

Free Personal Care for Older People: A Wider Perspective on Its Costs

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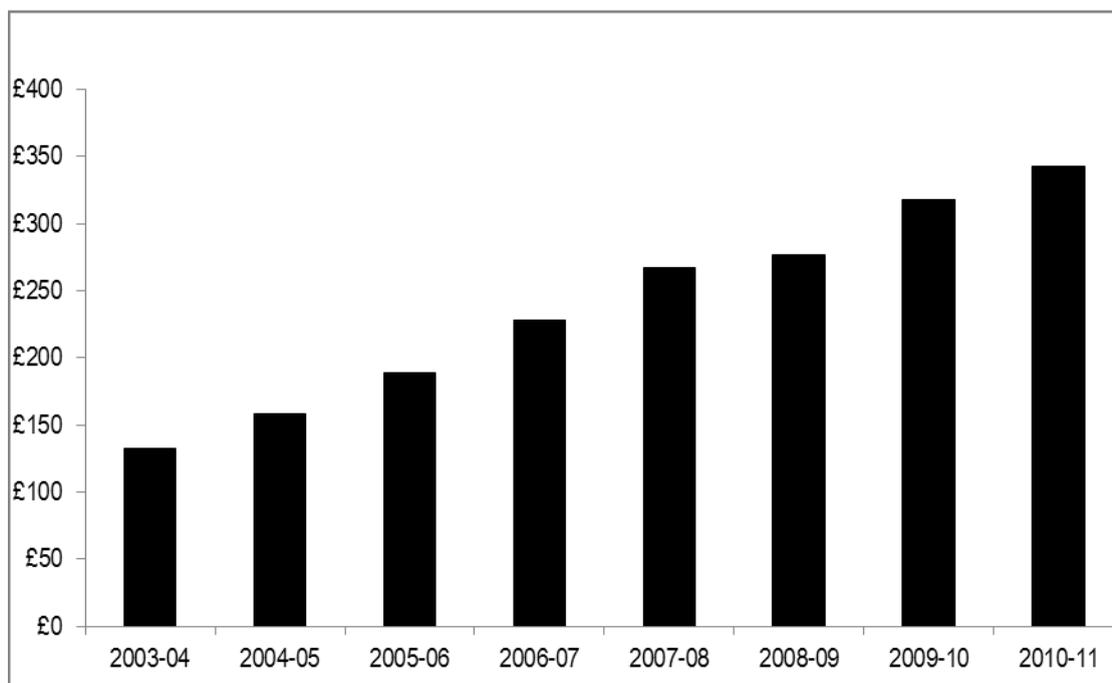
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Abstract: The paper comments on the so-called “Free Personal Care (FPC)” policy established in Scotland in 2002. FPC is the legal entitlement of people aged 65 and older, who have been assessed by the council as having personal care needs, to receive services that will assist them in their day-to-day activities. One view is that FPC may not be affordable in its current form because population ageing will increase dramatically the numbers eligible for assistance in the future. This paper discusses ways in which FPC may actually lower the total per-person cost of accommodating Scotland’s ageing population.

Introduction

The *Community Care and Health Act 2002* established a policy of “Free Personal Care (FPC)” in Scotland. A similar policy does not exist in the other countries of the UK. FPC is the legal entitlement of people aged 65 and older, who have been assessed by the council as having personal care needs, to receive services that will assist them in their day-to-day activities. These services include assistance with personal hygiene, eating and drinking, immobility problems, management of medication and personal safety. In addition, various aids may be supplied free of charge by the council, if deemed necessary, to support a person’s health and well-being. The introduction of FPC was a radical change in long-term care policy in Scotland and a clear departure from the rest of the UK.

