before. It was clear that there was a general unease about the classification of tasks.
   - Respondents explained that, in their experience, Single Shared Assessment was not fully implemented and not all staff were, therefore, ready to do assessments including personal care. A fear was expressed that people might not, therefore, receive the care and support they needed.

In this set of interviews, resources and their distribution were extensively discussed, and the following issues emerged.

- Local authorities were experiencing increased demand for services, possibly reflecting the demographic trends and changes in the balance of care already discussed. Some respondents felt that this came especially from middle-income groups. At the operational level, it was not clear that this was related directly to the introduction of free personal care or whether it was an existing trend.

- There was some challenge to the notion that free personal care would be cost-neutral. In better-off areas, some respondents felt there was a loss of revenue from people who had formerly paid for services and this had not been outweighed by the allocation of resources to fund personal care. Again, this raises the issue of the appropriateness of the Grant Aided Expenditure (GAE) distribution formula used by the Scottish Executive for this particular policy. GAE was intended to bias spending towards deprived groups, while free personal care principally benefits those who have the means to pay for personal care.

- These respondents noted the increases in care home charges and associated these with free personal care – one person described the increases as dramatic. There was a sense of criticism of the care home sector, which was widely perceived to have 'cashed in' on the resources freed up for former self-funders by free personal care.

- The negativity expressed towards the care home sector was also apparent in comments – made by a minority – to the effect that the policy benefited the well off, their families (considered likely to receive a larger inheritance), care agencies and care homes, which got more business.

- Similarly negative was some anecdotal evidence of potential 'abuse' within the system. For example, migration between local authorities and some cross-border migration (from England) was purported to be affecting demand for services as people 'shopped around', and there was some perceived queue jumping, whereby people would enter residential care under a privately negotiated agreement, then get an assessment for free personal care afterwards from the local authority. It is important to note, however, that neither of these scenarios was widely reported and there is no reason to suppose that they would have any more than the most marginal of impacts. This is contrary to some of the early 'scare' stories about the potential impact of free personal care.

For local authorities, therefore, our interviews suggest that free personal care had presented some challenges. Although the strategy was suggested initially to be simple, and to involve merely a movement from one budget heading to another, it was not experienced as simple by those actually implementing the policy in local authorities.

The impact on the voluntary sector

The voluntary sector was not directly involved in the implementation of free personal care and all the financial support for the process went to the local authorities. However, our interviewees, who together represented a broad overview of the Scottish voluntary sector, identified that there were indirect impacts and costs in terms of the need to respond to the policy change.

- When the policy was first introduced and during the early phases of implementation, the voluntary sector respondents reported an increased number of enquiries from the public seeking guidance. They had not all been prepared for this.

- Public misunderstanding was reported, in that people had not understood that they had to be assessed for free personal care and thought it would be an automatic entitlement, like NHS care.

- The complexity of the system as a whole, of which free personal care was just one element, was noted critically by these respondents. For them, this was linked with the extent of public misunderstanding and the difficulties in providing information.

- Interactions with other policies were one aspect of the system's complexity and Supporting People was seen as a particularly difficult area. In this, they echoed the local authority comments. Direct Payments were also mentioned as having the potential to give clients more control over the care and support they received. One respondent noted that perhaps local authorities were less than supportive of Direct Payments, because of this shift in control.

These respondents also commented more generally on the policy, aside from the particular impact experienced by the voluntary sector.

- They saw increased demand for care at home, while at the same time limits to it, in that care packages were being limited in size by local authorities.

- Since the introduction of the policy, they felt that care home charges had increased. As we shall see, this is borne out by the financial data.

- In general, the costs of caring for older people were expected to increase – but, from these respondents' viewpoints, the solution was seen as tackling poverty and inequality, not adjusting charges for care. They felt that an emphasis on older

people as a 'burden' on society failed to understand the difficulties many older people faced, resulting from poverty and discrimination against older people. They wanted to see fundamental changes in these areas and felt that small adjustments to the care system merely tinkered at the edges of basic structural problems.

Overall, the voluntary sector respondents supported the policy of free personal care. Like the local authority respondents, they noted that beneficiaries of the policy included the better off in particular – though it was also pointed out that only people with care needs would benefit and that inheritance tax would still raise significant revenues. With larger legacies, more wealthy people's estates would in the end yield higher taxation returns. People with dementia were also identified as a group who benefited particularly from free personal care, as many of them had care needs that were primarily for personal care rather than nursing, despite having a diagnosed medical condition. This argument was one of those originally used to support the introduction of the policy and it clearly resonated with these respondents.

The private sector and the need for partnership

There was a clear tendency, especially among the local authority respondents, for the private sector to be 'demonised' for overcharging, profiteering from the introduction of free personal care and exploiting self-funders. An opposing view, however, was presented eloquently from the private sector's own point of view by the interviewee who represented a federation of diverse private care providers.

- The need for partnerships between the different sectors involved in providing care and support for older people was emphasised, especially with reference to the range of expertise across sectors. For example, there was a need to recognise that the private sector may be more effective than local authorities in some areas, such as in raising finance to build care homes. Similarly, the voluntary sector has particular expertise in supporting people with complex needs.

- Linked to that argument, it was noted that local authorities did not have the capacity to meet current care needs and had to purchase services from other sectors. This was felt likely to increase with growing numbers of older people and there was a need to ensure that systems permitted this to occur effectively.

- The underfunding of the care home sector was a cause for concern. If care homes were increasing their prices, this was because they were otherwise unable to cover their costs and the practice was not necessarily linked with free personal care.

- Current systems tend to be orientated towards and best suited to the local authority service sector. This was noted to be potentially detrimental to the private client, whose interests might not be effectively protected if, for example, the inspection regime was particularly focused on publicly funded clients.

These points were not necessarily widely agreed across care sectors, as the other interviewees' views suggest, but, if there is a genuine need for 'joined-up' thinking and working of which free personal care is an element, it seems clear that issues regarding the role of the private sector require to be addressed. These would include the particular strengths of the private sector, the limitations on local authority capacity and the issue of underfunding in the care home sector generally.

Overall, the operational interviews reveal widely shared perceptions at this level about the impact of free personal care. These vary in their accuracy, but also reveal variation related to cross-locality and cross-sector experiences and interests. They indicate the perceived complexity of issues linked with free personal care.

Conclusion

Interviews with those in tactical and operational roles reinforce our argument that free personal care cannot be made sense of, or its implementation understood, in isolation from the context of other policies affecting the care and support of older people. This was widely appreciated by those interviewed. Many of the issues discussed related to difficulties of interaction with other policies, which had not been fully considered. There are arguments, for example, for linking budgets more effectively and reducing costly procedures such as repeated reviews of service packages. Such changes would also be linked with consideration of models of care that cross both professional and sectoral boundaries.

The impact of free personal care is perceived in different ways according to role, sector and location. At the tactical level, the focus in our interviews was, unsurprisingly, on wider issues and respondents took an overview of the system as a whole. Free personal care, it appeared, had served for them to focus attention on the

broad questions of care and support for older people. It is notable that, while they perceived a number of issues, they did not express the view that the 'doomsday' scenarios attached to free personal care had transpired. From their points of view, the policy was both desirable and workable and, while some difficulties were identified, these were seen as challenges to be met rather than insuperable problems.

One important factor that emerged from these interviews, to which we will return, was the central role of local authorities, which had been charged with implementing the policy. One result of this appeared to be the tendency for local authority models and issues to dominate, and other approaches to attract only secondary consideration. We have argued however that, since free personal care is an element of a much broader system of care and support, full appreciation of its impact can be achieved only in this wider context and not in isolation.

6 Implementing free personal care: older people's perspectives

Key points

1 Participants in the focus groups took a holistic view of the care and support needs of older people, and expressed strong and clear views, grounded in experience. They did not differentiate personal care from other types of care and support.

2 Throughout the focus groups, there was an emphasis on issues of service quality, with experiences of problems frequently expressed.

3 Older people emerged as actively negotiating their packages of support, maintaining independence and choice, which are highly valued, and combining help from formal and informal sources.

4 In the context of their extensive knowledge of care and support, and negotiation of packages for themselves, people expressed continuing confusion and lack of clear knowledge about free personal care.

5 Informal carers' dedication, commitment and crucial role were emphasised. There was no real evidence of 'substitution' following the introduction of free personal care, although free personal care could support carers to carry on longer and to devote their time to caring tasks other than personal ones if this was preferred.

Introduction

In this chapter, we examine the views and experiences of older people concerning free personal care in the context of services for older people more generally. To the participants in this part of the study, looking at free personal care in context was essential – they found it difficult to differentiate as a separate policy with distinct effects, and did not divide up older people's care and support into categories such as nursing, personal or non-personal care. In presenting their views, we have indicated both dominant and less popular perspectives. Where one group of people, such as minority ethnic participants or informal carers, expressed distinctive points, these are also highlighted.

Perspectives on care and support in older age

The findings from the focus groups are presented *to reflect the priorities that the older people themselves highlighted*. In common with the researchers for the Care Development Group (Machin and McShane, 2001), we found that people took a holistic view when describing care needs and services in the context of their everyday lives. They did not single out personal care from other kinds of support and several groups found it difficult to speak about free personal care as a specific policy change. Nevertheless, people expressed strong and clear views about the best kinds of care and support, and about how these should be paid for. In the groups, there was lively debate about the issues raised. It is important to note that, at the time of holding the focus groups (Spring 2005), free personal care had already been available for nearly three years and thus many of the experiences of services recounted by respondents had occurred under the new regime.

Experiences of services – what older people and informal carers get

The quality of services received emerged as one of people's main concerns, replicating the findings of the researchers for the Care Development Group. While many of the service users were appreciative of services they had received, a number of issues were also raised in the discussions, including the following.

- The need for services to be more person-centred – people did not like care workers who rushed; they did not like going to bed at unsocial hours (such as 5.00 p.m.); they did not like having a succession of different care workers calling on them during the day and preferred some continuity.

- Perceived under-resourcing of services, whereby, for example, assessments took too long or previously existing services were withdrawn. This issue was particularly prominent in the sheltered housing complex where a resident had died and lain undiscovered for a fortnight. The group felt that the warden service should not have been withdrawn.

- Some highlighted problems with less than effective links between health and social care services in relation to numbers of callers at their homes and assessment procedures, despite the move towards a Single Shared Assessment.

- Some sympathy was expressed for the social care workforce, with recognition of their low pay and poor working conditions. These were felt to be detrimental to the services that workers were able to deliver.

- The black and minority ethnic (BME) participants asked for services to be more culturally sensitive. They appreciated the specialist day centres for BME older people, but felt that other services were not sensitive to their needs. They mentioned that, as an alternative, they felt pushed into paying for services.

Participants were eager to put these points over – it was often difficult to steer the discussions towards a specific focus on paying for services and thence to free personal care, such was the strength of people's views and their enthusiasm for this topic. They were clearly knowledgeable (often from experience) and well informed about services.

What older people and informal carers want

In considering what older people and informal carers want from services, participants emphasised choice and independence. These had a range of meanings linked with the ability to control one's own day-to-day life while drawing on appropriate, flexible help, whether informal or from services outside the home.

- Some people spoke specifically of older people's wishes to stay in their own homes and, for many, this was a desirable goal. However, some participants who were in residential care spoke positively about it. It appeared that, where people had been able to make an active choice about being admitted to residential care, this was seen as a positive option. It also emerged that, in some cases in which a move had been forced by circumstances, where the person had had little choice or had apparently not been properly consulted, residential care was not seen as desirable.

- Linked with a discussion about the desirability of staying in one's own home, two groups spoke about the need for people's homes to be secure from intruders and for older people to feel safe at home. These comments were supported by accounts of worries about the safety of older people in communities.

- In terms of formal services, people sought flexibility, consistency and unobtrusiveness. It was evident that people had a clear sense of their own needs and that they were often mystified by services that could address some of these

and not others, or that required different personnel to complete tasks that they did not themselves see as differentiated.

- Support for informal carers, who might be friends as well as family, was a strong theme. In general, participants felt that informal carers were left to carry on alone, without support, and that services did not recognise their needs for support.

- Three groups raised issues of isolation and loneliness of older people, especially those with dementia, and the difficulties people faced in getting out and about. One group in particular felt that people with dementia were sometimes shunned by others, as a stigma was attached to the condition.

These comments are in tune with those about services people had experienced, both those statutorily provided and those they had bought for themselves, in that choice and independence were also strong themes there. It was notable that, in addition to speaking about services specifically provided (or not provided) for older people, participants made comment on wider social issues, such as community safety, transport and attitudes towards older people. These comments are a reminder of the need to move away from the stereotypical view of older people as consumers of support services, to consider their status as citizens.

In keeping with this perspective, in reality, the various sources of care and support that people wanted and used were combined in quite individual ways and there was evidence of people negotiating needs for support in an active manner, rather than as passive recipients of statutory help. We did not gain an impression of an avalanche of demand because of unmet need falling on statutory services following the introduction of free personal care. Rather, people were continuing to work hard to retain their independence, in many cases resisting outside help.

The role of informal carers

The contribution of informal carers was an important topic of discussion, both within the three carers' groups and across the rest of the groups.

- Participants emphasised the commitment of carers to their relatives, whatever their condition. It was clear that this commitment continued while people were receiving services from outside the home and also once they were in residential care.

- The positive benefits of family carers were emphasised, particularly their individual knowledge of the person and the importance of this for the quality of care they were able to give. This emphasis on individuality echoes the points made earlier about choice and independence.

- Two groups pointed out that, for personal care, sometimes non-family carers are more acceptable. They explained that the nature of relationship between a parent and child may be altered if the child starts to perform intimate personal tasks for the parent, and saw this as something to avoid if possible.

