Commission for Social Care Inspection

Making Social Care Better for People

Self-funded social care for older people: an analysis of eligibility, variations and future projections

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1. Introduction

People self-fund their social care for a number of reasons. Some people simply choose not to seek help from the public sector, perhaps relying on family or other informal care. Those people that do approach the public authorities – usually their local council – will normally only receive publicly-funded support if they are, first, sufficiently dependent and, second, have income and assets below certain limits. People who are not eligible on these financial and needs tests will need to make their own decisions about care and self-fund any care they wish to use. Self-funders are usually entitled to the set of universal care-related benefits such as Attendance Allowance if they pass a (differently-administered) need test, regardless of their wealth, but the amount of benefit in most cases falls significantly below the costs of care that are required. Furthermore, in theory all people are entitled to an assessment of their need from their council (as distinct from any care or support package), although this does not always happen in practice.

The 150 councils in England fund almost all publicly supported social care. In the main, councils are free to set their own eligibility criteria regarding needs within a national framework called Fair Access to Care (Department of Health 2003). This eligibility mostly takes the form of a threshold whereby people with sufficiently high levels of assessed need are helped but those who have assessed needs below the threshold are required to self-fund. It is essentially an 'access' test; there is no particular guidance on how much or what support a person should receive from the State should they be judged as eligible.

At present, councils can also choose which criteria they use to decide the amount of public funding support a person can receive for non-residential care relative to the cost of their assessed care package for non-residential care. In other words, for people above the needs threshold, the council can decide how much to charge people for non-residential care. National guidance exists that puts limits on the maximum that councils can charge people on low incomes but councils are free to reduce charges to a further degree should they wish. Indeed, councils care waive charges entirely, thus removing a means test, although this is rare. By contrast, for people with income and savings above the relevant minimum, councils can charge up to the full cost of care. So even where people are eligible on the basis on need and choose to opt for council supported care, in most cases people are potentially required to make some form of contribution from their own pockets.

National guidance applies for residential forms of care. This involves an asset or savings test and an income test. People with assets in excess of £21,500 currently, including eligible housing assets, do not receive any council support towards the costs of their residential care, although they are still entitled to Attendance Allowance (AA) or Disability Living Allowance (DLA). People with income below £21,500 are eligible for help. The council is allowed to charge individuals all of their income less a small personal allowance (around £20 per week), up to the full costs of care. Furthermore, if people have assets of greater than £12,500 (but less than £21,500) they are assessed as having a 'tariff' income of £1 per week for every £250 above the lower threshold. The charge to the resident can correspondingly be increased by

the amount of this tariff income. There are a range of caveats (e.g. housing assets are disregarded for the first 3 months), but these are the general principles. Even people that are eligible for support from their council are required pay a significant amount from their own income.

A number of councils are using the residential care rules for assets for non-residential care. In particular, the upper £21,500 threshold is an important marker for councils in offering any financial support to people.

In summary, there are various categories of self-funder. The following three groups will generally pay the full costs of care from their own pockets (with or without drawing on any disability-related benefits):

- People who choose not to approach public authorities
- People who have assessed needs below the need-eligibility threshold
- People who choose to approach, and are needs-eligible, but have savings above the relevant upper assets threshold.

The following people are classed as 'local authority supported', but may still pay a charge towards the cost of their care:

- People needing residential care (unless their income is below the personal allowance, which should not happen if Pension Credit is claimed)
- People with sufficiently high income to face a charge for non-residential care in areas where councils make a charge
- People who are eligible for council supported care but feel that the assessed care package is insufficient requiring them to top-up with privately purchased care.

The first main aim of this report is to calculate how much, overall, people in these groups contribute towards the costs of their care. We look at the overall levels of care use, public expenditure and private pay for social care used by people over 65. A necessary task regarding this aim is to estimate the numbers of people that buy care privately. Data is collected about council supported care recipients, but is not routinely collected about self-payers, especially numbers in the first three groups above. Furthermore, there are no routine data about the extent to which council supported people top-up their care from their own pockets. As a result we draw on a range of sources to make estimates of private-pay activity. Data about supported clients is better, but even this suffers the deficiency that data about the range of non-residential care used by people is not reported on an individual basis. We need therefore to estimate what packages of care individuals receive comparing the totals by each service category with the totals in the routine data.

A second aim is to calculate levels of unmet need – also referred to as shortfalls in care. Self-payers – by choice or through ineligibility – face the full costs of care. Consequently, some people decide to delay use of formal care or manage with low levels of care as a matter of affordability. Others prefer not to use formal services, regardless of cost concerns, given the very personal nature of care. In these cases, informal or unpaid care can sometimes be relied upon to meet needs, but in a number of cases, such informal care is not available. Furthermore, some people may receive care – council supported or otherwise – but where the amount of care falls

short of meeting their needs. It is therefore possible that a number of people have some need unmet. We look at this issue by comparing estimates of the total numbers of disabled or impaired people in the older population with the numbers receiving formal care, the amount of care, and also estimates of informal caring.

A third and related aim is to consider the consequences of changes in the needs eligibility thresholds that councils use. In recent years, councils have been raising their eligibility levels. We look at the current distribution of threshold levels set by councils. We then assess the implications of a further increase, assessing the cost, activity and unmet need implications.

A fourth aim is to make projections about the numbers of self-payers in the future. In making these projections, we will explore different assumptions regarding the growth of public expenditure available for social care relative to the growth in demand for care.

In the fifth section, we look at the variation between councils in the: rates of supported older people and expenditure, and therefore, by implication, the numbers of potential self-payers. Differences in prevailing levels of need, wealth, unit costs and supply locally account for some of the variation in rates between councils. But, for non-residential care especially, sizeable differences remain, reflecting the preferences and practices of individual councils.

In this report we concentrate on older people's services and support (reflecting the lack of data and analysis of other client groups). We use the PSSRU micro-simulation model – used for the Wanless Review of Social Care (Wanless 2006). Wherever 'hard' data exist, this is used to populate the model. In other places estimates are used. Using the simulation model allows us to check for consistency of these estimates with the available data to some extent because the model systematically interlinks needs, activity and expenditures. Nonetheless, outside of local authority supported care, there is a real dearth of information requiring us to make assumptions in the model. It is important to be clear that results outlined below are only as good as the assumptions that have been made.

The estimates that follow are those from the micro-simulation model. The sources of data and assumptions used are outlined in Annex 1. The randomness built into the model at an individual person level can result in the weighted totals for England deviating slightly from the relevant amounts from the data sources described in the Annex. However, given that there have been questions raised about the quality and accuracy of those sources (in particular, RAP data), this is a negligible consideration. We use the model to estimate the current balance between public and self-payers; to simulate the effects of changing eligibility criteria; and to make projections into the future about activity, expenditure and balance of costs. In what follows we estimate provision of support and services to meet the *personal care needs* of this dependent over 65s population.

2. Activity and expenditure – publicly and privately funded care

Drawing on the above categorisation, we distinguish use of services as arranged by the council – council or LA supported care – even where this entails a charge paid by the individual, from services that are purchased privately by the older person (or their families) using private resources. This distinction works for units of care purchased e.g. hours of home care, but not necessarily for classifying individuals, because a person can be in receipt of council arranged care but also top-up with additional privately purchased services.

According to the Wanless Social Care Review, in 2006 there were 2,450,000 older people with any dependency out of around 8,100,000 older people. These are people with difficulty or inability to perform a range of activities of daily living (ADLs) such as dressing, feeding, washing, toileting and so on. Of these, 850,000 had high levels of need (or just over 10% of older population), with the remainder having low levels of need.

In this section we outline the support and services that are being used by these people. We report estimates of service recipients, output levels and expenditure. Throughout, the following break-downs are made:

- Council supported care funded to some extent by public resources
- Council supported care funded by charges made to service users
- Care funded by top-ups (e.g. from third parties) for people using council supported services
- Support and services secured privately and funded by service users (and their families).

Service recipient and outputs

Table 1 shows the estimated numbers of service recipients in various categories for England in 2006. We distinguish all community-based care from care home services. Excluding professional support, there were just over 600,000 older people receiving community-based services at a given time. Around half of these were in receipt of home care. We estimate that just under 150,000 people were ineligible for council supported care and were purchasing care privately. This number would increase if we took a more broad definition of what is included in privately purchased care. We estimate that about a quarter of those in receipt of council funded community-based care top up their care package privately. Of the 750,000 people using any kind of community-based services, 40% of people pay for some care privately.

Some 25% of people using council arranged support are charged by their council. Together with private payers and those people with third-party top-ups, this implies that the significant majority of people overall make some form of private contribution.

