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Effects of Free Personal Care Policy in Scotland

EXAMINATION OF TRENDS IN THE USE OF INFORMAL
AND FORMAL CARE AT HOME AND IN RESIDENTIAL
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EFFECTS OF FREE PERSONAL CARE POLICY IN SCOTLAND

Examination of trends in the use of informal and formal care at home and in
residential care

Paul McNamee

King's Fund

This is one of a series of appendices to *Securing Good Care for Older People*. Download full report from www.kingsfund.org.uk/publications

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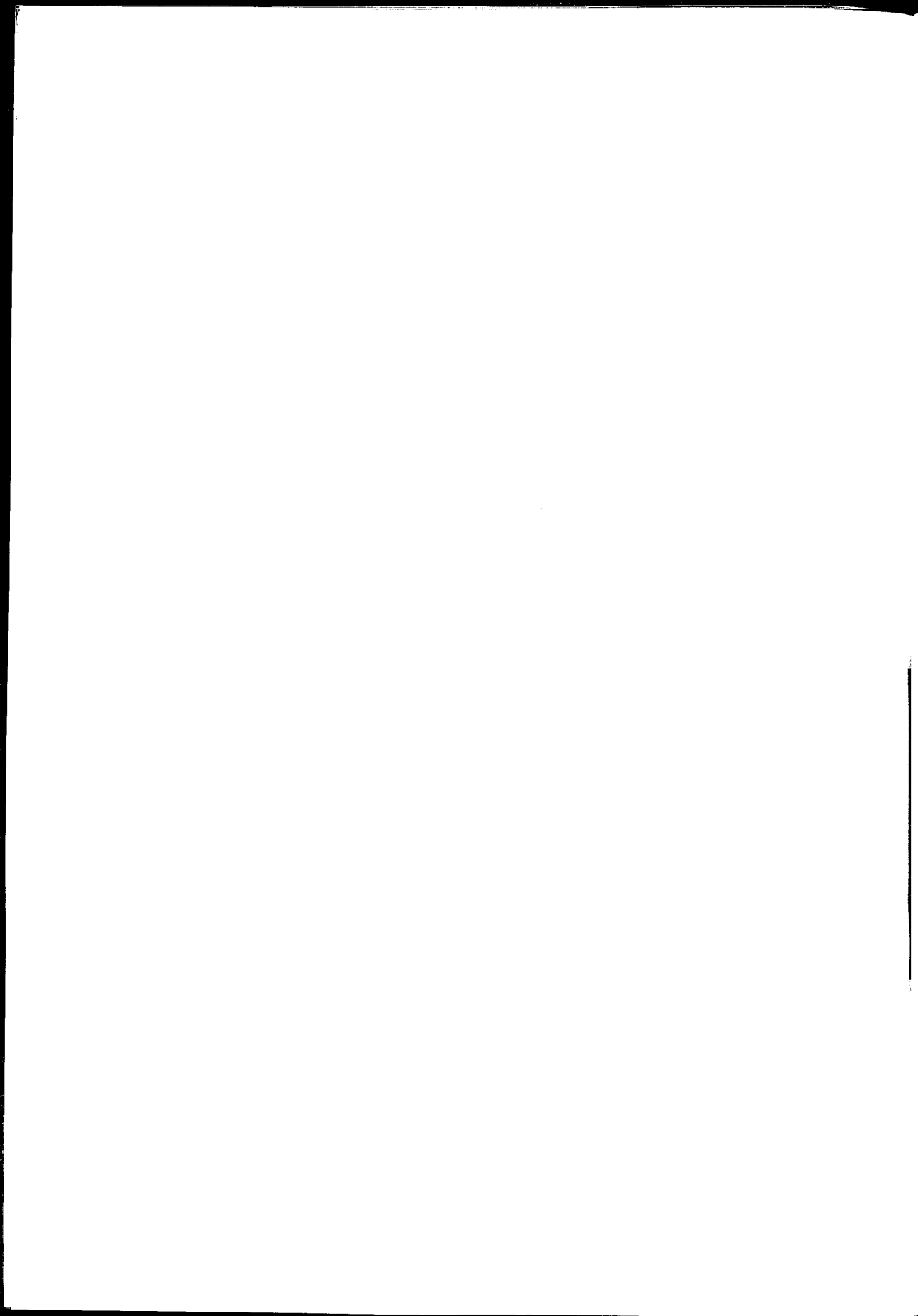
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Summary

- A policy of free personal care (FPC) was introduced by the Scottish Executive in July 2002.
- Possible consequences of a FPC policy are an increase in the demand for formal care at home, an increase in the demand for formal care within care homes and a reduction in the supply of informal care.
- The level of changes in demand and supply may differ according to household income.
- Scottish Household Survey data from 200 to 2004 and Scottish Community Care Statistics from 2001 to 2005 were used to estimate the extent of changes in demand and supply of formal (encompassing both personal and non-personal care) and informal care.
- For all households in which both respondents were aged 65 years or over, there was no evidence of any statistically significant changes in the supply of informal care or in the demand for formal care at home.
- There was some evidence to suggest that amongst households with lower annual incomes, there was a reduction in the likelihood of receiving informal care from other household members after the introduction of FPC.
- There was some evidence to suggest that households with lower annual incomes were less likely to receive local authority or private home care both before and after FPC, and that this effect persisted following the introduction of FPC.
- Lower income households were less likely to receive more hours of local authority home care before the FPC policy, but following the introduction of FPC they were equally as likely to receive more hours as higher income groups.
- There was no major change in trends relating to the number of care homes, or to the number of care home places or residents.
- It is not possible to draw conclusions over the changes in demand for personal care following the policy, as no distinction is made between personal and non-personal forms of care within the Scottish Household Survey.
- The costs associated with policy implementation in the first year were estimated to be £114 million, with substantial variation in costs by local authority area.
- The overall trends observed in changes in the use of informal and formal care are broadly consistent with prior hypotheses.
- Further research is required to ascertain the causal factors associated with differential access to formal care at home according to income.

