Paying for Long-Term Care for Older People in the UK:

Modelling the costs and distributional effects of a range of options

PSSRU
RESEARCH SUMMARY
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BACKGROUND

The Government considered the issue of long-term care funding sufficiently important and complex to warrant the first Royal Commission for many years. The Commission's key recommendation was that the nursing and personal care components of the fees of care homes and home-based personal care should be met by the state, without a means test, and financed out of general taxation. Means-testing would remain for the accommodation and ordinary living costs ('hotel' costs) covered by residential fees and for help with domestic tasks for people living in their own homes.

The Government accepted many of the Royal Commission's recommendations but removed the means test only for nursing care and not for personal care. Similar decisions were initially adopted by the National Assembly for Wales and the Northern Ireland Assembly. The Scottish Executive, however, made personal care free of charge as well.

Amongst the public, there continues to be 'widespread dissatisfaction with the current means-tested funding arrangements'. The recent Wanless Report, from which this phrase is taken, proposed a non-means-tested entitlement to social care, with government meeting two-thirds of the cost of the care package, and the remainder of the costs being met half by the user and half by government. The Joseph Rowntree Foundation (JRF) has argued for better funding arrangements and suggested various specific changes to the current system.

THE STUDY

The study makes projections of expenditure on long-term care services under a range of options for reforming the system for funding long-term care for older people. Each option includes a breakdown of expenditure between public sources of funding (NHS, social services and disability benefits) and private sources (service users) and an analysis of the projected differential impact on older people in different parts of the income distribution. The projections contribute important information for policy analysis of different funding options.

The study uses two simulation models designed to explore the expenditure implications over time of the range of policy options considered. The PSSRU has developed a macrosimulation model to make projections of demand for long-term care and associated expenditure. The core PSSRU model, designed for the Department of Health, makes projections to 2041. For the present analysis, the model was adapted to make projections for the UK to 2051.

CARESIM is a microsimulation model that simulates long-term care charges under different charging regimes. It simulates the incomes and assets of future cohorts of older people and their ability to contribute towards care home fees or the costs of home-based care, should such care be needed. The projections presented here have been produced through an innovative linkage between the PSSRU and CARESIM models.

'BASE CASE' ASSUMPTIONS

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

University of Essex

The Nuffield Foundation

Around one in two women and one in three men who turn 65 will require intensive long-term care in their late old age. How this care is to be funded is an important issue, which continues to provoke lively debate. It will affect many of us and our families.

This summary presents the findings of a new research study, funded by the Nuffield Foundation, on paying for long-term care for older people in the United Kingdom.

Raphael Wittenberg, Linda Pickard, Adelina Comas-Herrera, Derek King and Juliette Malley from the PSSRU at the London School of Economics and Political Science, Ruth Hancock from the University of Essex and Ariadna Juarez-Garcia from the University of Birmingham used two simulation models to model the costs and distributional effects of a range of options for reforming the system for funding long-term care. The options examined included changes to the capital limits in the means test, increases to the personal expenses allowance, a lifetime limit on private payments for care and free personal care.

The findings reported in this research summary are drawn from a longer report, Hancock, R., Pickard, L., Wittenberg, R., Comas-Herrera, A., Juarez-Garcia, A., King, D. and Malley, J. (2006) *Paying For Long-Term Care for Older People in the UK: Modelling the Costs and Incidence of a Range of Options*, report to the Nuffield Foundation, PSSRU Discussion Paper 2336. This report can be downloaded free of charge from the PSSRU website at www.pssru.ac.uk.