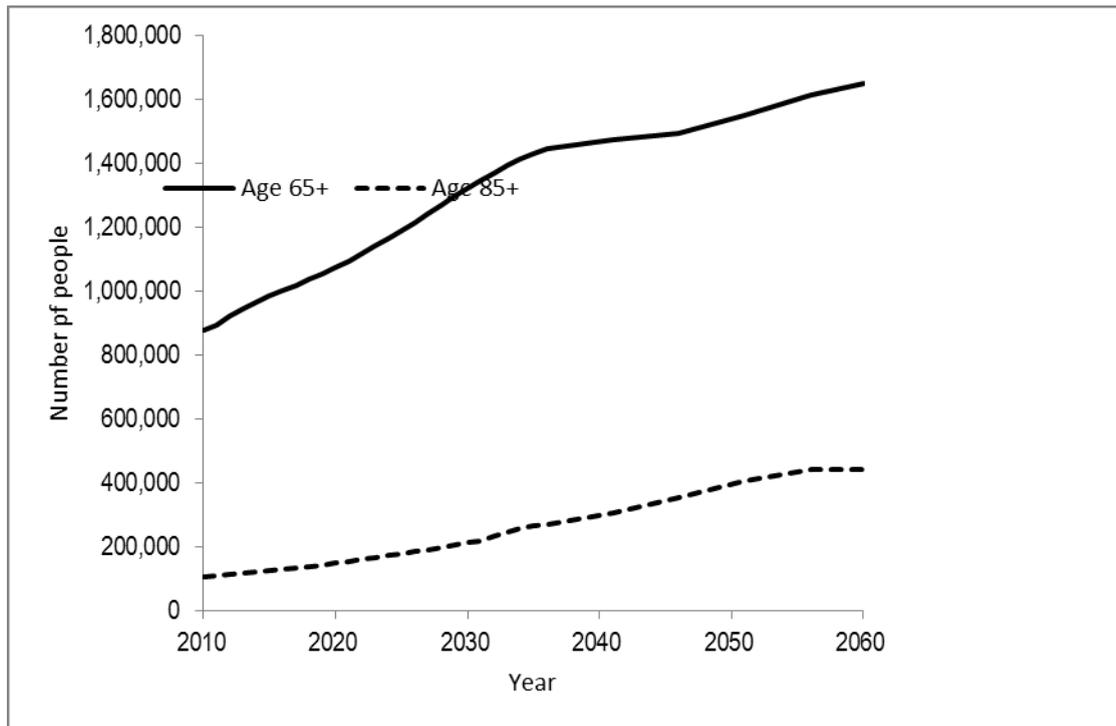
Figure 1 Total Expenditure on Personal Care Services at Home, Scotland, 2003-4 to 2010-11 (£millions)



Source: Scottish Government (2012a)

It has also proven to be a popular policy, with the number of people receiving care services growing considerably since its introduction (see Bell and Bowes, 2012). It is not surprising therefore that the amount of money spent on FPC has also increased. The scale of this increase is shown in Figure 1, which indicates that expenditure on personal care services at home increased from £133 million in 2003-04 to £342 million in 2010-11 (Scottish Government, 2012). This represents an increase of almost 160 per cent. In the same period, the number of people aged 65+ (those eligible for FPC) increased by around 9.2 per cent (Scottish Government, 2012b). Given the differences in these two changes, it is not surprising that the expenditure per-person aged 65+ has increased by about £146 in 2003-04 to £345 per head in 2010-11 (Figure 2). This supports an expenditure/population aged 65+ elasticity of +10.5!