Introduction

The purpose of this report is to examine trends in the use of informal and formal care provision at home and in the care home sector before and after the introduction of free personal care (FPC) to individuals aged 65 years or over in Scotland from July 2002. In addition, it examines the costs to the Scottish Executive that have arisen following the introduction of FPC.

Background

In order to consider the recommendations of the Royal Commission on Long Term Care (The Royal Commission on Long Term Care 1999) for Scotland, the Scottish Executive Health Department established a Care Development Group in 2001. At that time, means-tested charges were made for personal and nursing care required in care homes. In most cases, means testing also existed for personal care provided in a person's own home.

As a result of the recommendations of the Care Development Group (CDG) (Care Development Group 2001), since July 2002 personal and nursing care has been available without financial charge for everyone in Scotland aged 65 years or over who is deemed to require it, irrespective of whether an individual lives in their own home, in hospital or in a care home.

The implementation of the policy resulted in (Scottish Executive 2005b):

- the provision of payments for personal and nursing care for those aged 65 years or over who were already paying own care costs (self-funders) in care homes on the basis of an assessment of need;
- the provision of personal care services at home without charge to those assessed as requiring them;
- self-funders in care homes paying the remaining living or accommodation costs; and
- those receiving non-personal care services at home paying for them.

Guidance to local authorities on the definition of personal care to be used in the implementation of the FPC policy relates to care provided for the purpose of assistance with personal hygiene, continence management, problems of mobility, eating, preparation of special diets, provision of simple treatments and the provision of memory and safety devices (Scottish Executive 2003). For those living in their own home, eligibility for free personal care is subject to an assessment of need by the local authority, and is made irrespective of income, capital assets, marital status or the care contribution of informal carers. Eligibility for and payment of Attendance Allowance and Disability Living Allowance are not affected. For those in care homes, eligibility results in a payment to the care home of £145 per week for personal care and £65 per week for nursing care. However, individuals deemed eligible no longer receive the Attendance Allowance or the care component of Disability Living Allowance.

Theoretical considerations

Assuming that personal care is a market commodity with the usual characteristics associated with such commodities, it might be expected that a reduction in the price of personal care to current and potential users would be expected to lead to an increase in demand, all other things being equal. There are, however, a number of constraints on such a behavioural response. Fuller consideration of these factors is outlined in a separate report commissioned by the CDG (Machin and McShane 2001). However, three issues are worthy of further attention here.

First, it is important to be aware that the policy change affected only those who paid for personal care at the time of the policy implementation and, subsequent to the implementation, those who would have had to pay for personal care. There is a considerable degree of uncertainty over the size of the latter population, because no national means test existed for personal care provided in a person's own home.

In addition, the supplier of care is an important influence on demand. The probability of using personal care and the consequent level of use is determined to a large degree by local authority social services. It might be expected that were more individuals to request an assessment of need, that is, there is a degree of currently unmet need, there would be more individuals receiving personal care, assuming the same assessment of need continues to be used by local authorities.

Finally, a reduction in price may not lead to a rise in demand in personal care if other forms of support are preferred substitutes for such care. For example, informal care is the largest component of care for most frail older people, and many individuals may continue to prefer to receive such care, rather than substitute it for personal care from a local authority provider or for residence in a care home. In addition, local authority assessments may implicitly consider the availability of informal care in arriving at decisions over the supply of personal care.

Bearing these considerations in mind, five research questions are examined. More specifically, the report considers whether, after July 2002:

- the proportion of people receiving informal care fell
- the average hours of informal care that were received fell
- the proportion of people receiving home care rose
- the average hours of home care that were received rose
- the number of residents in care homes rose.

The hypothesis is that a fall in informal care, together with a rise in home care and the numbers of residents in care homes, would provide evidence to suggest that demand for personal care rose following the introduction of FPC. In addition, changes to the size of the effect of income on care decisions would point towards a particular change in use of informal or formal care. The hypothesis is examined using a non-parametric test of differences before and after implementation of the FPC policy, together with different forms of regression analysis. However, because of the nature of the data sources and the methods used to examine these questions, which are outlined below, it is not possible to attribute any changes with certainty to the implementation of the FPC policy. The final section of the results provides information on overall expenditure.

Data sources and methods

The Scottish Household Survey (SHS)¹ is used to address the first four questions (Martin *et al* 2005).

Briefly, the SHS is a continuous cross-sectional survey of a sample of the general population in private residences in Scotland that commenced in 1999. It is designed to provide nationally representative samples of private households and of the adult population in private households. This is achieved by splitting the interview between a household respondent and an adult selected at random from the permanent residents of the household. The survey uses two different sampling approaches. In areas of high population density (Glasgow, Edinburgh, Aberdeen, Dundee, etc) a simple random sample of dwellings is selected covering the entire two-year sample period. These are subsequently clustered into interviewer allocations. In areas of lower population density, Census enumeration districts are selected with probability proportionate to population.

The survey questionnaire is in two parts. The household section of the interview deals with topics such as household composition, housing and tenure, health, access to the internet, cars available to the household, the occupation and industry of the highest income householder, household income, housing costs and child care. The random adult section deals with individuals' housing change, tenure change, experiences of homelessness and housing problems, neighbourhood problems, transport and use of the internet, public transport, public services, income and employment.

The analyses in this report use data from 2001 through to 2004 for households where both the highest income householder and the random age adult were aged 65 years or over.

The Scottish Community Care Statistics (SCCS) are used to address the final question (Scottish Executive 2005a). The SCCS are based on information collected from local authorities via the Free Personal/Nursing Care Expenditure Return, the Quarterly Monitoring Information Return and the Local Financial Return 3. Data from 2001 to 2005 is used.

