CHAPTER 5

FREE PERSONAL CARE IN SCOTLAND, (ALMOST) 10 YEARS ON

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Introduction

The structure of long-term care finance in the UK is characterized by a multiplicity of funding streams, conflicts over responsibility for care, and incomplete insurance. This results in genuine hardship for those that are unlucky enough to have no "safety net" to meet the costs of their care. Over the last two decades, there has been considerable pressure to find a better solution—to get from "here to there." But, progress has been limited.

Since 1998, the process of devolution has led to the establishment of a new parliament in Scotland and assemblies in Wales and Northern Ireland. These 'devolved bodies' control a variety of policy areas, including the delivery of health care and long-term care (Bell 2010). They have used these powers to develop different long-term care policies.

Unlike US states, the devolved bodies have virtually no fiscal powers and therefore cannot use tax revenues to fund improvements in long-term care. They also have no powers to regulate financial markets and therefore cannot directly influence the private market for long-term care insurance. Financial regulation is entirely a matter for the UK government. So is the social security system, which, as we shall see, plays an important role in supporting those with long-term care needs.

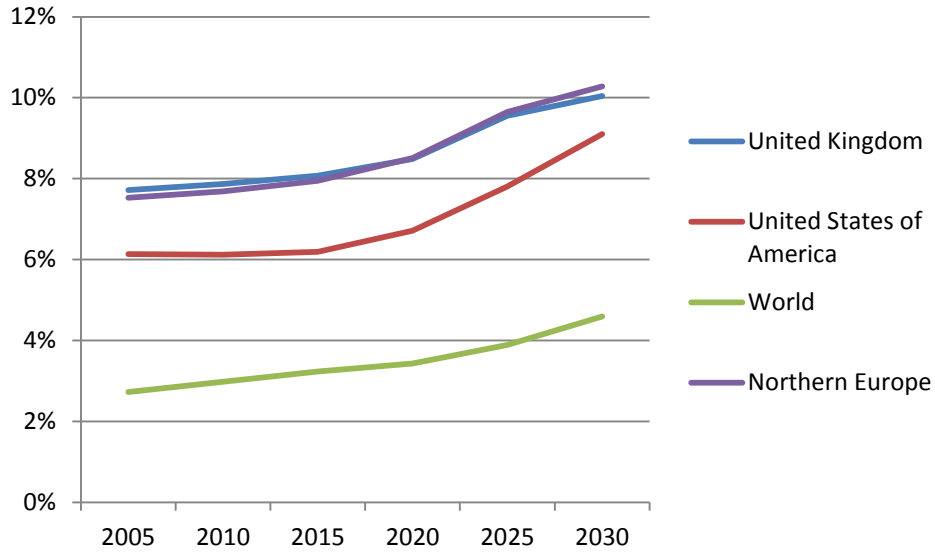
But devolution has allowed differences to emerge in the delivery mechanisms for long-term care across the constituent nations of the UK. This chapter focuses on one of the major differences that has emerged since devolution—the provision of free personal care to older people in Scotland.

We begin the chapter by describing the demand and supply of long-term care for older people in the UK. We then discuss long-term care financing in the UK, focusing on its recent history and on current efforts to "move it to a better place". There are similarities with the US system, but also some important differences. Finally, we describe the costs and benefits of the provision of free personal care in Scotland and distil some lessons for a US audience.

Organization of Long-Term Care in the UK

Like many countries, the UK has an ageing population. Figure 1 shows that by 2030, around 10 percent of the UK population will be aged 75+. For the UK, this implies a 47 percent increase among this age group over the next 30 years, while for the US, the increase in the proportion of the population aged 75+ the increase will be 81 percent. Figure 1 shows that the demography of the UK is similar very similar to that of the rest of Northern Europe. Although the US currently has a much lower share of those aged 75+, it is expected to catch up with Northern Europe over the next 30 years. And while the proportion of the world's population aged 75+ will almost double by 2030, it will still be less than half of the share in Northern Europe.

Figure 1: Population Aged 75+ As a Share of Total Population 2010-2040



Source: United Nations Population Division (2011).

From a UK population of 61.8 million in 2009, there were 4.8 million aged 75+ (See Table 1). England is the largest part of the UK, accounting for 83.8 percent of the UK population and an almost identical share of those aged 75+. Table 1 also shows that Scotland and England have a very similar share of population aged 75+, the age group most likely to require long-term care.

Figure 2 shows recent estimates of years of poor health and of disability in different parts of the UK. Northern Ireland and Wales have generally higher levels of poor health and disability than Scotland and England. Whereas the average woman in

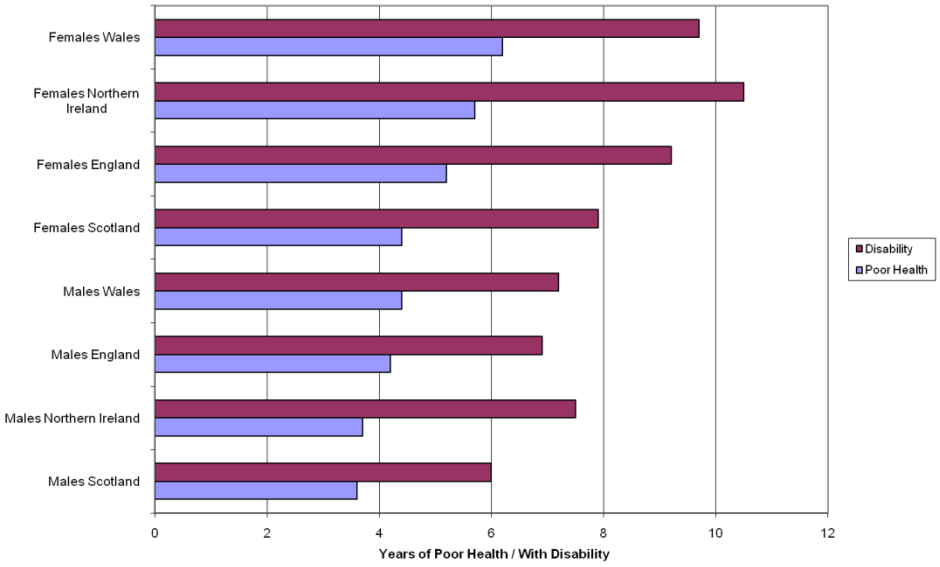
Northern Ireland can expect to experience 15 years of disability, males in Scotland are disabled on average for only six years. In Scotland and England, expected periods of ill health/ disability are roughly equal. The broadly similar levels of disability in Scotland and England reduce one major source of variability when comparing policy outcomes.

