Social Care Needs and Outcomes

A background paper for

The Wanless Social Care Review

July 2005

Wanless Review Team

Overview

The review of future health care spending in 2001 by Sir Derek Wanless highlighted the importance of social care and the need to integrate thinking about social care policies and health policies. This message has subsequently been underlined by a series of publications from government and from the field. These include most notably the Green Paper on adult social care from the Department of Health (2005a) published at the beginning of the year, the Care Services Inquiry from the King's Fund (2005), and the Health Select Committee's report on NHS continuing care. More broadly there has also been a raft of policy initiatives and developments that link closely with the social care agenda: the emphasis on managing long-term conditions in the NHS is one example; another is the work of the Pensions Commission due later in 2005.

In the run-up to the government's next Spending Review and the planned joint White Paper on adult social care and care received outside of hospital, there is an opportunity to conduct a thorough appraisal of the potential nature and funding of social care in the future. In the light of this opportunity, the King's Fund has commissioned the Wanless Social Care Review to look specifically at the situation for older people. A project team consisting of economists and social care specialists, based at the King's Fund and working in collaboration with the Personal Social Services Research Unit (PSSRU) at the London School of Economics, is undertaking an analysis of the challenges and demands facing social care, and the resources that will be needed to deliver social care fit for the 21st century. The terms of reference for the review are:

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

This paper presents our initial scoping of the first two areas. It constitutes a preliminary scan of the evidence and information that inform these issues, and is designed to feed into the main analysis that will be outlined in the full report due in Spring 2006. Only once these fundamental issues have been investigated, can we address the question of how to pay for social care, and the implications of this for delivery and resources – in particular, for the workforce in terms of its likely size and the skills that will be needed. We have used the information set out here to prompt key stakeholders' thoughts around the following areas:

- What outcomes should services in England be seeking to achieve for older people in the future?
- What would be the most suitable services to achieve these outcomes, given the expected range of need in the future?

We have set out these observations here so that interested parties have an insight into the principles on which the Review will be based, and an indication of the assumptions and ideas that we are working with at these early stages of the Wanless Social Care Review.

Introduction

The shape of social care for older people over the next 20 years will depend on the objectives that society wants to achieve. These objectives concern the outcomes that individuals and those who care for them are likely to want and, therefore, the kinds of needs that social care will address in the future. Some outcomes will be fundamental – for example, helping people with the basic activities of daily living (ADLs), such as keeping clean and fed, if they are unable to manage these activities alone. Other outcomes likely to be valued include a safe and clean environment for people to live in and good levels of social participation and inclusion. Generally speaking, the more ambitious we are about the types of outcome required, the greater will be the potential number of people who could be helped and the range and intensity of services required.

The breadth of need to be tackled in the population depends on society's aspirations regarding outcomes. The numbers of people falling into the defined needs range in the future will be driven by many factors, some beyond the direct influence of social care. The main factors are:
- the changing demographics (particularly the ageing of the population and dependency ratios)
- the progression of disease
- disability and frailty
- new technologies becoming available
- wealth and housing
- changing expectations and social trends.

Our initial challenges are:

- to clarify the role of social care by specifying in some detail the required outcomes. We are not at this stage concerned with whom – the State, the individual, and so on – is responsible for securing these outcomes. Instead we seek an overview of what society at large will require

- to decide what services might be provided to best achieve these different outcomes. For example, services to promote social inclusion will be different from services to address personal care needs. They will also differ according to severity of needs. Nonetheless, by assessing what services will be required, by how many people, and then factoring in estimates of the unit costs of those services, it will be possible to estimate total resources required in England over the next 20 years.

In practice, the feasible range of needs, outcomes, service solutions, as well as other relevant circumstances, is wide. We will, therefore, develop a number of scenarios of the future to illustrate the most critical factors. In particular, they will reveal how ambitious we might be about the potential outcomes.

In assessing strategic outcome objectives, we will form views about the policy literature, including the recent Green Paper on adult social care and the older people's National Service Framework (NSF). These provide direction but are not sufficiently detailed for our purposes. Also, there are a number of targets for social care laid out in the Department of Health's priorities and planning frameworks, and in the public sector agreements (PSAs). Although these targets are quite specific, the basis on which they are set is not always apparent; it is not clear whether they will reflect people's needs and ambitions adequately, and there is no reason to expect them to hold for a 20-year time horizon.

What is required is an evidence-based approach. However, at present, although there is some useful information available, the evidence base is not sufficiently comprehensive. In assessing what evidence

we have available and reflecting the idea of different degrees of ambition, we have developed a hierarchy of three possible outcome objectives for the system:

- first, to enable basic functioning or ADLs for people who are frail or have disabilities
- second, to support social participation and social inclusion
- third, to improve the morale or self-esteem of older people, and to enhance in a general sense their well-being and other quality-of-life outcomes.

We might refine the latter two by restricting our objective to social inclusion and well-being for people otherwise precluded as a result of physical and mental disability, frailty and poor health (rather than, for example, poverty, poor education or criminal activity).

Future outcomes

Preferences

Preferences about care services

A number of studies have sought to discover people's preferences for types of care and care settings should they suffer disability or frailty. In the main, the findings suggest that people overwhelmingly prefer to stay in their own homes (although some people revise their assessment of care home life after their move into it) (Boaz *et al* 1999; Means 1998). For example, in the event of disability, a Help the Aged survey found that three-quarters of older people would prefer to stay in their own homes and have them adapted, rather than move (Help the Aged 1999). As few as a fifth of people felt they had actively opted for residential care after having been presented with the choice of staying at home or going into care (Ware *et al* 2003). Many people found themselves in residential care despite their preferences, but accepted the move as necessary in some regard (Oldman *et al* 1998). The influence of other family members can be significant. Carers are often less negative about the idea of the people for whom they have been caring moving into care.

