



Department
of Health &
Social Care

Evidence review for Adult Social Care Reform

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Contents

1. Introduction and key themes	3
Introduction.....	3
Summary of key themes	3
Strengths and limitations of the evidence base	6
2. Background – introduction to Adult Social Care in England	8
How adult social care is funded and delivered.....	10
Quality of, and satisfaction with, services	20
3. Why demand for care is rising.....	24
The impact of population ageing on social care.....	24
The impact of increasing number of over 65s living with disabilities and multiple health conditions	29
.....	31
The future population of over 65s living with disabilities and multiple health conditions .	31
The impact of increasing numbers of adults under 65 living with disabilities	34
The role of preventative interventions.....	38
The impact of poor or unsuitable housing.....	39
The impact of changes in living arrangements	44
Variation in these challenges by geography and socioeconomic status	45
4. The resilience of the different aspects of Adult Social Care to present and future pressures.....	50
Unpaid care	50
The care home market	58
The home care market	61
People funding their own care	62
Adult Social Care workforce	63
Publicly-funded Adult Social Care Productivity	67
Technology in the Adult Social Care System.....	70
5. The relationship between the Adult Social Care system and other relevant support mechanisms.....	75
The relationship between Adult Social Care and the NHS	75
6. Future demand and individuals’ resources.....	80
The average cost of care.....	80
Barriers to protection from high care costs	81

International Comparisons of Adult Social Care funding systems	83
Future demand for Adult Social Care	88
Assumptions underlying demand projections and sensitivity analysis	91
How individuals' resources might vary in the future.....	91
Regional and socio-economic variation in individuals' resources	95
7. Evidence gaps.....	98
8. Conclusion	100
9. Appendix A – Base case assumptions for demand modelling.....	101
10. Appendix B: England level analysis of Family Resources Survey 2019/20.....	105

1. Introduction and key themes

Introduction

- 1.1 This document is being published alongside *People at the Heart of Care*. It outlines trends and challenges based on the current (as of 1 December 2021) adult social care system in England. Data and evidence are presented on changes in the numbers of people with care needs and the nature of those needs; current levels of formal care; and the interface with wider systems such as the NHS, housing and benefits. Key factors influencing the resilience of the current system are also outlined such as the characteristics and availability of unpaid care; challenges in the providers' market and workforce pressures. This is a technical paper summarising the existing evidence that has informed the development of policy proposals. Where the newly reformed system might affect future trends or challenges, we have commented on uncertainties and possible implications. The specific impact of Charging Reform announcements will be explored more fully in a forthcoming Impact Assessment. This paper has been produced in collaboration between the Department of Health and Social Care and the Government Office for Science, building on the *Future of Population Ageing Foresight* report¹.

Summary of key themes

Rising demand for care

- 1.2 Demand for social care has risen in both the older and working age population. The population in England is ageing and the over 65 population is becoming more diverse in terms of its care needs. Overall numbers of over 65s are increasing, partly due to longer life expectancy and partly driven by the large post-World War II birth cohorts entering later life. Although the latest data – which includes the higher mortality observed in 2020 during the COVID-19 pandemic – suggest a decrease in life expectancy for the period 2018-2020, it is too early to say what the impact of this will be on long-term trends in life expectancy.
- 1.3 Key drivers of increased demand in the under 65 population include the increased proportion of people with a learning disability following improvements in the diagnosis and reporting of disability and in the increased survival and longevity of babies born prematurely.

- 1.4 The extra years of life are not necessarily being spent in good health. As more people live to older ages, more of us are living with illness and disability, often with complex comorbidities and more challenges in managing everyday life. Of an estimated 10 million over 65s in 2018, 36% of people aged 65 to 74 had a long-standing illness, rising to 55% for those 75 years or older. For adults aged 20 to 64, this figure was 19%.
- 1.5 The proportion of over 65s with a disability has remained relatively constant. However, as overall numbers of over 65s have increased, the number of over 65s living with limiting conditions and requiring multiple forms of support has also increased. Disparities in disability-free life expectancy have risen as a result of larger gains in more affluent areas.
- 1.6 There is significant regional variation in the rate of population ageing, with rural areas ageing faster than urban. This is driven by significant migration of older people from cities to coastal and rural areas, which leads to different ratios of older people to the working age population, with related implications for matching workforce supply and demand. Levels of disability and illness also vary by region and socio-economic status, creating challenges for the capacity of services in some areas. Disability affects twice as many people in the most deprived areas as in the least deprived.
- 1.7 Much of social care spending on adults under 65 is concentrated among those with a learning disability as their primary need. It is projected that there will be a sustained growth in social care needs for adults with learning disabilities between now and 2030. Whilst there are more over 65s in receipt of adult social care than adults under 65, formal care for the latter can be more expensive, for example due to more intensive needs or because care is provided for a longer period.
- 1.8 It is too early to understand what, if any, impact COVID-19 will have on long-term demand.

Resilience of the care system

- 1.9 Growing numbers of people, especially in the 50 to 70 age group, are providing care to family members or others close to them: in 2011 the Census indicated 5.4m people in England provided care to a family member or a friend, equivalent to around 10% of the population. Research suggests that caring is associated with poorer physical and mental health and can adversely affect a person's employment, particularly at higher intensities. Reliance on unpaid care presents increasing challenges as the average number of children per family has declined and many families are geographically dispersed. COVID-19 has created further demand for

unpaid care, with many millions more people providing unpaid care during the pandemic than previously^{2,3}.

- 1.10 Both the care home and home care market (intended in its broader sense, e.g. including supported living) face significant financial and workforce pressures. This is particularly the case following the impact of COVID-19, as care home occupancy is recovering from a circa 10 percentage point peak reduction and infection prevention and control has imposed new costs on providers, albeit with increased government support such as the Infection Control Fund. There is significant variation in provider profitability across regions. This has been linked with variations in how far providers rely on publicly funded clients.
- 1.11 In common with other low paid occupations, social care experiences high rates of workforce turnover and vacancies as well as relatively low uptake of technology compared to other industries. Wages have been rising in line with the National Living Wage, although the wage differentials paid to staff with greater experience and responsibility have become compressed over time. There are limitations to measuring productivity growth within the care industry but the ONS' quality-adjusted approach suggests that there has been little improvement in the recent past.
- 1.12 Population ageing will also reduce the proportion of the population who are of working age (as currently defined), raising challenges for the staffing and funding of care services. The Care Policy and Evaluation Centre (CPEC), previously known as the Personal Social Services Research Unit (PSSRU) produce projections of Adult Social Care demand and expenditure under a certain set of assumptions (see Appendix A)⁴. CPEC projects that the total number of publicly funded users (over 65s and adults under 65) will rise by 43% from 2018 to 2038 as a consequence of demographic pressures. To meet this demand, the workforce will have to grow proportionally in line with this projection. Going forward, this will place stronger emphasis on the recruitment, retention and wellbeing of the workforce.

Interface with wider systems

- 1.13 The health and social care systems can place pressures on each other that lead to adverse impacts such as delayed transfers of care. There is also some evidence of positive impacts of the closer integration of the two systems on service quality and outcomes for patients. Evidence is less robust on integration's impact on cost-effectiveness and on how social care spending affects NHS performance.
- 1.14 Poor or unsuitable housing is a public health risk, particularly for over 65s, contributing to further care needs and pressures on the NHS and social care. The cost of poor housing to the NHS has been estimated at £1.4bn per annum, largely

due to excess cold and falls. Over 65s are more likely to live in a home that does not meet the Decent Home Standard.

- 1.15 Specialist housing and adaptations can help prevent and reduce care needs. On average, home adaptations delay the move to residential care by 4 years. However, demand exceeds supply and adaptations in rental properties require landlords' agreement.
- 1.16 Uptake of technologies to support independent ageing is happening, but is patchy, with variable information on available options and services. Depending on the delivery model, poorer households with the highest needs may need more support to benefit from technologies.

Financial implications of rising demand

- 1.17 According to CPEC, the total number of adult social care users in England is projected to increase by 50% between 2018/19 and 2038/39, from 980,000 to 1,470,000. CPEC project that expenditure (public and private) under the current, unreformed, system would likely need to more than double in real-terms, from £28bn to £56bn (in 2018 prices) over the same period in order to keep pace with the increases in demand and unit costs.
- 1.18 The median lifetime cost of care for over 65s (excluding "hotel" and accommodation costs) is approximately £22,000; the mean is approximately £45,000. In 2011, the independent Dilnot Commission estimated that around one in ten adults aged 65 faced lifetime costs of more than £100,000⁵. Given rising care costs, that estimate is now one in seven.

Strengths and limitations of the evidence base

- 1.19 Of the themes covered in this document, the evidence for demographic change is strongest, though it remains complex, especially regarding shifts in morbidity and disparities in life expectancy and healthy life expectancy. It is clear that demographic changes will substantially increase demand for care. There are significant variations both in care need and system capacity across the country and between socio-economic groups.
- 1.20 Areas where evidence is less developed include the type of care people and families will be able or willing to provide for themselves and the sort of support which would be most effective for them. We also need to know more about the potential impact of medical advances and the possible scalable impact of technological innovations. We also have less evidence on how public expectations are changing.

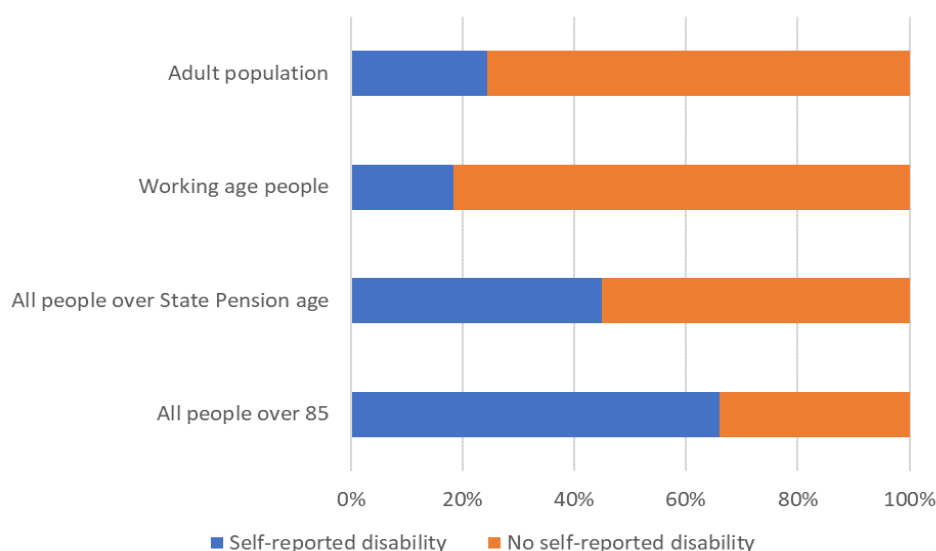
- 1.21 On the social care workforce, data is available from Skills for Care on employment, workforce demographics, qualifications and training, as well as trends in measures of recruitment and retention such as turnover. However, there is more limited evidence around the causal impact that changes in policy could have on either labour market outcomes or wider system outcomes such as quality of care, given the difficulties in isolating the effect of any specific factor in a complex landscape.
- 1.22 Precise data on the number of people funding their own care in England is not readily available for all types of care. Using data from CQC (the Care Quality Commission), which relate to around one third of care beds, and in conjunction with DHSC, the ONS estimated that between 2019 and 2020 (pre pandemic) around 37% of care home residents were self-funded, rising to 41% of residents in care homes for over 65s and/or dementia patients. There was significant regional variation in the share of self-funders, with this share typically being higher in the least deprived areas. In addition, the data show some relationship between a higher proportion of self-funders in a care home and better-quality ratings. There remains a data gap for estimating the number of self-funders in the community (e.g. domiciliary care, day services), particularly for adults under 65.
- 1.23 In general, care needs, and associated demand, increase with age. Therefore, evidence of supply and demand for care from the 'oldest old' is particularly relevant. Data sources vary in the age ranges they cover, and do not always segment findings by particular age cohorts e.g. over 65s, over 75s. Where possible we have drawn out evidence specific to the oldest age groups.
- 1.24 There remain gaps in our knowledge and ability to provide robust forecasts of the future. There is potential for improved modelling to enhance our understanding of demand drivers and provide more robust and nuanced projections and scenarios of future need. However, future trends in disability rates, the kinds of care families will be able or willing to provide, and public expectations will always be difficult to predict.

2. Background – introduction to Adult Social Care in England

Care needs increase with age. In Englandⁱ, 18% of working age adults and 45% of over 65s have a self-reported disability. People are supported by a mixture of formal and unpaid care.

2.1 As shown in Figure 1a, about a quarter of the adult population in England have a self-reported disability⁶. More specifically, the proportion having a self-reported disability is 18% for adults under 65, rising to 45% of those aged over 65 and 66% of those over 85. Self-reported disability does not necessarily lead to care needs but can do if the disability limits people’s ability to undertake everyday activities such as washing or dressing. Figure 1b shows the different types of care that people receive, including formal care and/or unpaid care from family and friends, and how this varies by age.

Figure 1a: Prevalence of disability in England, by age

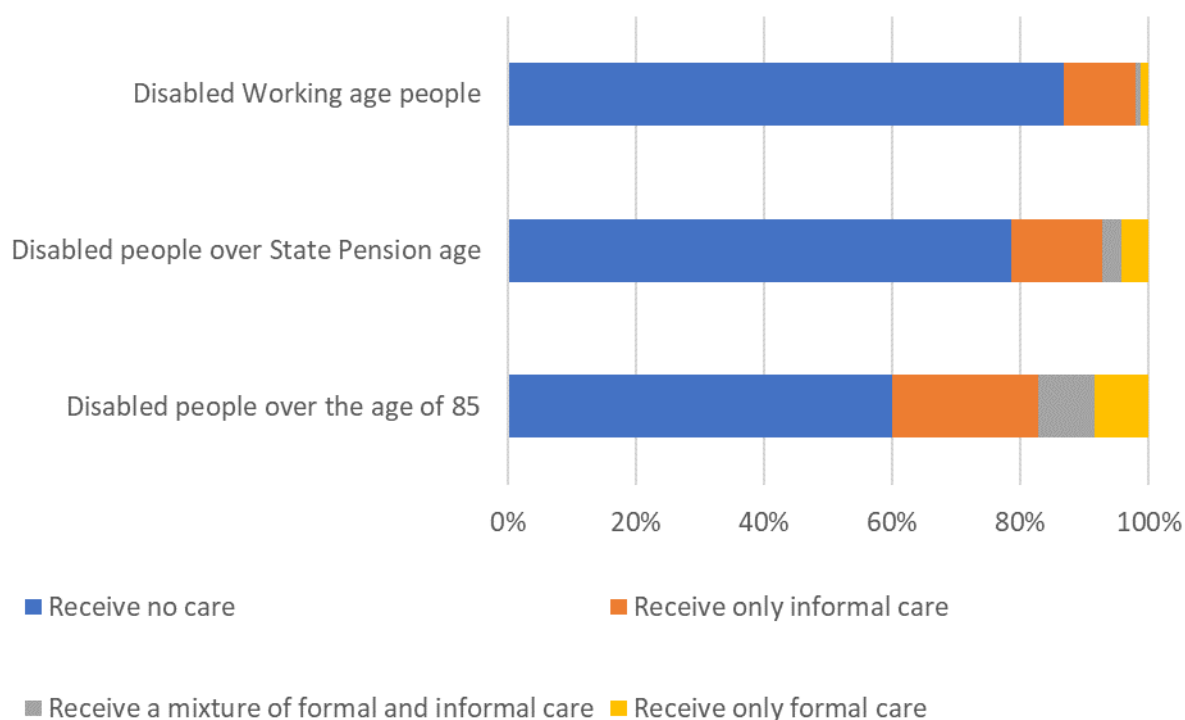


Source:

Analysis based on Family Resources Survey 2019/20

ⁱ All data and analysis included in this report refer to England, unless otherwise stated, because adult social care is a devolved matter.

Figure 1b: Receipt of care by disabled people in England



Source:

Analysis based on Family Resources Survey 2019/20. In the Family Resources Survey, the term “informal care” is used for what we refer to as “unpaid care” throughout the report.

2.2 Over 1.92m new requests for support were made to councils for adult social care in 2020/21, of which 30% were from adults under 65. This is in line with the two previous years. These requests for support were made by 1.34m clients, meaning an average of 1.4 requests for support per clientⁱⁱ. However, the number of requests per client varies across the country: from 1.3 in East of England to 1.7 requests per clients in London ⁷.

2.3 The number of adults under 65 approaching local authorities for support (even if they do not necessarily receive it) has grown by 15% since 2015/16 while the number of over 65s has grown by 2%^{8,9}.

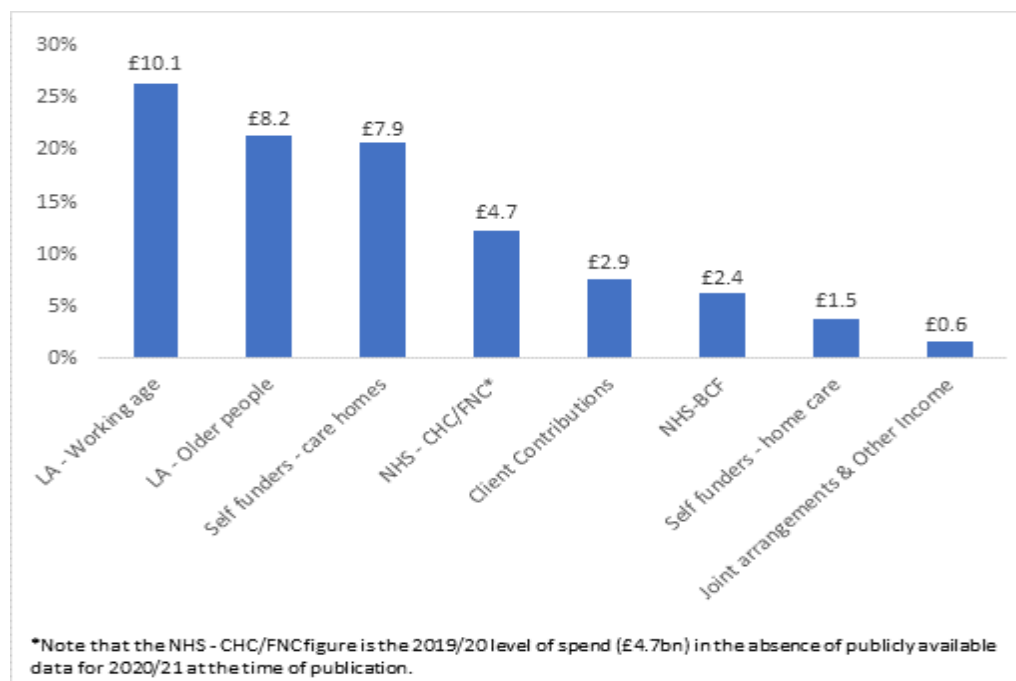
ⁱⁱ Multiple requests arise because of factors such as evolving needs.

How adult social care is funded and delivered

- 2.4 The main piece of legislation that governs care and support in England is the Care Act 2014. The primary responsibility for ensuring that people who need social care get the support they need from social care lies with local authorities. Funding for adult social care comes from private and public sources.
- 2.5 Core public funding includes revenue funding from central government to local authorities (not ring-fenced), locally generated income e.g. through council tax and business rates, and income from user charges¹⁰. Funding transfers from the NHS have also played a role since 2011/12, mostly through the introduction of the Better Care Fund in 2015/16.
- 2.6 Individuals with complex needs outside the remit of local authorities may be found eligible for NHS Continuing Healthcare (NHS CHC) and have their needs met solely (and without user charges) by the NHS. These needs can include accommodation costs where care is provided in a nursing home setting. In addition, an individual with nursing needs who is not eligible for NHS CHC but is a resident in a nursing home, may receive a payment under Funded Nursing Care (FNC) rules. Individuals with nursing needs who are in their own home or a residential home will have their nursing needs met through existing NHS services.
- 2.7 Figure 2 provides a breakdown of adult social care spending between different parts of the current unreformed system. Spending on all adult social care in 2020/21 was estimated to be over £38bn^{11, 12, 13, 14} from various sources, with individuals contributing around £12bn.ⁱⁱⁱ Individuals contribute either as self-funders or by paying means-tested charges for assessed local authority support.

iii Total spend is the sum of all columns; individual contributions include spend from self-funders in care homes and home care plus client contributions.

Figure 2: Total public and private adult social care related spend in England, percentage and £bn, 2020/21^{iv}



Sources:

NHS Digital, 2021. [Adult Social Care Activity and Finance: England 2020-21](#) (figures for LA spend, NHS-BCF, client contributions, joint arrangements and other income).

Wittenberg, Hu and Hancock. 2020. [Projections of Adult Social Care Demand and Expenditure, CPEC Working Paper 7](#). Data available in Table 2 (figures for self-funders)¹⁵.

NHS England, 2020. [CCG 2019/20 Q4 Data Collection, NHS Continuing Healthcare Quarterly Data](#). Data available in Table 1.1 (figure for NHS – CHC/FNC)¹⁶

2.8 These estimates of adult social care expenditure do not include the significant contribution of unpaid carers. A variety of estimates exists for the value of unpaid care provision. The Office for National Statistics (ONS) estimated that the Gross

^{iv} Presenting total ASC spend requires some approximation due to synthesis of different data sources. Reported annual Public Spending on Adult Social Care – as per NHS Digital Adult Social Care Activity and Finance Report, England, 2020-21 - excludes NHS-CHC and FNC, client contributions, joint arrangements and other income and self-funders (care homes and home care, older people). NHS-CHC and FNC are included here as they are expenditure to meet the health needs of those receiving adult social care services. NHS BCF contains both LA and NHS commissioned care. The "self-funders care homes" spend category uses CPEC (2020) data. Part of "NHS FNC" spend may already be counted in the "self-funders care homes" spend category.

^v Client contributions are defined as what users whose care is arranged by LAs are paying towards their care (either partially or in full).

Value Added of unpaid care in the UK was £59.5 billion in 2016^{vi17}. Buckner and Yeandle estimated, on behalf of Carers UK, that the economic value of the contribution made by carers in the UK was £132 billion in 2015 (£108 billion in England)^{18vii}.

2.9 Other wider support mechanisms for people with care needs include:

- Pensioner disability benefits^{viii19} (£10.3bn in 2020/21)
- Working age disability benefits^{ix20} (£12.3bn in 2020/21)
- Housing grants such as the Disabled Facilities Grant (£573m in 2020/21^{x21})
- Carers' Allowance - for those providing care to adults under 65 and over 65s for 35+ hours a week for one person (who is eligible for disability benefits) (c. (£3.0bn^{xi} in 2020/21²²))

2.10 There is also expenditure from charities on assistive-type services, relating to Instrumental Activities of Daily Living (IADLs), including shopping, cooking and managing finances. This figure was about £4.2bn in 2019^{xii23}.

2.11 Formal provision of care services occurs either in private homes or designated settings such as care homes. Services are paid for either by the state, based on needs and means testing, or by self-funded individuals. Figure 3 gives a breakdown of adult social care clients by care setting and funding source in 2020/21. As Figure 3 shows, most over 65s receiving formal care services are supported to some level

vi This was estimated by multiplying the total hours of care received (using the Family Resources Survey) by the wage rate of carers/nursing assistants (using the Annual Survey of Hours and Earnings). GVA is estimated by making an adjustment for the input of household housing services.

vii The unit cost of replacement care is taken as £17.20 per hour (Personal Social Services: Expenditure and Unit Costs, England - 2013-14, Final release), in line with the official estimates of the actual cost per hour of providing homecare to an adult. This cost is then applied to the number of hours carers spent providing care. The estimate of the number of carers in 2015 is calculated by applying the 2011 Census local carer prevalence rates by age, sex and amount of care to the official 2015 population projection.

viii This includes AA, DLA (for state pension age claimants) PIP (for state pension age claimants), SDA (for state pension age claimants) Includes England and Wales.

ix This includes DLA, PIP and SDA for working age claimants. Includes England and Wales

x This figure refers to funding allocation, rather than actual expenditure.

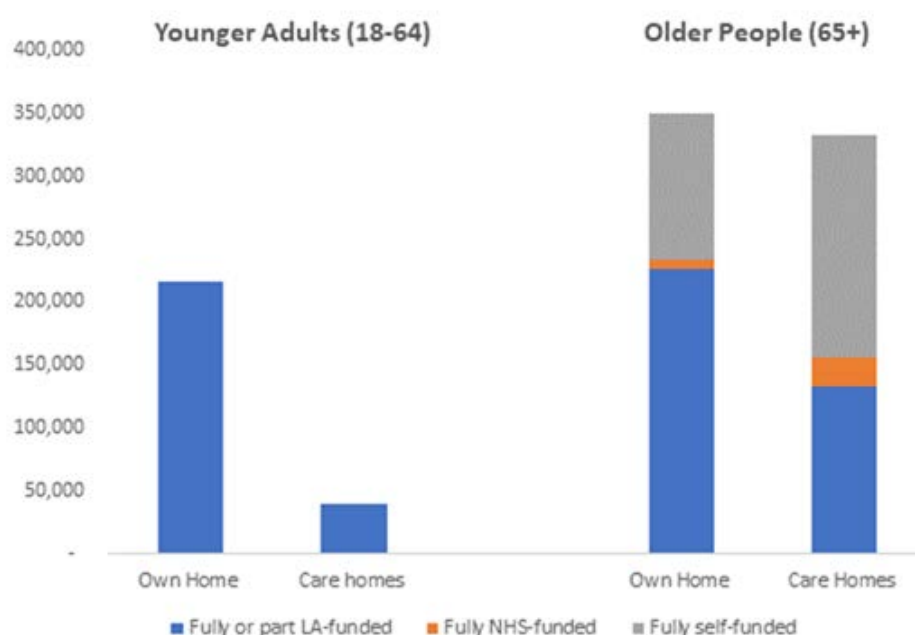
xi This figure is an estimation of the total CA expenditure that is paid where the care recipient is of working age (16+) or pension age (65+). It is calculated by assuming that the proportion of CA expenditure paid where the care recipient is a disabled child is equal to DLA Child expenditure as a proportion of the total of AA, DLA and PIP – 9%. We then remove this from the total CA expenditure.

xii Long-term care expenditure for England has been estimated by applying the ratio of England to UK health expenditure.

by the state, but a significant proportion pay for their own care. Also, most long-term users of publicly funded social care live at home (i.e. they receive home care).²⁴

2.12 While there is no reliable published data available on self-funded adults under 65, this number is expected to be low. This is because in many cases, the care needs of adults under 65 develop in childhood. They are therefore less likely to receive income from a pension or have savings or assets that would result in an individual being ineligible for local authority support.²⁵ The ONS estimated that only 5% of residents in care homes specifically for younger adults were self-funded (this analysis was based on a sample and excluded adults in the community).²⁶

Figure 3: People receiving adult social care by age group and setting, 2020/21^{xiii}



Sources:

This chart relies on DHSC internal analysis and assumptions, including some unpublished sources

Fully or part LA- funded: data from NHS Digital, 2021. [Adult Social Care Activity and Finance: England 2020-21](#)

NHS funded: NHS funded over 65s for 20/21 come from CPEC projections DHSC receive, although these are not published within the document Wittenberg R, Hu B and Hancock R (2020) [Projections of demand and expenditure on adult social care 2018 to 2038](#), Adult Social Care Research Unit, Care Policy and Evaluation Centre. The split between own home and care homes is estimated using 16/17

^{xiii} This figure includes data from DHSC, NHS-D and CPEC, and excludes analysis from the ONS based on the CQC sample

strategic improvement programme (SIP) data on the proportion of 65+ CHC users that are in care homes.

Self-funded: DHSC analysis assuming flat linear interpolation of published 5-year projections to estimate individual years. Original Source: Wittenberg R, Hu B and Hancock R (2020) [Projections of demand and expenditure on adult social care 2018 to 2038](#), Adult Social Care Research Unit, Care Policy and Evaluation Centre.

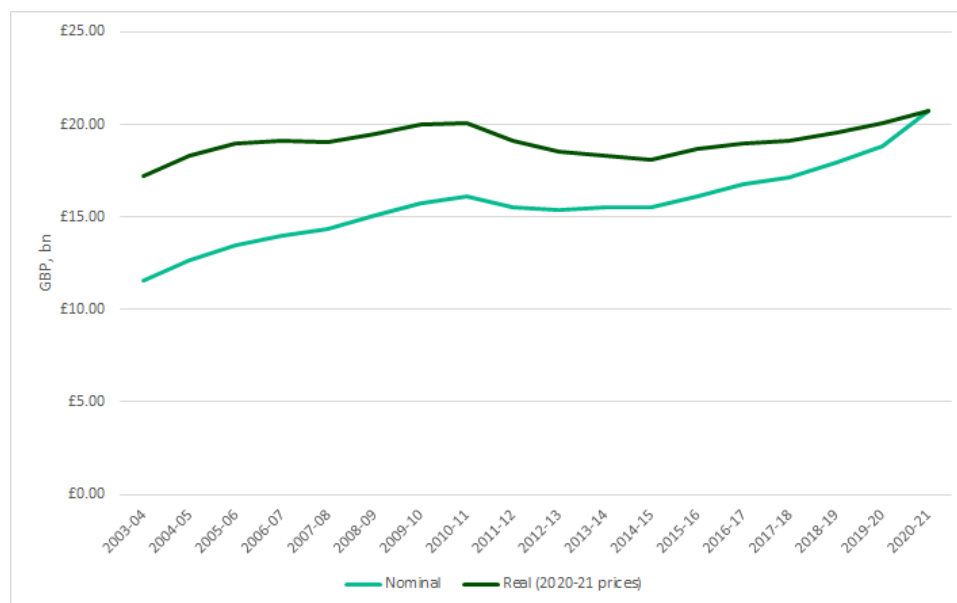
- 2.13 For adults under 65 the most common support reason was learning disability support (this was the primary support reason for 49% of clients receiving long-term support in 2020/21). The next most common support reasons were physical support (28%) and mental health support (18%). For over 65s the most common primary support reason was physical support (72%) followed by support for memory and cognition (13%)^{27xiv}.
- 2.14 A typical care package for an adult under 65 is more expensive per person than one for over 65s. For example, residential care for an under 65 costs £1,454 per week on average, compared with £736 per week on average for an older person. Nursing care for an adult under 65 costs £1,083 per week on average, compared with £787 per week on average for an older person. Home care is also often more expensive for adults under 65, as they require a higher number of care worker hours per user on average. The combined difference in the costs outlined above means that, though there are fewer adults under 65 with disabilities receiving care than over 65s, the total amount spent on care for both groups is very similar²⁸.

xiv The data collected from councils refer to the primary reason for requiring support. This means that there may be clients included in the activity data who have more than one reason they receive support for. This is more likely to be the case for older people.

Trends in expenditure and user numbers

- 2.15 Adult Social Care net public expenditure since 2003/04 is shown in Figure 4. Between 2003/04 and 2010/11, Adult Social Care net public expenditure increased by 17% in real terms. It then fell by around 10% between 2010/11 and 2014/15. Since then, spend has increased by 15% to the most recent reported year, 2020/21.

