Summary: Intervention & Options

Department /Agency:	Title:	
DH	Impact Assessment of Personal Care at Home Bill	
Stage: Final	**Version:** 12	**Date:** 06 January 2010

Related Publications: This document amends version 9 of the Impact Assessment published on 25th November 2009, correcting for transcribing errors.

Available to view or download at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/index.htm

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What is the problem under consideration? Why is government intervention necessary?

There is a shortage of private insurance policies to cover individuals against future personal care costs. This means that to those who subsequently require personal care, the cumulative costs can be large. Adverse selection raises the premiums of policies, making a private insurance scheme more expensive than one provided by Government.

Government intervention is necessary to fill an important weakness in market provision and pool risk across society at large.

What are the policy objectives and the intended effects?

i) Funding care to those in need at the time of their need; ii) providing peace of mind to everybody that they will be looked after, if necessary for a long period, without having to forego their life savings in order to meet potentially high household expenditure.

Intended effects - better support for people with highest needs, in their own homes, and a minimising of the costs of care by investment in appropriate interventions, to support and improve people's ability to look after themselves.

What policy options have been considered? Please justify any preferred option.

Option 1 - do nothing

Option 2 - proposed intervention to build on the vision set out in 'Putting People First' and to act as a bridge to a future National Care Service

Option 2 is the preferred option. It fulfils the objectives set out above in a way which keeps the additional demands on providers to a minimum.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

The policy implementation will be reviewed after twelve to eighteen months. We will also be consulting on the detail of the scheme to inform Regulations and Guidance.

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:

P. Hope. Date: 8th January 2010

Summary: Analysis & Evidence

Policy Option: 2	Description: Proposed intervention of free personal care for highest needs

COSTS

ANNUAL COSTS	
One-off (Transition)	**Yrs**
£ 0m	0
Average Annual Cost (excluding one-off)	
£ 670m	

Description and scale of **key monetised costs** by 'main affected groups' Exchequer Costs

The costs of providing free personal care in their homes to those in highest need, minus the costs of those in this group already receiving some form of state funded personal care plus the costs of re-ablement up to 2012/13

Total Cost (PV) **£ 1608m**

Other **key non-monetised costs** by 'main affected groups'

BENEFITS

ANNUAL BENEFITS	
One-off	**Yrs**
£ 0m	
Average Annual Benefit (excluding one-off)	
£ 868m	

Description and scale of **key monetised benefits** by 'main affected groups'

i) a transfer payment to those who would not otherwise qualify for free personal care due to their means. ii) a value to whole population for the certainty of receiving ofgovernment provided care

Total Benefit (PV) **£ 2083m**

Other **key non-monetised benefits** by 'main affected groups'

Helping people to stay in their homes for longer than would otherwise be the case, improved health and well-being to those whose needs are not currently met and those who are successfully re-abled, and the value of reduced uncertainty and risk of catastrophic costs from being insured.

Key Assumptions/Sensitivities/Risks Assumptions: more consistent application of Fair Access to Care Services (FACS) criteria across England. Sensitivities/Risks: Unknown impact on behaviour of informal family carers; unknown impact on take-up of people currently funding their own care; unknown impact of behavioural change in relation to residential care.

Price Base Year 10/11	Time Period Years 2.5	**Net Benefit Range** (NPV) £	**NET BENEFIT** (NPV Best estimate) **£ see para 6.1 - 6.3**

What is the geographic coverage of the policy/option?			England	
On what date will the policy be implemented?			1 Oct 2010	
Which organisation(s) will enforce the policy?			LAs	
What is the total annual cost of enforcement for these organisations?			£ N/A	
Does enforcement comply with Hampton principles?			Yes	
Will implementation go beyond minimum EU requirements?			N/A	
What is the value of the proposed offsetting measure per year?			£ 0	
What is the value of changes in greenhouse gas emissions?			£ 0	
Will the proposal have a significant impact on competition?			No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	No	No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ Decrease of £ **Net Impact** £ N/A

Key: Annual costs and benefits: Constant Prices (Net) Present Value

Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

Personal Care at Home Impact Assessment - Evidence

1. INTRODUCTION

1.1 The 1988 Griffiths Report into community care placed a strong emphasis on the importance of establishing services to help people live in their own homes and retain independence, dignity and choice. The introduction of the National Health Service and Community Care Act, 1990 gave support to this and it has been the policy of successive governments to support people to live independently and safely in their own homes for as long as possible if that is what they wish.

