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PERFORMANCE TRACKER | LOCAL

Adult social care across England

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About this report

This report looks at the variation in access to publicly funded adult social care across England, comparing local authorities' characteristics to examine what might explain differences in access for both working-age and older adults. It is part of the Institute for Government's Performance Tracker Local series, supported by the Nuffield Foundation.

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The provision of adult social care by local authorities in England should, in theory, be based on an individual's need and ability to fund their own care. But this is not what is happening in practice. There exists a damaging geographical and demographic 'care gap' in England that means access to care for older adults is increasingly based not on need but on other factors – some perhaps less surprising, like local levels of deprivation and disability, but some more so, like the number of older people who live in an area.

That this nationwide variation is not new should not excuse the government from action. That it has grown and may well continue to grow as the over-65 population of England outpaces that of all other age groups makes that action more urgent. But to act well government needs to better understand the problem and how and where this care gap is forming and is at its most extreme. This is what this report, the latest in our Performance Tracker Local series supported by the Nuffield Foundation, seeks to help it do.

Key findings

- The proportion of adults who receive long-term publicly funded social care has declined substantially since at least 2003/04, from 2.3% of the adult population to 1.4%.
- This is driven almost entirely by a decline in access among older adults (those aged 65 and over): 8.2% of older adults received long-term care in 2003/04 compared to 3.6% in 2023/24. In contrast, 0.8% of working-age adults (those aged 18 to 64) received long-term care at both the start and end of that period.
- When comparing rates of access across local authorities, there is large variation in the rate at which adults access adult social care around the country: 0.8% and 2.5% of the adult population receive publicly funded long-term care in the local authorities with the lowest and highest rates of access, respectively. The range for older adults was 2.0% to 8.8%. In comparison, the range for working-age adults was 0.4% to 1.5%.
- Some of the variation among older adults can be explained by factors that would be expected to drive differences in access to care. For example, levels of deprivation, rates of self-reported disability, and whether someone lives alone.

- But there are also lower rates of access in local authorities that have larger older populations, implying that local authorities ration care when a larger proportion of the population are older. This has not always been the case; that relationship did not exist to the same extent in 2004/05. And the same relationship does not exist for working-age adults.

- Despite these lower rates of access, local authorities with larger older adult populations spend a greater proportion of their budgets on long-term adult social care for that age group.

- More people provide unpaid care in local authorities with lower levels of access for older adults.

What the government should take away from these findings

- This problem is unlikely to disappear. The adult population aged 65 and over is set to grow more quickly than the rest of the population in the coming decades – other than those aged 90 and over, which will grow even faster.

- Some of the demands on care for these groups may be offset by further declines in reported disability rates, as seen in recent years, but the government should not bank on that trend continuing.

- Variation in access to care is warranted, but it should be determined by relative levels of wealth and need, not by who happens to live in a particular area.

- The government should ensure that funding supports its priorities for the sector. As the commissioners of adult social care, the amount of funding that local authorities receive is a crucial determinant of access to the appropriate support. The government's upcoming reform of local government finance is an excellent opportunity to align funding and ambition for better adult social care.

- Rationing care is not cost-free. The burden of reduced access to care can often fall on friends and family – predominantly poorer people and women – who step in to provide unpaid care. This is both unfair, and indirectly expensive for the government, as these people are less likely to be able to work full-time (or at all). Increasing access to care can therefore support the government's goal of improving workforce participation.

Introduction

Introduction

In 1997, a newly elected Tony Blair told Labour Party conference: "I don't want [children] brought up in a country where the only way pensioners can get long-term care is by selling their home."[1] He promised action. So has every prime minister in the nearly three decades since. Few have delivered, and most have delayed or abandoned substantive reform.

So far, this Labour government is no different. In its 2024 election manifesto, the party committed to creating a National Care Service and, separately, to implementing charging reforms, including a cap on care costs first recommended by Andrew Dilnot in 2011.[2] That pledge was abandoned less than a month after the election.[3] The government's announcement that Louise Casey would lead an independent commission on adult social care reform was welcome – but that this was not due to publish its final report until 2028 appears to be another signal that other reform is also unlikely to come quickly.[4] It is possible, as indeed we have argued for, that Casey should ignore her terms of reference and report more quickly,[5] though at the time of writing that seems unlikely.

Reforming the sector will be hard, practically and politically. Any decision requires difficult trade-offs. To take just the most recent example: the sector is highly, and increasingly, reliant on overseas staff, and these workers add to the inward net migration numbers at a time the government has placed some political capital in reducing this. In May 2025, the government went as far as to "end overseas recruitment for social care visas",[6] instead saying that it intends to improve pay and conditions to make the sector more attractive to British staff.

How it does this is unclear. Paying higher wages requires local authorities to pay higher fees to providers of care; in turn, requiring central government to better fund local authorities or else raise more funding through council tax. That it can find a politically palatable way to do this in a constrained fiscal environment is far from certain.

Inaction has a cost

Caught between political and financial costs the government may find it is scared into doing nothing. But inaction comes with a cost, too, one that is borne by the people who are unable to access the care they need.[7]

The result of continued government inactivity is stark. People already find it difficult to access the support they need as local authorities stretch increasingly inadequate budgets to meet demand. That failure is often communicated by the press in terms of the problems that it causes the NHS. But while there are implications for the health service, the greater problem is that tens, if not hundreds, of thousands of people are either denied the chance to, in the words of the House of Lords Adult Social Care Committee, live their "gloriously ordinary lives"[8] or have to spend substantial amounts of their own money on care during a continued cost of living crisis.

There are knock-ons too: where people cannot afford privately provided care, friends and relatives often step in to fill the gap – providing what is known as 'unpaid care' – and, in so doing limiting their own access to the workforce.

Access to care varies significantly across England

However, this report will show that just as problematic is that the ability of people to 'access care' – defined here by the extent to which it is possible for people to draw on publicly funded care when they need it – is often determined by the local authority they live in and the number of people living nearby who also need support. The main metric we use to judge this is the proportion of the population that receives publicly funded long-term care from a local authority.* This allows for comparison across the country, across time, and with other population and local authority characteristics.**

This nationwide variation is not a new phenomenon. The coalition government introduced the Care Act 2014 at least in part to reduce the variation in access to care across England. As the government said at the time of implementing the Act: "We do not want people to be dealt with differently based on the type of service they need or where they receive it."[9] In a perfectly working system they would not have to: local authorities should provide care to anyone who meets the needs and means tests. It should also be the case that someone should receive – at the least – the same level of care whether they live in Walsall or Walthamstow.