Box 1. Key assumptions of the base case

- The number of people by age, gender and marital status changes in line with the Government Actuary's Department (GAD) latest projections for the UK.
- There is a constant ratio of single people living alone to single people living with their children or with others and of married people living with partner only to married people living with partner and others.
- Prevalence rates of disability by age and gender remain unchanged, as reported in the 2001/2 General Household Survey (GHS) for Great Britain.
- Home-ownership rates, as reported in the 2001/2 Family Resources Survey (FRS), change in line with projections produced by the CARESIM model.
- The proportions of older people receiving informal care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, disability and other needs-related characteristics.
- The funding system remains unchanged as the current system for England which is applied for the whole of the UK. For residential care, the national means test is used. A stylised means test, based on national guidance is used for non residential services.
- Health and social care unit costs rise by 2% per year in real terms (but non-staff revenue costs remain constant in real terms). Real Gross Domestic Product rises in line with HM Treasury assumptions.
- The supply of formal care will adjust to match demand and demand will be no more constrained by supply in the future than in the base year.

RESULTS UNDER THE CURRENT ENGLISH FUNDING SYSTEM

The GAD 2004-based principal population projections for the UK project that between 2002 and 2051 the numbers of people aged 65 or over will rise by 86%. The numbers of those aged 85 or more are projected to rise faster during this period, by over 275%. The numbers of disabled older people, defined as those unable to perform at least one Instrumental Activity of Daily Living (IADL), such as shopping, or having problems with at least one Activity of Daily Living (ADL), such as bathing or dressing, would rise by 118% between 2002 and 2051, with unchanged disability rates.

The numbers of disabled older people receiving informal care are projected to increase by around 110%, from 2.0 million in 2002 to 4.3 million in 2051. The numbers of users of local authority home care services would need to rise by 135%, from 440,000 to slightly over 1,000,000 and the numbers of users of private home care services would need to rise by 120%, from 970,000 to 2,125,000. The numbers of older people in care homes would need to rise by 155%, from 400,000 to 1,030,000. This projected expansion of services is required under base case assumptions to keep pace with demographic pressures.

Total expenditure on long-term care services is projected to rise by almost 500%, from £15.7 billion in 2002 to over £94 billion in 2051. If Gross Domestic Product (GDP) rose in line with HM Treasury assumptions, long-term care expenditure would grow from 1.49% of GDP in 2002 to 2.32% in 2031 and 3.14% in 2051 (Table 1).

The models project that around £550 million of disability benefits – attendance allowance and disability living allowance (care component) – are used to purchase care privately or to meet user charges for care. This assumes that local authorities disregard part but not all of disability benefits for disability related expenditure and that service users put the remainder of their disability benefits toward care costs before other sources of income or savings. When disability benefits are included on this basis, projected public expenditure on long-term care rises from £10.2 billion (0.96% of GDP) in 2002 to £58.4 billion (1.95% of GDP) in 2051, an increase of 470% (Table 1).

These projections are sensitive to varying the assumptions about future life expectancy, trends in disability rates and trends in real unit costs. If, for example, disability rates fell under a compression of disability scenario, public expenditure is projected to rise in 2051 to around £38 billion (1.27% of GDP) rather than over £58 billion (1.95% of GDP) under the base case. If, however, mortality rates fell in line with GAD's high life expectancy population projection and real unit costs rose by 2.5% per year rather than 2%, public expenditure is projected to rise to almost £90 billion (3.0% of GDP) in 2051.

To assess the distributional effects of long-term care funding regimes we analyse the average contributions to total care costs by service users and by the state according to income level and housing tenure. The measure of income used for this purpose is net income (before housing costs) of the family unit that they would receive when living in their own homes without any care needs (that is excluding disability benefits). Individuals are classified by quintile of the relevant income distribution for their age band. The analysis covers all recipients of residential and home care services, both publicly and privately funded users.

On average across all users, 57% of the costs of care are currently met by public expenditure – 6% by the NHS (for nursing care in nursing homes), 46% by local authorities and 5% by disability benefits. The remaining 43% is met by users from their state pensions, pension credit, private pensions and other sources of income. Users in the highest income quintile meet just over two-thirds of the proportion of their care costs from their own resources compared with under 45% in each of the other income groups. Local Authorities meet 18% on average of the care costs of the highest income group compared with 57% of those of the lowest group and at least 45% in other income groups. The role of housing wealth is evident in a comparison by housing tenure. Owner-occupiers contribute around one half of the costs from their own resources compared with around one quarter for non-owners. Local authorities meet 42% of the care costs of owner-occupiers compared with 66% for others.

