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PAYING FOR LONG-TERM CARE: POTENTIAL REFORMS TO FUNDING LONG-TERM CARE

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All responsibility for the analysis and views expressed in this paper rests with the authors.

Paying for Long-Term Care: Potential Reforms to Funding Long-Term Care

Around one in two women and one in three men who turn 65 will require intensive long-term care in their late old age (Glennister 1996). How this care is to be funded is currently a first-rank social policy issue in England. There is widespread consensus that “the current system is underfunded, incoherent and unfair” (Keen and Bell 2009: 3). There is also concern that any reform of the system should be affordable in future years, in the context of population ageing.

Over the past ten years or so, there have been a number of options put forward for reform of the long-term care system. The most influential options include ‘free’ personal care, recommended by the Royal Commission on Long Term Care (1999) and adopted in Scotland; a ‘partnership’ approach, recommended by the Wanless social care review (2006); and a national insurance approach recommended by the International Longevity Centre (Lloyd 2008).

The debate has recently intensified with the publication of a Government Green Paper on care and support, with a White Paper expected in 2010 (HMG 2009). The underlying model advocated in the Green Paper is a ‘partnership’ approach, whereby some care is provided by the state and the remainder is funded either by means-testing, insurance or a comprehensive approach (HMG 2009). Even more recently, in the autumn of 2009, the Prime Minister announced a policy of free personal care for people with the highest needs living at home, while the Conservative Party proposed a voluntary insurance scheme whereby older people would pay an £8,000 premium to cover residential care costs (*Community Care* 29/9/09; *Health Service Journal* 7/10/09). Following on from the Prime Minister’s proposals, on 25th November 2009, the Government introduced into Parliament the *Personal Care At Home Bill*, on which consultation is now taking place (Department of Health 2009a, b).

The current long-term care system in England can be described as a “residual” system (Brodsky *et al* 2003) in that it only supports those with very severe needs who are unable to meet the costs of their care and do not have access to much family care. The means test for residential and nursing home care in England takes into account the income and assets (in most cases including any housing wealth) of residents. Those with assets over an upper limit, currently set at £23,000 are not eligible for local authority support. Those with assets below this level are required to pay some of the costs of their care, the amount depending mainly on their income. Local authorities have discretion over how they charge for home care services, although there are national guidelines which set out common principles to which local authorities must adhere in determining how much to charge users (Department of Health 2003a). There are also guidelines determining eligibility for publicly-funded support, the *Fair Access to Services* (FACS) guidance (Department of Health

2003b). These eligibility criteria state that disabled people who receive unpaid family care are ‘less eligible’ for publicly-funded support than those without family care, a situation that will not be substantially changed by recent proposed revisions to the guidance (Department of Health 2009c).

This paper examines the impact of a range of potential reforms to the funding system for long-term care in England. It presents current and projected future public expenditure costs of long-term care for older people under the reform options and the implications of the options for the costs of care borne by individuals in different income groups. The reform options considered in the present paper include a version of free personal care, based on the recommendations of the Royal Commission on Long Term Care (1999); a version of free personal care, as proposed by the Prime Minister at the Labour Party Conference (which formed the basis for the *Free Personal Care Bill*) and several versions of a partnership model along lines suggested by the recent Green Paper on care and support (HMG 2009). The Conservative proposals are not considered here as there is inadequate detail to model them.

In the light of concerns about the restricted coverage of the current system we compare expenditure under a selection of the reform options to expenditure under a potential expansion in care services for older people along the lines of the care packages recommended in the Wanless report on funding social care (Wanless 2006). Such an expansion could also come about as a result of the reforms themselves: by reducing the cost of care to individuals the reforms might generate an increase in demand for care. Because of the relative difference in fees for self- and local authority- funded residents, the reforms may also drive up the fees that care homes charge. The sensitivity of the reforms to such changes is therefore investigated. All estimates relate to England and are expressed in constant 2007 prices.

Methods and Data

The analyses were conducted using two linked models – the CARESIM microsimulation model and the Personal Social Services Research Unit (PSSRU) cell-based long-term care finance model.

The PSSRU model makes projections of demand for long-term care and associated expenditure, under clearly specified assumptions (Wittenberg *et al.* 2006). It makes projections of future numbers of disabled older people; future levels of long-term care services and disability benefits; future public and private expenditure on long-term care and the future social care workforce. The projected levels of expenditure are broken down between public expenditure by the NHS and local authority social services and private expenditure by older people themselves. Public expenditure also includes a separate estimation of expenditure by the Department for Work and Pensions (DWP)

on disability benefits that are used to fund care. Projected levels of public and private expenditure are compared with projected economic output, Gross Domestic Product (GDP). This means that the model can be used to make projections both of the future balance between public and private expenditure on long-term care and of the future proportion of GDP spent on long-term care.

The PSSRU model does not make forecasts about the future. It makes projections on the basis of specific assumptions about future trends. The approach involves simulating the impact on demand of specified changes in demand drivers, such as demographic pressures, or specified changes in policy, such as the introduction of free personal care. It does not involve forecasting future policies or future patterns of care.