Table 1: Service recipients – 2006, aged 65+

000s	LA supported care	Private pay only, not LA funded		Private pay top-up on LA funded care	Private pay - any		All funding sources
		No	*% of total*		No	*% of total*	
Community-based care	606	145	19%	154	299	40%	751
Care homes	199	118	37%	70	188	59%	317
Total	805	263	25%	224	487	46%	1068

Source: Model projections, see Annex 1

Some 199,000 people are supported in care homes with another 118,000 buying care homes services privately. An OFT report[1] suggests that 35% of council supported people also receive private third-party payments. In that almost everyone pays some charge for their council supported care in a care home, essentially 100% of people make some form of financial contribution.

Expenditure and charges

Gross council expenditure on services, less assessment and care management costs, and excluding capital charges totalled around £7.58bn in 2006. Council financial returns indicate that £1.73bn was collected as charges and joint arrangement income, with another £0.16bn coming from other income. Net public spend was therefore £5.69bn. Table 2 reports expenditure and charges from the model.[2] Overall, the amount of income comes to just under a quarter of council gross spending. A much higher proportion of income comes from the care homes sector, both absolutely and relatively, although net spending by councils on care home placements is still higher than for community-based care.

[1] Office of fair trading (2005) *Care homes for older people in the UK: a market study*, London:OFT

[2] The model slightly under-estimates income from people in care homes, where non-client charge income is slightly higher than in the case of community-based care.

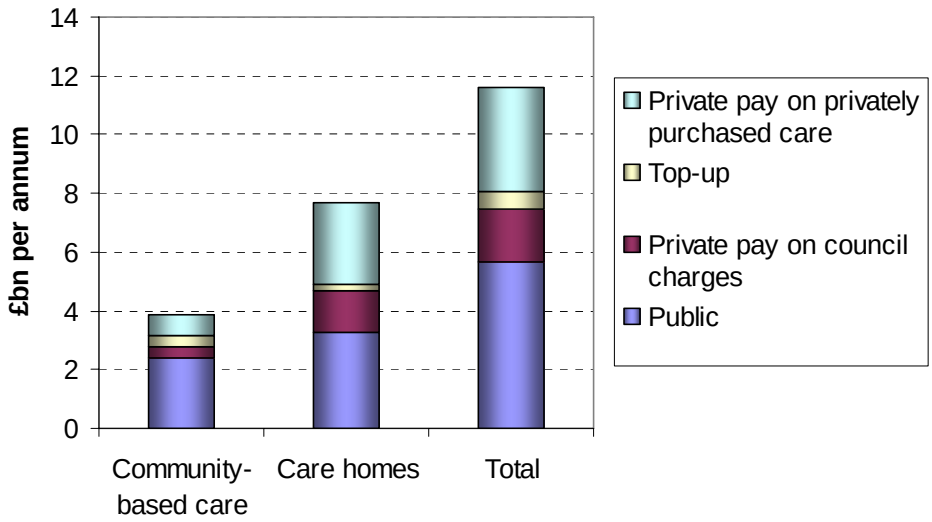
Table 2: Expenditure and charges – 2006, people aged 65+

	Council supported					Private pay	All		
	Public (net)	Charges (income)	Public plus charges (Gross)		Top-up		All private	Total Spend	
	£bn	£bn	£bn	% LA charge	£bn	£bn	£bn	£bn	% private
Community-based care	2.42	0.38	2.80	13.6%	0.35	0.74	1.46	3.88	37.7%
Care homes	3.28	1.40	4.68	30.0%	0.24	2.78	4.42	7.70	57.4%
Total	5.69	1.78	7.48	23.9%	0.58	3.52	5.89	11.58	50.8%

Source: Model projections, see Annex 1

The expenditure by people topping up their council supported care packages adds another £0.58bn to the total. People not eligible for council support spent an estimated £3.52bn in 2006, most of which went to care homes. This pure private payer (i.e. self-funders) sector constitutes about 30% of the total spend. However, when council charges and top-up expenditure is added, total out-of-pocket payment is estimated to be nearly £5.9bn, that is, about 50% of all expenditure on personal social care for older people. In other words, the combined effect of financial eligibility rules (which also determine care charges) and needs-based eligibility, along with perceptions of poor quality or insufficient care that leads some people to top-up, means that private individuals foot about half the bill for social care. The proportion is nearer three-fifths for the care homes sector. Figure 1 illustrates the contributions in these categories.

Figure 1. Expenditure on formal support for people 65+, 2006

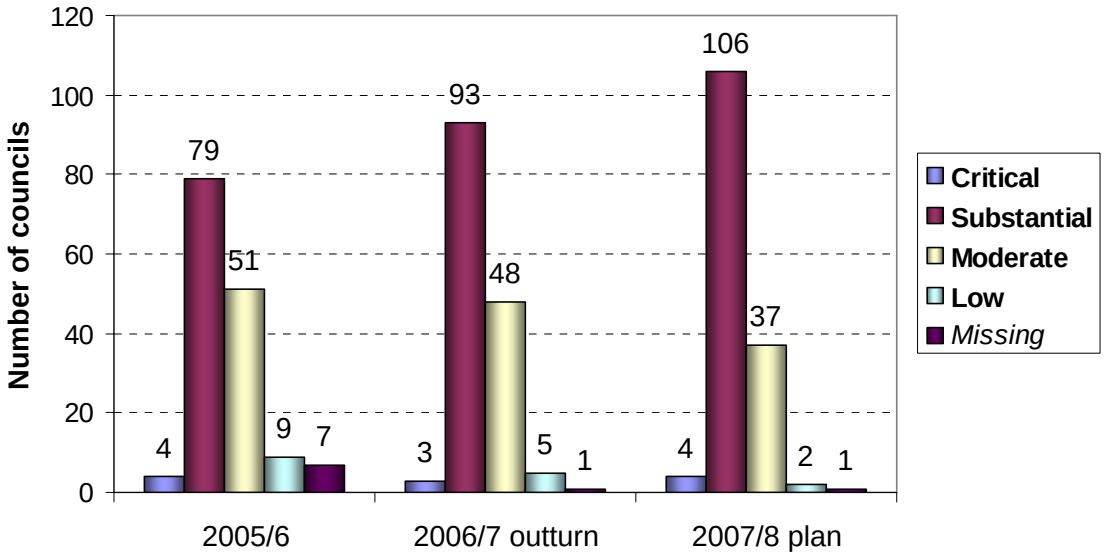


3. Eligibility thresholds

Councils set thresholds for eligibility to supported services on the basis of assessed need. A framework of four eligibility levels is used – as outlined by Fair Access to Care Services (FACS) – corresponding to increasing levels of need: low, moderate, substantial, and critical.

Figure 2 shows that most councils currently operate at the substantial or moderate levels. Over the 3 years, there has been or there is a planned increase in the threshold, so that in 2007/8 some 74% of councils plan to operate at the highest two levels, compared to 58% of councils in 2005/6.

Figure 2. Fair Access to Care eligibility thresholds, by council, 2005-7/8



Source: CSCI Self Assessment Survey (SAS) analysis tool, 2007

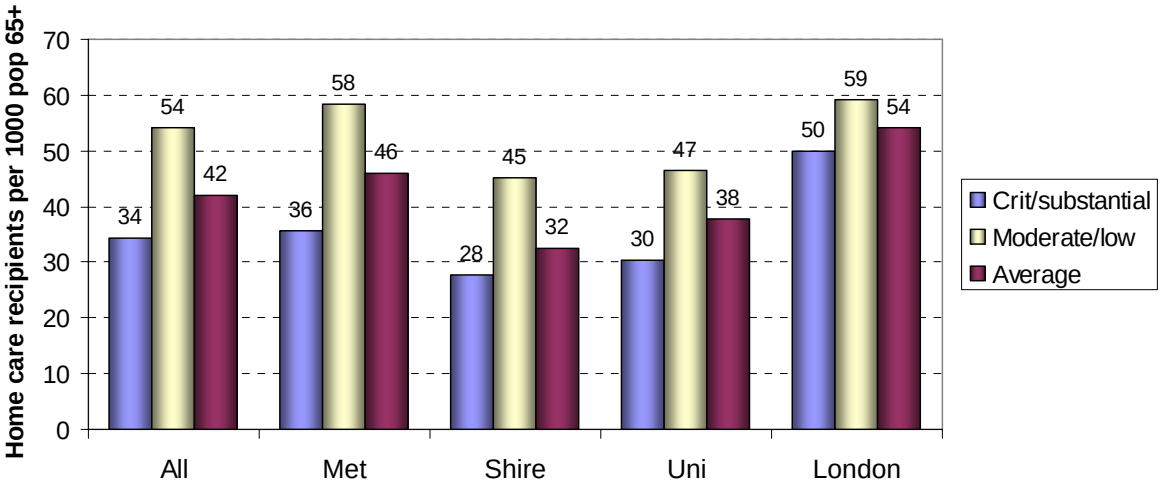
The setting of thresholds has had a significant effect on the level of non-residential services provided by councils, and particularly home care services. Since 1997, the numbers of households receiving supported home care has fallen from 479,000 to 358,000 in 2006[3]. At the same time, the number of hours of care has increased; the average hours per household in 2006 was 10.8 hours, double the 1997 figure.