OPTIONS FOR REFORM OF THE FUNDING SYSTEM

Reform of the means test

Options are considered for raising the capital limits above which service users are ineligible for local authority funded care. These include abolishing the upper limit and halving the tariff on capital between the upper and lower limits, resembling the system for Pension Credit. Around 90,000 privately funded service users would become eligible for public funding under this option. The gains would be heavily concentrated among home owners. The gains for the

Table 1. Projected public and private expenditure on long-term care as a percentage of GDP, 2002–2051

	2002	2012	2022	2031	2041	2051
Public expenditure	0.96	0.99	1.17	1.45	1.71	1.95
Private expenditure	0.52	0.56	0.70	0.87	1.03	1.19
Total expenditure	1.49	1.56	1.86	2.32	2.74	3.14

highest income groups would be below average, with the third and fourth income quintiles gaining the most. The cost to public expenditure would be around £900 million (in 2002).

One of the authors of the Note of Dissent to the Royal Commission report recommended an option under which liability to pay for long-term care privately would be limited to four years. The version considered here is a lifetime maximum payment of £100,000 for residential care. Around 15,000 care home residents would benefit from this option. They would mostly be home owners, with gains concentrated in the highest income group. The cost of this option would be around £250 million.

The current means test usually takes account of the value of the person's house for residential but not for home care. If the value of the house was ignored for residential care, around 95,000 care home residents, all of them home-owners, would gain. The cost to public funds would be around £1.0 billion.

If the value of the house was taken into account for home care, around 175,000 home care users, all of them home owners, would lose public funding. The savings to public funds would be around £750 million. This option could not realistically be implemented without a scheme similar to the existing deferrals arrangement for residential care, under which the local authority meets the costs initially, recovering the monies when the person's home is sold. The realised savings would therefore accrue over time. The losers would be home care users who are home owners with modest savings and low incomes.

Care home residents with capital below the upper limit have to put all their income apart from a small personal expenses allowance towards care homes' fees. A recent JRF report suggested doubling the personal expenses allowance. An increase to £73.10 per week is considered here, which would have a broadly similar cost to the introduction of free personal care in care homes. Around 270,000 care home residents would benefit from this option. Non-home owners would gain more than home owners. Gains would be greatest for the three lowest income groups, with the highest group gaining least. The cost of this option would be around £800 million.

If disability benefits were fully disregarded in the means-test for home care, a further 160,000 home care users would become eligible for publicly funded home care. The cost of this option would be around £425 million. Gains are above average in the middle three income groups, lowest in the highest income group but also below average in the lowest income quintile.

Figure 1 shows estimated public expenditure as a proportion of GDP under the current charging system (base case), the various reforms to the means test discussed here and free personal care discussed in the next section. It shows that public expenditure is projected to reach up to 2.25% of GDP under the reform options as against 1.95% of GDP under the base case.

Free personal care

We have examined three different versions of a policy of free personal care: a 'fixed hotel cost', a 'fixed care cost' and a 'Scotland' scenario. They do not differ in respect of home care but differ in the way in which the costs of residential care are divided between costs of personal care and 'hotel' costs:

- Under the 'fixed hotel cost' scenario, the means-tested part of care home costs (representing the hotel costs) would be determined as a matter of policy, and the non-means tested part would comprise the difference between the care home fee and the means-tested element;
- Under the other scenarios, the non-means tested part (representing the personal care costs) would be determined as a matter of policy, and the means tested part would comprise the difference between the care home fee and the non-means tested element.