Mann-Whitney non-parametric tests are used to consider whether any differences observed pre and post FPC policy are statistically significant. Separate binary logistic regression, multinomial logistic regression and ordinal regression analyses for periods pre- and post-FPC policy are also used to consider the association between socio-demographic and economic factors on care decisions.

Results

The proportion of the sample population in receipt of informal care and other forms of care

There were 15,040 respondent households in which both respondents were aged 65 years or over. Figure 1 below shows that the level and type of informal care received over the two periods was broadly similar in nature (Mann-Whitney significance test of all pre-post differences = 0.90).

Table 1 overleaf shows the determinants of the provision of care types between the two time periods. The exponentiated coefficients can be interpreted by considering whether they are greater or less than one. If less (more) than one, there is a decreased (increased) likelihood of a particular response category relative to the reference category (no care).

1 TYPE OF INFORMAL CARE AND OTHER FORMS OF CARE PROVIDED TO RESPONDENT HOUSEHOLDS

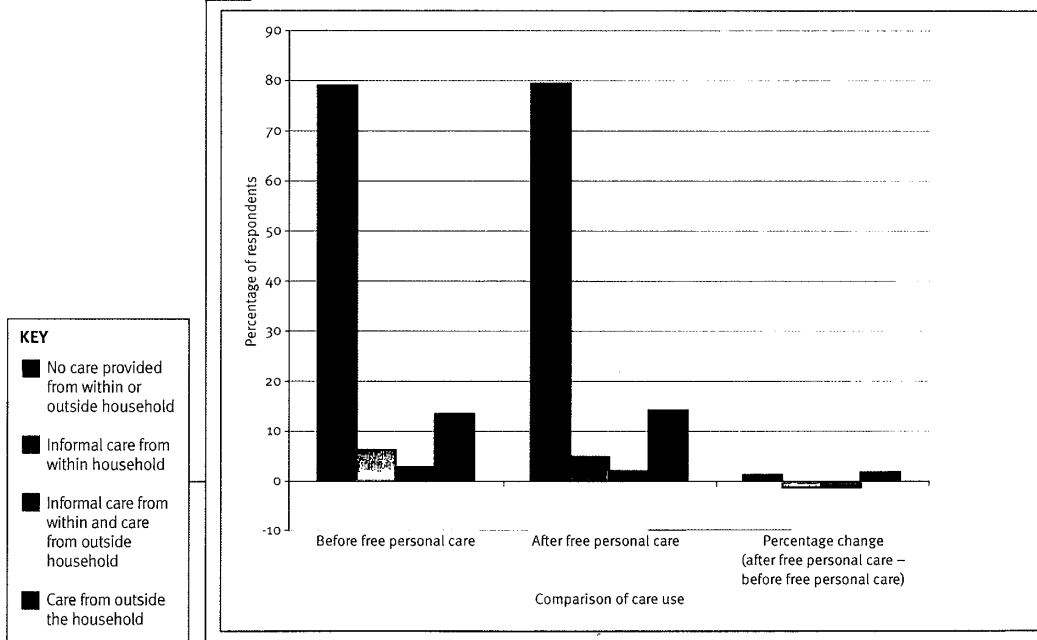


TABLE 1: THE DETERMINANTS OF THE PROVISION OF INFORMAL CARE AND OTHER FORMS OF CARE

Determinants	Pre-free personal care period			Post-free personal care period		
	Informal care from inside household	Informal care from inside and care from outside household	Care from outside household	Informal care from inside household	Informal care from inside and care from outside household	Care from outside household
Age in years	1.04*	1.07*	1.09*	1.02	1.07*	1.09*
Male	0.74	0.97	0.76*	0.82	0.77	0.95
Single/widowed/divorced	0.09*	0.36*	3.58*	0.10*	0.14*	3.33*
Not finding 3-5 ADLs difficult	0.32*	0.22*	0.09*	0.25*	0.21*	0.09*
Not finding 6+ ADLs difficult	0.08*	0.04*	0.03*	0.09*	0.04*	0.03*
Home not owned outright	1.71*	1.57*	1.71*	1.34*	1.59*	1.68*
Net annual income £0-£6,000	0.74	0.68	0.74	0.62	0.27*	0.63*
Net annual income £6,001-£10,000	1.15	0.85	1.09	0.71	0.29*	1.03
Net annual income £10,001-£15,000	2.02*	1.18	1.60	1.09	0.52*	1.28
Net annual income £15,001-£20,000	1.99*	1.51	0.82	1.22	0.72	1.18
χ^2 statistic (significance)	2,233 (0.01)			3,560 (0.01)		
Mcfadden pseudo R ²	0.30			0.30		

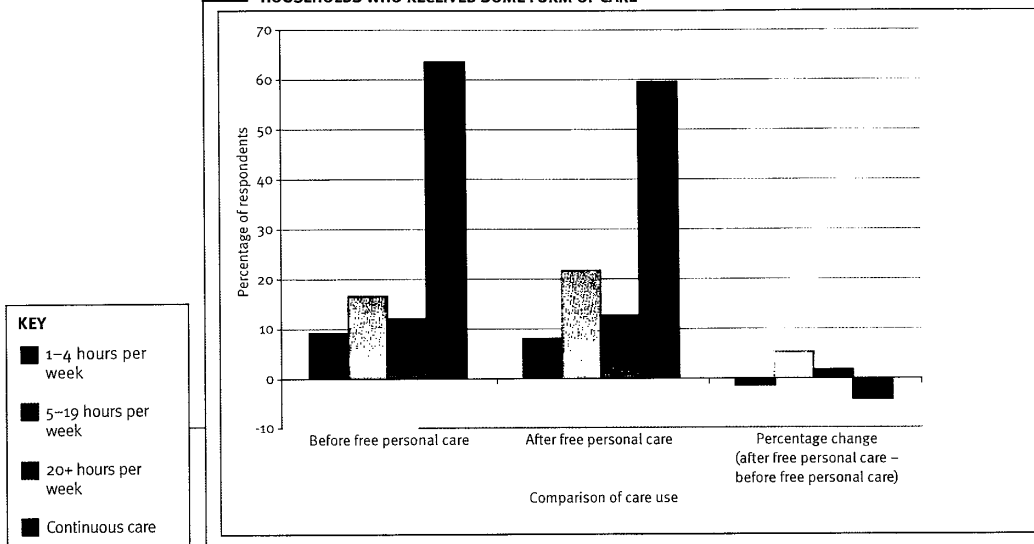
* Indicates $p < 0.05$.