Figure 3 shows how the provision of home care services per capita is affected by the FACS eligibility threshold set by the council. These results are estimated from a statistical analysis of the relationship between reported FACS levels and home care

[3] *Information Centre: Community Care Statistics, 2006* (all clients). These numbers include a small amount of double counting.

uptake rates for all councils in England in 2005/6 (see Annex 2).[4] The critical/substantial bar is the projected level of service provision if the council operated with only the top two levels. This level can be contrasted with the level of services when councils operate at the moderate/low level.

Figure 3. Home care uptake levels – by FACS level and council type, 2006



As reported in

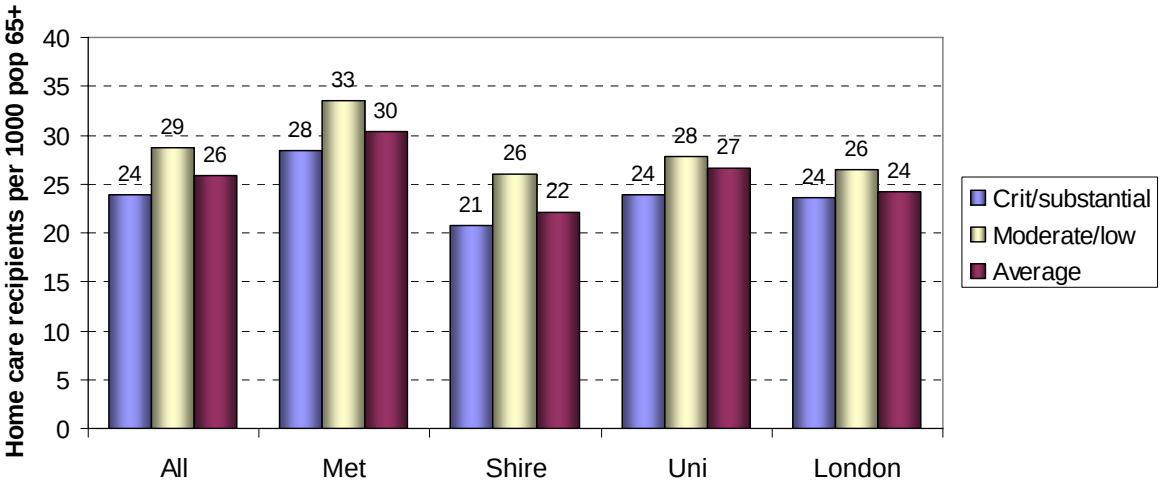
Figure 2, at present councils in England operate at different eligibility levels. The average level in England is between moderate and substantial and this average corresponds to the average council supported provision of home care at just over 40 recipients per 1000 population over 65. This level is the red bar in Figure 3. Using the results of the statistical analysis, we estimate that were all councils to operate only at the critical or substantial level, the average provision of council supported home care would fall by just under 20%. In some councils it would fall further, in others to a lesser extent as shown in the figure.

There is a similar picture with supported care home provision, except that the effect of an increase from the average to the critical or substantial level would lead to a much smaller reduction in the numbers of people supported – just over a 7% reduction. Given that most people who enter care homes now are highly dependent and most likely to be in the top two eligibility levels, we would not have expected much of an effect.[5]

[4] The analysis controls for differences in need, costs and revenue-raising powers of local councils – see Annex 2. Home care provision rates are from RAP data.

[5] If anything, this result is perhaps greater than anticipated.

Figure 4. Care home uptake levels – by FAC level and council type, 2006



Changing needs-related eligibility thresholds reduces the level of council supported care although the effect on the total level of care will be lessened because some people that would not now be eligible will turn to privately-funded care. We explore this effect and other consequences using the micro-simulation model below.

Model simulations

The PSSRU micro-simulation model can simulate the effect of all councils increasing their eligibility from current levels to only operating at critical or substantial levels (if they were not already at this level). We assume all other factors are unchanged. In particular, the service model – what care packages people with different levels of need can expect – and the financial eligibility rules are the same as before.

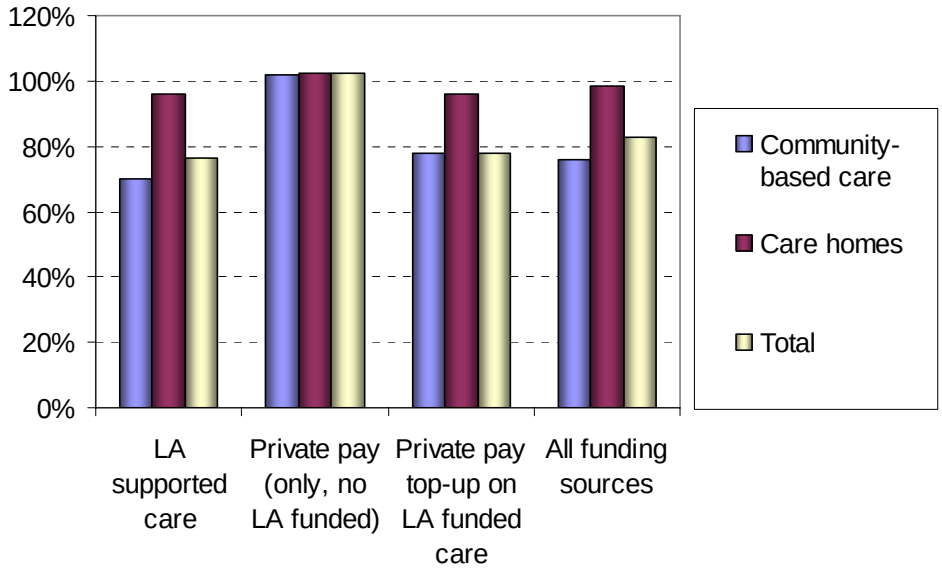
Raising the needs eligibility threshold means that more middle and lower dependency people are ineligible for council support even if they satisfy financial eligibility criteria, i.e. even if they are on low incomes. As before a number of assumptions have been made for modelling purposes.

Figure 5 shows the numbers of recipients following an increase in eligibility levels as a percentage of current recipients (as listed in Table 1). As we would expect, council supported numbers fall (to just over 70% of the current level). Supported care home placements are also projected to fall, but only modestly. Total numbers of supported recipients are down.

Some of the people that would have been eligible before now choose to pay for care privately. As a result the numbers of private pay only people *increases* slightly. But because some of those people that would have been eligible before are modestly well-off, many decide to delay seeking care. With the assumptions we have made in the model about the size of demand effects (which are unchanged from before), the total number of people with any funding source now taking up care support falls by around 15%. There is some uncertainty about the exact size of these demand effect,

but the essential point is unchanged, that is, total numbers of people benefiting from services is reduced. The implications for unmet need are considered in section 0. Furthermore, the ratio of people in supported care homes increases from 25% to over 30% of the total number of supported people.