CARESIM simulates the incomes and assets of future cohorts of older people and their ability to contribute towards care home fees or the costs of home-based care, should such care be needed (Hancock *et al.* 2003, 2007). It uses data from three years of the British Family Resources Survey (FRS) to perform simulations for single people currently aged 65 and over, and for the older partner in couples where at least one partner is aged 65 years or more. The simulations are performed for a base year and for future years. Simulations for future years involve: ageing the sample of those currently aged 65 and over, allowing for deaths and the consequent effects of widowhood; modelling the evolution of their incomes and capital under certain assumptions; and making assumptions about future costs of care and the care charging, social security benefit and income tax regimes which will be in place for the year of interest.

Because it is more difficult to predict the future incomes of people who are not yet retired than it is for those who are already drawing pensions, the base year sample is not 'refreshed' as it is aged. This restricts the years and age ranges for which the model can produce projections. For the base year (2007) simulations are performed for 17,764 FRS respondents aged 65 and over. By 2027 the simulations are representative only of people aged 85 and over (4,162 observations). However, it is at these oldest ages that the need for care is highest and institutionalisation rates rise sharply, so this restriction is not as limiting as it might seem.

Separate simulations are performed for three different types of care homes - independent sector residential homes, local authority residential homes and independent sector nursing homes – and receipt of four packages of home care corresponding to low, medium, high and very high intensity care. The model starts by simulating what each older person would have to pay, per week, on starting to receive care in each of these seven categories. Most of those having to meet the full costs of residential care will need to draw on their capital so that over time their capital will fall. Once capital has fallen to the upper capital limit, they may be eligible for local authority help with

the fees and, if in an independent sector home, also for the lower fee rate that local authorities are able to negotiate for residents receiving local authority support. Each older person is randomly assigned an uncompleted length of stay in each type of care home. Their contribution to care costs is calculated for that point. In this respect the model can be thought of as mimicking a cross-sectional survey of care home residents. Home care clients may also have to draw on their capital to meet charges although this is less likely under the base charging regime than for residents in care homes. Data from the social care User Experience Survey are used to assign a length of time for which recipients of home care have been receiving services according to age and gender. Their contributions to home charges are calculated for that point. Since there is no national system for means-testing home care, a stylised home care means test has been assumed.

The CARESIM microsimulation model is used to provide projections of four variables for incorporation in the PSSRU model:

- the proportion of care home residents and home care clients eligible for local authority support under the current or an alternative charging regime;
- for care home residents, the proportion of gross costs of care met by disability benefits in the case of those not eligible for local authority support;
- the proportion of gross costs met by users, in the case of those eligible for local authority support; and
- the proportion of gross costs of home care met by disability benefits, for those eligible for local authority supported home care.

The PSSRU model shows that, controlling for age, service users are not a random subset of the older population. The CARESIM model's results are therefore reweighted according to projection year, housing tenure (owned or rented), marital status (married/cohabiting or single, widowed or divorced) and gender within each five-year age group for which CARESIM produces output. The weights are based on the PSSRU model projections of the (previous) housing tenure and household type of service users, by age and gender.

Policy Options Considered¹

Funding Policy Options Considered

Free personal care: The policy of free personal care has been described and discussed in detail elsewhere (Royal Commission on Long-Term Care 1999, Wanless 2006). The Royal Commission

¹ The modelling of all options considered here assumes continuation of existing eligibility criteria relating to disabled older people who receive informal care. Disabled older people with informal carers are currently treated as “less eligible” for publicly-funded support than those without (DH 2003b). Some implications of this are discussed at the end.

report envisaged several ways of implementing free personal care, one of which was that, for residential care, there would be a personal care allowance, applied by all local authorities (Royal Commission on Long Term Care 1999: 66 #6.39). This sum would be deducted from the charges made in individual care homes, leaving the balance representing living and housing costs². There would be means-testing of ability to pay for hotel costs, entitling people with little means to receive help with the charges for living and housing. An important feature of this approach is that the amount allowed for personal care is applicable in any care home. This ‘fixed care costs’ version of free personal care is the one we model. The weekly personal care allowance was set at £248.70 in April 2007 and assumed to rise with general price inflation in future years. The cost of all need for personal care at home, as assessed by local authorities, is assumed to be met by the state under free personal care.

Free personal care for those with the highest needs living in the community: In September 2009, the Prime Minister announced the Government’s intention to introduce a policy of free personal care for older people with the highest needs living at home from October 2010. We model the implications of this policy by assuming that the means-test for local authority support for home care would be abolished for older people with personal care needs currently receiving ‘high’ or ‘very high’ packages of care, as defined by our model. In practice this means that those people with personal care needs receiving packages of home care of 5 or more hours per week would no longer contribute to the costs of their care.³ The means test remains for people receiving fewer than 5 hours of home care, for those without personal care needs and for older people living in care homes.

Options relating to a partnership model: The Green Paper proposes a partnership model in which everyone who qualifies for care and support on the basis of their care needs would be entitled to have a set proportion of their basic care and support costs met by the state. The proposal has a progressive element such that older people with fewer means will have more of their costs met by the state; and those with the fewest means will have all their care costs met by the state (HMG, 2009). Based on our interpretation of the Green Paper, we assume that all those who qualify for care are eligible to have one-third of their personal care costs met by the state.⁴ The Green paper is not specific on who would be eligible for more than a third of their care costs. We assume that those

² In nursing homes there is now also a standard NHS contribution to the costs of nursing care.