- One carers' group believed that free personal care was of particular benefit to informal carers, helping older people to stay at home longer because their carers had support.

These accounts of informal caring place it within a context of committed relationships, with content well beyond care tasks *per se*, and stress the holistic nature of informal caring. The emphasis on the commitment of informal carers has to be seen alongside the previous comments on the need for support for these carers and indicates some of the potential sources of stress in these intimate relationships.

In the focus group discussions, we did not find evidence of 'substitution' of informal care for formal services, except insofar as carers could be subject to considerable stress and might find it difficult to continue their role without support from services. There was no sense that carers would give up because care became free of charge. At the same time, there was a feeling that free personal care might be a source of support for carers, and in fact prolong some caring relationships, especially where personal care tasks were in some way problematic. These considerations are consistent with the statistical analysis we subsequently describe.

Paying for services

A range of views emerged about who should pay for care and support services, though the strongest suggested that services should be free, as 'people have paid their taxes'. Other points made included the following.

- Means testing emerged as very unpopular, being described as 'invasive' by one of the groups.

- ‘Money worries’ were described as a central problem faced by many older people and there was a general feeling that they should not have to experience these. The sorts of worries discussed included worries about whether people would have sufficient resources to pay for their care, what would happen if their money ran out and unspecified ‘big bills’.

- In general, the groups felt that older people are a low priority for services, with older women singled out in particular as having contributed informal care prior to their own older age and, therefore, having missed out on earning potential.

Discussion emerged about the relative merits of free services and services people paid for.

- Often at the same time as arguing that services should be free, groups pointed out that, if people pay for themselves, they are in a position to ‘call the piper’, therefore having more control over the services received and the tasks that could be done. This was seen as desirable in relation to the value attached to independence and choice. Indeed, there were many examples of people who had bought services privately for themselves at least partly because this meant they could have what they wanted. It was also noted by some groups that they could buy non-personal services at rates cheaper than the local authority charges.

- One BME group felt that free services might be lower quality and that services paid for might be better. Alongside this, they suggested that, by paying themselves, people could get care that supplied their particular cultural preferences.

- In one group, there was a discussion about whether Direct Payments could offer people the sorts of choices they preferred, but the balance of opinion was that these would be difficult to manage, and that assistance would still be needed to find suitable helpers and to deal with employment issues.

Thus, in spite of the general support expressed for free services, there were still views that more control could be exercised if people paid for care and support themselves. Such views may account for the widespread use of Attendance Allowance by people at home, which was discussed in Chapter 3 and which allows people freedom to choose the services they want. Clearly, debates about who should pay resonate for these participants with those about quality of services.

It is interesting to note that, in reality, people were operating their own 'mixed economies' of welfare, with informal carers, statutory services and privately purchased services put together in various combinations. It was clear that, in putting together these packages, as well as in considering who should pay for what, they had difficulty singling out personal care for separate consideration.

Care homes

Care home charges have, as previously discussed, been a contentious and difficult issue, and issues of how to fund them have become entangled with issues around free personal care, which has produced a new income stream. Among the focus group participants, different views appeared related to whether or not people had direct experience of care homes.

- One group in residential care had seen their charges reduced when free personal care was introduced – they were self-funders. However, a group of informal carers of people in residential care explained that the charges for their relatives had risen. This increase was described as coincidental, as costs had also risen, but it was not clear that the carers necessarily accepted this explanation.

- One activist group reported that care homes had raised their charges and referred to profiteering.

- There was some negativity towards care homes – as not what people want, and several carers expressed feeling guilty about their relative being in a care home. However, the residents themselves, as previously noted, were much more positive about the care they were receiving.

Throughout the report, we note mixed findings in relation to care homes and this is again reflected in these perspectives. The focus group participants add another dimension to the complex picture, highlighting varying attitudes and experiences. Care home charges in particular are a contentious issue from all points of view. For our participants, as we noted previously, 'money worries' were a key concern and care home charges represented a significant worry for some. The focus of discussion was again on the whole picture and personal care was not singled out as a separate issue, despite its significant impact on the charges.

Knowledge of free personal care

Much of the discussion in the focus groups centred on people's knowledge and understanding of the free personal care policy, which had been in force for more than two years at the time of fieldwork. Overall, the focus group discussions revealed that most people had some knowledge that personal care was free, but that there were many misunderstandings and confusions. It is important that these are seen alongside the considerable knowledge that the groups had of services in general.

- It emerged strongly that, particularly at the start, many people had thought that all care would be free. This was reported both as being the view of others and, in several groups, participants themselves explained that they had held the same misconception.

- The Scottish Executive leaflet was familiar to many participants, though we observed that some people, especially those with impaired sight, found it difficult to read and understand. The dark background and small print were simply unreadable for several participants. There was provision to obtain the leaflet in alternative formats, but this required some effort on the part of the enquirer. It would seem more appropriate that the main information medium should adopt a more accessible format.

- Activist groups had observed differences between councils and were not sure that free personal care had been implemented everywhere. Our review of these comments and the contexts in which they were made suggested that the comments did not in fact relate only to free personal care. Rather, they concerned more general variation between local authorities in terms of services available for older people. Again, personal care was being seen and discussed as part of a wider picture of services and in the context of an overview of care and support needs.

- Among those with the most knowledge of the policy, such as some members of the activist groups, there were still misunderstandings and confusion. The policy was described as difficult to understand and, in several groups, there were lengthy debates about which services people had to pay for and which were free. In this connection, it was noted that NHS services were free, but that people with conditions such as Alzheimer's still had to pay for essential care, which the NHS did not supply.

Despite the confusion over the policy, however, there was wide support for it and the view that older people should not have to pay for essential services was strongly expressed. The difficulty of distinguishing personal care and other sorts of care clearly informed these discussions. There was some regret that the initial positive impression that all care would be free had not been fulfilled and one group referred to disappointed expectations that the announcement of the policy had aroused.

Unmet need

Unmet need was not a term widely used in the focus group discussions, but evidence emerged indirectly. There was, as normal in this type of research, much talk of underfunded services being unable to meet people's needs. One group noted that, as demand for NHS services appeared insatiable, so might demand for free care services, and in that sense suggested that need might be infinite. Some more specific issues also emerged.

- Lack of support for informal carers has already been noted and this was seen as a particularly important issue.

- The general lack of culturally sensitive and culturally competent services was seen as implying unmet need among BME populations. The needs of BME older people were only partially met by the existing specialist services, which were limited in the range of support they could provide. One group noted that this was a particular issue for some 'invisible' minorities, such as several European groups, which had specific cultural needs.

- A link was made between some of the comments on quality of services when people spoke of unmet need for flexibility in service provision, including 'more personal time' and 'respect and understanding', as we have already discussed.

- Some unmet need was uncovered where services had been withdrawn, as in the case of the sheltered housing warden service – people felt that they had increasing need of support as they grew more frail and yet the service was no longer available.

These comments about unmet need often refer to quality rather than quantity of services, including, apparently, a local strategy for sheltered housing. Again, we do not see expressed views that might suggest upsurges in demand because of the free provision of services. It was much more likely, as several respondents stated, that they would 'just keep myself going' as well as they could.

Joined-up services

Although people did not use the term ‘joined-up services’, they frequently made comments on and discussed how different service providers might work together more effectively. For example, they discussed the following

- Undesirable divisions of labour among care staff – for example, restrictions on what home helps were allowed to do. One group described the division of labour between different groups of staff as ‘absurd’. Another categorised all who came to people’s houses to deliver services as ‘social work staff’, clearly using this as a catch-all term for a wide range of people including NHS staff. The term ‘home help’ was also used very generally and in one case meant a live-in companion.

- Lack of links between housing and social work services, social work services and the NHS and so on.

- Difficulties of distinguishing personal care from other care – this was a strong theme throughout the discussions, as we have noted.

These points all serve to emphasise that, for older people and their carers, needs for care and support are not neatly compartmentalised under budget headings or professional remits. The participants in our focus groups clearly saw care and support needs holistically and as part of the rest of their lives. Hence their wish to go to bed at ‘normal’ times, to receive respect for their individuality, to obtain care and support that responded to their particular needs, to have some choice, to have consistency of care and so on.

Conclusion

The difficulty that our participants had in singling out free personal care as a separate topic for discussion reflects the realities they faced as older people and informal carers needing care and support. This is an important finding and supports the policy. The introduction of free personal care has already gone some way towards reflecting these needs and wishes of older people and their carers in that, for example, there is no longer an artificial distinction between people who need personal care because of acute illness and people who need it because of chronic conditions. Furthermore, the indirect support for informal carers to continue with their work also reflects people’s own commitments and preferences.

The users emphasised their wish for choice in and control over the services they received, and were actively engaged in organising their own 'packages', using combinations of services, private help and informal care. One of their uppermost concerns was the quality of services. Free personal care has the capacity to support choice, control and good quality services by reducing (though not eradicating) artificial barriers between different needs, reducing financial burdens and worries, and supporting informal carers.

7 The financial effects of free personal care

Key points

1 Free personal care does not increase the costs of care to society as a whole – it shifts the balance between payment by individuals and payment from the public purse.

2 The Scottish Executive has incurred an annual charge, which is currently around £140m, to pay for free personal and nursing care. This is paid from the Scottish Executive's grant from Westminster, However, given that this grant exceeds £25bn, any reductions in spending on other policies caused by the introduction of free personal care have been small.

3 Free personal and nursing care in Scotland adds around 10 per cent to the total public costs of care for older people. This implies that the costs of free personal and nursing care amount to 0.2 per cent of GDP.

4 For clients, the main impact has been felt in care homes. However, higher charges in care homes have meant that individuals themselves have not necessarily retained the full amount allocated to cover free personal care.

5 Independent sector care homes have raised their charges, but this is only partly a consequence of free personal care.

6 Local authority spending on care at home has markedly increased, especially on intensive home care packages.

7 As in the rest of the UK, local authority social care budgets are not ring-fenced, permitting some policy discretion, though within statutory obligations to provide care.

8 There has been no discernible decline in informal caring. Thus, there have been no additional costs associated with a substitution out of informal care and into formal care.

In this chapter, we examine the financial effects of free personal care. This will help put subsequent discussions of the sustainability of the policy into context. We examine the financial impacts from the perspective of each of the key stakeholders.

Scottish Executive

Estimates of the financial effects of free personal care on public spending were included in the CDG report in 2001. In addition to the cost of free personal care, the CDG was asked to estimate in its report the cost of providing free nursing care in Scottish care homes. This followed the approach taken by the Royal Commission on Long-term Care, which had considered both nursing and personal care in its analysis.

The estimates that the CDG produced seemed manageable for the Scottish Executive and this must have played an important role in triggering the decision to proceed with free personal and nursing care in Scotland. The CDG estimates of the current and future costs constructed are shown in Table 9. They were constructed using the same methodology that was used by the Royal Commission for the UK as a whole. They were based on demographic projections, assumptions about changing health expectancy and research on unmet need, informal care and the income derived from charging for personal care by private providers and local authorities.

Estimates of the weekly cost of personal and nursing care in care homes were arrived at quite simply. The estimated cost of nursing care was based on the difference in average weekly charges between nursing and residential homes, as

Table 9 Care Development Group forecasts of the costs of free nursing and personal care

	No. of self-funding residents	Average nursing and personal care costs per week (£)	Annual costs (£m)
Residential care homes			
Personal care – residents	2,974	90	13.9m
Nursing homes			
Personal care – residents	4,599	90	21.5m
Nursing care – residents	4,599	65	15.5m
Estimate of charges collected by local authorities for personal care			10.0m
Estimate of private expenditure on personal care at home			10.0m
Estimate of existing private expenditure on nursing and private care			71.0m
Anticipated reaction to policy based on three-year phasing			
Estimated cost of switchover from informal to formal care			8.0m
Estimated cost of meeting existing unmet need for care			8.0m
Non-recurring investment in community care services			37.0m
Year 1 estimate of the cost of introducing free personal and nursing care			124.0m

Source: Scottish Executive 2001.

they were then described. Then, using estimates of 'hotel' charges derived from the work of the Royal Commission, the estimate of the weekly cost of personal care was derived by subtracting 'hotel' costs from the average weekly charge at a residential home.

However, the CDG made one important adjustment to the cost of personal care: it assumed that all those in care homes would receive an Attendance Allowance payment of £55 per week from DWP and that this could be used to offset the estimated weekly cost of personal care of £145. There were strong grounds for believing that those in care homes receiving personal care would also receive Attendance Allowance, since the criteria for claiming Attendance Allowance suggest a need for some form of personal care. However, the CDG, and subsequently the Scottish Executive, made the incorrect assumption that DWP would continue to pay Attendance Allowance to those receiving free personal care in a care home. DWP rules clearly state that Attendance Allowance will be withdrawn from care home residents if a local authority contributes in whole or in part to the cost of their care. And although the finance was provided by the Scottish Executive, it was the local authorities who were directly responsible for personal and nursing care payments. As a result, the estimated cost of free personal care to the Scottish Executive increased by £22m.

In the parlance of devolution, this issue came about as a result of an interaction between 'reserved' and 'non-reserved' powers. Since social security benefits are 'reserved', the Scottish Parliament had no jurisdiction to alter DWP regulations. Thus the additional £22m had to be paid by the Executive and the UK Government saved the equivalent amount. The real costs of care did not change.

Included in the total costs of free personal and nursing care were additional payments to meet charges that private individuals were believed to be paying for personal care – £10m to local authorities and £10m to private providers. The local authority charges were probably below the full economic cost of provision because some local authorities already subsidised the costs of personal care, but private sector payments were believed to reflect real resource costs. The total expected cost to the Executive of compensating individuals for charges for personal care was £93m, including the £22m arising from the failure to anticipate that DWP would not pay Attendance Allowance to self-funding care home residents receiving free personal care.