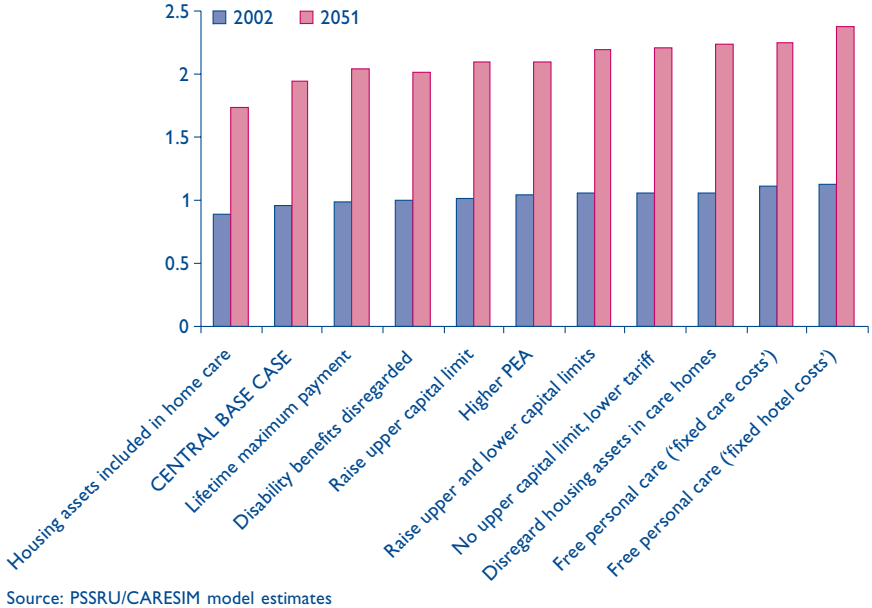
The effect is that the costs of higher than anticipated rises in care home fees would fall to the public sector under the 'fixed hotel cost' scenario and to service users under the other two scenarios.

In the 'Scotland' scenario, there is no uprating for inflation up to 2022 (assumed to mean a real decline of 2.5% per year), which reflects the current situation in Scotland. In the 'fixed care cost' scenario, the value of the personal care component increases in line with general inflation.

The numbers of older care home residents who receive public funding increases under each of these options from over 275,000 to nearly 400,000 in the base year. All care home residents would receive some public funding. Numbers of publicly-funded recipients of home care would increase from 440,000 under the current (England) funding regime to around 625,000 under a policy of free personal care. Free personal care would increase the number of publicly-funded care home residents and home care clients by more than any of the reform scenarios examined above.

The 'fixed hotel cost' version would increase public expenditure on long-term care in 2002 from an estimated £10.2 billion to approximately £12 billion, or by about 18%. The 'fixed care cost' version would increase public expenditure in 2002 by 15% and the 'Scotland' version by about 13%. The difference between the versions of free personal care increases over time. Public expenditure is projected to rise to approximately £58.5 billion in 2051 (in 2002 prices) under the current (England) funding system, to £71.3 billion under the 'fixed hotel cost' version of free

Figure 1. Estimated public expenditure as a proportion of GDP, in 2002 and 2051, under different charging systems



Source: PSSRU/CARESIM model estimates

personal care, £67.5 billion under the 'fixed care cost' version and £64.7 billion under the 'Scotland' version.

These projections assume that free personal care would not affect the volume of care provided. There could, however, be a demand response. We looked at two examples, in the absence of firm evidence on the responsiveness of demand to price changes. A 25% increase in domiciliary care demand is projected to raise public spending to around £71.9 billion in 2051 (2.4% of GDP), and a 50% increase in demand to approximately £76.3 billion (2.55% of GDP) in 2051, compared to £67.5 billion (2.25% of GDP) if demand does not increase.

