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Securing Good Care for Older People

TAKING A LONG-TERM VIEW



SECURING GOOD CARE FOR OLDER PEOPLE

Taking a long-term view

This report was prepared by:

Derek Wanless
Julien Forder (PSSRU at London School of Economics)

and

Jose-Luis Fernandez (PSSRU at London School of Economics)
Teresa Poole (King's Fund)
Lucinda Beesley (King's Fund)
Melanie Henwood
Francesco Moscone (PSSRU at London School of Economics)



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Derek Wanless

King's **Fund**

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List of abbreviations

AA	Attendance Allowance
ADL	activity of daily living
ADLAY	activities of daily living adjusted year
BGOP	Better Government for Older People
BHPS	British Household Panel Survey
AEI	average earnings index
CFAS	Cognitive Function and Ageing Study
CHD	coronary heart disease
CIS	Common Induction Standards
CPA	comprehensive performance assessment
CRAG	Charging for Residential Accommodation Guide
CSA	Care Standards Act
CSCI	Commission for Social Care Inspection
CSSR	councils with social services responsibilities
DLA	Disability Living Allowance
DWP	Department for Work and Pensions
ECCEP	Evaluating Community Care for the Elderly People
ELSA	English Longitudinal Study of Ageing
FSS	Formula Spending Share
GAD	Government Actuary's Department
GDP	gross domestic product
GHS	General Household Survey
GSCC	General Social Care Council
HALE	healthy active life expectancy
HE	horizontal efficiency
HES	Hospital Episode Statistics
HSE	Health Survey for England
IADLs	instrumental activities of daily living
ippr	Institute for Public Policy Research
ISD	intensive service days
LAAs	local area agreements
LFS	Labour Force Survey
LSP	local strategic partnership
LTCI	long-term care insurance
MDS	minimum data set
MLTV	maximum loan to value
MRC	Medical Research Council
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NMS	national minimum standards

NMW	national minimum wage
NPSS	National Pension Saving Scheme
NSF	National Service Framework
NVQ	National Vocational Qualification
ODPM	Office of the Deputy Prime Minister
OFT	Office of Fair Trading
ONS	Office for National Statistics
OPUS	Older People's Utility Scale
PBC	practice-based commissioning
PCT	primary care trust
PSA	public sector agreement
PSS	personal social services
PSSRU	Personal Social Services Research Unit
QALY	quality-adjusted life year
RNCC	Registered Nursing Care Contribution
SEU	Social Exclusion Unit
SIC	Standard Industrial Classification
SOC	Standard Occupational Classification
SPA	state pension age
SSI	Social Services Inspectorate
STG	Special Transitional Grant
UKHCA	UK Home Care Association
VE	vertical efficiency
VHIUs	very high intensive users
WTE	whole-time equivalent

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Jennifer Dixon
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King's Fund staff

Clare Bawden
Natasha Curry
Sarah Robinson
Tom Snell

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Actuarial Profession
Age Concern England
Alzheimer's Australia
Alzheimer's Society
Anchor Trust
Association of British Insurers
Association of Directors of Social Services
Balance of Care Group
British United Provident Association (BUPA)
Cambridge City and South Cambridgeshire PCT Falls Prevention Project
Care Funding Bureau
Care Services Improvement Partnership
Careful Decisions Ltd
Carers UK
Commission for Social Care Inspection (CSCI)
Consultant Disability Services
Council of Mortgage Lenders
Counsel and Care
Deloitte
Demos
Department of Health (various departments)

Department of Mental Health Sciences at University College London
 Department of Urban Studies at the University of Glasgow
 Department of Work and Pensions
 Disability Rights Commission
 Durham County Council
 Elderly Accommodation Counsel
 Employers' Organisation for local government
 English Community Care Association
 Equal Opportunities Commission
 Essex County Council Direct Payments Unit
 Extracare Charitable Trust
 Ferret Information Systems
 General Reinsurance Life UK Ltd
 Health and Social Care Information Centre
 Health Economics Research Unit at the University of Aberdeen
 Health Services Management Centre at the University of Birmingham
 Help the Aged
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 Partnership Assurance
 Personal Social Services Research Unit at the LSE
 Personal Social Services Research Unit at the University of Kent
 Portsmouth City Council
 Practice Learning Taskforce

PricewaterhouseCoopers
Rowan Organisation
Royal National Institute of the Blind
Safe Home Income Plans (SHIP)
School of Criminology, Education, Sociology and Social Work at Keele University
School of Social Studies at the University College Chichester
Skills for Care
Social Care Institute for Excellence
Social Policy on Ageing Information Network (SPAIN) coalition
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Summary

How much will it cost to provide social care for older people in England in 20 years time? What funding arrangements should be in place to ensure this money is available and supports the high-quality outcomes sought? Particularly now that the ‘baby-boomer’ generation is moving towards retirement, these questions pose serious challenges. Finding sustainable solutions will depend on understanding the demographic, economic, social and health trends driving demand over the coming decades.

At the heart of the issue should be a debate about what social care will do in the future. How will it help people? What outcomes should it aim to achieve? Who should it help? Once its purpose is understood and specified, important decisions can then be made about the range and type of services, the size and composition of the workforce, the implications for housing, the use of technology to assist people to live with more control, and the extent of preventive action required to avoid or delay need.

More than one million older people (aged 65 and over) currently use publicly funded social care services in England. Local authorities spent £8 billion on personal social care services in 2004/5, £1.6 billion of which was recouped from users through means-tested charges. A further £3.7 billion was paid out to individuals on (non-means-tested) benefits to help towards the costs of care. And private spending on residential and home care by older people is likely to be more than £3.5 billion a year.

Yet, despite these considerable sums, there is little information about whether this spending achieves the government’s desired aims for older people of promoting choice, independence and prevention. Some trends suggest that these aims are not being achieved. For example, older people prefer to receive care in their own homes, yet local authority spending on care home placements has risen at a faster rate than that on home care. In 2004/5, almost 60 per cent of local authority gross spending on older people’s social care went on residential and nursing home placements. Furthermore, in directing resources to people with the most intensive needs, a substantial number of people with lesser but still significant needs are not being helped in many cases.

There is also widespread dissatisfaction with the current funding system. In part this results from ignorance about what to expect. It often comes as an unwelcome surprise to older people to discover that social care is means-tested and they are expected to rely on their own savings and income until their assets have fallen to the threshold set for state-funded care. It is a common complaint that the existing system penalises those who have saved for their old age.

Overall, public spending on social care has historically been constrained or limited by the budget available. Budgets have generally been based on historical allocations and have

been subject to competing local demands. This has not allowed for any long-term assessment of funding requirements, despite the pressures of an ageing population and an increase in chronic health conditions.

Against this backdrop, the King's Fund commissioned this year-long Review, led by Sir Derek Wanless, whose previous reports for the Treasury covered future health care spending in the United Kingdom and public health in England. This Review seeks to determine how much should be spent on social care for older people in England over the next 20 years. It also considers what funding arrangements need to be in place to ensure this money is available and supports high-quality outcomes. It is hoped that the results will make a significant contribution to the debate on the future of social care.

The terms of reference for the Wanless Social Care Review are:

- to examine the demographic, economic, social, health, and other relevant trends over the next 20 years that are likely to affect the demand for and nature of social care for older people (aged 65 and over) in England (Part 1)
- in the light of this, to identify the financial and other resources required to ensure that older people who need social care are able to secure comprehensive, high-quality care that reflects the preferences of individuals receiving care (Part 2)
- to consider how such social care might be funded, bearing in mind the King's Fund's commitment to social justice (Part 3).

The Review team has examined social and health care policy, services and spending as well as demographic, social and technological trends. The analysis was used in the development of a model for estimating the level of need over the next 20 years. The model was used to calculate how much it would cost to fund social care under three successively more ambitious scenarios of social care outcomes. This incorporated a method for establishing 'benchmark' packages of social care services to produce the most cost-effective outcomes. Finally, the Review assessed a number of possible funding mechanisms for providing the additional sums required.

The main body of the Review is divided into three parts: Evidence and Trends, Resource Requirements and Funding Options. The final chapter concludes by setting out the overarching themes and main messages that emerge, as well as a set of recommendations.

PART 1. EVIDENCE AND TRENDS

Part 1 assesses the state of social care today. It examines how well social care helps older people with disabilities, impairment and other needs. It looks at the quality of care provided and the current cost and funding arrangements, including how much people using services have to pay. The implications for the workforce, the substantial contribution of informal care, and an assessment of emerging new models for providing care are also considered.

Social care today and the policy context

Current debates about the provision and funding of social care must be viewed against the policy shifts of the past five decades. Chapter 1 reviews the move towards supporting older people to remain in their own homes for as long as possible, rather than viewing care

homes as an inevitable destination for the very old. It looks at the revolution taking place over the past 15 years that has seen local authorities scale back in-house provision in favour of independent providers. And it highlights the emerging emphasis on prevention and rehabilitation, which aims to reduce demand for high intensity services.

The needs of an ageing population

The population of England is ageing. In the next 20 years, the number of people aged 85 and over in England is set to increase by two-thirds, compared with a 10 per cent growth in the overall population. Between 1981 and 2001, increases in healthy life expectancy did not keep pace with improvements in total life expectancy. In future, the total number of people with disabilities, and potentially in need of care, will be higher. ‘How much more care will be needed?’ is the key question addressed in Chapter 2. In particular, disability in later life arises as a result of heart disease and stroke, sensory problems (vision and hearing), arthritis, incontinence, dementia and depression, so trends in these diseases and conditions can be used to estimate future numbers of people with social care needs.

In 2002, around 900,000 older people were considered to have high levels of need, according to the standard assessment of being unable to carry out one or more of the main activities of daily living (ADLs) (being able to wash, dress, feed, toilet, walk and so on). A further 1.4 million older people had low levels of need. Over the 20 years to 2025, the Review projects a rise in the number of older people who do not require care of 44 per cent, a 53 per cent increase in those with some need and a 54 per cent increase in those with a high level of need. Based on expert analysis commissioned for the Review, these increases reflect a future where population health improves due to moderate reductions in obesity and other ‘lifestyle’ conditions, as well as the introduction of effective new treatments or technologies.

Overall, the number of people with impairment and dependency will increase significantly over the next 20 years. This will increase the demand for social care, putting pressure on available resources and funding.

Shortcomings of the social care system

Chapters 3–5 consider how well the present social care system is performing for older people, and finds areas of significant shortfall in what it achieves. Some of this is the result of poorly delivered services, but it is also caused by limited funding and other resources.

Expectations are changing, and the so-called baby-boomers (born 1945–54) are likely to present a cohort of more demanding social care users in the future, strongly objecting to age discrimination and insisting on greater choice and quality. Most older people prefer to receive care at or close to home, and there is evidence that greater emphasis on respite care, day care and social work would improve outcomes. For people with low levels of need, there is some evidence that social care, often provided in the community, can delay the use of more intensive services such as nursing home care (Chapter 3). However, the recent trend in service provision is a move away from relatively ‘low-level’ services towards more intensive ones. This is illustrated by the decline in the number of people who receive home care but an increase in the number of hours of care provided in total.

There is evidence of significant unmet need. The proportion of all people in their own homes who have care needs and who have those needs met is low, and has been falling. Budget-limited public resources are successfully being aimed at those with the highest levels of need but, even among this group, services are only being used by a relatively small proportion of people with apparently similar levels of need. The Review also finds that unmet need is particularly high among moderately dependent people. Overall, the proportion of older people receiving home care in England is low by international standards.

Good management, organisation and standards in the care system should lead to better performance. Chapter 4 considers how well the current system fares in this regard. The Review found that councils with good assessments for adult social care services tended to spend more than those with poorer records. While compliance with minimum standards for care homes and home care services is improving, there is significant regional variation.

There is a growing body of evidence relating to the gains from better joint working between the health and social care systems. The government has promoted a series of measures to improve partnership working, but their use is far from widespread. There has been progress in reducing delayed transfers from hospital, but this has not been matched by reductions in avoidable admissions to hospital. In addition, distinguishing needs at the boundary of health care (free at the point of delivery, including NHS continuing care) and social care (means-tested) creates considerable anger and distress among older people and their families. The interface has become a flashpoint for arguments about inequities in the system.

Overall, there is potential to shift more care out of hospital and into the community, including social care, but simply re-directing resources without making arrangements to coordinate and integrate those services will be the least effective strategy.

The best way to measure social care performance is to examine the outcomes achieved, but this is difficult to do. Chapter 5 illustrates how a number of tools can make outcome measurement a practical reality, leading to improved targeting of resources. The Review finds that improved outcomes would result from supplying more hours of home care to a larger number of people.

Who pays what for social care?

How much does society currently spend on social care for older people? Chapter 6 looks at the main funding streams for social care and the means-testing system, which determines the charges imposed on users. Estimating total expenditure on social care for older people is complicated by the many funding sources. In 2004/5, local authorities spent £8 billion on personal social care services, and recouped £1.6 billion of this through means-tested charges to users; in addition, approximately £3 billion was spent by the NHS on long-term care of older people. Two social security benefits also provide funds that can be spent on social care; Attendance Allowance and Disability Living Allowance (care component), are the main sources of non-means-tested funding for older people with disabilities and in 2004/5 paid out £3.7 billion. There is no reliable data for the total amount of private spending on care home fees and self-funded domiciliary care, but the sums spent are substantial. Estimates put the proportion of care home places that are wholly privately funded at between one-quarter and one-third.

There is widespread dissatisfaction with the current means-tested funding arrangements. Criticisms include: the complexity of the system and associated lack of understanding of how it works; that savers and people with even modest assets are penalised, having to (at least initially) cover most of their care costs without state support; and the ‘post code’ lottery for domiciliary care charges, which results in large, and seemingly inequitable, differences in the level of charges imposed by different councils for similar care packages. Implementation of means-testing can create some perverse incentives so that financial rules affect the type of services people receive.

A significant proportion of people aged 50 and over are unlikely to be able to afford to pay privately for social care in retirement. Survey data demonstrates that disability is correlated with lower income and assets, so that those who are most likely to need long-term care are also least likely to be able to pay for it.

Who will do the caring?

Social care services are labour intensive so the availability and quality of staff are key factors in achieving the desired outcomes. An estimated 559,000 people in 2003/4 were formally employed in England providing ‘core’ social care for older people, not including around 120,000 NHS staff doing some care work (Chapter 7). Staff costs represent a significant proportion of care costs; for example, care assistant wages average just over half the unit costs of local authority commissioned home care services. In care homes, labour costs are estimated to account for just over half the weekly ‘fair price’ for residential homes, and two-thirds for nursing homes. Since 2002, pay rates for social care jobs have risen faster than inflation but vacancy rates remain high.

The care of older people relies heavily on informal carers. There were around 5.8 million carers in England in 2000, between 3.4 million and 4 million of whom were providing care to people aged 65 and over (Chapter 8). Older people themselves supply a disproportionate amount of informal care; in 2000, one in six people over the age of 65 were providing some form of care. Carer support and information services do exist, but are currently received by only a minority of carers. The availability of informal care may not keep pace with increases in care needs in the future, but informal care will remain vital in supporting older people. Greater carer support is needed to relieve some of the pressures.

New services and technology

Chapter 9 reviews the likely impact and cost-effectiveness of the main new service models. Often it is clear that these improve the quality of life of older people, but it can be harder to judge the overall impact on costs. Telecare brings health and social care directly to an older person, usually in their own homes, supported by information and communication technology. It has the potential to postpone and divert older people from moving into residential care and possibly hospital, and many pilot studies have shown positive results. But there has been no consensus over assessing costs, so it is difficult to model the future cost impact of the national implementation of telecare. Nevertheless, there is enough evidence now to bring telecare services into the mainstream.

The demands of an ageing society come too low on the list of strategic housing priorities, with the housing concerns of first-time buyers and key workers appearing more immediate. Extra care housing provides self-contained homes with round-the-clock care and support,

and offers the potential for independent living for some older people who can no longer manage in their own homes.

New models of dementia care will also be important given the projected increase in older people aged 85 and over. The use of dementia-specific care services, including telecare and dedicated housing, together with specialist care workers appears promising.

There is evidence that a range of preventative measures can reduce dependency, disability and ill health, and that such schemes should be targeted at those whose condition is likely to deteriorate or who have a high predicted risk of costly future needs. The potential of intermediate care to rehabilitate also appears to be more effective when focused on specific conditions or groups of people.

PART 2. RESOURCE REQUIREMENTS

Modelling the future

Fundamental questions need to be asked when estimating the future resource requirements of social care for older people. What is social care? What is it trying to achieve? And for whom? The aims of social care fall into two broad groups: first, ensuring that people are able to live in safety and to satisfy personal care needs, including feeding, washing, dressing and going to the toilet; second, enhancing well-being and social inclusion, so that older people are able to engage socially, and maintain their self-esteem. The larger the number of people for whom these goals are attained, the higher the overall outcomes.

Public funds are currently targeted on the most dependent. If local authorities had more money, then more people could be helped and those currently receiving help could be supported more intensively. Generally speaking, as would be expected, higher expenditure achieves a greater improvement in outcomes, such as more frail, older people being able to live as they would wish, carrying out activities of daily living, and being less limited by their disabilities. The task of this Review is identifying the appropriate level of resources needed for social care in the future. Spending more on social care means less money for other public services or less money left in people's pockets. Where should the balance lie? The Review addresses this question by asking how much society and individuals are willing to pay for certain improvements in outcomes.

Chapter 10 outlines a number of scenarios for the future, reflecting different levels of ambition and achievement of outcomes.

- Scenario 1 (**current service model**) is the baseline case. It assumes that the patterns of social care services and outcomes in the future will be the same as now, that is, the system is no more ambitious. The driver of higher future costs will be changes in the numbers of people with care needs.
- Scenario 2 (**core business**) goes further, changing what the care system does, and what it provides, so that it achieves the highest levels of personal care and safety outcomes justifiable given their cost.
- Scenario 3 (**well-being**) uses scenario 2 as a starting point, but also provides improved social inclusion outcomes and a broader sense of well-being.

For each of these scenarios, the Review's model combines projections of future need with the services required to achieve the desired outcomes. A number of key building blocks are needed to make such an estimate.

- The first is to assess the impact of services on outcomes. As part of its methodology, the Review uses a generic outcome measure – the ADLAY. This is the gain for one year of life of having core activities of daily living (ADL) needs improved from being entirely unmet to being fully met. It has strong analogies with the quality-adjusted life year (QALY) used in health care research. Mirroring methods used by the National Institute for Health and Clinical Excellence (NICE) in assessing health care interventions, the model set a maximum cost of £20,000 per year for achieving each unit of outcome gain. Any increase in costs will divert resources from other productive uses, and so needs to be balanced against the outcome gain. For scenarios 2 and 3 this balance is struck when social care services are provided up to the point where they cost no more than £20,000 for further ADLAY outcome gain. This analysis defines the economically-justified 'benchmark' levels of services.
- The second main component of the modelling work is a calculation of the level of informal care and its contribution to meeting overall demand for care. The outcomes of carers are considered, including the extent to which caring might adversely affect their health and stress levels. The cost-effectiveness of carer support services is assessed as part of improving outcomes for carers and hence the sustainability of caring.
- Cognitive impairment (including dementia) causes ADL problems but also generates other risks, such as to the person's safety. Addressing these risks improves outcomes, but also increases short-term costs. An understanding of what services are required to address cognitive impairment is the third building block.
- Fourth is an estimate of the impact of charges on the demand for social care services. To what extent do charges discourage older people from seeking care or reduce the amount they use? This factor is important, because if people are put off, then total costs are lower, but so are total outcomes. In scenario 2, older people are offered benchmark levels of care. Some, according to current charging rules, would have to pay a charge and may therefore decide to do without adequate care.

Cost projections

Using the Review's population and dependency projections, the model produces the following estimates of the cost of social care (using the central assumptions). At this stage no assumption is made about changing the current funding system, and these represent total costs, including public and private expenditure.

- Under scenario 1, total costs are projected at £10.1 billion in 2002, rising by 139 per cent between 2002 and 2026 to £24.0 billion. This is an increase from 1.1 per cent to 1.5 per cent of GDP. Scenario 1's total costs are the actual expenditures on social care for older people by Social Services and by individuals (but, for comparison with the other scenarios, removes the modest NHS funding of long-term care).
- Under scenario 2, total costs would have been £12.2 billion in 2002 had this scenario been in place, and costs are estimated to rise by 142 per cent between 2002 and 2026 to £29.5 billion, an increase from 1.3 per cent to 2.0 per cent of GDP.

- Under scenario 3, total costs would have been £13.0 billion in 2002 and are estimated to rise by 142 per cent between 2002 and 2026 to £31.3 billion, an increase from 1.4 per cent to 2.0 per cent of GDP.

The Review also considers the more immediate impact on spending of the three scenarios. In 2007, the difference between scenarios 1 and 2 in 2007 reaches £2.5 billion. In practice, scenario 2 will include some additional non-modelled costs that would push up this difference to £3 billion. This therefore is the estimated extra cost in 2007 of moving to a level of social care that achieves economically justifiable levels of personal care and safety.

Assessment and case management are vital components in the commissioning of services. They too have a cost, which is included in the above projections. In scenario 2 this runs to over £1 billion, which means that care-only expenditure would have been £11.1 billion in 2002.

All these projections rely on assumptions about unit costs, use of new technology, availability of unpaid care, dependency and the value-for-money threshold (£20,000 per ADLAY). The assumptions about cost inflation are particularly important.

Implications

On the Review's assumptions, the potential to achieve economically justifiable outcomes is not currently being realised. Unless society is less inclined to support the same improvement in outcomes from social care as it would from, say, health care, then more should be spent on social care for older people.

However, additional funding should not be forthcoming without a commitment to re-configure services, demonstrating value-for-money and fairness. This would include an increase in the size of community-based care packages for all those needing care, particularly the middle-dependency group; an improvement in carer support services; and the tailoring of care-with-housing services for those with significant cognitive impairment.

To achieve the outcomes in scenarios 2 and 3, the system needs to be made more universal with broader eligibility criteria.

This Review has made only tentative steps towards satisfying the well-being agenda, considering the impact of helping people with loneliness only. This is likely to represent just a small part of what could be done. Improved social participation, self-esteem through occupation and a sense of control over one's life are all well-being outcomes, but there is limited evidence on their cost-effectiveness.

There are several key drivers of higher cost. These include improved outcomes, demographic pressures and ensuring the robustness and quality of supply. Both scenarios 2 and 3 involve significantly more spending compared to the current situation. But it is important to emphasise that, even if this extra funding were made available in the near future, the required response on the supply-side would take a number of years. Spending would therefore have to be built up over a transitional period.

PART 3. FUNDING OPTIONS

The way social care is funded has changed little since the modern welfare state was established at the end of the Second World War. Local authorities operate a system of public funding that provides state-funded services to those with assets below a threshold level – although these are often subject to charges. The better off are expected to pay for their social care, including personal care, themselves. The value of a house is included in the means-testing asset assessment if the older person is moving into a care home (and no partner or qualifying person remains living there), but not for home care.

The means-testing system relates charges to ability to pay. For those receiving state support in care homes, the local authority will take all income (including pension and benefits) apart from a minimal weekly personal allowance. An older person receiving social care in their own home will usually be asked to pay charges so long as this does not reduce their net income below a certain level, which is linked with the pension credit system.

There are many alternative ways to fund social care, and different arrangements exist in other countries. Possible options include:

- providing some form of universal entitlement to social care that is state supported and not means-tested, for instance free personal care, as now applies in Scotland
- a social insurance model in which the state acts as an insurer and provides a package of care for people enrolled in the scheme, should they need care
- a partnership between state and individual where costs of care are shared for those needing care
- a limited liability model which caps an individual's liability for social care costs, either after a certain period or after they have made a specified financial outlay
- savings-based models, often with a link to pension provision, where the state contributes to an earmarked savings pot that the individual can use to pay for care.

There are also many possibilities for changing the current means-testing rules. For example, the assets threshold above which state-funded care is no longer available could be raised. Alternatively, the income level before charges are levied for home care could be increased, so that fewer people have to pay.

Various commercial financing products might assist those people who contribute privately to the costs of long-term social care. These include:

- long-term care insurance products, including their potential role in public–private partnership arrangements
- the use of housing equity release schemes to raise funds for meeting social care costs
- various financial incentives which could be offered through tax incentives.

There are a number of ways in which the broad funding options can be categorised: the degree to which funds come directly from people's own pockets rather than the public purse; the extent to which risks of costs are pooled between a range of people; whether an individual is entitled to a pre-determined amount of financial support for care or whether the amount depends on the size of the budget available, and so on.

Deciding how to pay for social care – and in particular how to meet the funding requirements set out in Part 2 – is the subject of Part 3. How are these choices of funding

system to be made? How are the relative merits to be judged? The Review applies a comprehensive set of tests or filters to narrow down the wide range of options. The tests – detailed in Chapter 11 – are grouped together under the headings: fairness, economic efficiency, user choice, physical resource development, clarity and sustainability/acceptability.

Chapter 12 investigates a broad range of funding and charging options and highlights the complexity inherent in funding long-term social care for older people. Although there is widespread disquiet about the current arrangements, no single prescriptive ‘answer’ exists that suits every older person’s financial circumstances and preferences. Funding solutions need to relate closely to the development of the model of services chosen, as well as changing expectations and aspirations.

Assessing the options

Applying the Review’s tests narrows down the options. Scoring best are a partnership model, free personal care, and a limited liability model. As a basis for comparison, the current means-tested system is also included, although it ranked below these others. In all these models, it is assumed that housing costs in care homes and at home are supported, as now, by a means-testing system.

The frontrunners differ in important ways.

- The **partnership** model provides people with a free-of-charge minimum guaranteed amount of care – this is set in the model at 66 per cent of the total benchmark care package, but could be varied either up or down. Individuals can then make contributions matched by the state (up to a limit): in the model, every pound that people contribute is matched by a pound from the state until the benchmark care package is achieved (thereafter extra private contributions are not matched). Those on low incomes would be supported in making additional contributions through the benefits system.
- **Free personal care** provides a full package of personal care without charge.
- A **limited liability** model is a hybrid, effectively a means-tested system for the first three or four years of care and then free personal care thereafter.

Costs and outcomes

In Part 2, the Review team estimated the total resource required for each of the three different scenarios, but the funding system (means-testing) was left unchanged. The focus was on total (public and private) costs of social care (including care management and assessment), and how this would change as better outcomes were achieved.

Changing the funding arrangements – moving away from the present means-testing system – obviously affects the costs borne by the state and the individual. Crucially, individuals can decide not to buy care or to buy less if they feel they cannot afford it or that they are being asked to pay too much. Thus, moving away from means-testing would change the amount of care consumed, and therefore both the outcomes achieved and the total (public and private) costs.

The results (Chapter 13) show the very different levels of public expenditure that would be required for scenario 2 under the four different funding options. (These are scenario 2 *care* costs for the base year (2002), up-rated for inflation to 2004/5.)

- Means-testing (under the current eligibility and means-testing guidelines) produces the lowest level of expenditure on formal care of £12.4 billion, and the lowest demand on state funds at £6.2 billion of spending on direct care. There would be 1.2 million older people receiving personal care, an increase of 12 per cent compared to the current situation. This total expenditure of £12.4 billion is the care-only costs from Part 2 for scenario 2 (£11.1 billion), but up-rated to 2004/5 prices.
- A limited liability option would increase public spending by approximately £1.2 billion to £7.4 billion. Limited liability arrangements do not bring about changes in the number of people that use services and therefore do not change total expenditure, or personal care outcomes.
- The partnership model brings about a significant increase in both total levels of spending and the contribution by the state to care costs. Relative to the means-testing system, direct public spending in this model increases from £6.2 billion to £9.7 billion, with a total spend of £13.7 billion. Uptake would be around 1.5 million people (an increase of around 45 per cent over the current number).
- Free personal care has the highest levels of spend (£14.9 billion) and the greatest funding contributions by the state (either £11.6 billion or £12.2 billion depending on the variant considered).

With free personal care, the state contributes approximately 78 per cent of total (direct) care costs, compared with just over 71 per cent in the partnership model, 60 per cent with limited liability and 50 per cent in the means-testing model.

The differences in costs are substantial. This is partly because scenario 2 provides larger care packages for individuals than the current system and therefore even a small change in the proportion of care supported by the state means a large cost difference. For example, among individuals with three or more ADL problems, the cost of the benchmark care packages is over 70 per cent higher than those offered today. Moreover, as both the partnership and free personal care models involve moving to universal entitlements, significantly more older people receive support compared with means-testing (over 300,000 more).

The state also currently funds care indirectly via the benefits system. The main benefits – Attendance Allowance and Disability Living Allowance (care component) – cost around £3.7 billion. These benefits are used to help pay charges under means-testing, to top-up care beyond that which is directly funded, and to cover non-care related costs. The data about their use is poor, but under means-testing, a large proportion is used to pay charges for care packages.

Under the partnership and free personal care models, direct state expenditure would cover the care-related uses of these benefits, reducing their justification. They could be significantly scaled back or even stopped under partnership or free personal care, especially if their non-care use was small and if claimants would also mostly be entitled to social care support. As a result, the difference in total public sector cost (direct and benefits) between mean-testing and partnership would be much reduced. In particular, if two-thirds of the total spent on AA and DLA (£2.5 billion) was transferred, this would leave the increase in public social care expenditure compared with current levels at £1.7 billion and £3.6 billion in the partnership and free personal care models respectively. The cost of supporting people on low incomes through the benefits system to help them afford care charges would be £0.8 billion or more.

Free personal care and the partnership model both avoid penalising people who have made financial provision for their old age.

Means-testing fares poorly on choice, except for the most wealthy who always have choices. Free personal care puts the onus on social services in terms of what care is provided. Because there is a charge under partnership, people will feel more empowered to express choices.

The funding of social care is inherently complex. There are housing, domestic support, personal care and nursing care elements to many social care packages. Few people understand what they are entitled to and what they have to pay. None of the funding models escape this complexity. But in means-testing the rules for financial eligibility can be particularly difficult for older people to understand. Under free personal care and partnership models, no charge considerations apply for the guaranteed element. In partnership models, the rules for the amounts contributed by the individual and matched by the state are clear.

Where means-testing scores well is on financial sustainability, because many people either self-fund or are charged, and some of these are able to pay without difficulty.

Choosing a funding system

No single system for funding stands out in all respects above the rest. All have strengths and weaknesses. Choosing between funding options is therefore a process of comparing their relative strengths and weaknesses against the Review's tests.

On balance, the Review considers the partnership model the best option (Chapter 14). Assuming 2002 demand levels, the Review estimates that the additional public care expenditure required in scenario 2 ranges between £1.7 billion and £4.2 billion (at 2004/5 prices), depending on the extent to which dependency-related social security benefits (AA and DLA) would be scaled back and the money transferred into the partnership arrangement. In addition, the cost of supporting people on low incomes through the benefits system to help them afford care charges would be £0.8 billion or more. Scenario 2 is concerned with personal care and risk outcomes. Achieving broader well-being would involve further resources.

The particular strengths of the partnership model are as follows.

- It would limit means-testing to the benefits system, leaving care services to focus on meeting need.
- It provides a guaranteed minimum level of care, making the system universal and inclusive.
- It provides incentives for people to save for their needs in older age as almost everyone would be required to make some form of contribution.
- It produces best value-for-money – the best ratio of outcomes to costs.
- It forces far fewer people to dispose of assets to pay for care than under means-testing.
- It is sustainable – the system will cost more than means-testing but it also provides significant additional value by way of better outcomes in return; it also makes a charge that both deters use of service beyond the benchmark level and is an important source of revenue.

Implications

There are value-for-money implications. Benchmark levels of services balance outcomes against costs. Free personal care funds services to levels higher than the benchmark, that is, more than society seems willing to support (given central assumptions). This implies that some public money might be better spent elsewhere. Means-testing funds services to levels below the benchmark where the converse is true: spending more on social care would be good value for money. But the partnership model can be fine-tuned so that expenditure is closest to the benchmark level. As a result, the partnership model achieves the best ratio of valued outcomes to total expenditure (117 per cent), followed closely by the free personal care arrangements (116 per cent) and finally by the means-testing-system (with a ratio of 113 per cent).

Free personal care would generate the most substantial call on public funding, which must be raised from elsewhere in the economy. There are political and economic costs of public funding (including the effects on the economy of higher taxes) that would need to be considered.

Both partnership and free personal care have better risk-sharing benefits than means-testing, because they provide services to more people. The anxieties individuals have about facing large care bills would be much reduced. Instead, they would have a clearer picture of their entitlement and how much they would have to pay.

There are also equity and fairness implications. The model shows the financial impact and the improvement in outcomes of the different funding arrangements on individuals with different levels of need and different wealth. Under each of the three funding options, the most dependent people get the most care. With different funding arrangements, people also get different levels of services depending on their wealth. Under the means-tested system, the eligibility rules lead to a stratification of people into three groups:

- individuals with low wealth, who qualify for state support and receive benchmark levels of care
- individuals with high means, who are able to secure high levels of services by funding their own care
- individuals between the two groups, a significant proportion of whom struggle to pay for their own care, and as a result do not receive enough formal support.

Free personal care and partnership models significantly help this middle group, by providing more care at lower charges.

The partnership model does levy charges but does not include means-testing in the care system. Instead, to help the poorest, the partnership model combines a needs-based care system with support for low-income people through the benefits system. People receive additional income benefits depending on the care charges they pay. But, although the low-wealth group would be better off under a partnership model than now (in terms of how much care they receive and how much is paid in charges), relatively speaking they would be *even* better off under a means-tested system in the future, albeit by a modest amount. This should be taken in context. As Chapter 13 shows, the vast majority of people would be much better off under the partnership model. For example, far fewer people would have to ‘spend-down’, that is, sell off assets such as their homes.

- It provides clarity about what care people can expect, how much they are entitled to receive, and also how much they have to pay.

But there are weaknesses with the partnership model.

- Compared with means-testing, the differential between what better-off people pay and poor people pay is lessened.
- Social care funding arrangements need to work with the benefits system. The partnership model is no exception, with all the complexities that this implies.
- The partnership model is not as expensive overall as free personal care, but it is more expensive than means-testing, at least in terms of the direct care costs. The political and economic costs of public funding (for example, the effects on the economy of higher taxes) need to be considered.

Ultimately, however, the choice of funding mechanism depends on value-based choices about the relative importance of containing public sector costs, maximising equal access to care, and balancing outcomes between high- and low-income groups.

Next steps

This Review seeks to contribute to a much-needed debate about how much social care is likely to be required in the future, and how to fund it. Social care for older people has been changing over the last five decades. This compounds the difficulties of specifying precisely what the purpose of social care should be in the future, what outcomes it should aim to achieve and where the boundaries should lie. With a paucity of good evidence and, too often, without adequate information about what social care does now, the task of assessing resource requirements in the future is a challenging one. And yet it is a crucial question, one that over the past 12 months has prompted a Green and then a White Paper from government. Many questions still remain about the detail and the costs; this Review has gone back to first principles to begin the process of finding answers. If its recommendations are taken forward by all those involved, a much clearer picture should emerge.

This Review has also drawn out the implications and consequences of different funding choices. It has highlighted the relative merits of the frontrunners and has identified the partnership model as, on balance, its preferred option; its implementation would represent a radical shift which would take time to organise and would need to take place alongside major shifts in the benefits system.

The Review has made a number of specific recommendations and these can be found in Chapter 14.

Introduction

1 The context for the Review

People are living longer. That is good news but, as baby boomers reach old age, the changes in demographics pose serious challenges for society. Social care, health care and benefits provision, including pensions, are three of them. To create the conditions to address these issues in an affordable way will require careful thought and skilled implementation. The issues are inter-related and raise many policy questions for government about the principles which should underpin its thinking.

Currently, practical delivery of social care, health care and benefits policies are not effectively integrated but, more fundamentally, the policies themselves lack coherence and have developed relatively ad hoc to produce a complex labyrinth confusing to individuals requiring help and to the many involved in attempting to provide support.

The political and economic thinking required to decide how best to provide services and financial support will have to be wide ranging. One missing piece of the jigsaw is an analysis of the long-term demand for and supply of social care for older people in England.

This Review, commissioned by the King's Fund, seeks to fill that gap. Its terms of reference are:

- to examine the demographic, economic, social, health, and other relevant trends over the next 20 years that are likely to affect the demand for and nature of social care for older people (aged 65 and over) in England
- in the light of this, to identify the financial and other resources required to ensure that older people who need social care are able to secure comprehensive, high-quality care that reflects the preferences of individuals receiving care
- to consider how such social care might be funded, bearing in mind the King's Fund's commitment to social justice.

Success in delivery will require adequate real resources. They will take time to create. The planning of many resourcing decisions needs to be informed by estimates of likely long-term needs, including assumptions about people's changing expectations and their desire to make choices. At the heart of the issue is the question of what social care will do in the future. How will it help people? What outcomes should it aim to achieve? Who should it help? Once its purpose is understood and specified, important decisions can then follow, including the range and type of care services, the size and composition of the workforce required to deliver high-quality care, the use of technologies (including new technologies) to assist people to live with more control, the extent of preventive action to avoid or delay need, and so on.

The need for such an analysis has been evident for many years. In the consultation preceding *Securing Our Future Health: Taking a long-term view* (Wanless 2002), many respondents called for stronger links between social care policies and health care policies. That 2002 report concluded that no review of health care resources was complete without consideration of the links with social care. In planning the delivery of care, health and social care needed to be considered together to ensure that both provided high-quality and well-integrated services for the individuals receiving care and that both were efficient – not least because of the potential to redefine aspects of health care as social care and change significantly the impact on individuals and on those in various parts of the public sector responsible for providing care. The report suggested that demographic change and, in particular, the growth in the number of older people could, over the next 20 years, see social care costs begin to grow faster than health care costs.

The report recommended that future reviews of resource requirements by government should fully integrate the analysis of health and social care. In the interim, it asked whether a more immediate study of the trends affecting social care was needed. Efficiency of public spending was likely to be enhanced overall by effective integration of different types of care, driven by appropriate incentives and efficient flows of information. Allocation of health and social care funding through different mechanisms led to problems. To be as effective as possible, investment in health care needed to be accompanied by adequate investment in social care. Despite these powerful benefits both to individuals and to the government, no such study has subsequently been produced.

Evidence of inadequacies in current social care provision is not hard to find. In June 2005, the King's Fund announced the findings of an inquiry into care services in London (Robinson and Banks 2005) which concluded that the capital's care system is in a sorry state. With an under-staffed system offering little in the way of choice and quality, urgent action was seen to be necessary to avoid even more older people suffering from poor care in 20 years' time.

Older people and their carers were experiencing:

- restricted access to care and practical support
- limited choice and control over care services
- being put at risk from untrained and unqualified staff
- hardship caused by inadequate funding and controversy about who pays for long-term care.

The Inquiry concluded that, at the root of these problems is a complex care system which relies on a mixture of market forces and government policy to deliver the right quantity and quality of services. It found that many older people were highly vulnerable, lacking knowledge about what is available, the opportunities to influence the quality of care on offer to them and the money to purchase what they need. In conclusion, a poorly developed care market was failing older people and their carers. Empowering people with direct payments and individual budgets would not, the Inquiry concluded, succeed unless there were sufficient services of the right kind which people want to buy. It went on to assert that, unless there was serious investment in developing the care market to offer the quality and diversity of services people expect, then older people would not be able to exercise their consumer power to get the right care for themselves.

The London study questioned whether existing funding levels would deliver the ambitious agenda being envisaged by government. Although London has special characteristics, many of the findings are unlikely to be peculiar to London and indeed many of the findings were consistent with those of an earlier King's Fund review (Henwood 2001). Funding remained an issue at the heart of the problems, an issue that this Review would help to address.

This Review therefore needs to concentrate on both the resources needed to provide enough social care in the future as well as the difficult question of who pays.

2 Recent government positioning for the future

In Chapter 1, the origins and development of social care are set out, plotting the long path from the 1940s to the changing philosophies which are now determining government's plans for the medium term. In March 2005 the government set out, in a Green Paper (Department of Health 2005f), its vision for the future of social care for adults in England (of all ages). Empowering people to choose and improving people's well-being were the main focuses. Many respondents set out publicly their views on the Green Paper and helped inform this Review, as have discussions with representatives of many parts of government and other regulatory organisations.

The White Paper in January 2006, *Our Health, Our Care, Our Say* (Department of Health 2006) set out proposals across both health care and social care, emphasising again better integration, but also the role of prevention. The White Paper asserts that there is much that can be done within current funding. As far as conclusions about future charging arrangements and the consequences of local decision-making are concerned, it makes clear that they have to be delivered in the context of the government's wider agenda of local government reform. The White Paper indicates that the independent inquiry being undertaken by Sir Michael Lyons into the future role and functions of local government and possible funding reforms will inform the 2007 Comprehensive Spending Review, and that this Review too will be an important contribution to the discussion.

As far as this Review is concerned, its timescale is 20 years. The Green Paper and White Paper provide some direction but neither they, nor the older people's National Service Framework, are sufficiently detailed for the resource forecasting required in preparing this Review. Although there are some specific targets in the Department of Health's priorities and planning frameworks and in public sector agreements, the basis on which they are set is not always apparent; nor is it clear whether they will reflect people's needs and ambitions over a 20-year time horizon. The question of where to position social care, what it will do, and where it stands relative to other public services is as important as ever.

The House of Commons Health Committee in April 2005, reporting on 'NHS Continuing Care' (House of Commons Health Committee 2005) said artificial barriers between health and social care lay at the heart of the problems surrounding access to continuing care funding and recommended, not for the first time, that the government should remove the structural division between health and social care.

3 Structure of the Review

Part 1 of the Review examines the origins and development of social care, the present social care system, its current outcomes, trends in those outcomes and the likely developing extent of need.

Part 2 then creates a number of scenarios for the future, reflecting different levels of ambition and achievement of outcomes. It tackles the question of ‘What should social care do for older people?’ It also considers the delivery issues raised. Although there is some useful information available, the evidence base is not as comprehensive as it should be. In assessing the evidence available and reflecting the idea of differing degrees of ambition, a hierarchy of three possible sets of outcome objectives for social care have been defined and examined.

Finally, Part 3 deals with the question of ‘Who pays?’ setting out some general principles for making the assessment, identifying a variety of possible funding systems and working through their strengths and weaknesses. It looks at the experience in other countries, including Scotland, which is of particular interest given the move there towards free personal care. The most promising funding options are assessed in detail using bespoke models.

The Review commissioned two major research papers. The first developed a projection model to estimate the likely future costs of care under a range of scenarios. The second looked at future trends in ageing and disability in the population and used a model to estimate future numbers of people with social care needs. These are available in the Appendix to this Review, available from the King’s Fund website (www.kingsfund.org.uk/publications). A series of background papers is also available giving more detailed analyses of many important topics summarised in the Review.

Methods

The Review has attempted to bring together the many parts of the evidence base on social care. It has combined a review of policy and research literature with specific analyses of various datasets and surveys which illuminate social care issues.

The approach has been to scrutinise the evidence base for a wide range of information to feed into both the analysis and assessment of particular issues, and into the development of several comprehensive models. This Review uses three main models: a projection model of future needs, resources and costs to 2026; a simulation model of funding options; and a micro-simulation model of population ageing and onset of disability and need.

The analysis, and particularly the models, draw on a number of relevant datasets, including general surveys, such as the Office for National Statistics’ General Household Survey, the Institute of Fiscal Studies’ English Longitudinal Survey of Ageing and specific surveys such as the Department of Health’s Formula Spending Share (now re-named Relative Needs Formula)survey. The full list of these data sources is in the Annex, p 6.

This Review has striven throughout to ensure that implications and conclusions are based on sound evidence. There have been many occasions where the evidence concerning particular issues has appeared to be lacking or is embryonic. These are documented in

what follows. On those occasions, even where the line of inquiry is promising, the analysis has deferred to the established position. It would not be appropriate to estimate resource requirements that could run into many billions of pounds on potentially shaky assumptions.

The work of this Review, consequently, should be seen as part of the continuing development of knowledge and understanding of social care for older people. It seeks to promote further debate about issues of vital concern to millions of older people in this country and their carers.



Annex 1. Research and background papers

Research papers

RP1 (PSSRU model)	Malley J , Comas-Herrera A, Hancock R, Juarez-Garcia A, King D, Pickard L. 2006. <i>Expenditure on social care for older people to 2026: projected financial implications of the Wanless Review</i> . Wanless Social Care Review Research Report and PSSRU discussion paper 2332: PSSRU, London School of Economics
RP2 (Future disability)	Jagger C, Matthews R, Spiers N, Brayne C, Comas-Herrera A, Robinson T, Lindesay J, Croft P. 2006. <i>Compression Or Expansion Of Disability? Forecasting future disability levels under changing patterns of diseases</i> . Wanless Social Care Review Research Report: Leicester Nuffield Research Unit, University of Leicester

Background papers

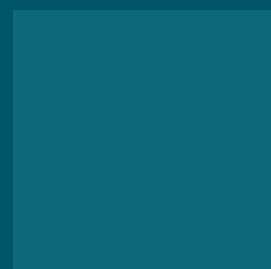
1 (Prevention)	Preventive social care: is it cost effective?
2 (Continuing care)	NHS continuing care in England: issues and developments
3 (Direct Payments)	Direct Payments and older people
4 (Private expenditure)	Private expenditure on older people's social care
5 (Workforce)	The social care workforce in England – the current position and the challenges of supply
6 (Informal care)	Informal care in England – an assessment of the current and future positions
7 (Telecare)	Telecare and older people
8 (Housing options)	Housing options for older people
9 (Dementia care)	Dementia care
10 (Scotland: Free personal care)	Free personal care in Scotland
11 (Scotland: care trends)	An examination of trends in the use of informal and formal care provision at home and in the care home sector
12 (Funding options)	Funding options for older people's social care
13 (Ideal inputs)	Professionally assessed ideal care inputs



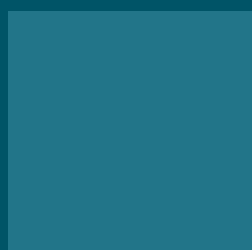
Annex 2. Main data sources

The main sources are:

- The General Household Survey (GHS), which is a nationally representative population survey of individuals. The GHS 2001 included a specific older people's extension with pertinent questions about dependency in particular. See: http://www.statistics.gov.uk/ssd/surveys/general_household_survey.asp
 - The Formula Spending Share (FSS) survey, which is a survey designed and undertaken by PSSRU (commissioned by the Department of Health) of just under 400 older people using community-based services in 13 local authorities in England. See Darton *et al* (2006).
 - The English Longitudinal Study of Ageing (ELSA) which is a nationally representative survey of the older population (50+) of which the first wave data is available (2002/3). See: <http://www.ifs.org.uk/elsa/>
 - The Evaluating Community Care for the Elderly People project (ECCEP) a quasi-experimental detailed longitudinal follow-up survey of 425 older people using services in 1995 and subsequent years up to 1999/2000 – see Davies *et al* (2000).
 - The British Household Panel Survey (BHPS), a nationally representative population survey of individuals following them through time, now on the 13th year of follow-up. See <http://www.iser.essex.ac.uk/ulsc/bhps/>
 - The Health Survey for England (HSE), a nationally representative population survey conducted annually. The 2000 survey had an extension sample of people in care homes. See: <http://www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/HealthSurveyForEngland/fs/en>
 - The Medical Research Council Cognitive Function and Ageing Study (MRC CFAS) is a large-scale multi-centre longitudinal epidemiological study of ageing, with a special focus on cognitive and physical decline in later years. See <http://www-cfas.medschl.cam.ac.uk/> and also Chapter 2.
 - Census 2001 – see <http://www.statistics.gov.uk/census/default.asp>
 - Department of Health Personal Social Services statistics – http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/StatisticalWorkAreas/StatisticalSocialCare/StatisticalSocialCareArticle/fs/en?CONTENT_ID=4086767&chk=4eMvuk covering: Community care statistics; Home help/home care statistics; Referrals, Assessments and Packages of care (RAP); Supported Residents (adults), England
 - Department of Health Personal Social Services finance statistics (PSSEX1) – see: http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/StatisticalWorkAreas/StatisticalExpenditure/StatisticalExpenditureArticle/fs/en?CONTENT_ID=4000111&chk=j2LMYP
 - Commission for Social Care Inspection (CSCI) database of care home inspections – See http://www.csci.org.uk/inspection_reports/default.htm
 - Government Actuary's Department population database and projections – See: http://www.gad.gov.uk/Population_Projections/Population_projections_background.htm
 - PSSRU extended survey of user experience (UES), a sample survey of 31 councils' home care user population – see Netten *et al* (2004).
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Part 1 



1

The origins and development of social care

SUMMARY

Current debates about the provision and funding of social care must be viewed against the policy shifts of the past five decades. This chapter sets out the key landmarks in the focus and role of social care services since the 1980s and provides a picture of the current system. It includes the following important themes.

- The fragmentation at both local and central government levels in the responsibility for social care, as outlined in the influential 1988 Griffiths review. The review also highlighted the ‘perverse’ financial incentives that were encouraging local authorities to place older people unnecessarily in residential care.
- The revolution in service provision as a result of the 1989 White Paper, *Caring for People*, (enacted in the 1990 Community Care Act) which declared that local authorities should be the brokers and care managers of social care, but not necessarily the direct providers. This led to a huge growth in the independent sector, which now provides the majority of state-funded residential care and 69 per cent of adult domiciliary care contact hours, compared with just 2 per cent in 1992.
- A new emphasis on prevention and rehabilitation, as outlined in the 1998 White Paper *Modernising Social Services*, amid the realisation that existing policies had removed support from those receiving ‘lower levels’ of help. Achieving timely hospital discharges by older patients became a key goal.
- A review of how to fund long-term care for the elderly through a Royal Commission report in 1999. This recommended that personal care should be free, a proposal that was rejected by the government.

Today, some 1.2 million people aged 65 and over use publicly funded social care services and a further substantial number are reliant on privately funded residential and domiciliary care. Choice, independence and prevention are the government’s avowed underlying values for the system. But a breakdown of total local authority expenditure shows almost 60 per cent is still committed to residential placements, with another 20 per cent for home care services.

In a significant development, the 2006 White Paper, *Our Health, Our Care, Our Say*, seeks greater integration of health and social care, and to manage performance against shared outcome targets. The challenge for government is whether continued incremental adjustments will be enough to achieve this subtle shift from partnership towards integration.

1 Introduction

It is impossible to understand fully debates about the future of social care without having some awareness of the history of welfare and the key policy developments that have shaped policy and practice in 2006. The purpose of this chapter is to provide some background and context to illuminate some of the current and emerging debates both about the funding of social care for older people and about its relationship with other public services, most notably the NHS. A summary of the origins of social care from 1948 is given in the box below.

The present phase of social care development dates from major debate and subsequent reforms which emerged in the late 1980s. In December 1986 Sir Roy Griffiths was commissioned by the Secretary of State to undertake an overview of community care policy. This marked the beginning of a period of significant reform that underpins social care of the present day. Specifically, the terms of reference required a review of ‘the way in which public funds are used to support community care policy’ and to make recommendations on how such resources might be used more effectively. The report of the Griffiths review in 1988 accepted that the work of the Audit Commission and of the House of Commons Select Committee inquiry into community care contained ‘the essential facts’ on which to base the analysis (House of Commons 1985).

The Griffiths report acknowledged the many submissions received addressing inadequacies of funding. This was outside the remit of the review, and the major focus was on achieving the more efficient use of resources, while it was accepted as self-evident that resources should be consistent with agreed responsibilities and objectives. Alongside questions of funding, the other major difficulties appeared to lie in divided responsibilities and fragmented services: ‘the complex network of relationships and responsibilities at the local level between the various authorities, voluntary groups etc’. The problems of fragmentation did not end at local level and were also evident in the split responsibilities between central government departments. The consequences for policy and practice were famously summed up by the report in the observation that ‘community care is a poor relation; everybody’s distant relative but nobody’s baby’ (Griffiths 1988). In response, the Griffiths report set out proposals to achieve clearer lines of responsibility and accountability from the level of the Minister to those delivering services to individuals.

A key component of the Griffiths recommendations concerned the use of social security resources within funding for social care. The ‘perverse incentives’ identified by the Audit Commission were concerned with the use of Supplementary Benefit payments (the equivalent to Income Support in current terms) to pay for residential care. A person who qualified for Supplementary Benefit and who wished to enter a private or voluntary sector residential care home could do so with their care fees being paid through the social security system. For local authorities trying to protect limited budgets this allowed a useful mechanism for diverting demand to another source of funding. However, the rapid growth in the numbers of people being supported through public funds, and the clear conflict which this introduced with an apparent objective to achieve community care, were the major factors driving the need for reform. The situation was summed up succinctly by Sir Roy Griffiths: ‘This particular benefit is at the interface between the social security open-ended financial commitment based on entitlement and a budgeted provision against priority of need, which is the social services approach. Prima facie the two approaches are diametrically opposed (Griffiths 1988, para 15).

ORIGINS FROM 1948

The origins of social care can be traced to the 1948 National Assistance Act and the birth of the 'Welfare State' (see Table 1, pp 27–29, for a time line of critical policy events). However, the origins of welfare support lie much further back in time, particularly in the mutual and friendly societies of the 19th century, and prior to that in the Elizabethan Poor Law and the workhouse. Insurance-based coverage for some health services and unemployment support was established by the Liberal government that came to power in 1906 (following the model established in Germany by Chancellor Bismarck). However, the need to establish a more coherent basis for welfare underpinned the establishment of the Beveridge inquiry in 1941 and the report of the following year (Beveridge 1942) laid out plans for vanquishing the 'Five Giants': want; disease; squalor; ignorance and idleness. The incoming Labour government of 1945 embarked on a series of reforms which laid the foundations for the welfare state, the key features of which remain to this day.

The 1948 National Assistance Act set out in broad terms the responsibilities of local authorities. These were few and largely concerned with residential provision. Thus Section 21 of the Act stated the duty of every local authority: '... to provide residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them'.

Beyond this the responsibilities of the local authority were narrowly conceived and had nothing to say about any remit for promoting the well-being of the community (as has characterised more recent developments). The most significant point about the origins of the welfare state is that while health care provision under the newly established National Health Service (NHS) was free at the point of use, social care services provided by the local authority could carry charges and would be subject to means-testing of the recipient. Moreover, while the NHS was regarded as a service for all citizens, the services of the local authority were viewed as a more residual provision (Means 1986).

From the late 1940s onwards the idea of 'community care' began to develop as a concept. Initially the merits of developing care outside of residential settings emerged in the child care field. The poor physical, emotional and cultural facilities in much institutional care highlighted by the report of the Curtis Committee (Care of Children Committee 1946) led to the development of fostering as the preference in providing for looked-after children. It was another decade before similar transitions began to develop in other areas of care and a shift was envisaged from long-stay hospital care to community-based alternatives. During the 1950s a consensus began to emerge about the preference of supporting older people to remain in their own homes as long as possible. This was driven in part by concerns to reduce financial pressures on state provision, but also by more humanitarian issues, particularly by the growing evidence from academic and other sources about the continuing poor quality of life offered in many residential homes (Townsend 1964). Into this new environment The Hospital Plan of 1962 similarly envisaged a major programme of institutional closure with a halving of numbers of psychiatric beds by 1975 and the development of facilities within general hospitals rather than in specialised institutions.

By the mid-1970s the need to expand services for the ‘priority groups’ in health and social care was an indication of how little development of community-based services had been achieved. A consultative document issued in 1976 set out objectives for achieving a re-distribution of resources away from the acute hospital sector and into community services for older people; those with physical disabilities; people with a mental illness and those with learning disabilities (Department of Health and Social Security 1976). Over the next few years a series of policy documents set out the various objectives for these different client groups, all of which shared the emphasis on redirecting development towards the community and away from residential and institutional facilities.

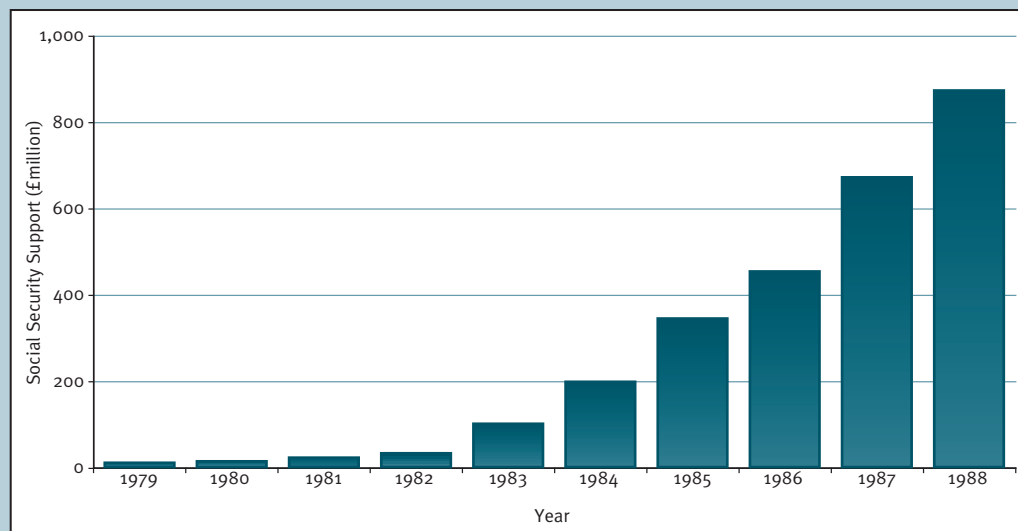
From the 1960s onwards attempts to co-ordinate health and social care also became evident. In the early days 10-year plans were developed for hospital and community care services, but were short-lived. By the 1970s it was becoming increasingly evident that the separation of health and social care was problematic. The creation of integrated social services departments in 1971 was shortly followed by the reorganisation of the health service in 1974 which served to move many services out of local government control and into the NHS. Attempts to improve the coherence of health services were arguably at the price of creating further barriers, gaps and overlaps with local authority social services (Hudson and Henwood, 2002).

It was accepted that the use of social security funding for residential care was ‘not wholly bad’. Many people who would have needed such care had been enabled to have it, but the availability of the budget took no account of whether it was the best option for the individual concerned, nor made it possible to explore alternative arrangements. As Griffiths concluded, with limited resources available there was a risk that this route into residential care would absorb funding that might otherwise be directed towards other means of supporting people in their own homes, and: ‘To use an increasingly expensive social security provision as a safety valve to keep the lid on the pot of community provision would be inconsistent with governmental and managerial responsibility.’ (Griffiths 1988, para 16)

It was the fact that this ‘safety valve’ relieved direct pressure on local authority social services budgets, while diverting it to a less conspicuous pot of money that allowed the situation to develop unchecked for as long as it had. Local authorities had every incentive, as the Audit Commission had pointed out, to develop services that were ‘social security efficient’ and shunted the costs of care elsewhere. Figure 1 below demonstrates the exponential growth rate in social security expenditure that occurred in less than a decade (from £10 million to almost £900 million). It was increasingly evident that the social security budget could not be allowed to continue to rise unchecked.

It was not only social services authorities that were making creative use of the availability of social security funds in this way. Health authorities too were maximising the opportunities to close long-stay hospitals (particularly for people with learning disabilities) by transferring patients to private and voluntary care homes where their fees would be paid through the social security system (Glennerster and Korman 1989; Henwood *et al* 1991). For both health and local authorities the availability of this funding might also be

1 SOCIAL SECURITY SUPPORT TO PEOPLE IN INDEPENDENT CARE HOMES, 1979 TO 1988



Source: House of Commons Social Services Committee 1990

seen to provide an alternative strategy to investing in often tortuous partnership working; such arrangements could simply be by-passed (Hudson and Henwood 2002).

2 The 1990s community care reforms

The Griffiths proposals recommended that local authorities would be responsible for assessing local community care needs, and setting priorities and objectives. At the individual level they would also be responsible for assessing needs and arranging packages of care. The idea of the local authority as broker and care manager, but not necessarily as direct provider was revolutionary at the time. The view that ‘the role of the public sector is essentially to ensure that care is provided’, but that *how* it was provided was a secondary consideration required a new way of working and a completely new role for the local authority social services department.

The Griffiths report provided the foundation for the community care reforms subsequently set out in the 1989 White Paper, *Caring for People*. Local authorities were assigned the lead role in planning community care (but would need to do so in co-operation with health service partners). The ‘key components’ of community care were identified as:

- services that respond flexibly and sensitively to the needs of individuals and their carers
- services that allow a range of options
- services that intervene no more than necessary to foster independence, and
- services that concentrate on those with greatest needs (Department of Health 1989).

The central objectives for service delivery which flowed from these aspirations are summarised below.

The 1989 White Paper was intended to provide the framework for social care for the 1990s and beyond. While many of the developments were highly controversial at the time, in

SIX KEY OBJECTIVES OF CARING FOR PEOPLE

- To promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible.
- To ensure that service providers make practical support for carers a high priority.
- To make proper assessment of need and good case management the cornerstone of high quality care.
- To promote the development of a flourishing independent sector alongside good quality public services.
- To clarify the responsibilities of agencies and so make it easier to hold them to account for their performance.
- To secure better value for taxpayers' money by introducing a new funding structure for social care.

Source: Department of Health (1989), *Caring for People*, Cm 849, London: HMSO, para 1.11

retrospect it is striking to realise how similar this agenda is to the one confronting policy-makers in the early part of the 21st century. What this also begins to indicate is how challenging this agenda has proved to be and the relative failure of services to achieve the vision set out over the past 20 years. But it is also evident that many of the difficulties which confront adult social care today are in large part the consequences (often unanticipated) of the reforms of the 1990s. A particular example is the effect of concentrating resources on people in greatest need. The targeting of services in this way inevitably led to a withdrawal of support at lower levels of need and raised the threshold for access to help and support. More recently the consequences of this for reducing the role that services might play in preventing needs increasing have been the focus of growing concern.

The 1989 White Paper was enacted in the NHS and Community Care Act of 1990. Initially implementation was planned for April 1991, but a major delay was announced which led to phased implementation with most of the changes not taking effect until April 1993. Considerable debate over the reasons for (and consequences of) this delay ensued at the time. The official justification concerned the lack of readiness of local authorities to assume their new responsibilities. Other likely factors included political unease over the financial implications of transferring these responsibilities to local government at the very time that alarm over local council spending and the impact on the poll tax was at its height (Hudson 1994).

The rationalisation of financial and managerial responsibilities for social care was reflected in the creation of new funding streams for local authorities (particularly the Special Transitional Grant (STG) for community care). This increased the transparency of funding for social care which also fuelled the debate about the apparent under-funding of this area.

A further strand of the *Caring for People* reforms worthy of exploration is the relationship between health and social care. In assigning the lead responsibility for community care to local authorities it was nonetheless recognised that there was an important interface with other key services, particularly those of the NHS. The White Paper stated that: 'Community

care is about the health as well as the social needs of the population (...) In some individual cases, it may well be difficult to draw a clear distinction between the needs of an individual for health and social care. In such cases, it will be critically important for the responsible authorities to work together.’ (Department of Health 1989, para 4.1–4.2).

The need for authorities to ‘work together’ had been a recurrent theme of policy probably since the 1948 Act. *Caring for People* acknowledged that joint planning achievements had been ‘mixed’, and generally fell short of the aspirations of the 1970s. In clarifying responsibilities the White Paper claimed to offer a fresh approach to collaboration, but stated a familiar message that ‘further efforts are needed to improve coordination between health and social services’.

The other main element of the 1990 Act, which saw the development of a market in social care, needs also to be seen as part of a wider movement in which Thatcherite policies were seeking reform of public sector bureaucracy and the introduction of the discipline and rigour of the market place. As other commentators have remarked, this brought some challenges to joint working and collaboration which had relied on co-operation between partners. In the new climate, competition became a more significant driver and the management of inter-organisational networks became considerably more complex and demanding (Hudson and Henwood 2002).

In the wake of the 1990 Act there were therefore significant challenges for social care. Some of these difficulties owed as much to what was *not* in the Act as to what was. In retrospect the failure of the Act to address health and social care issues in the round is striking. The 1989 White Paper observed (notoriously) that ‘the key functions and responsibilities of the health service as a whole remain essentially unaltered by the proposals’ (Department of Health 1989, para 4.2). Indeed, a separate document (*Working for Patients*) addressed reforms for the NHS. The failure to address these as an integrated agenda ensured that loose ends dangling from both would eventually unravel and require more fundamental attention.

3 Continuity and change: developments since the mid-1990s

The landslide victory of a Labour government in 1997 did not mark an immediate or substantial change of direction in social care. However, the new government did set up a Royal Commission on the funding of long-term care in December 1997 to explore ‘a way to fund long term care which is fair and affordable for the individual and the taxpayer’ (Royal Commission 1999). The Royal Commission looked at the system of funding arrangements at the time – which mostly prevail to this day – and highlighted a series of problems. The Commission was critical about the unfairness of the system, particularly its penalising of those with savings or homeowners. The system was also criticised as offering limited choice, being inconsistent, and having in-built incentives for care home use. Furthermore, the system was complex and provided no sense of security to people. The Royal Commission looked at private sector funding options but concluded that private insurance was unlikely to become a major part of the funding map.

The main recommendations were to provide personal care free of charge on the basis of need only, funded from general taxation and to establish a National Commission to

monitor progress, assess standards and develop social care. The Royal Commission members were, however, divided over the recommendations; a minority of the commissioners rejected the idea of free personal care, instead suggesting a more generous means-test. The government decided against the free personal care recommendation, but the other recommendations were largely accepted. A number of the specific options for funding were adopted by government, such as a three-month disregard for means-testing and making nursing care free. A number of options were also presented for alleviating the means-test, such as increasing the upper asset threshold to £60,000 (at 1995 prices), and limiting liability on service users by providing care used for four years or more free of charge.

In 1998 a White Paper was published which re-affirmed the broad commitment to promoting community-based care and promoting people's independence (Department of Health 1998). However, the document did open with a significant statement that indicated a change in the positioning of social care. In place of the residual model that characterised much of the history of welfare, it stated: 'Social Services are for all of us. At any one time up to one and a half million people in England rely on their help. And all of us are likely at some point in our lives to need to turn to social services for support, whether on our own behalf or for a family member.' (Department of Health 1998, para 1.1)

In re-affirming the importance of social care the incoming Labour government did not promote a highly ideological position about a return to public sector services. Rather it took the early opportunity to set out 'the third way for social care', which rejected both 'the last government's devotion to privatisation' and the 'one size fits all' approach' that had too often characterised old style local authority provision: 'Our third way for social care moves the focus away from who provides the care, and places it firmly on the quality of services experienced by, and outcomes achieved for, individuals and their carers and families.' (Department of Health 1998, para 1.7)

Prevention and low level support

While marking considerable continuity with earlier policy objectives, the 1998 White Paper also signalled an important shift in emphasis. The idea of targeting support on greatest need which had run through policy since the 1950s and which had been a central tenet of the *Caring for People* reforms, was recognised as problematic. It was acknowledged that the policy had led, for example, to an increase in the intensity of home care services, but also a reduction in coverage. A more intensive service was being provided but to a smaller group of people, and those most likely to lose support were those receiving 'lower levels' of help. The short-termism of this strategy was acknowledged in the admission that: 'This increases the risk that they in turn become more likely to need much more complicated levels of support as their independence is compromised. That is good neither for the individual nor, ultimately, for the social services, the NHS and the taxpayer.' (Department of Health 1998, para 2.6)

A central concern of the White Paper was therefore to engineer a new emphasis on 'helping people achieve and maintain independence wherever possible' through the twin tracks of prevention and rehabilitation strategies. Specific grants were subsequently introduced to facilitate such developments.

The importance of these agendas for the smooth operation of the NHS was clearly an important consideration in trying to bring about such a shift. In particular, the interface between health and social care services was sharply focused around the difficulties of achieving timely discharge from hospital, especially of older and frail patients. The development of models of ‘intermediate care’ that might avoid hospital admissions being required, or provide short term and focused support in the period following discharge from hospital, has been a key element of this strategy.

Partnership working

A further aspect of policy continuity was evident in the emphasis on the need to improve partnership working. Indeed, it would be more accurate to see the emphasis on partnership under New Labour as a rebirth for a concept which had gone somewhat stale over the preceding decade. *Modernising Social Services* underlined the importance of social services working with a number of statutory and non-statutory agencies. The desire to remove the ‘Berlin Wall’ that too often separates health and social care was stated alongside the objective of establishing ‘integrated care that puts users at the centre of services provision’. However, this did not signal a major structural reorganisation that would have rebuilt the architecture of the two services and removed the boundary which has often proved problematic. This radical solution was rejected over concerns that it would merely generate new service boundaries, divert management attention and cause destabilisation. Rather there was to be ‘a new spirit of flexible partnership working’.

Arrangements to remove some of the legal obstacles to joint working were announced and new partnership ‘flexibilities’ made possible (building on the model that had been outlined in the consultation document *Partnership in Action*). These were subsequently enacted in the Health Act 1999. The box below summarises the provisions created. It is important to note that these introduced permissive powers rather than duties; that is, authorities who wished to avail themselves of these new ways of working could do so. A short-lived attempt to make such arrangements compulsory was laid out in *The NHS Plan* of 2000, but was later diluted.

THE SECTION 31 HEALTH ACT FLEXIBILITIES

Section 31 of the Health Act 1999 removed legal obstacles to joint working by introducing a series of flexibilities allowing the development of:

- **pooled budgets** – where health and social services authorities put resources into a single budget to fund care services
- **lead commissioning** – where either the local authority or health authority/primary care group takes the lead in commissioning services on behalf of both
- **integrated provision** – where local authorities and health authorities can merge their services to provide a ‘one-stop’ package.

The development of the new flexibilities immediately raised fundamental issues about the different basis of health and social care services. When services are developed through pooled resources, or when integrated services are developed across health and care, it becomes increasingly artificial to maintain a distinction over what parts of the service are ‘free’ at the point of use, and which should carry charges as social care services. Concerns

over the unfairness of charging for social care had been a recurrent issue. The 1998 White Paper acknowledged the need for ‘greater transparency and fairness in the contribution that people are asked to make towards their social care’ (Department of Health 1998, para 2.37).

However, it was also noted that there were considerable inconsistencies in the charging regimes for non-residential care operated by local authorities. These were discretionary systems which meant that unlike residential care where there are national rules concerning how income and assets are taken into account and charges calculated, each authority could decide on its own approach to charging. An attempt to provide a more systematic approach was subsequently set out in guidance (Department of Health 2001c).

The NHS Plan reiterated many of the key messages around partnership working and developing models of intermediate care as a bridge between hospital and home. As with earlier emphasis on such developments it was apparent that the impetus for this policy owed much to the combination of a number of factors including:

- NHS waiting list pressures and targets and the consequent need to maximise throughput of patients
- renewed concerns over levels of delayed discharges
- reduced capacity in the care homes market reducing the options available to service commissioners trying to develop appropriate care packages.

The strategy set out in *The NHS Plan* (Department of Health 2000b) had three inter-related strands incorporating an emphasis on ‘whole systems working’ across health and social care economies; the development of intermediate care (as a means of improving health and social care integration while also improving outcomes for individuals), and building capacity for care through a ‘Cash for Change’ grant to develop capacity across the health and social care systems primarily to reduce hospital delays.

It is striking that the objectives of promoting independence, developing intermediate care, and improving partnership working, were recurrent across a number of health and social care policy documents from the mid-1990s onwards. These remain the key objectives of current policy (as will be outlined below). Their enduring presence in policy documents is testimony to the difficulties in achieving the significant changes required to deliver the objectives. It also points to the fact that increasingly the difficulties of managing two parallel but separate systems of health and care are being managed by strategies that attempt to integrate their respective agendas as far as possible.

Despite the continuities of policy since 1997, the other major theme is that of change. This has been a period of considerable change across health and social care, reflected in a series of Green and White Papers, plans, strategies and National Service Frameworks. One enduring difficulty has been the extent to which such developments have continued to take place in narrowly defined terms which take insufficient account of their impact on other service areas.

A further development in social care that should be noted is the extent to which other partners have become involved, both at local and national levels. The wider role of local government, beyond conventional social care responsibilities, is of particular importance. *The NHS Plan* recognised the need for the NHS and local government to engage more

comprehensively via neighbourhood renewal strategies and the development of Local Strategic Partnerships. This wider conceptualisation of partnership is also consistent with the objectives of social care around prevention and promoting independence. In addition to the conventional health and social care services, such strategies have implications for other dimensions including housing, education, leisure, transport, the built environment and income support. This wider conceptualisation of partnership and service development, and the attempt to establish a 'joined-up approach' was a defining feature of the initiative Better Government for Older People programme (BGOP) established in 1998.

The complexity of partnerships, and the potential fragmentation of policy, is clear in the fact that in addition to the responsibilities of the Department of Health a number of other government departments are involved. The Secretary of State for Work and Pensions is the Government Champion for Older People; and the Department for Work and Pensions (DWP) is the lead department on older people. While responsibilities for communities reside within the Office of the Deputy Prime Minister (ODPM), responsibility for social care lies within the Department of Health. The relationship between key policy initiatives across these departments is often far from clear (ADSS 2005).

A new vision for social care?

A Green Paper on adult social care issued in March 2005 set out a new 'vision for the future'. The approach outlined in that document is part of a wider reform of public services in the 21st century, and the introduction of 'an entirely different dynamic' characterised by more personalised services offering 'true choice, excellence and quality'. While the focus of social care remains sharply on promoting independence, the latest policy developments are more concerned with the nature of service support, and with the ways in which it is provided. In short, the Green Paper stated that 'it is not acceptable to continue to deliver social care in the way we do today' (Department of Health 2005f). The aspirations of a modern social care system are clearly a long way from the original (and minimal) intent of the 1948 Act. In place of basic services for a small minority of the population, there is a shift in emphasis, which promotes the concepts of citizenship and choice. The Foreword to the Green Paper underlined the importance of social care 'to us all'. The Secretary of State observed that: 'Social services and social care for adults touch all our lives at some point or another and, because of that, they are not about "other" people. They are about families and friends, neighbours and communities, in the towns and in the countryside in every corner of England.' (Department of Health 2005f, p 5).

The need for reform of social care was set in the context of rising demand (particularly associated with population ageing and wider demographic trends), alongside rising public expectations. The Green Paper introduced a focus on key outcomes for social care which should be applicable to all adults – whether or not they use social care services (see box below). The underlying values on which services should be built were restated as independence, empowerment and choice.

The emphases of the Green paper on choice, independence and prevention, and on seamless approaches to care, were familiar themes from previous policy documents. Criticisms of the paper raised questions about the coherence of the agenda with other important developments in public policy, particularly those in ageing, disability, long-term

WELL-BEING OUTCOMES OF SOCIAL CARE FOR ADULTS

Social care for adults can provide the following outcomes in terms of well-being:

- improved health
- improved quality of life
- making a positive contribution
- exercise of choice and control
- freedom from discrimination or harassment
- economic well-being
- personal dignity.

Source: Department of Health (2005f), *Independence, Well-being and Choice*, p 26.

conditions, the role of communities, and the interface with housing, children and families, and with the NHS (ADSS 2005).

From partnership to integration?

The Department of Health announced that it would take forward the Green Paper by developing an integrated White Paper across health and social care. That document was published at the end of January 2006 (Department of Health 2006). The central tenet of the policy is summed up in the objective to ‘move towards fitting services round people not people round services’. Four main goals were set out for health and social care services, namely:

- better prevention services with earlier intervention
- more choice and a louder voice for patients and service users
- tackle inequalities and improve access to community services
- more support for people with long-term needs.

There is no argument with the key objectives identified for social care in the 21st century. However, there remain questions about whether the White Paper offers the way forward. Many of the challenges confronting health and social care are long-standing. Indeed, particular difficulties at the boundary between the two services are the result of the historical legacy of the 1948 Act which established a separate constitution for health and social care. The White Paper re-emphasised this separation, making it clear that ‘social care is not a universal service’ (para 4.5), and highlighting the ‘major difference between the NHS and social care services’ whereby (with the exception of certain charges) ‘NHS care is free at the point of use’, while social care ‘is something that we generally provide for ourselves and each other’, and where needs are greater than friends and family can cope with ‘public resources get to those who need the most help and who cannot afford to pay for that extra support themselves’ (Department of Health 2006, para 4.4).

As has been outlined above, the solution to-date has focused primarily on improving partnership working. The White Paper continued this emphasis, but with some shift in the mechanisms through which to achieve it and a move towards increasing integration. In place of more exhortation there is a clearer attempt to establish some levers that might engineer the strategic shift required. An important aspect of this will be the development

of outcome measures to apply to both health and social care, reinforced through consistent performance assessment and inspection processes.

This more integrated approach across health and social care is to be further strengthened through aligning the budgetary and planning cycles of the NHS and local authorities. Tackling practical barriers of this nature is consistent with the approach that underpinned the introduction of the S31 flexibilities. Local area agreements (LAAs) and local strategic partnerships (LSPs) are seen as important (albeit relatively untested) tools in developing partnership. The other mechanism for improving coherence across health and social care is to be through stronger local commissioning between local authorities and primary care trusts (PCTs).

The quest for improved integration is further addressed in a number of ways in the White Paper. Improved co-terminosity of local authority and PCT boundaries would, it is believed, 'make it easier to achieve better integration of health and social care'. Decisions on PCT configuration were still a matter of consultation when the White Paper was issued. Others (notably the Health Select Committee) have observed that realigning PCT boundaries may remove some organisational boundaries, but is likely to create others: 'Links forged with providers of services at a district council level, such as housing, may founder if there is a return to larger, county-based structures, and several unitary councils (...) have argued that moving back to large, county-based structures would be a retrograde step, undoing much good work that has been done locally to address health inequalities.' (House of Commons Health Committee 2006)

Better integration of assessment across the NHS and social care information systems is seen as a further mechanism for facilitating shared care plans 'as part of an integrated health and social care record'. Integrated care for people with complex long-term needs is recognised as a particular challenge. This is to be met by encouraging the creation of multi-disciplinary networks and teams between PCTs and local authorities. More broadly, further integration is to be sought through the development of more co-location of key services within the context of joint commissioning frameworks. The expansion of practice-based commissioning (PBC) is seen as a further development that will lead to 'more responsive and innovative models of joined-up support', and increased use of the Health Act flexibilities. PBC is presented as the 'health equivalent of individual budgets in social care'; this might be debated, but certainly both measures are concerned with devolving purchasing power and bringing about more responsive and local services.

The aspirations of the White Paper will command widespread support. The government presents the plan as the first attempt ever 'to lay out both a comprehensive and compelling vision of preventative and empowering health and social care services and an effective programme for making this vision a reality'. Whether it succeeds in doing so remains to be seen. However, some important questions need to be asked about the solutions that are proposed.

4 A snapshot of the current social care system for older people

This chapter has set out a brief synopsis of how and why the present social care system for older people has evolved. So what does the current system look like? Local authority social

care spending has risen significantly in real terms and has more than doubled in the past decade. Total gross expenditure on adults and older people has risen from £6.55 billion in 1993/4 to £12.84 billion in 2003/4 (in 2003/4 prices) (*Public Expenditure Questionnaire* 2005) – see Chapter 6 for further details.

Approximately 1.2 million older people in England use social care services organised by their local council (Commission for Social Care Inspection 2005b). Typically an older person enters the social care process because of a short-term crisis (such as following a fall or a stroke), or increasing frailty and disability whereby they can no longer manage to live independently without some additional support. The 150 local councils in England have responsibilities for social services, and receive funding from a combination of central resources allocated through the Revenue Support Grant and an additional element from local council tax. Access to social care is managed through a process of assessment (and councils have a statutory duty to assess the needs and circumstances of anyone seeking help). A social worker or care manager will assess the needs of the person (and of any carers or other family members) and develop a care plan to meet those needs. Councils with social services responsibilities are the main commissioners of social care services. Commissioning services involves assessment and care planning alongside the procurement of services. The process of care planning will take account of the resources available to the local authority and will also assess the financial means of the service user to determine what, if any, contribution they will be required to make to the costs of their care.

The services arranged through local authorities are broadly classified in terms of residential/nursing care; domiciliary care (that is, support to people in their own homes), and day care (services and activities which are available to support people in other settings).

Regulation of care services

The Care Standards Act of 2000 established a framework for the regulation both of care services and of social care workers. The components of the regulatory framework are summarised in the box below.

The pattern of service provision

On 31 March 2005 there were just over 19,000 residential care homes for adults registered in England, providing 441,000 places (Commission for Social Care Inspection 2005b). It is believed that the total number of residential places is declining, and has fallen by around 5 per cent (20,000 places) in the past two years (Commission for Social Care Inspection 2005b). Homes providing care for older people are becoming larger (providing for more residents), while those providing for younger adults are getting smaller. Most providers are not large corporate bodies with multiple businesses. Annual analysis of market trends by Laing & Buisson indicates that only a third of residential care providers in the private and voluntary sectors have three or more care homes. However, the market is changing and the residential care market overall is becoming more concentrated with fewer, larger homes. On 31 March 2005 there were over 4,000 domiciliary care agencies and 900 nursing agencies registered with the CSCI (Commission for Social Care Inspection 2005b). The requirement to register was introduced in 2003 so trend data is not available. However, other research into the

THE REGULATION OF SOCIAL CARE

The Care Standards Act 2000 led to the establishment of the **Commission for Social Care Inspection (CSCI)** in April 2004 as the single, independent inspectorate for all social care services in England. CSCI brought together responsibilities that had formerly been split between the Social Services Inspectorate (SSI), the SSI and Audit Commission Joint Reviews Team, and the National Care Standards Commission.

The CSCI is responsible for registering local care services that are required to meet national standards. Further changes will see the merger in 2008 of the CSCI with the Health Care Commission to create a single new inspectorate across health and social care.

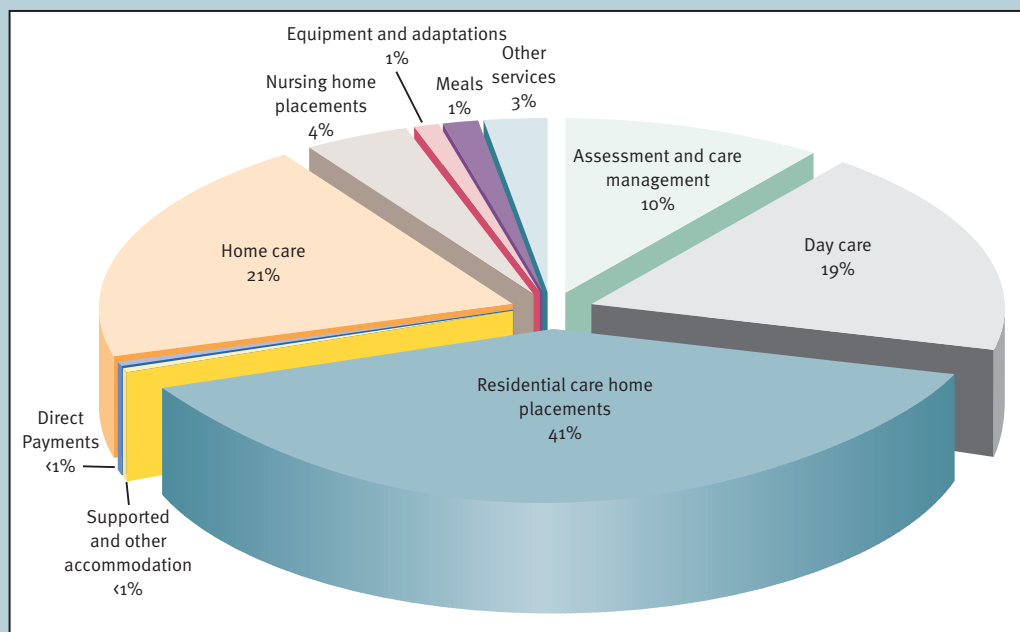
The **General Social Care Council (GSCC)** was established in October 2001, also under the Care Standards Act 2000. The GSCC is the social care workforce regulator for England (equivalent bodies exist in Scotland, Wales and Northern Ireland). The development of a Social Care Register for those working in social care began with social workers. Protection of title means that since 1 April 2005, anyone calling themselves a 'Social Worker' must be registered as such with the GSCC. Registrants must have completed appropriate training, abide by the GSCC Code of Practice, and be physically and mentally fit to do their jobs. The register will be opened to other groups of social care workers in the future. The next groups to be registered will be domiciliary and residential care workers (in both adult and children's services). It is believed that this will amount to more than 750,000 workers.

domiciliary care market (notably by Laing and Buisson) indicates that the market is characterised by multiple small providers.

Figure 2 overleaf demonstrates the percentage of council expenditure committed to different components of services for older people. Clearly the largest proportion of expenditure (almost 60 per cent) is committed to residential placements, with another fifth being committed to home care services. The share of personal social services (PSS) resources committed to residential care has remained largely constant in recent years.

The role of the local authority has shifted dramatically since the *Caring for People* reforms of the 1990s, and increasingly it is responsible for commissioning and procuring services, but much less so for direct provision. The majority of residential care is provided in the independent sector. In March 2004 there were 277,000 council-supported adult residents, accounting for 70 per cent of occupied residential places. People funding their own care accounted for 115,000 further places. However, it is likely that the level of self-funding is actually higher than this; CSCI points out that approximately 10,000 people who are fully self-funding but have their care managed by the local authority appear in the statistics as council-supported residents when in fact they are not. The key conclusion is that at least 30 per cent of places in care homes are occupied by people paying for their own care (Commission for Social Care Inspection 2005b).

The transformation of domiciliary care is evident in the fact that for England as a whole in 2004 the independent sector was responsible for 69 per cent of total contact hours of



Source: Based on data from the Commission for Social Care Inspection (2005b)

Note: Due to rounding, percentages do not add up to 100 per cent.

home care/home help. This compares with 66 per cent in 2003, but dramatically contrasts with *just 2 per cent* of such hours provided in 1992 prior to the introduction of the community care reforms (*Public Expenditure Questionnaire 2005*). With a diminishing role as a direct provider, councils increasingly have a vital role in commissioning and securing the delivery of services in their area. Strategic commissioning requires councils to ensure there are sufficient services (both in volume and type) to meet the needs of the community. In planning on the basis of population needs assessment, councils also have critical roles in actively developing and managing local care markets.

The council is also responsible for assessing the needs of individuals and for developing appropriate plans to meet those needs. In the case of services for older people this should be facilitated through the operation of the Single Assessment Process (which was integral to the National Service Framework for Older People). In practice, implementation of these arrangements has been slow and patchy (see Chapter 4).

The CSCI highlights the wide variation which exists between councils in the availability of different types of service. There appears to be some amount of substitutability in services with fewer residential care places being associated with more use of intensive home care and more people being supported at home (the opposite is also true, and for every 10 additional residential places per 1,000 older people there is a decrease of 2 percentage points in the amount of intensive domiciliary care used, and 3 fewer older people per 1,000 are supported at home) (Commission for Social Care Inspection 2005b).

The overview of services provided by CSCI, and from other sources such as the Department of Health, paints a broad picture. It is not possible from this to describe the nature of the

services provided in much detail. In particular, the data does not reveal anything about innovative service developments (such as those under the banner of Partnerships for Older People where prevention and well-being pilots are bringing together health, social care, housing, social security, and other local services). 'Home care', for example could be providing routine support with personal care needs, or it could be part of an intensive package of support associated with intermediate care. The CSCI notes that in many councils the profile of services still tends to be more traditional, with insufficient attention to promoting choice, control, flexibility and independence.

It is not only the pattern of service provision that is important, but also the quality of those services. Standards of care were laid down in the 1984 Residential Care Act, and subsequently developed in the Care Standards Act of 2000. Recent evidence on service quality comes from the CSCI's inspection against National Minimum Standards which address key domains of: choice; health and care; daily life; complaints & protection; environment; staffing, and management & administration. While the majority of services meet these standards, 20 per cent of residential providers and 30 per cent of domiciliary care agencies do not. The CSCI argues that there is evidence of service improvement since inspections against national standards began in 2002/3, however, 'some of the areas where there is little improvement are those that people using services tell us they value the most.' (Commission for Social Care Inspection 2005b, para 8.24). This includes factors which have a profound impact on quality of life, especially around issues of choice and independence.

Inspection of domiciliary care agencies against national standards began in April 2004 and not all services have been inspected at this stage. The standards least likely to be met in domiciliary care are also those which are of greatest concern to people using the services. These are issues of privacy and dignity, and being able to get the right kind of help. Problems with poor continuity of service, and of frequent changes of care worker, have been highlighted over several years and continue to be the most common reason for failing to meet standards on privacy and dignity.

Variation is also evident in the quality of services provided. This is true geographically, but there is also significant variation between providers in the private, voluntary and council-run sectors. In overall terms CSCI inspections indicate that both residential and domiciliary care provided by voluntary sector bodies significantly out-perform similar services in the private sector, and council-run services 'perform the poorest overall' (Commission for Social Care Inspection 2005b, para 8.105).

As Figure 2 opposite demonstrates, a small proportion of expenditure (0.3 per cent) on older people's services is committed to Direct Payments. The Community Care (Direct Payments) Act of 1996 introduced powers whereby certain categories of people eligible for social care services could receive a cash payment in lieu of services. Initially this did not include older people, but the scope of the arrangements was expanded in 2003, and the power to provide them was changed to a duty to offer direct payments to people able to make use of them. The take-up of Direct Payments is increasing, but from a very low base. Between 2001/2 and 2003/4 the numbers of adults receiving direct payments increased from 5,468 to 13,796 (Commission for Social Care Inspection 2005b, para 5.27). Most of those using Direct Payments are people with physical and sensory disabilities.

5 Conclusions

This brief overview of the development of social care has highlighted some important themes. First, has been the shift in the focus of the role and purpose of social care services, and in the models of care required to deliver this. Thus, from the 1950s onwards social care became increasingly concerned with trying to support people ‘in the community’ rather than favouring institutional care. Over time there has also been a shift from a highly marginal service likely to be required by a small segment of the population, to something far more mainstream and likely to be of relevance to everyone at some time in their lives. This has been accompanied by an emphasis on making care more responsive to individual needs and recognising the vital role of services in contributing to citizens’ quality of life.

The snapshot of services outlined above indicates the current shape of social care for older people and the extent to which the aspirations of policy are being translated into practice. It is evident that further progress is needed, and that the quality of services often falls short of standards.

Second, there has been a recognition – through the establishment of the 1998 Royal Commission – of deficiencies in the way social care was funded at the time. The main recommendation to provide free personal care was rejected; the government’s argued concerns were that the extra resources required would not necessarily improve services and would not help the least well off (Department of Health 2000c). These issues are tackled in Part 3 of this Review.

The third strand of policy development has been how best to manage the interface between social care and other key services, particularly the NHS. The birth of the Welfare State in 1948 not only established two parallel services with different constitutions, different funding mechanisms and a separate basis of eligibility, but ensured that the two policy streams would evolve in ways that were at times poorly related and even contradictory. Since the 1970s, attempts to rationalise services and improve the coherence between health and care have largely been directed towards incremental adjustments that have tried to establish a mechanism to mitigate the worst effects of organisational fragmentation. This has been reflected at different times in policy initiatives to encourage, cajole or require different degrees of collaboration and partnership working.

The most recent stage of this evolution has seen a subtle shift from partnership towards the language of ‘integration’. The manifesto for this particular redirection of health and social care is the 2006 White Paper: *Our Health, Our Care, Our Say*. In seeking greater integration of health and social care (and indeed of other local authority services) the White Paper has signalled the intention to replace exhortation with requirements, and to manage performance against shared outcome targets. This could be a highly significant development. All the experience of partnership working to-date has demonstrated that so long as collaboration remains an optional activity, it will remain marginal and merely the territory of ‘good practice’.