Figure 4: Adult Social Care Net Public Expenditure 2003/04 to 2020/21^{xv}



Sources:

NHS Digital, 2009/10 – 2020/21 data: [“Adult Social Care Activity and Finance Report: Detailed Analysis, England 2020/21”](#) (see table 2 or 4)

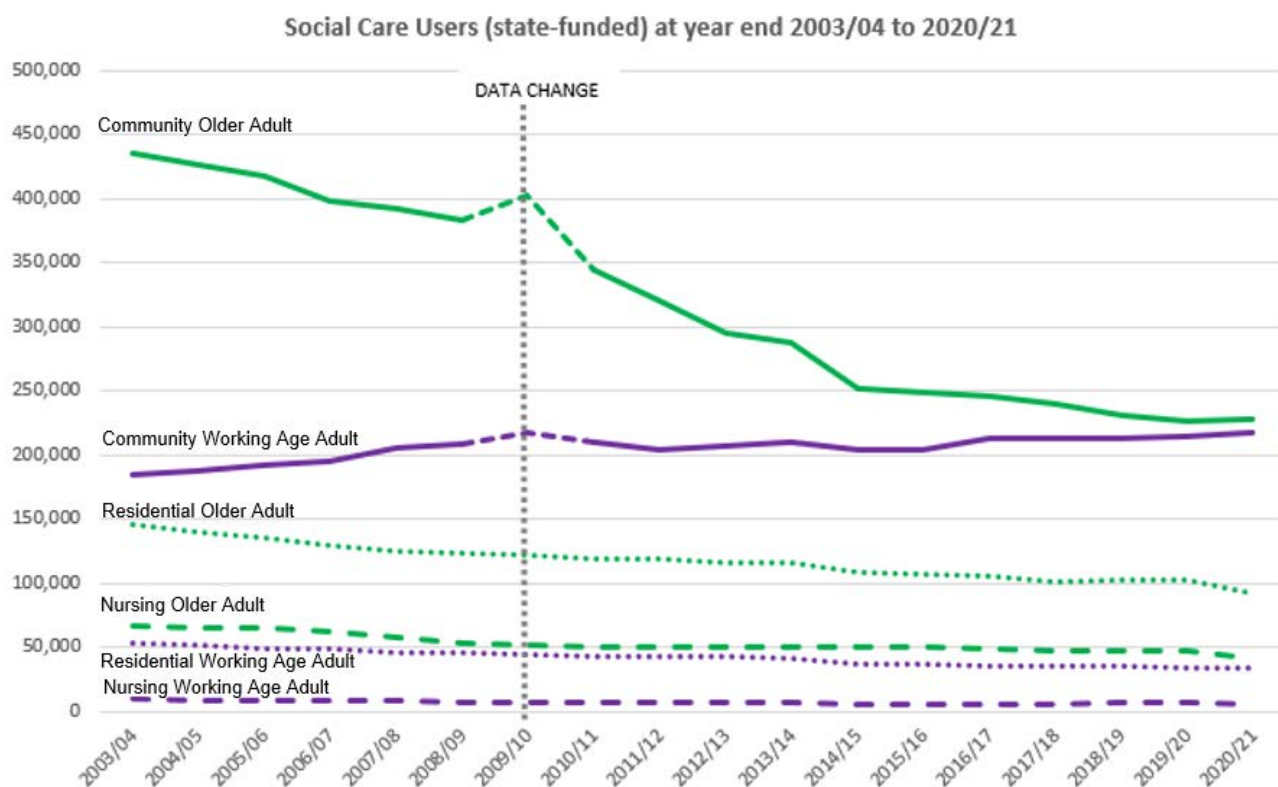
NHS Digital, 2003/04 – 2008/09 data: [“Personal Social Services: Expenditure and Unit Costs, England, 2013-14, Final Release: Gross Current Expenditure and Net Current Expenditure 1994-95 to 2013-14”](#)

- 2.16 As shown in Figure 5, the trend in overall numbers of adults under 65 in receipt of adult social care is essentially flat, with the suggestion of a slight rise in 2009/10 and a slight dip in 2015/16 (these conclusions are tentative due to data collection changes). The total number of adults under 65 using social care in 2020/21 was only around 4% higher than that in 2003/04. The numbers receiving community care

xv Adjusted for Valuing People Now grant – assuming constant real terms spending from published 2010/11 figures, backfilling to 2003/04.

support have increased, while those receiving residential or nursing care support have decreased.

Figure 5: Social Care Users by age group (state-funded) at year end^{xvi} 2003/4 to 2020/21



Sources:

NHS Digital, 2003/04-2013/14: "[Community Care Statistics, Social Services Activity, England - 2013-14, Final release](#)", Annex M - Compendium 2001-01 to 2013-14, "Short and Long-term Support",

NHS Digital, 2015: "[Community Care Statistics, Social Services Activity, England - 2014-15](#)"

NHS Digital, 2016: "[Community Care Statistics, Social Services Activity, England - 2015-16](#)"

NHS Digital, 2016/17 to 2020/21: "[Adult Social Care Activity and Finance Report, England](#)"

^{xvi} From 2014/15 the NHS Digital data collection changed and this means it is not possible to directly compare from after this point to data from prior years due to the different way users are catalogued. This chart represents DHSC officials best estimate for bridging the change in data collections. In particular for data prior to 2014-15, "Community" is the sum of the subcategories: Home Care, Day Care and Direct Payments. In 2009/10 'Direct Payments' includes 'Existing/new Direct Payments and Personal Budgets' – the inclusion of personal budgets is the presumed cause of the peak in this year.

- 2.17 Despite rising numbers of over 65s, the number of over 65s receiving state-funded long-term social care support has reduced²⁹, particularly those receiving community care support. Reductions in the number of over 65s receiving state-funded care could be driven by a combination of improvements in health or reduction in care needs, increased reliance on unpaid care, rising numbers of people funding their own care, and a greater number of people having unmet care needs. Trends in each of these factors are discussed later in this document. Data on the receipt of care are based on outputs, not outcomes for service users who may or may not be being signposted elsewhere, for example to universal services or the voluntary sector. There is limited data around self-funders, who may choose, or feel they might turn to, alternative providers. More broadly, there is wide local variation in service provision³⁰.

Access to Care

- 2.18 The Care Act 2014 sets out local authorities' (LAs') duties in relation to assessing people's needs and their eligibility for publicly funded care and support. Where it appears to an LA that an adult may have needs for care and support, the LA must assess whether an adult has needs, and what those needs are. If the adult does have needs, the LA must then consider whether those needs meet the statutory eligibility criteria and if they do, how to meet them. The LA must then consider whether it has a duty to meet those needs, which will include carrying out a financial assessment and considering which needs can be met by informal carers. If needs are being met by informal carers, the LA would not usually have a duty to meet those needs itself. In carrying out all its duties under Part 1 of the Care Act 2014, the LA must have regard to the duty to promote individual wellbeing. The LA also has similar assessment duties if it appears to the LA that a carer may have needs for support.
- 2.19 There are many reasons why individuals who have some need for support with their daily activities may not receive formal or informal support. Some stakeholders call this 'unmet need'. As highlighted by the CQC, understanding the number of people with social care needs who are not receiving support, and how these numbers are changing over time, is challenging³¹. There is no agreed definition of 'unmet need', either in the Care Act or the research literature. Due to these challenges, evidence on the number of people not receiving support for their care needs – and importantly, the drivers of this – is mixed and incomplete.
- 2.20 Estimates published by Age UK in 2019³², based on analysis of the English Longitudinal Study of Ageing (ELSA), suggest that around 1.5 million people in England over 65 struggled to complete an activity of daily living (ADL) in the past month and did not receive help for this need. Separate Age UK analysis in 2018³³

found that 300,000 reported difficulty with 3 or more ADLs in the past month and not receiving help with that need, of whom around 160,000 received no formal or informal care³⁴. These estimates do not account for the financial circumstances of individuals, so will include those who would not currently meet the means test for state-funded care.

- 2.21 Recent analysis by CPEC aimed to estimate the proportion of over 65s with care needs broadly in line with those currently receiving local authority-funded care but who are not receiving it, including those receiving no support at all.³⁵ Using pooled Health Survey for England (2015-2018) data, the research first examined the level of self-reported need amongst over 65s receiving local authority funded home-care services, to set a needs threshold above which the majority of this group fall. It then analysed the proportion of adults in the pooled sample whose self-reported needs exceeded this threshold but received no support (either formal care, informal care or attendance allowance).
- 2.22 This suggests that around 1% of all older people in the community-dwelling sample had care needs equivalent to those receiving LA-funded care but reported receiving neither attendance allowance, nor formal or informal support. The research did not account for financial eligibility for state-funded support, so a significant proportion of these individuals may have wealth exceeding the means test. In addition, the analysis was not able to determine other reasons why individuals eligible for state-funded care are not receiving it, including lack of awareness of available services and the extent to which some may choose to pay for their own care.
- 2.23 Evidence of any trends in the number of individuals not receiving support for their care needs is also mixed. Age UK analysis based on ELSA data suggests that levels among over 65s have increased markedly since 2010.^{36,37} By contrast, Health Survey for England (HSE) data shows that the proportion of respondents reporting difficulty with at least one ADL and not receiving any help with it in the last month has remained relatively stable between 2011 and 2018.³⁸
- 2.24 Much less evidence is available on the reasons why people who appear to be eligible for state-funded support are not receiving it, or on the impacts of unmet care needs on the individual, their friends and family, on their future care needs and on the wider public sector, such as the NHS. This hinders formulating an effective policy response and is a priority evidence gap for the Department to address.
- 2.25 Trends in the health and disability of older groups are discussed in Chapter 3. Evidence on unpaid care and self-funded care is discussed in Chapter 4. Measuring the number of people not receiving support for their care needs is discussed in the Evidence Gaps section of this report.

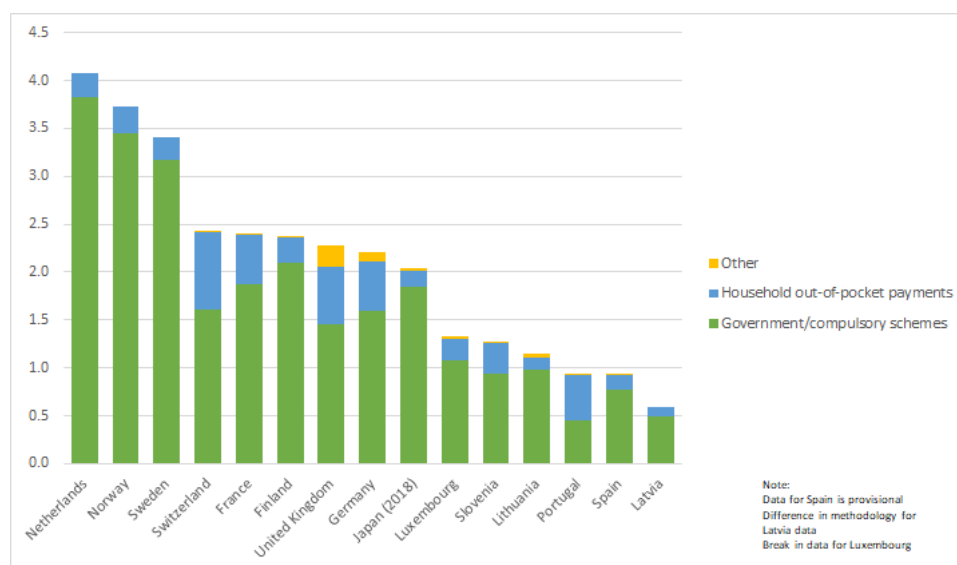
Public understanding of the current system

- 2.26 In the current system, there is a lack of public understanding about how social care services are provided, and by whom; Ipsos MORI found that the majority of people polled thought that the NHS provides social care services and that just under half (47%) wrongly thought social care is free at the point of need³⁹.
- 2.27 There are many barriers to people making well-informed choices in this area. Recent survey research by SCIE found that 28% of respondents over 65, and 54% of 45 to 64-year olds had not given any thought to their future housing and care needs. Additionally, recent survey research by SCIE found that respondents' awareness of social care services differed greatly by care setting, with 98% of over 65s aware of care homes compared with 66% aware of extra care housing, 40% of shared lives housing and 56% of supported living⁴⁰. Having conversations about ageing in advance can be difficult for people and it can be hard for people to know who to trust for advice. Available services, and their capacity to accommodate people, vary locally. Depending on where people receive care, there are differences in how people's needs and means are assessed in practice and in decision-making about how these needs should be met and funded. Many of these issues will affect care users of any age. There is also often very little prior consideration of care needs and options, meaning decisions about care are often made at a time of crisis⁴¹.

International comparisons

- 2.28 Taking an international perspective on long-term care funding, Figure 6 shows that the UK total expenditure on total long-term care as a proportion of GDP (2.3%) is just above the average for the Organisation for Economic Co-operation and Development (OECD) member states that report both public and private total long-term care expenditure (2.1%). Although the coverage and comparability of long-term care spending estimates has improved, there are still persistent difficulties in ensuring comparability. These are linked to factors such as issues in clearly identifying and separating long-term care activities into the health and social components, but also to differences in the interpretation of dependency among certain patient groups. Moreover, long-term care spending estimates are generally more robust for public than for private spending⁴². For example, these long-term care estimates include spend on hospital palliative care for some countries (including the UK), although this is not normally included in the UK understanding or definition of social care.

Figure 6: Expenditure on total long term-care^{xvii} as a % of GDP, selected OECD countries, 2019^{xviii}



Source:

OECD, 2019. [Health Accounts dataset](#).

Quality of, and satisfaction with, services

The majority of local authority-funded users reported that they are satisfied with their care, and 85% of providers were rated “good” or “outstanding”. However, there is significant variation in quality across local authorities.

- 2.29 In the 2019/20 Adult Social Care Survey (ASCS)⁴³, 61.2% of LA-funded adult social care users reported that they were very or extremely satisfied with their care and support, while 2.5% reported that they were very or extremely dissatisfied^{xix}. Figure 7 shows a full breakdown of responses. Adults under 65 reported a higher satisfaction

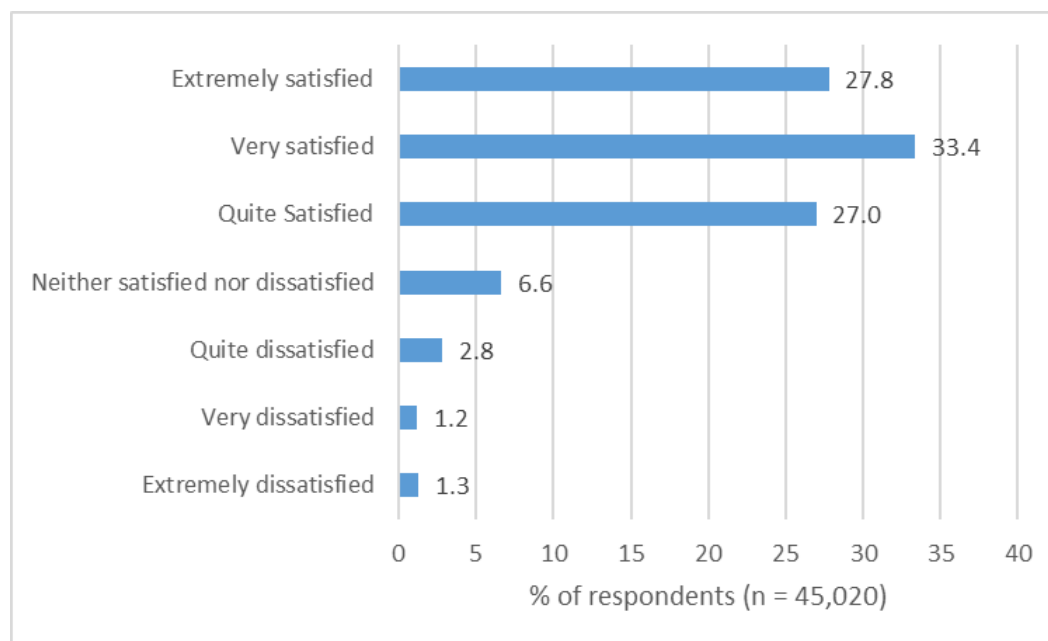
xvii Long-term care includes children's social care.

xviii Other spending is predominantly NPISH (non-profit institutions serving households, i.e. charity expenditure funded through donations, grants and investment income).

xix More recent ASCOF data for 2020-21 has now been published, but has not been included here because the impact of COVID-19 has led to incomplete data which is not comparable with previous years.

with their care (68%) compared to over 65s (62%) – this difference is statistically significant.

Figure 7: Self-reported satisfaction with care and support among LA-funded adult social care users, percentage of respondents, 2019/20



Source:

NHS Digital, 2020. [Personal Social Services Adult Social Care Survey](#)

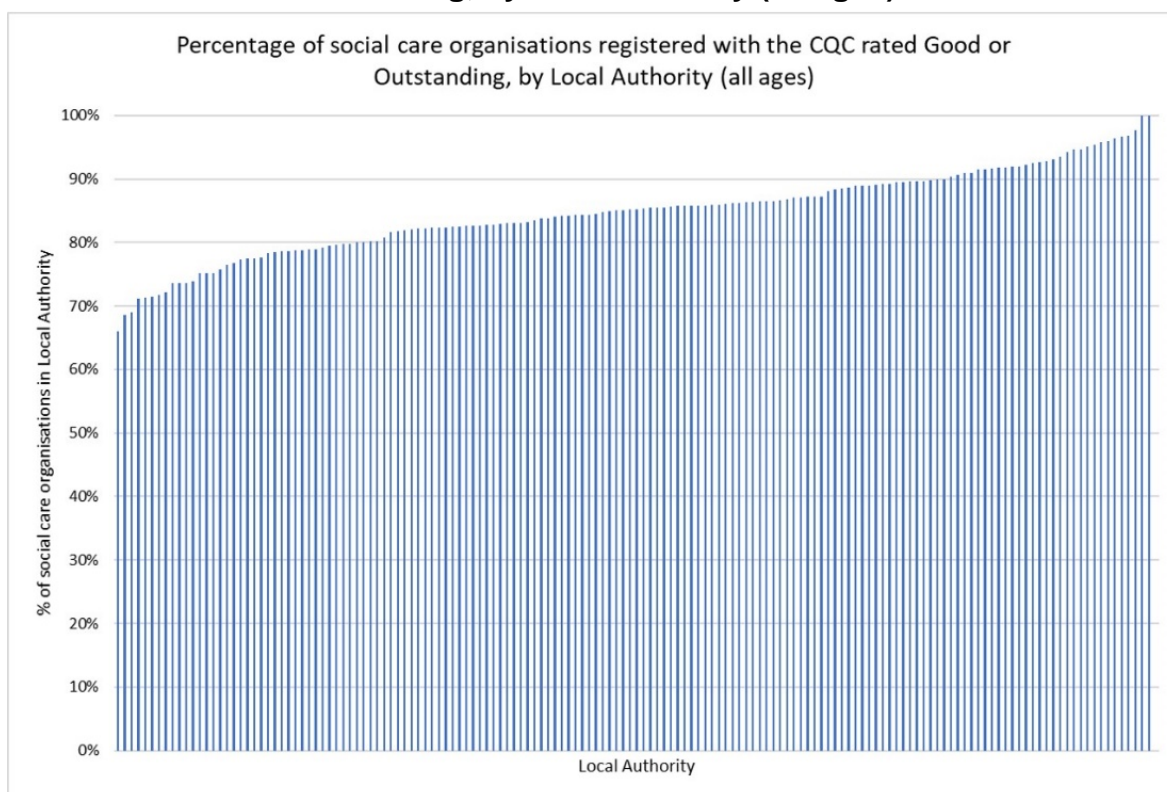
2.30 Also derived from the ASCS, the overall self-reported social care-related quality of life score for local authority-funded services users in England has remained unchanged at 19.1 out of a maximum score of 24 for the past 6 years; adults under 65 reported a higher quality of life (19.6) compared to over 65s (18.8)⁴⁴. A limitation of this data (both the satisfaction and quality of life scores) is that they are derived from self-reported surveys and therefore are potentially subject to reporting biases. Additionally, the ASCS user survey only covers local-authority funded users, excluding the self-funding population, and those not receiving formal care.

2.31 Care Quality Commission (CQC) data from October 2021 showed that 85% of providers were rated ‘Good’ or ‘Outstanding’, while 14% were rated ‘Requires Improvement’ and 1% were rated ‘Inadequate’⁴⁵. The overall quality rating of 85% has been very similar since March 2020, though part of this stability will have come from the suspension of inspections as part of measures taken to reduce the spread

of COVID-19. The overall quality rating had been slowly improving in 2017 and 2018 but has been stable around its current level since 2019.

- 2.32 In October 2021, nursing homes (care homes providing nursing as well as residential care) had the lowest-rated performance on average, with 20% currently rated ‘Requires Improvement’ and 2% ‘Inadequate’, while 78% were rated ‘Good’ or ‘Outstanding’⁴⁶. By comparison, 84% of residential care providers and 87% of home care locations were rated ‘Good’ or ‘Outstanding’.
- 2.33 There was significant regional variation in care quality; for example, several local authorities had 100% of social care services rated ‘Good’ or ‘Outstanding’, while the worst had around 65%⁴⁷. This can be seen in Figure 8.

Figure 8: Percentage of social care organisations registered with the CQC rated Good or Outstanding, by local authority (all ages)



Source:

CQC, 2021. DHSC analysis of data, [Care Directory with Filters, October 2021](#).

- 2.34 Comparisons of quality between sectors are challenging, but the CQC rates the NHS and social care providers in similar ways. At 31 March 2020⁴⁸, the latest comparable data, 85% of adult social care providers were rated ‘Good’ or ‘Outstanding’ compared to 75% of NHS acute services.

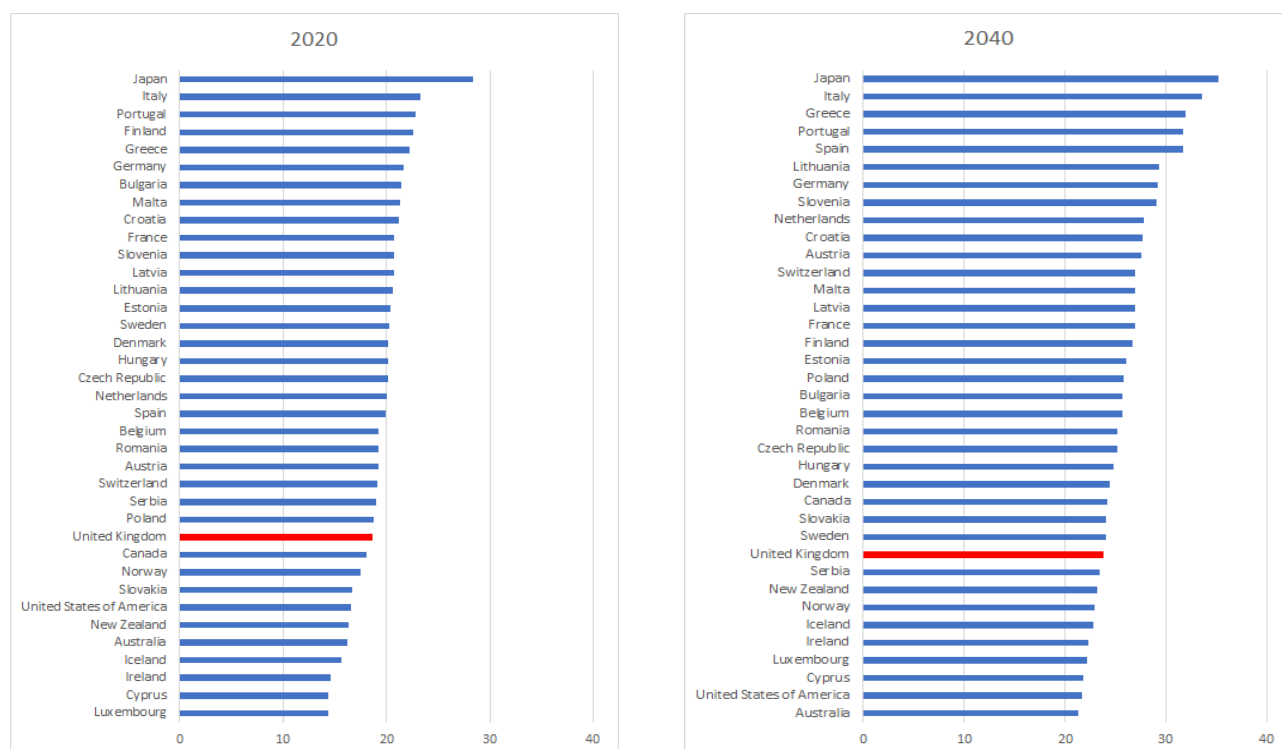
- 2.35 The Local Government and Social Care Ombudsman received 1,670 complaints about social care in 2020/21, representing a 33% decrease in the number of complaints compared with the previous year. However, in 2020/21, the Ombudsman stopped taking complaints for three months during the initial wave of COVID-19, which is reflected in the statistics. In the 4 years before the pandemic, complaints numbers had been stable. The Ombudsman focuses reporting on the outcomes of complaints once they have been examined: they found fault in 72% of investigations regarding adult social care in 2020/21, higher than in the previous year (69%) and higher than the rate across local government as a whole⁴⁹.

3. Why demand for care is rising

The impact of population ageing on social care

The percentage of people with morbidities, disabilities and care needs increases with age, particularly for the 'oldest old'. As the number of people in older groups grows, the number of people with care needs will also grow. Population ageing is the main driver of the projected increase in numbers of people needing care. Most of the data presented here predates the COVID-19 pandemic. It is too early to understand what, if any, impact COVID-19 will have on long-term demand.

Figure 9: Percentage of the population aged 65 and over in 2020 and 2040, EU and other selected countries

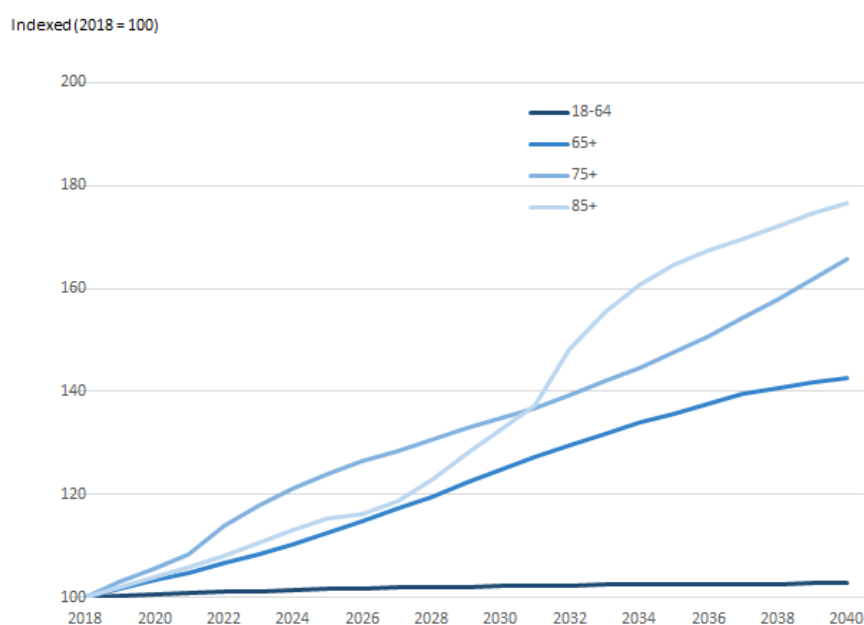


Source:

UN-DESA, 2019. [World Population Prospects: key findings and advance tables - 2019 revision](#), United Nations, New York.

- 3.1 Population ageing is a global phenomenon to be celebrated as the positive result of many factors, including improved healthcare and living conditions. But it also represents a significant challenge for social care provision – one where many other countries are experiencing even greater rates of change than the UK, as demonstrated by Figure 9.
- 3.2 According to the ONS 2018-based principal population projections, the population in England is ageing rapidly and lower levels of net migration would increase the rate of population ageing further. Population ageing is the result of a long-term decline in fertility rates, which has coincided with people living longer⁵⁰. In England the number of over 65s is growing at a faster rate than younger age groups. The overall numbers of over 65s is also increasing, partly due to longer life expectancy and partly driven by the large post-World War II birth cohorts entering later life.
- 3.3 Historically, inward migration has contributed to slow population ageing – those arriving in the UK have tended to be young and have more children⁵¹. As shown in Figure 10, the number of over 65s is projected to increase by 43% (from 10.2 million to 14.5 million) and the number of adults aged 85 and over is projected to increase by 77% (from 1.4 million to 2.4 million) between 2018 and 2040. By comparison, the 20 to 64 population is only projected to grow by 3%. As discussed later in this section, care needs and associated demand on adult social care increase with age, therefore increases in the number of the 'oldest old' are particularly relevant.

Figure 10: Projected change in population of England by age group, 2018 to 2040 (indexed at 2018) ^{xx}



Source:

ONS, 2019. [2018-based Principal Population Projections](#).

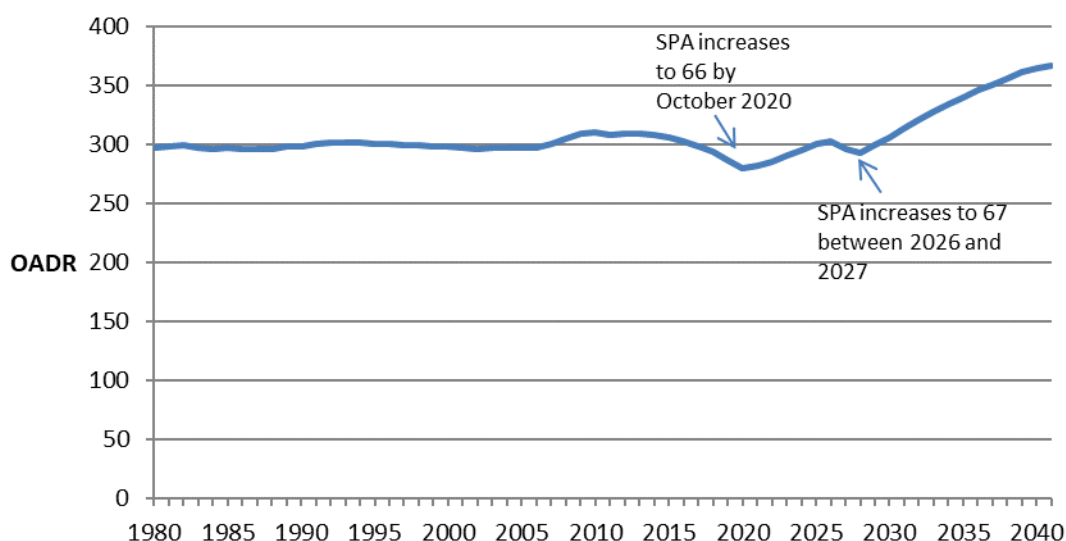
3.4 Population ageing is also expected to increase the proportion of people in England who are retired, relative to people of working age. The Old Age Dependency Ratio shows the balance between adults under 65 and over 65s. This is expressed as the number of over 65s per 1000 people under 65. It is important to recognise that “working age” is not a fixed term. The state pension age is legislated to increase, and people might retire before or work after it. This means the Dependency Ratio is a crude measure. For example, it overlooks the continuing trend for people to stay in work beyond the age of 65, and over 250,000 adults under 65 receive some social care. However, it gives a sense of how the population of England will change. As Figure 11 shows, the ratio is expected to increase.

3.5 Finally, population ageing will mean a proportionately smaller working age population, which could lead to challenges for family care and labour market

^{xx} Future population change is inherently uncertain, so the projections that ONS produce will inevitably differ from actual future outcomes to a greater or lesser extent. However, it is difficult to quantify the likelihood of a particular deviation – for example, international migration trends in particular are liable to change rapidly in response to political and economic circumstances. On that basis ONS do not produce confidence intervals around the projections.

shortages in the wider economy. These in turn could create a pressure on the social care workforce. The implications of this for care provision are addressed in more detail in the sections on 'Unpaid care' and 'Workforce Pressures'.

Figure 11: Old age dependency ratio^{xxi}, England, 1980 to 2041^{xxii}



Source:

ONS, 2018. [Old age dependency ratio, England, 1980 to 2041](#).