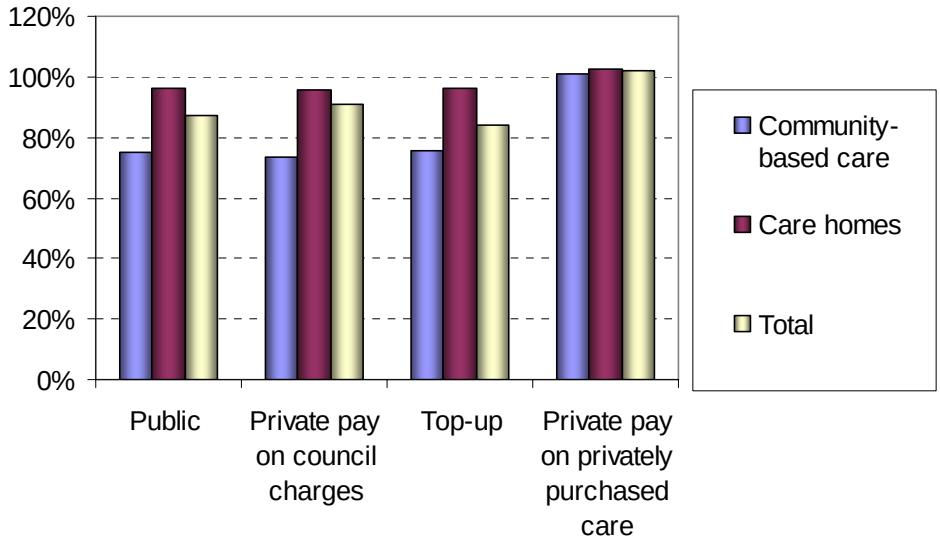
Figure 5. Percentage change in service recipients following full increase to critical / substantial FAC threshold



Source: Model projections, see Annex 1

The financial implications of the change in eligibility criteria are given in Figure 6. Savings accrue to the public purse, with council expenditure falling by more than 10% – bearing in mind that 58% of councils were already operating at the substantial or critical level in 2005/6. Also, the care costs of the people in the moderate band – who are no longer eligible – are much lower than the remaining substantial or critical level people (which is why the savings % is lower than the fall in recipients).

Figure 6. Percentage change in expenditure following full increase to critical / substantial FAC threshold



Source: Model projections, see Annex 1

4. Unmet need

The 2,450,000 older people with any disability or impairment are people with potential need, some of which is addressed by formal services and some by informal care. In theory the remainder is unmet need, although some of this unmet need is by choice on the part of the service user, whilst the rest is due to a combination of ineligibility to public supported services and a lack of affordability of private services (or an inability to find a suitable private provider).

Using the baseline numbers of people with disabilities, we can in principle make an estimate the level of unmet need. This calculation requires an estimate of the size of private purchase of care in addition to reported use of council arranged care. We also need an estimate of the likelihood that the service user in question will be receiving unpaid care. Finally, we need to establish not only the numbers of people with disabilities – as potential beneficiaries of care – but also how much care *ought to be provided* as appropriate for people with different kinds of need. Given the complexities involved and the lack of precise data an estimate is made using the micro-simulation model.

We can initially avoid having to decide how much should be provided by using the model to estimate the total numbers of people that appear to receive *no services and have no informal care* despite having impairment. There are about 6000 high dependency people in this category in England. In the context of the total number of people with high levels of need, this is a very small number – less than 1% – and the error margin would include zero people in this case. For the low dependency group, the equivalent number of people is 275,000, which is a little over 15% of the total number of people with low level need.

These are people that receive no care. But unmet need can also occur because people receive too little care relative to what they ought to receive. We look at two scenarios in this regard. In each case we are concerned with *personal care* need only – which now constitutes most of the support that councils provide.

In the first scenario, we compare what people actually receive with the size of the full council arranged support package they would receive given they had no informal care and lived alone. The latter condition is required because the average packages of care that councils provide take into account the informal care a person may be receiving and those with some informal care receive less council supported care. But as a marker, we need the total hours a person should receive. This amount of support is the *benchmark* level. Using data from the Relative Needs Analysis[6] the

[6] See Darton et al. Darton, R., J. Forder, et al. (2006). Analysis to Support the Development of FSS Formulae for Older People: Final report. Canterbury, PSSRU University of Kent and London School of Economics. for details of the survey work

current personal care service packages range from an *average* of over 15 hours per week for the highest needs people, to around 4 hours for the lowest needs group.[7]

In the second scenario, the support packages for different levels of need are set at the Wanless economically justified level.[8] This is a more generous support model than the current system and consequently the care people are currently receiving will look worse as regards care shortfalls.

In these two scenarios we consider the extent of unmet needs in terms of total hours of care. We assume that people in residential forms of care are given an equivalent of around 22 hours of care a week for this purpose. Table 3 gives the estimations from the model. In the first scenario, some 1.5m people (60% of the total number of people with disabilities) have some degree of unmet need *if we assumed that they received no informal care*, that is, whose actual hours of formal care, including council supported and private pay care, falls below the benchmark level. On average, for people with unmet need, the shortfall is 5.2 hours per week with a median of 4 hours or 34 minutes per day. The total would be 8 million hours a year, which is just over 70% of the formal care hours provided in the year. We should emphasise that this is unmet need relative to the types of personal care support that are included, which covers personal social care/support but not therapies, some professional support, nursing inputs etc.

To establish a more rounded picture of levels of unmet need we should include informal care inputs. Estimates of the amount of informal care vary; for example, the 2001 Census suggested that there were 3.4m carers in England of people over 65, whilst analysis of the General Household Survey put the figure nearer 4m (Maher and Green 2002). We use the estimates made in the Wanless Review. In particular, around 1.7m older people with personal care need *receive* some degree of informal care (Wanless 2006, p 192/3). We use estimated hours of informal care provided to older people as in the Review (Wanless 2006, Table 44).

When hours of informal care are included total levels of unmet needs fall to 1.4 million hours per year affecting 450,000 people – see – which shows the significant role that informal care plays. Much of the unmet need results from limited provision of council supported to services to people with low needs. Indeed, when we concentrate only on high needs people, total unmet need including informal care is only estimated at around 200,000 hours per year in this group, with only 50,000 people out of 850,000 with any degree of unmet need.

We are working with estimates of informal care inputs, and in some cases the input does not reach the benchmark level of care, meaning that even where a person has

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[7] These are averages, some individuals in each need group receive significantly more hours, some significantly less. We include all non-residential care except therapy services and professional support, and also residential care. The nursing element of care packages in care homes with nursing is removed.

[8] This is the level where support is provided up to the £20,000 cost-effectiveness threshold – see Wanless et al, Wanless, D. (2006). Securing Good Care for Older People: Taking a long term view. London, King's Fund. , chapter 10.

informal care (including people who also have formal care inputs) they can have some modest degree of unmet need. An alternative is to assume that where people have any informal care, this is sufficient to meet all their need. As shown in the table this reduces unmet need from 1.4 to 1.2 million hours.

We look at total hours of unmet need whereby implicitly an hour of unmet need for a low dependency person is equal to an hour of unmet need for a high dependency person. However, arguably an hour of unmet need to a person with high levels of impairment is worse than an hour of unmet need for a low dependency person. Indeed, in *outcome* terms, the Wanless Review showed this to be the case (Wanless, 2006, figure 44). In other words, we should be more concerned about unmet need for people with high levels of need, and it is therefore encouraging that unmet need for this group is relatively low.

Table 3. Personal care unmet need relative to current care[1] – 2006, people aged 65+

	Total hours without care(millions of hours)	People (000s)[3]	Shortfalls in care in hours per person over 65 - average hours per week
	A	B	C (A/B)
Relative to current care			
Disregarding informal care			
All	8.1	1550	5.2
Including informal care[2]			
All	1.4	450	3.1
All with high need	0.2	50	4.0
All with lower needs and no formal care	1.2	300	4.0
Relative to Wanless Scenario 2 care			
Disregarding informal care			
All	11.2	1750	6.4
Including informal care[3]			
All	2.3	650	3.5
All with high need	1.0	200	5.0
All with lower needs and no formal care	1.7	400	4.3

Notes: (1) Total where individuals have positive shortfalls in care relative to types of social care support included (i.e. excluding therapies, some professional support, nursing inputs etc).
(2) Informal help with personal care only (using Wanless Review estimates). Excludes informal care for non-personal care tasks. Also excluded is any informal care contribution where formal services fully meet need.
(3) This is the number of people at any given point in time during the year (and not the total number of people served during the year.

Table 4 presents the results of the simulations that distinguish unmet need levels between service receipt and eligibility for council support. Those people that are not eligible and choose not to take up privately-purchased services have the greatest levels of unmet need – some 350,000 people and 1.0m hours even where informal care is included). These are all people with personal care needs.

There is a small group of people that are entitled to council-supported care but choose not to take it up because of the charges they face. Just over 10% of people who are entitled drop out in this way in the model. Around 90% of these people who decide to put off paying for care are low dependency. The unmet need as a result is modest at around 300,000 hours a year (less than 3% of the total formal provision of support).

Table 4. Unmet need (incl. informal care) – 2006, people aged 65+, by receipt of formal services and eligibility (current services benchmark)

			Service recipients		
			Yes	**No**	**All**
Eligible for council supported care	**Yes**	Total unmet need[1]	0	0	0.3
		People[2]	0	50,000	50,000
	No	Total unmet need[1]	0.1	1.0	1.1
		People[2]	50,000	350,000	400,000
	All	Total unmet need[1]	0.1	1.0	1.4
		People[2]	50,000	400,000	450,000

Notes (1) millions of hour p.a.
(2) This is the number of people at any given point in time during the year.