The Commission for Social Care Inspection (CSCI 2005) carried out a MORI survey of preferences for social care when older. People were asked about the care options they would choose if they needed care and support in looking after themselves (when older, if not already). Table 1 (*see* below) shows the results.

Table 1: Preferences for receiving social care

Q. Which of the following would you prefer to happen when you are older, if you needed care and support looking after yourself? (people aged under 60) Q. Which of the following would you prefer to happen if you need care and support looking after yourself? (people aged over 60)	
Preference	**Percentage**
Stay in my own home with care and support from friends and family	62
Stay in my own home but with care and support from trained care workers	56
Move to a smaller home of my own	35
Move to sheltered housing with a warden	27
Move to sheltered housing with a warden and other social care services, eg hairdressing, outings	25
Move in with my son or daughter	14
Move to a private residential home	11
Move to a local council residential home	7
Move to a residential home provided by a charitable organisation	3
None	1
Don't know	2

Source: MORI for CSCI 2005.

Notes:
Base: all respondents aged 15+ (1049).
Respondents were allowed to give more than one option.

Choices about services are likely to reflect people's preferences regarding more fundamental aspects of care. To aid understanding, results from the older people utility scale (OPUS) project (Netten *et al* 2002)

have been studied. This project conducted a survey of older people, which revealed that the following domains were important to people:

- personal care/comfort
- social participation and involvement
- control over daily life
- meals and nutrition
- safety
- accommodation (standard of)
- employment and occupation
- role support (as a carer or parent)
- being in their own home.

The project also found out how important people felt it was that their needs were met in each of these domains. In particular, the study produced a numerical 'utility score' for each domain. Personal care needs, such as washing, dressing, going to the toilet and getting up and going to bed, were most important, closely followed by social participation. These two were twice as important to people as control over daily lives and meals/nutrition, and more than twice as important as the other domains. This information is very useful for understanding which services have the potential to improve people's outcomes the most. The relatively high valuation of the 'control' domain means that intensive home care can potentially score higher than care home placements. People's individual preferences will vary, as will the degree to which actual services can realise potential outcome gains, so such a result would, of course, imply only a rebalancing rather than a wholesale replacement of care homes. Nonetheless, this work does support the above work on preferences.

General expectations

Older people's expectations are changing, and the aspirations and preferences of people now in their 60s are vastly different from those of their counterparts 20 or more years ago. The so-called baby boomer generation (born 1945–54), who will be in their 70s in 20 years' time (Huber and Skidmore 2003), are already exhibiting a big change in approach towards their later lives.

The change of attitudes that is broadly, but not exclusively, characteristic of this generation, is reflected in an emphasis on demanding greater choice and quality, rooting out discrimination (most relevantly age discrimination), and embracing the human rights agenda. This has implications for all services, both in terms of how they engage with users, and for the mix of services required in the future – that is, there will be more of those types of services that are responsive to the people using them. Demand for choice in aspects of care, and the potentially wide range of differing services this could open up, will raise issues for both the range and funding of services. For example, the baby boomer spirit does not sit comfortably with care models based on communal living. Also, their attitudes in older age may well be influenced by their own observations about the adequacy of the care available for their parents' generation.

Variations in need and unmet need

Services are used because they can help to achieve certain outcomes that are important to people. Furthermore, the improvement in outcomes that can be achieved depends on the services used to address the different types of need that people may be experiencing. So the mix of services is important, and this is discussed below. But also important is the issue of who receives services and who does not. For example, at present social care is targeted at people with functional needs, especially those who are experiencing problems with ADLs and/or those who are at further risk as a result of cognitive impairment. More generally, whichever outcomes we are trying to achieve, it is possible to define the 'needs' characteristics of the people who should receive services and the intensity of those

services. When people with the relevant needs use those services, their outcomes will be improved. Going further, this means that total outcomes will be greatest when all people with relevant characteristics are in receipt of care of one kind or another. If, for whatever reason, this does not happen, then outcomes will be lower than they could be otherwise. In practice, there is quite a substantial variation in the extent of unmet needs.

To illustrate this, the following analysis shows how home care services have been targeted over the last 25 years. Using data from the General Household Survey (GHS), Figure 1 (*see* p 8) shows how the system has changed in terms of:
- **horizontal efficiency (HE)** the percentage of people within a defined typology of need that received any home care
- **vertical efficiency (VE)** the percentage of home care services targeted at a particular needs category.

The way that care needs are defined determines the size of these two percentages. In the figure, the following three sample needs groups are used:
- **Group 1 (G1)** people with personal care needs and with some informal care support, for example, people who can only get in and out of bed or the bath, climb stairs, and so on, with help from someone else or on their own with difficulty
- **Group 2 (G2)** people who cannot perform practical care tasks, such as cleaning windows, sweeping floors and washing clothes, by themselves
- **Group 3 (G3)** people with personal care or practical care task difficulties and no informal carer to provide assistance because, for example, they live alone or their carer also cannot undertake these tasks.

The solid lines in the figure refer to horizontal efficiency. In 2001, about 20 per cent of people within each of the needs categories defined above received some home care. That figure was a reduction from about 30 per cent in each category between 1981 and 1991. The dashed lines are vertical efficiency percentages for each of the three groups. Between about 60 per cent and 80 per cent of home care services were allocated to older people in the needs groups as defined above. The chart shows that people with personal care needs (Group G1) are now much more likely to receive care than in the past. In other words, services are more highly targeted at this group than in the early 1990s in particular.