³ Since our modelling was carried out, the Government has introduced the *Free Personal Care at Home Bill* and is currently consulting on a definition of those with highest needs that would include those in the ‘critical’ band of FACS with difficulty undertaking four or more ADLs (DH 2009a: 11). (See also footnote 8).

⁴ The Green Paper also indicates that there would be investment in prevention, such as investment in re-ablement and tele-care (HMG 2009: 51-2, 103). This has not been included in the modelling here.

who under the current funding system are entitled to a state contribution of more than one-third of their care costs, continue to receive the same state contribution as under the current system.⁵

Partnership model with withdrawal of some disability benefits: The Green Paper also proposed that the new National Care Service could be funded by transferring monies from some elements of the benefits system into the social care system. It suggests that one option is to withdraw Attendance Allowance (AA) for new claimants and transfer the money into the social care system (HMG, 2009). AA is a non means-tested benefit for disabled older people aged 65 and over and is payable at one of two rates. We model a variant of the partnership scheme in which AA and Disability Living Allowance (DLA) are withdrawn. (DLA is a similar benefit which can be received by people aged over 65 who started to receive it before reaching that age for over 65s). Since receipt of AA or the middle or higher rate of DLA determines eligibility for a Severe Disability Premium (SDP) in Pension Credit we assume that if AA and DLA were withdrawn, the SDP would also be withdrawn. Receipt of AA and DLA also determine eligibility for Carer's Allowance for carers of people with impairment, and the Pension Credit Carer Premium, but our analysis does not cover these benefits. Modelling of the withdrawal of AA under the current system, carried out by Forder and Fernandez (2009) for the Department of Health, has allowed for some targeting, but this does not seem to be described in the Green Paper itself and has not been modelled here. The Green Paper also implies some transitional arrangements, whereby "people receiving any of the relevant benefits at the time of reform would continue to receive an equivalent level of support and protection under a new and better care and support system" (HMG 2009: 104). The modelling here does not take account of this phasing-in of the reforms.

Effects of rises in care home fees: In independent care homes, fees paid in respect of residents who are supported by the local authority are often lower than those paid by 'self-funders'. The free personal care and partnership model options would increase the proportion of care home residents eligible for local authority support with their fees and it is implicitly assumed here that all those receiving local authority support with their fees under the reform options would be eligible for the lower local authority fee rates. There could therefore be pressure for local authorities to increase the fees they offer care home owners in respect of local authority supported residents.⁶ Two possibilities are considered here. In the first, local authority fees are assumed to remain at their

⁵ Although the options suggested by the Green Paper, modelled here, relate to the partnership option, it should be noted that there are similarities between the comprehensive option and free personal care.

⁶ In Scotland, when a 'fixed care costs' version of free personal care was introduced, private and voluntary care providers were reluctant to provide places for older people under 'integrated' contracts, under which local authorities managed the contractual arrangements with care homes on behalf of older people receiving free personal care (Age Concern Scotland, 2003: 19-20). The underlying problem, that local authority fees are lower than self-funders' fees, is addressed here by allowing for scenarios in which local authorities increase the fees they offer to care home owners.

current levels. In this case, part of the costs of the change would implicitly fall to care home providers, which is probably unrealistic. If fees for local authority-funded residents do not rise, the reforms would yield reduced revenue for care home providers and some might go out of business. In the second possibility, local authority fees are assumed to rise such that provider income per resident remains at its 2007 level under the current funding system. The higher fee rates are assumed to apply to all supported residents and not just to those specifically benefiting from the reformed funding system. The state contribution to personal care is taken to be unchanged so that all of the fee rise relates to hotel costs and is subject to means-tested user charges under all options.

Pattern of Care Policy Options Considered

Wanless pattern of care: A scenario describing an expansion of services for disabled older people is modelled along the lines of the ‘core business’ scenario described in the King’s Fund Social Care Review, led by Sir Derek Wanless (Wanless 2006). In the Wanless Review, under this scenario all older people identified as having personal care needs receive services at levels which are deemed to be cost-effective. Cost-effective services are defined as those which cost less than £20,000 per person per year to produce an outcomes gain equivalent to one ADLAY, where an ADLAY is an ADL⁷-adjusted life year and can be understood as a year of life fully ADL-compensated. In the scenario reported here we have expanded services so that the total numbers of older people receiving services match those reported in Wanless (2006).

This scenario addresses the criticism that there is large unmet need in the current system (CSCI 2008; HMG, 2009). It also demonstrates the sensitivity of the projections to changes in the eligibility criteria for care services, which is of central importance to the partnership model since the offer of public resources is available only to those who ‘qualify’ for care and support services. Combined with the free personal care and partnership funding reforms this pattern of care can also give an indication of the public expenditure consequences of demand for care increasing in response to the reduced care costs that individuals would face under those reforms.

‘Base Case’ Assumptions

The PSSRU and CARESIM models produce projections on the basis of specific assumptions about future trends in the key drivers of demand for long-term care (Box 1). A base case projection takes account of expected changes in factors exogenous to long-term care policy, such as demographic trends and trends in housing tenure. It holds constant factors endogenous to long-term care policy,

⁷ ADL stands for Activities of Daily Living. Difficulties in or inability to perform ADLs is a common measure of the need for care.

such as patterns of care and the funding system. The base case is used as a comparison when the assumptions of the model are varied in alternative scenarios.