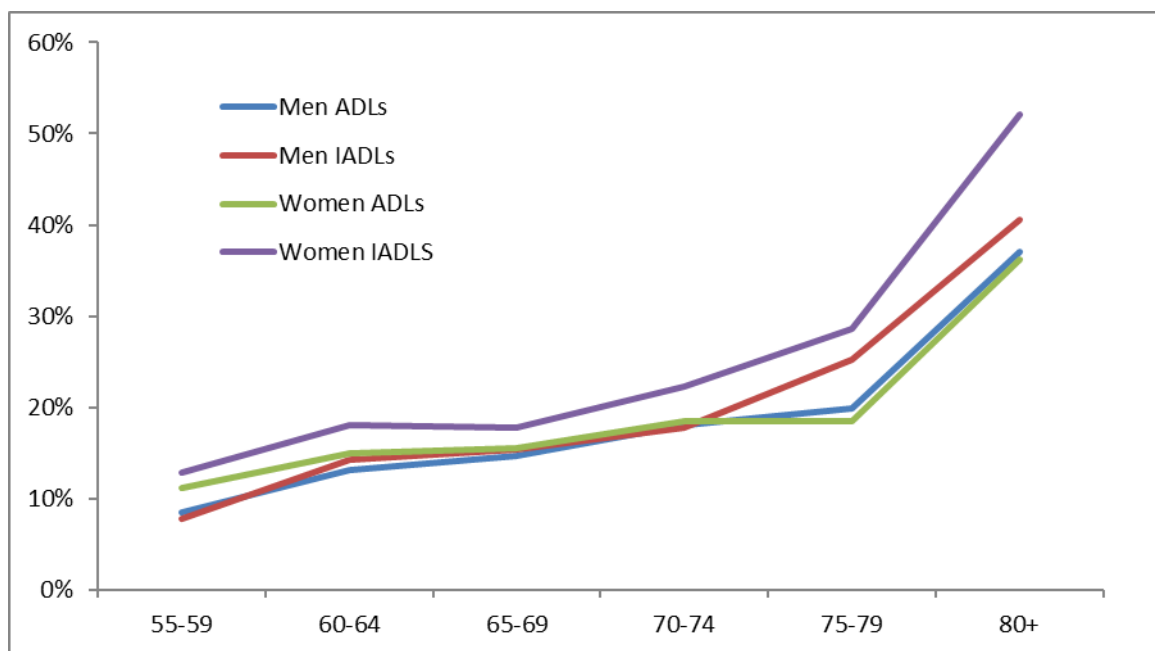
3.6 As people grow older, they are more likely to need more help with everyday activities⁵². Data from the English Longitudinal Survey of Ageing (ELSA) Wave 8 shows that the percentage of respondents needing help with one or more Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) increases with age, rising significantly in the 80+ age group, as shown in Figure 12. In older age in particular, women experience more difficulties with ADLs and IADLs than men. Studies suggest this is due to greater prevalence of mostly non-fatal but disabling conditions amongst women⁵³.

xxi Old Age Dependency Ratio (OADR) is the number of people of state pension age per 1,000 people of working age. OADR is calculated on population estimates from 1980 to 2016 and 2016-based population projections from 2016 to 2041. OADR takes into account forthcoming changes to SPA in current legislation.

xxii Future population change is inherently uncertain, so the projections that ONS produce will inevitably differ from actual future outcomes to a greater or lesser extent. However, it is difficult to quantify the likelihood of a particular deviation – for example, international migration trends in particular are liable to change rapidly in response to political and economic circumstances. On that basis ONS do not produce confidence intervals around the projections.

3.7 Multi-morbidity also increases with age. Around 21% of over 85s have 5 or more long-term conditions⁵⁴, these conditions are associated with increased care need as people often require more complex support⁵⁵.

Figure 12: Proportion of people reporting difficulties with one or more ADLs and IADLs (%), by age group and gender, England, 2016/17



Source:

IFS, 2018. [The Dynamics of Ageing, evidence from the English Longitudinal Study of Ageing 2002-16.](#) Page 274, Table H6a.

The impact of increasing number of over 65s living with disabilities and multiple health conditions

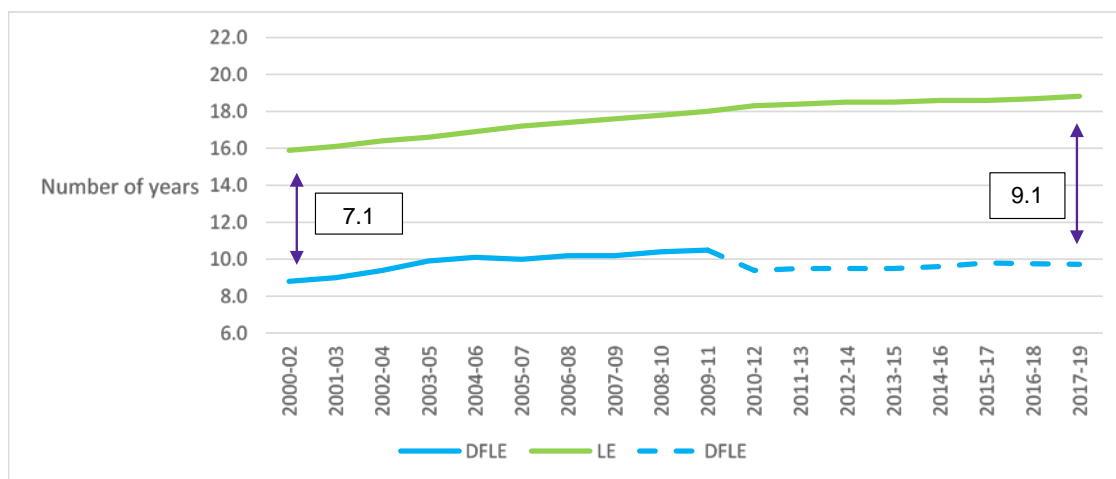
The number of people with conditions that require care is increasing. There have also been substantial rises in frailty and the number of people living with multiple conditions, resulting in complicated care needs. While life expectancy has broadly risen⁵⁶ - except for the period 2018 to 2020 which includes the higher mortality observed during COVID-19 - the extra years people live are not necessarily healthy or disability-free.

- 3.8 Two factors are important in explaining the expected increase in the number of over 65s living with conditions that require care. Given disease and disability prevalence increase with age, the increase in the number of over 65s and the changes in the age structure of that population - as discussed in the previous section - imply an increase in the number of people with a disability or long-standing illness. Moreover, although there is evidence of decreased prevalence of some long-standing conditions, mortality associated with those conditions has also fallen, implying that those who survive might experience an expansion of multi-morbidity and greater level of disability or ill health⁵⁷.
- 3.9 The proportion of people over 65 with a disability in England has remained relatively constant over the last ten years⁵⁸. However, as the absolute number of over 65s has increased, so has the number of over 65s with disabilities and long-standing illness.
- 3.10 The very oldest groups are particularly likely to experience long-standing illness or disability; of an estimated 10 million over 65s in England in 2018⁵⁹, 36% of people aged 65 to 74 have a long-standing illness, rising to 55% for those 75 years or older. For adults aged 20 to 64, this figure is 19%⁶⁰.
- 3.11 People are living longer, but those extra years are not necessarily being spent in good health. Compared to the early 1990s, people over 65 now spend more years of their life with some level of dependency⁶¹. As shown in Figure 13, Disability Free Life Expectancy (DFLE) at 65 has not kept pace with improvements in Life Expectancy (LE), meaning more years lived with a disability for both men and women; the gap has increased more for women.
- 3.12 Life expectancy for men remains shorter than for women, with an average gap of 3.7 years over the last 5 years⁶². Life expectancy and health vary significantly by socio-economic characteristics, as discussed below^{63, 64}.

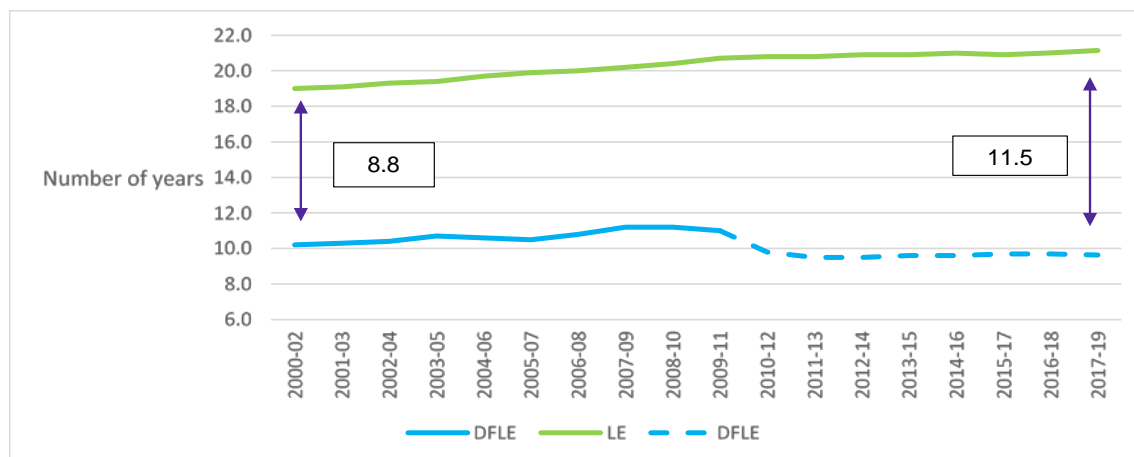
3.13 Note that the pandemic affected mortality and years of life lost more for men than for women⁶⁵. However, it is too early to understand what, if any, impact these changes will have on longer-term life expectancy rates⁶⁶.

Figure 13: Life expectancy (LE) and disability-free life expectancy (DFLE) at age 65, 2000 to 2019^{xxiii}

Males



Females



Sources:

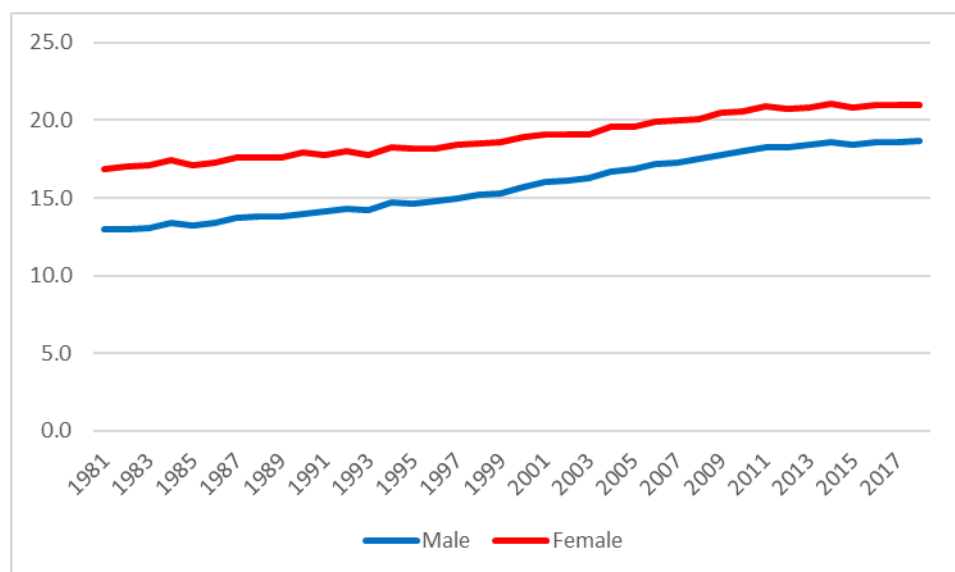
ONS, 2014. Solid line data: [Health Expectancies at Birth and at Age 65 in the United Kingdom: 2009-11](#).

xxiii The method, data source and items classifying a case of disability were different for the figures 2000-02 to 2009-11, compared with 2010-12 to 2015-17.

ONS, 2021. Dashed line data: [Health state life expectancies, UK: 2017 to 2019](#).

- 3.14 Though life expectancy in the UK has risen continually since the 19th century, these rises have been slowing down since 2011, as shown in Figure 14. This has been driven particularly by slower improvements in life expectancy for females and those aged 90 years and over.

Figure 14: Life expectancy at age 65, 1981-2018, UK



Source:

ONS, 2019. [Expectation of Life, Principal Projection, UK](#).

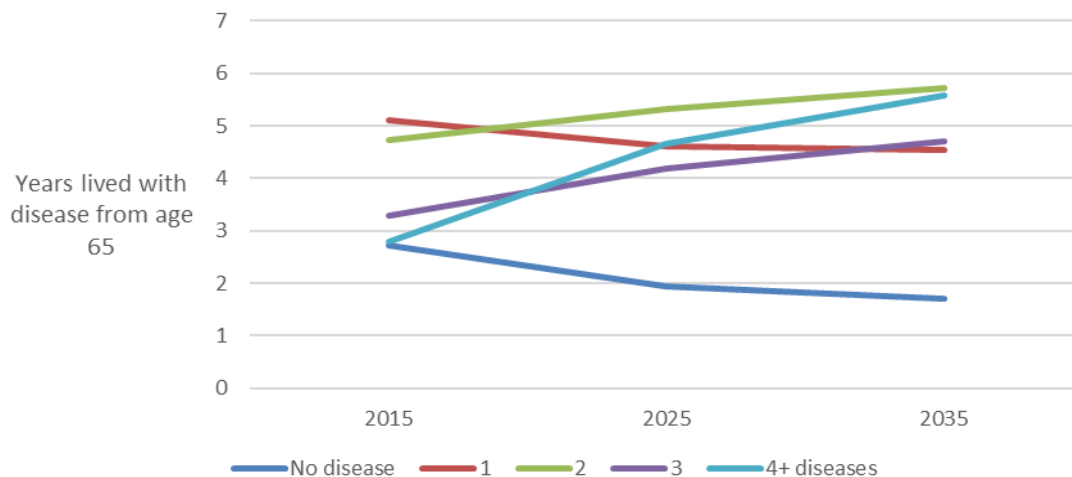
The future population of over 65s living with disabilities and multiple health conditions

It is projected that the number of over 65s with multiple conditions and disabilities will continue to grow.

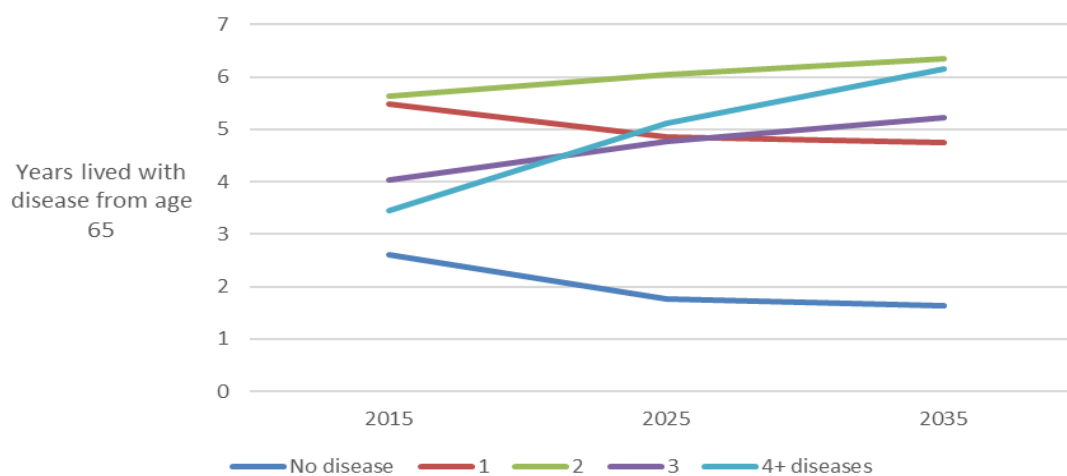
- 3.15 The increase in numbers of over 65s with disabilities and long-standing illness is likely to continue. Although there are different approaches to projecting this accurately, the number of years 65-year olds live with multiple conditions is expected to increase over the next 20 years, as shown by Figure 15.

Figure 15: Years lived from age 65 with multi-morbidity based on diseases and impairments^{xxiv}, by year (2015, with projections to 2025 and 2035) and sex

Males



Females



Source:

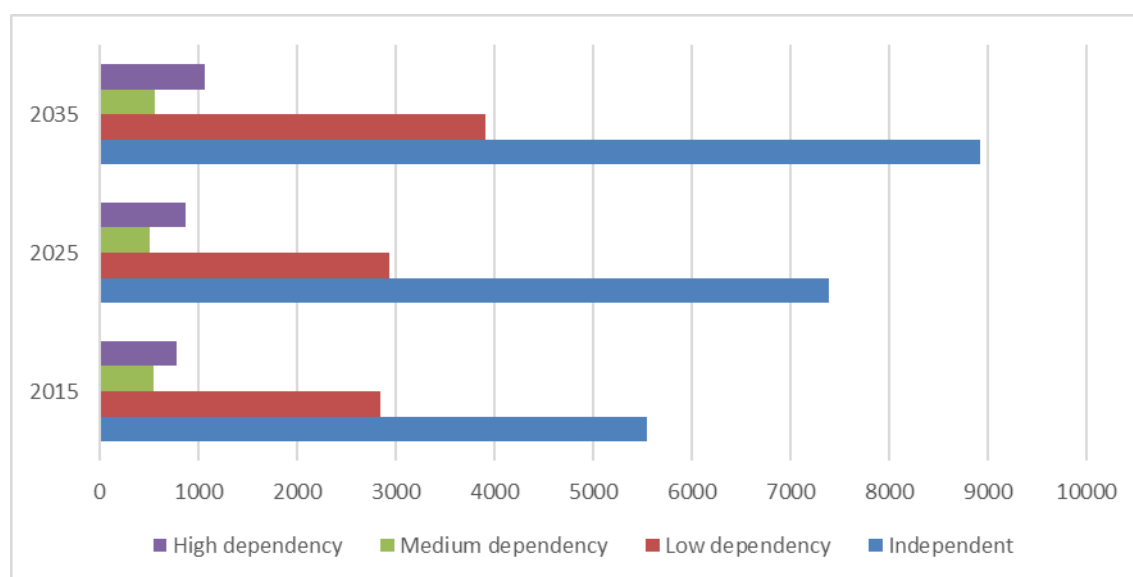
Kingston et al. 2018. [Projections of multi-morbidity in the older population in England to 2035: estimates from the Population and Care Simulation \(PACSim\) model](#). Reproduced with the permission of the authors.

xxiv Diseases and impairments include: CHD, stroke, hypertension, diabetes, arthritis, cancer, respiratory disease, dementia, depression, hearing impairment, vision impairment and cognitive impairment.

3.16 The number of over 65s needing help with one or more daily living tasks is projected to increase by 48% over 20 years: from 3.5 million in 2018 to 5.2 million in 2038⁶⁷. Stroke, cognitive impairment, arthritis and visual impairment have the biggest impact on the number of years over 65s live with a disability.

3.17 As shown in Figure 16, projections of the numbers of over 65s with dependency, measured in terms of intervals of care need, show that the numbers of people with medium or high dependency (requiring care at least daily) will increase from 1.3 million in 2015 to 1.6 million in 2035; of these, 1.06 million will have high dependency (requiring 24-hour care), compared to 783,000 in 2015⁶⁸. There is also a projected 61% increase in the number of people aged 65 and over living independently^{xxv}. The research indicates that this is largely driven by the growing number of independent men entering the over 65 population.

Figure 16: Projected numbers of people aged 65 years or older in England with dependency (thousands)



Source:

Kingston A Comas-Herrera A and Jagger C for the MODEM project. 2018. [Forecasting the care needs of the older population in England over the next 20 years: estimates from the Population Ageing and Care Simulation \(PACSim\) modelling study](#). *Lancet Public Health* (3): e447–55.

xxv Different definitions and interpretations of the concept of dependency exist, but, for the purpose of this paper, dependency is defined based on the so-called interval of needs: high dependency (needs 24-h care), medium dependency (needs help at regular times daily), low dependency (needs help less than daily), or independent (free from care)

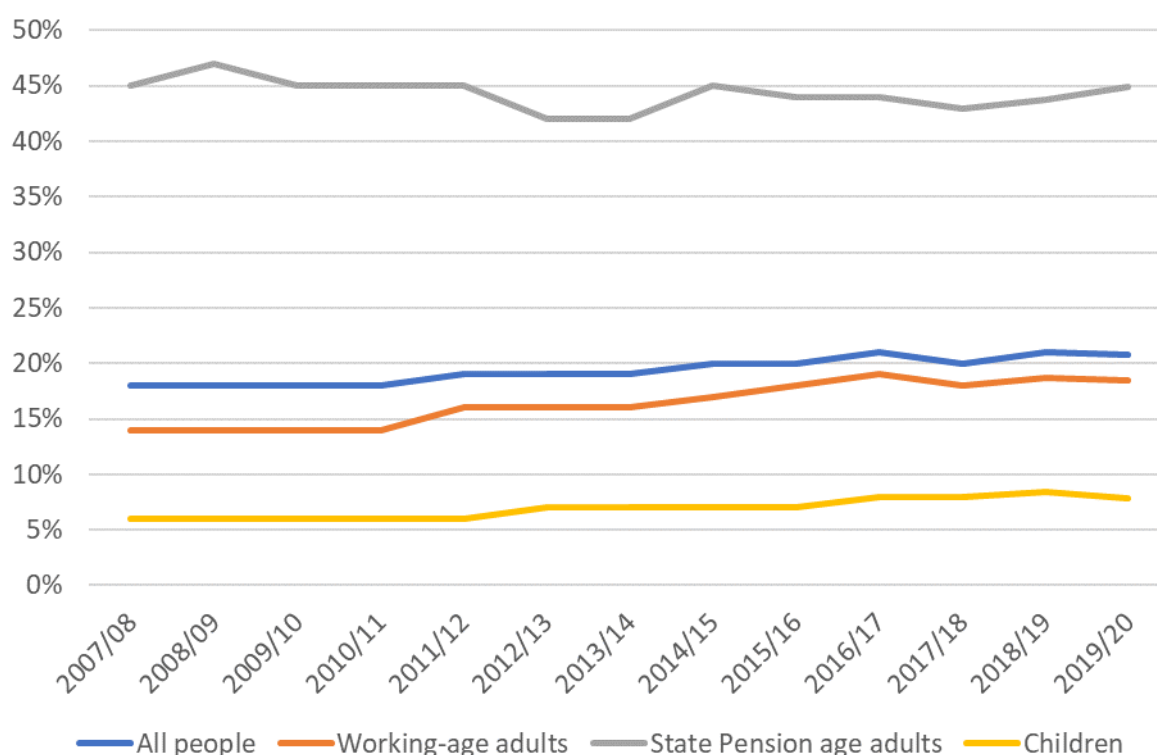
- 3.18 Co-morbidities may become an increasingly pertinent issue. For example, based on current trends, one in four adults is projected to be obese by 2030⁶⁹. Although long-term prevalence rates are challenging to predict, obesity is itself linked to other conditions such as arthritis⁷⁰ and cardiovascular disease. It is anticipated that obesity will be a driver of higher multi-morbidities amongst younger generations in the future and therefore increase the demand for social care.
- 3.19 Although the age-specific rates of dementia prevalence and incidence have decreased in the UK in the last two decades⁷¹, due to increasing numbers of people reaching older ages and surviving other illnesses, the total number of people living with dementia is rising.⁷²
- 3.20 60% of people receiving home-care services are living with dementia⁷³. Similarly, 69% is the average prevalence of people living with dementia in care homes in the UK (63% of men and 71% of women)⁷⁴. Recent projections, considering expected demographic trends and risk factors, suggest that the number of people living with dementia in England will increase from 750,000 in 2019 to almost 900,000 in 2025 and to more than 1.3 million by 2040⁷⁵. Among those living with dementia in 2035, over 900,000 people are expected to be living with substantial dependency (requiring daily care), and 732,000 will also have 2 or more other diseases⁷⁶.

The impact of increasing numbers of adults under 65 living with disabilities

The proportion of adults under 65 with a disability has risen in recent years. Much of the social care spending on this group is concentrated among those with a learning disability as their primary need. The number of people with learning disabilities is growing. This is driven by a combination of better diagnosis, increased longevity, and higher rates of survival of premature babies. It is projected that there will be a sustained growth in social care needs for adults with learning disabilities between now and 2030.

- 3.21 In England, 18% of adults under 65 had a disability in 2019/20, constituting a rise of 4 percentage points since 2007/08⁷⁷. This increase has driven up the proportion of people of all ages with a disability over the same period (from 18% in 2007/08 to 21% in 2019/20; see Figure 17)⁷⁸.

Figure 17: Disability Prevalence by age group, 2007/08 to 2019/20, England^{xxvi}



Source:

Analysis based on Family Resources Survey, 2019/20

3.22 There are different types of disabilities, including learning disabilities, physical disabilities, and mental health needs. Nearly half (49%) of adults under 65 who received long-term social care support from their local authority in 2020/21 were doing so as a result of a learning disability⁷⁹. Furthermore, 63% of adults under 65 accessing local authority funded residential care have a learning disability⁸⁰. Nursing and residential care are one of the major elements of social care spending for adults under 65 with learning disabilities (32% of net spending on long-term care for adults under 65 in 2020/21). The other major element is the combination of supported living and supported accommodation (38% of net spending).

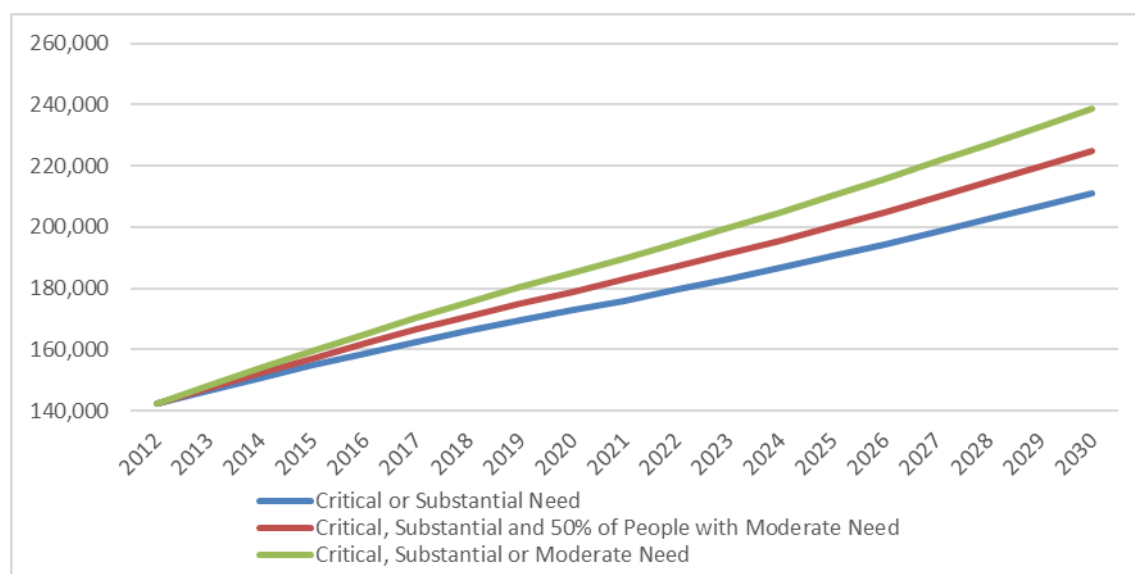
^{xxvi} From 6 April 2010, the State Pension age for women has been gradually increasing. FRS data contained in this report was collected throughout the financial year 2019/20, during which the State Pension age for both men and women increased from 65 years 2 months to 65 years 8 months

- 3.23 We do not know the exact number of people with learning disabilities in England, as no government body collects comprehensive information about this. The number of people on the Learning Disability Register in 2019/20 was 308,200⁸¹. However, this is likely to be an underestimate. The Public Health England Learning Disabilities Observatory estimated there were 1,087,100 people in England with learning disabilities in England, with 930,400 adults aged 18 and over and 156,700 children and young people (aged 17 or under) in 2015, combining information collected by various government departments⁸².
- 3.24 All sources suggest that the number of people with learning disabilities is growing. This is driven by better diagnosis and reporting of learning disability (e.g. better diagnosis in school with National Curriculum Tests known as SATs and Special Educational Needs protocols, and better recording by GPs), increased longevity and increases in the survival of premature babies⁸³. GP records suggest an annual growth of 7% in the number of people registered with learning disabilities from 2019/20 to 2020/21⁸⁴. This growth may have been partly driven by the need to register for a COVID-19 vaccine.
- 3.25 Whilst people with learning disabilities are living longer than they used to, their life expectancy is still shorter than that of people without learning disabilities. Data from 2018/19 showed men on the GP learning disabilities register are expected to live on average 14 fewer years than other men, while for women the reduction in life expectancy is 17 years⁸⁵. This data does not account for the impact of COVID-19 on life expectancy of people with learning disabilities.
- 3.26 Disability prevalence overall is more common in women than men⁸⁶. However, prevalence studies and service use data suggest more men than women have learning disabilities⁸⁷.

Users of Adult Social Care with Learning Disabilities in the future

- 3.27 Eric Emerson and Chris Hatton produced a report in 2012 stating that there would be sustained growth in the need for social care services for adults with learning disabilities between 2012 and 2030. They estimated average annual increases varying from 2.0% to 2.7% depending on whether services were only provided to new entrants to the system with critical or substantial need, or also offered to some with moderate needs. These estimates imply that support would need to be provided to between an additional 37,000 to 52,000 adults with learning disabilities by 2030 (see Figure 18).

Figure 18: Estimated Number of Users of Adult Social Care with Learning Disabilities, 2012-2030



Source:

Emerson and Hatton. 2012. [Estimating the need for Social Care Services for Adults with Disabilities in England 2012-2030](#), NIHR. Data available in table 5

3.28 The authors also estimated that:

- Approximately 25% of new entrants to adult social care with learning disabilities will belong to ethnic minority backgrounds;
- Approximately one in three of new entrants will come from a home in which the child is eligible for Free School Meals (nationally one in six children in this age range is eligible for Free School Meals).

3.29 These projections are based on a specific set of assumptions about the change in future underlying demand, though the authors suggest that the rate of change in demand for care could be higher than these projections suggest. This is because there could be a reduction in the capacity of networks providing unpaid care in the future due to a number of factors including: increases in single-parent families, increasing rates of maternal employment, increases in the percentage of over 65s with learning disabilities (whose parents are likely to have died or be very frail), and changing expectations among families regarding a person's right to an independent life⁸⁸.

The role of preventative interventions

- 3.30 Evidence shows that prevention and early intervention programmes, such as those promoted by the National Institute for Health and Care Excellence, can prevent or delay the onset of long-term conditions and improve over 65s' wellbeing and independence⁸⁹. The Lancet Commission on Dementia Prevention, Intervention, and Care, for example, estimates that prevention interventions could delay or prevent 40% of UK dementia cases⁹⁰. The recommended interventions were: active treatment of hypertension in midlife (45-65 years) and over 65s; more childhood education; exercise; maintaining social engagement; reducing smoking; and management of hearing loss, depression, diabetes, obesity, excessive alcohol consumption, traumatic brain injury and air pollution. CQC suggests that investment in lower-level preventative services can lead to a reduced need for care and support, leading to a £880 cost saving per person annually^{91, 92}.
- 3.31 One study found better identification and management of people with heart-related conditions^{xxvii} could help reduce the incidence of avoidable Atrial Fibrillation (AF)-related strokes by 5,000 nationally over five years⁹³. Falls prevention is another area where interventions can help reduce demand for social care. Reducing falls can help over 65s avoid functional decline and loss of independence⁹⁴, which in turn have impact on social care demand. The Public Health England Falls Prevention Return on Investment (ROI) tool⁹⁵, based on a systematic literature review of cost-effectiveness of falls interventions, highlights four successful interventions with consequent potential impacts on social care demand: home- or group-based exercise programmes, Tai Chi and home assessments and modification.

xxvii Atrial fibrillation (AF), High blood pressure and Familial Hypercholesterolaemia (FH). AF is a heart condition that causes an irregular and often abnormally fast heart rate. FH is an inherited high cholesterol condition affecting families, which can cause early heart disease.