1.2 The feedback from the public consultation on the Government's Green Paper, *Independence, Wellbeing and Choice*, in 2005, was clear that that is what people wanted. In response to that, the Government announced £80m funding to pump-prime investment in telecare and preventative technologies, and £60m for extracare housing to further support people living in their own homes.

1.3 More recent advances in telecare and telehealth have also meant that it is now possible for people to remain at home safely and for longer than it once was when previously the only option was to go into residential or nursing home care. Going into care is often seen by people as the last resort only after other options have been exhausted. The average length of stay in residential care homes (18 months to 2 years) and in nursing homes (9 months), even allowing for the small proportion of younger adults who will be included, is considerable. The 2006 White Paper, *Our Health, Our Care, Our Say,* gave further impetus to bringing more health and social care closer to home, strengthening the capacity of community health services and away from acute hospital care.

1.4 The policy on free personal care at home will provide people with another option to delay entering a care home and stay at home for longer if that is what they wish. The public's view on end of life care is similar to those on entering a care home. The 2008 *End of Life Care Strategy*, indicated that most people's first preference is to die in their own home, whereas only 18% are able to do so. A key thrust of the policy is to enable more people to do so if that is what they want.

1.5 A recent Department of Health publication [*Use of Resources in Adult Social Care*] points to a significant finding on re-ablement domiciliary care services "where up to 50% of older people who were offered a short-term package of re-ablement-based care did not require further social care support at the end of their treatment…[and] this has an impact in delaying a person's needs for further care by over two years."

1.6 More generally, this builds on the existing role of Government to provide social care where private insurance cover has proved inadequate. The nature of the uncertainty of the level of services that will be required to meet future personal care needs makes it difficult for the insurance market to price insurance policies, leading to a shortage of cover. The policies that are available are likely to be expensive relative to what can be obtained in a national scheme due to, for example, adverse selection into the private insurance schemes.

2. BACKGROUND

2.1 Putting People First set out the direction of travel for adult social care, recognising that people want to stay in their own homes for longer, will want a greater degree of choice and

control over the services available to them and that local authorities will need to re-profile their spending patterns to make more effective use of resources through targeted earlier interventions. This will support individuals to retain or regain some measure of independence and allow for better use of resources to meet the demographic demands of an ageing population.

2.2 The Green Paper, *Shaping the Future of Care and Support*, currently in consultation makes the case for future investment in social care. This proposal is in line with the direction of travel set out in the green paper.

3. POLICY OBJECTIVE

3.1 The aim of the policy is to deliver on the Government's commitment to provide free personal care to those with the highest needs, within their own homes. The provision of free personal care will incorporate a short period of intensive and focussed support to maximise the person's independent living skills, also known as "re-ablement", in order to support the independence of those wishing to remain in their own home. For those who continue to have the highest care needs we will then provide free personal care. It will also aim to take a step toward better joined up working in health and social care, in light of the proposals in the *Shaping the Future of Care and Support* Green Paper, by encouraging better working between the health and social care systems.

4. POLICY OPTIONS

4.1 We have examined two main options for meeting the policy objectives set out in section 3 above. These options are as follows:-

i) – Do nothing;

ii) – Proposed intervention of free personal care for highest need

Do nothing

4.2 At present, individuals only receive free personal care on a means tested basis. In order to receive free personal care an individual must first have a Fair Access to Care Services (FACS) assessment. Once their need for support has been assessed they then receive a further assessment to determine whether they satisfy the means test requirements. On passing both hurdles they will receive free personal care.

