

Crossley, Thomas F.; Zilio, Federico

Working Paper

The health benefits of a targeted cash transfer: The UK Winter Fuel Payment

ISER Working Paper Series, No. 2017-10

Provided in Cooperation with:

Institute for Social and Economic Research (ISER), University of Essex

Suggested Citation: Crossley, Thomas F.; Zilio, Federico (2017) : The health benefits of a targeted cash transfer: The UK Winter Fuel Payment, ISER Working Paper Series, No. 2017-10, University of Essex, Institute for Social and Economic Research (ISER), Colchester

This Version is available at:

<https://hdl.handle.net/10419/200389>

Standard-Nutzungsbedingungen:

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

Terms of use:

Documents in EconStor may be saved and copied for your personal and scholarly purposes.

You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.

If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.

The Health Benefits of a Targeted Cash Transfer: The UK Winter Fuel Payment

Thomas F. Crossley

University of Essex and Institute for Fiscal Studies

Federico Zilio

Institute for Social and Economic Research
University of Essex

No. 2017-10
August 2017



INSTITUTE FOR SOCIAL
& ECONOMIC RESEARCH

Non-Technical Summary

- *The Winter Fuel Payment (WFP) caused a significant reduction in the incidence of a blood marker of infection among those just eligible for the payment between 2000 and 2009.*
- *Other disease markers also point to health benefits of the WFP, although the results are less clear.*
- *The eligibility age for the WFP has recently increased, with increases in the Female State Pension age.*
- *These increases in the eligibility age will have eliminated the health benefits documented in this study.*

Each year, the U.K. experiences Excess Winter Mortality (EWM). Most EWM occurs among the elderly and is due to respiratory and circulatory diseases. In addition to EWM, cold weather is associated with increased demands on health care systems through increased incidence of illness requiring hospitalization or other treatment. A key policy response to EWM in the U.K. is the Winter Fuel Payment (WFP). The WFP is a labelled but unconditional cash transfer to households containing an older person (male or female) above the female state pension age. The stated intention of the policy is help older households keep their homes warm.

From 2000 to 2009, households containing an older person above age 60 received the WFP. This study compares older individuals in households that were just eligible for the WFP to older individuals in households that were not quite eligible for the WFP. To do this, we employ a regression discontinuity design and data from the Health Surveys for England (HSE), the Scottish Health Survey (SHeS) and the English Longitudinal Study on Ageing (ELSA). The outcomes we examine are self-reports of chest infection in the last 3 weeks, high blood pressure, and blood concentrations of two “biomarkers” of infection and inflammation.

We find a robust and statistically significant six percentage point reduction in the incidence of high levels of one of the biomarkers of infection (fibrinogen). Reductions in other disease markers also point to health benefits, but the estimated effects are not robustly statistically significant. Overall, the Winter Fuel Payment does appear to have had some health benefit among those just eligible.

The eligibility age has been rising with the Female State Pension age and will be 65 in 2018. The health benefits documented in this study will have been eliminated by these increases in the eligibility age.

The Health Benefits of a Targeted Cash Transfer: The UK Winter Fuel Payment

Thomas F. Crossley¹ and Federico Zilio²

August 2017

Abstract: Each year the UK records 25,000 or more excess winter deaths, primarily among the elderly. A key policy response is the “Winter Fuel Payment” (WFP), a labelled but unconditional cash transfer to older households. The WFP has been shown to raise fuel spending among eligible households. We examine the causal effect of the WFP on health outcomes, including self-reports of chest infection, measured hypertension and biomarkers of infection and inflammation. We find a robust and statistically significant six percentage point reduction in the incidence of high levels of serum fibrinogen. Reductions in other disease markers point to health benefits, but the estimated effects are not robustly statistically significant.

Keywords: benefits, health, biomarkers, heating, regression discontinuity

JEL Codes: H51, I12

¹ University of Essex and Institute for Fiscal Studies, London. tcross@essex.ac.uk. Crossley gratefully acknowledges support for this research from the Economic and Social Research Council (ESRC) through the Research Centre on Micro-Social Change (MiSoC) at the University of Essex (grant number ES/L009153/1) and Centre for Microeconomic Analysis of Public Policy at the Institute for Fiscal Studies (grant number RES-544-28-5001.)

² University of Essex. fzilio@essex.ac.uk. Zilio gratefully acknowledges the support of the ESRC through a doctoral fellowship (grant number ES/J500045/1).

1. Introduction

Each year, the U.K. experiences Excess Winter Mortality (EWM). The Office of National Statistics computes EWM by compares the number of deaths registered between December and March with the average number of deceases in the foregoing August-November and in the succeeding April-July. In 2014/15 the number of excess winter deaths in England and Wales was estimated at 43,900, the highest level since 1999. EWM has also been documented in Europe (Kunst et al., 1993; Eng and Mercer, 1998; Rose, 1966; Mackenbach et al., 1992; Keatinge and Donaldson, 1995), the USA (Kloner et al., 1999; Lanska and Hoffmann, 1999) and Asia (Cheng, 1993; Ornato et al., 1990). Most EWM occurs among the elderly and is due to respiratory and circulatory diseases (Donaldson, 2010; Lloyd, 2013; ONS Statistical Bulletin 2014/15).¹ In addition to EWM, cold weather is associated with increased demands on health care systems through increased incidence of illness requiring hospitalization or other treatment.

While outdoor temperatures may play a role in EWM,² living in a cold *indoor* environment has a direct impact on the health of elderly people (Wilkinson et al. 2001; Marmot et al. 2011; Dear & McMichael 2011; Rudge & Gilchrist 2007).³ In the U.K., a key policy response to EWM is the Winter Fuel Payment (WFP). The WFP is a labelled but unconditional cash transfer to households containing an older person (male or female) above the female state pension age. The stated intent of the policy is help the elderly deal with the cost of keeping their dwelling warm (Lloyd, 2013; Kennedy & Parkin, 2016) and the labelling of this cash transfer has been shown to be effective in inducing eligible households to increase fuel spending (Beatty et al., 2014).⁴ However, the key policy question is whether the WFP improves health of elderly people living in eligible households, and there is little evidence on this point.

¹ In the winter of 2014/2015 36 % of EWM was attributable to respiratory disease and 22.5% to cardiovascular disease (ONS, 2015).

² The strong association between exposure to outdoor cold temperatures and mortality or morbidity is well documented in the epidemiological literature (Curwen, 1997; Wilkinson et al., 2001; Keatinge, 1986, 1989, 2002).

³ Wilkinson et al. (2001) show that deaths attributable to cardiovascular diseases are 23 % higher in winter than the rest of the year and give evidence of a positive association of the EWM with the age of the property and the thermal inefficiency of the buildings. Rudge and Gilchrist (2007) find that their fuel poverty index which includes an energy efficiency rates and income is a strong predictor of the excess winter morbidity measured with number of emergency respiratory hospital admissions.

⁴ Beatty et al. (2014) estimate that eligible households spend 47% of their WFP on fuel. If the payment were treated as other income, eligible household would be expected to spend 3% of the payment on fuel.

The female state pension age, and hence the age cut-off for WFP eligibility, was 60 prior to 2010. It then began to increase so that it will equal the male state pension age of 65 in 2018 and then both will rise to 67 by 2028. Most EWM occurs among individuals over 75, leading Lloyd (2013) to propose that increases in the eligibility age could reduce the financial cost of the WFP with minimal if any reduction in health benefits. But there has been no direct evidence on the health benefits foregone through recent increases in the age cut-off or health benefits that may be lost through further increases.