Table 1: UK Population 2009

Population	United Kingdom	England	Scotland	Wales	Northern Ireland
Total	61,792	51,810	5,194	2,999	1,789
Share of UK	100.00%	83.80%	8.40%	4.90%	2.90%
Aged 75+	4,820	4041.2	399.9	257.9	114.5
Share of UK	100.00%	83.80%	8.30%	5.40%	2.40%

Source: Office of National Statistics (2008).

Figure 2: Expectation of Years of Health and Years of Disability, UK Nations



Source: Office of National Statistics (2008).

In the UK, long-term care is provided in a variety of residential settings, including clients' own homes. Care homes typically cater for those with greater needs. Care homes are provided by the private sector, voluntary and charitable organizations and local government. In England in 2009, 8.6 percent of places were provided directly by local authorities. In Scotland, 16.9 percent of care home places for those aged 65+ were provided by local authorities in 2009. Although the local authority share in Scotland has been falling, local authorities themselves provide relatively more care home places than in England. This may reflect Scotland's greater historic reliance on public sector solutions to care provision.

The cost of providing long-term care is shared between the private and public sectors. In the public sector, long-term care is largely the responsibility of local government. In the UK, local government only raises around 20 percent of the money that it spends. The remainder comes from grants. The bodies that provide grant aid to local authorities[1] are therefore in a powerful position to influence their long-term care policies. Rather confusingly, the relevant grant-providing body to local authorities in England is the UK Parliament; in Scotland, it is the Scottish Parliament, while in Wales and Northern Ireland, it is their respective Assemblies. And Northern Ireland is an exception in that its local authorities do not manage long-term care. Instead, the Health and Social Care Board, which was established in 2009, manages health and social care services jointly across Northern Ireland. It receives around £4bn annual funding directly from the Northern Ireland Assembly.

The Organisation for Economic Co-operation and Development (OECD) estimates that in 2000, the UK and USA spent broadly similar amounts on long-term care—1.37 and 1.29 percent of GDP respectively (see Table 2). In one sense, this is surprising. The latest OECD estimates of health care expenditures show that in 2009, the USA spent 16 percent of its GDP on health care compared with only 8.7 percent in the UK. In the USA, 46.5 percent of health spending came from public sources, while in the UK, 82.6 percent of all health spending was paid for from public funds. In relation to its GDP, the USA spends much more than the UK on health care and the public sector is much less important as a purchaser of health care. The health and long-term care sectors are closely linked. So the similarity of overall long-term care expenditures in the UK and USA is remarkable, given the vast differences in the volume and composition of health expenditure in the two countries. In the USA, over 40 percent of long-term care expenditures are paid by Medicaid. Thus, the balance between private and public support for long-term care expenditures in the USA is broadly the same as the balance in health care spending.

One very noticeable difference in long-term care expenditure however, is the difference in public support for care provision at home. In 2000, the UK spent 0.32 percent of GDP on home care provision, while the US provision was much less generous, at only 0.17 percent. These statistics are consistent with Gleckman's argument (this volume) that "[s]tate home care programs remain optional, vary widely in scope and quality, and are often underfunded. As a result recipients face either limited benefits or long waiting lists" (p. 41).

Table 2: Public and Private Expenditure as a Percentage of GDP, 2000

		UK	USA	OECD Average
Total Expenditure	Home Care	0.41	0.33	0.38
	Institutions	0.96	0.96	0.88
	Total	1.37	1.29	1.25
Public Expenditure	Home Care	0.32	0.17	0.35
	Institutions	0.58	0.58	0.64
	Total	0.89	0.74	0.99
Private Expenditure	Home Care	0.09	0.16	0.06
	Institutions	0.38	0.39	0.54
	Total	0.48	0.54	0.24

Source: OECD (2005) Table 1.2

The estimates in Table 2 are likely to significantly under-represent the current importance of home care provision in the UK, because a number of policy initiatives have taken place since 2000 aimed at extending long-term care provision at home.

Focusing on those aged 65+ with long-term care needs, gross public expenditure in England was £9.3bn in 2009/10. Local authorities recovered £1.93bn of these costs mainly in user charges, implying net public expenditure of £7.4bn. In Scotland, in 2008/09 gross expenditure on older people was £1.5 billion and net expenditure was £1.2bn. Charges comprised £201m, with a further £130m coming from other contributions. User charges understate the overall private sector contribution since

private care homes and privately purchased care at home are not covered by these data. These are not thought to be of great importance, however.

