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BRITAIN & NORTHERN IRELAND

# Ageing Societies:
## A Report on the Structure of the UK System and Emerging Opportunities

An overview of the UK health and care system and investment opportunities within Elderly Care

# Contents

# Executive Summary

This report aims to provide interested parties with a detailed overview of the key dynamics of the UK Elderly Care sector. This includes discussion relating to the demand, supply, regulatory and commissioning environment as well as potential opportunities within it.

There are some differences between the provision, funding and regulatory environments of health and social care in the devolved administrations of the United Kingdom (England, Wales, Scotland and Northern Ireland). This paper is focused predominantly on England.

The following is a brief summary of the key points raised in this report:

- Elderly Care is defined here as the care and support of individuals over the age of 65. This typically involves support with personal care and activities of daily living, combined with the management of various acute and chronic medical conditions which become more prevalent in this age group.
- Within the UK, health and social care operate in parallel systems. Healthcare is universally available and free at the point of access, whereas social care is subject to eligibility and means testing. Elderly Care is where the two systems converge.
- The UK's demographics of a growing and ageing population lead to a rise in the need for care and thus investment opportunities. However, it is important to note that 'need' does not necessarily translate into 'demand' for care as those needing care are often not the purchasers of care services.
- The overall demand for adult social care in the UK is in the region of £90-£130 billion per annum, although the majority of this (£60-£100 billion) is provided informally by friends and family.
- The health and care systems are regulated with the majority of provision coming from small independent providers.

*The UK's demographics of a growing and ageing population lead to a rise in the need for care and thus investment opportunities... The overall demand for adult social care in the UK is in the region of £90 to £130 billion per annum.*

- The UK is a 'supply-led' system characterised by the service that is being provided rather than the need that is being addressed. This has lead to a commodity pricing dynamic historically. However, the Care Act 2014 and other policy initiatives are shifting the balance towards the consumer: those in need of care.
- Fees being paid by Local Authorities are not enough to sustain the existing and future demand for care, which has led to self-funders subsidising Local Authorities by paying more for their care. Recent investment has focused on 'pure' self-funding provision rather than new services aimed at the Local Authority market. Local Authorities, if left unchecked, will not be able to provide services to those with eligible needs in the future.
- These shifting sector dynamics create significant opportunities to import, develop and establish best-in-class, disruptive models of care to meet the growing demand of an ageing UK population.

# Defining Elderly Care

'Elderly Care' is generally regarded as care and support for those over the age of 65, with those over the age of 80 being the most prominent constituency. The Census 2011 found that 25% of people aged 65 and older reported being limited with their day-to-day activities compared to 6% of people aged 64 and under. In 2016, people aged 80 and over were twice as likely to need help with activities of daily living as those aged between 65 and 69[1] .

**25%**

**The Census 2011 found that 25% of people aged 65 and older reported being limited with their day-to-day activities**

Medical and scientific advances, combined with greater affluence and an improved understanding of health and well-being, mean that individuals are living longer and surviving health conditions which would have been fatal historically. However, this has given rise to the increased prevalence of other conditions, e.g. dementia, and has shifted the dynamics of the system away from acute care to the management of chronic health conditions, which require an increasing level of support with personal care and activities of daily living.

'Elderly Care' is characterised by:

- Frailty and a requirement for support with activities of daily living;
- Multiple co-morbidities; and
- Chronic medical conditions in those aged over 65.

1 Health Survey England, 2016

# Elderly Care in context

## Healthcare

In the United Kingdom, **healthcare** is universally accessible based on clinical need irrespective of an individual's ability to pay. It is funded through general taxation (although various co-pay models exist, e.g. in the purchase of prescription medicines and dentistry) and commissioned through the National Health Service (NHS) at a local level via c.200 clinical commissioning groups (CCGs). Healthcare providers include public sector organisations, e.g. NHS Trusts, as well as independent sector profit and not-for-profit organisations, e.g. GP practices, charities and companies, who are contracted to provide healthcare services by their local CCGs. It is important to note that NHS and public-sector provision tends to be limited to acute care, with most non-acute services being provided by the independent sector. In addition to the NHS, a private-pay healthcare sector funded by insurance and individual payers also exists, which focuses on elective medicine and certain services that the NHS does not always fund where, perhaps, there is limited clinical need, e.g. cosmetic surgery and fertility [2]. Many healthcare providers operate in both the public and private pay markets.