But a decade on, this is not the case. As this paper will show, there is in fact substantial variation across the country in access to care for the over-65 population. The proportion of older adults that accessed care at the end of 2023/24 in London (4.9%) was, for example, much higher than it was in the South West (2.8%). Some of that is due to differences in wealth levels, meaning that someone is more likely to qualify for publicly funded support in London than the South West. Some is also explained by different levels of need.

But we show that these factors cannot fully account for the likelihood that someone will receive care. Specifically, we find that an older adult who lives in a local authority with a larger proportion of the population aged 65+ is less likely to receive care, after accounting for deprivation and rates of disability. This suggests that in areas with more demand, councils are responding to financial pressures by rationing care.

This report draws on publicly available datasets for most of the analysis and supplements this with a small number of qualitative interviews with policy experts, people working in government, and practitioners.

* From now on, all social care discussed in this report will be publicly funded care, unless stated otherwise.
** Please see the Methodology for a discussion about our reasons for using the metrics and data that we have. This includes acknowledgements of the limitations of various datasets.

Box 1: Notes on data

The quality of data on adult social care is poor. This makes it difficult to make judgments about both the wide range of factors that are important in determining the level of need for care and the extent to which a local authority meets that need. That we make use of imperfect data as proxies for various metrics that we are trying to observe is unavoidable; the Methodology contains a discussion about the strengths and limitations of each dataset.

Part 1. How does access to care vary across England?

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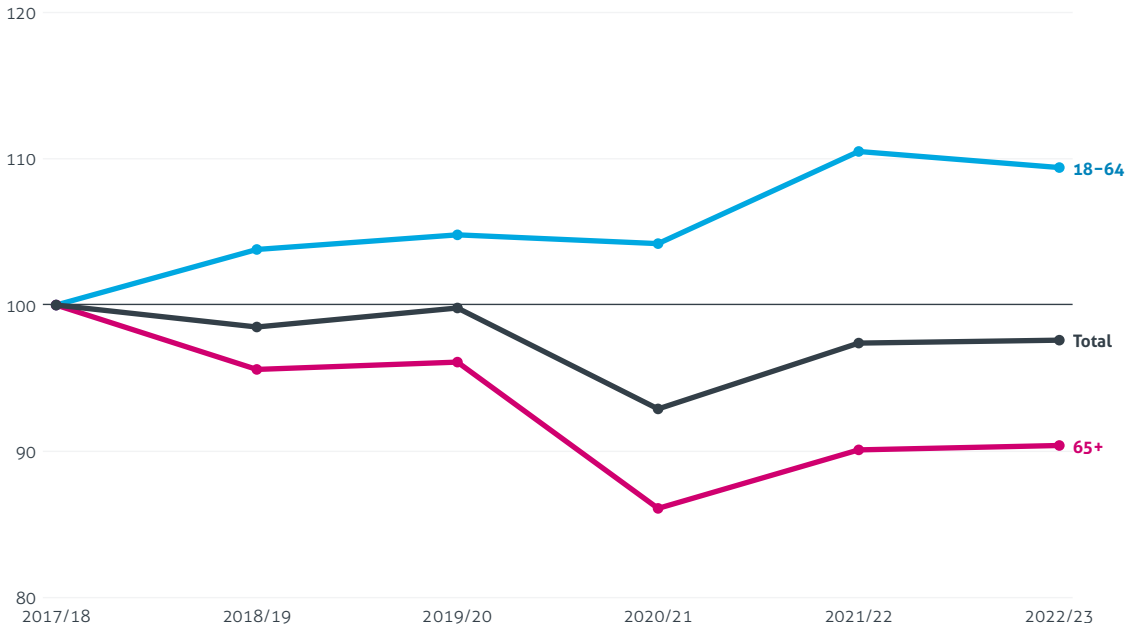
The proportion of people accessing long-term care has declined

Since 2017/18, the proportion of the population requesting support from their local authority has decreased, from 3.1 adults in every 100 to 3.0 in 2022/23.* There are differences between age groups, however. Among working-age adults (those aged 18 to 64) there were 1.2 people requesting support for every 100 adults in 2017/18, rising to 1.3 people in 2022/23 – an increase of 9.4%. In comparison, there was a decline in the proportion of the 65+ population requesting support: in 2017/18 this stood at 9.5 people for every 100 compared to 8.6 in 2022/23 – a fall of 9.6%.

Figure 1 **Change in proportion of adults requesting social care support from local authorities, by age group, since 2017/18**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity' ('T13' table), 2022/23 and ONS, 'Mid year population estimates', 2023. Notes: This shows the unique number of people requesting support. Data is not available before 2017/18 or after 2022/23.

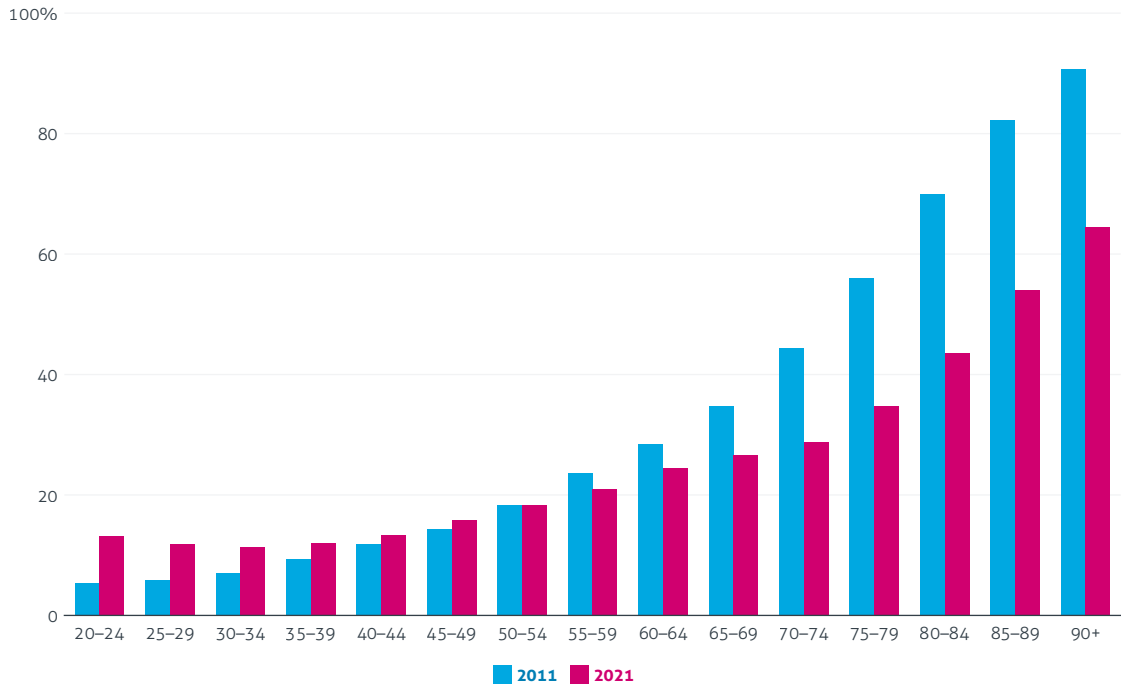
There are various factors that contribute to need for adult social care. This change could, for example, reflect increasing prevalence of reported disability among working-age adults, which rose from 13.4% in the 2011 census to 15.6% in the 2021 census. This was particularly driven by adults aged 20 to 34, where the rates of self-reported disability almost doubled, rising from 6.1% to 12.0% in that time.