But local authorities are not the only government agencies supporting long-term care needs in the UK. Cash support for those with care needs is also provided by the UK Government through the Department of Work and Pensions (DWP). Social security and welfare benefits are determined for the UK as a whole by DWP. The devolved bodies do not determine either their level or their coverage. There are two principal cash benefits for those with care needs: Attendance Allowance (AA) and Disability Living Allowance (DLA). AA is only available to those aged 65+, while DLA must commence before age 65, but can be continued beyond 65. Both are available to individuals that are deemed by a medical practitioner to need help with things such as washing, dressing, eating, getting to and using the toilet, communicating needs, requiring supervision etc. The current upper rate for AA and DLA these benefits is £71.40 per week. In May 2010, there were 1.9 million individuals aged 65+ claiming these benefits, 19 percent of this age group. The total cost of Attendance Allowance in 2009-10 was £5.3bn. Assigning DLA pro-rata by age, a further £1.3bn was paid to DLA claimants aged 65+.

AA and DLA are cash benefits to compensate for care needs. Horton and Berthoud (2010) argue that it has never been clear whether these benefits were intended as a contribution to the costs of care or to pay for the extra expenditures faced by people with disabilities. Based on a relatively small sample of clients, they argue that AA "was seen by most claimants as a component of their general income, aimed at maintaining or improving their standard of living, rather than as a direct contribution to the costs of caring" (p. 77). Hancock et al. (2004) argue that although that one might expect AA would be allocated on the basis of care needs, in fact the odds of receiving higher-rate payment depend on income, with poorer people more likely to receive higher-rate awards; on the type of disability, with bias in favor of physical rather than mental disability and on age with bias towards the young disabled.

Importantly, neither AA nor DLA is means tested. This makes these benefits almost unique in the UK social security system, which is almost exclusively based on means testing. They therefore contrast with Medicaid, the primary source of long-term care funding in the US, which is means-tested. However local authority support for long-term care in the UK is also largely means-tested.

The existence of two quite different funding streams to support long-term care in the UK illustrates the disjointed nature of UK long-term care policy. Care clients find this

complex system very difficult to understand. The development of different policies in different parts of the UK adds further to the complexity. In this chapter, we will focus on one component of this—the policy of providing free personal care (FPC) to those aged 65+ in Scotland. For a US audience, one interesting aspect of this has been the rapid expansion of home care in Scotland, paralleling the provision of FPC. But to understand the genesis of the FPC policy, we need to trace the recent evolution of long-term care policy in the UK as a whole and to understand the mechanisms for financing long-term care.

Long-Term Care in the UK: Recent History

An important starting point for a recent history of long-term care policy in the UK is the establishment of the Royal Commission on Long-term Care in December 1998 by the Labour Government under Tony Blair. The Commission was established as a response to widespread concern about long-term care provision throughout the UK. Major deficiencies of the system were seen to be:

- The absence of effective private or public insurance to spread the risks of care costs. Consequently, those spending extended periods in care homes had to use a large proportion of their assets to support their care.
- Unmet needs due to local authorities' being unable to meet demand within their fixed budgets.
- Wide, and seemingly arbitrary, divergences in provision of long-term care between local authorities. In the UK, this is popularly described as a "postcode lottery" (The US equivalent would be a "zip code lottery").

In addition, the Commission was asked to determine whether any proposed changes to the care system would be consistent with projected changes in the older population and in expected years of disability.

The majority report of the Royal Commission (Royal Commission on Long-Term Care 1999) recommended that the costs of nursing and personal care should be paid for by the state, but that hotel charges paid in care homes and other assistance people received at home should continue to be means-tested. It argued that personal care should be funded through general taxation and based on assessed need. But a minority report, signed by two of the Commissioners, argued that only nursing care should be provided free, and that some relaxation of the means testing system should be implemented. But, in its view, free personal care was unaffordable.

The recommendations of both the majority and minority reports were contingent on definitions of types of long-term care. For US readers, an understanding of these definitions is essential to an appreciation of recent long-term care policy in the UK. The two main types of care are nursing care, which is care involving the knowledge or skills of a qualified nurse; and personal care, which is care involving one or more of the following:

- personal toilet (washing, bathing, skin care, personal presentation, dressing and undressing);
- eating and drinking (as opposed to obtaining and preparing food and drink);
- managing urinary and bowel functions (including maintaining continence and managing incontinence);
- managing problems associated with immobility;
- management of prescribed treatment (e.g., administration and monitoring medication); and
- behavior management and ensuring personal safety (for example, for those with cognitive impairment—minimizing stress and risk).

There are other forms of support that relate to other services which disabled or frail individuals may require, including:

- for those living at home, household tasks such as shopping, cleaning and food preparation. It is recognized that these may provide an important preventative role resulting in reduced demands on the health service and on care homes;
- for those living in care homes, accommodation and meals.

Throughout the UK, the general presumption is that these other forms of support will be chargeable if provided or commissioned by a local authority. They can also be purchased privately. Local authority provision is likely to be means tested, whereas privately purchased care must be paid in full. Thus, for example, care home charges averaged £500 per week in 2009/10 ($41,600 per annum) (Forder and Fernandez 2009). Of this, an estimated £267 per week ($22,300 per annum) comprises charges for food and accommodation. Care home places will be purchased by local authorities on behalf of some clients, while others will meet their own charges privately.

The majority report argued that personal care should be treated as if it was part of the National Health System: it should be free at the point of delivery. The report suggested that the boundary of free health care provision should be extended to include personal care, even though personal care does not require the intervention of a

trained nurse. One of the more powerful supporting arguments was that if a cancer patient could expect to receive free treatment paid from general taxation, why should the same not apply to someone suffering from dementia? This argument was described as "diagnostic equity:" if individuals suffer from potentially terminal illnesses, it was deemed inequitable that the state should fully insure against the costs of one disease, while expecting those who contract another disease to meet all of their non-health costs.