A higher age is shown to be associated with the receipt of some form of care relative to no care. Single/widowed/divorced is found to be associated with a lower likelihood of informal care from within the household relative to no care, but a higher likelihood of care from outside the household. A better health state, that is, not finding activities of daily living difficult, decreased the likelihood of receiving informal care. Individuals who did not own their own home outright were more likely to receive some care rather than no care. A higher income was associated with a higher likelihood of receiving some form of informal care from within the household. In terms of changes in the sign or magnitude of coefficients across the two periods, there did not appear to be major differences. The only exception to this relates to income. It appears that the likelihood of provision of informal care from within the household is no longer dependent on income in the post-FPC period. In addition, for 'mixed care' (informal care from within and care from outside the household), poorer groups are now less likely to have this form of care in the post-FPC period.

Hours of informal care and informal/formal care per week for those who received some form of care

Figures 2 and 3 respectively indicate the hours of informal care time per week provided by household members and the hours of combined informal and formal care time provided per week by non-household members. It is not possible using SHS data to estimate separately the informal care hours provided by non-household members. There are no

2 HOURS OF INFORMAL CARE TIME PER WEEK PROVIDED BY HOUSEHOLD MEMBERS TO RESPONDENT HOUSEHOLDS WHO RECEIVED SOME FORM OF CARE



significant differences between the two periods (Mann-Whitney significance test of all pre-post differences = 0.28 and = 0.63 respectively). The greatest changes related to informal care time provided by household members, with an increase in the proportion of respondents receiving between 5-19 hours per week (up by 4.5 per cent) and a reduction in the proportion of respondents receiving continuous care (down by 4.1 per cent).

3 HOURS OF INFORMAL AND FORMAL CARE TIME PER WEEK PROVIDED BY NON-HOUSEHOLD MEMBERS TO RESPONDENT HOUSEHOLDS WHO RECEIVED SOME FORM OF CARE

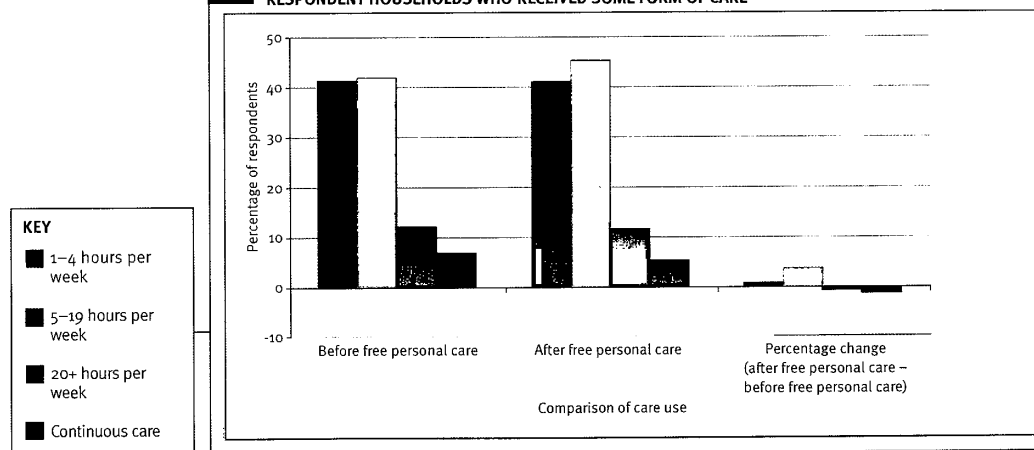


TABLE 2: THE DETERMINANTS OF THE HOURS OF INFORMAL AND FORMAL CARE TIME AMONG CARE RECEIVERS

Determinants	Pre-free personal care period		Post-free personal care period	
	Informal care hours provided by household members	Informal and formal care hours provided by non-household members	Informal care hours provided by household members	Informal and formal care hours provided by non-household members
Age in years	0.00	-0.01	-0.01	-0.01
Male	0.00	0.09	0.08	0.04
Single/widowed/divorced	-0.99*	0.06	-0.50*	0.03
Not finding 3-5 ADLs difficult	0.12	-0.12	0.34*	-0.06
Not finding 6+ ADLs difficult	-0.09	-0.65*	-0.01	-0.50*
Home not owned outright	-0.12	0.10	-0.10	0.09
Net annual income				
£0-£6,000	-0.43	0.01	-0.23	0.06
Net annual income				
£6,001-£10,000	-0.21	0.01	-0.11	0.00
Net annual income				
£10,001-£15,000	-0.09	0.06	0.03	0.06
Net annual income				
£15,001-£20,000	-0.13	0.24	0.07	0.16
χ^2 statistic (significance)	75.17 (<0.01)	62.04 (<0.01)	43.73 (<0.01)	72.80 (<0.01)
McFadden pseudo R ²	0.08	0.03	0.03	0.02

* Indicates $p < 0.05$.

Table 2 above shows the determinants of the amounts of informal care time and informal/formal care time amongst care receivers across the two time periods. Interpretation of the coefficients can be made by considering whether they are positive or negative. If negative (positive), there is a decreased (increased) likelihood of being in the higher response category.