Figure 1: The horizontal and vertical efficiency of home care services
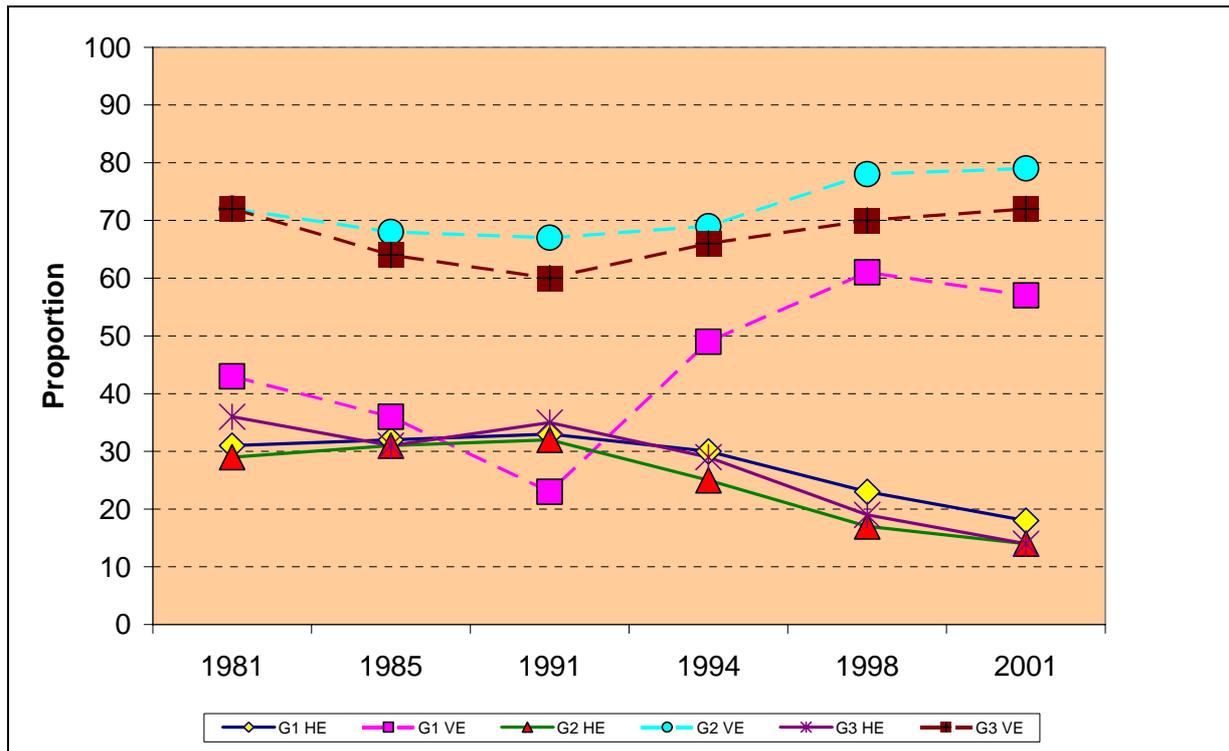
Source: Fernandez 2005

The implications of this analysis are twofold:

- The services available are fairly well-targeted at people with significant need, and this vertical efficiency has been improving, especially for people with personal care needs who may have informal care.

- The proportion of people with these needs who have them met is relatively low. This suggests an increasing rationing of resources – that is, a significant proportion of people who could benefit from publicly funded services do not receive them.

Prevention, productivity and service mix

Current research suggests there is scope for changes in the mix of service provision currently available – for example, between care homes, extra-care housing, intensive home care – that would improve outcomes at given costs (Davis *et al* 2000). Broadly speaking, improvements in outcomes can be achieved both in terms of meeting a person's immediate needs, and also in terms of preventing the onset of further need. One way of thinking about the latter is to assess how the provision of 'upstream' services might reduce the necessity for more intensive and expensive services 'downstream', as in the following diagram:
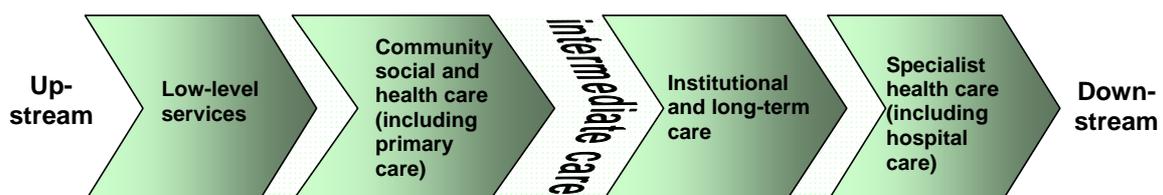
Another important element, especially on a 20-year time horizon, is the role that new services and technologies will be able to play in meeting the desired objectives. These developments range from low-level assistive aids which can enable older people to manage routine daily tasks for themselves, to more sophisticated telecare devices to promote safety and security in the home. Such technological developments can provide potential cost-savings but, in an outcomes-led process, will more importantly offer new ways in which an older person's preference to remain at home can be achieved.

Prevention

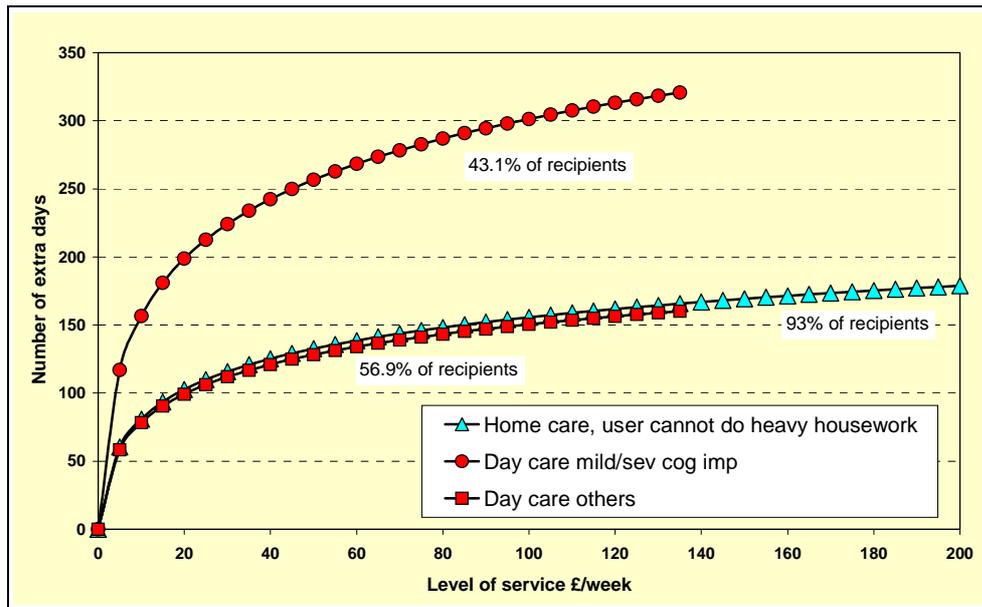### Community social and health care preventing care home admission