* This data was not published in the 2023/24 edition of the dataset, meaning 2022/23 is the most recent data that we have.

In contrast, levels of self-reported disability among older adults declined between 2011 and 2021, as Figure 2 below shows (though, as discussed in more detail in the Methodology, this may partly reflect changes to the census question that these figures are based on).[1] In 2011, just over half of adults over the age of 65 reported living with a disability (53.1%), compared to 35.2% in 2021.

It is also not limited to a decline in the *proportion* of older adults reporting a disability, there has also been a fall in the *absolute* number reporting a disability, from 4.6million in 2011 to 3.7million in 2021.

Figure 2 **Adults that report living with a disability, by age band, 2011 and 2021**

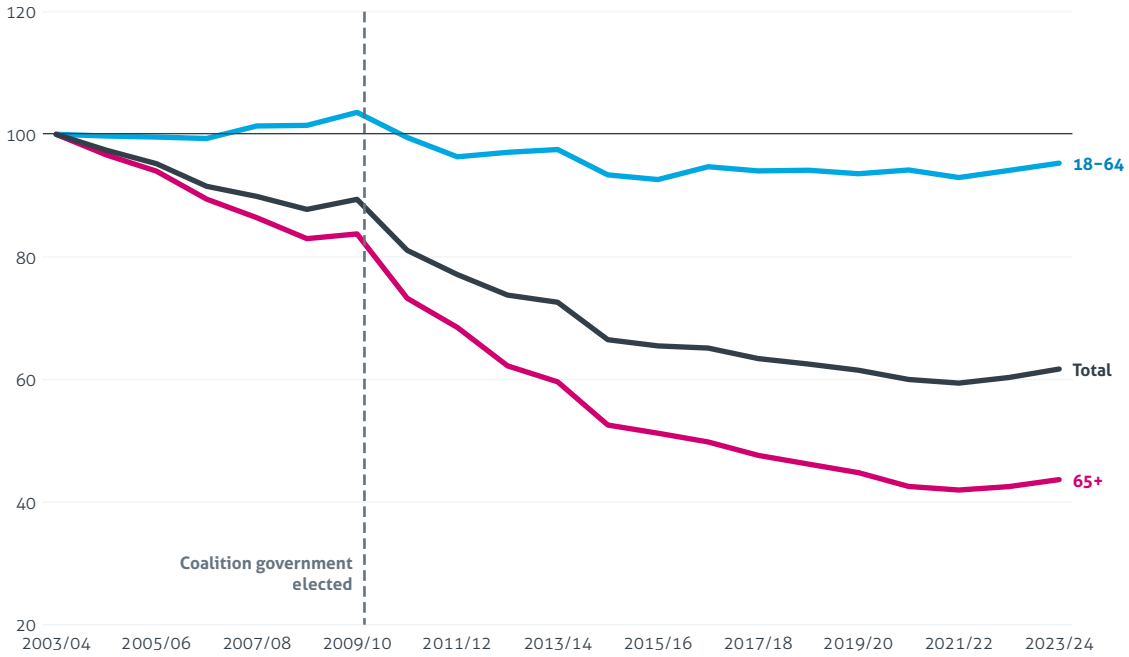


Source: Institute for Government analysis of ONS, 'Census: Disability by age, sex and deprivation', 2011 and 2021.
Notes: Figures relate to England only. The change between 2011 and 2021 is partially influenced by changes in the question asked in the census, though the ONS says that figures are "broadly comparable". Those aged 18 and 19 are not included here because the ONS groups them with children aged 15 to 17.

But while the proportion of all adults *requesting* support has declined, the proportion of people *accessing* care has declined further. The proportion of the adult population receiving long-term adult social care fell from 2.3% at the end of 2003/04 to 1.4% at the end of 2023/24. The difference between the two age groups, however, is stark. While the proportion of the working-age adult population that receives long-term care has remained broadly stable (at 0.8% in both 2003/04 and 2023/24), the proportion of the over-65 population receiving long-term care fell from 8.2% in 2003/04 to just 3.5% in 2023/24 – a drop of 56.3% as shown in Figure 3 below.

In short, fewer people in England are successfully requesting social care from their local authorities as compared to almost any point in the past two decades.

Figure 3 **Index of the proportion of adults receiving long-term care from local authorities, by age group, since 2003/04**