Marital status and activities of daily living are found to be significant predictors of the hours of care. Respondents who were single, widowed or divorced were less likely to receive more hours of care per week from household members. Similarly, respondents who were healthier (who did not have six or more problems with activities of daily living) were less likely to receive more hours of care per week from non-household members. The post-FPC period was associated with a reduction in the absolute magnitude of these coefficients, indicating a weakening of the effects of these variables.

The proportion of the sample population in receipt of home care

Figure 4 considers the proportion of respondent households who received home care and the form of home care received. It appears that there is little change across time in these proportions (Mann-Whitney significance test of all pre-post differences = 0.13).

4

THE PROPORTION OF RESPONDENT HOUSEHOLDS WHO RECEIVED HOME CARE AND THE TYPE OF HOME CARE RECEIVED

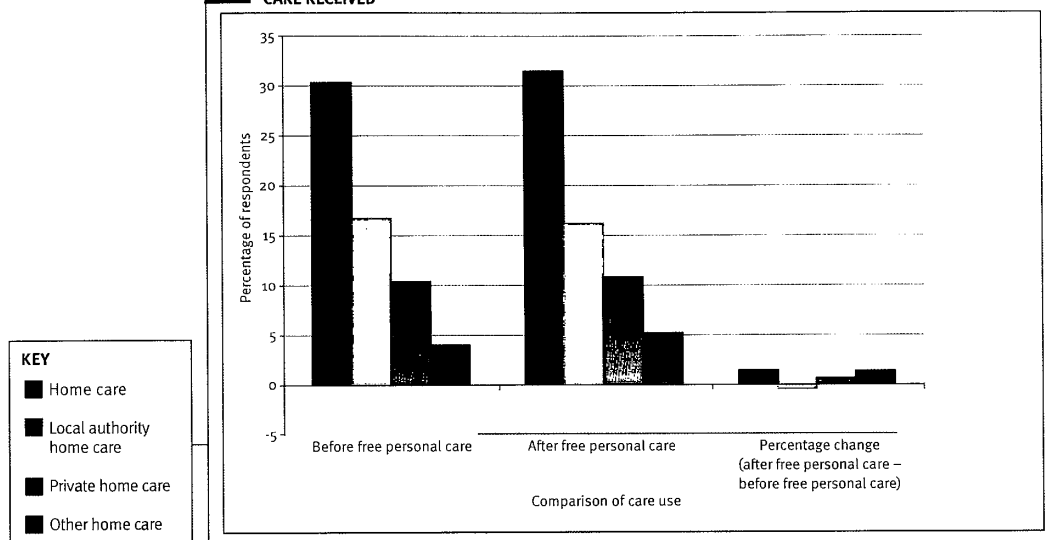


TABLE 3: THE DETERMINANTS OF THE PROVISION OF HOME CARE

Determinants	Pre-free personal care period		Post-free personal care period	
	Receipt of local authority or private home care	Receipt of local authority and not private home care	Receipt of local authority or private home care	Receipt of local authority and not private home care
Age in years	1.10*	1.01	1.11*	1.02*
Male	1.11	0.97	1.22*	1.38*
Single/widowed/divorced	4.61*	1.23	4.35*	1.26
Not finding 3-5 ADLs difficult	0.33*	1.16	0.33*	0.92
Not finding 6+ ADLs difficult	0.14*	0.65*	0.13*	0.49*
Home not owned outright	0.84	2.09*	0.99	1.86*
Net annual income £0-£6,000	0.47*	5.34*	0.25*	4.14*
Net annual income £6,001-£10,000	0.46*	5.37*	0.36*	3.22*
Net annual income £10,001-£15,000	0.60	4.13*	0.38*	2.36*
Net annual income £15,001-£20,000	0.40*	3.40	0.35*	2.13*
χ^2 statistic (significance)	641.04 (<0.01)	49.09 (<0.01)	1,206 (<0.01)	105.03 (<0.01)
Nagelkerke pseudo R^2	0.36	0.09	0.36	0.10

* Indicates $p < 0.05$.

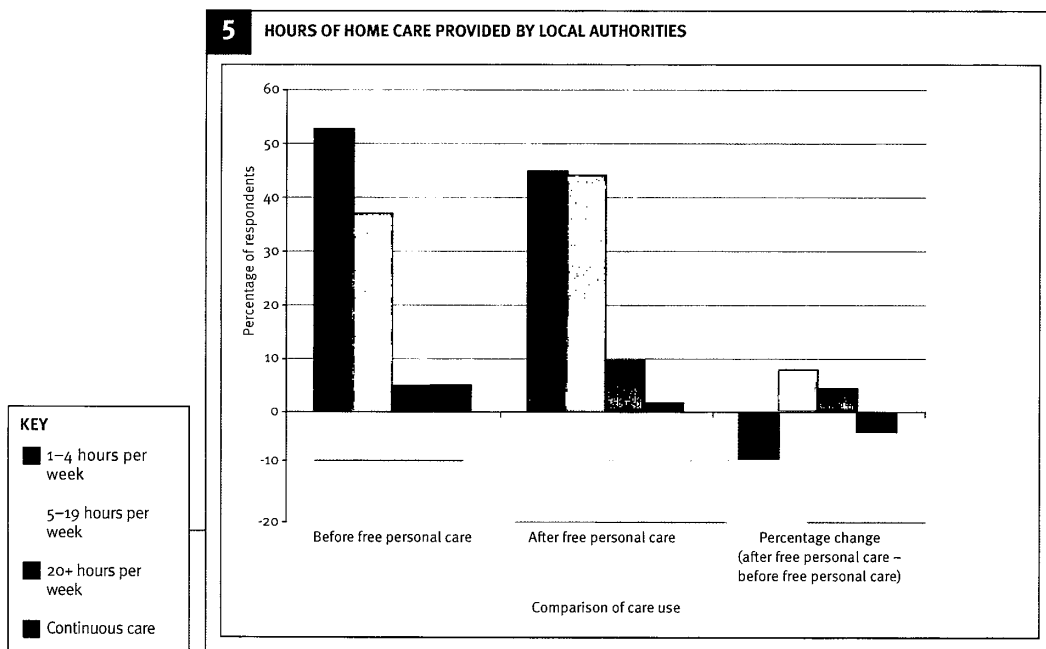
Table 3 provides an indication of the relationship between socio-demographic, health and economic variables and the provision of home care. The exponentiated coefficients can be interpreted by considering whether they are greater or less than 1. If less (more) than one, there is a decreased (increased) likelihood of the response category relative to the reference category (no home care, or not private home care).