The impact of poor or unsuitable housing

Poor or unsuitable housing can be a health risk and pose limitations on independent living for both over 65s and adults under 65, creating pressures on the NHS and social care. Adaptations and specialist housing can provide help for a range of client groups - on average, home adaptations delay the move to residential care by 4 years. Looking at the future, projected demand for adaptations and specialist housing are expected to rise.

Poor or unsuitable housing increases the need for care

- 3.32 As shown earlier in Figure 12, the number of people experiencing difficulties with daily living activities (ADLs) increases with age. Poor or unsuitable housing exacerbates those difficulties for the over 65 population and can pose significant health risks, with associated costs to both the NHS and social care. The total cost of poor housing to the NHS has been estimated at £1.4bn per annum, dominated by costs associated with excess cold and falls⁹⁶. Falls and fall-related injuries are also one of the leading precipitating factors for entering social care and for increasing social care need. They are also the major cause of emergency hospital admissions for over 65s and often result in moves from home into residential care⁹⁷.
- 3.33 In 2011, 24% of households lived in a home that failed to meet the Decent Homes Standards; in 2019 this figure had fallen to 17%⁹⁸. In 2014, those aged 85 years or over were more likely to live in a home that did not meet the Decent Homes Standards (29%). This compares to 17% for households aged 55-64 years and 20% for households where the oldest person was under 55⁹⁹. Many adults under 65 with disabilities or long-term conditions also face similar challenges.
- 3.34 Accessible housing provides safe and convenient approach routes into and out of the home and outside areas, suitable circulation space and a WC at entrance level within the home. In England in 2018, only 9% of homes had all of these accessibility features (up from 5% in 2009)¹⁰⁰. 10% of homes had at least one adaptation for a person with a disability. People whose need for accessible housing has not been met are four times more likely to be unemployed or not seeking work because of sickness or disability than those whose needs are met or who are disabled but do not need accessible housing.¹⁰¹

- 3.35 For people with hearing and visual impairment and physical mobility problems, housing adaptations can help maintain dignity, security and safety. In 2019/20, 8% of all households in England (around 1.9 million households) had at least one person with a long-term limiting disability that required adaptations to their home¹⁰². People with learning or physical disabilities or with mental health needs may also benefit from housing-related support including extra care or supported housing (e.g. with shared dining and other communal facilities) and help with personal care¹⁰³. Older adults may also benefit. Survey evidence suggests that many individuals would be more likely to consider living in extra care settings or retirement villages than in care homes if they needed support in old age¹⁰⁴. In 2016 it was estimated that 200,000 over 65s struggled to afford private rents and this is predicted to increase to over 600,000 by 2050. Additionally, in 2017/18, 43% of private renters aged 65-74 and 41% of those aged 75+ were in the low-income bracket, by 2037 this is projected to increase to 59% and 48% respectively.¹⁰⁵

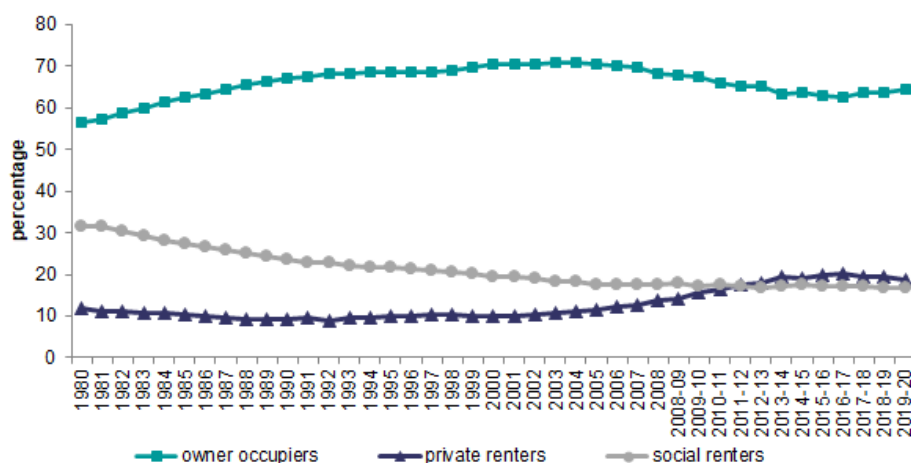
Relationships between client groups, living arrangements, deprivation tenure and housing standards

- 3.36 The majority of people with a learning disability known to local authorities live in one of the following types of accommodation: with family and friends (~36%), in supported accommodation (~23%), as a tenant or owner-occupiers (~15%) or in a registered care or nursing home (~15%)¹⁰⁶.
- 3.37 Housing standards vary between different tenures. 16% of owner-occupied homes failed to meet the Decent Homes Standards in 2019. However, the highest proportion of houses that did not meet the Decent Homes Standards (23%) is currently in the private rented sector¹⁰⁷. In the private rented sector, households which contained someone with a long-term illness or disability were more likely to live in poor housing^{xxviii} than other private renters. Households that included someone with a long-term illness or disability were also more likely to live in deprived areas than other households¹⁰⁸.
- 3.38 As shown in Figure 19, the private rented sector has more than doubled in size since 2002. There has been a considerable increase in the proportion of 35-44 year olds in

xxviii Defined as a home that has serious damp or mould, a Category 1 HHSRS hazard, is non-decent, or has substantial disrepair

the private rented sector (9% in 2003/04 to 27% in 2019/20)¹⁰⁹. Trends in housing tenure would have implications for future care needs.

Figure 19: Trends in tenure (proportions), 1980 to 2019/20¹¹⁰



Sources:

MHCLG, 2020. [English Housing Survey 2019 to 2020: headline report](#). Can be seen in figure 1.1.

1980 to 1991: DOE Labour Force Survey Housing Trailer

1992 to 2008: ONS Labour Force Survey

2008-09 onwards: English Housing Survey, full household sample

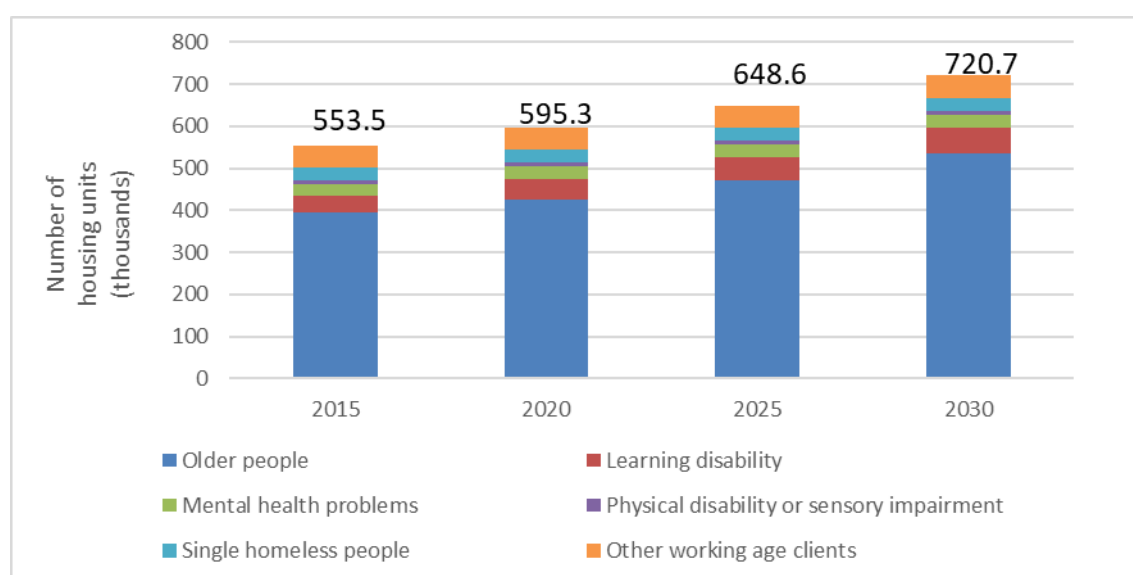
Increases in demand for housing across client groups

3.39 Demand for housing-related support for both older and under 65 adult groups is increasing as the number of over 65s and adults under 65 with disabilities increases. 53% of households that required adaptations did not have all the adaptations they needed (1 million households)¹¹¹. While the majority of households that required adaptations describe their homes as suitable, there are differences in satisfaction between different groups; People aged 75 and over with a long-term limiting disability were least likely to state their accommodation was unsuitable (13%). Households with a person aged under 55 who had a long-term limiting disability were more likely (30%) to state their accommodation was unsuitable than their counterparts in other age groups (20% or less) and nearly half of the households that wanted to move somewhere more suitable contained someone with a long-term disability aged under 55¹¹². This may be due to changing and developing health issues among younger occupiers with a long-term limiting disability, whose home does not meet their new needs and is yet to be adapted.

Factors which may reduce the impact of poor or unsuitable housing

- 3.40 Home adaptations such as grab rails, stair lifts etc. can reduce health costs and care costs by helping to reduce the risk of injury, enabling faster discharge from hospital, and delaying the onset of admission to residential care^{113,114}. On average, home adaptations delay the move to residential care by 4 years¹¹⁵.
- 3.41 It has been estimated that for every £1 spent on adaptations for groups at risk of a fall, there is a saving of £3.17 to the public purse (mainly social care and health)¹¹⁶. When quality of life benefits are included then £1 spent on home assessments and adaptations yielded £7.34 in benefits to society. Mitigating fall hazards on stairs amongst households with an adult aged 65 or older has been estimated to offer a positive return on investment of 62p per £1 with payback occurring within less than eight months¹¹⁷.
- 3.42 Specially designed housing can also support people to maintain independence and improve health outcomes and can be of benefit to a wide range of client groups including older, disabled and vulnerable people. Projected demand estimates as indicated in Figure 20 imply there is a potential untapped market for accessible properties.

Figure 20: Projected demand for supported housing in Great Britain 2015 to 2030 by user type



Source:

Wittenberg and Hu. 2017. [Projected demand for supported housing in Great Britain 2015 to 2030](#), CPEC. Data available in Tables 2, 3 and 4

- 3.43 Residents of housing built specifically for over 65s generally show high levels of satisfaction, improved wellbeing, better health outcomes and reduced healthcare costs¹¹⁸.
- 3.44 Significant numbers of people with needs for accessible features have the means to consider the purchase of a home, with 39% of households with an identified need for accessible housing having an income in the top half of the population distribution as a whole¹¹⁹.
- 3.45 The supported housing sector in Great Britain provides specialist accommodation and support for over 700,000 people to allow them to live as independently as possible in the community^{xxix}¹²⁰. An estimated 71% of supported housing units (461k) across Great Britain accommodate over 65s and 29% of units (189k) accommodate working-age people with a very wide range of support needs. Across Great Britain nearly half of all supported housing for working-age client groups is accounted for by provision for people with either learning disabilities (around 25%) or single homeless people (around 20%). Provision for people with mental health problems accounts for around a fifth (18%) of all working-age provision and together these groups account for more than three in five (63%) of all working-age provision^{121, 122, 123}.
- 3.46 A 2010 report by Frontier Economics^{124 xxx} suggested that investment in specialist housing delivered a net benefit for all adult client groups (over a 40 year period). The highest benefits per person were received by people with learning disabilities (£6,764 p.a.), with significant benefits also achieved for people with mental health problems (£4,671 per person per year). The net benefits for over 65s were lower, at £444 per year, but the larger client group numbers deliver a larger total net benefit overall. Sources of benefits were found to vary by client group. For older people, the primary benefits were in reducing reliance on health and social care services. For people with mental health issues the benefits were primarily associated with health services, while for learning disabilities they primarily accrued to social care services.
- 3.47 Estimates suggest 80% of the homes in which people will live in 2050 have already been built¹²⁵. Increasing the numbers of specialist homes and ensuring homes are accessible may help address unmet demand for those who wish to move; however,

xxix Definitions have changed over time. Can include sheltered + retirement + extra care, depending on the definition used Some include housing with no support built-in.

xxx £ figures are as modelled in 2010 and have not been adjusted.

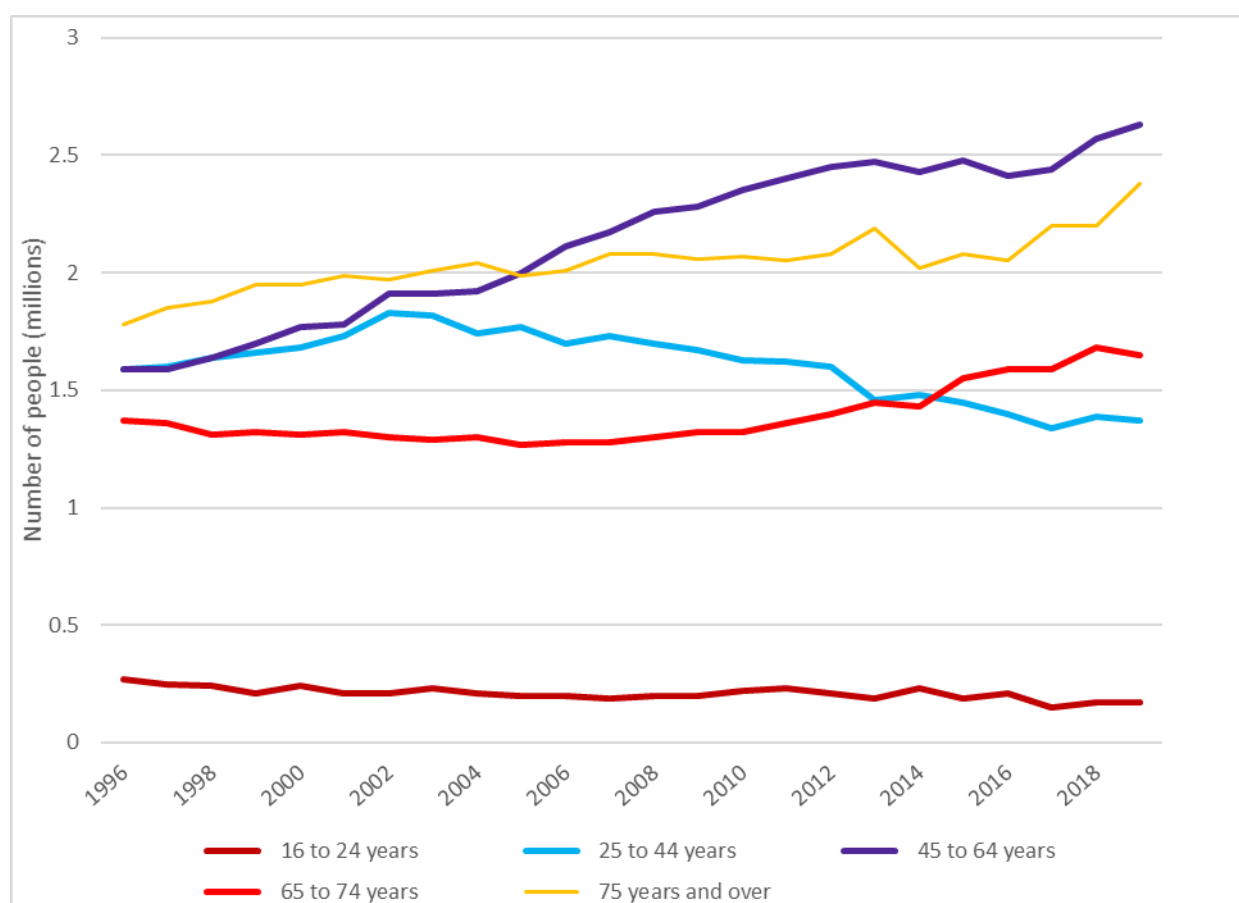
improving the condition, suitability or adaptability of the current housing stock is likely to have a more significant short-term impact.

The impact of changes in living arrangements

The increasing number of people over 65 living alone may further increase future care need.

- 3.48 As Figure 21 shows, the number of over 65s living alone is increasing. 49% of all people living in one-person households in 2019 were aged 65 and over; the equivalent figure for those aged 75 and over was 29%¹²⁶. Whilst many people living alone manage well and remain independent, this increase may have implications for care needs.

Figure 21: People living alone by age group, 1996 to 2019



Source:

ONS, 2019. [Families and Households](#).

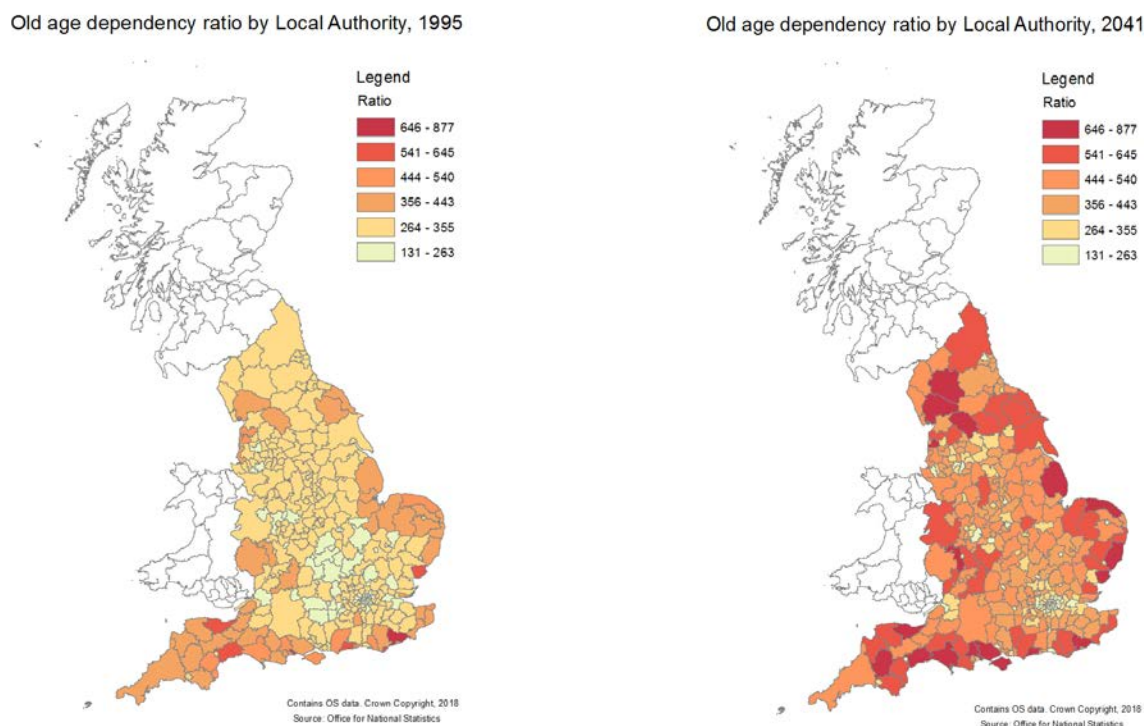
- 3.49 Widowed older homeowners living alone with long-term health conditions are found to be associated with greater risk of feeling lonely more often. Of all individuals in this group, 69% reported that they felt lonely “occasionally” or more frequently. This compared with 46% in the sample of adults in England overall who reported feeling lonely “occasionally” or more frequently. At even greater risk of feeling lonely more often were unmarried middle-agers also with long-term health conditions. In this group 81% of individuals reported that they felt lonely “occasionally” or more frequently. This shows that health problems or disability may be factors in the greater frequency of reported loneliness in these groups. However, the third group found to be associated with greater risk of feeling lonely more often were younger renters with little trust and sense of belonging to their area, showing that those in good health and without disability can also be at risk of experiencing loneliness¹²⁷.

Variation in these challenges by geography and socioeconomic status

Old age dependency ratios vary widely between regions as do the socioeconomic factors associated with high disability and morbidity rates.

- 3.50 The maps in Figure 22 below show that old age dependency ratios are significantly higher in rural and coastal areas. This is driven by the significant migration of older people from cities to coastal and rural areas, which leads to different ratios of adults over 65 to the working age population, with related implications for matching workforce supply and demand¹²⁸. In some regions they are projected to rise to over 500 people over 65 years old per 1000 people under 65.

Figure 22: Old age dependency ratio by Local Authority in England 1995 and 2041



Source:

ONS, 2020. Population of State Pension age and working age, and old age dependency ratios, for local authorities and regions in England. [1995 data](#) and [2041 data](#).

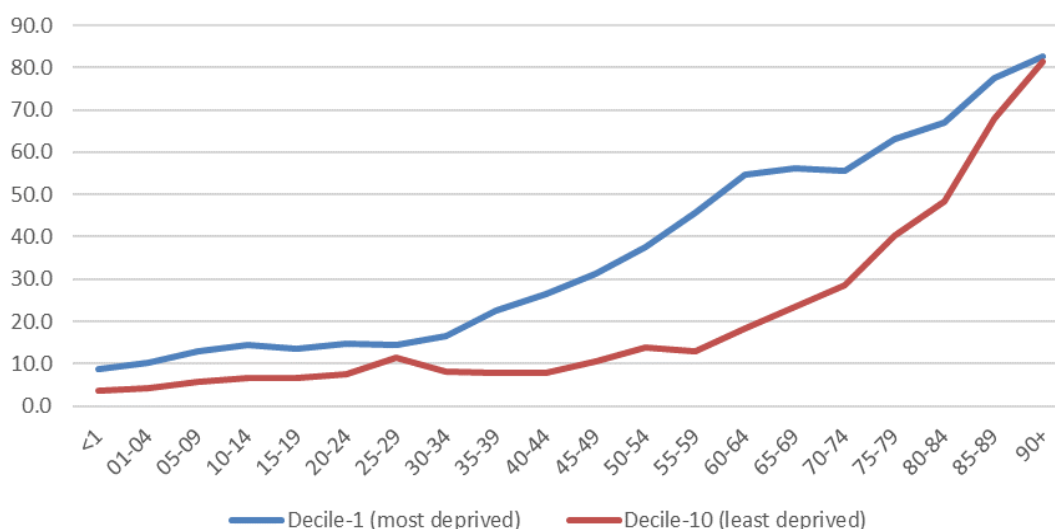
- 3.51 Disability affects twice as many people in the most deprived areas as in the least deprived (over 50% of 65 to 69 year olds in the most deprived areas are disabled, compared with c.25% in the least deprived)¹²⁹. There is a similar pattern for multi-morbidities, with people in more deprived areas becoming ill earlier, and more likely to experience mental health disorders¹³⁰.
- 3.52 The most deprived groups have a lower life expectancy at birth – for men the difference between life expectancy for the most and least deprived is nearly a decade (84 years compared with 74)¹³¹. Both men and women from the most deprived groups have a greater prevalence of disability across their life course than the least deprived - as shown by Figure 23 below. Disparities in disability-free life

expectancy have increased due to larger gains in more affluent areas^{132xxxi}. Patients from more deprived groups are also more likely to have multiple morbidities, though the gap narrows in older age, as illustrated in Figure 24.

3.53 As people from deprived groups are more likely to qualify for state funding, this variation in disabilities between the most and least deprived has important implications for local funding allocation.

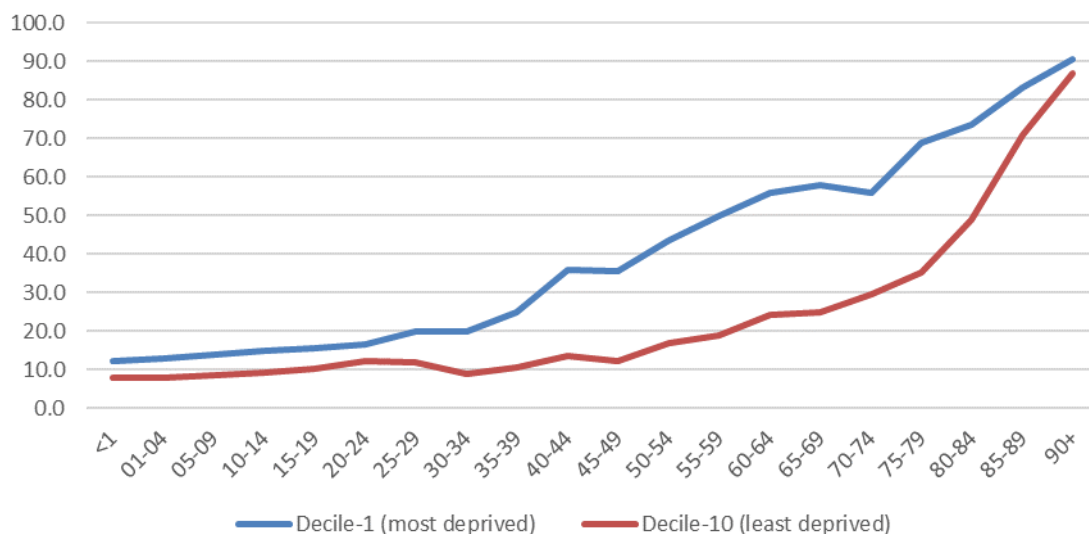
Figure 23: Prevalence of disability by level of deprivation and sex, England, 2014 to 2016

Males



xxxi Analysis was done using 1991 and 2001 data.

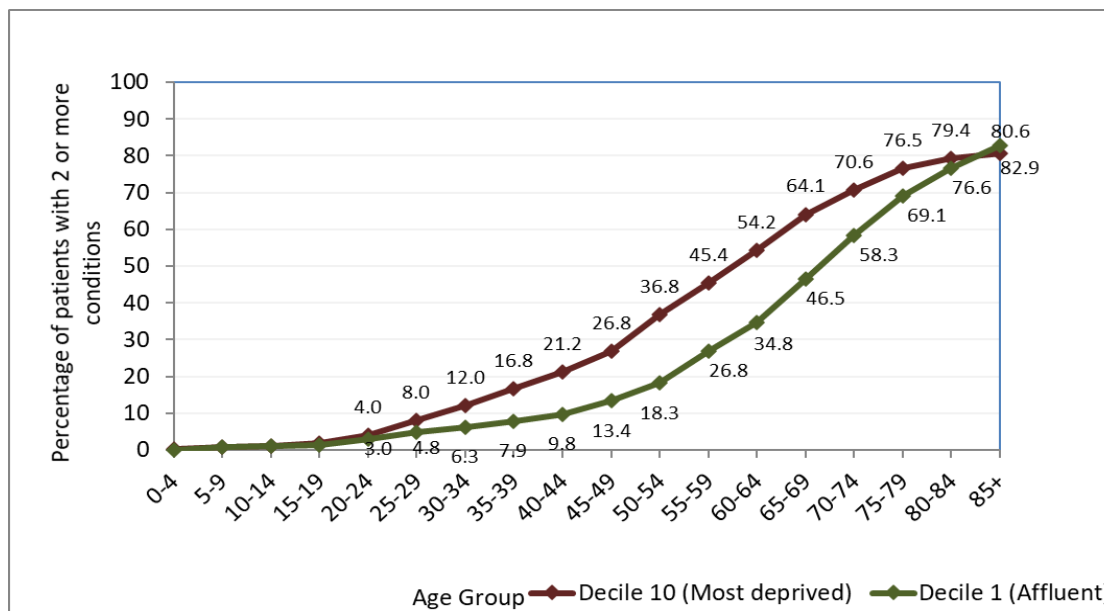
Females



Source:

ONS, 2018. [Prevalence of disability by deprivation decile, England, 2014 -2016.](#)

Figure 24: Multi-morbidity by age group and socioeconomic status

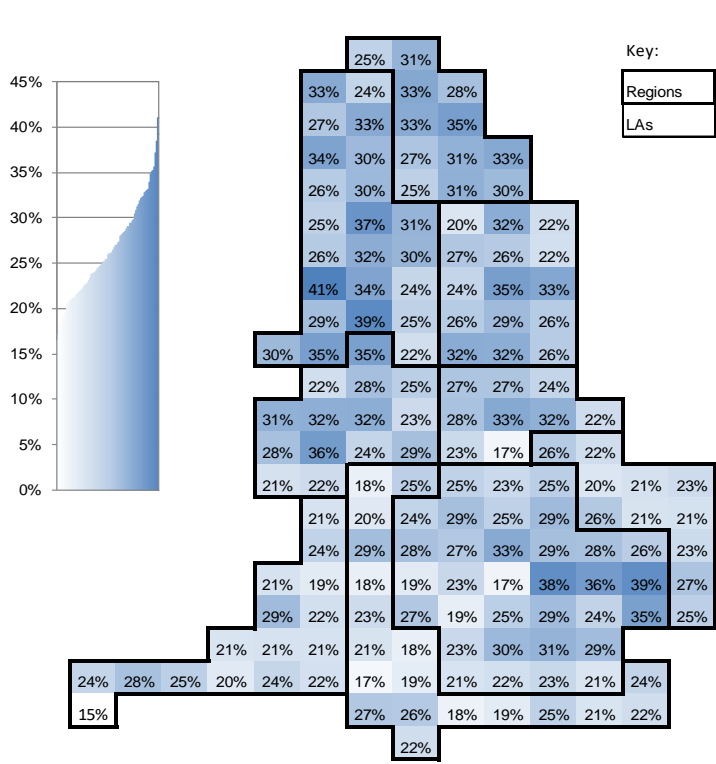


Source:

Barnett et al. 2012. [Epidemiology of multimorbidity and implications for health care, research and medical education: a cross-sectional study.](#) The Lancet 37-43 Reproduced with the permission of the authors

3.54 Figure 25¹³³ shows geographical variation in levels of disability. Those aged 65+ in the North are more likely to have their day to day activities limited substantially by disability. This may reflect earlier onset of illness and disability compared with other regions.

Figure 25: People aged 65+ reporting "day to day activities are limited a lot", as a proportion of older (65+) population^{xxxii}



Source:

DHSC analysis, based on data from Census 2011

xxxii Each square box on the maps above represents a local authority

4. The resilience of the different aspects of Adult Social Care to present and future pressures

4.1 The present chapter first discusses the characteristics and availability of unpaid care and how that might change over time. It then proceeds with reviewing the resilience of different aspects of the formal care system:

- the availability of care home beds and the variation in provider profitability due to the different proportion of LA and self-funded clients across regions;
- the availability of home care provision and the challenges the sector faces;
- the impact of people funding their own care on future patterns of provision;
- workforce pressures and pressures posed by the introduction of the National Living Wage;
- productivity in Adult Social Care;
- the use of technology in the Adult Social Care system.

Unpaid care

Unpaid carers support millions of people in meeting their care needs. However, factors such as people having children later in life, people having fewer children, a higher proportion having no children, and rising female employment all seem likely to reduce the number of people able to provide unpaid care. Providing unpaid care, particularly at high intensities, impacts individuals, society, and the economy. The extent of these impacts can vary depending on the needs of the person being supported and on the circumstances and experience of the person providing care.

4.2 The 2011 Census indicated that about 10% of the population in England was providing unpaid care (about 5.4m people in 2011)¹³⁴. Of the 5.4 million people

providing unpaid care in England, 3.4 million (64%) provide care up to 20 hours a week, while 720,000 (13%) provide care for between 20 to 49 hours a week and 1.3 million (23%) provide care for 50 hours or more a week.