There is some evidence that community-based social care in England can delay or prevent someone's needs deteriorating to the point where they require institutional care. Figure 2 shows how spending on services 'buys' additional days for people in the community before an institutional care solution becomes the only option for them. Two services are shown – home care and day care. Also, because outcomes (additional days) depend on both the service and the needs of the people using that service, the figure shows the effects of services for different groups of people. For example, £60.00 per week of day care corresponds to about 265 extra days for people with (mild or severe) cognitive impairment, or an extra 135 days for other people using day care. The figure also shows the outcome of home care services for the 93 per cent of people in the sample who could not do heavy housework.

Some people argue that 'low-level' services, such as help with housework, gardening, laundry, and home maintenance and repairs, both enhance quality of life for older people and help them maintain their independence (Clark *et al* 1998). These services are likely to improve people's happiness and satisfaction with life. For example, having a clean home is very important to many older people. What is less clear is whether this help reduces the need for downstream care. Do people become so depressed about a dirty home that their independence at home becomes at risk? If this is the case, then domestic help is part of the prevention agenda. If not, it is still important, but it is related to quality-of-life outcomes, rather than prevention specifically.

Evidence from the United States (the National Long-Term Care (Channelling) Demonstration project) concluded that the long-sought goal of overall cost-neutrality or even cost-savings in substituting home care for nursing home use is technically feasible, but requires tighter targeting of services and a more medically oriented service mix than major home care demonstrations have implemented to date (Greene *et al* 1998).

We have conducted bespoke analysis of 148 local authorities across England in 1999 and 2000, which suggests that, with a given budget and controlling for need, local authorities can substitute residential places with intensive home care packages at the same cost or slightly less. This implies that for some people, intensive home care is a feasible and within-cost alternative. Moreover, our analysis suggests that with fewer budget restraints the range of older people for whom intensive home care is a feasible alternative will be wider.

Figure 2: Home care and day care effects on the extra time an older person remains in the community

Chart showing "Number of extra days" (y-axis, 0 to 350) against "Level of service £/week" (x-axis, 0 to 200)

- 43.1% of recipients
- 56.9% of recipients
- 93% of recipients

Legend:
- Home care, user cannot do heavy housework
- Day care mild/sev cog imp
- Day care others

Source: Davis *et al* 2000

Community social and health care preventing hospital admission

There is a growing body of evidence that social care can reduce, prevent, or substitute for, the need for hospital services. There are studies that have found that increasing the use of community social and health services reduces the use of hospital services. This evidence is summarised in the annexe (*see* p 18). The implication is that an increase in the provision of these services to individuals can not only improve their immediate outcomes, but also their future health outcomes.

This is an example of an area where the integration of thinking about social care policies and health policies, and about their effective practical implementation, is needed. It can also be seen as part of a wider policy context around the management of long-term conditions, which is a potentially huge issue facing the health care system. Admissions of older people, particularly emergency admissions, have been increasing substantially. Much of the integrated work mentioned above and in the annexe has been able to tackle these problems by helping to manage and limit sudden exacerbations of people's long-term conditions. Interventions have included preventing falls and managing diabetes, chronic heart disease and respiratory conditions. For these interventions to be effective, they need to be closely targeted at people who are likely to experience these problems. Identifying these people is difficult and is the subject of a major analysis by the King's Fund. The role of social care in preventing demand is complementary to its role in facilitating more timely discharge from hospital. However, if this broad chronic disease agenda is to be achieved, a substantial rethink of how health services are organised will be required.

Prevention or delay of needs by enhanced public-health and risk-management initiatives

The over 65s of 2025 are now the over 45s, and their needs in 20 years' time will, to some extent, be determined by their experiences and lifestyles over the next two decades. Questions arise about the likelihood of preventing, or at least delaying, disabilities by achieving ambitious public health objectives over the period. This also raises questions about the way in which primary care is developed and integrated in its objectives and delivery with other services.

Productivity: New models of care substituting for traditional models

Consumer-directed care

Many European countries are developing 'consumer-directed' care models that involve giving users either a budget, or direct control of a budget held by authorities (Lundsgaard 2005). In most cases, users have significant freedom in how they use this money. There are several examples that illustrate this approach:

- In England, the main example is the direct payments scheme (another is the attendance allowance).
- In Germany and Austria, the comprehensive long-term care insurance system – which has specific entitlement levels of care for people eligible on the basis of need – allows potential users to take this entitlement either as services or as a cash payment (where the latter is about half the monetary value of the services option).
- In Holland, some eligible older people can take insurance benefits as a personal budget rather than services.
- In the United States, some government programmes give people significant discretion in employing carers.
- In Sweden, some informal carers can be eligible to receive wages.

From the developing understanding about preferences (*see* above) it is clear that older people greatly value the sense of 'being in control' that these models bring. Users of consumer-directed care report very high satisfaction (CSCI 2004) and a number of studies have found that older people receiving direct payments report feeling happier and more motivated, and have an improved quality of life than before (Clark *et al* 2004). However, there are a number of issues that need to be considered:

- **The administrative burden** Although people value being in control, this comes at a price with direct payments – specifically that most of the administrative burden falls on the user and their family. Direct payments have been available to older people since 2000, but take-up rates in England so far remain low. On 31 March 2004, there were 3,200 over 65s receiving direct payments, a big jump from 380 just three years earlier, but still only representing 0.5 per cent of all older people receiving community-based social care (Department of Health 2004). Although there are many possible explanations, one reason could be that people do not think the benefits are worth the extra 'hassle'.