Figure 2 Population Aged 65+ and 85+ Scotland, 2010-2060

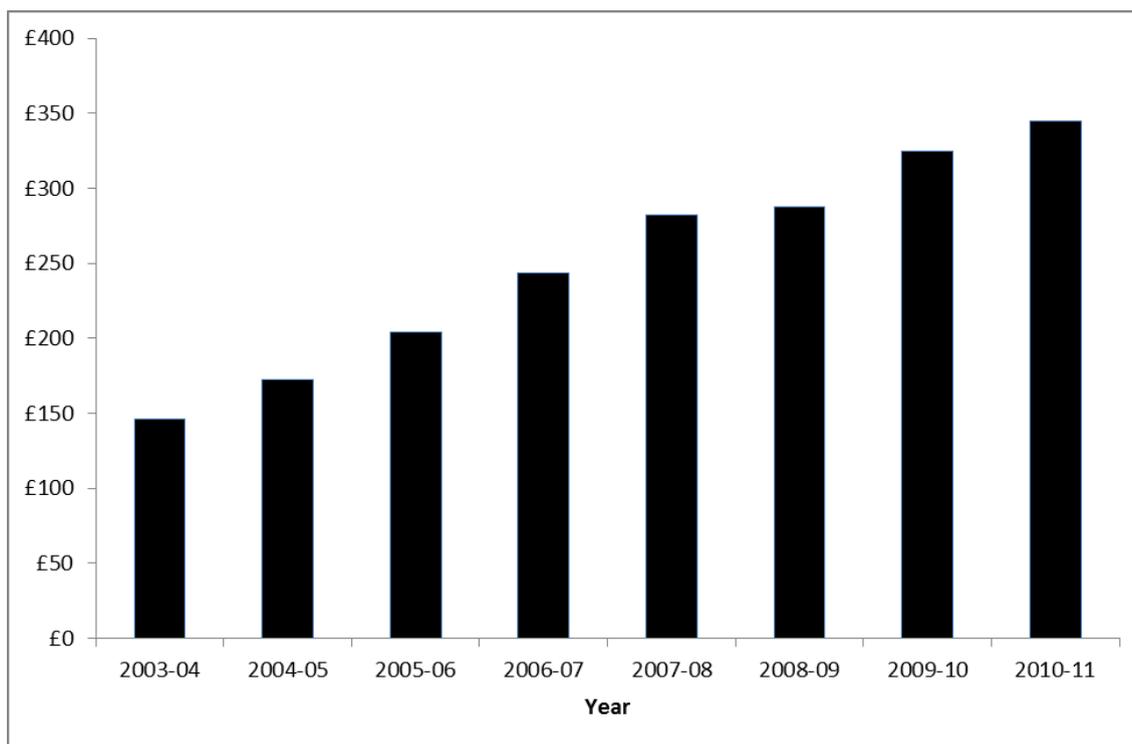


Source: Scottish Government (2011)

The large increase in the cost of FPC has led for some to argue that it may not be affordable in current form because population ageing will increase dramatically the numbers eligible for assistance in the future. The scale of this increase is shown in Figure 3. This figure shows the expected increase in numbers of people aged 65+ and 85+ up until 2060, based on the most recent set of “official” population projections (Scottish Government, 2011). The projections suggest the numbers aged 65+ will likely double and the numbers aged 85+ will likely triple over the next five decades. When the expected growth in the numbers eligible is combined with the past growth in expenditure per head, it is not difficult to conclude that the policy will not be viable in the future.

This conclusion is short-sighted—if not incorrect—since it fails to consider expenditure on FPC relative to the expected total expenditure needed to accommodate the ageing population. By “accommodate” we mean ensure that there is not a large reduction in the average standard of living of older people in the future. In this respect, FPC may lower the “total” per-person cost of accommodating the ageing population. That is, total government expenditure may be lower with the policy in place compared to its absence. FPC is not necessarily cheaper than private home care, but instead this assumes that individuals with lower wealth would switch to subsidised residential care if faced with having to pay for home care. However, we are under no illusion that FPC will make doing so “cheap”. In addition, it is no guarantee against average standard of living reductions in the future. There is no “quick fix” way to pay for an ageing population.