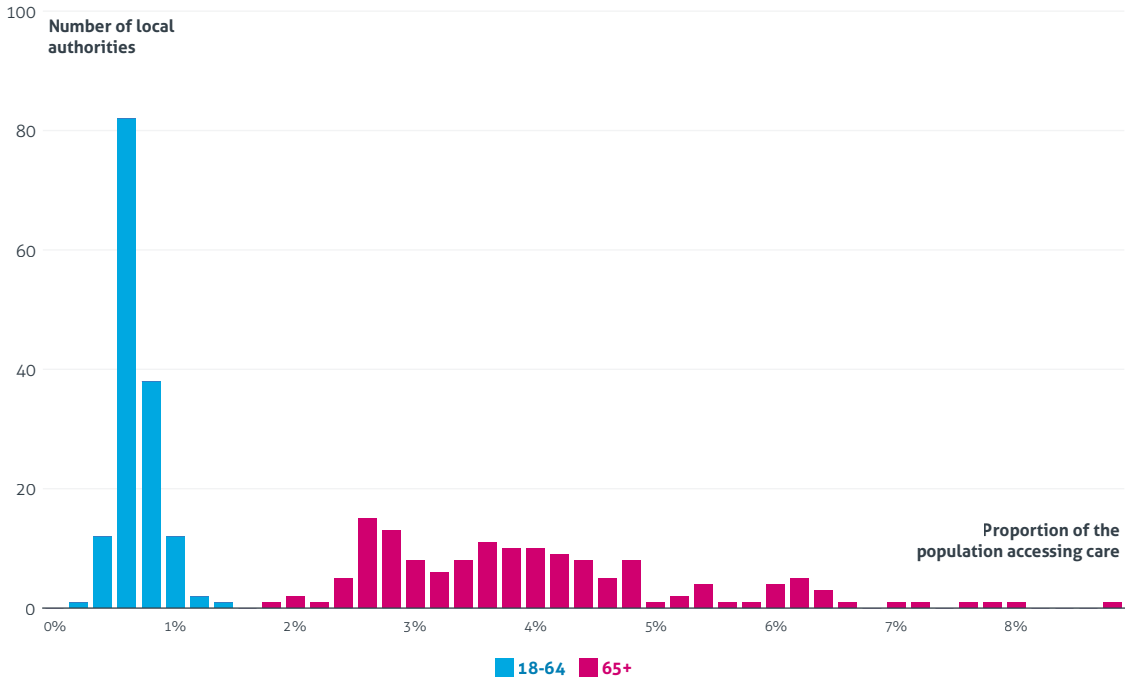


Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report', ('Appendix D: User numbers time series' table), 2023/24. Notes: This shows England only. This shows the number of people receiving care at the end of the financial year. This shows publicly funded care only.

There is a substantial geographic variation in access among older adults

Variation in access is not just visible across time but also across England. Geographical analysis of access rates in 2023/24 shows substantial variation between local authorities.

Figure 4 **Distribution of proportion of adults receiving long-term care, by local authority and by age group, 2023/24**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2023/24 and ONS, 'Mid-year population estimates', 2023.

The range of access is greater in the 65+ population than among working-age adults. At the lower end, Rutland provided 2.0% of its 65+ population with care in 2023/24, while at the upper end 8.8% of the 65+ population in Hammersmith and Fulham received care. The inter-quartile range (IQR, the difference between the 25th and 75th percentiles*) is 1.74 percentage points.

This translates into substantial regional variation in access to care among the over-65 population, as Figure 5 shows below. London is the region with the highest proportion of the over-65 population receiving long-term care, at 4.9%. Six London local authorities are in the top 10 for providing the most long-term care to the over-65 population: Hammersmith and Fulham, Tower Hamlets, Lambeth, Newham, Southwark, and Islington all provided more than 7% of their over-65 populations with long-term care at the end of 2023/24. Indeed at 14, a clear majority of the top 20 local authorities for this metric are London boroughs.

At the other end of the spectrum, the South West is the region with the lowest average, at 2.8%. It also has four local authorities – Bath & North East Somerset, Wiltshire, Gloucestershire, and Dorset – among the 10 lowest local authorities.

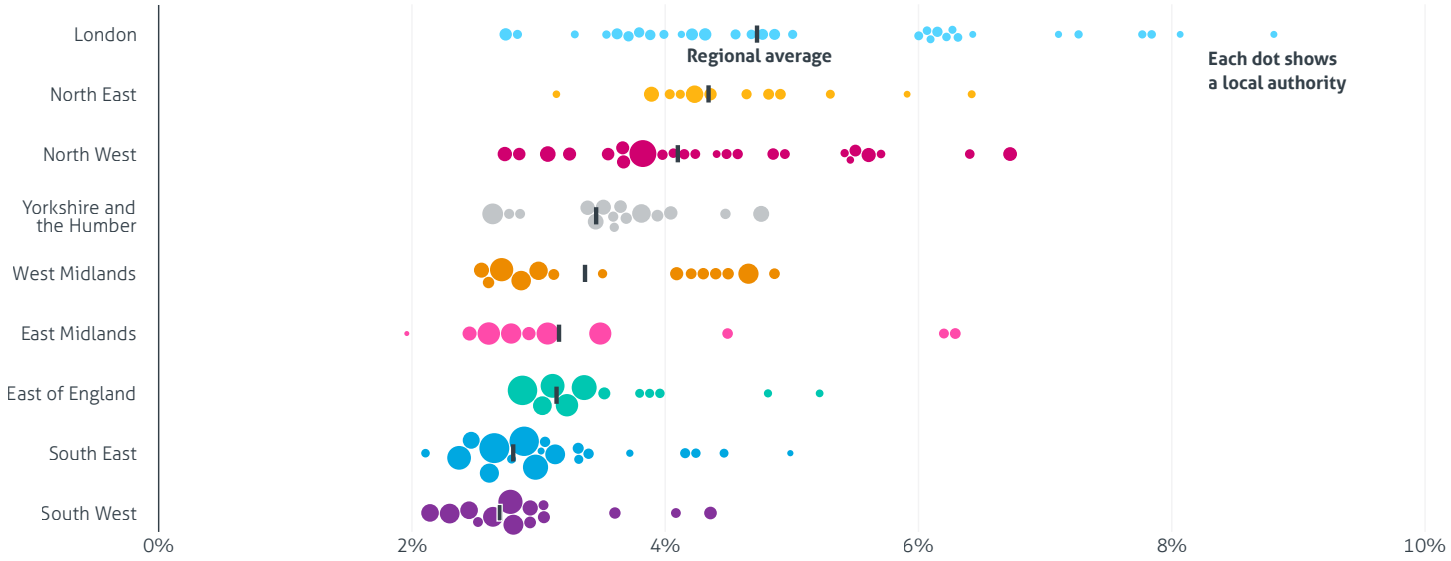
There is less variation for younger adults

As Figure 4 shows, there is a smaller range in the proportion of working-age adults that receive long-term care from their local authority. Among working-age adults, the range is 0.35% to 1.46% (with an IQR of 0.20ppts). The joint lowest regions for access to care for the 18 to 64 population are London and the West Midlands, where 0.7% of the working-age population receive publicly funded long-term care.

The North West is the region with the highest proportion of the working age population receiving long-term care, at 0.9%. Interestingly, as Figure 6 shows, the South West is home to the local authority with the highest proportion (Torbay) and the lowest (Gloucestershire).