Nevertheless, the UK government implicitly accepted the minority report and did not implement the Royal Commission's free personal care (FPC) proposal in England. The principal ground for its rejection was that the policy would be unaffordable in the light of future demographic change. But it also rejected the proposal on grounds of equity. The argument was that the removal of charges for personal care would mainly benefit relatively affluent older people. Those who could not afford to pay such charges would not gain from the introduction of FPC.

To follow this argument requires some detailed understanding of the system of charging for long-term care in the UK. So we now explain the key aspects of the UK charging system.

The system of charging for long-term care in the UK is complex and disjointed. The Law Commission (2008) described the current legal framework as:

> The legislative framework for adult residential care, community care and support for carers is inadequate, often incomprehensible and outdated. It remains a confusing patchwork of conflicting statutes enacted over a period of 60 years. There is no single, modern statute to which service providers and service users can look to understand whether services can or should be provided, and what kinds of services (p. 129).

Similarly, the King's Fund (2009) argued that:

> The current system for funding adult social care in England has been criticized as unfair, complex and financially unsustainable. There are significant local variations in who is eligible for what kinds of support and a host of complicated local and national rules that apply to the funding of different elements of social care services (p. 1).

Charges for long-term care are determined by local authorities, but the UK government and devolved bodies have issued guidelines that they hope will result in a

degree of consistency within their respective territories. Even though this process has led to greater consistency in charging structures and levels, the rules are still complex.

As in the US, care charges in the UK, are mainly based on means tests. The assessment of assets is critical to the means-testing process. Currently, most individuals in the UK with assets over £23,000 ($36,800) are expected to pay their care home charges in full. Those with assets of less than £14,000 ($22,400) in England and Scotland will have their charges fully met, but must contribute all of their income towards the costs, less £22.30 ($35.70) per week which they are permitted to retain for their own spending. Those with assets between £14,000 and £23,000 have their charges increased by £1 each week for each £250 ($400) of assets over £14,000.

The value of an individual's home is included in the means test from 12 weeks after entry into a care home unless a spouse or partner continues to live there. In recent years, home ownership rates in the UK among older people have increased sharply. This has had important consequences for care charging. The home ownership rate for those aged 50-64 is 79 percent and for those aged 85+ the rate is 61 per cent. Only one in five pensioners has a mortgage. In November 2010, the average UK property was worth £165,000 ($264,000). Given that the value of the average house massively exceeds the current asset limit of £23,000 and the majority of older people have housing equity that exceeds this limit, a large proportion of homeowners are expected to meet the full costs of their care. Typically older people are "asset rich and income poor". Unable to meet their weekly care home charges from income, many are forced to sell their houses or purchase a "reverse mortgage". This causes a significant amount of distress to older people and the potential beneficiaries of their estate. It is also a significant disincentive to saving, since those with assets whose value falls below the lower capital limit do not have to pay for their care. Older people therefore have an incentive to reduce their assets before they have any contact with the care system. Local authorities have the unpopular task of preventing asset transfers – such as gifts to children – that reduce liability for care home fees. Those who do not want to sell their home to pay care home fees may be able to apply for a deferred payment agreement whereby the local authority provides an interest free loan that is recouped from the individual's estate after death. In effect the local authority acts as a surrogate bank, providing credit at beneficial rates to pay for care home charges. But estate recovery policies vary widely between local authorities. This is reminiscent of the variation in effort by states to recover Medicaid costs from clients' estates (Fox-Grage 2006). There is a strong incentive for recovery in the UK, because none of the recovered funds are returned to the bodies that fund local government. In contrast, in

the US, a proportion of recovered funds are returned to the federal government. Hence, there is less to be gained from recovery in the US.

Commercial capital markets have not been successful in solving the problem of providing long-term care insurance in the UK. The private insurance market has failed to provide products that are simple, good value and readily available to protect against care risks. Until 2004, long-term care insurance plans were not regulated by the Financial Services Authority, which has the duty of protecting consumers in financial markets. Consumer confidence might have been increased had regulation been introduced earlier or if there had been some public-sector involvement in the products. An example of the latter would be a guarantee that insurance company liability would be time-limited and replaced by public sector funding after a fixed period, say three years. But successive governments and the insurance industry jointly failed to introduce innovative products that would be attractive to both the public and to insurance companies. As a result, there is virtually no market in long-term care insurance in the UK. This contrasts with around 10 percent coverage amongst those aged 60 and over in the US (Brown and Finkelstein 2009). The only product with some market share is the immediate needs annuity, which provides a contribution to the costs of those who already know that they require care. As an example, a woman aged 80, realizing that she needed nursing care, would have to pay a premium of around £54,500 ($87,200) to buy an annual income of £12,000 ($19,200) to set against care costs.

Now returning to the minority report in the Royal Commission, the equity argument against the introduction of FPC was that it would only benefit more affluent older people. This is because the means testing system ensures that the relatively poor have their care entirely paid for by the state. This group would not benefit from FPC. The affluent, who could pay for their personal care, would clearly benefit. Those whose assets placed them modestly above the capital limits, but who have little income, would also gain. This group typically comprises those in the third and fourth age-specific household income deciles. It was argued that a more effective use of public funds would be to focus assistance on this group rather than to provide FPC as a universal benefit. One way to achieve this objective might be to make the means test less restrictive.

In England, there have been a number of enquiries into care funding since the Royal Commission. Most notable among these, the Wanless Review (King’s Fund 2006), reported in 2006. It rejected FPC, favoring rather a “partnership model", which would entitle individuals to a minimum guaranteed amount of care. Thereafter clients would

be expected to contribute to the costs, with the state matching the contribution up to some limit.