Figure 3 Total Expenditure on Personal Care Services at Home Per Person Aged 65+, Scotland, 2003-4 to 2010-11 (£)



Source Scottish Government (2012a, 2012b)

Substitutability of Different Types of Care

In Scotland, like most high-income countries, long-term care is provided in a variety of different residential settings. The cost of long-term care is shared between the public and private sectors. For our purposes, it is helpful to simplify reality and focus on two main residential settings. The first is the individual's "own home". The second is some form of "care home". By "care home" we mean any private or public institution that provides the level of support needed. Care homes differ considerably in the level of support offered. It is useful to think in terms of the care on offer ranging from "low" to "high" in terms of both time devoted to and cost of caring. One example is a "nursing home" that provides hotel, personal care and medical care services for individuals with dementia or low levels of physical mobility. A second example is "sheltered accommodation" where the support is often only the security and monitoring of a group of rented flats or small houses. A third example is a geriatric long-stay wing in an NHS Scotland hospital.

One of the outcomes of FPC is that it increases the duration an individual is able to live in their own home. Since there is a strong desire from people to live in their own home as long as possible, FPC has the additional advantage of providing people with what they want. Without such services, living "at home" might not be feasible. Economic theory suggests that there will be a certain amount of substitutability between different types of care. Despite this, to date there has been no rigorous empirical research aimed at estimating the degree of substitutability. This seems remarkable since the abolition of FPC may increase the numbers living in care homes. A share of individuals who are unable to remain in their own home without the type of services offered by FPC would move into care homes. The size of this share is a total unknown.

It is important to note that care homes are not "free to all" in Scotland. Individuals with property asset and savings above a minimum (currently £25,000) are required to self-fund their residential care. Such individuals would have an incentive to remain in their own homes even if FPC was withdrawn. It is only those with no property or savings that would find residential care to be "free" and so preferable to privately buying home care. Regardless, the cost to the government is much higher in the care home setting compared to the own-home setting on a "per-head" basis. In our view there has not yet been a careful

study of how large the cost difference to the tax-payer is between the two care settings. However, all estimates we have seen suggest that it is sizeable.

FPC has likely affected the so-called “balance of care” in Scotland. It is government policy to provide a wide range of social, medical and care services outside the institutional setting. It has caused significant organisational changes in the way in which health and social care provision is delivered. That is, changes have likely occurred as a consequence of FPC and not through direct legislation. A key example is the switch in emphasis from hospitals and residential care to “care at home”. This does not imply that hospital and nursing homes are direct substitutes for home care. However, residential care and home care are, at least partially, substitutable. Indirect evidence consistent with this shift includes: (1) the number of “occupied geriatric long stay beds” decreased by 39% between the period 2003 and 2008; (2) The number of “long stay residents aged 65+ supported in care homes” decreased by 4% between 2002/3 and 2009/10; and (3) the number of “NHS delayed discharges within the six week discharge planning period” decreased by 93.2 % between January, 2001 and October, 2010. Further examples can be found in Bell and Bowes (2012). As mentioned above, the population has continued to age in this period so one might expect growth—and not decline—in such indicators. Based on this evidence, it is not unreasonable to hypothesise that FPC has been associated with a shift away from more expensive types of institutional care.

Care Supplied by Family Members

What is noticeable lacking in the discussion above is the role that family members play in providing care. Table 1 presents some estimated care rates calculated from various years of the *BHPS: British Household Panel Survey* (Taylor et al., 2010). It is worth stressing that Scotland, unlike England, Ireland and Northern Ireland (and most other high-income countries), does not have a longitudinal survey of ageing. Therefore, there is no high quality longitudinal data relating to the amount of care provided by family members and care rates must be pieced together from various less than ideal sources (such as the BHPS).

Table 1 Unconditional Care Rates: Percentage Receiving and Providing Care, Scotland

| Age Group: | 65-74 | 75-84 | 85+ | 65+ |
|--|-------|-------|-------|-------|
| (A) Receives care from inside the household from family member (N=3,369) | 8.3% | 12.9% | 17.4% | 11.0% |
| (B) Receives care from outside the household from children (N=1,012) | 39.1% | 43.1% | 36.1% | 40.4% |
| (C) Receives formal care (N=3,369) | 6.1% | 15.7% | 33.8% | 12.7% |
| (D) Provides informal care (N=3,369) | 21.7% | 17.6% | 5.5% | 18.5% |
| <i>Notes: Care inside the household is estimated from British Household Panel Study data 1991 to 2008 for Scotland. Care outside the household is estimated from BHPS data 2001, 2002 and 2006 for Scotland when a question about help from children was asked. Population percentages are shown, with observations weighted using the BHPS longitudinal population weights.</i> | | | | |