In addition it was expected that informal care might fall because of the increased provision of formal home care. After consulting relevant US research, it was decided to allow an additional £8m to cover the potential costs of substitution between

informal and formal care and a further £8m because one effect of the publicity associated with the policy might be to bring forward previously unmet demand.

Allowance was also made for the investment of £50m to build capacity in community care, £37m of which was to be spent in the first year. This was intended to cover, *inter alia:*

1 good quality and focused training for all social work and care staff

2 investment in IT to support the more efficient and streamlined delivery of services

3 investment in local authority infrastructure to support new policy initiatives in community care, such as a shift towards more Direct Payments

4 more training in care management and Single Shared Assessment procedures

5 the backlog of need for equipment and adaptations to homes.

The Scottish Executive finally allocated a budget of £107m to meet the costs of free personal care in fiscal year 2002/03. This was lower than the CDG estimate because the policy was introduced with three months of the financial year already gone. Some changes were also made to the budget. Spending on non-recurrent investment in domiciliary care services was cut by £12m, while upward adjustments were made to the costs of meeting the personal care costs of those contributing towards the cost of their care home place. In the first full fiscal year of its implementation – 2003/04 – the full cost was estimated at £144m (Scottish Parliament, 2004).

The resources thought necessary to support free personal care were added to the annual financial settlement for local authorities. This meant that the Executive chose not to force authorities to spend the extra funds specifically on free personal care – the budget was not ‘ring-fenced’. This meant that, though local authorities had a legal obligation to provide free personal and nursing care, they did not have a budget set aside solely for this purpose. Each hoped that the Executive would include sufficient additional funds in its grant to meet the costs of the policy without any need for cross-subsidy from other budgets. This meant that, even if the estimates of the costs of free personal and nursing care were accurate at the Scottish level, some authorities might have to cross-subsidise free personal care from other budgets. Others would find that they had been overprovided and could use the excess grant from the Scottish Executive for other priorities.

The mechanism used to allocate resources to local authorities was quite simple. For self-funding care home residents, adequate up-to-date data were available for each local authority from the Care Home Census. Thus, each local authority was allocated £7,540 per annum for each self-funding care home resident and £10,920 per annum for each self-funding nursing home resident.

For domiciliary care, there were no adequate data on the extent of private purchases of personal care. The Executive, therefore, decided simply to use the Grant Aided Expenditure (GAE) formula to allocate funds to local authorities. The GAE mechanism uses the 'client group' approach to determine relative need across Scottish local authorities for different kinds of services – schools, roads, older people, etc. However, it does not account both for the relative need for care *and for the likelihood that individuals are able to fund that care*. This meant that local authorities with relatively large numbers of poorer older people would be generously funded compared with those where the affluence of the older community meant that a larger proportion of them were contributing to the cost of their personal care. Councils with a relatively high proportion of self-funders were therefore likely to face difficulties in meeting their legal commitments.

In 2004, the Scottish Executive estimated total expenditure on care for older people in Scotland by private individuals, local authorities and the NHS to be £1.4bn (Scottish Executive, 2004a). Thus the cost of the provision of free personal and nursing care is almost exactly 10 per cent of the total expenditure on care for older people.

Again, it should be emphasised that the estimated budget for free personal care represents the *incremental* costs of extending personal and nursing care to all – not just to those who are unable to pay for it. This implies that some of the £1.4bn budget has already been spent on personal and nursing care. Some authorities may have subsidised personal and nursing care prior to the introduction of the policy as well as paying the full costs for those with insufficient means to make a contribution. This implies that care for older people in Scotland accounted for around 2 per cent of Scottish GDP and that the additional costs of free personal and nursing care therefore amounted to 0.2 per cent of GDP.

The incremental costs of free personal and nursing care were borne in the first instance by the Scottish Executive. There were two ways in which this may have impacted on its finances.

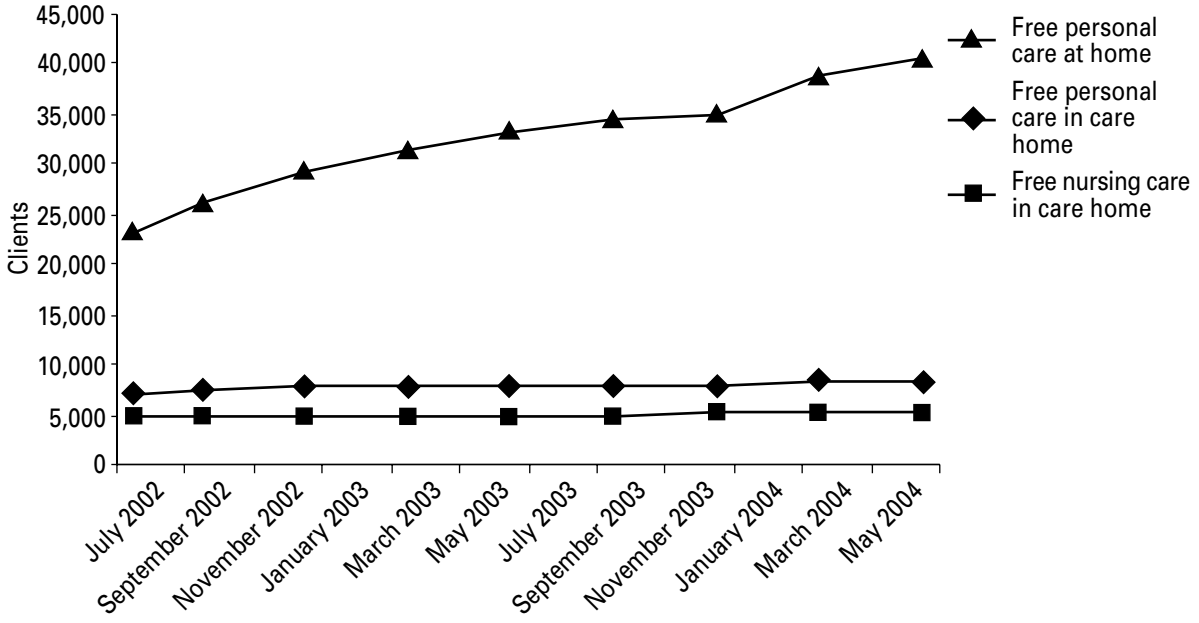
First, because the Barnett Formula effectively delivers an annual fixed budget to the Scottish Parliament (currently around £25bn), increased spending on care effectively

means less spending on other programmes. While it was not possible to identify particular programmes with the funding of personal and nursing care, politicians opposed to the policy were keen to argue that it was having negative effects on other priorities. For example, one of the previous health ministers, Sam Galbraith, argued that free personal care was being paid for by cuts in the cancer care budget.[1]

Second, the Executive does have the power, by varying the funding available to local authorities, to indirectly cause council tax bills to rise. This mechanism could have been used to shift some of the costs of free personal and nursing care to local authorities directly. In fact, council tax bills have been rising at around 6 per cent per annum, well ahead of inflation, since 2000/01. The average increase in monetary terms has been around £84m per annum, about 60 per cent of the cost of free personal and nursing care. However, increased council tax receipts relate to the whole range of local government activities and it is not possible to associate particular changes in council tax liabilities with the free personal care budget.

The Scottish Executive has produced data showing the volume and financial effects of free personal and nursing care for the period July 2002 to June 2004. One of the most striking findings is the rapid rise in domiciliary care over this period. Figure 2 shows that the number of individuals receiving free personal care in care homes increased from around 7,000 in July 2002 to 8,000 in May 2004.

Figure 2 Clients receiving free personal and nursing care, 2002–04



Source: Scottish Executive 2004c.

The CDG did not have direct estimates of the numbers receiving personal care in a domiciliary setting, since local authorities often did not differentiate between domiciliary personal care and other domiciliary services. However, knowing that there were around 70,000 individuals receiving care at home, it estimated that some 45 per cent of these (31,500) received personal care. This was a reasonably accurate estimate because local authorities reported that, in 2002/03, 34,000 individuals were receiving domiciliary personal care.

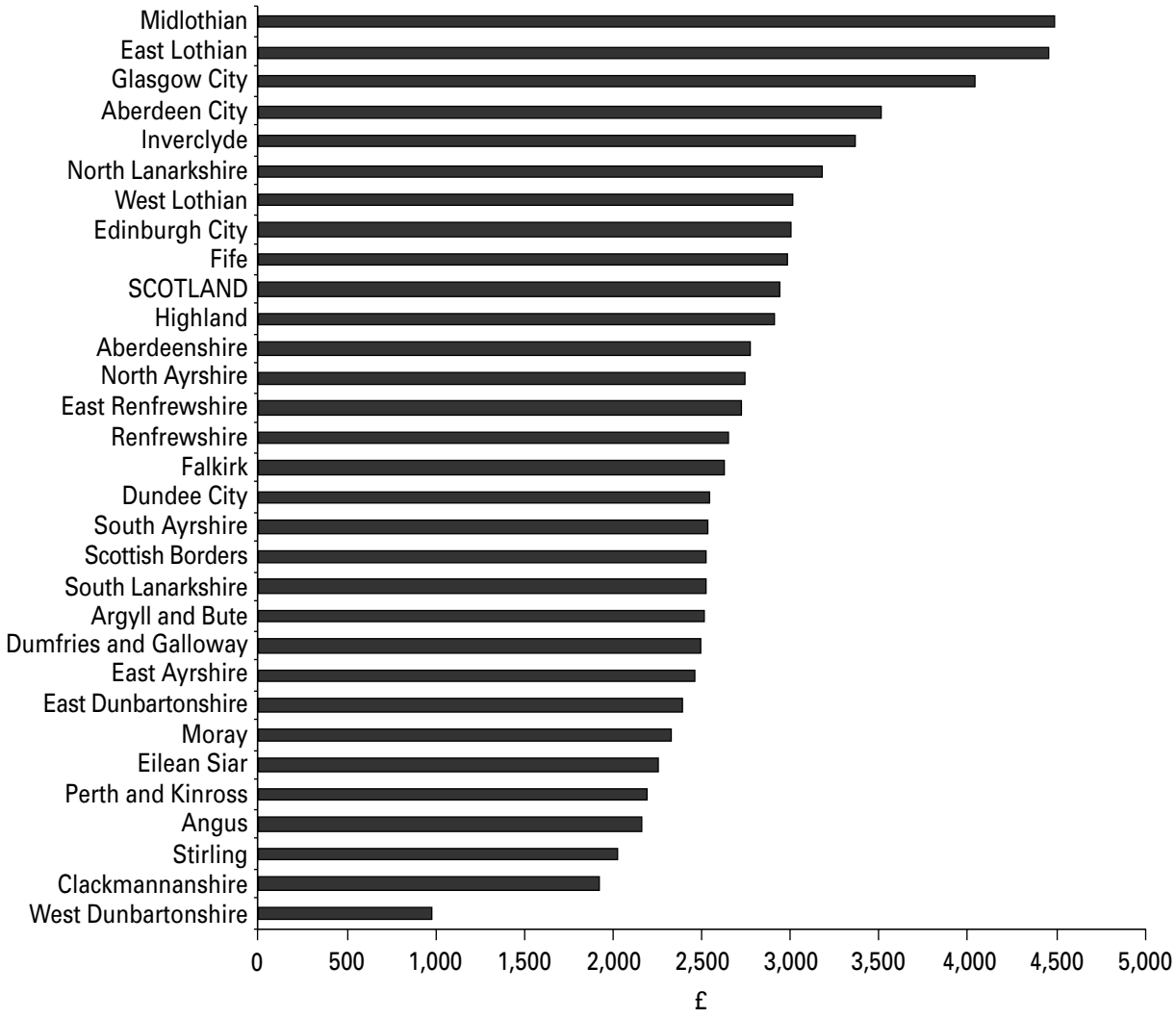
However, the Scottish Executive estimates show the number receiving free personal care rising to 41,000 by June 2004. This implies some underestimate of the rapid growth in demand for personal care at home and perhaps an underestimate by the CDG of the extent of unmet need. However, the results from our focus groups in Chapter 6 do not suggest that there was a substantial failure to meet the demand for home care prior to the introduction of the policy. There were some particular areas of demand that were not being met – such as those of some BME populations and of carers. Again, the fact that unmet need was often taken to refer to quality rather than quantity of services does not imply that there was a large group of clients whose needs were being ignored.

However, our previous discussion of the interaction between Supporting People and free personal care and the guidance given in respect of food preparation suggests that the increase may be partly attributable to uncertainties over the classification of care tasks. The increase may also reflect a lag in personal care assessments for domiciliary clients, which was not present for those in care homes.

Forecasts of the demand for personal and nursing care in care homes were reasonably accurate. The number receiving free nursing care was stable at around 5,000 throughout this period. This was around 400 more than the estimates produced by the CDG in 2001. The Scottish Executive accepted the CDG recommendation that those in care homes should immediately receive free personal and nursing care payments without any assessment of care needs. Without the need for assessment, it was not surprising that this group was immediately included in the data.

The impact of care home clients on the free personal care budget was also fairly predictable, given that the weekly payments for free personal care and nursing care in care homes were set by the legislation. But, for free personal care at home, the Community Care Act (2002) implied that needs should be met, irrespective of cost. In practice there was a substantial variation between local authorities in the annual costs of free personal care per home care client (see Figure 3). Costs directly associated with free personal care were lowest in West Dunbartonshire at just over £1,000 and highest in Midlothian at £4,500 per annum.

Figure 3 Expenditure per client on personal care at home



Source: Scottish Executive 2004c.