This paper reports the first tests for health benefits of the WFP based on individual-level data. We measure health outcomes in the Health Surveys for England (HSE), the Scottish Health Survey (SHeS) and the English Longitudinal Study on Ageing (ELSA). These studies include nurse visits allowing us study biomarkers and physical measures as well self-reports. To estimate the causal effect of the WFP, we follow Beatty et al., (2014) in employing a regression discontinuity design (RDD). The RDD is thought to be the most convincing of quasi-experimental designs (Lee and Lemieux; 2010).⁵ A RDD is possible where there is cut-off in eligibility for treatment, as there is for the WFP: in the period we study, households with no member 60 or above are ineligible.⁶ A RDD estimates the causal effect of treatment by comparing outcomes just below and above the eligibility cut-off. It estimates a *local* average treatment effect – at the eligibility cut-off. Thus our design estimates the causal effect of the WFP on the health of individuals living in households where the oldest member of the household is 61. These are precisely the individuals who lost any health benefits of the WFP as the eligibility age was incrementally increased from 2010, so our empirical strategy directly answers a key policy question.

To the best of our knowledge, Iparraguirre (2014) is the only prior assessment of the health benefits of the WFP. Using aggregate mortality data, Iparraguirre documents a decline in EWM in 2000/2001, coincident with the introduction of the universal WFP.⁷ EWM fluctuates significantly from year-to-year with changing winter weather conditions and viral environment. Using time-series econometric techniques, Iparraguirre finds a structural break in the EWM time series for England and Wales in 2000/2001 and estimates that half of the

⁵ The Regression Discontinuity Design was first introduced in the Education literature (see Thistlethwaite and Campbell, 1960) and has been widely adopted in economics (Lee and Lemieux; 2010)

⁶ Take up of the WFP is very high, so that there is little difference between eligibility and receipt. See Beatty et al. (2014) for further discussion.

⁷ The WFP was introduced in 1997 but it was initially means-tested and the payment significantly smaller. In 2000/2001 it took its current form (a universal payment to all households containing a person above the female state pension age of between 200 and 300 pounds).

reduction in the EWM in that year can be attributed to the introduction of the WFP. This is an important finding, but it does rest on the ability of the econometric methods to distinguish the policy effects from the very substantial year-on-year fluctuations in EWM. Moreover, the aggregate EWM time-series is necessarily silent on health effects that may precede mortality, and on benefits to particular groups. We add to the evidence base significantly by using a convincing quasi-experimental design in conjunction with individual level data; by considering a variety of measures of circulatory and respiratory illness, including biomarkers⁸; and by testing for health benefits particularly among the group that have been made ineligible by recent changes to the age cut off.

We estimate the effect of the WFP on circulatory and respiratory illness measured four ways:

- (i) self-reports of chest infection in the last 3 weeks
- (ii) Hypertension measured during a visit
- (iii) Serum values of C-reactive protein (CRP) in excess of 10 mg/l
- (iv) Serum values of Fibrinogen in excess of 4 g/l

Repeated exposure to a cold environment results in an increase in the blood pressure, and high values of systolic and/or diastolic blood pressure (hypertension) is a predictor of heart disease and stroke (Hoffman et al. 1983; Fraser 1986; Wilson et al. 1998; Collins et al., 1985; Collins et al., 1990). CRP is a blood plasma protein that is indicative of inflammation and infection and a risk predictor of cardiovascular disease (Pepys, 2003; Pearson et al., 2003). Fibrinogen is glyco-protein and marker of inflammation. It is strongly associated with exacerbations of chronic obstructive pulmonary disease (Duvoix et al., 2012; Mannino et al., 2015). High values of CRP or fibrinogen are considered evidence of current infection (Pearson et al., 2003).

Our principal finding is that, among those living in a household that just qualifies for the payment, the WFP leads to a six percentage point reduction in the incidence of high levels of serum fibrinogen (on a base of 12 %). This effect is statistical significant ($p < 0.01$) and very robust. For the other health measures we consider, while point estimates suggest health benefits, the estimated effects are less robust to changes in sample or specification, and rarely statistically significant.

⁸ Biomarkers have been increasingly drawing attention in the economic literature as an objective measure of health and a complement of self-reported health measures (see Jurges et al., 2013; Evans and Garthwaite, 2014; Michaud et al., 2016)

In the next section, we provide further detail on our data, outcomes measures, identification strategy and methods. Section 3 presents our results. Section 4 contains additional discussion of the findings.

2. Data and Methods

Data

The analysis reported in this paper is based on data from the Health Surveys for England (HSE) (2001, 2003, 2004, 2005, 2006, and 2009)⁹, the Scottish Health Survey (SHeS) (2003, 2008, 2009) and the English Longitudinal Study on Ageing (ELSA) (wave 2, 2004-05, and wave 4, 2008-09). The HSE and the SHeS are annual cross-sectional surveys of the health conditions of the population in England. ELSA is a longitudinal survey that captures the population in England aged 50 and over. The ELSA sample is derived from the 1998, 1999 and 2001 HSE. In both surveys a face-to-face interview is followed by a nurse visit. In the interview the respondents answer questions on their general health, smoking status and alcohol consumption and other individual characteristics such as education and employment status. After the interview an appointment for the nurse visit is arranged. In the visit a trained nurse asks questions on the health condition of the respondent, takes blood and saliva samples and reads the blood pressure and several other measures (height, weight, waist, hip, lung function and grip strength). Blood samples are sent to an external laboratory for analysis. ELSA, HSE and SHeS data contain several biomarkers that are recovered from the analysis of the blood samples. Among the biomarkers reported, there are two that are useful for our analysis because they are correlated with inflammation processes and infection and are markers of circulatory and respiratory illness. These are C-reactive and fibrinogen.

Following Beatty et al. (2014) we restrict the sample to single men and couples in which the man is the oldest in the household. Over the period 2003-2009 the Female State Pension age was 60¹⁰, coincident with the age of eligibility for the WFP. We discard single women and couples in which the woman is the oldest member of the household to avoid any confounding effect of receipt of the state pension on the fuel expenditure and the health outcomes of the elderly.

⁹ HSE 2001 contains hypertension measure and self-reports of chest infection only (not the biomarkers).

¹⁰ In the same period the male state pension age was 65.

Health Outcomes

We study four measures of circulatory and respiratory illness:

- (i) self-reports of chest infection in the last 3 weeks
- (ii) Hypertension
- (iii) Serum values of C-reactive protein (CRP) in excess of 10 mg/l
- (iv) Serum values of Fibrinogen equal or in excess of 4 g/l.

During the nurse visit, respondents are asked whether they have experienced any respiratory infection in the preceding 3 weeks (influenza, pneumonia, bronchitis or a severe cold). This self-reported outcome is available only in ELSA and SHeS.

Our second outcome is hypertension, a risk factor for strokes and heart attacks. The World Health Organization (WHO) defines hypertension as systolic blood pressure of 140 mm Hg or above and/or diastolic blood pressure of 90 mm Hg or above (WHO, 2013). In our sample, around the cut-off age for WFP eligibility, about 35 % of respondents are hypertensive.

The other outcomes in our study are CRP and fibrinogen, two acute-phase biomarkers. Serum concentrations of these two biomarkers increase sharply during an inflammatory process. CRP is considered an indicator of bacterial infection, pneumonia and tissue damage (Tillet and Francis, 1930; Pepys, 2003; Pearson et al., 2003; Simon et al., 2004). The median of CRP in our sample is 1.7 mg/l but its distribution is highly skewed. The value rises within few hours of disease onset. Inflammation and bacterial infection can produce a rise in CRP values up to 1,000-fold (Pepys, 2003; Gruys et al., 2005). Fibrinogen is a coagulation protein produced by the liver that helps the body in the formation of blood clots. The normal range of fibrinogen is 2-4 g/l, but the concentration increases up to 3-fold in the presence of an inflammatory process, infection or tissue damage (Fenger-Eriksen et al., 2008; Gruys et al., 2005; Schmaier, 2012). High concentrations of fibrinogen are also strongly associated with chronic obstructive pulmonary diseases and moderately with coronary heart diseases (Danesh et al., 2005; Duvoix et al., 2012; Mannino et al., 2015). In the epidemiological literature a value of the C-reactive protein in excess of 10 mg/l is taken as evidence that a person has an active infection or inflammatory process. Epidemiologists have often discard observations with these high values because of their focus on chronic processes (Pearson et al., 2003).