TABLE 1: POLICY TIMELINE: CRITICAL DEVELOPMENTS IN ADULT SOCIAL CARE, 1948 TO 2006

1948	National Assistance Act (based largely on a report by Sir William Beveridge, <i>Social Insurance and Allied Services</i> (1942)) set out the basis for an insurance-based system for health services and unemployment support. The Act established the framework for the establishment of the welfare state, which separated local responsibilities for welfare from national responsibility for social security. This created the National Health Service (NHS) as a universal service free at the point of need, alongside selective social services provision organised through local authorities and subject to means-testing and charging both for residential and non-residential services.
1957	Publication of a report entitled <i>Royal Commission on the Law Relating to Mental Illness and Mental Deficiency</i> .
1959	Mental Health Act aimed to establish community-based services for people with mental health needs and to close down long-stay hospital provision.
1968	Publication of Seebohm report, <i>Local Authority and Allied Personal Social Services</i> , which recommended the establishment of a family service and 'one door to knock upon'.
1970	Local Authority and Social Services Act addressed the establishment of integrated local authority personal social services departments in England.
1973	NHS Reorganisation Act established unified health authorities responsible for services previously divided between hospital boards, management committees, executive councils, and local authorities. The Act coincided with reorganisation of local government, and an attempt was made to align the boundaries of area health authorities and local authorities.
1974	Joint planning arrangements were established in the form of Joint Consultative Committees.
1975	White Paper, <i>Better Services for the Mentally Ill</i> , sought the expansion of local authority social services, with specialist mental health services provided through local general hospitals.
1977	Joint Finance introduced alongside Joint Care Planning Teams. Joint Finance was earmarked health service money intended for spending on joint projects with the local authority where it was believed this would 'make a better contribution in terms of total care than would deployment of equivalent resources directly on health services.'
1978	Consultative document, <i>A Happier Old Age</i> , published with the intention of setting the agenda for a wide-ranging debate 'to develop a long-term strategy to ensure the well-being and dignity of all elderly people.'
1980	Health Services Act brought further reorganisation, removing area health authorities and establishing district health authorities from April 1982. Previous co-terminosity between health and local authorities was lost in many localities.
1981	White Paper, <i>Growing Older</i> , emphasised that, in future, 'care in the community must increasingly mean care by the community' and the role of public services should be 'helping people to care for themselves and their families.'
1983	Establishment of Care in the Community initiative to support the resettlement of people from long-stay hospitals.

continued overleaf

TABLE 1 *continued*

1986	Appointment of Sir Roy Griffiths to undertake a review of community care policy. His report <i>Community Care: Agenda for action</i> was published in 1988.
1988	Publication of <i>Residential Care: A positive choice</i> , a report of the independent review of residential care chaired by Gillian Wagner. The review had been commissioned in 1985 and set out to promote a change in the perception of residential care and its place within ‘the spectrum of social care.’
1989	Publication of the White Paper <i>Caring for People: Community care in the next decade and beyond</i> .
1990	NHS and Community Care Act made local authorities responsible for organising community care, emphasising support for people in their own homes where possible. Introduced the requirement for local authorities to promote the independent sector. The implementation of the Act was phased over three years with the main changes introduced on 1 April 1993.
1995	The Carers (Recognition and Services) Act introduced the right for carers providing regular and substantial amounts of care to request an assessment of their needs when the person they are caring for is being assessed for community care services.
1996	The Community Care (Direct Payments) Act introduced powers for certain categories of people to be able to receive a cash payment in lieu of services that they could use to arrange their own support.
1997	Establishment of the Royal Commission on Long Term Care for the Elderly to explore options for funding long-term care that are fair and affordable for the individual and the taxpayer.
1998	Establishment of Better Government for Older People initiative to support pilot partnerships to develop local strategies for an ageing population.
1998	Publication of White Paper, <i>Modernising Social Services: Promoting independence, improving protection, raising standards</i> .
1999	Passing of The Health Act, which was particularly noted for Section 31, which introduced new ‘flexibilities’ facilitating joint working between the NHS and local authorities through use of pooled budgets, lead commissioning arrangements and integrated provision.
1999	Publication of <i>With Respect to Old Age: Long term care – rights and responsibilities. Report of the Royal Commission on Long Term Care</i> . The key recommendation (although not supported unanimously) was to remove personal care from means-testing altogether, although a co-payment should be made to cover living and housing costs.
2000	Launch of <i>The NHS Plan</i> , which rejected the central recommendation of the Royal Commission concerning personal care. The Plan emphasised the development of intermediate care as a bridge between hospital and home.
2000	The Care Standards Act established a National Care Standards Commission responsible for the registration and regulation of care services, and a General Social Care Council to make provision for the registration, regulation and training of social care workers.
2000	The Carers and Disabled Children Act extended carers’ rights to an assessment and introduced powers for services to be provided to carers in their own right including direct payments.

continued overleaf

TABLE 1 *continued*

2001	<i>The National Service Framework for Older People</i> set out standards to improve the quality of support in health and social care. Four themes informed the NSF: respecting the individual; developing intermediate care; providing evidence-based specialist care, and promoting healthy, active lives.
2003	<i>Direct Payments Guidance: Community care, services for carers and children's services (direct payments)</i> extended the scope of direct payments, making it a duty (and not merely a power) for direct payments to be offered to eligible people.
2003	The Community Care (Delayed Discharges etc) Act introduced new duties for councils with social services responsibilities and the NHS to communicate about the discharge of patients from hospitals. The Act also established a system of reimbursement for delayed hospital discharges where the council would be held responsible for the delay because it had failed to put in place the services required.
2004	The Carers (Equal Opportunities) Act meant that carers' assessments had to take account of carers' lives in terms of employment, life-long learning and leisure activities. Carers had to be informed of their rights and local authorities could enlist the support of other agencies in supporting carers.
2005	<i>The National Service Framework for Long Term Conditions</i> set out quality requirements and evidence-based markers of good practice in health and social care services for people with long-term neurological conditions and their carers.
2005	Publication of <i>Opportunity Age: Meeting the challenges of ageing in the 21st century</i> , a strategy document from the Department for Work and Pensions in partnership with other government departments.
2005	Publication of a Green Paper, <i>Independence, Well-being and Choice: Our vision for the future of social care for adults in England</i> , focusing on 'choice, excellence and quality' within the context of promoting independence.
2006	Publication of a White Paper, <i>Our Health, Our Care, Our Say: A new direction for community services</i> , presenting key policy reforms for health and social care focused on better prevention; more choice; tackling inequalities, and support for people with long-term needs.

2

Patterns of need for social care

SUMMARY

The population of England is ageing. In the next 20 years, the number of people 85 and over in England will increase by two-thirds, compared with a 10 per cent growth in the population as a whole. What remains uncertain is the likely number of older people who will become frail and disabled, thereby needing the support of social care services. This chapter looks at the drivers of demand for social care and presents projections of future need. It draws on expert analysis commissioned for this Review.

- Physical and cognitive impairment, housing, income and wealth, and family circumstances are all factors that drive the use of social care.
- In particular, disability in later life arises as a consequence of cardiovascular and cerebrovascular disease, sensory problems (vision and hearing), arthritis, incontinence, dementia and depression, so trends in these diseases and conditions can be used to estimate future numbers of people with disability.
- An expansion of morbidity – and a consequent increase in demand for social care services – will occur if the extra years from increased longevity are mostly spent in disability or poor health. Trends between 1981 and 2001 show that increases in healthy life expectancy have indeed not kept pace with improvements in total life expectancy.

Commissioned in-depth analysis of the literature and a micro-simulation model of progression through healthy life, illness and disability, and death, were used to develop three scenarios about future numbers of older disabled people.

- Using different scenarios of disease-specific progression of disability, the number of older people with substantial disability (1+ ADL limitations) increases significantly from 868,000 in 2005 to 1.4 million in 2025 (in the ‘no-change’ scenario); to 1.5 million (in the ‘poorer population health’ scenario); and to 1.4 million (in the ‘improving population health’ scenario). So even the optimistic scenario forecasts that the number of disabled older people will rise by 57 per cent over the next 20 years.
- The ‘improving population health’ scenario depends on two requirements: first, that moderate improvements in population health from reductions in levels of obesity and other negative health behaviours are forthcoming; and second, that emerging new treatments or technologies are effective at reducing the disabling consequences of disease.
- The modelling by this Review uses five main dependency classifications as defined by activity of daily living (ADL) and instrumental activities of daily living limitations, and a base case scenario which accords closely to the ‘improving population health’ scenario above. In the base case scenario, the forecast percentage increase in the number of older people without any dependency is 44 per cent. For the 1.4 million

people with low levels of need, the increase is 53 per cent. For those 900,000 with substantial need, the rise is 55 per cent.

In conclusion, a full understanding of likely disability trends in the future is hampered by a lack of good evidence. Nonetheless, disability, as measured by ADL limitations and cognitive impairment, is a very significant predictor of future service demand.

1 Introduction

By 2026, one in five people in England will be 65 or over. Whereas in the next 20 years the total population will grow by around 10 per cent, the number of people 85 or over will grow by two-thirds. Life expectancy at birth is increasing at the rate of three years every decade. There is uncertainty, of course, about these numbers, but it is clear that the older population will be significantly larger in 20 years' time. What is even more uncertain is the number of older people that remain healthy and independent. Yet knowing the numbers who are in ill health, have disabilities or are dependent is critical information for understanding the expected demand for social care and other services in the future. Old age itself need not generate demand – disability and ill health generate demand – but the chances of a person's health deteriorating are correlated with age.

Failing health, the progression of long-term conditions and disease, and frailty can all limit people from living their normal lives. If severe, these conditions can restrict people's ability to carry out even basic activities of daily living, such as washing and dressing on their own, let alone being able to get out and lead the fulfilling lives they would wish. Long-term social care can help people with the ramifications of those underlying conditions. The role of social care is broader but here the way that disability, disease, and dependency drive the demand for social care service for older people is considered.

2 Drivers of demand for social care

Demand and need

The factors that drive use of social care services by older people at present include (see Darton *et al* 2006):

- health and disability-related impairment (both physical and cognitive)
- housing circumstances
- family and (informal) carer circumstances.

Use of services, however, is different from underlying demand because the former is also affected by access to services and supply. This is why a person's income and wealth are also important. Although low income might exacerbate poor health, and explain poor housing, a person's ability to pay for care also dictates the likelihood and intensity of social care use. For publicly funded care, eligibility criteria can limit access to services for those with relatively low need. As a result, current service patterns are not reliable guides to the extent of need. This chapter examines indicators of demand for care. Later chapters describe the interplay of demand and supply.

TABLE 2: REASONS FOR ADMISSION OF OLDER PEOPLE TO CARE HOMES AS GIVEN BY SOCIAL WORKER, 1996

Reason for admission	Percentage
Physical health problems	69
Mental health problems	43
Functional disablement	42
Stress on carers	38
Lack of motivation	22
Present home physically unsuitable	15
Family breakdown (including loss of carer)	8
Need for rehabilitation	6
Fear of being the victim of crime	4
Abuse	2
Loneliness or isolation	2
Homelessness	1
<i>Number of individuals</i>	<i>2573</i>

Source: Bebbington *et al* 2001

Note: Multiple answers possible so percentages add to more than 100 per cent.

Table 2 (above) shows the reasons social workers give for admissions to care homes. Around 15 per cent of admissions were classified as having physically unsuitable housing, although that might not have been the primary cause. Health-related causes are more important. In any case, poor housing is an issue that goes beyond social care.

Informal care is considered in detail in Chapter 8. The supply of informal care affects demand for formal services. This chapter, however, is concerned with demand for care whichever way it is addressed, formally or informally.

Need and outcomes

Need, and hence demand, for care is measured against the outcomes that individuals and society more broadly wish to achieve. In a general sense a need will exist where a person is restricted – as a result of disability, social exclusion and so on – from being able to undertake activities or to achieve outcomes that they value. This Review is concerned with the role of social care vis-à-vis people who are restricted by disability from achieving outcomes such as being clean, fed, independent, safe (to a reasonable degree) socially included, fulfilled, etc. Need is therefore synonymous with a shortfall in outcomes, particularly where support and care could help people to improve outcomes.

3 Assessing need

ACTIVITIES OF DAILY LIVING

A standard way to assess need resulting from disability and impairment is in terms of people's ability to carry out basic Activities of Daily Living (ADLs). The following is a list of widely used (self-care) ADLs:

- get up and down stairs or steps
- go out of doors and walk down the road
- get around indoors (except steps)
- wash face and hands

- bath, shower or wash all over
- transfer: get in and out of bed (or chair)
- use toilet
- get dressed and undressed
- feed self.

People are asked whether they can usually manage these tasks: on their own without help; on their own with difficulty; only with someone else's help; or not at all. The latter two possibilities can be combined to define an ADL failure. The implications of an inability to achieve these ADLs depend somewhat on which ADLs we are considering. Four core ADLs can be identified from the above list:

- transfer: get in and out of bed (or chair)
- use toilet
- get dressed and undressed
- feed self.

In addition to ADLs, people's condition can be measured by their ability to perform instrumental activities of daily living (IADLs), which include activities like: shopping, cleaning, laundry, preparation of hot meals, managing personal affairs (for example, paying bills), etc.

Problems with functioning have both physical and cognitive causes. Cognitive impairment limits ability to carry out ADLs, but it also brings with it other problems, particularly concerns about the person's safety. There are a number of instruments for measuring cognitive functioning, which generally combine memory, awareness and reasoning tests (Comas-Herrera *et al* 2002). In categorising the results, it is usual to distinguish between mild and severe cognitive impairment.

Difficulties with or failures to undertake ADLs provide a direct measure of need. A number of surveys and data sources are available that collect information about people's ADL and cognitive functioning. This information can be used to model the demand for services. The rates and number of people with disability, so measured, are given below.

4 Disability and need

ADLs and cognitive functioning are direct indicators of need arising from disability. However, to estimate how need measured in this way might change in the future an understanding is required of the causes, alongside a theoretical framework with which to make extrapolations. Theories of the incidence and progression of disease and long-term conditions can be used. In particular, disability in later life is known to arise, *inter alia*, as a consequence of cardiovascular and cerebrovascular disease, sensory problems (vision and hearing), arthritis, incontinence, dementia and depression.

A significant evidence base exists about how these conditions will develop. Collecting together information about likely future trends of the major disability-causing diseases and conditions helps in the estimation of future numbers of people with disability. The Review has commissioned a major piece of research to address these questions. This was carried out by Professor Carol Jagger and colleagues and their report is attached as a Research Paper in the Appendix, *Compression or Expansion of Disability? Forecasting future disability levels under changing patterns of diseases* (Jagger *et al* 2006).

TABLE 3: SELF-REPORTED DISEASES ASSOCIATED WITH THE ONSET OF DISABILITY AND DEATH

Condition	Increases chance of onset of disability	Increases chance of death
Stroke	Yes	Yes
Peripheral vascular disease	No	No
Coronary heart disease (angina & heart attack)	Yes	Yes
Treated hypertension	No	No
Arthritis	Yes	No
Treated diabetes	No	Yes
Chronic airways obstruction	Yes	Yes
Parkinson's disease	Yes	Yes
Hearing problems	No	No
Eyesight problems	Yes	No
Cognitive impairment: mild	Yes	Yes
substantial	Yes	Yes

Source: Jagger *et al* 2006

Notes:

Yes = a significantly greater than zero chance.

No = a not significant or negative chance.

The study carried out an extensive review of the evidence about disease trends and also about the efficacy and diffusion of treatments for reducing disability and/or mortality. It then developed a micro-simulation model of how these conditions will affect both the onset of disability and death. Jagger and colleagues (2006) used data from the MRC Cognitive Function and Ageing Study, a nationally representative sample of people aged 65 years and over, to explore the effect of different health scenarios on the future numbers of older people with disability. The study reviewed four disease areas: dementia, stroke, coronary heart disease and arthritis and developed evidence-based scenarios for the health of the future older population.

Table 3 above shows which specific conditions were found to affect the probability of an older person in the sample developing disability and the probability of them dying. People were classed as disabled if they had an inability to perform at least one ADL.

Stroke and arthritis were particularly significant causes of disability, although the presence of arthritis did not increase the chance of death. A range of 'control' factors was also investigated, including age, sex, social class, household composition and lifestyle (smoking). Of these, old age was highly correlated with both disability and death. Males had a higher probability of dying at any given age, all other things considered, but not of becoming disabled. The same was the case for smokers and for people in social classes IV and V.

The study by Jagger and colleagues gives details of the review of the four main disease areas. The box below highlights some main points.

MAIN DISABILITY-CAUSING DISEASES

Dementia

The incidence rates for dementia rise exponentially with age. However, the only major established risk factors are cerebrovascular, which in particular, increase the risk of Alzheimer's disease. Other than this, no evidence was found to suggest either increasing or decreasing incidence in the future. The effect of treatments or interventions was mainly reported in terms of a change in cognition, but little was available about the impact on daily living or disability.

Coronary Heart Disease (CHD)

The evidence base indicates decreasing incidence of CHD in the past 20 years and suggests continued decreases in mortality and an apparent reduction in risk factors. The literature also suggests that continued refinement of endovascular and surgical treatments for acute coronary syndrome, and improved risk stratification will reduce incidence of disability. Most of the evidence on the effects of treatments concerns the effect on mortality, not disability. It does indicate that effective treatments might not be reaching older people, especially older women.

Stroke

The prevalence of cerebrovascular disease rises exponentially with age. Through time mortality rates have been declining and the evidence suggests continued decreases in stroke mortality. There is potential for reductions in stroke incidence and recurrence with good control of vascular risk factors such as hypertension. Again, most of the literature focuses on mortality. The evidence around effectiveness in preventing strokes is good (for example, the effectiveness of statins, oral anticoagulants, of treatments for hypertension, and aspirin for acute ischaemic stroke).

Arthritis

Age is the strongest predictor of osteoarthritis, but there is a lack of data on trends in either incidence or prevalence (there is some evidence that rising obesity levels will contribute to an increase in both the incidence and disabling effects). There was little evidence for the efficacy of treatments on the disease process, apart from joint replacements. However, there is evidence of some beneficial effects on the consequences, particularly pain reduction and disability. Jagger and colleagues tentatively speculate that efforts in identifying ways to affect the early triggers of the osteoarthritis process and on treatments that protect cartilage from degradation or the bone from micro-trauma, could have important consequences.

5 Future need

Future demand for services will depend greatly on how healthy people remain in old age. Life expectancy is increasing and in the future there will be many more older people in England. But will disability-free or healthy active life expectancy (HALE) keep pace? Will it increase more slowly or more quickly than the increase in life expectancy? For example, how will the chances of physical disability and mental impairment of an 85 year old in 20 years' time compare with those for an 85-year-old person now?

TABLE 4: HEALTHY LIFE EXPECTANCY (GENERAL HOUSEHOLD SURVEY ANALYSIS OF LIFE EXPECTANCY FREE OF LIMITING LONG-STANDING ILLNESS)

	Life expectancy at birth (years)	Healthy life expectancy at birth (years)	Lower 95% confidence interval (years)	Upper 95% confidence interval (years)	Percentage of life expectancy in good health	Percentage of life expectancy in good health (upper 95% confidence interval)
Men						
1981	71.08	58.34	58.07	58.60	82.1	
2001	75.97	60.84	60.49	61.19	80.1	80.5
Women						
1981	77.04	60.93	60.64	61.21	79.1	
2001	80.60	62.86	62.50	63.23	78.0	78.4

Source: Data from the Office for National Statistics 2006 and Parliamentary Office of Science and Technology 2006

In principle, if people are living longer because of later onset of disease and pathology, then they ought to be living longer in good health as well. But if people are living longer after they develop diseases and long-term conditions, the numbers with disability could rise significantly. Some long-term conditions are not inevitable consequences of old age; others, like dementia and arthritis, seem, at present at least, to be closely related to a person's age.

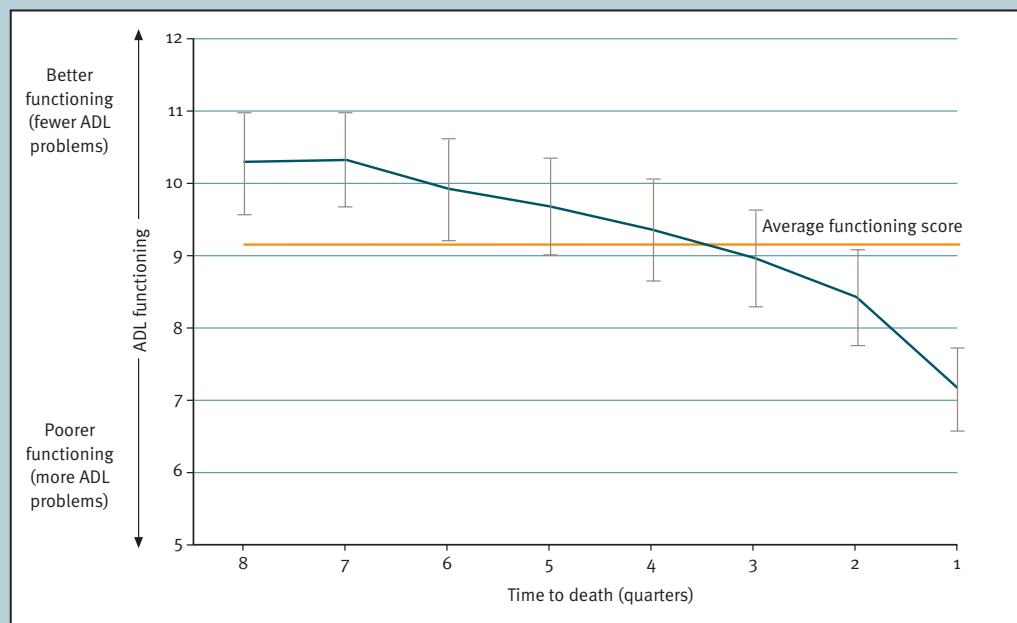
Total population years of people 65 and over in England will rise in the future. If those extra years are mostly spent in good health, a compression of morbidity is the likely consequence. An expansion of morbidity will occur where extra years tend to be with disability.

Trends in healthy life expectancy between 1981 and 2001 show that increases in healthy life expectancy are not keeping pace with improvements in life expectancy. Table 4 above reports Office for National Statistics (ONS) figures of healthy life expectancy at birth measured as number of years free of self-reported limiting long-standing illness. The results indicate a relative expansion of morbidity: disability-free life expectancy and years lived with disability have both increased, but disability-free life expectancy as a proportion of total life expectancy has decreased (Mathers 1999; *see also* Annex, p 45).

If healthy life expectancy increases as fast as life expectancy then age alone is not a good predictor of disability. In fact, *time to death* is a better predictor. By contrast if healthy life expectancy increases more slowly, a person's age is a good predictor of their disability. Using the PSSRU longitudinal study of care homes data (Bebbington *et al* 2001), time to death, not just age was an important predictor of severity of disability as measured by ADLs (on a 20-point scale) (*see* Fig 3, p 38).¹

As is inevitable when looking into the future, and exacerbated by the paucity of evidence about future disease-specific progression of disability, estimates of the numbers of people with disability are uncertain. For these reasons, a number of different scenarios are modelled. Although this approach limits apparent certainty when specifying future resource requirements, it does at least allow some clarity about the consequences of the trends as the future unfolds. Jagger and colleagues model three scenarios – *see* box below.

3 DEPENDENCY AND TIME TO DEATH IN A CARE HOME POPULATION, 1995 TO 1999



Source: Review analysis of PSSRU longitudinal care home dataset (Bebbington *et al* 2001)

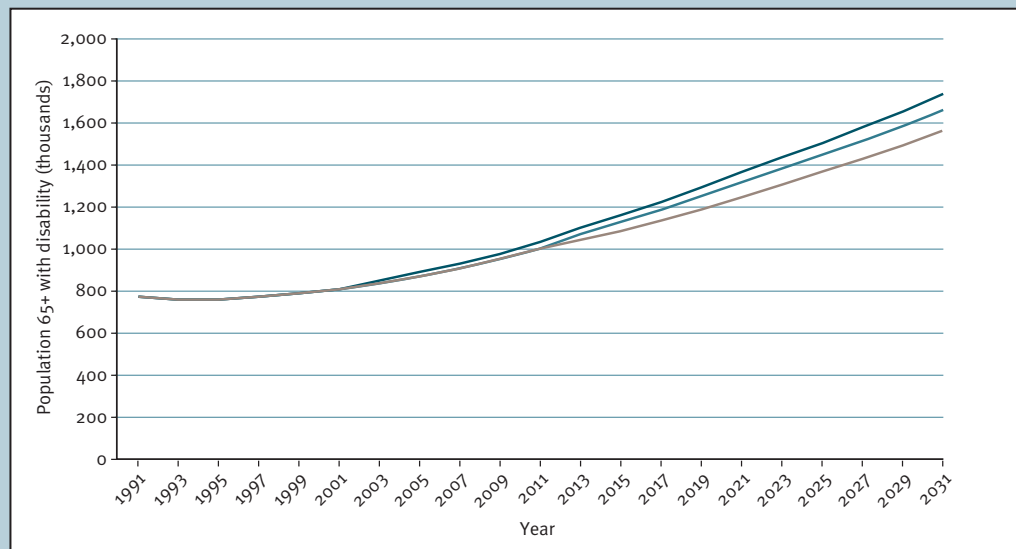
SUMMARY OF MAIN SCENARIOS

No change – the age-specific prevalence of diseases remains the same with prevention strategies and effective treatments simply offsetting the negative influences of obesity and other cohort trends that increase the prevalence of stroke and coronary heart disease. Incidence of and recovery rates from dependency remain the same with no further effect of treatments. Mortality rates continue to decline at levels commensurate with Government Actuary's Department (GAD) principal projections.

Poorer population health – obesity trends of an annual 2 per cent increase continue. This increases the prevalence of arthritis, stroke, coronary heart disease and vascular dementia but also the resulting dependency associated with these diseases. The emergence of ethnic minorities in significant numbers into the older population adds to the prevalence of stroke and coronary heart disease. Some prevention strategies are in place but they fail to offset the increasing prevalence. Treatments continue to focus on reducing the mortality from diseases rather than reducing the disabling effects.

Improving population health – individuals are taking their health seriously and there is a decline in risk factors, particularly smoking and obesity. The health service is responsive with high rates of technology uptake for disease prevention and excellent diffusion rates of treatments to all who can benefit, particularly in terms of control of vascular risk factors.

4 POPULATION AGED 65+ WITH DISABILITY, UNDER DIFFERING SCENARIOS OF DISEASE CHANGE, 1991 TO 2031



Source: Jagger *et al* 2006

In these three scenarios, assumed trends about the major disability-causing diseases are combined to affect the overall probability of onset of disability and the probability of death. The model then ages people in the Cognitive Function and Ageing Study (CFAS) sample (see Introduction, Annex 2, p 6, for more information) using these probabilities to project whether they are alive in good health, alive with disability, or have died for each year into the future. The model was initially calibrated so that it gave the same population by age and sex as the Government Actuary's Department (GAD) projections. At the baseline, in the CFAS sample, there were people with disability. This would include people with life-long disability or disability acquired before they reached old age.

Figure 4 shows the overall numbers of older people with disability (1+ ADL) in the future in the different scenarios. It is clear that overall numbers increase significantly in the next 20 years, regardless of which scenario is used.

No change scenario

Table 5 overleaf reports the numbers of disabled people under the assumption of no change in age-specific prevalence of disease, incidence and recovery rates to disability, and mortality rates continuing to decline at levels commensurate with GAD principal projections. This scenario shows that if rates of disease and other factors stayed as they are today the disabled population would grow by 67 per cent in the next 20 years. This growth in numbers of disabled people is simply the result of the ageing of the population.

Poorer population health scenario

In the poorer population health scenario the prevalence of arthritis, stroke and CHD are assumed to be increasing by 0.5 per cent every two years from 2001. The probability of disability at any time is taken to be increasing by 10 per cent from 2001 for arthritis, stroke

TABLE 5: SIMULATED TOTAL AND DISABLED POPULATIONS (NO-CHANGE SCENARIO), 2005 TO 2025

Population aged 65+	2005	2011	2015	2021	2025
Total (thousands)	8,457	9,217	10,202	11,205	11,961
Disabled (thousands)	868	1,004	1,125	1,316	1,446
Percentage disabled	10.26	10.90	11.02	11.75	12.09

Source: Jagger *et al* 2006

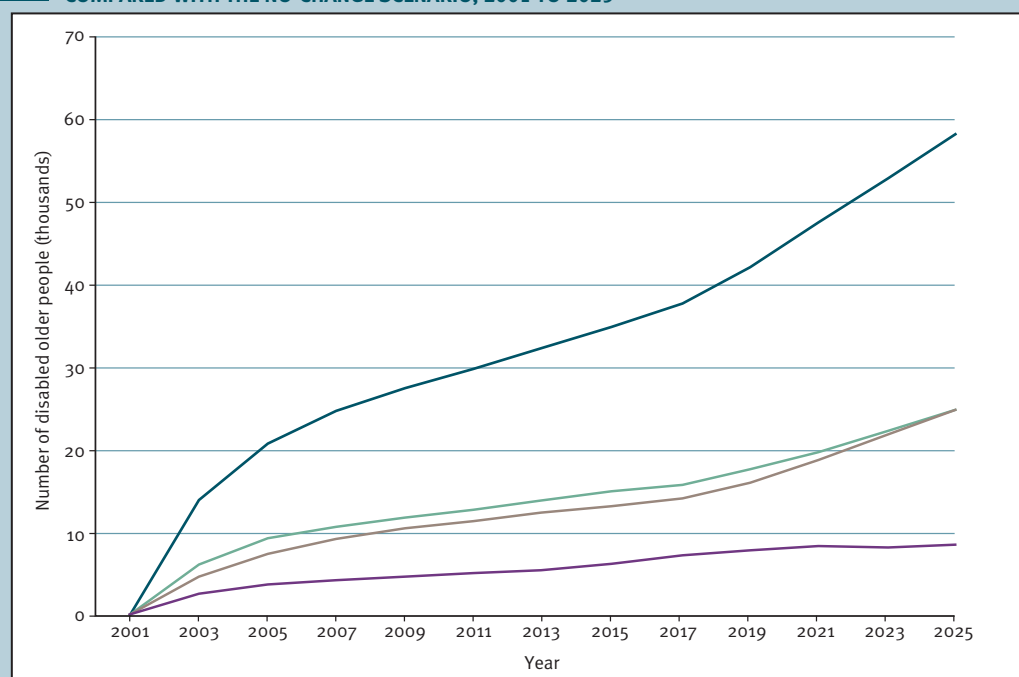
TABLE 6: SIMULATED TOTAL AND DISABLED POPULATIONS (POORER POPULATION HEALTH SCENARIO), 2005 TO 2025

Population aged 65+	2005	2011	2015	2021	2025
Total (thousands)	8,454	9,203	10,181	11,203	11,965
Disabled (thousands)	888	1,034	1,160	1,364	1,504
Percentage disabled	10.51	11.24	11.39	12.17	12.57

Source: Jagger *et al* 2006

and CHD; also mortality rates from disability are decreasing by 5 per cent for mild dementia, stroke and CHD from 2015. In other words, people are more likely than in the no change scenario to become disabled, and they live longer with disability. Table 6 above gives the numbers in the older population. In this case, numbers of disabled older people increase by 69 per cent over the 20-year period from 2005.

5 CHANGE IN NUMBERS OF DISABLED OLDER PEOPLE UNDER SCENARIO OF POORER POPULATION HEALTH COMPARED WITH THE NO-CHANGE SCENARIO, 2001 TO 2025



Source: Jagger *et al* 2006

TABLE 7: SIMULATED TOTAL AND DISABLED POPULATIONS (IMPROVED POPULATION HEALTH SCENARIO), 2005 TO 2025

Population aged 65+	2005	2011	2015	2021	2025
Total (thousands)	8,457	9,217	10,217	11,322	12,168
Disabled (thousands)	868	1,004	1,086	1,248	1,366
Percentage disabled	10.26	10.90	10.62	11.02	11.22

Source: Jagger *et al* 2006

Figure 5 above shows the additional number of disabled people compared to the no change scenario, broken down by age group. People over 75 are most affected in this scenario.

Improving population health scenario

Table 7 above shows the results of the improving population health scenario. In this case, the prevalence of arthritis, stroke, CHD and mild dementia are decreasing by 2 per cent every two years from 2011, and moderate dementia by 2 per cent every two years from 2015. The chance of disability is decreasing by 10 per cent from 2011 for arthritis, stroke, CHD and mild dementia; mortality rates from disability are decreasing by 5 per cent for mild dementia, stroke and CHD from 2015. Despite these improvements, the numbers of disabled people still grows significantly in the next 20 years, by 57 per cent in this scenario and the proportion of older people who are disabled increases by almost 1 percentage point to over 11 per cent.

Figure 6 below shows a significant reduction of disabled people compared to the no-change scenario. Because of the nature of the assumptions, the improvements occur in the second decade.

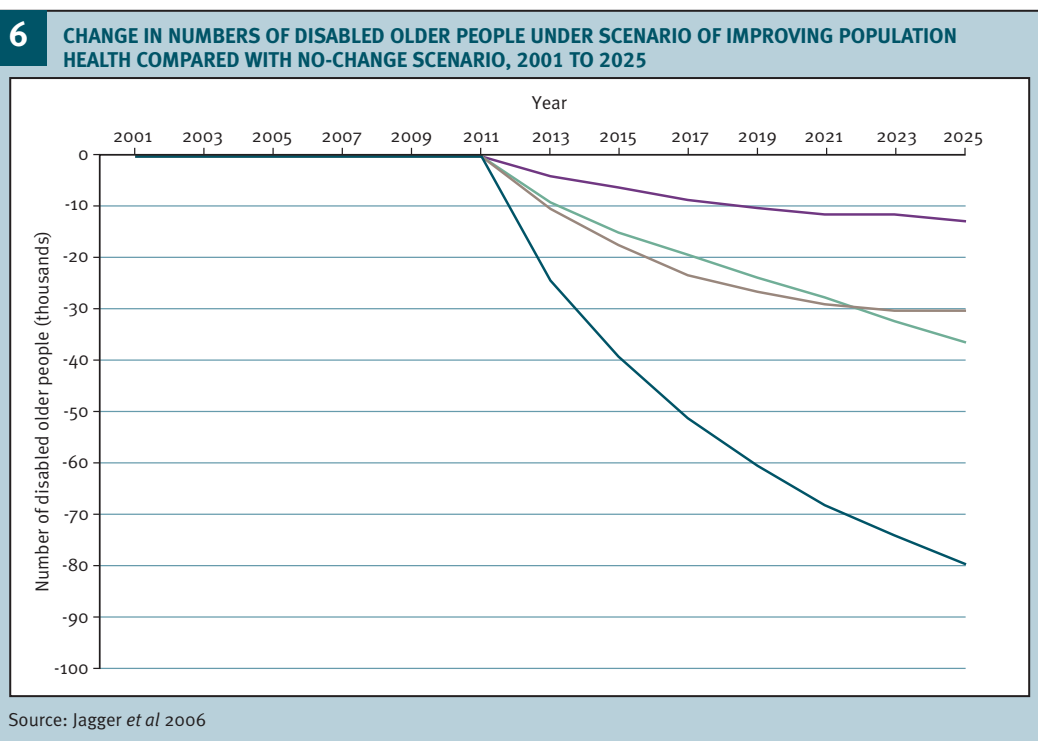


TABLE 8: DISTRIBUTION OF ADL COUNTS, BY DEPENDENCY GROUP

Dependency group	Core ADL failure	Core ADL difficulty only	Core ADL failure or difficulty	Any ADL failure	Any ADL difficulty only	Any ADL failure or difficulty
Group 1 (1 IADL)	0	0	0	1.1	1.0	2.1
Group 2 (IADL + ADL difficulty)	0	2.4	2.4	1.9	4.4	6.3
Group 3 (1 ADL)	1	1.6	2.6	3.7	3.1	6.9
Group 4 (2+ ADLs)	3.0	0.5	3.5	7.3	1.0	8.3
Average	1.0	1.2	2.2	3.4	2.4	5.8

Source: Review analysis of Formula Spending Share dataset (Darton *et al* 2006)

6 Estimating need: current levels and future projections

The approach of the PSSRU long-term care model (Wittenberg *et al* 2004) is adopted for the main model in this Review (*see* Chapter 10). It uses five ADL dependency groups.² The older population is stratified by dependency using the General Household Survey (2001). Added to this five-way classification is a further break-down of whether people have severe cognitive impairment. The prevalence of cognitive impairment is taken from the Health Survey for England (HSE) 2000, which includes the care home population (where cognitive impairment rates are much higher than the general disabled population).

Overall, the dependency classifications used in this report are as follows.

- Group 0: no dependency
- Group 1: no core ADL difficulties (but possibly non-core ADL difficulties), only IADL difficulties such as shopping and cleaning
- Group 2: as group 1 and also difficulty in performing one or more core ADLs
- Group 3: people who are unable to perform (without help) one core ADL
 - Group 3a: group 3 people with no or mild cognitive impairment
 - Group 3b: group 3 people with severe cognitive impairment
- Group 4: people who are unable to perform two or more core ADLs
 - Group 4a: group 4 people with no or mild cognitive impairment
 - Group 4b: group 4 people with severe cognitive impairment.

Table 8 above reports a count of the number of ADL difficulties and failures people had in the Relative Needs Formula/Formula Spending Share (RNF/FSS) survey (*see* Introduction, Annex 2, p 6). This survey has a more detailed break-down of dependency and need than the GHS. Although by the above definition, groups 1 and 2 have no core ADL failure, the RNF/FSS survey suggests that some failure and difficulty with non-core ADLs is likely in these population groups.

The Health Survey for England (HSE) 2000 suggests that just over 3 per cent of the older population have severe cognitive impairment based on its cognitive function scoring³. The HSE results compare reasonably well with the literature (Comas-Herrera *et al* 2003; Jagger *et al* 2006). Table 9 opposite shows the estimated proportion of the older population with severe cognitive impairment by age group. Table 10 opposite shows this information by dependency group as above. Because there are low rates of cognitive impairment in groups 1 and 2, these groups have not been split by cognitive impairment (*see* above definitions).

TABLE 9: PREVALENCE OF SEVERE COGNITIVE IMPAIRMENT, BY AGE

Age group	Percentage with severe cognitive impairment
65–74	1.5
75–84	3.1
85–94	13.8
95+	40.2

Source: Review analysis of data from Health Survey for England 2000 (Department of Health 2002b)

TABLE 10: PREVALENCE OF SEVERE COGNITIVE IMPAIRMENT, BY DEPENDENCY GROUP

Dependency group	Percentage with severe cognitive impairment
Group 1 (1 ADL)	3.0
Group 2 (IADL + ADL difficulty)	2.5
Group 3 (1 ADL)	7.1
Group 4 (2+ ADLs)	32.7

Source: Review analysis of data from Health Survey for England 2000 (Department of Health 2002b)

A number of population surveys as well as the GHS can be used to estimate how many people with different conditions and dependency rates are in the older population, including the Health Survey for England (HSE) and the English Longitudinal Survey of Ageing (ELSA). The numbers from these surveys are broadly consistent with the GHS numbers.

Projected numbers with disability

To project forward the numbers of people with disability the scenarios developed by Jagger and colleagues as described above are used. As a ‘base case’, to project numbers of people in the above 5 group dependency/disability classification, constant age and sex specific prevalence of disability is assumed in the population aged 65 and over (where population is given using the 2004 GAD principal projection). Although there is uncertainty as to which population health scenario will most closely represent actual future disability numbers, a base case in the model is developed in order to compare the implications of changing the other assumptions (such as future service levels, rates of informal caring, unit costs, quality adjustments etc). The base case assumption on population dependency accords very closely with the improved health scenario estimated by Jagger and colleagues and was chosen on the basis of the reasonable likelihood of such a scenario occurring.

Table 11 overleaf gives the population numbers used in the model. Table 12 overleaf gives the numbers of people with different levels of disability in the (constant prevalence) base case. For comparison, the corresponding numbers in the no change, poor health and improved health scenarios are also given (see Table 13). These later scenarios, as developed by Jagger and colleagues, relate to high-dependency groups only. Numbers with any dependency (as in Table 12) are greater than numbers with substantial disability as described above.

TABLE 11: POPULATION SIZE, BY AGE, 2002 TO 2026

Age group	Population (thousands)					% change 2002–26
	2002	2007	2012	2022	2026	
65–69	2,176	2,245	2,762	2,760	3,033	39.4
70–74	1,954	1,972	2,070	2,651	2,550	30.5
75–79	1,625	1,647	1,712	2,290	2,474	52.3
80–84	1,180	1,220	1,282	1,508	1,758	49.0
85+	956	1,085	1,215	1,577	1,775	85.6
All	7,891	8,169	9,040	10,787	11,589	46.9

Source: Review model estimates

**TABLE 12: POPULATION SIZE BY LEVEL OF DEPENDENCY, 2002 TO 2026, BASE CASE
(CONSTANT AGE- AND GENDER- SPECIFIC PREVALENCE OF DISABILITY)**

Dependency group	Population (thousands)					% change 2002–26
	2002	2007	2012	2022	2026	
Group 0 (no dependency)	5,553	5,723	6,375	7,517	8,024	44
Group 1 (IADL)	881	918	1,004	1,223	1,328	51
Group 2 (bath or ADL difficulty)	532	554	603	744	806	51
Group 3 (1 ADL)	373	393	427	534	583	56
Group 4 (2+ ADLs)	551	582	631	768	847	54
All with dependency	2,337	2,446	2,666	3,269	3,564	53

Source: Review model estimates

TABLE 13: POPULATION SIZE BY LEVEL OF DEPENDENCY, VARIOUS SCENARIOS

Dependency group (scenario)	Population (thousands)					% change 2002–26
	2002	2007	2012	2022	2026	
No change						
Group 3 (1 ADL)	373	399	444	575	631	69
Group 4 (2+ ADLs)	551	589	657	831	921	67
All with dependency	2,337	2,483	2,767	3,507	3,841	64
Poor health						
Group 3 (1 ADL)	373	407	456	592	652	75
Group 4 (2+ ADLs)	551	601	673	855	951	73
All with dependency	2,337	2,534	2,836	3,613	3,970	70
Improved health						
Group 3 (1 ADL)	373	400	441	539	583	56
Group 4 (2+ ADLs)	551	595	651	780	851	55
All with dependency	2,337	2,491	2,748	3,296	3,557	52

Source: Review model estimates

Progression of disability

The above tables refer to total numbers of people. The micro-simulation model used in Part 3 shows that at an individual level, people may not decline steadily from low to medium and then high dependency. There is considerable variation around this trend. A significant number of people improved for periods, before declining again. There are implications for both the design of services and the commissioning of those services. For example, packages of care could actually be reduced for periods when individuals improve and types of accommodation could reflect the variations.

7 Conclusions

The analysis by Jagger and colleagues commissioned by this Review suggests that even in relatively optimistic scenarios there will be a relative expansion of morbidity. Projection modelling, developed on the basis of a thorough review of the evidence and calibrated on the GAD's 2004 population projections, found that in each of the scenarios 'no change', 'poorer health' and 'improved health', the proportion of those 65 and over who are disabled increased in the future. The international experience is mixed. Jagger and colleagues report that, in the US and Spain, research tentatively suggests falls in the rate of disability. In Sweden the research suggests the opposite.

An overall understanding of likely disability trends in the future is hampered by a lack of good evidence. Much of the evidence base concentrates on mortality not the disability impacts of disease. It is also the case that although disability is a key driver of need, it is not the only factor. Dependency models of need encompass a broader set of factors than disease-related disability models of need. Some argue the importance of social and cultural factors and expectations, as well as health-related disability. For example, the 'social construction' of need (Sim *et al* 1998) might imply changing perceptions of what constitutes need over time.

Nonetheless, disability – as measured by activities of daily living and cognitive functioning impairment – is a very significant predictor of future service demand. The improved health scenario, to which the Review's 'base case' future numbers of disabled people closely approximates – is attainable subject to two overall requirements. First, that moderate improvements in population health from reductions in levels of obesity and other negative health behaviours are forthcoming. And second, that the emergence of new treatments or technologies are effective at reducing the disabling consequences of disease (Jagger *et al* 2006). Even if this occurs so that the chance of a person becoming disabled at any particular age falls, because many more people will live longer into old age, the total number of disabled older people will increase. Jagger and colleagues estimate that the number of disabled people will rise by 57 per cent in the next 20 years or so in this scenario. In the poor health case, the rise would be 69 per cent. It appears that an absolute or even a relative compression of disability is unlikely.



Annex. The evolution of disability-free life expectancy in a population

The following typology is useful (Mathers 1999):

- absolute compression of morbidity: the increase in disability-free life expectancy exceeds the increase in total life expectancy, reducing the years lived with disability
- relative compression of morbidity: disability-free life expectancy and years lived with

disability both increase, but disability-free life expectancy as a proportion of total life expectancy increases

- relative expansion of morbidity: disability-free life expectancy and years lived with disability both increase, but disability-free life expectancy as a proportion of total life expectancy decreases
 - absolute expansion of morbidity: disability-free life expectancy decreases and years lived with disability increase.
-

Notes

¹ This finding would rule out absolute expansion of morbidity – see Annex, p 45.

² The challenge for modelling the aggregate impact of dependency as measured in these ways is to be able to estimate numbers of people with dependency problems in the total (older) population. Individuals in specific studies can be characterised with a detailed break-down of their condition. But the number of such individuals at a national level needs to be known; generally for nationally representative surveys only a more simplified break-down of dependency is available.

³ See HSE documentation as available on the ESRC Data Archive, especially the *Interviewer Project Instructions* and *Individual Questionnaire*. Cognitive function scores of greater than 5 on the 11 point scale were used to indicate severe cognitive impairment.

3

How is the current system performing on services?

SUMMARY

Some measure of the benefits or outcomes of social care is necessary in order to make judgements about the performance of the current system. This chapter looks at what types of services are being provided, how people rate them and what level of need these services can address. Its findings include the following points.

- Expectations are changing, and the so-called baby boomers (born 1945–54) are likely to present a cohort of more demanding social care users in the future, strongly objecting to age discrimination and insisting on greater choice and quality.
- Most (but not all) older people prefer to receive care at or close to home if possible and there is scope for a further shift in the balance of care. The government's 2008 target is to increase the proportion of those supported intensively to live at home to 34 per cent of all those being supported at home or in residential care. There is evidence that greater emphasis on respite care, day care and social work would improve outcomes within current resources.
- There is some evidence that social care for people with lower needs – often provided in the community – can delay the use of high-level social care, such as in a care home. However, the recent trend in service deployment is for a move away from relatively low-level services and towards more intensive care packages. This is illustrated by a decline in the number of people who receive home care, but an increase in total inputs (for example, contact hours). The proportion of people receiving home care in England is low by international standards.
- Those people going into state-funded care home places are more dependent than ever before.
- Older people are high users of health care. The 5 per cent of 'very high intensive users' account for over 40 per cent of inpatient days, and compared with those under 65 the odds of being a very high intensity user are roughly 4.5 times higher for those 65 and over, and nearly 7 times higher for people over 75 compared with those under 65. There is a growing body of evidence that social care can reduce, prevent, or delay use of hospital services.

Unmet need arises when people do not receive the services that would provide benefit. Analysis by this Review suggests that available home care services are mostly used by people with significant need, and that this proportion has been increasing, especially for people with personal care needs who may have informal care. However, the proportion of people with given needs having these needs met by using services is relatively low. For whatever reason – be it choice or rationing or something else – services are only being used by a relatively small proportion of people with apparently similar needs.

1 Introduction

Chapter 1 outlined what the social care system does currently; what it provides and to whom. This and the next two chapters aim to measure the benefits or outcomes of this activity; in other words to assess how well social care is performing.

Three approaches to measuring performance are used. First, by looking at what types of services are being provided, how people rate them and what level of need these services can address. The more that highly valued service types are provided, the better the overall outcomes will be for users.

Second, performance can be assessed by looking at the processes, organisation and management in place to provide social care services. Evidence can help show which processes are good ones, and which are less good. Good processes will in turn facilitate the provision of those services that people rate most highly. These issues are covered in Chapter 4.

Third, outcomes can be measured directly. A whole industry of ‘outcome measurement’ has developed to evaluate health care, for example, the quality-adjusted life year (QALY). Such approaches try to unpack the fundamental characteristics that people value in relation to health care. The same approaches have not been much used in social care but they could be.

So, what do people value in services? What types of services do they prefer?

2 Service options for given need

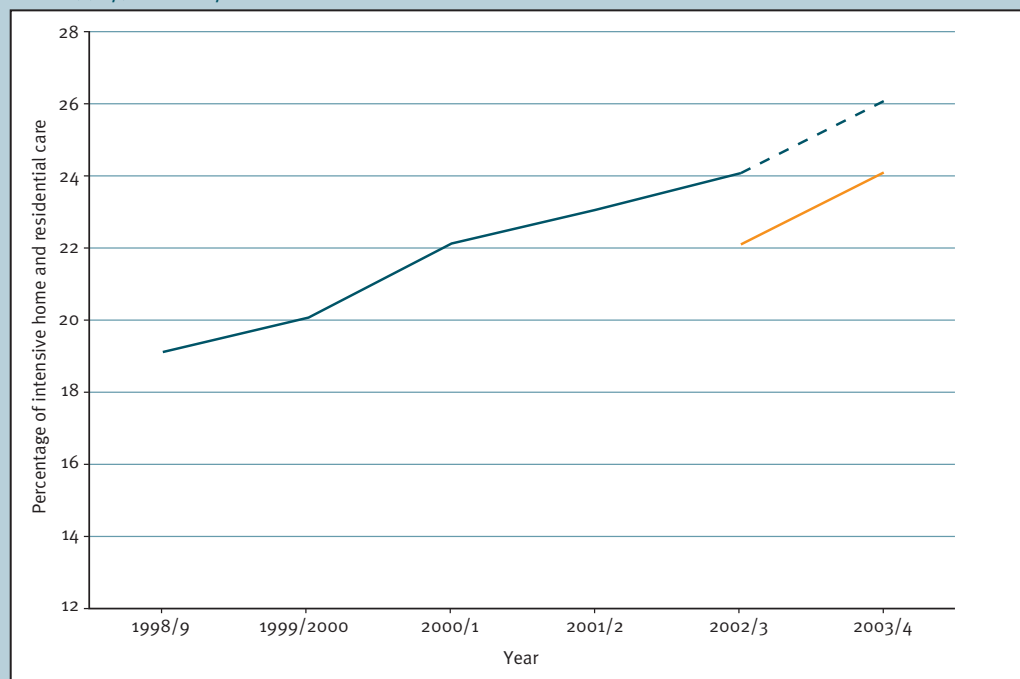
There are choices that can be made between different types of services that could potentially cater for similar, and usually significant, need, for example between community-based services and residential forms of care. Also, there are choices between services that cater for people with low needs and those with high needs; for example, day care or practical/housekeeping services against intensive home care and residential care.

PREFERENCES

People generally prefer to stay in their own homes to receive care although some prefer to move into a residential setting. Annex 1 (p 59) reviews the relevant evidence.

Preferences and expectations are changing. The aspirations and preferences of people now in their 60s are different from their counterparts 20 or more years ago. The so-called baby-boomer generation (born 1945–54 and in their 70s in 20 years’ time) (Huber and Skidmore 2003) are already exhibiting different attitudes towards their later lives.

The change of attitudes, that is broadly, but not exclusively, characteristic of this generation, is reflected in an emphasis on rooting out discrimination (most relevantly age discrimination), embracing the human rights agenda and demanding greater choice and quality. This has implications for all services, both in terms of how they engage with users, and for the required mix of services in the future – that is, more responsive to those using them. The baby-boomer spirit may not sit comfortably, for example, with care models based on communal living.



Source: Based on performance indicators data from the Commission for Social Care Inspection (2006)

KEY

- Old definition
- New definition
- - - Old trend

CURRENT HORIZONTAL SERVICE MIX

The legacy of policies in the 1980s is a relatively high number of care homes places, at least relative to people's stated preferences for living in the community. The trend is towards more community-based care options – Figure 7 above shows the trend in the last 6 years.¹ The government is actively promoting this shift in the balance of care. The last Public Service Agreement (Department of Health 2004a) set national targets of:

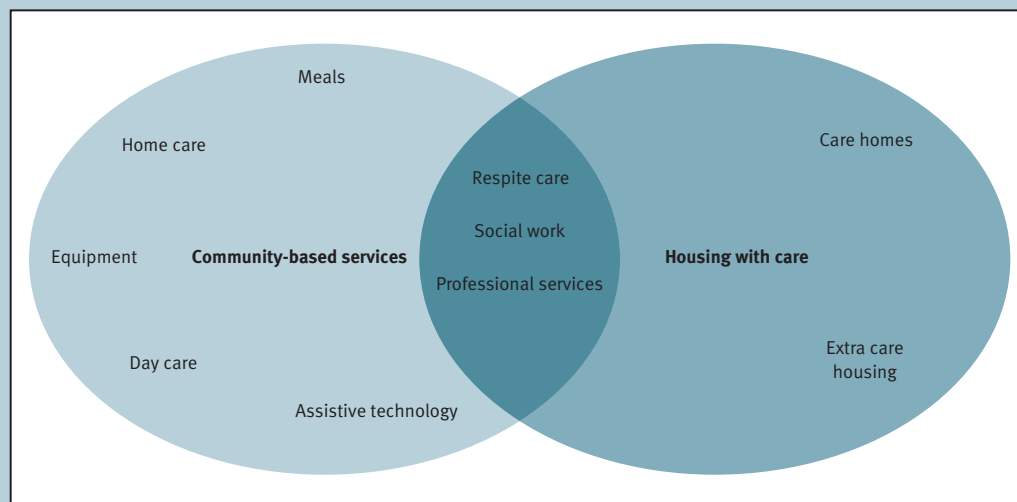
- increasing by 2008 the proportion of those supported intensively to live at home to 34 per cent of the total of those being supported at home or in residential care, and
- increasing the proportion of older people being supported to live in their own home by 1 per cent annually in 2007 and 2008.

Choices between broad service categories of community-based services, on the one hand, and care home/care with housing on the other, are *balance of care* issues. There are also important service choices within these service categories (see Figure 8, overleaf).

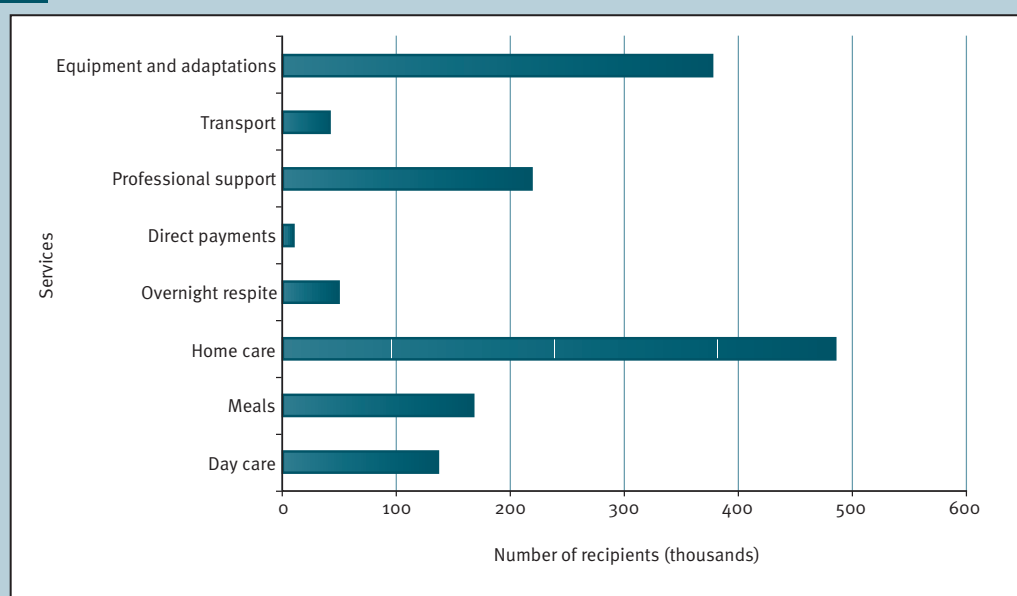
Most of the evidence about systematic comparisons of community-based services for older people have come from the Evaluating Community Care for the Elderly People (ECCEP) project. Looking at a range of outcomes, the study suggested that changing the balance of services, with more emphasis on respite, day care and social work would improve outcomes within current resources (Davies *et al* 2000). Figure 9 gives the current mix of services.

Within the 'housing with care' category, the care home is currently the dominant service model. However, there is a small but increasing number of newer alternative service models, such as very sheltered care or extra care housing, that can also cater for people

8 SERVICE OPTIONS WITHIN COMMUNITY-BASED SERVICES AND HOUSING WITH CARE



9 NUMBER OF RECIPIENTS OF COMMUNITY-BASED SERVICES AGED 65+ DURING THE YEAR 2004/5



Source: Community Care Statistics data from the Department of Health (2005)

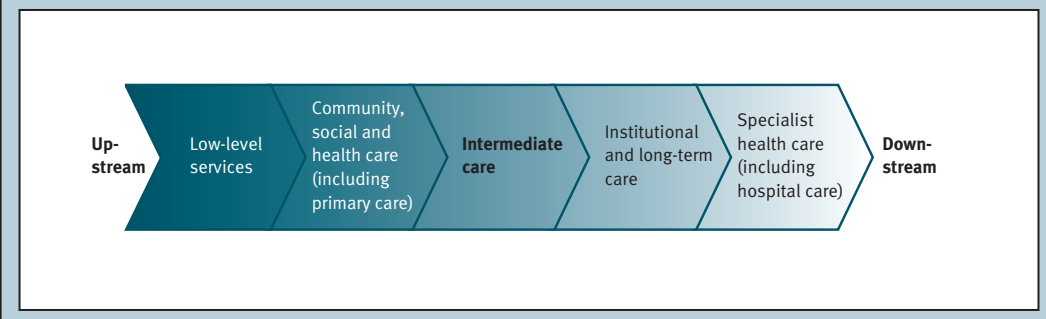
Note: The figures for the number of clients receiving each different component of service do not necessarily sum to the total of clients receiving community-based services because a client may receive more than one component of service during the year.

with relatively high need. Extra care is a developing model – see Chapter 9. Also considered in Chapter 9 is the role that new developments in care technology such as telecare might play in the future.

3 Service options for different need

As people's needs increase so more intensive forms of care are required. Progression of need is not steady, but as need changes people move through the continuum of services,

10 CONTINUUM OF SERVICES



often beginning with low-level ‘upstream’ services and ending up in intensive services ‘down-stream’ as in Figure 10 above. Locating people with complex needs at any given point on this sequence is a challenge. Services in practice are not continuously arrayed; gaps exist and the journey through care can be disjointed for people. Nonetheless, if people are moved too quickly to the intensive end of the spectrum, cost-effectiveness is in question. If people remain at the low intensity end for too long, safety and risk become issues.

The balance between low-level and high-level social care

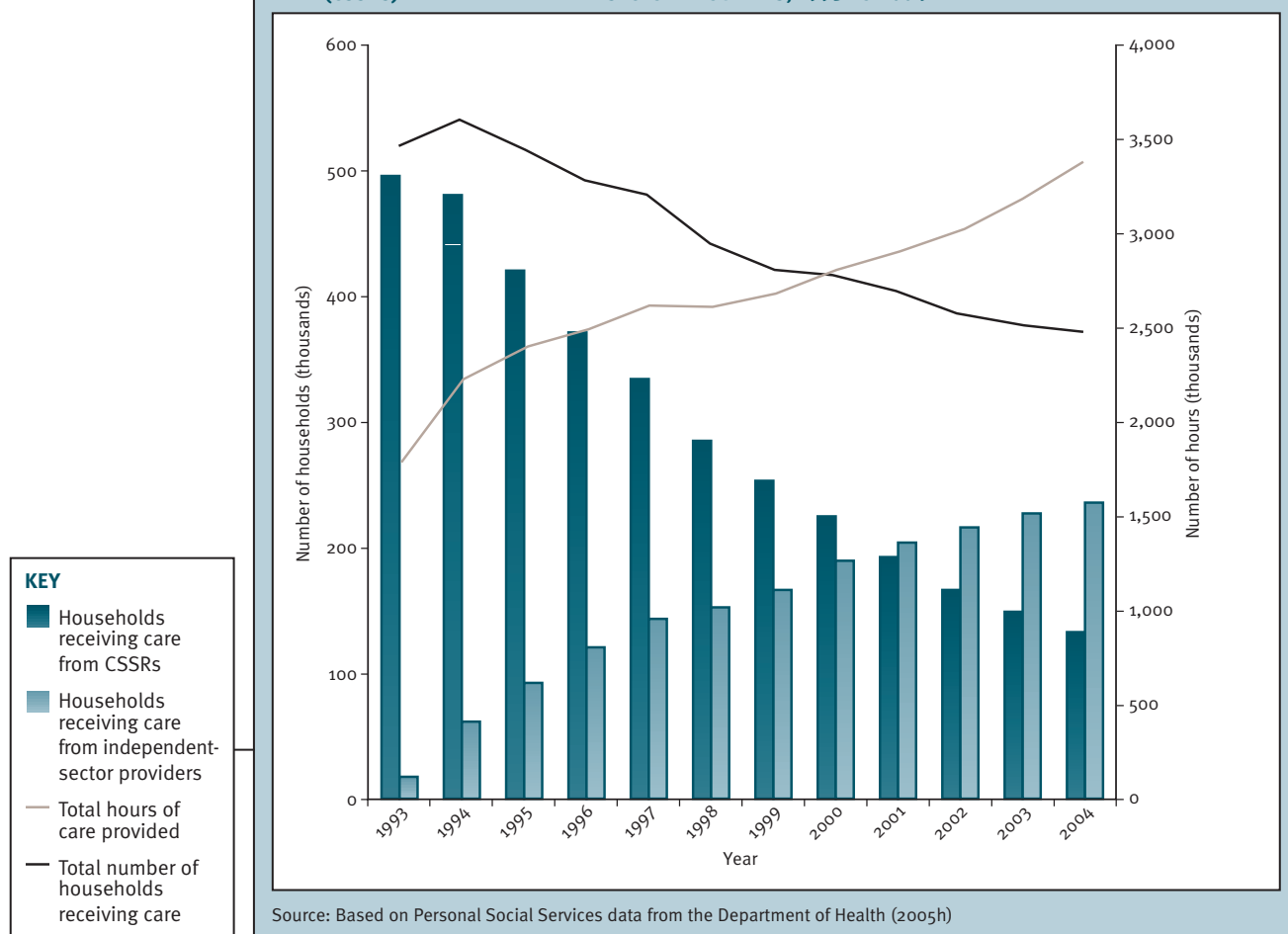
There is some evidence that social care for people with lower levels of need – often provided in the community – can delay the use of high-level social care, such as in a care home – see Annex 2, p 60 and also Background Paper 1 (‘Prevention’) in the Appendix. The recent trend in service deployment, however, is for a move away from relatively low-level services. The number of people who receive home care is falling, even though total inputs (for example, contact hours) are increasing – see Figure 11 overleaf. Those people going into care homes are more dependent than ever before (Darton *et al* 2006).

The proportion of people receiving home care in England is low by international standards. Table 14 (see p 53) shows, for a number of countries, the proportion of older people in long-term care institutions as well as the proportion receiving formal home-help services (Gibson *et al* 2003). Making international comparisons of long-term care is difficult because of differences in definitions and because data is generally poor, but a general sense of the relative position of different countries is revealed.

In respect of care homes, the situation in England is not atypical. The Nordic countries and the Netherlands have relatively high proportions of older people in institutions but the figures in the table include ‘service housing’, that is, very sheltered housing, which accounts for a large share.² Service housing might extend to lower needs users than care home places.

England is atypical, however, in home care coverage, with a relatively low proportion of the population receiving formal home care. Nonetheless there are a number of caveats. The 4 per cent figure for England includes only publicly funded home help/home care and is perhaps the closest figure for comparison (Department of Health 2005d). Analysis of the GHS and the Department of Health figures in Chapter 10 indicate that 6 per cent of over

11 DETAILS OF HOME CARE PROVIDED TO HOUSEHOLDS BY COUNCILS WITH SOCIAL CARE RESPONSIBILITIES (CSSRS) AND BY INDEPENDENT SECTOR PROVIDERS, 1993 TO 2004



65s received either one or some combination of home care, day care and meal services. By also including privately paid-for home care, the figure would increase to 9 per cent of over 65s.

The balance between community social care and (secondary) health care

Older people, and especially the very old, are high users of health care. According to a study in eight OECD countries, between one-third and one half of total health expenditure is on older people (Anderson and Hussey 2000). In England, GHS data indicates some 14 per cent of older people had an inpatient stay in the last 12 months, rising to over 21 per cent of older people with a limiting chronic disease (compared with less than 8 per cent of adults under 65). In England, older people (age 65+) account for well over one-third of admissions to hospital and nearly two-thirds of bed days – see Figure 12, p 54.

The rate of emergency admission *growth* is highest in the older age group. Hospital episode statistics (HES)³ indicate that in the period between 1989/90 and 2002/3 (in-year) emergency admissions *per capita* increased by 33 per cent for the over 85s but only 20 per

TABLE 14: PERCENTAGE OF THE OLDER POPULATION IN LONG-TERM CARE INSTITUTIONS AND PERCENTAGE RECEIVING HOME CARE

Country	Source year	Share of population aged 65+ in institutions (% of total) ¹	Share of population aged 65+ receiving formal help at home (% of total) ²
Australia	2003	6	21
Austria	1998	5	24
Belgium	1998	6	5
Canada	1993	6	17
Denmark	2001	9	25
Finland	1997	5	14
France	1997	7	6
Germany	2000	4	7
Israel	2000	5	12
Japan	2003	3–6 ¹	8
Netherlands	2003	9	13
Norway	2001	12	16
Sweden	2001	8	8
England	2003	5	4
United States	2000	4	9

Source: Based on data from Gibson *et al* 2003

¹ Estimates may vary according to the definition of institutions, for example, 2.9% of Japanese population aged 65+ are in nursing homes; if individuals in long-stay hospitals are also included, the share rises to around 6%. The US data does not include individuals in assisted-living facilities, whereas data from the Nordic countries and the Netherlands includes those in 'service housing'. In Denmark, the term 'older persons' is used to refer mostly to people aged 67+.

² Proportion of older people receiving formal help at home, including district nursing and help with activities of daily living.

cent for people between 15 and 64 (that is, increases over and above the effects of an ageing population).

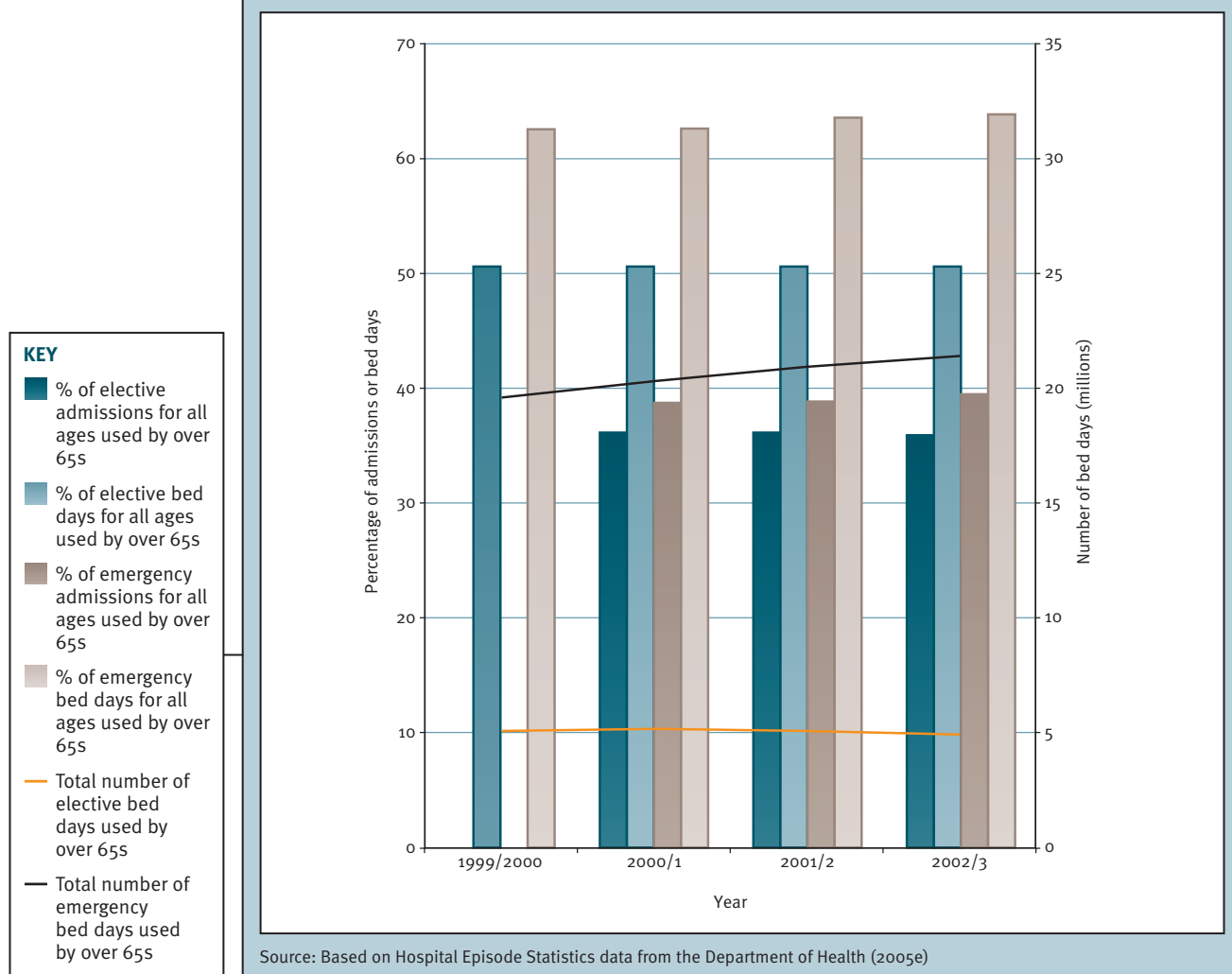
Figure 13 (see p 55) shows that a small proportion of patients utilise a hugely skewed proportion of total hospital bed days. The 5 per cent of 'very high intensive users' (VHIUs), account for over 40 per cent of inpatient days. The odds of being a VHIU are roughly 4.5 times higher for those 65+ than those under 65, and nearly 7 times higher for people over 75 compared to those under 65.

There is a growing body of evidence that social care can reduce, prevent, or delay use of hospital services – see Annex 3, p 61 and also in Background Paper 1 ('Prevention') in the Appendix. Reduction of delayed transfers of people from hospital into the community is one example. Furthermore, monitoring and low-level support, important in primary prevention, are practical in the context of ongoing contact between care workers and service users. Good nutrition, hygiene, support with mobility, help with medications and reducing environmental hazards will all help to limit some of the common causes of hospital admission among more dependent older people. Support with morale and confidence and in combating depression are other examples.

LONG-TERM SERVICES

The mix of social care services for older people is changing in a way that is consistent with this agenda. The proportion of people entering the social care system from hospital has risen over the years. In 1995 around 28.2 per cent of people were admitted into care

12 HOSPITAL ADMISSIONS AND BED-DAY USE BY PEOPLE AGED 65+, 1999/2000 TO 2002/3



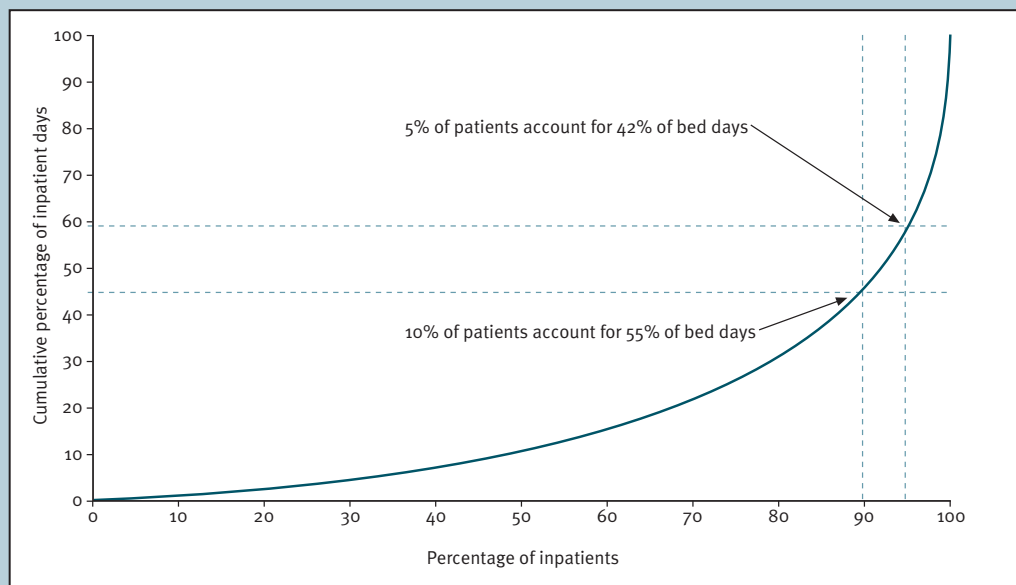
homes from domestic homes; in 2005 this figure had fallen to 23.6 per cent (Darton *et al* 2006).

There has also been an intensifying of the services provided and the levels of need of people receiving the services (for example a significant growth in the numbers of people receiving intensive home care). All care home placements have fallen in recent years, but the proportion of nursing homes has increased. Analysis of GHS data indicates a concentration of home care on more dependent older people.

INTERMEDIATE CARE

In 2000, the National Beds Inquiry showed that significant numbers of older people stayed in acute hospital longer than was necessary or desirable (Department of Health 2000d). In response, the concept of intermediate care was developed. Intermediate care is designed primarily to work at the interface of health and social care. The classification covers a broad range of services (Nancarrow *et al* 2005), as highlighted in Figure 14 opposite.

13 PERCENTAGE OF THOSE ADMITTED AS INPATIENTS BY CUMULATIVE DAYS SPENT AS INPATIENTS

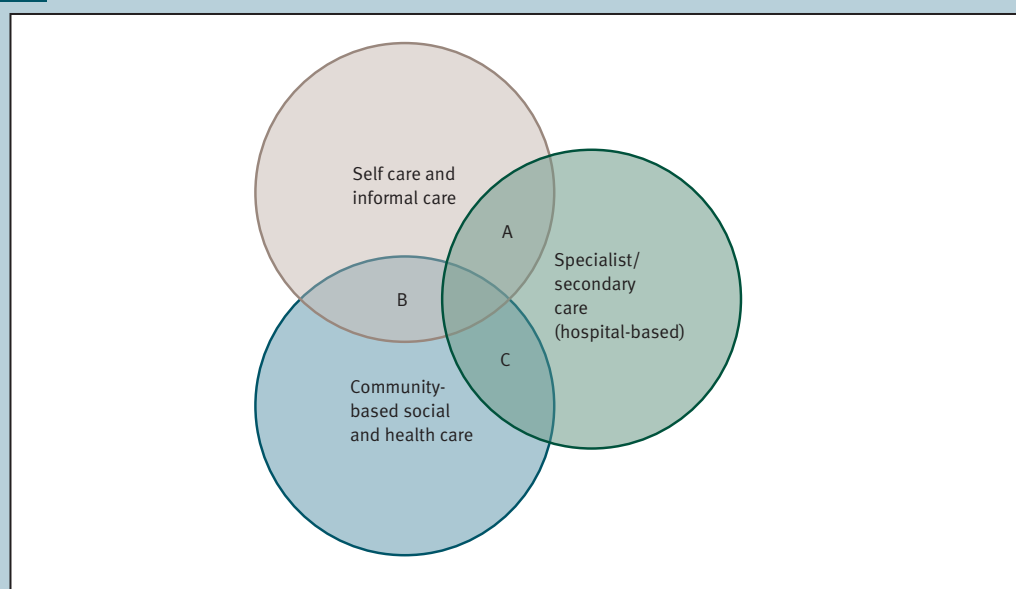


Source: Secretary of State for Health 2004

A first grouping is that range of services that exist on the interface between hospital and community-based social care and health services (intersection C). These usually facilitate hospital discharge and involve rehabilitation either into an appropriate long-term care setting or back to the person's home. Short-term intensive nursing services could also prevent avoidable admissions from long-term care (for example, US style Evercare).

14 FORMS OF INTERMEDIATE CARE

- KEY**
- A** Health-led rapid response, eg Evercare
 - B** Social care-led rapid response
 - C** Rehabilitation (post-acute)



Furthermore, there are intermediate services that potentially operate before people reach the existing formal care system on the interface with informal caring/self-care or no care. There are services that aim to prevent inappropriate hospital admissions (intersection A) and that rapidly respond in the run up to a possible use of long-term care services (intersection B). It is widely held that prolonged absence from home contributes to a loss of confidence which reduces the likelihood of returning home. Short-term intermediate care could help to restore confidence.

Intermediate care can be delivered in hospital, day hospital or at home and can offer a whole continuum of care from high intensity to low-level services (Godfrey *et al* 2005a). The service is usually offered to users for up to a maximum of six weeks. There are now 5,000 intermediate care beds jointly funded by health and social care, and the Department of Health claims that investment in intermediate care and related community services since 2001 had reduced delayed discharge from acute hospitals by 64 per cent by September 2005, releasing about 1.5 million bed days per year (Department of Health 2006). The White Paper believes that the potential to replace more acute bed days with less intensive beds 'is considerable'. For instance, the 946,000 acute bed days annually taken by people with hip fractures 'could be released if better use is made of intermediate care beds'. Of course this would require a significant increase in intermediate care beds. Whether or not there is a total cost saving (even setting aside the impact on people's outcomes) is in question.

So, how effective is intermediate care? The evidence is reviewed in Annex 4, p 62, which finds, as did a recent *BMJ* commentary, that although the evidence base is still tentative, there are some positive signs (Melis *et al* 2004). Others dissent, however (Vetter 2005). What is clearer is that more focused and targeted services should lead to greater benefits.

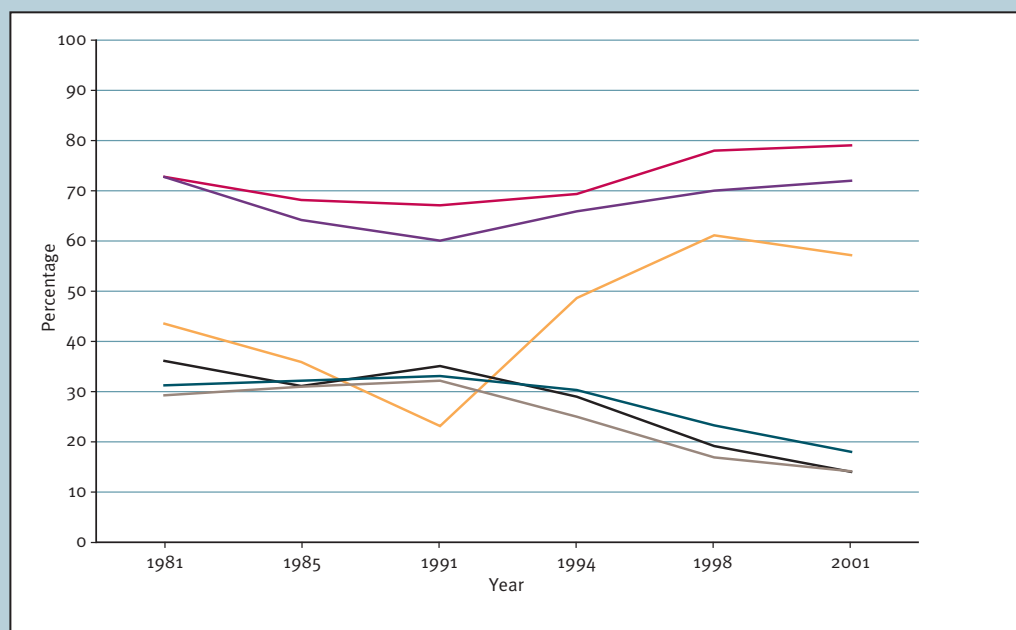
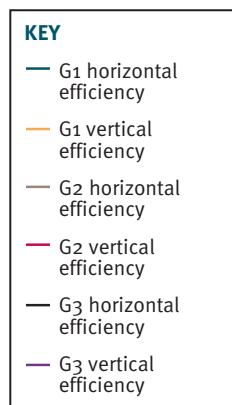
Progress on deployment of intermediate care services has been steady but has perhaps not reflected the initial optimism. *The NHS Plan* in 2000 called for an increase in the number of intermediate care beds by 5,000 and a further 1,700 supported intermediate care places, together benefiting around 150,000 more older people each year, and this has largely been met.⁴

4 Targeting and unmet need

For people with different types and levels of need, the mix and intensity of services received will affect their outcomes. Certain configurations of services will serve people better than others. Getting this mix and intensity right for people is therefore an important factor in how well social care performs overall. In addition, overall performance will depend on how many of those people who could benefit from services, do actually get them (if they want them). Grouping older people in the population in accordance with their need, disability or dependency shows that not all people in these groups receive services. This is unmet need. The way services are distributed between these groups is also important.

Population surveys provide estimates of the number of older people in various groupings defined according to need. Chapter 2 described population numbers by dependency groups. Where the same surveys ask about service receipt among people in these groups, two indicators can be developed:

15 THE HORIZONTAL AND VERTICAL EFFICIENCY OF HOME CARE SERVICES, 1981 TO 2001



Source: Based on General Household Survey data from the Office for National Statistics

- the percentage of people within a defined typology of need that received any home care – called *horizontal efficiency*
- the percentage of home care services targeted on a particular needs category – called *vertical efficiency*.

Figure 15 above uses the 2001 GHS to show how these two indicators have changed over the last two decades. In the figure, three sample typologies are given, each defining a group of people as follows.

- Group 1: people with personal care needs; but with some informal care support, for example, people who could get in and out of bed, or bath, or climb stairs etc only with help from someone else or on their own with difficulty
- Group 2: people who could not by themselves: clean windows, sweep floors, wash clothes (that is, practical care tasks)
- Group 3: people with either personal care or practical care task difficulties and no informal carer to provide assistance, for example, because they lived alone, or because the carer was also not able to undertake these tasks.

The lines in the figure relating to horizontal efficiency show that as of 2001, about 20 per cent of people within each of the needs categories defined above received some home care. The definitions used above are quite inclusive – they include people with any personal care/ADL difficulty. Tightening the definition to people with significant care needs, for example, to people with 2 or more ADL problems would increase this proportion significantly.

The vertical efficiency figures show that between about 60 per cent and 80 per cent of home care services were allocated to older people in the needs groups as defined above.

TABLE 15: PEOPLE'S PREFERENCES SHOULD THEY NEED CARE

Preference	Percentage
Stay in my own home with care and support from friends and family	62
Stay in my own home but with care and support from trained care workers	56
Move to a smaller home of my own	35
Move to sheltered housing with a warden	27
Move to sheltered housing with a warden and other social care services such as hairdressing and organised social outings	25
Move in with my son or daughter	14
Move to a private residential home	11
Move to a local council residential home	7
Move to a residential home provided by a charitable organisation	3
None	1
Don't know	2

Source: Commission for Social Care Inspection 2004

Note: Base: all respondents aged 15+ (1,049).

The chart shows that people with personal care needs (Group 1) are now much more likely to receive care than in the past. In other words, services are more highly targeted on this group than in the early 1990s in particular.

Two points can be made about social care over this period. First, the results suggest that services are well targeted on people with significant need, and that this vertical efficiency has been improving, especially for people with personal care needs who may have informal care. Second, the proportion of people having these needs met is relatively low. This latter point is particularly important. For whatever reason – be it choice or rationing or something else – services are being used by only a relatively small proportion of people of similar needs.

5 Conclusion

In terms of service mix, the evidence indicates that most individuals would prefer to receive care at or close to home and that most would prefer 'prevention rather than cure' if they thought it would work. By contrast, the services which are available at present are focused on people with high end need, and are still substantially provided in care homes. These are not surprising results given the aims and objectives of the current publicly funded social care system and that the system is cash limited.

So, the evidence suggests that social care services are effective at diverting some (inappropriate) use of downstream services such as long-term residential care and secondary health care. Furthermore, this effectiveness increases as more services are targeted on those people at risk of hospitalisation. Intermediate care has potential, but provision levels are still modest. It is vital to see how social care can and is engaging with public health to help limit, prevent and delay health related and other forms of dependency and disability.

Gauging overall performance is not only a question of what services are being provided, but also of who is using them. This analysis has given strong indications that uptake of

services varies significantly between people with apparently similar needs. This is an important element of the modelling work described in Part 2 of this Review.

Recommendations about appropriate mixes and intensity of services are considered in Part 2 when cost and societal willingness to fund care are factored in. Here, it is recommended that research is needed to explore the reasons for, and trends in, unmet need.



Annex 1. Preference concerning care settings

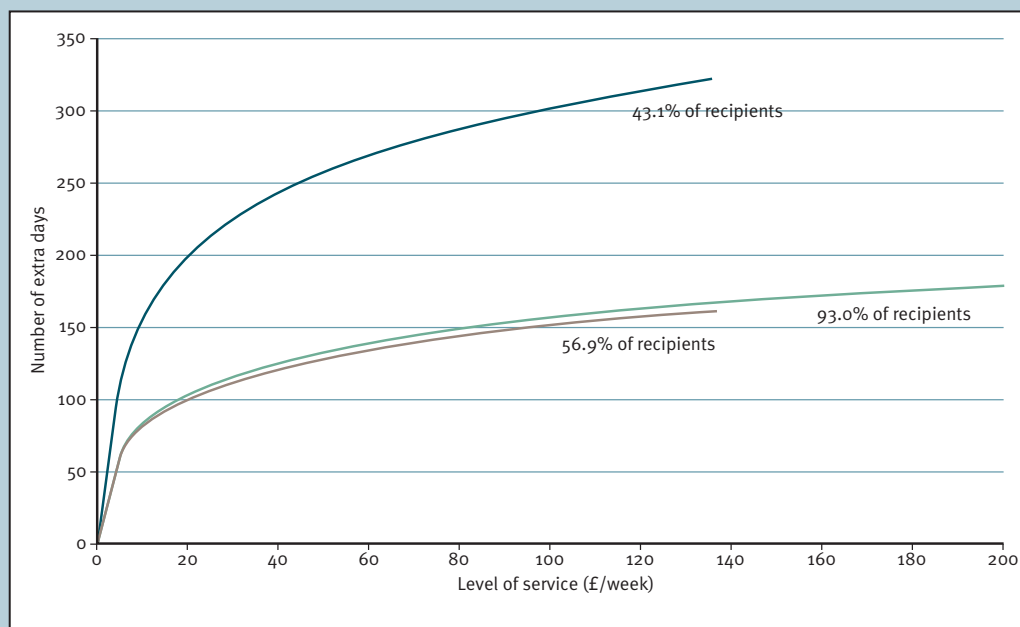
A national survey of older people living in the community (McCafferty 1994) found that after the onset of significant disability more than four-fifths of older people wished to remain in their present homes, supported by community-based services. Other surveys (Fell and Foster 1994) asked where people would like to live if they were housebound and again their current home was prioritised, although a significant number also chose sheltered housing. Only 5 per cent wanted to either move to a home or in with their family. One-third of the respondents in the Grey Matters survey (Sykes and Leather 1997) said that they would not like to move under any circumstances. A review of the literature carried out by the DWP (in 1999) supported this view (Boaz *et al* 1999).

In the event of disability, three-quarters of older people would rather stay in their homes and have them adapted, rather than move (Milne 1999). The PSSRU study of community care (Davies *et al* 2000) sought the views of people who had been assessed to receive community-based packages of care, that is, people who had care needs. Of the 333 responses, 41 per cent were definitely against going into residential care, 25 per cent strongly against, and 26 per cent would prefer not to; in total 92 per cent were against the residential care option.

As few as one-fifth of people felt they had actively opted for residential care after having been presented with the choice of staying at home or going into care according to a 2003 study (Ware *et al* 2003). Many people found themselves in residential care despite their preferences but accepting the move as necessary in some regard. Oldman and colleagues (Oldman *et al* 1998) interviewed residents in nursing and residential homes. They found varied responses to the move. The majority accepted the move as inevitable and sought to adjust, others felt enthusiastic but smaller numbers continued to resist the move and living in the home. The influence of other family members can be significant. Carers' views are often less negative towards moving into care.

CSCI commissioned a MORI survey of people's preferences for social care when they are older. People were asked about care options they would prefer if they needed care and support looking after themselves (when older, if not already). Table 15 (*see* p 58) gives the details.

16 EFFECTS OF HOME CARE AND DAY CARE ON THE EXTRA TIME AN OLDER PERSON REMAINS IN THE COMMUNITY



Source: Davies *et al* 2000



Annex 2. Community social and health care preventing care home admission

There is evidence that community-based social care in England can substitute for residential care. Figure 16 above shows how spending on services ‘buys’ additional days for people in the community before a residential care solution becomes the only option for them (Davies *et al* 2000). Two services are shown – home care and day care. Also, because outcomes (additional days) depend on both the service and the needs of the people using that service, the graph shows the effects of services for different groups of people. For example, £60 per week of day care for people with (mild or severe) cognitive impairment corresponds to about 265 extra days, or an extra 135 days for other people using day care. The graph also shows the outcome of home care services for the 93 per cent of people in the sample who could not do heavy housework.

It is thought that ‘low-level’ services, like help with housework, gardening, laundry, and home maintenance and repairs, both enhance quality of life for older people and help them maintain their independence (Clark *et al* 1998). These services are likely to improve people’s happiness and satisfaction with life because they correspond closely with the outcomes that people identify as important for themselves. For example, having a clean home is very important to many older people. What is less clear is whether this help reduces the *need* for downstream care. For example, how strongly is depression about an unclean home associated with risks to people’s independence?

Evidence from the US (the National Long-Term Care (Channelling) Demonstration project) concluded that substituting home care for nursing home provision was effective (it could also be cost-neutral or even cost-saving if tighter targeting of services was adopted) (Greene *et al* 1998).



Annex 3. The impact of social care on health care usage – evidence

The evidence shows that community-based services can be used to substitute for specialist health care (mainly hospital care), and that this substitution can be cost-effective, that is, total health and social care costs are either lower or outcomes are improved or both.

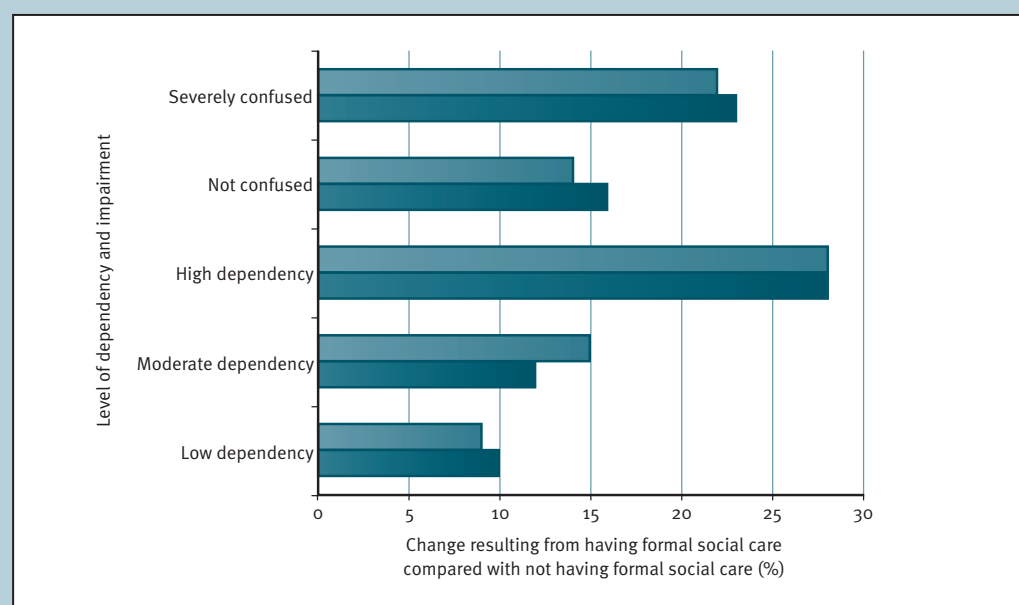
A large scale meta-analysis (of mainly US studies) investigated the impact of home care – which includes, in this case, home nursing and home health type arrangements – on hospital days. The paper concluded that although substitution effect sizes were small to moderate, the consistent pattern of reduced hospital days across a majority of studies suggests that home care does have a significant impact (Hughes *et al* 1997).

There is relevant research in the English case. First, a study of local authorities found that an increase in care home and/or home care provision had the effect of reducing rates of delayed discharge, and in turn, reducing average length of stay (all ages) and increasing hospital activity. Furthermore, the study indicated that increased care home use reduced re-admission rates (Fernández and Forder 2002b).

Second, a study in 12 local authorities found that an increase in home care provision for older people reduced hospital usage (see Fig 17, p 61). For very dependent older people, for every £1 spent on home care, average costs of hospital care fell by 30p (Fernández and Davies 2002a).

Third, the National Beds Inquiry found that 20 per cent of bed days for people over 65 would be inappropriate if alternative services were in place. A King's Fund study

17 IMPACT OF HOME CARE ON HOSPITAL USE



Source: Fernández and Davies 2002

KEY

- Reduction in probability of use of inpatient care
- Reduction in costs of inpatient care (% of community package cost)

(Stevenson and Spencer 2002) suggested an even greater inappropriate use of hospital beds.



Annex 4. Intermediate care

The most recent national evaluation of intermediate care (Barton *et al* 2006) looked at its impact on the service system as a whole and the costs of such schemes. It found that patient satisfaction levels were relatively high, but that intermediate care schemes currently have only a limited capacity to make a significant impact on other types of care provision. Patients admitted to the case study services also appeared to have been less dependent at admission compared to patients in earlier trials of hospitals at home, suggesting that intermediate care might be providing services for patients who would otherwise not need hospital care. ‘This was supported by the finding that about as many cases for admission avoidance were referred by nurses or social workers, who cannot admit to hospital, as by GPs and A&E doctors, who do have admission rights,’ the study said. In practice, intermediate care was thus providing an additional as well as a substitute service, with only about half of all intermediate care episodes in the case studies preventing or shortening a hospital admission.

In terms of actual service provision, the evaluation found that the six-week time limit on intermediate care was often perceived as being too narrow and restrictive. The timing of discharge was the one area which received the lowest satisfaction scores from users. A separate evaluation of older people’s personal experiences of intermediate care by Help the Aged found that most older people were positive about the service, but at the end of the six weeks they felt they had been left with no care. Users called for the voluntary sector to step in to fill this gap (Cornes and Manthorpe 2005).

In terms of implementation of intermediate care schemes, the evaluation by Barton and colleagues found that poor partnership working between health (PCTs) and social services organisations at both operational and strategic levels was the most serious impediment to facilitating the development of intermediate care in local contexts.

COST-EFFECTIVENESS

Barton *et al* (2006) looked in detail at the potential cost savings from shorter or avoided hospital stays, but when doing so looked only at the cost of the actual intermediate care episode (or the equivalent) up until discharge or transfer. Longer-term costs of care were not included. A central finding was that hospital admission avoidance (step-up) tended to be associated with cost savings (£285 per patient on average) while supported discharge (step-down) tended to lead to increases (£189 per patient on average) in costs overall. (These results were, however, very sensitive to the assumed costs of acute and intermediate care.) This divergence on cost impact was not surprising because admission avoidance tended to have shorter episode durations, was more likely to be non-residential and tended to be for patients with less severe conditions. Even when the time framework was extended to 4 months, and re-admissions included, the cost divergence persisted, because less non-intermediate care residential care was assumed for admission avoidance.