## Social care

Funding for personal or **social care**, generally described as support with activities of daily living, is the responsibility of the individual and is provided either formally, through the purchase of care services, or informally by friends, family, neighbours etc. One of the c.150 Local Authorities responsible for Adult Social Care may fund all or part of an individual's personal care support if there is an **eligible need** and the individual does not have the **means** to fund it themselves.

## Converging systems to care for the elderly

The healthcare and social care systems might be described as running in parallel. Throughout their lifetime, an adult will 'dip in and out' of the healthcare system based on their clinical needs with any personal care support likely being met informally, e.g. by friends and family following a hospital discharge. Alternatively, certain adults, such as those with physical or learning disabilities, may rely considerably on formal support with their activities of daily living throughout their lifetime. They too will dip in and out of the healthcare system as necessary to support any medical needs. Elderly Care tends to be where the two systems converge given an increased need for support with activities of daily living in conjunction with the increased management of medical conditions and the lack of a suitable or available informal support network.

## An evolving but still supply-driven system

The UK health and care systems can be characterised as 'supply-led', i.e. they are defined by the service that is provided rather than the need that is being met. For example, digital technologies, domiciliary (home) care, supported living, extra care housing and residential care of the elderly are typically thought of as separate markets, whereas they may all be providing services which address the same care needs of an individual, i.e. support with specific activities of daily living.

The Care Act 2014 sought to address this by putting the individual at the heart of social care. The Act focuses on 'choice' and access to information, support and advice to allow the consumer of care to demand, in the economic sense, the care they need. It seeks to minimise the monopsony purchasing power of Local Authorities and stimulate innovation amongst providers to address local demand by placing purchasing power in the hands of the consumer.

2 NB: depending on individual circumstances, the NHS may fund some of these treatments

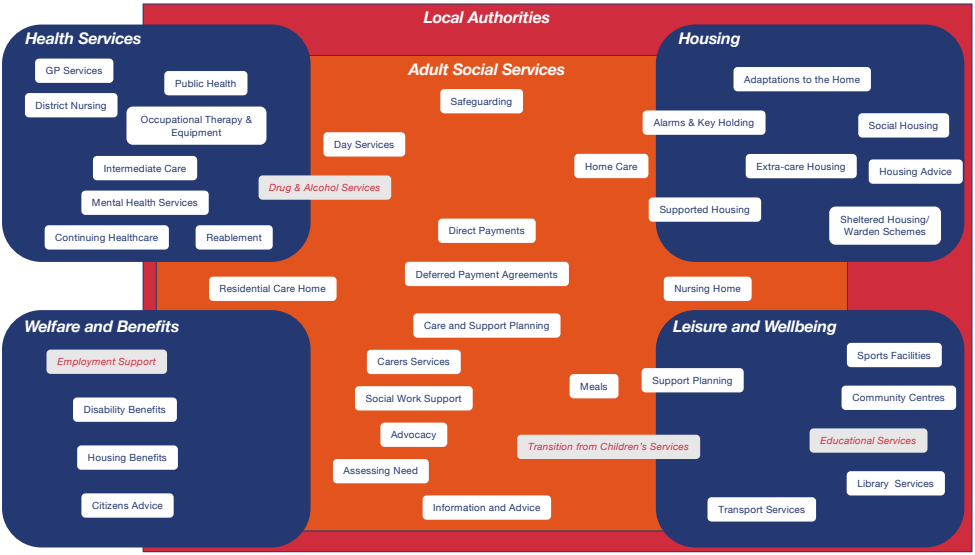



**Figure 1** The Health & Care Ecosystem: how well an individual's needs are met depends on a disparate range of public services interacting effectively

The Care Act 2014 envisages that all adults who require support with their activities of daily living will be assessed holistically and supported to meet their eligible needs by their Local Authority irrespective of who ultimately funds the cost of that care. However, this cultural and behavioural shift amongst consumers, payers and providers is still working its way through the system.