Table 1. Descriptive statistics. C-reactive protein, Fibrinogen, Hypertension and Self-Reported Chest Infection.

	Age Window	Median	90 th percentile	Prob(Illness)
C-reactive protein				<i>Prob(CRP>10 mg/l)</i>
	58-63	1.7	7	0.055
Fibrinogen				<i>Prob(Fib≥4 g/l)</i>
	58-63	3.1	4	0.125
Hypertension				<i>Prob(Hypertension)</i>
	58-63	-	-	0.353
Self-reported Chest Infection				Prob(Chest Infection)
	58-63	-	-	0.101

Observations with a fractional probability of being eligible to the Winter Fuel Payment are dropped.

However, as our interest is whether the WFP plays a role in reducing the incidence of a respiratory or circulatory disease among the elderly, extreme values (in excess of 10 mg/l for CRP) are the appropriate object of our analysis. The epidemiological literature has not defined an equivalent disease threshold for fibrinogen but we take values in excess of the top the standard range (2-4 g/l) as evidence of current infection or inflammation.

Regression Discontinuity Design

The RDD allows health outcomes to vary with the “forcing variable”, which is the age of the oldest person in the household of subject i at the time of the interview t . Denote this by (A_{it}) . The econometric model includes smooth functions of the value of the forcing variable relative to the cut-off age ($A_{it} - 60$). It also includes an indicator (or dummy) variable, D_{it} , for whether a respondent’s household was eligible for the last WFP payment before the interview at which health outcomes were measured. Finally, it includes additional covariates X_{it} , to increase the precision of the estimator by capturing individual background variation in health (unrelated to the WFP).¹¹

¹¹ The assumption behind the RDD is that all health determinants apart from WFP eligibility should evolve smoothly with A_{it} , including (but not limited to) the covariates X_{it} . For the covariates Z_i , we can test this by estimating an RDD in Z_i . There should be no discontinuity in the Z_i at the 60 or, equivalently, observables should be balanced between eligible and not eligible in the region of the cut-off (analogous to covariate balance in a randomized trial). We have tested this and cannot reject for balance for any of the included covariates Z_i (see the notes in Table 2 for a complete list). This implies that the point estimate of the treatment effect is not affected by the inclusion of the covariates, which we confirm in our robustness checks. The covariates can, however, improve precision by reducing the unexplained variation in the outcome variable (again, as in a randomized trial).

Thus the econometric model is:

$$H_{it} = \beta_0 + f(A_{it} - 60) + \tau D_{it} + f(A_{it} - 60) \times D_{it} + X_{it}\gamma + e_{it}$$

We employ both linear and quadratic functions for $f(\cdot)$. The model is estimated by ordinary least squares. Note that all of the health measures (H_{it}) we consider are binary so that $E[H_{it}] = \text{Prob}(H_{it} = 1)$ and this is a linear probability model. The parameter of interest is τ , which measures the local causal effect of the WFP on $\text{Prob}(H_{it} = 1)$, around the cutoff. Formally:

$$\tau = \lim_{A_{it} \downarrow 60} E[H_{it} | A_{it} = 60, X_{it} = x] - \lim_{A_{it} \uparrow 60} E[H_{it} | A_{it} = 60, X_{it} = x].$$

As the H_{it} are measures of illness, if the WFP improves health τ should be negative. We report standard errors that are robust to heteroscedasticity and clustering by the age in years of the oldest member of respondent's household.

The WFP was between £200 and £300 (about 300-450 USD) during the period 2002-2009 when our data were collected and it was paid in November-December.¹² Eligibility is determined by the age of the old household member in the preceding September. Thus a respondent's household will have received a WFP in the December prior to the nurse visit date only if the oldest member of the household was 60 in the September immediately before the December before that date. All households with an oldest member aged 59 or less at the date of the nurse visit will not have received a WFP. All households with an oldest member aged 62 or more at the date of the nurse visit will have been eligible for at least one WFP, and, given the very high take-up of this benefit, almost surely received it. For households with an oldest member aged 60 or 61, whether they have been eligible for a WFP will depend on both the date of the nurse visit and the birthday of the oldest member of the household. A complication is that, although the month of the nurse visit is known, ages are recorded in the data in years. That means, the WFP status of some households with an oldest member aged 60 or 61 can only be determined probabilistically. This is described in Table 6 in the Appendix.¹³ We deal with this in two ways. First, we define D_{it} according to Table 6, so that $D_{it} = 0$ if $A_{it} < 59$, $D_{it} = 1$ if $A_{it} > 61$ and $D_{it} \in [0, \frac{1}{12}, \frac{2}{12}, \dots, 1]$ if $A_{it} \in 60, 61$ following

¹² From 2000 to 2007 the WFP was £200 for most eligible households but £300 for households with an over-80s member. In 2008 the WFP was temporarily uplifted to £ 250 for over 60s and to £ 400 for over 80s but this increase was reversed in the Budget of March 2011.

¹³ For example, if an individual has the nurse visit in January, their household will have received a WFP in December (one month before), as long as the oldest member is more than 60 years and 4 months old, so that they were 60 in the preceding September. If the oldest member of the household reports age 60 and was born in August, the household will have been eligible for a WFP in December. However, if the oldest member of the household reports age 60 and was born in October, the household will not have been eligible for a WFP in December. Of those oldest members of a household aged 60 in years at a given nurse visit, 2/3 will be older than 60 years and 4 months, and 1/3 will be 60 years four months or less.

the mapping in Table 6. Second, as a robustness check, we re-estimate the model dropping all observations for which WFP cannot be discretely determined. Note that when these cases are dropped, $D_{it} = 1[A_{it} > 60]$ (exactly), where $1[.]$ is an indicator function.

3. Results

We begin with the now standard graphical presentation of the RDD in Figures 1 through 4. Each figure corresponds to one of our four measures of circulatory and respiratory illness. The vertical axis measures the incidence of illness, after regression-adjustment for covariates at the individual level. These covariates are listed in the notes to the figure but of course exclude age and WFP eligibility. The horizontal axis measures the age of the oldest member of a respondent's household. Each plotted point is the average value of the illness measure for a given year of age (of oldest household member). As our illness measures are binary, this mean is a probability. The cut-off for WFP eligibility (at age 61) is indicated in Figures 1 through 4 by the vertical line and separate least-squares best-fit lines are plotted to the left and the right of the cut-off. A treatment effect is indicated by a discontinuity between these two best-fit lines at the cut-off.

Figure 1: Effect of the Winter Fuel Payment on the probability of having a C-reactive protein level larger than 10 mg/l .