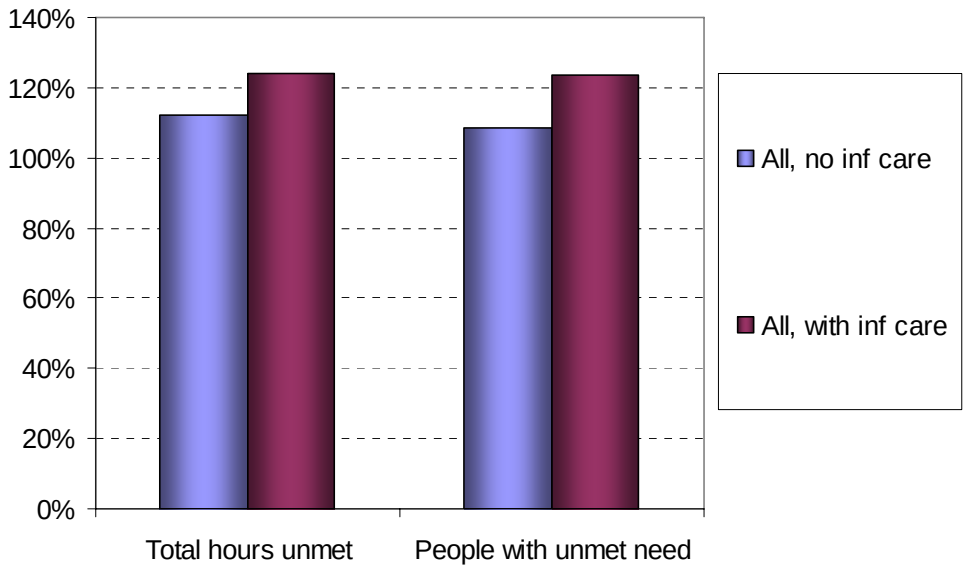
These estimates of care shortfalls serve to show that a significant minority of people are experiencing some care shortfall. It is important that we understand that care shortfalls can and are happening. Nonetheless, this analysis should be considered as a starting point and further work is required to be more precise. Changes in the

assumptions that have had to be made will lead to different numbers, even though the 'order of magnitude' of the estimates is robust.

Changing eligibility thresholds

Figure 7 shows the projected impact on levels of unmet need of an increase for all councils to the substantial or critical FAC threshold. Unmet need increases by around 15%, although this is less than the fall in the number of public recipients (25%).

Figure 7: Percentage change in unmet need following full increase to critical / substantial FAC threshold



5. Projections

Looking forward we anticipate three significant pressures on the future affordability and costs of social care. The first is demographic pressure. People are living longer, but what is less clear is whether the extra years of life are spent in relatively good health or relatively poor health. The evidence from Western Europe suggests the latter – not only will the over 65 population increase, but the proportion of people with disability in the over 65 population will increase (Wanless 2006).[9]

The second pressure is the anticipated increase in unit costs in real terms. In order to secure a good quality supply of care services, and following Wanless, we assume that expected unit costs will rise at 2% in real terms per year less a productivity improvement of 0.5%. The third pressure is the expected reduction in the availability of informal carers. We model a 1 percentage point drop in the proportion of people with informal care and a 1 percentage point increase in the numbers living alone.

Countervailing these affordability pressures is the expected real terms increase in pensioner wealth. In line with the Turner Commission we assume that this rises by 2% p.a. in the projections below. Driving this improvement is the value of second state pensions and home owner rates.

We can use a model to project how these many and complex trends might play out in the future. Under the current means-tested system, increases in pensioner wealth mean that fewer people are eligible for state supported care (or face higher council charges), other things being equal. But paying higher charges or fees overall has a demand effect, reducing pro-rata rates of service use and increasing unmet need. Increases in unit cost further fuel this demand effect, as well as increasing the costs of services for each person.

[9] We use numbers as in the Wanless Review improving health scenario.

Table 5 shows future projections in service utilisation (made with base case assumptions). Council supported places increase from 805 to 950 in the next 10 years. Private payer recipients increase at a faster rate. Total recipients increase by 20%. To put this in context, in the next 10 years the population over 65 will grow by 22%. In other words, numbers of people with any formal support falls as a percentage of the older population in England. This result arises because the real-terms growth in income and wealth, with the current eligibility thresholds unchanged in real terms, means that more people are self-payers.

Table 5. Projections of service utilisation – on base case assumptions

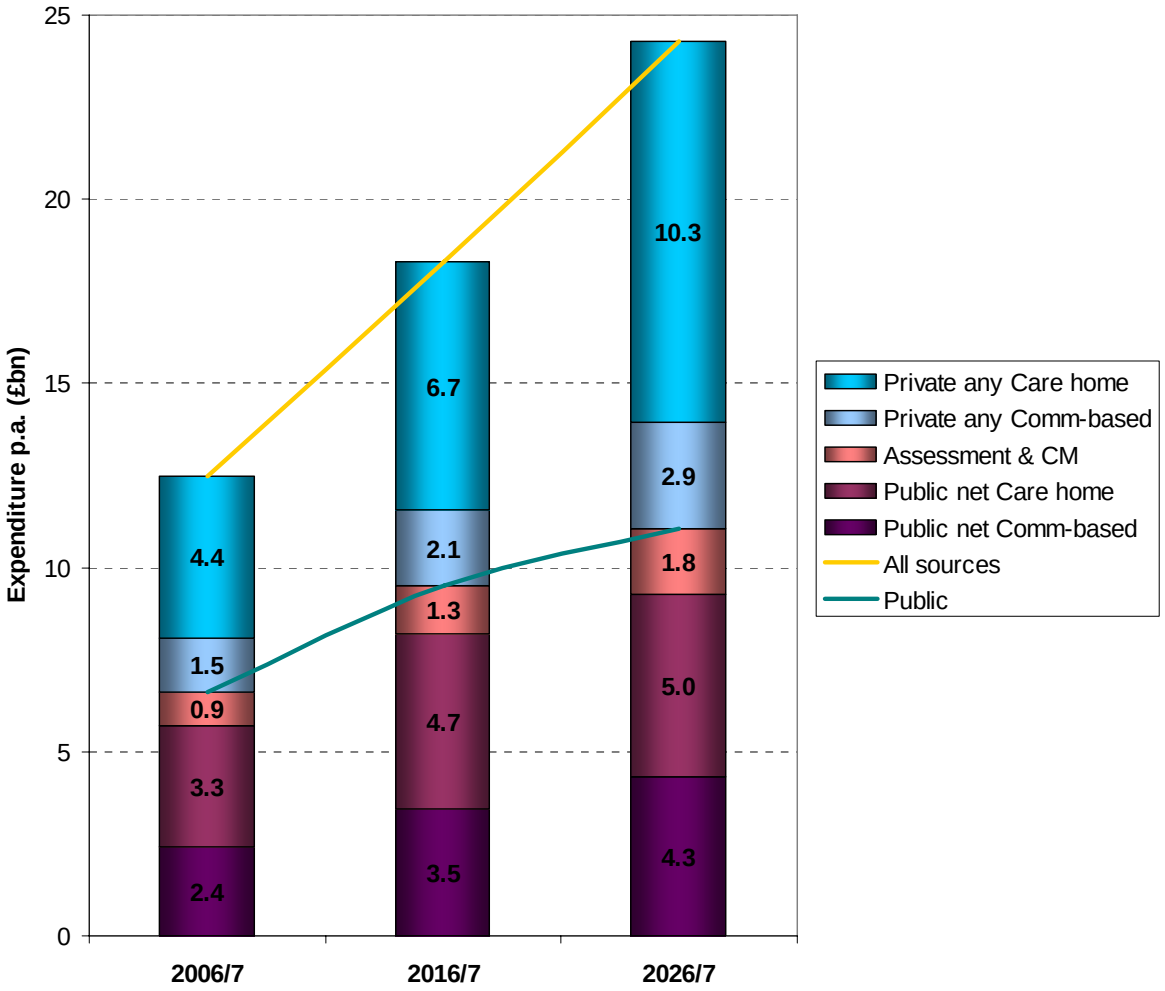
			Year		
			2006/7	2016/7	2026/7
Service recipients (000s)	**LA supported**	Comm-based	607	695	761
		Care home	199	255	276
		All	805	950	1037
		% of pop 65+	9.9%	9.5%	8.9%
	Private any	Comm-based	299	360	415
		Care home	188	241	296
		All	417	511	615
		% of pop 65+	5.1%	5.1%	5.3%
	All	All	1222	1461	1652
		% of pop 65+	15.0%	14.6%	14.3%
Self-payers (%)		All	34.1%	35.0%	37.2%

gives the projections of expenditure, all of which are in real terms (i.e. after inflation or specifically, in 2006/7 prices). Public net spending by councils is projected to increase by 44% in the next 10 years (63% in the next 20 years). Private payers will spend about 50% more in the next 10 years and 125% more in the next 20 years. Total spending from all funding sources will increase, given our assumptions, to £24.3bn. As a result mainly of the effects of increasing income and means-testing, the percentage of self pay expenditure increases significantly in the next 20 years. This change is illustrated starkly in Figure 8. The total spend from all sources increases steadily, but the public spend shows a reducing rate of increase.