A separate question related to choosing which patients should be selected for intermediate care. If the objective is to target intermediate care resources in a way which produces the biggest quality of life and/or functional improvements, then the evaluation offers support for targeting patients with the greatest clinical need, who would otherwise require care in an acute setting. Higher levels of severity, however, are associated with higher intermediate care costs. If the goal is instead on limiting direct costs, then the focus should be on admission avoidance.

There is a lack of consensus in the literature over the cost-effectiveness of intermediate care, and very limited material on admission avoidance rather than hospital discharge. Measuring cost-effectiveness is complex because of the range of different service inputs and outcome measures, and also because any evaluation is very dependent upon the length of time over which the impact is considered (Godfrey *et al* 2005a). Several papers point to intermediate care leading to longer lengths of stay (including acute and post-acute care) but with the positive impact that patients are discharged with a high level of physical functionality. The strongest evidence for the cost-effectiveness of intermediate care comes from services that target specific groups/illnesses/events. (A summary of the effectiveness of various intermediate care schemes is given in Background Paper 1 ('Prevention') in the Appendix.)

Notes

¹ A very simple extrapolation, assuming a constant rate of improvement would see a rise to over half by 2026.

² In Denmark and the Netherlands, specialised housing solutions are the predominant choice (the number of places in residential nursing homes has halved between 1987 and 2003 in Denmark). In the Dutch case, a recent report states that only 4 per cent (150,000) of all people aged over 55 spend any length of time in a care home or institution, not including specialist housing. This result would suggest the 9 per cent figure in the table includes a significant amount of specialist housing.

³ Department of Health. Hospital Episode Statistics. Website available at: <http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/HospitalEpisodeStatistics/fs/en> (accessed 08.02.06)

⁴ Department of Health. Older people's NSF standards: Standard Three – Intermediate care. Department of Health website, available at: http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeopleArticle/fs/en?CONTENT_ID=4002288&chk=KTYh5B (accessed 07.02.06)

4

How is the current system performing on standards and processes?

SUMMARY

Good organisational processes and standards in the care system will lead to good performance. How well does the current system fare in this regard? The government has established a broad performance management process, with specific targets and standards to be achieved. Further key processes are the partnership working of health and social care agencies, and the range of initiatives to promote choice and responsiveness.

- In 2004, 57 per cent of councils were either serving all or most of their adult clients well. Analysis by this Review suggests that councils with good assessments for adult services tend to spend more.
- The 2000 Care Standards Act (CSA) put in place a series of national minimum standards (NMS) against which care homes should comply. On average, 72 per cent of standards are now met compared with 59 per cent in 2002/3. However, significant regional variation remains.
- Inspections for domiciliary care indicated in 2004 that two-thirds of agencies were meeting standards. Again, the range across the country was wide.

There is a growing body of evidence relating to the impact of health and social care integration. It can reduce unnecessary admissions to hospital and residential care and improve efficiency. However, although there are substitution possibilities between health and social care, simply increasing the provision of the latter without making arrangements to co-ordinate/integrate will be the least effective strategy.

- The policy direction is consistent with effective partnership working but there is still some way to go. Work is needed to develop a case targeting tool; community matrons offer some case management opportunities but are health focused. The single assessment process has promise but it is far from being used routinely. Section 31 flexibilities could also deliver aligned financial incentives (pooled budgets) but they are in limited use. The Partnership for Older People pilots will also explore better ways to provide incentives, where at present they are largely absent.
- There has been progress in reducing delayed transfers from hospital, with the number being halved from a high of more than 7,000 people in 2001 by 2005. The picture on admissions is less promising.
- The operation of two parallel systems (of health and social care), and the difficulty of distinguishing between needs at the boundary of these systems, is at its most acute with NHS continuing care. Unlike social care, continuing care is fully funded by the NHS (including 'hotel' costs), with no means-testing of the user, and has become a flashpoint for arguments about inequities in the system.

Current social care policy is based on a belief that outcomes will be better for people using services if they have choice or if the system is responsive to their needs. Choice and control are offered by the option of taking a direct payment rather than services, but take-up has been very low. Choice in social care also occurs where individual users or local authority staff are able to select from a range of potential providers in a care market. There is evidence that where there are more providers (more competition), prices are lower. What is not clear is whether the lower prices mean quality suffers when there is significant competition.

1 Introduction

Good organisation and management leads to good outcomes. At least this is the theory. The government has put a great deal of emphasis on measuring how well certain processes are being undertaken. These can concern commissioners (councils), including ensuring access to services, standards relating to the mix and quality of services and the cost efficiency of service provision. Providers also have to meet standards covering how well they serve users of services. The National Service Framework for Older People set standards covering the availability of services, mix of services, how organisations interact with service users and how organisations operate. Some standards relate to service inputs, some to processes, while others are close to final outcome indicators.

The government has a performance assessment system in place to measure achievement of these standards and criteria. It provides overall ratings of local authority commissioner performance, and of social care providers relative to national minimum standards (NMS). This system scrutinises a range of processes. Several warrant individual attention in this chapter: the integration/partnership working of health and social care agencies and the various initiatives to promote choice and responsiveness.

2 Relevant processes for social care

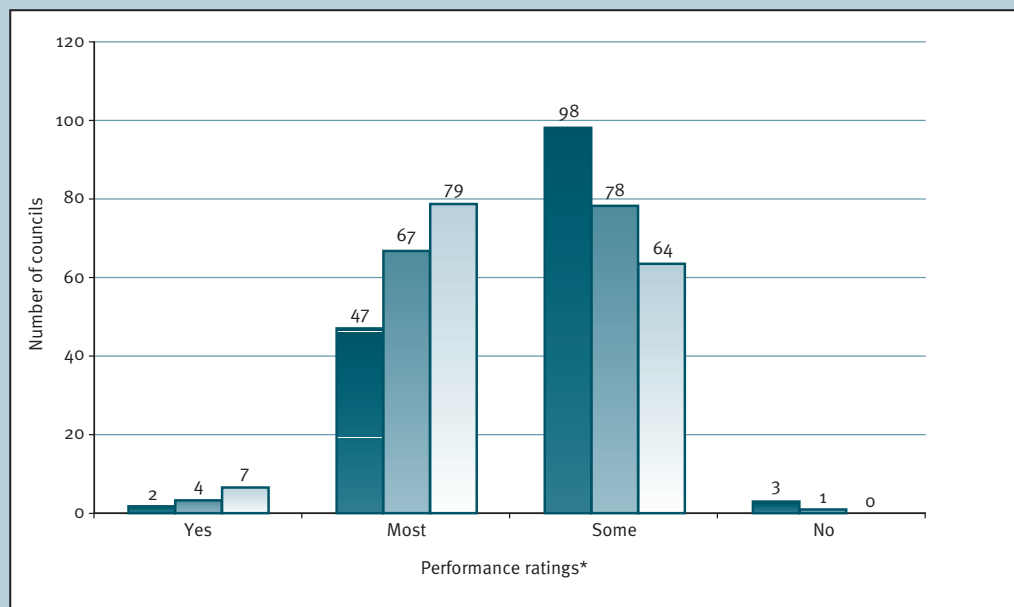
Performance assessment

COUNCIL STAR RATINGS

As part of the Comprehensive Performance Assessment (CPA) of councils, the Commission for Social Care Inspection (CSCI) assesses social services. At present, using a range of criteria, CSCI judgements concern how well both adults and children ‘are being served by the council’ and what the potential capacity is for improvement. These judgements are based on performance indicator data, on-site inspection and evaluation and monitoring. The latter draws on a large dataset that councils supply voluntarily. Figure 18 opposite gives details of the distribution of ratings across the 150 councils showing how well they are serving their adult population. Councils are rated into four categories: ‘yes’ serving adults well, ‘most’ adults being served well, ‘some’ being served well, and ‘no’ to the question of whether they are serving adults well.

There has been significant improvement in the star ratings over the years. As of 2004, 57 per cent of councils were serving either all or most of their adult clients well. The ratings are based on a rigorous process of evaluation. Although open to criticism that organisations could be selectively achieving rating criteria at the expense of other aspects of performance, this combined data and monitoring approach minimises this possibility.

18 JUDGEMENTS ABOUT HOW WELL COUNCILS SERVE ADULTS, BY PERFORMANCE RATING (150 COUNCILS), 2002 TO 2004



Source: Based on data from the Commission for Social Care Inspection
* See text for details of ratings.

On average, there has been significant improvement but it still remains very difficult for councils to achieve the highest rating.

Analysis conducted by the Review suggests that councils with good judgements for adult services did tend to spend more on adult services (after accounting for a range of other explanatory factors). To be more precise, the results indicate that for the average local authority, a 1 per cent increase (from the mean) of total adult expenditure per head of population 65+ corresponds to a 0.9 per cent increase in the chance of being rated a high performer.

The performance indicators that relate to adult and older people's services are divided into a number of sections, as summarised in Table 16 overleaf. The performance league tables for each council in England are published by CSCI. Furthermore, CSCI rates each indicator into one of five performance bands that range from 'investigate urgently' (band 1) to 'very good' (band 5). The bands partly reflect the distribution of the indicator between councils (that is, are league tables), but are mostly set according to professional judgement. These have taken into account available evidence from research and inspection on what level good/poor performance is, whether performance against an indicator is perceived to be good or not, the distribution of performance, data quality and other factors.

NATIONAL MINIMUM STANDARDS

The 2000 Care Standards Act (CSA) put in place a series of NMS against which care homes should comply. The 38 standards are grouped under the following topics:

- choice of home
- health and personal care
- daily life and social activities

TABLE 16: PERFORMANCE INDICATORS MEASURED BY THE COMMISSION FOR SOCIAL CARE INSPECTION

Area of performance	Measures
National priorities and strategic objectives	Extent of integrated working with health care
Cost and efficiency	Range of service unit costs offered and, more importantly, the balance between intensive home care and care home provision
Effectiveness of service delivery and outcomes	Appropriateness of the levels and mix of services offered – mainly between home care and care home services
Quality of services for users and carers	Quality of services, such as the provision of single rooms in homes and good information about assessment, and the accessibility of services in terms of the length of waiting times for assessments and care packages offered
Fair access	Accessibility of care to different ethnic groups

Source: Commission for Social Care Inspection 2005a

- complaints and protection
- environment
- staffing
- management and administration.

Regulators look for evidence that the standards are being met and a good quality of life enjoyed by service users through discussions with service users, families and friends, staff and managers and others; observation of daily life in the home; and scrutiny of written policies, procedures and records.

The *State of Social Care report* (Commission for Social Care Inspection 2005b) indicates that for care homes for older people on average, 72 per cent of standards are now met compared to 59 per cent during the first inspection year (2002/3). Some 22 per cent were top performers (that is, meeting more than 90 per cent of standards) compared with 7 per cent in 2002/3. However, significant regional variation remains. In some council areas less than 50 per cent of homes meet the standards; in others over 90 per cent. For domiciliary care, inspections began in 2004. These indicated that two-thirds of agencies were meeting the standards, with 18 per cent of all agencies being top performers. Again the range across the country was wide (from an average of less than 40 per cent to over 90 per cent of agencies meeting the standards).

The improvement in the number of providers meeting standards is laudable. Scope remains for further improvement overall. Although the trend is strongly upwards, questions remain about the variability.

ACCESS INDICATORS

The government also publish indicators relating to access and waiting for services. Time from first contact to completed assessment for new clients has fallen very slightly between 2003/4 and 2004/5. At present around a quarter of assessments are done within 2 days, but 30 per cent take more than 4 weeks.¹ Assessed services are mostly delivered in the first two weeks after assessment (75 per cent) but just over 10 per cent take more than 6 weeks.

National Service Framework

The National Service Framework (NSF) for Older People in 2001 laid out a number of standards for the health and social care systems in both the implementation of new or extended service models and also system-level processes to be followed:

- Standard One – Rooting out age discrimination
- Standard Two – Person-centred care
- Standard Three – Intermediate care
- Standard Four – General hospital care
- Standard Five – Stroke
- Standard Six – Falls
- Standard Seven – Mental health in older people
- Standard Eight – The promotion of health and active life in older age.

Some standards have milestones, which act as targets for relevant agencies. The NSF was issued as Section 7 guidance under the Local Authority Social Services Act 1970 and is therefore a statutory requirement for local authorities. A progress report was published in 2003 (Department of Health 2003b) and it signalled reasonable progress to achieving what are in practice challenging standards.

Health and social care integration

In principle, greater integration between the health and social care systems can improve outcomes and efficiency by producing better co-ordinated services. Given the high utilisation of both health and social care by more dependent older people, the potential is significant.

There is a growing body of evidence relating to the impact of health and social care integration (see Annex, p 77). The main messages are as follows.

- Overall the integration of health and social care is effective in terms of reducing utilisation of downstream services (that is, reducing inpatient hospital use, nursing home admissions and lengths of stay). Improved co-ordination helps reduce unnecessary, often emergency, admissions. Integration and co-ordination, in other words, can help to achieve a better balance of services as described in Chapter 3.
- Efficiency can be improved. Where needs are complex, the timing, interaction and mix of services is important in affecting overall outcomes. Co-ordination between health and social care can reduce wasteful duplication, particularly in regard to collecting and sharing pertinent information (especially about the user and the user's circumstances). Co-ordination helps to mitigate the delays and inefficiencies in transferring individuals from one care setting to another, for example in tackling delayed discharge (see Chapter 3).
- Although there are substitution possibilities between health and social care, simply

increasing the provision of the latter without making arrangements to co-ordinate/integrate will be the least effective strategy.

- Notwithstanding the above, wholesale structural integration – that is where all or the majority of health and social care services are managed within a single structure – is unlikely to be the most effective strategy.
- The most effective arrangements focus on high-cost, complex need users. This is argued to be the case because integration measures are expensive and difficult and so only justified for people with a significant chance of needing intensive (health) services in the absence of integration.

There are a number of common features of successful arrangements (Andersson and Karlberg 2000; Hardy *et al* 1999a; Kodner and Kyriacou 2000; Kodner and Spreeuwenberg, 2002). According to the evidence, therefore, if the following processes and structures are adopted, and done well, then overall outcomes will be improved as follows:

- identification and targeting of complex need cases (as discussed above)
- case management/care co-ordination that spans time, setting and discipline. This task includes care planning, service authorisation and arrangement, and ongoing patient monitoring and follow-up
- comprehensive geriatric assessment spanning the full spectrum of service needs and professional discipline
- intensive, interdisciplinary teams, including nurses, social workers and other health professionals, providing care
- an aligned set of professional values with a geriatric philosophy and focus. There is a need for ‘buy-in’ from participating professionals, that is, mutual trust, concerning both motivations and professional competence
- a single-entry point – that is, no competition over commissioner/plan, avoiding the problems of case selection. Single entry also supports coherent funding and case management
- the use of aligned financial incentives to promote downward substitution (which generally involves some form of pooling of budgets)
- a single line of accountability.

So how far is the health and social care system developed in this regard?

CURRENT PROGRESS

The Department of Health has set a number of targets related to (the implications of) greater integration. In particular, targets have been set yearly from 2003 seeking a reduction in the number of people 75 and over delayed in hospital (in acute beds) awaiting a social care assessment and/or care package.

The government has also set a target – in the current public service agreement (PSA) – for the reduction in emergency admissions rates (or bed days) for older people. The Department of Health is promoting the management of long-term conditions (or chronic disease management) taking a health care emphasis. The Community Matron initiative is an example (Department of Health 2004b), as is the Expert Patient Programme (NHS 2006).

The 2006 White Paper, *Our Health, Our Care, Our Say*, sets out in unequivocal terms the intention of government to shift health resources to the community and to underline the duty of health and social care to work together. The Partnership for Older People pilots are

designed to test and evaluate (through pilots to be established during 2006/7 and 2007/8) innovative approaches that sustain prevention work involving health and social care systems jointly to improve outcomes for older people (Department of Health 2006). The Innovation Forum project 'Reducing Hospital Admissions of Older People' being led by Kent County Council, along with nine other pilot councils, is testing to what extent and in what ways creating a single point for strategic commissioning can achieve a significant reduction in the use of unscheduled inpatient care by people aged 75 and over.

Indicators of the development of integrated working come from the notifications of use of the Section 31 Health Act flexibilities in relation to older people. These flexibilities make legal provision for health and social care organisations to work together, jointly commission and pool budgets. As of September 2005, some 50 projects for older people were notified, totalling up to £200 million in resources (Department of Health 2006b). This is likely to be an underestimate, but at this level represents a small proportion of total expenditure on older people's services (£200 million is less than 5 per cent).

Care trusts are NHS organisations, eight currently, with their own governance structures including representation from local government. Five are 'providing' care trusts, mainly of services for people with mental health problems and/or learning difficulties (Bradford, Camden and Islington, Manchester, Sandwell and Sheffield). The remaining three are 'commissioning' care trusts for older people (Northumberland, Witham Braintree and Halstead, and Bexley).

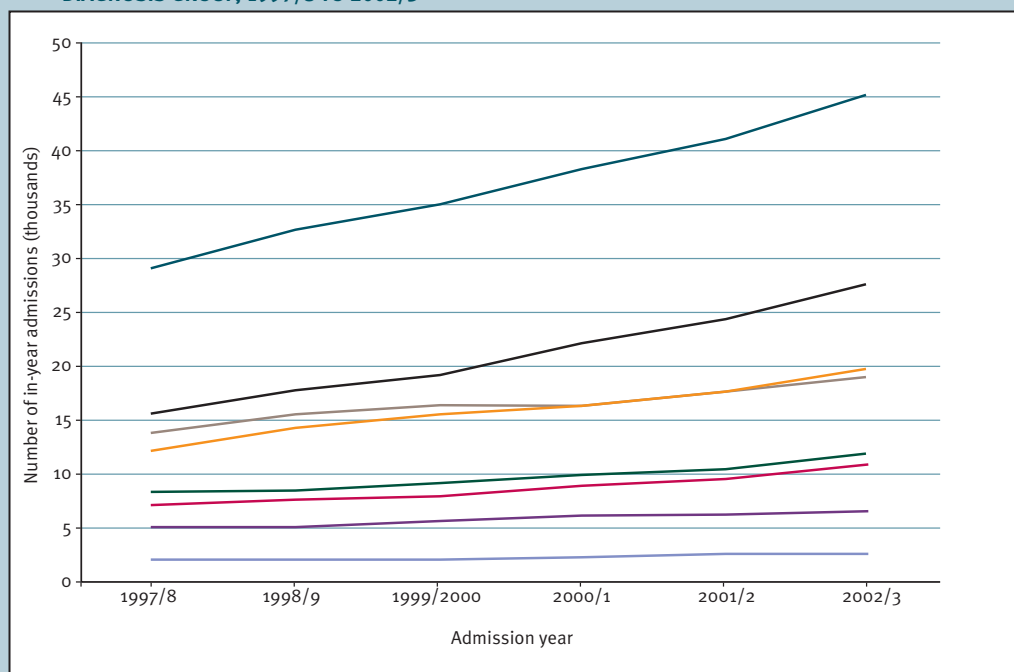
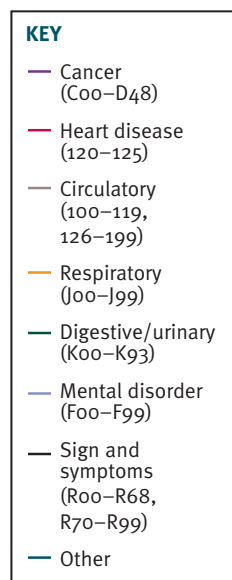
There are also local arrangements that include joint senior appointments and also the use of local partnership boards (for example, in the recent period, Somerset, Knowsley, Southwark and Shropshire). There is no systematic data on the numbers, but in the context of 150 English local authorities and many PCTs, the proportion with joint appointments appears to remain modest.

The single assessment process is a key pillar of joint working. In terms of progress, the Department of Health required (at least technical) compliance to the single assessment process by April 2004. The government's policy of reimbursement for delayed transfers of care also implemented formal systems locally to increase co-ordination between health and social care around people being discharged from hospital back into the community. This system has been in place since 2004.

There are also a number of community health care initiatives that are well placed to work closely with social care (the 2006 White Paper, *Our Health, Our Care, Our Say* announced further developments). NHS community matrons (of which the government intends to have 3,000 by March 2007) provide health care management functions in the community.

In terms of the features for successful integration listed above, the policy direction is consistent with them but there is still some way to go (Hudson and Henwood 2002; Glasby 2004; Glasby and Littlechild 2004). Work is needed to develop a case targeting tool; community matrons offer some case management opportunities, although they are health focused. The single assessment process has promise but it is far from being used routinely. Section 31 flexibilities could also deliver aligned financial incentives (pooled budgets) but they are still in limited use. The Partnership for Older People pilots will also explore better ways to provide incentives, where at present incentives are largely absent.

19 PATIENTS AGED 80+, ADMITTED AS AN EMERGENCY THREE OR MORE TIMES IN A YEAR, BY MAIN DIAGNOSIS GROUP, 1997/8 TO 2002/3



Source: Based on Hospital Episode Statistics data from the Department of Health

Beyond looking at progress in putting the processes and organisations for integration and joint working in place, the state of development of this strategy can be inferred by assessing rates of transfers of people between the social care and health system. The level of delayed transfers of care for people needing social care packages after hospital care is a main indicator. The increase in the rate of emergency admissions and re-admissions among older people is also an indicator of potential deficiencies in this regard, although this increase could have other, non-relevant, causes. More telling is the increase in 'signs and symptoms' (that is, often 'social') causes of admissions.

There has been significant progress in reducing delayed transfers from hospital from a high of more than 7,000 people in 2001. The number so delayed in March 2005 was 2,570, equivalent to 33 people per 100,000 65 and over (Department of Health, 2006).

The admissions picture is less promising. The PCT Evercare pilots found that only about 35 per cent of people who had two or more emergency hospital admissions in the previous year had any contact with social care (Evercare 2004). Another indicator of the relative paucity of community-based social care (and health care) is the increase in 'social admissions'. The number of 'signs and symptoms' and 'other' diagnoses have been increasing rapidly – see Fig 19 above – and these are potential targets for health and social care (intermediate care) services. In very recent years these issues have been the attention of health policy and a number of actions have been taken in this regard (Department of Health 2005)

CONTINUING CARE

The harshest inconsistency between health and social care comes with NHS 'continuing

care' for people who have a high level of health care needs but who do not need to be in an acute hospital. Unlike social care, continuing care is fully funded by the NHS (including 'hotel' costs), with no means-testing of the user. About 20,000 people in England currently receive continuing care after satisfying eligibility criteria which specify that the patient:

- must need regular (weekly or more frequent) supervision of a consultant, specialist nurse or other NHS multidisciplinary team member
- requires routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff
- has a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.

Debate about eligibility for continuing care has focused on the sharp divide between this fully funded care package and the position of someone of apparently similar disability who might, for instance, be cared for in a nursing home with free Registered Nursing Care Contribution (RNCC) nursing care but liable for all other charges subject to a means-test. At present all people can be assessed as needing RNCC contributions in a care home and this cost (which falls into three bands) is free of charge (see Chapter 6, p 96). A recent inquiry by the House of Commons Health Committee into NHS Continuing Care drew attention to 'considerable confusion and significant overlap' between the RNCC system and continuing care (House of Commons Health Committee 2005). A further issue has been the way the continuing care eligibility criteria are applied locally by individual health authorities, leading to diverse sets of criteria (see Background Paper 2 ('Continuing Care') in the Appendix).

The operation of two parallel systems (of health and social care), and the difficulty of distinguishing between needs at the boundary of these systems, is at its most acute with continuing care. There is evidence that the eligibility criteria are insufficiently responsive to the health needs of older people, individuals with chronic degenerative and progressive conditions (such as motor neurone disease and Parkinson's disease) and people with mental health needs. In the pivotal Pointon case, the Ombudsman upheld Barbara Pointon's complaint that her husband, with dementia, had wrongly been denied continuing care. It was judged that the eligibility criteria had concentrated too heavily on physical health care needs and failed to take adequate account of mental health care and psychological needs. Most recently (January 2006), in the Grogan case the judge rejected Bexley NHS Care Trust's decision not to fully fund care for a disabled 65-year-old woman with multiple needs, saying that the criteria drawn up by the South East London Strategic Health Authority were 'fatally flawed' as they did not reflect the fact that those with a primary health need should be NHS funded.

A new national eligibility framework for continuing care is currently under development, which needs to improve consistency, take full account of physical and psychological needs, and clarify the interface between NHS continuing care and RNCC free nursing care. However, it will not address the fundamental underlying tension which results from the operation of two parallel but largely separate systems for meeting health and social care needs. The shifting boundary only adds to that tension. As the Health Committee observed: 'In practice the boundary between the two services has shifted over time, so that the long term care responsibilities of the NHS have reduced substantially, and people who in the past would have been cared for in NHS long stay wards are now often accommodated in nursing homes. This means that responsibility for funding long term

care has to a major extent been shunted from the NHS to local authorities and individual patients and their families.’ (House of Commons Health Committee 2005, para 41)

The development of closer working between the health and social care systems and the opportunities around pooled budgets offer a positive development. The only way to ensure complete equity in the system would be for the difference between health and social care funding in this respect to be removed, and the Pointon and Grogan cases illustrate the difficulty the government will have in persisting with the present systems.

At the minimum, there would be benefits from bringing the two funding models into closer alignment. This would require greater transparency about financial responsibilities for the costs of care and a re-distribution of those responsibilities between individuals and the state in a way that treats all citizens more equally regardless of the nature of their needs for care.

Chapters 11–13 deal with possible changes in systems for social care funding.

Choice, responsiveness and commissioning

One of the four principles of the Prime Minister’s reform of public services is the introduction of more choice and responsiveness for users of services (see <http://www.cabinetoffice.gov.uk/opsr/>). The government through the Office of Public Sector Reform in the Cabinet Office has developed the case for choice (Minister For State For Department Of Health, Minister of State for Local and Regional Government, and Minister of State for School Standards 2005). The argument is that outcomes will be better for people using services if they have choice or if the system is responsive to their needs.

In the case of social care, new ‘consumer-directed care’ initiatives increase choice for users. As discussed in Chapter 12, many European countries are developing consumer-directed care models involving giving users either a budget, or direct control of a budget held by authorities (Lundsgaard 2005) (see Background Paper 3 (‘Direct Payments’) in the Appendix). In most cases, users have significant freedom in how they use this money. There are several examples that illustrate this approach.

- Direct payments are the main example in England (Attendance Allowance is another model).
- In Germany, the comprehensive long-term care insurance system – which has specific entitled levels of care for people eligible on the basis of need – allows potential users to take this entitlement either as services or as a cash payment (at about half the monetary value of the services option).
- Similarly some eligible older people in Holland can take insurance benefits as a personal budget rather than services.
- In the US, some government programmes give people significant discretion in employing carers.
- In Sweden, some ‘informal’ carers can be eligible to receive wages.

With the developing understanding about preferences, it is clear that older people value the sense of ‘being in control’ that these models bring. Users of consumer-directed care report very high satisfaction (Commission for Social Care Inspection 2004). There have been a number of studies that have found that older people receiving Direct Payments

TABLE 17: NUMBER OF CLIENTS RECEIVING DIRECT PAYMENTS IN ENGLAND

Over the year	Aged 65+	At year end	Aged 65–74	Aged 75+
2003/4	6,000	On 31 March 2004	1,200	2,000
2002/3	2,700	On 31 March 2003	700	800
2001/2	900	On 31 March 2002	300	400
2000/1	500	On 31 March 2001	200	180

Source: Department of Health 2005d

Note: All figures are rounded.

report feeling happier, more motivated and having an improved quality of life than before (Clark *et al* 2004). The high uptake among younger physically disabled adults testifies to the role of the independent living movement in campaigning for Direct Payments. However, uptake among older people has been much more modest. In England, Direct Payments were introduced in 1997 for adults of working age, and in 2000 were extended to those aged 65 and over. Since April 2003, local councils have had a duty to make Direct Payments ‘where individuals consent to and are able to manage them, with or without assistance’. Direct payments can currently be used to pay for personal assistants, or to purchase goods or services – although not from the local authority. The money can pay for care from close relatives and friends who do not live in the same household, and this is a common choice. In exceptional circumstances, Direct Payments can be used to pay a relative who does live with the care recipient, but only if the local council agrees that this is the only satisfactory way of meeting the care needs.

So far the take-up by older people of Direct Payments has been extremely low (see Table 17). At 31 March 2004, only 0.5 per cent of all those aged 65 and over receiving community-based care were in receipt of Direct Payments, compared with 3.3 per cent of those aged 18–64. The barriers to take-up are considered in Background Paper 3 (‘Direct Payments’) in the Appendix.

Even in countries where a high proportion of older people have opted for cash payment options, this tends to occur where the cash payment can be used to pay for informal care, including co-habiting relatives (see Chapter 12). The purchase of formal services with a cash payment tends to remain rather modest.

There are a number of issues. First, although people value being in control, this comes at a price with Direct Payments – specifically that a significant burden of administration falls on the user and their family.

Second, what is the quality of the services people commission themselves? In using Direct Payments, do people trade-off improved ‘control’ against reductions in the quality of the personal care? In Germany, for example, there have been concerns about quality, so much so that informal carers are encouraged to undertake some formal training.

Third, can the use of consumer-directed care be cost saving? When carers had previously been providing some form of informal help, this had shifted them in status from informal to quasi-formal or ‘paid informal’, and can therefore shift some funding from private to state. In the German system, despite the cash benefit being (much) lower in value, as

many as 80 per cent of people chose cash rather than services when the policy was first introduced (Geraedts *et al* 2000). Some of this shortfall was met by greater claims on the social security system, but this does suggest that people might willingly take lower cost services in exchange for greater control. To counteract this advantage, there were undoubtedly people who would not have claimed in the absence of a cash benefit. Another rather less positive aspect is that users of Direct Payments will get a poorer deal from formal provider agencies than local authorities.

Fourth, it is apparent that Direct Payments give people more choice over services and, as a consequence, over the outcomes they personally want to achieve. Many people choose services that meet not only their personal care needs but also practical and quality of life outcomes. For example, a 1997 study in the Netherlands found that 54 per cent of personal budget recipients used their budget to pay for home help, 14 per cent for home nursing or personal care, and 32 per cent for a combination (see Glendinning 1998). In England, the majority of Direct Payments money is, in practice, used to pay for personal assistants, whose willingness to take on a wider range of duties than traditional formal carers fits well with the concerns of older people. However, research is lacking on exactly how Direct Payments money is spent. The greater flexibility is helpful for the people involved, but it does mean that older people with personal care needs can also obtain practical/instrumental care services (for example housework or shopping), while older people with only practical/instrumental care needs would be denied such help unless current eligibility criteria changed for them too.

Choice in social care also occurs where commissioners – whether individual users themselves or local authority staff on their behalf – are able to select from a range of potential providers in a care market. There is good evidence that where there are more providers (more competition), prices are lower, most other things considered (Forder and Netten 2000). What is not clear is whether the lower prices mean quality suffers when there is significant competition. The analysis of the NMS data for care homes suggests that lower prices are associated with lower quality (see Chapter 10).

How well is the social care system currently providing choice? The choice of provider of care home places is high. There are some 15,000 care homes which people can choose; many accept local authority supported placements. In principle, councils work under the *Direction on Choice* which is legislation requiring councils to offer people a choice of home, at least where those homes would accept the council's usual rate. However, the Office of Fair Trading (OFT) report, *Care Homes for Older People in the UK: A market study* (May 2005) underlined how difficult the choice to enter a care home was for people. The report highlighted a paucity of information, advice and price transparency.

The degree to which people can make choices about exactly what care to use ('personalisation' – see Leadbeater 2004) is reflected in the low uptake of Direct Payments. Commissioning by local authorities, which could support user choice where people do not wish to take a Direct Payment or similar, is also generally improving, although procurement and contracting especially offer scope to go further (Commission for Social Care Inspection 2005b).

3 Conclusion

The government has put in place a broad set of targets and standards by which to assess and direct the operation of the social care system. Furthermore, it has two flagship policy strategies: social care and health integration and choice/personalisation of social care. The performance assessment framework looks at a range of information from service inputs, mix and quality; access to the system; its throughput and productivity; who uses services and so on. Taken together they offer a scorecard by which to rate social care performance.

Targets and standards are rarely conceived in any absolute sense; instead they are often about incremental change on past performance. It is not surprising therefore that reasonable improvement has been found, but that scope for further improvement exists. The problem with this approach is about deciding when, if ever, social care has 'done enough'. Substantial sums of public money are involved, but it is difficult to relate how much to spend to process and service targets.

The evidence around integration and choice is supportive if not yet definitive. But there are caveats. Progress in reforming social care according to the two strategies has been initiated by a range of policies and guidance. Delayed transfers of care have fallen significantly as a result of the new process measures and incentives put in place. However, step-up services and admission diversion have not yet shown much success in reducing admission rates among older people. The systems and arrangements required for successful integration according to the evidence are not yet in place, but the policy direction is aligned with their achievement. Case targeting tools, care management, Section 31 flexibilities and the single-assessment process are all being developed but are far from being in routine use. The Partnership for Older People pilots should also cast some important light on how to achieve better integration on the ground. The 2006 White Paper re-emphasised commitment to these strategies. There is an opportunity for cost savings and/or outcome gains in these areas. The Review welcomes the government's agenda to promote further integration. It is promising but there is some way to go. In general, the Review recommends that implementation of this policy agenda continues on the present course, subject to better confirmation of the expected cost-effectiveness of the component parts.

The review also recommends attention to the financial arrangements. The results of the Prevention for Older People pilots will be helpful. But it is recommended that both health and social care organisations be given greater incentives to pool resources and to clarify joint funding streams. At present the mechanisms in place are facilitating and passive, but more active financial encouragement is required such as incentives to pool resources (for example, matching contributions).

The interface between the health and social care funding systems in respect of continuing care is a major problem and is likely to be subject to further challenge by people required to make significant personal contributions to their care. Closer integration of the systems is desirable and probably inevitable.



Annex. Better service mix under integrated programmes

There is direct evidence of the value of integrated approaches. A systematic review (Johri *et al* 2003) found a number of specific programmes that combined health and social care for older people in an integrated and co-ordinated fashion. Programmes were reviewed from the US (Programme for All-Inclusive Care for the Elderly, PACE, and social HMOs, SHMOs), Canada (SIPA), Italy and the UK (the Darlington case management project).

The results were overwhelmingly positive indicating that for the specific projects, acute hospitalisation rates, in particular, were significantly reduced with greater use of preventive community-based care (for example intensive use of day health centres, care at home). Long-term care institutionalisation rates were also reduced and outcomes and satisfaction improved. There was also evidence of overall cost savings in a number of these programmes. Although downward service substitution was a key feature, better co-ordination and case management of services between health and social care drove much of the beneficial results. In one study in Italy, decreases were reported in the use of both institutional (including hospital) and community-based services. In other words, good integrated case management prevented apparently inappropriate/excessive use of all service types.

The evaluations of social HMOs in the US, which attempt to integrate the entire range of health and social care for all enrollees (not just a targeted, high-risk population) are mixed and show that social HMOs are less effective than the above specific programmes (Kodner and Kyriacou 2000).

The *Evercare* programme in the US combines care management (by specialist nurses) with provision of intermediate care. Catering for people in nursing homes, nurse practitioners identify and manage users with an increased risk of hospitalisation. This management involves attempting to avoid hospital admission using a short-term burst of intensive service (intermediate care) within the nursing home (called intensive service days, ISDs). The evaluation of the *Evercare* demonstration programme (Kane *et al* 2002) showed, first, a minor preventive effect, that is, a small improvement of conditions that lead to a need for hospitalisation. Second, there was a large substitution effect: many patients stayed in the nursing home rather than going to hospital. When they did go, they stayed for less time. Average admissions per 100 enrollees were at 50 per cent compared with controls; hospital length of stay (LoS) was at 80 per cent compared with controls, although adding the average ISDs of those 'admitted' brings the total LoS to about the same as the control. ISDs are, however, significantly cheaper and easier to implement. Since outcomes differences were negligible, *Evercare* represents a cost-effective programme.

The *Evercare* pilots in England involved focused intermediate nursing care on people at high risk of admission to hospital. Patients were identified primarily if they had two or more emergency admissions in the previous year. The effectiveness of these interventions is, nonetheless, in some question because at any given time, high-use patients are outliers who tend to naturally fall back towards the mean level of use in following years. A recent study found that although patients 65 and over with two or more admissions were responsible for 38 per cent of admissions in the index year, they were responsible for fewer than 10 per cent of admissions in the following year and just over 3 per cent five years later. In other words, relatively few people would potentially benefit from help targeted in this way (Roland *et al* 2005).

The NHS has begun to address this issue with a risk prediction system which uses various datasets to identify individuals at greatest risk of future admission to hospital, thus enabling NHS resources to be targeted at those most relevant for intervention. This may involve identifying individuals who are not yet at high risk but likely to become so in future.² There is potential to transfer this learning into the social care sphere in order to allocate resources efficiently to those who have not yet deteriorated to a point where emergency admission to hospital has occurred but who are likely, in the near future, to deteriorate further.

The Innovations Forum project on ‘Reducing Hospital Admissions of Older People’, which is being led by Kent County Council along with nine other pilot councils,³ is also showing some promising results relative to its target of a 20 per cent reduction in unscheduled hospital inpatient bed days occupied by people aged 75 and over (by 2007).

In Sweden, in the early 1990s, much of the (community) health and social care system was reorganised so that it was integrated at the local government level. In addition a system of cross-charging was put in place. Sweden subsequently experienced a significant fall in acute hospital bed numbers (from 6/1000 in 1988 to 3.5/1000 in 1998). In geriatric care this reduction was greatest (Pederson 1998).

In 1997 the Australian government implemented a *co-ordinated care* trial to run for two years. This approach has much in common with the PACE program undertaken in the US. The first phase of the program demonstrated that integration was feasible for a range of scenarios. However, whilst being very popular with users, the first phase of the trial (to 1999) did not result in a reduction of intensive service use; if anything hospital utilisation was greater than for the control group. The second phase, which targets much more closely the very frail, appears to be much more successful.

There is evidence relating directly to England. First, the NSF for Older People described how integrated services best prevent falls (Department of Health 2003b). DTI statistics show that one-third of people 65 and over fall each year; a PCT of 250,000 has approximately 250 fractured neck of femur as a result of falls each year, with an average length of stay of 26 days (Todd *et al* 1995). The Healthy Communities Collaborative scheme aims to reduce falls in the elderly through a combination of various practical measures and greater awareness. The first wave started in September 2002 and worked with three PCTs in collaboration with local health, social care, local authorities and charities. After 24 months, the number of falls resulting in an ambulance call-out in the pilot areas had reduced by 37 per cent. A recent survey (Dalley 2005) of PCTs in England found that another PCT with a specialist falls service had reduced by 12 per cent the number of people admitted to hospital after a fall, saving around 1,000 bed days a year.

An integrated approach has also been used successfully in a nurse-led assessment service for vulnerable older people at Kings College Hospital, which was introduced to support the 4-hour trolley wait target by redesigning assessment services to better identify frail and vulnerable older people. A&E emergency care nurses directly refer high-risk patients to medical teams without needing to wait for an A&E doctor (Davies-Gray 2003).

The Castlefields model applied at a GP practice in Runcorn reduced admissions of older people by 15 per cent, average length of stay reduced by 2 days to 4 days and hospital bed days used by the practice reduced by 41 per cent (Hankley and Warlow 1999). The London

Older People's Development Programme also provided more tentative evidence in support of these findings. The Evercare pilots in nine PCTs indicated that a significant proportion – around a third – of admissions and bed days are used by a small proportion of high-intensity users (that is, some 2–3 per cent of patients).

The limited and early research on care trusts and close equivalents is less promising. The combined health and social care trust (a forerunner to the full care trust model) in Somerset that jointly commissioned and provided mental health services failed to produce significant benefits to users over its first two years (Peck *et al* 2002). Users considered that access to services deteriorated and concerns remained that there was no alternative to hospital admission in crises. Users and carers were included as non-voting members of the commissioning board, but users felt less involved in care planning than previously.

A recent examination (Dec 2003) of the eight care trusts currently in operation by the Health Services Management Centre (HSMC) at the University of Birmingham (Peck *et al* 2003) was more positive. The study concluded that the majority of respondents within the eight sites felt that care trust status gave further impetus and identity to health and social care partnerships in a locality, building upon the relationships that led to their creation. It was clear, however, that care trusts were not a panacea; where poor relationships were inherited, care trust status seems to have done little to resolve problems.

Most of the supporting international evidence on integration highlight benefits in terms of utilisation of downstream services (that is, reducing inpatient hospital use, nursing home admissions and lengths of stay), patient outcomes including user satisfaction, and overall costs (Johri *et al* 2003). Benefits were particular evident where schemes featured:

- a single entry point system
- case management
- geriatric 'single' assessment by a multidisciplinary team
- identification and targeting of complex need cases;
- the use of aligned financial incentives to promote downward substitution (which generally involves some form of pooling of budgets).

The benefits were less for universal programmes (for example social HMOs in the US) that did not target specific at-risk clients. Targeting is important because case management is expensive and needs to be justified against service cost savings (which increase with case complexity).

In summary, what does seem clear is that downward substitution requires good co-ordination and integration between service areas (including more generally between health and social care teams). For high-risk people, the most effective packages are those combining health and social care services.

Notes

¹ NHS Health and Social Care Information Centre, Adult Social Services Statistics, RAP 2005

² www.kingsfund.org.uk/health_topics/patients_at_risk/predictive_risk.html.

³ www.idea-knowledge.gov.uk/idk/core/page.do?pageId=77735.

5

How is the current system performing – on outcomes?

SUMMARY

The best way to measure service performance is in terms of the outcomes achieved, but this is difficult to do. This chapter illustrates how a number of tools can make outcome measurement a practical reality, leading to improved targeting of resources.

- The challenge is to capture what are often very complex sets of preference and decision criteria that are being used, sometimes unconsciously, by people when they judge the outcomes of social care.
- A generic outcome measure provides a yardstick that can be used alongside measurement of the costs of services to assess efficiency, value-for-money, or cost-effective levels of services. This is the approach adopted in Part 2 of the Review.
- To achieve greater outcome gains, services would have to be used more intensively and extensively. For example, from the average of around 6 or 7 hours per week of home care, additional hours would increase the probability of people experiencing increased independence.

Assessing some form of ideal level of social care provision in the future requires further elements to be added to the equation. In particular, it is important to establish what it costs to produce further outcome gains, which outcomes are most important to people and how much individuals and indeed society as a whole are willing to pay for these outcomes.

1 Introduction

Outcome information is distinguished from process information primarily because it concerns the first-hand experience of service users or in some cases their proxies. The challenge is to capture the often very complex sets of preference and decision criteria people are using, sometimes unconsciously. With the practical and ethical requirements of interviewing a sufficiently high number of people, this means that outcome studies are rare. Nonetheless, when done well, outcomes studies clearly provide the best information. This Review has drawn heavily on the research of Professor Ann Netten and colleagues at the PSSRU, University of Kent, who have pioneered quantitative, preference-based outcome measurement in social care for older people in this country. This body of research includes the Older People's Utility Scale (OPUS) project which develops and values social outcomes found to be important to older people; the Formula Spending Share (FSS), now re-named the Relative Needs Formula, project that measures the impact of services on these outcomes;¹ and the home care user experience extension project that extend this work. The ECCEP project (see Annex 2 of the Introduction) also measured the impact of services on outcomes (see Davis *et al* 2000).

2 Older People's Utility Scale (OPUS)

The OPUS project (Netten *et al* 2002) was designed to elicit and value a number of underlying domains. The approach involves determining those domains of outcome of social care services that people potentially value. Social care is concerned with managing or reducing the effect of impairment on people's daily lives. Relevant domains of outcome therefore relate to important aspects of how people live. Based on the original OPUS project, the work on outcomes was extended as part of the Atkinson review of development of government output measurement, including social care (Netten *et al* 2005a, 2006). The following domains were found to be important to the people surveyed:

- A. personal care/comfort
- B. meals and nutrition
- C. safety
- D. social participation and involvement
- E. control over daily life
- F. accommodation (cleanliness, order and accessibility)
- G. employment and occupation
- H. role support (as a carer or parent)
- I. being in their own home.

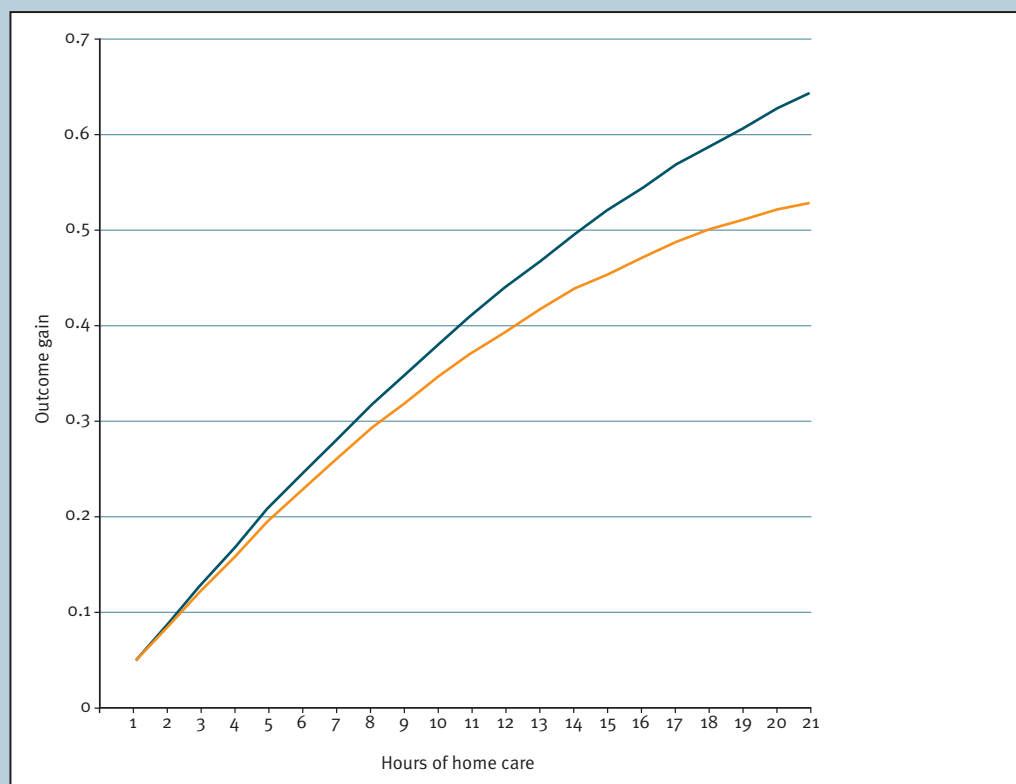
The project was also able to elicit how important people thought it was for their needs in each of these domains to be met. In particular, the study derived a numerical 'utility score' for each domain (for details see Annex, p 85). Personal care needs (washing, dressing, getting up and going to bed, going to the toilet etc) were most important, closely followed by social participation. These two were a third more important to people as control over daily lives and more than twice as important as the other domains. This information is very useful for understanding which services have the potential most to improve people's outcomes.

IMPROVEMENTS IN OUTCOMES FROM DIFFERENT SERVICES

The FSS/Relative Needs survey collected information on what people reported to be their outcomes while using services and also their reports of what their outcomes would be without those services. Community-based services, and in particular home care services appeared to improve people's outcomes. Figure 20 opposite shows the relationship between the hours of home care people use and the increase they reported in their outcomes. These outcomes are measured on a zero to one scale. A person with the worse possible outcomes is described by a score of zero. Someone who has their outcomes fully achieved has a score of one. People with partially met need have scores between zero and one.

In the figure, outcome gain is the difference between the score before and after services. The lower line is the relationship between hours and (weighted) outcomes in domains A–G above (that is without carer outcomes and the effect of being in one's own home). The higher line is outcomes A–C above – these are perhaps most relevant to what the current social care system tries to achieve. This chart does not differentiate between people of different levels of dependency; people with higher dependency would be expected to gain more (see Chapter 10 for a further analysis of this issue). Other services, including day care and therapy services, also had positive effects on outcomes.

20 OUTCOME GAINS FROM HOME CARE SERVICES



Source: Review model estimates using Formula Spending Share data

KEY

- All care outcomes
- Personal care, nutrition and safety

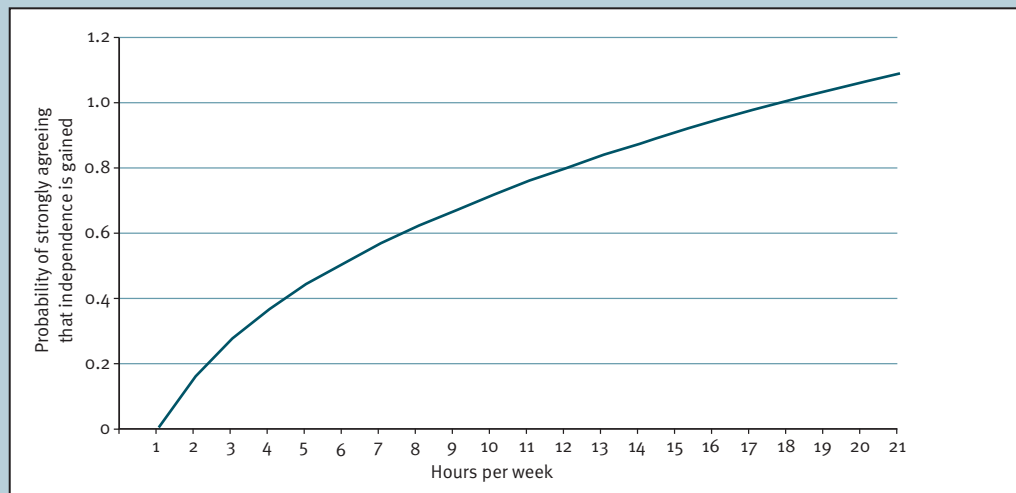
3 User satisfaction

Since 2001 all councils (with social care responsibility) have been required to carry out user satisfaction surveys. In 2002/3 a full survey was conducted for older users of home care. All councils were required to ask four compulsory questions of users of this service. This user experience survey was also extended for a sample of councils to ask a number of more detailed questions about service use and quality. Nationally, 57 per cent were 'very' or 'extremely' satisfied with the help from social services that they received in their own home.

The vast majority felt that they received sufficient visits from services although almost a third felt that at least on occasions less time was spent with them than they were entitled to. Furthermore, over half of the respondents reported that, at least sometimes, care workers were in a rush (Netten *et al* 2004).

The number of hours of care that a person received was positively related to the chance that they strongly agreed that social services had improved their independence. In the survey 32 per cent of people in the sample 'strongly agreed' that services had increased independence. The average care package in the sample was just under 6 hours per week, but varied between less than one hour to all 168 hours. Gaining independence, or loss of dependency, can be considered synonymous with increased outcomes as cast in OPUS terms. A person 'strongly agreeing' that their independence has been increased is likely to

21 THE RELATIONSHIP BETWEEN THE NUMBER OF HOURS OF CARE RECEIVED PER WEEK AND THE PROBABILITY THAT RECIPIENTS STRONGLY AGREED THAT SERVICES HAD IMPROVED THEIR INDEPENDENCE



Source: Review model estimates using User Experience Survey data

have experienced significant outcome gain. The relationship between gained independence and service input is complicated by the different capacities of people to benefit from services, for example, depending on what health problems they are suffering. Compensating for these other influences, Figure 21 above shows an (estimated) relationship between inputs and the chance that people strongly agree that they would gain independence from services.

Whilst this data source has less specific information about outcome gain, it does have the benefit of being based on a very large, robust survey (over 13,000 respondents). The results look highly compatible with the OPUS results.

4 Conclusions

Since services are used to improve people's outcomes, the best way to measure service performance is in outcome terms. At present, the majority of social care commissioning is based on service inputs (so many places, hours of home care etc). There is a relationship between inputs and outcomes, but it is complicated and depends on what conditions the service user is suffering, their family and housing circumstances, the location and quality of care and so on. Commissioning on the basis of outcomes, not inputs, is likely to improve the targeting of resources.

Outcomes are difficult to measure (which is why commissioning is often on inputs). But this chapter shows that yardsticks are becoming available and with some further development could make outcome measurement a practical reality. Understanding and being able to measure 'well-being' outcomes is challenging however.

For the purposes of determining resource and funding requirements for social care, outcome measurement is extremely useful. A generic outcome measure can be used to compare a range of different services. It is a yardstick that can be used alongside measurement of the costs of services to assess efficiency, value-for-money, or cost-

effective levels of services. This is an approach used in Part 2 of this report (see Chapter 10 in particular).

This and previous chapters have reported evidence that social care is making a significant difference to people’s lives and has begun to determine how much service input produces required outcomes. The information and evidence base does need further work. But already the work is promising and justifies further rigorous development.

The current levels of services, and the processes being used in social care, are generating some good outcomes but there appears to be significant opportunity to further improve outcomes. To achieve greater outcome gain, services would have to be used more intensively and extensively. For example, from the average of around 6 or 7 hours per week of home care, additional hours would increase outcomes and the probability of people experiencing increased independence. There is also likely to be scope to improve productivity through a different service mix, new service model and new technology. These possibilities are considered in Chapters 9 and 10. Although additional outcome improvement might be possible, this information alone is not sufficient for making assessments about how much extra funding, if any, should be provided. Assessing some form of ideal level in the future requires consideration, in particular, of what it costs to produce further outcome gain, what outcomes are most important to people and how much individuals and indeed society in some broader sense is willing to pay for these outcomes. In Part 2 of this Review the various strands of information are brought together to make such an assessment.

It is recommended that resources are devoted to a programme of research designed to assess:

- the continuing development of generic outcome measurement that can support both comparison across a wide range of services and practical application as a set of outcome measurement tools
- development of the evidence base about how, and by how much, services of different types improve outcomes for different service users.



Annex. The Older People’s Utility Scale (OPUS)

The OPUS and outcomes work determined and then valued the underlying outcome domains important to people. This valuation recognises that not all domains of outcome are equally important to people. When weighing them up, people will value some higher than others. To reflect this, the OPUS work determined a numerical valuation for each domain, indicating their relative importance.

Table 18 overleaf gives the domains covered and the associated scores. On a score of 0 to 1, with 1 being the score if a person has no need in any domains and 0 if the person has high need in all domains, the table shows the scores if a person’s needs in the particular domain are fully or partially met.

TABLE 18: THE DOMAINS AND SCORES OF THE OLDER PEOPLE'S UTILITY SCALE

Domain	All needs met	Low needs	High need
1. Personal care/comfort	0.22	0.10	0
2. Social participation and involvement	0.19	0.12	0
3. Control over daily life	0.12	0.11	0
4. Meals and nutrition	0.09	0.07	0
5. Safety	0.06	0.03	0
6. Accommodation	0.06	0.03	0
7. Employment and occupation	0.06	0.03	0
8. Role support (as a carer or parent)	0.10	0.05	0
9. Home	0.10	0.00	0
Total	1.00	0.53	0

Source: Based on data from Netten *et al* 2002

Notes

¹ The Review is indebted to Professor Netten and her team for access to the Formula Spending Share data.

6

Who pays what?

SUMMARY

Estimating the total expenditure on social care for older people is complicated by the multitude of funding sources. These include NHS funds, local authority expenditure, private payment by individual users and their families, and a number of one-off grants. This chapter looks at the main funding streams and the means-testing system which determines the charges imposed on users.

- In 2004/5, Department of Health figures for gross spending, excluding capital charges, in England on personal social services for older people reached £8.0 billion (44 per cent of total spending on personal social services). Charges to users then recouped £1.6 billion.
- The PSSRU model estimates that in 2003 the total NHS contribution to long-term care of the elderly amounted to £3.0 billion.
- Over the past decade, expenditure on residential and nursing home placements has risen at a faster rate than that on home care, and now accounts for almost half of total net expenditure by local authorities.
- Attendance Allowance (and Disability Living Allowance (DLA) for those who continue to receive this benefit after the age of 65) represents the main source of non-means-tested funding for older people with disabilities. In 2004/5, these benefits paid out £3.7 billion (not including DLA mobility payments). There is a paucity of information about how this money is spent.
- There is no reliable data for the total private expenditure on care home fees and self-funded domiciliary care, but the sums spent are substantial. Estimates put the proportion of care home places that are wholly privately funded at between one-quarter and one-third.
- The rules for charging user fees for care home places are implemented on a national basis, with state funding unavailable to older people with assessable assets above £20,500 (2005/6). In contrast, the charging regimes for domiciliary care are designed by local authorities under national guidelines. This has produced large, and seemingly inequitable, differences in the level of charges imposed in different areas for similar care packages.
- Survey data for people aged 50 and over demonstrates that disability is strongly correlated with lower income and assets, so that those who are most likely to need long-term care are also least likely to be able to pay for it.

There are repeated data deficiencies surrounding the question of total expenditure on older people's social care, both in terms of public and private spending. Any judgement about desirable funding levels and the appropriate public/private responsibility for paying for care is hampered by this lack of comprehensive information.

1 Introduction

Social care for older people relies on a number of income streams. One estimate for 2000 suggested that 38 per cent of expenditure was funded by local authority social services departments, 27 per cent by the NHS and 35 per cent by individual service users or their families (Comas-Herrera *et al* 2004). The private funding was split fairly evenly between paying user charges that are imposed by local authorities after means-testing, and private expenditure arranged directly by the user. Looking at the situation from the point of view of the individual needing care shows how complex it is. This chapter includes a number of vignettes which illustrate how the required contribution from an older person varies very significantly depending on their financial situation and where they live (see Annex, p 115).

2 State expenditure on long-term care

Central and local government

Boundaries have shifted over time in the state sector, with responsibilities which were previously within the NHS now transferred to social services, and Supporting People's housing-related support services providing some lower-level help that was formerly funded by social services (Spain 2005). Most central government funding for older people is not ring-fenced, and older people's services are often perceived to lose out to children's and younger adults' services when competition is fierce for state money. Overspending also tends to be more prevalent in children's services, with cuts then falling on older people's services.¹

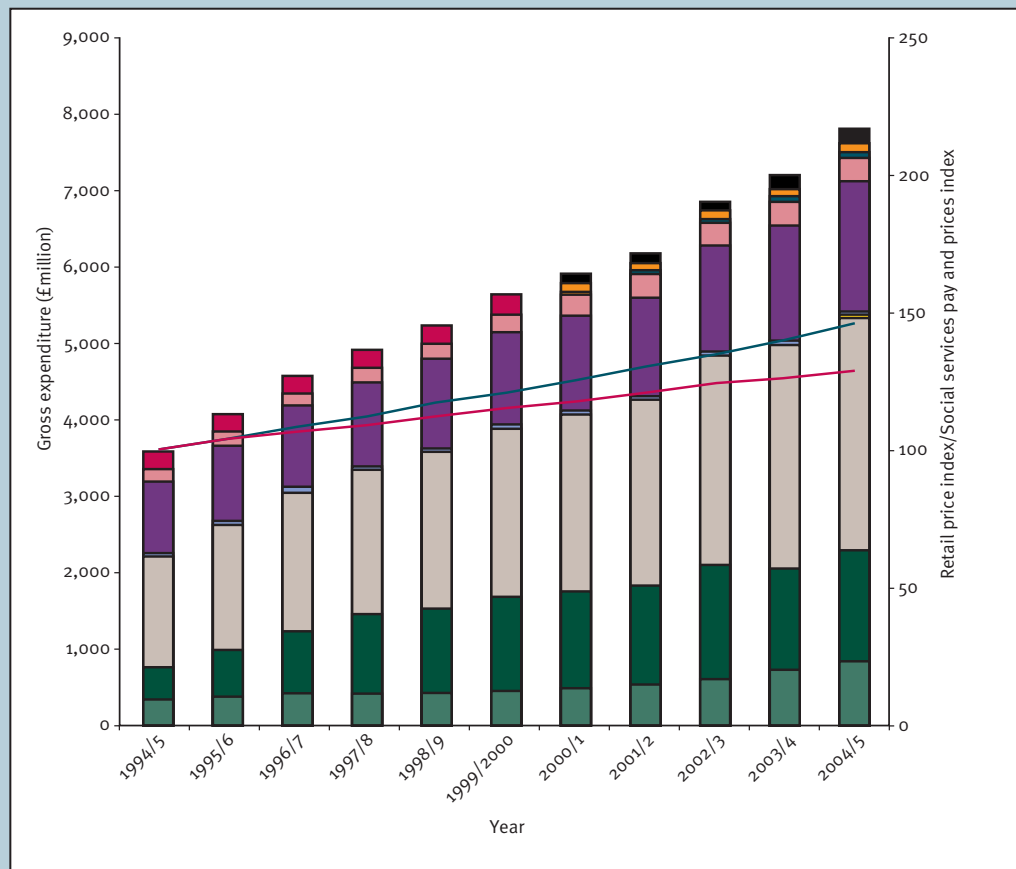
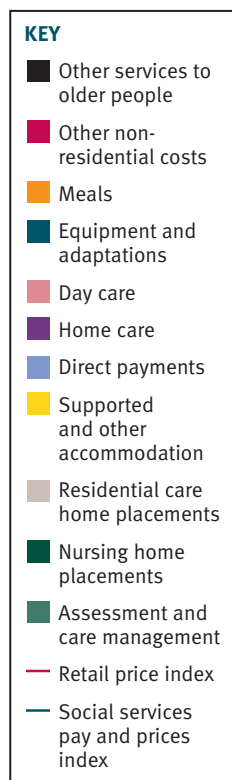
Other pressures on budgets for older people's services include (Williams 2005):

- the rising costs of domiciliary and nursing care
- difficulties in recruiting staff at low wages
- faster discharge from hospital into the community shifting more costs onto social services without a commensurate shift in funding
- increased pressures on budgets for equipment and adaptations as more older people remain longer in their own homes
- reduction in Supporting People expenditure
- growth in numbers of older people with learning disabilities
- more older people supported at home with intensive care packages moving responsibility from health towards social care.

In 2004/5, Department of Health figures for the gross spending, excluding capital charges, in England on personal social services for older people reached £7.97 billion (44 per cent of gross spending on personal social services). (This figure includes both Department of Health and local authority spending). There was an annual increase of 8 per cent, compared with an 11 per cent increase for children's and families' service. £1.59 billion of the £7.97 billion was recouped by local councils in charges levied on older people under the means-testing regime. The net total expenditure on older people (£6.39 billion) was 39 per cent of total net personal social services expenditure.

Figure 22 opposite demonstrates the rising gross expenditure on social services for people aged 65 and over. The data is not inflation-adjusted, but can be seen to have risen faster than the retail price index and social services pay and prices index (right-hand scale). Expenditure on residential and nursing home placements has steadily increased, as has

22 GROSS EXPENDITURE ON SOCIAL SERVICES FOR OLDER PEOPLE IN ENGLAND, 1994/5 TO 2004/5



Source: Based on data from the Department of Health

that on home care but at a slower rate. Between 1994/5 and 2004/5 the proportion of gross expenditure spent on home care fell from 27 per cent to 22 per cent.

Table 19 overleaf gives a detailed breakdown of social care spending on elderly people in England (2004/5). Residential and nursing home placements together account for half of the total net expenditure.

One of the main drivers of increased expenditure has been the rise in residential and nursing home unit costs for older people across the country (see Fig 23 overleaf). Despite these rises, one study by Darton *et al* (2003) found that price changes between 1986 and 1996 had been kept below those expected from increases in costs. Such cost rises resulted from both higher levels of dependency among care home residents and raised standards of provision. Figure 24 (see p 91) shows how the unit costs for home care (for adults and older people) have also increased significantly. The average gross hourly cost for England rose by more than one-third between 1997/98 and 2004/5, to more than £13 per hour. One significant factor has been the introduction of the minimum wage in April 1999, and the subsequent above-inflation pay increases, which home care providers say has led to a sharp rise in their costs (see Chapter 7).

TABLE 19: BREAKDOWN OF EXPENDITURE ON SOCIAL SERVICES FOR OLDER PEOPLE IN ENGLAND, 2004/5

Services provided	Gross expenditure (net expenditure after charges) ¹ (£million)	Percentage of total net expenditure
Residential care home placements	3,040 (2,150)	33.7
Nursing home placements	1,420 (990)	15.5
Other residential provision	30 (20)	<1
Home care	1,700 (1,510)	23.6
Assessment and care management	860 (860)	13.5
Day care	320 (300)	4.7
Other services to older people	240 (230)	3.6
Equipment and adaptations	90 (80)	1.3
Meals	100 (50)	<1
Supporting people	180 (170)	2.7
Total	7,970 (6,390)²	

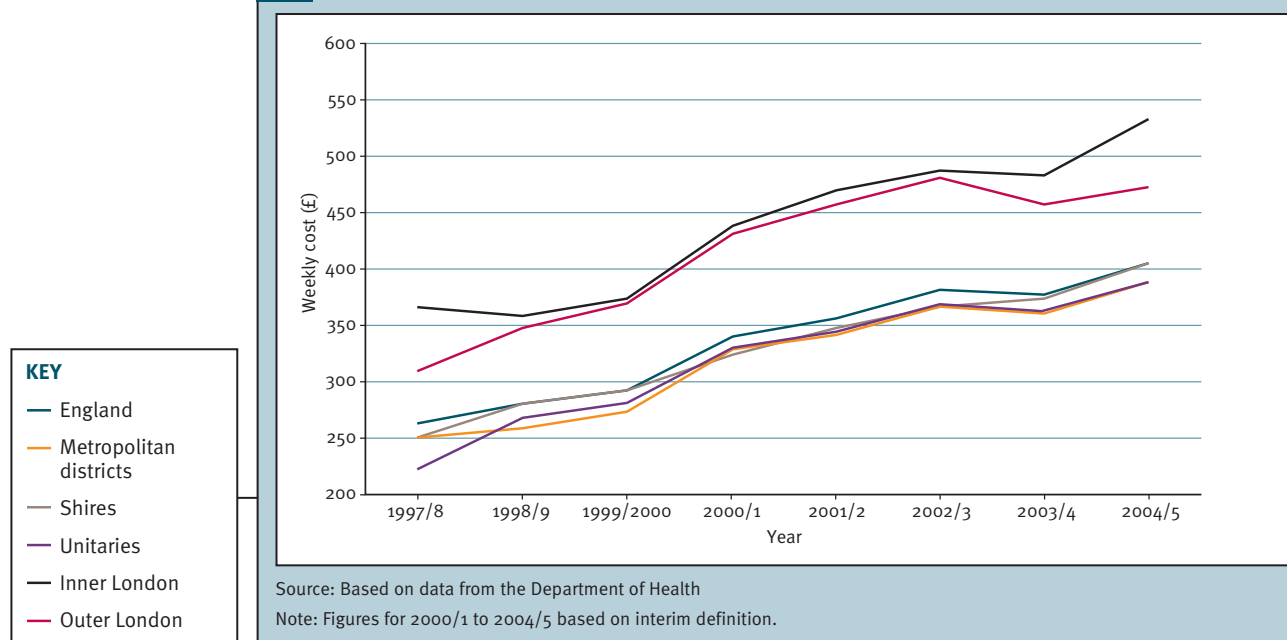
Source: Based on Department of Health figures 2006

¹ Department of Health figures.

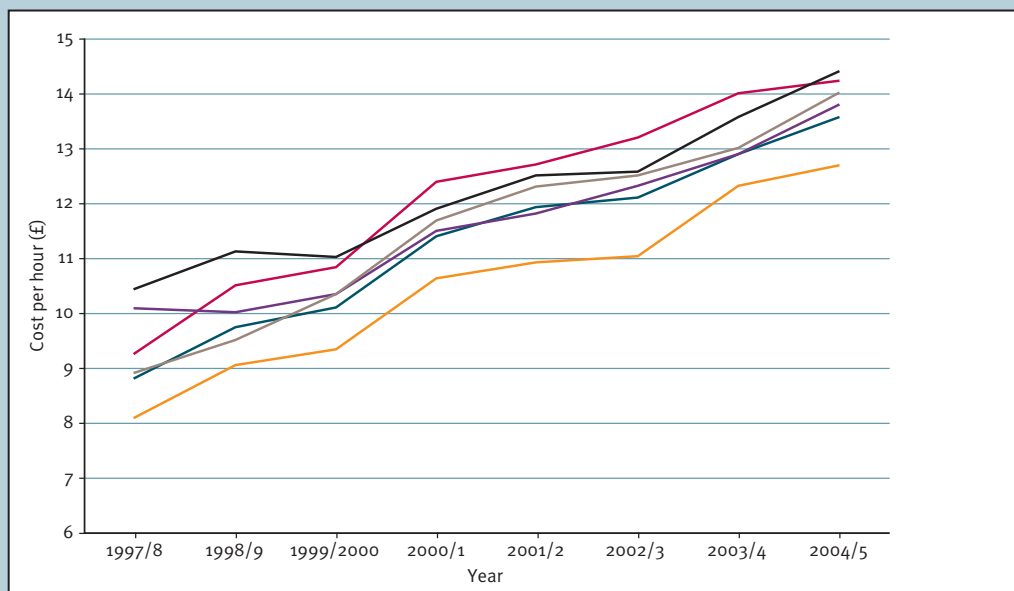
² Due to rounding there may be discrepancies with totals.

Department of Health funding to local authorities to cover the cost of older people's services is based on the Formula Spending Share (FSS), which endeavours to compensate for differences in needs (for example because of the age structure of the local population) and variations in input prices (especially labour costs). An analysis of the data suggests the mechanism is reasonably fair. The per capita (aged 65+) allocated elderly social care

23 UNIT COST OF RESIDENTIAL AND NURSING CARE FOR OLDER PEOPLE IN ENGLAND, 1997/8 TO 2004/5



24 UNIT COST OF HOME CARE FOR ADULTS AND OLDER PEOPLE IN ENGLAND, 1997/8 TO 2004/5



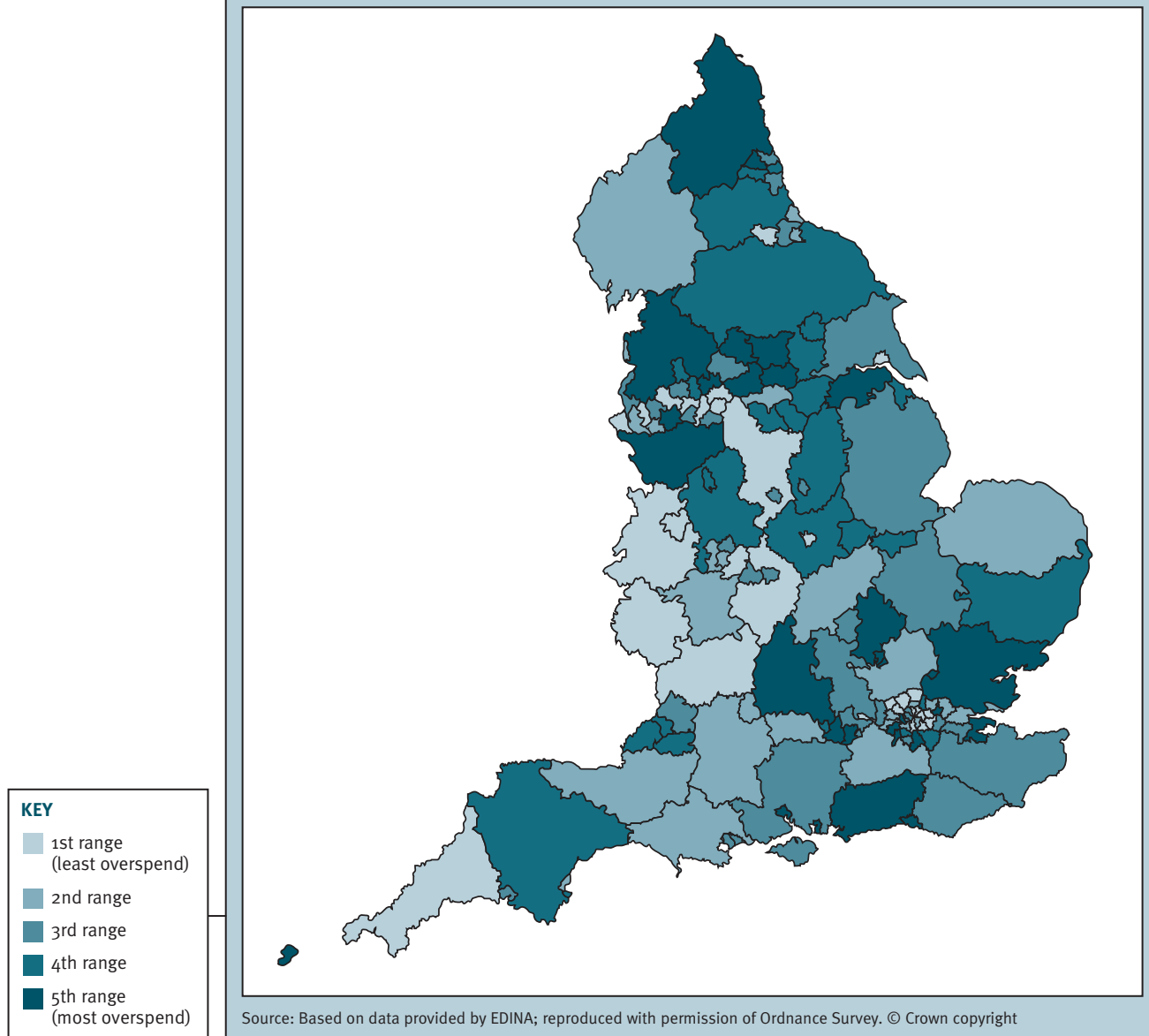
Source: Based on PAF Indicators data from the Department of Health
 Note: Figures for 2000/1 to 2002/3 based on new definition.

budget was compared with the actual per capita net spending for each local authority. This demonstrated that areas receiving bigger allocations generally spent more, but that in some places this correlation was broken. Such disparities are shown in Figure 25 overleaf which maps the distribution of the difference between per capita expenditure and budget allocation by local authorities. The darker the colour in the map is, the greater the degree of overspending by a local authority.

The map raises the question of whether the allocation–expenditure gap is significantly large. Figure 26 (see p 93) demonstrates that in only a very few places is the difference greater than would be expected by underlying randomness alone.

Attendance Allowance

Attendance Allowance, and Disability Living Allowance for those in receipt before the age of 65 who continue to qualify, are the main universal state benefits for older people with dependency. Attendance Allowance is paid at two rates, depending on whether the older person needs assistance during the day and/or night, and is not means-tested. In total, these two benefits account for a large slice of state spending. In 2004/5, £3 billion was paid in Attendance Allowance in England and a further £0.7 billion in Disability Living Allowance care component (this does not include £900,000 in Disability Living Allowance mobility component) to those aged 65 and over,² a total of £3.7 billion in non-means-tested funding. Attendance Allowance eligibility arises from new disabilities which start after the age of 65. In February 2005, 1.14m people were receiving Attendance Allowance in England. As a point of comparison, the government usually cites a figure of £1.5 billion as the current cost of introducing free personal care. Chapter 13 provides more analysis of funding options.



Eligibility for Attendance Allowance is governed by the need for help or supervision, but the claimant does not actually have to be in receipt of such support. It is a compensation for disability rather than a payment to cover the costs of services.

Figures 27 and 28 (see p 95) show respectively the uptake of Attendance Allowance by income group and by dependency as measured by ADL count, of people living the community. Apart from the very low-income group, uptake declines steadily with income. The very low-income group often includes people that cede financial responsibilities to others (three-quarters of this group are female). Uptake shows the expected increasing relationship with dependency.



Anecdotally, Attendance Allowance appears to provide a base level of state support for those who need social care, but are above the means-testing threshold. In this sense, Attendance Allowance offers even more flexibility than a direct payment, and without the means-testing. Often those who receive it rely on informal care, but some of the benefit money may be used by such individuals to pay for care, either formally or in the 'grey' market. Attendance Allowance also subsidises private funding of care home places, because self-funders in residential care continue to receive the allowance, unlike anyone receiving state support.

A recent survey of care homes found that 22 per cent of people were claiming Attendance Allowance/Disability Living Allowance (Darton *et al* 2006). It has the additional attraction of not being taxable.

ATTENDANCE ALLOWANCE ELIGIBILITY*

The benefit is for people aged 65 and over. To be eligible, a claimant must normally have needed help for six months before the allowance is paid. This benefit is not means-tested.

There are two rates of allowance. To qualify for the higher rate (2005/6 £60.60 a week), the claimant must fulfill the criteria for help both during the day **and** the night. To qualify for the lower rate (2005/6 £40.55 a week), help must be needed during either the day **or** the night.

There are two ways of qualifying for needing help during the day, based on the need for:

- frequent attention during the day in connection with bodily functions. This is interpreted to cover activities such as eating, toilet use, washing and dressing, communicating with other people and walking. The allowance is not paid if the only help that is needed is with domestic chores, or
- supervision during the day to avoid substantial danger to oneself or others.

There are two ways of qualifying for needing help during the night, based on the need for:

- repeated attention in connection with bodily functions, or
- another person to be awake for the purpose of supervision to avoid substantial danger to oneself or others.

* <http://www.disabilityalliance.org>

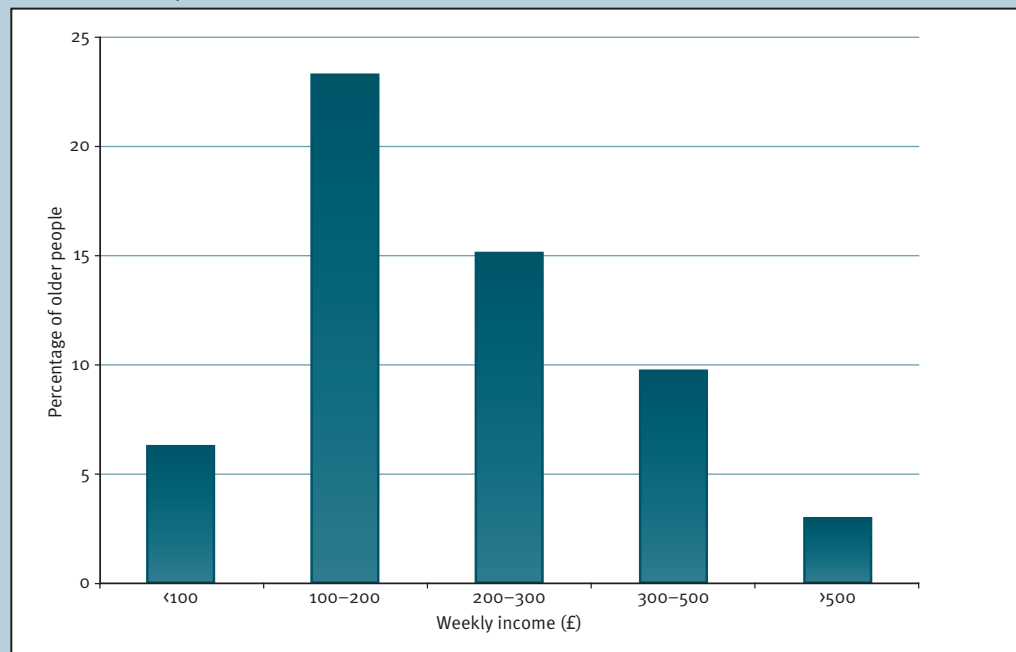
Table 20 below shows the percentage of older people in The English Longitudinal Study of Ageing (ELSA) dataset claiming Attendance Allowance who were using social care of various types. Only a minority (27 per cent) of claimants used either state funded or privately funded formal social care. Some 29 per cent were receiving neither informal nor formal care. This is consistent with the eligibility requirements for Attendance Allowance which, as mentioned, specify the need for care but not its receipt. Eligibility for Attendance Allowance is also less stringent than for local authority funded care. The figure suggests that there is a very significant number of people who qualify for Attendance Allowance while surviving without any care. Analysis of data from the FSS

TABLE 20: PERCENTAGE OF ATTENDANCE ALLOWANCE CLAIMANTS USING CARE

Care type	Percentage of Attendance Allowance claimants
Formal social care only	9
Formal social care and informal care	18
Informal care only	44
Neither informal nor formal care	29
Any	100

Source: Review analysis of ELSA 2002 data (Banks *et al* 2004)

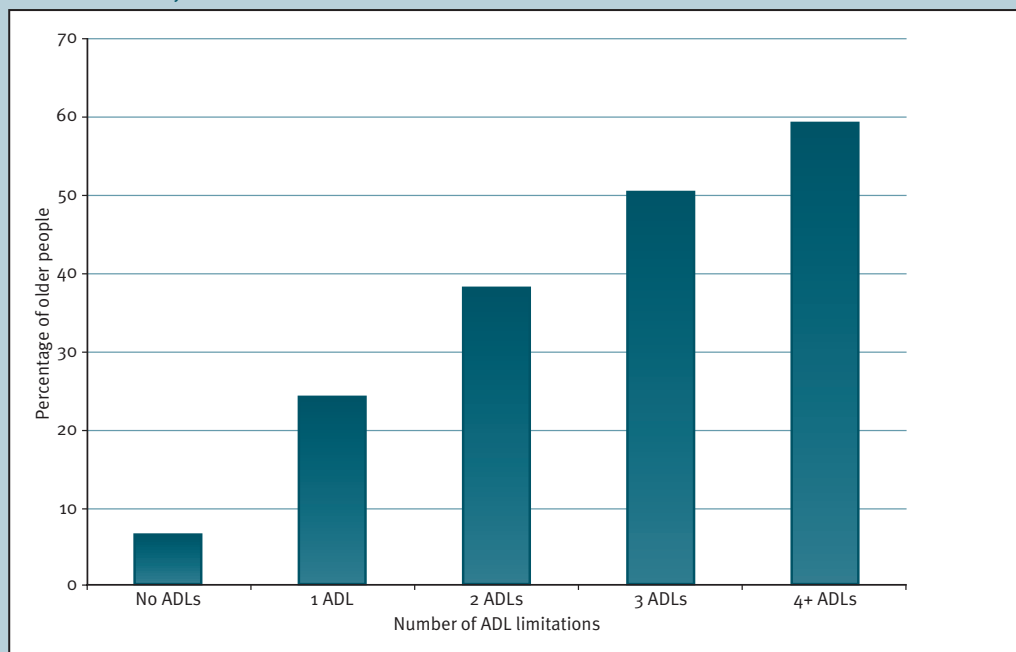
27 PERCENTAGE OF OLDER PEOPLE LIVING IN THE COMMUNITY WHO ARE TAKING UP ATTENDANCE ALLOWANCE, BY INCOME GROUP



Source: Based on ELSA 2002 data from Banks *et al* 2004

Note: Attendance Allowance claimants weighted to England total.

28 PERCENTAGE OF OLDER PEOPLE LIVING IN THE COMMUNITY WHO ARE TAKING UP ATTENDANCE ALLOWANCE, BY NUMBER OF ADL LIMITATIONS



Source: Based on ELSA 2002 data from Banks *et al* 2004

Note: Attendance Allowance claimants weighted to England total.

survey suggested that between 70–80 per cent of community-based service users claim Attendance Allowance.

NHS expenditure

The PSSRU model estimates that in 2003 the total NHS contribution to long-term care of the elderly amounted to £3.005 billion (see Research Paper 1, in the Appendix). This included a range of non-acute services, of which there are two particular areas of interest, because they relate to the boundary between health and social care: Registered Nursing Care Contribution (RNCC) free nursing and Continuing Care (it also includes day centre placements and chiropody services).

NURSING

Following the Royal Commission, the government extended the provision of free nursing care to people in care homes. This covers the care provided, planned and supervised by a registered RNCC nurse, but does not pay for tasks which are undertaken by a care assistant. A banded system operates. Following an assessment of needs, people in care homes are allocated to a low, medium or high band (from 1 April 2005 £40, £80 and £129 respectively per week). When free RNCC was introduced in October 2001 there were 42,000 self-funders who had been paying for nursing, and in April 2003 a further 90,000 residents of nursing homes were also assessed (Department of Health 2005i). A survey conducted in 2003 found some 20 per cent were in the low band, 60 per cent in the medium band and 20 per cent in the high band (figures provided by the Department of Health). If one assumes there are around 130,000 recipients of all ages of NHS-funded free nursing care in nursing homes in England, and that the great majority are likely to be aged 65 and over, then NHS expenditure on free nursing care in nursing homes is around £550 million at the 2005/6 bands. No exact data is available.

There is no Department of Health data on the numbers of older people receiving community nursing services in their own homes. The PSSRU long-term care finance team use an estimate of 425,000 older recipients in England. This is based on an analysis of the 2001/2 General Household Survey, and it excludes people receiving NHS community nursing services in care homes. The annual cost is likely to be around £450 million at 2002/3 prices (figures provided by the Department of Health).

CONTINUING CARE

NHS continuing care is a term which refers to care that is fully funded (that is, to which the service user or patient makes no financial contribution). It is for people who do not need to be cared for in an acute hospital, but who have a high level of health care needs (see Chapter 4 and Background Paper 2 ('Continuing care') in the Appendix). The boundary between free continuing care and means-tested social care is one of the most controversial aspects of social care for older people, because of the potentially dramatic impact of charging. It is difficult to qualify for continuing care; the government has said that the NHS is funding 20,000 continuing care places in England (Department of Health 2005i). There is no Department of Health data on NHS expenditure on continuing care in nursing homes. The PSSRU long-term care finance team uses an estimate of £535 per week at 2002/3 prices for NHS fully funded nursing home care. This is based in part on a finding from the PSSRU 1996 survey of care homes for older people. Based on this weekly cost, the estimated annual cost would be around £550 million at 2002/3 prices. There are no estimates for people receiving continuing care outside nursing homes.

3 Privately purchased social care

There are several ways in which people can contribute their savings and income towards social care:

- a care home place privately arranged with little or no contact with the local authority and then fully self-funded
- a care home place arranged through a local authority and then fully or partly self-funded from savings and income after a means-test
- a care home place state-funded, with relatives paying ‘top up’ fees
- domiciliary care arranged by the local authority and which, after a means-test, is partly or fully funded by a user’s savings or income
- private funds spent on domiciliary care privately arranged, either through an agency or directly with a care worker.

In contrast with state-funded care, the data available on self-funded care is very incomplete. Much of the information available on self-payers also covers all adults rather than just those over 65. Any estimate of the total private expenditure on social care is therefore, at best, only an indication.

Self-funded care home places

It is estimated (Laing & Buisson 2005a) that since 1988 the number of self-funded places in private and voluntary care homes for older and physically disabled adults (including those under 65) has varied between 100,000 and 125,000 for the whole of the UK, with the number level at around 120,000 for the past two years. This represents 25 per cent of all care home places (public, private and voluntary) and 32 per cent if only the independent sector (private and voluntary) care homes are considered. In a crude estimate, given that the UK/England ratio for care home places is 1.19/1, scaling down would give an approximation of 100,000 self-funded places in England. In 2001, the last year the Department of Health collected information on the total number of registered care home places, there were 348,000 places in then residential and nursing homes, including 40,000 places in local authority run homes. In that year some 205,000 places were local authority supported, leaving 143,000 private places. Since 2001, the number of care home places has fallen. Using an average weekly figure of £370 for residential care (not including any free nursing element), and assuming 100,000 self-funded places, would produce a figure of around £1.9 billion a year, of which one could assume the majority is for older people.

Laing & Buisson does not include people whose placements have been arranged through the local authority but who do not receive any state funding. It also does not include people who are making a contribution after means-testing. In 2003/4, these categories of people appeared to have paid charges totaling £1.38 billion (based on figures in Department of Health 2005h).

Also, there are the increasing numbers of people whose care home fees are partly met by third parties ‘topping’ up what the local authority is willing to pay. The Office of Fair Trading’s report into care homes for older people in the UK (OFT 2005) found that 44 per cent of residents received support only from the local authority, 24 per cent received local authority funding that was then ‘topped up’ by third parties, and 32 per cent were self-funding. This means that one-third of people receiving any local-authority funding also rely on top-ups from third parties, strengthening the argument that the amount that local

authorities are willing to pay is often not adequate to buy a level of care that the resident is happy with. There does not appear to be any evidence available about the total amount paid in these top-up fees.

There is clearly a discrepancy between the OFT’s figure of 32 per cent of all older people in care homes being self-funded, and Laing & Buisson’s 25 per cent figure (which also includes those under 65). However, a possible rough estimate for the amount of private funding of care home places can be reached from the £1.9 billion and £1.38 billion, which would total £3.28 billion (for £2003/4), in addition to which would be the total value of the top-up fees paid by third parties that are not arranged through the local authority.

Self-payers in care homes are sometimes charged more than local authority funded residents for the same level of accommodation and service, thus subsidising state-funded occupants. Care home managers argue that this is necessary because the fees they receive from local authorities are inadequate. The evidence is not clear-cut. A 2001 DWP commissioned survey of 500 care homes concluded ‘by the time of the study, self-funders appeared to be more likely to be charged the same as publicly funded residents’ (Netten *et al* 2001). But the more recent OFT research found that around one in five homes were charging self-funders more than authority-funded residents for a similar package (OFT 2005).

A recent case brought to Age Concern involved someone who had been temporarily covered by a local authority contract while her house was sold. The contract price for the local authority was £356 a week, and the user repaid this amount in full. But when the house was sold and the user became a self-funder with her own contract, the price went up to £520 a week. (In both cases, the fee excludes the nursing care band.) A similar picture was provided by one industry source who gave this Review three examples from care homes where there were approximately 50 per cent private-pay residents (see Table 21).

Self-funded formal domiciliary care

There is relatively little information about the market for privately purchased home care either in terms of hours bought or amount spent. The data available usually assesses all home care, not just that for the over 65s. It also tends only to include self-funded care provided by local authorities and independent agencies, and not payments to care workers directly employed by the older person. ‘Self-funded’ in these studies almost always refers only to care which is wholly privately funded; it does not include local-authority funded home care for which the means-tested recipient pays a part-contribution through charges.

TABLE 21: CARE HOME FEES FOR LOCAL AUTHORITY FUNDED RESIDENTS AND SELF-FUNDED RESIDENTS

Care home fees (per week)	Somerset	Surrey	East Sussex
Local authority base fee	£464	£566	£436
Private fee	£597	£785	£597
Difference	£133	£219	£161

Source: Industry source

Regarding the latter, Department of Health figures (Department of Health 2005h) indicate that around £160 million was contributed by older people in such charges and fees for domiciliary care in 2003/4.

According to Laing & Buisson's Domiciliary Care report (Laing and Buisson 2005b), there is uncertainty whether the volume of home care purchased privately is growing or declining, although some of those surveyed did report demand is increasing. The report estimates the number of hourly charged, overnight and live-in home care hours that were privately funded to have been approximately 854,000 hours a week in 2004 in England, of which local authorities provided only 10,000 hours a week. It estimated the total annual value of this privately purchased domiciliary care as approximately £417m. The 854,000 hours a week was split between 318,000 hours of hourly paid home care and 536,000 hour of sessional or live-in care. No current estimate is given by Laing & Buisson for the proportion of the home care which is going to customers aged 65 and over, but it can be assumed that it is the large majority. Similarly, no separate estimate is given for the amount of domiciliary care purchased direct from care workers. The Laing & Buisson data (Laing and Buisson 2005b) is summarised in Table 22 below.

A very different picture is presented by two surveys which the UK Home Care Association (UKHCA) has conducted with its members. This found an unexpected decline in the number of privately purchased hours of home care in England (McClimont and Grove 2004). The surveys covered domiciliary care for all adults, but the UKHCA has typically found in the past that around 90 per cent was for older people. The UKHCA's estimate of total privately funded home care in England in 2004 was around 500,000 hours a week, including care from independent providers, local authorities and any other sources. The equivalent estimate from the 2000 survey was approaching 1 million hours per week implying that the amount had halved. (Neither figure includes nursing services.) This result was the opposite of what might have been expected, given both demographic factors and tighter local authority eligibility and funding criteria which was expected to increase the

TABLE 22: AMOUNT OF PRIVATELY PURCHASED DOMICILIARY CARE, 2004

	Number of hours per week (thousands)	Percentage of total home care market in England	Value (£million)
Hourly paid			
Independent providers	308	7	188
CSSR in-house providers	10	~ 0	6
Both provider sectors	318	7	194
Sessional or live-in			
Independent providers	536	13	223
CSSR in-house providers	–	0	–
Both provider sectors	536	13	223
Total hours			
Independent providers	844	20	411
CSSR in-house providers	10	~ 0	6
Both provider sectors	854	20	417

Source: Laing & Buisson 2005b

TABLE 23: ESTIMATE OF TOTAL WEEKLY HOME CARE HOURS BY SECTOR IN ENGLAND, 2004 AND 2000

Sector	Hours for 2004 (figures from 2000 survey)	Percentage for 2004 (figures from 2000 survey)
Local authority direct provision (Department of Health data)	1,043,200 (1,324,400)	28 (38)
Purchased by local authorities from the independent sector (Department of Health data)	2,069,800 (1,354,000)	55 (37)
Privately purchased from the independent sector	499,970 (948,653)	13 (26)
Purchased by the NHS from the independent sector	168,060 (66,373)	4 (2)
Total	3,781,030 (3,693,426)	100

Source: McClimont and Grove 2004

amount of privately purchased home care. (As with Laing & Buisson, these figures do not include any care hours privately purchased directly from a carer rather than through an agency.) Another trend clearly demonstrated by these figures is the sharply higher proportion of domiciliary care which is now purchased by local authorities from third-party independent firms, after proving a cheaper option for social services departments than providing services in-house. The detailed estimates are shown in Table 23 above.

The UKHCA cautions that the higher representation of sheltered housing and voluntary sector providers among respondents to the 2004 survey will have contributed to the decline in self-funded home care, as they tend to provide a smaller proportion of private care. Nevertheless, the association believes the survey results demonstrate a significant trend, even if the precise figures are not accurate. Background Paper 4 ('Private expenditure') in the Appendix includes details of the other limited data on the use of private domiciliary care.