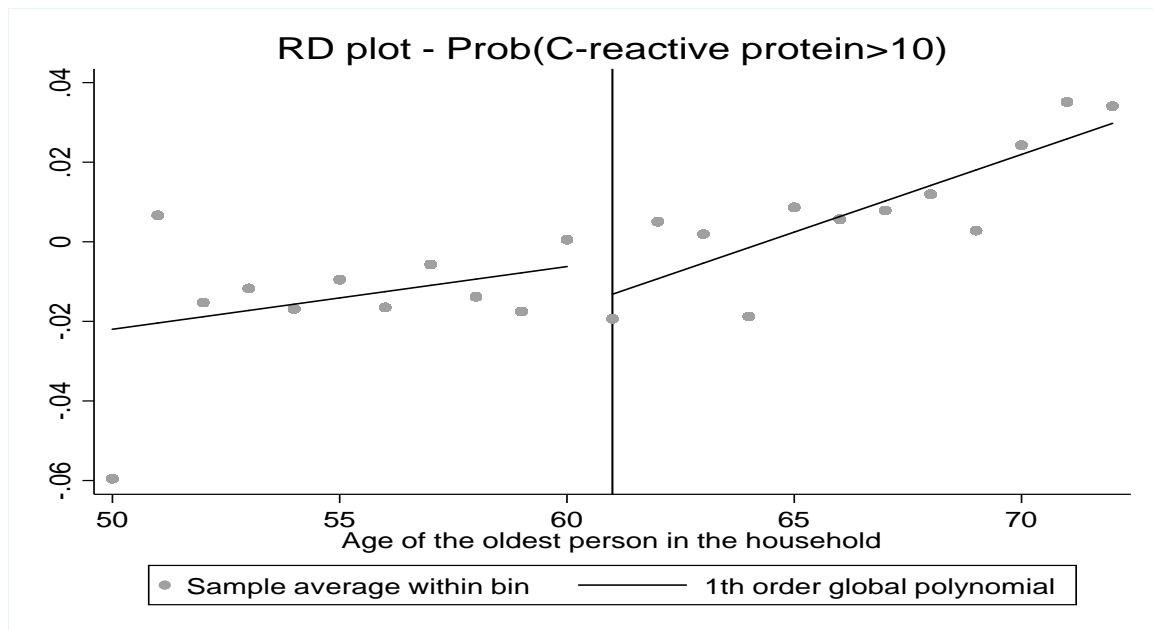


Figure 1 plots the residuals of a regression of the Prob (C-reactive protein>10 mg/l) on type of household, gender, smoker status, alcohol consumption Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

Three of the four figures indicate decline in illness incidence with WFP eligibility. The exception is self-reported chest infection. The plots also indicate that the paths of illness incidence across age of the old household member are quite noisy, with significant year on year fluctuations. Although we have substantial sample sizes (each point represents about 400 observations), we are modelling relatively rare events (in our sample 5.5 % of the elderly just below the cut-off present a CRP value larger than 10 mg/l and 12.5 % a fibrinogen value in excess of 4 g/l, see Table 1). To assess the magnitudes and statistical significance of the discontinuities visible in these figures we turn to formal RDD estimates (as described above). These are reported in Table 2.

Figure 2 Effect of the Winter Fuel Payment on the probability of having a fibrinogen level larger than 4 g/l.

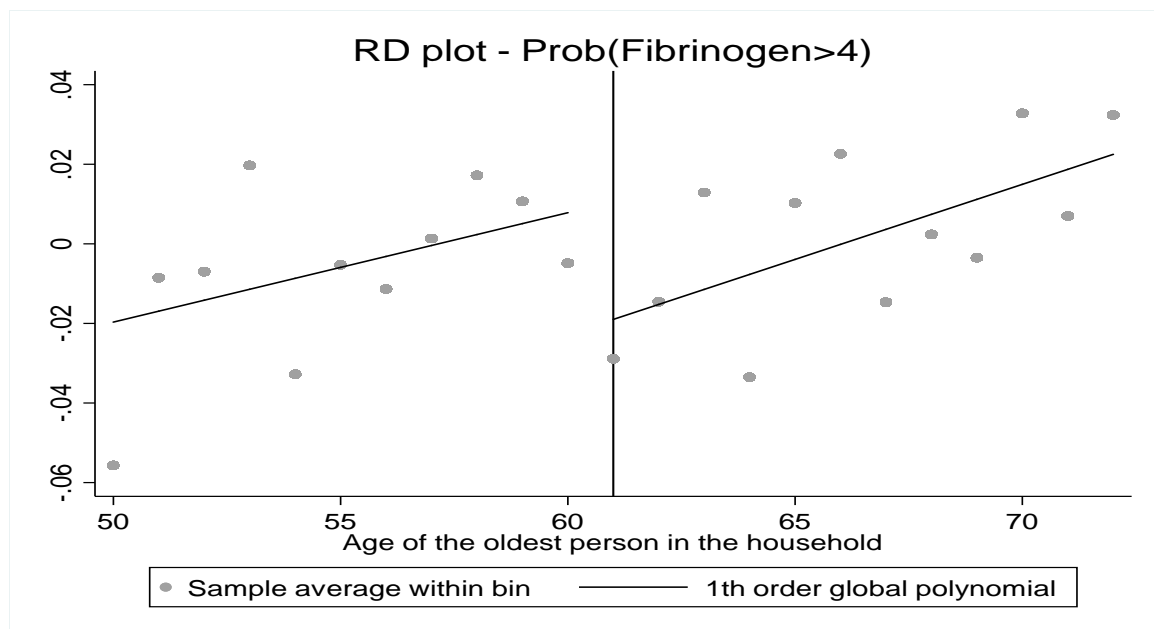


Figure 2 plots the residuals from a regression of the Prob (Fibrinogen \geq 4) on type of household, gender, smoker status, alcohol consumption, Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

Figure 3 Effect of the Winter Fuel Payment on the probability of having had a recent chest infection.

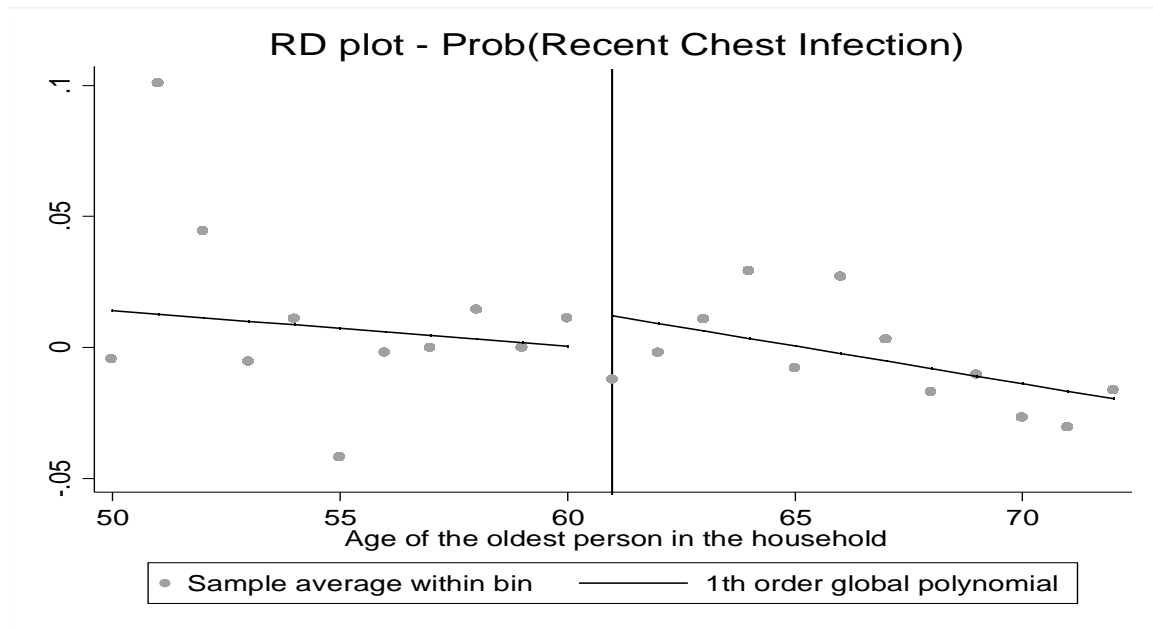


Figure 3 plots the residuals from a regression of the Prob (Chest Infection in the last 3 weeks) on type of household, gender, smoker status, alcohol consumption, Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

Figure 4 Effect of the Winter Fuel Payment on the probability of having hypertension.