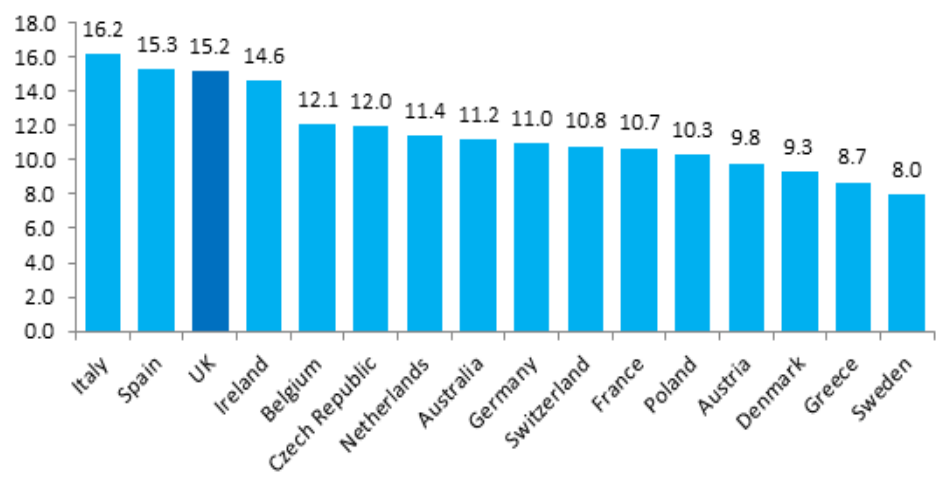
- 4.3 The 2011 Census shows that unpaid carers are people of all ages: 110,000 (2%) are under the age of 16, 4.1 million (76%) are under 65 and 1.2 million (22%) are aged 65 or over. In terms of the number of men and women providing unpaid care, 2.3 million (42%) unpaid carers are male and 3.1 million (58%) are female. Many unpaid carers have jobs and other caring responsibilities alongside the unpaid care they provide for friends and family: of those carers over the age of 16 years and including carers of pension age, 2.9 million (54%) are employed, 2.2 million (42%) are economically inactive and 200,000 (4%) are unemployed.
- 4.4 The number of people providing unpaid care and the intensity of the care provided is rising^{135, 136, 137}. Between the 2001 and 2011 censuses, the number of unpaid carers in England increased by 500,000 from 4.9 million to 5.4 million. The largest growth was in the category of people providing fifty or more hours per week of care. Unpaid care has been growing faster than population growth since 2001 in all regions in England, except for London and Yorkshire and the Humber^{138, xxxiii}.
- 4.5 Of the 5.4 million unpaid carers in England recorded through the 2011 Census, 4.8 million (89%) are white, 70,000 (1%) are multiple ethnicity, 350,000 (7%) are Asian/Asian British, 130,000 (2%) are Black/African/Caribbean/Black British and 40,000 (1%) are from 'other' ethnic groupings not captured in the 2011 Census. Much of the difference in the size of these groups will reflect national demographics. The difference in proportions is less stark when looking at the proportion of different ethnicities who provide unpaid care. This shows that 11% of white people, 6% of people from multiple ethnicities, 9% of Asian/Asian British, 7% of Black /African/Caribbean/Black British people provide unpaid care and 7% of people from 'other' ethnic groups provide unpaid care. Further differences in the age profile and health status between different ethnicities might also contribute to differences in the proportion of people providing care across ethnicities.
- 4.6 Alongside the Census other data sources exist that provide us with rich information about the provision of unpaid care in England, including the Family Resources Survey, the Health Survey for England and Understanding Society. These alternate, more recent data sources also inform the view that the number of people who

xxxiii Based on data 2001-11.

provide unpaid care in England will have increased since the 2011 Census. All data sources which provide estimates of the number of carers and information about their characteristics will have limitations, including people not recognising themselves as unpaid carers. In addition, there exists some variation across data sources in question wording asking about the provision of unpaid care.

- 4.7 Women tend to provide more unpaid care. Data from the Health Survey for England (2019) reports that around 20% of women have caring responsibilities, compared to 14% of men. The difference in the provision of care between genders is most pronounced amongst adult carers aged 45-64 where 30% of women provide unpaid care compared to 18% of men. In terms of the intensity of care provided, women between the ages of 16-44 and 45-64 tend to provide more care per week compared to men of the same age, though men aged 65 and over tend to provide more intensive care than women¹³⁹. It is uncertain how the gender balance will change in the future.
- 4.8 The number of over 65s who are providing unpaid care is rising¹⁴⁰. Almost 1 in 4 unpaid carers are aged between 45-65, and 1 in 5 are over the age of 65. Spouses are one of the fastest growing groups of care providers, including growing numbers of older men¹⁴¹. In terms of who receives unpaid care, 50% of carers provide care to a parent, and around 20% care for a spouse, partner or cohabitee within the same household¹⁴². 35% of adult unpaid carers provide care and support to someone they live with, those providing unpaid care to someone they live with are far more likely to be providing care at a higher intensity compared to someone caring for someone who does not live with them¹⁴³.
- 4.9 The UK has a relatively high proportion of older unpaid carers supporting over 65s compared to other countries. As shown in Figure 26, in 2011 the UK was third only to Italy and Spain out of a selection of OECD countries in terms of the number of people aged 50 and over caring for people aged 65 and over¹⁴⁴.
- 4.10 Figure 27 illustrates the spread of caring responsibilities across different age cohorts, showing a spread of responsibilities across generations for those carers aged under 65, in contrast to over 65s who are more likely caring for each other as they age.

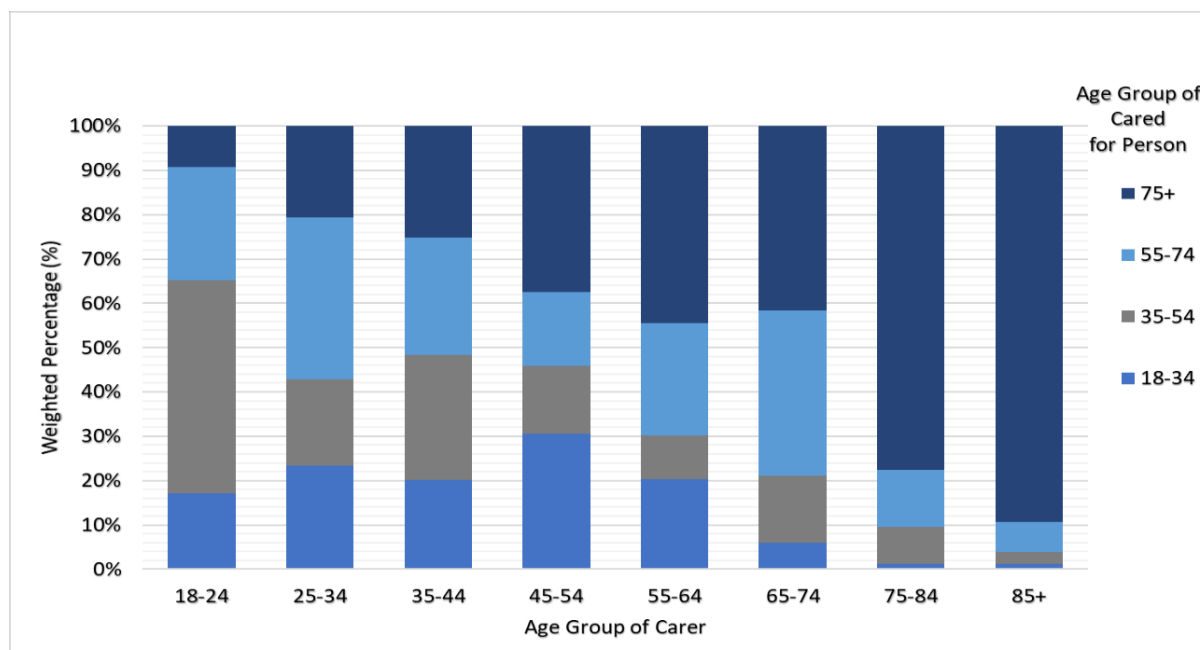
Figure 26: Percentage of population over 50 reporting to be unpaid carers for over 65s, providing help with activities of daily living (ADLs)



Source:

Colombo, F., Llena-Nozal, A., Mercier, J., Tjadens, F. 2011. [Help Wanted? Providing and Paying for Long-Term Care](#). OECD Health Policy Studies, OECD Publishing, Paris.

Figure 27: Age group of carers by age group of the person they care for



Source:

SACE, NHS Digital, 2019. [Personal Social Services Survey of Adult Carers in England \(SACE\) 2018-19](#). Data available from Table 2A.

Future role of unpaid care

- 4.11 Several factors may limit the willingness or ability of people to provide care in the future. Potential pressures include reduced numbers of children that are in adulthood living with or near to their older parents¹⁴⁵, rising employment levels including amongst women¹⁴⁶, increasing childbirth age and rates of sandwich caring (i.e., as individuals are having children later in life¹⁴⁷ this increases the risk of having to care for children and over 65s at the same time) and the increasing complexity of family and working lives, including growing divorce rates amongst over 65s^{148, 149, 150}.
- 4.12 In addition, decreased fertility rates, a trend towards smaller family sizes, and increasing numbers of lone parents or childlessness will mean a higher proportion of over 65s will not have children or will have fewer children who could potentially provide care for them in the future^{151, 152}. In 2019, there were estimated to be 23,000 women aged 80 years in England and Wales who did not have children. By 2045, this is projected to increase to 66,000¹⁵³.

Impact of providing unpaid care on carers

- 4.13 The provision of unpaid care, particularly at high intensities, can negatively impact the health, well-being, quality of life, and economic and employment outcomes of the person providing care. As the number of carers increase, and the proportion providing high intensity care grows, we can expect to see a greater number of carers experiencing these adverse impacts.
- 4.14 Although some studies report positive impacts of providing unpaid care on an individual's health and wellbeing at low intensities¹⁵⁴, most research suggests caring, particularly at higher intensities, is associated with poorer physical and mental health¹⁵⁵. Research finds that, after considering age and other sociodemographic factors, carers are 16% more likely than non-carers to live with 2 or more long-term health conditions¹⁵⁶. The negative impacts on health and quality of life are worse for high intensity caring^{157 158}
- 4.15 Caring can adversely affect a person's employment, particularly when caring for many hours a week. A greater number of carers who are providing care for 10 or more hours a week report having had to reduce their hours, find a new job or reduce responsibility at work as a result of caring compared to those providing less intensive care¹⁵⁹. In fact, evidence finds that for some groups of carers, caring for 10 or more hours per week is significantly associated with an increased probability of that person having to leave employment, for example amongst female carers aged between 50 and State Pension Age¹⁶⁰.

- 4.16 Amongst those carers who have been assessed and/or are in receipt of local authority support, we see that the proportion of carers who report feeling tired, depressed or having disturbed sleep have all increased from 2016/17 to 2018/19. Amongst the same group, the number who report not being in paid employment because of their caring responsibilities increased from 21% in 2016/17 to around 23% in 2018/19. The proportion who reported that their caring role caused 'a lot of financial difficulties' increased from around 10% in 2016/17 to around 11% in 2018/19¹⁶¹.
- 4.17 According to a survey of 2,000 UK employees, almost one in five (19%) employees aged 45 and over expect to leave work in order to care for adult family members. Women in particular (20%) are more likely to see their careers cut short by the need to care for a relative or a partner, but men are not far behind (17%)¹⁶².
- 4.18 Caring has also been shown to affect overall wealth and pensions and savings for retirement¹⁶³. As the age group most likely to provide care is between 50 to 64, this group is particularly affected as this is also the time when people are consolidating their pensions¹⁶⁴.
- 4.19 Different sub-groups of unpaid carers may have different experiences of providing unpaid care. One example might be sandwich carers - those who care for both sick, disabled or older relatives and dependent children – who are more likely to report symptoms of mental ill-health, feel less satisfied with life, and struggle financially compared to the general population¹⁶⁵. Alternatively, the rates of depression are higher among those who provide care for people with dementia than among caregivers of people with other chronic illnesses¹⁶⁶. In addition, research finds that younger carers, and those with poor social and financial support, may experience higher 'carer burden', and that older carers, and those living in the most disadvantaged areas, are providing the most care (in terms of the number of hours per week). More time spent caring may place carers who are older or living in disadvantaged areas, at greater risk of poor health or delays in meeting their own needs¹⁶⁷.

Local Authority support for unpaid carers

- 4.20 In 2020/21, there were 388,730 unpaid carers who had been assessed and/or were in support of local authority support. This includes 338,180 who were in receipt of direct support including 'direct payments' and 'managed personal budgets'. Of those in receipt of direct support, the majority (68%) had received 'information, advice and other universal signposting'. In addition, 33,045 carers had been indirectly supported through support delivered to the cared-for person. This type of support may include respite or other forms of carer support delivered to the cared-for person¹⁶⁸.

- 4.21 Of the 388,730 carers assessed and/or supported by their local authority in 2020/21, 7,105 (2%) were under the age of 18, 211,015 (54%) were between 18-64 and 170,610 (44%) were 65 or over.
- 4.22 Compared to the previous year (2019/20)¹⁶⁹, there had been a 3% increase in the total number of unpaid carers assessed and/or supported from 376,130 to 388,730. In absolute terms, there has been an 11% increase in the number of unpaid carers in receipt of information and advice, and a 28% reduction in carers who had been supported indirectly through support delivered to the cared-for person, including respite.
- 4.23 Looking over a longer period, back to 2014/15, we see that there was a general decline in the number of carers assessed and/or supported up until 2019/20 where there was a 9% increase on the previous year. Since 2014/15 there has been a growth in the number and proportion of carers supported through 'direct support', from 76% in 2014/15 to 87% in 2020/21. This growth has primarily been driven by an increase in the proportion of unpaid carers who have been assessed/reviewed who are supported through information and advice, growing from 45% in 2014/15 to 59% in 2020/21. Information and advice has seen the largest growth out of all types of carer support across this period; in fact, aside from direct support, the other support types have seen a reduction in the number and proportion of assessed/reviewed carers in receipt since 2014/15.
- 4.24 Of the carers who have been assessed or are in receipt of local authority support in England, over half (51%) care for someone with a physical disability, 21% care for someone with a learning disability or difficulty, 22% care for someone with a mental health condition and 35% care for someone with dementia¹⁷⁰.
- 4.25 The Health Survey for England (2019) reported that 55% of adult unpaid carers were providing care without receiving any form of support themselves. Possible support included support from their local authority/social services, professional care staff, charity organisations, or friends and family. The most common form reported was help from other family members (33%), followed by friends or neighbours (12%).
- 4.26 The Survey of Adult Carers in England surveys carers aged 18 and over in England who are in receipt of local authority support during the year, most recently in 2018/19. The survey reports that carers have found it increasingly difficult to access information or advice in relation to their caring role. Around 38% of carers who accessed information and advice found it 'fairly' or 'very' difficult to find in 2018/19, compared to around 36% in 2016/17. The proportion of carers who find information/advice difficult to access has been steadily increasing since 2012/13 when the survey began. There has been an increase in the proportion of carers who

find the information/advice they receive to be unhelpful. 14% of carers reported that the information/advice they received was 'very' or 'quite' unhelpful in 2018/19, compared to 13% in 2016/17¹⁷¹.

Implications of people providing unpaid care for society and wider economy

- 4.27 In England, it has been estimated that the public expenditure cost of carers leaving employment is at least £2.9 billion a year^{xxxiv, 172}.
- 4.28 Looking specifically at unpaid carers between the ages of 16-25, it has been estimated that across the UK the provision of care amongst this group creates a total additional annual cost to the state of £1,048 million compared to people aged 16-25 who are not providing unpaid care. This cost is based on lower tax revenue from young adult carers, welfare benefit payments and health service use by this group¹⁷³.
- 4.29 The New Economic Foundation (NEF) developed a model which draws on data from a number of disparate data sources to capture and illustrate a wide range of socio-economic costs associated with unpaid care. What the model captures includes lost earnings from employment, monetised estimates of anxiety/depression, and monetised estimates of social isolation – much of which can then lead to a cost to the state. The NEF estimates the cost of the provision of unpaid care to be between £24bn to £34bn per year¹⁷⁴.

xxxiv Based on increased benefits combined with lost earnings from the group leaving work, but without accounting for lost input into the economy through decreased spending by carers.

The care home market

The care home market is facing several specific challenges. In some regions, providers are reliant on a high proportion of local authority funded clients because lower home ownership rates and house prices mean that more people fall below the means test threshold for paying for their own care. This makes it increasingly difficult to maintain a viable market as LAs in some regions are paying significantly below the full economic cost of care. In areas where there is a higher share of self-funders, private sector investment is increasingly focused on that group, which constrains the size of the market local authorities can afford to buy into.

- 4.30 65% of people in England aged 85 or over were disabled in 2012^{xxxv}, this is equivalent to 670,000 people¹⁷⁵. Between 2012 and 2020, the number of disabled people aged 85 or over had increased by just under 20%, to 800,000, though disability prevalence remained similar at around 66%¹⁷⁶. The oldest age groups are most likely to require residential or nursing care home support as their care needs become increasingly complex.
- 4.31 The latest Capacity Tracker data (for week ending 24th August 2021) suggests over 310,000 adults live in care homes for over 65s in England¹⁷⁷. CQC data from October 2021 suggests that there are around 11,150 such care homes for this age group, operated by c.5,400 providers¹⁷⁸. Around 95% of beds are provided by the independent sector¹⁷⁹. The sector is dominated by SMEs; 80% of care home providers operate a single home¹⁸⁰.
- 4.32 Since 2004, the number of care home beds has been roughly constant. Before the pandemic, occupancy rates were around 85% of CQC registered beds but will have significantly reduced since, due to additional mortality from COVID-19^{181, xxxvi}. The share of these beds in care homes with nursing rose from 39% in 2004 to 47% in 2013, with a commensurate reduction in the share of beds in care homes without

xxxv The definition of disability used in the Family Resources Survey changed in 2012/13. 2012/13 values are used here to aid comparison with 2016/17.

xxxvi ONS (2021, Care homes and estimating the self-funding population, England: 2019 to 2020) estimates 85% CQC bed occupancy before the pandemic

nursing, but this trend has largely stopped since 2014. Meanwhile the number of LA supported care home clients aged 65+ has fallen from around 215,000 in 2003/04 to around 170,000 in 2010/11¹⁸². Numbers of care home client aged 65+ have continued to drop to around 150,000 in 2019/20¹⁸³ (though a data collection change in 2014/15 means numbers are not directly comparable).

- 4.33 The flat number of care home beds and reductions in local authority funded care home residents, at a time of rising demand, implies that care home residency will be concentrated amongst people who require complex care. Within the available supply, there remains significant regional variation in local authority and self-funder fee rates, CQC quality ratings and the share of smaller and larger providers. As of October 2021, the number of adult care homes has reduced by 16%¹⁸⁴ since September 2010, showing that the market is slowly consolidating. The extent of consolidation remains limited, with CQC data for November 2021 showing that the top five providers operate only 12% of beds. Around 90% of beds are privately run, based on subtracting beds with charity numbers in the CQC dataset and taking account of NHS Digital information for 2020/21 on the share of local authority funded client weeks in local authority run homes.
- 4.34 Within the market for over 65s' care homes, there is significant variation in provider profitability across regions, with Earnings Before Interest Tax Depreciation Amortisation Rent and Management (EBITDARM) ranging from 25% in Yorkshire and the Humber to almost 35% in the South East.¹⁸⁵ A key driver for this is the percentage of self-funded clients in the care home, which varies from 53% in the South East to 26% in the North East (Table 1).

Table 1: Region by the proportion of self-funded and state-funded care home residents in care homes for over 65s and/or providing dementia care, 2019 to 2020

	Self-pay percentage
East of England	43.2%
East Midlands	41.1%
London	32.4%
North East	26.0%
North West	33.9%
South East	52.5%
South West	49.7%

West Midlands	38.5%
Yorkshire and the Humber	39.5%
England	40.9%

Source:

ONS, 2021. [Care homes and estimating the self-funding population, England: 2019 to 2020](#).

- 4.35 Care homes in regions with few self-funded clients are less likely to cover their full economic cost. The Competition and Markets Authority (CMA) concluded that this is because LAs are paying as much as 10% below the economic cost of care in some regions, due in part to some local authorities' significant monopsony power arising from low shares of self-funders¹⁸⁶. According to the Care Quality Commission (CQC), care homes with more than half of their turnover financed by councils reported fee income per bed as 10% lower than other providers, and profits per bed 28% lower¹⁸⁷. To offset low LA fees, care homes often charge substantially higher fees for self-funded clients in the same care home, as the CMA has shown. The CMA concluded that self-pay fees were on average 41% higher (£236 per week/£12,000 per year higher) than LA fees in the same care home in 2015/16 (though this was based on a sample of larger providers that may not be representative, as smaller providers make up a large share of this part of the market). There was significant variation around this 41% average, with some care homes charging more than double to self-funders than they receive from local authorities.
- 4.36 Services for clients aged under 65 present a different picture, as the vast majority of clients are state funded, often with high needs. There were around 39,080¹⁸⁸ people under 65 in local authority funded residential or nursing care at the end of March 2021, which after adjusting for occupancy rates, represents around 10% of adult care home beds.
- 4.37 Local authority commissioning activity involves a range of activities beyond the procurement of services, such as deep working relationships with individual providers and local provider groups (e.g. to understand costs), quality and outcomes monitoring and broader support such as provision of additional training^{189, 190}. Such relationships will have been of particular value during the pandemic¹⁹¹. Low local authority fee rates may reflect resource constraints and there is also evidence of variability in the way local authorities deliver the market shaping duty under the Care Act. The CMA found significant variation in the quality of the 20 local authority Market Position Statements that they reviewed¹⁹² and a recent NAO report highlighted the limited levers local authorities have to influence the market¹⁹³.

The home care market

The home care market is growing but faces challenges including high levels of entry and exit and financial pressures.

- 4.38 The CQC estimates that around 500,000 people receive some form of personal care in their communities¹⁹⁴. The number of home care agencies increased by 87% between September 2010 and October 2021, and there are now around 10,800 home care agencies. Whilst there has been limited growth in extra care locations (6% increase) between April 2013 and October 2021, there has been significant growth in supported living locations (43% increase). The growth in supported living locations may be connected to the decline in the number of care homes that are not for older people and/or dementia, which has fallen by 31% over the same period¹⁹⁵.
- 4.39 Between 2012/13 and 2020/21 the number of jobs in home care services increased from 450,000 in 2012/13 to 590,000 in 2020/21, an overall increase of 31%, with the largest increase, of 7% (40,000 jobs) coming between 2019/20 and 2020/21¹⁹⁶. However, ASC-WDS data collected between March 2021 and August 2021 shows a decrease in home care jobs (filled posts) in recent months¹⁹⁷. Although local authority funded clients make up the largest share (approximately 42%, with 28% of home care purchased by the NHS, 27% purchased by self-funders and 3% by direct payments¹⁹⁸), the number of LA funded clients has dropped considerably since 2010¹⁹⁹, as shown in Figure 5.
- 4.40 As with the care home market, home care is highly fragmented. 62% of home care providers are very small and provide care from a single location (as opposed to providing care from multiple sites)²⁰⁰. Home care also has a higher rate of providers entering and leaving the market (compared to the care home market)²⁰¹, although this varies by region. This is because there are fewer barriers to entry and exit (such as the cost of property) in the home care market than the care home market.
- 4.41 Despite overall growth in the numbers of home care agencies and jobs, providers argue that they face financial challenges due to inadequate fee rates from LAs. The Homecare Association (HCA), formerly the United Kingdom Homecare Association (UKHCA), calculates the minimum cost of providing home care per contact hour at £21.43/ hour in 2021/22 (including profit margins) but found that only 13% of councils who responded to their survey were paying at or above this rate²⁰². The greater proportion of local authority funded users in an area, the more providers are exposed to the impact of LA rates. Additional rises in wage costs would increase pressures on funding.

- 4.42 The impact of low local authority fee rates for home care is manifested in workforce pressure, with annual turnover in this service being 29%²⁰³. The complexity of worker pay around travel time and mileage creates a risk that workers could be paid below the relevant minimum wage²⁰⁴. 'Time and task' procurement is still prevalent, where councils pay per contact hour, with limited take-up of more outcome-focused models²⁰⁵. Even more so than in care homes due to home care's higher use of labour inputs, providers have faced significant cost pressure from the National Living Wage rises beginning in April 2016.

People funding their own care

Precise data on the number of people funding their own care is not readily available, although it is likely to be changing substantially with the announcement of charging reform.

- 4.43 Precise data on the number of people funding their own care in England is not readily available for all types of care. Using data from the CQC (Care Quality Commission) which relate to around one third of care beds and, in conjunction with DHSC, the ONS estimated that between 2019 and 2020 (pre pandemic) around 37% of care home residents were self-funded (143,774 residents), rising to 41% of residents in care homes for older people and/or dementia. There was significant regional variation in the share of self-funders, with the most self-funders in the south east (45%) and fewest in the north east (25%). Care homes located in the least deprived areas had a statistically significant higher proportion of self-funders (54%) than care homes in the most deprived areas (22%). There was a significantly higher proportion of self-funders in rural areas (44%) compared with urban areas (35%). In addition, the data show some relationship between a higher proportion of self-funders in a care home and better-quality ratings. Only around 5% of residents in care homes specifically for adults under 65 were self-funded. There was a lower proportion of self-funders in the smallest care homes (below 20 beds). However, the relationship largely disappears when we look only at older people and/or dementia homes, as the smallest care homes are likely to have more younger adults who are less likely to be self-funders²⁰⁶.
- 4.44 Evidence on how the number of self-funders has changed over time is not immediately available but can be inferred from other sources as follows. Before the pandemic, the total number of care home beds in England had remained almost unchanged since 2010²⁰⁷ whilst occupancy also remained stable. This suggests that the number of total users was also likely to have stayed at a consistent level. As the

number of local authority supported clients had fallen, it is therefore likely that the number of self-funders had increased over time.

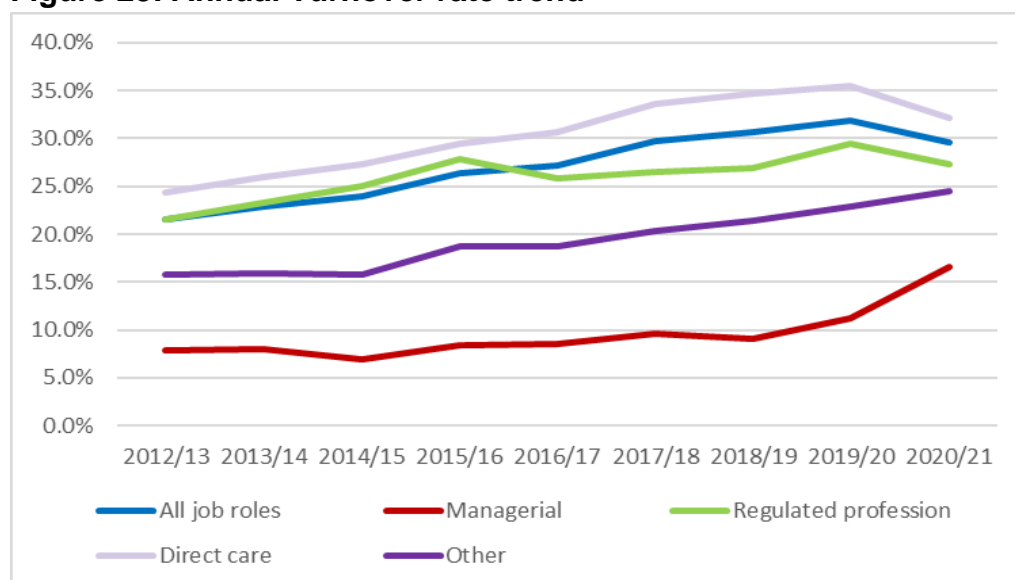
- 4.45 Similarly, the number of home care agencies and jobs in the sector has increased since 2010²⁰⁸, while the number of local authority funded clients receiving home care has reduced²⁰⁹. This may imply that the number of self-funders increased although it is hard to draw strong conclusions without good trend data. For example, the average number of hours worked may have decreased and/or the degree of needs of people receiving care increased, affecting the ratio of staff to clients.
- 4.46 There is limited data specifically on the number of self-funders aged under 65. People with lifelong disabilities are less likely to have been able to build up wealth, although some of those who become disabled during their life (such as with early onset dementia) will have done so.

Adult Social Care workforce

Areas with rising old age dependency ratios will face high demand for care but a weak workforce supply of adults under 65. Attracting and retaining staff is a challenge for the adult social care system.

- 4.47 Population ageing will mean that there is a proportionately smaller working age population, which could lead to labour market shortages in adult social care and the wider economy. More over 65s staying in work for longer could compensate for this. However, this pressure will be occurring as population ageing is also driving an increase in need for care. Ultimately, the more that over 65s provide paid or unpaid care, the less this group will be available to compensate for labour shortages elsewhere in the economy²¹⁰.
- 4.48 In 2020/21 there were an estimated 1.67 million jobs in the adult social care sector, with 1.56 million of these being within local authorities, independent sector employers and jobs working for direct payment recipients²¹¹. The number of full-time equivalent jobs (for those working within local authorities, independent sector employers and jobs working for direct payment recipients) was estimated at 1.12 million. The number of adult social care jobs in England increased by 3% (by 45,000 jobs) between 2019/20 and 2020/21. ASC-WDS data collected between March 2021 and August 2021 shows that numbers of jobs (filled posts) have started to decrease.

- 4.49 Non-mandatory returns for the independent sector in the collection of the ASC-WDS data mean that the dataset provides coverage for approximately half of the workforce. Skills for Care use this data to provide estimates for the whole adult social care workforce by making estimates of workforce characteristics for each geographical area, service type, employer type and job role combination. These estimates are weighted according to the coverage/completeness of the sector in each of these areas. Using this methodology allows for the analysis to be representative of all adult social care workers. This methodology has been peer reviewed by universities and an independent statistician.²¹²
- 4.50 As set out in Section 6, based on CPEC projections, the total number of publicly funded users (over 65s and adults under 65) is projected to rise from 631,000 in 2018 to 904,000 in 2038 (an increase of 43%), to keep pace with demographic pressures. To meet this demand increase, the workforce will have to grow proportionally in line with this projection. With the current growth rate of jobs, including a reduction in the workforce size over the course of 2021/22²¹³, creating a workforce supply gap. This places a strong emphasis on recruitment and retention of the workforce, building on the existing challenges set out below.
- 4.51 Workforce pressures are a significant challenge for adult social care. Pay rates and status in the social care sector are relatively low, leading to competition with other sectors as well as high turnover and vacancy rates²¹⁴. However, competition also exists for some higher paid roles, with nurses in adult social care and healthcare having the same professional requirements and so their employers being in direct competition – this is shown by their mean annual pay rate (per FTE) being similar, with a Registered Nurse in adult social care being £33,600 in 20/21²¹⁵ and a Nurse in the NHS being £34,371²¹⁶.
- 4.52 Funding levels have also been cited as one of the underlying causes of recruitment and retention challenges²¹⁷. As shown in Figure 28, the overall annual staff turnover rate in 2020/21 was 30%, increasing from 23% in 2012/13²¹⁸, with 37% leaving the sector. There are also high levels of staff movement between providers, as 63% of recruitment comes from within the adult social care sector. There are, however, examples of effective practices at the level of providers: Skills for Care research among employers with turnover of less than 10% found that activities including investing in learning and development, celebrating the organisation's and individual achievements and involving colleagues in decision making all contributed to staff retention²¹⁹.

Figure 28: Annual Turnover rate trend**Source:**

Skills for Care, 2021. [Adult Social Care workforce estimates, England](#). Turnover data available in Table 4.10.