It is unsatisfactory that the information on self-funded domiciliary care is so incomplete and uncertain. Any estimates of the amount spent on private domiciliary care are therefore based on patchy evidence. As an initial guide, one can include the £160 million paid to local authorities through charges, and the £417m Laing & Buisson figure, plus unquantifiable expenditure by those who employ their care workers directly.

The Review also produced estimates of the private purchase of home care. The difficulty with all attempts to assess private paid home care is to distinguish between private *care* and private domestic help. ELSA gives specific information on uptake of private home care in response to ADL dependency. The Health Survey for England (HSE) 2000 gives information about intensity. Table 24 reports the Review's estimates (for older people).

SUMMARY OF PUBLIC AND PRIVATE EXPENDITURE

Given the inadequate data, any aggregated estimate is very uncertain. The tables opposite pull together the estimates mentioned earlier, with the further caveat that they do not

TABLE 24: PRIVATELY FUNDED HOME CARE, 2002/3

	Dependency group ¹					All
	Group 0	Group 1	Group 2	Group 3	Group 4	
Number of recipients (thousands)	108	115	31	25	10	290
Input per recipient (hours per week)	2.9	3.7	3.7	3.7	8.4	2.9
Total hours per week (thousands) ²	317	432	116	93	85	1,042
Total annual private expenditure at £12.70 per hour ³ (£million)	210	286	77	62	56	690
Total annual private expenditure at £9.40 per hour ⁴ (£million)	155	211	57	45	42	510

¹ For a description of dependency groups, see Chapter 2.

² Figures are liable to rounding errors.

³ Hourly rate assumed in Review model.

⁴ Average hourly rate from Laing & Buisson 2005.

always refer to the same year. No estimates are made for missing data, in particular the total value of ‘top-ups’ and directly contracted domiciliary care. So this will be an underestimate. The two totals cannot be aggregated because this would lead to double-counting. For example, self-funders often use Attendance Allowance to part-fund care home fees or domiciliary care.

TABLE 25: STATE EXPENDITURE ON SOCIAL SERVICES FOR PEOPLE AGED 65+

Department of Health net expenditure on personal social services for older people (2004/5)	£6.3 billion
Attendance Allowance and Disability Living Allowance (care component) for 65+ (2004/5)	£3.7 billion
NHS expenditure on long-term care for the elderly (PSSRU model figure) (2003)	£3.0 billion
Total	£13.0 billion

TABLE 26: PRIVATE EXPENDITURE ON SOCIAL CARE FOR PEOPLE AGED 65+

Self-funded care home places	approx £1.9 billion
Charges paid to local authorities towards care home fees (2003/4)	£1.38 billion
Self-funded domiciliary care 2004 ¹	£417 million
Charges paid to local authorities towards domiciliary care (2003/4)	£160 million
Total	£3.86 billion

¹ Laing & Buisson 2005b

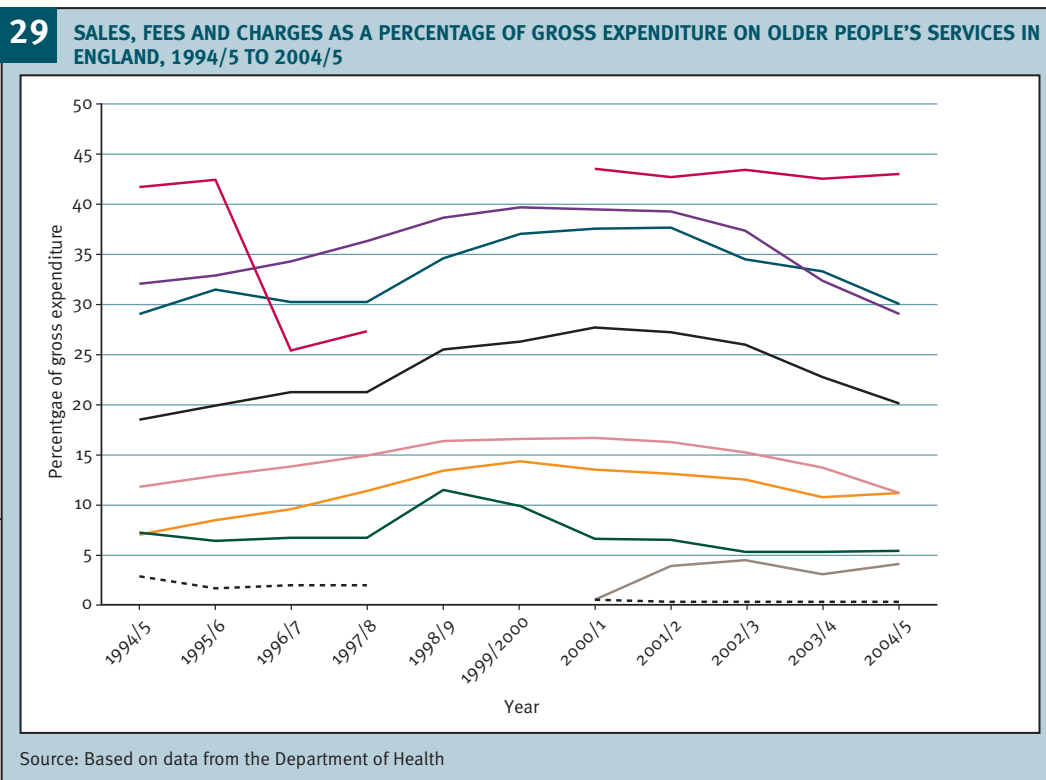
4 The charging and means-testing system

The eligibility of an older person for state-supported social care depends on their income and wealth, including home ownership. The current means-testing framework restricts state funding to those with relatively low financial means, something which often comes as a surprise to older people who have assumed that social care for a frail older person with dementia or severe arthritis will be provided by the state in the same manner as NHS-funded health care. If the assessed person's assets and income are too high to qualify for state funding for any type of social care, they are free to choose and pay for social care privately, but will get no state financial support.

Figure 29 below shows the proportions of gross expenditure on local authority-brokered social services recouped through fees, charges and sales. There is a big variation between different services in the amount recouped, ranging from 5 per cent for day care, to around 30 per cent for residential and nursing home care and over 40 per cent for meals. The proportion recouped by local authorities for residential care has declined in recent years due to the government responding to widespread care home closures by providing greater funds to local authorities for care home fees.

The financial eligibility rules

Full details of the means-testing system as it applies to social care for the elderly are given in Background Paper 4 ('Private expenditure') in the Appendix. In broad terms, RNCC nursing care is free in any setting after an assessment, and is paid to older people in care homes according to three weekly bands: Low £40, Medium £80, High £129. Community nursing is free. In England, almost all the other costs of both residential care and care in



RESIDENTIAL CARE FEES IN ENGLAND

- National rules for means-testing care home fees ('hotel' costs and personal care) are set out in the Charging for Residential Accommodation Guide (CRAG) (Department of Health 2005c). If the older person has assets over a specified amount (£20,500 in 2005/6), they must pay the full cost of the care home (except for any eligible free nursing care). Assessed assets include savings, investments and the value of any home unless a spouse/partner or other specified person remains in residence. The value of the home is disregarded for the first 12 weeks. The local authority can offer a 'deferred payments arrangement' whereby the accrued fees must be paid back (interest free) when the home is finally sold or the estate wound up.
- Anyone with total assets of less than £20,500 (2005/6) will be assessed for both savings and income in order to determine the amount of state funding. The value of any savings is converted into a notional 'tariff income' which adds £1 to the older person's income for every £250 (or part of £250) between the lower savings limit (£12,500 in 2005/6) and the upper savings limit (£20,500 in 2005/6). A person's assessed income includes this tariff income plus most other sources of income such as pension (state, occupational or personal), state benefits (including Attendance Allowance, Housing Benefit and Council Tax Benefit) and investment income. (The rules are complex, and some income is exempt.) Generally, any income over the 'personal expenses allowance' of £18.80 a week (2005/6) must be contributed towards the care home fees. It is therefore slightly misleading to describe someone as receiving 'fully funded' residential care because, at the minimum, an older person will be expected to contribute all but £18.50 of the state pension. If someone's assets are below the lower savings limit, their income will still be assessed.
- Attendance Allowance stops after 4 weeks if the older person is receiving a local authority contribution to care home fees. The effect is to shift this slice of state funding from central government to the local authority budget.

the community are means-tested, including the bill for personal care. The means-testing system, alongside the inter-relationship between state-funded social care and the receipt of state benefits, is complex. State support for the cost of an individual's social care affects some state benefits. Similarly, many state benefits are taken into account when assessing income during the means-testing process. The box above and the box overleaf summarise the main elements.

Shortcomings of the funding system

Aside from the perceived stigma often associated with means-testing, there is widespread agreement about some shortcomings and inconsistencies in the existing system. A number of vignettes have also been produced by the Review which illustrate how the required contribution from an older person varies enormously depending on their financial situation and where they live (see Annex, p 115). The main complaints include the following points.

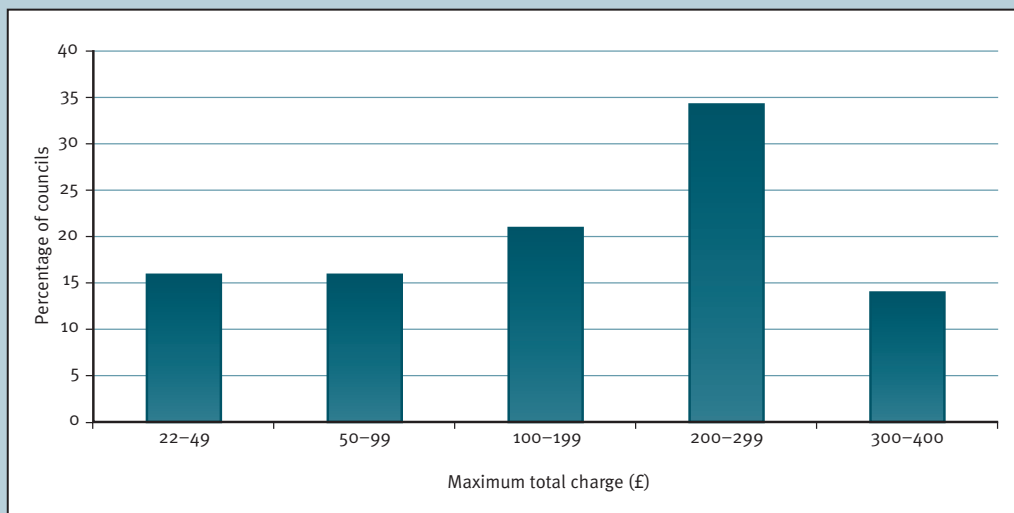
- **Ignorance about the system.** Too many people reach retirement without an accurate understanding of what the state will provide in terms of social care. At a time of crisis, perhaps after a fall or a sudden deterioration in health, an older person can discover for the first time that state funding for social care is available only to those who meet both the means-testing and needs eligibility criteria.

COMMUNITY-BASED CARE CHARGES IN ENGLAND

- The charging structure for non-residential social care services is set by the local authority, although there are national guidelines (Department of Health 2003a). Means-tested charges can be imposed for almost all non-residential social care services including personal care, but councils are free to be more generous than the guidelines. There is a huge variation in what is on offer. Some councils provide many services free, some use means-tests, others charge a flat rate. Full details are in Background Paper 4 ('Private expenditure') in the Appendix.
- In broad terms, assets can be assessed according to the CRAG rules, except that the value of the home is not included. Thus an older person with savings above £20,500 (for 2005/6) can be asked to pay the full charges for the social care services, but whether this happens will depend on the local authority.
- Anyone receiving the guarantee credit part of Pension Credit should not be charged for non-residential care.
- Charges should never reduce an older person's net income to less than an amount 25 per cent higher than the appropriate guarantee credit part of Pension Credit (including any carer's premium but not the Severe Disability Premium). This sets a minimum net weekly income of about £137 (if single) and £209 (with a partner) in 2005/6, regardless of the level of services received.
- If disability benefits (for example Attendance Allowance) are taken into account as income in assessing ability to pay a charge, councils should also assess the individual user's disability-related expenditure and this amount should be deducted from assessed income.

- **The health care and social care boundary** is far less clear-cut in reality than the funding regime implies. As mentioned in Chapter 4, in the scenario with the most extreme financial consequences, it is sometimes very difficult to distinguish between the needs of someone receiving free continuing NHS care (including free accommodation) and someone with very high personal care needs due to, for instance, severe dementia. The latter may well receive some free nursing care (under one of the three bands), but will only receive state funding towards their personal care if income and assets are below the means-testing threshold. The difference can be between receiving completely free NHS continuing care and ending up in residential care with a personal expenses allowance of just £18.80 a week. The Select Committee on Health (Health Committee 2005) suggested that someone eligible for the top band of free nursing care was likely to have needs of similar severity to someone in continuing care. The committee recommended the integration of the system for funding NHS continuing care and that for funding free nursing care, but this has not been taken up by the government. (See Background Paper 2 ('Continuing care') in the Appendix.) At the other end of the nursing spectrum, the distinction between care under the (free) lowest band of RNCC nursing care and (means-tested) high-end personal care can be difficult to draw, especially when non-nurses take on tasks previously carried out by RNCCs. Those suffering from dementia appear to be particularly ill served by the system as definitions of nursing care tend not to include the care demands of someone with dementia.
- **The complexity** of the means-testing system discourages older people from pursuing state funding for which they might be eligible. For instance, in estimating future costs, the government currently assumes that no more than 75 per cent of those eligible will claim Pension Credit (Pensions Policy Institute 2005). A review of the take-up of means-

30 MAXIMUM WEEKLY CHARGE FOR COMMUNITY-BASED SOCIAL SERVICES



Source: Thompson and Mathew 2004

tested benefits by British pensioners (Hancock *et al* 2004) looked at data from 1997 to 2000 and found 36 per cent of sampled pensioners failed to claim at least one benefit, and 16 per cent failed to claim amounts worth more than 10 per cent of their disposable income. The intricacies of the means-testing rules mean mistakes are easy to make. There is evidence that around 6 per cent of people were being admitted to homes as self-funders when their income and assets profile meant they were entitled to public support (Netten *et al* 2001).

- **A 'postcode lottery'** exists for domiciliary care charges because of the different charging regimes adopted by local authorities. For example, a survey by Age Concern (Thompson and Matthew 2004) found that 71 per cent of responding authorities set a maximum threshold for total charges (while others charged the full amount or used a banding system), but that there was a huge variation in that maximum level, as shown in Table 30. There was a similarly wide variation in the hourly charge for home care set by the councils, ranging from £3.50 to £15.50. There was also a very big difference in the amount allowed in disability-related expenditure (DRE), which can play a big part in reducing the final charges. In a case study used by Age Concern, the average DRE was £34.76 a week, but the amount determined by the local authorities ranged from £4.09 to £70.38.
- **Savers are penalised** by the means-testing system because a relatively low-income worker who accumulates fairly modest savings above £20,500 (2005/6 limit) for old age will be liable to pay all of any care home fees, regardless of any housing wealth, and may be liable for full charges on domiciliary care. A private pension income, combined with assets, would similarly increase the likelihood of incurring charges for community-based care, where the weekly net income cut-off level is around £137 for care charges to be due from a single person.
- **The 'perverse incentive'** of the means-testing system can encourage local authorities to promote residential care rather than community-based care so that the value of the older person's home can be included in the means-test. Unnecessary entry into residential care will indeed erode a self-funder's assets, but once these assets fall

below the upper capital limit the local authority will have to take over paying for some and then all of the care home place, which could cost more in the long term than if it had originally encouraged a domiciliary care package.

5 The future: people's ability to pay more

Social attitudes to paying and inheritance

Attitudes to self-funding social care are often inconsistent. Yet, before turning to the financial health of older people – their ability to pay – it is important to understand people's willingness to pay for care themselves.

A public opinion survey carried out in 1995 (Parker and Clarke 1997) found that public opinion was divided. Twenty-four per cent of respondents supported state support for all, regardless of income, while 24 per cent supported a means-tested approach, with the state providing only for those who could not otherwise afford care. The most popular option, chosen by 48 per cent of respondents, was for the state to provide a basic level of service for older people, with the option open to people who could afford to do so of 'topping-up' or supplementing this basic service.

A more recent survey carried out in the wake of the Royal Commission report asked people aged over 25 about whether the state or individuals should pay for long-term care costs of the elderly (Deeming 2001). More than three out of five people believed that personal care should be provided free to all who needed it, regardless of whether the care was provided in hospital, in care homes or in people's own homes. Stronger support for universal free personal care for all was found among younger voters (25–44 years) – precisely those people whom government wants to encourage to save for their old age. On personal care in nursing homes, only one in 10 thought it reasonable to pay the full cost of personal care; six out of 10 people thought it unreasonable to pay anything at all. On personal care in one's own home, only two in 10 thought it reasonable to pay for the full cost of personal care; and five out of 10 people thought it unreasonable to pay anything at all. A subsequent analysis (Deeming and Keen 2003) found a significant majority (61 per cent) were in favour of collective public financing of comprehensive health and social care services, 26 per cent supported a top-up model of finance and 12 per cent supported a means-tested system of finance.

Many older people resent the idea of using up savings which had been planned as an inheritance for children and other relatives. But there is some evidence that the desire to leave a bequest is not felt as strongly among those approaching retirement as it is among the current older population. A recent empirical study (Rowlingson 2005) into people's attitudes to inheritance found that two-thirds of those with some potential to leave a bequest in the future said that they would enjoy life and not worry too much about what was left. Just over a quarter said that they would be careful with their money so that they could bequeath something. The group least supportive of the concept of inheritance appeared to be those in their fifties. The baby boomers' apparent willingness to erode their children's inheritance in pursuit of an enjoyable lifestyle might not, of course, extend to paying care home fees and social care costs in 20 years' time. Further details are in Background Paper 4 ('Private expenditure') in the Appendix.

Separately, six focus groups involving people in three age categories over 45 were held in the North West and South East of England (Age Concern England, unpublished). These found widespread confusion concerning the basis for charging for personal care services, including among those currently paying for such services. The existing charging situation was felt to discriminate against those who had saved in order to provide for themselves, but who would lose these savings in payment for services which would be provided free of charge to others who had not saved. Throughout, both north and south, the younger people (45–59) were most convinced that the state should pay for personal care for all. In the south this view was very forcefully supported. The two older groups in the north, and the oldest group in the south, were more willing to consider at least a contribution to care costs. Participants in all groups generally agreed that items of expenditure over which a person had some choice should be met by that person whatever their financial situation, even where these contribute very significantly to the person's quality of life. These included items such as transport (taxis) and services which might relieve a condition.

Financial health of older people

A willingness to contribute to the costs of long-term care is only relevant if there is money available. There are numerous small and large surveys of the income and assets of older people. For example, one study (Deeming and Keen 2002) looked at a small survey of middle- to lower-income individuals, half of whom were in their 70s and half in their 50s. The research concluded that it was unrealistic to expect people in the lower half of income distribution to be able to save for old age and long-term care. Those who struggled most were middle-income individuals not covered by the state because of means-testing but whose assets and/or income were inadequate to fund long-term care.

Most useful for this review is the data from ELSA, which provides detailed financial information on the cohort that will be moving into and through retirement over the next 20 years. It also provides a basis for comparing the existing means-testing rules with the income and assets of those most likely to need long-term care in future. In the data below, the income and assets of various cohorts of people are considered, with particular emphasis on a person's ADL status. ADL limitations start relatively early in life for a significant number of people. Some 12.6 per cent of those aged 50–59 reported difficulty with one or more ADL. That figure varies between different occupational classes with 7.7 per cent of managerial and professional people reporting one or more ADL difficulties, 9.8 per cent in intermediate occupations, 17.8 per cent in routine and manual jobs, and 18.4 per cent classified as 'other'. Thus, well before the state retirement age, those already showing indications of being at risk of needing long-term care in old age are more likely to be in lower-paying jobs (Banks *et al* 2004). The figures below show that by late middle age, a person with one or more ADL limitations is likely to have a lower income and fewer assets.

INCOMES OF THE 50+ POPULATION

ELSA (Banks *et al* 2004) illustrates how single women tend to have lower incomes than single men, but the disparity is less for the 50–54 age band than older cohorts. Most relevantly for social care issues, ELSA provides figures for income by age and self-reported health (see Table 27 overleaf) which demonstrate how poor health is correlated with lower incomes. The income figures for single men and single women in 'fair/poor' health are low enough that after allowable expenses there would be little or nothing to contribute

TABLE 27: TOTAL WEEKLY FAMILY INCOME, BY AGE AND SELF-REPORTED HEALTH STATUS (UNEQUIVALISED*)

Age band	Self-reported health status	Single men	Single women	Man in a couple	Woman in a couple
50–59	Excellent/very good	£295	£278	£583	£541
	Good	£257	£178	£503	£477
	Fair/poor	£162	£173	£381	£360
60–74	Excellent/very good	£259	£196	£423	£414
	Good	£193	£173	£387	£334
	Fair/poor	£166	£154	£351	£337
75+	Excellent/very good	£181	£138	£318	£315
	Good	£168	£182	£292	£287
	Fair/poor	£159	£141	£268	£255

Source: Based on ELSA 2002 data (Banks *et al* 2004)

* 'Unequalised' means that no adjustment has been made for whether the family unit contains more than one person. (Income is net of taxes and includes employment income, private pension income, state pension income, benefit income (excluding housing benefit and council tax benefit), asset income and any other measure.)

towards means-tested home-based social care. Thus those who are most likely to need domiciliary social care in the future are also those who are least likely to be able to fund it themselves (unless they have significant non-housing wealth).

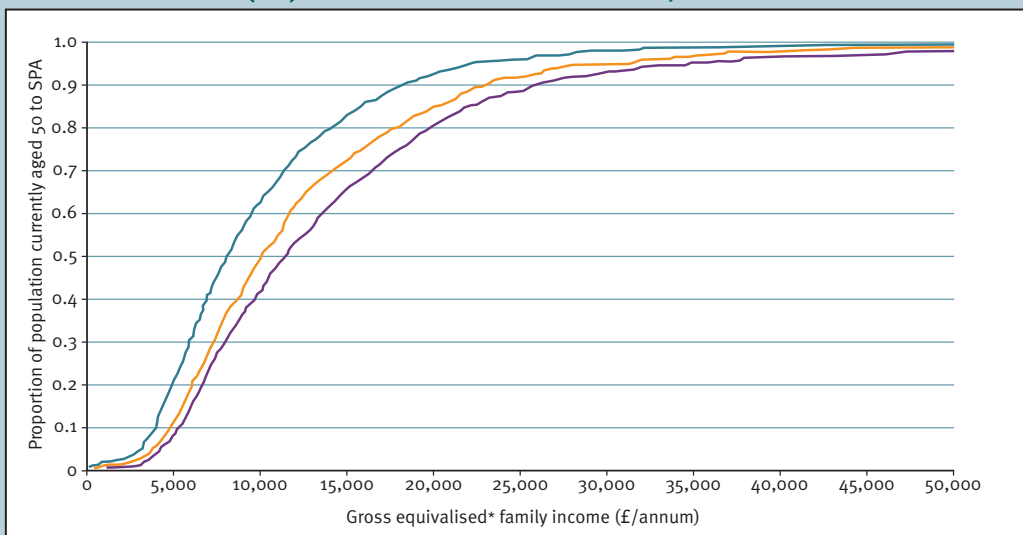
It is total wealth after retirement that is most relevant when considering whether the baby-boomer cohort will be capable of paying for long-term social care in later life. Data prepared by the Institute for Fiscal Studies for this Review appears in more detail in Background Paper 4 ('Private expenditure') in the Appendix, based on ELSA data. This work covers people aged between 50 and the state pension age (SPA). Based on people's income sources and assets it sets out what regular stream of income individuals could realise consistently into the future after reaching their SPA. In particular, the income includes future pension income, either as a defined benefit or as an annuitised defined contribution. Other non-pension, non-housing wealth is annuitised at 5 per cent. When housing wealth is included, this is done on the basis that 50 per cent of the home's value is annuitised at 5 per cent. In the case of couples, the total joint income is assumed to be split 50:50.

The data was considered in several ways.

- Where the data is adequate, there is a three-way split: no ADL limitations, 1 ADL limitation, and 2+ ADL limitations.
- Otherwise, there is a two-way split: no ADL limitations, 1+ ADL limitations.
- Individuals were also categorised as either living alone or living with others.

The results are given in Figures 31 and 32 opposite and the trends are clear. A person's predicted retirement income declines as the number of ADL limitations increases. The

31 DISTRIBUTION OF PREDICTED RETIREMENT INCOME (PENSION AND NON-HOUSING WEALTH ONLY)* AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION

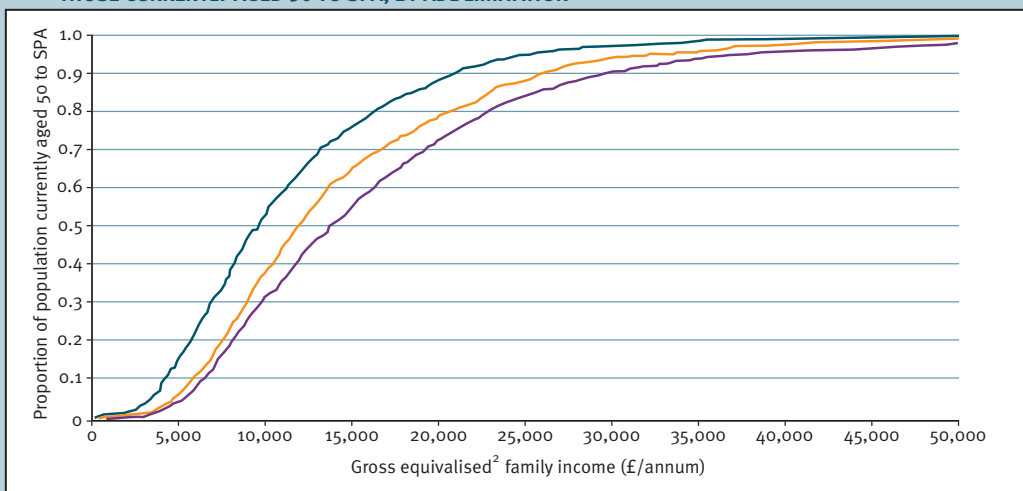


Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review
* The wealth of couples is split 50:50.

KEY

- No ADL limitations
- 1 ADL limitation
- 2+ ADL limitations

32 DISTRIBUTION OF PREDICTED RETIREMENT INCOME (TOTAL WEALTH¹)² AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION



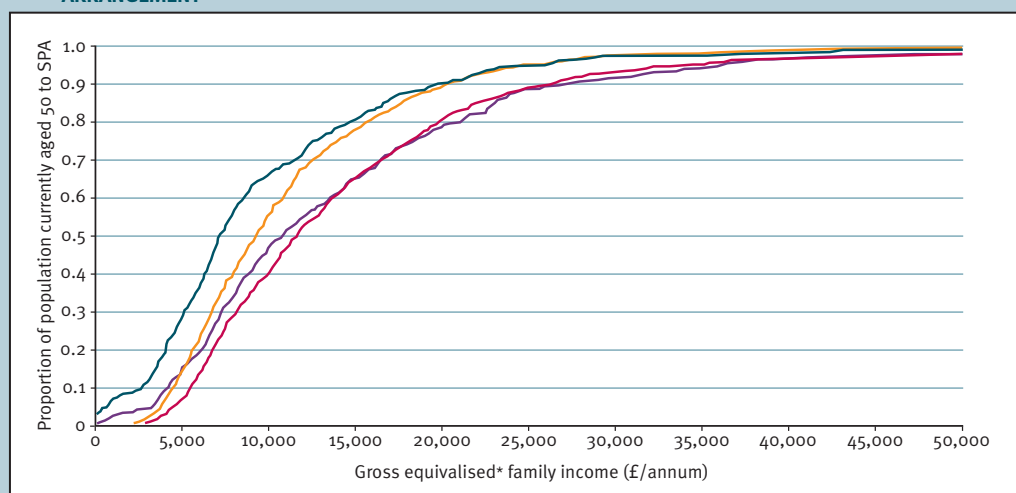
Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review
¹ Total wealth includes housing and expected inheritance.
² The wealth of couples is split 50:50.

KEY

- No ADL limitations
- 1 ADL limitation
- 2+ ADL limitations

steeper the line on the graph, the higher is the proportion of individuals on a lower predicted retirement income. Figure 31 includes pension and non-housing wealth, and under the current means-testing rules would be relevant in the case of someone needing domiciliary care who did not release any housing equity. Figure 32 includes housing wealth (and expected inheritance), and so is more relevant for someone releasing housing equity to fund either domiciliary care or care home fees.

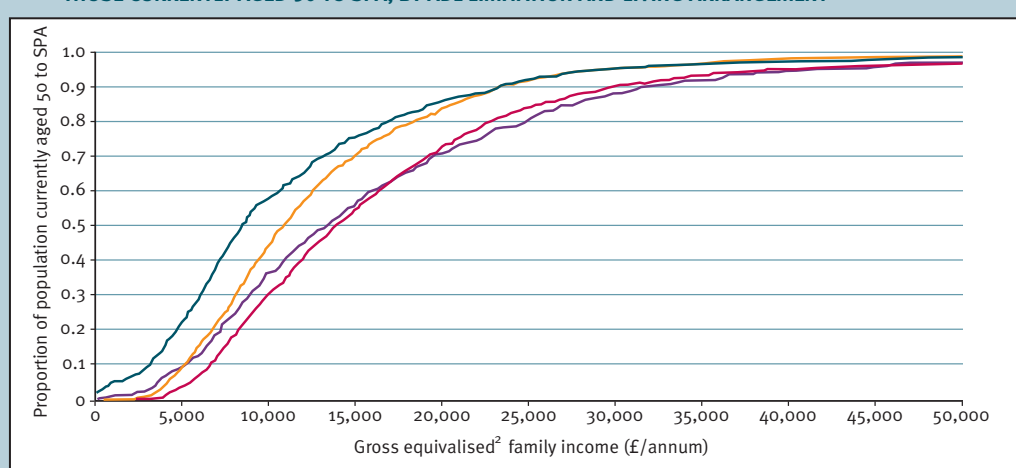
33 DISTRIBUTION OF PREDICTED RETIREMENT INCOME (PENSION AND NON-HOUSING WEALTH ONLY)* AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION AND LIVING ARRANGEMENT



Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

* The wealth of couples is split 50:50.

34 DISTRIBUTION OF PREDICTED RETIREMENT INCOME (TOTAL WEALTH¹)² AT STATE PENSION AGE (SPA) FOR THOSE CURRENTLY AGED 50 TO SPA, BY ADL LIMITATION AND LIVING ARRANGEMENT



Source: Figures prepared using ELSA 2002 data by the Institute for Fiscal Studies for this Review

¹ Total wealth includes housing and expected inheritance.

² The wealth of couples is split 50:50.

Thus, the median predicted income from pension and non-housing wealth for those currently with no ADL limitations is £11,350; with 1 ADL limitation it is £10,000; and with 2+ limitations it is £8,000. When all sources of wealth are included, the gaps widen and the median predicted income for those currently with no ADL limitations is £13,650; with 1 ADL limitation it is £11,800; and with 2+ limitations it is £9,550. To put these figures in a social care context, the current annual cost of a care home placement is just under £20,000 (at £370 per week). Only about 30 per cent of fit people, 20 per cent of people with 1 ADL and

10 per cent of people with 2 ADLs could (just) afford this amount (that is, as above, where half the value of any house is taken into consideration and annuitised).

The distinction between whether someone is living alone or with others also has an impact on the predicted retirement income. In this case, the data was not adequate to provide the same three-way split in terms of ADL limitations, so the two-way split was used instead. Figures 33 and 34 (opposite) demonstrate how predicted retirement income is affected both by ADL limitations and living situation. For those people with 1+ ADL limitations, living alone is associated with lower predicted retirement incomes than for people living with others. This is true regardless of whether housing wealth (and expected inheritance) is included. There is a similar pattern for around 60 per cent of those with no ADL limitations, but it is not as pronounced, and it is no longer the case at higher predicted incomes.

Thus, the median predicted income from pension and non-housing wealth for those currently living alone with no ADL limitations is £10,550; and living alone with 1+ ADL limitation it is £7,100. For those living with others with no ADL limitations it is £11,500; and with 1+ ADL limitations it is £9,200. Similarly, when all sources of wealth are included, the median predicted income for those currently living alone with no ADL limitations is £13,150; and living alone with 1+ ADL limitations it is £8,350. For those living with others with no ADL limitations it is £13,800; and with 1+ ADL limitations it is £10,750.

FINANCIAL ASSETS AND HOUSING WEALTH

The retirement income figures in the previous section were based on estimates of future assets. In this section, a snapshot of current assets is examined, again based on the ELSA survey data collected in 2002. This demonstrates that inequality in wealth across the elderly population is more extreme than inequality in incomes. For example, for the total population over 50, the average net financial wealth (not including housing) is more than £40,000, but half this cohort has less than £12,000 and a quarter has less than £1,500 (Banks *et al* 2004).

The distribution of wealth is shown in Tables 28, 29 and 30 (see pp 113–114) categorised by age, gender and ADL limitations. Separate figures are given for total (non-pension) non-housing wealth and housing wealth. (Unlike with the predicted retirement income, pension wealth is not included in any of these figures.) The (non-pension) non-housing wealth is potentially relevant in the context of someone being assessed under the current means-testing rules for domiciliary care. Housing wealth enters the equation for anyone being assessed under the CRAG rules for care home fees. (See Background Paper 4 (‘Private Expenditure’) in the Appendix for detailed data.)

A large inequality in (non-pension) non-housing wealth is demonstrated for each type of individual (reading horizontally along rows in the tables). Also those with two or more ADL limitations have a markedly lower level of (non-pension) non-housing wealth (reading vertically down column sections). In practice, local authority-needs eligibility criteria mean that someone with two or more ADL deficiencies would be likely to qualify for social care on needs grounds, so it is the assets of this group which are particularly relevant. In Part 2 this data is used in the models to assess people’s eligibility. As an illustration, with the lower assets means-testing threshold in England at present of £12,500 (2005/6), about 75 per cent of single people with two or more ADLs in most age groups have lower net (non-

pension) non-housing assets (see Tables 28 and 29 opposite). They would therefore qualify for state-funded domiciliary social care (unless their income was higher than the limits).

An older person's net housing wealth becomes relevant if they are being means-tested for a residential care home place. The distribution of net housing wealth according to age and ADL limitation is also shown in Tables 28, 29 and 30. The disparities between renters and property-owners will have widened as property prices have increased sharply since 2002 when the ELSA data was collected.

As with non-housing wealth, there is great inequality within each category (the horizontal inequality). Similarly, those with higher levels of ADL disability tend to have lower housing wealth (the vertical disparity). The biggest distinction, however, is simply between people who have any net housing assets at all and those who do not. Current property values means that the vast majority of those who have any housing assets that become assessable under the means-testing regime will have to pay for some or all of their residential care home costs. (The housing wealth of most couples would not be assessable for means-testing as long as the partner continued to live in the family home.)

It is misleading to generalise across different age cohorts and between men and women, but by looking at the ELSA data (not reproduced here) for total wealth (non-housing and housing combined), it is possible to get an indication of the proportion of people who could self-fund a care home place from assets (in practice, income would also be used). For example, a stay in a residential or nursing home of two years would incur a cost of more than £38,000 in total on average (at £370 per week). A detailed breakdown of the ELSA figures shows that 20 per cent of single men currently aged 50 to 59 with 2+ ADL limitations appear to have enough total wealth to fund residential care costs over that sort of time period before their assets are eroded to the upper threshold for means-tested support. For women in the same category, the proportion is more than 30 per cent with the potential to self-fund. For the whole population in this age group, regardless of ADL status, the figure is about 50 per cent. That still leaves a very significant proportion of those currently aged 50–59 and single who appear unlikely to amass a level of assets which would be adequate to fund a care home place (unless through inheritance).

ASSETS AND INCOME OF SELF-FUNDED CARE HOME RESIDENTS

Detailed information is available about the financial status of older people who are already self-funding their places in residential and nursing homes (Netten *et al* 2001). Some 56 per cent of self-funding care home residents had savings and investments (non-housing) below £30,000, and around 53 per cent had weekly incomes below £174 (at the time of the survey). Overall, one-third had total assets of £60,000 or less but nearly two-fifths had assets in excess of £100,000.

The research found that 71 per cent of residents had a weekly income which was insufficient to meet the charges for their care but had assets higher than the means-testing cut-off threshold for state funding. (Only around 16 per cent could meet the charges from income alone.) Most self-funding residents had enough assets to last for several years before they had spent down to the means-testing capital threshold. However, a smaller group of residents had levels of assets that would be likely to last for a much shorter period.

TABLE 28: DISTRIBUTION OF TOTAL WEALTH AMONG SINGLE MEN, BY AGE AND NUMBER OF ADL LIMITATIONS

Single men	Total (non-pension) non-housing wealth*			Housing wealth		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
Aged 50–59						
No ADL limitation	£200	£11,000	£57,600	£0	£45,000	£113,000
1 ADL limitation	£0	£7,000	£87,000	£0	£38,500	£100,000
2+ ADL limitations	(£100)	£0	£3,100	£0	£0	£29,000
Aged 60–74						
No ADL limitation	£1,000	£10,200	£55,100	£0	£50,000	£100,000
1 ADL limitation	£600	£3,700	£18,300	£0	£0	£54,000
2+ ADL limitations	£0	£1,100	£10,600	£0	£0	£60,000
Aged 75+						
No ADL limitation	£1,900	£8,000	£35,000	£0	£40,000	£120,000
1 ADL limitation	£2,500	£10,500	£33,000	£0	£0	£100,000
2+ ADL limitations	£600	£5,000	£13,500	£0	£15,000	£80,000

Source: Based on ELSA 2002 data (Banks *et al* 2004)

* These figures include non-housing physical wealth such as second homes, farm or business property, business wealth, land, antiques, works of art and jewellery. Under means-testing rules, the last three of these item types would not be included when assessing an older person's assets.

TABLE 29: DISTRIBUTION OF TOTAL WEALTH AMONG SINGLE WOMEN, BY AGE AND NUMBER OF ADL LIMITATIONS

Single women	Total (non-pension) non-housing wealth*			Housing wealth		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
Aged 50–59						
No ADL limitation	£0	£3,800	£28,500	£0	£53,000	£127,000
1 ADL limitation	(£100)	£0	£46,300	£0	£0	£95,000
2+ ADL limitations	(£300)	£0	£2,700	£0	£0	£75,000
Aged 60–74						
No ADL limitation	£1,300	£10,300	£42,100	£0	£75,000	£141,000
1 ADL limitation	£200	£3,400	£26,000	£0	£42,500	£140,000
2+ ADL limitations	£0	£1,700	£11,800	£0	£28,000	£82,000
Aged 75+						
No ADL limitation	£1,200	£6,800	£28,200	£0	£50,000	£120,000
1 ADL limitation	£1,000	£4,500	£20,000	£0	£26,000	£139,000
2+ ADL limitations	£800	£4,000	£12,200	£0	£0	£90,000

Source: Based on ELSA 2002 data (Banks *et al* 2004)

* These figures include non-housing physical wealth such as second homes, farm or business property, business wealth, land, antiques, works of art and jewellery. Under means-testing rules, the last three of these item types would not be included when assessing an older person's assets.

TABLE 30: DISTRIBUTION OF TOTAL WEALTH AMONG COUPLES, BY AGE AND NUMBER OF ADL LIMITATIONS

Couples (jointly)	Total (non-pension) non-housing wealth*			Housing wealth		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
Aged 50–59						
No ADL limitation	£5,200	£33,000	£105,000	£65,000	£126,000	£200,000
1 ADL limitation	£200	£13,000	£42,600	£30,000	£80,000	£165,000
2+ ADL limitations	£0	£2,600	£29,000	£0	£59,900	£128,200
Aged 60–74						
No ADL limitation	£7,400	£32,200	£104,100	£63,000	£120,000	£200,000
1 ADL limitation	£1,900	£13,800	£48,000	£35,000	£90,000	£160,000
2+ ADL limitations	£1,000	£7,700	£40,000	£0	£70,000	£140,000
Aged 75+						
No ADL limitation	£6,000	£22,000	£72,800	£42,000	£110,000	£200,000
1 ADL limitation	£4,100	£15,800	£53,000	£0	£80,000	£170,000
2+ ADL limitations	£1,800	£7,200	£29,000	£0	£55,000	£110,000

Source: Based on ELSA 2002 data (Banks *et al* 2004)

* These figures include non-housing physical wealth such as second homes, farm or business property, business wealth, land, antiques, works of art and jewellery. Under means-testing rules, the last three of these item types would not be included when assessing an older person's assets.

TRENDS FROM THE ELSA DATA

- People aged 50–59 have higher incomes than people over 60. But their non-housing and housing net wealth is generally lower or equal to that of the 60–74 age group, and for those on low incomes there is very little scope to amass increased savings for later life.
- ADL limitations start relatively early in life for a significant number of people.
- The means-testing system limits state-funded social care to those older people with low incomes and little wealth. The income and wealth levels of people aged 50–59 in ‘fair/poor’ health or with 2+ADL limitations are already such that a majority of this cohort would be unlikely to amass enough savings over the next 20 years to take them out of the net for state-funded care under the current system. (This ignores the potential for inherited wealth.)
- Housing wealth provides a potential source of funds for domiciliary social care for a significant number of people if attractive products were available. However, the level of net housing wealth owned by about half of those over 50 and single with 2+ ADL limitations is either non-existent or would be inadequate to pay for long-term care costs, given that only a proportion of the net housing equity can be released.

6 Conclusions and recommendations

Although there are questions about what constitutes social care expenditure, the sums involved are large. Even excluding NHS spending, and benefits, the funding of social care for older people exceeds £10 billion at present. A considerable proportion of this, over two-fifths, comes from people's own pockets. Some of this private contribution is paid for using the £3.7 billion worth of Attendance Allowance and Disability Living Allowance that is presently funded.

It is recommended that a research programme is carried forward to build up an accurate picture of all funding sources. Currently there are significant gaps.

- There appears to be an absence of evidence or research about exactly how Attendance Allowance is spent. The majority of claimants living in the community did not report using formal community-based services. It would be particularly useful to know how much is used on services which would not be considered traditional social care, such as paying someone to do the shopping, taxis, helping meet informal carers' expenses etc. This would allow consideration of whether this benefit is achieving the desired outcomes, although any moves to link it to the delivery of specific services could conflict with wider aims of greater choice for older people.
- The NHS contribution to what might be described as social care is also very blurred. Official data on NHS continuing care for older people in England is not available and this should be rectified.
- It has not been possible to find an official figure for the annual cost of free nursing care available to those aged 65 and over in care homes, or data which aggregates the total amount spent on free nursing care for older people in all care settings, including for those receiving social care packages in their own homes. Such information should be collected.
- Private expenditure by older people on long-term care is large and increasing, yet there is a lack of data on the total amount being spent. This is particularly the case for the self-funding of domiciliary care, where the figures which are available appear to be incomplete and inconsistent.
- There does not appear to be any evidence available about the total amount paid by third parties in top-up fees to care homes, which would be a further useful addition to the data on private funding.

More broadly, there is a need for debate as to how social care related benefits such as Attendance Allowance work alongside commissioner-mediated funding (by councils and the NHS). The pros and cons of means-testing for social care are considered in Part 2. However, while this benefit is very popular precisely because it can be obtained without passing through the means-testing process, its role relative to means-tested social care needs to be clarified.

The data from ELSA show that only a minority of people can afford intensive levels of social care (for example, being in a care home). This data on income, non-housing and housing wealth are used in the models described in Part 2 to assess potential private contributions under different funding arrangements.



Annex. Charging vignettes

The charge that an older person will be asked by the local authority to pay towards social care varies enormously depending on their financial situation and where they live. This Review has prepared a number of very simple illustrative vignettes to demonstrate the impact of different charging regimes.

The box overleaf gives the financial profiles of four single people aged 65+. These four individuals are then 'assessed' for charges, first for a care home place under the national charging rules, and then for a domiciliary care package under a number of different local authority charging regimes. As described in this chapter (pp 102–6), the freedom that local

FOUR EXAMPLE FINANCIAL PROFILES OF FOUR SINGLE PEOPLE AGED 65+:

Person A

Net housing wealth: £100,000
Savings: £25,000
State pension: £98 a week (net)
Occupational pension: £120 a week (net)

Person B

Net housing wealth: £60,000
Savings: £12,000
State pension: £98 a week (net)
Occupational pension: £50 a week (net)

Person C

Net housing wealth: None
Savings: £25,000
State pension: £82.10 a week (net)
Occupational pension: None

Person D

Net housing wealth: None
Savings: £12,000
State pension: £82.10 a week (net)
Occupational pension: None

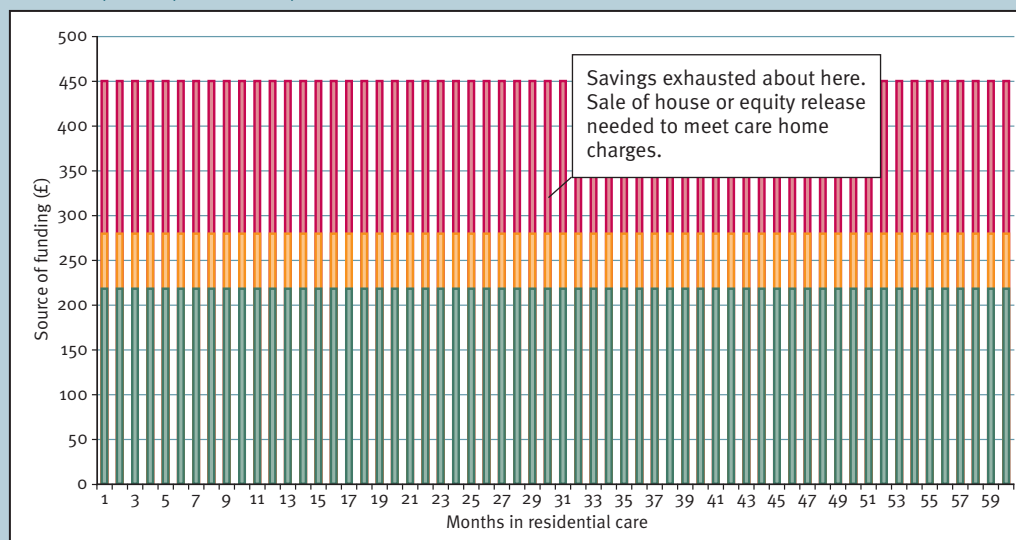
authorities have within the national guidelines to decide their charging rules for domiciliary care means that charges vary greatly between areas for the same care package.

CARE HOME CHARGES

Charges towards care home fees can only be levied according to the rules set out in the Charging for Residential Accommodation Guide (CRAG) (Department of Health 2005c). A timeframe of five years is used in these vignettes. In the examples below, the weekly care home fee is assumed to be £450 (not including any nursing care element). A number of assumptions³ have been made when calculating the charges. Three are particularly important. First, all pension credit and CRAG calculations are (unrealistically) re-done every month so that a self-funder immediately benefits from any erosion of assets. Second, self-funders only allow themselves £18.80 a week of personal spending money, in line with the amount given to state-funded residents. In doing the calculations, a self-funder is assumed to take that weekly allowance out of savings, whereas anyone who is state funded keeps £18.80 of his/her pension income. Third, the two individuals with housing assets (Person A and Person B) do not sell their homes immediately on moving into a care home; this is either because they do not want to, or because someone else remains living in the property but that person is not in one of the categories (for example, an incapacitated relative under the age of 60) which removes the house from the means-testing assessment.

35 PERSON A: FUNDING SOURCES FOR SELF-FUNDER ADMITTED TO RESIDENTIAL CARE COSTING £450 PER WEEK, WITH £18.80 PER WEEK PERSONAL EXPENDITURE OR ALLOWANCE

Net housing wealth: £100,000 Savings: £25,000 State pension: £98 per week (net)
Occupational pension: £120 per week (net)



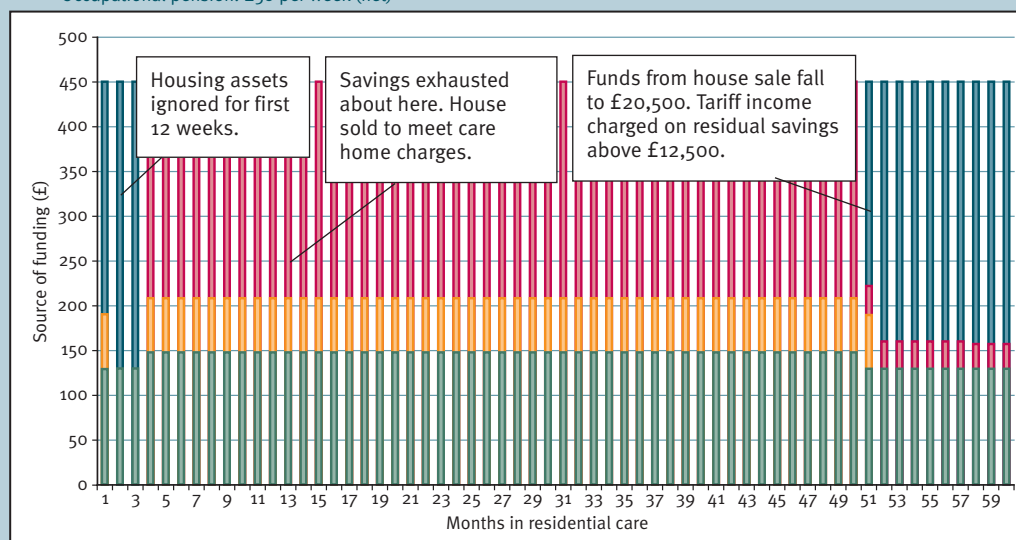
Source: Figures produced using software from Ferret Information Systems

KEY

- Pension income: state and occupational combined
- Attendance Allowance
- Private assets

36 PERSON B: FUNDING SOURCES FOR CARE HOME PLACE COSTING £450 PER WEEK, WITH £18.80 PER WEEK PERSONAL EXPENDITURE OR ALLOWANCE

Net housing wealth: £60,000 Savings: £12,000 State pension: £98 per week (net)
Occupational pension: £50 per week (net)



Source: Figures produced using software from Ferret Information Systems

KEY

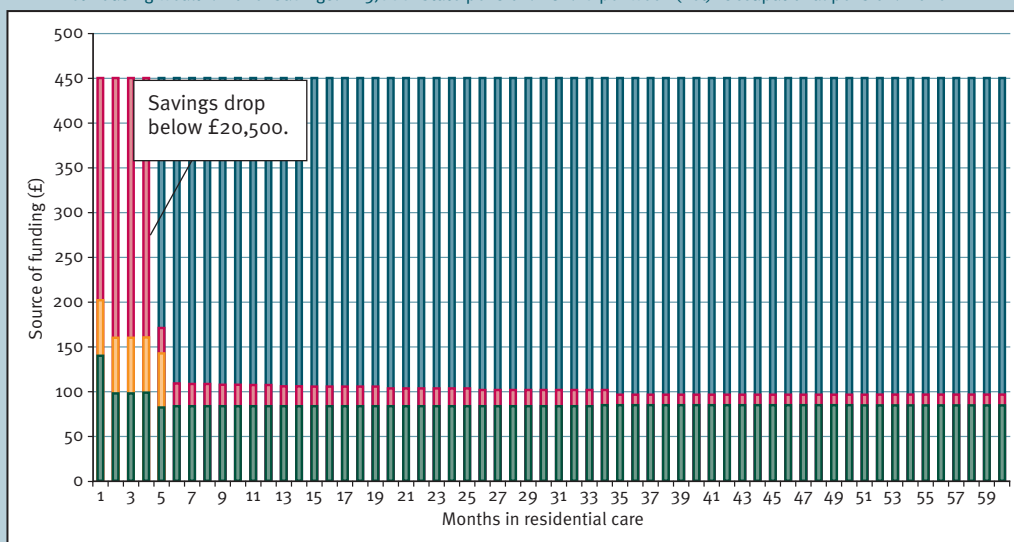
- Pension income: state and occupational combined
- Attendance Allowance
- Private assets
- Local authority contribution

Figures 35 to 38 (see above and overleaf) show the source of the money which pays the weekly care home fees for each of the four case study individuals.

- It can be seen in Figure 35 that Person A never qualifies for state funding under the five-year horizon. After about 30 months the user's savings are exhausted and it is necessary to sell the home or use equity release to meet the care home fees.
- Figure 36 shows how Person B receives some state funding in the first 12 weeks, when the value of the house is disregarded. After that the user is fully self-funding, and is

37 PERSON C: FUNDING SOURCES FOR CARE HOME PLACE COSTING £450 PER WEEK, WITH £18.80 PER WEEK PERSONAL EXPENDITURE OR ALLOWANCE

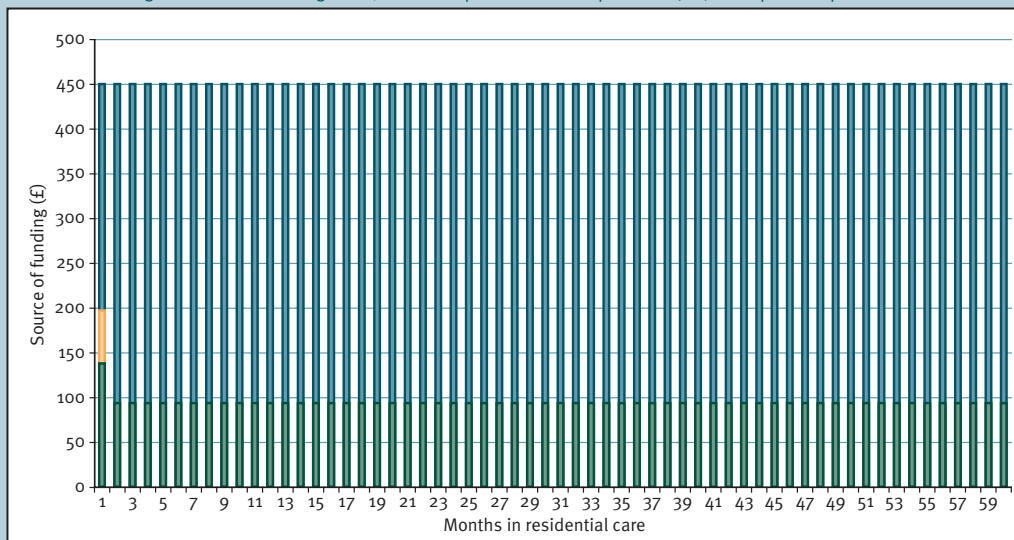
Net housing wealth: None Savings: £25,000 State pension: £82.10 per week (net) Occupational pension: None



Source: Figures produced using software from Ferret Information Systems

38 PERSON D: FUNDING SOURCES FOR CARE HOME PLACE COSTING £450 PER WEEK, WITH £18.80 PER WEEK PERSONAL ALLOWANCE

Net housing wealth: None Savings: £12,000 State pension: £82.10 per week (net) Occupational pension: None



Source: Figures produced using software from Ferret Information Systems

forced to sell the home after about 14 months in total (the net value of the house is probably too low for equity release). It is not until after 52 months that this person's assets are eroded to the upper threshold (£20,500 in 2005/6), and the local authority starts to contribute. After this point, the tariff income is charged on the total value of the assets between £12,500 and £20,500, and this tariff income declines as the assets are further eroded.

- Person C very quickly erodes their savings down to £20,500 and from month 5 onwards is significantly funded by the local authority. As with Person B, the tariff income then

becomes relevant. Figure 37 shows clearly how long it takes for that tariff ‘tail’ to diminish, as the resulting contribution is always less than £32 a week.

- Person D’s financial circumstances are such that from the start they are wholly state-funded (Figure 38), although as usual this involves parting with all pension income except for the £18.80 personal allowance.

DOMICILIARY CARE CHARGES

The picture for domiciliary care charges is rather more complex because of the freedom that local authorities have to design charging regimes with the Fairer Charging guidelines. In this case the Review has used actual charging rules as operated in mid-2005 by two (anonymous) local authorities in England to calculate the weekly charge that would be imposed at the start of a care home package, based on various assumptions.⁴ One was a low charging council, and one a high charging council, when compared with the average. It turned out that neither of these two councils took an older person’s (non-housing) assets into account when assessing a user for charges. Under the national guidelines, a council can assess (non-housing) assets as under the CRAG rules if it chooses, but can be more generous. In order to demonstrate the impact of ignoring (non-housing) assets, a second set of calculations were performed on the assumption that each of the two councils kept the same charging rules but also assessed for assets. These figures are all given in Table 31 below.

It can be seen that the decision to ignore assets has a big impact on Person A and Person C if they live in the high-charging local authority area, and a lesser impact on Person C in the low-charging area. This suggests that if councils charged the maximum permitted under the guidelines, significantly more money could be recouped in charges. If assets are ignored, Person A is still well-advised to move into the low-charging council’s area, as this will save more than £50 a week in charges.

TABLE 31: WEEKLY CHARGES DUE FROM USER FOR DOMICILIARY CARE PACKAGE

	Weekly charges			
	Person A	Person B	Person C	Person D
Low-charging council (ignores assets)	£33.88	£33.88	£0	£0
Low-charging council (assesses assets)	£33.88	£33.88	£33.88 (After 133 weeks this drops to £0.)	£0
High-charging council (ignores assets)	£87.32	£32.22	£0	£0
High-charging council (assesses assets)	£147.00 (After 31 weeks this drops to £119.32. It then declines by about £2.00 a month down to £87.32.)	£32.22	£147.00 (After 31 weeks this drops to £0.)	£0

Source: Figures produced using software from Ferret Information Systems

Table 31 also gives some indication of how the charges will evolve over time as a user's assets are eroded. As housing assets are never assessed for domiciliary care, this has less severe consequences than when paying care home fees.

Notes

¹ For instance, a survey of local government treasurers by the Association of Directors of Social Services (ADSS) in 2004/5 found that 73 per cent were forecasting overspend on children's services (Williams 2005)

² All figures provided by the Department for Work and Pensions.

- ³
1. Pension credit and tariff income calculations are (unrealistically) re-done every month
 2. Savings/financial assets do not produce any income, and nor is any vacated property rented out
 3. All calculations assume benefits, prices and charging rules as at 2005/6
 4. Self-funders only allow themselves £18.80 a week of personal spending money, in line with those who are state funded
 5. A self-funder provides that £18.80 a week out of savings, whereas anyone who is state funded keeps £18.80 of his/her pension income
 6. Care home fees are the same for both self-funders and the state funded.
 7. The £450 a week does not include any nursing care
 8. Before moving into the care home, everyone receives Attendance Allowance at the higher rate or £60.60 a week
 9. All the older people are single, aged 65+, and any housing assets are included in the financial assessment.
- ⁴
1. All get Attendance Allowance higher rate of £60.60 a week
 2. Council tax: £12 a week
 3. Someone receives Carer's Allowance for looking after the person
 4. 14 hours a week (2 hours each day) of personal care is awarded
 5. £5 a week charge for community alarm
 6. 0–3 loads of laundry
 7. £3 a week for heating
 8. Both councils implement any maximum threshold for charges
 9. Councils charge at their own hourly rate.

7

Workforce

Summary

Social care services are very labour intensive so the availability and quality of staff is a key aspect of achieving the desired outcomes. This chapter considers the current position, whether labour force meets demand, and what constraints will affect future workforce supply.

- In 2003/4, an estimated 559,000 people were formally employed in England providing 'core' social care for older people, not including around 120,000 further NHS staff also doing some care work for older people.
- Staff costs represent a significant proportion of care costs. For instance, care assistant wages average just over half the unit costs of local authority commissioned home care services. In care homes, staff costs are estimated to account for just over half the weekly 'fair price' for care homes providing personal care, and nearer two-thirds of the 'fair price' for homes providing nursing care.
- Changes in pay suggest that pay rates for social care jobs have risen in line with or at a faster rate than average earnings index for some time. Prior to 2002, pay rate rises for this group were lower than inflation, but since then, they have been in line with or higher than inflation. The relationship with the national minimum wage has been variable.
- The limited information available shows that vacancy rates are high, both absolutely and relatively. In 2004 for example, there were 53,000 vacancies for social workers, occupational therapists and other care-related occupations notified to JobCentres in England. This potentially imposes a significant constraint on service expansion.
- Wider use of technologies, such as telecare, could influence the quantity, skills and price of care staff in the future, and other influences also exist.
- The social care workforce is increasingly monitored and regulated. This improves quality but can also push up costs.
- Perceptions of care work are generally not positive, either among the public or the staff themselves. Pay levels, conditions and career prospects are all factors in this. Perceptions of the care staff themselves, however, can be positive.
- Quality of care provided is variable. There is insufficient evidence to recommend action to remedy this. This needs to be addressed and appropriate action taken.

The key question about whether the social care workforce could expand to meet higher demand for higher quality care is difficult to answer. There is a range of circumstantial and anecdotal evidence that is, on balance, positive. But there are no definitive studies to be able to confidently decide this issue. The difficulty of interpretation is compounded by the complexity of the issue. Supply of labour to the social care market depends on

wages and conditions, people's willingness to work in social care, barriers to market entry, the capacity in the wider economy for people to work in the low-pay sector, the action of 'competitor' industries such as health care and so on. Also, the UK is operating within an international labour market in a way not seen previously. It is clear that the sector will need to act in a more competitive manner to attract staff in the future. This then needs to be combined with appropriate and cost-effective training to ensure the outcomes received are of a high quality.

1 Introduction

The number of staff needed for the operation of an effective social care service in 2026 will depend on the outcomes the service expects to achieve, the services offered, their location and the way in which they are structured. This chapter examines the workforce in the context of social care supply. This is a particularly important element because social care services are extremely labour intensive and the human capital available to provide the services to clients has a significant impact on the supply of social care.

What follows is a brief assessment of the current position with regard to this fundamental aspect of social care in three main parts:

- the current position (numbers, pay, vacancies, training provision and cost)
- the responsiveness of the workforce
- factors affecting supply.

One recurrent limiting factor is the generally incomplete and inadequate information regarding the social care workforce. The situation has been significantly improved by the work of individuals such as Christine Eborall in her 'State of the Workforce' reports and will be further improved by the introduction of the National Minimum Data Set for Social Care (NMDS-SC) (Skills for Care 2005), but significant deficiencies remain.

2 Current position

Staff numbers

PUBLIC AND INDEPENDENT SECTOR

According to the most comprehensive source available (Eborall 2005), in 2003/4, an estimated 922,000 people were employed in England in 'core' social care including local authority social services staff, residential, day and domiciliary care staff, agency staff and a limited number of NHS staff. An estimated 61 per cent of these were working in services for older people (Eborall 2005) – approximately 559,000 people (headcount).

In addition, in 2003/4 198,000 people worked in the NHS doing some care work (but were considered outside this 'core' staff). Assuming 61 per cent of the additional workforce also worked in services for older people (121,000), this would increase the figure for people working in this area to 680,000 people. Table 32 gives details of sector share and types of occupation included.

This number does not include any equivalent staff numbers for overtime worked by employees paid or otherwise. Anecdotally, overtime is frequently worked during the provision of social care, particularly in the public sector. There is very little information

TABLE 32: ESTIMATED SIZE OF SOCIAL CARE WORKFORCE IN ENGLAND (HEADCOUNT), EXCLUDING STAFF CARING SPECIFICALLY FOR CHILDREN, 2003/4

Service type	Size of workforce			Total	% of core total
	Local authority	Independent sector*	NHS		
Social services departments (central, area, field, other)	112,000	–	–	112,000	12
Domiciliary care services	56,000	107,000	–	162,000	18
Day care services	38,000	57,000	–	95,000	1
Care homes (including nursing staff)	72,000	390,000	–	462,000	50
Agency staff	11,000	19,000	Not known	30,000	3
NHS (narrow definition)	–	–	62,000	62,000	7
Core workforce total	288,000	572,000	62,000	922,000	100
<i>% of core total</i>	<i>31</i>	<i>62</i>	<i>7</i>	<i>100</i>	
NHS (including other unqualified staff who may do some care work)	–	–	198,000	198,000	

Source: Adapted from Eborall 2005

*Includes both private and voluntary sectors.

Note: All figures are rounded.

available about this, an omission which arguably leads to significant underestimates in the number of staff required to provide the existing services.

The staff numbers in the table are arguably the most reliable available as they take account of possible problems with the information, such as incompleteness. However, the table integrates data from a number of sources so issues with these need to be taken into consideration. Briefly, data is derived either from the Labour Force Survey (LFS), or from local authority returns. The former, while nationally representative, can lack specificity. Two classification systems are available: SOC2000 (Standard Occupational Classification) or SIC92 (Standard Industrial Classification). Both have gaps in coverage and are based on self-assessment. Local authority data meanwhile was only introduced relatively recently, and there are concerns over its accuracy and reliability. Any count of workforce will also vary according to definition.

While alternative figures for social care staff numbers are quoted, they do remain broadly in the region of those detailed above when differences with data are taken into consideration. The SIC92 gives a total of 1,235,000 for workers in social work for all client groups in Great Britain (Simon and Owen 2005). It is not possible to determine details on client groups from this data. The SOC2000 estimates that in 2003/4 there were 1.5 million people working in care-related occupations as their main job in England (Eborall 2005), a figure that falls to 930,000 when those working specifically with children are subtracted (it is not possible to separate out those working exclusively for older people from this source's information). Local authority estimates give a figure of 870,000 staff in adult services and 608,900 for staff working with older people specifically (after adjusting for

incomplete and non-response (Eborall 2005)). With the caveats highlighted above in mind, we can see that the social care workforce for the care of older people in England in 2003/4 numbered in the region of 600,000 to 700,000 (headcount).

The staff involved in the provision of social care span several occupations. These include:

- social care staff including professional staff: social workers, care assistants, etc
- health professionals and staff employed in both the social care or health sectors (allied health professionals (AHPs), nurses, health care assistants (HCAs))
- support staff (cleaners, catering staff, porters etc)
- managers (for various levels, context and roles)
- administration and clerical.

‘Flexible’ or agency staff

Counts of agency staff are rarely included in the data. In theory, their use is temporary, but it often becomes semi-permanent. Indications are that the numbers in this group are considerable, but data is very poor. Laing & Buisson estimate that, in 2003, expenditure on flexible staffing for both health and social care for all ages of client, was £4.47 billion (Laing & Buisson 2004). The information available provides estimates for some occupational groups, so by way of example, in 2003 there were approximately 36,000 care assistants employed across the social care sector, 6.3 per cent of the total number.

PUBLIC SECTOR

The data available for the public sector specifically is more extensive than that for the private sector or all employees, but still less than an ideal level. According to the Department of Health data, in September 2004, there were 213,300 whole-time equivalent (WTE) members of staff employed in councils with social services responsibilities (CSSRs) in England (that is, not including staff in the independent or voluntary sector) (Department of Health 2005g). It is difficult to identify a figure for staff working with older people specifically; many staff are recorded as working in generic services and cannot be attributed to a particular client group, in addition to other problems reflecting those for service-wide figures (above). Subtracting from the total those identified as working specifically with client groups other than older people gives 138,500 WTE. (This will be an overestimate, but it is as precise a calculation as possible on the basis of data available.)

Estimates undertaken by the Review suggest there are also approximately 2,000 WTE agency staff working on a long-term basis for older people, or in generic non-age-specific services in the public sector, not included in the above figure. This number does not include short-term agency staff.

In addition to this number are the staff employed by the NHS, in roles that one could identify as partly, or wholly, social care. Estimates for this number vary considerably. A reasonable estimate is 58,000. This does not include some occupational groups, most notably nurses.

Further details on all these figures are provided in Background Paper 5 (‘Workforce’) in the Appendix.

PRIVATE SECTOR

There is a particular paucity of information for private sector staffing. Estimates suggest that the private sector labour force accounts for 411,000 people working in older people's services; 68 per cent of the total provision for the older age-group and 73 per cent of private sector provision in social care as a whole (local authority estimates, Eborall 2005). Figures are subject to caveats on data collection and its reliability, as outlined above.

VOLUNTARY SECTOR

The voluntary sector accounts for a significant minority of the workforce, employing approximately 67,500 staff in services providing care for older people; 11 per cent of the total provision for the older age-group, and 39 per cent of voluntary sector provision in social care as a whole (with caveats, local authority estimates (Eborall 2005). Very little information is available on this group. This is particularly significant not only because of the numbers of staff involved, but also given the increased emphasis and greater involvement envisaged for this sector in recent policy and initiatives (for example, *Our Health, Our Care, Our Say* (Department of Health 2006)).

If the workforce of the future is to be available much more needs to be known about the current workforce, its adequacy and adaptability. It is recommended that methods of data collection should be established and information produced on:

- the independent sector workforce, its size and structure (to match public sector data)
- the numbers of agency staff used and their patterns of employment
- the ethnicity of the workforce
- the prevalence and extent of overtime worked.

This information would be invaluable in making assessments of supply responsiveness, impacts of technology and service development for diverse groups, all of which are essential for effective workforce planning.

Training

At present much of the social care workforce is minimally qualified and often poorly trained. High-quality service in the future is likely to require a skilled and motivated workforce operating well in teams. That in turn is likely to require additional spending on training of some kind.

THE IMPACT OF TRAINING

The current emphasis is on the acquisition of NVQs and specific qualifications. Very little work has been done on the impact training and qualifications have on outcomes of services for people using them. Some particular points do emerge.

- There is some evidence of correlation between the training record within the organisation and the quality of care provided (Commission for Social Care Inspection 2006) but this is by no means conclusive. There is some significant work currently under way by PSSRU (Netten *et al* forthcoming) which promises to offer some quantitative results on the relationship between the qualifications obtained and the outcomes for the clients. Their results should fill an important gap.
- There are still problems with both the training and the quality of care delivered. This is illustrated, for example, in the recent report by CSCI which identified ongoing issues around medication administration and management in homes for older people (Commission for Social Care Inspection 2006).

- Research shows a link between other related factors, such as a correlation between some types of training and satisfaction and motivation levels within the organisation and the recruitment and retention of staff (Kramer and Schmalenber 1991, Parker and Whitfield 2006). There is, in turn, a correlation between recruitment and retention and the outcomes and quality of care (Aiken *et al* 1994).

COSTS

Information about the costs of training activity is tentative at best. Work for this Review by Skills for Care gives the estimated real cost of preparing a new member of staff for and then delivering training up to NVQ level 2 as:

- £2,400 for a new member of staff
- £3,700 for an English speaker who requires ‘essential skills’ learning
- £6,400 for an individual requiring ‘essential skills’ learning and English as an additional language.

The Annex (see p 135) gives more details and important caveats for these figures.

RANGE OF TRAINING

There are several organisations with responsibility for training and acquisition of qualifications in the social care workforce from the provision, commissioning and regulation perspectives. While the situation is arguably not as problematic as that regarding funding of training, there is still scope for confusion over the role of the different authorities and the relationship they have to the providing organisations and to each other.

The range of training extends from basic induction and statutory training (Common Induction Standards (CIS); manual handling; fire awareness etc) through the vocational training and qualifications (NVQs, post-registration training) to the more intensely academic (Diploma in Social Work, the new social work degree and Post Qualifying and Advanced Awards). In addition, this range of available training is applicable for each of the occupations in social care. This huge variety has the benefit of offering the potential to accommodate each staff member at their own level of ability and development in the career direction of their choice. However, it also offers scope for confusion within the service, for both staff and employers, and amongst the public regarding their level of understanding of the competence level of the staff caring for them.

In general, entry criteria and standards for the various courses are set and specified by the GSCC, with CSCI regulating the levels of training that need to be obtained within the organisation. In addition to the oversight of these bodies, there is also a range of other quality measures in place, ranging from those at the very local level, such as organisational policies and procedures, to the national commissions with responsibility for monitoring aspects such as racial equality and disability. Currently, the responsibility for ensuring that the various quality levels for the different issues are met appears to be widely dispersed. While there has been significant progress in joining up these streams of working, the existence of various organisations and means of measuring quality increase the scope for either overlap, and hence unnecessary expenditure, or gaps in application and monitoring, and in either case, the possibility of higher levels of bureaucracy.

NUMBERS

Various sources give information on the numbers of staff both registered for and having completed the various courses or training. Data available reflects findings in other spheres, that is there is reasonable information with regard to the local authority workforce, but information for the independent sector providers is poor. As an indication of the scale and extent of training within the social care sector, in 2003, an estimated 135,000 care assistants and home carers (for all client groups) held some level of NVQ or SVQ, 29 per cent of the total¹ (Social Services Inspectorate 2004, cited in Eborall 2005).

The incentives for people to undertake training appear to be limited at present. It is not generally the case that the level of qualifications obtained are linked to the pay of the employee. Furthermore, the cost to the individual of taking the qualification can be considerable, both financially and in time. This lack of incentives might explain the relatively low level of qualification in social care.

It is clear that further work is urgently required. If significant sums of money are being, and will continue to be, spent on training then we need to be assured that real benefits to service users and staff are forthcoming. It is recommended that:

- the link between training received and the quality of outcomes is established, together with the other factors that impact on increases in quality
- the real costs of training are ascertained
- current capacity for training is ascertained, together with the additional infrastructure necessary to increase training levels as needed.

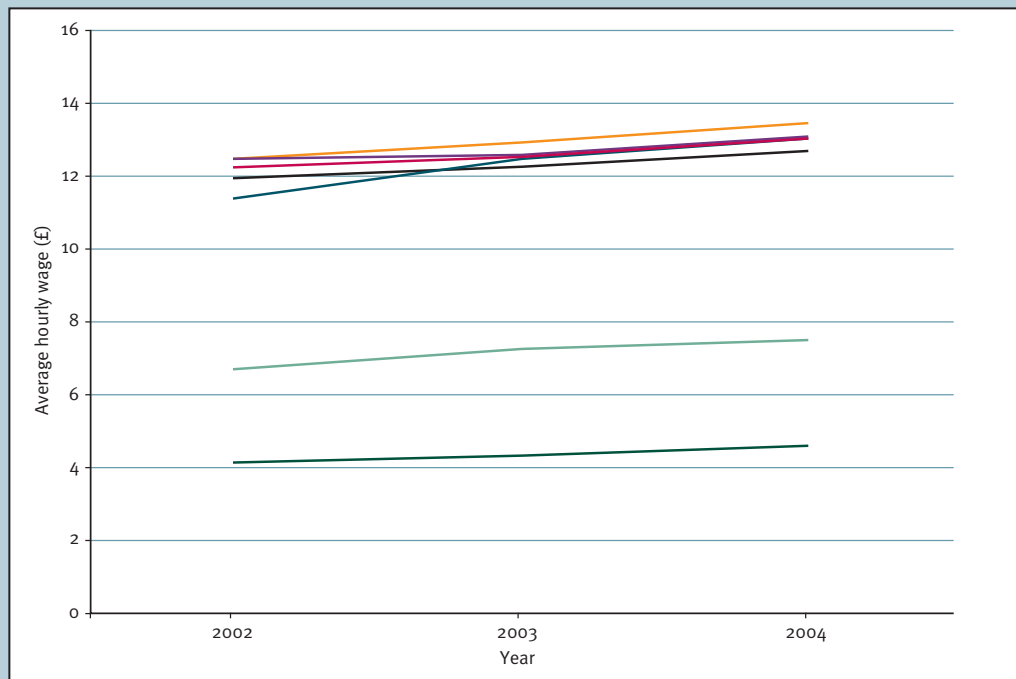
Staff costs

Wage rates in social care vary according to various factors (see Eborall 2005).

- **Geographical location** The East Midlands, for example, has consistently lower wages than the national average, with London and the South East being generally higher.
- **Gender of employee** The data shows that females still receive lower wages than their male counterparts for equivalent work.
- **Client group** Staff in children's services frequently receive higher pay than colleagues in adult services.
- **Type of employer** There is some evidence to suggest that wages received by staff employed in the private sector are lower than those of their public sector counterparts.
- **Nationality** There is sparse data on this factor, but that which exists suggests that foreign-born staff earn less than their UK-born colleagues (Redfoot and Houser 2005). There is not sufficient data available to assess whether there is also a distinction between ethnic groups born in the UK.
- **Size of employing organisation** It appears that managers in care homes with larger numbers of clients are, on average, likely to earn more than their colleagues in smaller equivalents.

Factors often combine to either accentuate the differences or cancel each other out. For example, in 2003, an employee in a children's home in the South East would earn on average between £8.06 and £11.08 per hour, while an employee in a home for older people in the North West would earn £5.80 (Eborall 2005).

39 HOURLY WAGE RATES FOR SELECTION STAFF TYPES, 2002 TO 2004



Source: Prepared for the Review by the Department of Health

Figure 39 above gives hourly wage rates for selected staff types shown against national minimum wage (NMW) (2002–4).

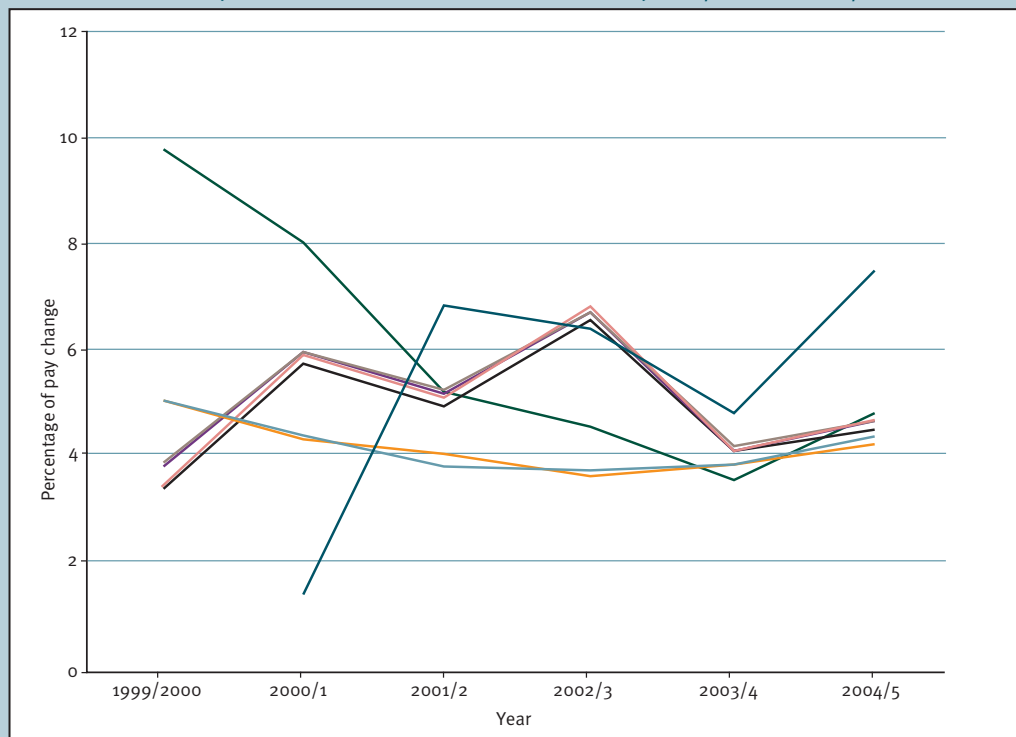
Care assistant wages average just over half the unit costs of home care services (local authority commissioned). For care homes, a toolkit for residential and nursing care costs (Laing & Buisson 2004) also finds that all staff costs account for just over half the weekly ‘fair price’ for care homes providing personal care and nearer two-thirds of the fair price for homes providing nursing care.

Figure 40 opposite compares wage rate growth in the social care sector with changes in NMW, inflation and average earnings index (AEI). It also illustrates the relationship between local authority pay in relation to the rest of the sector. Key points are as follows.

- Personal Social Services (PSS) pay appears to change at very similar rates across sectors and client groups.
- PSS pay rates for PSS staff have been rising at a higher rate than the AEI for some time
- Prior to 2002, PSS pay rate rises were lower than inflation, but since then, they have been in line with or higher than inflation, although the relationship with the NMW has been variable.

The key lesson to be drawn from this information is that rather than not keep up with the economy, the comparative changes in pay suggest that since 2002, pay has in fact risen in line with or at a faster rate than inflation and the AEI.

40 COMPARISON OF WAGE RATE GROWTH IN THE SOCIAL CARE SECTOR WITH CHANGES IN NATIONAL MINIMUM WAGE, INFLATION AND AVERAGE EARNINGS INDEX, 1999/2000 TO 2004/5



Source: Prepared for the Review by the Department of Health. Based on data from the Office for National Statistics and the Personal Social Services Research Unit

¹ National minimum rate changes are based on the Adult Rate national minimum wage, which is calculated in terms of hourly pay. The national minimum wage changes in October each year, so the national minimum wage rate used to calculate the change is six months of one year and six months of the next. The national minimum wage rates for 2006/7 have not been confirmed.

² Average earnings changes are calculated using quarterly average earnings index data from the Office for National Statistics, averaged over Q2-4 in year 1 and Q1 in year 2.

³ Average earnings index for the whole economy including bonus (series 2,000 = 100 – not seasonally adjusted).

⁴ Average earnings index for the whole economy including bonus (series 2,000 = 100 – seasonally adjusted).

⁵ Weighted average personal social services salary changes are calculated using changes in gross weekly pay for relevant occupations weighted by share of the pay bill. Each occupation's share of the pay bill is calculated using Department of Health estimates of workforce numbers and ASHE (Annual Survey of Hours and Earnings) data on mean pay. The estimated personal social services pay change for 2004/05 is calculated as the average real pay change in the previous three years combined with projected inflation (HMT GDP deflator).

Vacancies and turnover

The limited information available suggests that vacancy rates in social care are high, both absolutely and relatively. In 2004, there were 53,000 vacancies for social workers, occupational therapists and other care-related occupations notified to JobCentres in England, with vacancies having been running at more than 50,000 per quarter since the last quarter of 2003. For 'care assistants and home carers' between April 2003 and January 2005, vacancy rates varied a great deal, and ranged between 4,200 and 13,500, with no particular increasing or decreasing trend being evident (based on data from Eborall 2005). In addition, the National Employers Skills Survey showed that, in 2003, vacancy rates in social care were about twice as high as those for the totality of all private and public sector business activity in England (Eborall 2005). Even with the significant geographical variations reported across the country, this still represents an issue in social care far bigger than in other sectors.

This is confirmed by figures in the public sector, for which there is a higher quality of information available. Figures suggest that in 2003, national vacancy rates for CSSRs ranged from 8.1 per cent (residential home managers and supervisors – older people) to 18.7 per cent (occupational therapists), varying according to the occupation in question. These rates vary regionally, from 1.5 per cent (home care organisers – Eastern Region) to 32.9 per cent (occupational therapists in London) (all from Eborall, 2005).

Turnover rates reflect a similar pattern. National rates are high (Revans 2005 cited in Parker and Whitfield 2005), although there is little information to substantiate this across the sectors. Sources from the public sector suggests a range of between 8.7 per cent and 17.1 per cent including retirement, or 6.9 per cent and 16.3 per cent excluding retirement (for England in 2003). Again, regional variation is large.

3 How responsive is the workforce?

A crucial question when looking ahead is whether the supply of formal services can keep pace with the anticipated increase in demand for care. The responsiveness of the size of the workforce is a pivotal factor. How quickly can workforce supply increase to meet growing demand? What quality of workforce will be forthcoming? What pay rates will be required to sustain a long-run increase in supply (quantity and quality)? What other factors influence and constrain workforce supply?

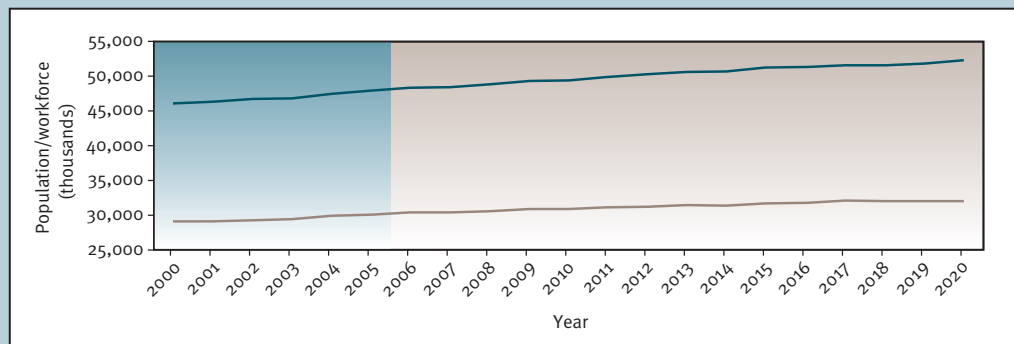
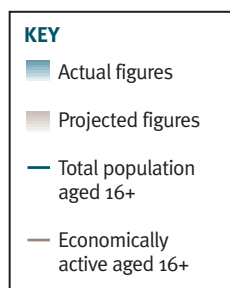
There is no direct research evidence on how quickly workforce supply responds to demand. Nonetheless, there are indicators, some of which appear contradictory.

High levels of vacancy suggest that supply either lags behind demand or that it is unresponsive. In all industries, the workforce changes over time. However, as noted above, social care vacancy levels appear to be high compared with the rest of the economy. Also, the introduction of the national minimum wage does not appear to have had a significant impact on vacancy rates to date (see Background Paper 5 ('Workforce') in the Appendix).

However, other sources conflict with this. Analysis of the Labour Force Survey in Scotland (Bell *et al* 2006) suggests that there has been a significant increase in the numbers working in social care over a relatively short period. In the period during the introduction of free personal care (see Chapter 12), between 2001 and 2004, employment in the care sector increased in total by over 50 per cent and weekly hours by 11 per cent. Total hours supplied by care assistants increased by over 75 per cent in that period. At the same time, average hourly wages increased by only 5 per cent. The study was based on a small sample size, but does strongly imply a high responsiveness of workforce supply, at least among care assistants in Scotland at that time.

In addition, in the past, the provision of services has appeared to react quickly to demand opportunities. For example, during the 1980s the number of care home places for older people increased by 90 per cent (1982 to 1992, Department of Health community care statistics). Analysis comparing local authorities in England estimated that significant increases in the supply of both care home places and home care hours would be forthcoming with only small increases in price, if demand increased (Fernández and Forder 2002). This also suggests that the workforce is responsive.

41 ESTIMATES AND PROJECTIONS OF THE LABOUR FORCE IN THE UNITED KINGDOM, 2000 TO 2020



Source: Based on data from the Office for National Statistics (2006)

4 Factors affecting supply

There is a range of factors that could affect workforce supply in the future.

National labour force and population

The population of England is ageing; the number of older people in the population is expected to rise significantly. However, estimates and predictions by ONS suggest that there will be little change in the proportion of the population (over 16) that is economically active (see Figure 41 above). This proportion changed from 63.1 per cent in 2000 to 63.0 per cent by 2006, and to a predicted value of 61.7 per cent by 2020. This would suggest the feared shortage of labour caused by increases in the proportion of people above the working age may not be as significant as many assert. Numbers potentially available to form the social care workforce would not appear to diminish substantially in the near future.

Although relative numbers in the economic active population may not decline significantly, the average age of economically active people will increase. The implications for social care are not fully clear. Nonetheless, there are suggestions that older care workers are well-received by service users.

Migration and immigrant workforce

The immigration of individuals from outside the UK, and internal migration within the UK, to work in the social care sphere is not a new phenomenon. In recent years, however, there has been an anecdotal increase in the proportion of the workforce from overseas, and a change in the workforce structure as a result. The active recruitment of staff from other countries, particularly the developing world, together with the increased freedom of movement between EU states resulting from the 2003 Treaty of Accession (European Commission 2003), and the expansion of EU membership (Jandl and Hofmann 2004 cited in Redfoot and Houser 2005), would support this assertion. According to Redfoot and Houser (2005) the UK is now one of the largest importers of professional health care workers in the world, with a large percentage of these staff working in the long-term care system. If it is the case that a significant part of the care workforce is sourced from the immigrant population, then changes in national policy with regard to immigration

(particularly of people with low skills) will have a relatively large impact on social care. This is especially the case if there are also trends in UK staff migrating abroad to work, which appears to be the case. This would mean that the UK social care workforce is effectively operating within an international market in a way not seen previously, and will need to respond accordingly.

Changes in service development and care technology

One of the most significant changes to the staff required for the supply of social care is the introduction of technology, either in ways that are in addition to existing methods, or replacing current methods of operation (see Chapter 9). There are several key ways in which this could influence staff supply.

- **Quantity** Work done to date suggests that the introduction of technology leads to initial increases in the staff needed, before a subsequent fall. It is difficult to be clear about the size of any long-run substitution of technology for labour inputs, but a potential area is in supervision. While some work has been done to estimate possible savings associated with the introduction of technology (such as in Audit Commission 2004), these generally concentrate on the positive impact on care-staff time, and fail to consider the staff required for monitoring and operating equipment, thus leading to potentially misleading results.
- **Skills** More technological knowledge will be required of staff, both for monitoring, and to a lesser extent for responding to alerts, which may include 'frontline' staff, particularly in home/domiciliary care.
- **Price** It is likely that the specialisation of work and the introduction of a greater range of skills required will mean staff expect and attract higher salaries (especially the groups using the technology). Work done by the Audit Commission (2004) indicates that the cost overall of using technology would be considerably less than the current labour intensive methods. This Review's research has found, however, that rather than reduce costs overall, it is likely that use of more technologically focused methods may utilise the time of the staff better, thus enabling them to cater for more people, but that this would not necessarily involve reductions of cost overall.

Types of staff and skill mix

The existing labour market is based on the skill mix required by the current service. This might be expected to change through time. The 'Options for Excellence' workforce review recently initiated by the Department of Health, has recognised this issue in workforce planning and is working on possible ways forward. There has been some analysis of extension and redesign of roles for the social care workforce (see Department of Health 2004c, General Social Care Council 2002) – although this is far less developed than in health care (see Department of Health 2000a, Department of Health 2002a, Department of Health Modernisation Agency 2004a and 2004b, Jenkins-Clarke and Carr-Hill 1996, Richardson and Maynard 1995). However, many argue that this is not the coherent response to changes in demand that is really needed (Milton Keynes and South Midlands Health and Social Care 2005), and it is generally agreed that more is needed to develop roles so that they meet demand in the most appropriate and effective way. It is important that the impact of changes is considered ahead of changes being made, however, so the response can be adequate and timely, or even pre-emptive. To date, very little work has been done on the impact of changes on the market supply. This needs to be addressed.

Training capacity

The supply of trained staff will be constrained by the capacity to provide training. A substantial expansion of workforce would, under current conditions, require a corresponding increase in staff able to facilitate the necessary training and assessment, adding an additional constraint to the time taken to train the staff themselves. This would have time and funding implications. A lack of data undermines attempts to quantify this requirement.

Regulation

The social care workforce is increasingly monitored and regulated. This has the potential to impact on the quality of services and also on supply, for example in the way that regulations impose additional staff costs.

- **Criminal Records Bureau (CRB) checks** These are currently necessary for all people working with children or vulnerable people, which includes elderly people.²
- **Qualification requirements** The Department of Health previously set a target for 50 per cent of staff to reach NVQ level 2 and this has implications for recruitment of non-qualified staff (Department for Education and Skills 2003), while there are barriers to both the employers and the employees in acquisition of this level of training, with implications for the provision of services.
- **Qualifications from other countries** The equivalency procedures to assess the competency of staff who have qualified abroad are arguably necessary to ensure public protection, but they do have resource implications and the potential to introduce an additional time lag to any increase in supply that would involve this process.

Motivation and perception

In general, perceptions of care work are still frequently negative among the public or the staff themselves (Alcock 2003). Among the public, a poor attitude towards social workers and social care workers and the job that they do appears to be prevalent across age groups, genders and socio-economic class (COI Communications 2001). This is largely reinforced by the media, with research indicating that the majority of coverage is adverse, or frequently unrelentingly critical rather than supportive (Eborall and Garmeson 2001). While some suggest that this poor perception is rapidly decreasing, with the public sector fast becoming an attractive option for ambitious young people (The Guardian Newsprint Supplement 2005), this is yet to translate into reality for many, with anecdote and perception still very much at the more negative end of the spectrum.

Within the service, it appears the perceptions are also poor, with research showing that there are certain aspects and conditions within the system that are particularly prominent and influential in causing staff to reflect the negative emphasis seen externally (Eborall and Garmeson 2001). Staff also feel that their work is undervalued in society and their image is negative, largely as a result of media stereotyping (COI Communications 2005). This could be turned to advantage, as it offers recognisable factors that can be worked on in order to improve perceptions and motivation both within and outside the service.

It should be noted that the public's negative perceptions of care work are generally not shared by the staff themselves. Despite being aware of the negative aspects of their job, staff have been found to value and show dedication to their work and their clients (COI

Communications 2005) (for further details, see Background Paper 5 ('Workforce') in the Appendix).

Conditions and career prospects

While pay levels are arguably a key factor in the acquisition and retention of staff, other benefits, both financial and non-financial, also have an impact on the appeal of the work and have a key role in motivating people to join the sector. Particular problems at present include the following.

- Some employees do not have adequate savings or pension rights (Ungerson 2000).
- A lack of graduated pay according to qualifications acts as a disincentive to 'careerists'.
- Few workers are given contracts, often putting workers at a disadvantage (Andrews and Phillips 2000).
- Where contracts do exist, these are frequently 'zero-hour' with no guaranteed hours for the working week.
- There is frequently little, if any, compensation for travel between clients (for staff working in the community), with time travelling and not spent directly on care frequently subtracted from paid-for hours.

5 Conclusions

The social care workforce is large in scale and spread out across a wide range and number of employers. There is, however, a lack of robust evidence and data about the exact size and composition of the sector, although a number of promising initiatives are now in train to remedy this situation.