- **The quality of individually commissioned services** In using direct payments, are we seeing people trade off improved 'control' against reductions in the quality of the personal care? In Germany, for example, there have been concerns about quality, so much so that informal carers are greatly encouraged to undertake some formal training.

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

- **Choice of services** More fundamentally, it is apparent that direct payments and their like give people more choice over services and, as a consequence, over the outcomes they personally want to achieve. Many people choose services that meet not only their personal care needs but also practical and quality-of-life outcomes. For example, a 1997 study in Netherlands found that 54 per cent of personal budget recipients used their budget to pay for home help, 14 per cent for home nursing or personal care, and 32 per cent for a combination of the two. It would not be at all surprising to find a similar pattern in England, especially the

high funding of practical care, although we do not as yet have sufficient information to verify this. If this is the case, and continues to be in the future, then this is entirely laudable for the people involved, but it does mean that within current eligibility criteria, older people with personal care needs can also obtain practical/instrumental care services (for example, with housework, shopping), while older people with only practical/instrumental care needs are denied such help.

Overall, direct payments or cash benefits appear to offer users improved outcomes at potentially lower cost to the public purse. The new individualised budget model referred to in the adult social care Green Paper can be regarded as an umbrella concept incorporating direct payments at one end of the spectrum, with commissioned services from a pre-determined notional budget at the other end. Between these endpoints is a mix or hybrid of cash and notional budget, self-commissioning and third-party commissioning. By tailoring this mix to individuals, it may be possible to improve net benefits for these people further. We do not yet have the evidence, but the Department of Health is committed to carrying out a series of pilots to test the pros and cons, and these will start by the end of 2005 and probably run for 18 months.

Housing with care

Housing is an important dimension of care for older people. In addition to regular sheltered housing, very-sheltered or 'extra-care' housing (that is, having an on-site care team) is a more recent innovation that has the potential to substitute for some care homes placements. The Nordic countries and the Netherlands have for some time now embraced the philosophy of separating the care and accommodation/hotel/housing elements of services for frail older people, primarily to support people's independence. The evidence from the Netherlands is that 'regular' sheltered housing has little impact on future care needs, particularly the chance of needing a care home placement. But studies of the Dutch 'extended' sheltered housing arrangements suggest that it can substitute in part for care home placement, reducing the rate of admission into residential and nursing homes (Coolen *et al* 1998). There was evidence that the cost of these housing schemes was lower than care homes. The research found a small improvement in the well-being of clients, but no reduction in reported loneliness rates.

In Denmark, the 1988 Housing for the Elderly Act promoted specialised housing over institutional care, and entrenched the separation of care and nursing from the accommodation aspect of care schemes. Specialised housing is well-established and the evaluations are promising. Some of the most successful projects have also involved the integration with health services. For example, traditional nursing homes have been reorganised as 'health care centres' with attached private residences available for rent, and with a 24-hour, multi-disciplinary care team on site. The evidence is of improved (user perception of) health status, greater ADL independence, but without an increase in costs.

In the United Kingdom, there are around 30,000–35,000 extra-care units for rent/sale – a scale of provision that is currently dwarfed by the 440,000 people in registered residential or nursing care, and 700,000 receiving home care. We lack systematic evidence of the potential and cost-effectiveness of extra-care, but there are a number of individual studies that suggest that extra-care residents tend to show a reduction in need (for example, Helen Ogilvy Associates 1999). In addition, the Extra Care Charitable Trust (which runs 25 housing/care schemes with 2,000 residents) has reported independent research showing that extra-care residents improve more than people in traditional forms of care: they show an average mobility improvement of more than 35 per cent; a 20 per cent improvement in daily living functions; a ten per cent increase in sensory ability; and a 25 per cent reduction in medication use (Extra Care Charitable Trust 2005). According to Laing and Buisson, it is still unclear whether extra-care housing is more or less expensive than residential care or dispersed home care. However, they assert that 'there are early indications that very-sheltered housing may reduce the incidence and duration of

admission to hospital; if this proves to be the case, it will generate significant savings for the NHS that should be considered when comparing forms of care' (Laing and Buisson 2003/04).

On balance it is likely that the total costs of extra-care housing will be higher than care home costs for clients with care needs above a certain level. The per-resident costs of the care input should be comparable with a care home. The rental costs are likely to be higher because the space is greater and often the design is ergonomically better. If the latter results in a reduction, or easier management of people's needs, the total care costs might be lower, partially offsetting the greater rental costs. Outcomes for users should be better than for care homes because of the extra autonomy provided. So to generalise: extra-care housing probably offers better outcomes but at greater cost. It is an increasingly popular service option; the current very low level of provision appears to be too low.

The need for a holistic method to assess where public funding is justified

The public sector is currently heavily involved in the funding and delivery of social care and health services. The impact on the whole economy of these services and the extent to which they should be publicly funded are important considerations when assessing future options. In the case of social care, there is a particular need to take account of the cost of informal care, both to the economy and to individuals who provide it. A relevant current case in health care is the investigation by NICE into certain drugs for Alzheimer sufferers where an initial recommendation was based only on NHS costs but where the former Secretary of State for Health referred the case back for consideration of the implications for carers.

Service mix

Table 2 (*see* p 14) illustrates the balance of older people in long-term care institutions against those receiving formal home help services in a number of developed countries. Making comparisons of long-term care is difficult because people use different definitions and because the data are generally poor. But we can get a sense of the relative position of different countries.