In terms of receipt of public or private home care, older respondents, together with single, widowed, or divorced respondents, are more likely to be in receipt of home care. A better health state, that is, not finding activities of daily living difficult, decreased the likelihood of receiving home care. Relative to the reference category of the highest net annual income of more than £20,000, those on lower incomes were less likely to receive home care. For public home care relative to private home care, those respondents who did not own their own home, together with those with net annual income of less than £20,000, were more likely to receive public home care than private home care.

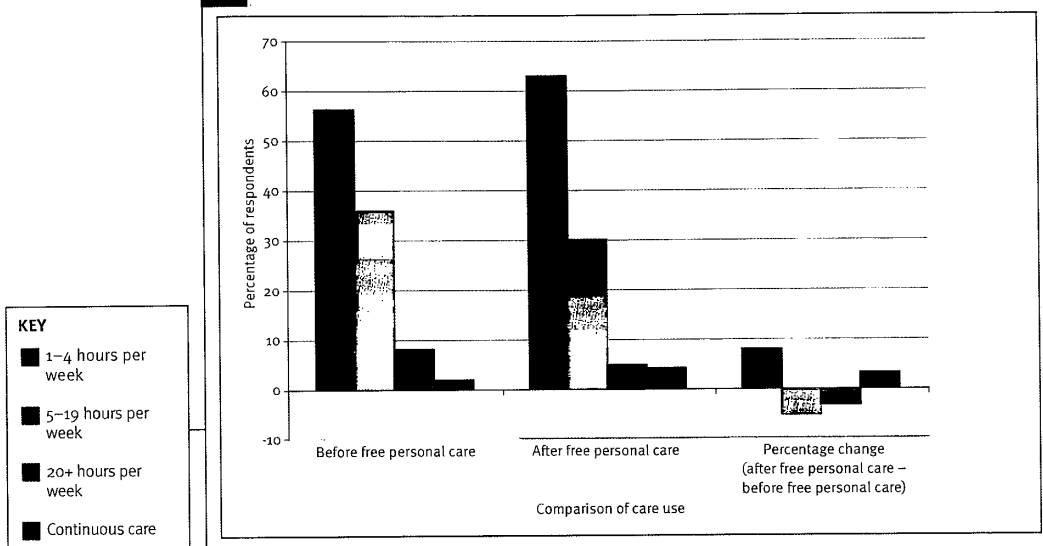
For changes between the two time periods, the main changes were a reduction in the magnitude of the home ownership and income coefficients. This suggests a further reduction in the likelihood of receiving home care, and a weakening of the income effect relating to the likelihood of receiving public as opposed to private home care.

Hours of home care per week for those who received some form of care

Figures 5 and 6 provide information on the weekly hours of public and private home care.



6 HOURS OF PRIVATE HOME CARE PROVIDED TO RECIPIENTS



There was a trend for more hours of public home care to be provided after the FPC policy, although this did not reach levels of conventional statistical significance ($p=0.06$). There was no significant difference in the number of hours of private home care ($p=0.32$).

TABLE 4: DETERMINANTS OF THE HOURS OF LOCAL AUTHORITY AND PRIVATE HOME CARE

Determinants	Pre-free personal care period		Post-free personal care period	
	Local authority	Private	Local authority	Private
Age in years	0.01	0.00	0.02*	0.01
Male	0.22	-0.84	-0.06	-0.29
Single/widowed/divorced	0.50	0.03	-0.14	0.13
Not finding 3-5 ADLs difficult	-0.19	-0.21	-0.40*	0.17
Not finding 6+ ADLs difficult	-1.27*	-0.98	-0.98*	-0.35
Home not owned outright	-0.36*	0.26	0.02	-0.14
Net annual income £0-£6,000	-1.69*	0.04	-0.41	0.31
Net annual income £6,001-£10,000	-1.51*	-0.04	-0.18	-0.15
Net annual income £10,001-£15,000	-1.27	0.05	-0.37	-0.20
Net annual income £15,001-£20,000	-1.97*	-0.35	-0.05	-0.18
χ^2 statistic (significance)	62.75 (<0.01)	14.42 (0.15)	678.57 (<0.01)	252.43 (0.31)
McFadden pseudo R^2	0.13	0.10	0.06	0.04

* Indicates $p < 0.05$.

Table 4 indicates that the main determinants of hours of public care related to difficulties with activities of daily living and income. Those respondents who were healthier (who did not have problems with activities of daily living) were less likely to receive more hours of care per week. Similarly, relative to a net annual income of more than £20,000, those on lower incomes were less likely to receive more hours of public home care. However, after the implementation of FPC, the income effect was no longer significant.

Changes in the numbers of care homes, places and residents in care homes

Using information from Scottish Community Care Statistics (Scottish Executive 2005a), Table 5 shows that between March 2001 and March 2005:

- the number of care homes fell by 5.5 per cent from 1,037 to 980
- the number of registered places in care homes rose by 0.1 per cent from 38,285 to 38,327
- the number of residents in care homes fell by 2.3 per cent from 34,382 to 33,589
- the occupancy rate fell from 89.8 per cent to 87.6 per cent.