There are key issues, pertinent to this Review. First, is the question of whether there is currently sufficient capacity in the workforce. In the context of expected increases in demand for care in the future, there is a very real issue of whether it is possible realistically to expect supply to increase in response. There are mixed signals about supply responsiveness, and about what factors might bring about increases in supply. Trends in recruitment and retention suggest that the current policies and pay are not closing the gap between demand and supply. But, there is a range of circumstantial and anecdotal evidence that is, on balance, positive about future supply. Overall, the problem is not having definitive studies to be able to confidently decide this issue. This difficulty of interpretation of the evidence is compounded by the complexity of the issue. Supply of labour to the social care market depends on wages, people's willingness to work in social care, barriers to market entry, the capacity in the wider economy for people to work in the low-pay sector, the action of competitor industries like health care and so on. Also, the UK is operating within an international labour market in a way not seen previously. It is clearer that the sector will need to act in a more competitive manner to attract staff in the future. This then needs to be combined with appropriate and cost-effective training to ensure the outcomes received are of a high quality.

Second is the question of quality of care received by service users. Current systems of measurement concentrate on the processes rather than the outcomes achieved. Minimum standards such as bringing 50 per cent of social care staff up to a minimum NVQ level 2 focus on the levels of training rather than the outcomes achieved as a result. As set out above, any indications of the relationship between acquisitions of qualifications and quality of service are not conclusive, and seem to be dependent on other factors, including, most

importantly, the existence of a working definition of what constitutes a high quality of service. Evidence suggests that training alone is not sufficient to ensure favourable outcomes in service provision, but that it must be combined with other factors to ensure the quality of care received is as effective and favourable as possible. A great deal more work is required to substantiate possible correlations and produce viable methods of ensuring that positive outcomes are introduced in practice. Rigorous substantiation of a link between qualifications and quality would need to be followed with introduction of proven incentives for the employees to undertake training and the employers to provide it.

In the models described later the central assumption is that unit costs need to grow consistently by at least 2 per cent real over the 20-year period. The sensitivity of overall funding requirements is also tested. Work is urgently needed to objectively examine supply responsiveness of the workforce and the potential impact of pay on supply.



Annex. Unit costs – Training

Obtaining costs for the training of social care staff is problematic. Not only is there a range of qualifications and types of training available from various organisations, but individuals enter the workforce at very different levels of competence, thus requiring varying levels of input. This is in addition to the fact that there is a range of occupations within the social care workforce, all of which will have all these variables. As a result, it is very difficult to put a cost on training in social care. It should be noted that this is not particularly unusual.

Work done for the Review by Skills for Care has made an estimate of the cost of training care workers to the 3 NVQ levels from various stages of development. While this is only one occupational group within the care remit, the care workers represent a large proportion of the workforce for current methods and systems of provision, so is the group most sensible to concentrate on. It has been argued that the costs to qualify an individual to NVQ levels 2–4, need to include the cost of bringing a member of staff up to a basic level of competence prior to their being able to work effectively in the workplace and start the more formal training (see Background Paper 5 (‘Workforce’) in the Appendix). Informal reports suggest that approximately 50 per cent of staff recruited for NVQ levels 2 and 3 need assistance with additional learning (termed as essential skills), and up to 40 per cent of recruits for these levels need assistance with English language training, both initially and as they progress. The core estimated costs for the training and the additional ‘skills’ training are shown in Table 33 overleaf. These figures are an indication only of the training costs and do not correspond to the amount that training institutions might charge.

There are expenses not included here which also need to be considered when estimating the unit cost of training staff in the social care sector. These are discussed at greater length in Background Paper 5 (‘Workforce’) in the Appendix. They include:

- supervision and appraisal of staff, and HR costs, estimated at 10 per cent of workforce costs and 5 per cent of workforce costs respectively
- acquisition of the supplementary funding to support staff training. The sources of supplementary funding are many but rarely generous and require a level of technical knowledge and brokerage to access. It is estimated that the cost of organising this can add an additional 20 per cent on the training costs
- induction
- health and safety training depending on responsibilities

TABLE 33: ESTIMATED COST OF TRAINING CARE WORKERS TO NVQ LEVELS 2–4, PER INDIVIDUAL BY LEVEL OF COMPETENCE

Training unit	Cost of achieving level of competence (£)			
	NVQ2	NVQ3	NVQ4	Total to NVQ 4
English as an additional language	2,000	2,500	3,000	3,000
Essential skills	1,000	2,000	3,000	3,000
NVQ learning	600	800	800	2,200
NVQ assessment/registration	600	770	770	2,140
NVQ only total	1,200	1,570	1,570	4,340

Source: Prepared for the Review by Skills for Care

- cost of recruitment
- replacement cost for the period of time in which staff are released for training.

Notes

¹ Total number 459,000 – figure from the SOC2000 (LFS) for occupation code 6115 (Eborall 2005).

² The wait for CRB clearance was 3 months in 2005. There are ways in which this delay can be minimised and decreased (see CSCI Policy & Guidance) but this still remains a potential constraint on staff employment, albeit only short term.

8

Informal care

SUMMARY

The provision of long-term care to older people relies very heavily on the contribution from informal carers. This chapter looks at the provision and costs of informal care, and factors such as changing demographics which will influence the future availability of informal care.

- It is estimated that in 2000 there were around 5.8 million carers in England, of whom between 3.4 million and 4 million were providing care to those aged 65 and over. More than one-fifth of carers who are living with the care recipient provide care for 100 or more hours a week.
- Informal carers provide personal care and monitor medication, but they generally devote most time to practical care tasks, such as shopping and laundry. Large numbers of carers also see a key role as providing company and ‘keeping an eye’ on the older person, particularly if the care recipient is cognitively impaired.
- The older generation supplies a disproportionate amount of care. In 2000, 16 per cent of people over the age of 65 were providing some form of care, and this age group made up 28 per cent of carers providing 20 hours or more care each week.
- Women tend to have heavier care commitments, although the gender division with regard to caring has become less stark.
- Other factors impacting on the propensity to provide care include economic status, level of education, location and ethnicity.
- Carer support and information services do exist but are currently received by only a minority of carers.
- Estimating the true gross financial cost of informal care to either society or individuals is difficult. An accurate figure would need to take account of reduced earnings from employment, the consequent loss to the Exchequer, the long-term impact of reduced pension contributions and the cost of carer support services. There are also indirect or non-financial costs of caring, such as social exclusion, erosion of personal relationships and adverse effects on health (which then presents a cost to the NHS).
- Availability of informal care may well not keep pace with increases in care needs in the future. Assuming current patterns of care, the PSSRU model suggests that from 2003 to 2026 the ‘demand’ for informal care will increase by around 45 per cent.
- Various trends affect availability of informal care. There has been a significant decline in co-residence between adults and elderly parents, and an increase in one-person households, both of which point to lower availability of informal care. Second, people who might currently be prepared to care for those in need in certain circumstances may not be so willing in future.

Informal care will continue to provide a very significant input to social care, even if increases in availability fall short of future demand. Greater carer support is needed to relieve some of the pressure of care, as the costs of increasing formal care to meet a significant reduction in informal care would be prohibitively high.

1 Introduction

In this Review, the term ‘informal care’ includes support (looking after or other ‘special help’) provided to the sick, disabled or elderly in a non-professional capacity. It excludes instances where only financial support is given to the recipient.

‘Informal care’ is a misleading term for the magnitude of the task it describes and the dedication of the individuals who perform it. There is debate over the correct term to use for carers who provide support in these circumstances, with all proposed definitions presenting issues. The Review Team considers the term ‘informal care’ to be the least problematic regarding clarity, but recognises the issues around its usage.

Many of the issues summarised in this chapter are discussed in more detail in Background Paper 6 (‘Informal care’) in the Appendix.

2 Current position

Carer inputs

In recent years, there has been a small (but not steady) increase in the prevalence of caring in Great Britain. Households with carers and carers in the population have stayed between 16–21 per cent and 11–16 per cent respectively between 1985 and 2000 (Maher and Green 2002). The situation of people being cared for is changing, however. There has, for example, been a consistent increase in the number of one-person households in Great Britain. Taken together, these trends have significant implications for the amount of care needed in the future.

As is the case in formal care, the data varies according to the source that is used and the definitions and inclusions within this. According to *Carers 2000* (Maher and Green 2002), in 2000 there were approximately 6.7 million carers in Great Britain; 86 per cent of them in England (5.8 million). Seventy per cent of the care recipients were over 65. So, in 2000, England had a caring population for the over 65s of around 4 million people. Analysis of the 2001 Census, however, gives a figure of 4.9 million people providing some care in England, which would imply around 3.4 million people caring for those over 65. This chapter uses data from *Carers 2000*.¹

The time devoted to caring varies. Some people spend more than 100 hours per week providing care, although 70 per cent of carers provide care for less than 20 hours per week. Hours vary significantly with factors such as whether the carer lives in the same or another household. While those living in another household are very unlikely to care for 50 or more hours per week, more than 20 per cent of carers living in the same household are caring for 100 or more hours per week (see Table 34 opposite).

Nature of care

The tasks performed by informal carers reflect those performed by formal carers, but vary in the proportions devoted to different types of support. Tasks such as personal care and medication make up the majority of formal carers' work but are provided by smaller proportions of informal carers (Maher and Green 2002), especially where the carer does not reside with the care recipient (Hirst 2001). Informal carers devote most time to practical care tasks, such as shopping and laundry. Large numbers of carers also see a key role in providing company and 'keeping an eye' on the person generally (what some describe as 'supervision'). This task is particularly important when the cared-for person is cognitively impaired.

TABLE 34: CARERS OF PEOPLE AGED 65+, HOURS PER WEEK SPENT CARING, 2000

Number of hours per week spent caring for main person cared for	Percentage of carers of people aged 65+		
	Person cared for in carer's household	Person cared for in another private household	All
0–19	33.4	89.0	78.0
20–34	14.3	5.7	7.3
35–49	9.8	2.0	3.5
50–99	11.8	0.8	2.9
100 or more	20.7	0.4	4.3
Varies, 20 or less	2.2	0.7	1.1
Varies, 20 or more	6.4	0.5	1.6
Other	1.4	1.0	1.3

Source: Based on unpublished analysis of the General Household Survey 2001, prepared for Review by Office for National Statistics

Factors affecting the provision of informal care

Categorising the provision of informal care is important, not least because disaggregating allows us to be more accurate when attempting to predict future numbers. Many personal and circumstantial factors impact on the likelihood of a person providing care, as follows.

HOUSEHOLD STATUS

The residence of the carer in relation to the care recipient has a significant impact on the time spent caring; those who live in the same place tend to care for a much higher number of hours. That also has an impact on the likelihood of being a main or subsidiary carer, with those who live in the same household being twice as likely to be the main carer as those looking after someone who lived elsewhere (Maher and Green 2002).

Table 35 overleaf shows the numbers of carers for older people in England according to their relationship with the care recipient. These have been derived from figures from *Carers 2000* applied to the carer population for England (Maher and Green 2000). It is important to note that the number of carers tends to be higher than the number of care recipients. In particular, many older people have more than one child providing care.

Of carers in total, the highest numbers are children (and children-in-law) of the care recipient (filial carers). Married or cohabiting adults appear to be more likely to be carers

TABLE 35: NUMBERS OF CARERS BY RELATIONSHIP WITH CARE RECIPIENT, 2000

Relationship of carer to care recipient	All carers		
	Great Britain ¹ (%) ²	Great Britain (millions) ³	England ⁴ (millions)
Spouse	18	1.2	1.0
Child/child-in-law	52	3.5	3.0
Friend/neighbour	21	1.4	1.2
Other	30	2.0	1.7
Total		8.1	7.0

¹ Based on figures in Maher and Green 2002.

² Percentages add to more than 100 because some carers were looking after more than one person and are therefore counted more than once in these figures.

³ Estimate, Wanless Review.

⁴ 86 per cent of total for Great Britain.

than those who are single or previously married (19 per cent compared with 10 per cent and 12 per cent) (Maher and Green 2002). This is also significantly linked to gender, age and household status trends.

AGE AND GENDER

The likelihood of being a carer also varies with age and gender. The burden of care is shouldered disproportionately by the older generation, both in the proportion caring and in hours of care. The probability of becoming a carer increases with age, with probability notably higher for co-residential care the older one becomes (Hirst 2002). In 2000, 16 per cent of people over the age of 65 were providing some form of care, equating to 28 per cent of carers providing 20 hours or more care each week. Some 37 per cent of those carers over the age of 65 were caring for 50 hours or more per week for a care recipient they lived with against an average of 31 per cent for 30- to 64-year-olds co-residing with the recipient.

The role of caring has traditionally been performed by females. In recent years, the gender division with regard to care provision has become less stark, but care tends still to be administered by more women than men; similar to older people, women disproportionately shoulder caring responsibility. Key points regarding this are:

- a greater proportion of women are carers than men (Office for National Statistics (ONS) 2004b)
- women tend to have the heavier commitments, with 11 per cent of women compared with 7 per cent of men being main carers, and 5 per cent of women compared with 3 per cent of men spending 20 hours a week or more on caring tasks (Maher and Green 2002)
- in both spousal and filial relationships, women generally perform the caring role more than the man; nonetheless, in their later years (70+) a high proportion of male spouses are carers.

ECONOMIC STATUS/INCOME

There is disagreement over whether the wealth and economic status of the person has an impact on the levels of informal care. Some claim those from less advantaged backgrounds are more likely to provide intensive care, especially to a spouse (Young *et al* 2005a), (possible reasons for this including higher levels of poor health and disability in manual groups). Opposing this view, however, is the assertion that wealth is not a deciding factor in provision of informal care; additional income does not reduce the

probability of individuals providing informal care, if other factors are constant (Leontaridi and Bell 2005).

The correlation between working status and caring is more certain. Caring rates are higher (21 per cent) among the economically inactive (that is, not specifically seeking work due to retirement, long-term illness, etc) compared with full-time workers (13 per cent), part-time workers (17 per cent) and the unemployed (15 per cent) (Maher and Green 2002). Economic status can be influenced by the need to provide care, however, with the reduced income, pensions and reduced likelihood of employment frequently negatively impacting on finances.

EDUCATION

Level of education has some impact on the propensity to care. Higher levels of education appear to reduce the probability of caring (for those living outside the household of the care recipient) (Machin and McShane 2001).

LOCATION

The provision of informal care across the UK varies considerably with region and local authority. General trends seem to include:

- very rural areas generally have a higher proportion of adults providing care (ONS 2004a)
- some degree of clustering of higher propensity to provide informal care in the heavily industrialised areas, such as the West Midlands
- lower levels of caring in the more affluent areas, such as London and the South East and South-Central England.

It has also been suggested that there may be some correlation between levels of informal caring and levels of deprivation and poor health (Young *et al* 2005a), although the evidence is not conclusive.

In addition to the location of the carer and care recipient, the proximity of the carer to the care recipient can have an impact on the likelihood of caring. This is particularly the case where a child is the carer. Unsurprisingly, the further a child lives from the parent, the less likely they are to administer care on a regular basis.

ETHNICITY

Research in the UK on the correlation between informal care and ethnicity has been limited but suggests that ethnicity does have an impact on propensity to care, with prevalence being highest among Bangladeshi, Pakistani and Indian groups (Young *et al* 2005a). Reasons suggested for this include socio-economic and cultural factors.

Carer support services currently provided

At present there is a range of services available to support carers, including respite care of various types, information and training of carers, social work and counselling. The government collects information on total numbers of carers that receive council assessments and services (NHS Health and Social Care Information Centre 2005). Table 36 overleaf gives details. To put these numbers in context, the lowest estimates of carers for older people is 3.4 million people (derived from the Census). If it is assumed that only those people providing more than 20 hours a week would benefit from carer support (not necessarily a valid assumption) then only about 20 per cent of 3.4 million might apply, that

TABLE 36: NUMBER OF CARERS RECEIVING CARER ASSESSMENTS AND SERVICES, 2004/5

	Number of carers (thousands)
Carer assessments	
Carers assessed or reviewed separately	46
Carers assessed or reviewed jointly	148
Carers declining an assessment during the period	30
Carer services	
Carers receiving 'carer specific' services	65
Carers receiving information only	79

Source: Based on Department of Health Referrals, Assessments and Packages of Care Project data

is 680,000 carers. The figures in Table 36 suggest around 10 per cent of the 680,000 receive support services.

The apparent low level of provision of information is particularly concerning. As to the type of services received by carers, information is not routinely collected, but a picture can be put together from various sources (Keeley and Clarke 2002) (*see* Annex, p 152).

3 The current cost of caring

Costs of caring are not simple to define or establish. The evidence base is poorly developed.

Individual costs

The reasons why people provide informal care are complex. That people are motivated to do so is self-evident from the large numbers of people who do devote time and effort in this way (*see also* Evandrou and Glaser 2003, Young *et al* 2005a). Whether because of some sense of commitment, duty or emotional attachment, people provide care despite the potentially significant costs.

People suffer a loss of income if they forgo employment opportunities. In practice, while there are many who successfully combine work and a caring responsibility, this is difficult for carers to manage (Arksey *et al* 2005b, Machin and McShane 2001) found from an analysis of the Family Resources Survey that 75 per cent of carers living elsewhere from the cared-for person and 19 per cent of co-habiting carers were economically active. (The latter low figure reflects the high number of spousal carers who will have retired.) The loss of income can also have a detrimental effect on pensions, particularly for women in pre-retirement years (Thomas Coram Research Unit 2002, Hirst 2002).

It has been argued that the regulations around receipt of carers' benefits are overly restrictive, creating a disincentive to work (Arksey *et al* 2005). Those caring for older people are particularly affected, despite reforms such as removing the upper age limit for Carers Allowance (CA) in 2002 (Department for Work and Pensions 2005, Evandrou and Glaser 2003). People also incur care-related costs such as travel, food, accommodation costs etc (Pickard 2004).

THE HEALTH OF CARERS

The main self-reported problems experienced by carers which have been attributed to some extent to caring responsibilities include (from Maher and Green 2002):

- feeling both tired and stressed (20 per cent)
- being short-tempered (17 per cent)
- feeling depressed (14 per cent)
- disturbed/loss of sleep (14 per cent).

This is in addition to other problems and conditions which have been associated with caring, particularly when for long hours and over extended periods (Hirst 2005, Keeley and Clarke 2002). These can include anxiety, depression and psychiatric illness, lowered social functioning, increased susceptibility to physical illness, increased rates of chronic diseases during episodes of caring and general negative impacts on physical well-being.

The propensity to have health problems as a result of caring varies with a range of factors including severity and duration of need and the intensity and nature of caring. The characteristics of the carer also matter (age, sex, relationship with care recipient) (Doran *et al* 2003, Glasser *et al* 2005, Hirst 2005, Maher and Green 2002). The effects can be compounded by a lack of support or respite for carers generally or poor access to health care (Arksey and Hirst 2005).

In addition, there are potentially considerable indirect or non-financial costs of caring, costs such as social exclusion, erosion of personal relationships and adverse effects on health. The Princess Royal Trust for Carers indicated that 85 per cent of carers said that caring had a negative impact on their health (Keeley and Clarke 2002), a factor corroborated by *Carers 2000*. (The possible effects are summarised in the box above.) Various types of support are available for carers, some of which have been shown to reduce carer stress and other adverse health effects, and produce other positive outcomes. In Chapter 10, below, and in Background Paper 6 ('Informal care') in the Appendix, the cost-effectiveness of possible interventions is considered.

Economy-wide costs

The costs to the economy of informal caring are twofold: the direct cost of the services provided to carers, and the cost to the economy of the carers not being engaged elsewhere and thus not able to make an alternative contribution to the economy. At present there is little information on either. In Chapter 10, carer support services as they might be deployed in the future and their possible costs are specified. The modelling work by PSSRU on current service patterns detailed in the accompanying paper by Malley and colleagues, Research Paper 1 ('PSSRU model'), identifies costs of respite care services. These are estimated to cost around £200 million in 2007.

INDIRECT COSTS

Costs at an individual level are clearly felt (as described above). Determining the cost of informal care to the economy, however, presents considerable methodological challenges. The initial reaction to the National Institute for Health and Clinical Excellence (NICE) for excluding these costs in its appraisal of new drugs for treatment of Alzheimer's disease testifies to the strength of concern in this regard (see box below, and Chapter 9).

ALZHEIMER'S DRUGS – NICE APPRAISAL

The high level and cost of informal care for people with dementia has been debated following NICE's appraisal of various Alzheimer's drugs. People with dementia and their families argue that assessment of the cost-effectiveness of dementia care should include the hidden costs of informal care.

In its preliminary 2005 recommendation, NICE concluded that the drugs in question should not be used in the NHS, (except memantine as part of certain ongoing clinical studies). It judged that the drugs lay outside the range of cost-effectiveness considered appropriate for the NHS.

The NICE evaluation found that the literature was sparse on the costs associated with Alzheimer's, but that a significant proportion of these costs fell on patients and caregivers. A review of nine studies on costs for community-based people with Alzheimer's estimated that the proportion of total costs represented by informal care ranged between 36 per cent and 85 per cent (McDaid 2001). The wide range was in part due to differences in the type of costs included and the methods used to quantify and value caregiver time. A cost study in Ireland found that family care accounted for almost 50 per cent of the overall resource burden for Alzheimer's (based on an opportunity cost valuation of carer time) (O'Shea and O'Reilly 2000).

There was a fierce reaction to the NICE preliminary recommendations, with families and pressure groups strongly opposed to the suggestion that the drugs should not be prescribed by the NHS. The then Health Secretary indicated that he had brought a number of questions to NICE's attention:

- Had NICE carried out a cost-effectiveness analysis of this medication compared to non-drug interventions for cognition, behaviour, activity of daily living and carer burden?
- Would NICE consider including carer time when reassessing cost-effectiveness? In its response to NICE, the Department of Health asked: 'Has NICE considered whether there would be a different answer if the costs of carers as opposed to the benefits were included? Would this make a difference? It is our understanding that NICE generally only considers NHS costs. Is it satisfied that this is sufficiently wide-ranging to cover adequately all the potential benefits of the drugs involved? The care of people with dementia relies heavily on family caregivers. As there is data from randomised controlled trials on reduction in caregiver time as a benefit from these medications, would NICE reconsider re-assessing cost-effectiveness including a factor for carer time in the outcome?' (Department of Health 2005l).

In January 2006, NICE issued a revised appraisal saying that certain drugs should be available on the NHS but only to those with moderate Alzheimer's. In the economic modelling, an adjustment was made to cover the quality of life (utility) gains of carers that arose when an Alzheimer's patient in receipt of one of the drugs did not progress to later and more difficult stages of the disease within 5 years or because of death. However, it was decided that it was not appropriate for carer costs to be included in the economic model. It cited the potential for double counting if the effect on carers was incorporated both as improvements in utilities and some monetary value of the

opportunity costs. In addition, current NICE guidance calls for only the use of NHS and PSS resources to be included. So, the hopes of users groups were dashed that NICE's Alzheimer drug report might set a precedent for the opportunity costs of carers to be taken into account when assessing the cost-benefits of social care models.

STATE BENEFITS

In acknowledgement of their financial position, some carers are able to claim Carers Allowance. This benefit is estimated to cost at least £19.7 million per week. As of August 2005 there were 441,000 claimants in Great Britain (Department for Work and Pensions 2006b) and the basic benefit rate was £44.35 per week.² Carers can also be eligible for income-related benefits and premiums or in-work financial benefits depending on their situation (Arksey *et al* 2005). Given the complexity and repeated testing for entitlement, uptake can be low. The introduction of Individual Budgets (IBs) will help to streamline the process for claimants.

LOST CONTRIBUTIONS

The level of contribution that individuals would be making to the economy is dependent on whether they would be working (more or at all) were they not in a caring role. As noted above, having caring responsibilities does not automatically result in withdrawal from the labour market, with even those who provide care for longer hours showing a relatively high participation rate (Machin and McShane 2001, Maher and Green 2002). There does, however, appear to be some impact on the decisions and behaviour of carers regarding involvement in the labour market, with correlations existing between both length of time spent caring and the propensity to work, and the level of caring responsibility with the number of hours worked (both inversely proportionate). Furthermore, the likelihood of a person returning to work is affected, as are the wages and position of the employee compared to that prior to the caring break. For those that participate in the workforce throughout caring episodes, employment is frequently compromised by factors such as the need for flexibility, restrictions imposed for benefits and other responsibilities. It is noteworthy, however, that the perceived impact of the caring role on workforce participation is significantly higher than the figures suggest is the case (Machin and McShane 2001). This gives some indication that the caring role may have some impact on optimal employment as well as actual employment rates.

Measuring the economy-wide cost is problematic. There are two broad approaches. These costs can be measured in terms of what it would cost to replace informal care inputs with formal care (market replacement cost), or they can be measured as the income/working and leisure forgone due to time being devoted to caring. The former is likely to underestimate the full economic cost, but the latter is demanding to calculate and involves assumptions about the value of work and leisure for people. Nonetheless, there have been attempts to estimate these costs. Examples cited in Pickard (2004) include consideration of aspects relating to both the individual and to the economy, such as direct expenditure, forgone waged and non-waged time and forgone career prospects and accommodation income. Estimates by Netten *et al* (cited in Pickard 2004) were of a cost to the carer of £31.42 per week and to society of £29.98 overall in 1990. Up-rating by inflation (GDP deflator) this is equivalent to a cost per carer in 2006 of £47.13 and £44.97 respectively. If this were to be applied to all those currently caring for those over 65, this would create a figure of £9.4 billion cost to 'society'. In addition Chapter 10 estimates replacement costs

of £3.5 billion using the projection model. This difference in figures is consistent with the expectation that full economic costs exceed replacement costs.

4 Future position

In Chapter 10, numbers of older people using informal care in the future are estimated. Assuming current rates hold in the future, the Review model requires an increase of informal care input of just over 50 per cent from 2002 to 2026, in its central projection – details of these assumptions are given in Research Paper 1 ('PSSRU model') in the Appendix.

There are two ways in which rates of informal care will change in the future. First, if patterns of informal care remain constant with respect to these personal characteristics, then the changing circumstances of older care recipients will affect the chances that informal care will be available. If, for example, there are more older people living alone then the overall rate of informal care will be lower (because people living alone receive less informal care individually). Second, patterns of informal care may not stay constant. For example, people who might currently be prepared to care for those in need in certain circumstances may not be so willing in future.

It is unlikely that rates of informal care will keep pace with increases in care need in the future.

INCREASING AGE OF CARERS

Whether spousal care will keep pace with the projected increase in demand for care will depend, not least, on the health status of those spouse carers themselves. The age of the caring population as a whole will increase. This has possible implications for the care provided, not only in terms of tasks and hours of care, but also in the nature of the support required for carers themselves.

DECLINE IN FILIAL CO-RESIDENCE

The number of caring hours is much higher among those that co-reside with the care recipient. Most of those caring for people living in another household care for less than 20 hours per week (89 per cent) and there has been a significant decline in co-residence between adults and elderly parents (Grundy 1999). The implication of a trend towards care being provided by carers living in a different household is that the number of hours spent caring will decrease, specifically for the tasks that are largely currently administered by those that live within the household, such as personal care. Furthermore, there is a decline in more intensive and demanding care where the carer lives apart from the carer recipient, and increases in the intensity of care within households, particularly for elderly spouses (Hirst 2001).

EXPECTATIONS AND ATTITUDES

Expectations about quality of life and levels of independence have risen, and will continue to rise, amongst recipients and carers. Care recipients have growing expectations of support that will enable them to have increased freedom and independence. Carers' expectations reflect the increasingly atomistic perspective of society, with individuals wanting more freedom to determine their own life and fewer restrictions (which would arguably include those effectively imposed by caring responsibilities). This is in line with a school of thought that suggests the filial responsibility assumed by many in the UK and

other countries is eroding, and the ‘fixed obligations’ no longer compel to the extent seen previously (Finch 1995).

Reconciling such conflicting views would require increasing expectation on the role of formal care and the rights it should support for the individual, including, for example, the right to personal independence. With regard to caring there seems to have been a move towards the assumption that when a person forgoes their individual rights, such as through sacrificing their time by caring for someone else, they should be compensated by the rest of society, that is, by the public purse (such as in the case of *Stephenson vs Stockton on Tees Borough Council* 2005).

In addition to the numbers of people requiring care rising at a rate faster than that of informal care supply, the nature of the care provided will change, for example, with an increase in care provided from outside the household. This shift would mean less hours per carer and less provision of the more intimate forms of care, such as personal care. Meanwhile, care recipients will arguably expect increasing levels of independence, thus possibly requiring greater input. This combination of developments seems likely to create a widening gap between the available supply and the required care inputs. Projections of the extent are developed in Chapter 10 onwards.

5 New strategies on informal care

At present, there is a high reliance on informal care, with significant costs falling on carers and potential carers. In the future, the indications are that informal caring rates can be expected to reduce.

A number of strategies can be adopted in response to this. These include:

- improving support for carers
- giving potential carers further incentives to supply informal care
- increasing the provision of formal care services.

Supporting carers

SUPPORT SERVICES

The current provision of services to support carers in their role varies significantly with location and personal circumstances (such as residential status), and is argued to be inadequate (Keeley and Clarke 2002, Maher and Green 2002). There have been steps to improve the situation, for example, by articulating more clearly the rights of carers and the obligations of local councils through the 1995 Carers Recognition and Services Act, and Subsequent Acts in 2000 and 2004. The recent White Paper (Department of Health 2006) also focuses on carers to some degree.

There is evidence that support for carers can be effective (Pickard 2004). The impact of services on carer outcomes can be judged in (at least) two ways. First, in the way that services delay the need for people to go into care homes (because it delays a breakdown of the caring situation at home). Second, in the way that services directly impact on measures of carer stress. Davies and Fernández (2000 in Pickard 2004) find that social care services and especially day care and respite care are effective in both ways. Social work can also be highly effective at tackling carer stress.

Improving the situation of carers also has consequences for their employment opportunities (and so broader economic performance considerations). In principle, reductions in carer stress ought to go hand-in-hand with improvements in the working situation of carers (even where work cannot be continued, opportunities to develop human capital during a caring episode would help maintain employability and keep skill levels at a preferred level). Similarly, reductions in these ‘costs’ of informal care to potential carers are likely to improve supply. It might also be an effective strategy to cover some of the financial costs of caring, as discussed above. However, there is no evidence to confirm any of these later conjectures directly.

Improvements and increases in carer support should also directly impact on the quality of care provided. A less stressed, overworked, unhealthy or tired carer will have an increased ability to care, and there is likely to be a generally improved atmosphere. In addition, training support should mean care of a higher quality.

It is recommended that evidence on the cost-effectiveness of services regarding delays in institutionalisation and carer outcomes is developed, and used, together with that which is currently available, to justify further development of carer services.

INCENTIVES

Payment for informal caring potentially improves carer supply as well as providing compensation to carers for some of the costs of caring. The benefits system already provides payments via provision of Carer Allowance and other benefits with carer-enhanced rates. Many other countries have similar benefits or allow direct payment or care budget equivalents to compensate informal carers (see Lundsgaard 2005).

Paying carers has a range of consequences.

- There are potentially deadweight costs in reimbursing carers who would, without payment, maintain levels of caring.
- Some claim that carer payment creates ‘incentive traps’ that attract carers away from the labour market (Lundsgaard 2005).³
- Carer payments help people who choose to care for loved ones even though they bear significant adverse financial and other consequences.
- Even a relatively small payment can induce a significant supply of care as the experience in Germany – where an older person’s cash payment for care can be used to pay carers – testifies (see Background Paper 6 (‘Informal care’) in the Appendix).

If people want to provide care despite the opportunity costs they face, then paying them will improve the outcomes of those carers, but may not induce more people to care. Alternatively, if payment sufficiently offsets the opportunity costs of those who otherwise would not care, then carer supply will increase, but the net effect on the economy is likely to be negative. However, if the opportunity cost is not much greater than the replacement cost of care, and both the carer’s and the care recipient’s outcomes are greater with informal rather than formal care, a case would exist for carer payments. Furthermore, there are strong fairness arguments that where people provide care and their financial and other situations become poor as a result, help should be provided.

Any conclusions to be drawn also depend on the supply of formal services, an issue explored in Chapter 7. If formal care supply is limited, then inducing more informal care would imply a significant improvement in overall care recipients’ outcomes, especially

where needs would otherwise remain unmet. It is not clear that the supply of informal care will meet projected demand for care in future years (Pickard *et al*, forthcoming). Without some introduction of incentives or support for people, it is difficult to see how the gap could be closed from the informal care side.

Where payments are forthcoming, the situation of carers will be improved. This could be achieved either by reimbursing carers directly (for example through benefits) or allowing them to be paid from a care recipient's cash payment for care.

The care recipient would benefit from these incentives to carers if their formal care remained unchanged. The potential problem, however, is that formal care might be reduced. Paying carers from a fixed overall budget clearly diverts resources. This problem will be compounded if wider economic performance is also affected by withdrawal of carers from the workforce. Ideally, the care recipient and the carer would be jointly assessed and services deployed, as needed, to address both their outcomes. The *Older People's Utility Scale* (OPUS) could be used to develop tools to measure the impact of services on care user outcomes (see Chapter 5). It is recommended that further work is undertaken to extend this scale to account for carers' outcomes.

Increased formal care to older people

Increases in mainstream formal services to older people appear to have little impact on how much informal care is provided. Work done by the Care Development Group for the Scottish Executive (Leontaridi and Bell 2005) suggested that evidence for substantial substitution away from informal care, as a result of the extension of formal provision of care services, is weak. More recently, following increased formal provision under Free Personal Care in Scotland, little evidence could be found of a reduction in informal care (Bell and Bowles 2006). This supports evidence from controlled experiments on substitution in the USA (Leontaridi and Bell 2001). It appears that even when formal care provision is offered, individuals providing care do not easily 'opt into' work.

There is some apparently contradictory evidence, however. In Denmark a positive correlation between greater emphasis on formal provision of care and greater workforce participation – particularly for women between 50 and 59 years of age – has been identified (Lundsgaard 2005). However, research suggests that that this change of emphasis needs to be combined with other factors to ensure the net result is increased participation rather than the opposite (as seen in the Netherlands, for example (Lundsgaard 2005)). This would also support the findings of research done for the Department for Work and Pensions (Arksey *et al* 2005), which show that decisions about caring and employment status are influenced not only by finances, but by a range of factors, with no single factor dominating the final decision. The possibility of earning more through employment is not necessarily sufficient in itself to entice people to cease or reduce their caring responsibilities.

A greater availability of care services for the older person would improve carers' outcomes but arguably not as effectively as formal services tailored to supporting carers. This is particularly the case with spousal carers, who are overall less likely to reduce their input than filial carers. With regard to filial carers the situation is less clear-cut, with the level of informal care provided and the likelihood of returning to the labour market being influenced to a greater degree by the support that is received. Where the care recipient's

children are the primary care givers, the case for care services as well as carer support services is strengthened as part of a strategy to improve carers' outcomes. Effective support for filial carers could then be provided through a range of options.

While practical support is essential, it is not the only aspect that needs to be addressed. Increases in formal care provision alone will not ease the financial burden on those who do care. Moreover, if formal services do not induce carers to reduce their own inputs much, then the opportunity to earn is not increased to any significant degree.

It is recommended that to improve outcomes for spousal carers, developing carer support services should be the main focus rather than care services for cared-for people. For filial carers, it is recommended that a range of options are considered and additional work is undertaken to ascertain the most preferable approach. In line with this latter recommendation, the modelling work in this Review (see Chapter 10) examines the implications of social care being 'carer-blind' to children carers.

Alternative and development options

Potentially more wide-ranging options regarding informal care could include:

- further engagement and support of local community and voluntary networks. The use of *Time Banks* for example is embryonic in this country, but experience from the US in particular, is promising
- further development of new types of carer support services such as adult day care and home sharing
- promoting support for carers from employers regarding both flexible working practices for working carers and also support for retired employee carers. Examples of good practice do exist in some organisations, but the onus is currently on employers. This needs to be developed.

It is recommended that these possible initiatives are investigated further.

6 Other issues to consider

Specific policy on carers now and in the future is also affected by other considerations.

- There is a need for increased clarity in overall policy on the role and the responsibilities of the state, family and individuals (which affect the perceptions of potential carers).
- There is a need for regular assessment and review of carers' needs. This would help to improve the quality of the informal care they provide and ensure the support and information they receive is appropriate and effective. Some have concerns, in principle, about the quality of care that is provided by unpaid carers, but there is limited evidence (Lundsgaard 2005). There are legitimate questions to ask about the potential for risk and abuse. However, any response needs also to consider the wider regulatory burden that would be imposed. More work is required to weigh the benefits in terms of better quality and safety against the costs, and the conclusions need to be acted upon in future policy.

Extending choice to care recipients is high on the policy agenda. Allowing Direct Payments or similar to pay for informal care from co-habiting relatives is a relevant issue. As noted above, payment of informal care (especially close relatives) has a range of pros and cons,

which will need to be resolved. Sufficient evidence does not yet exist to form a view on which direction should be followed. It is recommended that additional research is done on this question, and the results are used to direct future policy.

7 Conclusion

Informal (and unpaid) care plays a vital role in the support of older people. Very large numbers of people provide at least some level of care, with some providing a very substantial input. Key questions are: Should we continue to rely on informal care? If so what are the consequences? Are the resultant situation and outcomes for carers reasonable? And is the supply of informal care going to keep pace with likely increased demand for care?

Given demand and also the willingness of many to care for others, it is inevitable that informal care will continue to provide a significant input. Many decide to care with little regard for 'substitution potential' of formal care and are motivated by many factors other than the provision of formal care or lack of it. Moreover, as detailed in Chapter 10, the costs of increasing formal care to address unmet need arising from a reduction of informal care would be prohibitively high, even if the trained workforce could be created (see Chapter 7).

Based on current patterns, it is expected that informal care rates will fall short of increases in demand. Furthermore, at present, outcomes for some carers deteriorate to unacceptable levels. This can be expected to continue into the future if current arrangements persist. There are solutions ranging from support services to carers and payment for carers, through to broader attempts to foster better societal attitudes to caring.

The evidence base is not as developed as it should be, but the case for further carer support services looks strong. The cost and outcomes implications of this are modelled in Part 2 of this report. For spousal carers, the best form of support seems to be services that address carers' outcomes directly, relieving some of the pressures of care. For filial carers, this argument also holds, but the case for possible substitution of informal care by formal services for the care recipient is stronger. The implications of a 'children carer blind scenario' are examined in Chapter 10.

There are also strong fairness arguments, particularly around supporting those people committed to caring whose financial and other situation is reduced to low levels as a result. This argument can support a case for extending financial support for all carers. It is reasonable to expect that those individuals fulfilling the perceived obligation of caring for the vulnerable are not actively disadvantaged, both financially and personally, and are not driven to poor health through an excessive workload.

These arguments concern not only the implications for the cared-for person, but also the carer themselves. Policy development in this area should not undervalue improvements in carer outcomes, even if this creates tensions with improving service user outcomes.

**TABLE 37: PROVISION AND EFFECTIVENESS OF CARER SUPPORT SERVICES**

Type of service	Current provision	Effectiveness
Respite care and short breaks from caring, including day care services, in-home respite services, institutional/overnight respite services and mixed carer support	<ul style="list-style-type: none"> • Service most widely used/provided but still only a minority of councils providing good support • Wide variation in amount, source and type available • In 1995, 5% of older people received sitting services, 24% received day care and 18% received respite care¹ 	<ul style="list-style-type: none"> • Some evidence of positive impact on carers' stress levels and health, and can help to prevent health problems resulting from caring • Offers psychological comfort so enhances well-being of carers • Produces high levels of satisfaction
Carer support groups	<ul style="list-style-type: none"> • Varied providers and availability 	<ul style="list-style-type: none"> • No conclusive evidence
Social work and counselling support	<ul style="list-style-type: none"> • Received by a minority of carers – in 2000, 18% received therapeutic social work² 	<ul style="list-style-type: none"> • Reduces subjective carer burden • Relieves carer distress • Can reduce psychological problems in carers
Further formal care services to older people	<ul style="list-style-type: none"> • Targeted at older people who live alone rather than with carers • Increasing focus on personal care 	<ul style="list-style-type: none"> • Reduces carer stress (but perhaps less well than services above) • Can postpone or reduce rates of institutionalisation among care recipients
Multi-dimensional approaches, including community care packages such as MADDE ³ and Care Management in the UK, with different services of potential benefit to carers	<ul style="list-style-type: none"> • Depends on care managers – majority of carers in the United Kingdom do not have access to care management 	<ul style="list-style-type: none"> • Results depend on what services are included • In some circumstances, can reduce carer burden and depression • Can increase carer stress

¹ Based on Bauld *et al* 2000² Based on data from Pickard 2004³ Medicare Alzheimer Disease Demonstration and Evaluation

Notes

¹ Although 2001 Census data is more recent, it is much less detailed and thus offers less scope for analysis. Data from Carers 2000 excludes from its figures: those caring as a volunteer or for other organisations and those caring for individuals receiving care in an institution or with a temporary illness or disability (as defined by the respondent).

² If there are 6.7 million carers in Great Britain, then those that care for more than 35 hours per week would number around 1 million. On this basis, with 441 thousand claimants, take-up looks low, perhaps only 50 per cent.

³ These arguments are somewhat contradictory in that these traps only apply to people would be unwilling to provide care without payment (people who would provide with payment would not be trapped)

9

New influences on care

SUMMARY

New service models and technology have an important role in enabling older people to remain in their own homes and avoid unnecessary moves into residential care or hospital. This chapter reviews the evidence for the impact and cost-effectiveness of the main new service models.

- Telecare (any service bringing health and social care directly to a user, generally in their own homes, supported by information and communication technology) has the potential to postpone and divert older people from moving into residential care and possibly hospital, and in doing so will redistribute costs and benefits around the system. This needs to be taken into consideration when apportioning budgets and telecare implementation costs.
- Most telecare pilot studies have provided positive results, but there has been no consensus framework for the cost assessments, so it is difficult to model the future cost impact of telecare if implemented nationally. However, enough lessons have been learned from pilot studies that the emphasis should now shift to moving telecare into the mainstream.
- The demands of an ageing society come too low on the list of strategic housing priorities, with the housing concerns of first-time buyers and key workers appearing more immediate.
- Extra care housing offers the potential for extended independent living and better quality of life for some older people who can no longer manage in their own homes, but barriers to expansion mean that it is unlikely to be available to more than a minority. Nor is it always clear how cost-effective it is compared to the alternatives.
- New models of dementia care will be important given the projected increase in older people aged 85 and over. There is a need for greater provision of dementia-specific care services and care workers, and consideration should be given to ring-fenced funding for dedicated services.
- Preventative measures can reduce people's dependency, disability and ill health, but rigorous quantitative studies are rare. Evidence suggests that such schemes should be targeted at people whose condition is likely to deteriorate or who have a high predicted risk of costly future needs.
- The rehabilitation potential of intermediate care also appears to be more effective when targeted at specific conditions or groups of people. The cost impact is unclear, however, because many studies do not take into account resource utilisation over the longer term.

Standard outcome measures need to be developed to facilitate the evaluation of various new service interventions, as this will allow future studies to be compared and a more robust evidence base to be collected. It is also often difficult to establish a clear causal link between a specific service and its impact on outcomes because of the complex nature of care packages. Nevertheless, technology and new models of care will be needed to address the future demand for long-term care.

1 Introduction

Social care must continually develop in response to changing needs, attitudes and expectations. It will also be influenced by technological possibilities, policy priorities, improvements in incidence of some of the major disability-causing diseases such as cardiovascular disease, and less promising trends around dementia. Cognitive impairment is a very significant driver of social care demand, so an important area of development will be new models in social care for people with dementia.

People's attitudes to traditional forms of social care are changing. As the baby-boomer generation moves into old age, they expect choices and control, regardless of significant disability. New models, such as extra care housing, can meet these changing demands and also alleviate other pressures on the system. Social care is very labour intensive at present but technology offers possibilities, especially concerning supervision and monitoring functions, and might shift some of the balance.

High on the policy agenda is the potential for preventative services and strategies to reduce the need for mainstream services. Intermediate care is an important part of this agenda. Some see the prospect of early help from low-level services reducing more significant need as people age.

Some of these new models (for example, intermediate care) have swiftly been adopted into the mainstream. Others (such as telecare) are still mostly confined to pilot studies. Many are likely to become more commonplace over the next 20 years as part of a new approach to care. This chapter begins to consider their worth and how they might evolve.

Such models are complementary and might achieve most when combined. Specialist dementia care, for instance, can successfully be provided in extra care housing units fitted with a range of telecare systems. Similarly, intermediate care can take place in an older person's telecare-equipped house, in an extra care setting or some appropriate health care facility, and generally includes preventative measures. Applied successfully, and sensitively, the new service models should be able to help some older people live in lower-intensity care settings.

Determining the cost implications of the various new care models is challenging. Often, there are shortcomings in the evidence base for similar reasons.

- Many new models – such as telecare, intermediate care and prevention – straddle the boundary between health and social care.
- Costs and cost savings usually fall to different organisations. Most commonly, investment and costs are incurred by social services, but the financial benefits accrue to the NHS in terms of reduced acute and hospital care.

- There is a lack of standard outcomes for measuring the impact and effectiveness of new service models. Some studies have used extra life years gained. Others have opted for quality-adjusted life years. Others have taken a measure specific to the intended outcome (for example number of falls prevented). General quality of life measures are more nuanced, but can be very subjective.
- It is often difficult to establish a clear causal link between a specific service and the outcomes.

While the primary aim must be to improve quality of life and care provision, these new service models will be needed to meet the wider challenges of providing social care to more people. These include shortages of appropriate accommodation, the need to adapt older people's own homes for continuing residence, an inadequate supply of formal care workers and a shrinking pool of informal carers.

2 Telecare and related technology

'Telecare' describes any service bringing health and social care directly to a user, generally in their own homes, supported by information and communication technology (Audit Commission 2004). In most cases, data is collected through sensors, fed into a home hub and sent electronically to a call or monitoring centre. Existing basic telecare units include fall alarms, safety sensors for risks such as gas leaks and bath floods, and 'wander' monitors for people with dementia. In the UK, around 1.5 million elderly people already use community alarms to contact a central control centre which can summon help; this is often the basis for the introduction of telecare. More advanced 'intelligent' systems are designed to recognise changes in activity levels, such as visits to the toilet or fridge, which may indicate that a person's condition is deteriorating. Early targeted interventions can then be implemented, with the emphasis on prevention. Separately, 'telehealth' can be defined as the remote monitoring of vital signs such as temperature and blood pressure which can be used by medical professionals for diagnosis, assessment and prevention.

The government believes that telecare can increase independence and choice by helping the elderly remain in their own homes longer. It can also 'give carers more personal freedom and more time to concentrate on the human aspects of care and support and will make a contribution to meeting potential shortfalls in the workforce' (Department of Health 2005f), while 'using technology appropriately can re-balance the all-or-nothing approach to care and independence, where people either have daily visits by a care worker, or nothing at all' (Ladyman 2005). The Department of Health's 'Preventative Technology Grant' is paying out £80 million over two years from April 2006 to promote the use of new technology as a way of reducing avoidable admissions to hospital and residential care. Looking further ahead, the recent White Paper promotes telecare as a means of enabling people 'to feel constantly supported at home, rather than left alone, reliant on occasional home visits or their capacity to access local services' and plans 'intensive use of assistive and home monitoring technologies'. The Department's own IT targets aim to provide telecare in 20 per cent of homes requiring it by the end of 2007, and in all homes requiring it by the end of 2010, levels which look very ambitious unless a very low definition of telecare need and service is used.

Since loneliness is a big issue in old age, it might seem contrarian to promote technology which could reduce interaction with carers. But proponents of telecare argue that it can allow a redeployment of carer time, with a shift of resources towards more meaningful

interactions. Given that an ‘intensive’ care package is usually defined as domiciliary care of more than 10 hours a week, that leaves many hours when telecare can complement formal care rather than substituting for it.

Costs per individual can be modest, for example typically £360 for a basic home safety and security package of equipment, plus monitoring costs of £5 a week; additional sensors are around £80 each, and an extra £1 per week per sensor (Department of Health 2005k). Home health monitoring packages tend to be more expensive, at around £700 for an initial package, and £10 a week monitoring cost. Government guidelines for the Preventive Technology Grant state that if telecare equipment is provided after a community care assessment as an aid to assist with nursing at home or aiding daily living, it should be provided free of charge. The local authority’s normal means-testing regime can be used for the service elements, that is, the weekly charges. Equipment installed for preventive reasons can be charged for (Department of Health 2005a).

An overview of telecare, including a number of pilot studies and its acceptability to older people, is provided in Background Paper 7 (‘Telecare’) in the Appendix. For this Review’s modelling exercise, the relevance of this technology is its apparent potential to offer value in a number of ways.

- It can avoid or defer an elderly person’s move into a care home or hospital. (Although, in some cases, the level of care necessary to keep someone at home can make a move into a care home the cheaper option.)
- It can reduce or replace some of the routine inputs needed from carers, formal and/or informal, in the home setting, permitting them to be more effectively deployed.
- It can speed up an elderly person’s discharge from hospital by providing added support in their own home or in another intermediate care setting, thus freeing up hospital beds.
- It can help someone maintain a healthier lifestyle, thereby reducing or delaying future needs.
- It can improve efficiency within a care home and help keep down costs.
- Using wireless technology, much of the available equipment can be installed in existing homes, and removed when no longer needed.

The evidence base

Various pilot studies are beginning to offer evidence that providing an early, limited package of telecare to someone in a low-needs category can delay a move into a higher-needs service band, particularly when an inexpensive telecare package can prevent a move into residential care by an older person who feels unsafe and vulnerable in the community.

The UK’s biggest telecare pilot study is the ‘Opening Doors for Older People’ project in West Lothian, launched in 1999. The council is rolling out technology packages for its ‘Home Safety Service’ to everyone in the district aged 60 and over (about 10,000 households). The aim is to increase the level of care as needs increase, rather than moving the person into increasingly intensive care settings. Separately, smart technology is being used in newly built housing developments designed to offer ‘Housing with Care’ with an onsite staff team for those who really cannot manage in their own homes. By February 2006, there were 1,950 Home Safety Service households with a package consisting of:

- a ‘lifeline’ unit, which links sensors to the call centre when triggered
- two passive infra-red (PIR) detectors to monitor activity and potential intruders

- two flood detectors, activated by leaking pipes, overflowing baths, etc
- one heat sensor, sensitive to both high and low temperatures
- one smoke detector.

About 10 per cent of participating households had additional technology such as falls detectors, falls alarms, medication reminders and bed occupancy monitors. The whole project is supported by a care team of staff from a range of backgrounds who have been given intensive training to identify the appropriate technology for a user. In an interim evaluation (Bowes and McGolgan 2005), nearly all the respondents reported the positive impact of the smart technology, which had been important in relieving worries about falling and about home security.

Preliminary cost analysis suggests that cost savings can be achieved from the new services, when compared to the cost of an institutional care place. The gross costs of the various care options are: a care home place in West Lothian (February 2005) at £21,840 per annum; a Housing with Care tenancy at £16,400 a year, including a technology package, personal care and housing support; and support in the community, including the Home Safety Service technology package and 10 hours of formal care a week, at £7,121 a year (Bowes and McGolgan 2005). The director of the council's community and support services estimates that the cost of a package of telecare equipment amortised over five years plus the staffing costs to support the scheme work out at around £7 a week in total (Kelly 2005). Until January 2006, the weekly fee to a user for the Home Safety Service package was a means tested £4.87 per week, but that was discontinued because it was depressing take-up, even though most people after means-testing did not have to pay. In the two months after the fee was abandoned, demand for the service tripled.

Any cost-benefit analysis of telecare is highly sensitive to whether potential NHS costs are included in the calculation. In West Lothian, the average length of stay in a care home has dropped from around three years in 2000 to around 16 months in 2005. As of April 2005, the proportion of people over the age of 65 experiencing delayed discharge from hospital in West Lothian was 1.4 per 1,000, compared with an average in Scotland of 2.7 and a Lothian average of more than 4. The mean length of stay by someone delayed in hospital is 30 days, compared with a Scottish average of 112 days (Kelly 2005). Further analysis of the cost-benefits of the telecare project will be published in a forthcoming final evaluation by Bowes *et al.*

Models of telecare

Examples of successful small telecare schemes have encouraged a growing consensus that even basic telecare can reduce the demand for care home and hospital beds. The danger comes from trying to extrapolate from small pilot studies into the population as a whole, and from seeing telecare as some catch-all 'magic bullet' solution.

There is a lack of rigorous data on telecare cost implications due to the mostly small-scale, short-term nature of trials (Barlow *et al* 2005). There have also only been a handful of attempts to model the potential cost-effectiveness of the introduction of telecare on a very large, or national, scale. One theoretical cost model for a city-based advanced telecare scheme (based on Birmingham) involving 11,618 community alarm users (Brownsell *et al* 2001) predicted a return on the necessary investment after 10 years. Expected savings in the model arose mainly from a reduction in the time spent in hospital and residential care.

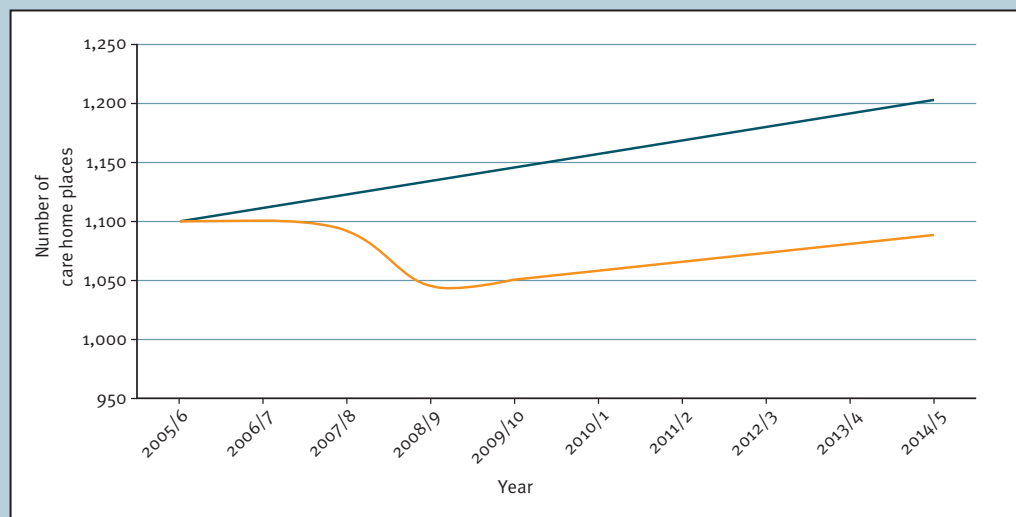
If the results were extrapolated for the whole of the UK, assuming 1.6 million community alarm users, there would be savings in excess of £1 billion over the first 10-year period (Brownsell and Bradley 2003). Over the following 10 years, telecare could produce even greater savings as the infrastructure would already be in place.

The time-lag effect shown by Brownsell was also seen in a separate model (Bayer *et al* 2005) which explored the effect of the introduction of telecare under different scenarios, in particular the effect on the number of clients in institutional care and the overall cost. Under the most optimistic combination of assumptions, the institutional care population after 5 years dropped by 11 per cent compared to the non-telecare case; under the most pessimistic assumptions by less than 1 per cent. It was when looking at the longer-term – more than 20 years – that the effect of telecare was far more pronounced, and a substantial reduction (albeit with a large funnel of doubt) was seen in the long-term care home population. This is because the impact on the care home population is small in the short term with those who are already very frail or in care homes. The improved outcomes are seen in the longer term, when the provision of telecare to users with mild or medium needs feeds through to produce an extended period of independence at home. This model supported the view that telecare development should be focused on those in the middle, rather than high frailty groups, to have an impact on subsequent moves into care homes.

Several pilot studies have concluded that telecare will divert and shift people from residential care and possibly hospital, and that the costs and benefits will be redistributed around the system. In July 2005, the Department of Health made available two separate – but related – telecare models to assist local authorities in designing cost-effective projects under the £80 million 2006/08 Preventive Technology Grant. The Balance of Care model illustrates, at a strategic level, the potential shift in service provision that might be feasible if telecare were introduced, and the resulting impact on the gross cost profile. Three scenarios were used: baseline (no telecare), low invest (introduction of telecare services for the more dependent older population only), and extended (wider rollout of telecare to lower dependency older people). The scenarios were applied to ‘Telecare Valley’ which represents an imaginary ‘average’ council whose population and service levels are the current England totals divided by 150 (the number of councils). The overall impact on annual costs showed that the £42.5 million total for the low invest scenario was only around 5 per cent cheaper than the baseline scenario, while the extended scenario was 5.5 per cent cheaper, despite both these figures including estimated savings on acute bed costs for some older people receiving more than 10 hours of care a week. The model thus introduces a note of caution about claims of very large immediate financial savings from telecare. In particular, the levels of care assistant hours assumed in the scenarios remain high. However, these costs could reduce substantially if telecare helped to prevent people from moving into residential care for reasons other than personal care needs (for example concerns over risks or security not otherwise addressed by personal care). Details are given in Background Paper 7 (‘Telecare’) in the Appendix.

The associated Business Case Model provides a 10-year view of the potential impact in ‘Telecare Valley’ of investment in telecare using the Preventative Technology Grant money in 2006–08. It therefore only shows the possible effect of giving telecare to a relatively small number of people with immediate need for telecare, and does not model a more strategic decision to invest in telecare on a long-term basis. Forecasts of the total requirement for care home places (for existing and new users) confirm that the decline only becomes evident after a time-lag of a few years (see Figure 42 opposite), when

42 IMPACT OF TELECARE ON THE NEED FOR CARE HOME PLACES,* 2005/6 TO 2014/5



Source: Department of Health 2005k

*Potential impact of the 2006–08 Preventative Technology Grant investment on the estimated future requirement for care home places in Telecare Valley.

KEY

- No telecare
- Telecare

telecare recipients are able to remain in their own homes for longer. In this model, it is the expected delay in entry to a care home which has the main impact on the total estimated for care home places in future years.

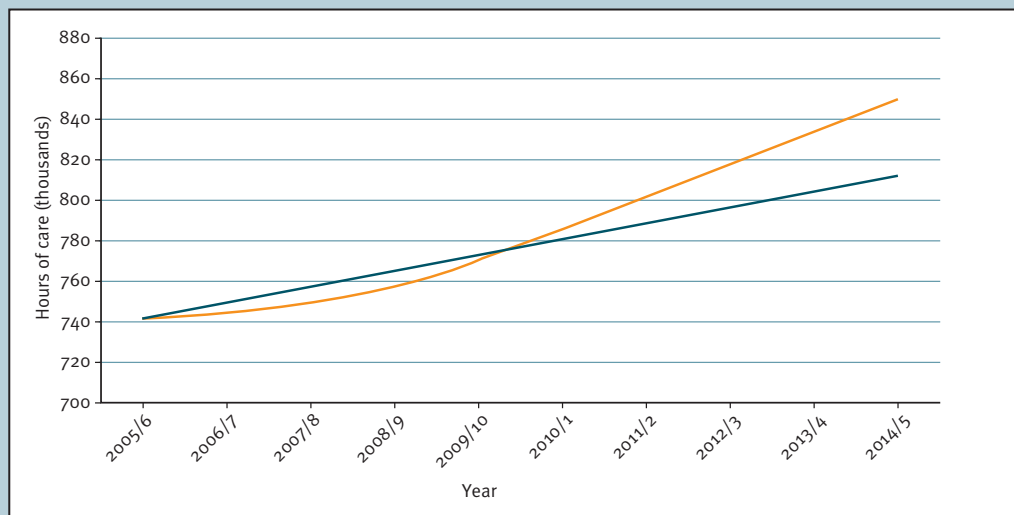
With more people able to remain in their own homes longer, there is a commensurate increase in the numbers of visits and hours of home care (including both personal care and practical help) (see Figure 43 overleaf). The introduction of telecare changes the total care package, and in the medium and long term an older person who continues to live at home rather than moving into residential care will increase the overall demand for domiciliary care. As with both these graphs, the model only looks at the impact of the telecare investment relating to the two-year Preventative Technology Grant.

A rigorous business case for the long-term benefits of making telecare a mainstream feature of social care is complex and has to rely on many assumptions. There is also the uncertainty of how the technology itself will evolve, and how its price will change, over 20 years. To get the complete picture, social care costs, NHS costs, and the state benefits system all need to be included, as well as the impact on the economy of any improvement in the earnings potential of informal carers.

The future

- Advances in technology over the next 20 years will play an important role in long-term care. The difficulty is in predicting the impact on total costs. There has been a large number of relatively small pilot studies, plus the much more extensive introduction of telecare in West Lothian. Most studies have provided positive results, but there has been no consensus framework for the cost assessments, so it is difficult to model the future cost impact of telecare if implemented nationally. Nevertheless, enough lessons have been learned from the pilot studies to ensure that the emphasis should now shift to moving telecare into the mainstream.

43 IMPACT OF TELECARE ON THE NEED FOR DOMICILIARY CARE,* 2005/6 TO 2014/5



Source: Department of Health 2005k

*Potential impact of the 2006–08 Preventative Technology Grant investment on the estimated number of hours of domiciliary care needed in Telecare Valley (excluding care homes).

- Telecare will postpone and divert older people from moving into residential care and possibly hospital and, in doing so, will redistribute costs and benefits around the system. This needs to be considered when apportioning the costs of implementing telecare. In particular, it is important to make like-with-like comparisons. Often the full costs of residential care (that is, including the ‘hotel’ element) are compared with the personal care costs of home care. This comparison stems from an artefact of the current funding system. In other funding systems, the housing costs of care homes could be made much more distinct. After all, when someone moves into a care home, they free up the housing stock from where they moved and possibly release capital.
- There is evidence that telecare development should be focused on those in the middle, rather than high frailty groups, in order to have an impact on subsequent moves into care homes. This means that the associated cost benefits will take some time to feed through, which in turn demands a realistically long-term investment horizon. As a word of caution, the micro-simulation models used Chapter 13 suggest that a person’s needs fluctuate over time; there is not a simple transition at the individual level from low to middle to high dependency (see Chapter 2).
- If the aim is to improve quality of care, then technology may not actually reduce the amount of care worker hours needed because of the demands of older people who remain in their homes for longer.
- The biggest challenge in bringing telecare into the mainstream will be creating the necessary organisational structures and retraining staff. Telecare should become an automatic consideration in any care package after a needs assessment.
- A key issue will be to decide who is offered telecare, and the specification of the equipment provided. It needs to be debated whether national standards will be set for such decisions, or if local authorities will implement their own telecare eligibility regimes. Related to this will be the level of free or means-tested provision for telecare services for older people.

3 Housing and extra care housing

The homes currently being planned and built will contribute to the housing stock in 20 years' time. Yet the demands of an ageing society often come low on the list of current strategic priorities, with the housing concerns of first-time buyers and young families appearing more immediate. Recent government-backed programmes for new affordable housing do not specifically promote houses for the elderly. Yet looking ahead to 2026, the rising number of older people, combined with increased longevity, will create a much greater need for properties suitable for the impaired and averagely frail very old. This calls for a commitment for new 'lifetime' homes to be constructed with the lifestyles of older people in mind. There is a need to plan ahead for the whole of the ageing population, not just those who will be eligible for state-supported social care. This includes the increasing number of ageing owner-occupiers who require suitable smaller properties into which to downsize.

If older people are to have the choice of staying in their own homes as they become more dependent then properties need to have the potential for assistive technology features such as stair-lifts, and/or ground floor bedrooms and bathrooms. The ODPM in 2004 announced a potentially helpful review of the Building Regulations to look at changes which would allow people to remain in their own homes for longer as they aged, with a view to legislating by 2007.

Research into how far, and at what cost, the existing housing stock can be modified to accommodate different types of assistive technology has been carried out by King's College, London and the University of Reading, with a focus on social rented housing (Tinker and Lansley 2005). A range of assistive technology adaptations was considered including telecare and stair-lifts. Access and mobility issues played a major role in determining whether a property could be adapted to meet an elderly person's abilities; many properties, for example, cannot be made wheelchair accessible. Obstacles to adaptations included changes in floor level within the same floor, a small bathroom or no scope for enlargement, concrete structures and restricted areas around the property.

Current housing arrangements for older people

The 2006 White Paper recognises that there is a growing evidence base showing that preventive measures involving a range of services, including suitable housing, 'can achieve significant improvements in well-being'. Some 30 per cent of all UK households are currently headed by someone aged 60 or older (Easterbrook 2005), but the current provision of housing for the elderly is of very variable quality. According to the English House Condition Survey 2001, 35 per cent of people aged over 60 lived in property that did not meet its 'decent home' standards, only slightly above 33 per cent for the population as a whole. But the rate was above 40 per cent when the older person was either aged 85 and over, resident in the same house for 30 years or more, or a private tenant (Office of the Deputy Prime Minister 2003).

There are clear age-related differences in the tenure of housing (see Table 38 overleaf) which will influence the provision of, and payment for, long-term care in the future. Home ownership has steadily increased so that 80 per cent of those who will reach the age of 65 over the next 20 years already own their own homes. This means there will be a bigger market for privately owned homes suitable for the elderly. As well as wanting the

TABLE 38: AGE OF HOUSEHOLD REFERENCE PERSON, BY HOUSING TENURE

Tenure	Age 45–64 (%)	Age 65–74 (%)	Age 75+ (%)
Owned outright	32	69	64
Buying with a mortgage	47	7	2
All owners	80	76	67
Rented from council	10	13	18
Rented from residential social landlord	5	7	10
All social rented sector tenants	14	20	28
Rented privately	6	4	6

Source: Office of the Deputy Prime Minister website
Note: Residents of communal establishments not included.

opportunity to downsize into smaller owner-occupier units, there is also the possibility that some older people will in future choose to sell and move into rented accommodation in order to release capital.

Extra care housing

The choices that older people will make in the future about where they want to live will be influenced by many factors. These include rising home ownership, the trend away from residential care and towards intensive home care, and the variety of emerging housing options including extra care housing (also referred to as very sheltered housing), ‘close care’ and specialist housing designed for dementia sufferers. The future demand for these different types of homes will depend largely on demographic pressures. But it will also demonstrate the changing preferences of the ‘new old’ for whom independent living and control are increasingly a priority.

There are no hard and fast definitions of the various types of properties aimed specifically at older people; many terms are used in different ways by different organisations. (A full description of the various housing models is included in Background Paper 8 (‘Housing options’) in the Appendix.) There is often also a variety of tenure options including ownership, part-ownership and rental, although not necessarily on the same site. Unlike those in care homes, residents in extra care and sheltered housing have security of tenure.

Extra care units are self-contained, but with round-the-clock care and support on offer, sometimes with nursing support and a meals service. The service element is integral to the extra care product, and not an added extra. The communal facilities tend to include social and practical facilities, such as lounges and laundries, but can be more extensive with gyms and small shops, depending on the size of the whole scheme. Extra care aims to be a permanent home for life (although this cannot always be the case), and to promote independent living and a higher quality of life than a residential care home.

The commonly expressed preference of older people for avoiding a move into a residential care home has encouraged interest in extra care housing. As Table 39 opposite shows, however, even when using a very wide definition, extra care units are much less common

TABLE 39: EXTRA CARE AND SHELTERED HOUSING UNITS IN ENGLAND, JULY 2005

	Rent			Sale	All	Population of 65+	Units per 1,000 (65+)		
	Local authority	Residential social landlord	Both				Rent	Sale	All
Extra care* housing	5,558	14,904	20,462	6,162	26,624	7,807,600	2.6	0.8	3.4
Sheltered housing	183,073	195,549	378,622	90,782	469,404	7,807,600	48.5	11.6	60.1

Source: Based on figures from the Elderly Accommodation Counsel (personal communication 2005)

* Includes extra care, very sheltered, close care and assisted living.

than sheltered units, at only 3.4 per 1,000 people aged 65+ compared with 60.1. Extra care is only available to a very limited number of people; approximately 20,000 older people live in self-contained extra care schemes, compared with over a third of a million residents of care homes and a comparable number of people receiving dispersed home care in the community (Laing and Buisson 2005c). The Elderly Accommodation Counsel figures (EAC, personal communication) also show considerable regional variation in availability, ranging from 1.9 units per 1,000 in Yorkshire and Humberside to 5.4 units per 1,000 in the West Midlands.

Benefits and costs

One survey (Sitwell and Kerslake 2004) of a group of older people recently admitted to residential care looked at whether extra care would have offered an alternative. In 28 of the 36 cases, the decision to enter a care home followed a critical event such as a fall and/or hospital admission. In the absence of community-based 24-hour care, residential care was seen by relatives and professional teams as the option of least risk, with the older person agreeing to the decision in order to avoid being a burden. It was estimated that two-thirds of those surveyed could instead have entered extra care either currently or at the time of an earlier move. The extra care model can be tailored for specific groups of potential residents. Extra care housing can also help to limit the splitting up of elderly couples when an elderly carer can no longer cope alone.

There are individual studies that suggest extra care residents tend to show a reduction in need. The Extra Care Charitable Trust (which runs 25 housing/care schemes with 2,000 residents) cites independent research from 1997 showing that extra care residents demonstrated significant improvements in their condition after admission; the superficial physical assessment score jumped more than 50 per cent on average; there was a mobility improvement of more than 35 per cent; a 20 per cent improvement in daily living functions; a 10 per cent increase in sensory ability; and a 25 per cent reduction in medication use. The majority of residents had transferred from hospital or nursing homes, and the greatest improvements were seen in the first 10 weeks in extra care. It is of course unclear whether people would have improved anyway after discharge from hospital, and since no control group was reported caution is needed. Nonetheless, there is sufficient promise to justify a more rigorous analysis.

It is not clear whether extra care housing saves money overall compared with alternative care packages. It can be cheaper to social services because the housing costs are often covered by housing budgets and Supporting People. The financial outcomes for the various stakeholders depend on many variables including whether the individual qualifies for means-tested financial support and state benefits. The different charging policies of local authorities for home-based care also mean that it is impossible to generalise for the whole of England. Finally, the strong support and the recent availability of government funds for extra care schemes also tend to make the financial picture look more attractive than it might be in the longer term if those subsidies are no longer available. A recent detailed model of the comparative costs of extra care housing and other care options in the Yorkshire and Humber region is included in Background Paper 8 ('Housing options') in the Appendix.

Any estimate of the cost impact of extra care housing will be based on a number of changeable assumptions. In an initial comparison with residential and nursing care homes, capital costs can look more expensive because the accommodation units are much larger. But the ongoing cost profiles of different housing options will depend on an individual's type and scale of care needs, and extra care can prove cheaper over time. The cost argument will also depend on which costs are taken into account. 'There are early indications that very sheltered housing may reduce the incidence and duration of admission to hospital; if this proves to be the case, it will generate significant savings for the NHS that should be considered when comparing forms of care,' according to Laing & Buisson (2005c). From the viewpoint of self-funders, extra care will probably be cheaper for less dependent people than a residential home (Laing & Buisson 2005c), but for someone who is very dependent that may well not be the case because of higher domiciliary care costs. The final financial outcome for a self-funder is likely to be dependent on changes in property values and the final judgement by individuals will be based on their perceptions of the value of the relative benefits of each housing option.

There may be a proportion of residents for whom extra care housing cannot provide a home for life, and for whom a move into residential care may become inevitable. Although extra care housing normally has 24-hour onsite care, it does not provide the same level of support as the care home model which is designed specifically for people who have unpredictable and continuous need, particularly people with severe dementia.

Barriers

There are a number of financial barriers to setting up extra care housing particularly associated with the significant up-front capital costs. Often multiple partners are required as a result and this slows the process. The government is keen to see public/private partnerships for extra care housing, in order to increase supply and also promote new models of provision, but such partnerships have yet to become widespread. The Association of Retirement Housing Managers (ARHM) is pessimistic saying that most local authorities 'have no proper housing need assessments to justify private sector investment'.

One of the biggest obstacles cited by private developers is obtaining land and planning permission. A partnership with the local authority can help overcome this problem, if the council provides a site. Re-modelling existing social sheltered units into extra care housing also has the benefit of providing an existing site, although the initial capital costs can be

more expensive than a new-build scheme (see Background Paper 8 ('Housing options') in the Appendix).

The future

- There is a need for government housing policy to be directed more at older people's housing both in the private and social sector. Such a policy shift would lead to greater opportunities for older owner-occupiers to downsize, thereby releasing housing stock for families and younger people.
- Greater awareness should be promoted among the public of the various new housing options available to older people including the continuum of care offered by extra care housing.
- Improved knowledge about extra care housing is also needed among planning officials, with more flexibility in the planning categories that recognise the need for a continuum of provision in housing for the elderly. This would help promote financial models to cover the high capital costs, including public–private partnerships.
- Extra care may not always provide a home for life. Also, it is not always clear how cost-effective extra care housing is compared to alternatives. It can sometimes be more expensive than a care home, although there are important factors that affect the cost-benefit calculation. Extra care does offer the potential for extended independent living and better quality of life for some older people who can no longer manage in their own homes. A comprehensive evaluation is required.

4 Dementia care

The level of social care needed by those with dementia varies according to the stage of the disease, the level of support available from informal carers and the need that those carers themselves have for support. In the initial, mild stages, many people with dementia continue to live in their own homes and rely on informal care from family members, sometimes augmented by formal social care services. However, as the disease progresses through the moderate to the severe stages, there is a greater need for formal social care services and an increased likelihood of admission to a residential or nursing care home.

People with dementia represent a large proportion of those in institutional care. A typical study (Matthews and Dening 2002) found that 34 per cent of people with dementia lived in institutions, and that within institutions dementia prevalence was 62 per cent. Earlier research (Kavanagh *et al* 1993) on those with advanced cognitive impairment found 13 per cent lived alone, 50 per cent lived with others, and 37 per cent in residential settings (including NHS). The decision to move into a residential or nursing home is most common among those who suffer both cognitive impairment and ADL disability. The MRC CFAS figures (see Introduction, p6 for information about this survey) show that 17 per cent of those with only cognitive impairment, and 53 per cent of those with combined disability lived in institutions. Its data showed that, overall, 46 per cent of all those living in institutions had diagnostic levels of cognitive impairment, somewhat lower than the earlier figure due to a relatively strict definition.

A detailed comparison of dependency and living arrangements for those 65 and over based on 1998 data (Comas-Herrera *et al* 2003) is shown in Table 40 overleaf. Some 85 per cent of those with both ADL limitations and cognitive impairment were living in institutions.

TABLE 40: PERCENTAGE OF THE POPULATION AGED 65+, BY DEPENDENCY AND LIVING ARRANGEMENTS

Living arrangement	Level of dependency			
	No dependency (%)	Cognitive impairment only (%)	ADL limitation only (%)	Combined (%)
Alone without informal carer	28	21	14	1
Alone with informal carer	9	22	25	4
Single with others	6	7	7	2
Couple	56	38	29	8
All in community	100	88	75	15
Residential home	–	7	15	51
Nursing home	–	4	9	30
Hospital	–	1	2	4
All in institutions	0	12	25	85
Total number by dependency	6,548,000	234,000	770,000	227,000

Source: Comas-Herrera *et al* 2003**TABLE 41: PERCENTAGE OF THE POPULATION AGED 65+ LIVING OUTSIDE INSTITUTIONS, BY DEPENDENCY AND TYPE AND SOURCE OF HELP**

	Level of dependency	
	Cognitive impairment only (%)	Combined cognitive and physical impairment (%)
Receiving any help	49	80
Type of help received		
Personal and household	2	38
Personal only	0	0
Household only	47	43
Type of helper		
Spouse only	21	21
Other informal	13	25
Mixed (including formal)	2	11
Formal services only	14	23

Source: Comas-Herrera *et al* 2003

The MRC CFAS data also provides a detailed breakdown of the level of demand that people with dementia living outside institutions present to the social care system. Table 41 above demonstrates that even the most dependent group relies heavily on help from spouses and informal carers, boosting calls for significantly more support for carers of people with dementia.

A study conducted in the United States (Langa *et al* 2001) looked at the need for informal care (defined as assistance with ADLs or IADLs from a relative or unpaid non-relative. It found that after adjusting for socio-demographic characteristics, co-morbidities and potential care-giving networks, the number of hours needed increased sharply as the dementia progressed.

Normal cognition	Received average of 4.6 hours per week of informal care
Mild dementia	Received average of 13.1 hours per week of informal care
Moderate dementia	Received average of 39.4 hours per week of informal care
Severe dementia	Received average of 46.1 hours per week of informal care

New models of care

Services for people with dementia in the UK are often criticised for failing to provide what users and their families really want and need (Godfrey *et al* 2005b). Care models for dementia need a variety of elements to achieve the best outcomes, something which the Department of Health recognised in November 2005 with the publication of *Everybody's Business, Integrated mental health services for older adults*. Meeting carers' needs is a particularly acute issue, especially as many of the informal carers of people with dementia are themselves elderly. Partners and relatives have to cope with the emotional toll of seeing a loved one's cognitive abilities decline, as well as the challenging behavioural aspects of dementia, including aggression, wandering, and insomnia. The rising number of people with dementia over the next two decades, as outlined in Chapter 2, will require new types of service provision to meet these needs. A well-designed social care package can promote the independence of someone with dementia, provide assistance towards maintaining an active life and help avoid admission into a care home (unless that is the preference).

Important aspects of dementia care include:

- continuity in care staff, so that the person with dementia is not unsettled by regular changes in domiciliary care staff
- staff with specific training in dementia care
- an emphasis on maintaining physical health, despite the mental deterioration
- high-quality day care centres for leisure and social contact
- 'memory clinics' – effectively a 'one-stop-shop' offering assessment, diagnosis, support and counselling, information, monitoring of treatment, and education and training
- regular respite care as part of a package of measures to relieve the burden on informal carers.

Telecare and extra care housing are often elements of new models of dementia care. Technology, including 'wander monitors', can make it considerably safer for someone with dementia to remain living in an extra care unit or at home, although there are ethical issues including the question of obtaining informed consent for the installation of monitoring devices. Several extra care housing pilot schemes have been designed specifically for dementia residents and have produced positive results, but they tend to be small. Examples of telecare and extra care case studies are summarised in Background Paper 7 ('Telecare') and Background Paper 8 ('Housing options') in the Appendix.

A review commissioned by Age Concern and the Mental Health Foundation (Godfrey *et al* 2005b) looked at successful models of dementia care provision in Europe, the US and Australasia. One study compared the provision of integrated family support services with psychiatric day care attendance, and found family support was more beneficial in improving behavioural problems and increasing engagement. Work conducted in Finland found that offering intensive community-based support from a dementia family care co-ordinator for two years significantly reduced admission into institutional care during the first months of the intervention but by the end of the period the institutionalisation rates were the same. Institutionalisation was thus delayed but not avoided. There is little published research relating to specialist domiciliary care for older people with dementia, in terms of improving and maintaining well-being and quality of life and little in the literature on what constituted quality home care for people with dementia.

Care homes often lack the type of design features which enhance the environment for those with dementia, such as high light levels, non-institutional dining areas, highly visible toilets and the use of colour and décor to ease corridor negotiation. This is despite the high proportion of residents who have dementia symptoms, and the fact that many with advanced dementia have no alternative to residential care. The Age Concern/Mental Health Foundation review cites a UK study which compared nursing home ‘intermediate care’ (aimed at rehabilitation and discharge back home) with permanent ‘home for life’ nursing home care for people with dementia. The behaviour of participants in the intermediate care group deteriorated more than those in permanent settings, and those who moved back to their own home fared worst of all. So, high-quality care homes have an important role to play.

Many of the interventions which have proved most effective for people with dementia do not demand specialist technology or housing inputs. Behaviour therapy, activity programmes, planned walking, pet therapy, and music and light therapy are various interventions that for some people with dementia can improve behaviour and well-being, although the lack of randomised controlled trials makes firm conclusions difficult.

The need for greater provision of all dementia-specific care services remains. The Alzheimer’s Society argues for more ring-fenced funding for dedicated services, saying that people with dementia tend to lose out otherwise. One example of such ring-fencing is Australia which in January 2005 launched the development of a National Framework for Action on Dementia to co-ordinate a ‘strategic, collaborative and cost-effective response’ to dementia. In its 2005 Budget, the Australian Government announced A\$320.6 million (£136 million) over five years to support people with dementia and their carers, as well as training and support for health care professionals and care workers. This included A\$225 million for an extra 2,000 ‘care at home’ places specifically targeted at people with dementia.

It is possible that new treatments will emerge to prevent, delay or alleviate the symptoms of dementia. Dementia is most common at an advanced age, so a fairly modest delay of a few years in the onset of the disease or on its progression could potentially mean a significant reduction in the number of more severely affected people and the future cost of social care. For instance, a decline in the UK of 1 per cent per year in the prevalence of moderate to severe cognitive impairment could broadly offset the impact of the expected increase in the overall numbers of older people between 1998 and 2031 (Comas-Herrera *et al* 2003). A study in Australia estimated that, if the onset of Alzheimer’s disease could be

delayed by five years, by 2050 there would be a 49 per cent reduction in the total number of cases projected (Access Economics 2004). However, there are as yet no immediate candidates to provide such a breakthrough among the wide-ranging research into vaccines, enzymes, drugs and gene therapy.

The future

- The burden on informal carers is particularly acute with dementia care, and this cost to society, which was raised by the NICE appraisal of dementia drugs, needs to receive greater attention (see Chapter 8).
- There also needs to be a big increase in the number of carers and care home staff with specialist dementia training and skills.
- The scope for greater provision of dementia-specific care services remains, and consideration should be given to ring-fenced funding for dedicated services.
- Basic information is lacking for planning in that there remains a shortage of dementia-specific data including the cost of care at home, details of the services that people with dementia receive, and the number of people in contact with an 'old age' psychiatrist.
- Residential care will remain a core option for people with severe dementia and more high-quality care homes will be needed which are specifically designed to meet the living and care needs of people with dementia.

5 Prevention

Preventive services have become increasingly prominent in health and social care policy in recent years, in part because of their perceived potential to reduce demand for high-intensity, high-cost services. Proactive measures which reduce older people's dependency levels, or slow their decline, appear to offer an opportunity to improve quality of life and independence, while also saving money. Preventive and rehabilitation services for older people usually seek to break the cycle of unplanned admissions to hospital or unnecessary moves into residential care.

The term prevention covers a lot of ground. Two distinct concepts have been described as part of the prevention agenda:

- public health and low-level services preventing or delaying the need for social care services by reducing people's dependency, disability and ill health
- prevention in the sense of preventing inappropriate use of more intensive services for people with given dependency, disability and ill health.

The latter is more concerned about an appropriate mix of services from low-intensity services (such as low-level home care) to intensive services (such as hospital treatment) and was discussed in Chapter 4. In this chapter, the focus is on the former, the question of whether low-level services and interventions can prevent people's conditions from deteriorating, or at least slow the deterioration.

The 2006 White Paper comes out strongly in favour of prevention. It mixes both forms of prevention outlined above, for example stating that integrated preventive health and social care services can help prevent inappropriate use of specialist or acute health care, and that timely interventions and enhanced social inclusion can prevent or reduce the severity of episodes of mental illness or homelessness (Department of Health 2006). The key issue is how much spending on prevention can be justified and the type of preventive

services most effective in reducing long-term need. The White Paper calls for ‘an increased commitment to spending on prevention’, recognising that the UK spend on prevention and public health is low relative to other advanced economies. In order to bring about an increase in such spending, PCTs are to be scrutinised against a number of preventive spending goals from 2008 onwards (Department of Health 2006).

Determining the cost-effectiveness of preventive measures is complex mainly due to the challenge of attributing cause and effect. Even when using a very narrow specific target such as reducing the number of falls in a locality, determining cost-effectiveness is not straightforward. Although there may be fewer falls following a prevention scheme, there may be numerous factors at play (for example new transport facilities). When subjective measures such as independence or quality of life are included in the assessed outcomes, the challenge of judging cost-effectiveness is even greater. Preventive services often only have an impact over a long period of time, beyond the timescale of a typical pilot study.

Low-level services: the evidence base

While rigorous quantitative studies are relatively uncommon, there is a wealth of qualitative information (for example, Joseph Rowntree Foundation 2005), which suggests that low-level interventions are highly valued by older people. These services include help with gardening, laundry, cleaning and DIY, and/or the provision of low-cost home adaptations, such as handrails and ramps. Several pieces of research have reported that good self-esteem brought about by, for example, a clean house and a feeling of control over one’s life, leads to better health and, as a result, reduced utilisation of health and social care services (New Economics Foundation 2005). Thus, it has been argued that services such as home help, befriending and gardening can be considered as preventive (Godfrey *et al* 2005a). This type of low-level intervention, however, is usually discussed principally in terms of the impact it has upon immediate quality of life. The extent to which it delays deterioration or reduces service utilisation is unclear on the evidence available.

The government’s Social Exclusion Unit (SEU) has attempted to calculate the extent of potential cost savings from a wide range of low-level interventions, based on work produced by PSSRU (Wittenberg 1998). PSSRU has estimated that if age-specific dependency prevalence rates fall by 1 per cent (not 1 percentage point) per year and the proportion of elderly people in institutional care also falls by 1 per cent per year, the projected number of elderly people in residential, nursing home or hospital care in 2031 would rise by just 14 per cent (on 1995 figures) compared with 64 per cent if there were no reductions. The SEU states that lowering age-specific dependency rates by 1 per cent per year could reduce public expenditure by £94 million per year by 2031 and lowering the rate of institutional care by 1 per cent per year could save £3.8 billion (Office of the Deputy Prime Minister 2006). Another study concluded that 10 per cent of Disability Facility Grant recipients were kept out of residential care as a ‘direct result of adaptations’, and that 98.5 per cent of those using the grant to fund adaptations reported improved quality of life, with 89.1 per cent saying it had improved ‘a lot’ (Office of the Deputy Prime Minister 2006).

One area in which there have been several attempts to quantify costs is falls prevention. The cost of falls to health and social care services is significant. Scuffham *et al* (2003) estimates that in 1999, falls by people over 60 years of age cost health and social care services around £1 billion, approximately 41 per cent of which was paid for by social

services. In addition to the acute care costs incurred as a direct result of a fall, research shows that people who have fallen also have an increase in morbidity, mortality and health care utilisation increasing general health care costs (Hendricks *et al* 2005). The evidence on prevention is mostly about health care impact. It is generally positive, but only indirectly affects social care (see Annex, p 175).

While falls programmes can be applied across cohorts, stroke prevention schemes tend to fall into the category of ‘secondary prevention’ in that they generally target individuals who have already had one episode and are therefore at risk of a further event. Strokes are the third highest cause of death and the leading cause of severe disability in the UK (Rennison *et al* 2003) and cost the NHS between 4 per cent and 5 per cent of its total budget (Ebrahim 2000). The direct cost of an individual stroke patient is estimated to be between £4,600 per stroke episode (1988) in Scotland and £5,900 (1983) in Sweden, but the expenditure on associated long-term care costs also needs to be considered. An estimated 100,000 people have a ‘first stroke’ in England and Wales every year and there is a 30 per cent to 50 per cent chance of recurrence over 5 years (Rennison *et al* 2003). An important aspect therefore is identification of the most appropriate individuals to include in any programme. The Stroke Association states that there is ‘strong evidence’ that the risk of stroke recurrence can be reduced by lifestyle changes, such as reducing smoking rates (Rennison *et al* 2003). Ebrahim (2000) claims that modification of such factors as cholesterol, blood pressure and smoking can be ‘very cost effective’ if effectively targeted. For instance, smoking cessation advice from a GP is estimated to cost £270 per QALY, and anti-hypertensive treatment for stroke prevention (ages 45–64) costs £940 per QALY (Ebrahim 2000). Similarly, another study found effective strategies for secondary prevention of stroke to include treatment of hypertension (Sharon *et al* 2002), although this paper did not include cost-effectiveness analysis. If these interventions were fully implemented the demand for care would be reduced, as modelled in Chapter 2.

Wider community services

These are services that can help maintain an independent and high-quality life and, ultimately, promote social inclusion. Such ‘interventions’ may include public health programmes (some of which may also target specific conditions) and services such as housing, transport and policing. These general services can be considered to play a role in prevention because social inclusion has been shown to be critical to good mental health, which in turn is important in reducing the consumption of health and social care resources. As found by the House of Lords Select Committee on Science and Technology, ‘inactivity and isolation accelerate physical and psychological decline, creating a negative spiral towards premature, preventable ill health and dependency’ (House of Lords 2005).

Recent research shows a link between social engagement and happiness (Puttnam 2001), social contact and happiness (Clark *et al* 1998), and good self-esteem/happiness and good health (Layard 2005, Clark *et al* 1998). If people are happy, they tend to have lower needs and are able to participate in society. The New Economics Foundation’s Well-being Manifesto even goes as far as claiming that ‘the scale of the effect of psychological well-being on health is of the same order as traditionally identified risks such as body mass, lack of exercise and smoking’ (New Economics Foundation 2004). The key complexity underlying measuring the cost-effectiveness of such interventions is that the main outcome (social inclusion and engagement) is ill-defined, making it very difficult to attribute outcomes to specific services. Taking a very expansive approach, work by the SEU

also considered the economic benefits of older people's contribution to society and community services, arguing that older people in good mental and physical health not only consumed fewer health and social care resources but also made an economic contribution to society (often through volunteering and unpaid care). This embryonic evidence base is sufficient to prompt further work.

The future

- Recognition should be given to the wealth of qualitative evidence about the value placed on lower-level services by older people in helping them to maintain their independence.
- Given the difficulty of collecting robust evidence about the impact of low-level preventive services, a proactive approach should be encouraged whereby certain promising interventions could be implemented and formally evaluated during roll-out. At the same time, longitudinal surveys, such as the English Longitudinal Survey of Ageing and the British Household Panel study should be encouraged to collect information about low-level services.
- Priority should be given to targeting interventions at people whose condition is likely to deteriorate or who have a high predicted risk of costly future needs.
- Standard outcome measures of prevention need to be developed to facilitate the evaluation of various interventions, as this will allow future studies to be compared and more robust evidence to be collected.
- The recent White Paper puts much emphasis on prevention including the need to shift resources towards these services. It would be regrettable if this did not extend to low-level interventions, although this may also need greater public awareness and willingness to self-fund.
- Further work on any link between the emotional well-being of older people and their broader contribution to society would be a useful addition to the literature.

6 Intermediate care and rehabilitation

Intermediate care includes those services that exist on the boundary between intensive health care (mainly hospitals) and community services, including social care. Intermediate care has three functions. First, it provides a service option for people with long-term conditions who experience an acute exacerbation of their condition, but which need not be managed in a hospital. Second, it provides a short-term solution for people ready to be discharged from hospital in order for their long-term care options to be assessed and arranged. Third, on discharge from hospital, it seeks actively to rehabilitate people to make it easier for them to adjust to life back in the community. In this case, the aim is to improve people's functioning and independence, and help to restore confidence. Often the second and third functions are linked. However, what differentiates the third function is the emphasis on trying to improve people's underlying health condition. The first two functions were considered in Chapter 3. In this chapter, the focus is on the rehabilitation potential of intermediate care.

Original proponents of intermediate care saw it as an active service designed not to facilitate better patient flows around the care system, but to improve people's conditions, especially after an acute episode. Intermediate care was intended to include short-term preventive measures, such as rehabilitation and provision of community equipment. The National Services Framework (NSF) for Older People describes intermediate care as 'an

opportunity to maximise people's physical functioning, build confidence, re-equip them with the skills they need to live safely and independently at home, and plan any on-going support needed' (Department of Health 2001a).

There is reasonable consensus that intermediate care and rehabilitation which is geared towards a targeted group is more effective than general services (Young and Sykes 2005). The NSF for Older People stated that the evidence is 'strongest for specialist units for stroke rehabilitation and geriatric orthopaedic rehabilitation with evidence of faster improvement in physical function and fewer hospital re-admissions with no greater costs' (Department of Health 2001a). Based on evidence published in the *British Medical Journal*, the NSF states that there is strong evidence that people who have a stroke are more likely both to survive and to recover more function if admitted promptly to a hospital-based stroke unit with treatment and care provided by a specialist co-ordinated stroke team within an integrated stroke service. It claims that these benefits can be achieved at no overall additional cost to health and social care (Department of Health 2001a).

Stroke units have been the subject of several reviews. An article in *Bandolier* (Bandolier 2005) states that, with lower lengths of stay, they deliver better outcomes in terms of mortality and return home, but that benefits weaken over time. A Cochrane review of stroke units (Stroke Unit Trialists' Collaboration 2001) concluded that they decreased mortality and improved physical function, and achieved better destinations at discharge. Inpatient rehabilitation generally reduced mortality when compared to usual care, but the review found that this might reduce over time. In terms of cost-effectiveness, some evidence suggests that inpatient rehabilitation and day hospitals would lead to additional costs for the health service, although this is contradicted by other studies (Bandolier 2005). Young and Sykes' (2005) systematic review found cost savings of 20 per cent from reduced length of acute hospital bed days for a group discharged under the care of a specialist stroke team when compared to another group that stayed in hospital. (A full summary of stroke prevention studies appears in Background Paper 1 (Prevention) in the Appendix.)

A review of intermediate care in general found it to be generally more costly than a hospital stay (see Curtis and Netten 2005, Godfrey *et al* 2005a). Another study looked at cost per bed day and found only a marginal difference, with one medical bed day costing £136 and one intermediate care bed day costing £131 (Bernhaut and Mackay 2002, Godfrey *et al* 2005a). These studies, however, did not consider resource utilisation by patients over the longer term. One analysis has demonstrated that nurse-led intermediate care patients had a longer length of stay and higher inpatient costs than patients receiving standard hospital post-acute care, but post-discharge costs were lower (Richardson *et al* 2001). The question of relative cost therefore depended on the length of time for which the post-discharge costs were incurred. In the Richardson study, the nurse-led intermediate care inpatient costs averaged £10,278 compared with £7,757 for those in standard care (all at 1996/7 prices), but post-discharge costs, evaluated one month after discharge, were significantly lower for the nurse-led group (£990 compared with £1,259). Thus, one month after discharge, the average cost of total services (inpatient and post-discharge) used by the nurse-led intermediate care patients were higher, but if long-term reductions in post-discharge resource use were maintained, the use of intermediate care might not eventually add to costs.