In terms of the number of older people in long-term care institutions, the situation in England is not atypical. Although, the Nordic countries and the Netherlands appear to have comparatively high proportions in institutions, the figures in the table include 'service housing' – that is, very-sheltered housing – which accounts for a large share. In Denmark and the Netherlands, specialised housing solutions are the predominant choice (the number of places in residential nursing homes has halved between 1987 and 2003 in Denmark). In the Dutch case, a recent report states that only four per cent (150,000) of all people aged over 55 spend any length of time in a care home or institution, not including specialist housing (de Klerk 2004). This result would suggest that the nine per cent figure in the table includes a significant amount of specialist housing.

Where England is atypical is in respect of home care coverage, with a relatively low proportion of the population receiving formal home care. Nonetheless, there are a number of caveats. The four per cent figure for England includes only publicly funded home help/home care and is perhaps the closest figure for comparison (Department of Health 2005b). However, eight per cent of over 65s received some form of community-based services where the latter includes meals, aids and adaptations as well as day care, home care, and so on. Around five per cent of the older population receives community-nursing services but there will be a very large overlap with people also receiving community-based social services. Privately organised and funded home help is received by eight per cent of over 65s according to survey results. This would give 13 per cent total home care (after rounding, not including all community-based services) of the population over 65 – but this definition could also include purely domestic help (for example, cleaning) that is not care (or age) specific, and overlaps are possible (Walker *et al* 2002;

Personal Social Services Unit 2005). This comparison does not account for the intensity of home care service provision per recipient, which has gone up significantly in England.

Table 2: Share of older population in long-term care institutions and receiving home care

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

Sources: Gibson, Gregory and S Pandya 2003; S Jacobzone 1999.

Notes:
[1] Estimates may vary according to the definition of institutions, for example, 2.9 per cent of Japanese 65+ are in nursing homes; if individuals in long-stay hospitals are also included, the share rises to around 6 per cent. The US data do not include individuals in assisted living facilities, while those from the Nordic countries and the Netherlands include those in 'service housing'. For Denmark, 'older persons' refers mostly to 67+.
[2] Proportion of older persons receiving formal help at home, including district nursing and help with ADLs.

Future needs factors

Overall demographic forecasts will be an important influence on resource estimates. There has been a tendency in recent decades to underestimate the number of older people. The scenarios in the 2002 Wanless report varied the number of older people and only its least optimistic scenario ('slow uptake') used the central government forecast. The other scenarios were more optimistic assuming greater life expectancy. Since then the Government Actuaries forecasts have been increased (Government Actuary's Department 2004a).

Uncertainty in this area is critical for the work of the Pensions Commission, which set out a number of scenarios spanning the current central forecast (Pensions Commission, 2004). It has been suggested that all areas of government resource allocation should take account of this range of forecasts. We hope to ensure that the sensitivity assumptions we use for our population estimates are consistent with those of the Pensions Commission.

The first half of this paper focused on the outcomes for individuals. How far these can be achieved overall will depend on the number of people in need and the extent of their need. Specifying outcomes implicitly defines need. For example, if the objective of social care is to ensure that people can undertake activities of daily living (ADLs), then need is defined in terms of people who are unable to undertake these activities without support as a result of frailty, disability, illness, and so on. If the objective is also to improve social inclusion, then those in need are people who are socially excluded.

At present the most important reasons for social care service use are as follows, listed in order of importance (Bebbington *et al* 2001; Wittenberg *et al* 2002):
- health problems (physical and mental), functional disability, ADL problems, a need for rehabilitation and similar
- a lack of, or break-down in, informal care, or stress on carers
- poor or inappropriate housing and environment
- social reasons such as loneliness, fear of crime and abuse.

There are also many underlying factors. Conditions such as cardiovascular and cerebrovascular disease, sensory problems, arthritis, incontinence, dementia and depression are causes of disability, most of which are correlated with age (Stuck *et al* 1999). Living alone is a factor in limiting informal care or perpetuating loneliness. Low income and living in rented accommodation tend to correspond to inappropriate housing, and are also drivers of health problems.

At present, we can project how these factors will change in the future on the basis of current trends, for example, projections for numbers of people by age, sex, disability rates, housing tenure and composition and income. Indeed, statistical modelling based on population dynamics indicates:
- an ageing of the population, for example, a 183 per cent increase in the numbers of over 85s and a 143 per cent increase in those over 65 by 2025 (Government Actuary's Department 2004b)
- some indication of healthy active life expectancy (HALE) increasing faster than life expectancy (or, put another way, a fall in age-specific disability rates), resulting from later onset of disease and other health conditions
- increased numbers of dementia sufferers as the absolute number of over-85s increases sharply
- fewer people with adult children available to act as carers, but more people with spousal carer

- increasing home ownership and housing wealth. Owner-occupation by 65-year-olds is around 80 per cent, compared with around 67 per cent for 75-year-olds (Office for National Statistics 2003; Office of the Deputy Prime Minister 2004; Department of Work and Pensions 2004; Walker *et al* 2002). The mean net housing wealth among 60 to 64-year-olds was £79,500.00 in 2002 (Marmot *et al* 2003)

- widening disparities in income and net (non-housing) wealth on reaching retirement. One quarter of 60 to 64-year-olds have net financial and physical wealth of less than £3,200.00, while the richest quarter have more than £88,000.00 (Marmot *et al* 2003)

- inadequate pension saving by individuals ahead of retirement. If tax rates, savings rates and average retirement ages are held constant, pensioners will on average suffer a 30 per cent decline in income relative to average incomes from now to 2035 (Pensions Commission 2004).

We also know the relationships between indicators of the above needs factors and current service use. For example, people unable to undertake one ADL have a heightened chance of receiving care. For people with two or more ADL inabilities, the chance is substantially higher. Living alone is a strong factor in care home admission. Receipt of benefits is also an important indicator.