The pattern of change in care home places between March 2001 and March 2005 differs between sectors (Table 6):

- the number of care home places in the local authority and voluntary sectors fell by 3.3 per cent and 2.4 per cent respectively
- however, the number of places in the private sector rose by 1.3 per cent.

TABLE 5: TRENDS IN THE CARE HOME SECTOR, 2001 TO 2004

	March 2001	March 2002	March 2003	March 2004	March 2005	Change in number (%)
Number of homes	1,037	1,018	995	988	980	-57 (-5.5)
Number of places	38,285	38,051	37,847	38,166	38,327	+42 (+0.1)
Number of residents	34,382	34,517	34,251	34,081	33,589	-793 (-2.3)

Note: The data on care homes from 2001 onwards are not directly comparable with data on residential and nursing homes for earlier periods (1990–2000). During the 1990s, data on dual registered homes were sometimes included in the figures for both residential and nursing homes. This led to an element of double counting, thus inflating the overall care home capacity figures. It is therefore not appropriate to make earlier comparisons.

TABLE 6: CHANGES IN THE NUMBER OF CARE HOME PLACES BY SECTOR, 2001 TO 2005

Sector	Number of care home places		Change in number (%)
	March 2001	March 2005	
Local authority	6,051	5,849	-202 (-3.3)
Private	27,612	27,965	+353 (+1.3)
Voluntary	4,622	4,513	-109 (-2.4)
Total	38,285	38,327	+42 (+0.1)

Table 7 shows the changes in the number of care homes between March 2001 and March 2005:

- in the local authority sector 19 homes closed while 13 new homes were opened
- in the private sector 72 homes closed while 30 new homes opened
- in the voluntary sector 16 homes closed while 8 new homes opened.

TABLE 7: CHANGES IN THE NUMBER OF CARE HOMES BY SECTOR, 2001 TO 2005

Sector	Closures	New homes	Net change
Local authority	19	13	-6
Private	72	30	-42
Voluntary	16	8	-8
Total	107	51	-56

A total of 107 care homes closed over this period, with 51 new homes opening. However, overall there was no significant change in the number of places because the reduction in the number of care homes was largely offset by an increase in the average size of care homes. Table 8 shows the change in the size of care homes by sector between March 2001 and March 2005. This shows that:

- there was no significant change in the average size of local authority homes
- the average size of voluntary homes increased by 2.7 per cent, while there was a more substantial increase of 7.9 per cent in the average size of private sector homes.

TABLE 8: CHANGES IN THE AVERAGE NUMBER OF PLACES IN CARE HOMES BY SECTOR, 2001 TO 2005

Sector	Average number of care home places		Change (%)
	March 2001	March 2005	
Local authority	31.7	31.6	-0.3
Private	40.3	43.5	+7.9
Voluntary	28.9	29.7	+2.7
Total	36.9	39.1	+6.0

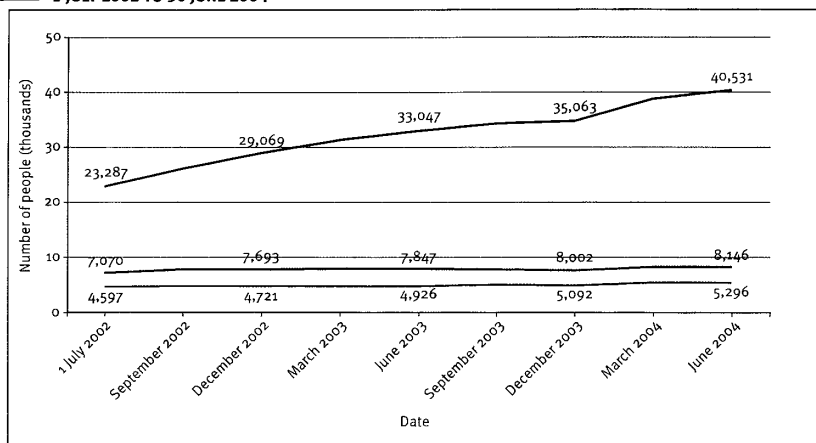
The larger size of care homes in the private sector, compared with both the local authority and voluntary sectors, and the continuing rise in this figure in recent years, may reflect the greater financial incentives for private providers to take advantage of the economies of scale associated with larger homes.

Overall cost implications

Information available from Scottish Community Care Statistics (Scottish Executive 2004) indicated that over the period 1 July 2002 to 30 June 2004:

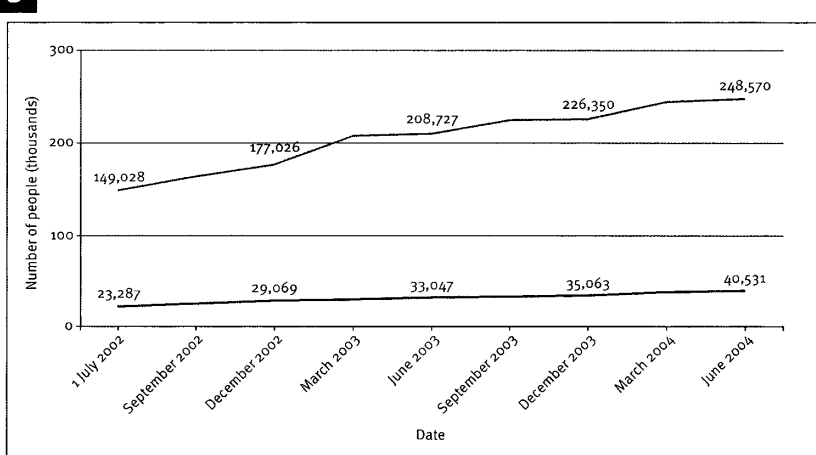
- the number of people receiving free personal care in a care home increased by 15 per cent

7 NUMBER OF PEOPLE RECEIVING FREE PERSONAL CARE AND NURSING CARE, BY LOCATION OF PROVISION, 1 JULY 2002 TO 30 JUNE 2004



Source: Scottish Executive, 2004

8 NUMBERS OF RECIPIENTS OF FREE PERSONAL CARE AT HOME AND THE CARE HOURS RECEIVED



Source: Scottish Executive, 2004

- the number of people receiving free nursing care increased by 15 per cent
- the number of people in receipt of free personal care at home increased by 74 per cent.