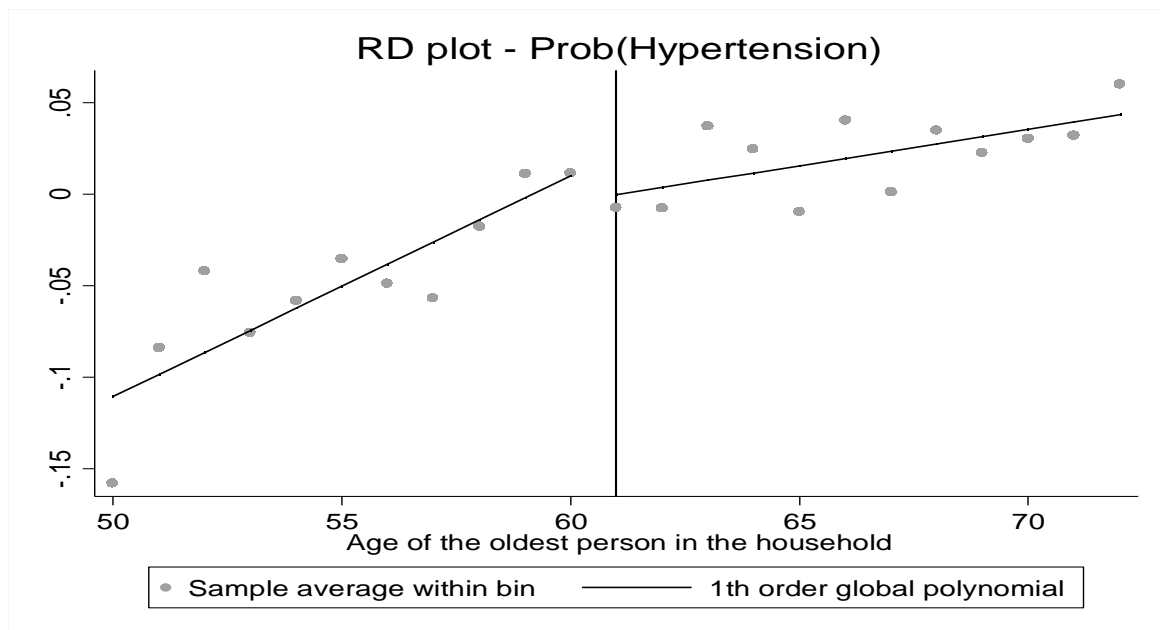


Figure 4 plots the residuals from a regression of the Prob (Hypertension) on type of household, gender, smoker status, alcohol consumption, Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

In Table 2 each column gives the estimate of the WFP effect on the health outcomes in our preferred specification with linear functions of the forcing variable, $f()$, covariates, and a sample age window (for the age of the oldest member in the household window) of 50 to 72 years. The point estimates suggest that the WFP improved the health of the elderly at age 61, reducing all our measures of illness. Effect sizes are 1 to 6 percentage points.

Table 2. The impact of the Winter Fuel Payment on predictors of infection.

Effect of the WFP on Fibrinogen, C-reactive protein, Self-reported Chest Infection and Hypertension				
	Fibrinogen	C-reactive protein	Self-reported infection	Hypertension
Causal Effect of Eligibility [95% Confidence Interval]	-.055*** [-.077; -.033]	-.012 [-.044; .020]	-.024* [-.049; .001]	-.018 [-.049; .012]
Minimum Detectable Effect (at 80% power)	±0.028	±0.040	±0.031	±0.038
Unadjusted P-Value (Adjusted for Multiple Testing)	0.000 (0.022)	0.418 (0.221)	0.058 (0.091)	0.207 (0.119)
Number of observations	3,974	4,517	4,569	6,295
Age Window	55-65	55-65	55-65	55-65

Standard Errors clustered by age of the oldest household member. The RDDs have a linear specification in the age of oldest member in the household. Additional covariates in the RDD: type of household, gender, smoker status, alcohol consumption, Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

*** p<0.01 **p<0.05 *p<0.1

However, the WFP only has a statistically significant effect at 5 % level on having a high concentration of fibrinogen.¹⁴ It decreases the probability of a fibrinogen value in excess of 4 g/l by 5.5 percentage points. As 12.5 % of the elderly just below the cut-off have a value of fibrinogen in excess of 4 g/l, our estimate implies a 44 % reduction in the incidence of this measure of illness at the age cut-off. Data on the CRP are noisier and the discontinuity effect at the cut-off is not statistically significant at conventional levels. Nonetheless, the magnitude of the WFP effect (1.2 percentage points) is sizeable and implies a 22 % reduction in the incidence of illness by this measure, again at the cut-off.¹⁵ In Column 3 we report the effect on self-reporting a chest infection in the last 3 weeks and in Column 4 we report the effect on the incidence of hypertension. The effects are about 2 percentage points, but neither is statistically significant at 5 % level. The largest point estimate of an effect is for Fibrinogen

¹⁴ This finding is robust to the adjustment for multiple testing using the Romano-Wolf algorithm (see the third line in Table 2).

¹⁵ The fraction of elderly just below the age 61 cut-off with CRP value larger than 10 mg/l is 6.3%.

above the normal range. This is also the most precisely estimate effect. To get an idea of the power of our tests, we calculate, for each outcome, the minimum effect size we would have 80% power to detect. These are displayed in the third row of Table 2. Although we have quite large samples sizes, minimum detectable effects are quite large. This is partly because we are examining the incidence of extreme values, and partly because we only have clean identification of treatment effects at the eligibility cut-off and must model the evolution of illness incidence on either side of the cut-off.

Table 3. Robustness checks. The impact of the Winter Fuel Payment on predictors of infection.

Effect of the WFP on Fibrinogen, C-reactive protein, Self-reported Chest Infection and Hypertension				
	Fibrinogen	C-reactive protein	Self-reported infection	Hypertension
Quadratic specification in age of oldest household member [95% Confidence Interval]	-.079*** [-.132; -.026]	-.030 [-.073; .013]	.001 [-.028; .029]	-.089*** [-.132; -.046]
No additional covariates [95% Confidence Interval]	-.046*** [-.069; -.024]	-.010 [-.042; .023]	-.026* [-.057; .004]	-.014 [-.043; .015]
Narrower Age Window: 57-63 [95% Confidence Interval]	-.087*** [-.118; -.056]	-.033** [-.066; -.001]	-.015*** [-.024; -.006]	-.049*** [-.072; -.025]
Wider Age Window: 50-70 [95% Confidence Interval]	-.044*** [-.068; -.019]	-.015 [-.038; .008]	.015 [-.009; .040]	-.022 [-.050; .005]
Dropping observations whose eligibility cannot be discretely determined [95% Confidence Interval]	-.060*** [-.091; -.030]	-.012 [-.047; .024]	-.015 [-.046; .017]	-.032 [-.073; .009]

Standard Errors clustered by age of the oldest member level. Age window in the quadratic in age of oldest household member specification and no additional covariates specification: 55-65. Additional covariates in the RDD: type of household, gender, smoker status, alcohol consumption, Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

*** p<0.01 **p<0.05 *p<0.1

In Table 3 we explore the robustness of our results by varying our RDD specification in 5 ways. We first implement a quadratic polynomial for $f(\cdot)$, the function of the forcing variable relative to the age cut-off. We then re-estimate the models without including covariates in our specification. We further investigate whether our findings are sensitive to a change in the choice of the sample age window (either wider or narrower).