But no legislative action was taken to put the Wanless proposals in place. And, at the May 2010 election, any hope for a political consensus on funding long-term care evaporated. With politicians keen to knock down any proposals put forward by their opponents, progress was impossible. Suggestions for a compulsory single-premium insurance taken out at age 65 were rejected. A national policy to recover care costs from a person's estate after death was labeled emotively as a “death tax." From a public finance standpoint, it may seem irrational that housing wealth is not seen as a legitimate source of funding for long-term care. But, in the UK, estate duty—a tax on individuals’ estates after death—is highly unpopular. However, there is also a growing lobby that suggests that the "baby boomers" have been a particularly lucky generation. If future generations cannot expect the same good fortune, then, in the interests of intergenerational equity, perhaps the baby boomers should be expected to make the main contribution to the costs of their care rather than the (younger) taxpayer.

The new UK government that came to power in May 2010 has established yet another commission to look into all of the issues around the funding of long-term care. It will report in 2011. It is assumed that the intention of its establishment was to provide a funding solution for England. However, within its terms of reference, the commission is to consider changes to disability-related benefits for older people, such as AA and DLA. These apply to the whole of the UK, not just England. So the commission’s deliberations may indirectly influence long-term care in the rest of the UK. Confusion reigns.

Thus, twelve years after the publication of the Royal Commission report, the UK government is still searching for a sustainable and equitable solution to the problem of long-term care funding in England. Getting from “here to there” in an English context has proved elusive. There has been widespread pressure from those who support those in need of long-term care, a general acceptance among politicians of all parties that “something needs to be done,” but no significant progress, perhaps because long-term care does not have a high political priority.

Scotland has made some definite policy decisions. One of these is the introduction of free personal care for those aged 65 and above. In the next section, we review long-term care policy development in Scotland. We argue that the distributional consequences of FPC have been as described—it mainly helps the relatively affluent. But to focus on this outcome alone takes a narrow view of the policy, which has had a

number of intended and unintended consequences. And, if one takes a holistic view of both health and long-term care costs, the argument that the policy is unaffordable is less clear.

Free Personal Care in Scotland

In response to the Royal Commission, the Scottish First Minister, Henry McLeish, set up the Care Development Group with the task of looking into the implementation of a FPC policy in Scotland. It reported in 2001 (Care Development Group 2001); legislation was introduced in 2001 and the policy itself was implemented in July 2002. One of the key elements supporting the legislation was the definition of personal care:

> …unless the context otherwise requires: 'personal care' means care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without prejudice to that generality, to remembering to eat and wash).[2]

This was a less prescriptive definition than that of the Royal Commission. Inevitably, once the policy was introduced, its precise meaning was contested. The Scottish Government issued various guidance notes to local authorities with the intention of arriving at a definition agreed by all local authorities. In particular, the precise definition of "food preparation" led to disputes between the local authorities and the Scottish Government. The local authorities, seeking to contain costs, argued for a limited definition. This was hotly contested by carers and care recipients, and the Government was forced to revisit its guidance on several occasions.

Once a definition of personal care was agreed, another important aspect of the policy was the assessment of potential clients. A separate group was set up, the Care Assessment Group, to design a "single shared assessment" which was meant to streamline the way in which individuals' care needs were assessed. Previously individuals could be asked to undergo a number of different assessment procedures by different agencies such as social work, housing, NHS and occupational therapy to design a service package to meet their care needs. The single shared assessment was intended to allow one professional from a multidisciplinary team to assess individual need. It was hoped that the professional would then arrange services from all relevant agencies.

Social care funding had traditionally been "ring-fenced" within local authority budgets—resources allocated under this heading could not be reallocated to other local authority services. This had clear benefits, but also disadvantages. Some authorities spent beyond their allocations: ring fencing made it more difficult for them to defend this spending politically. Local politicians resented policy direction from the center. Ring fencing of most social care funding was abolished.

The FPC legislation simply prevented local authorities from charging for personal care. This meant that the local authority had a duty to provide personal care free once need was established through assessment. This obviated the need for ring-fencing – at least in respect of personal care. The Scottish government provided local authorities with additional resources to compensate for the loss of this charging income. The details of the FPC policy were:

- **For those in care homes**, the policy provided a flat rate weekly payment of £145. This payment was intended to compensate care homes for the costs that they incurred in providing personal care. A further £65 per week was added if the client was assessed as also requiring nursing care. Payments for nursing care were also introduced in other parts of the UK, typically at rates more generous than those provided in Scotland. Care home clients were still responsible for their "hotel" costs. Thus if the weekly charge for a care home was £500, a self-funding[3] client requiring both nursing and personal care would receive a contribution of £210 per week from the local authority and would be required to meet the remaining £290 per week from their own resources. This could include contributions from state pensions and other benefits. Controversially, the DWP took the view that one of these benefits, AA, would not be payable to clients in Scottish care homes receiving FPC. This decision was based on a very strict interpretation of the AA rules and generated a substantial degree of political animosity to the DWP in Scotland.
- **For those receiving care at home,** the FPC policy meant that, so long as need was established, no charges would be levied for personal care at home. This was an open-ended commitment. It covered services from relatively modest packages of care to highly intensive arrangements that might require a carer to stay overnight or at weekends. Other forms of local authority domestic support continued to be charged. There is some evidence that charges for these services increased significantly after the introduction of Free Personal Care, though it is difficult to identify a clear causal link.

The introduction of FPC heralded a radical change in long-term care policy in Scotland. The popular view is that the policy was limited to the financial measures described above. However, in reality there were very significant organizational changes involving both health and social care provision that were linked with the policy, but which were not directly legislated. The primary example of this switch in emphasis from hospitals and care homes to care at home, which was described as "changing the balance of care." This policy was specifically aimed at offsetting institutional bias.