Risks of doing nothing

4.3 Those people for whom it may be possible to stay in their own home, if given a support package including intensive support and personal care, may be forced inappropriately into residential care.

4.4 Those whose needs are not sufficient to qualify for free personal care or whose income is too great for the current threshold are unlikely to receive a full assessment of their needs. Therefore, they will not receive any of the benefits which undergoing assessment can bring about (for example, greater access to information and advice on appropriate services for their level of need).

Proposed intervention of free personal care at home for those in highest need

Initial Assessment

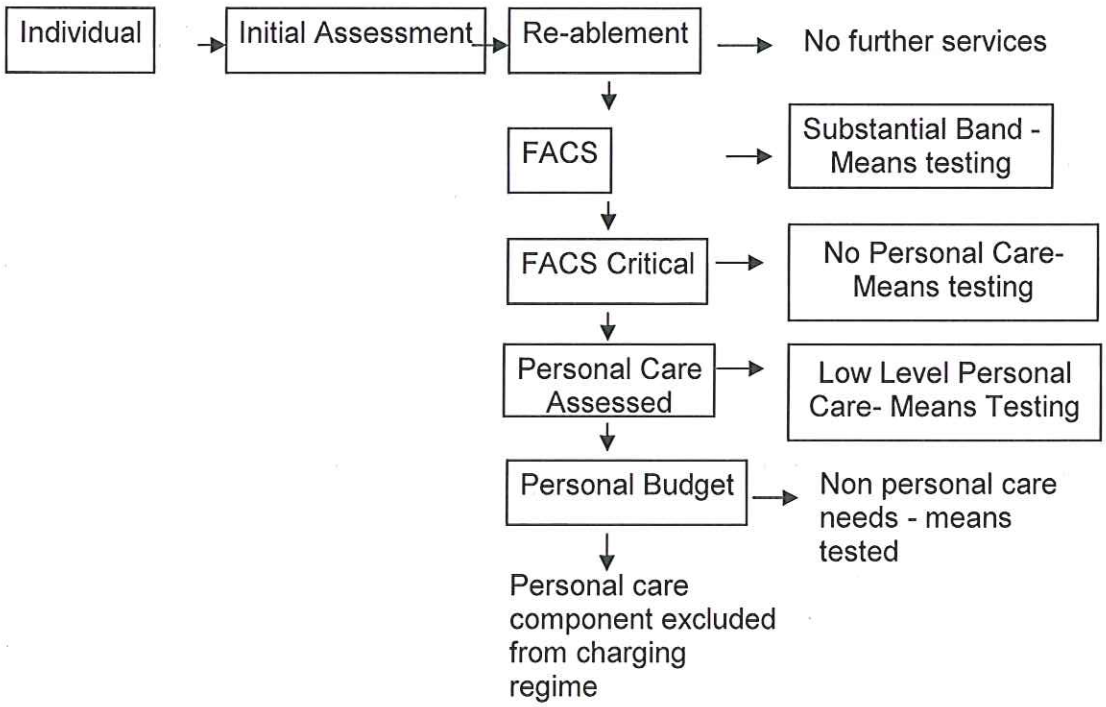
4.5 The individual would have an initial assessment on first contact with the Council for help or, for the self-funder, when seeking free personal care (FPC). Where appropriate (in the majority of cases, but excluding those receiving palliative care) the Council would provide a period of

intensive intervention or re-ablement to build or re-build skills and functioning – supporting people's independence. They would also be able to identify whether specific adaptations or interventions such as telecare might be appropriate to reduce dependency levels. Only at this stage would a formal community care assessment be undertaken which should identify the range of needs, the personal care component and the appropriate Fair Access to Care Services (FACS) banding. A significant number of people undergoing this process would have been supported to reduce their levels of dependency through a re-ablement package – and hence reduce the overall numbers in the highest category of need.

4.6 An individual placed in the highest FACS Band – Critical – would have as part of this, an assessment of personal care needs and where they need help with four or more Activities of Daily Living (ADLs), be offered an indicative sum to cover the cost of their personal care. Not everyone in the Critical Band will have high personal care needs, but we anticipate that most of the older people in this band will need high levels of personal care. We are currently modelling costs and will be consulting more widely with stakeholders to test costing assumptions.