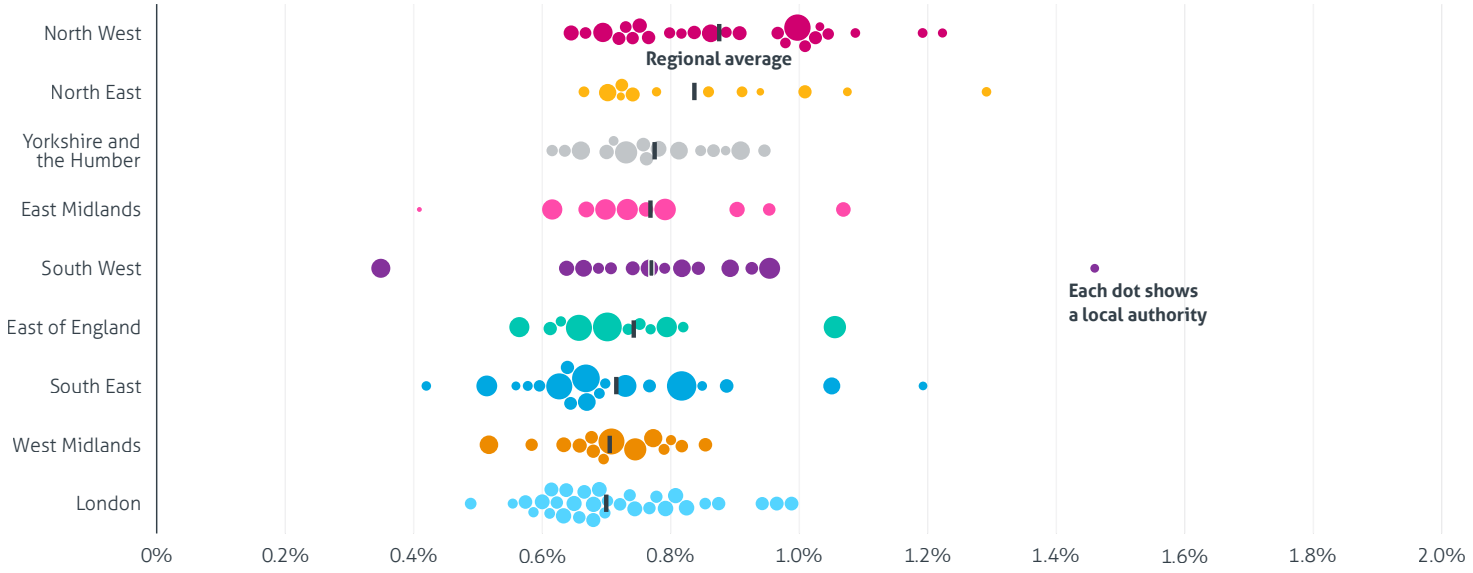
* The 25th percentile value is the local authority that is one-quarter of the way between the bottom and the top of the distribution of adults accessing care. The 75th percentile is the local authority that is three quarters of the way through the distribution.

Figure 5 **Proportion of people aged 65 and over receiving long-term care, by region, 2023/24**



Source: Institute for Government analysis of NHS Digital, 'Adult social care activity and finance report' (Table 'T38'), 2023/24; and ONS, 'Mid-year population estimates', 2023. Notes: This shows people receiving care at the end of the year. This shows only publicly funded care. The size of the dots is relative to the number of people aged 65+ in that local authority. This excludes the Isles of Scilly, the City of London, and Hackney. The x-axis scale differs to the scale in the chart for adults aged 18–64.

Figure 6 **People aged 18–64 receiving long-term care, by region, 2023/24**



Source: Institute for Government analysis of NHS Digital, 'Adult social care activity and finance report' (Table 'T38', 2023/24; and ONS, 'Mid-year population estimates', 2023. Notes: This shows people in care at the end of the year. This shows only publicly funded care. The size of the dots is relative to the number of people aged 18 to 64 in that local authority. This excludes the Isles of Scilly, the City of London and Hackney. The x-axis scale differs to the scale in the chart for adults aged 65+.

Variation in access to care is explained in part by differences in need and wealth

A person's level of need and wealth should determine whether they receive care

Local authorities provide adult social care to people when they meet two tests. The first is the 'needs test'. Adult social care is intended to support people who are "unable to do, or have difficulty with, daily living tasks".[2] Anyone can apply to their local authority for support if they or someone they know is struggling to support themselves. The local authority then carries out a needs assessment, in which they visit the person to interview them and to assess their living conditions.[3] From there, the local authority will outline what support – if any – it believes an individual needs.

The local authority will then conduct a 'means test', in which it assesses the value of an individual's assets. If a person has assets worth more than £23,250 then they will be expected to fund their own care.[4] If the value of their assets is below £14,250, then a person "will pay only what they can afford from their income" and the local authority will pay the rest.[5] Between £14,250 and £23,250 an individual will make a pro-rated contribution depending on the value of their assets.*

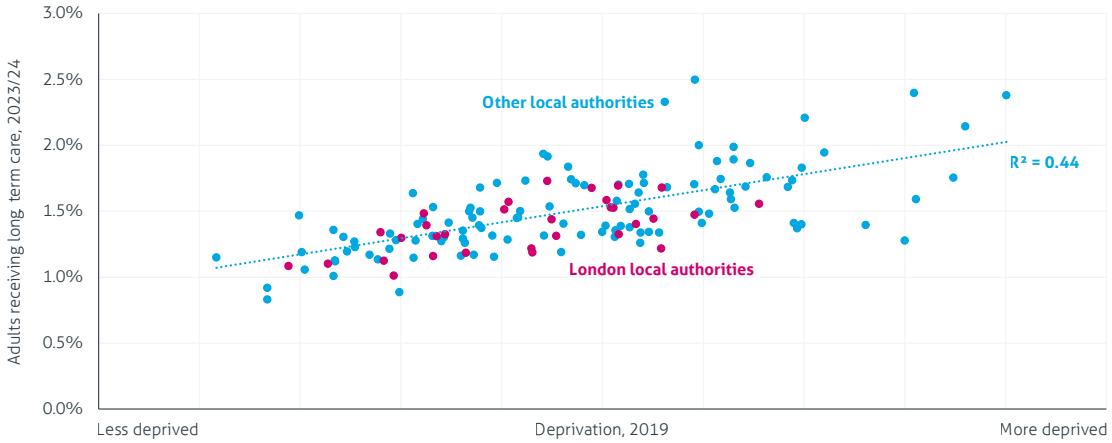
The likelihood that an individual will be eligible for the local authority to pay for at least some of their care is therefore a function of the severity of their condition and their level of wealth. The more someone struggles to support themselves and the less affluent they are, the more likely it is that they will be eligible for support from the local authority.

It has, however, become harder to meet the means test over time. The last time that the government updated the means test thresholds was in 2010/11,[6] meaning that between 2009/10 and 2025/26, the upper and lower capital limits have become 36.6% and 36.1% less generous in real terms, respectively.

* Whether or not housing wealth is included in this calculation depends on the type of care that the individual needs. If someone requires home care or a temporary stay in a care home, then housing wealth is not considered. If someone is moving permanently into a residential or care home, then the value of their property may be included in their total assets – though this will not be the case if a spouse or dependent lives in their house.