Such stark differences may seem difficult to explain. Further, the highest levels of expenditure are concentrated in largely urbanised authorities (with the exception of East Lothian) where one might expect transport costs to be low and economies of scale to be available. One possible explanation may be that shortages of care homes places in urban locations force authorities to provide more intensive packages of domiciliary personal care.

Another is that these authorities are providing free personal care at home for clients whom other authorities might assess as requiring a care home place. This is an important mechanism that local authorities may use to differing extents to control costs. For example, if (a) the care home package is likely to cost more than £210 per week, (b) the individual is a self-funder and (c) there are care home places available, then the local authority may seek to have the client placed in a care home. If the

person is not a self-funder, then the local authority will have to pay in addition for the 'hotel' costs of the client and may be prepared to offer more intensive home care support if the costs are lower than the care home charge. This issue has frequently been discussed in the context of the implications of free personal care, but no data on its prevalence are available.

Personal and nursing care clients

The direct financial impact on the recipients of free personal and nursing care is primarily felt by those in care homes. Projected annual payments to this group are estimated at around £60m in each fiscal year from 2003/04 to 2006/07 (Scottish Parliament, 2004). Free nursing care payments add a further £16m per year. Finally, compensating domiciliary care clients for charges that they previously paid for personal and nursing care costs a further £21m per annum. In total, the costs previously being paid for privately that are now being paid by the Scottish Executive are £97m per annum.

The *Range and Capacity Review* (Scottish Executive, 2004a) estimated that total private spending on care in Scotland in 2004 was £318m. Thus, by transferring costs of around £97m to the Scottish Executive, free personal care has reduced the costs of care to private individuals by around 30 per cent. It is important to bear in mind that this transfer does not actually change the costs of care to society as a whole at all – it simply changes the balance between private and public funding.

However, this argument is based on a premise that may not be correct – that those who contribute to the costs of their care will receive the full benefit of the free personal care payments. This is incorrect because those charging for personal and nursing care may capture some of the benefits by raising their charges.

Care homes

If independent care homes increased charges after free personal and nursing care was introduced at a faster rate than any increase in costs that they faced, then care home owners may have captured some of the benefits of the policy. For local authorities, the effect of additional funding from the Executive to pay for free personal care reduced the pressure to increase fees in their own homes.

Both local authority and independent care homes were subject to the same changes in the regulatory framework. They were also faced with broadly the same cost pressures. If free personal care had no impact on care home fees, then one would expect fees to increase at the same rate in both the local authority and independent sectors when the policy was introduced. This was not the case: between 2002 and 2004, care home fees increased by £116 per week in the private sector and by £64 per week in local authorities (see Table 10).

These are extremely large increases in charges over a relatively short period. The independent care homes have lobbied for increased charges, arguing that factors outside their control are driving up their costs. Some of these increases were effectively imposed by the Scottish Executive – such as increasing the level of qualifications of the care home workforce and imposing additional requirements on buildings used as care homes. Further, the Executive is keen to reduce the amount of 'bed blocking' by older patients. The Delayed Discharge Action Plan was launched in March 2002 and has been extended from 2004 to 2008 with a target of reducing bed blocking by 20 per cent each year from 2004 to 2008. Additional funding of £239m has been made available to fund care home places and increased home care over this period. Knowledge of the high priority given to this policy clearly strengthens the bargaining position of care homes.

Have the increases in independent care home charges been excessive? If independent care home fees had increased at the same rate as local authority homes, then Table 10 suggests they would have increased at 16 per cent. They would then have been £354 rather than £427 per week – £67 per week less than was actually being charged.

Does this constitute evidence that independent care homes increased their charges in response to the additional payments being made available as a result of free personal and nursing care? This may be the case, but one must be careful not to assume that 2002 fee levels were adequate to assure the viability of care homes given the changes in regulations that are described above.

Table 10 Care home fees: Scotland 2002–04 (£ per week)

	Local authority (increase)	Independent (increase)	All
2002	395	305	340
2004	459 (16%)	421 (38%)	427
Change 2002–04	64	116	87

Source: Care Home Census, Scottish Executive.

From our earlier discussion, it is clear that there is strong pressure to reduce 'bed blocking' in the NHS and that, even at higher weekly charges, private care homes are more cost-effective than NHS provision. For this to continue, care homes must be able to make sufficient profit to stay in business. But the number of nursing home places in Scotland in recent years has been largely static, which does not suggest that the industry has been making excessively large profits.

Local authorities

The Scottish Executive decided from the outset that free personal care would be delivered by local authorities. This implied both increased income for local authorities from the Scottish Executive and a new statutory obligation to provide personal and nursing care. In this section, we describe both the financial effects and the changes in service.

Previous chapters have emphasised that free personal care is only part of the social care framework in Scotland. Further, the resources to support free personal care are not ring-fenced. Indeed, overall social care budgets are not ring-fenced. The obligations on local authorities to provide social care are statutory rather than financial. Nevertheless, Table 11 makes clear that there has been a very substantial increase in spending by local authorities on social care in the early years of this decade. The increase between 2000/01 and 2003/04 is £568m – an increase of 51.7 per cent. This is well in excess of the provision made by the Executive to pay for free personal and nursing care.

The financial data also indicate that there was a significant shift from residential care to home and community services during this period. In 2000/01, home and community care services cost £38m less than residential care. By 2003/04, spending on home care services was £100m more than that on residential care.

Table 11 Gross expenditure by local authorities, 2000/01 to 2003/04 (£m)

	2000/01	2001/02	2002/03	2003/04	Increase 2000/01–2003/04	% increase
Home and community-based services	530	503	590	883	353	66.6
Long-term residential and nursing care	568	564	699	783	215	37.9
Total	1,098	1,067	1,290	1,666	568	51.7

Source: Audit Scotland Performance Indicators.
Totals may not be exact due to rounding.

This additional expenditure purchased a considerable increase in activity, which is demonstrated in Table 12.

The number of community care assessments for those aged 65 and over rose by 14.8 per cent and the number of reviews for those with dementia by 31 per cent. The overall number of community care clients rose by only 3.6 per cent, but the number of hours of care increased by 27.8 per cent. This development is explained by the trend towards having fewer clients receiving relatively few hours of care per week: the numbers receiving ten or more hours, weekend and overnight support have each increased by more than 30 per cent.

Substantial though the growth in measurable outcomes has been, the growth in spending has been more rapid. This may be associated both with an increase in the number of staff involved in providing care and with the premiums that have to be paid in order to supply non-standard care – such as that at weekend and overnight.

Table 12 Social care activity by local authorities, 2000/01 to 2003/04

	2000/01	2001/02	2002/03	2003/04	Change from 2000/01 (%)
Number of community care assessments or reviews for older people aged 65+	160,296	149,362	170,540	184,012	14.8
Number of community care assessments or reviews for older people aged 65+ with dementia	11,434	12,345	14,309	14,978	31.0
Number of older people aged 65+ receiving a community care service	175,050	178,449	197,500	210,230	20.1
Total number of clients	64,287	59,981	66,618	n/a	3.6
Receiving personal care	28,929	28,739	34,299	n/a	18.6
Hours per week					
0–2	14,628	12,704	14,431	n/a	–1.3
2–4	18,373	16,707	17,612	n/a	–4.1
4–10	19,755	18,313	19,426	n/a	–1.7
More than 10	11,531	12,257	15,149	n/a	31.4
Weekends	27.1	29.7	36.0	n/a	33.1
Overnight	12.8	14.6	16.9	n/a	32.2
Total hours	389,555	402,237	497,961	n/a	27.8

Source: Audit Scotland Performance Indicators.

Labour Force Survey data confirm these changes. While one must be careful not to read too much into relatively small samples, the wage and employment data do suggest a substantial increase in activity in the care sector between 2001 and 2004. Employment has increased by over 50 per cent, weekly hours by 11 per cent and weekly pay by 17 per cent.

The growth in care provision has been accompanied by substantially increased spending on the social care workforce and in particular by increased spending on care assistants (see Table 13). Nevertheless, even though there is clearly increased demand for their services, care assistants wages are still at the lower end of the earnings distribution, with average hourly pay of £6.37 in 2004.

Table 13 Care assistants in Scotland, 2001 and 2004

	2001		2004		2001	2004	2001	2004
Age group	Employment (000)	Share (%)	Employment (000)	%	Weekly hours		Weekly wage(£)	
0–19			4.0	5.4	n/a	38.7	n/a	147.0
20–35	13.8	29.2	24.2	32.2	31.2	33.0	196.3	199.4
36–50	20.8	44.1	26.9	35.8	29.1	33.5	182.5	231.1
51–65	12.3	26.0	19.6	26.1	28.1	29.8	158.5	201.5
Over 65	0.4	0.8	0.4	0.5	12.0	20.0	46.2	92.0
Total	47.3	100.0	75.1	100.0	29.2	32.5	178.7	208.4

Source: Labour Force Survey, 2001–04.

Informal carers

One of the key concerns of the Care Development Group was that provision of free personal care would lead to reductions in informal care and consequent increases in the costs of formal provision. US research (Christianson, 1986; Pezzin and Schone, 1999) suggested that some modest reduction in informal care could be expected after the introduction of free personal care. However, thus far, no such reduction has been observed. Table 7 in Chapter 4 shows that the numbers of instances of informal care have been increasing in recent years.

We conducted a 'difference-in-difference' analysis of informal caring behaviour between 2000 and 2004 using the Family Resources Survey and the British Household Panel Survey to test whether there has been a significant reduction in informal caring relative to England and Wales since the introduction of free personal care. Our technique allows us to take account of differences in the age, marital status, gender, number of children, number of ill and disabled people in the household, household size and education of the survey respondents. In addition, the

British Household Panel Survey, because it is longitudinal, allows us to take account of unobserved differences between respondents, such as willingness to care, provided these do not change through time.

Our results showed that there has been no significant change in informal caring behaviour in Scotland relative to England over the two years after the introduction of the policy for which data are available. Clearly, this is a relatively short time period and it is too early to identify long-term changes in informal caring behaviour. But at least this analysis rules out any immediate catastrophic fall in informal care arising from the introduction of free personal care.

This finding links to our interview results, which implied that there was a strong commitment of carers to relatives, irrespective of the services being received from outside the home, and also once they were in residential care. Informal carers often also had closer knowledge of the person and would still be required for some services that formal carers could not, or would not, provide. The informal carer may better recognise and be more sensitive around issues of choice and independence, which are clearly very important to frail older people. Finally, the role of formal care provision in supporting informal carers may have reinforced the willingness to provide informal care.

Our finding perhaps suggests that the £8m included in the free personal care budget to cover the costs of substitution between informal and formal care may have been unnecessary. There is no way to directly track what has happened to this money, since a share of it will have been included in each local authority's overall financial settlement with the Scottish Executive.

Application to the rest of the UK

In the next chapter we consider the costs of extending the the Scottish policy to the rest of the UK. Because of the similarities in the modes of delivery of care, the approach to costing free personal care is broadly similar throughout the UK. However, adopting the full Scottish policy also implies implementing Scotland's policy on nursing care. This would imply reversion from the more generous policies on nursing care that have been put in place in England, Wales and Northern Ireland. We return to this issue when we discuss the wider lessons of the policy.

Conclusion

The financial effects of free personal care have been varied. The Scottish Executive has incurred an annual charge for free personal care that is currently around £140m. This has reduced its freedom to spend on other priorities. However, within a total budget of more than £25bn, the impacts on other policies have been small. Local authority supported care provision, particularly home care, increased rapidly between 2001 and 2004. A key feature of this has been the extension of intensive home care packages involving more than ten hours per week and possibly attendance overnight or at weekends. There has been a reduction in less intensive provision, perhaps indicating that the supply of domestic tasks by local authorities has declined. This may explain why informal caring has not shown any downward trend since the introduction of free personal care: the increase in the number of home care clients receiving intensive care packages provides a clear role for the informal carer in providing domestic support, which is now being given lower priority by local authorities. And, as the number of clients being cared for at home increases, there are more opportunities for the provision of such informal care.

The overall increase in spending (£568m) between 2001 and 2004 is much larger than the annual budget for free personal and nursing care (£144m). And, while free personal and nursing care may have played a role in triggering the shift towards more care at home, it is difficult to identify its impact separately from the general increase in spending on home care.

Even with increases in the volume of service provision of around 30 per cent, spending has grown more rapidly – at a rate that is far in excess of any plausible rate of UK economic growth. However, a lower growth rate in overall spending on care should be quite feasible so long as the economy grows at rates close to its historic average. We investigate this issue in the next chapter.

8 Sustainability in Scotland and the UK

Key points

Free personal care will not be sustainable unless both the political will and the economic resources are available to sustain it. This chapter uses simulations to explore the impact of economic and policy changes on the costs of implementing free personal care in Scotland. The simulations show the following.

- If payments for free personal care keep pace with inflation, costs rise modestly until 2035, then fall back. However, if payments rise in real terms above inflation, there is a much steeper rise in costs until 2063.
- Increases in home ownership in Scotland will increase the costs of free personal care because of loss of income from more self-funders until 2035, and then costs will reduce.
- Shifting the balance of care towards care at home can dramatically reduce costs, because the average costs of care at home are less than the £145 and £65 for personal and nursing care in a care home. However, if the costs of care at home increase at a rate above average economic growth, a shift to care at home creates an initial saving, but there is little difference in costs by the end of the period.
- If personal care costs rise more rapidly than the economy as a whole, the costs of the free personal care policy reach 1 per cent of GDP by 2053. However, changing the balance of care in favour of care at home can offset this.
- Sustainability issues in the rest of the UK are similar to those in Scotland.

There have been considerable changes to care policy for the over 65s in Scotland. The introduction of free personal care was an important part of these changes. But any changes that have been made will not be sustainable unless both the political will and the economic resources are available to support these activities. In this chapter we simulate future costs of care in Scotland under a variety of assumptions about the evolution of costs and the balance of care. We also examine likely costs for other parts of the UK if the Scottish policy was directly implanted on their care systems.