4.7 The remaining, non-personal care, element of the support package will remain subject to the means test and local authorities will be able to levy charges on it in accordance with Fairer Charging policy. The chart below indicates the process diagrammatically.

Assessment of Free Personal Care



Personal care means—

- physical assistance given to a person in connection with—

  eating or drinking (including the administration of parenteral nutrition),

  toileting (including in relation to the process of menstruation),

  washing or bathing,

  dressing,

  oral care, or

  the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist); or

- the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision;

4.8 Activities of daily living (ADLs) relate to the above descriptors.

4.9 This definition **excludes** costs attributable to:
- cleaning and housework;
- laundry;
- shopping services;
- specialist transport services (e.g. dial-a-ride);
- sitting services where the purpose is company or companionship.

4.10 We will be consulting on the principles which should inform the working of the proposals and the Regulations.

5. COSTS AND BENEFITS OF OPTIONS

5.1 These options, and the benefits, risks and costs of each, are described below.

Option 1 - Do nothing

Costs

5.2 The costs of doing nothing (i.e. continuing with the current means tested assessment) is assumed to have a zero baseline. Costs of providing personal care may increase over time, even if there is no policy change, as the population, in general, ages. However, in line with impact assessment guidance on best practice, costs not directly attributable to the policy options under consideration are not incorporated in the analysis. Compared to option 2, people will not be protected from future increases in personal care charges by councils as part of their domiciliary care charging policies.

Benefits

5.3 The benefits of the status quo are also assumed to have a zero baseline. As with costs, benefits not directly attributable to the policy option under consideration are not incorporated in this analysis.

Option 2 - Proposed intervention of free personal care at home for those in highest need

Costs

<u>Personal care</u>

5.4 The costs of offering free personal care in their homes to those in highest need depend crucially on how those in highest need are defined. The existing Fair Access to Care Services (FACS) framework's highest level of need is FACS Critical.

5.5 Data relating to the number of people who are defined as FACS Critical at any point in time and the relative distribution of their needs/disability is not something that is routinely collected at the centre. For this reason, we have used a survey of older people (the English Longitudinal Study of Aging) to estimate the number of people who would be considered to be FACS Critical

(whether they currently are or not) and then summarised their ability to perform Activities of Daily Living (ADLs) as a proxy for their level of need. The results are shown in the table below:

Table 1			
No of ADLs	no.	%	predicted need
1 or 2	72	35%	0.35
3	48	24%	0.42
4+	84	41%	0.51
Total	204		0.43

5.6 The case for offering state insurance against risk is most compelling where the alternative is either to place an unknowable proportion of the population at catastrophic risk of high cumulative costs of care or the charging of excessively (perhaps prohibitively) high insurance premiums. The scale of costs is likely to be higher at higher levels of need.

5.7 Concentrating, therefore, on those in highest need – those who are FACS Critical and with difficulty in undertaking 4 or more ADLs – we estimate the additional number of people and the costs of providing free personal care to the main beneficiary groups with 4 or more ADLs as follows:

Table 2		
2011/12	volume	additional costs (£ millions)
Older people		
4 + ADLs		
Already receiving state-funded care	76,274	
Making means-tested contribution	37,061	
Self-funding plus unmet need	46,089	
Residential care switchers	2,384	
Informal care switchers	5,100[1]	
sub total	**166,909**	**442**
Younger adults		
Already receiving state-funded care	c. 90,000	68
Self-funding plus unmet need	c. 20,000	
administration		27
Total	**276,909**	**537**

Totals in bold may not sum exactly due to rounding

Details of the assumptions and data used to derive these figures are given in Annex A.

5.8 We know very little about the disability of those younger adults who do not already receive free personal care, so all of the estimated costs of extending free care to this group have been included in the 4+ ADL figures. These costs are themselves uncertain, but if any younger adults currently paying for their care have less than 4 ADLs, the costs of offering free care to this group will obviously be lower.