Many individuals do not know that they are entitled to a Local Authority assessment, for example, and simply purchase their care privately, or their care needs are met informally by a relative, friend or neighbour. Conversely, some Local Authorities continue to 'set fees' and purchase care on behalf of the individual from preferred providers rather than encourageing the person in need to choose their care provider.

# Demand dynamics

## The UK's growing and ageing population leads to a greater need for care

The arguments of a growing need for care based on the ageing demographics in the UK are well rehearsed:

- the population is growing and ageing;
- as people get older, they require greater support with their activities of daily living;
- an ageing population gives rise to chronic medical conditions, such as dementia, which require management outside of a traditional setting such as an acute hospital.

## UK demographics

The UK population continues to grow and is projected to do so into the future, with an increasing proportion of the population aged 65 and over, and a particularly fast growth in those aged over 90. An ageing population leads to a rising need for care.

The UK had a population of around 65 million people in 2015 which is expected to grow to c.77.5 million by 2050. The proportion of those aged over 65 is expected to grow to c.25% of the population by 2039, compared with c.14% in 1974, with the number of people over the age of 90 continuing to increase steadily [3].

**Figure 2** Projected growth of UK population (1960 to 2050)

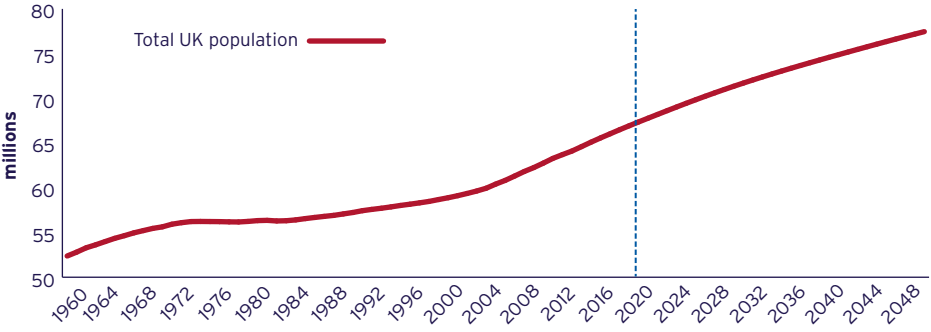



**Figure 3** Percentage of population by age (1974 to 2039)

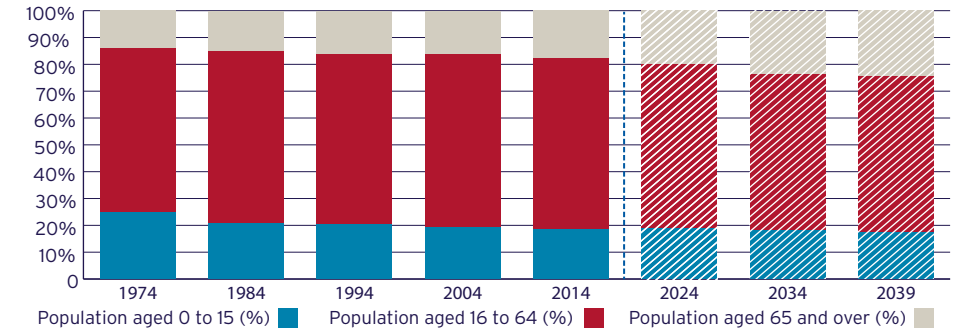
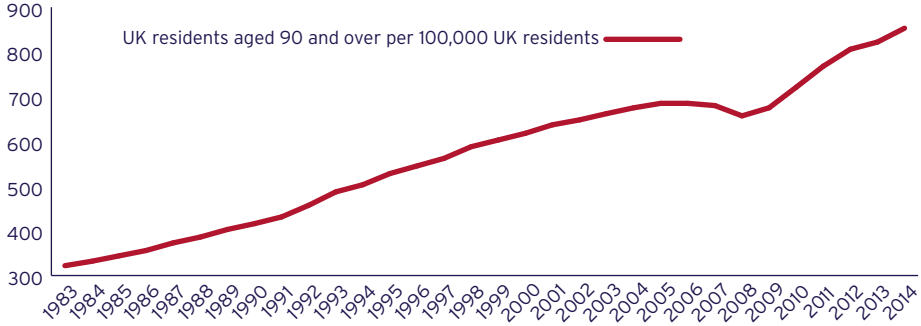