BOX 1

KEY ASSUMPTIONS OF THE BASE CASE

- The number of people by age and gender changes in line with the Government Actuary's Department 2006-based population projections for England.
- Marital status changes in line with GAD 2006-based marital status and cohabitation projections for England and Wales.
- Prevalence rates of disability by age and gender remain unchanged, as reported in the 2001/2 General Household Survey (GHS) for Great Britain.
- Home-ownership rates, as reported in the pooled 2003/4, 2004/5 and 2005/6 Family Resources Survey (FRS), change in line with projections produced by the CARESIM model.
- The proportions of older people receiving informal care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, disability and other needs-related characteristics.
- The funding system remains unchanged as the current system for England.
- Health and social care unit costs rise by 2% per year in real terms (but non-staff revenue costs remain constant in real terms). Real Gross Domestic Product rises in line with HM Treasury assumptions.
- The supply of formal care will adjust to match demand and demand will be no more constrained by supply in the future than in the base year.

Public Expenditure under Current Funding System and Policy Options

All results relating to public expenditure under the current funding system and policy options are shown in Tables 1 and 2 and Figure 1.

Public Expenditure under Current Funding System

Public expenditure on long-term care and disability benefits for people aged 65 and over is projected to rise, under base case assumptions, from £15.8 billion in 2007 to £37.6 billion in 2032, an increase of 140%. These figures relate to public expenditure on long-term health services and social services and to all disability benefits for older people in England. If Gross Domestic Product (GDP) rose in line with HM Treasury assumptions, public expenditure on long-term care and benefits would rise from 1.29% of GDP in 2007 to 2.05% in 2032. These projections are sensitive

to varying the assumptions about future life expectancy, trends in disability rates and trends in real unit costs (Wittenberg *et al.* 2006). They relate to the funding system currently used in England.

Public Expenditure Costs of Options

Under free personal care (fixed care costs variant) around 100,000 privately-funded care homes residents and around 200,000 privately-funded users of home care would become eligible for public support. The additional net public expenditure cost, compared to continuation of the current funding system, would be around £1,980 million at 2007 prices comprising an additional cost of around £2,075 million to social services, offset by a saving of around £95 million in disability benefits. This saving occurs because publicly-funded care home residents cease to receive AA/DLA and under free personal care, all care home residents are publicly-funded. The additional net public expenditure cost would rise to around £3,750 million in 2027 and £4,890 million in 2032 at constant 2007 prices. Public expenditure on long-term care and disability benefits would rise from 1.46% of GDP in 2007 to 2.31% in 2032.

Under free personal care at home for people with high needs the additional net public expenditure cost would be around £660 million in 2007. The net additional cost would rise to around £1,380 million in 2027 and £1,770 million in 2032 at constant 2007 prices. Public expenditure on long-term care and disability benefits would rise from 1.35% of GDP in 2007 to 2.14% in 2032.

Under a Partnership model (with 33% of personal care costs guaranteed), the additional net public expenditure cost, above continuation of the current system, would be around £475 million in 2007, comprising a cost of around £570 million to social services offset by a saving of around £95 million in disability benefits. The net additional cost would rise to around £1,170 million in 2027 and £1,590 million in 2032 at constant 2007 prices. Public expenditure on long-term care and disability benefits would rise from 1.33% of GDP in 2007 to 2.13% in 2032.

If, under a Partnership model, disability benefits are withdrawn, net public expenditure cost would be around £4,145 million *lower* than under the current system in 2007.⁸ There would be additional costs of around £1,175 million to social services but this is offset by a reduction of £5,320 million in disability benefits. The net reduction in public expenditure would rise to around £6,040 million in 2027 and £6,480 million in 2032 at constant 2007 prices. Public expenditure on long-term care and disability benefits would be 0.95% of GDP in 2007, which is a lower figure than the current

⁸ The modelling looks at the effects if AA and DLA for people aged 65 and over were withdrawn in 2007 and therefore does not take into account transitional arrangements which, as indicated earlier, the Green Paper suggests would be introduced.

percentage (1.29%). This would rise to 1.69% in 2032, which again would be lower than the percentage in 2032 under the current system (2.05%).⁹

Sensitivity Analysis: Care Home Fees

Under free personal care where care home fees for local authority-supported residents rise, the additional net public expenditure cost, above continuation of the current system, would be around £2,200 million at 2007 prices rising to around £4,220 million in 2027 and £5,510 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.47% of GDP in 2007 to 2.34% in 2032.

Under the Partnership model where care home fees rise, the additional net public expenditure would be around £710 million in 2007 rising to around £1,660 million in 2027 and £2,200 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.35% of GDP in 2007 to 2.17% in 2032.

If, under the Partnership model, disability benefits are withdrawn and LA fees rise, net public expenditure cost would be around £3,900 million *lower* in 2007. The reduction in public expenditure would be around £5,540 in 2027 and £5,820 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 0.97% of GDP in 2007 to 1.73% in 2032. These percentages are both lower than their respective equivalents under the current funding system.

Sensitivity Analysis: Wanless Packages of Care

This sensitivity analysis considers the net public expenditure cost of an expansion of care services for older people as per the care packages recommended in the Wanless report on the funding of social care. The additional net public expenditure cost, compared with continuation of current care packages, would be around £3,235 million at 2007 prices comprising a cost of around £2,550 million to social services, £200 million to the NHS and £485 million in disability benefits. The net cost would rise to around £8,110 million in 2027 and £10,140 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.56% of GDP in 2007 to 2.60% in 2032.