- 4.53 Future migration rates may also affect workforce pressures, particularly in areas where there is a high proportion of migrant workers such as London (63% of the London workforce have a British nationality, compared with 77%-88% in the South and Midlands and over 93% in the North ²²⁰). Since many other countries have similar or more rapidly ageing demographic profiles (see Figure 9), this may potentially increase competition for highly mobile migrant workers. Though the proportion and origin of the migrant workers within the adult social care workforce has been broadly stable over the last five years (7% of the workforce have EU and 9% have non-EU, non-British nationality), the share of staff starting a job in the sector having entered the UK in the previous 12 months (a proxy for international direct recruitment) is low and has fallen²²¹. This suggests that while migration controls may affect employers' decisions to recruit directly from overseas²²², the immediate impact of recent changes to migration law on the workforce employed to deliver social care may have been limited. This also suggests that the medium-term impact on the labour supply available to adult social care employers, especially where they compete or will increasingly compete with employers in other sectors, may be more substantial.

- 4.54 Whilst firm-level turnover for adult social care roles is broadly comparable to some other low paid occupations such as sales/retail assistants and cleaners^{xxxvii}, evidence suggests both over 65 and under 65 disabled people receiving care particularly value continuity as this enables them the chance to get to know their regular carers well. As such, a high turnover/variety of staff has an emotional impact on them and may reduce the quality of care they receive ^{223, 224}.
- 4.55 Retention and recruitment challenges can also cause issues for both providers and staff who remain in the workforce. Skills for Care estimate that the cost of recruiting one replacement care worker can be up to £3,600²²⁵, capturing cover for exiting staff, advertising, and hiring for the role (including training) and lost productivity of the new worker relative to the more experienced departing worker. Though the cost may vary from provider to provider based on size, recruitment approach and the roles being hired, continual recruitment when faced with high turnover is challenging, especially where funding levels remain problematic. Workers remaining in their roles may face increased burdens of covering additional work, which could contribute negatively to the wellbeing of the workforce and increase the likelihood of burnout. ONS figures from February 2021²²⁶ show 26% of care home workers were likely to be experiencing some form of depression at the start of this year, and 27% likely to be experiencing an anxiety disorder (compared to 20% and 18%, respectively, for all adults). This situation may likely be exacerbated over time if the demand for services increases at a faster rate than the workforce size.
- 4.56 In addition to workforce numbers, the skills of the workforce are important in determining access to, and the quality of, care. By improving the productivity of the workforce (through providing the same level of care more efficiently, or providing higher quality care), skills investment may improve both outcomes for care users and pay and progression for workers, potentially encouraging retention in the sector. Skills for Care²²⁷ estimates that whilst around 44% of the workforce providing direct care have a relevant social care qualification, the remaining 56% have no relevant qualification recorded, highlighting scope for further upskilling of the workforce and formal recognition of their existing skills. In direct care roles specifically, 43% of staff held a qualification at Level 2 or above in 2021/21. Ensuring that the workforce is undertaking the relevant qualifications and training around their role going forwards,

xxxvii Skills for Care and the Longitudinal Annual Population Survey use slightly different sampling and definitional approaches. This accounts for the slightly different percentages indicated in the turnover trend and occupational rates figures above

to equip them with the necessary skills and knowledge, will be key to the care provided to users.

- 4.57 Ultimately, current workforce pressures and low skills investment impact on provider costs, workforce wellbeing and the quality of, and access to, care. Given the decrease in workforce size over 2021/22, the forecast growth in care and support needs presents a risk that these impacts may be worsened on current trends. If that happens, workforce supply pressures may mean a greater number of people needing to provide unpaid care for friends and relatives. This would reduce their own labour market participation, with consequent impacts on the wider economy (as discussed earlier in this chapter). These pressures are likely to grow over time unless mitigated by the newly reformed system.

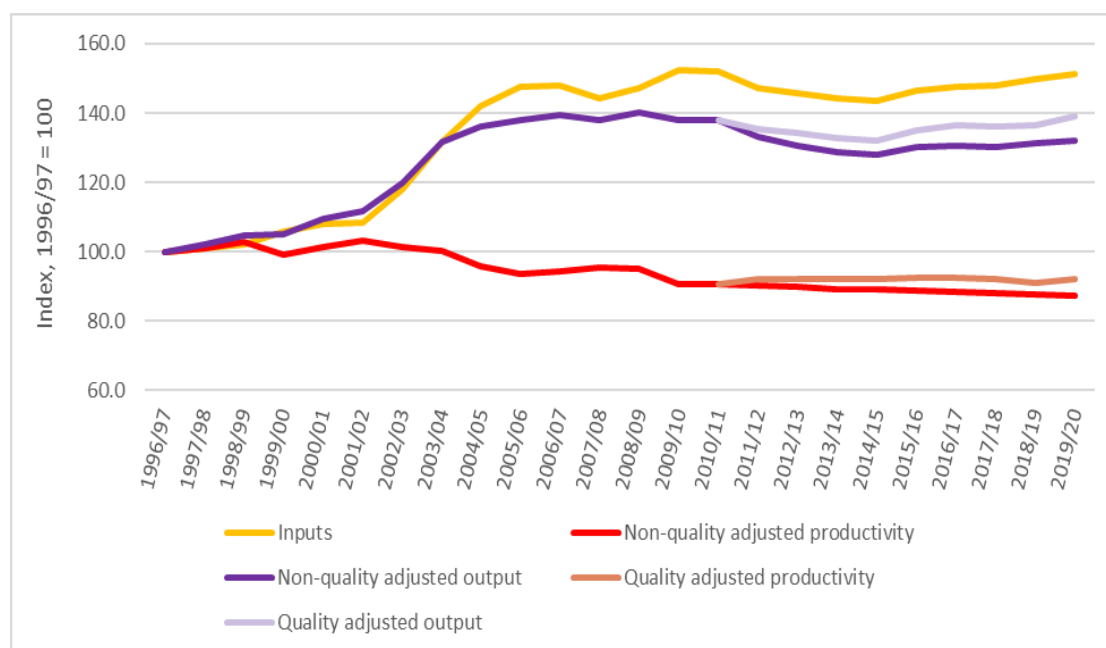
Publicly-funded Adult Social Care Productivity

The social care sector has historically been a relatively low productivity growth and low pay sector.

- 4.58 Productivity in the social care sector is a long-term challenge. While there are methodological difficulties in measuring Adult Social Care productivity, available measures suggest this has declined over time, as shown in Figure 29. However, if the data is adjusted to account for the impact on clients' quality of life^{xxxviii}, productivity shows a marginal increase between 2010/11 and 2019/20²²⁸.

xxxviii The quality adjustment to adult social care output is based on the concept of adjusted social care-related quality of life

Figure 29: Public service adult social care, change in inputs, output and productivity, England^{xxxix}



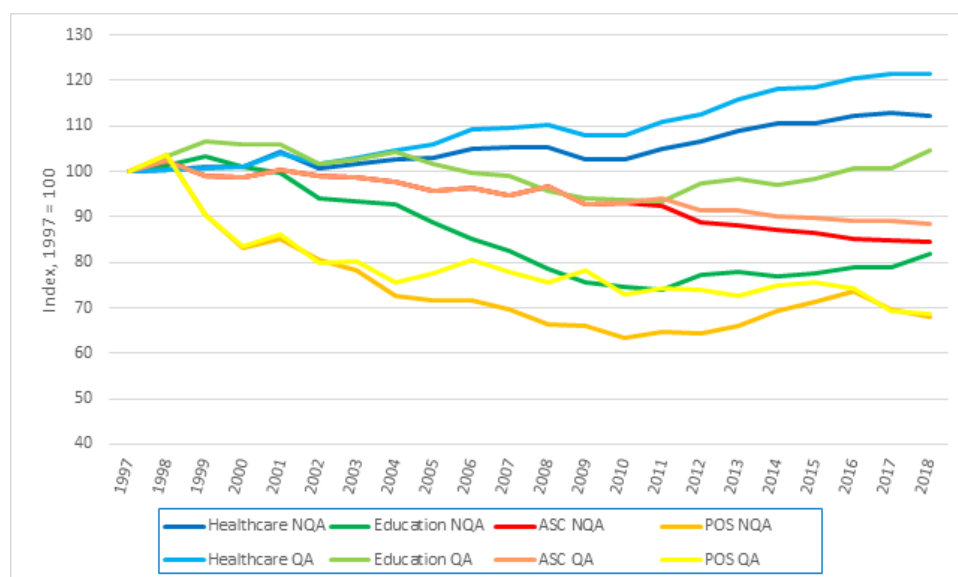
Source:

ONS, 2021. [Public Sector productivity: adult social care, England, 2019/20](#). Table 1a.

4.59 The trend of falling productivity in the 2000s, followed by more limited changes since 2010, is common to other public service sectors. Other potential drivers of low productivity in the social care sector include high levels of workforce turnover; relatively low wages; high levels of industry entry and exit, and risk-averse approaches to innovation. Local delivery of services may limit national competition between providers. Long-term investments may be delayed by a lack of certainty on returns set against more immediate financial pressures²²⁹. The relatively small size of many social care firms may not support optimum productivity, as discussed further below. As shown in Figure 30, the exception to low productivity trends in the public sector is the NHS, which has experienced improving productivity over most of the last 20 years due to improvements in technology.

xxxix The data used to produce the quality adjustment (Adult Social Care Survey - ASCS) by ONS are only available from the financial year ending (FYE) 2011 onwards, and output before this cannot be quality-adjusted. At the same time, a change to the ASCS between FYE 2014 and FYE 2015 means that no quality change can be calculated for FYE 2015.

Figure 30: Adult social care productivity in comparison with other public service sectors^{xi}



Source:

ONS, 2021. [Public service productivity estimates: total public service](#), UK 2018.

4.60 Methodological limitations on the measurement of productivity mean that it cannot be taken as a comprehensive measure of gains or losses across all facets of efficiency, which may be particularly true of social care. For example, the productivity measure in Figures 29 and 30 does not capture potential efficiency gains from shifting demand from towards different, lower cost patterns of care, or any efficiency gains made by increasing the provision of support for carers or signposting services. Furthermore, the measure is limited in its ability to capture changes in the intensity of clients’ care needs and does not capture savings made by the NHS as a result of changes in adult social care provision. In addition, there are significant challenges in interpretation. For example, in adult social care it is possible that speeding up certain tasks might at face value increase output but adversely impact upon quality.

^{xi} QA means quality-adjusted and NQA means non-quality adjusted. CSC refers to Children’s Social Care. POS refers to Public Order and Safety (excluding the Police). QA and NQA series for CSC are identical. Values for CSC are not quality-adjusted.

Technology in the Adult Social Care System

Low levels of uptake of technology and innovation are one potential driver of low productivity in the sector. Other industries have been quicker than the social care sector to adopt and scale-up technologies that have transformed their business models. There is potential for improvement, though evidence of what works is currently limited.

- 4.61 Digital and technological innovation has proliferated in other industries.²³⁰ Although not a silver bullet, technology offers potential routes to complement care worker support, improve quality and address the social and economic impact of increasing care needs, if appropriately applied²³¹. Technology has the potential to reduce service demand and allocate resources more efficiently, for example, by preventing emergencies and treating people closer to home. The internet of things, sensors, robotics, big data and Artificial Intelligence could all support this goal but are not widely adopted in the adult social care industry at present, though examples of good practice are accumulating both in the UK and internationally. Telecare offers the ability to link data from a range of home sensors with personal alarms and activity monitoring. Data patterns produced by such devices can help staff identify and respond to incidents (e.g. detecting when people become stuck in bed) and predict incidents before they happen. For example, changes to gait could indicate a higher likelihood of falls. Alerts produced by these systems could then be monitored by remote control centres that can respond quickly to emergencies.
- 4.62 Estimates for what can be automated are hard to come by. The Institute for Public Policy Research calculates 30% of work done by adult social care staff could be automated, with savings and improvements valued at £6 billion (based on the value of time saved).²³² However, the assumptions underpinning these estimates are not based on the English health and social care system but on U.S. emergency departments²³³ and should be treated with caution. A lot will therefore depend on whether these automation improvements are applicable both to the UK and to adult social care.
- 4.63 The pandemic has highlighted how low uptake of technology and digital approaches in adult social care can exacerbate delivery problems. For example, a lack of comprehensive, accessible data hindered COVID-19 death reporting²³⁴. However, multiple reports suggest that COVID-19 has prompted a step change increase in the use of some technologies in the sector, such as video-conferencing, online training, and secure email²³⁵. These can bring practical benefits: making it easier for citizens

and carers to interact with services; using anonymised outputs to improve commissioning; creating a better understanding of what interventions will have greatest impact; and enabling professionals to work from multiple locations and in multi-disciplinary teams, exchanging information securely.²³⁶

- 4.64 Technology can be used to improve quality of care, improve efficiency of services or enhance autonomy and quality of life – these are mutually supportive. Online platforms offer the opportunity to help service users connect with carers and services and combat social isolation. For instance, the Digital Lifeline provided a connected tablet to 5.5k adults with learning disabilities – 90% reported a positive impact including 68% feeling more confident and 52% less lonely²³⁷. Increasing the uptake of robotics could improve people’s mobility and their independence. Such approaches are being enthusiastically adopted in care homes in Japan, where examples include beds that can adapt into wheelchairs, balance support robots, assisted limbs, and powered back supports for carers. They are also deployed for therapeutic purposes, offering social interaction, basic conversation, exercises and games²³⁸. Growing use of consumer technology, such as common smart home platforms, represents an opportunity to use lower-cost devices which people are already familiar with without the stigma associated with specialist technologies. However, questions around continuity of service and privacy need to be managed²³⁹.
- 4.65 Wider use of sensors and remote alarms, telehealth and apps could support people with long-term or complex conditions such as diabetes to live more healthily, either by monitoring their own health or sending data to clinicians who could monitor them remotely. Interconnected homes and information collected by sensors have the potential to monitor activity levels and identify problems, such as over 65s with early stage dementia waking at night confused and disorientated²⁴⁰. Adopting such approaches may therefore bring productivity benefits, but to be successful they may also require significant changes in service design, commissioning and the structure of firms.
- 4.66 Technology also has the potential to improve the efficiency of individual providers. For example, increased use of digital processes facilitates faster, potentially more secure information flows and a more efficient movement of people through the health and care system²⁴¹. Adult social care providers could make better use of standard office packages widely adopted in other industry sectors. Simple software, if used for staff rotas, could free up managers’ time. In addition, by registering patterns in the data, they could help highlight regular gaps or peaks in demand that, if addressed, would potentially improve service efficiency. The Enterprise Research Centre suggests that use of customer relationship management software raises organisational productivity by 18%, cloud-based computing by 14%, and web-based accounting software by 12%²⁴². Cumbria has implemented electronic referrals to

support effective transfers of care, an approach that has delivered annual efficiency savings of £400,000 to date²⁴³. Technology can also support staff to work from any base, including remote and mobile working. In addition, technology can support collaboration in multi-disciplinary teams²⁴⁴. These sorts of technologies may have broader applicability in social care, supporting existing firms that may be struggling but who could improve their efficiency if they invested in new approaches alongside additional training for their workforce and management.

- 4.67 Opportunities range from low to high technological initiatives; simple adaptations include handrails to help prevent falls while, at the opposite end of the spectrum, the influence of Artificial Intelligence and robotics is growing. Cognitive assistance robots (CARs) could support users in performing cognitive tasks with the potential to support people with dementia, Alzheimer's disease and other cognitive impairments²⁴⁵. The UK could learn from initiatives in Japan, such as the use of care homes as test beds for new technologies in elderly care. For example, devices for lifting patients and supporting their mobility and robots for comforting and stimulating elderly patients^{246, 247}. The market for personal care robots currently stands at \$155m in Japan and is predicted to grow to \$3.7bn by 2035²⁴⁸.

Barriers to the use of technology

- 4.68 Barriers to using technology in adult social care apply at a number of different levels.

System level

- 4.69 Uncertainty around future levels of both public funding and self-funder contributions can act as a barrier to both development of new products and investment in them. High upfront costs combined with uncertain returns, limited budgets and unwillingness by private individuals to invest in 'ageing' create challenges to develop and market price-sensitive products at scale. Wider infrastructure can be a problem: variable regional broadband and 4G capacity is a critical barrier to adoption of technology. 24% of care providers surveyed cited 'lack of infrastructure' as a barrier implementing technology in the next five years²⁴⁹. Areas with rapidly ageing populations, for example rural or coastal areas, often have worse connectivity²⁵⁰. Financial pressures can restrict the scaling and sustainability of new approaches²⁵¹. The deactivation of analogue telephone services in 2025 represents a challenge to care providers using legacy technology.
- 4.70 Local authorities' assessments of their own digital maturity highlight ongoing concerns such as poor interoperability with partner organisations, particularly the NHS^{252, 253}. There can also be a lack of buy-in to innovation from organisational leadership²⁵⁴; poor inter-organisational sharing of 'what works', and a lack of risk appetite in councils²⁵⁵, particularly where changes may require closure of existing

services²⁵⁶. At a firm level, high labour mobility may mean firms do not reap the benefits of training individual staff. However, there is evidence that the social care sector has steadily increased its use of digital tools in recent years. The pandemic saw a "seismic shift" in the use of videoconferencing software and 20% of social care organisations now consider themselves to be digitally "expert" compared to 12% in 2019²⁵⁷.

- 4.71 There are also system level security risks. 111 UK councils experienced 256 ransomware incidents between March 2014 and April 2017²⁵⁸, with a 2017 iGov survey stating 76% of those surveyed had experienced a cyber-attack and 50% were ransomware victims in the last 12 months²⁵⁹.

Provider level

- 4.72 Providers also acknowledge that technology has not yet been widely adopted by individual organisations. Social care managers surveyed²⁶⁰ note that use of digital technology has been concentrated in areas such as workforce learning (96% of respondents say this), recruitment (97%) or external marketing and communications (95%), rather than in frontline service delivery with clients. For example, 40% or fewer reported the use of assistive technologies for helping people with daily living. Care providers report uncertainty about how to create a technology strategy, and whose responsibility this is²⁶¹.
- 4.73 A potential contributory factor is that the sector is fragmented and dominated by Small and Medium Size Enterprises (SMEs). Smaller firms are over-represented in the least productive of British businesses²⁶². Average levels of productivity are materially lower for small firms (fewer than 50 employees) than larger (on average by around 7%)²⁶³. Research by the OECD²⁶⁴ suggests a large number of (cross-sector) SMEs have not been able to reap the benefits of technology to improve productivity, due to a lack of investment in knowledge-based assets e.g. research and development, human resources, organisational changes and process innovation. Better knowledge-sharing of 'what good looks like' between more and less productive firms could be critical to improving productivity in adult social care.
- 4.74 Recent research commissioned by NHSX suggests high levels of agreement that digital technology plays an important role in adult social care and widespread but mixed use. The research identified potential for greater use, particularly to deliver care and support independence. The research also found barriers among some of the workforce to developing digital skills and to increased use of digital technology. Lower awareness of technology was found among care users and unpaid carers. Lack of familiarity and opportunity to use digital technology were the main barriers to developing digital confidence, rather than lack of skills. Learning and development to

build confidence and stronger digital leadership were proposed as solutions²⁶⁵.

- 4.75 Finally, there has been a succession of funds to support innovation in the sector, for example the £98m Healthy Ageing Challenge²⁶⁶. Interviews with the sector raised the need for broader investment in care technologies²⁶⁷.

Individual level

- 4.76 There is relatively less evidence on what users of adult social care most want from technology. Some service users and their carers may feel uncomfortable relying on technology to provide important aspects of their care. Currently, over 65s remain less likely to use the internet – of the 4m adults who had never used the internet in 2019, more than half (2.5m) were aged 75 years and older²⁶⁸. 92% of non-disabled adults use the internet compared with 81% of disabled people. The differences are greatest among adults over 75²⁶⁹. Regardless of age or familiarity with technology, users may be concerned that technology will replace a human carer or demonstrate that they aren't coping²⁷⁰. Assumptions that the NHS will cover adult social care needs may prevent over 65s themselves investing in improvements²⁷¹. This all presents a risk that, as more and more processes move online, disparities may emerge between those who are comfortable using the internet or have easier accesses to it, and those who do not²⁷². The growth of home technologies and digital assistants provides an opportunity to use these for care.

5. The relationship between the Adult Social Care system and other relevant support mechanisms

The relationship between Adult Social Care and the NHS

The health and social care systems work closely together but can place pressures on each other, leading to adverse impacts such as delayed transfers of care. Government policy is driving closer integration of the two systems, with some evidence of positive impacts on quality and outcomes for patients, but so far there is less evidence of cost-effectiveness. There is some research indicating a link between social care spending and NHS performance, but more research is needed to strengthen the evidence base.

- 5.1 The purpose of the adult social care system is to improve the quality of life for care recipients and their carers, but it can also help manage NHS demand. The community support that local authorities provide to individuals can reduce the number of unnecessary GP consultations, ambulance call outs and Accident and Emergency (A&E) attendances, whilst the right amount of investment in social care can ensure there is appropriate capacity to meet demand coming from acute care such as people being discharged from hospital. Conversely, the NHS can help manage demand for social care services by ensuring that people are not discharged from hospital before they should be²⁷³, preventing admissions, e.g. by providing more GP support in care homes²⁷⁴, or by focussing preventative healthcare efforts in key areas that can drive repeat hospital admissions for over 65s (e.g. stroke, dementia, continence, and falls)²⁷⁵.
- 5.2 Since 2015/16, there has been an increased amount of spend on adult social care every year from the NHS contribution to the Better Care Fund (BCF), as recorded in the BCF planning data. This has increased from around £1.8 billion in 15/16 to £2.4 billion in 2020/21²⁷⁶.

- 5.3 This is largely due to the BCF mandating an increase in NHS contribution to the BCF each year (by maintaining the value in real terms in most years). The BCF also allows the voluntary pooling of CCG & LA funds into joint BCF Plans. Since its inception, local areas have voluntarily pooled at least £1.5 billion above the minimum required, in each year, with approximately £2.8 billion planned in voluntary pooled funding in 2019/20²⁷⁷.
- 5.4 Discharging patients as soon as they are clinically ready is the most effective way to support patient outcomes. Delayed hospital discharge is associated with detrimental impacts on over 65s' health and wellbeing, as being inactive can result in loss of ability to perform everyday tasks. It has been estimated that 20 to 25% of all hospital admissions and up to 50% of all bed stays could be substituted for more appropriate care out of hospital²⁷⁸.
- 5.5 Lower rates of GPs and other primary care staff per person may lead to higher A&E attendance by adults with care needs, including over 65s. The number of over 65s attending and being admitted to hospitals has increased (11% in the two years before 2016/17). Of the attendances to A&E, 380,000 came from care homes. Of the 270,000 of these that went on to be admitted, 35% stayed in hospital longer than a week. In the community, between 2009 and 2017, there was a 40% fall in the number of community matrons, and a 44% fall in the number of district nurses²⁷⁹.
- 5.6 Discharging individuals to their usual place of residence (wherever possible) as soon as they no longer need acute hospital care, and providing integrated rehabilitation and reablement support, maximises people's independence (such as regaining or learning skills to stay within their communities) and could potentially improve outcomes and lead to efficiency savings. Conservative approaches to care planning and risk assessment can lead to over-cautious decisions that restrict people's independence and increase costs. A study of five areas found 24% of people discharged from hospital with a care package could have been discharged on a pathway that delivered better outcomes at lower cost. A significant subset of these pathways leads to costly and potentially unnecessary long-term residential placements, so discharging people onto appropriate pathways is especially important. In Kent, a study found that over 80% of service users referred to residential care after an acute stay could have been given a different (non-residential) option, with greater independence and no compromise to their safety. Practitioners taking part in the study estimated that, overall, 59% of long-term residential placements following acute hospital admission could have been delayed or avoided²⁸⁰.
- 5.7 Reablement services give adults short, intensive bursts of care to regain lost skills and build confidence and independence after an injury or illness. These services

have been shown to reduce readmission into hospital. Analysis by the Care Quality Commission (CQC) shows that 83% of over 65s who received reablement following discharge from hospital in 16/17 were reported as still being home 91 days later²⁸¹. There is wide regional variation in the number of over 65s with access to reablement services: some local authorities report 1 in 10 receiving them, while others report 1 in 160²⁸². In addition, work is needed to establish best practice in the reablement for particular groups, such as adults with learning disabilities or dementia.

- 5.8 There is some research into the relationship between adult social care spending (either in absolute terms or measured in care home bed provision) and NHS performance. The research undertaken does suggest various links, for instance that increasing home care provision for over-75s reduces the number of consultations with a primary care doctor²⁸³. Other research has suggested that past cuts to adult social care spending in the England led to more A&E visits among over 65s but no aggregate impact on inpatient admissions or outpatient visits²⁸⁴.

Driver for more integration and personalisation

- 5.9 The Quality and Outcomes of Person-centred Care Policy Research Unit (QQRU) central estimate suggests a reduction in delays of 9% as a result of BCF spending up to 2018²⁸⁵. Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) have built on learning from the Vanguard programme and are the key driver to develop population health management capabilities. As part of this, ICSs are considering how they can effectively use integrated primary and acute care systems, and multispecialty community providers to support integration.
- 5.10 The growing number of people with complex multi-morbidities including mental health conditions and dual sensory (hearing and sight) impairments will require better integration of services in the future^{286, 287}. National Institute for Clinical Excellence (NICE) guidelines highlight the importance of personalised and integrated care for people with multi-morbidities in order to reduce duplication and errors, as well as early intervention to prevent further conditions manifesting²⁸⁸.
- 5.11 There is some evidence to show that some aspects of integration of care - including secondary care - can help to improve the quality of provision²⁸⁹, patient outcomes²⁹⁰ and the potential for benefits that may lead to cost-savings^{291, 292, 293} but evidence is limited as many interventions are still at an early stage of implementation²⁹⁴. Technology can help optimise integration but, as noted earlier, uptake in the social care sector has been relatively slow compared with other sectors.
- 5.12 Interim findings of a CQC review of 20 local areas identified some positive examples of using technology to support integrated care²⁹⁵. For example, Stoke is piloting

video technology to enable GPs to support people who live in care homes more promptly.

- 5.13 There has also been a move to make services more person-centred, to better address bespoke need. Evidence suggests that when delivered well, personalised care can improve individuals' quality of life and wellbeing; particularly when the personalised care packages provide individuals with more choice and control²⁹⁶. This is particularly noticeable for people with long-term conditions. Personalised care, support planning and shared decision-making reduce unwarranted variation in the provision of care, treatment and support by ensuring that all decisions are informed based on personal preferences, bespoke to the individual's circumstances^{297, 298}.
- 5.14 The National Audit Office report on Personalised Commissioning in Adult Social Care highlighted that where personal budgets are properly implemented, supported by well-equipped practitioners and effective commissioning, evidence suggests that they are popular and effective²⁹⁹.
- 5.15 Evidence^{300, 301} also demonstrates that people who are involved in decisions about their health and care tend to:
- report greater satisfaction with the services they receive;
 - experience less regret about the decisions they have been supported to make and are more likely to say that the decision made was most appropriate for them;
 - make fewer complaints than those who were not involved in decisions.
- 5.16 Personalised approaches to health and care can also help to reduce direct pressures on acute and primary care. For example, those individuals who had more control, knowledge, skills and confidence had 18% fewer GP contacts, and 38% fewer emergency admissions. Personalised care also has a positive impact on health inequalities, taking account of people's different backgrounds and preferences, with people from lower socio-economic groups able to benefit the most from personalised care³⁰².
- 5.17 Personalised care can also be cost-effective. Giving people more choice and control over decisions about their care can lead to people accessing more appropriate services, improve co-ordination of their care, and reduce costs³⁰³. For example, personalised care has reduced costs of Continuing HealthCare home care packages by an average of 17%³⁰⁴, through providing an agreed package of care that better addresses the individual's needs and circumstances, taking into account their preferences and goals. The evidence base on personalised care needs further

development, however, studies to date have only focused on local areas and specific cohorts.

6. Future demand and individuals' resources

The average cost of care

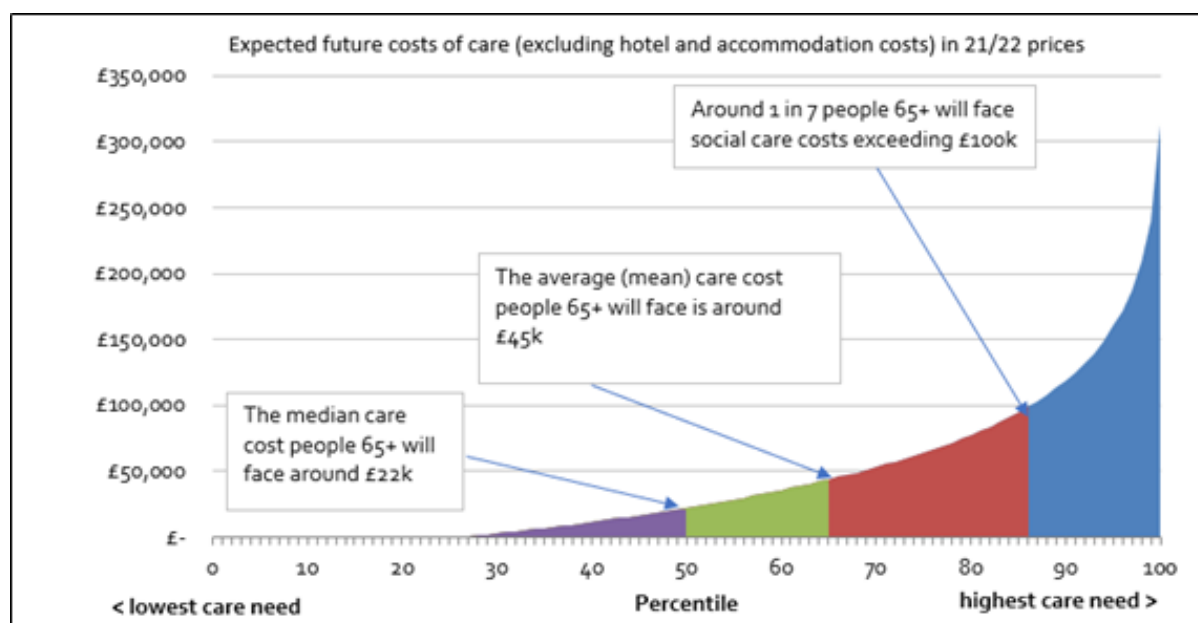
The median lifetime cost of care for over 65s (excluding “hotel” and accommodation costs) is approximately £22,000; the mean is approximately £45,000. Costs exceed £100,000 for around one in seven over 65s.

- 6.1 The 2011 Commission on Funding of Care and Support³⁰⁵ produced estimates of the lifetime cost of care for over 65s (including those who never need any care). Since then, the Department of Health and Social Care and external experts have undertaken further research and analysed new data to better understand these costs. The analysis showed that the distribution of lifetime care costs has changed very little since the 2011 report, other than by inflation in the cost of care, despite the changes that have occurred within the adult social care system. The 2011 Commission on Funding of Care and Support lifetime care cost curve, updated to 2021/22 prices, remains the best estimate of lifetime care costs.
- 6.2 As Figure 31 shows, the median lifetime cost of care (excluding “hotel” and accommodation costs) paid by users and councils combined is estimated at approximately £22,000; the average (mean) is approximately £45,000^{xli}. Costs of care exceed £100,000 for around one in seven over 65s and exceed £120,000 for around one in ten over 65s^{xlii}.

xli Figures are updated to 2018/19 prices

xlii This estimate excludes hotel costs: an amount of a residential care fee which covers room and board, rather than the costs of care received.

Figure 31: Estimated lifetime social care costs-excluding ““hotel” and accommodation costs (2021/22 prices)



Source:

Commission on Funding of Care and Support, 2011. [Fairer Care Funding: The Report of the Commission on Funding of Care and Support, UK](#)

Barriers to protection from high care costs

There are several significant supply and demand-side barriers that have prevented the development of voluntary products to enable individuals to protect themselves against these high care costs.