**Figure 4** Proportion of UK residents aged 90 and over, per 100,000 residents (1983 to 2014)




## Need does not necessarily translate to 'demand'

An important distinction needs to be drawn between **'need'** and **'demand'** and how it relates to the UK systems. In an economic context 'demand' refers to a consumer's desire and willingness to pay a price for a good or service. In the context of the UK health and care systems, the consumer (those in 'need' of care) and payer are often different, creating a disconnect between 'need' and 'demand'. The Health Survey England 2016 found that only a minority of people who said they needed help received it: 28% of people aged over 65 said they needed help with activities of daily living in the last month and less than half (12%) said they received help with those activities.

Therefore, when considering the demand dynamics of Elderly Care, the funding principles behind the health (free at the point of service based on clinical need not an ability to pay) and social care (eligibility and means tested) systems need to be considered.

## Around £90-130 billion annual demand for care

Demand for care can be considered in the following terms:

- **Local Authority funding (c.£20 billion)** the individual's Local Authority pays for some or all of the individual's eligible needs regardless of where it is provided.
- **Self-funder (c.£11 billion)** the individual (and/or their family) arrange and pay for their care privately either because they have bypassed the Local Authority or because they do not meet Local Authority eligibility and/or means criteria.
- **Informal Care (c.£60-100 billion)** care provided by family members and friends.

**Figure 5** Accessing social care: eligibility and means tested

The Care Act 2014 requires Local Authorites to ensure the provision or arrangement of services, facilities or resources to help **prevent**, **delay** or **reduce** the development of needs for care and support. To get social care, people need to meet national eligibility criteria and if the Local Authority charges for the required support, undergo means-testing (except for information and advice, and safeguarding).

## Care needs

An adult or their carer may require help to manage their social care and support needs, such as:

- Manageing and maintaining nutrition
- Maintaining personal hygiene
- Manageing toilet needs
- Being appropriately clothed
- Being able to make use of the adult's home safely and maintain a habitable environment
- Developing and maintaining family or other personal relationships
- Accessing and engageing in work, training, education or volunteering
- Making use of necessary facilities or services in the local community including public transport and recreational facilities or services
- Carrying out caring responsibilities for a child

There are several routes to getting these met

## Local Authority funding

- Approach the Local Authority social services to apply for help
  - This is subject to an eligibility assessment
- The provision of social care is means tested
  - Depending on an individual's financial situation, they may be asked to contribute to some or all of their costs of care

## Self-funder

- Arrange and pay for care privately
- An adult may choose to do this where they have capital and savings above the Local Authority financial thresholds
- An individual who decides to do this may be described as a **'self-funder'**

## Informal care

- Receive care and support from family members or friends

## Financial assessment

- An individual will have to pay the full cost of their care if they have more than £23,250 in savings
  - Unless they are going into a care home, this amount does not include the value of an individual's property
- If savings are less than £23,250 but more than £14,250 then the Local Authority will pay for care
  - The individual must contribute £1 to the fees for every £250 of personal savings
- If an individual has less than £14,250 in savings, their care will be fully paid for by the Local Authority
- Local Authorities also take into account an individual's income during the assessment

## NHS continuing care

Some people with long-term complex health needs qualify for their social care to be arranged and funded solely by the NHS. This is called **NHS Continuing Healthcare**. To be eligible for NHS Continuing Healthcare, an individual must be assessed by a multidisciplinary team of healthcare professionals. The team will look at all their care needs and relate them to:

- what help the individual needs;
- how complex their needs are;
- how intense their needs can be; and
- how unpredictable their needs are, including any risks to health if the right care isn't provided at the right time.