Ultimately, decisions about the sustainability of the policy are political. However, its affordability will heavily influence such decisions. When thinking about affordability, it is important to distinguish between the overall resource costs to society of providing care for older people and the distribution of these costs between private individuals and the various levels of government. This policy is intended to fund the costs of personal care for those who, under current income rules, are expected to contribute to such care. It does not ostensibly alter the total resource costs of free personal care. Nevertheless, if an indirect effect of the policy is to switch the balance of care towards more efficient modes of provision, including care at home, then it can play an important role in moderating these costs.

To estimate the affordability of free personal care, we have constructed a model to forecast care costs from 2003 to 2063 in Scotland. This model has the following features.

- It uses the 2003-based forecasts of Scotland's population by five-year age group from 2003 to 2063 provided by the Government Actuary.

- It can allow for changes in health expectancy based on data from the 1996–97 extension to the Family Resources Survey. However, because there is no clear evidence of trends in healthy life expectancy at present, the simulations described make a neutral assumption about changing patterns of health among older people.

- Individuals are allocated to forms of care depending on level of dependency. These are adjusted so as to reproduce the 2003 allocation of clients between NHS long-stay beds, care homes and care at home.

- The costs of care provision are also adjusted to coincide with the 2003 estimates. These can be projected at different rates for different care types.

- It projects adjustments to the share of self-funding clients based on the age distribution of home ownership in Scotland from the 2003 Family Resources Survey. Since homeowners are likely to have an asset base that exceeds the capital limits above which individuals are expected to fully fund their care, increases in the share of homeowners are likely to lead to a corresponding increase in the share of self-funding clients.

- We have assumed that the increase in self-funding will be paralleled by the same proportionate rise in the numbers of those who make partial contributions to the costs of care – those whose assets lie between the lower and upper capital limits. But we have not analysed the impacts on this group separately in this exercise.

- The model has the facility to alter the balance of care from its 2003 structure. This can be done by placing limits on the size to which particular care types can grow. For example, we can limit the growth in NHS long-stay provision in response to an assumed policy of reducing hospitalisation among frail older people. We can also limit growth in the care home sector in response to, say, a desire by local authorities to reduce their provision and to a lack of profitability among independent providers.

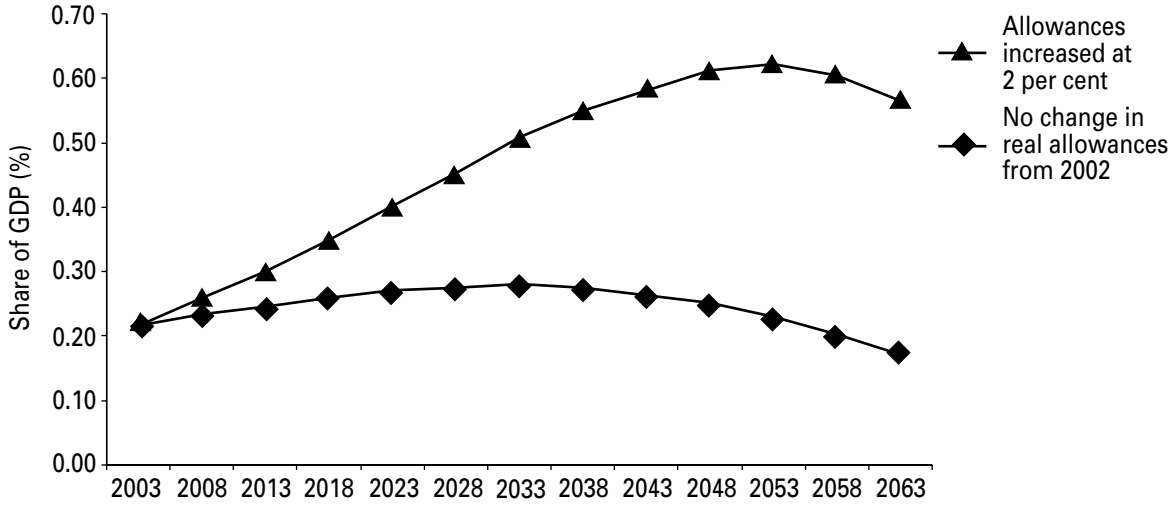
- Finally, the model expresses the costs of free personal care as a share of GDP under different assumptions about economic growth. There is, for example, an argument that economic growth may be restrained by the overall ageing of the population: hence we have examined scenarios where future growth is lower than its historic average of around 2 per cent. All costs and GDP measures are expressed in real terms based in 2003 prices.

We consider a number of simulations to explore the costs of free personal and nursing care between 2003 and 2063. The uncertainty associated with the projections increases with distance from the base year. For example, the projections suggest that the number of people aged 65+ in Scotland will decline from 2038 onward and that the number aged 80+ will decline from 2048 onward. The latter projection is in particular subject to some doubt because a feature of recent population forecasts has been a consistent underestimate of the number of 'oldest old': life expectancy among those aged over 80 has been growing more rapidly than demographers have historically predicted.

Simulation 1

In our first simulation, we consider what will happen if personal and nursing care payments are increased in real terms (see Figure 4). As mentioned previously, the payments for personal and nursing care in care homes have not changed since 2002, when the policy was introduced. This means that their real value has declined. In this simulation, we assume that the allowances keep pace with inflation and compare that with the case where they are increasing at 2 per cent in real terms. The argument behind such an increase might be that, to ensure an adequate supply of services, payments must grow at least as fast as the economy as a whole. In this simulation we assume that the economy is growing at its long-term trend rate of 2 per cent and that the balance of care does not change when the demand for services increases.

Figure 4 Simulation 1: effect of changing personal and nursing care payments



The rate at which payments increase has a substantial effect on the estimated costs of free personal and nursing care. If real costs were held constant, then the total cost of provision would increase quite slowly, reaching a peak of 0.28 per cent of GDP in 2038. The increase is driven mainly by changing demographic patterns but is moderated by steady real growth of the economy as a whole. On the other hand, a 2 per cent real increase in payments for free nursing and personal care results in significantly higher costs, these peaking at 0.62 per cent of GDP in 2053. A 2 per cent real increase in the costs of care is the most common assumption made in other estimates of the future costs of care for the UK as a whole (see, for example, Wittenberg *et al.*, 2004).

Simulation 2

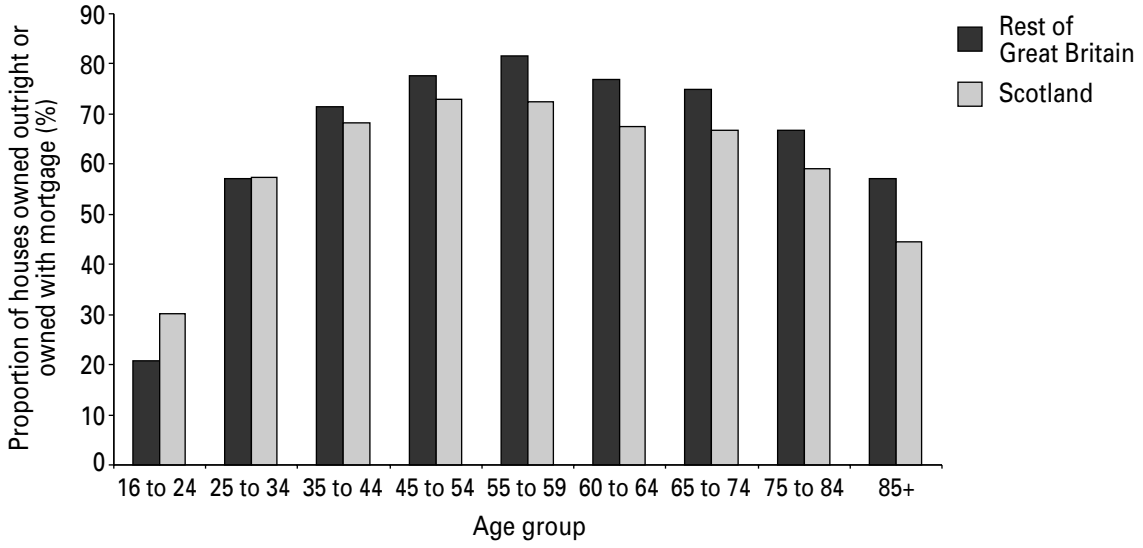
In the second simulation, we investigate the impact of changing home ownership patterns on the costs of free personal care. This issue was not considered extensively by the CDG. The financial means tests for free access to care operating in Scotland are very similar to those in the rest of the UK. The upper limit for assets is currently £19,500, which is substantially below the average value of Scottish houses, which was £118,000 in 2004. In 1988, only 47 per cent of the Scottish housing stock was owner-occupied: in 2004, that proportion had increased to 66 per cent. Thus, the likelihood of new care clients having assets in excess of current limits will increase substantially in the future.

If the number of private individuals eligible to pay for their care increases, then the private sector cost increases and there is an offsetting decline in charges to the public purse. But, if the public sector agrees to fund all personal and nursing care while the number of people who would be eligible to pay rises, then the cost of the policy increases because, in the absence of the policy, the public sector's share of the costs would be falling.

We make allowance in the model for an increase in the number of clients who could contribute to the costs of their care under current capital rules. We adjust the numbers of self-funding clients in line with the increased rate of homeownership among middle-aged compared with older Scots. The difference is clear from Figure 5, which gives the proportion of houses that are owned outright or being bought with a mortgage in Scotland and the rest of Great Britain based on the 2003 Family Resources Survey. Two features are clear.

First, the number of homes owned or being bought with a mortgage in Scotland is lower than Great Britain as a whole, which suggests, in line with our previous arguments, that there is a lower proportion of Scots likely to be self-funders compared with the rest of Great Britain. As a result, other things being equal, free personal care is likely to be relatively less expensive in Scotland because it benefits those who are expected to contribute towards their care. Again, it is important to emphasise that free personal care affects the share of care costs paid by individuals and does not affect the total costs of care.

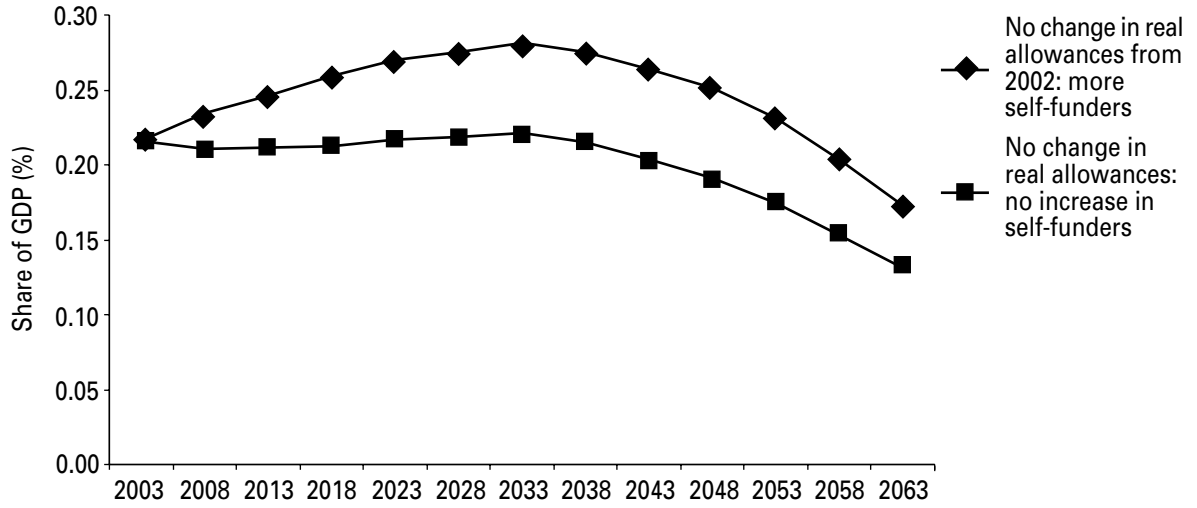
Figure 5 Homeownership by age of head of household Scotland and GB, 2003–04



Source: Family Resources Survey 2003–04.

Second, older Scots are less likely to own their home than middle-aged Scots. As the middle-aged group matures, the proportion with sufficient assets to be expected to fund their own care, wholly or partially, will increase. It is this effect that we have built into the second simulation. To be precise we compare costs with and without additional self-funders under the same assumption of no increase in real personal care payments used in Simulation 1. We do this, not because we expect there to be no increase in personal care payments, but simply to provide a background against which to assess the impact in changes to the number of self-funding clients (see Figure 6).