Finally we drop the observations with the oldest member of the household aged 60 or 61 for whom we cannot determine whether they received the WFP or not exactly. We find that our

estimates of the discontinuity effect for the fibrinogen are robust to any of these changes in the RDD specification. The coefficient of the WFP effect is always statistically significant at 1 % level and the effect size lies between 4.4 percentage points and 8.7 percentage points.¹⁶ This implies a reduction of 35 % to 70 % in the incidence of a high serum concentration of fibrinogen at the age cut-off. For the other measures of illness we find a negative coefficient in all the specifications indicating an improvement in health with WFP eligibility. However, the estimates are variable and rarely statistically significant at conventional levels.

We now provide some further checks on our main finding of a WFP effect on the incidence of high concentrations of fibrinogen. In Table 4 we present falsification tests for an effect at age cut-offs of 55 and 65. As these are not the eligibility cut-off, we should find no effect at these ages. As a further falsification test we check for an effect on the incidence of fibrinogen concentrations above the sample median. The idea here is that having an above-median concentration of fibrinogen is not a marker of disease. If we are measuring a reduction in disease incidence, that effect should be observed only in the upper tail of the distribution (as in our main estimates) and not around the median.¹⁷ As Table 4 illustrates, we do not find any evidence of an effect across these specifications. This increases our confidence in the main effect reported in Table 2.

We also considered what our estimated effects for the incidence of fibrinogen concentration in excess of 4 g/l imply for levels fibrinogen in the upper tail of the distribution. To do this we estimate a quantile regression version of the RDD. Note that our base specification studies the probability that measured serum Fibrinogen exceeds a specified cut-off, and how this probability differs with WFP eligibility holding the cut-off constant at k :

$$P_{it}(WFP_{it}) = Prob(H_{it}^{Fib} > k | WFP_{it})$$

A quantile regression inverts this relationship, holding the probability constant (at the chosen quantile, $1 - P$) and asking, essentially, how the cut-off varies with WFP eligibility.

$$k_{it} = F_{1-P}(H_{it}^{Fib} | WFP_{it})$$

¹⁶ All estimates are statistically significant at 5% level after adjusting for multiple testing except for the specification with a quadratic function of the forcing variable, where $p=0.074$.

¹⁷ The median fibrinogen in the neighbourhood of the age cut-off is 3.1 g/l (see Table 1).

Table 4. Falsification Tests: Effect of a “placebo” eligibility at age 55 and age 65, and effect on above median fibrinogen concentration.

	Effect of WFP on Fibrinogen
Cut-off age 55	-.015
[95% Confidence Interval]	[-.057; .026]
Age Window	50-60
Cut-off age 65	.004
[95% Confidence Interval]	[-.052; .060]
Age Window	60-70
Prob(Fibrinogen\geq3.1 g/l)	.009
[95% Confidence Interval]	[-.046; .065]
Age Window	55-65

Standard Errors clustered by age of the oldest member level. Additional covariates in the RDD: type of household, gender, smoker status, alcohol consumption, Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

*** p<0.01 **p<0.05 *p<0.1

In our sample $\text{prob}(H_{it}^{Fib} = 1) \approx 12\%$ and the RDD estimates show that this falls by 6.1 percentage points with WFP eligibility. In this robustness check we consider how the 85th and 90th conditional quantiles of H_{it}^{Fib} vary with WFP eligibility (corresponding to $P = 0.15$ and $P = 0.1$). We find in both cases a drop in Fibrinogen of about 0.11 g/l. However the effects are less precisely estimated than the probability models.¹⁸

We finally follow Kling et al. (2007) and create a Health Index to improve the statistical power of detecting effects of the same sign and implement the RDD on this new measure. The Health Index synthetises in a single measure our indicators of cardiovascular and respiratory diseases. We exclude self-reports of chest infection and focus on our binary objective measures, serum-Fibrinogen in excess of 4 g/l, serum-CRP in excess of 10 mg/l and Hypertension.¹⁹ For each of these outcomes we calculate the *z-scores* subtracting the mean of the group of people just below the eligibility cut-off and dividing by the standard deviation

¹⁸ Inference for quantile regression is not straight forward. Asymptotic standard errors are not regarded as reliable and we employ a bootstrap procedure. Full details and results are available from the authors on request.

¹⁹ Self-reports of chest infection is the only measure that does not show a clear pattern in the data and is not reported in HSE.

of the same group. The Health Index is the average of the three *z-scores* and a low value of the index is evidence of better health.

Figure 5 Effect of the Winter Fuel Payment on the Health Index.

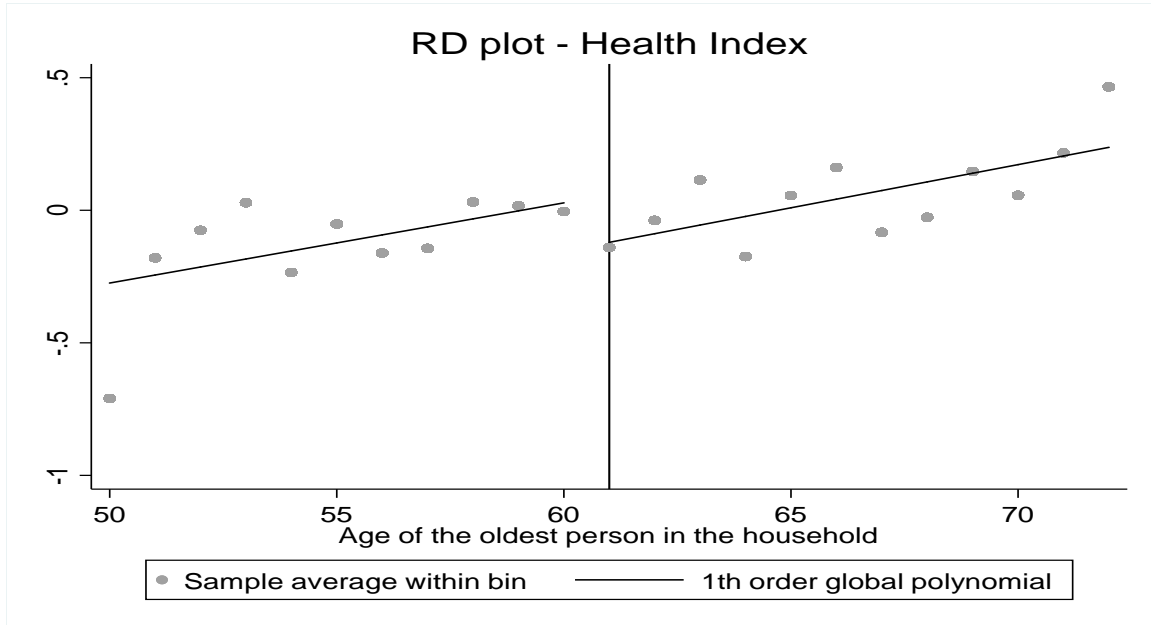


Figure 5 plots the residuals from a regression of the Health Index on type of household, gender, smoker status, alcohol consumption, Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

We first present the impact of the WFP on the Health Index graphically in Figure 5. As in the Figures reported before, we interpret a discontinuity at the eligibility cut-off as evidence of an effect of the WFP on our index. The data in Figure 5 are still noisy as in the analysis of the single objective health outcomes, but there is a visible drop in the health index around the eligibility cut-off.