Eligibility for NHS Continuing Healthcare depends on assessed needs, and not on a specific diagnosis or condition. If needs change then eligibility for NHS Continuing Healthcare may change.

## Informal care

The majority of care is provided informally by unpaid family, friends and neighbours who provide personal care, practical help and coordinate formal services. Estimates of the value of informal care are as high as **£100 billion per year**, based on the replacement cost if these were to be provided formally. This estimate reduces to around **£60 billion per year** based on the cost of care the Local Authority would likely commission if it were not being provided informally. These estimates do not consider the opportunity cost to the economy, e.g. people giving up their jobs to care for a relative or friend. By way of reference, the total spending on health in the UK is c.£120 billion.

**£90-£130**billion

**The total demand for care in the UK is estimated at £90-130bn.**

## Local Authority care

The total value of care arranged by Local Authorities in 2016-17 was **c.£20 billion**. Local Authorities fund the care they arrange primarily from three sources:

- Council tax, government grants and business rates (c. £15 billion);
- User contributions: social care is means tested with some users paying contributions towards the cost of their care (c.£2.7bn); and
- Income from the NHS and other joint arrangements: Local Authorities cannot lawfully commission services that are clearly the responsibility of the NHS, for example nursing care needed for health reasons. Where this is the case, Local Authorities will receive income from the NHS to cover the cost of meeting those needs they do not have a duty to meet (c. £3.2 billion).

## Self-funded care

In 2016-17, the National Audit Office estimated that privately bought care by self-funders without Local Authority involvement amounted to around **£11 billion**.

## Total demand for care

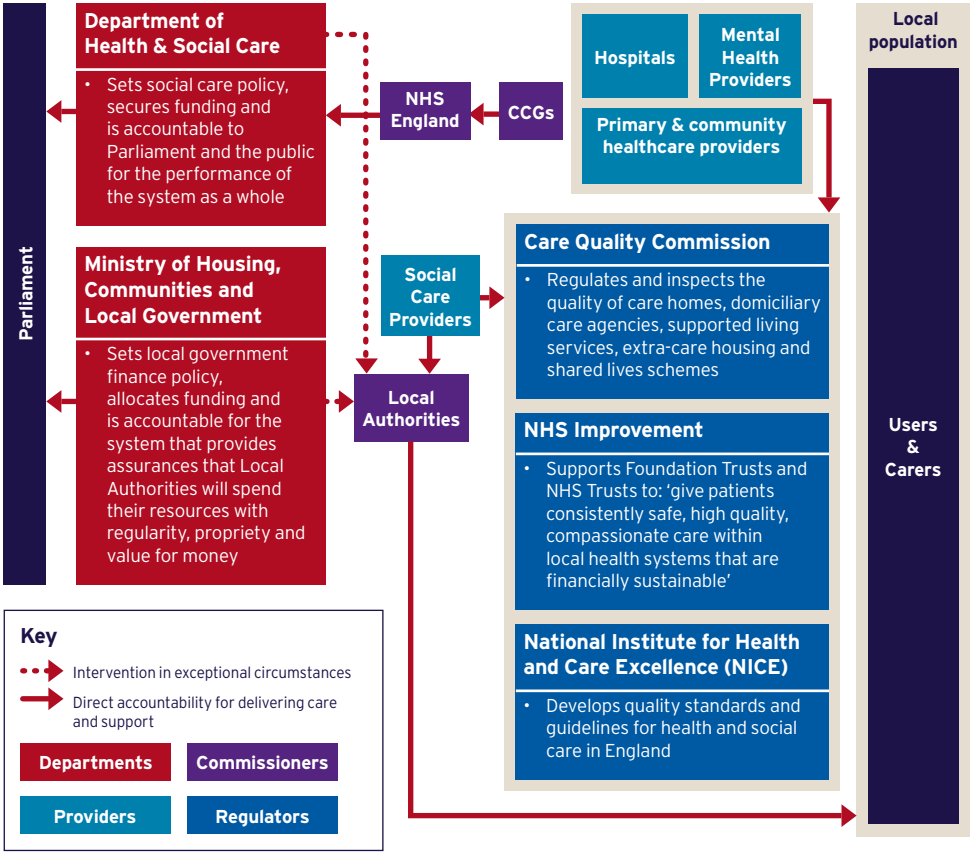
Therefore, the overall demand for adult social care services can be estimated as being **c.£90 – 130 billion per year.**