Figure 6 Simulation 2: increases in the number of self-funders

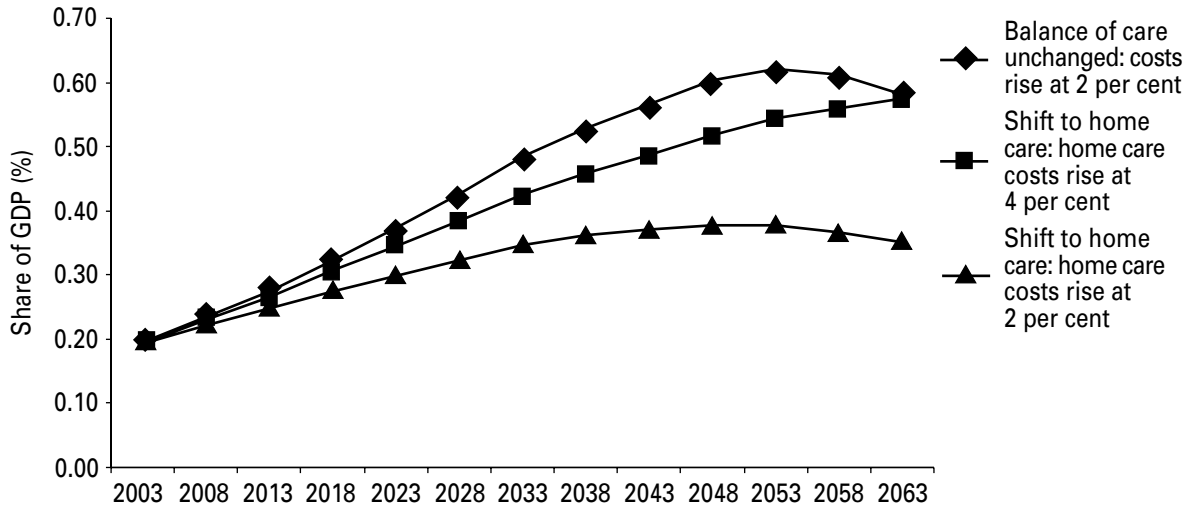


The results show that not levying charges on this increasing pool of homeowning clients would significantly increase care costs. Without any rise in the number of self-funders, the costs of the policy would be around 0.06 per cent of GDP lower than when the increase is accounted for. Note that the difference between the costs increases initially and then tends to stabilise as the level of homeownership peaks at just over 70 per cent.

Simulation 3

In the third simulation, personal care costs in care homes, home care costs and GDP all grow at 2 per cent, but the NHS long-stay and care home sector are fixed at their 2003 size. Home care takes up the slack in provision of personal care. The purpose of this simulation is to investigate whether switching the balance of care towards domiciliary care moderates the growth in costs (see Figure 7).

Figure 7 Simulation 3: changing the balance of care



The model assumes that only around one quarter of those who have to transfer from care homes to care at home in order to keep the care home sector at its present size receive free personal care. This is because only around 25 per cent of care home residents in Scotland are self-funding. We therefore assume that the same share of the additional home care clients are self-funding. The remaining 75 per cent of those transferred would anyway have received most of their personal care free. The net effect on public spending on care is that:

1 there are general savings resulting from the transfer of low-income clients from care home settings to care at home

2 there are savings in respect of self-funding clients because the average costs of care at home for these clients are less than the allowances of £145 and £65 per week for personal care and nursing care in a care home.

However, it is only the latter form of saving that is relevant to the policy of free personal care.

The results show that the increased payments and costs will increase the ratio of free personal and nursing care costs to GDP to just over 0.6 per cent. However, switching the balance of care towards home care dramatically reduces costs because of the lower unit costs of provision of care at home. If real home care costs rise at 2 per cent, then the cost of the policy does not rise above 0.36 per cent of GDP.

However, changing the balance of care will not significantly affect the health conditions of frail older people. Hence, one might expect that the average condition of the additional home care clients will be more difficult, resulting in greater need for

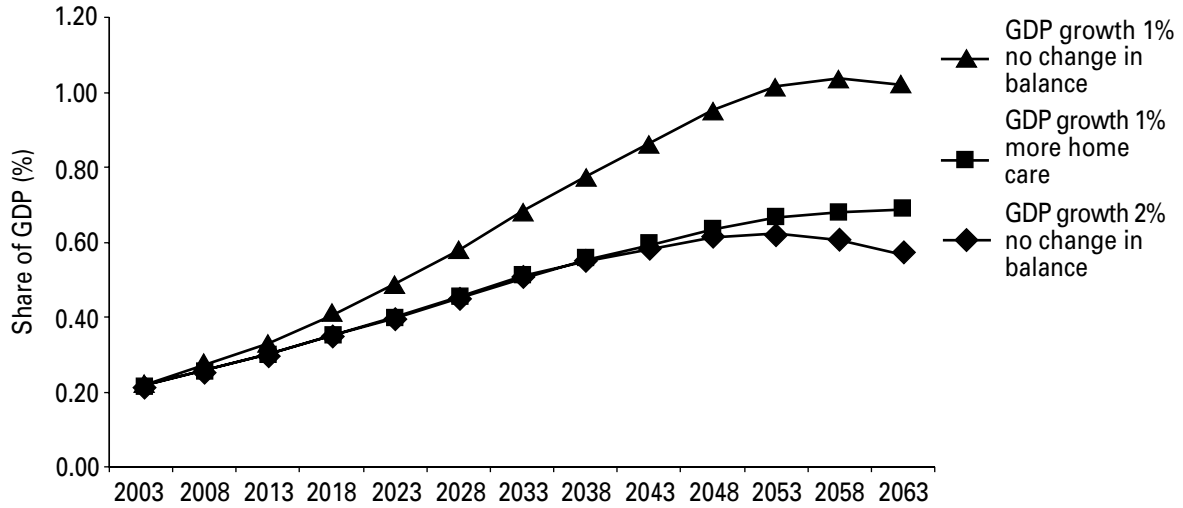
intensive home care support. This will put upward pressure on costs. Simulation 3 also shows that, if the balance of change moves towards home care but real home care costs rise at 4 per cent, then there is little difference in costs by the end of the period compared with a scenario where costs rise at 2 per cent and there is no change in the balance of care.

Simulation 4

In the final simulation, personal care costs increase more rapidly than does the economy as a whole (see Figure 8). There are a number of reasons why real costs in the care market might grow more rapidly than the economy. These include the possibility that ageing of the population will itself have an adverse effect on growth. For the simulation, we reduce the rate of growth to 1 per cent and, as a result, the real costs of the policy measured in relation to GDP rise. We also explore the effect of offsetting the slower economic growth by changing the balance of care in favour of home care as in the previous simulation.

The results imply that slowing growth would increase the costs of the policy to around 1 per cent of GDP by 2053. Recall that the policy only accounts for the incremental costs of ensuring that personal and nursing care are free to all clients. However, the adverse cost impacts can again be offset by changing the balance of care. Comparing outcomes with lower growth and changed balance of care against higher growth and no change in the balance of care, Figure 8 shows that increased costs of lower growth are almost completely offset by changing the balance of care, except towards the end of the period.

Figure 8 Simulation 4: economy grows more slowly than real care costs



Scottish outcomes

To summarise.

- *Simulation 1* shows that, if payments for free personal care keep pace with inflation, costs rise modestly until 2035, then fall back. This is because it is relatively easy to absorb a cost that is fixed in real terms when the economy as a whole is growing at a steady rate. This effect counteracts the impact of population ageing. However, if payments rise in real terms at 2 per cent and the economy grows at 2 per cent, costs triple, reaching a peak of around 0.6 per cent of GDP in 2053.

- *Simulation 2* shows that rising homeownership in Scotland will increase the costs of free personal care because of loss of income from more self-funders until 2035, and then costs will reduce. Currently, free personal care is relatively less expensive to implement in Scotland because there are fewer homeowners than in the rest of GB.

- *Simulation 3* shows that shifting the balance of care towards care at home can dramatically reduce costs, because the average costs of care at home are less than the £145 and £65 for personal and nursing care in a care home. However, if the costs of care at home increase at a rate above average economic growth, a shift to care at home creates an initial saving, but there is little difference in costs by the end of the period.

- *Simulation 4* shows that, if personal care costs rise more rapidly than the economy as a whole, the costs of the free personal care policy reach 1 per cent of GDP by 2053. However, changing the balance of care in favour of care at home can significantly moderate the increase.

In general, our simulations show that the costs of free personal and nursing care expressed as a share of national output depend on underlying demographic change, but costs are also sensitive to:

- the balance of care provision

- changes in the costs of care

- the rate of economic growth

- changes in the proportion of self-funders in the population.

Substantial swings in any of these factors can dominate the impact of demographic change and in turn they are susceptible to policy change. Clearly, control over economic growth is outside the scope of this report, but the balance of care, the costs of care and the rules regarding self-funding can be directly influenced by social care and social security policy. The key lesson is that the future costs of free personal and nursing care are uncertain, but that there are a variety of policy levers that can be used to control their cost. This finding counters the argument made by Stephen Ladyman, MP to the House of Parliament Health Committee that free personal care is unaffordable because its costs are driven exclusively by demography:

> Will we go down the route of free personal care, which would be a way of resolving this point at a stroke? No, absolutely we will not. It would cost £1.5 billion at today's prices … We know roughly speaking that there will be four times as many people needing care by 2050 … by 2050 at today's prices the cost of free personal care will rise to somewhere between £8.5 billion and £10 billion. That will be close to 1 per cent of gross domestic product. There is just no way that that is a sustainable system.
> (Ladyman in House of Commons, Health Committee, 2005)

The policy of free personal care really concerns the distribution of care costs between the private and the public sectors. The arguments in its favour are bound up with issues of equity and the fact that the UK has a health service where health care is provided free at the point of delivery, whereas charges for social care are levied at different rates to different groups of individuals.

Sustainability in the rest of the UK

This section considers what would be the impact of implementing the Scottish system of free personal and nursing care in other parts of the UK. It applies the model described in the previous section to England, Wales and Northern Ireland. The differences that result in different outcomes for these simulations are determined by differences in demography and in levels of GDP.

We replicate one of the outcomes described in Simulation 1 in which the real costs of care grow at 2 per cent and GDP also grows at 2 per cent. Then we let the differing demography and initial levels of GDP drive the outcomes. This means that the balance of care moves towards the 2003 distribution of care in Scotland. We know

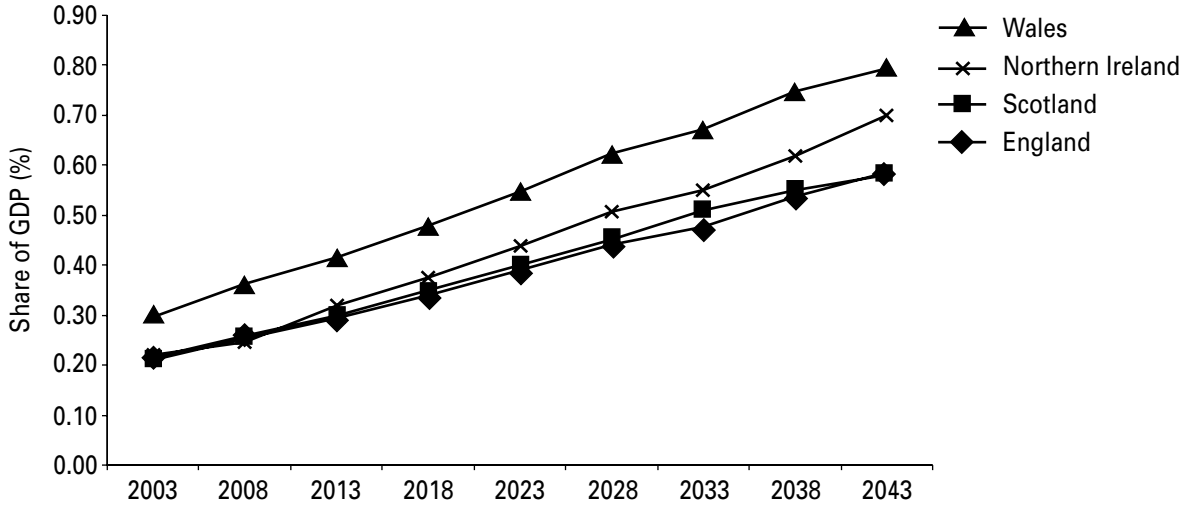
from Table 8 in Chapter 4 that Scotland has a higher share than its population share of long-stay beds and of home care than England and Wales. These will tend to have offsetting impacts on the overall costs of care since long-stay beds are relatively high cost, while home care is, on average, low cost.

However, the costs of the Scottish policy of free nursing and personal care are driven specifically by the proportion of the older population who are self-funders receiving free nursing and personal care in care homes and the share receiving free personal care at home. These shares are applied to the population of England, Wales and Northern Ireland at the same rates as in Scotland. Other features of the simulation model as described previously are held constant. The simulation is run from 2003 to 2043 (see Figure 9).

The results of Simulation 5 show that the costs of free personal and nursing care would evolve at very similar rates throughout the UK. This reflects the great similarities in demographic structure and in the assumption that economic growth will be evenly balanced over this period. The costs expressed as a share of GDP in Scotland and England differ very little: higher costs in Wales and Northern Ireland largely reflect lower levels of GDP per head in 2003.

Under the assumptions of this simulation, between 2003 and 2043, the costs of free nursing and personal care in all parts of the UK are likely to increase threefold to around 0.6 per cent of GDP.

Figure 9 Simulation 5: care costs and GDP increased by 2 per cent in England, Scotland, Wales and Northern Ireland



However, given the similarity of outcomes with this simulation, it is likely that the lessons from the other simulations on the Scottish costs of care could also be applied to other parts of the UK. Thus, for example, changing the balance of care towards home care would moderate the growth in costs.

In 2003, the estimated costs in England are £1.7bn. However, as mentioned above, the Scottish policy involves significantly lower nursing care costs than in England. This illustrates one key point about the transferability of the policy of free personal care from Scotland to the rest of the UK. As previously discussed, all other parts of the UK have followed their own policies in providing free nursing care since 2001. All of these are more expensive than in Scotland. Lower cost nursing care is an integral part of the Scottish policy and therefore for other parts of the UK to adopt the Scottish model would involve realignment of nursing care costs.

Lower support for nursing care would mean that some individuals would lose compared with the support they receive or might expect to receive. This would create political difficulties. The alternative would be to create a hybrid model, with free personal care along Scottish lines and nursing care based on the local funding arrangements. This would add to costs. As discussed previously, the budget for nursing care in England now exceeds £580m. The inclusion of these additional costs for nursing care would increase the total budget for free nursing and personal care in England to £2.1bn.