[1] 50% of the estimated total number of informal care switchers, representing 60% of the cost

5.9 It is to be noted that an estimated further 108,964 older people already have their personal care needs met free of charge.

5.10 Due to the inherent uncertainty in estimating the costs of offering free personal care in their homes to those with 4 or more ADLs, the overall costs reported in this Impact Assessment are estimated over a period of just two and a half years. With better information and two and a half years' of experience, more accurate costs will be able to be produced. Volumes have been assumed to increase by 1.5% per annum due to demographic pressures and prices by 2% per annum. On this basis the net present value of the costs in the first two and a half years are summarised below:

Table 3	
From October 2010/11 to end 2012/13	NPV costs (£ million)
Older people (4+ ADLs)	1072
Younger adults	164
administration	65
Total	**1301**

Costs of re-ablement

5.11 Estimating the costs of re-ablement is difficult. We do not know for certain how many people are already receiving re-ablement services. In addition, we do not know exactly what proportion of individuals require no further care following re-ablement or for how long they derive such a benefit.

5.12 We have developed a simple model to estimate the costs and benefits of offering re-ablement. The assumptions under-pinning this analysis are shown in Annex B.

5.13 On the basis of our central assumptions, we do estimate some net savings over the two years that follow – 2011/12 and 2012/13. However, given uncertainties in the model's parameters we do not include these savings in the estimated costs of the policy in these years. If savings are realised, either to individuals or Local Authorities, this will free up resources that can be spent on helping more people in need.

5.14 However, in terms of overall costs and benefits, financial savings from re-ablement that accrue to either individuals or councils as a result of delaying the point at which formal personal care is required, are offset by the reduced income received by providers of formal personal care services. However, if individuals or LAs use the money they would have spent on personal care to buy other things the impact on the economy as a whole is neutral. Individuals who receive re-ablement will be better off as they will have a higher level of wellbeing and a greater capacity for independence.

5.15 If we assume the cost of a package of re-ablement is £1,000 per person, an annual budget of £130 million could help the equivalent of 130,000 people over the course of a year bringing the total number of people supported by this policy to approximately 400,000. The total full year cost of offering Free Personal Care to those who are FACS Critical and have difficulty with four or more ADLs plus an extended offer of re-ablement is then £670 million in 2011/12 (and a Present Value of £1608 million from October 2010 to end 2012/13)

Benefits

5.16 The following table shows a breakdown of the benefits that accrue to different groups (using the costs shown in table 3 plus the estimated costs of re-ablement shown in paragraph 5.15).

Table 4	
	Estimate of benefit £ million
Older people	£1543
Younger adults	
Meeting unmet need	£a
Re-ablement	£b
Equity distribution	£154
Insurance coverage	£386
Reduction of savings disincentive	£c
TOTAL	£2083

Older and younger people

5.17 The benefits to older people and younger adults are shown in the first two rows. These people currently pay for all or part of their personal care services out of their own pocket. Following implementation of the policy, they will no longer have to pay. The monetary value of the benefit is therefore the same as the cost of the service (minus the costs of administration) which appears in the previous table. In other words it is a transfer.

Meeting unmet need

5.18 As a result of changing the criteria for receiving services from being means tested to being needs tested, there is a section of the population who will receive personal care who previously did not. These people will receive a net benefit in terms of improved well being and health. A value on this benefit has not yet been calculated and views on what this might be are welcome.

Re-ablement

5.19 As set out above, re-ablement is an intensive period of assistance for people designed to help them get back on their feet. It allows people to live in their home for longer. People receiving re-ablement services receive a benefit formed of two components. First, people value living in their own home rather than in a care home. Secondly, people receive an improvement in health and well being. A value on this benefit has not been calculated and views are invited on this.