⁹ A *reduction* in net public expenditure costs is also shown in the impact assessment prepared by the Department of Health, which shows a reduction in public expenditure of £1.1 billion in 2024 under the partnership option with withdrawal of some disability benefits (DH 2009d: 3). This is a smaller reduction than that shown here in 2027, but the precise reasons for the difference are difficult to ascertain because the DH has not yet published details of its modelling of the reform options.

If free personal care was implemented alongside expanded packages of care, the additional net public expenditure cost would be around £5,640 million in 2007 rising to around £12,750 million in 2027 and £16,100 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.76% of GDP in 2007 to 2.92% in 2032.

If partnership was implemented alongside expanded packages of care, the additional net public expenditure cost would be around £3,610 million in 2007 rising to around £9,170 million in 2027 and £11,580 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.59% of GDP in 2007 to 2.27% in 2032.

Table 1
Public expenditure on long-term care and disability benefits for people aged 65 and over
under potential reforms to funding long-term care, England, 2007

	Public expenditure on long-term care and disability benefits for people aged 65+	Long-term care		Disability benefits for people aged 65+*
		Personal Social Services	NHS	
<i>Base case – Current funding arrangement in England</i>	15,810	6,765	3,725	5,320
Free personal care in all settings	17,790	8,840	3,725	5,225
Free personal care for high/very high domiciliary care users	16,465	7,420	3,725	5,320
Partnership with 33% guarantee	16,280	7,330	3,725	5,225
Partnership, AA/DLA (65+) discontinued	11,670	7,945	3,725	0
Free personal care + fee rise	18,010	9,060	3,725	5,225
Partnership + fee rise	16,515	7,565	3,725	5,230
Partnership, AA/DLA (65+) discontinued + fee rise	11,910	8,185	3,725	0
Wanless packages of care	19,015	9,295	3,915	5,805
Wanless packages of care + free personal care	21,455	11,855	3,915	5,685
Wanless + partnership	19,425	9,825	3,915	5,685

*Source: Caresim and PSSRU Model; Note: *'Disability benefits for people aged 65 and over' refers to Attendance Allowance (AA) and Disability Living Allowance (DLA).*

Table 2
Public expenditure on long-term care and disability benefits for people aged 65 and over
under potential reforms to funding long-term care, England, 2007 and 2032

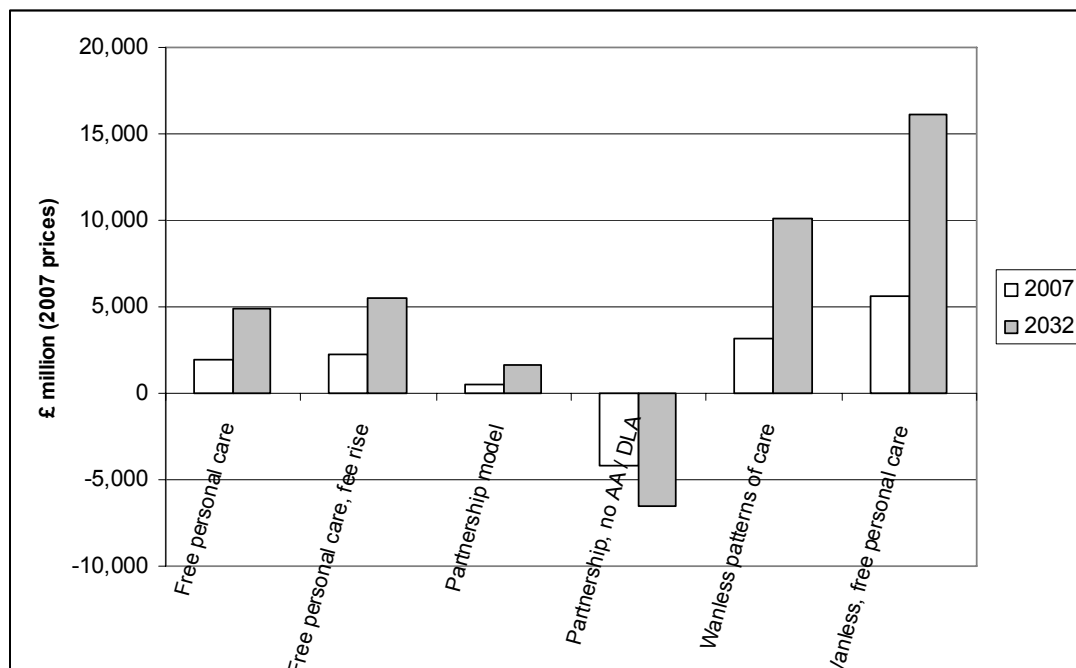
	Public Expenditure - in £ million (2007 prices)		Public expenditure % GDP	
	2007	2032*	2007	2032*
<i>Base case – Current funding arrangement</i>	15,810	37,590	1.29	2.05
Free personal care	17,790	42,480	1.46	2.31
Free personal care for high/very high domiciliary care users	16,465	39,355	1.35	2.14
Partnership	16,280	39,180	1.33	2.13
Partnership, no AA/DLA	11,670	31,115	0.95	1.69
Free personal care + fee rise	18,010	43,100	1.47	2.34
Partnership + fee rise	16,517	39,815	1.35	2.17
Partnership, no AA/DLA + fee rise	11,910	31,770	0.97	1.73
Wanless	19,015	47,735	1.56	2.60
Wanless + free personal care	21,455	53,685	1.76	2.92
Wanless + partnership	19,425	49,165	1.59	2.67

Source: Caresim and PSSRU Models

Note: * Projections of public expenditure are under-estimates since they assume constant take-up rates of DLA by age and gender and do not allow for maturation of the DLA scheme.