Table 6: Projections expenditure – on base case assumptions

			Year		
			2006/7	2016/7	2026/7
Expenditure	**Public net**	Comm-based	2.42	3.46	4.30
(£ billions)		Care home	3.28	4.73	4.97
		All care	5.69	8.19	9.27
		Assess & CM	0.91	1.32	1.79
		All	6.60	9.51	11.06
	Private any	Comm-based	1.46	2.06	2.89
		Care home	4.42	6.74	10.33
		All care	5.89	8.80	13.21
	All (care)	Comm-based	3.88	5.52	7.19
		Care home	7.70	11.47	15.30
		All care	11.58	16.99	22.49
		% GDP	1.1%	1.3%	1.4%
	All (assess & CM)	All	12.49	18.31	24.28
		% GDP	1.2%	1.4%	1.5%
Self-payers (%)		All care	50.8%	51.8%	58.8%
		All	47.1%	48.1%	54.4%

Figure 8: Projections of expenditure on social care for older people



The greater reliance on self-payers means a greater proportion of people will face higher charges in the future. Even though people will have higher income and wealth in the future, these higher charges will mean that a lower proportion overall uses care.

Table 7 shows the impact on unmet need. Measuring unmet need in equivalent hours of support against the current service model, the percentage of unmet need hours to the total hours of formal care people use increases in 10 years by 3 percentage points from 13% to 16%.

Table 7. Unmet need, including informal care – percentage of total formal hours

	Year		
Service model benchmark	**2006/7**	**2016/7**	**2026/7**
Wanless	21%	25%	28%
Current	13%	16%	18%

In these projections the eligibility rules for council supported care have been kept unchanged in real terms. In the context therefore of increasing pensioner wealth, in the future we would expect to see more self-payers. The rate at which wealth grows is critical. With all other assumptions unchanged, if wealth grew by 1% instead of 2%, then the proportion of self-pay expenditure by 2026/7 would be only slightly greater than it is now (53% on care expenditure, compared with 51% now – see Table 6). However, public spending would be nearly £1.5bn higher then the 2026/7 total with 2% income growth.

This example illustrates that future projected expenditure will depend on the assumptions used in the modelling. Exact figures will differ according to the assumptions made. But the central message is that with numbers of disabled people increasing at around 2% per annum and the unit costs of services rising by just under 2% in real terms, the compounded effect over 20 years will be substantial.

The scenario illustrated in Table 5 and Figure 8 requires public funding to increase by 3.7% per annum in real terms over the next 10 years, with an increase in the number of self-payers, but eligibility rules unchanged. Suppose that public funding rises by only 2% per annum. Then by 2016/7, public care expenditure would have to fall to £6.93bn rather than the projected £8.19bn. This could only be achieved by limited services through the raising of needs eligibility criteria. With the assumptions, and modelling of FAC levels as described above, achieving this expenditure target would require around 25% of councils to operate only at the critical level with the remainder operating at substantial and higher. Around 55% of total spend would be from the private purse. Council supported service recipients would fall by 30% of the base level in 2016/7 (i.e. where there are no changes in eligibility). Private purchases (only) would increase by 5%. Total recipients from any funding source would be down by 20%. Finally, unmet need rates would be up by 40%.

6. Variations between councils

The estimates described above regarding the balance between self-pay and council supported care for England were established using national survey data (see Annex 1). Without equivalent data for all 150 councils in England it is not possible to estimate rates of self-paying for each council. However, it is possible to identify some important indicators of this variation. Suppose all councils operated with the same financial and needs-related eligibility criteria (i.e. the same charging policy and FAC thresholds). Then if we accounted for need and wealth in each local council – for example using the Relative Needs Formula –we would expect to see only modest variation in rates of service recipients per capita between councils. Or to put this another way, if after accounting for differences in need and wealth with the RNF we still see significant variation, then we can infer than councils are operating with different eligibility policies and therefore the balance between public and private expenditure in each council must also vary.

The variation in supported care home placement rates between councils is a good marker for such a comparison. Councils operate with the national framework for financial eligibility and charging of care homes, so there should be minimal differences between councils in this regard. Furthermore, we know from the above analysis that changing FAC eligibility thresholds in a council does not have a very large effect on supported care home placement rates because most potential care home residents are now in the substantial or critical bands.

The 2006 deprivation adjustment of the relative needs formula is used to weight the over 65 populations of each council. This weighting is a factor that ranges between 0.58 and 1.79 based on the age distribution of the population (proportion of over 90s), uptake rates of Attendance Allowance and Pension Credit, rates of one pensioner households, and proportion of older people who rent rather than own their home.

Table 8 reports statistics regarding the variation between councils in England of uptake rates for supported care homes and home care recipients. Low numbers indicate the lowest difference between councils. It is clear that adjustments for need do reduce the degree of variation between councils in service use rates for both care homes and home care. The lowest variation occurs where utilisation rates are adjusted for both need and FAC levels. But it is also clear that variation is much lower for supported care home services rather than home care. Figure 9 to Figure 14 show the (adjusted and unadjusted) utilisation rates for each council (councils along the x-axis, sorted in order of utilisation rates). These charts confirm the results in the table.

Table 8. Variation in uptake rates of supported services – LAs in England

	Supported care homes		Supported home care	
	Coefficient of variation	1%- to 99%-tile range /mean	Coefficient of variation	1%- to 99% -tile range /mean
Recipients per 1000 people 65+	0.26	1.19	0.37	1.69
Recipients per 1000 people 65+, adjusted for RNF need	0.19	0.96	0.29	1.43
Recipients per 1000 people 65+, adjusted for RNF need and FAC levels	0.18	0.93	0.29	1.25

The remaining variation between councils after adjusting for need and wealth – particularly for home care – indicates that councils have different policies regarding eligibility thresholds. This implies different levels of self-pay rates in these councils even where their need profile is the same. In practice, because need and wealth does vary between councils, we do observe significant and legitimate differences in net spend rates across these councils. The ratio of net spend on all services to gross spend varies between 64% and 91% (of council supported expenditure), with an average of 77% (cf. Table 2), but some of the difference is due to these unavoidable need and wealth differences between councils. Nonetheless, differences would remain after adjustment is made for these factors.[10]

[10] Furthermore, these reported expenditure data do not include top-up payments

Figure 9. Variation in supported care home recipient rates per capita

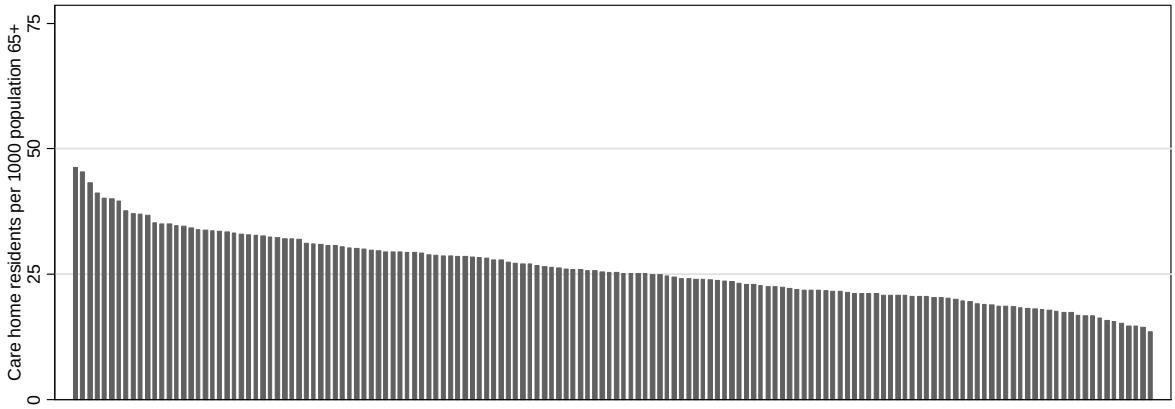


Figure 10. Variation in supported care home recipient rates per capita, need adjusted