More people receive long-term care in more deprived local authorities

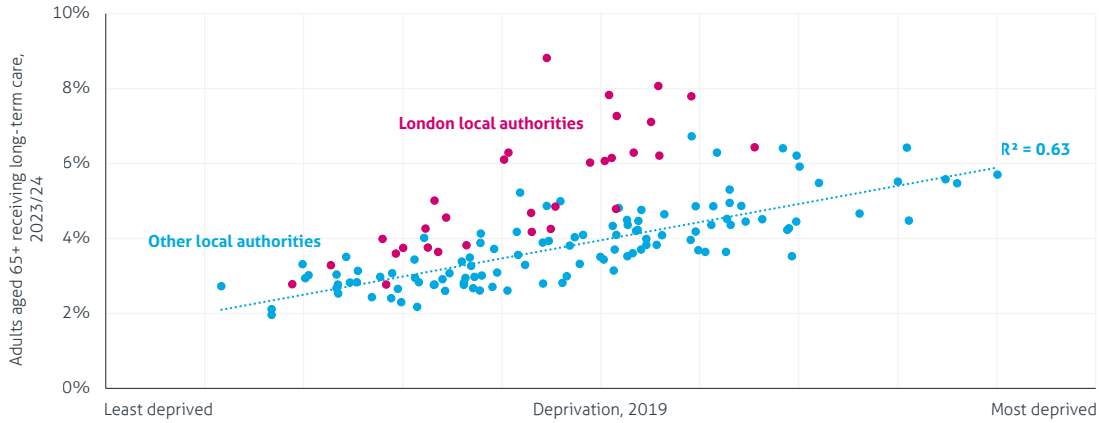
Figure 7 **Proportion of adults receiving long-term care, 2023/24, compared to deprivation, 2019, by local authority**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023 and MHCLG, 'English indices of deprivation', 2019. Notes: This shows English local authorities only. It shows long-term care at the end of the year. Deprivation is the average score for each local authority.

Maybe unsurprisingly, then, there is a strong relationship between the proportion of the adult population that receives long-term care and the deprivation of the population in a local authority: the R-squared is 0.44.[*] In the 10% most deprived local authorities, 1.6% of adults received long-term adult social care at the end of 2023/24, while in the least deprived decile, just 1.2% did.

Figure 8 **Proportion of adults aged 65+ receiving long-term care, 2023/24, compared to deprivation, 2019**



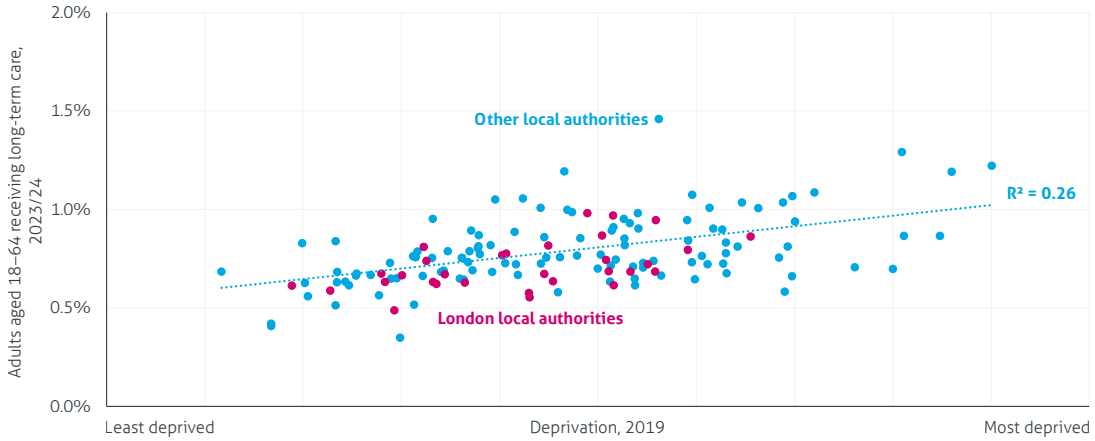
Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023 and MHCLG, 'English indices of deprivation', 2019. Notes: This shows English local authorities only. It shows long-term care at the end of the year. Deprivation is the average score for each local authority.

[*] The R-squared value shows the amount of variation in one variable – access to adult social care in this case – which is explained by the independent variable, deprivation in this instance. R-squared values range between 0 and 1. Across this report, we will interpret R-squared relationships in the following way: 0 = no relationship; 0–0.1 = weak; 0.1–0.35 = moderate; 0.35+ = strong. From now on, we won't refer to the numerical value of the R-squared in the text, only the strength of the relationship. The R-squared value is observable in the charts.

The same relationship holds when splitting the population into older adults and working-age adults. The more deprived the population in an area, the more likely it is that a person aged 65+ will receive long-term care. London is split out in this analysis because it is so unusual on a lot of measures. For example, a far smaller proportion of adults are aged 65+ in London (15.5% compared to 23.6% for England as a whole), the implications of which are explored in more depth below.

The gap between the most and least deprived 10% of authorities is even larger than it is for the entire adult population. Some 5.0% of adults aged 65+ receive long term care in the most deprived decile of local authorities, compared to 2.9% in the least deprived decile.

Figure 9 **Proportion of adults aged 18–64 receiving long-term care, 2023/24, compared to deprivation, 2019, by local authority**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023 and MHCLG, 'English indices of deprivation', 2019. Notes: This shows English local authorities only. It shows long-term care at the end of the year. Deprivation is the average score for each local authority.

Similarly, among working-age adults, the more deprived a local authority, the more people aged 18 to 64 receive long-term care. Though the relationship is only moderate, meaning that deprivation explains less of the variation in access than it does among the over-65 population.

The proportion of working-age adults accessing care does not increase as quickly with deprivation as it does in the over-65 population. Just 0.6% of working-age adults in the least deprived decile of local authorities draw on social care, compared to 0.8% in the most deprived decile. There is therefore only a 34.0% increase in the proportion of the population accessing care between the least and most deprived decile for working-age adults, compared to a 73.3% increase among older adults.

Unlike for care among the over-65 population, local authorities in London look similar to other authorities in terms of the relationship between deprivation and care access for working-age adults. It is unclear why London local authorities look so different between the two age groups.