Following the changes since 2001 to nursing care throughout the UK and personal care in Scotland, path dependency has been built into the care systems in the respective countries. This magnifies the difficulties of transferring the Scottish model of free personal and nursing care to the rest of the UK. The policy switch would create losers as well as winners.

Personal care cannot be isolated from the rest of care provision. Unless there is reasonable consistency in the funding of other aspects of care, providing free personal care in other parts of the UK is likely to lead to significant divergences in overall care costs. This will strain the mechanisms for fairly distributing public expenditure to England, Scotland, Wales and Northern Ireland unless the relevant Parliaments or Assemblies are willing to accept the costs in terms of lost opportunities to fund other expenditure plans.

Note that, throughout this discussion of the costs of free nursing and personal care, costs have been expressed as a share of GDP. While this is a conventional way to express these costs and enhances their comparability, the costs that are simulated by the model are all public sector costs. Hence they all have to be met from general

or local taxation. Each of the devolved bodies may be able to influence local tax revenues by manipulating council tax, and the Scottish Parliament has the power to vary income tax, but the majority of the funds are likely to come from general UK-level taxation. Hence the link from spending on care at the local level to GDP is indirect. This complicates the political dynamics of free personal and nursing care since the implementation of local care policies is ultimately dependent on Treasury funding.

Conclusion

The key message of these simulations is that the future sustainability of a policy of free personal and nursing care is not solely dependent on future demographic trends. These are important, but the real costs measured as a share of GDP depend on several other factors. Rates of real cost increase relative to the rate of growth of the economy as a whole are important, as are the rules on capital limits and the impact that these have on the number of clients who would be expected to contribute to their care. But the costs are also vitally dependent on how care is delivered. When alternative mechanisms are possible, opting for the lower-cost method, which will often be home care, can have a substantial impact on the overall cost of care.

Thus, if payments for free personal care keep pace with inflation, costs rise until 2035 and then decline. But, if real costs rise at 2 per cent and the balance of care does not change, then the cost of the Scottish policy of free personal and nursing care will rise to 0.6 per cent of GDP by 2063 even if economic growth is also 2 per cent. If economic growth was only 1 per cent, care costs reach 1 per cent of GDP by 2058. But changing the balance of care in favour of care at home can significantly offset this.

Sustainability issues in the rest of the UK are similar to those in Scotland, largely because of similarities in demographic and economic conditions. Therefore, the lesson that it is not simply demographic pressure that will drive the cost of care is also applicable to England, Wales and Northern Ireland.

9 Wider lessons

Key points

1 Clients' views about services emphasise person-centred, sensitive services without artificial boundaries and free personal care has capacity to support these.

2 Shifts in the balance of care can moderate costs – it is important that projections of future trends do not merely reproduce existing models.

3 A new approach to costing care packages, which avoids boundaries, could address many difficulties, both for individuals and for the delivery and costs of service provision.

4 Equity issues remain, as people of modest means – especially women – and people with conditions such as Alzheimer's disease may be charged inappropriately, where the care they need is not free at the point of delivery because it is not considered to be a health cost.

What are the wider lessons from the implementation of free personal care in Scotland?

The best place to start such a discussion is from the perspective of service users. We know that the recipients of free personal care expressed strong desire for culturally sensitive, person-centred care that does not recognise boundaries.

There appears to be increased satisfaction with service provision since the introduction of free personal care, though users' views are not uncritical. They also wish to exert more control over the packages of care that they receive. While substantial efforts have been made and resources expended to create a more customer-focused service, the most effective way of achieving such an outcome may be to give the user the power to directly purchase services. This is, of course, still a matter for debate (Riddell *et al.*, 2005) and our focus group participants were not enthusiastic about such an approach. However, other countries, such as Germany, have moved to allowing clients to purchase services directly. There are disadvantages as well as advantages to such a model: these include the need to ensure quality of service and possible failure to reap economies of scale. Nevertheless, the policy of free personal care has had no direct effect on the empowerment of clients.

Clients did not perceive boundaries in care provision in the same way as providers. Thus they did not clearly distinguish between personal care and other forms of care. The data suggest that there has been a substantial increase in personal care delivered at home coupled with a reduction or levelling off in local authority support for domestic care tasks. This may be responsible for the lack of any significant reduction in informal caring since the introduction of the policy. It may have also expanded the private demand for domestic tasks. Thus, the policy may have moved the boundary at which individuals are expected to pay for care provision or to rely on informal carers from personal care to domestic tasks. This is still likely to be confusing to some clients and the importance of the provision of domestic tasks in maintaining independent living should not be underestimated.

Scotland has been able to fund free personal and nursing care partly because it receives a generous level of support from Westminster through the Barnett Formula. The Scottish Executive is not directly concerned with the raising of revenue to cover what is a relatively modest charge against its overall budget. In England, spending ministries must justify to the Treasury their plans, which are always focused on how costs can be met.

The previous discussion suggests that the costs of free personal and nursing care depend on how care is already being provided. We have shown that changing the balance of care towards care at home can moderate the growth in costs. But implementing the Scottish policy in the rest of the UK is problematic because of the different approaches that have been taken to nursing care in different parts of the UK since 2001.

Overall solutions would require radical revision to the funding of care. Alternative mechanisms could be designed that would reduce the private costs of care without causing distortions around the boundaries of different categories of care that have been described previously and are an impediment to the extension of the Scottish policy to other parts of the UK.

A more radical approach that would not require the determination of client needs in relation to particular care boundaries would be to evaluate the cost of the entire care package. This would include the cost of domestic tasks, which may have an important role in preventing clients moving to a care home. Some agency, possibly the local authority, could be charged to provide a proportion of these costs. Funding could come from existing sources along with some contribution either directly or indirectly from DWP through a restructured Attendance Allowance. Finally, clients would be means-tested using significantly less onerous capital limits than those at present. Those deemed able to contribute could provide a co-payment to meet the remainder of the costs. The advantages of such an approach are as follows.

1 It meets clients' wishes not to be involved with boundaries of care provision.

2 It recognises the importance of all forms of care including domestic tasks.

3 It is more equitable in that co-payment rates could be set uniformly so that there would be no differences in charges across local authorities – this is particularly important in the light of the variations in local authority spending discussed earlier.

4 Co-payment rates can be adjusted (though increases might cause political difficulties).

5 It is more transparent than the present system of benefits from DWP and subsidies (from local authorities).

6 It would avoid local authorities rebalancing their charges towards components of care for which they are permitted to charge.

7 It could be designed to allow greater client control over the structure of their care package. This might require the creation of new institutions with a mission to support the older person's agenda in health, social care and housing.

8 If the individual's financial risks associated with co-payment were controlled, these would become more insurable than the existing risks associated with disability and frailty.

The desire to avoid boundaries also has strong implications for the integration of the activities of health boards and local authorities. The case for joint budgeting and for the transfer of appropriate resources to local authorities is clearly consistent with a client-centred approach. In Scotland, there has been a massive shift away from health and towards local authority provision of care for older people. Local authority spending on all forms of care for older people increased by over 50 per cent in nominal terms between 2000/01 and 2003/04, while NHS spending on geriatric care increased by only 15 per cent between 2000 and 2004. And, within local authorities, there has also been a significant switch in emphasis with spending on care homes increasing by 38 per cent while spending on care at home increased by 66 per cent (Table 11 in Chapter 7).

The amounts involved are much larger than the free personal care budget, but free personal care may have played an important catalytic role in changing the balance of care towards more home care. Both the CDG report and the provision of resources

to support the expansion of home care as an integral part of the free personal care policy played a role in changing the direction of policy towards the expansion of home care. Our simulations show that cost savings may result from this policy. Our qualitative evidence suggests that this outcome is consistent with clients' wishes. This illustrates how the benefits of free personal care cannot be evaluated independent of its impact on the balance of care. And this is why one must be careful about accepting estimates of the costs of free personal care based on an extrapolation of the existing balance of care.

We can now consider how free personal care fits within the general debate concerning the funding of long-term care in the UK. A number of political parties in England, Wales and Northern Ireland are committed to the implementation of free personal care. It is not a policy that would be difficult to implement. It would be much more difficult to implement radical change in the funding of long-term care. For example, adopting the Japanese approach of using long-term care insurance would require extensive change in benefit and tax structures, and would be difficult to align with a health system that is funded through general taxation.

As mentioned previously, provision of free personal care does not alter the total costs of care. Rather it shifts the balance of funding away from private individuals and towards the public sector. The UK approach would be to raise general taxation to fund such provision. Clearly this has distributional implications. The recipients of free personal care are those who, under current means-testing arrangements, are deemed to have sufficient income to pay for personal care. This may seem regressive, but current means tests catch many older people, particularly women, who have modest incomes but sufficient capital to make them ineligible for fully publicly funded care. Free personal and nursing care has reduced, but not eliminated, the costs of care for this group. Those who live in care homes must still pay for their 'hotel' and accommodation costs.

Further, the observation that an older person with Alzheimer's disease and modest income is receiving free personal care is no different in principle from the case of a rich person with cancer not being charged for the costs of operations and after care.

Part of the challenge to the Scottish Executive is to provide equality of provision across widely differing local circumstances. A further layer of complexity is added because this provision must come from local authorities, which do not have ring-fenced budgets for free personal care. If local authorities continue to be the main suppliers of personal care, then the allocation mechanism used by the Executive must adequately compensate the local authorities for the costs of supplying free personal care.

10 Conclusions

Our initial objectives were to consider:

1 practical problems encountered in Scotland during the introduction of free personal care

2 looking forward, the key threats to the sustainability of the Scottish policy

3 the wider lessons for the UK as a whole in designing policies to care for older people.

We begin our conclusions by highlighting the practical problems encountered and threats to sustainability. We then explore issues relating to the potential transferability of the free personal care policy to the rest of the UK. We discuss issues of comparability and the nature of the free personal care policy and the changes associated with it. We then return to the remaining key questions raised in Chapter 1.

- *The balance of care:* has there been a shift in the provision of care as a consequence of the changes to the care funding model? For example, has it affected the balance between formal and informal care provision? What is the effect on the overall demand for care?

- *The costs of care:* what is the cost of various funding models? What is the balance of funding between State and individuals? Has the overall cost of care risen since the introduction of free personal and nursing care in Scotland and free nursing care in England and Wales? If so, how have the respective funding systems contributed towards this?

- *Equity and fairness:* what issues of equity and fairness arise in relation to paying for care and support for older people?

- *Consumer perspectives:* is there any evidence that changes to the funding models have affected consumer attitudes to care provision. For example, does the availability of free personal care discourage older people from living more independently? If the costs of personal care are being met, what impact does this have on the ability to pay and willingness of relatives to provide informal care?

- Finally, we address the *question of transferability*. How transferable is the Scottish funding model to England and Wales? What costs would be involved?

Practical problems encountered in Scotland during the introduction of free personal care

As we have described, care policy for Scotland was in a considerable state of flux around the time that free personal care was introduced. There was a feeling among those providing services that change had been complex and piecemeal. Policies also had significant unexpected consequences – particularly in the ways that they interacted with each other. Partly this was due to the interactions of the various agencies both within Scotland and the Department for Work and Pensions from outside Scotland.

The introduction of free personal care itself had a number of side effects. The most notable were:

- a sharper focus of debate about issues of long-term care for older people
- indications that free personal care could support informal carers to continue their caring
- a continuing and heightened debate about care home fees
- an increased volume of care at home and a stronger focus by service users on the quality of care at home.

A central issue was the impact on local authorities, which occupy a pivotal role in relation to care services. They experienced early difficulties around resourcing, setting up of contracts, and managing additional work in classifying tasks and conducting assessments. They also faced challenges posed by the interaction between free personal care and other policies, notably Supporting People.

Local authorities had to deliver care in a wide range of settings – affluent/deprived, rural/urban – which posed their own particular challenges in terms of resources, balance of care, meeting quality standards, workforce availability and other key considerations.

If local authorities are to have a dominant role in policy delivery, a balance must be struck between providing nationally agreed outcomes and allowing authorities to vary policy to respond to local conditions. If the former is to be emphasised, there may be a case for ring-fencing care budgets.

We found that the central role of local authorities to the implementation of free personal care had led to a marginalisation of the voluntary and private sector providers. The role of the private sector in delivering care and support for older people – including much free personal care in care homes – had also been rather neglected, and there is scope to construct more effective partnerships between sectors.

This finding is consistent with the dominance of the public sector in care provision in Scotland, which is shared in Wales, but to a lesser extent in England where the private sector plays a much more influential role in the market for care at home.

We also found that the complexity of the care landscape contributed to the problems encountered during this initial phase. Even though it had been widely reported in the media, people expressed continuing confusion and lack of clear knowledge about free personal care – there was clear difficulty of knowledge and understanding, linked to wider confusion about the care system.

Clients and informal carers commented at length about the quality of services. It was apparent that the complex system did not tune in well with clients' own, more holistic, perspectives on their needs for care and support.

We conclude that, if local authorities are to be given a statutory duty to provide free personal care, then they should be adequately resourced for that provision. This means ensuring a sufficient allocation mechanism exists to influence the setting of local authority budgets.

Looking forward – key threats to the sustainability of the Scottish policy

Looking to the future, we drew a number of conclusions in relation to the sustainability of free personal care in Scotland.

In terms of finance, the sustainability of the policy of Scotland depends on the generosity of the funding arrangements between the UK Parliament and the Scottish

Parliament. The settlement that Scotland has received has traditionally been quite generous and any significant change to this arrangement would pose a threat to the maintenance of the relatively high levels of public spending in Scotland, including those associated with care for older people.

This is particularly the case when the ageing of the population is likely to place upward pressure on the costs of the policy for the next 35 years at least. Other economic factors that may impact on the sustainability of the policy include (a) any reduction in economic growth below its long-term trend and (b) increased cost pressures.