Figure 1

Public expenditure on long-term care and disability benefits (65+): Difference between current system and reform options, England, 2007 (£ million)



Source: Caresim and PSSRU Models. Notes: see notes to Tables 1 and 2

Financial Gains and Losses to Care Home Residents and Home Care Users from the Reform Options

The average financial gains from reform options, in pounds per week (April 2007 prices), are shown in Table 3. Figures are given for people aged 65+ and aged 85+ in 2007, and aged 85+ in 2027. They are shown separately and in combination for care home residents and home care users. The gains are largest under free personal care for care home residents who would be on average about £95 a week better off in 2007 and £130 in 2027, or a little lower if care home fees rise. Gains to care home residents would be between £30 and £40 a week under the partnership options.

Under free personal care, gains are somewhat lower for home care users – some £20-£30 per week. They are a little higher under Wanless patterns of care. This is because these patterns of care assume that more people are cared for at home with more expensive packages of care than at present. A move from the current funding system to free personal care under these patterns of care is therefore more beneficial for home care users than under current patterns of care. Home care users gain only small sums from the partnership model when AA and DLA are retained. If AA and DLA are withdrawn they lose about £40 a week.

These losses need some explanation. Because there are variations in how local authorities charge for home care services, we have assumed a standard means test that embodies the principles set out in national guidance. We have also had to make assumptions about how the means tests would work if AA and DLA were withdrawn. For the current funding system we assume that all Local Authorities include AA and DLA in the income which is taken into account in assessing user contributions to home care. We also assume, to comply with national guidance, that they therefore disregard part of any AA/DLA that the recipient uses towards Disability Related Expenditure (DRE)¹⁰. Under current guidance, if LAs disregard AA/DLA into account in the means tests, they do not need to make any allowance for DRE. We have assumed that if AA/DLA were withdrawn, LAs would not make any allowance for DRE but would apply an otherwise similar means test to the proportion of care costs not met by the state (i.e. two-thirds). Thus although some users gain from the non means-tested 33% state contribution, the loss of AA/DLA (and in consequence the DRE disregard) more than outweighs this gain for most.

¹⁰ DRE can include e.g. higher transport, laundry and heating costs attributable to the person's disability.

Table 3: Average weekly gains, care home residents and home care users, 2007 and 2027

£s pw, April 2007 prices

	Care home residents and home care users combined			Care home residents			Home care users		
	2007		2027	2007		2027	2007		2027
	65+	85+	85+	65+	85+	85+	65+	85+	85+
Free personal care in all settings	47.00	56.30	71.30	95.50	96.30	131.20	24.60	28.40	31.30
Free personal care for high/very high needs home care users	12.40	13.20	14.10	0.00	0.00	0.00	18.10	22.40	23.50
Partnership model, 33% guarantee	12.90	16.60	25.70	37.30	38.10	61.10	1.60	1.70	2.10
Partnership model, AA/DLA (65+), discontinued	-16.10	-8.20	0.80	37.30	38.10	61.10	-40.80	-40.50	-39.50
Free personal care + LA fee rise	43.80	52.10	64.30	85.30	86.30	112.60	24.60	28.40	31.30
Partnership + fee rise	10.10	13.10	19.20	28.40	29.10	44.70	1.60	1.70	2.10
Partnership with AA/DLA (65+) discontinued + fee rise	-19.00	-11.90	-5.80	28.40	29.10	44.70	-40.80	-40.50	-39.50
Free personal care in all settings under Wanless patterns of care	44.60	54.60	65.70	96.00	101.70	135.70	31.80	38.30	42.60
Partnership under Wanless patterns of care	8.70	11.50	17.50	36.80	40.00	62.90	1.70	1.70	2.50
Partnership with AA/DLA (65+) discontinued under Wanless patterns of care	-18.90	-13.00	-10.40	36.80	40.00	62.90	-32.70	-31.20	-34.70

Source: CARESIM model

How do Financial Gains and Losses Vary by Income Group?

To assess how the financial effects of the reform options for care recipients are likely to vary across different income groups, the average gains within each fifth (quintile) of the income distribution are compared¹¹. Care recipients are classified according to the quintile of the income distribution in which their income falls, where that distribution is specific to five-year age group. In the analysis that follows, someone classified as having an income in the highest income quintile has a high income relative to people of a similar age. This may not be a high income relative to the total population. When compared to the total population income distribution, older people are in general concentrated in the second and third quintiles of the income distribution, and this is even more pronounced for those aged 85 and over.

Financial gains and losses are measured by changes in users' disposable incomes after meeting care costs¹². The distribution of these gains and losses are shown for care recipients aged 85 and over, in figures 2 (2007) and 3 (2027).