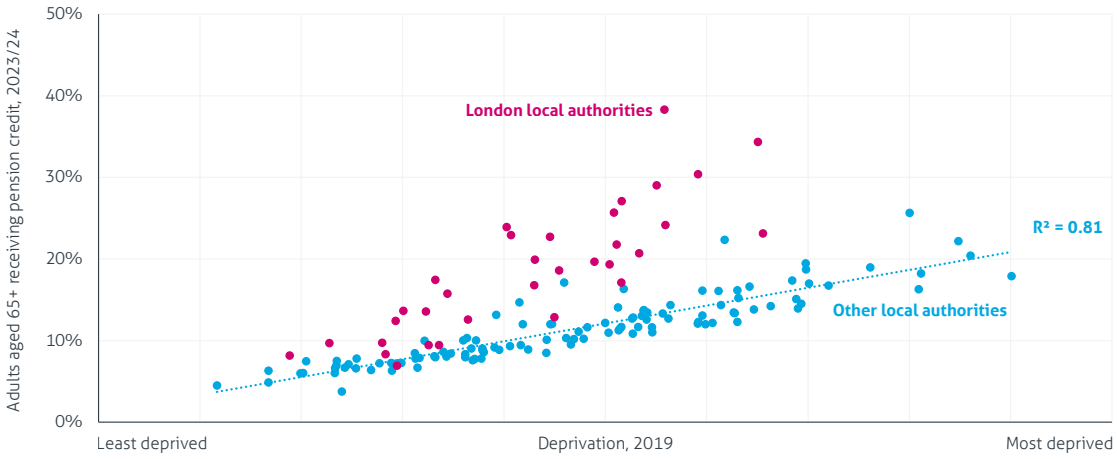
There are two likely causes of the relationship between deprivation and access. First, by definition, those living in more deprived areas are likely to be less wealthy than those in more prosperous ones. This means they are more likely to meet local authorities' means tests.

Second, people in more deprived areas tend to have worse health outcomes, and so are more likely to meet the needs test. For example, people start to live with multiple long-term health conditions 10 to 15 years earlier in the most deprived parts of the country compared to the least deprived.[7] And, as discussed below, there is a strong relationship between levels of deprivation and disability.

A greater proportion of people claim pension credit in the most deprived local authorities

Another metric for deprivation in older adults is the proportion of the over-65 population that claims pension credit. Pension credit is a government benefit intended to support people who are over the state pension age and on a low income with their living costs.[8]

Figure 10 **Proportion of adults aged 65+ claiming pension credit, 2023/24, compared to deprivation, 2019, by local authority**



Source: Institute for Government analysis of DWP, 'Pension credit caseload', ONS, 'Mid-year population estimates', 2023 and MHCLG, 'English indices of deprivation', 2019. Notes: This shows English local authorities only. Deprivation is the average score for each local authority.

Once again, and unsurprisingly, this metric has a strong relationship with deprivation. In the 10% most deprived local authorities, 18.5% of people aged over 65 claim pension credit, compared to 6.5% in the 10% least deprived local authorities and an England average of 10.9%.

More people receive long term care in areas with higher rates of disability

Local authorities that have higher rates of self-reported disability* also tend to provide a greater proportion of the population with long-term adult social care. There is also a strong relationship between deprivation and rates of disability: adults living in more deprived local authorities are more likely to report being disabled, with rates rising more quickly among older adults as deprivation increases than for working-age adults.

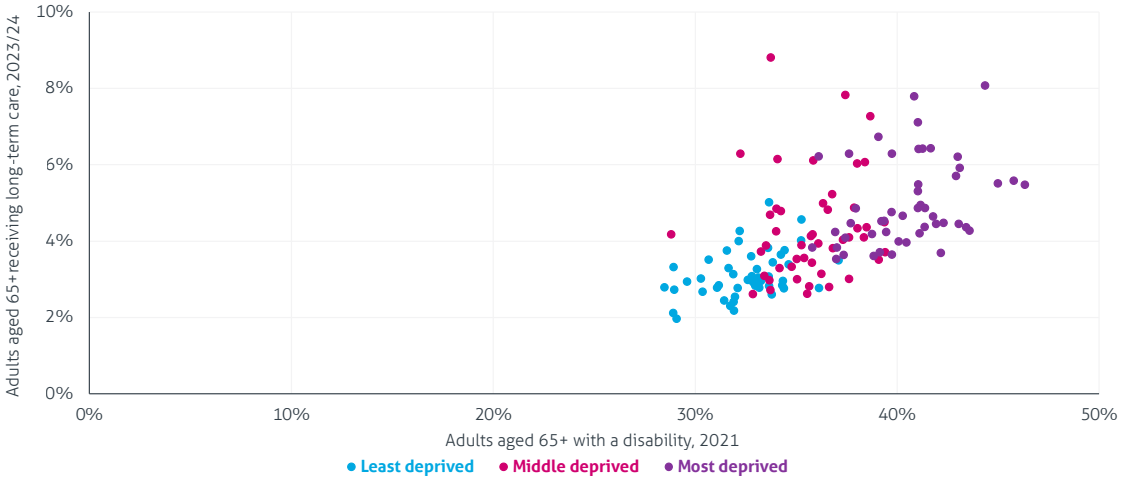
Figure 11 **Proportion of adults receiving long-term care, 2023/24, compared to disability rates, 2021, by local authority and by deprivation**

Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023, ONS, 'Census: Disability by age, sex, and deprivation', 2021 and MHCLG, 'English indices of deprivation', 2019. Notes: This shows English local authorities only. It shows long-term care at the end of the year. Deprivation is the average score for each local authority.

There is a strong relationship between the rates of disability in a local authority and the proportion of the adult population that receives care. There are a couple of ways to interpret this result. First, it likely indicates that local authorities respond to greater need by providing more long-term care. But second, as Figure 11 shows, there are higher disability rates among more deprived local authorities, making it more likely that someone living in more deprived local authorities will also meet the needs and means test.

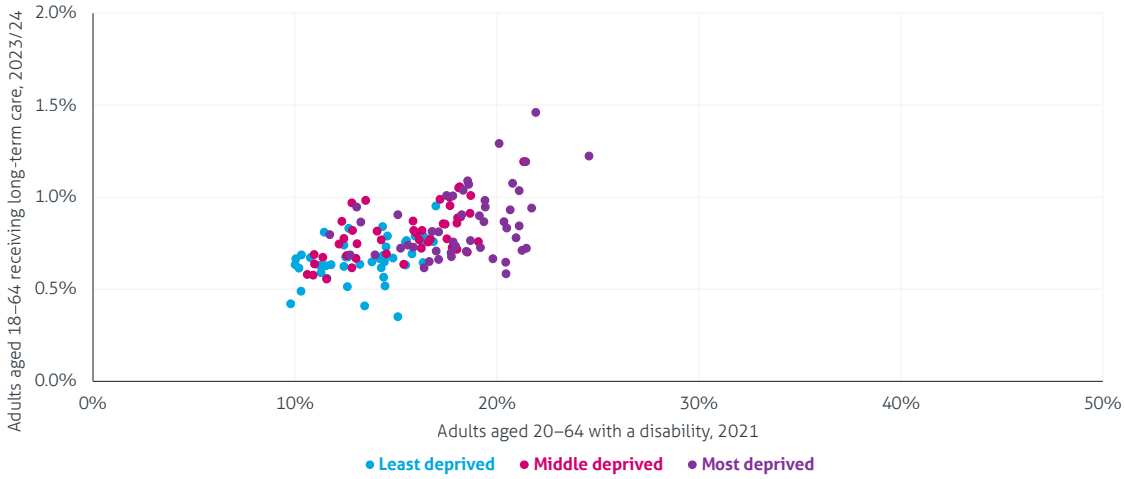
* In the 2021 census, the Office for National Statistics (ONS) asked respondents: "Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?" If respondents answered "Yes" to the first question, the ONS then asked, "Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?", with the possible responses being: "Yes, a lot", "Yes, a little", and "No". The ONS then classifies those who answered "Yes, a lot" or "Yes, a little" as "Disabled".