# Supply dynamics

The health and care sectors are regulated, with all providers requiring registration from the Care Quality Commission, who regularly inspect the quality of services being provided. Depending on the nature of the provider, there are various other bodies who have accountability for delivering care and support, including government departments and Local Authorities.

The **Department of Health & Social Care (DHSC)** is responsible for health and social care in England. The **Ministry of Housing, Communities and Local Government** has responsibility for local government finance and the accountability system. **NHS England** is responsible for supporting clinical commissioning and the commissioning of NHS services overall. **Local Authorities** commission social care and a small minority might also provide care services (although most is outsourced to the independent sector). Local Authorities do not have direct accountability to Parliament, instead they are accountable to the Local Population.

**Figure 6** Accountability for Adult Social Care: a complex web of Departments, Commissioners, Providers & Regulators



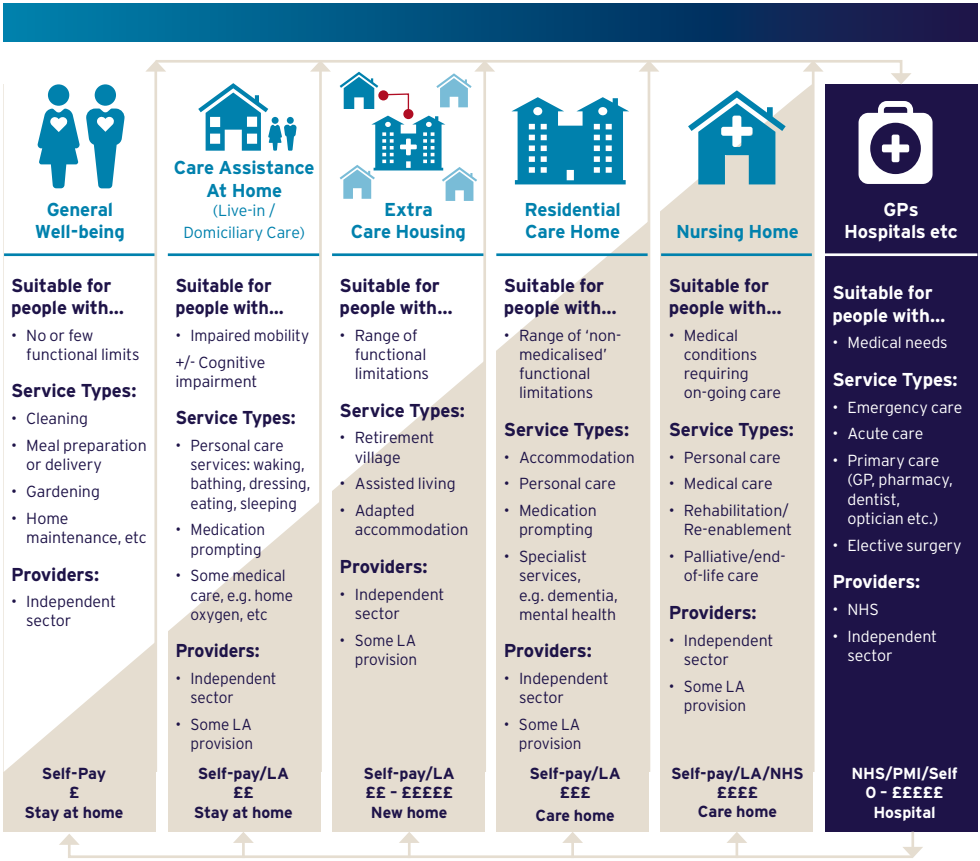
## A sector characterised by small, independent providers