Table 1 reports what can be termed the “unconditional” care rates broken down into three age groups estimated from the BHPS. The care rates are simply the percentage receiving care from family members such as a spouse, sibling or children. The data suggest that 12.7% of people aged 65+ receive some form of formal care (either FPC or paid for privately) compared to 40.4% who receive care from children not living with them. In addition, 11.0% receive care from another family member living with them. What is clear from these estimates is that family members contribute a considerable amount of care. These estimates however are simply participation rates and not a measure of the quantity or quality of care provided (e.g. hours spent per week providing care, number of visits per or type of provided). There is a commonly held view that family members provide “more care” than “the state” in Scotland based on participation rates of the type we measure. However, if state care covers more intensive tasks then the state could be providing forms of care not readily available from unpaid carers.

Table 2 reports what can be termed the “conditional” care rates, and selected demographic characteristics, of older households broken down by age group. They are “conditional” in the sense that they are based on the existence of family members of a certain type (e.g. children). The table highlights the role played by spouses in providing care. However, the number of households with spouse present decreases dramatically with age, with almost three-quarters of those households containing an individual aged 85+ being single person household (mainly women). The data suggest that 57.1% receive care from children not living with them. As a general remark, the estimates presented in Table 2 suggest even more strongly that family members—both living and not living with them—are important providers of care.

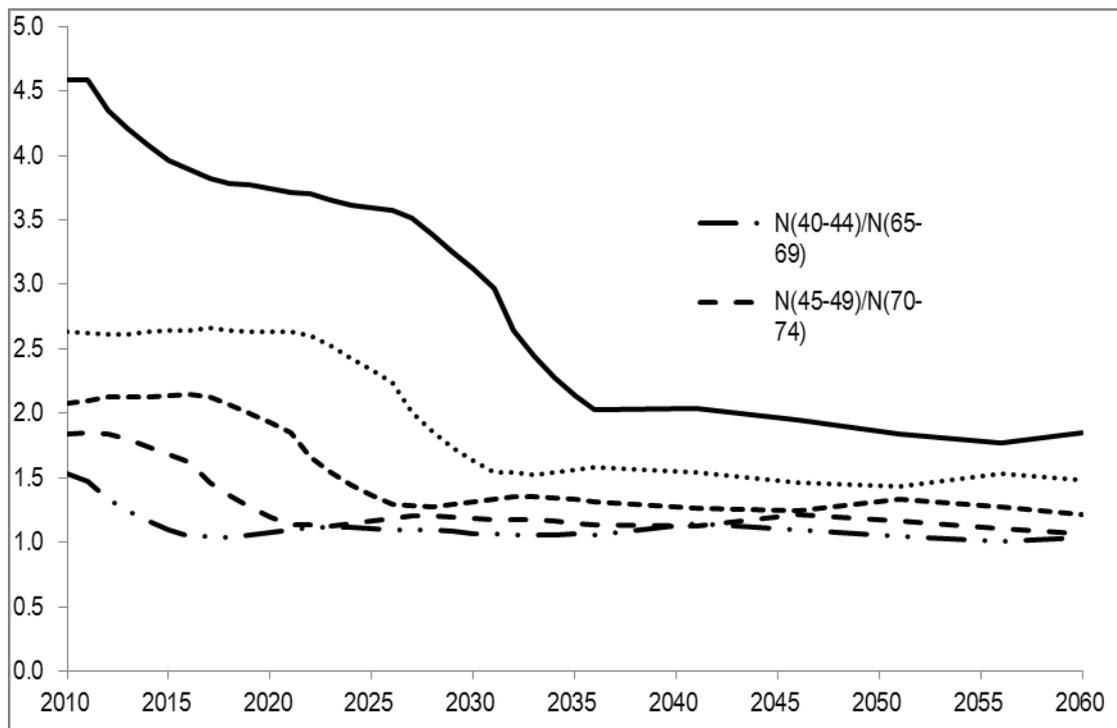
Table 2 Conditional Care Rates: Percentage Receiving Care, Scotland