However, to understand future demand for social care, we also need to know the following:

- whether new developments will cause actual needs factors to depart from these projections – for example, the development and use of new therapies that reduce the incidence of dementia, or improvements in public health that reduce age-specific mortality and morbidity. If this is the case, we need to know by how much

- what types and levels of services people with various combinations of needs factors should receive in the future. This will include an assessment of the new technologies that are already on offer and a judgement of where those technologies are heading. If we wish to see a change in the services deployed in the future then we need to know at whom they should be targeted, that is, what types of needs they are designed to address

- whether these needs factors are the ones that will matter in the future – in other words, are there other, more important objective factors to add to the list? This question is especially important if we are talking about a future system that does have social inclusion and quality of life as outcome objectives.

Closing comments

To determine a total envelope of required resources for social care, we are considering a number of future scenarios, each of which involves four main stages:

- In broad terms, it is necessary to determine strategic objectives about which (individual-level) outcomes are to be achieved.
- We then need to specify which services best achieve those outcomes for individuals, accounting for their needs.
- Looking ahead 20 years, we need to anticipate the numbers of older people in the future falling into respective need categories.
- We can then estimate what total volumes of each type of service will be required and the cost.

This paper has briefly reviewed evidence relevant to the first two stages. In summary:

- Evidence on preferences suggests that people desire more responsive services, 'being in control' and good social participation. However, having personal care needs met is most highly valued.

- Public provision of social care has in recent years shown significant variation in how it has targeted resources. At present, services are predominantly aimed at people with high need. However, a significant proportion of these high-need people are not receiving public (home and residential care) services.

- There is some limited evidence that 'upstream' social care can reduce 'downstream' service use, notably health care services. However, a major contribution of low-level services is about improving quality of life.

- Direct payments and extra-care housing are promising service options; they appear to improve outcomes compared with traditional models of care, although they are not necessarily the lowest cost option.

- Compared with other developed countries, England has roughly comparable proportions of older people using institutional care, but rather lower proportions using home care.

There are various overall implications that can be read from this evidence, but of course there are dangers in generalising too far. Nonetheless, there is a strong suggestion of the value of moving away from residential care, towards alternatives such as extra care. Furthermore, low-level services can be effective at improving people's quality of life beyond personal care needs. At present, services are targeted at high-need people. However, many people in these high-risk groups do not currently receive public services. Finally, it is unclear how much resource could be targeted at lower need groups to achieve prevention benefits.

Annexe: The impact of social care on specialist health care usage – the evidence

The evidence shows that community-based services can be used to substitute for specialist health care (mainly hospital care) and that this substitution can be cost-effective, that is, the total health and social care costs are either lower, or outcomes are improved, or both. The likelihood of cost-effectiveness seems to increase with the extent to which preventative community-based services can be targeted at high-risk people and the degree to which health and social care services are organised in a co-ordinated and integrated fashion.

Substitution possibilities

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

There is also relevant research in England:

- A study of local authorities found that an increase in care home and/or home care provision had the effect of reducing rates of delayed discharge, and in turn, reducing average length of stay (all ages) and increasing hospital activity (Finished Consultant Episodes). Furthermore, increased care home provision reduced re-admission rates.

- A study in 12 local authorities found that an increase in home care provision for older people reduced hospital usage (*see* Figure 3). For very dependent older people, for every £1.00 spent on home care, average costs of hospital care fell by almost £0.30 (Fernández and Davies 2002).

Figure 3: Impact of home care on hospital use
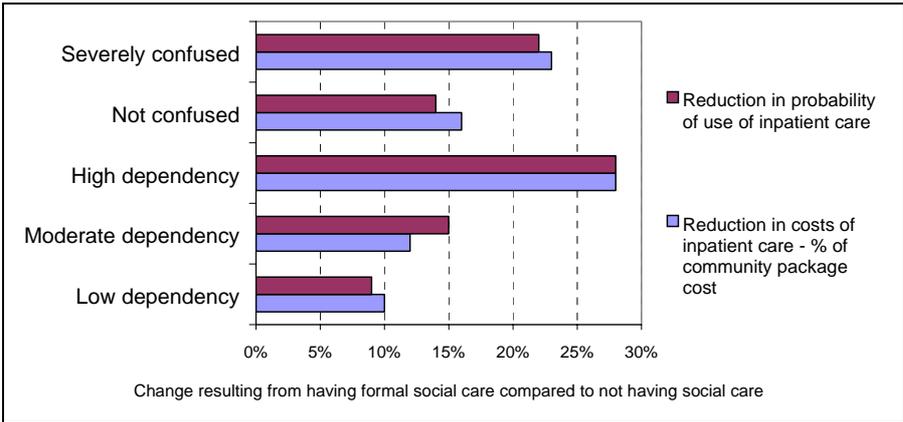
Source: Fernández and Davies 2002

- An analysis of admissions to Nottingham City Hospital indicated the emergency admissions could have been reduced by 13 per cent, and bed days lost by eight per cent, had alternative community-based services been in place.

- The National Beds Inquiry found that 20 per cent of bed days for people over 65 would be inappropriate if alternative services were in place. A King's Fund study (Stevenson and Spencer 2002) suggested an even greater inappropriate use of hospital beds.

There is a limited (but growing) body of evidence of the impact of intermediate care on other service use, including hospital use. Intermediate care covers a range of time-limited services fall between long-term care and acute or emergency care. Examples include rapid-response-teams staffed by nurses that can provide a short burst of intensive nursing and personal care with the aim of managing a sudden exacerbation of a person's long-term condition, short-term rehabilitation stays in care homes or extra-care housing for people coming out of hospital, or time-limited home health services (Department of Health 2001). There are no completed systematic evaluations, but intermediate care is both diverting people from unnecessary hospital stays and, in particular, facilitating earlier discharge (Department of Health 2002; Stevenson and Spencer 2002). For example, a study in Bradford indicated that intermediate care services providing post-acute care for older people should have the capacity to address the needs of up to one-quarter of acute admissions to District General Hospital (DGH) elderly care departments (Young *et al* 2003).