Equity distribution

5.20 HMT's Green book provides a framework by which weighted values can be placed on benefits that accrue to different sectors of society. In particular, it gives weights based on an underlying utility function which links personal utility to income. The population split into quintiles based on income has the following weights

Quintile	Bottom	2nd	3rd	4th	Top
Weight	1.9 – 2.0	1.3 – 1.4	0.9 – 1.0	0.7 – 0.8	0.4 – 0.5

Source: HMT Green Book, Annex 5
http://www.hm-treasury.gov.uk/data_greenbook_index.htm

5.21 The recipients of free personal care are believed to fall into the bottom, 2nd and 3rd quintiles because even the wealthiest older people (who represent the main beneficiary group) are in the middle of the income distribution of society at large. The exact distribution is unknown. For

illustrative purposes, the distribution is assumed to be 60% in 3rd quintile, 30% in 2nd quintile and 10% in bottom quintile.

W = (60*1 + 30*1.4 + 10*2)/100 = 1.22

5.22 We then assume, that some of the population in the bottom and 2nd quintiles already receive free care and adjust for that accordingly. Let us assume that all individuals in the bottom quintile and 10 percentage points of those in the 2nd quintile already receive services, the weighting co-efficient becomes:

W = (60*1 + 20*1.4 + 0*2)/80
= 1.10

Therefore, the distributional gain will be an additional weight of 0.10

5.23 Again, it is important to make clear that the following is for illustrative purposes and that further work is needed on the distribution of the relevant population who will receive the free personal care and on the distribution of those who already receive it.

Applying this weighting to the benefits gives a figure of 0.10 *£1543m = £154m

Insurance coverage

5.24 The availability of insurance against risks provides a welfare gain for individuals and society where individuals are risk-averse. A risk averse person may prefer to pay a fixed premium with certainty rather than face a possibility of suffering a loss greater than premium with uncertainty. The enrolee effectively buys a degree of certainty. Individuals who are risk averse may thus rationally choose to insure against risks though the expected pay out is less than their premium. The difference between the total premiums and the payout is the amount the enrolee is willing to pay for that certainty.

5.25 At present a private insurance market does not exist for personal care following the demise of an embryonic market in the 1980s. This situation is probably caused by both supply side failures. Insurers have found it difficult to assess not only the uncertainty of future payouts, but also to define the criteria by which the payouts would be forthcoming. This creates adverse selection, i.e. the mix of individuals seeking insurance are weighted towards those enrolees with higher needs in a way that insurers cannot fully assess, which leads to under provision in the market and high insurance premiums. On the demand side, the potential high premiums result in low demand. Individuals lack knowledge about risk and the extent of the costs of personal care creating a myopic approach to insurance. Additionally this may be exacerbated by a belief that ultimately the state will provide the services as insurer of last resort.

5.26 The benefit of providing certainty of provision of personal care services is the premium over and above the actuarial fair premium the population would be willingly to pay. This in turn is equal to the profits and administration costs an insurer would receive for providing the cover. If we can calculate the profit and administration cost of providing the cover we can estimate the benefit the population will receive from knowing that personal care services will be provided.

5.27 The USA has an established market for health care. The proportion of premiums that an insurer pays out to cover medical cost is known as the medical loss ratio. Typically this is in the region of 80%, (see http://healthcare-legislation.blogspot.com/2009/11/does-actuarial-value-trump-medical-loss.html). The remaining 20% reflects the willingness to pay by enrolees to receive certainty.

Applying this, benefit from certainty = 1/0.8 * £1543m * 0.2 = £386m

Reduction of savings disincentives

5.28 The current system may force some individuals at the margin to run down savings in order to qualify for free personal care. This provides a disincentive to save. As a result the level of savings in the UK may be sub-optimal. By extending the provision of free personal care to all in highest need irrespective of their means, the disincentive to save is reduced which should result in a savings ratio closer to the optimum. Therefore, the reduction of the savings disincentive provides a benefit to the economy as a whole. No attempt has been made here to estimate the size of this benefit.