Increases in the wealth of older people (which is mainly tied up in housing capital) will raise the net costs of the policy in terms of charging income foregone. However, even in the Scottish case, where rapid increases in homeownership rates have taken place, this effect is unlikely to be on a significant scale.

Failure to rebalance care away from NHS long-stay and care home settings is likely to increase policy costs substantially. In the long run, one of the more important effects of free personal care may have been to provide an added impetus to provision of care at home, which appears to be relatively cheaper.

If care homes capture the free personal care 'dividend' for care home clients, then the policy will have no effect on clients' income and wealth.

Wider lessons for the UK as a whole in designing policies to care for older people

An important driver for this work was to investigate the lessons that the Scottish experience might have for the rest of the UK. In drawing comparisons we have been mindful that:

- Scotland is a good exemplar for the rest of the UK, except in its greater reliance on public sector solutions to policy issues
- the research showed clearly that there was much more variation between local authority areas in Scotland than between countries in the UK.

We have grouped the wider lessons for the UK under the following headings.

The nature of the free personal care policy

Policies to support care for older people are extremely complex. They lack overall coherence. Both suppliers and older people themselves find them difficult to understand.

In our view, free personal care has added to the complexity both in itself and through the ways it interacts with other policies. It is frequently misunderstood and in particular is sometimes taken to mean ‘free care’. Clearly, communicating the distinctions to consumers remains a key challenge.

We also conclude that the introduction of free personal care does not increase the costs of care to society as a whole – it redistributes the balance between payment by individuals and payment from the public purse.

The balance of care

We were interested to examine whether the introduction of free personal care had influenced the balance of care.

From our review of the initial experience in Scotland we found no evidence that informal carers’ support diminished after the introduction of the policy. This finding was consistent both from our qualitative and statistical analysis. Indeed, in Scotland, the supply of informal care has increased in recent years.

Free personal care may well lead to reduced provision of domestic care, but it may have played an important catalytic role in changing the balance of care in favour of care at home.

There is a need to understand much more clearly the operation of the private market for providing personal care and domestic care at home. Its scale is very much larger in England than in Scotland and this is one of the few major differences in care provision.

The costs of care

Calculating the true costs of care is extremely complex, but the differences between the benefits and allowances provided in Scotland, England and Wales for self-funding care clients are significantly smaller than is commonly assumed.

The costs of personal care in the future in Scotland will rise because of increases in the level of homeownership.

Simulations of the future costs of care suggest that it is not simply demography that will drive costs, but that the balance of care, costs changes, the rate of economic growth and changes in proportions of potential self funders will also have effects.

The balance of care, cost changes, the rate of economic growth and changes in proportions of potential self-funders are amenable to policy changes, given political will to make these.

To evaluate the impact of free personal care, it is essential to have systems in place that accurately record its costs and benefits.

Equity and fairness

Our research showed that the main beneficiaries of the free personal care policy were people with conditions such as dementia and people of modest means who had previously found charges particularly burdensome.

On average, self-funding care home residents in Scotland now pay for approximately half of the costs of their care – around £10,000 per year. While this is still a substantial payment, it is much fairer to those on modest incomes.

There is a clear need for greater equity in the rules governing Attendance Allowance, which have quite different effects on care home residents compared with those receiving care at home.

If boundaries have to be defined (e.g. for nursing care), they must be precise. Otherwise it becomes difficult to allocate budgets and so account for policies. It also opens potential for disputes over assessment outcomes.

If policy is to be designed at a national level, it must be capable of providing equity and fairness to both affluent and deprived populations, to both urban and rural dwellers, and to minority ethnic groups, whose access to culturally appropriate services is limited.

Policies designed to assist older people's financial problems should not be derailed by care homes increasing their fees. The setting of care home fees should be addressed in a different context.

Consumer perspectives

It is vital that any review of care provision pays close attention to the views of service users. Clients and carers take a holistic view of the care and support needs of older people. Our respondents did not differentiate personal care from other types of care and support. This is a key issue for those designing policy.

Clients were keen to influence the design of their own care packages including both formal and informal provision. They are thus active participants in the process of obtaining and using care and support. Clients are frequently critical about the quality of services and link their debate around who pays with the wider questions about service quality.

If, as our research suggests, free personal care promotes more 'joined-up' approaches to social care, reduces means testing and money worries, and enables informal carers to continue the caring work that they want to do, it can improve clients' quality of life.

Overall transferability

We conclude that Scotland is in general a good examplar for the rest of the UK. Simulated application of the Scottish policy of free personal and nursing care to the rest of the UK shows that the costs would evolve similarly, because of the close correspondence in demography and in economic circumstances.

This implies that lower than expected economic growth or more rapid increases in costs will significantly increase the cost burden of the policy, while changes in the balance of care towards lower cost provision or improvements in health will have the opposite effect.

However, changes since 2001 in the provision for nursing care throughout the UK and for personal care in Scotland have caused the funding of the care systems in different parts of the UK to diverge. This increases the difficulties of transferring the Scottish model of free personal and nursing care to the rest of the UK. If the Scottish policy is to be implemented in England, Wales and Northern Ireland in a way so as not to produce losers, then its costs will be significantly increased because nursing care is significantly less expensive in Scotland.

Consequently, the divergent policy paths since 2001 suggest that direct application of Scotland's free personal care policy to other parts of the UK would now be problematic. Such policies would probably incur higher costs than would have been the case had the decision been taken to proceed with free personal care in 2001.

More radical solutions might require changes to the boundaries within care provision that heavily influence resource allocation. Such change would probably require the involvement of the Department for Work and Pensions, which is problematic because of the devolved nature of social care policy.

Many of the lessons learned in Scotland about the application of the policy, its funding and its reception by clients and providers will have parallels in the effective delivery of free personal care in other parts of the UK. All parts of the UK will face increases in demand for personal care in the next few decades, posing a challenge to all seeking to improve the outcomes for frail older people.

Notes

Chapter 2

1 We are unable to include full discussion of Northern Ireland in the report. We have included relevant material where possible.

Chapter 3

1 See the website describing the allocation mechanism for local government finance in Scotland. http://www.scotland.gov.uk/Topics/Government/local-government/17999/GAE

2 The national housing agency, now called Communities Scotland. http://www.communitiesscotland.gov.uk/

3 See the Joint Future Agenda website. http://www.scotland.gov.uk/Topics/Health/care/17673/9471

4 See the Supporting People website. http://www.scotland.gov.uk/Topics/Housing/Housing/supportpeople/Page2

5 http://www.dh.gov.uk/assetRoot/04/08/15/21/04081521.pdf and http://www.scotland.gov.uk/Publications/2005/09/12111353/13567.

Chapter 4

1 These data are for 2002–03 – before the introduction of pensioner credit. A significant boost to the Family Resources Survey (FRS) sample within Scotland since 2002 has made it possible to analyse areas within Scotland in some detail. However, ONS and the Scottish Executive are considering whether the weights can be further improved and hence estimates may subsequently be adjusted, though the adjustment is not expected to be very large. We have also calculated the total capital (excluding housing capital) held by households that include someone receiving care using the FRS. However, because of the relatively small number of households, these estimates are too unstable to be considered reliable.

2 Those receiving free personal/nursing care payments but paying ‘hotel’ charges are regarded as self-funding.

3 Community Care Statistics 2002, Scottish Executive.

4 The Department of Social Security was, broadly speaking, the predecessor to the Department for Work and Pensions. ‘Preserved rights’ refers to those who were resident in a care home before March 1993 and were allowed to preserve their eligibility to receive Income Support from DSS rather than local authority support.

5 Since there are no data on private home care in Wales, the Welsh proportions are expressed as a share of the total cared for in geriatric care, care homes and local authority home care.

6 Scottish Healthcare Costs Report 2004. http://www.isdscotland.org/isd/info3.jsp?p_applic=CCC&p_service=Content.show&pContentID=797

7 Department of Health. http://dh.gov.uk/assetRoot/04/10/67/19/04106719.pdf

8 Department of Health. http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/IntegratedCare/NHSFundedNursingCare/NHSFundedNursingCareArticle/fs/en?CONTENT_ID=4000383&chk=Fa%2BbIN

9 Description of Attendance Allowance at DirectGov (http://www.direct.gov.uk).

10 Attendance Allowance Quarterly Statistics.

11 Guidelines for charging in England were issued by the Department of Health, 2003, *Fairer Charging Policies for Home Care and other Non-residential Social Services*. Similar guidelines were issued in Wales – see Welsh Assembly, 2002, *Fairer Charging Policies for Home Care and other Non-residential Social Services: Guidance for Local Authorities*.

Chapter 5

1 This was unlike England, where the NHS became responsible for the nursing payments in care homes. In Scotland, nursing costs are still the responsibility of the local authority.

2 These comments reflect those of our respondents. It is worth noting that they are borne out in recent research (Riddell *et al.*, 2005, p. 78), which reports that, of the 18 local authorities in the UK in which there were no recipients of Direct Payments, ten were in Scotland.

Chapter 7

1 *Scotland on Sunday*, 8 August 2004.

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Appendix: Research methods

Interviews

In order to explore the experiences and lessons of implementing free personal care, 20 interviews and one group discussion were held with people involved in implementing the policy at strategic, tactical and operational levels. Those interviewed included:

- three members of the Care Development Group (strategic)
- eight civil servants (seven of whom participated in a group interview) (tactical)
- six individuals with identified special expertise in housing and health, contracts, workforce and service quality (tactical)
- five representatives of local authorities at senior management level (operational)
- five representatives of the voluntary and private sectors, also at senior management level (operational).

The interviews covered the following topics.

Strategic level

- How the implementation group had worked.
- Relations between the implementation group and local authorities, the NHS and the voluntary and private sectors.
- Interactions between free personal care and other policies.
- Unintended or unexpected consequences of the policy.
- Political and popular reaction.

The strategic level interviews inform the whole report, especially the sections giving the background to implementation.

Tactical level

- Interactions between free personal care and other policies.
- Unintended or unexpected consequences of the policy.
- Political and popular reaction.

Operational level – local government

- Interactions between free personal care and other policies.
- Unintended or unexpected consequences of the policy.
- Reactions to the policy locally.
- Implementation locally.

Operational level – voluntary and private sectors

- Understanding of policy.
- Tactical, financial and operational impact of policy on organisation.

In addition to these general areas, individual interviewees were also asked to comment on issues specific to their areas of expertise.

The tactical and operational level interviews are discussed in Chapter 5.

In order to permit them to speak freely, we granted all our interviewees anonymity and therefore do not include a list or identify them in the text.

Focus groups

The views of older people were sought through a series of 15 focus groups. These consisted of between three and nine people, and involved a total of 88 participants. Thirty-seven of these people were in care settings as users of residential care, day centres and sheltered housing. The remaining 51 participants were members of

organisations for older people and/or carers – these included Better Government for Older People (BGOP) groups, pensioners' action groups and carers' groups. All but one of these was a 'natural group', that is a group of people who already knew one another.

The groups were held in Glasgow, Edinburgh, Stirling, Inverness and Perth. We examined the 'Carstairs' deprivation scores for the postcodes at which participants lived, and found that these covered a broad range of areas. Two groups consisted of minority ethnic people, one was ethnically mixed and the rest white. Of the minority ethnic groups, one was in a care setting and included people of South Asian background. The other was an older people's organisation, consisting of people from South Asian, Chinese and European minorities.

There were 21 men and 67 women, ranging in age from under 60 (14 people, mainly describing themselves as carers) to 96. The age distribution was as shown in Table A1.

Half the participants (44 people) were currently receiving support from outside the home, 24 were caring for an older person and nine of these were living with the person for whom they cared.

Overall, while the participants were not a random sample of Scotland's older population, they were reasonably representative of the range of this group, in terms of age, location, index of deprivation, receipt of services, care giving and ethnicity. In presenting the results, we identify both widely shared and less popular views. Where a sub-group of respondents (such as minority ethnic participants or informal carers) raised particular points, these are highlighted.

In advance of the session, focus group participants were sent an outline of the research, the list of topics for discussion and the Scottish Executive leaflet on free personal care. The topics for discussion drew, for consistency, on some of the original research done for the Care Development Group (Machin and McShane,

Table A1 Age distribution of focus group participants

Age group	Number of participants
<60	14
60–69	25
70–79	23
80–89	15
90+	6

Four people did not give their age.

2001) by Scottish Health Feedback and Queen Margaret University College, adding topics concerned with knowledge and experience of the policy. Topics discussed included:

- people's knowledge and understanding (using the leaflet as a prompt)
- their own expectations of care and support
- views on and experiences of family and informal care
- experiences of free personal care (which had been a change for some)
- other policies and services that they saw as related
- specific issues such as minority ethnic issues, issues for carers or issues attached to residential care.

Analysis of the financial and resource effects of the policy

This part of the project was conducted through secondary analysis of datasets. These included the following.

National Statistics Datasets

- 2001 Census
- Family Resources Survey
- Family Resources Survey (1996 Disability Extension)
- General Household Survey
- Labour Force Survey
- Scottish Household Survey
- Small Area Census Statistics

Scottish Executive Datasets

- Care Home Census
- Free Personal Care Dataset
- Grant Aided Expenditure
- Health Care Costs Report
- Healthy Life Expectancy Report
- Housing Bulletin
- Local Government Financial Statistics
- Nursing Home Data 1997–2002
- Older People's Health Status (ISD)
- Supporting People

Audit Scotland

- Performance Indicators: Housing and Social Work

ESRC

- British Household Panel Survey

DWP

- Attendance Allowance, Carer's Allowance and Disability Living Allowance
- State Pension
- Council Tax Benefit

Department of Health

- NHS Funded Nursing Care
- Home Care Services

Government Actuary

- Population Forecasts by Year