Some local authorities were well prepared for the policy: others were not. Previously, local authorities had had considerable freedom to design their own social care policies. Some had already introduced elements of a FPC policy. This group found the transition relatively easy. Others had a very steep learning curve. There were inevitable arguments over whether the funds provided by the Scottish government to individual local authorities were sufficient to implement FPC.

Opponents of the policy argued that there would be large numbers of older people migrating from other parts of the UK to Scotland to take advantage of its more generous care provision. There is no evidence that such migration took place, though there are concerns around the Scottish-English border. This is largely a rural area, so the scale of movement is limited. The lack of extensive migration is not surprising, given the social and financial costs associated with moving as well as uncertainty over the future of care policy.

FPC particularly benefited those who would otherwise have had to pay for the full costs of their care. These were people with assets valued above £23,000. Thus the policy might have promoted diagnostic equity, but it was in another sense regressive. In Scotland, perhaps surprisingly, this aspect of the policy never became politically contentious, though, as mentioned previously, equity issues contributed to the rejection of FPC in England.

While "free personal care" was the phrase that grabbed the headlines, the policy should be seen as a catalyst in a wider exercise to change the structure of social care provision in Scotland. A key part of this was the impetus from long-term care clients, carers, politicians, and health and social care professionals to change the "balance of care". This had the dual benefit of being what clients wished and of reducing average costs. It had high-level political support. The strategy of "Changing the Balance of Care" is part of the Scottish Government's set of performance indicators – the set of criteria by which it has chosen to be judged.

Some of these ramifications are shown in Table 3. The data are all drawn from Scottish Government statistics and cover the maximum time span available between 2000 and 2010. The first example of shifting the balance of care is the reduction in the number of geriatric long stay beds in hospitals. These were reduced by 39 percent between 2003 and 2008. The average weekly cost of geriatric continuing care services in hospitals was £1462 per week in 2009-10. This is more than double the average cost of a care home place. But care home places themselves declined by 4 percent for those aged 65+ and by 8.9 percent for all long stay residents between 2002-3 and 2009-10. So the decline in geriatric care beds was not offset by a compensating increase in care home places. Instead, there was a sharp increase in the number of people receiving FPC at home, the numbers increasing by 69 percent between 2002-3 and 2009-10.

Table 3: Indicators of Change in the Balance of Care in Scotland 2002-2010

Occupied Geriatric Long Stay Beds			
Year	2003	2008	% Change
Number	2,704	1,661	-39.00%
Number of Long Stay Residents Aged 65+ Supported in Care Homes			
Year	2002-3	2009-10	% Change
Number	32,248	31,082	-4.00%
Number of self-funders receiving FPC in Care Homes			
Year/Quarter	2002/Q2	2010/Q3	% Change
Number	7,068	9,922	40.40%
Number of Long Stay Residents Supported in Care Homes			
Year/Quarter	2002/Q2	2010/Q2	% Change
Number	38,529	35,082	-8.90%
Number of People Receiving FPC at Home			
Year	2002/03	2009/10	% Change
Number	27,372	46,277	69.00%
Local Authority Home Care Clients			
Year/Quarter	2004 Q2	2010 Q3	% Change
Number	69,433	64,839	-6.60%
% of people 65+ receiving personal care at home			
Year	2003	2010	% Change
Percent	44%	58%	32.90%
Home Care clients aged 65+ getting 10+ hours of care per week			
Year	2002/3	2009/10	% Change
Number	11,998	15,736	31.00%
% of people 65+ with intensive needs receiving care at home			
Year	2003	2010	% Change
Percent	26%	32%	26.30%
Total Hours of Home Care			
Year/Quarter	2004/Q2	2020/Q3	% Change
Number	545,564	673,521	23.50%

(Table 3 continued)			
Number of self-funders receiving FPC at Home			
Year/Quarter	2002/Q2	2010/Q3	% Change
Number	24,313	47,149	93.90%
No. of emergency bed days in acute specialties for people aged 65+			
Year	2004-5	2009-10	% Change
Number	2,811,417	2,859,999	1.70%
NHS Delayed Discharges out within six week discharge planning period			
Year	2001 (Jan.)	2010 (Oct.)	% Change
Number	1887	128	-93.20%
Total Expenditure on Personal Care at Home			
Year	2003-4	2008-9	% Change
Amount (£m)	128.8	273.7	112.60%
Expenditure on FPC Payments in Care Homes			
Year	2003-4	2008-9	% Change
Amount (£m)	65.3	79.3	21.50%
Average Weekly Expenditure on Clients Receiving FPC at Home			
Year	2002-3	2008-9	% Change
Amount (£m)	75.3	119.1	58.20%

Source: Author's compilation of Scottish Government statistics.

But this did not mean an overall increase in the total number of clients being cared for at home by local authorities. These declined by 6.6 percent between 2004 and 2010. Because local authorities now had a duty to provide FPC within the constraints of fixed budgets, they tended to reduce the provision of non-personal social care and increase charges for this type of service. The proportion of their client base receiving FPC increased up to 2010. Thus, an unintended consequence of the FPC policy was increased charges for services associated with non-personal care such as mobility, shopping etc. Increased charges may also have reduced demand, with care clients purchasing services privately.

Little is known about what has happened to these less needy clients who would previously have received local authority support. They may have become more reliant on unpaid carers or may be purchasing care from the private sector. There is a debate around whether reducing support for the less needy is cost effective in the long run. Some argue that early intervention can prevent more expensive episodes in the future, but the evidence for this is difficult to establish convincingly.