Risks

5.29 The proposed option assumes that it will be possible for assessments to be carried out consistently, and that those with the highest needs will be identified appropriately. There is also a risk that the current research and evidence available does not accurately estimate the true numbers who may come forth to seek assessment and services. An evaluation of the policy shall be carried out after twelve to eighteen months to attempt to address these risks.

Evaluation

5.30 We plan to review the operation of the policy after twelve – eighteen months.

Variants

N/A

6. SUMMARY OF COSTS AND PREFERRED OPTION

6.1 Due to uncertainties in certain components of estimated benefits (see £a, £b and £c in Table 4 above), it is not possible to say whether the net benefits of this intervention definitely outweigh the costs. However, as £a, £b and £c are either zero or greater than zero and the quantified benefits from equity distribution and insurance coverage are already positive, it seems plausible that the net benefits are substantial.

6.2 One may view opportunity cost as the deadweight cost of raising the taxation to fund the policy. Typically this deadweight cost of taxation is estimated at 25% of the sum raised. In this case that would be £402 million. The benefits from distributional effects and providing insurance cover of this policy are estimated at £540 million, which more than covers the opportunity cost. This would be appropriate if it were the case that additional taxation could be raised to fund this policy.

6.3 It is plausible that some proposals, those that address problems besetting the population at large rather than a subset, would if adopted mitigate the general reluctance to pay taxes – for the benefit delivered in exchange would be welcomed very widely by the taxpayers themselves. The policy under review may plausibly fall into this category – as it addresses a market failure from which much of the population suffers. Whilst current proposals involve utilisation of DH funds for this purpose, rather than raising additional taxation, it is nonetheless arguable that adoption of this policy will over time ease the government's overall budget constraint by mitigating taxpayer resistance – in which case there is some ground for using the deadweight cost of taxation rather than the opportunity cost of exchequer funds as the truer indicator of the full cost of the proposal.

7. SPECIFIC IMPACT TESTS

Small Firms Impact Test

7.1 We expect that fewer people will have recourse to institutional care, or – if they do – it will take place later than is sometimes the case now. We therefore expect there to be some reduction in the demand for residential care with an offsetting increase in the demand for home care services. This will also be offset by increasing underlying demand due to our ageing population. This change is in line with existing policy on supporting people to live for longer in their own homes.

Health Impact Assessment

7.2 More discussion is given to this in earlier sections. The main impact of this policy is a transfer of costs from individuals to the state, so the health impacts for this group are zero. Those individuals who receive services whose need was previously unmet will receive a health gain. However, since the justification for intervention is to correct failures in the market for personal care insurance, it is expected that there will be gains to the well-being of the population from the reduced uncertainty from being fully insured against the cost of personal care for high levels of need. The benefits section above also shows a distributional gain as individuals in lower quintiles of income distribution gain more than other groups. This may reduce health inequalities and is very unlikely to increase them.

Rural Proofing

7.3 We recognise that for some people in rural areas, access to services and support is more difficult, but this builds on current policy on the transformation of adult social care, which recognises the need for diversity of provision and sensitivity in relation to geographic setting. We would expect councils, in discharging their wider duties, to support the commissioning of care pathways for people that work in rural and island communities as well as for people in urban areas.

7.4 A separate screening EqIA has been undertaken to consider the policy on specific groups. A full EQIA will be carried out as part of the consultation process on the Personal Care at Home Bill.

Race

7.5 Extending free personal care should not create any problems or barriers to any communities or groups. Nor should it have a negative impact.

Disability

7.6 Extending free personal care should not create any problems or barriers to any communities or groups. Nor should it have a negative impact

Gender

7.7 The policy should benefit women more as women generally live longer than men and also are more likely than men to have higher care needs in old age, a fact that was established as part of the work on the Care and Support Green paper

Age

7.8 Free personal care will be available to adults, with the highest needs, who live in their own home. We expect that the majority of recipients will be older people but it should also benefit some people of working age as well. The policy is aimed at adults only as care for children is covered by separate legislation. There is no upper age limit for the policy. Revised FACS guidance should identify specific needs relating to age and therefore removes the possibility that some groups will not have access to free personal care

Social

7.9 The policy is aimed at adults receiving social care, regardless of age. It is likely to be of particular benefit to older people as the demographic make-up of those receiving adult social care is weighted towards older people. Children's social services are offered on a different basis.