- 6.3 The lack of an insurance market means that people who would seek to protect their financial assets against the risks of high care costs are unable to do so, with the exception of immediate needs annuities that are expensive to purchase (average cost of £69k³⁰⁶) and therefore only available to a small, wealthy proportion of the population. There are several barriers on both the demand and supply-side that have prevented a private market for adult social care insurance developing.
- 6.4 Although there are currently no insurance options available on the market in England to spread this risk, there are in some other countries, like France. In France, 15% of over 40-year-olds population have private insurance³⁰⁷. Three key factors have affected the take up of insurance in France:

- Firstly, the fact that 45% of policies are sold as group policies as part of employment benefits, which stop after employment terminates³⁰⁸. This means that a large proportion of people with private long-term care (LTC) insurance are unlikely to be covered once they retire, and therefore when the risk of needing LTC services is greatest.
- Secondly, French individuals are used to purchasing private medical insurance to cover the user charges of medical bills and are more prepared to purchase insurance to cover LTC.
- Thirdly, public discussion in the media of how social care will be funded in the future has raised awareness of the issue.

Supply side barriers

- 6.5 Definitive evidence for why a market does not exist is, by definition, difficult to provide. However, uncertainty about the future unit cost of care and the length of time individuals will need care – known respectively as indemnity and longevity risks – make it difficult to cost insurance products accurately³⁰⁹. In addition, there is potential for there to be significant changes in the care needs of the over 65 population or the number of individuals requiring care. These potential ‘aggregate shocks’ act as a barrier to insurance providers giving a market solution to potential high care costs.
- 6.6 As with other forms of insurance products, there is also the risk of adverse selection. This is where the individuals who purchase insurance have more information than the insurance providers³¹⁰. Those with higher risk are more likely to purchase insurance than those with lower risk. This leaves the insurers carrying higher liability than would be assumed from average population levels.
- 6.7 Private long-term care coverage in other OECD countries tends to cover a small share of the cost of care, generally less than 10% of long-term spending³¹¹. Products tend to complement available public coverage or provide benefits where there is no public provision³¹².

Demand side barriers

- 6.8 On the demand-side, public misconceptions over who pays for social care may reduce demand for social care insurance products. There is limited public understanding of the system³¹³. For example, around half of the public (47%) think that social care is free at the point of need³¹⁴.

- 6.9 Behavioural science tells us that individuals are often over-optimistic about their personal level of risk relative to the average. This is referred to as ‘optimism bias’ and is displayed by around 80% of the population^{315, 316}. If individuals perceive themselves to be less likely to face social costs than the average person, they are unlikely to purchase insurance priced at the population level of risk.
- 6.10 Individuals tend to think more of immediate benefits when making decisions³¹⁷. Whilst people may be aware of their potential future social care needs and associated costs, they may not have access to the right evidence. This may prevent them from considering the value of insurance over a long-time horizon.

International Comparisons of Adult Social Care funding systems

The demand pressures that are faced by the adult social care System in England are not unique. Different countries have implemented a variety of methods to fund adult social care; from state funded (Norway and the Netherlands) to private insurance markets (France and US).

- 6.11 The following table shows a selection of countries and describes the way they fund their adult social care system. These countries were selected to show the range of options available, from state funded (Scotland, New Zealand, Norway and the Netherlands) to private insurance markets (France and US).

Country	Funding of Adult Social Care
Scotland	<p>State Offer: Scotland has a free personal care policy, which is delivered differently in respect of residents of care homes and those receiving care in their own home.</p> <p>Personal and nursing care provided in a person’s home is free.</p> <p>However, self-funders (people with assets above £28,750 in April 2021) in care homes are liable to pay a proportion of their care and “hotel” costs, while the state contributes a set amount ³¹⁸. From April 2021, the state’s contribution rates are £193.50 per week for personal care and £87.10 per week for nursing care in care homes.</p>
Wales	<p>State offer: Funding of adult social care in Wales is means tested. There is a weekly cap on home care costs and a charge for care in a care home.</p>

	<p>In a home setting, the maximum contribution is £100 per week for those that have savings and investments over £24,000 (not including the value of a home) or if the individual has a high level of disposable income³¹⁹.</p> <p>In a residential setting, the single capital limit is set at £50,000, those below the limit contribute only from their income and local authorities must ensure individuals retain a minimum income of £33 per week.</p>
Northern Ireland	<p>State offer: The adult social care funding system is similar to the current adult social care system in England, in terms of the lower capital limit, upper capital limit and contributions towards funding for residential settings. Home care is provided mostly free of charge.</p> <p>In a residential care setting the upper capital limit is £23,250, and the lower capital limit is £14,250³²⁰. Individuals contribute £1 for every £250 of assets that they have per week. Social care funding is means tested.</p> <p>In a home setting, NI Trusts tend not to charge for most home care services, the exception is Meals on Wheels. Sometimes, individuals may be charged on a means-tested basis. No one over the age of 75 is required to pay for home care³²¹.</p>
New Zealand	<p>State offer: The system provides some free care in the home, and there are charges for care in a care home.</p> <p>Home personal care is free of charge and subject to a needs test. The kind of care that is provided includes help getting in and out of bed, washing, dressing, going to the toilet. People under 65 with disabilities can also receive personal care for free. Other kinds of support, such as cleaning or shopping, is chargeable and subject to a means test.</p> <p>Residential care is subject to a needs test, but individuals are expected to pay for their own care and “hotel”/accommodation costs. There is a means test, so people under the threshold will have their savings and assets protected but will continue to contribute what they can afford from their income (down to a minimum income guarantee).</p> <p>As of 1 July 2021, the asset limits are as follows³²². Those aged 65 and above must have total assets (with their partner if applicable) of under \$239,930 or less to qualify for funding. If the partner is not in long-term residential care the couple have two options on how to calculate their assets:</p> <ul style="list-style-type: none"> • Asset Threshold A: \$239,930 or less (includes the house, car, cash, savings, investments) – roughly £123,100 • Asset Threshold B: \$131,391 or less (includes cash, savings, investments) – roughly £67,400 <p>Aged 50 to 64 and single with no dependent children, you automatically meet the asset test to gain funding</p>
Netherlands	<p>State offer/ Insurance market: The state has primary responsibility for long-term Care (LTC) needs, there is a mandatory LTC insurance scheme administrated by the private sector that both employers and employees</p>

	<p>contribute to from aged 16 upwards. It has the highest spending of European and OECD countries at around 4% of GDP in 2019 (Figure 6). There is a universal compulsory health insurance scheme (WLZ) which pays for the care of the most dependent over 65s and the disabled. The scheme is funded through Premia equivalent to 9.65% of the income tax, with a ceiling of €35,129 in 2021, and includes an income-dependent co-payment for adults.³²³ The scheme is administered by 32 regional care offices.</p> <p>A separate system (WMO) covers personal care, nursing and home care for individuals that need assistance but are not as severe cases. This system is administered by local authorities and funded through central government grants. Under both systems, individuals can choose whether they receive their care as benefits-in-kind, or a personal budget to pay for personal care, pay unpaid carers, home nursing, and support with ADLs³²⁴.</p>
Norway	<p>State offer: Norway has a tax-based, universal public social care system funded through national and local taxation. Total LTC costs in 2009 were €8.7 billion of which around €0.6 billion were covered by private sources/co-payments³²⁵. While co-payments make up a relatively low proportion of the total spend, there is still potential for them to take up a considerable share of individuals' income for many older people. There is no national means test system and municipalities have freedom to set their own user contribution rates. The majority of care is received at home (70%), 10% of the LTC population live in assisted housing and 20% in care homes with 24-hour assistance available³²⁶.</p>
Japan	<p>State offer: Japan has a compulsory long-term Care social insurance system, 30% of funding for adult social care comes from premiums collected from 20 to 64-year olds; 20% from premiums collected from 65+ year olds and the remaining 50% from general taxation^{327, 328}. The insurer makes a lump sum payment into the Social Insurance Medical Fee Payment Fund which is distributed to municipalities who pay independent care service providers.³²⁹ Users are expected to make a 10% co-payment for “hotel” costs’ (this is capped at £75 a month for low earners).³³⁰ Eligibility criteria are set nationally but administered locally. Applicants are assessed by municipal officials using a 74-item questionnaire focusing on ADLs that cover physical and mental health. All 65-plus are eligible, as are people aged 40-plus suffering from age-related disabilities. Neither the availability of unpaid care nor income is taken into account in the assessment of eligibility. Support is only provided in-kind³³¹.</p> <p>Private insurance market: There is a voluntary private insurance system but take up is less than 1% of the 40-plus population because state provision is high and most insurance is compulsory and covers most of LTC costs. People pay-in as a lump sum payment, an annuity, or a mix of the two³³². Individuals receive cash benefits once they reach a certain level of dependency.</p>
Germany	<p>State offer: A mandatory LTC insurance makes a partial contribution to the costs of covering long-term care needs, but individuals are expected to contribute private funds or apply for welfare payments. Premiums for social LTC insurance are calculated as a fixed proportion of the labour income</p>

	<p>(2.55% for insured with and 2.80% for insured without children in 2017)³³³. There is also a monthly contribution ceiling of €4,350³³⁴. A means-tested, regional social assistance system helps individuals who cannot afford to pay the full costs of their care. There is also a family obligation to pay for some forms of home or residential care³³⁵.</p> <p>Insurance market: Higher income groups (around 10% of the population) can opt to buy private LTC insurance if they choose to opt out of the public LTC insurance system³³⁶. 1.6 million people in 2009 (around 4% of over 40-year olds) were covered by private voluntary insurance³³⁷. Private LTC insurance premiums are based on the same criteria as (income independent) premiums of the public LTC insurance.</p> <p>Recipients of LTC services can choose between cash benefits, home care (in kind), and institutional care. Cash benefits allow for unpaid care, allowing the recipient to live at home and be taken care of typically by their relatives. Cash benefits and benefits in kind are paid based on three levels depending on severity.³³⁸</p>	
Singapore	Before 2020 reforms	Post 2020 reforms
	<p>State offer:</p> <p>IDAPE: a state funded, means-tested safety-net for those who cannot otherwise meet their costs a person can collect \$150 or \$250 a month for up to 72 months.</p> <p>Eldercare fund: a state subsidy aimed at voluntary sector provision³³⁹.</p>	<p>State offer:</p> <p>A government run mandatory social insurance scheme called the CareShield Programme was introduced in 2020 and is currently being rolled out³⁴⁰. Individuals pay-in from the ages of 30 to 67. For this they can receive a monthly payment for life in cash (if care costs are higher than this they must cover the difference themselves). The government will subsidise the premiums for those with low and middle incomes. Subsidies start at 30% of the premium for the lowest income groups³⁴¹. Annual premiums are slightly higher than then Eldershiield programme.</p>
	<p>Insurance market:</p> <p>The Eldershiield programme is a voluntary insurance scheme that captures 25%-40% of long-term care costs³⁴² and is only for the severely disabled (unable to perform 3/6 ADLs)³⁴³. It is an opt-out scheme with auto enrolment at the age of 40. Take up is 47% of over 40-year olds³⁴⁴. Affordability, irrationality, preference for unpaid care (80% of care provided in Singapore is unpaid) are reasons cited for this level of take-up.</p> <p>Premiums are paid regularly by those aged between 40 and 65 or as a lump sum (40% cheaper).</p> <p>ElderShield pays a monthly cash benefit of \$300 per month for up to 60 months, or \$400 per month for up to 72 months if</p>	

	you have a severe disability and require LTC.	
France	<p>State offer: Social universal cash benefit APA (Allocation Personnalisée d'Autonomie) was established in 2002. It provides a universal, in kind benefit to all individuals over 60 (assessed according to six levels of severity) who are dependent and live at home or in a retirement centre, the assessment is 'carer blind'. The amount they receive depends on their income. Around 4% of the population have income of over €2,927.66 per month and must pay 90% co-payments, whereas the poorest 23%, with income below €734.66 have no cost sharing requirements. The APA eligibility is decided purely on income and does not consider wealth or the value of their estates³⁴⁵.</p> <p>Insurance market: 15% of the over 40 population have private insurance. Most benefits are paid in cash rather than services using the needs criteria used in the APA system. Take up is relatively high due to discussion of how social care will be funded in the media, the variety of products offered and the fact that 45% of policies are sold as group policies (part of their employment contract), premiums are also cheaper than other insurance based social care economies with employer based policies even cheaper (with the employer bearing 40% to 50% of the cost). The average age of enrolment is 40 to 44.</p>	
US	<p>State offer: The public provision of LTC services is minimal; Medicaid is the jointly funded social health insurance programme with a means-tested programme to assist those with limited income to pay for their medical expenses. An individual must have income less than \$2,382 a month to be classified as eligible for Medicaid³⁴⁶. All states must provide institutional nursing facility services, but most of the benefits provided are at the discretion of the state³⁴⁷. Apart from this programme, individuals must cover their own cost of care.</p> <p>Insurance market: Voluntary private insurance with 5% of over 40-year-olds taking it up in 2015, and around 8% in 2016, this is expected to rise to 17% by 2020³⁴⁸. The rest of the population, if they are not protected by Medicaid, pay for their social care privately from their wealth and income. In 2010, Medicaid covered 62% of long-term care service costs; 22% was covered out of the wealth/income of individuals receiving care; 12% from other private sources^{xliii}, and 4% from other public sources^{xliv}³⁴⁹. Coverage by Medicaid is a significant proportion of costs due to the high cost of nursing home beds in the US depleting individuals' assets (in 2020 the annual cost for a private room was \$106,000, up from \$75,000 in 2011.)³⁵⁰³⁵¹.</p>	

xliii "Other private" sources includes private long-term care insurance, other health insurance, and other private spending for nursing homes.

xliv "Other Public" sources includes Department of Veterans Affairs, state and local programmes, and general assistance spending.

Future demand for Adult Social Care

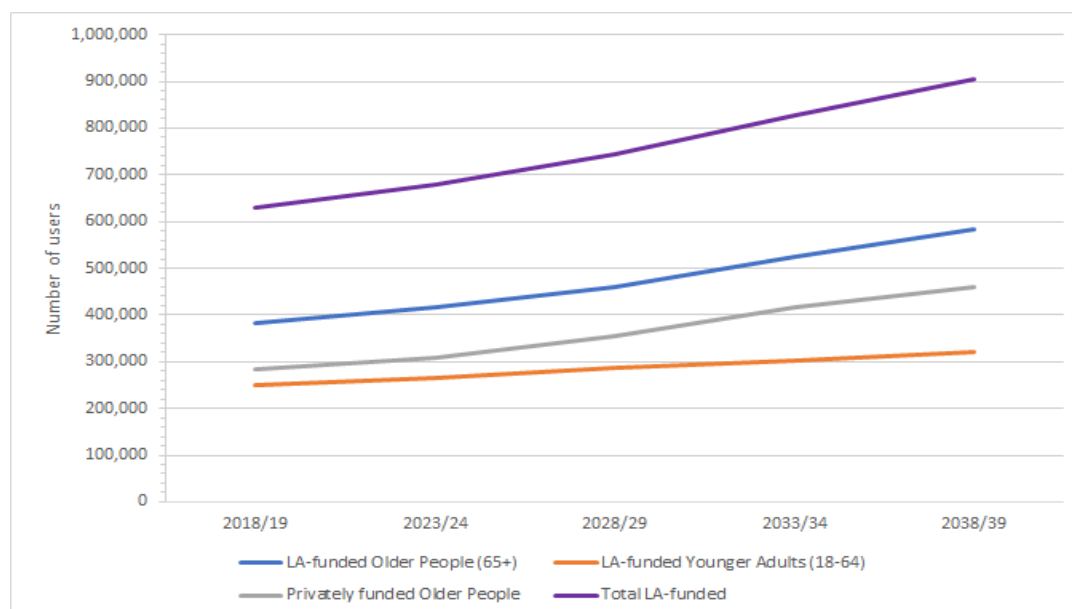
Projections based on the drivers discussed above suggest that demand for care is highly likely to increase in the future due to demographic changes. Increased demand combined with unit cost pressures will affect both public and private expenditure on formal care services. Whilst long-term projections are uncertain and should not be treated as precise forecasts, it is very likely that the number of people needing long-term support will rise over the coming decades.

- 6.12 CPEC (formerly PSSRU) produces projections of the long-term demand for adult social care services in England. These projections need to be treated with some caution because they are based on specific assumptions about future socio-economic and demographic trends. CPEC projections relate to current patterns of care and the current (unreformed) funding system. They do not allow for the potential impact of rising expectations or other behavioural or policy changes.
- 6.13 CPEC (2020) projections are based on the ONS 2018-based principal population projections for England, which projects that the number of people aged 65 and over will rise by 41%, from 10.1 million in 2018 to 14.3 million 2038, and the number of people aged 85 and over is projected to rise by 72%, from 1.4m in 2018 to 2.3m in 2038. The CPEC model projects that the number of disabled over 65s, defined as those unable to perform, without help, at least one activity of daily living (ADL), to rise by 48% between 2018 and 2038, from 3.5m in 2018 to 5.2m in 2038. This projection is on the basis that the rates of disability remain constant by age and gender: the projection is sensitive to this assumption. The model's projection of demand for care – that is, the number of people actually in receipt of publicly funded care or purchasing care privately – is based on future numbers with disability.
- 6.14 As shown in Figure 32, the number of over 65 users of local authority funded care services is projected to rise from 381,000 in 2018 to 583,000 in 2038 (an increase of 53%), to keep pace with demographic pressures. At the same time, the number of self-funders aged 65 and over is projected to increase from 283,000 in 2018 to 459,000 in 2038 (an increase of 62%). In total, the number of older users (both

publicly and privately funded) is projected to rise by 55%, from 664,000 in 2018 to just over 1m in 2038^{xlv, xlvi}. The data excludes the impact of social care reform.

- 6.15 The total number of publicly funded users (over 65s and adults under 65) is projected to rise from 631,000 in 2018 to 904,000 in 2038 (an increase of 43%), to keep pace with demographic pressures.
- 6.16 The total number of local authority funded adults under 65 in receipt of formal care services is projected to increase from around 249,000 in 2018 to 321,000 by 2038. This represents an increase of 29%. There are no reliable projections of the number of privately funded adults under 65 in receipt of care, although this number is expected to be relatively small.

Figure 32: Projected number of adults in receipt of long-term social care, 2018/19 to 2038/39



Source:

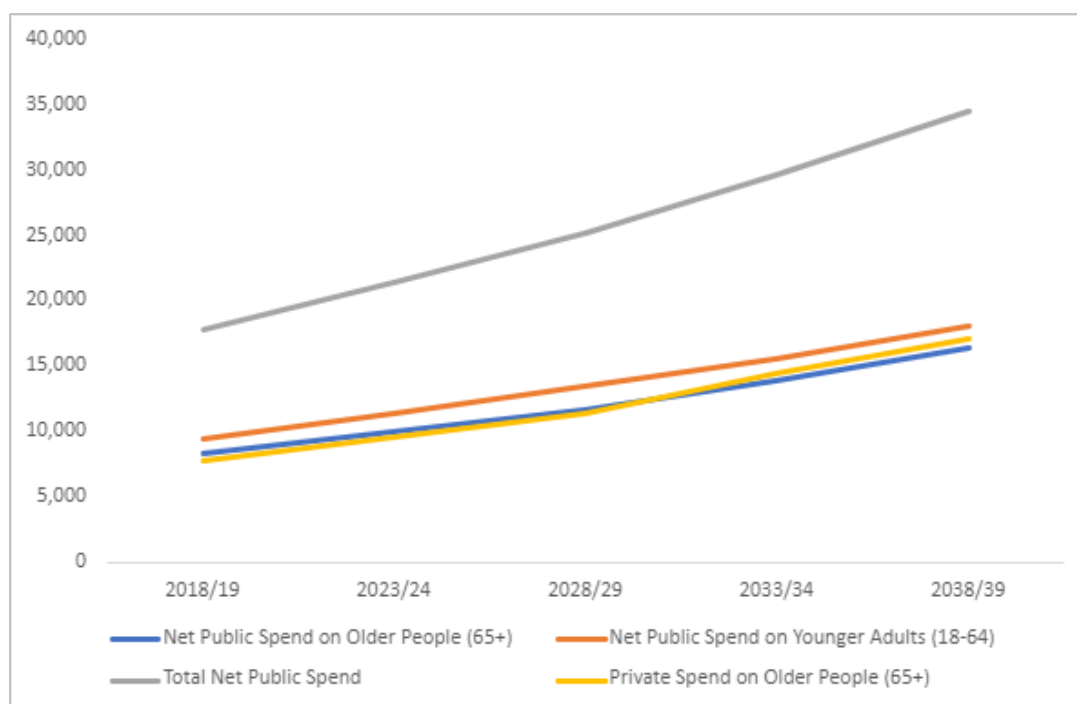
Wittenberg R, Hu B and Hancock R. 2020. [Projections of demand and expenditure on adult social care 2018 to 2038](#), Adult Social Care Research Unit, Care Policy and Evaluation Centre.

xlv This excludes over 65s receiving long-term care and support funded by the NHS.

xlvi There is no robust source of information on the number of people funding their own care. The estimates presented above are based on specific assumptions and data from a range of sources, for example the Health Survey for England finding that around one third of older home care users are privately-funded.

- 6.17 Figure 33 shows how the increase in projected demand impacts upon projected expenditure. Under the current (unreformed) system, if spend were to keep pace with expected demand, public spend on over 65s (net of user charges) is projected to almost double (an increase of 98%) from around £8.4bn in 2018 to £16.5bn in 2038 (in 2018 prices).
- 6.18 Private spend is projected to rise by 119%, from £7.8bn in 2018 to £17.2bn in 2038. Combining public spend, user charges and private spend, total expenditure on over 65s is projected to rise from £18.3bn in 2018 to £37.7bn in 2039. This represents a 106% increase in total spend on social care for over 65s.
- 6.19 Net public spend on adults under 65 is projected to rise by 90%, from around £10bn in 2018 to around £18bn in 2038. Therefore, total public spend (on both over 65s and adults under 65) is projected to increase by 93%, from around £18bn in 2018 to around £35bn in 2038.

Figure 33: Projected expenditure on adults in receipt of long-term social care, 2018/19 to 2038/39 (constant 2018 prices)



Source:

Wittenberg R, Hu B and Hancock R. 2020. [Projections of demand and expenditure on adult social care 2018 to 2038](#), Adult Social Care Research Unit, Care Policy and Evaluation Centre.

Assumptions underlying demand projections and sensitivity analysis

Projected expenditure on long-term care is particularly sensitive to changes in future disability rates in old age, the prevalence of learning disability in adults under 65 and the unit costs of care.

6.20 Long-term demand projections are based on specific assumptions about trends in the drivers of demand for care. CPEC has tested the sensitivity of the projections to changes in key variables, including:

- Population structure (e.g. over 65 or adults under 65 population structure^{xlvii})
- Trends in functional disability for over 65s
- Trends in the number of adults under 65 with learning disabilities
- Unit costs of care

6.21 Appendix A provides more information on the assumptions used in the demand modelling and the impact of changes in these assumptions on people receiving care and total spend.

How individuals' resources might vary in the future

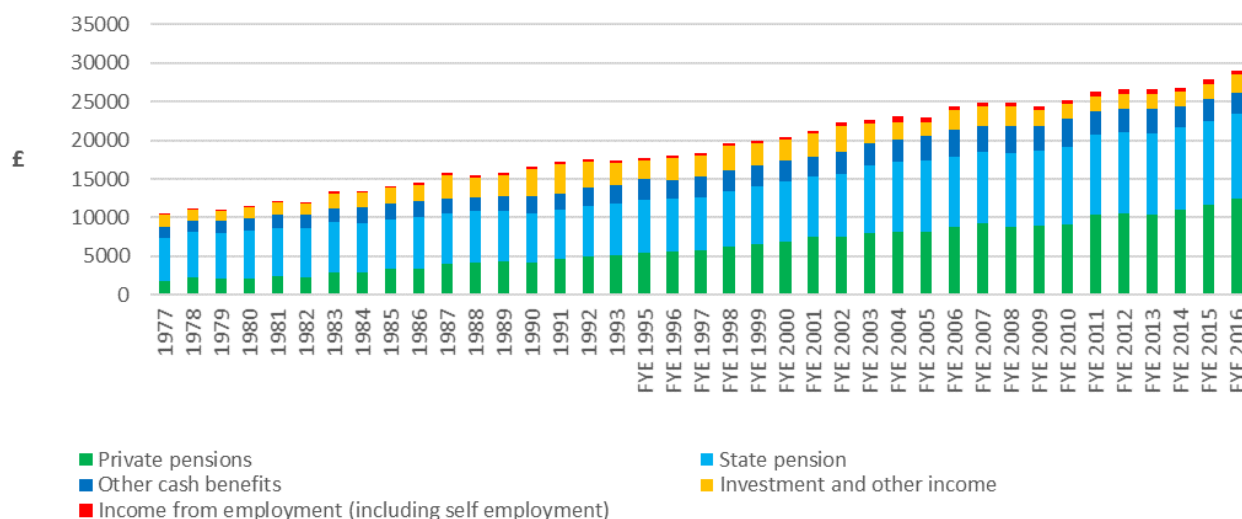
The wealth of older age cohorts has been increasing in recent years but is peaking and it is not evenly distributed

6.22 Wealth is often built up over a lifetime before being run down in retirement. Those aged 55-64 are the wealthiest age cohort in Britain, holding 28% of total wealth between 2014 and 2016. The main component of wealth for those over 75 is

xlvii This reflects variant ONS assumptions about future fertility, migration and mortality rates.

property wealth. Figure 34 below demonstrates how the components of wealth for over 65s have changed over time.

Figure 34: Average gross incomes of retired households by component type, UK, 1977 to 2016/17



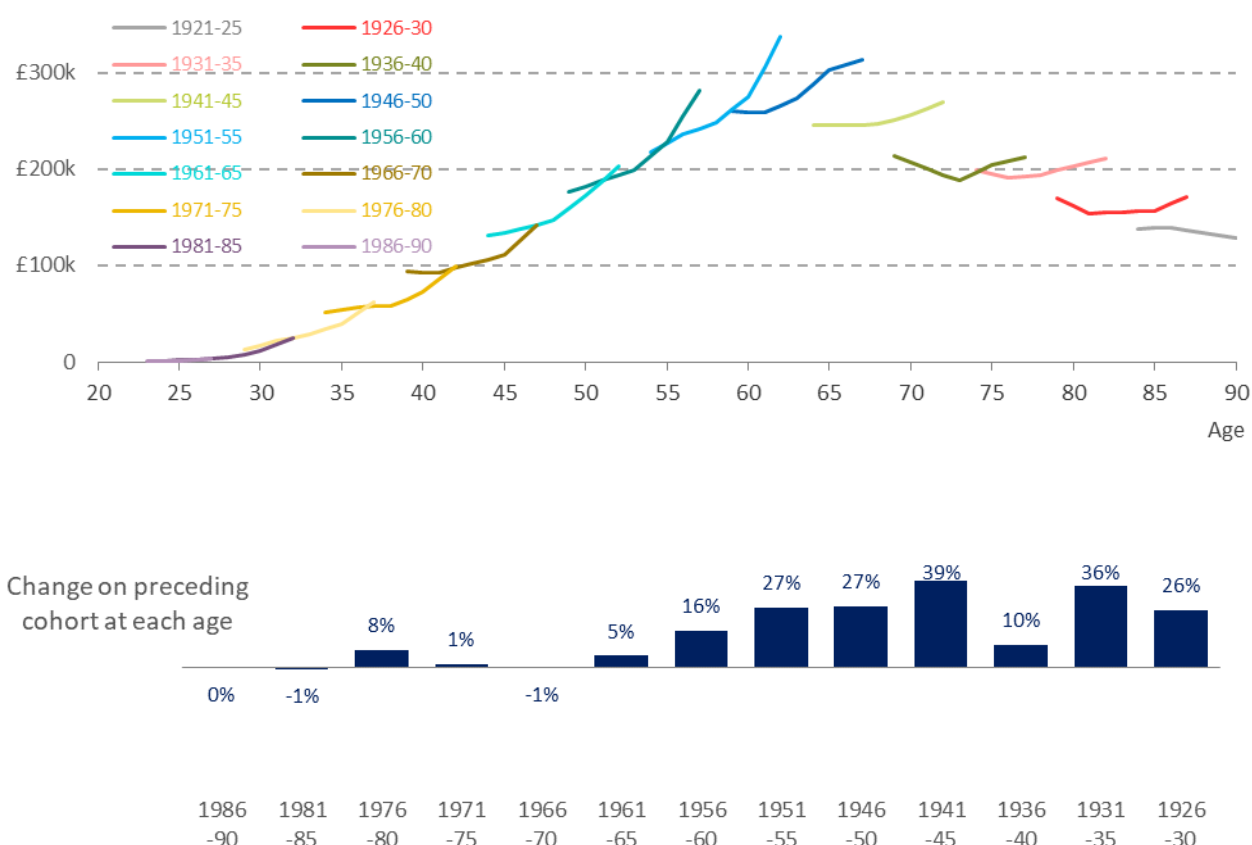
Source:

ONS, 2017. [What has happened to the income of retired households in the UK over the past 40 years?](#) Data available from [Figure 3](#)

- 6.23 As noted in Chapter 3, the home environment can have a positive or negative impact on the inhabitants’ health and independence. An owned home can also be a financial asset to draw upon to fund care and it is taken into consideration when individuals are assessed for local authority funded care.
- 6.24 There are many uncertainties affecting future generations’ potential assets and incomes. This includes what stage in life intergenerational wealth will be transferred to younger generations in the future^{352, 353}, given increased longevity and the likelihood that more people will experience complex multi-morbidities and the associated costs.
- 6.25 Employment patterns for older generations are also important. 28% of 50 to 64 year olds are not in work. For some this is by choice, but others are limited by health conditions, with lower income groups disproportionately affected. Half of all men aged 55 to 64 in the poorest quintile have a health problem limiting the kind or amount of work they can do³⁵⁴.

6.26 Expectations of generational progress in wealth accumulation are no longer being realised. Figure 35 below shows the lack of substantial progress in wealth accumulation for cohorts born after 1960³⁵⁵. As the column chart shows, in general the strong intergenerational progress that had occurred between previous generations has ceased from 1961-65 onwards: before 1956 each cohort was around 25% wealthier than the previous one, whereas for younger cohorts the difference is much smaller or even negative.

Figure 35: Mean total net wealth per adult, by cohort, 2006-16



Source:

Resolution foundation, 2017. [The Generation of Wealth: asset accumulation across and within cohorts](#). Based on ONS Wealth Assets Survey

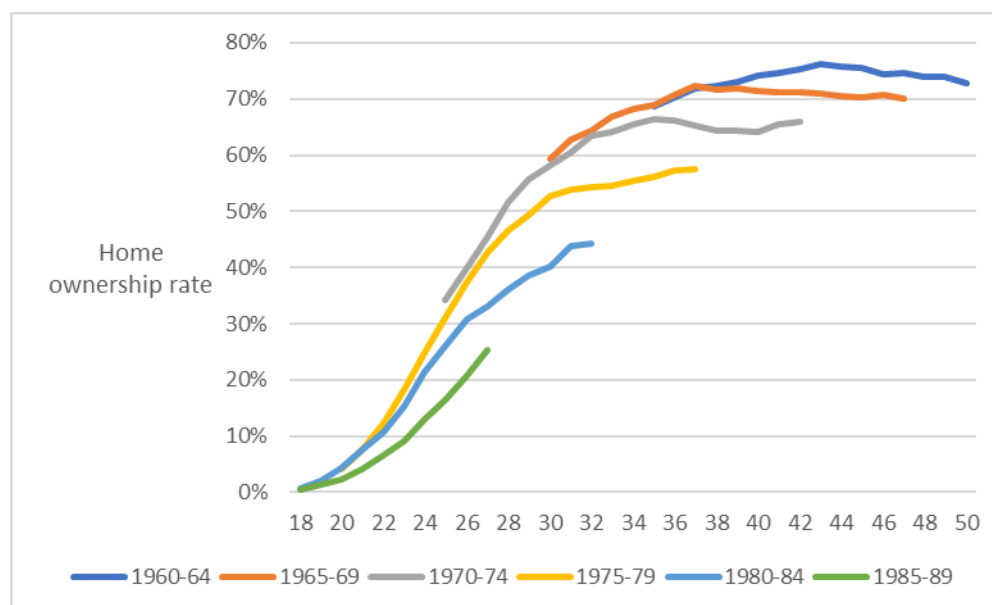
6.27 Changes in wealth accumulation have been driven by a number of factors, including lack of access to relatively generous defined benefit pension schemes, and reduced savings compared with previous cohorts.