Local authorities adapted to supplying complex care packages for those living at home. Table 3 also shows that the number of clients receiving at least 10 hours of care per week and the proportion of people with intensive needs receiving care at home increased by 31 percent and 26 percent, respectively, between 2003 and 2010. The

shift to care at home resulted in a 23.5 percent increase in the number of home care hours provided by local authorities.

The number of "self-funders" in care homes increased by 40 percent between 2002 and 2010. The interaction of the means testing system and the trend towards increased home ownership may have increased the proportion of clients expected to contribute towards their care costs. There was a very dramatic increase of 93.9 percent in the numbers of self-funders receiving FPC at home between 2002 and 2010.

With a presumption towards care in the community, care homes increasingly focused on those whose needs could not be met in their own homes. So although the size of the care home population stayed roughly constant, average levels of disability of residents tended to increase.

What is the value of FPC to care home residents? A rough calculation might go as follows: the estimated average annual cost of a care home place in 2008-9 was £24,500. Given the size of the care home population, this implies that the total value of care home fees in Scotland in 2008-9 was around £860 million. Nursing care and FPC payments in care homes in 2008-9 cost £79 million. Around 30 percent of care home residents are self-funders. This suggests that FPC and nursing care payments cover around 29 percent of the care home fees of self-funders.

There is a widespread belief, which the media in England do little to contradict, that care homes are free in Scotland. This is obviously incorrect: the chance that a self-funding care home resident in Scotland will have to sell their house to fund their care is lower in Scotland than in England, but it is still significant.

But the more significant growth has been in the clients receiving FPC at home that increased from 24,300 in 2002 Q2 to 47,100 in 2010 Q3. This growth was not anticipated at the time the policy was introduced, and is well in excess of the increase one might predict from demographic trends. This implies that there was a reservoir of unmet need prior to the introduction of the policy. It also raises concerns as to whether assessment procedures were applied consistently, though this would be difficult to establish.

The average hours of care received by FPC clients increased from 6.9 hours per week on average in 2002-3 to 7.5 hours a week in 2008-9. There was a shift towards more intensive home-care packages. The average wage cost for such packages was around £13 per hour, making the average wage cost per package in 2008-9 just over £100 per week. Wages are the main component of home care costs. If one adds transport costs,

payroll taxes, training and administration costs, average weekly costs of home-care packages are still well below those in care homes. Average weekly expenditure per FPC client at home was estimated to be £119.1 in 2008-9.

Of course, patients in hospital typically have greater needs than those in care homes, whose needs in turn are greater than those receiving care at home. Nevertheless, there is some overlap between these categories and the development of intensive home-care packages has increased this overlap. And, the differences in costs are stark. On average, one week's care in a geriatric continuing care ward would buy 3.1 weeks in a care home or 12.3 weeks of average personal care packages delivered in the community. The case for community care is strengthened by clients' expressed preference to stay at home. Hospitals and care homes may provide greater quality, security and safety. But, these effects must be very strong to overcome both the cost advantage and client preference that argue in favor of focusing policy on care in the community.

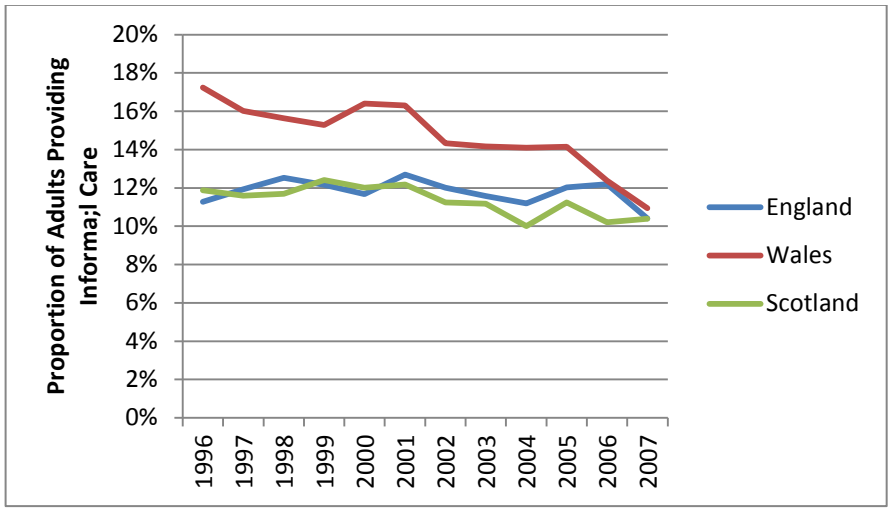
Another change in policy affecting the demand for personal care is the drive to reduce the number of delayed discharges of older people from hospitals. Frail older people are sometimes held in hospital because no suitable accommodation can be found in care homes or in the community. The beds they occupy can be put to other uses. Such "bed blocking" is an impediment to the efficient running of hospitals. Often those discharged required personal care. Table 3 shows that this policy has been quite successful. Between 2001 and 2010 the number of delayed discharges was reduced by 93 percent. But, though the net effect on costs, efficiency and patient satisfaction may be positive, the increased demand for personal care increases the costs of free personal care to local authorities. With fixed budgets and legal responsibilities to provide other services such as education and transport, their ability to respond is constrained. This raises the issue of whether hospitals should transfer funds to local authorities to facilitate the reduction in delayed discharges. This happens to a limited extent.