7.10The policy intention is to remove the current means test applied to those needing the highest levels of care. This will bring into scope a number of people currently excluded on grounds of income and assets.

Devolved countries This policy applies to England only

Particular regions of the UK? We are exploring this in more detail with key stakeholders, particularly ADASS and LGA. We are consulting on a range of options for allocating the funding to LAs so that more money is given to those areas with relatively more beneficiaries.

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	*Results in Evidence Base?*	*Results annexed?*
Competition Assessment	No	No
Small Firms Impact Test	Yes	No
Legal Aid	No	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	Yes	No
Race Equality	Yes	No
Disability Equality	Yes	No
Gender Equality	Yes	No
Human Rights	Yes	No
Rural Proofing	No	No

Annexes

Annex A – key costing assumptions (see tables 1 and 2)

OLDER PEOPLE

For estimating the ADL needs profile of those deemed to be FACS Critical:

- Source: English Longitudinal Study of Aging (ELSA)[2], Wave 3
- Each individual's need for formal care predicted on the basis of a logistic model using their age, ADL disability and whether or not they live alone
- 4.7% of those in highest estimated need assumed to be FACS Critical (derived from CSCI's State of Social Care report, and assuming that all those in residential care are FACS Critical by definition)
- costs are linearly related to the average predicted need within each ADL group

For estimating the costs of expanding Free Personal Care

- Source: PSSRU's micro-simulation model for older people[3]
- Home care is 74% of overall community care costs, and personal care is 85% of that
- Residential care switchers – estimate based on simple stock and flow model; central assumption is that 10% of the flow into residential care will switch to home care
- Informal care withdrawers – estimate based on the additional number of people that would become FACS Critical if all individuals in ELSA lived alone; central estimate is that 5% of these would have informal care withheld

[2] http://www.natcen.ac.uk/elsa/

[3] For further details see http://www.pssru.ac.uk/pdf/dp2644.pdf

Annex B – key assumptions for modelling the costs and benefits of re-ablement

Stocks and flows

New flow of clients is 14,815 per month (estimated on the basis of a current stock of 400,000 home care clients and an average duration of home care of 27 months).

Outflow of clients is equal to applying a 3.7% attrition rate to all those receiving personal care at home – i.e. both those who have gone through re-ablement and those who have not – which is based on the steady-state starting outflow of 14,815 per month.

Effectiveness of re-ablement

Duration of enablement is 2 months.

Everybody receives 1 package of re-ablement.

At the end of the period of re-ablement:

- 49% of people require no immediate help[4] (this amounts to 51% or 7,556 clients left requiring care immediately after re-ablement)

2 years after the period of re-ablement:

- 36% continue not to require a home care package[5]

Using linear extrapolation, this is equivalent to 95 returners each month.

Costs of re-ablement

It has been estimated that re-ablement costs £1000 per person (roughly 30 hours of re-ablement at £30 per hour).

Normal care

Using the results from the DH/PSSRU estimates of the costs of introducing free personal care in their homes to those in highest need, the average number of hours of personal care per week is 6.54. The estimated cost per hour is taken from PSSRU and is £15.75 in 2011/12 prices.

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[4] Based on West Berkshire CSED data (Benefits of Homecare Re-ablement for people at different levels of need; Care Service Efficiency Delivery).

[5] Using the lowest figure reported by SPRU's 2-year follow-up of 4 re-ablement schemes. None of these schemes exclusively worked with FACS critical clients nor reported the FACS critical results separately (Retrospective Longitudinal Study; Social Policy Research Unit; October 2007).

Counter-factual

The alternative to re-ablement is assumed to be that the monthly flow of new clients receive a personal care package as shown above for an average period of 27 months – i.e. the stock is in steady state.

Only the costs and effectiveness of providing re-ablement to the monthly flow of new clients has been modelled.