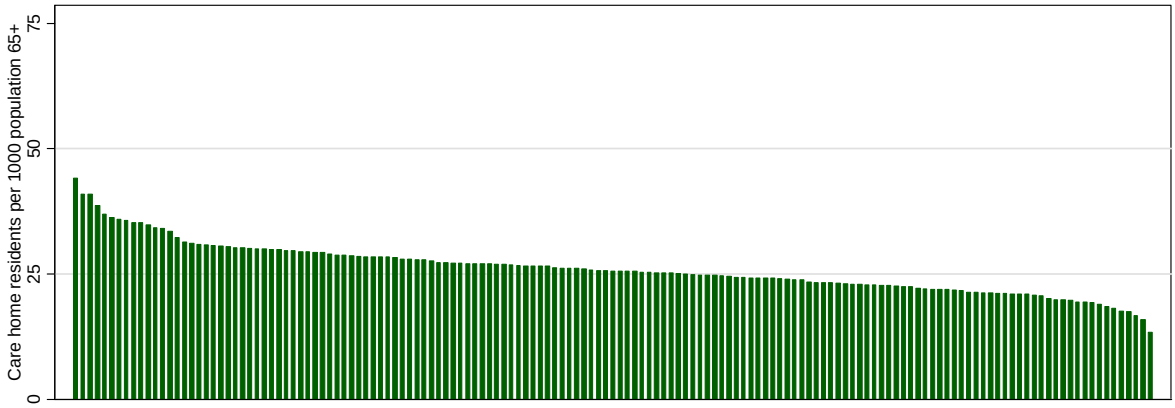


Figure 11. Variation in supported care home recipient rates per capita, adjusted for need and other factors

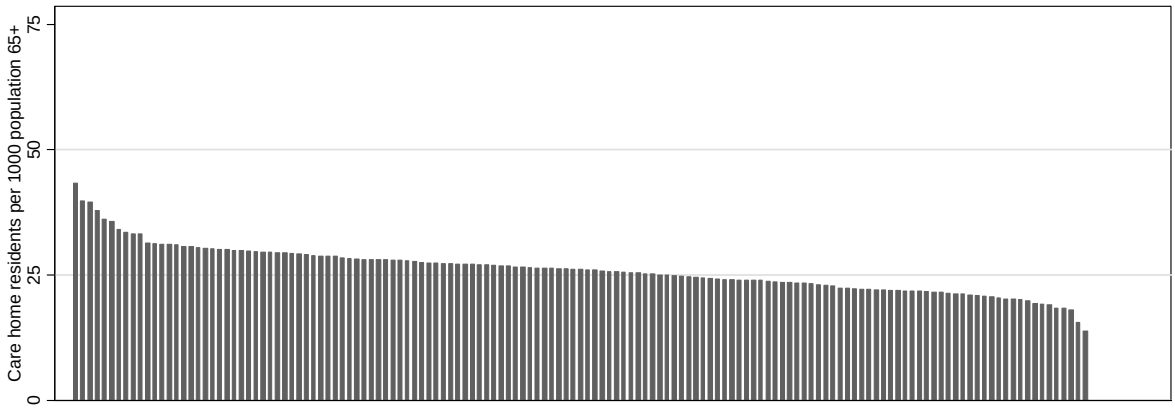


Figure 12. Variation in home care recipient rates per capita

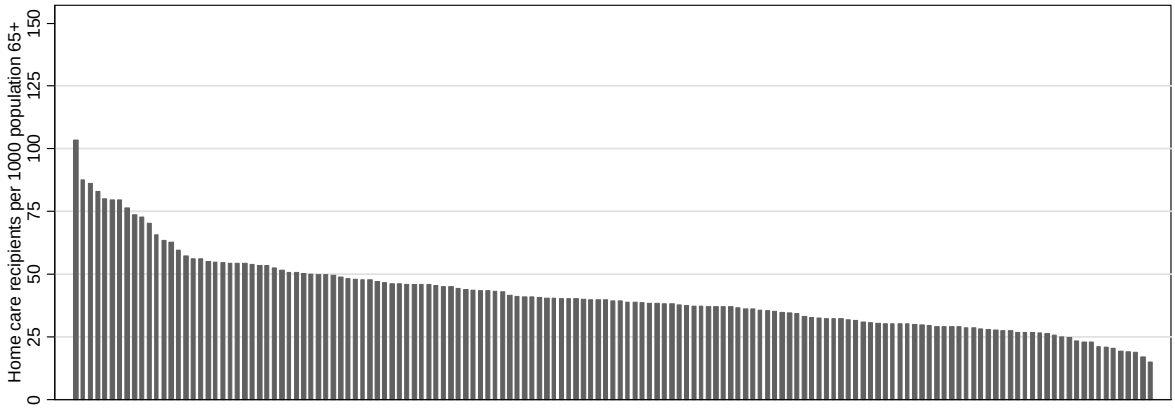


Figure 13. Variation in home care recipient rates per capita, adjusted for need

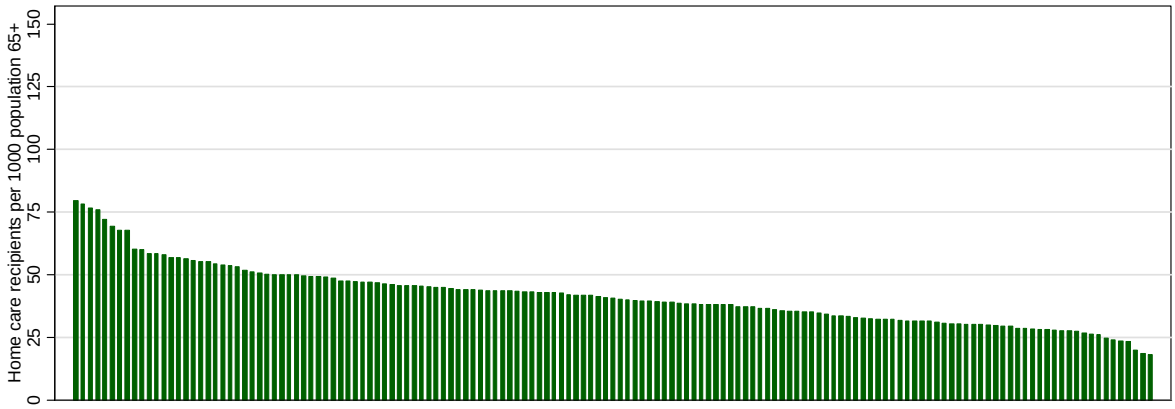
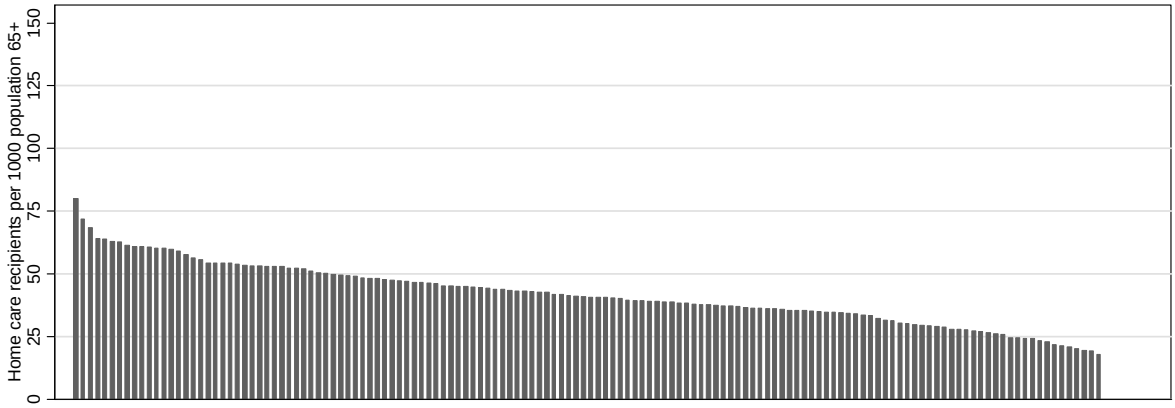


Figure 14. Variation in home care recipient rates per capita, adjusted for need and other factors



7. Discussion

The data available to make the above assessments of the current funding situation are very limited and a range of assumptions have had to be made. These assumptions are based on a range of indirect data sources, but we must necessarily make caveats about the quality of the data, and therefore the analysis. It is clear furthermore that our ability to address important policy questions is limited in this way, and consequently, there would seem to be a strong case for collecting much better data on self-funders.