| Age Group: | 65-74 | 75-84 | 85+ | 65+ |
|--|--------------|--------------|------------|------------|
| Demographic characteristics | | | | |
| Average household size | 1.8 | 1.6 | 1.5 | 1.7 |
| Per cent one-person households | 29.3% | 49.5% | 73.1% | 41.7% |
| Per cent living with spouse | 65.5% | 45.4% | 11.1% | 52.1% |
| Per cent living with children | 6.7% | 4.8% | 14.7% | 6.8% |
| Per cent living with siblings | 1.3% | 0.1% | 0.0% | 0.7% |
| Care rates | | | | |
| (A) Receives care from inside the household from family member (N=1,905) | 11.7% | 25.5% | 64.2% | 18.8% |
| Spouse (N=1,719) | 11.2% | 23.1% | 25.9% | 15.6% |
| Children (N=218) | 8.9% | 28.2% | 95.4% | 33.4% |
| Sibling (N=17) | 28.5% | -- | -- | 32.5% |
| (B) Receives care from outside the household from children (N=1,012) | 52.0% | 63.9% | 59.5% | 57.1% |
| Personal care (N=744) | 0.2% | 2.3% | 4.5% | 1.4% |
| Housework (N=744) | 17.9% | 27.5% | 40.0% | 23.3% |
| Notes: Care inside the household is estimated from British Household Panel Study data 1991 to 2008 for Scotland. Care outside the household is estimated from BHPS data 2001, 2002 and 2006 for Scotland when a question about help from children was asked. Population percentages are shown, with observations weighted using the BHPS longitudinal population weights. | | | | |

Is it reasonable to assume that the significant care contributions that family members make (especially children) will continue into the future? This seems unlikely given demographic patterns. The baby boom generation is both a “large cohort” and “low fertility” generation. What this implies is the potential supply of “children as carers” will plummet. This demographically-determined outcome rarely enters the FPC debate but it is of central importance. Put rather dramatically, relative to the current cohorts of older people, the potential carers of the future were “never born”.

Figure 4 demonstrates the seriousness of this point. The figure shows various population ratios defined as the number of individuals in two age groups separated by 25 years based on the most recent set of population projections (Scottish Government, 2011). For example, the number of people aged 40-44 relative to the number of people age 65-69. In this exercise, we assume that the average age of childbearing is 25, although the average age of child-bearing has increased. Given this assumption, these figures can be thought of as “children-to-parent” ratios or as measures of cohort-specific measure of fertility. For our purposes they represent the maximum potential number of children who can provide care (supply) relative to the maximum number of parents who may need care (demand). As Figure 4 shows, regardless of the combination of age groups considered, the ratio is expected to plummet in the future. In the future there will simply be fewer adult children available to assist in the caring of their elderly parents. This suggest that FPC will become an even more important sources of care services in the future, since for an increasing number of people it will become the only option that will allow them to stay in the their home.