Our own research on the impact of FPC on unpaid carers showed that it presented opportunities for carers to make choices about the care they give. It also enabled the overall quantity and quality of care to increase. In respect of choice, our qualitative work (Bell and Bowes 2006; Bell, Bowes, and Dawson 2007) suggested that carers welcomed the possibility of not delivering personal care for their relatives. It seems that they had voluntarily provided this, but that once it was free, they preferred to withdraw. However, and this is contrary to some expectations about the effect of the policy, they did not withdraw from care altogether, but switched to performing other tasks. Examples included more social visiting and more taking the person they cared

for on outings. Estimates of the aggregate quantity of care given following the introduction of FPC showed that Scotland did not differ from significantly from England: this serves to corroborate our finding that substitution rather than withdrawal was occurring, and that the second opportunity—an increase in the quantity and quality (more social activity) of care following the introduction of FPC—was also occurring.

Information on care provision by friends and relatives is available from GB-wide household surveys. The Family Resources Survey is an annual survey of representative households. Figure 3 shows the proportion of adults giving care, either

Figure 3: Proportion of Adults Providing Informal Care: England, Scotland and Wales 1996 to 2007



Source: Author's analysis of Family Resources Survey data.

in the home or outside the home, respectively. One argument raised in opposition to FPC was that it would cause a reduction in unpaid care. There is no prima facie evidence in its favor from the trends in unpaid care provision in Scotland, England and Wales shown in Figure 3. In particular, the proportion of unpaid carers in Scotland and England is approximately equal throughout the period.

Conclusions

What are the policy lessons for the US from the Scottish experiment in FPC? The first, perhaps surprising point is that there are many points of similarity between the UK and US systems for funding of long-term care. Both countries largely use means tests rather than entitlements as the basis for allocating funds to those requiring long-

term care. In both countries the private long-term care insurance is weak. Both systems are complex and disjointed with public funding coming from different levels of government. Reform has been slow due to the difficulties of establishing political consensus and urgency around long-term care. These points of similarity are surprising given the significant differences in the organization of the health care systems in the UK and the US.

Scotland has introduced the most significant change in long-term care funding in the UK over recent decades. For those in care homes it has introduced a flat rate contribution to pay for personal care. For those receiving care at home it no longer allows local authorities to charge for personal care. Free personal care has become an entitlement in Scotland, but not in the rest of the UK.

The obvious drawbacks around its introduction are its future affordability given demographic change, and the extent to which it provides a subsidy to the relatively rich who could afford to pay for their care. But it has promoted "diagnostic equity" between conditions requiring long-term health interventions and those requiring long-term care—obvious examples being cancer on the one hand and dementia on the other.

Nevertheless, the introduction of FPC also acted as a catalyst towards fundamental change in the delivery of long-term care in Scotland. There has been a very substantial relative shift over a relatively short period from geriatric hospital care and care homes as the settings for long-term care provision in favor of care at home. In US terms this would be described as removing the "institutional bias" in care provision. It also provides some important markers for how to get from “here to there.” These include:

Resources

The delivery of care at home is labor-intensive. Care workers require training. They also have to be willing to provide clear at the non-standard times, such as overnight and weekends. Reducing the demands on hospitals and care homes should release resources to support these workers. This will be facilitated if there is some mechanism for transferring resources from institutional care facilities to those providing care at home. It may be difficult to provide incentives for the different agencies involved to make such transfers happen. In addition, establishing a successful, well-regulated private market for home care may help to drive up quality standards.

Governance

Changing institutional bias involves a number of different agencies with different governance structures. Some may be democratic while others are corporations, charities or voluntary organizations. It is important to find mechanisms, which allow those with governance responsibility in these organizations to work together towards the common objective of shifting the balance of care.

Leadership

Significant change is unlikely to happen without strong leadership. Sen Kennedy clearly played this role in the development of the CLASS Act. In the UK, the Royal Commission (1999) had an important role in changing the debate on long-term care. But in the UK as a whole there has been no equivalent political force to Sen Kennedy. It remains to be seen whether the report of the recently appointed commission on long-term care will command sufficient political support to effect significant change. In Scotland, all of the political parties supported FPC. This may have partly been due to conviction, but it may also reflect a desire to differentiate social policy in Scotland from that in the rest of the UK.

Boundaries

In public provision, the establishment of clear boundaries between those who receive an entitlement and those who do not are essential. In Scotland, the definition of personal care was such a boundary issue. Fuzzy boundaries lead to lengthy legal disputes and hostile media attention.

Unintended or Unanticipated Consequences

In Scotland, there was an unexpectedly large uptake of FPC following its introduction. This has been ascribed to "unmet need." Careful piloting of the policy might have alerted legislators to this possibility. In addition, it was not anticipated that the introduction of FPC would lead to a reduction in the public provision of other forms of social care. Unpaid carers may now be shifting their provision towards such forms of care. FPC may also have stimulated the private market in non-FPC care. The lesson is that very careful evaluation is required before the introduction of radical change in social care policy.

Taking the Holistic View

To meet the challenge of demographic change will require that resources be allocated to areas such as health care and long-term care as efficiently as possible. Taking a "partial equilibrium" view of resource saving can lead to the perpetuation of inefficiencies and outcomes that do not meet the needs of those requiring long-term care. Thus, for example, the resource costs of long-term care differ substantially between hospitals, care homes and care at home. Thinking of long-term care as being in a separate silo from health care runs the risk of substantial resource misallocation. The classic example in Scotland has been the success of the delayed discharge policy that has improved efficiency in health care but has increased long-term care costs. The holistic view would suggest that the net effect of this intervention has been positive. Costs have been reduced and efficiency improved and older people generally appreciate being in settings other than hospital.

Notes

[1] "Local authority" is the term used to describe a body with responsibility for local government across a specific geographical area within the UK. There are 32 local authorities in Scotland, 353 in England, 26 in Northern Ireland, and 22 in Wales.

[2] Regulation of Care (Scotland) Act 2001.

[3] In this context "self-funding" means having assets in excess of the capital limits set in the means test.

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