Most of the provision in the Elderly Care sector comes from independent providers through both for-profit and not-for-profit organisations, the majority of which are small 'mom & pop' enterprises with a local focus. The most developed of the 'corporate' provision is within the residential care sector (including nursing homes) and includes organisations such as: **HC-One, Four Seasons Healthcare, Barchester, Bupa** and **Anchor**.

## Markets defined by service provided, not needs met

The health and care markets in the UK are generally characterised in terms of the goods and services that are being provided rather than the care needs that are being met. For example, domiciliary care and residential care homes are frequently considered as different markets, whereas they may in fact be satisfying the same need: support with personal care and activities of daily living. The principal difference being the location in which the service is provided rather than the service itself: akin to the difference between eating in or taking out at a restaurant.

**Figure 7** The continuum of care, various supply-side models of care provision



This characterisation has led to a commodity pricing dynamic historically, with Local Authorities exercising monopsony powers to set the prices at which they will, for example, purchase residential care based on a fee per bed model regardless of the care package being provided. It can be thought of as buying/selling a room which includes a package of care versus buying/selling a package of care which includes a room. Providers have been price takers as historically the fees paid by Local Authorities were enough to cover the cost of care and encouraged providers to operate efficiently.

## Reduction in supply at odds with demand dynamic

In recent years, Government and Local Authority austerity measures, heightened regulation and the increasingly complex needs of those receiving care has put pressure on providers, leading to a focus on provision to self-funders and an overall reduction in supply. This is clearly at odds with the need and demand dynamics of the sector.

**75%**

**In about a quarter of care homes more than 75% of residents are funded by their Local Authorities.**

## Local Authorities being subsidised by self-funders

Self-funders pay more for care than Local Authorities and the gap is widening. In England in 2016-17 when compared with the average price paid by both Local Authorities and self-funders, the average price paid by Local Authorities for residential care was 43% less for nursing care and 8% less for residential care. This compares to a difference of 32% and 1% respectively in 2012-13. As such, self-funders are subsidising the cost of care for those being funded by their Local Authorities. Consequently, investment has focused on the self-funder market and affluent areas, whilst in other areas providers have closed or handed back contracts.

There is evidence to suggest that the current level of fees being paid by Local Authorities are not enough to sustain the current levels of care. In their November 2017 report, the Competition and Markets Authority (CMA) found across the UK:

- in about a quarter of care homes more than 75% of residents are funded by their Local Authorities;
- if Local Authorities were to pay the 'full cost of care' for all residents they fund, the additional cost to them of these higher fees would be £0.9 billion to £1.1 billion a year; and
- there have been few examples of investment in new care home capacity primarily focused at the Local Authorities funded sector.

As a result, the CMA concluded that, left unchecked, in future, Local Authorities will not be able to provide services to all those with eligible needs. The CMA found that the market-shaping duties of Local Authorities under the Care Act 2014 were 'not proving sufficient' to encourage and support private investment in new and modernised care capacity aimed at Local Authoritiy funded care home residents or to ensure that the right mix of capacity is provided in the future.

# Opportunities

The favourable market dynamics of a growing need, particularly for the care of more complex conditions, and the reduction in supply, provide significant opportunity for disruptors and new and innovative models of care. Through legislation and otherwise the operating environment is shifting away from a supply-led market towards a consumer demand-led system. Opportunities exist to establish best-in-class models of care in the UK to meet the growing demands of an ageing population.

*Favourable market dynamics provide opportunities for new and innovative models of care.*

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