The evidence is insufficiently robust at present to be certain that this substitution effect is also cost-effective. What is clear is that intermediate care can be brought on-line relatively quickly, and is effective (and probably cost-effective) at minimising delayed discharge. Its effectiveness will depend greatly on how well-co-ordinated health care teams are with intermediate care teams, particularly community-based (social care led) intermediate care.

Better service mix under integrated programmes

There is also direct evidence of the value of an integrated approach. A systematic review (Johri *et al* 2003) found a number of specific programmes that combined health and social care for older people in an integrated and co-ordinated fashion. Programmes were reviewed from the United States (Programme for all-inclusive care for the elderly (PACE) and social health management organisations (SHMOs)), Canada (Système de services intégrés pour personnes âgées en perte d'antonomie (SIPA) meaning Integrated System of Care for Frail Elderly Persons), Italy (programmes in Vittorio Veneto and Rovereto) and the United Kingdom (the Darlington case management project).

The results were overwhelmingly positive, indicating that for the specific projects, acute hospitalisation rates, in particular, were significantly reduced with greater use of preventative community-based care (for example, the intensive use of day health centres and care at home). Long-term care institutionalisation rates were also reduced and outcomes and satisfaction improved. There was also evidence of overall cost savings in a number of these programmes. Although downward service substitution was a key feature, better co-ordination and case-management of services between health and social care drove much of the beneficial results. In one study in Italy, decreases were reported in the use of both institutional (including hospital) and community-based services. In other words, good integrated case-management apparently prevented inappropriate or excessive use of all service types – that is, not only downward substitution, but true needs prevention.

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

The *Evercare* programme in the United States combines care-management (by specialist nurses) with provision of intermediate care. Catering for people in nursing homes, nurse practitioners identify and manage users with an increased risk of hospitalisation. This management involves using a short-term burst of intensive service (intermediate care) within the nursing home (called intensive service days, ISDs) with the aim of avoiding hospital admission. The evaluation of the Evercare demonstration programme (Kane *et al* 2002) showed, first, a minor preventative effect, that is, produced a small reduction in the events that lead to a need for hospitalisation. Second, there was a large substitution

effect: many patients stayed in the nursing home rather than going to hospital. When they did go, they stayed for less time. Average admissions per 100 enrolees were at 50 per cent of the control level; hospital length of stay (LoS) was at 80 per cent compared with control, although adding the average intensive service days (ISDs) of those 'admitted' to ISD brings the total LoS to about the same as the control. ISDs are however significantly cheaper and easier to implement. Since outcomes differences were negligible, Evercare seem to represent a cost-effective programme.

The Evercare pilots in England have focused on intermediate nursing care for people at high risk of admission to hospital. Patients were identified primarily if they had two or more emergency admissions in the previous year. The effectiveness of these interventions is, nonetheless, in some question because at any given time, high-use patients are outliers that naturally tend to fall back towards the mean level of use in following years. A recent study found that although patients >65 with two or more admissions were responsible for 38 per cent of admissions in the index year, they were responsible for fewer than ten per cent of admissions in the following year and just over three per cent five years later (Roland *et al* 2005). In other words, even without the intervention, people would 'get better' to a large extent.

The Innovations Forum project on 'Reducing Hospital Admissions of Older People', which is being led by Kent County Council along with nine other pilot councils, is also showing some promising results relative to its target reduction of a 20 per cent reduction in unscheduled hospital inpatient bed days occupied by people aged 75 years and over by 2007 (for example, Improvement and Development Agency 2004; Personal Social Services Research Unit 2005).

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

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

There is evidence relating directly to England. First, the older people's NSF described how integrated services best prevent falls (Department of Health 2003). Department of Trade and Industry statistics show that one-third of people over 65 fall each year; a primary care trust (PCT) of 250,000 has approximately 250 cases of neck of femur fractures as a result of falls each year, with an average length of stay of 26 days (Todd *et al* 1995). The Healthy Communities Collaborative scheme aims to reduce falls in the elderly through a combination of various practical measures and greater awareness. The first wave started in September 2002 and worked with three PCTs in collaboration with local health and social care teams, local authorities and charities. After 24 months, the number of falls resulting in an ambulance call-out in the pilot areas had reduced by 37 per cent. A recent survey (Dalley 2005) of PCTs in England found that another PCT with a specialist falls service had reduced the number of people admitted to hospital after a fall by 12 per cent, saving around 1,000 bed days a year. Separately, the Southern Cambridgeshire Falls Prevention Project (Help the Aged 2003) is another example of a multi-agency approach for preventing falls among high-risk older people. One of its projects is to develop an exercise policy across health, social services, housing, the voluntary sector and leisure services, with the goal of delaying the onset of intrinsic risk factors for falling, and modifying existing risk factors.

An integrated approach has also been used successfully in a nurse-led assessment service for vulnerable older people at King's College Hospital, which was introduced to support the four-hour trolley

wait target by redesigning assessment services to identify frail and vulnerable older people better. Accident and Emergency (A&E) care nurses directly refer high-risk patients to medical teams without needing to wait for an A&E doctor (Davies-Gray 2003).

The Castlefields model applied at a GP practice in Runcorn reduced admissions of older people by 15 per cent, average length of stay reduced by two days to four days, and hospital bed days used by the practice reduced by 41 per cent (Hankley and Warlow 1999). The London Older People's Development Programme also provided more tentative evidence in support of these findings. The Evercare pilots in nine PCTs indicated that a significant proportion – around a third – of admissions and bed days are used by a small proportion of high-intensity users (that is, around two to three per cent of patients).

Implications

What does seem to be clear is that downward substitution requires good co-ordination and integration between service areas (including more generally between health and social care teams). Indeed, for high-risk people, the most effective packages are those that combine health and social care services.

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