Under all the options, gains are highest and losses smallest in the top income group; gains are smallest and losses largest in the lowest income group. In 2007 care recipients (aged 85+) in the top income group gain around £90 a week from free personal care, some £20 a week from the partnership options and lose a maximum of £8 a week under the partnership models when AA/DLA is withdrawn. Care recipients in the lowest income group gain £20-£25 a week from free personal care, between £3 and £9 a week from partnership options which retain AA/DLA and lose up to £26 a week on average, when AA/DLA is withdrawn.

¹¹ Income is the net income (before housing costs) of the family unit (single older person or older couple) that they would receive when living in their own homes without any care needs. The before housing costs definition is not identical to that used in the annual National Statistics publication 'Households Below Average Income'. Here we do not include Housing Benefit (HB) as income on the grounds that high HB is at least in part the result of high rent so that to include it in income, without deducting rent, may exaggerate the economic well-being of people with high rents. Income is adjusted for family size using the OECD equivalence scale of 1 for the first adult, 0.5 for each subsequent person aged at least 14 years and 0.3 for each child aged under 14.

¹² There may also be changes in users' wealth if capital is depleted at different rates under the different options. This is not taken into account explicitly.

The picture in 2027 is similar to that in 2007, except that the extent to which the highest income group gain compared with a continuation of the current funding system is more marked, and differences in gains/losses across the lowest three income groups are less pronounced.

The distributional results take no account of how the revenue to finance the reform options might be raised, yet these may affect the results. In past work, we have examined the effect of financing free personal care by an increase in the higher rate of income tax and found that gains from free personal care would in fact be redistributive (Hancock *et al* 2007: 79). There are of course many different ways in which revenue could be raised to finance extra public spending on long-term care and they will differ in their distributional effects. Analysis of a range of revenue raising options is planned for the future as part of MAP2030.

Under the partnership options where AA and DLA for those aged 65 and over is withdrawn, we have not shown the effect for people who are not receiving care services who would also lose their AA or DLA.

Discussion of Findings

A key finding is that current public expenditure would be lower by approximately £4 billion if disability benefits for older people were discontinued, even if a partnership model was introduced. The Green Paper does not contain much detail about its proposals and the modelling here has therefore relied on an interpretation of its intentions. For example, the Green Paper proposes to improve preventative services, such as re-ablement and tele-care, but these were not included in the modelling here because there is no indication of the extent of increases in spending on these services that might be implied. Nevertheless, if we had included these non-personal care costs, public expenditure costs would have been higher. Public expenditure costs would also have been higher in the initial period after the introduction of the reforms, had allowance been made here for some phasing-in of the changes. Finally, the detailed implementation of any withdrawal of disability benefits for older people, such as a targeting of the withdrawal, would also affect public expenditure costs and distributional effects.

However, there are also reasons why a discontinuation of disability benefits would reduce public long-term care expenditure under a partnership model. One reason is that disabled older people use disability benefits to pay for other disability-related expenditure, such as extra heating and special diets. A second reason is that disability benefits are a universal entitlement and all disabled older people, including those with informal carers, receive them. However, the Partnership model would not necessarily be universal in this sense. The Green Paper seems ambiguous on this point.

Following some statements in the Green Paper (HMG 2009: 103-104), it has been assumed here that there would be a continuation of existing eligibility criteria, under which disabled older people with informal carers (including some of the most severely disabled in the community) are regarded as 'less eligible' for publicly-funded long-term care than those without informal carers (Royal Commission on Long Term Care 1999, FACs 2003b, CSCI 2008). Elsewhere, the Green Paper seems to suggest that the new National Care Service might include disabled older people with informal carers (HMG 2009: 119). If the modelling were to assume a genuinely universal entitlement to publicly-funded social care by *all* disabled people, public expenditure on long-term care would be greater and more of the public expenditure saved from withdrawing AA/DLA would be transferred to social care funding.

Our modelling highlights the importance of the (as yet unspecified) details of how, under the Partnership Model, the means tests for the part of the care costs not met automatically by the state would operate, particularly if AA/DLA are withdrawn. If for example, LAs were required to disregard DRE even with AA/DLA withdrawn, home care users would lose less or even gain under this scenario. Likewise, if the means test applied to the two-thirds of care costs for care home residents were more generous than at present, the proposals would benefit those on lower incomes more than our results suggest.

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Figure 2

Distribution of weekly gains, £s pw, April 2007 prices: care home residents and home care users aged 85+, 2007