The choice of service model for intermediate care delivery can have a significant impact on outcomes, and therefore cost-effectiveness. The models considered in one review (Young

and Sykes 2005) included hospital at home, day hospitals, nurse-led units, community hospitals and short-term care/nursing home placement with the following conclusions:

- hospital at home (generic): cost neutral when compared with standard care
- hospital at home (specialised focus): yields savings when compared with standard care
- nursing-home based intermediate care (generic): not effective for short-term rehabilitation. More effective for slower track, step-down care. Unlikely to be cost effective
- nurse-led unit: longer length of stay than standard care but more independent at discharge. Higher mortality than usual acute care.

One study of post-acute nurse-led intermediate care found similar results. The nurse-led units were associated with longer lengths of stay than in standard care but post-discharge resource use was lower, possibly because the cohort in nurse-led intermediate care were discharged with a higher level of functionality (Griffiths *et al* 2005). In addition, patients in nurse-led units had lower medical inputs, which are a key driver of cost. A further finding in this study, which is consistent with Godfrey's work, was that discharge into institutional care was considerably lower, along with early re-admission to hospital, than for those who received standard post-acute care. However, this difference between the two cohorts reduced with time, until at the 6 month follow-up there was no significant difference. This conflicted with the evidence presented by Richardson *et al* about long-term cost savings.

A Quick Response Unit can provide one form of step-up intermediate care. A Canadian study considered the costs of a community-based alternative for hospital treatment (the Quick Response Program, QRP) for elderly patients who presented at an accident and emergency (A&E) department with non-acute needs. The treatment included nursing home care, physical therapy, occupational therapy, social work and meals-on-wheels. The study found the QRP to provide an appropriate and effective alternative level of care for non-acute individuals, compared with hospital care. The average cost of providing such services to a user in a hospital setting was C\$3,927 for 2 admissions, totalling 12 days of non-acute hospital care. The cost of providing community-based services, including QRP costs, to the user for 30 days after an A&E visit was C\$358 (Franko, 2001).

MEDWAY TEACHING PCT

Medway Teaching PCT was able to supply the Review with figures about the impact of its intermediate care rapid response team. The scheme specifically targets individuals who have had a non-complicated elective orthopaedic operation and is intended to bring about early discharge.

Data relates to 53 patients who received a total of 116 hours nursing care, 92 hours occupational therapy care and 54 hours of physiotherapy. The patients each spent an average of 16 days in the care of the rapid response team following discharge. Overall, their length of stay in hospital was reduced from an average of eight days to five. Over the five month period of the study, this amounted to a total saving of 141 bed days. This translates to an extra 18 orthopaedic patients being treated (average stay of eight days) or 28 extra patients (reduced average stay of five days). Although the PCT has not undertaken a costing study, the initial findings do suggest that patients are receiving a higher quality standard of care with early discharge home.

The future

- Clarity is needed on the desired outcomes from intermediate care. If these are immediate improvements to quality of life and/or functional status, then the most recent evidence suggests targeting patients with the greatest clinical need whose intermediate care services will be relatively expensive. If immediate cost savings are the main aim, then admission avoidance schemes should receive more emphasis, although this does not take long-term care costs into account. A balance is needed between the two approaches. (See also Chapter 3.)
- There appears to be scope for more non-residential intermediate care schemes, which are also associated with lower costs.
- The six-week time limit for intermediate care services is often too rigid, and this should be reassessed with the possibility of it becoming more flexible.
- The evidence points to the higher cost-effectiveness of intermediate care schemes targeted at specific conditions or groups of people, and this is likely to shape the development of intermediate care in the future.



Annex. Falls prevention evidence

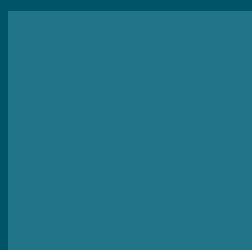
A full review of prevention is presented in Background Paper 1 ('Prevention') in the Appendix. Falls is an area where the evidence is relatively developed.

One study provided evidence for the cost-effectiveness of a multi-factor targeted falls prevention programme (Rizzo *et al* 1996). This randomised controlled trial in the US is one of the few to provide detailed cost information. The results found that the average costs of the intervention group (those who received a combination of medication adjustment, behavioural recommendations, and exercise) were US\$2,000 less than the group receiving usual care. Hospital costs were \$7,509 per person for the intervention group compared with \$11,509. Given that the intervention cost was an average \$906, the programme was considered to be cost-effective overall.

One UK paper studied an exercise pilot for the over 65s and found exercise classes to offer a low-cost way of preventing death and reducing inpatient episodes, including falls. The evaluation found that the scheme, with a cost of £854,700, was estimated to have prevented 76 deaths and to have avoided 230 inpatient episodes, saving costs of around £601,000 to the NHS. Based on an assumption that average life expectancy after 65 was (an apparently low) 10 years, the programme cost about £330 per life-year saved (Munro *et al* 1997).



Part 2



10

The outcomes needed in 2026?

SUMMARY

This chapter maps out the future demand and cost for older people's social care over the next 20 years. It uses a number of possible future scenarios to explore the complex relationships between people's disability or need, service use and outcomes. The Review's model then quantifies the likely resource requirements and the cost of providing the services. There are three parts to this chapter:

The first part discusses the building blocks of the analysis, including the following points.

- An outline of the outcomes which are the potential goals of a social care system.
- Definitions of the three scenarios that are used in the modelling:
 - scenario 1 (current service model): a base case that assumes that the current patterns of service, and hence the outcomes produced, will be the same in the future; that is, the system is more ambitious than now. The scenario projects future costs as they are affected by changes in need
 - scenario 2 (benchmark): changes what is provided so as to achieve the highest levels of personal care and safety outcomes that can be justified given their cost
 - scenario 3 (well-being): as scenario 2 but also providing improved social inclusion and a broader sense of well-being.
- Estimates for the association between the care a person receives and the improvement (if any) in their outcomes, and the costs of these improvements.
- Use of a standard outcome measure of the gain for one year of life of having core ADL needs improved from being entirely unmet to fully met – an ADL-adjusted year, or 'ADLAY'. This provides a way to compare and rate improvements in outcomes, and is used to calculate economically justified 'benchmark' levels of service.
- Estimates of the impact of charges on the demand for community-based (home care) services.
- Analysis of the impact of informal care and the appropriate level of service provision for different dependency levels.

The second part concentrates on the results of the modelling work.

- Under scenario 1, total costs are estimated (with central assumptions) at £10.1 billion in 2002, rising by 139 per cent between 2002 and 2026 to £24.0 billion, and from 1.1 per cent to 1.5 per cent of GDP.
- Under scenario 2, total costs would have been £12.2 billion in 2002 and are estimated to rise by 142 per cent between 2002 and 2026 to £29.5 billion, and from 1.3 per cent to 2.0 per cent of GDP.

- Under scenario 3, total costs would have been £13.0 billion in 2002 and are estimated to rise by 142 per cent between 2002 and 2026 to £31.3 billion, and from 1.4 per cent to 2.0 per cent of GDP.
- The difference between scenario 1 and 2 in 2007 reaches £2.5 billion. Scenario 1 is equivalent to the current service picture, but scenario 2 is based on benchmark service requirements. In practice, scenario 2 will include some additional non-modelled costs that would push up this difference to over £3 billion.
- The scenarios are tested for sensitivities to changes in unit costs, use of new technology, availability of unpaid care, dependency and the value-for-money threshold.
- Both scenarios 2 and 3 involve significant increases in expenditure compared to the current situation. Even if this extra funding were made available in the near future, the required response on the supply-side would take a number of years, so spending would have to be built up over a transitional period.

The third part draws out the implications of the results.

- On the Review's assumptions, the potential to achieve economically justified outcomes is not currently being realised. Unless society is less inclined to support the same improvement in outcomes from social care as it would from health care, then more should be spent on social care.
- However, additional funding should not be forthcoming without a commitment to re-configure services, and without demonstrating that value for money and fairness are achieved.
- To achieve better outcomes, the system needs to be made more universal, open to more people and with broader eligibility criteria for services.

In conclusion, the need for an increase in resources is driven by the benefits of improvements in outcomes (both social care outcomes and collateral benefits for example in health care), demographic pressures and the need to ensure sufficient robustness and quality of supply. Overall, the target level of total resources required over a 20-year period would increase to 1.4 per cent of GDP in 2007 and up to 2.0 per cent of GDP in 2026.

1 Introduction

Previous chapters have described the current social care system for older people, what it does, how it helps people, what resources it uses, and how it is funded. This chapter maps out a number of possible future scenarios. The aim is to quantify future resource requirements. A clear picture is needed about the range of services, support and other forms of help which people will use. This set of services ought to be determined relative to the outcomes to be achieved, and by both the willingness of individuals to contribute and of society to pay for these outcomes.

Services are used because they improve people's lives; being clean, comfortable, having sufficient food, being safe and protected; also enjoying fulfilling lives, social inclusion, self-esteem. Services also provide outcomes for carers, such as reductions in stress. The benefit people receive will depend on the extent of their disability and also on how good the service is in overcoming the effects of that disability. The more people are limited by

disability, the more they will benefit from services. The degree to which services can help will vary with the types and combinations of services used, the intensity of their use, their quality, their timeliness and also the characteristics of the service user. There is, in other words, a complex relationship between people's disability or need, service use and outcomes.

Professionals on the ground will understand these relationships and make decisions accordingly. This chapter considers how this information can be conveyed at a national level, and in a way that helps with national funding and resource decisions. To date, the system has been good at counting the cost of using services. It has been less good at counting the benefits in a way that can be summed up and compared at the national level. Without a way of quantifying improvements seen in outcomes that is systematic, consistent and supports comparison, making a business case about funding levels is difficult. What is needed is a framework for measuring outcomes, evidence about how services improve outcomes and ways to measure need and disability.

The first part of this chapter discusses the building blocks of the analysis. The second concentrates on the results of the modelling work. The third draws out the implications. The main data sources are listed in the Introduction, p 6.

2 Social care outcomes and costs – building up the picture

Outcomes

The policy literature, including the Green Paper on adult social care, the National Service Framework (NSF) for Older People and the Department of Health's priorities and planning frameworks, along with the public sector agreements (PSAs) help in assessing possible objectives, as do the practice and academic literatures. Four sets of outcomes are important:

- first, the 'core' outcomes; being clean, comfortable, having sufficient food and so on, that is achieving basic standards of personal care
- second, being safe and protected from unreasonable risks, including potentially self-induced risks and also those that stem from service users' circumstances
- third, enjoying fulfilling lives, including social participation and social inclusion, self-esteem and a sense of well-being, and
- fourth, for carers, to lead, where possible, normal lives and be free of undue stress.

As discussed in Part 1 of this Review, not all people who could potentially benefit enjoy this full set of outcomes as a result of the help they receive from social care. A lack of resources might be part of the reason. Generally speaking, when greater levels of resources are put in, more support can be provided to more people and so a greater gain in these outcomes can be achieved. How much more money and resources would be needed is the key question of this chapter.

In trying to think ahead 20 years, it is assumed that appropriate levels of quality and choice will be available throughout social care; also, that people using services will be afforded dignity in their use of services.

Throughout this chapter three main scenarios are used capturing the degree to which these sets of outcomes are to be achieved in the future. The future view of social care is

cast in terms primarily of what outcomes it can deliver (and not necessarily what services and other inputs it uses). It is self-evident that the more ambitious the outcomes sought, the more the social care system must do, and the more, consequently, it is likely to cost. The scenarios are progressive; the first is the least ambitious, the third the most ambitious.

- Scenario 1 (current service model) represents the starting point or 'baseline'. It assumes the services and support that are currently provided, and hence the outcomes enjoyed by dependent older people will be the same in the future. This scenario is used as a baseline for comparison. It is chosen because it would give essentially the same level of services to people in the future. What would change would be mainly the demographics – that is, the numbers of people needing care and the cost of that care.
- Scenario 2 (core business) goes further to change what the care system does, and what it provides for people, so as to achieve the highest levels of personal care and safety outcomes that can be justified given their cost. This scenario focuses on what might be considered the core business of the social care system. It considers how far society and service users are willing to support these outcomes and how much they are prepared to contribute.
- Scenario 3 (well-being): as scenario 2 but also seeking to improve the other outcomes above; people being socially included, able to participate socially, achieve a sense of well-being and so on. These latter outcomes are harder to define precisely; their achievement is more difficult to measure objectively. But, they are important to people. The question of how to audit the extent to which these well-being outcomes are being achieved has also to be developed.

Service inputs

The task of attempting to map out a detailed picture of all the individual services, interventions, care processes, care settings and technology that might be available in the future is beyond our remit, even if it were possible to do. But it is vital to develop a general mapping of the broad range of service and other inputs that might be available, at what intensity and at what cost. Broadly speaking in the modelling work services are grouped into those providing:

- personal care for people that cannot otherwise undertake activities of daily living for themselves, for example, home care
- supervision support for people, particularly those that might expose themselves to avoidable risk;
- measures that promote people's well-being such as social participation, for example, clubs, adult day care.

Formal services can also help to improve the situation of carers, to reduce their levels of stress or help to prevent them becoming overwhelmed (even where they do want to provide this care).

The main service categories are informal or unpaid care, community-based home care, community-based other care, and care with housing, the latter embracing the wide range of accommodation-based care options available such as care homes. The model considers a number of options for technology care. Intermediate care can be undertaken in various settings and is characterised by time-limited, intensive bursts of intervention. Professional therapy services are also considered. The emphasis in the modelling, and of this report, is on the long-term, continuous-use services.

Informal care plays a crucial role in providing support to people with care needs, and will continue to do so in the future. The model distinguishes between informal care provided by spouses and others (normally children) and care provided by resident and non-resident carers.

The impact of services on outcomes and costs

Work on outcomes for older people and outputs of services, including that conducted as part of the Costs, Quality and Outcomes programme at PSSRU (see Chapter 5)¹ describes the capacity for people to benefit from services on the one hand, and the productivity of services on the other. Most mainstream social care provides support to help people undertake activities of daily living, where they are limited by (chronic) disability, frailty and impairment. The more people are limited by disability, the more will be their capacity to benefit. The degree to which services address this potential for benefit, that is, their productivity, depends on the types of services used, the intensity of their use, their quality, their combination with other services, their timeliness etc. Furthermore, both the capacity for people to benefit and productivity vary with the characteristics of the service user.

Two approaches have been used; first, a review of the professional literature was undertaken looking at professional judgement of the help people with various conditions could benefit from. These inputs – essentially hours of contact time between a carer and the care recipient – represent the ideal and often do not (explicitly) account for the cost implications of the service levels proposed. They nonetheless give a detailed picture of what can be achieved with certain amounts of time by a reasonably trained care worker, and hence form a basis for costing that input.

Second, research, and in particular the work of Professor Ann Netten and colleagues at the PSSRU, University of Kent, has been used.² This work has been instrumental in the development of preference-based outcome measurement in social care. Recent work has generated a comprehensive outcome classification, measured how older people rate its domains, assessed how services impact on outcomes and is in the process of determining a full set of preference weights and valuations (Netten *et al* 2005b). Professor Netten's team collected data for this research as part of a survey to inform the Formula Spending Share (FSS) or more recently known as the Relative Needs Formula (Darton *et al* 2006). This provides vital data to estimate how far services can improve outcomes for older people. Grouping people in the survey according to their dependency characteristics, the Review has used this data to estimate the association between the hours of input of care each person received and the improvement (if any) in their outcomes.

The next step was to cost these improvements in people's outcomes, by costing the amount of services required to achieve them. These cost estimates vary for many reasons. There are variations in the quality of services from place to place, person to person. Some people receive good-quality care, some people receive less good care; the former are likely to have a better effect on outcomes than the latter. Also, the analysis is based on current care technology and quality (because the data is drawn from real experience with real services). There are variations in the unit cost of care services. The mix of home care with other services will matter. These cost-to-outcomes relationships might therefore change in the future. Nonetheless, a fairly robust starting point or baseline from which to work is necessary.

DEPENDENCY

Services are needed because people suffer impairment or disability through health-related or other causes. Disability or dependency prevents these people from achieving the outcomes described above. A standard way to measure a person's level of dependency is to assess their functioning against a set of normal activities of daily living (ADLs). These would include whether people can manage or not (with or without help) tasks such as washing, using the toilet, getting dressed, feeding themselves and getting around the house. In addition to ADLs, people's condition can be measured by their ability to perform instrumental activities of daily living (IADLs), which include activities like: shopping, cleaning, laundry, preparation of hot meals and managing personal affairs (for example, paying bills). Problems with functioning have both physical and cognitive causes, but cognitive impairment, with its complex and multiple causes, can bring with it other problems. Here mild and severe cognitive impairment is differentiated.

The approach of the PSSRU long-term care model (Wittenberg and Comas-Herrera 2003) is adopted in this Review. It uses the General Household Survey to stratify the older population by ADL dependency adding further breakdowns of whether people have severe cognitive impairment (the prevalence of cognitive impairment is taken from the Health Survey for England 2000). An overall dependency classification as follows is used.

- Group 0: no dependency
- Group 1: no core ADL difficulties (but possibly non-core ADL difficulties), only IADL difficulties such as shopping and cleaning
- Group 2: as group 1 and also difficulty in performing one or more core ADLs
- Group 3: people who are unable to perform (without help) one core ADL
 - Group 3a: group 3 people with no or mild cognitive impairment
 - Group 3b: group 3 people with severe cognitive impairment
- Group 4: people who are unable to perform two or more core ADLs
 - Group 4a: group 4 people with no or mild cognitive impairment
 - Group 4b: group 4 people with severe cognitive impairment.

The relationship between care inputs and outcomes

A review of the professional literature (see Appendix 'Ideal service inputs') gives a detailed breakdown of ideal levels of (personal) care services people should receive for a range of scenarios covering possible care recipients' disability and dependency. There is a relatively developed literature on current service inputs, but much less on what would constitute some ideal, optimal or appropriate levels. Nonetheless, the synthesis was designed to describe the level of care input that would produce the highest outcomes for service users. Put another way, these levels were those deemed necessary for people to achieve maximum personal care and safety outcomes. Table 42 opposite summarises the results for people with no or mild cognitive impairment.

The Relative Needs Formula/FSS project has collected data from actual service users about their experiences of care, and in particular their assessment of how much services have helped them in terms of the outcomes listed above (Darton *et al* 2006). The Older People's Utility Scale (OPUS) scale covers five elements of outcome (Netten *et al* 2002). Three of these: personal care, nutrition and safety correspond closely with the personal care set of outcomes described above. These 'OPUS scores' are a shorthand for describing people's outcomes. A person with the worst possible outcomes is described by a score of zero. Someone who has their (personal care) outcomes fully achieved has a score of one. People with partially met need have scores between zero and one.

TABLE 42: 'IDEAL' SERVICE INPUTS BY DEPENDENCY GROUP (NO OR MILD COGNITIVE IMPAIRMENT)

Level of dependency	Dependency group	Per day				Per week		Total hours per week	Total ADL hours
		Morning	Lunch	Dinner	Evening	Bathing	IADL tasks		
No dependency	Group 0	0	0	0	0	0	0	0	0
IADL or bathing	Group 1	0	0	0	0	3	3	6	3
ADL difficulties	Group 2	0.5	0	0	0	3	3	9.5	6.5
1 ADL	Group 3	0.5	0	0.5	0	3	3	13	10
2+ ADLs	Group 4	1	0.5	0.75	0	3	3	21.75	18.75
5+ ADLs, walk <2m	Group 4	1	1	1	0.25	3	3	28.75	25.75
5+ ADLs, cannot walk	Group 4	1.25	1	1	0.5	3	3	32.25	29.25

Source: Review model estimates

TABLE 43: CAPACITY TO BENEFIT FROM SERVICES, BY DEPENDENCY GROUP

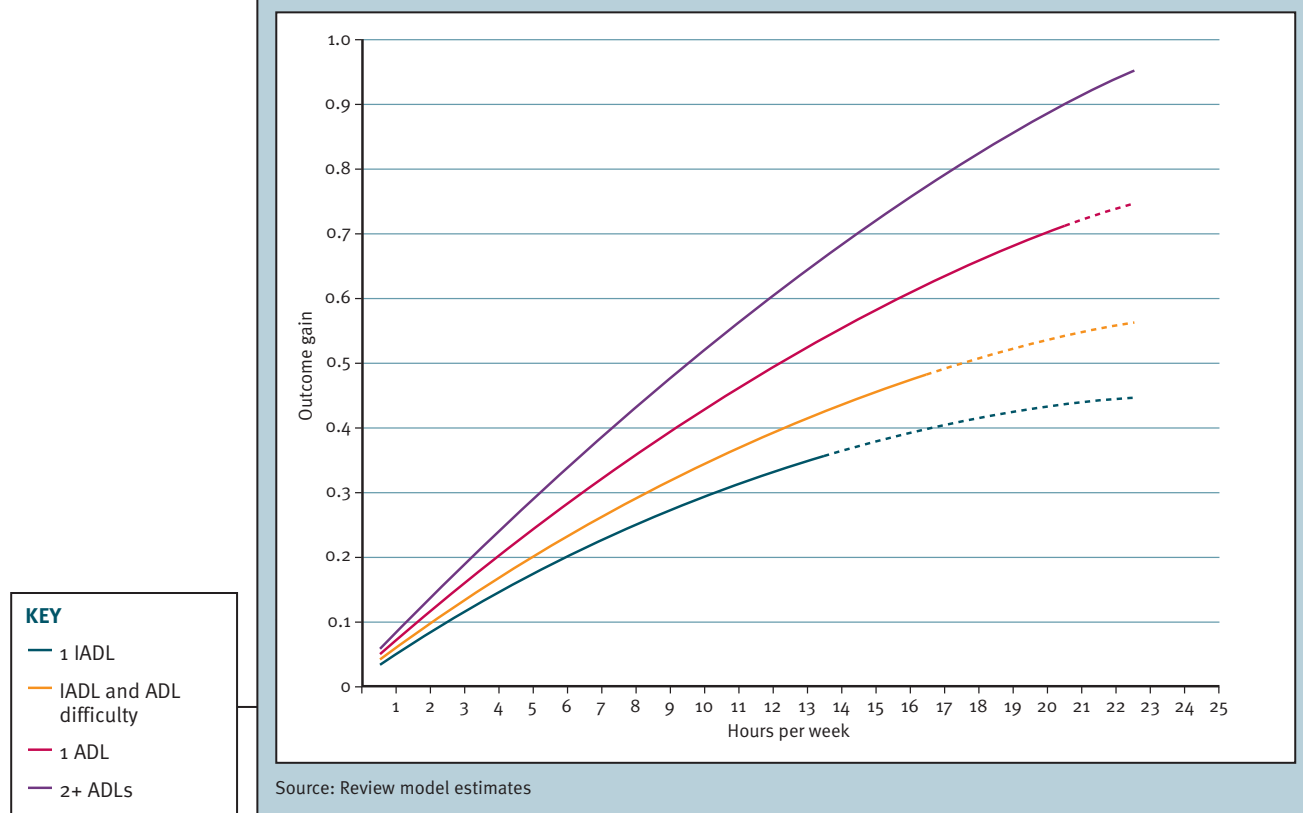
Dependency group	Without services	Capacity to benefit
Group 1 (1 IADL)	0.7	0.3
Group 2 (IADL + ADL difficulty)	0.5	0.5
Group 3 (1 ADL)	0.3	0.7
Group 4 (2+ ADLs)	0.1	0.9

Source: Review model estimates

The research covers a full range of outcomes going beyond only personal care and functional ADLs to include social participation, being in control, occupation and carer outcomes. These latter outcomes are revisited in scenario 3. Scenario 2 concentrates on the three outcomes noted above. To make this distinction clear, one person moving from no needs met to full needs met (that is, zero to one) for one year for these three domains combined together³ is described as gaining a year of life fully ADL-compensated – an ADL-adjusted-year, or ADLAY. Although this is somewhat artificial, it does provide a way to compare and rate improvements in outcomes. Such an approach is fully established in the work of the National Institute for Health and Clinical Excellence (NICE) where the quality-adjusted life year (QALY) score uses a similar scale. There are strong analogies between these measures; the EuroQol version of the QALY considers outcomes in terms of: mobility, being able to carry out activities of daily living (self-care), being able to undertake IADLs and other usual activities such as work and leisure, pain/discomfort and anxiety/depression (see Annex 1 p 210).

The improvement measured by this ADLAY score per hour of care provided can be further broken down by service user dependency group and by the numbers of hours of care received. The results are given in Figure 44 overleaf. It shows for different dependency groups how much people with different hours of home care reported their outcomes to be improved. People who were most dependent (in the 2+ ADL group) had the most to gain from services. People in this group with high levels of home care improved the most. For example, 13 hours of care input for people in the 2+ ADL group produced an average outcome gain of 0.63. People in the 1 IADL group gained only half as much (0.34). This

44 THE RELATIONSHIP BETWEEN OUTCOME IMPROVEMENT AND SERVICE INTENSITY, BY DEPENDENCY GROUP



estimated relationship between outcomes and service inputs is consistent with that found using other sources (see Davies and Fernández 2000).

The survey results also showed that the first hour of care input has the greatest effect; for example, the outcome gain for the first hour for 2+ADL people was *twice* as effective as the last hour (the 23rd hour per week). This is not surprising; people only have so much capacity to benefit from services.

The scores people reported for their situation without services are listed in Table 43 (p 185), scored from 0 (worst) to 1 (needs fully met). Capacity to benefit is the maximum outcome score (1) minus the without-services score (in order to account for the effects of informal care, ‘before’ scores are calculated on the basis that people were living alone). They compare very closely to people’s dependency levels. Very disabled or dependent people have the lowest outcomes without support from services (or informal care).

QUALITY OF SERVICES

The quality of services, as well as the intensity (number of hours), is important to people’s experience of care. The Department of Health user experience survey of older home care users found that 57 per cent of respondents in England were ‘extremely’ or ‘very’ satisfied with the help received from social services. While these surveys are useful for comparison, for example, between councils or different groups of older people, they are not suited to portraying an absolute sense of quality.

The Commission for Social Care Inspection (CSCI) conducts inspections of care homes (and also other services) relative to a set of national minimum standards issued by the Department of Health. The standards for care homes cover a range of factors, including: the degree of choice people are afforded, the personal care people receive, their daily life and social activities, people's opportunity to complain, physical aspects of their care environment, staffing, and the management of the care home. At present, each care home is rated on a 4-point scale:

- 4 – standard exceeded (commendable)
- 3 – standard met (no shortfalls)
- 2 – standard almost met (minor shortfalls)
- 1 – standard not met (major shortfalls)

The criteria for each standard – that is, specifying what is required for the standard to be met – are determined by professional judgement. Although there is inevitably some flexibility in terms of how high to set the 'hurdle', they do provide an explicit statement of the (minimum) quality that is required.

There are 38 standards for care homes for older people. Of these a sub-group relate closely to the core outcomes asked of social care in the future.⁴

- health care
- privacy and dignity
- social contact and activities
- community contact
- autonomy and choice
- meals and mealtimes
- protection
- premises
- adaptations and equipment
- hygiene and infection control

Using data provided by CSCI of the 2004 inspections, the relationships between the prices that the homes charged and the scores achieved on the 4-point scale for these 10 standards could be examined. In a provisional analysis, after accounting for the size of the home, the proportion of high-dependency users, whether the home was from the independent or local authority sector, the costs of labour in the local area, and whether the inspection was announced, it was found that homes that scored highly were also those with the highest prices. In particular, homes that met or exceeded all the standards were estimated to have prices 25 per cent (£100 per week) higher than those homes that have shortfalls against all these standards. Homes meeting all these standards had prices some 7 per cent above the average price.

These results give some indication that against professionally determined standards some services are falling short. But further inquiry is required.

UNITS COSTS

Any assessment of appropriate service deployment now and in the future must consider the (unit) cost of services. The details of the unit costs used in the cost models are outlined in Research Paper 1 ('PSSRU model') and Chapter 6. Much of the modelling approach is based around the idea of a standard hour of care input. At the baseline (2002/3), a unit cost of £11.5 for this hour is used. The cost of a standard care with housing

(care home) placement in the model is £370 per week, which is the cost of a local authority supported care home placement with the nursing cost element removed (before further quality adjustments).

The assumption about how unit costs will change in the future has a critical bearing on projected total resource requirements. Again this is detailed in Research Paper 1. Labour is the main element of service costs and wage rates in the care sector have been increasing at around 2 per cent per annum in real terms. This 2 per cent real figure is used as the central assumption of how unit costs of services will increase in the future.

PREVENTION

As discussed in Chapter 9, there is potential for services to have ‘downstream’ effects on future outcomes of care users as well as their current outcomes. The problem is that a good evidence base on the effectiveness and cost-effectiveness of preventive services does not exist (see Chapter 9). As a result the modelling work does not include any specific preventive effects of social care interventions in the base case.

The evidence does show there are benefits from low-level services but these are on people’s current outcomes.

The base population dependency assumptions do assume that incidence rates for the key disability-causing conditions are falling through time as a result of improved health from public health and health care interventions.

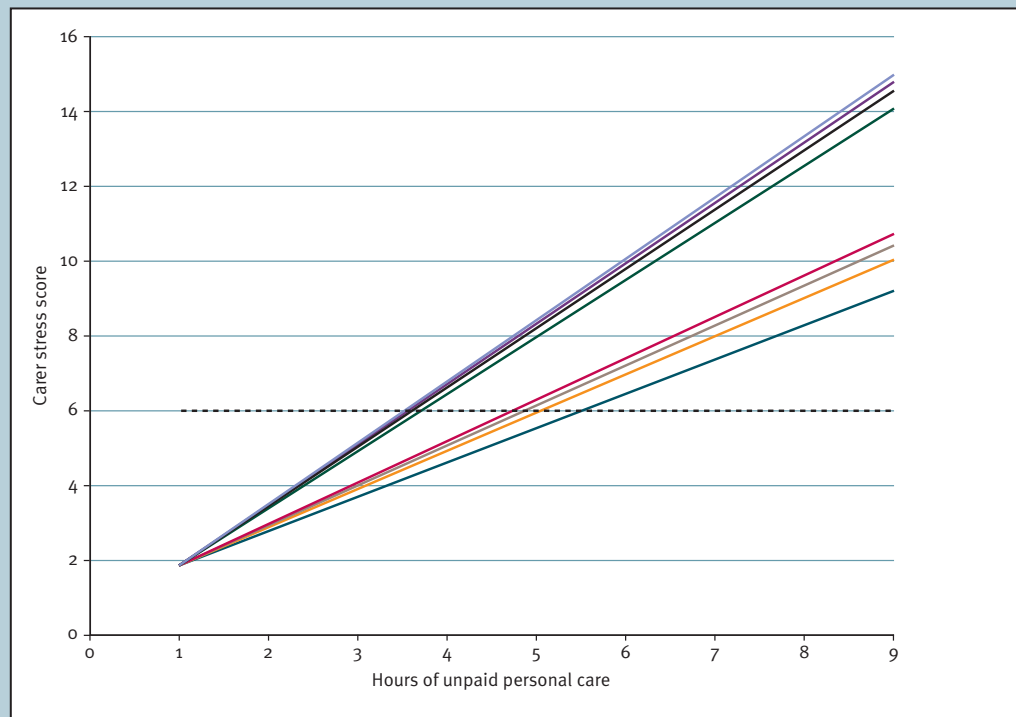
The effects of informal care

Informal carers undertake a range of care and care-related tasks, from companionship, practical care and supervision to (intensive) personal care. As discussed in Chapter 8, various sources indicate, to varying degrees, the numbers of people providing care, the number of recipients, how much care and to what intensity. Unfortunately there is not a single source that can comprehensively and reliably give all this information together. Estimates have been made from the various sources.

Carers provide support for many reasons. Providing informal care is something that many carers value highly, devoting significant amounts of time to it. But it also has costs, in people’s time, and sometimes their health. The provision of formal services to people cared for also affects the outcomes for carers. The evidence suggests that levels of informal care do not diminish much, if at all, when formal services are provided. There is some suggestion that there may be some change in the type of care that is provided, and presumably if formal services greatly exceeded usual levels, there would be some substitution. These possibilities were examined using the ECCEP dataset; a very modest substitution effect between people’s reported level of personal care provided informally and formal home care levels was found.

As the intensity of caring increases, generally speaking, it becomes more stressful. Carers looking after people with high levels of dependency have a chance of being overwhelmed by this situation. But formal services can help. Figure 45 opposite shows the (estimated) relationship between carer stress (as measured on the Kosberg Scale – see Davies and Fernández 2000) and the hours of (personal) care provided by carers (the results are

45 THE RELATIONSHIP BETWEEN INFORMAL CARE AND CARER STRESS, BY DEPENDENCY GROUP AND LIVING ARRANGEMENT



Source: Review analysis of ECCEP data (Davies *et al* 2000)

* Kosberg stress score: A value of 6 is the stress threshold.

stratified by dependency group and whether the person receiving care lives alone). The Review has estimated that about 1 in 10 hours of total informal care is personal care – the remainder includes IADL tasks, companionship and so on.

The analyses indicate that day care, as currently configured, is effective at mitigating some of this stress. In the future a set of respite, community well-being, adult education and day care services would be effective at supporting carers. Data are not available to assess the cost-effectiveness of these services directly in these terms, but professional judgement (of care managers) can be used to indicate whether people are overwhelmed by their caring input (also see the evidence in Chapter 8). On average this level corresponds to a stress score of more than 6 on the Kosberg scale (see Figure 45). The modelling work indicates that an average of 2 sessions of day care per week would ensure that no one has stress levels beyond the threshold (a score of 6). This analysis could be presented in terms of QALYs or ADLAYS for carers. Reductions in stress and preventing people from being overwhelmed, reduces depression and anxiety for carers and helps them regain the opportunity to do some of their ‘usual activities’ in life. A reduction of carer stress to manageable levels might be expected to correspond to a QALY gain of at least 0.15 using the EQ5D scale (see Annex 1 p 210). Adding in the value of improving the physical health of carers strengthens the case further.

The willingness of individuals to contribute and of society to pay for these outcomes

A SOCIETAL PERSPECTIVE

Services improve outcomes at a price. Not providing services would free up resources to be used elsewhere, to improve other outcomes that may be valued more highly. The funds directed at improving social care outcomes through providing services and other support ought to be set at a level where none of the money would be better used elsewhere. Value for money is widely used as a key principle in deciding where to draw the line in spending.⁵

In practice all possible alternative uses of any money released cannot be identified and people will differ in how they value different potential uses. Some might never expect to use social care and might place a lower-than-average value on social care outcomes. Others will rate social care outcomes more highly. A practical way to apply a value-for-money principle is to set a general amount of money that society is prepared to spend to achieve additional gains in (social care) outcome.⁶ The National Institute for Health and Clinical Excellence (NICE) uses such an approach to feed into their guidance on NHS resource levels.

NICE implicitly use a cost range of between £20,000 and £30,000 per quality-adjusted life year (QALY) (see Devlin and Parkin 2003); essentially if an intervention produces an outcome gain of one QALY for less than £30,000 additional cost it is deemed to be cost-effective. In this Review a cautious position has been taken, setting the central value-for-money threshold at £20,000 per ADLAY.

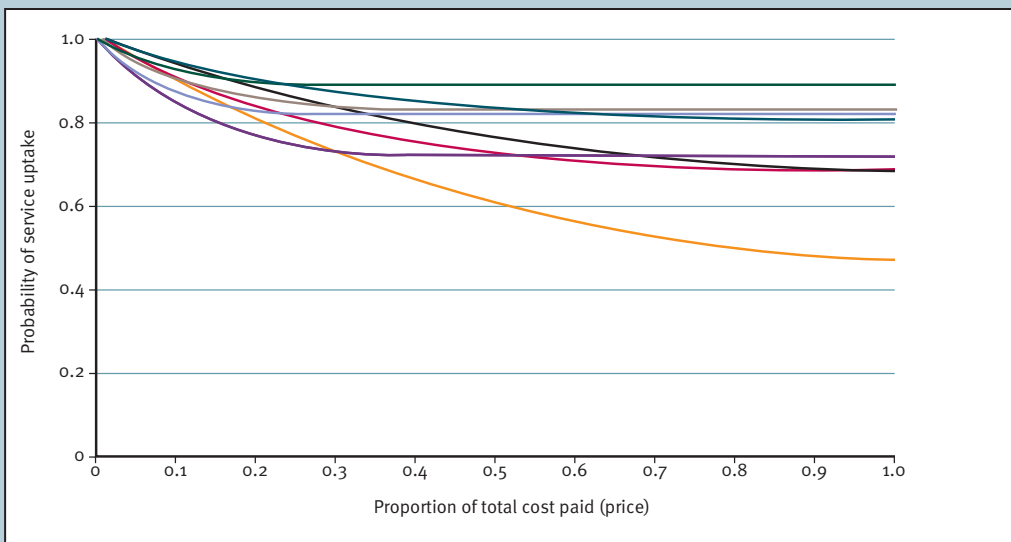
What this means is that social care services which cost less than £20,000 per person per year to produce an outcome gain equivalent to one ADLAY are considered to be of acceptable value for money. In other words, society is willing to pay for these services and they merit funding. In principle, if all potential social care services for older people were evaluated to determine how much outcome they produced (measured in ADLAY terms) and for how much cost, it would be possible to say which of those services should be funded. This evidence base is far from complete, but using the results summarised in Figure 44, the target levels of community-based services can be assessed in this way.

ASSUMPTIONS ABOUT INDIVIDUAL WILLINGNESS TO PAY

Societal valuations of the £20,000 threshold are based on assumed population preferences. Individual service users could easily have a different view. When those service users are charged for their care, even if that charge is below the full cost of the service, some people will be unwilling or unable to pay. The actual charge people pay will depend on the funding arrangements in place to be considered in Part 3. In some cases people will have the opportunity to adjust how much care they receive. If people do not have this opportunity, some will decide not to use services at all or at least put off seeking formal help.

Where people are put off from using services because they consider the charges to be too high, they are forgoing services deemed to be value for money at a societal level. This is unmet need. Demand effects also partly explain why the number of people using social care services is much lower than the number of people with disabilities and who could benefit from those services.

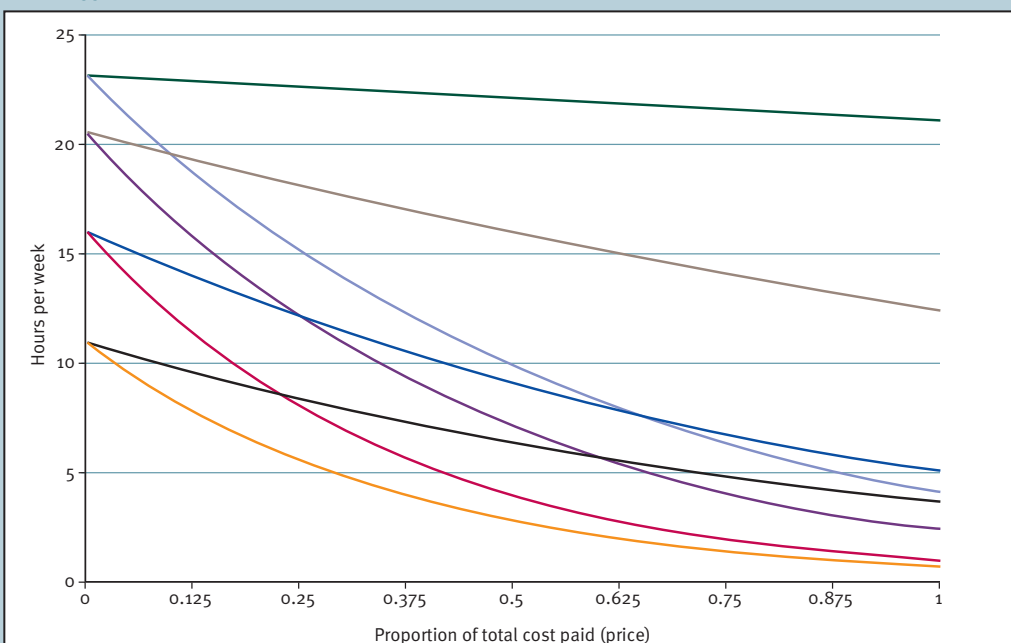
46 THE EFFECTS OF CHARGES (PRICES) ON THE PROBABILITY OF SERVICE UPTAKE, BY DEPENDENCY GROUP AND INCOME



Source: Review model estimates

Figures 46 and 47 show respectively the estimated effects of charges on the chance that people take up community-based (home care) services and the numbers of hours they secure. These graphs show the charges people face expressed as the proportion of the total cost of the service.⁷ In all cases, people asked to pay a higher proportion – the

47 THE EFFECTS OF CHARGES (PRICES) ON THE HOURS OF CARE SECURED, BY DEPENDENCY GROUP AND INCOME



Source: Review model estimates

highest prices – are those least likely to take the service, and if they do, to opt for smaller, less costly care packages. People with higher levels of need are less likely to be put off by charges. Also, people with higher incomes can afford to and would opt for larger care packages.

People's willingness to pay for services can also depend on their own, and their family's, decisions about providing informal care. Where informal care is provided, the demand for formal care is lower. Society's willingness to support people will be subject to similar considerations. It is assumed that it is inputs of care, not so much who provides them, that matters.

Total levels of informal care

The total numbers of older people with informal carers are taken from the PSSRU Long-term Finance Projection model (LTCF model). Details of the derivation of these numbers can be found in Wittenberg *et al* (2004), in Pickard *et al* (2000) and also in Research Paper 1 ('PSSRU model') in the Appendix to this report. Overall, some 1.7 million older people receive informal care. The Census 2001 suggested that the total number of carers was 4.9 million (see Chapter 8). Some 70 per cent of the care they provide goes to older people (Maher and Green 2002) with many older people having multiple carers (generally a principal carer but also others that help). Table 44 (opposite) reports the weekly level of personal care provided by carers per care recipient.

Applying these figures nationally and cross-validating using the Census 2001 break-downs of hours provided, it is estimated that some 13 million hours of informal personal care is being provided to 1.7 million older people.

Services for personal care and supervision

A main task in modelling future funding requirements is to determine what the right level of services should be for individuals with dependency and need. The current levels of service provision are constrained by the current total level of funding. Since this latter total is the central question of this review, the current level of service gives little indication of what is right for the future. Therefore to find services in scenario 2, a first principles approach is adopted. This section summarised this approach.

BENCHMARK HOURS FOR PERSONAL CARE

In what follows, assumptions about future service requirements for community-based care (home care and other) and for care-with-housing (care homes, extra care, etc) are described. Using a value-for-money threshold of £20,000 per ADLAY and taking the results in Figure 44 implies a willingness to pay for personal care 'benchmark' hours as reported in Table 45 opposite. These are the economically justified average levels of care for older people with varying dependency in scenario 2. The table also shows the current hours of care for those people with the same corresponding level of need who are using (local authority supported) services. Because, in the current arrangements, uptake of services by dependency group is much lower than in scenario 2, average benchmark hours of care are higher than at present.

These target hours compare well with the 'ideal' levels synthesised from the literature and summarised in Table 42 (see p 185)

TABLE 44: PROVISION OF INFORMAL PERSONAL CARE (HOURS PER WEEK), BY DEPENDENCY GROUP AND LIVING SITUATION

Dependency group	Living situation of person cared for	
	Not alone	Alone
Group 0 (no dependency)	9.5	2.8
Group 1 (1 IADL)	9.8	2.8
Group 2 (IADL + ADL difficulty)	9.7	2.8
Group 3 (1 ADL)	10.1	3.0
Group 4 (2+ ADLs)	10.4	3.2

Source: Review model estimates

The Relative Needs Formula/FSS and ECCEP surveys both have people using services that report no ADL dependency or cognitive impairment that is, they are in dependency group 0. In the Relative Needs Formula/FSS data, two-thirds of these people report a limiting long-standing illness, and about 75 per cent report an instrumental ADL difficulty. This points to a low level of need, and highlights the problems of just using ADLs and cognitive impairment measures. People in this group did report on average a small gain in personal care outcomes from services, but to levels that were not good value for money. What is clear is that most of the 5.5 million older people with no ADL and cognitive impairment do not need any services. Only 1 per cent of this 5.5 million people in group zero currently do get services, or about 15 per cent of all people currently getting services. In scenario 2, people in dependency group zero get zero services. This is right for 99 per cent of that group. But it may be that some people with apparently zero dependency should (cost-effectively) receive help and this should be borne in mind.

UPTAKE OF FORMAL (PERSONAL CARE) SERVICES

Not everyone with dependency in the population uses social care – in fact at present only a minority do so. Reasons for non-use include the eligibility criteria set by councils, demand effects, sufficient levels of informal care, and also, simply, a preference not to seek formal support. In terms of benchmark levels of service use, the first, eligibility, is relevant. In scenario 2, eligibility criteria for services are relaxed so that anyone who could potentially benefit sufficiently from services should have access to those services. This

TABLE 45: BENCHMARK HOURS FOR COMMUNITY-BASED SERVICES FOR PERSONAL CARE, BY DEPENDENCY GROUP

Dependency group	Service recipients		Per capita 65+	
	Benchmark hours of care	Current hours (estimated)	Benchmark hours of care	Current hours (estimated)
Group 1 (1 IADL)	4	5.3	1.1	1.1
Group 2 (IADL + ADL difficulty)	7.5	7.0	6.0	1.1
Group 3 (1 ADL)	13.5	10.6	11.6	2.5
Group 4 (2+ ADLs)	20.5	16.9	18.6	14.4

Source: Review model estimates

TABLE 46: PROPORTION OF PEOPLE WITH INFORMAL (PERSONAL) CARE THAT EXCEEDS TARGET HOURS, BY LIVING ARRANGEMENT AND DEPENDENCY GROUP

Living arrangement	Dependency group			
	Group 1	Group 2	Group 3	Group 4
Alone	0.05	0.01	0.01	0.00
Not alone	0.58	0.38	0.32	0.27

Source: Review model estimates

would include all people in dependency groups 2 and above and around 40 per cent of group 1.

In any funding system which charges users (as does the current system), demand for services will reduce as summarised in Figure 46 (*see* p 191). Turning to preferences, in a high-quality, high-choice, universal service in the future, it is assumed that a negligible number of people would choose not to seek care simply because they felt stigmatised or did not like what was on offer.

The General Household Survey gives a breakdown of the hours of informal care provided to people and this information is the basis for estimates of the future number who would meet their needs without resorting to formal services (*see* Chapter 8). Table 46 above indicates the proportion of people that receive more informal care hours than would be supplied by formal services. People with co-habiting carers, particularly those with lower dependency, often receive more informal care than services would provide.

This proportion of care recipients is assumed to have sufficient care from family, friends and others to decide not to seek formal services. This assumption is equivalent to 15 per cent of older people with any dependency deciding not to seek services.⁸

Most other people with dependency also have some access to informal care (*see* Table 44, p 193) for the average by dependency group). This informal care is assumed to be equally as effective at producing care outcomes as in Figure 44 (*see* p 186), and so the number of formal care hours required is reduced by this amount.

CHOICE AND PERSONAL CARE

It is assumed that in the future people will be able to choose between care settings for their personal care. The only constraint on this choice is that the care option must represent reasonable value for money. Benchmark levels of home care do meet this condition. For people with moderate or greater dependency (groups 3 and 4) but without significant cognitive impairment, a care placement with housing – for example, a care home or extra care housing – also meets this value for money requirement. It might not be met for people with low dependency, but it is assumed that no one with low dependency would want to move into a care home. Based on survey results it is assumed that up to 15 per cent of people in the high dependency groups would choose to move into a care-with-housing setting to address personal care needs.

COGNITIVE IMPAIRMENT AND SUPERVISION

A major risk factor for admittance to care homes (or other forms of care-with-housing) is significant cognitive impairment. Some two-thirds of people currently in care homes have moderate or more severe cognitive impairment. A 2005 survey of care home admissions produced consistent findings; only 15 per cent had no cognitive impairment.⁹ In addition to personal care, people with severe cognitive impairment often require supervision, particularly if they exhibit challenging or aggressive behaviour or wander. Leaving people who suffer these conditions alone for extended periods can put them at risk and adversely affect their outcomes. Home care services (as currently configured) are poorly suited to this task and would become prohibitively expensive. In the future, care with housing solutions, particularly nursing care homes, will remain an important option for people with high dependency and severe cognitive impairment.

Some people with cognitive impairment will have (co-habiting) informal carers able to undertake supervision tasks (backed up with an intensive home care package), and these people remain at home (as noted in Chapter 8 and Langa *et al* 2001, the caring input becomes very large for the most cognitively impaired). Technology could play a part, being well suited to help carers with supervision tasks. The evidence base is still limited (although developing) with regard to technology of this type. Special provision is not made in the models for it. Nonetheless, if this technology were forthcoming, more people with high-end need and cognitive impairment could be cared for at home.

For modelling purposes, the base assumptions are as follows. In dependency group 4, around one-third of people will go into care-with-housing, which is equivalent to nearly half of people in group 4 living alone and one-fifth living with others. These assumptions are based on three factors: the population prevalence of severe cognitive impairment, people's choices and the potential availability of informal care for supervision. It is assumed that no one in this group living alone could be supported by informal carers. For group 3, about one fifth of people will go into care-with-housing, a quarter of those who were alone and just over 15 per cent of those that were with others.

PROFESSIONAL (THERAPY) SERVICES

Therapy services such as occupational therapy and physiotherapy span both the health and social care systems. Initial analyses indicate that these services do have a significant beneficial impact on personal care outcomes. The Relative Needs Formula/FSS survey recorded use of these services and the analysis showed that use of therapy increased people's OPUS score. A full analysis has not been possible, but the initial results suggest that these services are under-utilised. Whilst this is not factored into the model, further consideration of an increase in the funding of these services in the future is recommended.

Services for carer support

With reference to Figure 45 (see p 189), carer support services are set at the level that would reduce carer stress to 6 where it is exceeded. Applying a £20,000 outcome threshold, if a reduction in carer stress – and also positive impacts on carer health – was valued at anything more than 0.15 on the QALY scale, which is assumed, these levels of support service would also be acceptable value for money. This implies benchmark (scenario 2) carer support services at (the equivalent of) two sessions of day care per week. In the future, this service package might range from sitting services, lunch clubs or adult education, through to full respite care.

Services for well-being

The previous section discussed services for scenario 2 (described as ‘benchmark’ service levels). Scenario 2 does not include well-being services. However, in scenario 3, they are included, and as a result services that promote well-being are added to the total resource requirement.

Inevitably there will be some speculation as to what well-being services are, what impact they have, and consequently, how much they should be deployed in the future. The White Paper, *Our Health, Our Care, Our Say* echoes the Green Paper *Independence, Well-being and Choice* in promoting the well-being agenda. It is, however, a broad agenda. It covers transport for people with disability and frailty, leisure opportunities, sitting and companionship and adult education to promote social participation and learning. It can also include low-level services like gardening and cleaning that help people retain their self-esteem. It includes measures aimed at improving social inclusion and happiness.

The most developed area of this agenda is on loneliness, social isolation and the promotion of social participation. The lead provided by the ESRC *Growing Older* programme has been followed to focus on these areas in scenario 3. *Growing Older* found that up to 17 per cent of the older population living alone could be described as lonely and lacking opportunities for social participation (Victor *et al* 2003). Social participation is consistently rated as one of the most important facets of people’s lives. The *Growing Older* programme (Bowling *et al* 2002) found this to be highly rated by people. The OPUS work found social participation was rated second only to basic personal care (Netten *et al* 2002). Day care services as presently configured are effective at improving people’s social contact. The analysis of the Relative Needs Formula/FSS data indicated good value for money from providing on average one day session every eight or so days to people who were lonely and living alone.

Using current day care as a marker for the (cost) effectiveness of potential future social participation services is probably an underestimate. Overall, the evidence base in this area needs to be developed. Well-being outcomes are very important to people, but there is not sufficient detail about the best ways to achieve them.

3 Model results

The modelling work aims to estimate resource requirements for social care now and up to 2026. The main model commissioned by the Review is based on and developed from the PSSRU long-term care model. Details are reported in the accompanying Research Paper 1 (‘PSSRU model’) in the Appendix. This Review also developed a micro-simulation model to look at some alternative funding arrangements and this is detailed in Chapter 13.

The three scenarios described above are modelled, as are a number of model ‘sensitivities’. These involve adjusting the key assumptions to assess the implications for services, outcomes and costs in the future.

In what follows the results of the ‘base case’ with the most plausible choice of assumptions are reported. As well as these projections, sensitivities are investigated to consider the implications of alternative sets of assumptions. This gives a sense of which assumptions are most critical in the estimation of future resource requirements.

The main ‘base-case’ assumptions are:

- population: 2004 GAD
- functional disability: prevalence rates unchanged (see Chapter 2)
- marital status: 2003 GAD
- tenure: Family Resources Survey
- unit costs: 2 per cent real increase
- quality adjustment: as current initially but increasing as reflected in real increase in wages
- value for money: £20,000 threshold
- informal care: includes estimated inputs from all carers (spouses, children, others)
- funding system (where relevant): current means-testing.

The model considers only (personal) social care, not health care, and so nursing inputs are not included in the results discussed below.

Dependency

The models are based on 2004 GAD central population projections (Table 47). These projections correspond closely with the projections developed by Professor Carol Jagger and colleagues for this Review (see table 2.2 in Jagger *et al* 2006). The model makes projections of what proportion of this older population will fall into different dependency groups in the future. These numbers are critical and will drive demand for care services in the future.

The base case in the model is for prevalence rates of disability to remain unchanged (see Table 48 overleaf), a population scenario very close to the Improved Health scenario estimated by Jagger and colleagues. For prevalence rates to be constant, incidence rates of the main disability-causing conditions need to be falling as people live longer (see Chapter 2).

Scenario 1 comparison

Scenario 1 assumes service use that is the same as current use – distinguishing between dependency, age, household composition, informal care, and tenure – and projects these

TABLE 47: POPULATION SIZE, BY AGE GROUP, 2002 TO 2026

Age groups	Older population (millions)					% change 2002–26
	2002	2007	2012	2022	2026	
65–69	2.18	2.25	2.76	2.76	3.03	39
70–74	1.95	1.97	2.07	2.65	2.55	31
75–79	1.62	1.65	1.71	2.29	2.47	52
80–84	1.18	1.22	1.28	1.51	1.76	49
85+	0.96	1.08	1.21	1.58	1.77	86
All	7.89	8.17	9.04	10.79	11.59	47

Source: Review model estimates

TABLE 48: POPULATION SIZE, BY DEPENDENCY GROUP, 2002 TO 2026

Dependency group	Older population (millions)					% change 2002–26
	2002	2007	2012	2022	2026	
Group 0	5.55	5.72	6.37	7.52	8.02	44
Group 1	0.88	0.92	1.00	1.22	1.33	51
Group 2	0.53	0.55	0.60	0.74	0.81	51
Group 3	0.37	0.39	0.43	0.53	0.58	56
Group 4	0.55	0.58	0.63	0.77	0.85	54
All with dependency	2.34	2.45	2.67	3.27	3.56	53

Source: Review model estimates

forward. The results of the PSSRU long-term care model are used for this scenario. Full details and break-downs can be found in the accompanying Research Paper 1 ('PSSRU model') in the Appendix. Table 49 provides estimates of the total costs in this scenario. Although not the actual costs of care at present – due to minor simplifications in the models – scenario 1 results are very close and can be taken as a comparator of current spend.

Scenario 2 base-case results

COMMUNITY-BASED (HOME) CARE PACKAGES

The starting position is that all people with some ADL dependency are eligible for benchmark levels of services. For the base year (2002/3), this potential number is 1.5 million people. From this number those who decide not to seek care (for example, those with full informal care packages) are subtracted to leave a revised set of figures. The actual number of people using services then depends on people's willingness to pay for services,

TABLE 49: TOTAL COSTS OF CARE IN SCENARIO 1, 2002 TO 2026

Aspect of care	Costs of care (£billion)					% change 2002–26
	2002	2007	2012	2022	2026	
Community-based care	2.6	3.0	3.6	5.4	6.5	150
Institutional care	6.3	7.3	8.5	12.3	14.6	131
Total care	8.9	10.3	12.1	17.7	21.1	139
Care management and assessment	0.6	0.7	0.9	1.3	1.5	171
Other	0.5	0.6	0.8	1.2	1.4	137
Total scenario 1	10.1	11.6	13.7	20.2	24.0	139
<i>Total as % of GDP</i>	<i>1.1</i>	<i>1.1</i>	<i>1.2</i>	<i>1.4</i>	<i>1.5</i>	<i>38</i>

Source: Review model estimates

TABLE 50: GROSS EXPENDITURE ON COMMUNITY-BASED CARE, 2002 TO 2026

Community-based care	Gross expenditure (£million)					% change 2002–26
	2002	2007	2012	2022	2026	
All	4,625	5,378	6,427	9,645	11,481	148

Source: Review model estimates

that is, on demand effects. The level of charge that different potential service recipients face is determined by the funding arrangement that is in place; this is something assessed in detail in later chapters. Here it is assumed that the current arrangements continue. In that case it is estimated that demand effects reduce actual user numbers to those reported in Figure 48 overleaf, which also shows potential numbers. For comparison, there are some 704,000 older people using community-based services if estimates of private pay home care are included.

Multiplying benchmark hours of care in Table 45 with recipients in Figure 48 gives total service volumes of 7.6 million hours in 2002 increasing to 11.8 million in 2026, a rise of 54 per cent. These numbers translate into a gross expenditure as described in Table 50 (see p 201).

CARE WITH HOUSING

Actual recipients of care with housing in scenario 2 are estimated in the model as shown in Figure 49 overleaf. This number of places is around three-quarters of the current number of care home places (330,000) and less if the number of extra care housing places that are currently being used is added in.

The corresponding gross expenditure, in Table 51 below, is based on a unit cost (less nursing) of £370 per week. It is estimated to increase more slowly in the years to come than community-based care because the capital element of the total cost (the hotel or housing element) is not assumed to increase in real terms at the same rate as labour costs.

CARER SUPPORT SERVICES

Carers also provide personal care and supervision for people with disabilities. A proportion of these will benefit from support services as described above.

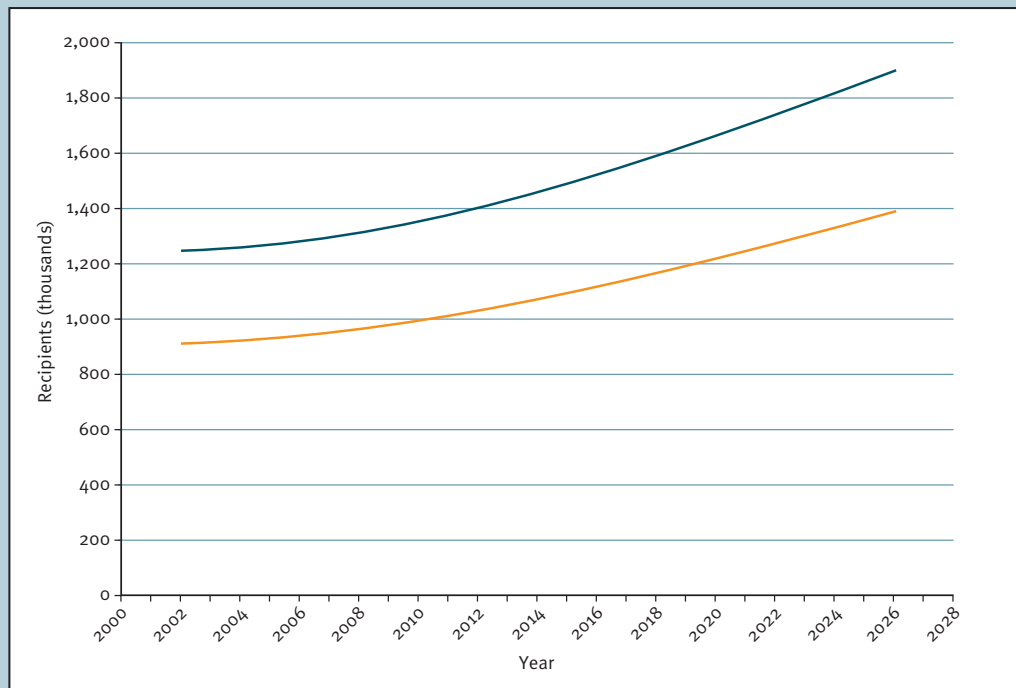
Figure 50 (p 201) gives the estimated number of recipients (after preferences and demand effects). The total cost of these services is given in Table 52 (p 202).

TABLE 51: GROSS EXPENDITURE ON CARE WITH HOUSING, 2002 TO 2026

Care with housing	Gross expenditure (£million)					% change 2002–26
	2002	2007	2012	2022	2026	
All	4,896	5,624	6,624	9,674	11,434	134

Source: Review model estimates

48 POTENTIAL NUMBER AND ACTUAL NUMBER (UNDER MEANS-TESTING) OF RECIPIENTS OF COMMUNITY-BASED CARE, 2002 TO 2026

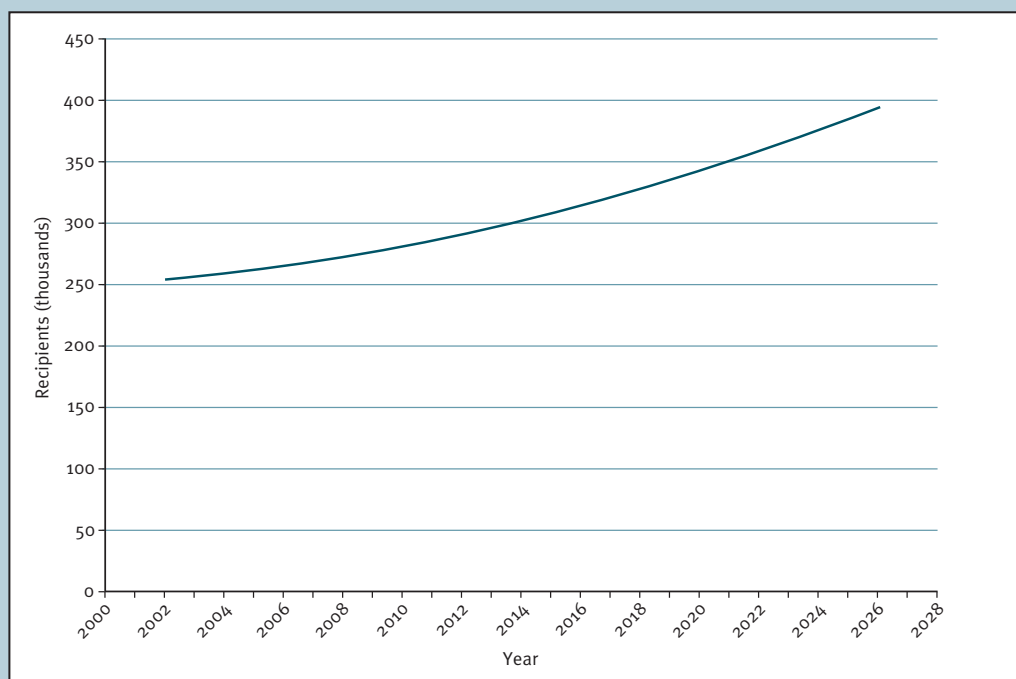


Source: Review model estimates

KEY

- Actual recipients
- Potential recipients

49 RECIPIENTS OF CARE WITH HOUSING, 2002 TO 2026



Source: Review model estimates

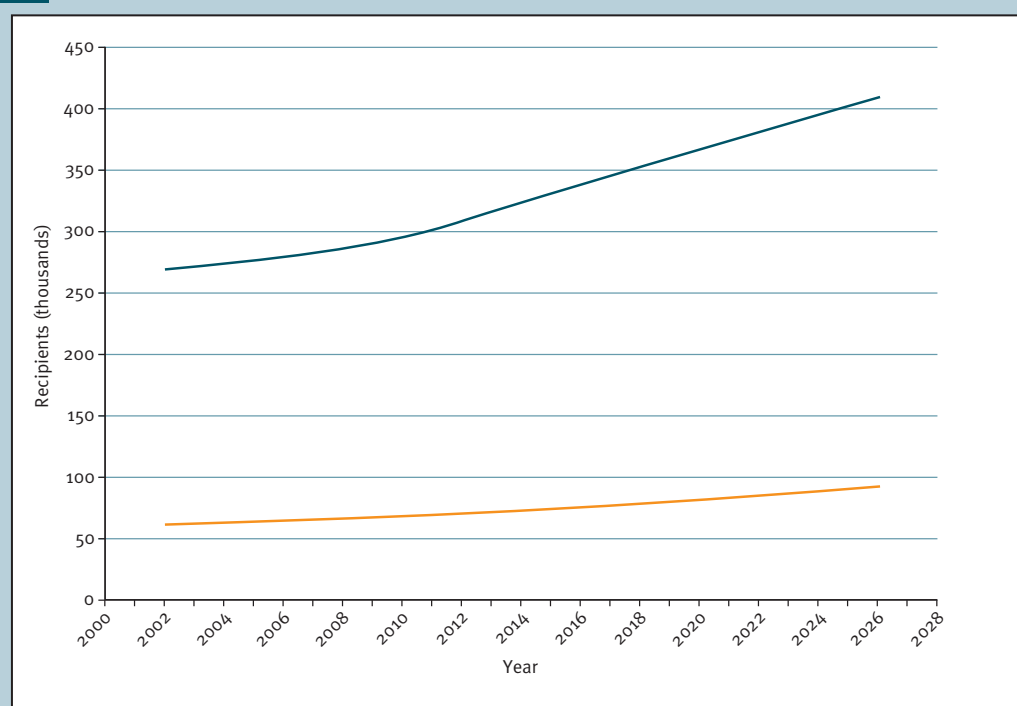
INFORMAL CARE

The number of people receiving informal care – for either reasons of care or supervision – is given in Figure 51 (see p 202). The estimated numbers of hours of input (reported in Table 53, p 202) are for personal care. If care provided for other tasks was also added in, the total would be far greater.

There is substantial debate about whether or not to cost informal care, and if so, what to take into account. The most straightforward option is replacement cost, that is, the cost to formal services of undertaking the tasks presently carried out by informal carers. An alternative is to use the opportunity cost of people's time in caring for others (see Chapter 8). This would include the value to carers of forgoing work and leisure. It could also figure against wider economic performance, for example, economic growth. But this calculation also requires getting some sense of the value people place on caring itself. Opportunity costs are argued to be especially significant for filial carers who might otherwise be at work, often at a critical time with regard to maximising their own earning and pension situation.

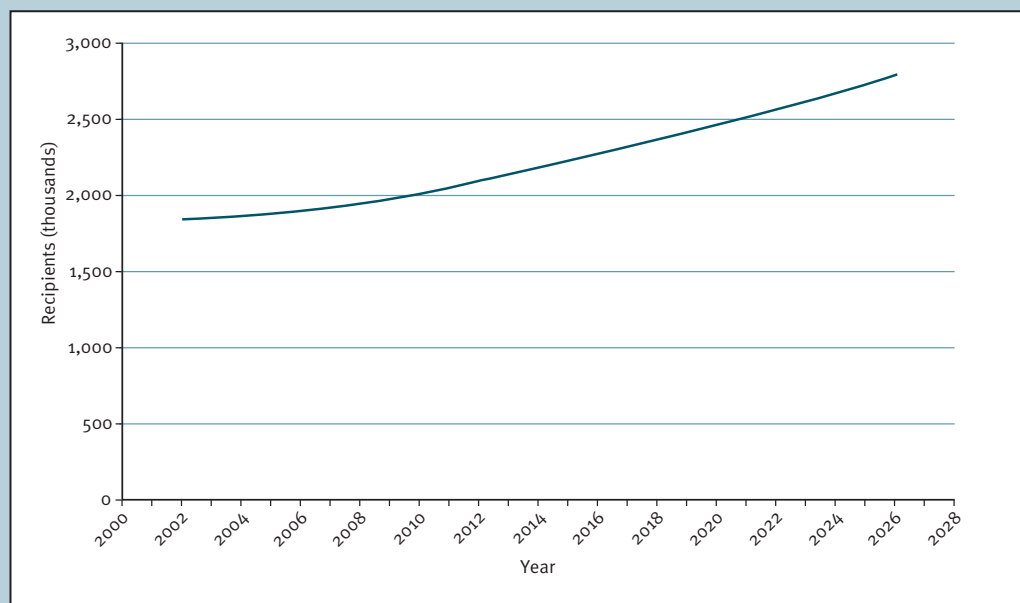
The replacement cost of these volumes of informal personal care in 2002 and 2007 are respectively, £3.3 billion and £3.5 billion, potentially increasing to nearly £8 billion by 2026. Opportunity costs are not calculated but, acknowledging the situation for filial carers, a scenario in the model is run below where no filial carers are required to provide care inputs.

50 RECIPIENTS OF CARER SUPPORT SERVICES, 2002 TO 2026



Source: Review model estimates

51 RECIPIENTS OF INFORMAL CARE, 2002 TO 2026



Source: Review model estimates

OTHER INPUTS

The model has considered broad service categories as described above. Because benchmark levels of service have been calculated only in these categories, it is possible that some services currently provided that do not fit into these categories are not counted, despite their acknowledged value to the recipients. This will be a modest amount (see below).

TABLE 52: GROSS EXPENDITURE ON CARER SUPPORT SERVICES, 2002 TO 2026

Carer support services	Gross expenditure (£million)					% change 2002–26
	2002	2007	2012	2022	2026	
All	1,624	1,877	2,278	3,399	3,993	146

Source: Review model estimates

TABLE 53: HOURS OF INFORMAL CARE PROVIDED (PERSONAL CARE), 2002 TO 2026

Informal care	Hours of care provided (thousands)					% change 2002–26
	2002	2007	2012	2022	2026	
All	12,750	13,310	14,609	17,839	19,335	52

Source: Review model estimates

TABLE 54: WORKFORCE REQUIREMENTS, 2002 TO 2026

Occupation	Workforce requirements (thousands)					% change 2002–26
	2002	2007	2012	2022	2026	
Social workers	18	19	21	21	28	53
Occupational therapists	1.4	1.4	1.6	1.9	2.1	54
Home helps/care assistants	403	424	461	566	620	54
Managers	95	99	108	133	146	54
Support staff	91	95	104	127	140	54
Total	608	639	695	854	935	54

Source: Review model estimates

Assessment and care management are important tasks. They are central in care planning, review and the direct provision of support to service users. They also play a key role in determining the eligibility of individuals to services and to public funding support. In particular care managers spend significant amounts of time on means-testing individuals, including doing benefit checks, assessment of assets and income etc. Recent research has demonstrated that care management inputs are important in setting up the right care package for people, which in turn improves their outcomes (Davies and Fernández 2001).

In 2007, the model suggests assessment and care management costs of some £1.2 billion rising to £2.6 billion in 2026. The bulk of this is on care management (65 per cent).

WORKFORCE REQUIREMENTS

The workforce implications of scenario 2 are summarised in Table 54.

TOTAL EXPENDITURE

Adding all the above costs gives a total resource forecast for scenario 2 (see Table 55). The total increases from £12.2 billion to £29.5 billion over the period. Much of this significant increase over time is due to the compounding effect of the 2 per cent real unit cost growth assumption. When set against predicted increases in gross domestic product (GDP), these expenditures are equivalent to 1.4 per cent in 2007 increasing to 2.0 per cent in 2026.

TABLE 55: TOTAL COSTS OF CARE IN SCENARIO 2, 2002 TO 2026

Aspect of care	Costs of care (£billion)					% change 2002–26
	2002	2007	2012	2022	2026	
Care with housing	4.9	5.6	6.6	9.7	11.4	134
Community care (all)	6.2	7.3	8.7	13.0	15.5	148
Total care	11.1	12.9	15.3	22.7	26.9	141
Total scenario 2	12.2	14.2	16.8	25	29.5	142
<i>Total as % of GDP</i>	<i>1.3</i>	<i>1.4</i>	<i>1.5</i>	<i>1.8</i>	<i>2.0</i>	<i>46</i>

Source: Review model estimates

TABLE 56: TOTAL COSTS OF CARE WITH A 10 PER CENT AND 20 PER CENT ONE-OFF COST INCREASE, 2002 TO 2026

Cost increases	Costs of care (£billion)					% change 2002–26
	2002	2007	2012	2022	2026	
10% total, then 2% per annum	12.2	15.2	18.1	26.8	31.8	160
20% total, then 1% per annum	12.2	15.9	18.1	24.4	27.8	127
20% total, then 2% per annum	12.2	16.5	19.6	29.2	34.5	183
Base case (0%) total	12.2	14.1	16.8	25.0	29.5	142

Source: Review model estimates

How do these costs compare with the current situation as described by scenario 1? Comparison of total costs would suggest that total costs would increase by about £2.5 billion in 2007, an increase of just over 20 per cent. In fact, this difference might be an underestimate. No price premium for privately purchased care homes has been assumed. This is partly because improvements in the functioning of the market should reduce price differentiation in the future. Also, some of the price premium might be due to a more luxurious ‘hotel’ aspect to care or other amenities, costs that are not care related. If a price premium of £50 per week is assumed from 2007 (increasing by inflation), the extra cost in 2007 would be £270 million rising to £660 million by 2026. This premium is included in scenario 1. Also, as noted above, the system would have to account for people with needs that are not well captured by ADL measures. Currently, more than £1 billion of services are provided for people in dependency group o. Some proportion of this cost might still apply in scenario 2.

Scenario 2 sensitivities

UNIT COSTS

The main part of the modelling work is to estimate demand in the future. To meet this demand, supply of services needs to be forthcoming, particularly workforce supply. The picture in relation to future workforce supply is mixed, as noted in Chapter 7. There is currently a relatively high level of unfilled vacancies in the care sector. However, other studies suggest that supply is flexible and responsive to demand.

Real growth in unit costs of 2 per cent is the base assumption. Compounded over 20 years this corresponds to an increase in unit costs between 2007 and 2026 of around 50 per cent. This increase reflects the need to raise the prices paid for staff and other inputs to induce the extra supply as demand increases (see Chapter 7). Higher unit costs will bring on-stream more supply.

The work on quality suggests that unit costs would increase if a higher level of quality were required. The implications are tested by looking at the effects of a one-off increase in unit costs of 10 per cent and 20 per cent followed by either a 1 per cent or 2 per cent annual rate of growth – see Table 56 above.

NEW TECHNOLOGY

The cost impact of new technology, like telecare, is very hard to predict as discussed in

TABLE 57: TOTAL COSTS OF CARE WITH ZERO INFORMAL CARE FROM CHILDREN CARERS BY ASPECT OF CARE, 2002 TO 2026

Aspect of care	Costs of care (£billion)					% change 2002–26
	2002	2007	2012	2022	2026	
Care with housing	4.9	5.6	6.6	9.7	11.4	134
Community care (all)	7.1	8.2	9.8	14.7	17.4	147
Total care	11.9	13.8	16.4	24.4	28.8	143
Total scenario 2	13.1	15.1	18.0	26.7	31.7	142
<i>Total as % of GDP</i>	<i>1.4</i>	<i>1.4</i>	<i>1.5</i>	<i>1.8</i>	<i>2.0</i>	<i>40</i>

Source: Review model estimates

Chapter 9. There is some consensus that the benefits begin to flow some time after the initial investment. There are two likely consequences. First, supervision will be made easier, perhaps reducing demand for care homes. The second, linked, benefit is a saving on labour inputs, which is modelled by reducing the rate of growth of unit costs. An optimistic scenario to explore the consequences would be a 20 per cent initial increase in unit costs to reflect the initial investment, followed by a 1 per cent growth thereafter. This would mean a 128 per cent change in costs in the period to 2026.

Also, as outlined in Chapter 9, a change within ‘housing with care’ of the balance between care homes and extra care housing will make a very small difference when taken as a proportion of the £12.2 billion spend in the base case.

TABLE 58: TOTAL COSTS OF CARE WITH ZERO INFORMAL CARE FROM CHILDREN CARERS, 2002 TO 2026

	Costs of care (£billion)					% change 2002–26
	2002	2007	2012	2022	2026	
Total	12.0	13.8	16.5	24.4	28.9	142

Source: Review model estimates

TABLE 59: TOTAL COSTS OF CARE WITH CHANGING DEPENDENCY ASSUMPTIONS, 2002 TO 2026

Dependency assumption	Costs of care (£billion)					% change 2002–26
	2002	2007	2012	2022	2026	
Poor health	12.2	14.4	17.5	26.7	31.8	160
Improved health	12.2	14.3	17.1	25.2	29.6	143

Source: Review model estimates

INFORMAL CARE

The estimated extra expenditure required on formal services if those formal services had to replace the informal care provided by filial carers in the base case is reported in Table 57 above.

The numbers of people who would not seek formal help is dependent on whether they have a high degree of informal care help. This assumption needs to be explored further, not least because, at present, take-up of services is much lower than potential take-up levels. Accordingly, if 20 per cent more people had full informal care packages only, costs would be lower (see Table 58, p 205).

DEPENDENCY

If the population is less healthy than suggested by the figures in Table 48 (see p 198), service demands will rise more rapidly. With a further ‘compression of morbidity’, demand would grow more slowly. Research Paper 2 (‘Future disability’) in the Appendix, commissioned from Professor Jagger and colleagues, develops a poor health and an improved health scenario. Table 59 (p 205) shows these results. As noted above, the improved health scenario – which is perhaps the more likely – is very close to the fixed prevalence base case. If people do not engage with their health and the poor health scenario applies, the extra cost will be very significant by 2026.

Scenario 3

WELL-BEING SERVICES

Figure 52 below shows the numbers of people who could benefit from well-being services. Population growth pushes up the numbers of people who are socially isolated significantly by 2026. A tentative estimate of the costs of these services is approximately £0.6 billion for the base year.

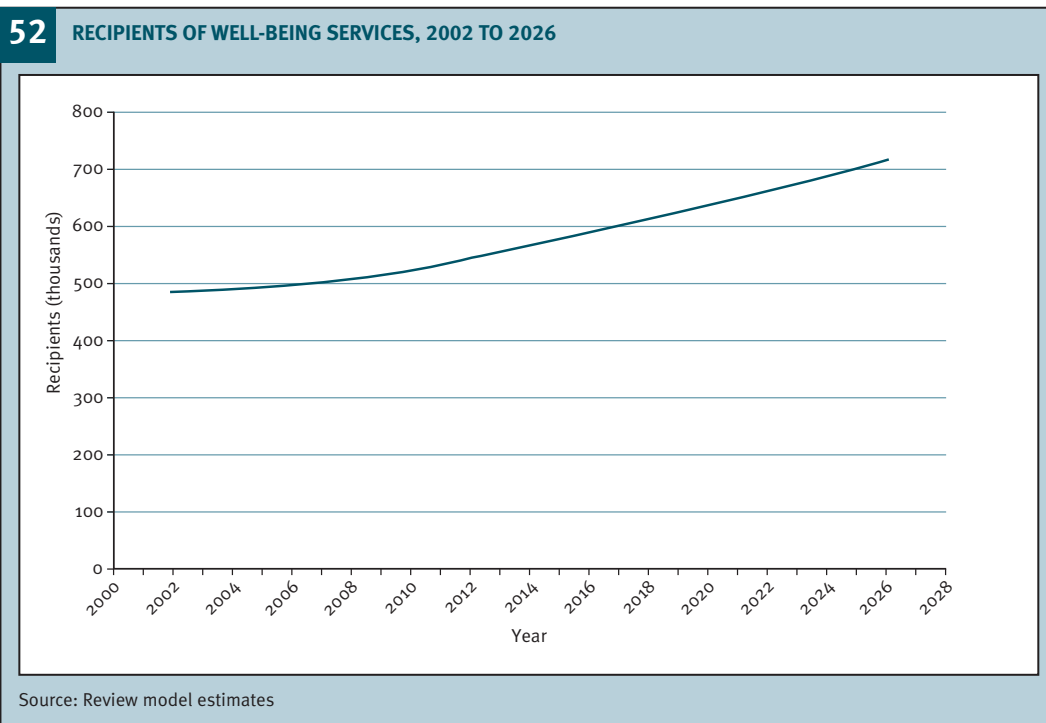


TABLE 60: GROSS EXPENDITURE ON WELL-BEING SERVICES AND TOTAL COSTS OF CARE IN SCENARIO 3, 2002 TO 2026

Aspect of care	Expenditure and total costs of care (£billion)					% change 2002–26
	2002	2007	2012	2022	2026	
Well-being services	0.6	0.6	0.7	1.1	1.3	117
Total scenario 3	13.0	15.0	17.8	26.4	31.3	142
<i>Total as % of GDP</i>	<i>1.4</i>	<i>1.4</i>	<i>1.5</i>	<i>1.8</i>	<i>2.0</i>	<i>46</i>

Source: Review model estimates

Table 60 above reports the estimate of well-being service costs until 2026. The total expenditure required in this scenario would then increase to £13.0 billion in the base year and £31.3 billion in 2026 using base case assumptions. As a proportion of GDP the scenario 3 estimates are only modestly greater than the scenario 2 case. However, as discussed above, a very cautious line has been taken on what is appropriate to include as well-being services. Greater spending than this can be anticipated in the future.

Transition paths

The modelling has estimated service use and costs going back to 2002 and forward to 2026. Both scenarios 2 and 3 involve significant increases in expenditure compared to the current situation. Even if this extra funding were made available in the near future, the required response on the supply-side would take a number of years to develop. In practice, therefore, spending would have to be built up over a transitional period.

TABLE 61: IMPLICATIONS OF CHANGING THE VALUE-FOR-MONEY THRESHOLD (BASE YEAR)

		Thresholds		
		£20,000 (base)	£17,000	£23,000
Hours of input per week (by dependency group)	Group 1	4.0	0.5	7.0
	Group 2	7.5	4.0	10.5
	Group 3	13.5	10.0	16.5
	Group 4	20.5	16.5	23.5
Community-based care cost		£6.2 billion	£4.4 billion	£8.0 billion
Total care cost		£11.1 billion	£9.3 billion	£12.9 billion
Percentage of base case cost		100	83	116
Variant threshold amount as percentage of base threshold (£20,000)		100	85	115

Source: Review model estimates

Changing the value-for-money threshold

As a guideline, a value-for-money threshold of £20,000 per annum is a sensible, if cautious, starting point. It could, however, be debated and varied. Whatever threshold is used, it is for guidance only, to be used alongside other evidence. To explore the implications, the model was also run with other thresholds, namely, £17,000 and £23,000. Table 61 (p 207) gives the results for the base year of the model. It shows that cost implications are rather sensitive to threshold choices.¹⁰ The incremental cost of further increases in the threshold would be somewhat less.

4 Discussion

Conclusions about the main findings

Social care offers crucial support for a sizeable proportion of people aged 65 and over. It can make a real difference by improving basic outcomes that others take for granted. Being clean, dressed, fed and safe is fundamental. But social care also helps people who are lonely, socially excluded and whose self-worth is jeopardised. It enables people to re-gain respect. The people around the older person can be supported as they provide informal care, reducing the adverse effects on the carer's own physical and psychological health. These outcomes are often not required just for short periods.

The potential value of helping vulnerable dependent people is justification for directing scarce and limited public funds to social care. But social care can also facilitate health care objectives and cost savings, such as reducing inappropriate hospital admissions and facilitating people's timely return to the community.

At present, on the assumptions made, the potential to achieve full, value-for-money outcomes is not being realised. Unless society decides it is less inclined to support the same improvement in outcomes from social care as it does in, say, health care, then more should be spent on social care.

Whilst the above results would support a call for additional funding, this should not be forthcoming without a commitment to re-configure services, and without demonstration that value for money and fairness are achieved. The system will need to be made more universal with broader eligibility criteria, that is, reaching more frail older people. The way this is achieved will depend on the nature of the funding system in place, but in any case explicit national entitlement or similar criteria for the whole package of care is not the proposal here. Instead local commissioners should use evidence-based practice guidance along the lines of the analysis developed above to determine with service users the package of care. Furthermore, this is an agenda for a 20-year period.

The main messages regarding service re-configuration are:

- to increase the size of community-based (home care) care packages for all dependency groups, but especially the middle dependency groups
- to tailor care with housing services for people with significant cognitive impairment and also high dependency groups who express a choice for this form of care. Care with housing would include care homes (mostly with nursing) but also extra care housing and other more short-term options. It is anticipated that the percentage of placements in care with housing of all the people cared for in high dependency groups (3 and 4)

including with home care packages will shift from current levels of about 52 per cent to about 30 per cent

- continued development of carer support services to a level consistent with funding of £2 billion and more in the future, including community-based care support such as respite, day care and also relevant technology. Housing with care support options should also be considered, particularly for filial carers
- increased spending on professional therapy services, subject to a more in-depth evaluation of their effectiveness and value for money
- development of services targeted at improving well-being. Again further work is required, but initiatives to tackle loneliness and social isolation appear to be good value of money in a spending range of around £500 million
- more emphasis on case finding in order to encourage people with dependency to use services where currently they do not have access and have unmet need.

Increased resourcing of ‘middle’ if not low-level social care services is suggested because these have immediate beneficial outcome effects. It is anticipated (although it cannot be confirmed) that these services would also have long-term prevention effects reducing future need. This would significantly strengthen the case for their increased funding. In any case, the need to improve understanding of the cost-effectiveness of prevention strategies is clear. The Review has also found evidence that social care reduces inappropriate use of more intensive health care services, and also supports timely transfer of patients back into the community.

The increase in resources estimated as needed is driven by:

- first, the benefits of improvements in outcomes (both social care outcomes and collateral benefits, for example in health care); this is consistent with moving from scenario 1 to scenario 2, for example
- second, demographic pressures from the ageing of the population
- third, from a need to ensure sufficient robustness and quality of supply in the future.

Overall, the target level of resources required over a 20-year period would increase to 1.4 per cent of GDP in 2007 and 2.0 per cent of GDP in 2026.

Caveats and comparisons

Unlike most modelling on social care costs in the future, the work here (on scenarios 2 and 3) is not based on the current service model. It is instead a development of the present service model into a model specifically tailored around the outcomes that define scenarios 2 and 3. This is both a strength and a weakness. The strength is that the current service model is in any case undergoing change and development and is, according to most commentators, deficient in a number of ways. It is not likely to be a good description of the service model that people and policy-makers would aspire to in the future. The weakness is that such a development is very difficult to make, relies on a range of assumptions and uses a very limited evidence base. The strengths outweigh the weaknesses, but the weaknesses must be recognised; the most important are:

- estimation of the relationship between inputs and outcomes. There were three datasets on which to draw but the main one (Relative Needs Formula/FSS data), although the most recent and relevant, was a relatively small sample (around 400 older people)

- demand effects. These, although again extremely important, are difficult to estimate because there are limited sources of data on both price and service package. Also, there are no direct data on the charges that people would have paid if they had not decided against seeking services
- choice and uptake. Aside from the effects of charges and informal care, there may be people who prefer not to seek support (even though they could benefit from such support). There is very little data on the size of such an effect.

There have been a number of studies predicting social care expenditure in the future. The PSSRU model referred to above is the most important. The work in this Review – in part commissioned from the PSSRU model team – has developed the PSSRU model in a bespoke way. Other relevant work is described in Annex 2, opposite.



Annex 1. EuroQol (EQ5D) and ADLAY

There are a range of techniques for determining what the QALY outcome gain is for improvements in people's health. These rate health improvements on the zero to one QALY scale. The EuroQoL technique considers five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression (see the Box below for details of what is covered in these dimensions).¹¹ Self-care is defined as whether people have problems washing and dressing. Usual activities include work, study, housework, family or leisure activities. Along with mobility these dimensions accord closely to ADLs and IADLs that underpin the ADLAY scale. Using the EuroQoL value sets, the Review determined that a full gain in these three EuroQoL domains produced the same ADLAY improvement score (c. 0.85) as for the QALY. We therefore conclude that the value society places on a QALY outcome gain is comparable with the value of an ADLAY outcome gain.

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

- I have no problems in walking about ☐
- I have some problems in walking about ☐
- I am confined to bed ☐

Self-care

- I have no problems with self-care ☐
- I have some problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

Usual activities (eg, work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities ☐
- I have some problems with performing my usual activities ☐
- I am unable to perform my usual activities ☐

Pain/discomfort

- I have no pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have extreme pain or discomfort ☐

Anxiety/depression

- I am not anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am extremely anxious or depressed ☐



Annex 2. Studies of projections of social care costs

The Cass Business School (Karlsson *et al* 2004) modelled residential and domiciliary care, (but unlike Wittenberg *et al* 2004 did not include long-stay hospital care and community nursing). Cass found that public and private expenditure on formal long-term care under its baseline scenario would increase from £11 billion today to approximately £15 billion by 2040 (in constant prices). Cass suggests several reasons for why its projections show a less dramatic increase than Wittenberg *et al*'s including that the projected increases in the disabled elderly population are considerably higher in the PSSRU model, and the institutionalised population increases more in the PSSRU model.

Given the significant differences between the two models, it is perhaps more useful to note that both baseline projections agree that, for the next 10 years or so, the cost of long-term care as a proportion of the total economy is broadly flat, but from 2015 there is significant increase, reaching a plateau around 2040.

Notes

¹ See below, and in particular work by Ann Netten and colleagues on the Older People's Utility Scale (Netten *et al* 2002) and measurement of personal social services output for purposes of national accounts (Netten *et al* 2005a, 2006)

² The review is indebted to Professor Netten and her team for access to home care survey data collected as part of the FSS/Relative Needs Formula research.

³ The three elements were weighted together to give a single score using the weights derived by Netten *et al* (2002).

⁴ The full details of these standards can be found in *Care Homes for Older People: National Minimum Standards*, published by the Department of Health (<http://www.dh.gov.uk/assetRoot/04/05/40/07/04054007.pdf>, accessed Jan 2006).

⁵ This value for money is not the only criterion that could be used to govern the use of public money. But it is a key one, and it is, for example, central to the work of NICE on deployment of health care resources.

⁶ This threshold acts to approximate a general value of outcomes in the best alternative use of the required funds.

⁷ These results are based on analysis of the current position, but they are adjusted to account for the effects of the means-tested funding system that is currently in place. They are, in effect, estimates of people's willingness and ability to pay for services (their demand) that lies behinds the service use seen under the current funding arrangements.

⁸ Eligibility and demand effects explain why some of the remaining 85 per cent of people do not use formal services.

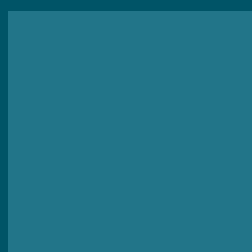
⁹ This finding was also supported by analysis of 2005 care homes admissions FSS survey data by Robin Darton, PSSRU, University of Kent. Based on the MDS-CPS (n=825) (Also see Darton *et al* 2006).

¹⁰ This result is not unexpected given that inputs are determined where marginal benefit equals marginal cost.

¹¹ In particular, this is described as the EQ5D (5 dimensions) set.



Part 3



11

How should social care funding systems be judged?

SUMMARY

There are many different possible funding systems for social care. This chapter presents the Review's framework for judging the relative merits of rival systems, and sets out:

- the suggested overall aims for a successful funding regime, given a 20-year time horizon
- a range of tests/questions which can be used to evaluate each potential system's relative strengths and weaknesses. The tests are grouped together under the headings: fairness, economic efficiency, choice, physical resource development, clarity and sustainability/acceptability.

1 Funding and delivery

Social care helps people to manage or reduce the effect of impairment on their and their families' lives. Individuals who need help are interested in whether it is available, whether their preferred choices are available and how much it will cost them. They or their family can pay from income, savings, by releasing capital from assets or from benefits received.

Governments, national and local, bear costs in making assessments of need, in providing care direct (net of charges) and in providing benefits which enable people to buy (or contribute towards) their own care or, possibly, pay family and others to assist them. The insurance aspects of the government's role could be provided by private or social insurance, voluntary or compulsory. Similarly the private and voluntary sectors can deliver services.

This Review has examined many different possible funding systems and the purpose of this chapter is to set out suggested aims for the overall system and a wide range of tests/questions which can be asked to help judge each potential system's relative strengths and weaknesses.

2 Aims of social care systems

As a first step it is necessary to define the aims of the overall systems established, of which the funding system is a critical part. These aims form the basis of the tests.

For this Review, with a 20-year time horizon, the aims have been defined as:

- to identify those needs of individuals and those who care for them that are supported (by the State)
- to ensure individuals so identified can receive support, advice etc consistently and with confidence about its sustainability

- to design and implement a system which will allocate resources to those who need them in a way which is clear and sustainable, which develops physical resources to meet expected demand, which promotes fairness, economic efficiency and choice and is consistent with the principles which emerge for the provision by individuals for their pension arrangements
- to ensure the availability throughout England of sufficient diversity and quality of care to satisfy all those who need and choose to receive it.

3. Tests to help judge systems

Many tests can be applied to systems of social care funding and delivery. Some can be contradictory but, by asking all the questions, it is possible to assess the strengths and weaknesses of different systems. Particularly where they are contradictory, it is important to assess the relative weight placed on each test.

The tests used in this Review are grouped together under the headings: fairness, economic efficiency, choice, physical resource development, clarity and sustainability/acceptability.

The tests are set out in Table 62 opposite, along with an indicative frame of reference to show whether they have been met or not.