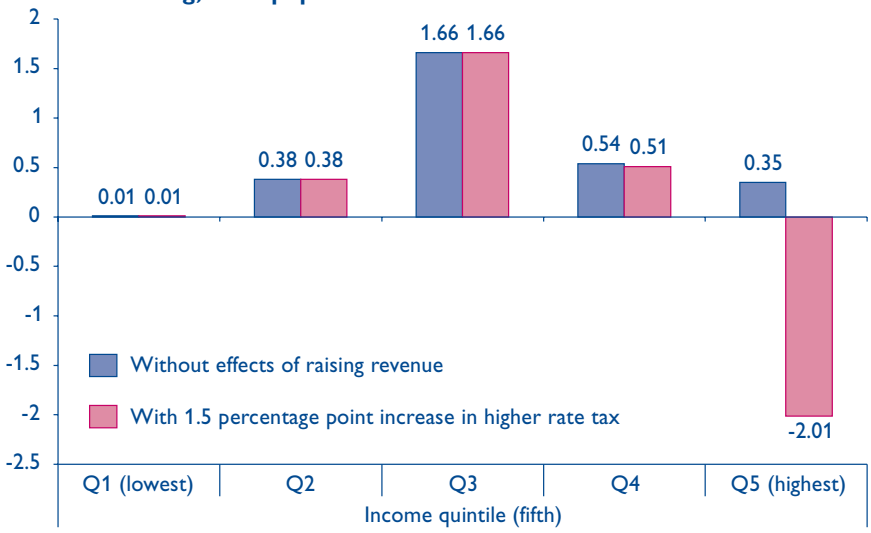
The gains from free personal care are above average among home owners and among the highest income groups among the older population. They are below average for the lowest three income groups and for non-home owners. These are results before considering the impact of raising the revenue to fund free personal care.

An increase in the higher rate of income tax from 40% to 41.5% is estimated to be just sufficient to meet the extra public expenditure costs of the 'fixed care cost' version of free personal care. To examine the distributional effects of this it is necessary to consider the income distribution of the whole population. The gains from free personal care before taking account of the tax increase are concentrated in the middle income group of the whole population. When the tax change is taken into account, the highest income quintile loses an average of £2 per week rather than gaining 35 pence per week; but the position of the remaining income quintiles is little affected, as illustrated in Figure 2.

Box 2. Main findings

- Overall expenditure on long-term care for older people in the UK is projected, on base case assumptions, to rise from around 1.5% of GDP in 2002 to around 3.15% of GDP in 2051.
- Public expenditure – covering long-term health care, social care and disability benefits used to fund care – is projected, on base case assumptions, to rise from around 0.95% of GDP in 2002 to around 1.95% of GDP in 2051.
- These projections are sensitive to assumptions about future mortality rates, disability rates and rises in the real unit costs of care.
- The option for taking account of housing assets in the means test for home care would reduce public expenditure by some £750 million. The losers would be home care users who are home owners with modest savings and low incomes.
- The other options for reforming the means-test considered in this paper would cost between £250 million and £1,000 million in 2002 in additional public expenditure: they would take public expenditure to around 2.25% of GDP in 2051 rather than around 1.95% under the current funding system.
- The options for reform mostly favour home owners and higher income groups, with the exception of the option of raising the personal expenses allowance.
- The three options for introducing free personal care would cost between £1.3 billion and £1.8 billion in 2002, or more if they had a significant impact on demand for care. They would take public expenditure to between 2.15% and 2.40% of GDP in 2051, or more with allowance for an impact on demand.
- Free personal care would benefit home owners and the higher quintiles of the income distribution of older people (before considering the impact of possible revenue-raising changes).
- The costs of free personal care ('fixed care cost' version) could be funded by an increase in the higher rate of income tax from 40% to 41.5%.
- The net gain from the combination of free personal care and higher tax rate would be greatest for the middle quintile of the income distribution of the whole population, while the highest quintile of the whole population would lose.

Figure 2. Mean gains/losses from free personal care with/without revenue raising, total population 2002



Source: PSSRU/CARESIM model estimates

The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas — including services for elderly people, people with mental health problems and children in care. Views expressed in PSSRU publications do not necessarily reflect those of funding organisations. The PSSRU was established at the University of Kent at Canterbury in 1974, and from 1996 it has operated from three branches:

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