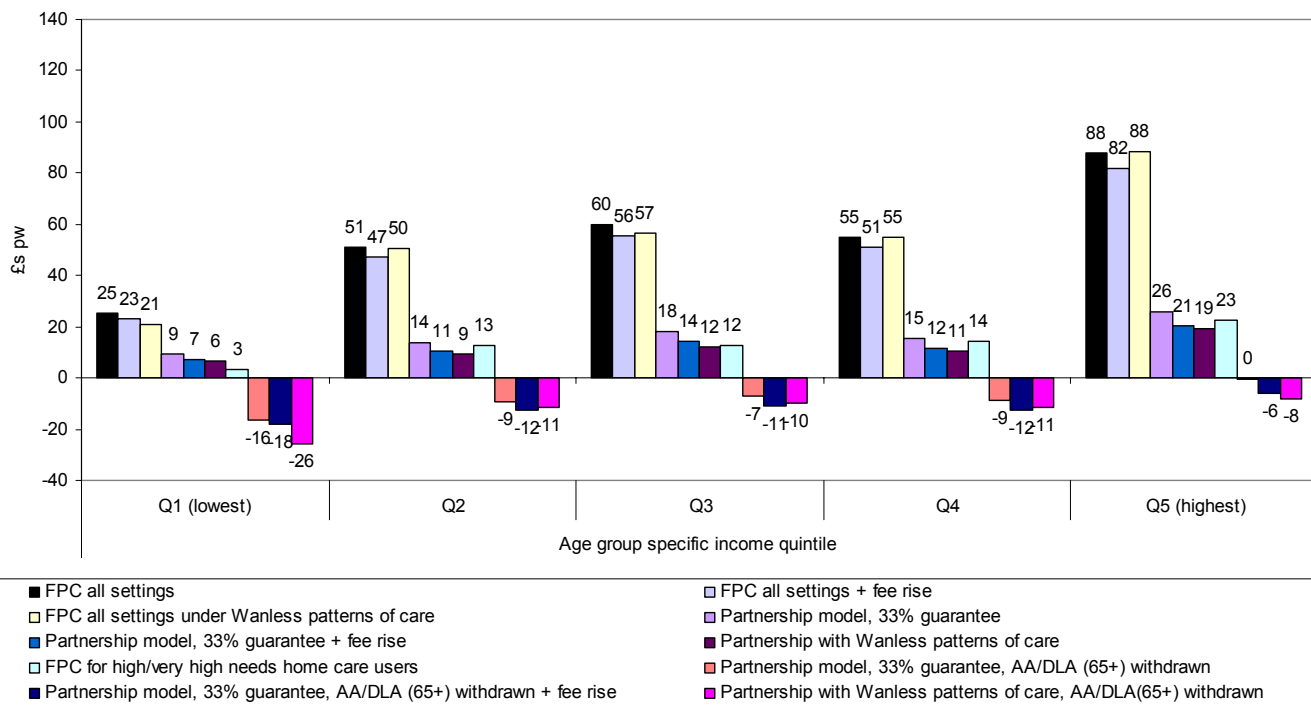
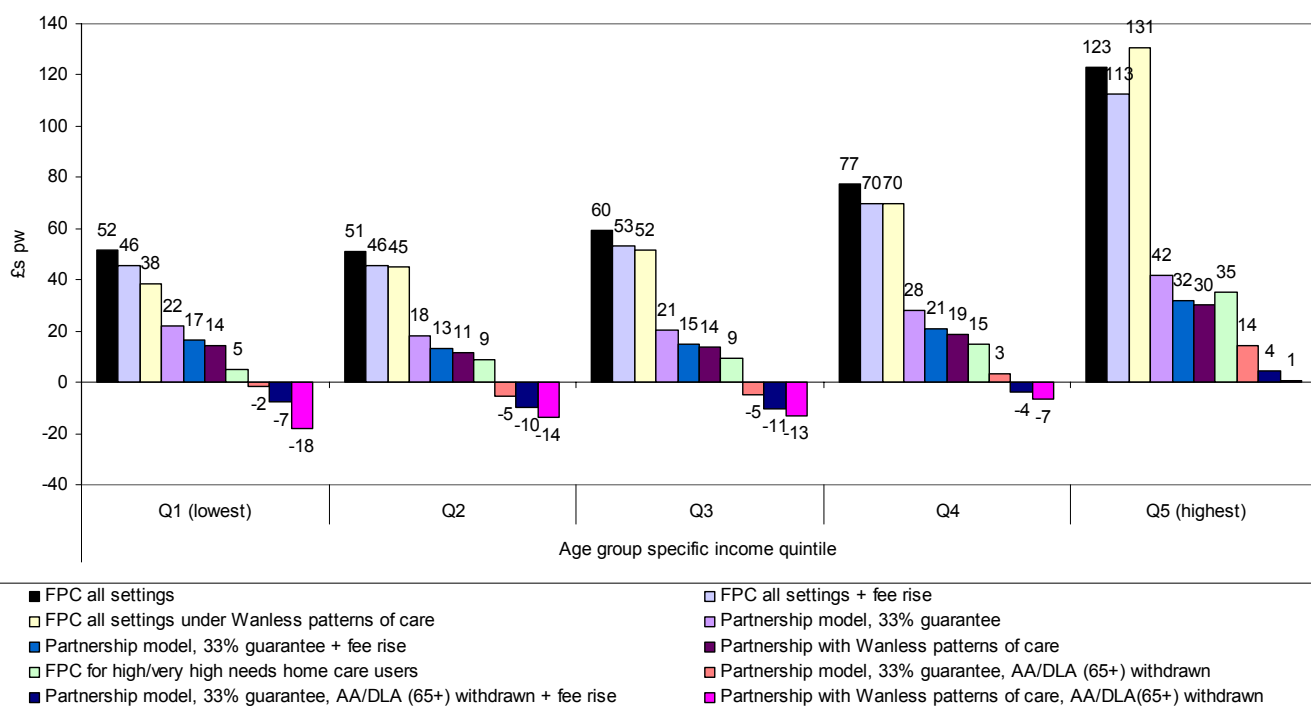


Figure 3

Distribution of weekly gains, £s pw: care home residents and home care users aged 85+, 2027



Source: CARESIM model