TABLE 62: REVIEW TESTS APPLIED TO SYSTEMS OF SOCIAL CARE FUNDING AND DELIVERY

	Met	Not met
Fairness		
Is it based on assessment of identified needs?	All service decisions depend directly on assessed need	No service decisions depend directly or indirectly on assessed need
Is it based on need rather than ability to pay?	All service decisions depend on assessed need only and not ability to pay	Ability to pay is the most important factor
Is it based on need and ability to pay in a progressive way?	All service decisions depend on need only and not ability to pay or, where ability to pay is a factor, poor people pay a much lesser proportion of their means for given services	Service decisions depend mostly on ability to pay, with the amount paid the key determinant of service provision and quality
Does it provide dignity (through the care available)?	Public support is not underpinned by a principle of 'less eligibility' and/or is universal	Public support is strictly means-tested and acts in the last resort to help the very poorest or neediest only
Does it provide dignity (through the resources left to the user)?	On average, the system draws on only a small proportion of people's resources	The system leaves people with only residual assets or income
Does it avoid penalising people who make their own financial provision?	People who are able and prepared to pay themselves can expect significantly better service levels and quality	People with their own means will pay more for the same quality/intensity of care (even accounting for the progressiveness of the general tax system)
Does it engage with health care funding and delivery (for example, continuing care)?	Social care is funded on a basis consistent with the health care system	The system for funding social care is very different from that of the health care system and acts as a barrier to joint working
Does it identify and promote personal, family and state responsibility?	The system makes clear to people, their families and the public sector what is required of them and encourages all to take on those responsibilities	The system does not make clear the responsibilities or provides perverse incentives
Does it encourage informal caring in a fair and economic way?	The contribution of informal carers is recognised in formal service decisions but informal carers are supported and not over-burdened	The contribution of informal caring is not recognised, with the result that informal carers can be potentially over-burdened

continued overleaf

TABLE 62 *continued*

	Met	Not met
Economic efficiency		
Does it support best core user outcomes compared to alternative uses of social care resources?	The system is close to or at benchmark service levels	The system fails to achieve benchmark service levels
Does it support low indirect costs, particularly those falling on the wider economy?	The cost and efficiency ramifications for the wider economy are modest and have little effect on broader economic performance	The cost and efficiency ramifications for the wider economy are significant and will have an effect on broader economic performance
Does it confer benefits of financial risk protection by effective risk pooling?	Premiums are reasonably ‘actuarially fair’ and most people can expect only modest co-payments at the point of need	People are expected to self-insure against risks or pay high co-payments
Does it encourage supply to meet diverse and changing demand?	Supply can be, or is, encouraged to meet the full spectrum of demand-side preferences	The system provides a core ‘one-size-fits-all’ product
Does it reward those who have made or make their own provision to a reasonable extent?	People can expect a good return on their own money in terms of extra value from services	People can expect little or no return on their own money in this way
Does it reward measures that reduce the amount of care needed?	The system encourages measures that are cost-effective in reducing the amount of care needed	The system has no such encouragement or has the potential to encourage people to over-invest in this regard
Does it support cost-effective preventative measures?	The system encourages measures that are cost-effective in reducing the future amount of care needed	The system has no such encouragement or has the potential to encourage people to over-invest in this regard
Does it deal with ‘catastrophic’ risks (which only the state can cover)?	The system can easily absorb unexpectedly high costs without bankrupting the user or endangering sustainability	The risk pool is small and susceptible to risk shocks
Does it enable measurement of value and identification of best value overall?	Mechanisms are in place to identify and offer incentives for best value activities	The system does not readily propagate best value
Choice		
Does it accommodate the diversity of needs and preferences of individuals?	People have freedom to choose service options within reasonable financial limits	The system is geared up to produce core services
Is it free of bias towards particular types of care or providers of care?	Except where the cost implications are unreasonable, people can choose their type of care	The funding of different forms of care differs and perverse incentives can occur

continued overleaf

TABLE 62 *continued*

	Met	Not met
Physical resource development		
Does it encourage the creation of a suitably trained workforce for the future?	There are close links between service development and workforce needs	The demand (and supply) of workforce is un-coupled from the demand and supply of services
Does it encourage the development of local networks to meet local needs?	The funding system shares the principles and values of other local organisations involved in the provision of care and makes co-operation simple to organise	The system is inconsistent with local values and causes difficulties in attempts to integrate
Does it encourage the development of suitable housing stock?	The housing cost component is fully recognised and factored into service decisions	Housing costs and decisions are divorced from the funding of social care
Clarity		
Is it widely understood or capable of being clearly interpreted?	The principle at least, if not the detail of the system, is straightforward and intuitive	The system is ad hoc, patchy or inconsistent with respect to the logic of its design, or the details are highly complex
Sustainability/acceptability		
Is it sustainable and capable of adapting to changes in need drivers?	The system has in-built mechanisms to curtail inefficient cost growth	The system has no in-built mechanisms to inhibit cost growth
Is it a stable, long-term basis for users and carers to plan ahead?	The system is robust and not especially sensitive to certain factors	While possibly producing good outcomes short-term, the system has important risks that are not fully underwritten
Could it command sufficiently widespread long-term public support?	The system is fair and efficient and attracts widespread support	The system is out-of-tune with society's preferences and values
Are the principles and values that underpin this system consistent with those used in the broader public sector, in particular, the benefits system?	The system rests on principles that are consistent with other elements of the welfare state (for example, embodying a progressive approach, targeted at the poorest and the neediest)	The system rests on principles that are at odds with other key elements of the welfare state

12

Changing the way the system is funded

SUMMARY

There are many options for financing social care in old age, with different implications for the split between the public and private funding of long-term care. The degree of risk pooling also varies greatly between different systems. This chapter offers a conceptual framework within which funding regimes can be placed, and describes some of the main options, which include the following.

- Abandoning aspects of means-testing, for instance by offering free personal care as now happens in Scotland.
- Changing the means-testing rules so that fewer users pay charges.
- A partnership model which provides a universal minimum level of care. It then offers incentives for private top-ups through some form of matching funding.
- A limited liability model which caps any individual's potential private liability for social care costs, either after a certain period or a specified financial outlay.
- Savings-based models, often with a link to pension provision.
- A social entitlement model which offers a public sector version of insurance risk pooling.

The costs and roles are also considered of the various non-means-tested state benefits which are aimed specifically at older people, including Attendance Allowance for older people with dependency, Winter Fuel Payment and free TV licences.

Various commercial funding instruments are outlined which might assist those people who contribute to the costs of long-term social care.

- Long-term care insurance products, including their potential role in public–private partnership arrangements.
- The use of housing equity release schemes to raise funds for meeting social care costs.
- Various financial incentives which could be offered through tax incentives such as the provision of vouchers.

This chapter highlights the complexity inherent in funding long-term social care for older people. There is widespread disquiet about the current funding arrangements, but no single prescriptive ‘answer’ to suit every older person’s financial circumstances and preferences. Funding solutions will need to relate closely and coherently to development of the service model, as well as people’s changing expectations and aspirations. Some options could be adopted relatively easily and quickly, while others are more far-reaching and would require a longer timeframe.

1 Financing options

Financing options need to be considered in the context of the overall aims of social care. There are many options for financing social care in old age, varying the balance between the state and the individual in terms of responsibility for funding. The choice of financing regime will significantly affect the number of people receiving social care and the amount of social care likely to be commissioned. Different funding arrangements influence the level of demand and determine the way in which the system decides who receives social care; for instance, England's current needs eligibility criteria are based on a broad-ranging, individual-focused assessment, whereas private insurance payouts are usually linked simply to the number of ADL failures.

Chapter 1 showed that the present arrangements for funding social care have their roots in historical policy development, some of it not particularly rational. Alternatives to incremental approaches to reform and more far-reaching strategies are available, and this chapter sets out a classification system for funding arrangements that allows a comprehensive assessment of alternative arrangements.

While, in principle, alternatives could be considered where the state plays only a residual role, in practice, the imperatives described in the last chapter will mean that these alternatives are very unlikely. Rather, private funding might be considered as a part of a system that includes a significant state-funded element. On a 20-year horizon, this raises issues concerning the priority which governments will give to social care funding, the alternative methods of financing state-funded care and whether the existing means-tests should continue, be amended or abandoned. There might also be the potential for the state to offer new 'partnership' arrangements which could encourage a sustainable public-private division of the costs of long-term care.

Any proposed future social care funding system needs to consider both public and private funding mechanisms. The state has a facilitating role in the latter case. For example it could provide incentives for affordable private financial products, such as housing equity release and long-term care insurance.

This chapter presents a range of options changing the state and private funding of social care in England. In Chapter 13, these options are assessed and for the most promising, the financial and outcomes consequences are calculated.

2 Some key features

Possible ways to fund social care are many, varied and complex. To help in both identifying the various options and then assessing them systematically, the detail of alternative arrangements can be pared back to reveal a set of key features. The following framework builds on the analysis set out in Brodsky *et al* (2003).

- Whether key responsibility for funding rests with the individual/family or the state. Put another way, paying for social care can be on a state-organised or private basis. With the former, having made some indirect contribution, the person can expect financial support from the state if they develop social care needs. Otherwise, they can largely expect to pay themselves if the need arises. State funding might be:
 - general taxation based, or
 - from social insurance, where the state mandates a compulsory insurance system

with contributions collected using payroll taxes and from hypothecated taxation of individuals.

- The degree of risk pooling. The risks attendant with social care need are complex and difficult to measure. There is the risk of developing conditions or disabilities that in turn imply a need for social care. There is also the risk associated with how long people remain in poor condition, principally but not only in the cost of services. Risk pooling is a way for people to reduce the financial risk, and particularly the ‘catastrophic’ costs of high-intensity social care, should it be needed. Insurance (either public or private) is the usual way to pool risks. An example with no risk pooling occurs when people meet potential costs ‘out-of-pocket’, generally from their savings.
- There can be an explicit entitlement to funds so that in any particular financial period people (should) always receive funds if they meet certain entitlement criteria – so-called ‘defined benefits’. Alternatively, the system can be budget-constrained, that is, funding can be adjusted within a time period according to the available budget as well the need.
- Whether the funding system is distributive with respect to people’s income or means, or in other words, how pro-poor it is in terms of what support people with different income and wealth receive from the system.
- Whether benefits are set according to a person’s (assessed) need, for example numbers of ADLs, or to cover the costs of services to meet those needs.
- Whether the size of the payout or entitlement is determined nationally or locally.
- The system can allow individuals choice as to how much they receive and contribute. For private arrangements, this is the usual arrangement. However, public systems can also have top-up arrangements. The payment of additional voluntary contributions (AVCs) in the pension system is a relevant example.
- The degree of reliance on informal care. Although not strictly a funding issue, informal care can be leaned upon to reduce the funding requirements of formal services. Informal care involves family-based funding or resourcing of care.

Trends in other countries

Funding strategies tend to emerge from a combination of political inclinations and cost considerations, and governments around the world have made very different decisions about where and how to draw the line between public and private responsibility. Most developed countries have a mixture of arrangements. Those with predominantly state-organised arrangements can be distinguished as follows. In all these examples, there is risk pooling and assessment according to need.

- Systems funded from general taxation with an explicit entitlement to services. For those deemed eligible for help, a tax-funded system can fund social care that is universally available regardless of wealth (Austria, Sweden, France).
- Systems funded from general taxation with eligibility through a needs assessment that is focused on the individual’s particular circumstances, including access to informal care, and also means-testing (England, Scotland). The level of disability at which services are offered, and the amount of services provided, will depend on available resources. Following all the assessment processes, the government agency is usually tasked with arranging the appropriate services, although a cash payment may be available instead, as with direct payments in England. Means-testing can apply to all elements of care (England) or just to some such as the housing and practical care elements (Scotland).

- Social insurance programmes with explicit entitlement (for example Germany, Luxembourg, Netherlands). Compulsory contributions are collected (usually, at the minimum, from employees and employers) and put into a designated (hypothecated) fund. People then have explicit entitlements based on nationally applied objective measures, often including the number of ADL failures. In the social insurance schemes currently in place, there is no means-testing and little or no consideration of the informal care available (these systems are ‘carer blind’). Benefits from such a scheme could, in theory, be paid out in some way which varied with the wealth of the recipient. The level of benefits is set according to need, although a person’s past contributions to the scheme may be relevant. Benefits can often be taken in cash or vouchers.

The adoption of an entitlement approach is a relatively recent development in long-term care internationally (Brodsky *et al* 2000). All developed countries provide long-term care for older people, although it is mostly on a budget-limited, income-testing basis. Five countries have led the way in moving to entitlement-based systems (some of which are tax, and some social-insurance funded): Austria, Germany, Israel, Japan and the Netherlands.

A more detailed account of the different social care funding systems that currently operate in various OECD countries is included in Background Paper 12 (‘Funding options’) in the Appendix.

3 Options for state-organised funding of social care

No means-testing

It has been argued that there are enough parallels in old age between the need for long-term care and the requirement for health care that the two services should be provided on an equal basis. For instance, the potentially ‘catastrophic’ cost for a minority of older people with high levels of long-term care needs suggests the desirability of a high degree of risk pooling. A low entry point for eligibility for services would, under a system of universal coverage, also provide social care which might achieve much more in terms of preventing physical and emotional decline.

FREE PERSONAL CARE

The free personal care model was developed and recommended by the majority report of the Royal Commission, *With Respect to Old Age*, and was subsequently adopted in Scotland but not England.

There are a number of variants of the free personal care model, but the essential features (with reference to the framework above) are as follows. The state, drawing on the proceeds of regular tax revenue, provides care services at a highly subsidised or zero charge at the point of need. Benefits are, in other words, made on a universal basis, irrespective of the income or means of the service user. This is a fully risk-sharing, publicly funded solution, with a re-distributive feature where a progressive tax system is used. Furthermore, the government is gatekeeper of the level of services that people receive, with eligibility subject to a local assessment of need. In the case of care home services, generally only the personal care element is covered, and then at a fixed rate of subsidy. Where a subsidy approach is used, people are also free to top-up from their own means.

In practice, under free personal care, users are still liable for ‘hotel’ costs, but personal care (although not domestic help) is free. Within a personal care framework, there remain several options. Free personal care can be provided according to a sliding financial scale or there can be one fixed flat sum of money for everyone. A maximum financial limit might be set, so that people are not always free to opt for very expensive home care packages rather than a care home place. Free personal care would halt the need for means-testing of community-based recipients of personal care, but a financial assessment would still be necessary for care home residents because of the ‘hotel’ costs. Means-testing would also be necessary for domestic help.

The reported experience of free personal care in Scotland is described in the box.

FREE PERSONAL CARE IN SCOTLAND

The best available case study for the introduction of free personal care is Scotland, where it was introduced in 2002. The key elements of the policy are as follows.

- **Care home residents:** A flat rate of £145 a week is paid by the local authority for personal care. Residents may also receive another £65 for nursing costs if eligible. However, anyone in residential care in receipt of free personal care is no longer paid Attendance Allowance (£60.60 higher rate).
- **Domiciliary care:** There is no upper limit on the value of the free personal care package, and Attendance Allowance is still paid. Free personal care does not cover domestic tasks. Average annual expenditure per home care client receiving free personal care in 2002/3 was £3,000, that is, £58 a week, but there was a substantial variation between different local authorities (Bell *et al* 2006).
- **Policy:** Free personal care has been introduced in Scotland without changes in taxes, state benefits or in the market for longer-term care insurance. The policy was based on higher public funding and a decline in private expenditure.

It is a mistake to think that social care for the elderly is now free in Scotland. The cost of an average care home in Scotland in 2004 was £427 a week, and self-funders represent about 40 per cent of Scottish care home residents. So, after the £210 a week maximum from the state (£145 plus £65), these self-funders in an average cost care home are still paying £217 a week (that is, more than half). Also self-funders no longer receive Attendance Allowance. In England, someone self-funding a care home place, who is on the highest of the three free nursing bands and who is also receiving Attendance Allowance will be getting £189.60 a week (2005/6) from the state, in comparison with the £210 in Scotland. For a self-funding older person in residential care who is not receiving free nursing care, the comparison is between £60.60 higher rate Attendance allowance in England and £145 free personal care in Scotland. So the Scottish system is sometimes, but not always, significantly more generous for those in residential care. Self-funders receiving domiciliary care are better off in Scotland because there is no cap on personal care costs and Attendance Allowance is still paid. The residual amount left to the self-payer is mainly the housing element, as the spirit of the policy was to cover the costs of personal care.

A recently published evaluation (Bell *et al* 2006) provides the most thorough analysis of the impact of Scotland’s new policy on demand and cost. Scotland as a whole is broadly

comparable with other parts of the UK in terms of demography and the average economic circumstances of older people, so the study has implications for other parts of the UK. However, the unavailability of some data means that the policy's full impact is still unclear. The evaluation's main conclusions were as follows.

Costs

- The main cost impact of free personal care is to shift the balance from payment by individuals to payment from the public purse.
- Free personal and nursing care (combined) in Scotland adds around 10 per cent to the total public costs of care for older people, equivalent to about 0.2 per cent of Scottish GDP.
- The increased annual cost to the Scottish Executive of free personal and nursing care is currently around £140 million.
- The state-funded costs of free personal care and free nursing care have been higher than initially predicted: £107 million was set aside for 2002/3, compared with actual expenditure of £127 million; the full cost for 2003/4 was £144 million. This figure represents 0.6 per cent of the Scottish Executive's total grant from Westminster of £25 billion.
- Higher charges in care homes since 2002 have meant that self-funders have not benefited by the full £145 a week. Between 2002 and 2004, care home fees increased by £116 a week in the private sector and by £64 a week in local authority homes. Several factors contributed to these higher fees.

Balance of care

- The number of hours of formal care in the community provided by local authorities increased by 27.8 per cent between 2000/1 and 2002/3 (latest figure) because of the shift from private to public payment.
- Scottish Executive data shows that the number of individuals receiving free personal care in care homes increased from around 7,000 in July 2002 to 8,000 in May 2004. For free personal care at home, the Executive's data shows an increase from about 23,000 to 41,000 over the same period, since when it has appeared to stabilise. There has been a change in the pattern of local authority provision of domiciliary care, with a decrease in the number of users receiving less than 10 hours of personal care a week and a 31.4 per cent increase in the number receiving more than 10 hours a week. This suggests that the supply of domestic tasks by local authorities may have declined in favour of more intensive home packages.
- There has been a shift in the balance of care from residential care to home and community services during this period. In 2000/1, home and community care services cost £38 million less than residential care. By 2003/4, spending on home care services was £100 million more than on residential care. Free personal care may have played an important role in changing the balance of care towards more home care.
- The introduction of free personal care has not reduced the level of informal care. It has enabled carers to devote their time to caring tasks other than personal ones if the older person and the carer prefer. Free personal care may support carers so that they can carry on caring for longer. Informal carers may also have stepped in following what appears to be a reduction or levelling off in local authority support for domestic care tasks. 'Thus the policy may have moved the boundary at which individuals are

expected to pay for care provision or to rely on informal carers from personal care to domestic tasks,' the report states.

- Free personal care has made provision for those of modest means – especially women – and people with conditions such as Alzheimer's disease more equitable. For this latter group, personal care payments are no longer a burden, particularly towards the end of their lives when such care is vital. However, these groups still face charges for some aspects of their care.

Overall, the Scottish example leaves questions unanswered. The report's conclusion that free personal care has not increased the costs of personal care to society as a whole is based on apparent evidence that there has not been any substantial increase in the total amount of free personal care being provided. However, in the report a different picture is provided by Labour Force Survey statistics, which show that between 2001 and 2004, the number of care assistants in the public and private sector rose from 47,300 to 75,100. The average number of hours worked by each rose from 29.2 hours to 32.5 hours per week. Combining these figures (this is not done in the evaluation) produces an increase of 77 per cent total in total hours of formal domiciliary care provision in society. The evaluation cautions against the relatively small Scottish care worker sample that is behind this labour survey, but even if the increase is exaggerated, it does suggest that the full impact of free personal care might not be showing up in the local authority figures and other data. This may be connected to the other big question posed by the review's authors. Between 2001 and 2004, the overall total increase in public spending on older people's services (£568 million) was much greater than the incremental increase which resulted from free personal and nursing care (£144 million). It remains unclear how the balance of that big increase was spent. It is possible that, for reasons of definition or inaccurate accounting, some additional free personal care has been included in that balance. Separately, as in England, statistics on the private purchase of personal care are lacking in Scotland and it remains very unclear how much private expenditure on personal care there might still be, with self-funders augmenting whatever free personal care packages have been awarded them by local authorities.

There are issues about the precise implementation of the policy in Scotland. It seems inconsistent, for example, to halt the payment of Attendance Allowance to older people receiving free personal care in care homes but to continue paying the benefit to those receiving personal care in their own homes. Similarly, it might be more consistent for there to be a maximum amount for the costs of personal care for someone remaining in their own home, as is the case for residential care. At the moment, if someone is eligible for a care package which costs more than £210 a week in personal and nursing care (the amount available to someone in residential care), then there is a perverse incentive for the local authority to put the person into residential care. It might also be possible to contain costs by restoring some element of means-testing for the 'truly affluent'. For example if someone's income/assets were above a certain level, then there could be a maximum amount that the state would contribute towards personal care costs.

Meanwhile, a separate study commissioned for the Review (Background Paper 11 ('Scotland: care trends') in the Appendix) used Scottish Household Survey data from 2001–2004 and Scottish Community Care Statistics from 2001–2005 to estimate the

extent of changes in demand and supply of formal (both personal and non-personal) care and informal care. Its findings were consistent with the Bell analysis. In particular:

- For all households in which both respondents were aged 65 years or over, there was no evidence of any statistically significant changes in the supply of informal care or in the demand for formal care (including both personal care and domestic help) at home.
- It is not possible to draw conclusions over the changes in demand for personal care following the policy, as no distinction is made between personal and non-personal forms of domiciliary care within the Scottish Household Survey.
- There was some evidence to suggest that among households with lower annual incomes, there was a reduction in the likelihood of receiving informal care from other household members after the introduction of free personal care.
- There was some evidence to suggest that households with lower annual incomes were less likely to receive local authority or private home care and that this effect persisted following the introduction of free personal care.
- Lower-income households were less likely to receive more hours of local authority home care before the free personal care policy, but following the introduction of free personal care they were as likely to receive more hours as higher-income groups.

In conclusion, the precise impact of Scotland's introduction of free personal care still remains uncertain because of the lack of much of the data which would be needed for a full analysis.

Since 1997, the Labour government has consistently rejected the idea of free personal care. The modelling work reported in Chapter 10 and Research Paper 1 ('PSSRU' model) in the Appendix, suggests that even without demand effects (that is, no extra demand as a result of charges falling), the introduction of free personal care would cost £1.7 billion in 2007, rising to £3.2 billion by 2026. Reasons usually given against providing free personal care include: it would not help the poorest people, or the sickest, as the care of these people was already funded. Indeed, those in residential care with some state support (that is, not self-payers) were unlikely to benefit at all (because their contributions do not generally cover more than the 'hotel' costs). The government insisted that free personal care would divert resources from schemes that could help all older and disabled people; and that it would, in particular, divert money that was used to help people maintain their independence and stay longer in their own homes.

In February 2006, the Welsh Assembly announced it would not implement free personal care despite an election manifesto commitment. Instead it plans to increase the minimum net income that an older person must be left with after paying domiciliary social care charges. This will rise from 125 per cent to 135 per cent of the relevant pension credit level. The decision followed a study (Bell 2006) which found that the current cost of providing domiciliary personal care to those aged 65 and over is currently around £95 million, of which £17.6 million is recouped in charges. The report estimated that the additional cost of free personal care for the elderly would, under a base case scenario, rise from £49 million in 2005, to £64.7 million in 2015, and £88.2 million in 2025 (at constant prices). This was based on various assumptions about unmet demand, private expenditure, and demographic changes. A further issue was the potential interplay between free services and the state benefits system. One DWP-funded benefit, the Independent Living Fund

(ILP), would be withdrawn if local authorities removed their charges for personal care so there would be no gain for 1,700 ILP recipients and there would be a cost to the Welsh Assembly, all of which were given by the Welsh government as reasons for not pursuing free personal care.

VARIANTS

An ‘NHS’-style version would cover a wider range of services without charge. This coverage would include the ‘hotel’ costs of residential care, as is the case in hospitals and under continuing care. It could also include non-personal domiciliary care. The potential costs of such extensive state provision are such that this option is not explored here.

A more affordable personal care system could be devised which would provide free personal care for some users, but not everyone. One suggestion is that there should be some universal claim on (non-means-tested) publicly funded care once a person’s needs are assessed as being above a certain level (Glendinning *et al* 2004). That threshold level could either be specified in terms of the number of hours of care, or the total cost of the care package. The universal funding could then cover the care needed above the threshold, thus capping anyone’s maximum private liability.

Varying the current means-testing system

PUBLIC FUNDING – MEANS-TESTING

Chapter 6 outlined the details of the means-testing system in England as it applies to social care for older people, and also the commonly perceived shortcomings of the current arrangements. The essential feature of the means-testing model is that the state funds are, to a greater or lesser degree, a safety net for those unable to make provision for themselves. The underlying principle is one of social security. Eligibility for state support depends on both needs and a means-test (and also generally an assessment of informal care availability). For those covered, risks are pooled. Otherwise, those whose income or wealth exceed the eligibility thresholds must make private arrangements. Given that care benefits are means-tested, they are highly re-distributive towards the poor. Mostly benefits are in terms of services and the generosity of the system is determined locally. They are also budget-constrained.

CHANGING THE RULES

As described in Chapter 6, the practical application of the means-tested model in England involves a complex set of rules to determine who is eligible or not. In considering alternative funding arrangements, one option is to re-configure these rules, but to keep the essential character of means-testing. For instance, a quantitative study (Hancock 2000) of the impact of changing the means-test showed that ‘disregarding more income in the means-tests would be well targeted on the poorest and cost less than disregarding more capital ... This is because, whatever their capital, people have to put nearly all their income towards the cost of residential care’.

The existing means-tested system includes both income and assets, so there are many possible permutations (see Background Paper 12 (‘Funding options’) in the Appendix) for introducing changes.

- Raise the higher assets threshold (£20,500 in 2005/6).
- Raise the higher and lower assets thresholds.

- Scrap the ‘window’ between the higher and lower assets thresholds (currently just £8,000).
- Greatly widen the ‘window’ between the higher and lower assets thresholds.
- The very low personal expense allowance of £18.80 a week (2005) for someone receiving state-funded residential home care could be increased. Similarly, the net residual minimum income for someone receiving domiciliary care could be increased above the current level of 125 per cent of the relevant pension credit level.

Alternatively, changes to the funding system could instead be made on the charging side of the equation, particularly for domiciliary care. The Joseph Rowntree Foundation (Hirsch 2005) has made two proposals:

- a national scale of maximum fees for older people in any particular income band, or
- a national percentage limit of one’s income above the threshold that can be used to pay for home care.

At present, the means-testing system in England allows councils some freedom when deciding exactly how to charge for domiciliary care. There are big differences in the treatment of capital. The most thorough survey (Thompson and Mathew 2004) received responses from 86 of the 150 English local authorities and found that only one did not take savings into account when assessing for charges. The majority imposed full charges on anyone with savings above the upper threshold for residential care under the CRAG (Charging for Residential Accommodation Guidance) rules, currently £20,500 (2005/6). However, a non-representative look by this Review at eight local authority charging schemes as implemented two years ago (the same period as the Age Concern research) found that four did take capital into account and four ignored it completely. So it is unclear what a full survey would show. Given the Fairer Charging guidelines, it appears that overall state financial support for long-term care in the home could be reduced if all local authorities were compelled to charge the maximum permitted under the Fairer Charging rules. In the next chapter, the model results suggest that charge income would be more if a stringent interpretation was applied.

CO-PAYMENTS

In the current means-tested system in England, individuals potentially pay a charge that is based on their income, assets and the cost of the care package. Some people pay nothing, some potentially pay the full cost. Instead, a co-payment could be made that is either a fixed proportion or a fixed absolute amount, applied universally. This co-payment would have to be means-tested to avoid it being regressive; alternatively there could be some cut-off so that co-payments only applied, for instance, to users on a full basic state pension, regardless of total income level, or were not charged to anyone in receipt of a particular state benefit such as pension credit. In Japan’s social insurance system, a flat-rate 10 per cent co-payment is charged on the cost of the care package, with a lower rate for those with less income (see Campbell and Ikegami 2003).

Adjusting the amount of the co-payment could presumably contain demand to a lesser or greater degree. Thus a co-payment system provides a direct test of how much an older person values a particular service, so long as the co-payment is affordable. The impact will depend on the elasticity of demand, and the relative crowding in and crowding out effects. Co-payments also provide a revenue stream for the funding of social care, and depending on how they are structured, can be used to make the system more progressive.

A partnership model

Le Grand (2003) argues for partnership arrangements between the state and the individual which would remove the disincentives for saving that currently exist. Such schemes would end the means-testing system, and the expense of administering it. Anyone assessed as needing care would be entitled to a basic, minimum level of care met from public funds. Le Grand states: 'This minimum, although adequate, would be basic.' (In the case of an older person needing residential care, the financial 'price' put on this minimum would need to be enough to pay for a basic care home place.) Above this minimum, Le Grand then proposes state-funded grants which would match private contributions made by an individual (or relatives) to social care costs. That matching could be on a pound for pound basis, or could use some other ratio or formula. To limit the number of people eligible for the scheme, the needs eligibility criteria for social care under the partnership arrangement would be set in line with available funding resources. To keep spending under control, a maximum would be set for the total amount that would be paid towards any individual's care.

Le Grand argues that such schemes are 'co-operative' rather than 'adversarial'. The incentives to hide assets or give them away are no longer there, for instance. The role of choice is also expanded, in that an older person and their relatives can decide whether or not to contribute private resources to the costs of care. One consideration may or may not be a desire to leave an inheritance to one's children.

The scheme is designed to 'help those who help themselves', but some form of 'approved expenditure' system might be necessary to avoid public funding of types of care not sanctioned by the state. Thus it would have to be decided what type of care (for example domestic help) would be included in the scheme. Administration and accounting procedures would need to be introduced to log eligible expenditure on care by those older people who preferred themselves to organise and manage their care packages.

Le Grand accepts that this scheme would provide more benefit to those who paid more, and would therefore be less targeted on the poor than the current means-tested system in England. But he argues that there would still be a 'progressive' aspect to the scheme, in that the more expensive the care chosen, the lower the proportion of the total cost met from public funds. The degree of progressiveness could be increased by reducing the ratio by which funds were matched as the level of private spending on social care increased. The system is also more equitable than tax relief because it benefits non-taxpayers and standard-rate taxpayers to the same degree as higher-rate taxpayers.

The biggest challenge for such a scheme is to address the argument that this sort of partnership deal leaves the poorest members of society with only the basic, minimum level of social care. Le Grand suggests that people with few or no financial resources might be allowed to make non-financial contributions that would in some way substitute for financial contributions. This could include community service, for instance, or caring duties by the individual or their relatives. However, fixing a tariff rate for such arrangements would be very subjective.

A problem would also arise if an older person ran out of money and could no longer continue to make the contributions. The user would then have to fall back to the basic, minimum level of state-funded care, which might mean reducing the care package or

moving to a cheaper care home. Le Grand suggests that this possibility could be overcome 'by making it a condition of the matching grant that the individual or their family use their own resources to purchase an annuity of a value sufficient to cover the costs of the private contributions'. Such 'impaired life' annuities are available from private providers, but such a condition might make a partnership deal less attractive to many individuals, would add to costs and would not be flexible enough to account for changing care needs (including possible reduction in care needs).

Capping the potential private liability for social care costs – the limited liability model

The state could agree to pick up long-term care costs for anyone after a certain period or expenditure of a certain amount of money, thus limiting the financial liability of private payers. A relevant example of this model would be where the current means-tested system applies, except that after a certain period (for example 3 years), those not eligible under the current means-test have the full costs of their care met by the state. The financial risk of care is therefore curtailed; there is an element of pooling of the 'tail' of the financial risk. In particular, it protects people against the fear of eroding all their assets should the time of care be longer than is expected or is affordable. The limited liability component is pro-rich, helping the middle classes. The means-tested safety net part is pro-poor. The overall extent of income re-distribution implied is therefore mixed.

Various practicalities would need to be addressed. For instance, there would have to be some sort of assessment, presumably under national eligibility criteria, which would start the clock ticking on the period of self-funding. It would also be necessary to stop someone paying for a couple of years of cheap care and then, without good reason, switching to a much more expensive package. Such a personal liability-limiting system would need to cover both residential care and domiciliary care, if it were not to undermine the policy of encouraging people to remain living in their own homes for as long as possible.

Any such system would bring a large number of people into the needs assessment fold, because of the gate-keeping that would be necessary. It would also make no difference to the poorest older people, who would in any case qualify for state-funded care. The main beneficiaries would be those with catastrophic long-term high care needs who would otherwise have had to spend down all their assets to the means-testing threshold. The wealthy would also benefit, so long as they were not averse to engaging with the state gate-keeping apparatus. However, the apparently regressive nature of the policy could be counterbalanced by the tax or national insurance methods used to pay for the costs of the system.

Savings-based models

This option involves people paying for their care from a specific savings pot that they have accrued at some time during working age. The state could make a financial contribution to this pot for example through a tax break. The idea is that the amount of savings would grow so that at an age when care is likely to be needed, it is sufficient to meet the costs. There is little or no risk-sharing under this arrangement. Generally, some form of 'stop-loss' insurance is used for people who experience particularly high care costs.

LINKING WITH PENSIONS SAVINGS

There are some parallels between pension provision and long-term care finance. Both involve long-term planning for old age, although not everyone who starts to draw a pension will need long-term care. Several years ago, one annuity company launched a pension annuity product which paid out at an initial rate on retirement, but this increased to a higher level if/when the annuity holder failed, say, two ADLs. The product was abandoned when the Inland Revenue decided that it was not 'approved' (necessary for proceeds of the pension pot to be taken tax free). However, under the new pensions rules that come into effect in April 2006 there is now considerably more flexibility. An Inland Revenue 2005 Technical Note on Pensions Simplification allows one-off increases in the amount of the annuity, adding that 'this will allow annuity products that provide for an increase in the level of income in the event of the member becoming seriously ill and requiring long term care', suggesting that such a product would be a possibility. This proposal differs from a social insurance approach, because it is about the type of annuity that is purchased on retirement, rather than about increasing the amount saved in an individual pension pot. It is about spreading the risk of needing social care within certain cohorts of people. It does nothing for people without pension arrangements. Indeed, many people who already have ADL limitations at the point of retirement have inadequate pension provision for their ordinary retirement income.

A more straightforward approach to linking the pensions regime to long-term care was suggested at the time of the Royal Commission by the British Bankers Association. It proposed that the tax-free status of the lump sum that can be taken from an occupational or personal pension on retirement (equal to a maximum of 25 per cent of the pension pot) could be made conditional on part of it being used to purchase long-term care insurance.

MIRRORING THE PENSION COMMISSION PROPOSALS

Debate about the need to promote pensions savings has followed the final report in November 2005 from Adair Turner (The Pensions Commission 2005). Although the report made only passing reference to the need to fund long-term care, its proposals for encouraging pension saving would eventually mean that more pension income would be available to pay for long-term care. One of the Commission's main recommendations was for a new National Pension Savings Scheme (NPSS) to augment the state pension, with so-called 'soft-compulsion' so that employees would have to opt out of the scheme rather than needing to opt in. The proposed contributions to an individual's NPSS pension pot would be made up of 4 per cent from employees, 1 per cent from the tax relief on those contributions, and 3 per cent from matching employer contributions. The target annual management charge would be just 0.3 per cent.

If the government were to back this proposal, then an option to consider is whether saving towards long-term care should be grafted onto the NPSS. For instance, also using soft-compulsion, employees could contribute an extra slice of earnings, with the same tax break, which would build up a ring-fenced parallel pot of money in a 'care fund' to be drawn on in the case of needing long-term care in old age. The uses to which this money could be put would have to be fairly flexible. Any unused money at death would be part of the saver's estate. The combination of soft-compulsion, tax incentives, and low charges might encourage early saving towards long-term care costs, although this method does not offer any risk pooling.

Social entitlement models

Social entitlement is also a risk pooling, public sector model. The state acts as insurer, covering the risks of dependency and using explicit criteria to assess claimants. Once assessed, claimants are entitled to benefits that depend only on their assessed need, that is, all eligible people receive the same scale of benefits regardless of their means. These benefits are also made available on a carer-blind basis. But the scale of benefits can fall short of the actual costs of meeting certain care needs (in which case people either pay out-of-pocket or rely on means-tested social assistance or social security mechanisms).

Social entitlement models usually work in conjunction with social insurance-based funding. Individuals and their employers generally contribute through (proportional) payroll taxes. Those not in work or otherwise on low incomes are usually required to make reduced contributions. In most cases, the fund is also hypothecated or ring-fenced, with contribution and payout criteria set nationally.

Specific public funding issues

ATTENDANCE ALLOWANCE AND OTHER NON-MEANS-TESTED PAYMENTS

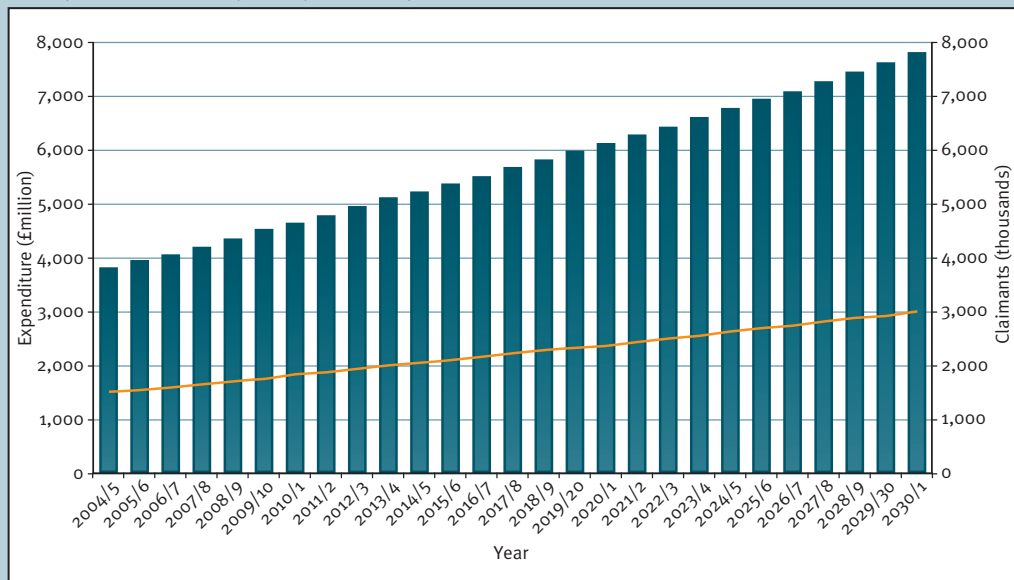
The role of Attendance Allowance in meeting social care needs could benefit from clarification and further research, as argued in Chapter 6. In particular, Attendance Allowance could be consolidated into mainstream social care budgets, in the way that income support supplementary benefit for care home placements (see Chapter 1) was abolished with the funds re-routed instead via council commissioners (see Chapter 13 for this analysis).

The DWP prepared projections for this Review for the number of recipients in England of Attendance Allowance and Disability Living Allowance care component (not mobility), and the expected growth in expenditure in real terms. These are shown in Figure 53 opposite, and demonstrate the possible future cost of these benefits, which represent a significant proportion of total state spending in England on social care for the elderly.

Any decision to introduce means-testing for Attendance Allowance would entail increasing the number of detailed financial assessments needed. There would also be a knock-on impact on people receiving other benefits. For instance, a higher level of pension credit is sometimes paid to some people who also receive Attendance Allowance, so any decision to target Attendance Allowance would have to take this into account.

A similar but separate question about the appropriateness of means-testing arises when considering universal benefits aimed at the elderly: Winter Fuel Payment (worth up to £300, depending on age), free television licences (over 75s) and any one-off age-related payments (up to £200 in 2005/6). Such non-means-tested benefits are significant. The DWP's planned benefit expenditure for 2005/6 for older people in Great Britain includes Winter Fuel Payment (£1.98 billion), free television licences (£451 million), and Over 65s Payment (£970 million) (Department for Work and Pensions 2006b). Using the DWP's pro rata ratio, this would suggest expenditure in England of Winter Fuel Payment (£1.60 billion), free television licences (£365 million), and Over 65s Payment (£786 million). It could be argued that a proportion of such funds would be better spent on improving the provision of long-term care.

53 REAL EXPENDITURE ON AND CLAIMANTS OF ATTENDANCE ALLOWANCE AND DISABILITY LIVING ALLOWANCE (CARE COMPONENT), 2004/5 TO 2030/1



Source: Based on data from the Department for Work and Pensions (2005)

Notes:

Expenditure figures are in £million, rounded to the nearest £10 million.

Caseloads are in thousands, rounded to the nearest thousand.

Caseload figures are on a consistent basis with Department for Work and Pensions figures.

The caseload figures for 2004/5 are an annual average of actual data, rather than a forecast.

The 2004/5 expenditure is the latest estimate of actual expenditure, rather than a forecast figure (may be subject to revision).

The forecast figures are derived from those that underpinned the Department for Work and Pensions Budget 2005 forecast.

The Department for Work and Pensions long-term forecasts are GB-based; it is assumed that the proportion of the GB payroll resident in England will remain constant.

Real terms figures calculated using the GDP deflators published by HMT on the 28th September 2005 for years up to 2009/10.

A long-term GDP growth assumption of 2.8% has been used to calculate real terms expenditure for 2010/1 onwards.

KEY

■ Expenditure

— Claimants

DEALING WITH THE CONTINUING CARE ANOMALY

Various proposals have been suggested to deal with the funding anomaly created by the continuing care arrangements (see Chapter 4). These are discussed in Background Paper 2 ('Continuing care') in the Appendix. Among the possibilities are the two following.

- Offering free personal care, or banded contributions to personal care, to anyone eligible for the top-rate of the three bands of nursing care. This could be made more generous by extending it to the middle band, or to anyone qualifying for nursing care. However, narrow nursing-based criteria might well not catch a person with dementia with very high care needs.
- The cost of extending free personal care could partly be mitigated by introducing means-tested 'hotel' charges for continuing care patients in nursing homes, who currently pay no board and lodging fees. This rationale does not extend to someone receiving temporary NHS health care because there is an assumption that the person will recover and move back home. Thus the costs of maintaining the family home in this case are ongoing, which may not be true for someone in a nursing home with a continuing care package (depending on their family and other relationships).

In any system without free personal care and free 'hotel' costs there will always be a boundary somewhere between means-tested and non-means-tested care. Under a system

of free personal care, the boundary would be between an existing continuing care patient with no ‘hotel’ charges and a recipient on higher-band nursing care with board and lodging fees. Under the proposal above, the junction between two different bands of nursing care becomes the new cliff face between fully funded and means-tested personal care.

EXTENDING DIRECT PAYMENTS

Direct Payments promote choice (see Chapter 4). In Germany, some 73 per cent of domiciliary care users were taking the option of a cash payment in 2001 even though it was only about half the value of the services-in-kind package on offer (see Background Paper 3 (‘Direct Payments’) in the Appendix). One of the main reasons for preferring cash is that the money can be used to pay close relatives and spouses living in the same house. This is not permitted in England.

Relaxing the restrictions so that Direct Payments in England were as flexible as in Germany has pros and cons. If the cash payment was similarly worth less than services in kind, but also popular, then increasing the take-up of direct payments would potentially cut the care budget. Allowing co-habiting relatives to adopt the role of paid personal assistant might also alleviate the problem of workforce shortages.

A less desirable result would occur if the cash were simply absorbed into general household budgets, and not used to buy the care needed. The payment would subsidise existing informal care. Thus less care might then be commissioned than under the existing Direct Payments rules – though this would be a result of personal choice. State expenditure could, however, rise by making cash available for ‘paying’ co-habiting relatives which would encourage claims from people who only want to be cared for by someone very close, or who are averse to receiving services through the local authority. There is little research to assist in balancing these considerable uncertainties.

4 Options for privately funded long-term social care

In theory, social care could be considered predominantly the responsibility of the individual. People would then rely on familial support and pay for formal services out-of-pocket as required. There would be no pooling of risk, or any other form of collective response to care-need risks. Where there is a risk of a person having to bear a large financial cost, private insurance arrangements generally develop. In the US private health insurance is the predominant model for health care.

The income and assets data in Chapter 6 demonstrates that there is already a significant proportion of people aged 50 to 65 who would be very unlikely to be able to afford private formal care services. This is particularly true of those who already suffer from ADL limitations before retirement as their financial and property wealth tends to be lower than average. Yet these are people very likely to need long-term care. Unless such a person is set to benefit from inherited wealth, it seems unlikely that there will be much opportunity to increase savings before retirement to provide for future long-term care costs. Such people would be eligible for significant state support under the current means-tested system. Thus there is a significant minority of the population for whom a mostly privately funded system – in the form of out-of-pocket payments, long-term care insurance or home equity release schemes – would in practice mean inadequate care.

Equally, the English Longitudinal Study of Ageing (ELSA) data shows that there are many people who will always have to fund at least a proportion of their social care costs. Under the current means-tested system, even those who are eligible for state help can be required to contribute large portions of any income they might have. If free personal care were to be introduced, people would still be liable for the ‘hotel’ costs of residential care, and elements of care in the community. Members of this group have income and assets above existing means-testing thresholds, yet many cannot be called wealthy. People with even a relatively low level of assets can begin by paying a significant proportion from their own pockets. For the minority who in their final years incur ‘catastrophic’ long-term care costs, this can mean considerable hardship and the complete ‘spend-down’ of assets and savings. It is these prospective self-funders who could benefit from reliable, affordable financial products designed for the needs of older people.

So far, the financial services industry has failed to meet or kindle demand. Most providers of long-term care insurance (LTCI) have pulled out of the market, and home equity release schemes for older people have the reputation of offering poor value or being appropriate for relatively small numbers. What, then, is the future for such funding mechanisms, and could they play a role in encouraging people to make their own provision for long-term care? Could they also promote more private spending on social care? Should the government consider taking steps to encourage the development of the market? This section looks at various options available for self-funding long-term care.

Long-term care insurance

There are insurance-based products providing long-term care benefits. For most plans, benefits can be claimed if the policyholder can no longer perform a specified number of ADLs or is cognitively impaired. The recipient is given a choice about the type of care that is delivered, and whether to receive this care in a residential unit or at home. Premiums are generally set according to the individual’s circumstances (so called ‘experience rating’). Private insurance is entirely voluntary; there are no collective enrolment aspects to this arrangement. Risk pooling occurs as a result of other members paying into the scheme and adding to a funded insurance pot.

On the face of it, there ought to be a market for long-term care insurance (LTCI). A fairly predictable proportion of the population will need LTCI, and for a minority the costs will be catastrophic. It is therefore attractive to limit financial exposure for the individual by pooling the risk. The market for LTCI products, however, remains very small. People are generally reluctant to think that they may need social care in the future, and many individuals with inadequate pension savings would in any case arguably be better advised to boost those before opting for LTCI. It is perceived as a very expensive option.

A detailed description of the various types of LTCI is given in Background Paper 12 (‘Funding options’) in the Appendix). These are as follows.

- **Pre-paid LTCI.** Regular or lump sum premiums are paid by the policyholder in the years before long-term care is needed. If the person should need long-term care, the policy pays out a pre-agreed annual amount (which can be index-linked) throughout the time the care is needed, however long that may be. The policyholder must meet any difference between the insurance cover and the actual cost of the long-term care. The insurer usually has the right to review the premiums at a later date.

TABLE 63: SAMPLE PREMIUM FIGURES FOR LONG-TERM CARE INSURANCE FOR 50-YEAR-OLD WOMAN SEEKING MONTHLY BENEFIT OF £1,000

		3-month deferment	6-month deferment	12-month deferment	24-month deferment
Monthly premiums	0% escalator	£72.85	£68.77	£61.85	£50.99
	3% escalator	£185.37	£174.00	£154.62	£123.91
Single premium	0% escalator	£13,431.00	£12,671.00	£11,381.00	£9,353.00
	3% escalator	£34,448.00	£32,327.00	£28,711.00	£22,984.00

Source: Partnership Assurance 2005

Following the withdrawal from the pre-funded LTCI market of most of the providers, only one UK company currently offers a pre-funded product, Partnership Assurance (formerly PAFs). Table 63 above gives sample premium figures for standard cover for a healthy woman aged 50 who wants a future monthly benefit payment of £1,000. This cover only starts paying the regular monthly benefit after 3 ADL failures or when help is needed because of mental impairment. The deferment period relates to a delay between eligibility and the onset of the benefit payments.

- **Investment-based bonds.** An investment bond is purchased with a lump sum. The premium needed to pay for the pre-paid LTCI policy is then withdrawn by the company each month from the value of the investment bond. In the meantime, the investment element continues to be fully invested. There is both investment growth potential and risk with these plans. For example, it is possible for the plan to increase in value but it is also possible for it to decrease in value. If it decreases significantly then it may well be that the benefit amount may have to be reduced or a top-up paid. In practice, this type of product was a casualty of the sharp stock market declines following the dotcom boom. Several thousand policyholders who took out bonds in the 1990s have since been told that they have to make extra contributions or accept lower cover because the investment bond was not producing adequate returns to meet the benefits. No UK company is now selling long-term care investment bond products.
- **Immediate needs annuities.** These are annuities purchased with a lump sum to pay for immediate care. If an older person is in poor health and already needs care, or is about to go into a nursing home, it is possible to pay a single premium to buy an annuity policy which will begin paying a fixed amount towards care immediately. These policies guarantee future payments, at the pre-fixed levels, towards the cost of residential home fees or domiciliary care for as long as necessary. In practice, many purchasers use the proceeds of a house sale to fund the immediate care annuity, so it is less common for this type of funding instrument to be used to pay for domiciliary care. The benefits can be index-linked, but this pushes up the cost. The policyholder must pay any difference between the pre-fixed policy benefit payment and the actual cost of the care.

Immediate care annuities are the only part of the LTCI market which is showing any growth, albeit from a very low base. There is no income tax payable on the immediate needs annuity benefits provided they are paid direct to a formal care provider (that is, not a friend or relative). These annuities can be attractive because for the majority of people paying for care, the biggest concern is the unknown period of time for which

TABLE 64: SAMPLE QUOTES FOR ANNUITY FOR 92-YEAR-OLD WOMAN SEEKING ANNUAL INCOME OF £18,000

	No RPI ¹ link		Escalating at RPI ¹ + 2%	
	No capital protection	50% capital protection	No capital protection	50% capital protection
Provider A	£49,289	£57,028	£52,582	£61,504
Provider B	£75,224	£82,239	£90,434	£100,506
Provider C	£62,061	£70,079	£67,381 ²	£77,030 ²
Provider D	£54,972	n/a	£65,571	n/a

Source: The Care Funding Bureau (unpublished)

¹ RPI = Retail Prices Index

² Escalates at 5%.

those costs will be payable. The annuity ‘caps’ the cost of care at a set initial lump sum amount.

Only four UK providers currently offer immediate needs annuities, and the cost of the product varies widely for exactly the same benefit levels. Table 64 above gives one real example for the annuity purchase price for a 92-year-old woman who wanted an annual income of £18,000. Given the age of the woman, the high quotes look particularly expensive. (The provider companies have not been identified.)

Most industry players see immediate care annuities as being the only viable part of the LTCI industry. Price, uncertainty and complexity are usually cited as the reasons why pre-funded LTCI failed to take off with consumers. The income and assets figures given in Chapter 6 illustrate how LTCI premiums are too expensive for the majority of people over 50. The minority who can afford the current typical premiums are probably also in the best position to fund long-term care – if they ever need it – out of savings. Those who could most benefit from LTCI – the ‘middle wealth’ cohort – are less likely to be able to pay for it.

Most insurance providers dropped out of the pre-funded LTCI market because they were caught in a vicious circle. They could not sell enough policies to achieve the economies of scale which would have allowed them to bring down the price to a level at which individuals would buy the products. The providers also lacked adequate data on which to base estimates of future claims. Re-insurers generally lost money, while customers were left feeling that the premiums were very high.

LTCI public–private partnership arrangements

There are various ways in which LTCI could be integrated with the public supported part of the overall funding system.

- Individuals could be liable (under the means-tested charging regime) for an initial fixed period of long-term care costs, with the guarantee that the state would then step in to pick up the bill. The private liability for long-term care costs would thus be capped. If that initial period was, say, two years, then an individual might choose to take out pre-

funded LTCI to provide for care costs during that period. From the insurers' point of view, this would be a fairly easy risk to quantify because the insurance benefit would at the most be payable for two years.

- A reverse version of the above could involve the state paying the costs for an initial fixed period of X years, with individuals assuming responsibility for the (means-tested) costs of care *after* that period. That residual period could be provided for through LTCI, either through a pre-paid scheme or an immediate needs annuity. This type of insurance cover would cover the 'catastrophic' minority cases where someone needed more than X years of social care, rather than the more predictable initial fixed period of social care. This open-ended cover is more typical of an insurance-covered risk. However, insurers would again suffer, at least initially, from the problem of lack of adequate data for pricing a pre-funded product for this purpose.

The Annex (*see* p 246) summarises some examples of these types of partnership arrangement, including work by Kent County Council on a private insurance-based system. The very small size of the pre-paid LTCI market testifies to the difficulties of purely private solutions in social care.

Use of housing equity to fund long-term care

The substantial housing wealth of older people is increasingly being identified as a potential new source of financial support in old age. After the sharp rise in property prices of recent years, many older people now expect to rely on their home to augment inadequate pension arrangements, creating income which can also go towards paying for long-term care. The aggregate housing wealth of those aged 65 and over has been estimated at £1,100 billion (Actuarial Profession 2005).

Many people are homeowners but have inadequate retirement income.¹ Traditionally, such people might think of downsizing by moving to a small home and releasing capital. But buoyant house prices have encouraged a new trend of using equity release products to gain access to property wealth without having to move house. In the context of funding long-term care, the question is whether this will provide a meaningful new source of ongoing mainstream funding for social care.

There are broadly two ways to release equity.

- **Mortgage schemes:** In this case, the provider lends a homeowner a lump sum and takes a mortgage charge on the customer's property. There are four main types of product (Actuarial Profession 2005; Background Paper 12 ('Funding options') in the Appendix), but Fixed Interest Lifetime Mortgages, or 'roll-up' mortgages, probably account for more than 90 per cent of sales. Interest is compounded at a fixed rate during the lifetime of the loan, with no repayments until the customer dies or moves into residential care. The capital and rolled-up interest are repaid from the proceeds from the house sale. There is usually a 'no negative equity' guarantee, so that the total amount owed is not greater than the sale price of the house. The providers differ in the fixed interest rate they offer and the maximum loan to value (MLTV) – the proportion of the property value which can be released as cash. With a Drawdown Mortgage, it is possible to take smaller, regular amounts instead of a single lump sum. This total debt then grows more slowly.

TABLE 65: ILLUSTRATION OF THE IMPACT OF COMPOUND INTEREST ON FIXED-INTEREST LIFETIME MORTGAGE

Loan period (years)	Amount owed on an equity release lump sum of £45,000, with an annual interest rate of:		
	5%	7%	9%
5	£57,433	£63,115	£69,239
10	£73,301	£88,522	£106,532
15	£93,552	£124,157	£163,912
20	£119,399	£174,136	£252,199
25	£152,387	£244,235	£388,039

Source: Financial Services Authority 2005a

Roll-up mortgages provide a very stark illustration of the impact of compound interest. Figures in Table 65 from the Financial Services Authority (Financial Services Authority 2005a) illustrate why the MLTV can look low to anyone who does not realise how a debt can grow. With the no negative equity guarantee, and increasing life expectancies, a lender needs to be cautious.

- **Reversion schemes:** In this case, the provider buys a share (up to 100 per cent) of the customer's home, but the customer continues to live in the property rent-free until the end of their life. The price paid for the stake in the property is at a discount to the market value. For example, £60,000 might be paid for a 50 per cent stake in a £250,000 house. The cash sum can be invested to create a regular income. The percentage of the stake's value that is paid out will be higher the older the person is when entering into a reversion scheme arrangement. On death, or a move into a care home, the property is sold and the reversion company receives the value of the share of the home that it bought, while the remainder belongs to the older person or their estate.

The equity release market has grown steadily since the early 1990s, boosted by the introduction of roll-up mortgages in 1998. Overall business trends are illustrated in Table 66 below.

Equity release schemes are regularly criticised. In January 2006, *Which?* looked at 39 products from 24 different providers and concluded that equity release schemes can be

TABLE 66: VALUE OF NEW BUSINESS IN THE EQUITY RELEASE MARKET, 1998 TO 2005

	Value of new business (£million)							
	1998	1999	2000	2001	2002	2003	2004	2005
Lifetime Mortgages	6.3	84.7	297.4	359.2	651.1	1,032.0	1,151.8	1,048.9
Reversion Sales	121.0	155.4	226.8	213.0	200.8	129.4	40.5	54.6
Total	127.3	240.1	524.2	572.2	851.9	1,161.4	1,192.3	1,103.5

Source: Based on figures from Safe Home Income Plans (personal communication 2006)

‘expensive, inflexible and leave people with little or no equity in their home’. It recommended that equity release should only be used ‘as a last resort’ (WhichOnline 2006). Providers argue that the interest-rate differential is now as low as 0.50 per cent when compared to non-lifetime deals (for example tracker loans and 15-year fixed loans), and that there is little scope to reduce that differential further as it needs to cover the no negative equity guarantee, the cashflow cost as the lender does not receive any interest until death/a move occurs, and the extra risks incurred because the loan has no fixed-term maturity.

Financial advisers are required to take a detailed look at the impact of equity release on a customer’s wider financial position. This can be time-consuming, because of the potential impact on state benefits and means-testing if a large amount of cash or an income is released, and has led to high commission rates. In May 2005, the FSA published the result of a ‘mystery shopping’ exercise on lifetime mortgages which found that more than 70 per cent of advisers in the firms did not gather enough relevant information about their customers to assess their suitability for the product, and more than 60 per cent of the mystery shoppers reported that their adviser had not explained the downsides of equity release (Financial Services Authority 2005b). For a substantial number of people, equity release will not be attractive because of the disincentive presented by its interaction with the means-tested benefits and social care system. As outlined in Chapter 6, housing wealth is disregarded when means-testing for domiciliary care and for care home costs when a partner (or certain other dependents) remains living in the property. In such cases, it might be perverse for anyone receiving, or within sight of, state-funded care to release a cash sum that would subsequently be included in the means-test, and therefore extend the period of self-funding. Releasing a cash lump sum can also have a big impact on eligibility for a range of means-tested state benefits, such as pension credit, which do assess savings and financial assets. If the lump sum is used to buy an income-generating annuity, this will also affect state benefits. One ippr (Institute for Public Policy Research) analysis (Sodha 2005) estimated that about 9 per cent of retirees had more than £100,000 of equivalised² net housing wealth, but would suffer loss to state benefits after releasing housing equity.

The potential market among older people for equity release products is also limited by the value and condition of their homes. Low-value properties in a bad state of repair are the least likely to qualify for a commercial home equity release plan. Minimum lending figures are often around £20,000, because of the start-up costs of an equity release scheme, and some lenders will not lend against ‘first generation’ right-to-buy properties (Maxwell 2005).

Various estimates have been made of the potential size of the overall equity release market in the future. The Actuarial Profession study (Actuarial Profession 2005), used a ‘top-down’ approach to forecast a big increase in annual sales of equity release products, with an average release of £50,000 assumed in the figures. Its findings are shown in Table 67 opposite.

The ippr study looked into the potential of housing wealth to combat low income in retirement (Sodha 2005) using data collected in 2002 in the ELSA survey. It identified 10.2 per cent of those who were retired as having an income below Age Concern’s ‘modest, but adequate’ standard (£157 per week before housing costs) and owning equivalised² net

TABLE 67: FORECAST OF SIZE OF EQUITY RELEASE MARKET, 2005 TO 2031

	2005	2010	2015	2031
Population, aged 60+ (millions)	12.78	14.08	15.07	19.43
Percentage of homeowners	70	72	73	78
Percentage buying equity release scheme at some time	6	10	13	15
Number of sustainable annual sales (thousands)	20	40	50	80
Value of sustainable annual sales (£million)	1,000	2,000	2,500	4,000

Source: Actuarial Profession 2005

housing equity of more than £100,000. Looking ahead for the next generation of pensioners, for those currently aged 50 or over who were yet to retire, 15.6 per cent were projected to own equivalised² net housing equity worth £100,000 while having accumulated state and private pension wealth below the level needed to create an income of £157 a week.

The ELSA data in Chapter 6 provided housing wealth figures stratified according to the number of ADL limitations and age. They indicated:

- more than 40 per cent approximately of single people have no housing wealth to release
- couples have significantly more housing wealth than single people
- housing wealth tends to decrease as the number of ADL limitations increases, so the people who are most likely to need long-term care are less likely to have enough housing wealth for this to make a difference
- housing wealth among the aged 50–59 cohort who already have 2+ ADL limitations is generally lower than those aged 60 and above with 2+ ADL
- given the MLTV percentages, only a minority of single people could raise enough money through housing equity release to pay for ongoing significant long-term care costs.

In theory, housing equity could, for those with adequate housing assets, be used in several different ways at different stages of decline. Equity could first be released to provide income support while receiving care at home. On entry into residential care, the home can be sold, and the residual housing equity used either to purchase an extra care housing unit or to buy an immediate needs annuity to cover the care home fees.

PUBLIC ATTITUDES TO EQUITY RELEASE

A recent study into attitudes towards inheritance also looked in detail at people's opinions of equity release (Rowlingson 2005). The survey found that equity release was perceived as very risky and did not provide good value for money (though many people felt they could not answer the value question). The level of trust towards providers was very low. The survey results are given in Background Paper 12 ('Funding options') in the Appendix. But these negative views about existing equity release products contrasted greatly with opinions about whether such schemes are a good idea in theory. In this case, 62 per cent

PACKAGING HOUSING AND CARE

The funding options available to residents at the Joseph Rowntree Foundation's (JRF) flagship Hartrigg Oaks retirement community near York can be thought of as an insurance scheme which packages housing and care. Briefly, older people usually move into the community when still fit and active, but the financial arrangements allow for an insurance-type pooling of the risk of needing care at some point in the future, either in one's own home (up to 21 hours a week) or in the community's on-site residential home, The Oaks. The fees, and their options, are as follows.

- Residence fee – covering the right to occupy a bungalow and, if necessary, The Oaks.
 - Fully refundable – a one-off payment on joining; the full sum is repaid on leaving/death, but there is no indexation to account for any property price increase/decrease.
 - Non-refundable – a lower one-off fee, generally not refundable.
 - Annualised – Annual fee, paid monthly – in effect a rent.
- Community fee: This covers the cost of care support and communal services and facilities.
 - Standard – Annual sum (paid monthly) which does not vary according to the amount of care received, and does not change on entry to The Oaks.
 - Reduced – A lump sum payment, plus a reduction in the Standard fee by up to half.
 - Fee for care – A lower annual charge to cover fixed services; care services are then paid for as and when needed. No benefits from risk pooling.

Could such a model provide the basis for care on a commercial basis, either on a single site or as a 'virtual community' with users remaining in their existing homes (if suitable for long-term use with adaptations) or moving to dispersed scheme properties? This 'virtual' approach might be particularly suitable for urban areas where sites for new retirement communities are difficult to find. Members could buy into the scheme at the start in the same way as at Hartrigg Oaks. Domiciliary care would be included in the care fee package, as would a care home place or respite care when the need arose. This would replicate the insurance basis of the Hartrigg Oaks model, with risk pooling. The emphasis would similarly be on encouraging people to be rehabilitated, and to return to their own homes if at all possible. This mirrors the pattern of residency observed by the JRF at Hartrigg Oaks whereby older people live in the bungalows until a crisis puts them in the care home. High-quality care and rehabilitation then means they can usually return to their own homes, until the next crisis when the cycle begins again. This contrasts with the JRF's original expectations that the residents would steadily progress from unsupported care at home, through needing domiciliary care, to a move into the care home and then death.

Richard Walsh at the Association of British Insurers has suggested that a commercial operator of such a system could reduce any property valuation risk through partnership with property developers and venture capitalists. Part of the care cost risks could be met through insurance. Under the Hartrigg Oaks model, would-be residents are either accepted or rejected, but it would be possible in a commercial scheme to charge different prices depending on the level of risk applicants brought to the 'pool'.

either agreed or strongly agreed. So there appears scope to increase the use of equity release if the right products and providers are on offer.

Financial incentives for social care expenditure

There have been various suggestions about how the government could encourage more private spending on long-term care by offering financial incentives.

- **Vouchers along the lines of nursery vouchers:** A system similar to the existing scheme of employer-supported child care has been proposed (Counsel and Care 2005). This would introduce income tax and national insurance exemptions on employee contributions towards the costs of care and support for older relatives. Staff would have the option of contributing a weekly sum (up to some maximum) in return for vouchers which could be used by the older person to purchase care services from a wide range of accredited and approved sources. As with the child-care vouchers, the employers would meet the administrative costs of the scheme, and would also be exempted from employer national insurance payments on the total amount contributed by their workforce, to make the scheme cost-neutral. The key question is whether such a scheme would bring new money into the system, or just subsidise existing private funding of social care. Further details of the proposal are in Background Paper 12 ('Funding options') in the Appendix.
- **Tax breaks:** Third-party top-ups and expenditure by self-funders is paid out of taxed income, but it would be possible to offer some form of tax deduction to encourage increased spending. For instance, social care expenditure by older people could be tax deductible for those self-funding private care but who pay income tax on personal pensions. This might counterbalance the disincentive to save resulting from the means-testing system. In order to qualify for the tax break on care expenditure, the older person would have to be formally assessed according to some national framework and judged in need of care.
- **Home equity release:** Releasing equity to pay for social care currently means the assets and/or income obtained will usually be included in any means-test assessment, sometimes resulting in a reduction in state-funded care. Such funds could be exempted from the financial assessment.

5 The future

This chapter testifies to the high degree of complexity that is inherent in funding long-term social care for older people. There is no single solution to funding long-term care that stands out above the rest, and no prescriptive 'answer' to suit every older person's financial circumstances and preferences. It is also feasible to have different funding systems for different elements of service.

The next chapter seeks to assess some of the main funding options against the tests for fairness, economic efficiency, choice, physical resource development, clarity and sustainability and acceptability outlined in Chapter 11. Because there is significant complexity, making a systematic comparison of the main alternatives requires a focus on key features. Table 68 overleaf summarises the main models and their features as defined in the earlier section 'Some key features' (see pp 222–4). It presents a stylised picture to convey the breadth of options that are available. This table simplifies the many nuances of real world arrangements.

TABLE 68: FEATURES OF MAIN OPTIONS FOR FUNDING SYSTEMS

Feature	Public funding: means-tested	Public funding: free personal care	Social entitlement (insurance)	Partnership models	Limited liability	Private insurance	Out-of-pocket payments	Saving-based models
Public or private	Mixed	Public	Public	Mixed	Mostly private	Private	Private	Mixed
Risk sharing	Mixed	Risk pooling	Risk pooling	Mixed	Partially	Risk pooling	Savings	Savings
Distributive	Yes	Yes	Yes	Partially progressive	Limited	No	No	Partially
Service- or need-specific	Services	Services	Need	Usually services	Services	Need	Services	Services
Explicit entitlement	No	No	Yes	Yes	Partly	Yes	No	Partly
National or local	Local	National	National	National	National	Varies	Local	National
Top-ups	Partial	No	No	Yes	Yes	Yes	Yes	Yes
Carer blindness	No	Partial	Yes	No	No	Yes	Either	No

In summary, first, what is clear is the widespread disquiet about the current arrangements. The principles behind these arrangements were put in place many years ago and have had only incremental change since then. Aspirations, expectations, demography, technology and wealth (especially housing wealth) have all moved on.

Second, there are many options available; some could be adopted relatively easily in the immediate term, others are more far-reaching and would require a longer timeframe.

Third, funding solutions will need to relate closely and coherently to the developments of the service model. In particular, housing with care and owner-occupation imply a substantial private payer involvement.

In conclusion, the prospects of being able to improve the situation overall, albeit having losers as well as winners in this process, appear to be good.



Annex. State-supported LTCI

KENT COUNTY COUNCIL AND LTCI

One English local authority, Kent County Council, has attempted to model the introduction of a partnership arrangement involving LTCI. The council became aware that there was a sizeable proportion of the local elderly population who started off paying for social care as self-funders, but whose assets then eroded to a level at which the state stepped in under

the means-testing rules. These older people also tended to live longer than residents who were state-funded from the start. Overall, it therefore appeared worth considering some way to promote the take-up of LTCI.

The quantitative work was mainly carried out in 2004 with a leading insurance company, and has been made available to this Review. The plan was to offer a new partnership insurance product, targeted at people from middle age to retirement with middle incomes and a property, and at people with retirement pension lump sums. Under the existing social care funding system, these people would, if needing social care, either pay charges or be wholly self-funding. The LTCI partnership product would create a new category for Kent social services of ‘fully funded through insurance’. There would be no need for a means-test for policyholders.

Aside from financial considerations, Kent County Council was also aware that many self-funders were perhaps being inappropriately placed in care homes in the absence of any care management advice. The proposed LTCI scheme therefore included care management in the expectation that more people would then be supported to remain in their own homes.

Under the scheme, which was designed with the help of the Association of British Insurers, eligibility of the policyholders for care would be assessed by Kent County Council, and this assessment would be accepted by the insurance company. Any future payout by the insurer would be on the basis of the Kent County Council eligibility criteria in force at the time the policy was originally taken out, thus protecting the policyholder against changes over time. Those criteria would have to be very clearly delineated, which would be one of the challenges of the scheme.

Kent County Council’s proposed LTCI scheme followed certain guidelines, which could be used by other councils around the country.

- The ‘partnership’ would be between the council and a single insurance company (although one insurer might have agreements with several councils in order to spread the risk).
- The product would be priced on the basis of premiums that were simple to understand, age-related and gender-related.
- The policy would be significantly less expensive than current long-term care products.
- In the pricing it was assumed that Attendance Allowance would always be put towards the costs of the care package.
- The benefits would be portable, and could be used to pay for care in another local authority area if the insured person moved.
- There could be the choice of standard level and enhanced level cover.
- The LTCI would be separately targeted but ideally with an option to ‘package in’ with a Stakeholder Pension in order to encourage pension saving.

A detailed breakdown was carried out to demonstrate the impact of the proposed insurance partnership on various types of user. This is illustrated by the charts (see Figure 54, p 248 and Figure 55, p 249), and shows the contrast in the break-down of funding between the current system and the proposed LTCI scheme. The LTCI greatly reduced the financial burden on self-funders, but also alleviated the costs to Kent County Council. (Poorer users who could not afford the LTCI premiums would not be affected by the scheme.)

54 IMPACT OF KENT COUNTY COUNCIL'S LONG-TERM CARE INSURANCE SCHEME ON WEEKLY CONTRIBUTIONS TO THE COSTS OF RESIDENTIAL CARE, BY DIFFERENT TYPES OF USER

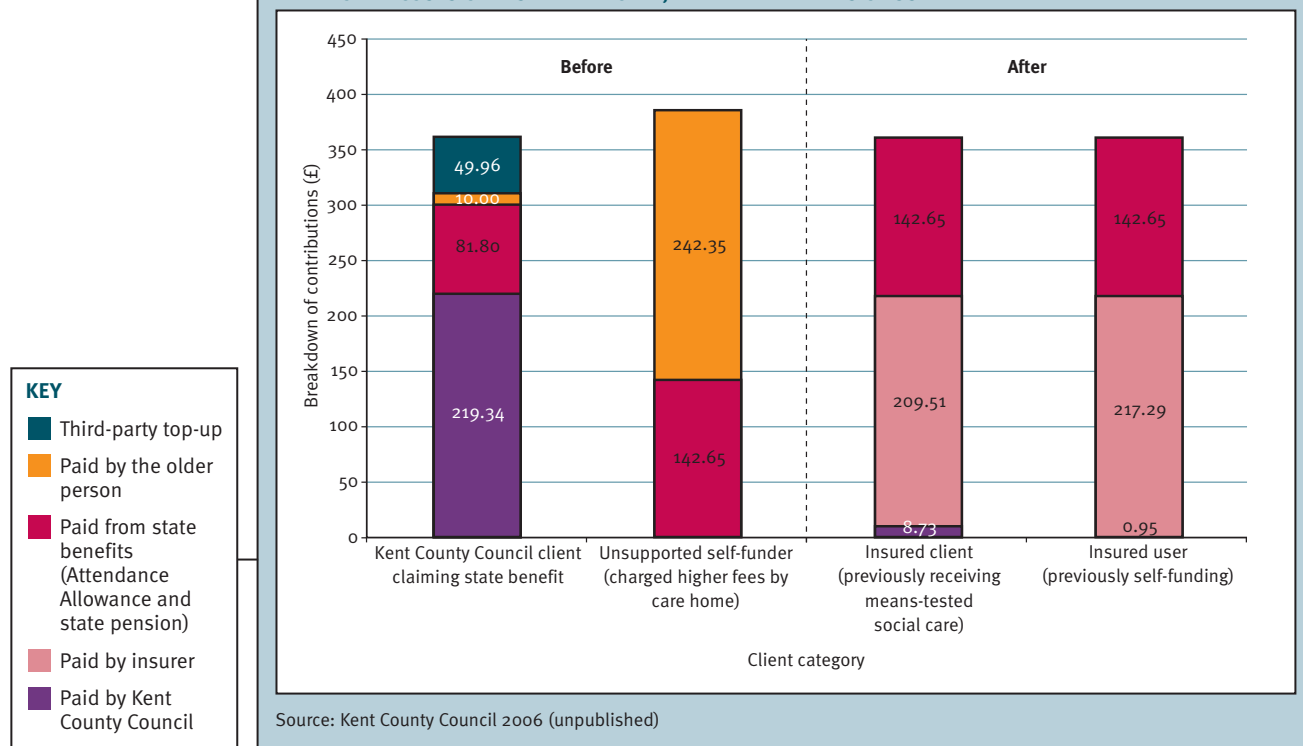
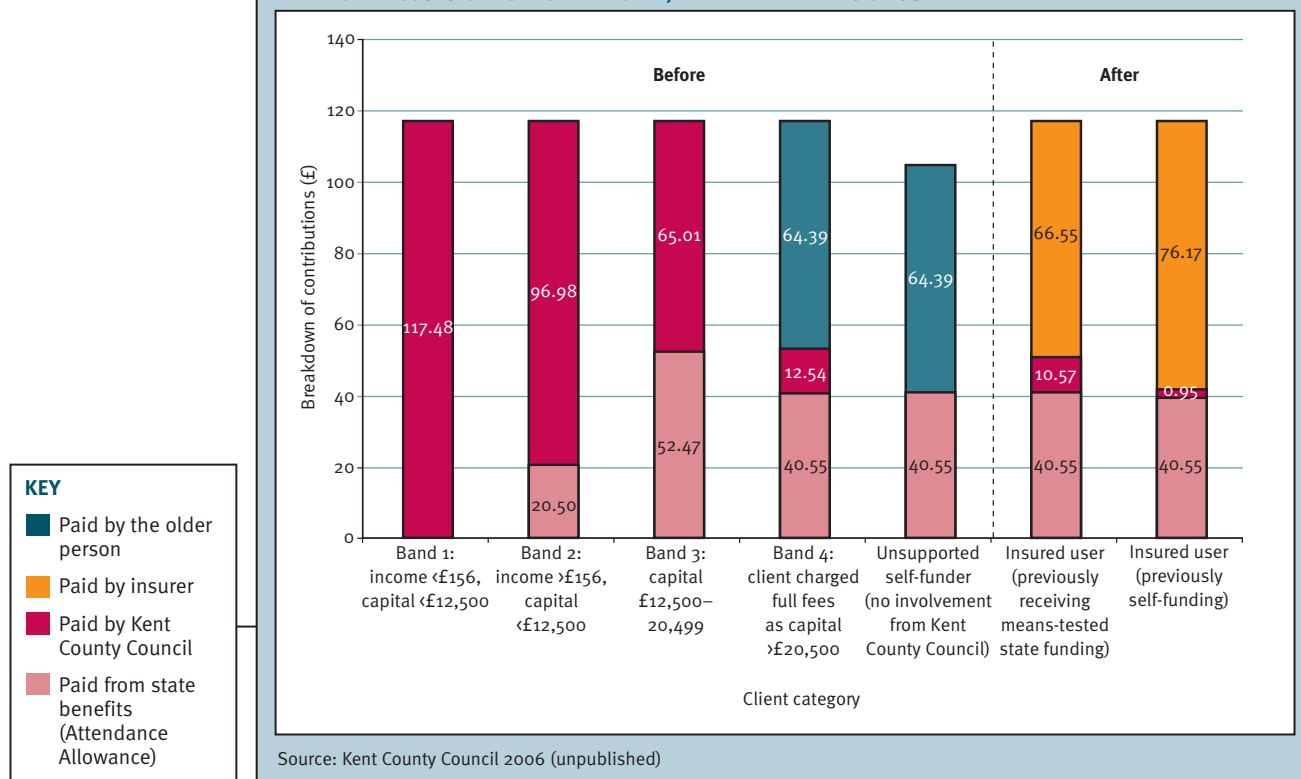


Figure 54 illustrates the impact on paying for care home fees.

- Self-funders are usually charged higher fees by care homes (see chapter 6).
- State-supported residents do not receive Attendance Allowance.
- Insurance cover replaces Kent County Council's contribution for a user who would otherwise have received means-tested state support (except for a residual £8.73 administration cost).
- Insurance cover replaces a self-funder's contribution, and the partnership scheme means that the care home place is contracted at the lower-fee rate. (A notional £0.95 administration cost is incurred by the council.)
- User retains an income of at least the personal allowance (£18.80 in 2005/6).
- All figures are illustrative for Kent County Council's charging structure, based on a 75-year-old man who has paid the maximum national insurance contribution, has savings of £15,000 and whose family is willing to pay a 'top-up' fee.

Figure 55 illustrates the impact on paying for domiciliary care.

- Illustrative figures are based on Kent County Council's own charging bands for domiciliary care fees.
- Insurance cover replaces the council's contribution to users who would otherwise have been state-funded after a means-test.
- Insurance cover replaces the self-funding contribution of an older person not qualifying for state support.
- It is assumed that any Attendance Allowance payment is contributed towards the care costs.



- A small administration fee is borne by Kent County Council for Band 4 and insured clients.
- User retains a net income of at least 125 per cent of the relevant pension credit level.
- The figures are based on a 75-year-old man who has paid the maximum national insurance contributions.

The challenge, as always with LTCI, was whether the estimated premiums would be affordable. The insurance company produced draft premiums varying from £20 a month for a 45-year-old man to £110.75 a month for a 75-year-old woman. Subsequent estimates were higher and it was considered that this level of premiums would not be taken up by enough consumers to create a viable product.

Kent County Council was keen to do further analysis in order to build a case for some type of central government subsidy to bring down the price. It was suggested that this could possibly be through council tax reductions for policyholders, or tax breaks on policy premiums. Wider savings might be achieved, the council argued, because care management would help self-funders postpone residential care and offer preventive measures which would reduce demands on free NHS nursing.

In the end, Kent County Council found there was no appetite from either the Department of Health or the Treasury to fund further modelling on how such a scheme could be implemented, each department wanting the other to sponsor the work.

PARTNERSHIP MODELS IN THE US

In the US, there have been various initiatives to promote the purchase of LTCI such as a limited tax deduction for premiums, the Federal Long Term Care Insurance Program for federal employees, and a consumer education campaign (Ahlstrom 2004b). Nevertheless, despite being the most developed market for private LTCI, it accounts for only about 10 per cent of the total money spent on long-term care. Details of some studies into the low take-up in the US are included in Background Paper 12 ('Funding options') in the Appendix.

One example of a US partnership and incentive deal is the LTC Partnership Program (Ahlstrom 2004a). This combines private LTCI with preferential access to Medicaid for those who have exhausted their insurance benefits. By putting a ceiling on the amount of long-term care that is covered by the insurance policy, the premiums become more affordable. When the cover runs out, the policyholder then gets access to Medicaid without spending down all of their assets to the usual thresholds, although all income must still be devoted to care costs (Ahlstrom 2004a). Four states have implemented the programme, but it is too early to say whether the anticipated savings to the public purse will be realised.

- The **dollar-for-dollar model** (California and Connecticut) allows people to buy LTCI policies that protect a specific amount of their assets, for example a policy with a maximum benefit payout coverage of \$50,000 would protect \$50,000 of assets in the event of Medicaid being claimed. Once the benefits of the insurance policy are exhausted, all other assets down to \$50,000 and all income must be used to pay for long-term care, but the user then becomes eligible for Medicaid.
- The alternative **total assets model** (as in New York) requires a user's LTCI to cover three years of nursing home care, six years of home care, or a combination of the two. The LTCI premiums are higher under this model, but it provides protection of 100 per cent of assets if users exhaust their policies and require Medicaid.
- Indiana's **hybrid model** offers a choice of either of these schemes with the dollar-for-dollar version offering some assets protection if a user purchases a minimum of one year LTCI.

Notes

¹ The Actuarial Profession study (Actuarial Profession 2005) argues that if 75 per cent of the population have inadequate income in retirement (Deloitte 2002), and 70 per cent of the retired population are homeowners (ONS data), then on the assumption that most of the 25 per cent with adequate income are also homeowners, that would mean some 45 per cent of the current retired population – or 4.3 million people are homeowners but have inadequate retirement income.

² Equalised per person in the case of a couple.

13

Assessing the funding options: implications from the model

SUMMARY

This chapter assesses the main funding options against the tests outlined in Chapter 11. It then takes the most promising three of these options and models in detail the costs, benefits and distributional implications of each of them. The options modelled in this way are: means-testing, partnership and free personal care. The costs associated with a limited liability model are also investigated. These are measured against the current means-testing model.

The choice of funding system affects significantly the share of financial resources contributed by individuals and the state. However, it is also shown to have important implications in terms of who receives formal support, the level of support received and the levels of outcomes achieved by the system.

Of the models considered, means-testing is associated with the lowest levels of formal care consumption (significantly below benchmark levels), the lowest levels of aggregate outcomes, and with the lowest demand on the state for financial resources. Given the particular arrangements explored, means-testing policies raise concerns about inequalities in access to care, particularly for middle-income groups. In contrast, the free-personal-care model produces the highest levels of formal social care support (in excess of benchmark levels) as well as the greatest state contributions to the funding of care. Overall, the partnership model is found to provide a more flexible set of arrangements for mediating overall levels of consumption, ensuring equal access to formal support across society, while maintaining incentives for services to reflect individuals' preferences in the provision of care.

Ultimately, however, the choice of funding mechanism responds to value-based choices about the relative importance of containing public sector costs, maximising equal access to care, and balancing outcomes between high and low income groups.

1 Introduction

There are many ways to fund social care; the system in England has tended to mix private and public systems. The public arrangements have involved a number of different elements, with specific funding for social care combined with disability-related funding from the social security system.

Assessing the pros and cons of each system involves political as well as economic judgements, based on the criteria and values used. *Prima facie*, there do not appear to

be absolute winners. This chapter shows the detailed analyses used in narrowing the range of possibilities. First, approximate assessments of the performance of contender systems are made using the criteria described in Chapter 11. This eliminates those options that clearly have low overall performance and are unlikely to be realistic contenders. Second, the model of Chapter 10 is used to estimate the costs and benefits of the remaining options.

The costs are apportioned between those borne by the individual or their family as charges, fees, co-payments or premiums, and those that fall on the public purse. Scenario 2 is used, but the conclusions apply to the other two scenarios. As an indication of benefits, the model is also used to calculate the total impact of these services on personal care outcomes as based on the older people's utility scale (OPUS) (see Chapter 10). Although this is a partial picture of the impact these services would have across all relevant outcomes, the purpose here is primarily comparative. Each funding option is based on the same service model; although the choice of funding model does affect uptake and use of services, the starting basis for comparison is the same.

2 Assessing ways to fund social care

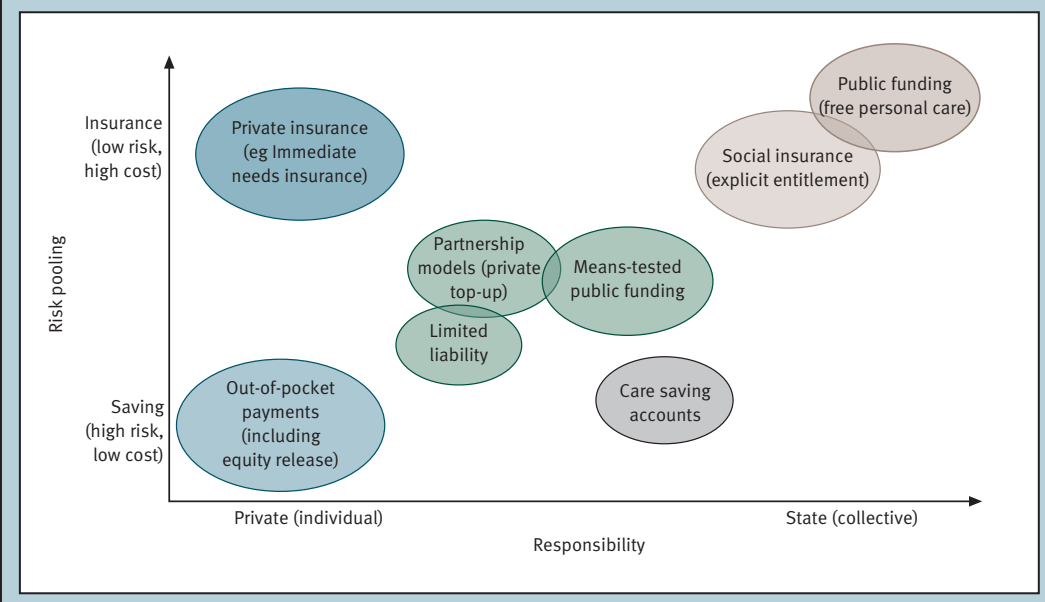
Chapter 12 described the range of possible funding options and their essential features (see Table 68, p 246). In this chapter the 'main' models are compared, having been chosen to cover the range of possibilities – see Figure 56 opposite.

Some of these models will be significantly at odds with any criteria set to judge their desirability. The tests are a matter of value judgement and reflect wider considerations in society about how public services are positioned. The tests are designed to capture important elements of fairness, efficiency, choice, resource development, clarity and sustainability. In theory, it is not so much a question of whether a test is met, but rather to what degree, so they embody a continuum of responses. A frame of reference, as provided in Chapter 11, is then required to establish how far, or to what extent, the tests must be achieved for outcomes to be considered 'good' or 'bad'.

Table 69 (see pp 254–255) summarises the Review's judgements of the models against the 28 tests. In some cases, the test is clearly passed or failed. In others, the test may be partially met or failed and classified as mostly met ('mostly yes') or mostly failed ('mostly no'), neutral or unknown. Finally, the system might potentially allow the test to be passed, but be dependent on the specifics of that model.

Each model is scored according to how well it passes or fails the tests.¹ Weighted scores are given in the table. The weights reflect the relative importance associated to the test. A hierarchical approach is used. First, weights are assigned to the six domains and then to the specific tests within each domain. This approach helps to clarify the relative importance of the philosophy behind the domain, that is, fairness, efficiency, and so on, allowing for a varying number of specific tests within the domains. Fairness, efficiency and sustainability are assumed to be equally important. Choice is rated as half as important as fairness, efficiency or sustainability, as are resource development and clarity. The weights are reported in Table 69.

56 ARCHETYPAL FUNDING ARRANGEMENTS



Using this approach, out-of-pocket payments and care savings accounts have negative scores, which ought to put them out of contention as exclusive mechanisms for funding social care systems (out-of-pocket payments, in particular, are likely to feature to some degree in all funding systems). The current system, means-testing, has a low (but positive) score, as does the private insurance model. The limited liability model is next.

Free personal care, social insurance and partnership models come out on top. Although inevitably subjective and capable of debate about the interpretation of how the models fare with each test (and the specific weights), this analysis does suggest a three-way grouping:

- least attractive: out-of-pocket payments and care savings accounts
- neutral: private insurance, public means-tested
- most attractive: partnership models and free personal care, ahead of social insurance and limited liability.

The composition of this grouping persisted even after quite substantial change in interpretation of specific tests and in the weights attached to them.

The main issues with the first group are that the care delivered depends heavily on people's ability to pay; they have no, or limited, risk sharing. Because the payments by individuals are potentially very high, it is likely that care will be under-provided in these systems. The individual nature of these systems does mean good accommodation of choice and responsiveness, but also means poor co-ordination in terms of prevention, early intervention and engagement with the health care system.

By contrast, the most promising group does have risk pooling and low point-of-use cost of services. They tend to control excess demand by having 'gate-keeping' by public commissioners, although gate-keeping can potentially be inflexible and lack sensitivity, leading to a poor allocation of services.

TABLE 69: TESTS OF DIFFERENT FUNDING SYSTEMS

	Private insurance	Out-of-pocket payments	
Fairness			
Is it based on assessment of identified needs?	Yes	No	
Is it based on need rather than ability to pay?	No	No	
Is it based on need and ability to pay in a progressive way?	No	No	
Does it provide dignity (through the care available)?	Yes	No	
Does it provide dignity (through the resources left to the user)?	Yes	Mostly no	
Does it avoid penalising people who make their own financial provision?	Yes	Yes	
Does it engage with health care funding and delivery (for example, continuing care)?	Mostly no	No	
Does it identify and promote personal, family and state responsibility?	Neutral	Mostly no	
Does it encourage informal caring in a fair and economic way?	Yes	Mostly no	
Total domain weight			
Economic efficiency			
Does it support best core outcomes compared to alternative uses of social care resources?	Mostly no	Mostly no	
Does it support low indirect costs, particularly those that fall on the wider economy?	Yes	Yes	
Does it confer benefits of financial risk protection by effective risk pooling?	Mostly yes	No	
Does it encourage supply to meet diverse and changing demand?	Mostly yes	Mostly yes	
Does it reward those who have made their own provision to a reasonable extent?	Yes	Yes	
Does it reward measures that reduce the amount of care needed?	Mostly no	Yes	
Does it support cost-effective preventative measures?	Mostly no	Mostly yes	
Does it deal with 'catastrophic' risks (which only the state can cover)?	Potentially	No	
Does it enable measurement of value and identification of best value overall?	No	No	
Total domain weight			
Choice			
Does it accommodate the diversity of needs and preferences of individuals?	Yes	Yes	
Is it free of bias towards particular types of care or providers of care?	Yes	Yes	
Total domain weight			
Physical resource development			
Does it encourage the creation of a suitably trained workforce for the future?	Mostly no	No	
Does it encourage the development of local networks to meet local needs?	No	No	
Does it encourage the development of suitable housing stock?	No	Mostly yes	
Total domain weight			
Clarity			
Is it widely understood or capable of being clearly interpreted?	Yes	Yes	
Total domain weight			
Sustainability/acceptability			
Is it sustainable and capable of adapting to changes in need drivers?	Mostly no	No	
Is it a stable, long-term basis for users and carers to plan ahead?	No	No	
Could it command sufficiently widespread long-term public support?	No	Mostly no	
Are the underpinning principles and values consistent with those of the broader public sector?	No	Mostly no	
Total domain weight			
Weighted score	3.3	-17.8	

Funding systems							
	Public funding: free personal care	Social entitlement (insurance)	Public funding: means-tested	Partnership models	Limited liability	Care saving accounts	Test weight
	Yes	Yes	Mostly yes	Mostly yes	Mostly yes	No	0.06
	Yes	Mostly yes	No	No	No	No	0.19
	No	Mostly no	Yes	Mostly yes	Mostly yes	No	0.10
	Yes	Yes	No	Mostly yes	Mostly no	Yes	0.13
	Yes	Yes	Mostly no	Mostly yes	Mostly yes	No	0.13
	Yes	Mostly yes	No	Yes	Mostly yes	Yes	0.06
	Yes	Mostly yes	Mostly no	Mostly yes	Mostly no	Limited	0.06
	Neutral	Neutral	Potentially	Yes	Mostly yes	Mostly yes	0.13
	Mostly no	Yes	Potentially	Mostly yes	Mostly no	Mostly no	0.13
							1.00
	Yes	Mostly no	Mostly yes	Mostly yes	Mostly yes	Mostly no	0.25
	No	No	Neutral	Mostly yes	Mostly no	Yes	0.13
	Yes	Mostly yes	Mostly yes	Mostly yes	Mostly yes	No	0.13
	No	Mostly yes	Limited	Mostly yes	Mostly yes	Mostly yes	0.06
	No	No	No	Yes	Yes	Yes	0.13
	No	No	Mostly no	Mostly yes	Mostly no	Yes	0.06
	Potentially	Mostly no	Potentially	Potentially	No	Limited	0.06
	Yes	Yes	Yes	Mostly yes	Yes	Mostly no	0.13
	Yes	Mostly yes	Yes	Neutral	Neutral	No	0.06
							1.00
	Potentially	Mostly yes	Limited	Mostly yes	Mostly yes	Yes	0.25
	Potentially	Mostly yes	Potentially	Mostly yes	Potentially	Yes	0.25
							0.50
	Mostly yes	Mostly yes	Mostly yes	Mostly yes	Mostly yes	Mostly no	0.22
	Mostly yes	Mostly yes	Mostly yes	Mostly yes	Mostly yes	No	0.11
	Mostly yes	Mostly yes	Mostly yes	Mostly yes	Mostly yes	No	0.17
							0.50
	Yes	Yes	No	Neutral	Mostly no	Mostly yes	0.50
							0.50
	Mostly no	Mostly no	Mostly yes	Yes	Mostly no	Neutral	0.38
	Yes	Yes	Mostly no	Mostly yes	Mostly yes	Neutral	0.25
	Yes	Yes	No	Mostly yes	Yes	No	0.13
	Mostly no	No	Yes	Neutral	Yes	Mostly no	0.25
							1.00
	39.2	28.5	5.4	42.2	16.9	-3.3	

The frontrunners

The options that merit further scrutiny here are free personal care, partnership models, limited liability (because it is essentially a development of the means-testing system) and, due to its incumbency, means-testing. The analysis includes: a further detailing of features, an estimation of the costs and benefits and an assessment of the pros and cons.