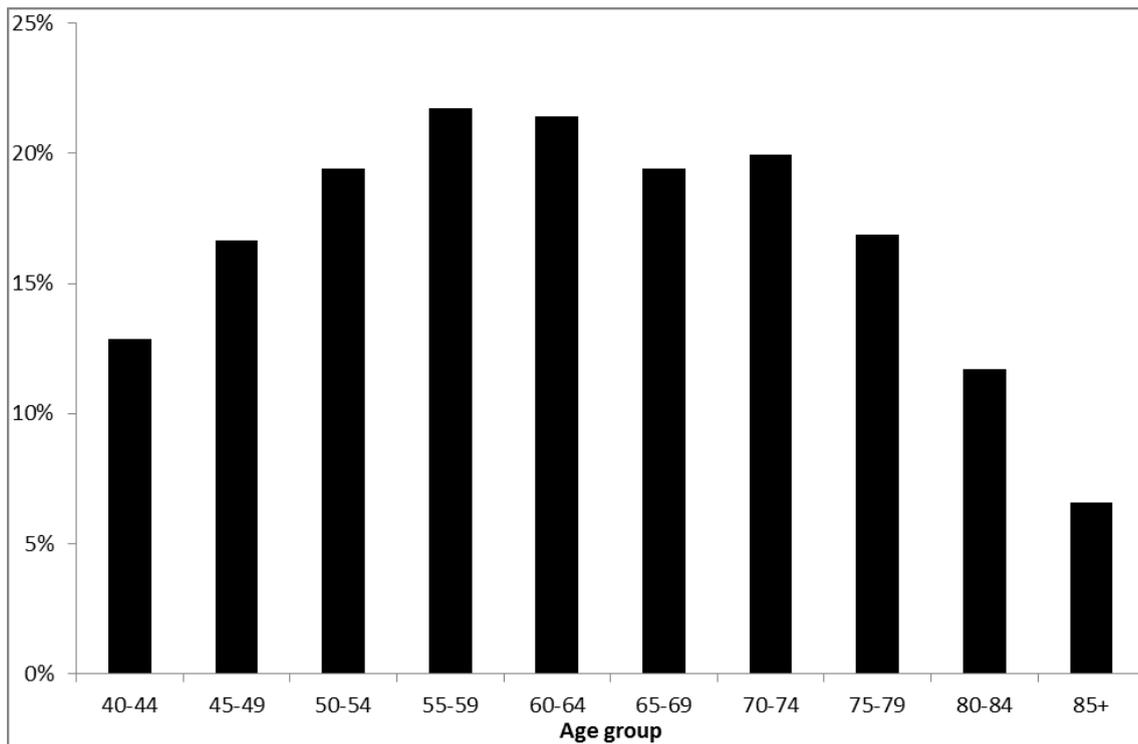
Figure 4 "Children-to-parents" Population Ratios Scotland, 2010-2060



Source: Scottish Government (2011)