The analysis indicates that around half of the expenditure on personal social care for older people comes from private contributions, either in the form of charges and top-ups on council supported care, or from spending on privately purchased care. This is the case for formal services, before we even begin to add in the private contribution of resources in the form of informal caring.

Financial eligibility and needs-related eligibility rules in the current system focus help on poorer people and those who have high level needs. This means that the moderate and lower needs groups, and the moderately and more wealthy income groups are poorly served. A key issue, therefore, is whether it is appropriate to do more for those many people that fall outside of the eligibility criteria.

On plausible assumptions about future trends, this excluded group looks set to increase in size. We have shown above that increasing eligibility thresholds reduces not only number of people supported by the public purse but also the total number of people because high self-pay costs put some people off. Even with increases in pensioner wealth, the call on public funding increases by over 3.5% per annum in real terms over the next 10 years. If available resources do not keep pace, then a smaller proportion of people can be supported as compared to now. Levels of unmet need would therefore increase.

Unmet need can occur when people choose not to take-up care or, more relevantly, when they cannot afford to pay for care. It is difficult to establish absolute levels of unmet need at any given time, although the data do suggest unmet need does occur. Unmet need is particularly high in the moderate or lower needs population.

Much of the above modelling is at the national level (given data limitations). But there is also huge variation between councils in rates of council supported care, especially for community-based services. Some variation is legitimately due to unavoidable local needs and cost drivers. The analysis indicated, nonetheless, that significant variation remains after best attempts are made to remove these factors. These results are consistent with councils operating difference financial as well as FAC needs eligibility arrangements.

We have concentrated on council funded social care for people over 65 which is the vast majority of such public support. The NHS does also provide funded social care for people with high levels of on-going nursing and social care need. These services are largely fully funded with no care-related charges for individuals, regardless of

their wealth. We have not considered adults with disabilities who are less than 65. Nonetheless, many of the same issues will apply in these cases.

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8. Annexes

Annex 1. Estimating provision and expenditure

Local authority supported care

The main source of information on non-residential care services is the *Community Care Statistics 2006: Referrals, Assessments and Packages of Care for Adults* or RAP collection. We use table P2s, the number of clients on the books to receive community based services on the last day of the period by primary client type and components of service for over 65s. This data is reproduced in Table 9. In order to match these data with another survey source – the Relative Needs Formula survey (RNF) data (Darton, Forder et al. 2006) – we include all services except professional support. The RAP data do not give details of the combined use of individual services and therefore we make estimates based on the RNF data. This produced a total number of recipients of community-based services of approximately 600,000, including equipment services.

Table 9. The number of clients on the books to receive community based services on the last day of the period, people 65+

Total number of clients receiving services	Home care	Day care	Meals	Planned short breaks	Direct payments	Professional support	Equipment & adaptions	Other
652,000	309,000	99,000	101,000	31,500	10,200	113,000	174,000	51,000

Along with the RAP data, we use the *HH1 home care and home help* data, although the latter do not give break-downs by age group.

Care homes data are taken from the *Community Care Statistics 2006: Supported Residents (Adults) England*. This source indicates that there were 199,000 older people in supported care homes (personal care and nursing care homes).

The intensity of community based care packages are estimated for different needs levels using the RNF data. A statistical model was used to calculate the intensity of care packages in home care hour-equivalents for people with different levels of ADL need and informal care. Other needs factors, such as age and ethnicity were also included but did not prove to be sufficiently significant once ADL and informal care factors were accounted for in the model. Table 10 shows the intensity of care packages by need (ADLs) and whether or not the person lived at home in equivalent hours of home care per week.

Table 10. Care package intensity – by need and household composition, equivalent hours per week of home care

No of ADL difficulties	Hours (alone)	Hours (not alone)
1	6.6	4.5
2	7.5	5.1
3	8.6	5.9
4	11.3	7.6
5	15.4	10.4

Eligibility to council supported care is determined by assessed need against the FAC framework. A statistical model using RNF data was estimated which related the person's characteristics to assessed FAC levels. The included characteristics were a person's number of ADL difficulties, their receipt of informal care, whether or not they were home owners, and whether they had a limiting long-standing illness. This statistical modelling produced a set of probabilities of people being in different FAC levels, and these were was used in the micro-simulation model. Final uptake of services in the model was then determined by: which FAC threshold was chosen; whether people had sufficiently great informal care support such that they chose not to approach formal services; and demand effects according to the charges they faced. Initially, the FAC threshold was chosen to correspond to the England average in 2006 as given in Table 9.

Figure 2. The resulting level of uptake of non-residential services was then checked to ensure that it corresponded with the actual totals as given in Table 9.

Once eligible, people in the model were allocated services packages as summarised in Table 10. Together with uptake, this produces an estimate of total hours of care provided in any given week. Data on current total contact hours of LA supported home care for over 65s are available from Laing and Buisson. The total hours in the model include other non-residential services as outlined above, so a precise direct comparison cannot be made. Nonetheless, the total hours produced by the model were consistent with the total home care hours plus a plausible additional amount for the other community-based services.

On residential care the situation is much clearer. The Information Centre for health and social care *Community Care Statistics 2006: Supported Residents (Adults), England*, gives the number of supported places for older people in residential and nursing homes are 199,800 people.

Privately financed care

Recipients and hours of privately-funded care are calculated in the micro-simulation model based on the demand functions estimated in the Wanless Review (Wanless, 2006, figures 46 and 47). These in turn were estimated by statistical modelling using

RNF data and English Longitudinal Study of Ageing (ELSA) data. The same demand functions were used for council supported care (having demonstrated consistency with council supported uptake of services). For people who were not eligible for council supported services, either on the grounds of wealth or need, the chances of wanting to purchase private services, and the amount, was calculated given their needs, wealth and the costs of that care, and also an adjustment for the availability of private supply. In addition, for people who are eligible for council support, we compared their demand for care, given the above factors, with the amount and charge from their council supported care. In some cases accordingly, people top-up with additional private purchase of personal care.

Top-up was calibrated in line with the data on private top-up in the RNF data. That source suggested that around 25% of people using council supported services also report buying private services. Usually the additional amount is modest – around 4 hours a week – but some buy a lot more.

One of the major problems in establishing the amount of private care is in drawing the distinction between personal care and domestic support. A number of population surveys ask people whether they buy additional private care (such as the General Household Survey), but it is not always clear whether this would also cover some domestic care. The ELSA survey does however specifically ask people whether they buy care privately as a result of having difficulties undertaking activities of daily living. This source suggested that over 280,000 older people with at least one ADL difficulty did purchase private help. This number would cover both those who are sole private purchasers and the 25% topping up on council care.

The 2000 Health Survey for England (HSE) not only asks older people about their use of private help but also about the number of hours a week they use. The number varies between around 3 hours per week for the lowest need group using this care, to over 9 and a half hours for the highest needs people. Summing up the ELSA and HSE results suggests private purchase of 1.2m hours. We suspect that this source underestimates the use of private pay live-in care. Laing and Buisson's (L&B) domicilary care market survey (Laing & Buisson 2006) shows that a significant minority of private hours are provided by live-in carers. Altogether L&B report that over 1.3 million hours of private help was provided in England, although again this is only help that was counted and provided by agencies. Private ad hoc purchase of care, arranged independently, is not counted. We estimate, using the model, that 1.4m hours were used in 2006.

The UK home care association has also undertaken two surveys on this issue, but with very different results. Their 2000 survey suggested around 1m hours were self-funded. But their 2004 survey suggested only half as much, which is not only a big difference, but in the wrong direction given what has been happening to (a) council eligibility criteria and (b) pensioner wealth. But this example does serve to underline the caution we must have about these estimates.

The established source for privately funded residential care is Laing and Buisson's care the elderly market report (Laing & Buisson 2006). This puts the number of older people in self-pay residential care at around 118,000 for England (318,000 in total less 200,000 council supported).

Third-party top-up of council supported resident care home fees is estimated to happen for around 35% of council supported residents and to cost an average of £65 per resident (Office of Fair Trading 2005). We use these estimates in the analysis, where the England total would be £240m in 2006.

Annex 2. Estimating the impact of FAC eligibility levels on uptake and expenditure on services

The CSCI published the eligibility thresholds from which councils were operating for the first time in 2005/6 – see

Figure 2. A range of sources including benefits data from DWP and Census 2001 data, were put together at council level for 2005/6. Council supported service uptake data from the above sources were also added. A statistical analysis was undertaken to map the relationship between uptake and FAC levels for both supported home care recipients and care home residents per capita 65+.