ATTITUDES

In surveys that have been undertaken to gauge the public's attitudes to different ways of paying for the long-term care of older people (see Chapter 6), the public have shown strong support for a major financial input from the state. The 1995 survey by Parker and Clarke (1997) found that the majority of people supported a partnership or 'top-up' model (48 per cent) with free (personal) care and means-testing second equal (at 23.7 per cent for both²). More recently Deeming and Keen's (2003) survey results suggest that the majority of people would prefer the free personal care option.

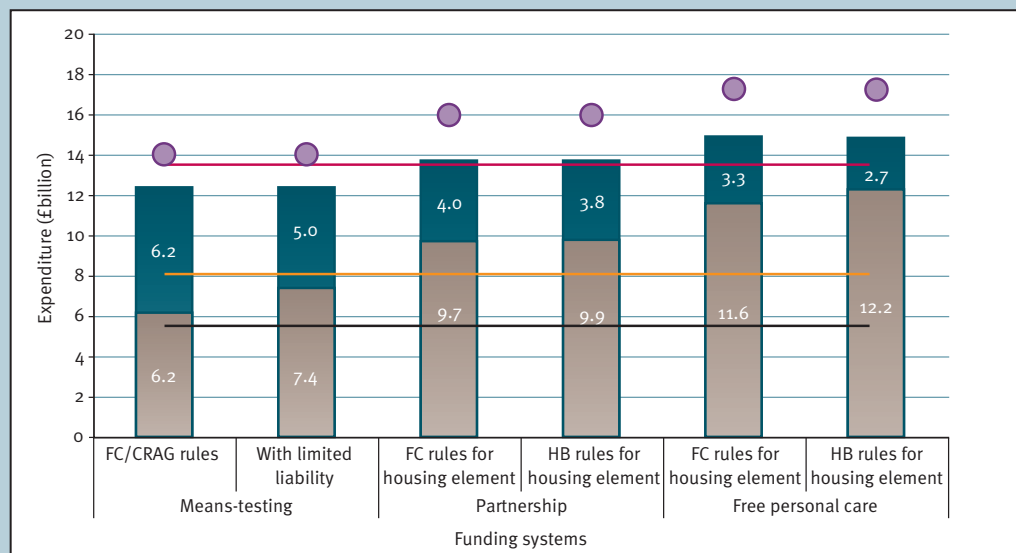
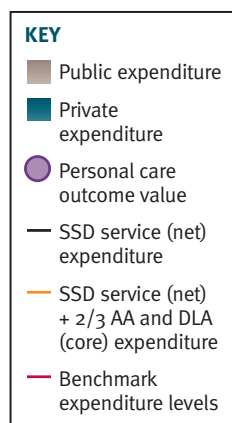
Analysis of attitudes is useful to gain an understanding of how receptive people would be to a change in system. But it is difficult to convey the cost implications of these preferences to people, which of course could change the picture.

Changing the funding arrangements – moving away from the present means-testing – affects how much of the total costs are supported by the state and how much by individual people. However, because private individuals can decide not to buy care if they feel that charges are too high, moving away from means-testing would also change the total cost as well as the net cost to the state. As a result of these complications, the analysis below looks only at scenario 2. Furthermore, it models core costs (that is, excluding care management and assessment costs). Finally, only the base year (2002) costs for different funding arrangements are modelled. Nonetheless to bring them up to date, the expenditure figures reported below are up-rated for inflation to 2004/5 (the latest year for which relevant inflation figures are available).

3 Costs and benefits

The main features and assumptions of these funding mechanisms are outlined in three insets (see pp 276–278). The analysis of their impact on costs and benefits is based on a person-level model built on data for people aged 65 and above from the English Longitudinal Study of Ageing. Specifically, the model uses available information on disability, social environment, housing tenure and wealth to simulate individuals' social care requirements as estimated in Chapter 10. Because of its micro-level nature, the model can provide a picture of the distributional impact of the policies. In particular, it can describe the effects of alternative funding scenarios on individuals of varying disability and wealth. In terms of disability, the analysis distinguishes individuals by the number of problems with ADL tasks they face. In terms of wealth, individuals are split into three groups: the low-wealth group, corresponding to people with non-housing-wealth below £20,500, and therefore entitled to some level of state support under Fairer Charging; the middle-wealth group, with non-housing-wealth above £20,500 and weekly assessable incomes equal to or below £392 (corresponding to the 75th percentile of the distribution); and the high-wealth group, with non-housing-wealth above £20,500 and weekly assessable incomes above £392.

57 TOTAL PUBLIC AND PRIVATE SERVICE EXPENDITURE AND AGGREGATE PERSONAL CARE OUTCOME VALUE, BY FUNDING SYSTEM



Source: Review model estimates

Figures 57 to 65 below and Table 70 (see p 275) provide a summary of the results of the modelling of funding mechanisms.

TOTAL CARE COSTS

Figure 57 above summarises the differences in total public and private expenditure and outcome levels (in money terms) associated with the means-testing, partnership and free personal care funding arrangements. It confirms the significant impact that different funding mechanisms can have not only on the balance between private and public shares of expenditure, but also on the total levels of expenditure on services and therefore on the levels of welfare outcomes achieved. The relative cost implications of the funding options considered should be taken to apply relative to total expenditure requirements as projected forward to 2026 in Chapter 10. In Chapter 10 the (care) costs as they apply to the current means-tested model were described.³

Of the three funding systems considered, means-testing leads to the lowest level of service expenditure, and to the smallest proportional contribution from the state. Hence, assuming Fairer Charging arrangements, the state is estimated to be responsible for approximately £6.2 billion worth of direct care expenditure (less than half of total expenditure on care, and approximately £0.7 billion above actual council expenditure on services, indicated in Figure 57 by the lowest horizontal line). Relative to actual levels, this increase in state expenditure is brought about by changes in the targeting of care packages in scenario 2. In particular, there is an increase of 12 per cent in the number of recipients of care due to changes in need-related eligibility criteria, and significant increases in the intensity of care packages associated with a move from the current position to benchmark levels in scenario 2 (see Chapter 10 for a detailed account of benchmark care packages).

When fair charging arrangements include protection against catastrophic risks through a limited liability component, as specified in Inset1 (see p 276), (direct) public spending

increases by approximately £1.2 billion to £7.4 billion. It is important to note that the limited liability arrangements do not bring about changes in the levels of utilisation of services and therefore do not improve personal care outcomes. They constitute purely a transfer of resources from the state to individuals, and particularly to those individuals who, because of their assets, would have had to contribute to the long-term funding of their care. The cost of the limited liability scheme was found to vary significantly with the nature of the minimum eligibility criteria to the scheme (the minimum number of years of care and the minimum level of disability). Relaxing the eligibility criteria to include individuals with three or more ADL problems increased the cost of the scheme to approximately £2.2 billion per year, and reducing the minimum period of care to two years raised the cost to approximately £2.3 billion. Interestingly, given the high disability thresholds required to make the scheme financially sustainable in the long-run, most of the additional public expenditure associated with the limited liability arrangements would be destined to paying for residential care fees, including housing costs. In fact, restricting the limited liability facility to individuals in residential care only reduced costs by approximately £0.1 billion.

Moving from the means-testing arrangements to the partnership model brings about a significant increase in total levels of spending, and a very significant increase in the contributions made directly by the state to care costs. Relative to the means-testing system, direct public spending in the partnership model increases from £6.2 to £9.7 billion. These figures are significant and the differences are due to:

- substantial increases in the intensity of personal care allocated to the most disabled implied by benchmark care packages (amongst individuals with 3 or more ADL problems, the benchmark care packages are over 70 per cent higher than currently observed)
- significant increases in the number of recipients (due to demand effects) of more than 300,000
- the impact of greater dependency on personal care costs in care homes (the analysis assumes £199, in contrast with the Scottish model which funds £145)
- differences in the interpretation of current charging arrangements.

If, instead of scenario 2 care packages, the more modest current care packages were used, the introduction of partnership would result in significantly smaller increases in public expenditure.

Of the three funding mechanisms explored, the free personal care system has the highest levels of care and the greatest relative and absolute funding contributions by the state (for the reasons given above). With free personal care, the state contributes approximately 78 per cent of total (direct) care costs, compared with just over 71 per cent in the partnership model and between 50 and 60 per cent in the two variants of the means-testing arrangements. Overall, free personal care is associated with £14.9 billion worth of total expenditure.

INDIRECT STATE CONTRIBUTIONS

In the present system, the state also funds care indirectly via the benefits system. Attendance Allowance (AA) and Disability Living Allowance (DLA) are care-needs-tested benefits for older people. These benefits currently reach almost £3.7 billion (see Chapters 6 and 12). For individuals in receipt of formal social care, some proportion of these

benefits is used to pay for care charges. The data on the use of AA and DLA is limited (see Chapter 6), but an estimate is that approximately £0.8 billion of social security funds are contributing to funding social care charges in England at present. In scenario 2 with means-testing, and assuming that 100 per cent of individuals in receipt of formal care received AA or DLA, such contribution would rise to £1.5 billion. It is difficult to speculate how the remaining amount would be used. It could be care-related or it could be extra income for disabled older people.

In order to design an efficient social care funding mechanism, it is vital to consider how to co-ordinate the direct and indirect state financial contributions to care. In the means-tested systems, where direct public social care support is concentrated onto low-income groups, social security benefits such as AA and DLA can act as valuable contributions to the care of individuals, particularly of those not entitled to public support. In systems such as the partnership and free personal care models, however, there is likely to be an overlap between the guaranteed care element offered to all individuals assessed as being in need of care and these monetary benefits. In other words, the guaranteed care element is likely to fulfil to a considerable degree the support with care intended by these social security benefits. In fact, the entitlement to a guaranteed level of care built into both the partnership and free personal care arrangements has an estimated coverage of the older population in line with AA and DLA (1.2 million people). Without more information precise amounts are uncertain, but a significant proportion could be incorporated into the entitlement part of either the partnership or free personal care system. This would offset some of the net costs of these two models.

However, a hypothetical diversion of resources currently spent on AA and DLA to fund the guaranteed care element of an entitlement system such as the partnership model would present transitional difficulties. If an entitlement system was adopted, some people would have to be compensated with respect to the affordability of charges. In particular, for low-income recipients, who receive heavily subsidised care packages, AA and DLA payments are likely to exceed care charges and represent therefore supplements to the household income. For these reasons, a hypothetical integration of any disability-related social security moneys into a social care entitlement system would require a transitional period in which special arrangements are put into place.

A first possible set of arrangements would imply that existing AA and DLA beneficiaries in receipt of public social care support would be given the choice. They could keep their current arrangements or give up AA and DLA payments in order to benefit from the partnership arrangements. Similarly, in the period 1992 to 2002, following the termination of the social security funding of institutional care, preserved-rights residents carried on receiving free care while new admissions were subject to a new set of charging rules. A more complicated set of transitional arrangements from the implementation point of view would involve the immediate termination of AA and DLA payments. All social care service users would be transferred to the new partnership system, and those individuals whose previous combined social care package and AA or DLA payments exceeded the value of the new entitlement would be compensated financially. In the first year such compensation could amount to about £0.6 billion.

Estimating the length of the transitional period is difficult, because of the lack of detailed information about length of receipt of AA and DLA payments and the reasons for

termination. Assuming the current rate of turnover in the awards of AA was to remain constant, it is estimated that it would take approximately five years for AA payments to be phased out. Such a process may, however, take significantly longer because a small proportion of the AA recipients could be expected to claim for significantly longer than the average case.

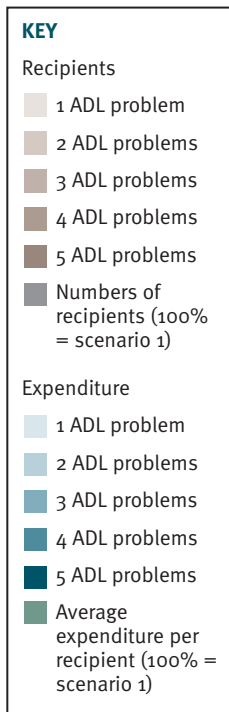
A further consideration to make when speculating about the possibility of transferring disability-related social security payments for older people into a social care entitlement system is the fact that DLA payments precede the entitlement to social care services for older people (they start being received prior to the age of 65). As a result, individuals in receipt of DLA would be 'forced' to give up their cash benefit to enrol into the partnership system upon turning 65 years old. Alternatively, such individuals could be offered the choices implicit in the transitional arrangements discussed above. However, this would be at the cost of maintaining permanently a DLA system in parallel to an entitlement system.

Finally, it is important to emphasise, as noted above, that AA and DLA resources might provide justifiable support for disability-related expenditures other than those purely linked to personal care tasks. It might therefore be unrealistic to expect that the totality of social security payments could be transferred to fund a partnership or free personal care system. Assuming that two-thirds of AA and DLA funds were aimed at supporting social care needs, the transfer of social security payments would reduce the demands on the public purse of implementing the scenario 2 partnership or free personal care models by approximately £2.5 billion. This would leave the increase in public social care services expenditure relative to current levels at £1.7 billion and £3.6 billion in the partnership and free personal care systems, respectively.

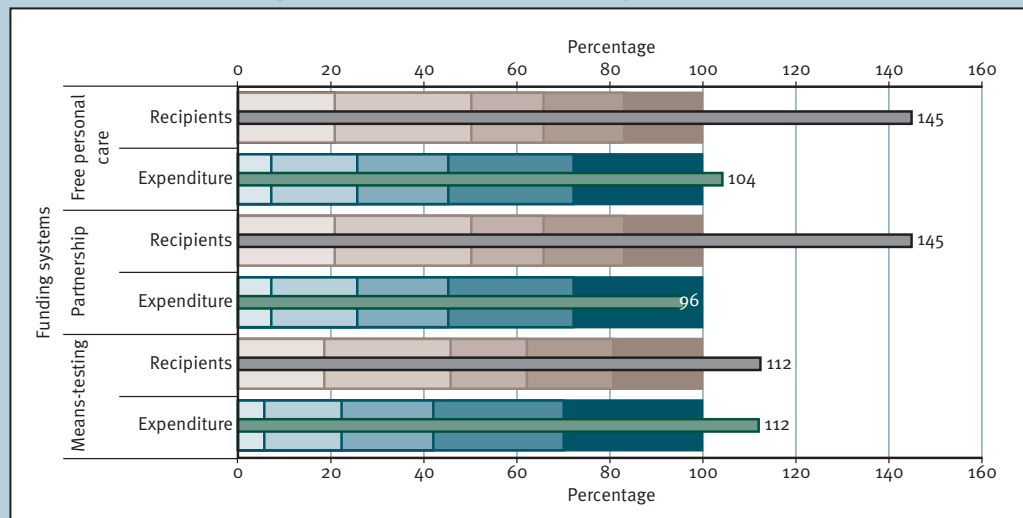
UPTAKE OF SERVICES

In contrast with the partnership and free personal care funding scenarios, total expenditure in the means-testing scenario falls below the economically justifiable benchmark levels. Figures 58 (see opposite) and 61 (see p 264) illustrate that the shortfall in expenditure with means-testing is not due to less intensive care packages than in the other two funding scenarios, but rather to differences in the number of people taking up formal care. Figure 58 shows that the number of recipients of care in the two entitlement-based funding options would be expected to grow relative to scenario 1 (the actual uptake in the base year) by approximately 45 per cent, compared with just 12 per cent in the means-testing model. As a result, Figure 61 shows, a greater proportion of disabled older people would be expected not to benefit from formal support with means-testing.

The differences in the rates of uptake of services in the older population between means-testing and the two other funding options are explained by the lack of a universally entitled, guaranteed level of care and by the high levels of charges faced by individuals, particularly those with assets over £20,500, who are expected under the means-testing regime to pay for their care themselves. Because of the existence of a free, universal, guaranteed level of care in both the free personal care and partnership arrangements, all older disabled persons would be expected to take up services (consuming at least their guaranteed level of care). The exception is a small proportion (equivalent to approximately 20 per cent of individuals) who would be expected not to seek formal help because of either the presence of a substantial informal care network or because of a general dislike of services (see Chapter 10 for a detailed discussion of these estimates). In contrast, the low uptake of services in the means-testing scenario, particularly among those that do not

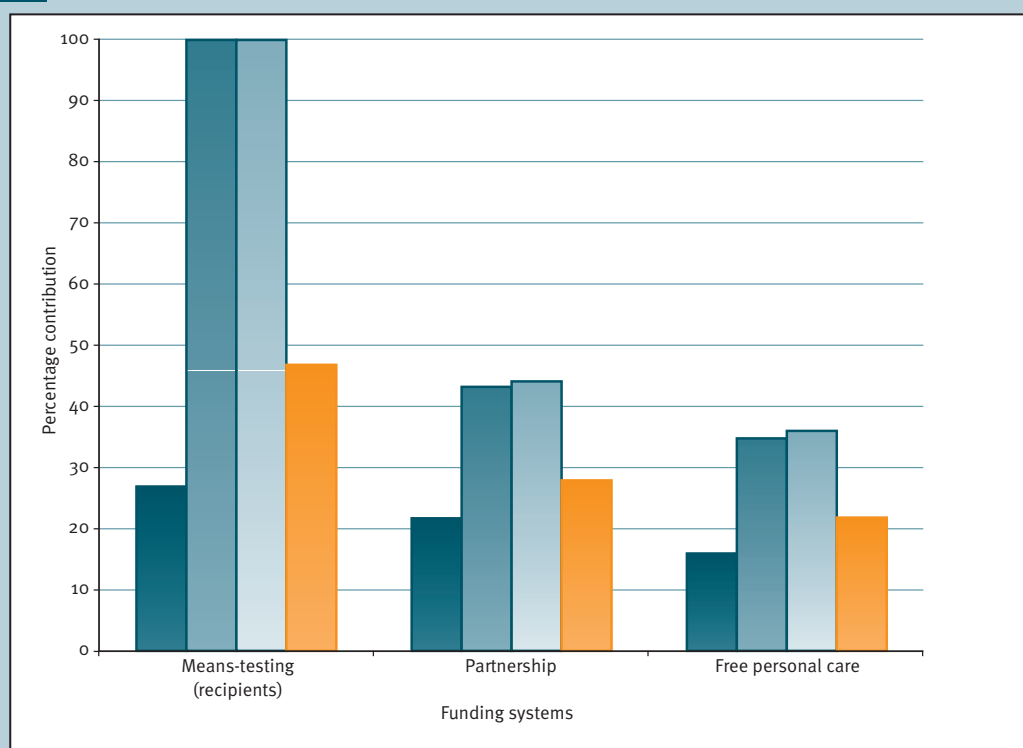


58 DISTRIBUTION AND CHANGES IN LEVELS OF EXPENDITURE AND CARE RECIPIENTS, BY LEVEL OF DISABILITY AND FUNDING SYSTEM (SCENARIO 1 RELATIVE TO SCENARIO 2)



Source: Review model estimates

59 PROPORTIONAL INDIVIDUAL CONTRIBUTIONS TO CARE PACKAGE, BY WEALTH AND FUNDING SYSTEM



Source: Review model estimates

qualify for help on the basis of their assets, is due in part to the effect of charges, which can sometimes be very large. Figure 59 below illustrates clearly that whereas in the three funding models explored, high-wealth individuals contribute a greater share of the cost of their care package, the difference between the contributions of high- and low-wealth individuals is much more extreme in the Fairer Charging, means-testing scenario.

OUTCOME

The free personal care system yields the highest personal care outcome levels (worth an estimated £17.2 billion) followed by the partnership scheme (with outcomes worth £16.0 billion) and by the means-testing regime (with outcomes worth £14.1 billion). Even though in all three funding models outcome levels exceed total costs, the highest ratio of outcomes to costs corresponds to the partnership model (1.17), followed closely by the free personal care arrangements (1.16) and finally by the means-testing system (with a ratio of 1.13).

4 Implications from the model

As noted above, the micro-simulation model employed in the analysis is designed to allow the exploration of value-for-money and equity implications of different funding systems.

Value for money: outcomes and costs

In the free personal care model people are predicted to consume levels of care in excess of the benchmark levels defined in Chapter 10 (see Figure 57 (p 257) and Figure 60 opposite). This results from people having no charges for their personal care. If people feel that their needs are not yet fully met, they might be prepared to purchase private support in addition to their entitled levels of care. In that respect, it is important to underline that the benchmark levels of service input were set in Chapter 10 at the societal cost-effective level, and not at the (higher) level required to exhaust the potential of services to improve outcomes. So there is scope for outcomes to be further improved. Whilst, from the point of view of the individual reacting to a highly subsidised overall charge, going beyond the benchmark might be right, it nonetheless implies that the state is supporting more care than the level society is willing to fund.

This effect is reduced in the partnership model because the guaranteed care package is set at a lower level than the entitlement in the free personal care scenario. As a result the higher charges people face from the public programme puts them off buying more care privately. By proportionately matching the financial contributions of individuals to their care up to the benchmark packages, the partnership model also allows service users to have greater flexibility and control over the levels of care they wish to consume.

In the particular partnership scenario postulated in the analysis, the guaranteed levels of care were set to be equal to scenario 1 package levels to ensure that the amount of care consumed by individuals, and particularly by high-dependency individuals, would be at least equal to currently observed levels even if individuals decided not to contribute privately to their care. In general, however, guaranteed levels could be set differently. For instance, the amount of the guaranteed service and the level of the matching rate for people's contributions could be set instead so that people use services at about benchmark levels.

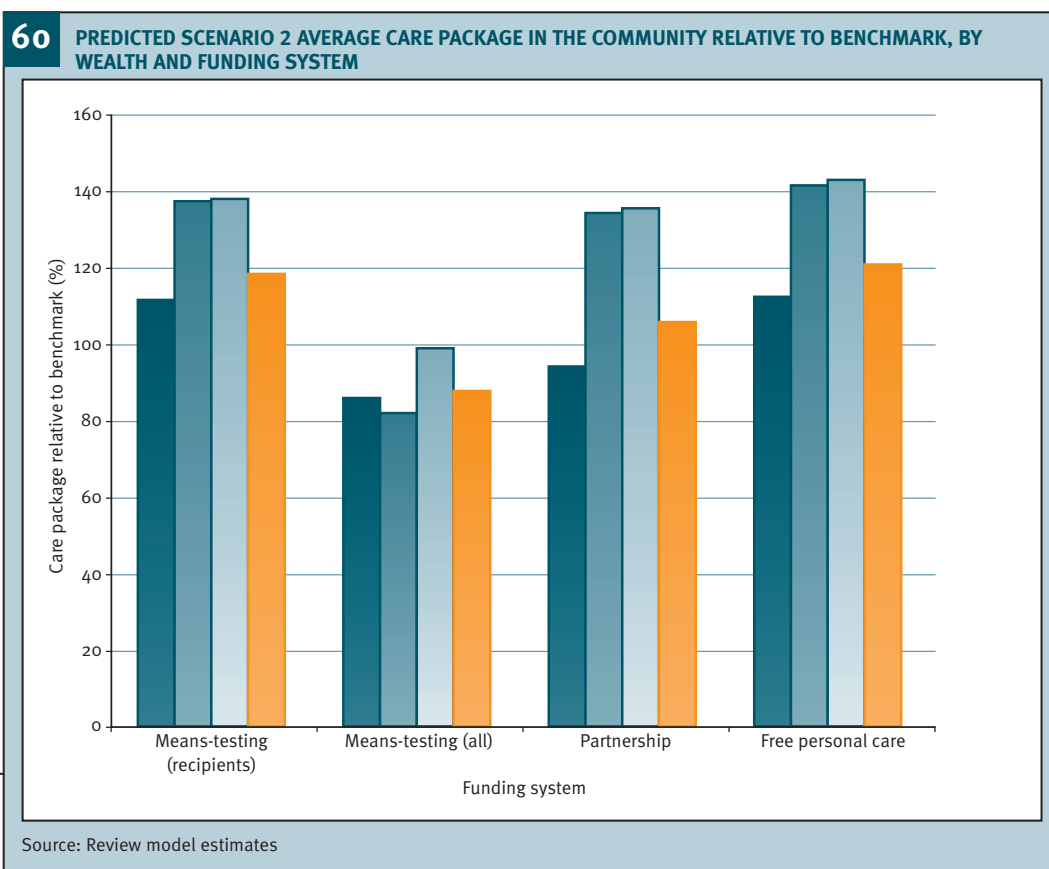
Figure 60 opposite shows total predicted levels of care by levels of wealth in the three models examined. The figure presents two sets of values for the means-testing system: one for care recipients only, and the second for all individuals potentially in need of care (that is, including non-recipients). In the partnership and free personal care models, all dependent people take up services. The figure shows that whereas, among recipients of care, the means-testing system achieves levels of consumption comparable to free personal care, on average the levels of utilisation fall significantly below the other two systems, due to the relatively low take-up of services linked to the negative effect of charges.

Equity

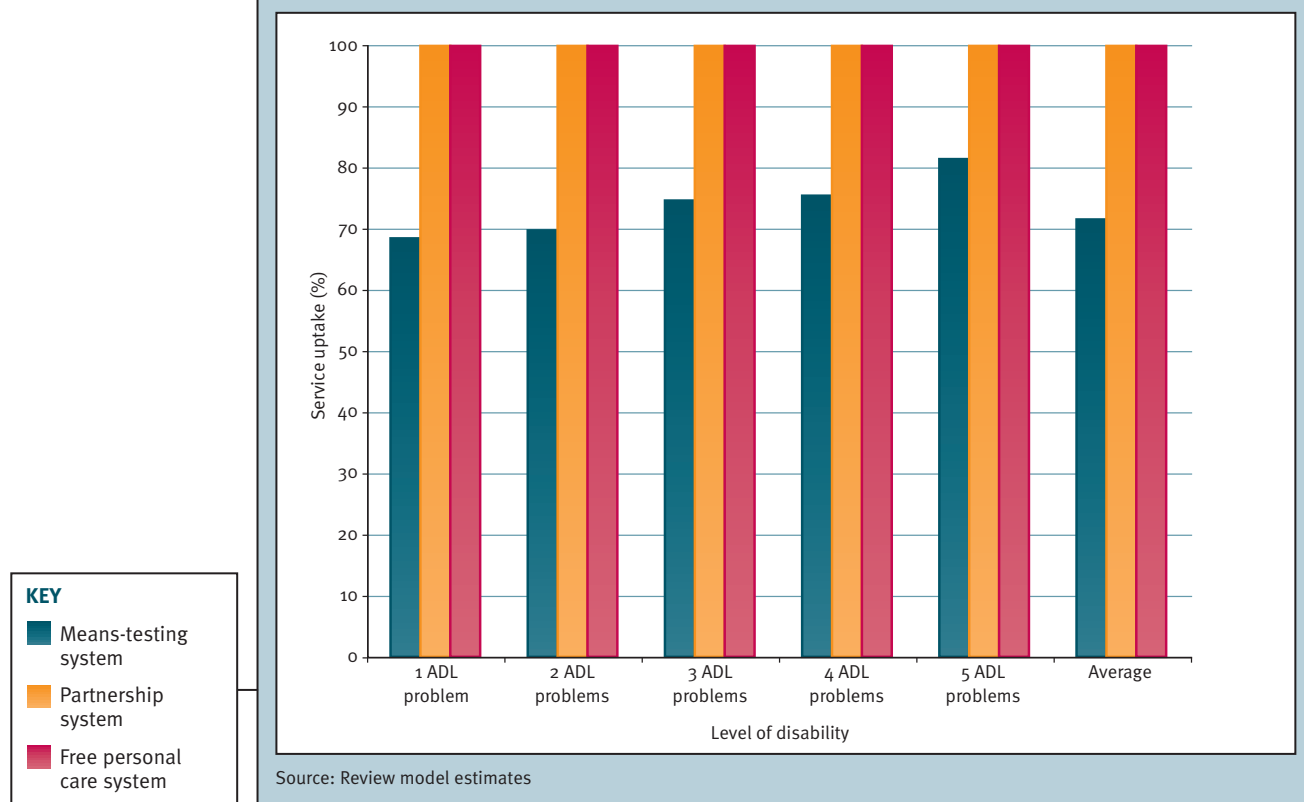
PATTERNS BY LEVEL OF DISABILITY

Whereas there are marked differences in the impact of the different funding mechanisms on the care received by high- and low-wealth individuals, the analysis suggests a remarkable degree of consistency in the patterns across disability levels. Figure 58 (see p 261), for instance, indicates that the distribution of recipients by level of disability, and the relative share of resources distributed to the different client groups in the three funding scenarios, are very similar.

Figure 61 overleaf shows that more dependent individuals appear, other things equal, significantly more likely to take-up services. Overall, Figure 58 (see p 261) suggests that, in all three scenarios, resources appear to be concentrated on the most disabled individuals, with between 55 and 58 per cent of service expenditure consumed by users with at least 4



61 PREDICTED SERVICE UPTAKE, BY LEVEL OF DISABILITY AND FUNDING SYSTEM



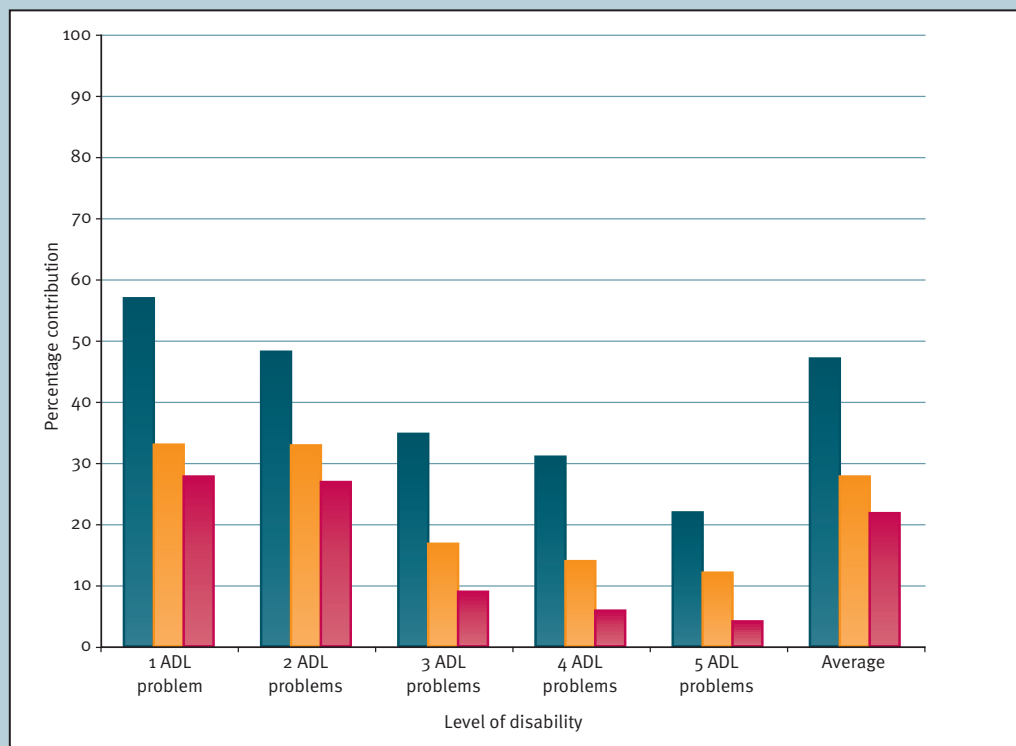
ADL activities, who are between 34 and 38 per cent of all recipients of care. Also, Figure 63 (opposite) indicates that in spite of these high levels of resources going to the most dependent, it is individuals with relatively low levels of disability who are predicted to secure levels of care significantly above the benchmark levels. It should be noted that more dependent individuals receive significantly more intensive care packages.

In terms of the public/private funding split, the results again do not indicate significant differences in the trends by dependency. Hence, Figure 62 shows that the proportional contributions to care packages decrease significantly with the level of disability across the three funding models.

PATTERNS BY LEVEL OF WEALTH

In general, means-tested systems, almost by definition, are expected to perform well on fairness in that service provision is based on need and only on ability to pay to a limited extent – they are highly progressive/pro-poor arrangements. In particular, individuals who simply cannot afford care (even if prepared to make significant financial sacrifices elsewhere) are able to secure a reasonable level of care. In other words, the intention is to ensure that poor people are able to benefit from levels of service that would only be affordable to wealthier people, absent any public help. The models, however, suggest that this effect has gone too far. In fairness terms, it appears that for those people not eligible for support but nonetheless with only modest wealth by current standards, access to care is more limited than for people who are eligible. As a result, the effect of means-testing arrangements, at least in the most stringent interpretation of Fairer Charging guidance, might support a polarisation in the patterns of service utilisation between three groups:

62 PROPORTIONAL INDIVIDUAL CONTRIBUTIONS TO CARE PACKAGE, BY LEVEL OF DISABILITY AND FUNDING SYSTEM

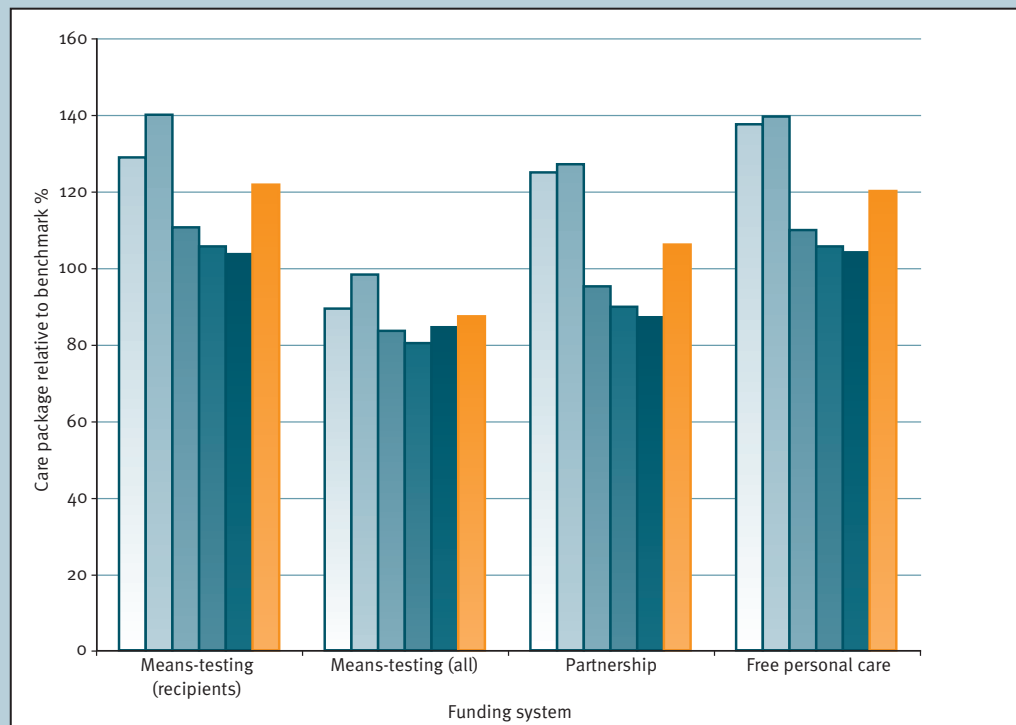


Source: Review model estimates

KEY

- Means-testing (recipients) system
- Partnership system
- Free personal care system

63 PREDICTED SCENARIO 2 AVERAGE CARE PACKAGE IN THE COMMUNITY RELATIVE TO BENCHMARK, BY LEVEL OF DISABILITY AND FUNDING SYSTEM

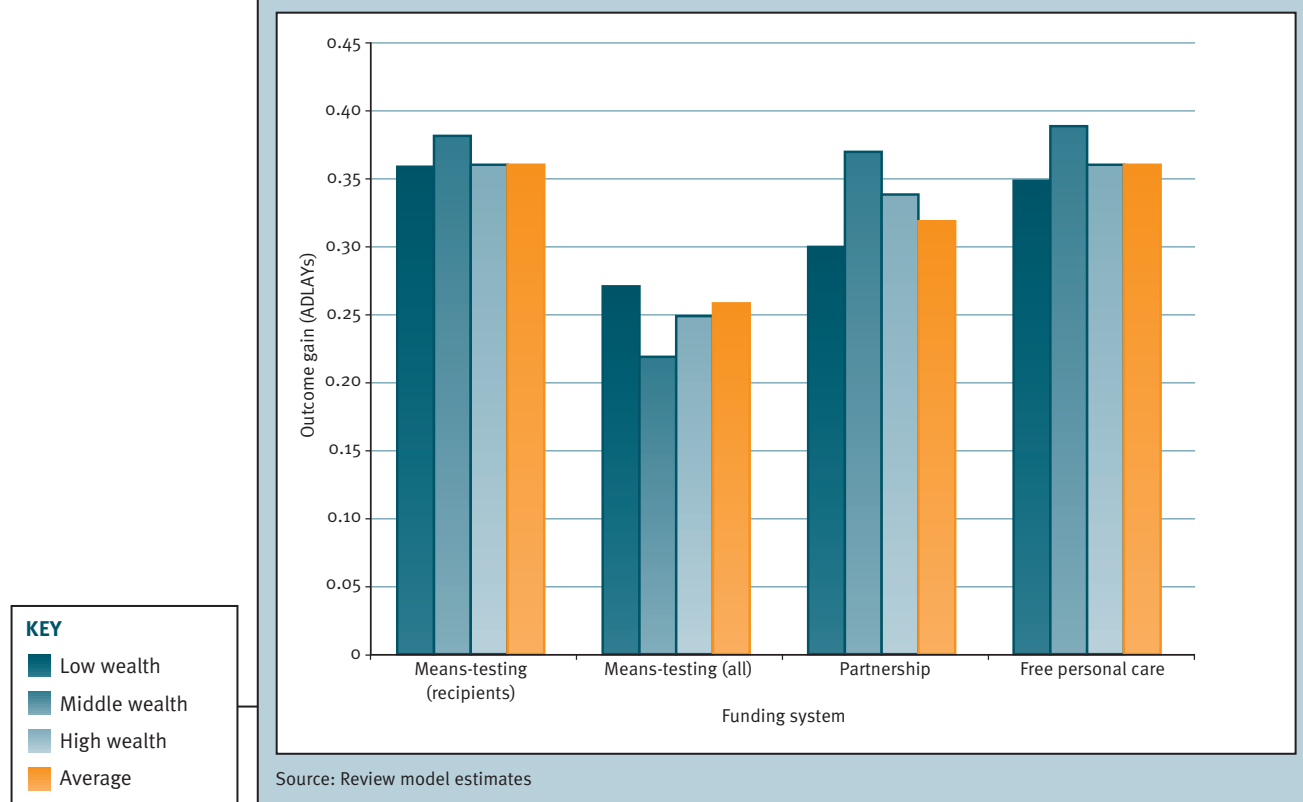


Source: Review model estimates

KEY

- 1 ADL problem
- 2 ADL problems
- 3 ADL problems
- 4 ADL problems
- 5 ADL problems
- Average

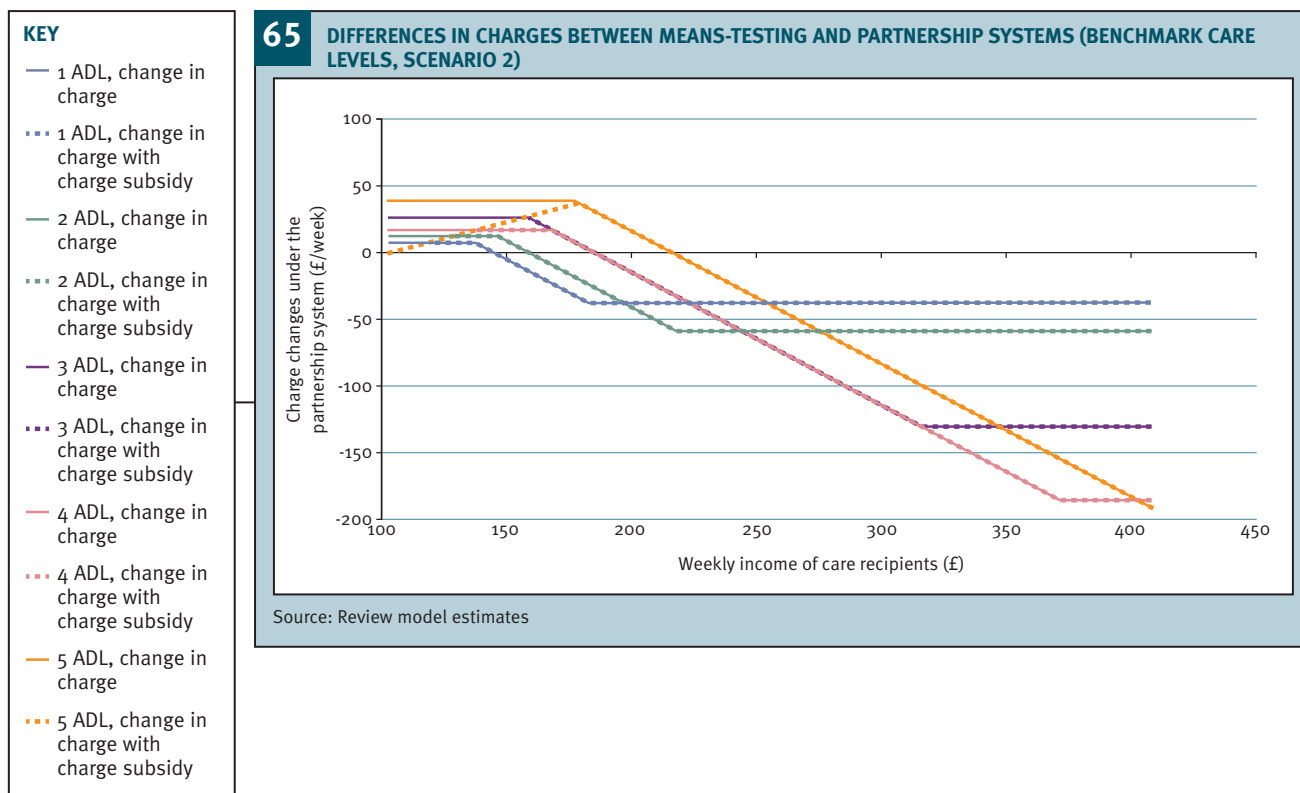
64 PREDICTED OUTCOME GAINS (ADLAYS), BY WEALTH AND FUNDING SYSTEM



- those of individuals with means that are sufficiently low to qualify for state support, and whom as a result might receive appropriate levels of care
- those of individuals with high means who are able to consume high levels of services by funding their own care
- those of individuals between the two groups, a significant proportion of whom might struggle to pay for their own care, and as a result might not receive enough formal support.

Some of the implications of this feature are illustrated in Figure 64 above, which shows the average levels of personal care outcomes achieved by individuals of different wealth in scenario 2 in the three funding models. Figure 64 shows that, whereas amongst care recipients, means-testing services appears to have had the intended effect, that is to equalise outcomes across wealth groups, the average outcome gains overall are lower than in the other two funding scenarios for all groups, and significantly lower for the middle-wealth group.

Incorporating a universal entitlement appears therefore to play an important role in ensuring a more equitable distribution of outcomes, by making it possible for all individuals in need of care to receive some support. Whereas the free personal care model also achieves this, the analysis above suggests that the partnership model represents a more sophisticated, less costly mechanism. However, because of the lack of means-testing, the basic partnership model would mean that people with low incomes, who would receive their care free under the means-testing model, would pay some charges for



any level of care above the guaranteed level. Consuming the benchmark levels, in other words, would entail a charge from any service user, including low-income groups. In a scenario 2 partnership model, for individuals with moderate or high levels of need, the compensation for paying a charge would be a substantially increased care package. For people with low levels of need, many would be entitled to a care package which they would not have been eligible for under current arrangements. However, relative to the scenario 2 means-testing system, some low-income people who would receive the benchmark care package for free, would be likely to face charges under the partnership model.

In order to provide all people with the opportunity to achieve their respective benchmark care levels, the analysis has explored the cost of a scheme which would give financial assistance in paying their charges to low-income individuals. Starting from a subsidy equivalent to the total value of the charge for individuals with incomes below or at the pension credit minimum income guarantee level, the level of subsidy would be reduced proportionately at a rate of 50p for each £1 of income above the minimum income guarantee level. Figure 65 depicts the implications for individuals with varying levels of dependency and wealth of moving from the charging arrangements of the means-testing system to those in the partnership model, as well as the effect of the charge subsidy.

In Figure 65, the smooth lines indicate the changes in the levels of care charges, while the dotted lines indicate the combined effect of the changes in care charges in addition to the receipt of the subsidy. Importantly, the charge levels implied in the example are those associated with benchmark packages of care, and so represent the maximum possible

difference between the two charging regimes. Care packages set at the guarantee levels, for instance, would imply no charges for any recipient of care in the partnership model, and would therefore show it as a more attractive alternative than means-testing for all users.

Not surprisingly, Figure 65 highlights significant reductions for high-income individuals in the levels of charges following a move from means-testing to the partnership system. Equally, the results show how for low-income individuals, the transition from means-testing to a partnership system would imply, at benchmark care levels, increases in the charges faced. The figure highlights the beneficial effect of the charge subsidy on such individuals, who see the charges they face drop substantially. The proportional nature of the decrease in the subsidy avoids cliff-edge effects (in contrast with the arrangements implicit in the Fairer Charging policy), whereby individuals with marginally different levels of income face significantly different charges. On aggregate, the estimated cost of such a scheme for community packages would amount to £0.8 billion. It is important to note, however, that the introduction of financial assistance with charges, while it does not reduce the universal nature of the partnership system, introduces an element of means-testing, and therefore erodes the opportunities for savings in transaction costs implicit in the basic partnership specification.

The housing costs of those in care homes are a significant part of the total cost (£170 per week). Under current means-testing no distinction is made; the whole cost of care homes (£370 per week, without nursing) is tested. The free personal care and partnership models also means-test housing costs. The advantage of this approach is that it distinguishes care costs from housing costs and therefore minimises some of the ‘cost-shunting’ incentives that currently exist.

In theory, means-testing could be applied to the partnership arrangements and could take place at three levels. First, by means-testing the guaranteed element, with higher resources offered to low-income groups. Second, the means-testing could operate on the matching element, by insuring that the rate of matching of individuals’ contributions by the state decreases proportionately with individuals’ wealth. Finally, the state could provide financial support with charges through a scheme such as the one detailed above, while maintaining both care guarantee and matching rates invariant across income groups. But this would undermine one of its key advantages: removing means-testing from the care system.

Sensitivity

The implications of the model turn crucially on the size of the demand effect, that is, how people react to charges in terms of the probability of them deciding to pay for care, and, where they have a choice, how much care they buy. The demand effect is strong if people scale back their demand for care significantly in the face of high prices. The implications of the models were tested by strengthening and weakening the demand effect by 25 per cent each way of the base effect. The result was a change in overall costs of around half the amount of the demand change that is, minus 13 per cent for the 25 per cent increase in the strength of demand, and vice versa. It is therefore important to stress that the model’s implications are sensitive to small changes in the estimated demand effects.

5 Comparing funding models: pros and cons

Fairness and dignity

Whereas the results confirm that means-tested systems protect the very poor, they also demonstrate that people who fall just outside the eligible range for state support can do significantly worse. As a result, many ‘asset rich, income poor’ people are forced to dispose of assets in order to pay for care. Means-tested systems can be so pro-poor that they result in a skewing of resources overall and that is the case with England’s current system.

The free personal care model scores well on most aspects of fairness. Service provision is based very largely on need, rather than ability to pay; the system is universal, and situations in which assets have to be run down are more readily avoided. Furthermore, because personal care is free for all, it avoids penalising more wealthy people who have made financial provision for their old age.

The partnership model has strengths and weaknesses with regard to the fairness tests (it ranked third among the eight options (see Table 69, p 254)). For the guaranteed element, support is based entirely on need and not ability to pay, but the converse is largely the case for the matched element (save that the capping of the matching element is set only on need criteria). Overall, the arrangement is still progressive and it is universal in assisting all; as a proportion of their income, and their care package, low-income people receive greater state support (see Chapter 12). The very poor would receive the guaranteed level at no charge and it is expected that the benefit system would be adjusted to assist them to make contributions under the partnership model. Compared to the present situation they would be no worse off. Compared with a means-testing model that funds benchmark levels of care, low-income people would face charges for which they would receive support from the benefits system, as described above.

Means-testing performs less well on dignity than the other two funding models in that its care recipients must demonstrate themselves to be of limited means before they can expect any help. Furthermore, individuals need to have run down their resources in order to qualify for state support. Additionally, individuals who pay the full cost are penalised relative to others in this system in that they pay more for the same service. As pointed out above, of particular concern are those people just above the eligibility threshold, who are likely to be constrained in meeting their own needs by their ability to pay.

At the other end of the spectrum, free personal care and partnership arrangements, and in general arrangements which imply some care entitlement to individuals, appear compatible with a human rights stance. A particular rationale for adopting long-term care insurance systems in Germany and elsewhere was the rejection of the requirement for people to impoverish themselves before receiving support (see Chapter 12).

The partnership model scores particularly well on dignity as means-testing can be removed from the social care system. Instead, any means-testing required could be undertaken in the benefits system. The social care system would become far more universal in this respect, not just a system geared around the poor. Given the numbers of people aged 65 and over that will need some form of social care in the future (see Chapter 2), this feature is clearly appealing. Also, it raises the profile of the industry from

a workforce perspective. Means-testing appears to reduce levels of social trust and this has wider costs.⁴

Efficiency

The model results show that the partnership model gets closest to the benchmark level of care and so has the highest return of outcomes to cost. Overall, in means-testing there is under-use of services. By contrast, there is over-use of services in free personal care, albeit to a relatively modest degree.

The models differ significantly in how much public funding they require. The impact more broadly of securing additional funding from public sources, that is, taxation, must be considered. Both the political and economic implications of increased taxation need to be taken into account by policy-makers. The means-tested model is cheapest, with free personal care imposing the greatest burden on the public purse. Alternatively, extra funding could be secured from paring back other public services. Although clearly also implying a large political cost, were funds to be transferred from health care, there could at least be a return for the health care service, as discussed in Chapter 3.

Two of the three funding mechanisms explored, free personal care and the partnership model, do not require the application of means-tests to prospective community-based users of formal services, and as a result are likely to economise on assessment costs. The potential for such savings, however, remains uncertain, and was therefore not factored into the calculations presented. The costs, not just financial, of means-testing should also be considered for the service user.

There are risk-pooling benefits from each of the models. Where more people are protected against the risk of substantial care costs, and where the amount of their contribution to the (insurance) pot does not directly affect any payout they might expect, these benefits are greatest. Free personal care has the best performance in this regard. Partnership has good coverage, but people have some matching contributions. Means-testing covers the low-wealth people very well, but largely fails private payers (at least until they erode all their wealth).

Social care often combines housing and care, the care home being the obvious example. There are strong economic arguments for distinguishing the costs of each element in funding arrangements. In particular, counting the costs of housing in the total costs of care home services precludes a like-with-like comparison with the costs of home care. The responsibility for home care users' housing costs falls outside of the social care system. But under Charging for Residential Accommodation Guide (CRAG) means-testing rules, this is not the case for care homes. This potentially perverse incentive could mean a choice of care that is driven by financial considerations as much as need. Under partnership as modelled, housing costs are treated in the same way regardless of whether a person is at home or in a care home, so this problem is avoided.

Choice

Choice can be limited by regulations, for example, one-size-fits-all public programmes. It can also be limited by people's ability to pay, especially choices between more and less expensive options. Choice for private payers is not constrained by the first factor, but

potentially is by the second, especially for poorer people. In public programmes, especially those with little or zero charge, services have to be mediated by publicly mandated commissioners. Means-testing fares poorly on choice, except for the very rich, who always have choice. The free personal care model requires public commissioners to determine service packages, as is also the case for the guaranteed element of the partnership model. However, the 'matched' element offers significant choice and flexibility.

By potentially combining a nationally fixed guarantee with a locally variable matched element, the partnership model could insure a significant degree of local homogeneity in the provision of care services, whilst allowing individuals and local policy-makers an opportunity to influence the levels and types of services actually delivered to meet local resources and preferences. In addition, the variable element provides an incentive, albeit a relatively weak one, to take measures that might reduce the amount of care individuals need. People will not have a free choice over the care they receive in the same way as if they paid out-of-pocket, but they would have an opportunity to change the size of their overall care package (in a way that would be more difficult under means-testing or free personal care). Having the choice would motivate people to demand services better suited to their needs.

Clarity

The funding of social care is complex. There are housing, domestic support, personal care and nursing care elements to many social care packages. Combining the funding of housing/support service with the care costs generally creates significant perverse incentives as discussed. None of the models escape this complexity. In means-testing, furthermore, the rules for financial eligibility are particularly opaque. Under free personal care and partnership models no charge considerations apply for the guaranteed element. For the matching element in partnership, the rules are fairly clear: in the example examined, for every pound a person pays, so will the state.

Sustainability

Fiscal sustainability and control of costs are usually in tension with the achievement of high outcomes for service users. But in a heavily publicly funded system, the importance of sustainability needs to be recognised. Means-testing is the front-runner in this regard. It takes a substantial amount of money (over 50 per cent of the total) from those who can most afford to pay. Eligibility criteria can be raised to restrict support for the most in need, although doing so could easily generate unmet need for the low and moderately dependent who have no choice but to make provision privately.

Free personal care and partnership have an entitlement element that is more difficult politically to change. In particular, it would be very difficult to reduce the size of care packages for equal (personal care) need. Demand effects are also potentially high for the free personal care model. There is uncertainty about the size of demand effects when the price of care is reduced to zero, but every indication is that demand will grow, and that a snowball effect is possible.

In the partnership model, the guaranteed entitlement can be scaled back to reduce costs (or held constant in cash terms over time) or the matching contribution can be reduced. The problem is that this impacts on the poorest as much as it impacts the richest. If the

poorest are protected by commensurate increases in income support, then the implications of scaling back are less severe.

Sustainability is also dependent on public perception as well as hard fiscal calculation. The means-testing model is unpopular because it is associated with spend-down and financial hardship for people (see Chapter 6). Partnership and free personal care are universal in not differentiating between people on the basis of income. There is also a sense in which people will understand the contract between them and the state in providing at least a guaranteed level of care, and without the obscuring complexity of means-testing. Whatever happens therefore, people are entitled to a minimum guaranteed level of support.

6 Discussion

Summary points

Clearly, the implications to be drawn from the analysis depend to a significant degree on the particular arrangements assumed for the three funding mechanisms. For instance, increasing the guaranteed element in the partnership system could approximate both the costs and the outcomes it produced to those of free personal care. The results presented here cannot be interpreted therefore as covering the whole spectrum of possibilities offered by the different funding mechanisms investigated. They offer nevertheless three approaches to balancing the funding responsibilities between individuals and the state. At one end of the spectrum, the means-testing regime represents a system whose support is significantly targeted on low-wealth individuals. At the other end, the free personal care system assumes that the state provides complete financial support for personal care needs of all individuals. The free personal care arrangements are associated with significantly greater levels of expenditure, and in particular of public expenditure, but also with the highest outcome levels and with significantly greater numbers of care recipients.

The way that social care is funded has a significant impact, beyond any consideration of need, on what services different people are likely to use. These are not only distributional questions. Changes in funding do not just affect the balance of costs between rich and poor and between state and individual. They also change overall expenditure levels and outcomes. Even if the same underlying service eligibility against need was used by public commissioners, the different funding mechanisms would mean different levels of service use for people. However, there is no panacea for social care funding. There are tensions in serving a range of different people; changing funding arrangements invariably creates winners and losers. This is not to say that improvements cannot be made; the deficiencies of the present system are serious and can be expected to intensify.

The analysis presented above shows that, on balance, the partnership model has much to commend it. The modelling work brings out its particular strengths and weaknesses. Perhaps the fundamental question is whether means-testing can be stopped without at the same time having to provide all care via public funding.

In both means-testing and partnership models, and to some extent in free personal care, private contributions to care account for a substantial share of total expenditure. There are benefits in this requirement. But a number of steps could be taken to soften the impact on

people. The last chapter discussed a range of mechanisms to support private paying, from insurance products to equity release arrangements. These would have effect in the long term.

Variants and options for the partnership model

The partnership model could be refined in a number of ways.

SUPPLEMENTARY PUBLIC INSURANCE

In this version, the state would also support or facilitate a savings or insurance programme, which people could pay into and then drawn on to pay their matching contribution should the need for care arise. An option would be to implement a soft-compulsion arrangement in a national savings programme in line with that proposed by the Pensions Commission (2005). This arrangement would not also involve a benefits provision as above.

INDEPENDENT REVIEW OF PAYMENT LEVELS

Internationally, as highlighted in Chapter 12, countries with entitlement-based social care systems have tended to erode through time the amount of care available through the scheme by increasing the value of the entitlements by less than price inflation or even, as in the case of Germany, by not increasing it at all since its inception. Therefore, the likely long-term acceptability and sustainability of a partnership model would be assisted by the setting-up of some independent mechanism to review payment levels periodically. The aim of such a mechanism would be to ensure that the guaranteed care component reflects a fair compromise between society's need for care and the inputs and resources available to cover such needs. Whereas, understandably, government is likely to feel reticent about releasing some of its control over expenditure decision-making, there exists now an established experience of organisations such as the National Institute for Health and Clinical Excellence (NICE) assisting government in taking decisions about which services to fund or not to fund.

ATTENDANCE ALLOWANCE AND DISABILITY LIVING ALLOWANCE

As discussed above, an important issue about affordability would be the option to incorporate Attendance Allowance and Disability Living Allowance into the guaranteed payment in the partnership model. Although more work needs to be done on exactly who currently gets these benefits, the analysis in Chapter 7 suggests that AA use is highly correlated with ADL dependency. Assuming the overlap is as large as this initial investigation suggests, much or all of these benefits could be transferred. It would effectively be available to people with the same conditions, and also could be offered with the option to be taken as a cash (direct) payment.⁵

Variants and options for the means-testing model

INCREASING THE THRESHOLD

One of the key shortcomings of the means-testing model is the steep cliff-edge for people above the upper eligibility threshold (£20,500). A way of potentially reducing the gradient is to increase the upper threshold, either with or without a commensurate increase in the tariff income rate. The problem, however, is that despite a number of asset-rich, income-poor people, mostly there is a strong correlation between asset wealth and income. Raising the upper threshold does not therefore reduce significantly the charges people in

the community pay, and in turn, does not affect demand. It could, however, lower the charge for some care home residents (especially those with assets just above £20,500 but income below about £310 per week).

ANNUITISED INCOME

Although likely to add complexity to an already highly complex system, an option to address the concerns voiced about the impact of current charging arrangements on people that are ‘asset rich, income poor’ is to means-test not on assets but on annuitised income. As described in Chapter 12, a rule could be implemented which annuitises some proportion of people’s eligible assets at a fixed interest rate. People would be tested on regular and annuity income. It would still mean, however, that people would have to divest of those assets, or use a financial product to actually annuitise those assets.

Pace of change

This partnership model is not an agenda for now, or for next year. Implementation would need to be careful and thorough. The results here concern very significant amounts of money and changes in funding arrangements that would affect over a million older, sometimes vulnerable, dependent people. These considerations cannot be taken lightly. This Review aims to trigger a substantial and robust debate about the nature and funding of social care for older people. The incrementally developed and frequently patched system which has now been in place for nearly 60 years is not fit for purpose in the medium term as all the implications of longevity, demographics, technological change, a culture of human rights and more widespread wealth accumulation work their effects on society.

Any move towards a fundamentally different system will require a significant period of transition. The results of Chapter 10, if accepted, suggest that an overall increase in funding of social care for older people is required. In this situation, transition can occur without absolute losers, even if there are losers in relative terms and, in the short term, the gap of unmet need will not be met without increased state funding.

Boundaries with health care

There are pointed criticisms of the current system of NHS continuing care and the way it works with the social care system (see Chapters 4 and 12). A significant part of the problem is funding, and the problem that an apparently small change in diagnosis can have significant financial implications for a person. The difference, for a more wealthy person, could be between having care and housing costs covered by the NHS, on the one hand, and paying the full costs of social care on the other. It is clear that addressing the problem of where the boundary lays is both a health and social care issue. The Review has approached the problem from the social care side. In moving to a partnership or free personal care model, the gradient of the financial cliff-face between the two systems is significantly reduced. This is perhaps a case of tackling the symptoms and not the cause, but in practice will significantly mitigate this problem for many people.

Interfacing with commercial financial products

Scope exists for some people to use private financial products to insure or save against the charges they would pay under the partnership model. The Review believes that top-up

TABLE 70: RESULTS OF THE ESTIMATIONS FOR THE DIFFERENT FUNDING MECHANISMS, SCENARIO 2, 2002 SPEND LEVELS UP-RATED TO 2005 PRICES

	Number of problems with ADL tasks							Value ratio
	0	1	2	3	4	5	All	
Means-testing (fair charging)								
Recipients (thousands)	–	213	320	188	219	221	1,161	113%
Total cost (£million)	–	693	2,082	2,454	3,486	3,699	12,413	
Total charges to users (£million)	–	385	1,163	1,236	1,746	1,686	6,216	
Total public cost (£million)	–	308	919	1,218	1,740	2,012	6,196	
Personal care outcomes (£million)	–	757	2,219	2,615	3,967	4,512	14,071	
Means-testing (fair charging) with limited liability								
Total charges to users (£million)							5,010	
Total public cost (£million)							7,402	
Partnership (fair charging rules for housing component)								
Recipients (thousands)	–	307	446	232	260	253	1,498	117%
Total cost (£million)	–	956	2,585	2,649	3,684	3,816	13,691	
Total charges to users (£million)	–	317	924	717	1,026	992	3,976	
Total public cost (£million)	–	640	1,661	1,932	2,658	2,824	9,715	
Personal care outcomes (£million)	–	1,058	2,817	2,936	4,351	4,798	15,960	
Partnership (HB rules for housing component)								
Total charges to users (£million)	–	317	900	685	974	961	3,836	
Total public cost (£million)	–	640	1,685	1,965	2,710	2,855	9,854	
Free personal care (fair charging rules for housing component)								
Recipients (thousands)	–	307	446	232	260	253	1,498	116%
Total cost (£million)	–	1,060	2,798	2,888	3,992	4,143	14,882	
Total charges to users (£million)	–	285	845	582	773	814	3,298	
Total public cost (£million)	–	775	1,954	2,306	3,219	3,330	11,583	
Personal care outcomes (£million)	–	1,172	3,042	3,191	4,666	5,166	17,238	
Free personal care (HB rules for housing component)								
Total charges to users (£million)	–	285	773	441	595	558	2,651	
Total public cost (£million)	–	775	2,026	2,446	3,397	3,586	12,231	

forms of long-term care insurance or equity release are much more feasible than when these products are required to cover the whole cost. Nonetheless, on current patterns of income and wealth many people would still be unable to afford more than a modest premium. As mentioned above there is also the possibility to tie contributions in the partnership model with any national saving or pension scheme, for example those proposed by the Turner Commission.

INSET1 THE MEANS-TESTING SYSTEM

Means-testing, like any other system, can be configured in a number of ways. The means-testing system currently in place, described in detail above (see Chapter 6), incorporates a national system for care homes, but a variety of local interpretations for community care services. The government's Fairer Charging guidance for community care services specifies the highest level of charges that councils can make and mirrors the arrangements for care homes (as laid out in the Charging for Residential Accommodation Guide (CRAG)). Two main conditions define whether people are eligible for state support towards the costs of care. First, people with assets above the upper threshold (£20,500), where assets include housing assets for people moving to care homes and non-housing assets otherwise, must pay the full cost of their care. Second, people with income (less certain allowances such as the £18.80 personal allowance for care homes) equal to or exceeding the package cost, are also full payers. People not satisfying either of these conditions are supported but must contribute their entire income less the relevant allowance, with the remaining cost borne by the state.

For community care packages, most councils are not taking the maximum charges allowable under Fairer Charging, although there appears to be a move in that direction. In particular, many councils allow disregards that are more generous than a strict interpretation of Fairer Charging; many operate a universal cap on charges; a minority waive charges altogether or levy a token charge. The models presented assume weekly disregards amongst service recipients of approximately £22, ranging from £10 per week for the least dependent clients to £50 per week for the most dependent.

For the people who are not eligible for help, care must be secured in a market by the individual or their family/friends according to their own assessment of need and constrained by their ability to pay. The details of the situation at present are outlined in Chapter 6. Approximately a third of people fall into this category currently. They effectively pay either out-of-pocket, perhaps supported by an equity-release arrangement, or more rarely, use private insurance.

Finally, the results of the Fairer Charging regime were extended to look at the implications of the limited liability model, by estimating the additional costs to the state of fully funding the packages of care (in residential care or in the community) of users of a given minimum level of dependency after receipt of care for a minimum period of time. Specifically, the analysis looked at the additional cost of full state support for packages for individuals with four or five difficulties with ADL tasks and in receipt of care for over three years.

INSET₂ FREE PERSONAL CARE

Under this arrangement, service users are not charged for community-based personal care services or for the personal care element of institutional care options. It comes closest of all options to the ‘NHS model’ for social care but it doesn’t provide free ‘hotel services’ for all. In order to configure a ‘free personal care’ system, it is useful to distinguish between the nursing, personal care, practical/domestic care and hotel components of a care package. The hotel component is the accommodation or housing, which could be provided separately from the care and nursing inputs. Whilst these components are inter-related, they vary in the extent to which they promote outcomes such as personal care, nutrition and safety, as well as social participation and happiness.

Whilst recognising their importance for the well-being of older persons, it is generally agreed that the funding of practical, domestic care and particularly of hotel or housing aspects of a care package constitutes primarily the responsibility of service users. Such a position is argued on the grounds that such costs, and particularly hotel costs, are less directly the consequence of a physical impairment; such services contribute less strongly to improvements in personal-care-related outcomes and the under-utilisation of these components of care does not have as serious ramifications for disability-related outcomes as the other components. In addition, ascribing practical care and housing costs to the state would increase social care public expenditure to unsustainable levels. Therefore, the option considered here involves the state bearing the full cost of the personal care element of the care package.

For community-based services, the free personal care scenario therefore assumes that the entire benchmark care packages derived in Chapter 10 are funded by the state. However, the estimates of total expenditure also include estimates of levels of care above such benchmark levels which might be purchased in addition. In such a case, individuals are expected to pay the full amount of the additional services purchased.

For institutional care, there is the housing or hotel element of the care package to consider. At present, this is covered as part of the means-test, in that the test is applied to the full cost of the placement. The results considered two possibilities.

- First, that the housing component of residential care costs is charged using current Fairer Charging policies. The arrangements laid out in the Charging for Residential Accommodation Guide (CRAG) was used. As outlined above, people with assets or income (to cover the fee less £18.80 personal allowance) above certain levels must pay the full cost of their placement, which in this case would be just the hotel and practical care element. Otherwise, people must instead contribute their entire income less the personal allowance with the remaining cost borne by the state.
- Second, that housing costs are subject to housing benefit. This latter charging regime, applicable to individuals with wealth below £16,000, and designed to reduce the risk of rapid spend-down of assets, provides full state support for housing costs to individuals with income below hotel costs, and makes others responsible for contributing 35 per cent of the difference between their income and hotel costs.

In Scotland, the personal care component of care home costs was set at £145 (see Chapter 10). In the English context, Laing and Buisson (2004) estimated the average number of hours of personal care support in residential care to be approximately 18 hours. Given the assumption in the model of significant increases in the average dependency of residential care users, the model therefore set the care element of the residential care cost to £199, with the remaining £170 associated with hotel costs.

INSET₃ THE PARTNERSHIP ARRANGEMENTS

Partnership models are something of a hybrid, characterised by combining a publicly financed entitlement to a guaranteed level of care, with a variable component made up of contributions from individuals matched at a given rate by contributions from the state. The guaranteed level of care is fixed nationally or locally on the basis of assessed need and becomes an explicit entitlement. The remainder is the matched element, and is determined locally through negotiation between commissioners and the service user.

The specific arrangements in the estimations assumed equal guarantees and matching rates by physical impairment. The guaranteed levels of care were therefore equivalent to approximately 66 per cent of the benchmark care levels, and the matching rates at 50 per cent (that is, pound for pound). Alternative specifications of the partnership model could, for instance, increase the levels of guaranteed care and reduce the matching rates by levels of disability. These arrangements were designed to ensure that the amount of care consumed by individuals, and particularly by high-dependency individuals, would be at least equal to currently observed levels even if individuals decided not to contribute privately to their care.

The charging arrangements in the partnership models selected do not involve means-testing for care. However, in order to limit the risk of over-consumption, and particularly the risk that high-wealth individuals might consume disproportionately higher levels of resources, the matching of user contributions by the state was restricted to levels of care up to those implied by the benchmarks described in Chapter 10.

Following the free personal care arrangements noted above, the partnership arrangements imply different charging arrangements for the hotel element of residential care costs. The same two variants used in the free personal care scenario were applied to the analysis of the partnership system: first, a charging system which applied current CRAG charging rules, and second, a system which made housing support available for low-income individuals, as described in the free personal care scenario.

While the basic partnership model does not imply any form of means-testing, the analysis of the partnership model investigates the cost of providing financial support with charges to individuals with the lowest income. Specifically, such a scheme would provide assistance equivalent to the full charge for individuals with incomes below or at the minimum income guarantee level. This subsidy to the charge would then diminish proportionately to the excess income above the minimum income guarantee. The example worked out in the analysis assumes a 50p reduction in the benefit per £1 in weekly income exceeding the minimum income guarantee.

Notes

¹ Scores are: yes=2, no=-2, mostly yes=1, mostly no=-1, potentially yes/partially=1, neutral =0.

² See table 3 of Parker G, and Clarke H (1997).

³ Note that base year (2002/3) cost for care in Chapter 11 is £11.1 billion. The figure here is for 2005 up-rated by 9%. The slight remaining discrepancy (£0.3bn) is because (a) the modelling here is based on an individual level micro-simulation that introduces a degree of randomness at the individual person level, and (b) the numbers here include privately paid top-up care hours.

⁴ There is evidence that interaction with means-tested welfare state institutions seems to lower interpersonal trust. Social trust is important because it is associated with a range of desirable outcomes such as people having a positive view of their democratic institutions, to participate more in politics and to be more active in civic organisations. It is also associated with higher economic growth and less crime and corruption (see Rothstein and Uslaner 2005).

⁵ It would be important to ensure the cash payments were only used to address social care needs (otherwise these payments are simply benefits to compensate for the effects of disability).

14

Discussion and recommendations

This Review addresses two big questions: how much will need to be spent on social care for older people in England in 20 years' time and what funding arrangements should be in place to ensure that these funds are available and do support the good quality outcomes sought. These questions are at the heart of the terms of reference of this Review. The approach has been to gather together and build up the evidence base in order to develop outcomes-led estimates of the costs of addressing care needs. In the light of the evidence and the results of the models used in the analysis, some powerful conclusions and messages emerge.

After considering these overarching themes, this chapter lists the specific recommendations of the Review. These concern:

- estimated resource requirements
- funding and funding arrangements
- services and service re-configuration; and, where they seem particularly important to effective delivery,
- comments on organisational and delivery processes.

There are also recommendations about the Review's perceptions of the evidence base, in terms of both what it currently supports and where it ought to be further developed.

1 Financial and other resource needs

The level of need will clearly increase substantially, and the present system is not a satisfactory basis to create the conditions in which social care for the elderly in future can develop and thrive. People will live longer. And even if the chance of disability is falling for successive generations, the fact that people live longer means that the total years of disability they will experience is likely to increase. For total years of disability in the population to fall would require very substantial reductions in the incidence of disability-generating conditions. In principle there could be significant breakthroughs in treatment or other interventions that would bring such an improvement. For example, if radically effective treatments for dementia were forthcoming, the demand for care would be much lower, but the likelihood of this happening does not appear to be high (see Chapter 2). The extra cost implications will not be significant this year or next, but they will be significant in 20 years' time.

So, growing need will increase demand and cost. If the case were accepted, another cost pressure would occur from increasing the intensity of care to ensure that older people were able to secure comprehensive, high-quality services that reflect their preferences. The Review has taken as a starting point that the costs of care need to be explicitly set against the outcomes that care produces. Total funding requirements cannot be decided just by

assessing the outcomes that could be produced. But neither can they be decided just by looking at the costs. In the context of all the other uses of public funds, this cost-benefit calculation is difficult. The approach used here is to work within a limit of how much society is likely to be willing to pay for a given improvement in the outcomes of social care users. It entails using a generic measure of 'outcome' in social care, described as an 'activities of daily living adjusted year' (ADLAY) (see Chapter 5). The Review works with a central assumption that the per annum cost threshold is £20,000 per ADLAY. This approach mirrors that of the National Institute for Health and Clinical Excellence (NICE) and its use of the quality-adjusted life year (QALY).

The costs of providing care vary according to the quality and intensity of services. The pay rates needed to secure a suitable workforce are also a major factor. There are dangers in generalising, but there are areas of social care where quality is not high enough, for example, in some care home services according to the Commission for Social Care Inspection (CSCI). Good estimates of the improvements in quality required are not available and this is an important information deficiency. Nonetheless, to recognise the additional costs of improved quality and better workforce supply, the models assume a 2 per cent real increase per annum in the unit costs of services. This creates a significant cost pressure over 20 years, but it is considered a cautious assessment when compared with historical increases (see Chapter 7).

Also important when determining national policy are the political and economic impacts of additional public funding, including, for example, the disincentive effects of taxation and also people's potential resistance to high tax rates. When the broader fiscal climate is tight, these impacts are more likely to be significant. The approach taken here is to fund services that are cost-effective, notwithstanding other considerations. It is not just a choice about which services should be provided within a fixed overall budget, it is also about how large the funding base, public and private, should be. The Review accepts that funding implications on the scale shown to be required cannot be achieved in the short term. Over a longer period, it is important that the systems that are put in place encourage private resources to be brought into the overall funding base in ways that are understandable and achieve popular acceptance.

There are uncertainties regarding the size of each of these future cost pressures. In Chapter 10, a central projection of total costs is modelled along with a range of sensitivities. In the central case (for scenario 2) the resource requirement is modelled to increase to £14.2 billion in 2007 (1.4 per cent of gross domestic product (GDP)) and to £29.5 billion in 2026 (2 per cent of GDP). Increasing unit costs by, for example, a one-off 20 per cent to ensure the delivery of further improvements in quality and workforce inputs would push this cost to £16.5 billion in 2007 (1.6 per cent of GDP), and to £34.5 billion (2.2 per cent of GDP) by 2026.

The approach of the Review is strategic. It has not been about particular services or even particular types of services. It has been about how much support people should expect. Within the broad service categories used, estimates are of the average effects. In practice, because people have different needs, and because these service categories encompass a range of specific services (for example, what type of home care; forms of day care; the range of respite services), there would be scope to improve efficiency by tailoring services to particular people's needs. These efficiency gains could mean doing more for the money,

or opting for lower cost, or some combination (although specific evidence is lacking). For example, if after a one-off 20 per cent increase in unit cost, ongoing costs increased by only 1 per cent per annum in real terms rather than 2 per cent, that is, at 1 percentage point efficiency gain, total cost by 2026 would fall from £34.5 billion in 2026 to £27.8 billion, a difference of £6.7 billion. This illustrates the uncertainties and the sensitivity of the forecasts.

The role of new technology needs consideration. The evidence so far about telecare is far from definitive but there is promise. Quantifying the long-term impact is not yet possible, but efficiency gains might well be expected. The model has worked across a general category of ‘care with housing’ (care homes, extra care housing and other models). It does not appear unreasonable to expect further savings from a better choice of models within this category. There is also the wider issue of how housing and care operate together, which is considered in Chapter 9. Having a broader range of options between care in a person’s own home and a care home should offer a better match of needs and services for many people.

Although intertwined, it is important to see that at least some part of housing is separate from care. The distinction between care and housing elements needs to be made. Home care services can be a cheaper option for council social services if they do not include housing costs. However, those housing costs are being met somewhere. A person might be supported by housing benefit; they might be in a property that is too large for their needs. Even owner-occupiers who have paid off their mortgages have housing costs, and would, if they moved, be able to realise some of their housing assets.

The 3 to 4 million carers looking after older people play a vital role. The model suggests that informal care accounts for half of the required total care input of intensive personal care (in the main scenario). In addition, carers provide other non-personal care inputs. Their motivation for providing care is complex, but carers may suffer. There may be adverse effects to their health and well-being, and there are also financial costs, possibly substantial. A policy of supporting the carers can not only improve their outcomes, but also can sustain or extend the time people are prepared to care.

Social care also requires an extensive paid workforce. There are strategic questions needing to be tackled; in particular, will workforce supply keep up with demand, and what degree of qualification or training of the workforce is required? The evidence on these issues is mixed. Vacancy rates are currently high, but historically the supply of services in the long run appears to track changes in demand. Determining appropriate rates of qualification is also difficult. The current workforce is largely unqualified, at least in terms of formal qualifications, but many care workers have invaluable experience. The models used in the Review assume a long-term real increase in unit costs mainly to reflect higher pay rates for a higher skilled workforce.

The Older People’s Utility Scale (OPUS) work indicates those outcomes which people rate as important. Many are well-being outcomes, including social participation, loneliness, occupation and role-fulfilment, and to some extent control over life. This Review has made only very tentative steps towards addressing such a well-being agenda, mainly because the evidence is lacking. Those well-being services described in Chapter 10 concerned loneliness, and are likely to represent only a small part of what could be done.

People can lose self-esteem and confidence if they are unable to carrying on doing those things that have been part of their life. The limiting effect of disability is a main cause of reduced well-being outcomes.

Mainstream care services do appear to improve people's well-being outcomes. However, more comprehensive attempts to improve well-being will have further resource implications. Within current, fixed social care budgets there appears to be little scope to improve well-being without reducing care services.

On present evidence, it is hard to make a case that low-level services will have strong enough preventive effects to generate overall cost savings. This is not to suggest that such preventive effects do not exist. But the evidence is not yet definite on this issue. There is better evidence that social care helps to reduce inappropriate admission to hospital, and to facilitate discharge from hospital. Two implications follow. First, this improves the value for money of the relevant care services. Second, it supports the argument that overall value could be enhanced if funds were to be re-directed from the NHS to help pay for these services.

Overall, the lack of evidence prevented the modelling of a wider range of prevention-type services. The indications are, however, that substantial extra resources could be economically justified for improving well-being outcomes.

2 How should social care be funded?

No single system for funding social care stood out significantly above the rest. All have strengths and all have weaknesses. The relative importance of these strengths and weaknesses depends on the particular set of values used to make the assessment. For example, if protecting the poorest is paramount even if this means disadvantaging others, then systems with strong means-testing would score highly. If improving access to services for all people is paramount then funding arrangements with universal entitlement approaches would rate well.

It is reasonable to compare only feasible alternative arrangements, starting from the present complex situation which has emerged over decades of often incremental change. Radical change has not been ruled out in the alternatives considered but would need time for careful implementation. What is feasible depends on the timescale for change and what is happening around it in benefit and taxation policies.

Notwithstanding the nature of the value judgements used in any assessment, some funding options appear to have more strengths than weaknesses, and, furthermore, to be strong in areas felt to be important. The Review considered a wide range of possibilities; some would rely heavily on private contributions and have limited collective, risk-pooling opportunities; others are universal, publicly funded, free at the point of use, arrangements. Assessment against a set of 'tests' – covering fairness, efficiency, choice, physical resource development, clarity and sustainability – reduced these options to the following models: the current means-testing (Fairer Charging) system for comparative purposes; means-testing with limited liability; two partnership model variants and two free personal care variants.

Following a detailed exploration of the relative costs and benefits, the Review found that the partnership model fared the best overall against the tests. It has several important strengths, compared to the other systems.

- It does away with means-testing in the care system. The Review believes that means-testing should be undertaken in the benefits system and that social care should be guided by need.
- Almost everyone makes some form of contribution, however modest, in the partnership model. This puts important incentives in place for people to save to provide for their needs in older age. Indeed, people who make financial provision for themselves benefit from a matching contribution by the state (up to a limit).
- The partnership model produces close to ‘benchmark’ levels of outcomes, offering a better cost-to-outcome return than either means-testing or free personal care.
- Under the partnership model many fewer people will be forced to dispose of assets, possibly including their homes, to pay for care than under means-testing.
- People can choose not only what care to use, but also how much they personally want to use.
- The system is universal and inclusive. Everyone is eligible for the guaranteed level of care, based on their assessed need. The expectation is that this would reduce the stigma and the partiality of using social care. Older people, whatever their background, could expect a basic level of help even if they chose not to make further (matched) contributions.
- It is sustainable. The partnership model will cost more than means-testing. However, it also provides significant additional value in terms of better outcomes compared with means-testing. Unlike free personal care, it also makes a charge that both deters use of services beyond that benchmark level and provides an important source of revenue (depending on the precise parameters set, which are variable).
- The partnership model is flexible. There is a guaranteed element that could be expressed as an explicit entitlement; this part might be set consistently across the country. The matching element, however, does allow flexibility. Contribution rates could be set locally and reduced for people with particular needs, if that fitted more general philosophies about state revenue raising.
- The partnership approach supports the distinction between care and housing costs. This is important in limiting perverse care incentives, and also in clarifying debates about the funding of care rather than of housing costs.

There are weaknesses.

- Compared with means-testing, partnership is not as progressive in that it reduces the differential between what poorer people pay and what better-off people pay. Wealthier people would pay less than they do under means-testing and so the state would be contributing towards the cost of care for some people who could afford care themselves. With the partnership model as costed here some people with incomes of around £150 to £200 per week would either pay more than under a means-tested system in the future, or they would consume less care (although this amount of care would still be greater than the current levels). In absolute terms this group would be better off than now, but relatively speaking they would be even better off under a means-tested system in the future. Much depends on the level of benefits, the amount of disregard for care-related expenditure under means-testing, and the needs of the user. Someone with an income of £180 per week, assets below £12,500, and £50 per week of disregarded care expenditure, would pay nothing for benchmark levels of

service under means-testing. Under partnership, the maximum they could pay with a matching contribution would be £37 per week. If that person had lower disregarded expenditure or assets above £12,500 that generated a tariff income, charges would be likely under means-testing as well. In any case, if that person only opted for the free-of-charge guaranteed level this would still be worth some £25 per week more than the present case.

- The partnership model is not as expensive as free personal care, but it is more expensive than means-testing, at least in terms of the direct care costs. It is difficult to factor in accurately the costs of Attendance Allowance and Disability Living Allowance because of poor information, but if they were included, the total costs of the current system would be seen to be significantly higher. The partnership model does require additional direct care public funding compared with the current system, but the extent of the increase could, *prima facie*, be substantially reduced by transferring some of these AA and DLA funds.

Ultimately, the appeal of the partnership model depends heavily on the priority given by society to containing public sector costs, maximising equal access to care, and balancing the achievement of outcomes between high- and low-income groups. In other public services such as health and education society has taken the decision to achieve universal coverage, supporting all individuals including the wealthy.

Scope exists for some people to use private financial products to insure or save against the charges they would pay under the partnership model. The Review believes that top-up forms of long-term care insurance or equity release are likely to prove much more feasible than when these products are required to cover the whole cost. Nonetheless, on current patterns of income and wealth, many people would be unable to afford more than a modest premium. There is also the possibility of encouraging the development of immediate-need annuities, possibly linked to equity release.

All potential viable funding models draw heavily on public funds. Moreover, the costs pressures above suggest that increased public funding will be required. Developing estimations of this possible cost to the public purse has been the focus of the work. The Review has not discussed how further public funds should be raised.

Recommendations

Recommendations are drawn together below in the following categories: funding and funding arrangements, services and service re-configuration processes, and evidence and methods. (References show the relevant chapters, for more detail.)

1. Funding and funding arrangements

- The potential to achieve value-for-money outcomes is not currently being achieved (given the assumptions made). Unless society decides it is less inclined to support the same improvement in outcomes from social care as it does, for example, in health care, then more should be spent on social care. In the central projection of the model, the target level of resources required over a 20-year period would increase up to 1.4 per cent of gross domestic product (GDP) in 2007 and 2.0 per cent of GDP in 2026 (Chapter 10).

- While the results support a call for additional funding, it is recommended that this should not be forthcoming without a commitment to re-configure services (see below), and without demonstration that value for money and fairness (at least) are achieved. The system needs to be made more universal with broader eligibility criteria (Chapter 10).
- The demand for services will grow in the next 20 years. While the size of this increase is uncertain, it is recommended that policy-makers begin to recognise, plan and prepare for the financial consequences (Chapter 10).
- The choice of funding arrangement affects who receives care, how much care they receive, and what they pay. The Review recommends a partnership model (see Chapter 13) in broad terms, but accepts the need to explore the details and practical implications. The Review recognises that there are distributional consequences and that inevitably these will fit well with some values and poorly with others (Chapter 13).
- There is a need for research and debate about the role of relevant disability-related social security benefits, especially Attendance Allowance, which is not means-tested and involves high state spending. The Review recognises the importance of the financial help that Attendance Allowance provides, including support in meeting care costs and also compensating people for other needs-related expenditures. However, it appears that Attendance Allowance might not be the best vehicle to provide both forms of this financial help. The Review recommends integrating support for care costs from Attendance Allowance into the care system to improve targeting of resources. It would be particularly difficult to sustain in its present form if the care system provided a guaranteed care entitlement to all those people who would, in theory, be eligible for Attendance Allowance. It is also suggested that financial help for the other needs-related expenditures would be better co-ordinated with that part of the benefit system that deals with income compensation, such as pension credit (Chapters 12 and 13).
- Universal, non-means-tested benefits for older people such as winter fuel payments and other age-related payments, are expensive, and for 2005/6 account for around £2.75 billion of planned expenditure in England. The judgement will be heavily political and there are issues, for example, about high energy prices, but consideration should be given to whether a proportion of such funds would be better targeted at improving the provision of long-term care for older people (Chapter 12).
- The autonomy given to local authorities in deciding means-testing systems for domiciliary care has produced stark differences in user charges for very similar packages of care. While some local flexibility may be desirable, the ‘postcode lottery’ which now exists is inequitable, and greater uniformity in charging structures should be established (Chapters 6 and 12).
- The future role of private long-term care insurance appears very limited as a stand-alone funding mechanism, but insurance could play a part in public–private partnership arrangements. Kent County Council has carried out some preliminary work on how such a system might work. Further modelling should be pursued by the government in collaboration with the insurance industry on the potential for such a scheme and the desirability or otherwise of offering any financial incentives (Chapter 12).

2. Services and service re-configuration

- It is difficult to model the long-term cost impact of technology but enough pilot studies have now achieved positive results for telecare to be moved into the mainstream when planning long-term care for the elderly. The Review endorses current government policy in this regard, which is consistent with this recommendation. Funding should be

deployed to realise the potential net value of telecare (Chapter 9). It is recognised that there will be workforce implications which also need to be factored into the research (Chapter 7).

- More emphasis should be put on expanding dementia-specific care services and training carers (both formal and informal). There is a shortage of dementia-specific data including the cost of care at home and details of the services which people with dementia receive, all of which is vital for proper planning for the expected rise in the number of people with dementia (Chapter 9).
- The Review has a number of specific recommendations on service reconfiguration.
 - First, to increase the size of community-based (home care) care packages for people with high levels of dependency and, especially, for people with moderate levels of dependency.
 - Second, to tailor care with housing services to people's needs, particularly people with significant cognitive impairment. There is a need to distinguish between housing and care costs.
 - Third, to increase significantly funding to help carers, including carer support services and also relevant technology. Support for filial carers is especially important (see next recommendation).
 - Fourth, to develop services targeted at improving well-being. Further work is required, but initiatives to tackle loneliness and social isolation appear to be good value of money (Chapter 10).
- It is recommended that to improve outcomes for spousal carers, developing carer support services should be the main focus rather than care services for cared-for people. For filial carers, it is recommended that a range of options are considered and additional work is undertaken to ascertain the best approaches (Chapter 8).
- An increase in resources aimed at 'middle' if not low-level social care is recommended. Immediate benefits on service user outcomes would be the expected result. It is anticipated (although it cannot be confirmed) that these services would also have long-term prevention effects reducing future need (*see below*) (Chapter 10).

3. Processes

- The Review recommends that policy on health and social care integration continues to develop on the present course, subject to better confirmation of the expected cost-effectiveness of the component parts (Chapter 4).
- National criteria are urgently required to draw a clear line between long-term health/nursing care and social care. Where the former are the primary need, then the NHS should cover the costs of long-term care in a way that is consistent with other NHS care. An increase in the intensity of personal social care provision (heavily supported by the state) is recognised in this Review and will limit the 'cliff-edge' between the health and social care systems as will the adoption of the partnership model. There is an important distinction to be made between housing or hotel and care costs, and especially the basis on which these different types of costs are met (Chapters 4 and 13).
- The Review also recommends attention to financial arrangements regarding health and social care integrated working. The results of the Prevention for Older People pilots will be helpful. However, it is recommended that both health and social care organisations be given greater incentives to pool resources and to clarify joint funding streams. At present the mechanisms in place are facilitating and passive, but more active financial encouragement is required, such as, financial incentives to pool resources (for example, matching contributions) (Chapter 4).

- It is recommended that more flexibility and choice is introduced into the range of support services available to carers, both with regard to the type of service provided and the access to those services. It is also recommended that this is accompanied by an increase in assessments of carer needs and support required to enable the most cost-effective use of services (Chapter 8).
- Many new models of care – such as telecare and extra care housing – straddle the boundaries between health, social care and housing. Costs and cost savings usually fall to different organisations, and greater recognition of this needs to be given when apportioning budgets in order to encourage implementation (Chapter 9).

4. Evidence and methods

Information and evidence

- The social care evidence base is under-developed. The Review recommends that the funding of research is increased. Efficiency savings are expected to result from changes in service configuration and resource deployment. It is specifically recommended that the evidence base is improved with comparative research and systematic review (general).
- There is a developing evidence base about future rates of disability in the ageing population. However, really robust conclusions can only be drawn on good longitudinal survey data. The Review recommends a full examination of the English Longitudinal Study of Ageing (ELSA) data once further data waves become available (Chapter 2).
- It is recommended that a dedicated survey of disability is carried out rather than relying on general survey results (Chapter 2).
- It is recommended that research is carried out to explore the reasons for, and trends in, unmet need (Chapter 3).
- Private expenditure by older people on social care is large and increasing, yet there is a lack of data on the total amount being spent. This is particularly the case for the self-funding of domiciliary care, where the available figures are incomplete and uncertain, and for third-party ‘top-up’ care home fees, where there is no data. A comprehensive assessment of total private expenditure is urgently needed (Chapter 6).
- The Review recommends that methods of data collection be established, and information produced on:
 - the independent sector workforce – including reliable data on size and structure (the Review applauds the initiatives of Skills for Care in developing a minimum data set)
 - agency staff – reliable data on numbers and patterns of employment
 - immigration and migration workforce – including reliable data on numbers and trends in immigrant working in the social care sphere
 - overtime – data on both rates of overtime worked and the de facto increase in staffing levels this translates into.

This information will be invaluable in making a recommended assessment of supply responsiveness, impacts of technology and service development and migration and immigration (Chapter 7).
- At present much of the social care workforce is minimally trained. Many call for action in this regard. The Review recommends that:
 - the link between the training received and the quality of outcomes is clearly established, together with the other factors that impact on increases in quality
 - the real costs of training are ascertained

- current capacity for training is ascertained, together with maximum capacity within existing structures, and additional infrastructure necessary to increase training levels (Chapter 7).
- A development of evidence is recommended about how services of different types improve outcomes for different service users. In particular, the cost-effectiveness of extra care housing, care home placements (for people with cognitive impairment), day care services and carer support services needs to be better understood (Chapters 3, 5 and 10).
- A specific request is for further information to be collected about services used by older people in the English Longitudinal Study of Ageing (Chapter 10).
- There is an urgent need to establish the cost-effectiveness of prevention and preventive services. There appears to be significant promise in this regard, but the evidence base is not yet sufficiently developed (Chapters 3 and 9).
- It is recommended that further work is undertaken to develop and scale (comparable) measures of carer outcomes (Chapter 8).
- Research is needed on how Attendance Allowance is spent by recipients in order to judge whether the funds could achieve improved overall outcomes by being redeployed (Chapter 6).
- It is also recommended that an investigation is carried out to determine how people use the funds made available to them as Direct Payments.

Methods

- The Review strongly recommends the adoption of an outcomes approach. Resource decisions, where possible, should be assessed in light of their implications for the outcomes of service recipients (Chapter 10).
- The Review specifically recommends the use of generic social care measures, where appropriate. The important work in this area, particularly the OPUS project, and the work to value preferences is recognised and endorsed. It is further recommended, after suitable practical development, that it becomes an integral part of resource allocation and policy development (Chapters 5 and 10).
- The Review recommends a greater alignment of resources around a value-for-money principle. This should be balanced with other principles, such as fairness and sustainability. In practice, the methods, tools and information are lacking but should be developed. The Review recommends a debate about how value for money should be defined in social care. In particular, this debate should address the appropriateness of cost-outcome thresholds and the valuation of those thresholds in social care (Chapter 10).
- Regarding the workforce, economic evidence about cost-effectiveness of various types of training appears to be limited. The remit of this Review has not been on the specifics of workforce policy and delivery. Nonetheless, it is recommended that the workforce organisations address any deficiency in this area (Chapter 7).
- Standard ways to measure the outcome of preventive services need to be developed. They would facilitate the evaluation of these services and allow future studies to be compared, and a more robust evidence base to be collected, particularly for low-level services (Chapter 9).

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