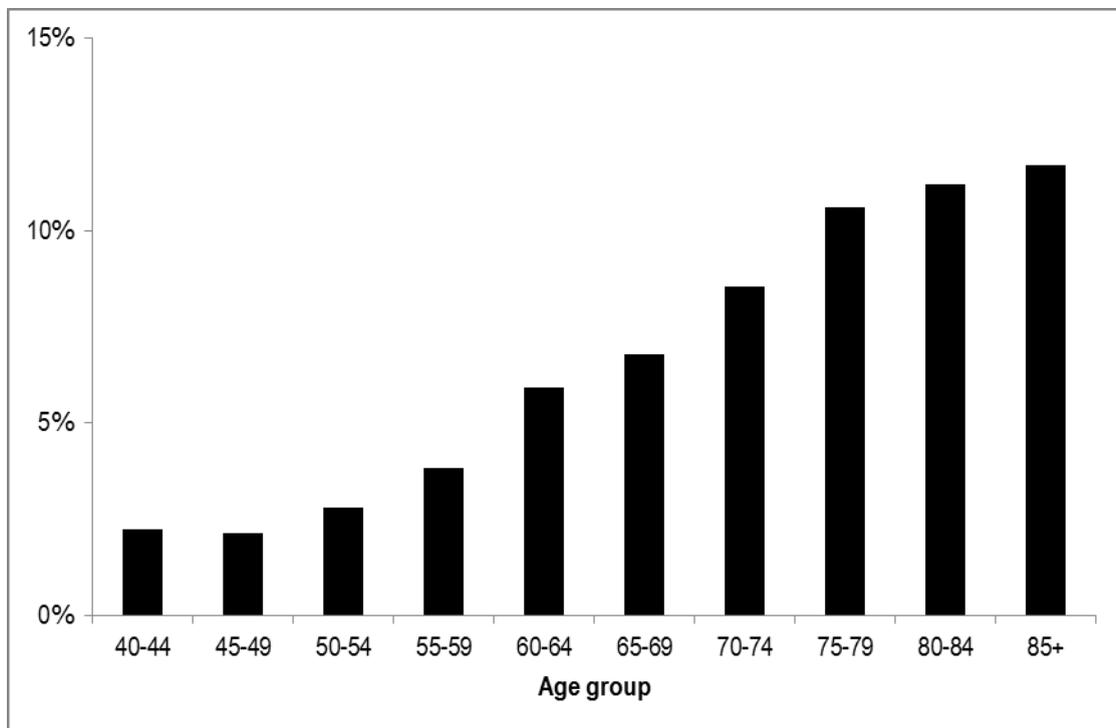
Figures 5 and 6 show the percentages providing and receiving care broken down by age for the UK as a whole, estimated with data from the BHPS. There are simply too few cases in this dataset to generate the analogous Scotland-specific estimates. Figure 5 suggests that there is an inverted U-shaped relationship between age and care provision. The rate peaks in the age range “55 to 64” age range and then drops off considerably. On the other hand, as is suggested in Figure 6, there is a steep upwards sloping relationship between age and receiving care. We have no reason to believe that a similar set of relationships does not exist for Scotland. These figures are consistent with Figure 4, which shows that there is a switchover from those giving care to those receiving care around the age of 65. At this point, unpaid care from younger generations becomes more important.

Figure 5 Percentages Providing Care by Age Group, United Kingdom



Source: BHPS (various years)

Figure 6 Percentage Receiving Care by Age Group, United Kingdom



Source: BHPS (various years)

Concluding Comment

In its current configuration, Free Personal Care for older people is an expensive policy and will become even more expensive in the future as the Scottish population ages. However, this does not mean that it necessarily increases the per-head cost of accommodating the ageing population. It is also likely that if the policy was abolished, there would be a substitution towards more expensive forms of care such as care homes, hospitals and other institutions, at least amongst individuals incapable of self-funding their care. For many elderly Scots, moving into a more formal setting would be their only option. In addition, Scotland's demography is such that in the future there will be fewer adult children available to help care for their elderly parents. It is dangerous to assume that the significant amount of care provided by the current generation of adult children (i.e. the so-called "baby boom") will be replicated by the next generation of adult children (i.e. the so-called "baby bust").

This is not to say that the policy can't be made more cost effective. In fact this must be a priority. For example, this can be achieved by increasing efficiency through economies of scale in service production, competitive tendering in service provision and the privatisation of certain aspects of care delivery. Of course, pursuing such policies is quite controversial. There is a risk that quality of care may be sacrificed, so wellbeing of older people might not be maintained even if costs are driven down.

The overall cost of the policy could be reduced—perhaps substantially—by means-testing, which already takes place for care home funding. This will only be true if the overall cost increase of administering the means-testing is lower than the cost savings made by excluding those with higher levels of savings and/or wealth from the programme. In addition, costs will not be reduced (or reduced less than expected) if means-testing results in a substitution towards more expensive forms of institutional care. Removing the subsidy for home care, while still subsidising residential care, might cause some older people to switch between these forms of care. Both policies would have to be reviewed together. There is some evidence that means-testing increases stigma, which may lead to lower take-up rates, and consequently raises issues relating to fairness and equity.

Finally it is worth stressing that there is a clear preference amongst older people to remain in their homes as "long as possible". For many older people, the transition from their own home to an institution is not an easy one. FPC is a policy that has been instrumental in allowing older people to realise their preferences of living in an environment that is known to them, without causing a significant net increase in the overall costs of care provision when compared with alternative social care policies.

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