Figure 7 indicates the change in absolute numbers. Figure 8 shows that the number of hours of free personal care received by clients at home increased by 67 per cent between the implementation of the policy and June 2004.

From this, it is estimated that over the period 1 July 2002 to 31 March 2003:

- expenditure on free nursing care for care home residents was £12.1 million.
- expenditure on free personal care for care home residents was £42.1 million
(expenditure on free personal care for home care clients was £71.9 million)
- the total expenditure on free personal care therefore amounted to £114 million.

Expenditure on free personal care in a care home per 1,000 population aged 65 years or over varied across different parts of the population. Expenditure was greatest in Perth & Kinross at £105,000 and, excluding Shetland, lowest in North Lanarkshire at £14,000. Average expenditure was £52,000 per 1,000 population.

Expenditure on free personal care at home per 1,000 population aged 65 years or over was greatest in Glasgow at £157,000 and, excluding Shetland, lowest in Argyll & Bute at £48,000. Average expenditure was £88,000 per 1,000 population.

Discussion and conclusions

Free personal social care (FPC) for individuals ages 65 or over was introduced in Scotland in July 2002. This report considered the effects of the introduction of FPC on trends in the use of informal and formal care provision at home and in the care home sector. In addition, it examined the costs to the Scottish Executive that arose following the introduction of FPC.

Overall, there is evidence to suggest that implementation of the policy was associated with no statistically significant change in the use of informal or formal care at home, together with no major change in the care home sector. However, there was some evidence of small changes in informal and formal care use, along with small changes in the number of care home places and residents. Moreover, the analysis did reveal some changes in the determinants of care decisions.

First, following the implementation of policy, it appeared that the likelihood of informal care being provided from within the household was less dependent on income. Before the implementation of the policy, relative to those with a net annual income of £20,000 or more, those with a net annual income of between £10,000 and £20,000 were more likely to receive informal care from other household members rather than no care. In addition, after the implementation of the policy, poorer groups were less likely to receive 'mixed care' (informal care from within and care from outside the household).

Holding all other variables constant, the first effect is consistent with the prior hypothesis of a reduction in informal care. The second effect is more difficult to interpret, as it is impossible to know whether the change relates to informal care from within the household or care from outside the household. If it relates to informal care, this is also consistent with the prior hypothesis of a reduction informal care, everything else being equal.

Second, following the implementation of policy, the effect of income on decisions about home care remained; the effect was slightly stronger for any form of home care, but weaker for local authority care relative to private care. Prior to the implementation of the policy, relative to those with a net annual income of more than £20,000, those on lower incomes were less likely to receive home care (local authority and private). Following the implementation of the policy, they continued to remain less likely to receive home care. In contrast, they were more likely to receive local authority home care relative to private home care. Following the policy, they remained more likely to receive local authority care, but less so.

The first income effect appears puzzling, as it might be expected that those on lower incomes would be more likely to receive home care. However, prior to the introduction of FPC, it may be explained by differential charging policies and the inclusion of both public

and private home care. Following the introduction of FPC, one might have expected to see the income coefficient increase and become closer to one. A reduction in the magnitude of the income coefficients instead suggests that those with income of greater than £20,000 are slightly more likely to receive public or private home care. This is consistent with a shift in public resources from lower to higher income groups, which was an argument made by the 'splinter group' in the Royal Commission. However, the higher income groups were no longer more likely to receive more hours of local authority home care.

The Scottish Household Survey was used to provide estimates of these effects. However, the survey is not designed to address changes in formal and informal care separately, nor is not possible to discern whether personal or non-personal care is provided within the definition of home care. For that reason, it is difficult to draw firm conclusions over the changes in demand for personal care following the policy. Further work should consider the use of alternative data sources, such as the Family Resources Survey.

In addition, it should be noted that the regression estimation methods in this report do not explicitly consider the possibility that informal care is endogenously related to formal care decisions, and vice versa. If this is the case, then the effect of the socio-demographic and economic variables on informal and formal care decisions may have been overestimated, through the omission of a significant variable. This is particularly the case in the analyses relating to care provided by non-household members, where it is not possible to separate informal from formal care. To address these concerns, further research using alternative data sources and different estimation methods would be required.

There was a small reduction in the level of support offered by the care home sector, which is inconsistent with the prior hypothesis. However, these changes may be determined by a number of other policy initiatives operating in the direction of a reduced supply. In addition, the creation of additional demand through the reduction in charges is possibly much weaker for care home admissions relative to home care decisions, as care at home is likely to be a preferable option for the majority of people. In addition, as the Attendance Allowance and care component of Disability Living Allowance are withdrawn following admission to a care home, the overall financial effect may be broadly neutral.

The costs to the Scottish Executive in the first year of the implementation of the policy totalled £114 million. There is no data relating to other years of the policy. However, this estimate masks substantial variation across local authority areas. This may reflect differences between local authorities in the balance of care services provided for older people. For example, a local authority may have a small amount of expenditure relating to free personal care for people in care homes, as it provides more home care to support people in their own homes. It may also reflect other unmeasured influences on the use of home care and care homes, such as relative deprivation.

In conclusion, bearing in mind the caveats surrounding the use of the SHS to examine the research questions, the trends observed in changes in the use of informal and formal care are broadly consistent with the prior hypotheses. The association between lower household income and a reduced likelihood of home care is however suggestive of differential take-up of free personal care. Further research would be required to determine the causal factors and whether this apparent effect persists once these factors are accounted for.



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