In Table 5 we show the size of the effect of the WFP on the Health Index implementing various specifications of the RDD. The analysis includes only observations with a valid measure of Fibrinogen, CRP and Hypertension. The reduction of the Health Index is in the range of 0.2 to 0.45 standard deviations with our estimates all statistically significant at 5 % level. Our preferred specification is presented in Column 1 and shows a decrease in the Health Index of 0.23 standard deviations.

We replicate the analysis on the Health Index for three sub-samples of observations to investigate whether there are specific groups that drive our findings. In the first Column of Table 6, we report the estimates on a sample which excludes observations with a nurse visit in summer.

Table 5. The impact of the Winter Fuel Payment on the Health Index.

Linear Specification in age of oldest household member	Quadratic specification in age of oldest household member	Narrower Age Window	Wider Age Window	Dropping observations whose eligibility cannot be discretely determined
-.225** [-.418; -.032]	-.449*** [-.642; -.257]	-.445*** [-.607; -.283]	-.194** [-.376; -.013]	-.286** [-.563; -.010]
N= 3481	N= 3481	N= 2343	N= 5709	N= 3142
Age Window: 55-65	Age Window: 55-65	Age Window: 57-63	Age Window: 50-70	Age Window: 55-65

Standard Errors clustered by age of the oldest member level. 95% Confidence Interval. Additional covariates in the RDD: type of household, gender, smoker status, alcohol consumption, Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

*** p<0.01 **p<0.05 *p<0.1

Table 6. Impact of the Winter Fuel Payment on the health index in sub-groups.

Excluding Summer Months	Low-Income: 1st quartile	Low Educated
-.367* [-.772; .039]	-.039 [-.433; .354]	-.460*** [-.681; -.239]
N= 2351	N= 786	N= 980

Standard Errors clustered by age of the oldest member level. 95% Confidence Interval. Linear Specification in age of oldest household member. Age Window: 55-65. Summer months: June, July, August and September. Low-Educated highest qualification reported: No Qualification, NVQ level 1, NVQ level 2. Additional covariates in the RDD: type of household, gender, smoker status, alcohol consumption, Body Mass Index, waist, education, income, employment status vs age of the oldest person in the household.

*** p<0.01 **p<0.05 *p<0.1

The rational is that we do not expect any beneficial effect of the WFP on health in the summer months. Consistent with this expectation we find a slightly larger reduction in the Health Index than in the full sample (a point estimate of 0.36 standard deviations that is statistically significant at 10% level.) Second, we estimate the effect of the WFP on the Health Index for low-income respondents. Beatty et al. (2014) show a particularly significant increase in the fuel expenditure for poorer households. These households should therefore experience larger health benefits. We find an effect magnitude of -0.04 standard deviations that is not precisely estimated, in part because of the reduction in the sample size. Finally, we consider the effect of WFP eligibility among low education respondents. Here we find a very large and statistically significant effect of around 0.46 standard deviations.

4. Discussion and conclusions

We find evidence to suggest that raising the cut-off age for WFP eligibility had a negative effect on the health of individuals made ineligible. We find a robust and statistically significant effect for only one of the individual illness measures we consider, though point estimates for all the markers we consider point in this direction. Reductions of 1 to 6 percentage points (for fairly rare events) are large effect sizes. Using a health index that combines our illness markers, we find particularly large effects for low education individuals.

For policy makers, these results challenge the assumption that incremental increases in the eligibility age for WFP carry no health cost. At a minimum, further research is needed to determine the loss of health benefits associated with potential future increases in the eligibility age.

For primary healthcare providers, these results highlight the need to be sensitive to inadequate indoor heating as a potential winter health risk, perhaps particularly among low education individuals who fall just short of eligibility for the WFP.

References

- Beatty, T. K., Blow, L., Crossley, T. F., & O'Dea, C. (2014). Cash by any other name? Evidence on labeling from the UK Winter Fuel Payment. *Journal of Public Economics*, 118, 86-96.
- Chen, G. (1993). [Investigation on the correlation between the mortality of cerebrovascular diseases and the meteorological factors in Zhanjiang City]. *Zhonghua liu xing bing xue za zhi= Zhonghua liuxingbingxue zazhi*, 14(4), 234-236.
- Collins, K. J., Easton, J. C., Belfield-Smith, H., Exton-Smith, A. N., & Pluck, R. A. (1985). Effects of age on body temperature and blood pressure in cold environments. *Clinical Science*, 69(4), 465-470.
- Collins, R., Peto, R., MacMahon, S., Godwin, J., Qizilbash, N., Hebert, P., ... & Fiebach, N. H. (1990). Blood pressure, stroke, and coronary heart disease: part 2, short-term reductions in blood pressure: overview of randomised drug trials in their epidemiological context. *The Lancet*, 335(8693), 827-838.
- Curwen, M. (1841). Excess winter mortality in England and Wales with special reference to the effects of temperature and influenza. *The health of adult Britain*, 1994, 205-216.
- Dear, K.B. and McMichael, A.J., 2011. The health impacts of cold homes and fuel poverty. *BMJ*, 342, p.d2807.
- Donaldson L (2010) 2009 Annual Report of the Chief Medical Officer. London: Department of Health.
- Duvoix, A., Dickens, J., Haq, I., Mannino, D., Miller, B., Tal-Singer, R., & Lomas, D. A. (2013). Blood fibrinogen as a biomarker of chronic obstructive pulmonary disease. *Thorax*, 68(7), 670-676.
- Eng, H., & Mercer, J. B. (1998). Seasonal variations in mortality caused by cardiovascular diseases in Norway and Ireland. *Journal of cardiovascular risk*, 5(2), 89-95
- Evans, W. N., & Garthwaite, C. L. (2014). Giving mom a break: The impact of higher EITC payments on maternal health. *American Economic Journal: Economic Policy*, 6(2), 258-290.

- Fenger-Eriksen, C., Lindberg-Larsen, M., Christensen, A. Q., Ingerslev, J., & Sørensen, B. (2008). Fibrinogen concentrate substitution therapy in patients with massive haemorrhage and low plasma fibrinogen concentrations. *British journal of anaesthesia*, 101(6), 769-773.
- Fraser, G. E. (1986). *Preventive cardiology*. Oxford University Press, USA.
- Gruys, E., Toussaint, M. J. M., Niewold, T. A., & Koopmans, S. J. (2005). Acute phase reaction and acute phase proteins. *J Zhejiang Univ Sci B*, 6(11), 1045-1056.
- Hofman, A., Feinleib, M., Garrison, R. J., & van Laar, A. (1983). Does change in blood pressure predict heart disease?. *Br Med J (Clin Res Ed)*, 287(6387), 267-269.
- Iparraguirre, J. (2014). Have winter fuel payments reduced excess winter mortality in England and Wales?. *Journal of Public Health*, fdu063.
- Jürges, H., Kruk, E., & Reinhold, S. (2013). The effect of compulsory schooling on health—evidence from biomarkers. *Journal of population economics*, 26(2), 645-672.
- Keatinge, W. R. (1986). Seasonal mortality among elderly people with unrestricted home heating. *British medical journal (Clinical research ed.)*, 293(6549), 732.
- Keatinge, W. R. (2002). Winter mortality and its causes. *International Journal of Circumpolar Health*, 61(4).
- Keatinge, W. R., & Donaldson, G. C. (1994). Cardiovascular mortality in winter. *Arctic medical research*, 54, 16-18.
- Kennedy, S. and Parkin, E. (2016), *Winter fuel payments update*, House of Commons Library Standard Note SN/SP/6019
- Kling, J. R., Liebman, J. B., & Katz, L. F. (2007). Experimental analysis of neighborhood effects. *Econometrica*, 75(1), 83-119.
- Kloner, R. A., Poole, W. K., & Perritt, R. L. (1999). When throughout the year is coronary death most likely to occur? A 12-year population-based analysis of more than 220 000 cases. *Circulation*, 100(15), 1630-1634.
- Kunst, A. E., Looman, C. W., & Mackenbach, J. P. (1993). Outdoor air temperature and mortality in the Netherlands: a time-series analysis. *American Journal of epidemiology*, 137(3), 331-341.