6.28 Home ownership has been a key asset base to contribute to care costs. However, this will vary over time depending on house prices and patterns of home ownership,

which will lead to greater variations within and between generations' ability to pay for care.

6.29 As shown in Figure 36 below, there have been drops in home ownership rates in successively younger generations. In 1993 over half (56%) of those under 35 years old owned their own home, whilst one-fifth (20%) were renting in the private sector. In 2011 this had almost reversed; 34% owned their home whilst 46% were in privately rented accommodation³⁵⁶. Private renters on average spend twice as much of their income on housing and would have to continue to pay rent in older age^{357, 358} so need more retirement savings. This may postpone or reduce future generations' assets available to help pay for care.

Figure 36: Home ownership rates by birth year and age



Source:

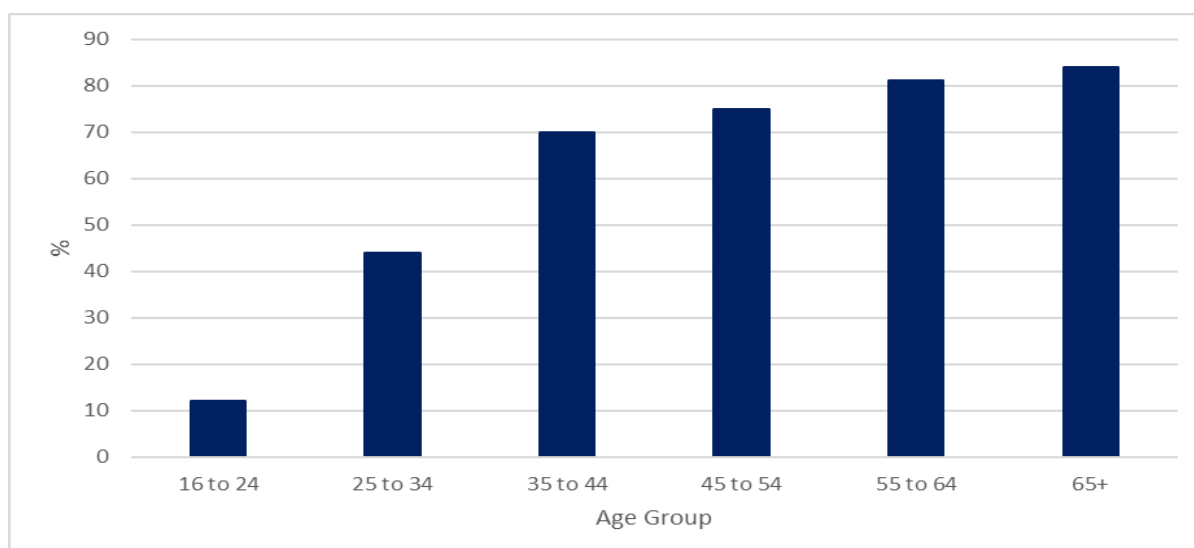
IFS, 2018. [The decline of homeownership among young adults.](#)

Regional and socio-economic variation in individuals' resources

There are important regional and socioeconomic differences in the distribution of income and assets.

- 6.30 There are significant variations in income and wealth distributions by age. On average over 65s are wealthier than younger cohorts. For example, between 2016-18, there was a greater percentage of householders with total wealth exceeding £85,000 for older age groups. For the 16-24 cohort, 12% of householders have total wealth exceeding £85,000. This compares to 84% for those aged 65 and over (as shown in Figure 37).^{359xlviii}

Figure 37: Percentage of householders with total wealth of £85,000 and greater.



Source:

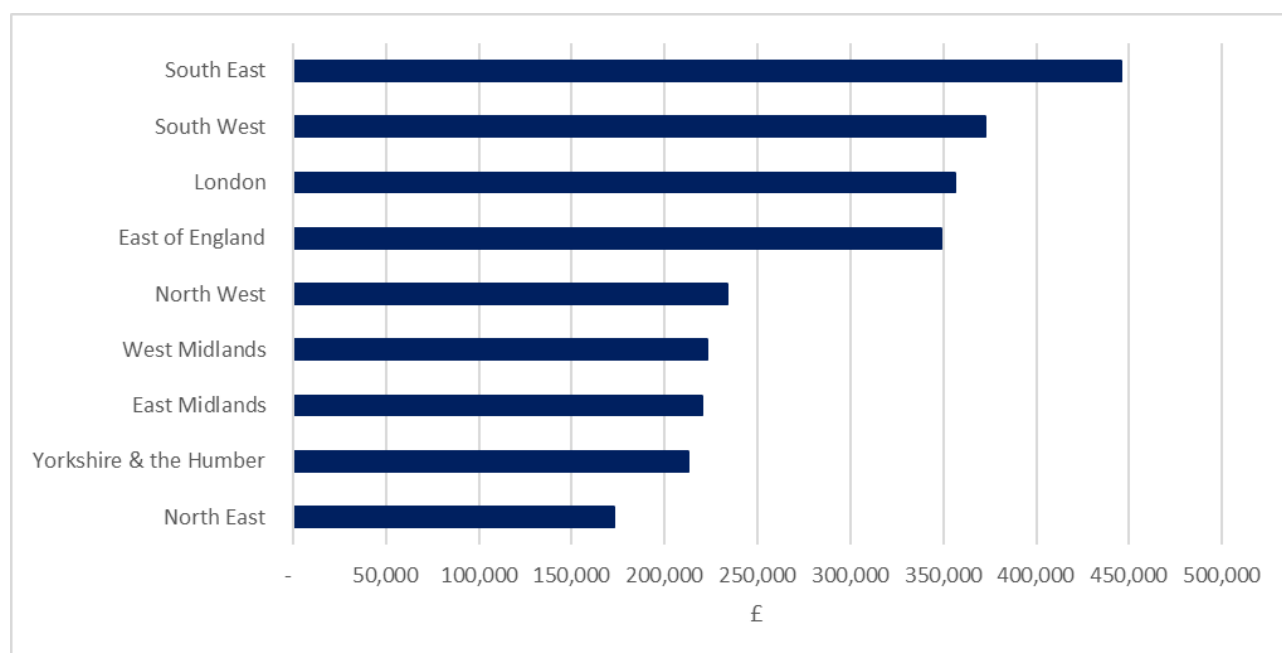
ONS, 2019. [Total wealth in Great Britain: April 2016 to March 2018](#). Data from figure 9.

xlviii "Householders" refers to the household reference person. This is the sole or joint householder or is responsible for household affairs. Where there are joint householders, the HRP will be the person with the highest income. In cases where income is the same for a joint householder, the eldest person is assigned as the HRP. Figures are deflated to April 2016 to March 2018 average prices using the Consumer Prices Index including owner occupiers' housing costs (CPIH) to reflect the change in the value of money over time.

6.31 The English Housing Survey also shows significant variation in the distribution of homeowners by age group. In 2019/20 the average age of outright homeowners was 68 years, with 63% of outright owners aged 65 or over.³⁶⁰ Despite the fact that individuals aged over 65, on average, have more total wealth there are also significant variations in income and wealth within this cohort. For example, single women, ethnic minorities and the over 80s are more likely to have lower total wealth in older age.³⁶¹

6.32 There is also a significant variation in total household wealth across geographical regions. Figure 38 illustrates that between 2016-18 the region with the highest median total wealth in England was the South East at £445,900. The region with the lowest median total wealth was the North East at £172,900^{362, xlix}.

Figure 38: Total median household wealth by geographical region.



Source:

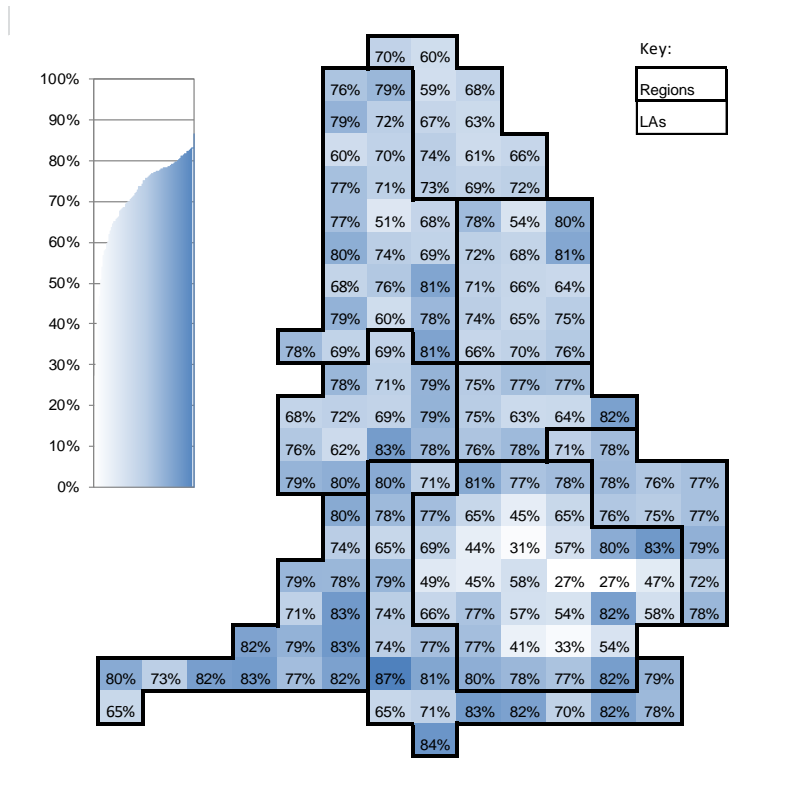
ONS, 2019. [Total Wealth: Wealth in Great Britain](#). Data taken from table 2.8.

6.33 Additionally, there are significant disparities in home-ownership rates across geographical regions. Figure 39 shows the rates of home ownership amongst the

xlix Figures are deflated to April 2016 to March 2018 average prices using the Consumer Prices Index including owner occupiers' housing costs (CPIH) to reflect the change in the value of money over time.

over 65s in local authorities. In areas with low home ownership, care is more likely to be funded by local authorities. As such, local authorities with high need and low home ownership are more likely to face funding pressures.

Figure 39: Percentage of households aged 65+ who own their home¹



Source:

DHSC analysis, based on data from Census 2011

¹ Includes shared ownership and outstanding mortgages.

7. Evidence gaps

- 7.1 We need to improve our understanding of how people fund their own care, how this might change, how this will interact with trends in the private market and state-funded eligibility criteria and what this means for access to care. This is particularly true for the care population of adults aged under 65 where we do not have a robust published estimate for the number of self-funders. Improved understanding of these funding issues would include exploration of saving and spending behaviours in relation to care and how people plan for the future.
- 7.2 There is a lack of evidence on the length of care journeys for the care population and transitions between stages of care, particularly for adults aged under 65. Whilst there is some evidence for the over 65 population, key elements are from the BUPA commissioned report by CPEC in 2011, which requires an update. There is also a lack of evidence about how people make decisions about their care and the factors that inform these decisions and influence care journeys.
- 7.3 Under a reform, we will want to better understand take-up of the means test, the cap and local authority commissioned care from the care population. Care journeys data will also be an important aspect in understanding the impact of reform on individuals and the costs. Information on the distribution of income and wealth is also not available for the care population. We currently use data from ELSA (English Longitudinal Study of Ageing) to estimate this. Improved data in this area would allow us to improve our understanding of how income and wealth depletes over the course of an individual's care journey.
- 7.4 An individual's need for care, and the extent to which these needs are met or unmet, are complex concepts and challenging to measure. They are influenced by available supply (private and state funded), a person's environment, ability to source support for themselves, underlying health, and expectations. Through the National Institute for Health Research (NIHR), DHSC has funded a research project exploring outcomes for those who fall just below the threshold for local-authority funded care, to help build the evidence base on what support these people receive and the effect on outcomes³⁶³.
- 7.5 The evidence on the level of access to care and trends over time is mixed, and estimates depend, in particular, on how studies define care needs and the degree to which they are met. There are important evidence gaps on the causes of some people not receiving support for their care needs. This includes its drivers, where individuals are currently eligible for state-funded support but are not receiving it; and the impacts of lack of access to care on the individual, their friends and family, future

care needs and the wider public sector, such as the NHS. We also know much less about the care needs, and the extent to which they are being met, for adults under 65, as adult social care data in national surveys is currently mainly collected from over 65s. NIHR Policy Unit in Adult Social Care is undertaking a project to better understand needs and care packages using local authority held data.

- 7.6 While an increasing number of the elderly population will suffer with comorbidities, health systems research and medical education remain largely focused on single conditions. Multi-morbidities are also an issue for the under 65 population with learning disabilities. We need to improve understanding around shared risk-factors and the effectiveness of prevention, how diseases progress, how conditions interact with one another³⁶⁴ and how this translates to different care needs. This may be supported by strengthening the field of geriatric medicine. The NIHR has issued two large funding calls and funded several projects to build the evidence base on this.
- 7.7 On the adult social care workforce, there is limited evidence around the direct (or causal) impact that a change in a policy may have on either labour market outcomes such as turnover, or wider system impacts such as quality of care, given the difficulties in isolating the effect of the lever at hand since there are a large number of variables that affect these.
- 7.8 Within the evidence gaps identified above, there is a need to develop our understanding of inequalities within the adult social care system by exploring disparities in access, outcomes and experiences of different groups. This is particularly the case in relation to groups who share one or several protected characteristics.
- 7.9 Although there will always be uncertainty, there is also potential for improved modelling to better our understanding of demand drivers and provide more robust and nuanced projections.

8. Conclusion

- 8.1 This report collates a wide range of evidence on challenges and changes facing social care and what is driving them. It has been developed to inform policymakers considering the impact of those challenges and changes on social care services, the people they support, and the staff who work in the sector.
- 8.2 The evidence is clear that both the absolute numbers of over 65s, and the proportion of the population they represent, are growing. People are living longer (although the impact of COVID-19 on long-term life expectancy trend is still unclear). This is a success to be celebrated. However, as people live longer, many are spending more years in ill health, with complex health needs or disabilities. Similarly, there is an increasing number of adults under 65 with disabilities. This is driven in particular by more people with learning disabilities being diagnosed and supported, and many are now living longer than they did in previous generations. There are also uncertainties around the impact of COVID-19 on this trend. Again, this is a success that should be celebrated, but it poses new challenges for services.
- 8.3 Overall, the total number of users of long-term adult social care in England is projected to increase by 50% between 2018/19 and 2038/39. This would mean total expenditure on adult social care services under the current, unreformed, system would more than double in real terms, from £28bn to £56bn (2018 prices), over the same period. To put that into context, the total adult population in England is projected to grow by a mere 11% over the same period³⁶⁵.
- 8.4 Our evidence shows significant variations both in care need and system capacity across the country. There is also significant variation in health and disability between socio-economic groups. This will have implications for regional and local provision. The increasing prevalence of long-term conditions and complex comorbidities, driven in part by factors such as rising obesity rates, may require different models of care. Other drivers of ill health such as poor or inappropriate housing, and changes in living arrangements that affect people's ability to care for themselves, may also increase future demand for care. At the same time, issues such as workforce turnover and a fragmented provider market are potential barriers to the system responding, for example through new technology that could help manage that demand.

9. Appendix A – Base case assumptions for demand modelling

A1. CPEC's (formerly PSSRU) projections³⁶⁶ should be treated as indications of the likely number of people requiring adult social care services (and the costs of providing this care) under the current unreformed system if the drivers of demand follow the modelled trends.

A2. The model is based on the following key assumptions:

- The number of people by age and gender changes in line with official ONS 2018-based principal population projections. Prevalence rates of disability by age and gender remain constant for over 65s and younger physically disabled people. Learning disability prevalence is projected to rise, primarily due to improved survival rates for children with learning disabilities who are going into adulthood.
- The unit costs of care rise broadly in line with Office for Budget Responsibility (OBR) forecasts for future trends in productivity and average earnings, with an uplift to take account of the planned rises in the National Living Wage in the years to 2024.
- Household composition – home ownership for over 65s changes in line with the CARESIM model; the probability of living alone or with others is assumed to remain unchanged.
- Patterns of care – formal and unpaid - remain unchanged.
- Long-term care system remains unchanged, as the current system for England.

A3. There are different views about whether age-specific disability rates can be expected to rise, fall or remain broadly constant in the future³⁶⁷. Constant age specific disability rates underpin CPEC's base case projections. Broadly, the justification for this assumption is that while the prevalence of conditions such as coronary heart disease has decreased over time, conditions associated with increased longevity (e.g. arthritis and hypertension) have increased. Yet, if age-specific disability rates remain constant while life expectancy rises, the number of years with a disability will rise as well as the number of years without a disability. In addition to prevalence, the numbers of disabled over 65s in the future will depend on the disabling diseases they suffer from and whether optimal treatments to alleviate or postpone the disablement are both available and widely diffused throughout the population in need.

A4. The level of state support for adults under 65 with learning disabilities is expected to rise, although there is uncertainty around the additional numbers of people that will require support. The number of adults under 65 receiving state support in the future will depend on the number of adults under 65 with a learning disability in the population, the severity of disability and the interaction between severity and eligibility for support.

A5. Since adult social care is highly labour intensive, changes in the unit costs of care are driven largely by changes in earnings in the sector. There is uncertainty about how social care wages will change in the future and if they will increase in line with average earnings as assumed in CPEC’s base case projections.

A6. The ONS’ principal population projections are constructed on the basis of specific assumptions about trends in future mortality, fertility and migration. If actual mortality rates deviate from the assumed trends, for example, this will alter the size and age structure of the general population and hence the population that may require care.

Table A1. Results of Illustrative Sensitivity Analysis on Projected Number of People Receiving Care

Driver of demand (central assumption)	Sensitivity scenarios	Difference from central scenario, people receiving care, %
<p>Disability rates in over 65s</p> <p>Prevalence rates of disability in old age by age group and gender remain unchanged, as reported in the Health Survey for England.</p>	<p>a) Age-specific disability rates rise by 0.5% (not percentage point) per year relative to the base case</p> <p>b) Age-specific disability rates fall by 0.5% (not percentage point) per year relative to the base case</p>	<p>a) Higher disability rates increase the total projected number of over 65s in care (both public and privately funded) by 12% in 2040/41</p> <p>b) Lower disability rates decrease the total projected number of over 65s in care (both public and privately funded) by 11% in 2040/41</p>
<p>Learning disability in adults under 65</p> <p>Learning disability rates for adults under 65 rises in line with</p>	<p>a) Higher demand - LD rates for adults under 65 include adults with critical, substantial and 100% moderate needs</p> <p>b) Lower demand - LD rates for adults under 65 include adults with critical and substantial needs only</p>	<p>a) Higher learning disability demand increases the total number of adults under 65 in publicly funded care by 5% in 2040/41</p> <p>b) Lower learning disability demand decreases the total number of adults</p>

Emerson & Hatton (2012) ^{li} and assumes support for individuals with critical, substantial and 50% of those with moderate needs.		under 65 in publicly funded care by 4% in 2040/41 ^{lii}
Demography The number of people by age and gender changes in line with ONS principal population projections.	a) Old age structure (low fertility, high life expectancy and low net migration) b) Young age structure (high fertility, low life expectancy and high net migration)	a) Old age structure increases the total projected number of over 65s in care by 4% (both public and privately funded) in 2040/41 b) Young age structure decreases the total projected number of over 65s in care (both public and privately funded) by 6% in 2040/41

Note:

Varying assumptions about the rate of increase in the unit costs of care do not materially affect projections of numbers of service users and have therefore been excluded from the table comparison.

Table A2: Results of Illustrative Sensitivity Analysis on Projected Adult Social Care Expenditure on over 65s

Driver of demand (central assumption)	Sensitivity scenarios	Difference from central scenario, total Adult Social care expenditure, %
Disability rates in over 65s Prevalence rates of disability in old age by age group (65 to 69, 70 to 74, 75 to 79, 80 to 84, 85+) and gender remain unchanged.	a) Age-specific disability rates rise by 0.5% (not percentage point) per year relative to the base case b) Age-specific disability rates fall by 0.5% (not percentage point) per year relative to the base case	a) Higher disability rates increase projected total spend by 8% in 2040/41 b) Lower disability rates decrease the total projected spend by 7% in 2040/41
Learning disability in adults under 65 Learning disability rates for adults under 65 rises in line with	a) Higher demand - LD rates for adults under 65 include adults with critical, substantial and 100% moderate needs	a) Under a high LD scenario projected total adult social care spend would increase by 2%

li Emerson E, Robertson J, Coles B, Hatton C (2012) Estimating the Need for Social Care Services for Adults with Disabilities in England 2012 –2030, CeDR, London.

lii User number for working age adults only include state supported adults.

Evidence review for adult social care reform

<p>Emerson & Hatton (2012) and assumes support for individuals with critical, substantial and 50% of those with moderate needs.</p>	<p>b) Lower demand - LD rates for adults under 65 include adults with critical and substantial needs only</p>	<p>b) under a low LD scenario projected total adult social care spend would decrease by 2%</p>
<p>Unit costs</p> <p>Unit costs of care rise in line with Office for Budget Responsibility assumptions for future trends in productivity, with an uplift for the years to 2020 to take account of the planned rises in the National Living Wage (except that non-labour, non-capital costs remain constant in real terms)</p>	<p>a) Unit costs rise by 0.5% faster than under the base case</p> <p>b) Unit costs rise by 0.5% lower than under the base case^{liii}</p>	<p>a) Higher unit costs increase projected total expenditure by 12% in 2040/41</p> <p>b) Lower unit costs decrease projected total expenditure by 10% in 2040/41</p>
<p>Demography</p> <p>The number of people by age and gender changes in line with ONS principal population projections.</p>	<p>a) Old age structure (low fertility, high life expectancy and low net migration)</p> <p>b) Young age structure (high fertility, low life expectancy and high net migration)</p>	<p>a) Old age structure increases projected total expenditure by 3% in 2040/41</p> <p>b) Young age structure decreases projected total expenditure by 4% in 2040/41</p>

^{liii} DHSC analysis based on Wittenberg et al. (2018) projections

10. Appendix B: England level analysis of Family Resources Survey 2019/20

B1. In the tables that follow, the following conventions have been used:

- -: negligible (follows standard FRS guidelines)
- N/A: information is not available
- Figures have been rounded to the nearest 0.1 million or percentage point, however for expenditure they have been rounded to the nearest £million. Individual figures have been rounded independently, so the sum of component items will not necessarily equal the totals shown.

B2. The Family Resources Survey (FRS) is a continuous household survey which collects information on a representative sample of private households in the United Kingdom. It has been running since October 1992. Detailed information is recorded on each respondent: their incomes, from all sources including self-employment; housing tenure; caring needs and responsibilities; disability; expenditure on housing; education; pension participation; childcare; family circumstances and child maintenance. This information here has been collated using the underlying data (2019/20) as opposed to the published findings. In the 2019/20 financial year, over 19,000 households were interviewed. For further information regarding the FRS please visit [here](#).

B3. The estimates in the tables are based on sample counts that have been adjusted for non-response using multi-purpose grossing factors that control for tenure type, Council Tax Band and a number of demographic variables. Estimates are subject to sampling error and remaining non-sampling bias.

B4. In the tables that follow:

- Figures refer to people.
- The Family Resources Survey (FRS) defines all those giving help on an informal basis (that is, not as part of a paid job) as unpaid/informal carers. Professional carers can also be informal carers if giving help outside of work. What should be counted as care is not prescriptively defined but includes activities such as going shopping for someone and helping with paperwork.
- FRS only records the age of someone being cared for within the same household as the carer. These figures therefore do not include those who care for someone aged 65+ who lives outside of the household. The figures presented here are likely to be a large undercount of care given to adults aged 65+ both inside and outside of the household. Note that just over half of all carers care for someone outside of their household.
- Pension age people are defined as those above State Pension age in each particular year.

- The definition of disability used in the FRS is consistent with the core definition of disability under the Equality Act 2010. A person is considered to have a disability if they have a long-standing illness, disability or impairment which causes substantial difficulty with day-to-day activities. Some people classified as disabled and having rights under the Equality Act 2010 are not captured by this definition, such as people with a long-standing illness or disability which is not currently affecting their day-to-day activities. From 2012/13 disabled people are identified as those who report any physical or mental health condition(s) or illness(es) that last or are expected to last 12 months or more and which limit their ability to carry out day-to-day activities. Consistent information on disability is therefore only available from 2012/13 onwards.

B5. For table B4b, analysis of internal unpublished DWP forecasting data was carried out to determine the expenditure relating to Severe Disability Premium in Pension Credit, as there was no published data available. There are no known data limitations which would materially impact these results.

Table B1a: Adult population totals, disability status and who they live with 2019/20

	UK		England	
	number	%	number	%
Adult population	51,700,000		43,400,000	
Working age population	40,100,000		33,700,000	
Pensioner population	11,600,000		9,700,000	
of whom, aged 85 and over	1,400,000	12%	1,100,000	12%
Disabled adults	13,000,000	25%	10,600,000	24%
Disabled working age adults	7,700,000	19%	6,200,000	18%
Disabled pensioners	5,300,000	46%	4,400,000	45%
of whom, aged 85 and over	900,000	17%	800,000	17%
Disabled working-age adults living with at least one other disabled adult	3,200,000	42%	2,600,000	42%

Disabled pensioners living with at least one other disabled adult 2,300,000 43% 1,900,000 43%

Source:

DWP Family Resources Survey 2019/20

Note:

Some UK disability prevalence figures published by DWP in [table 4.1](#) of the FRS 2019/20 publication

Table B1b: Disability prevalence by age group, 2007/08 to 2019/20, England

Year	All people	Working-age adults	State Pension age adults(1)	Children
2007/08	18%	14%	45%	6%
2008/09	18%	14%	47%	6%
2009/10	18%	14%	45%	6%
2010/11	18%	14%	45%	6%
2011/12	19%	16%	45%	6%
2012/13	19%	16%	42%	7%
2013/14	19%	16%	42%	7%
2014/15	20%	17%	45%	7%
2015/16	20%	18%	44%	7%
2016/17	21%	19%	44%	8%
2017/18	20%	18%	43%	8%
2018/19	21%	19%	44%	8%
2019/20	21%	18%	45%	8%

Source:

DWP Family Resources Survey 2007/08 - 2019/20

Note:

(1) From 6 April 2010, the State Pension age for women has been gradually increasing. FRS data contained in the 2019/20 report were collected throughout the financial year 2019/20, during which the State Pension age for both men and women increased from 65 years 2 months to 65 years 8 months.

UK disability prevalence time series figures published by DWP in [table 4.1](#) of the FRS 2019/20 publication.

Table B2a: Adult informal carers, 2019/20

	UK		England	
	number	%	number	%
All adult informal carers	4,400,000	8%	3,600,000	8%
All working age informal carers	3,400,000		2,800,000	
All pension age informal carers	1,000,000		800,000	

Source:

DWP Family Resources Survey 2019/20

Note:

UK figures for total number of informal carers published by DWP in [table 5.1](#) of the FRS 2019/20 publication (these include the whole population and therefore differ slightly from the above)

Table B2b: Adult informal carers by care recipient, 2019/20

	UK		England	
	number	%	number	%
All adult informal carers	4,400,000		3,600,000	
of whom:				
caring for parent	1,700,000	39%	1,400,000	40%
caring for spouse/civil partner/cohabitee	800,000	18%	600,000	17%

Source:

DWP Family Resources Survey 2019/20

Note:

Some UK figures are published by DWP in [table 5.7](#) of the FRS 2019/20 publication

Table B2c: Pension age informal carers by care recipient, 2019/20

	UK		England	
All pension age informal carers	1,000,000		800,000	
of whom:				
caring for someone else aged 65+ within the household	400,000	42%	300,000	40%
of whom:				
caring for a spouse	400,000	87%	300,000	87%

Source:

DWP Family Resources Survey 2019/20

Note:

UK figures for total number of informal carers published by DWP in [table 5.1](#) of the FRS 2019/20 publication (these include the whole population and therefore differ slightly from the above)

Table B2d: Percentage of people providing informal care by age and gender, 2019/20, England

Age	All	Males	Females
All providing care	7%	6%	8%
0-15	-	-	1%
16-24	4%	3%	5%
25-34	4%	3%	6%
35-44	7%	5%	9%
45-49	11%	9%	12%
50-64	14%	12%	17%

Evidence review for adult social care reform

65-74	10%	9%	11%
75-84	8%	9%	7%
85+	4%	6%	3%

Source:

DWP Family Resources Survey 2019/20

Note:

UK figures for the percentage of people providing informal care by age and gender is published by DWP in [table 5.2](#) of the FRS 2019/20 publication (these include the whole population and therefore differ slightly from the above)

Table B3a: Pension age people receiving care, 2019/20 (thousands)

	UK		England	
All pension age adults receiving care	1,200	11%	1,000	10%
of whom, aged 85 and over	400	31%	300	33%
All pension age disabled adults receiving care	1,200	22%	900	21%
of which:				
only formal care received	200	19%	200	20%
both formal and informal care received	200	15%	100	14%
only informal care received	800	66%	600	66%
All pension age disabled adults aged 85+ receiving care	300	39%	300	40%
of which:				
only formal care received	fewer than 100	21%	fewer than 100	21%
both formal and informal care received	fewer than 100	24%	fewer than 100	22%
only informal care received	200	55%	200	57%

Source:

DWP Family Resources Survey 2019/20

Note:

Totals may not sum due to rounding

Table B3b: Working age people receiving care, 2019/20 (thousands)

	UK		England	
All working age adults receiving care	1,100	3%	800	3%
All working age disabled adults receiving care	1,000	14%	800	13%
of which:				
only formal care received	fewer than 100	9%	fewer than 100	9%
both formal and informal care received	fewer than 100	7%	fewer than 100	7%
only informal care received	900	83%	700	84%

Source:

DWP Family Resources Survey 2019/20

Note:

Totals may not sum due to rounding

Table B4a: Working age disability benefits expenditure, 2019/20

£ million, real terms (2020/21 prices)

	England
Disability Living Allowance (of which working age)	1,344
Personal Independence Payment (of which working age)	8,892
Total	10,236

Source:

DWP Benefit Expenditure 2019/20

Table B4b: Pensioner disability benefits expenditure, 2019/20

£ million, real terms (2020/21 prices)

	England
Attendance Allowance	5,065
Disability Living Allowance (of which pensioners)	2,676
Personal Independence Payment (of which pensioners)	1,550
Severe Disablement Allowance (of which pensioners)	75
Severe Disability Premium within Pension Credit	1,206
Total	10,572

Sources:

DWP Benefit Expenditure 2019/20

Levels of expenditure for pensioners in receipt of PC SDP are carried out via internal analysis of DWP data

Table B4c: Disability benefit claimants, England, February 2021

Attendance Allowance	1.17m
Disability Living Allowance	1.12m
Personal Independence Payment	2.26m

Source:

[DWP Stat-Xplore, February 2021](#)

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