Lanska, D. J., & Hoffmann, R. G. (1999). Seasonal variation in stroke mortality rates. *Neurology*, 52(5), 984-984.

Lee, D. S., & Lemieux, T. (2010). Regression discontinuity designs in economics. *Journal of economic literature*, 48(2), 281-355.

Llyod, J (2013) Cold Enough. Excess Winter Deaths, Winter Fuel Payments and the UK's problem with the cold. The Strategic Society Center SSC, London.

Mackenbach, J. P., Kunst, A. E., & Looman, C. W. (1992). Seasonal variation in mortality in The Netherlands. *Journal of Epidemiology and Community Health*, 46(3), 261-265.

Mannino, D. M., Tal-Singer, R., Lomas, D. A., Vestbo, J., Barr, R. G., Tetzlaff, K., ... & Martin, U. J. (2015). Plasma fibrinogen as a biomarker for mortality and hospitalized exacerbations in people with COPD. *Chronic obstructive pulmonary diseases* (Miami, Fla.), 2(1), 23.

Marmot M, Geddes I, Bloomer E, Allen J, Goldblatt P. *The health impacts of cold homes and fuel poverty*. Friends of the Earth/Marmot Review Team, 2011.

Marmot, M., Oldfield, Z., Clemens, S., Blake, M., Phelps, A., Nazroo, J., Steptoe, A., Rogers, N., Banks, J., Oskala, A. (2017). English Longitudinal Study of Ageing: Waves 0-7, 1998-2015. [data collection]. 27th Edition. UK Data Service. SN: 5050, <http://doi.org/10.5255/UKDA-SN-5050-14>

Michaud, P. C., Crimmins, E., & Hurd, M. (2016). The Effect of Job Loss on Health: Evidence from Biomarkers. *Labour Economics*.

National Centre for Social Research, University College London. Department of Epidemiology and Public Health. (2010). *Health Survey for England, 2001*. [data collection]. 3rd Edition. UK Data Service. SN: 4628, <http://doi.org/10.5255/UKDA-SN-4628-1>

National Centre for Social Research, University College London. Department of Epidemiology and Public Health. (2010). *Health Survey for England, 2003*. [data collection]. 2nd Edition. UK Data Service. SN: 5098, <http://doi.org/10.5255/UKDA-SN-5098-1>

National Centre for Social Research, University College London. Department of Epidemiology and Public Health. (2010). *Health Survey for England, 2004*. [data collection]. 2nd Edition. UK Data Service. SN: 5439, <http://doi.org/10.5255/UKDA-SN-5439-1>

National Centre for Social Research, University College London. Department of Epidemiology and Public Health. (2011). *Health Survey for England, 2006*. [data collection]. 4th Edition. UK Data Service. SN: 5809, <http://doi.org/10.5255/UKDA-SN-5809-1>

National Centre for Social Research, University College London. Department of Epidemiology and Public Health. (2015). *Health Survey for England, 2009*. [data collection]. 3rd Edition. UK Data Service. SN: 6732, <http://doi.org/10.5255/UKDA-SN-6732-2>

Joint Health Surveys Unit, University College London. (2016). *Scottish Health Survey, 2003*. [data collection]. 3rd Edition. UK Data Service. SN: 5318, <http://doi.org/10.5255/UKDA-SN-5318-2>

Scottish Centre for Social Research, University College London. Department of Epidemiology and Public Health. (2016). *Scottish Health Survey, 2008*. [data collection]. 3rd Edition. UK Data Service. SN: 6383, <http://doi.org/10.5255/UKDA-SN-6383-3>

Scottish Centre for Social Research, University College London. Department of Epidemiology and Public Health. (2016). *Scottish Health Survey, 2009*. [data collection]. 5th Edition. UK Data Service. SN: 6713, <http://doi.org/10.5255/UKDA-SN-6713-3>

Ornato, J. P., Siegel, L., Craren, E. J., & Nelson, N. (1990). Increased incidence of cardiac death attributed to acute myocardial infarction during winter. *Coronary Artery Disease*, 1(2), 199-204.

Pearson, T. A., Mensah, G. A., Alexander, R. W., Anderson, J. L., Cannon, R. O., Criqui, M., ... & Rifai, N. (2003). Markers of inflammation and cardiovascular disease application to clinical and public health practice: a statement for healthcare professionals from the centers for disease control and prevention and the American Heart Association. *Circulation*, 107(3), 499-511.

Pepys, M. B., & Hirschfield, G. M. (2003). C-reactive protein: a critical update. *The Journal of clinical investigation*, 111(12), 1805-1812.

Romano, J. P., & Wolf, M. (2016). Efficient computation of adjusted p-values for resampling-based stepdown multiple testing. *Statistics & Probability Letters*, 113, 38-40.

Rose, G. (1966). Cold weather and ischaemic heart disease. *British journal of preventive & social medicine*, 20(2), 97-100.

Rudge, J., & Gilchrist, R. (2007). Measuring the health impact of temperatures in dwellings: Investigating excess winter morbidity and cold homes in the London Borough of Newham. *Energy and Buildings*, 39(7), 847-858.

Schmaier AH. Laboratory evaluation of hemostatic and thrombotic disorders. In: Hoffman R, Benz EJ Jr, Silberstein LE, Heslop HE, Weitz JI, Anastasi J, eds. *Hematology: Basic Principles and Practice*. 6th ed. Philadelphia, PA: Elsevier Saunders; 2012:chap 131.

Simon, L., Gauvin, F., Amre, D. K., Saint-Louis, P., & Lacroix, J. (2004). Serum procalcitonin and C-reactive protein levels as markers of bacterial infection: a systematic review and meta-analysis. *Clinical Infectious Diseases*, 39(2), 206-217.

Thistlethwaite, D. L., & Campbell, D. T. (1960). Regression-discontinuity analysis: An alternative to the ex post facto experiment. *Journal of Educational psychology*, 51(6), 309.

Tillett, W. S., & Francis, T. (1930). Serological reactions in pneumonia with a non-protein somatic fraction of pneumococcus. *The Journal of experimental medicine*, 52(4), 561-571.

Wilkinson, P., Armstrong, B. and Landon, M. (2001) *Cold Comfort: the Social and Environmental Determinants of Excess Winter Deaths in England, 1986-1996*. Bristol: Policy Press.

Wilson, P. W., D'Agostino, R. B., Levy, D., Belanger, A. M., Silbershatz, H., & Kannel, W. B. (1998). Prediction of coronary heart disease using risk factor categories. *Circulation*, 97(18), 1837-1847.

World Health Organization (2016). A global brief on hypertension: silent killer, global public health crisis. *World*.

Appendix

Table 6. Winter Fuel Payment eligibility.

Month of the nurse visit	Eligibility age	WFP eligibility Aged 60	WFP eligibility Aged 61	WFP eligibility Aged 62
January	60 + 4 months	8/12	1	1
February	60 + 5 months	7/12	1	1
March	60 + 6 months	6/12	1	1
April	60 + 7 months	5/12	1	1
May	60 + 8 months	4/12	1	1
June	60 + 9 months	3/12	1	1
July	60 + 10 months	2/12	1	1
August	60 + 11 months	1/12	1	1
September	61	0	1	1
October	61 + 1 months	0	11/12	1
November	61 + 2 months	0	10/12	1
December	61 + 3 months	0	9/12	1