Figure 12 **Proportion of those aged 65+ receiving long-term care, 2023/24, compared to disability rates among those aged 65+, 2021, by local authority**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023, ONS, 'Census: Disability by age, sex, and deprivation', 2021, and MHCLG, 'English indices of deprivation', 2019. Notes: This shows English local authorities only. It shows long-term care at the end of the year. Deprivation is the averaged score for each local authority.

Figure 13 **Proportion of adults aged 18–64 receiving long-term care, 2023/24, compared to disability rates, 2021, by local authority and by deprivation**

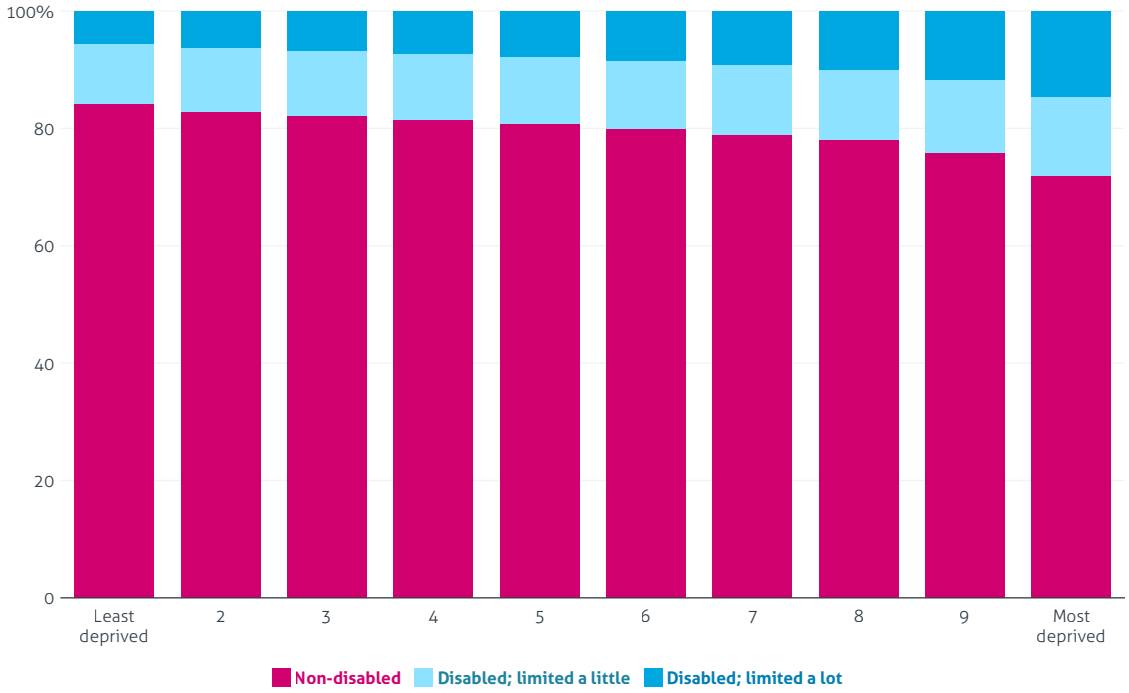


Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023, ONS, 'Census: Disability by age, sex, and deprivation', 2021 and MHCLG, 'English indices of deprivation', 2019. Notes: This shows English local authorities only. It shows long-term care at the end of the year. Deprivation is the average score for each local authority. Disability data starts from age 20 because of the way that the ONS groups the data.

When splitting this into working-age adults and older adults, there are strong relationships between disability rates and the proportion of the respective populations receiving long-term care for both populations. The effect of increasing rates of disability is stronger among the older adult population: a one percentage point increase in the proportion of the 65+ population that are disabled is associated with a 0.2ppt increase in the proportion that receives care. In contrast, the same increase among the 18–64 population that are disabled is associated with a 0.03ppt increase.

A greater proportion of the population report being limited "a lot" by their disability in more deprived parts of the country: 14.5% in the most deprived decile of local authorities compared to 5.5% in the least deprived.

Figure 14 **Disability among adults aged 20+, by decile of local authority deprivation, 2021**



Source: Institute for Government analysis of Office for National Statistics, 'Census 2021 – Disability in England and Wales' ('Table 8'). Notes: The lower bound of age bracket is 20 because the ONS does not provide any data for 18- and 19-year-olds that is not aggregated with other age groups.

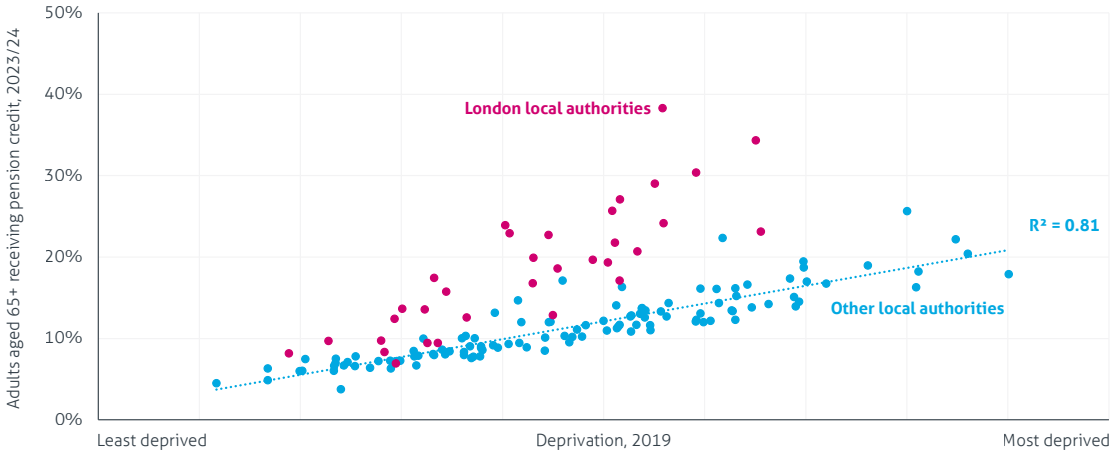
Living arrangements also contribute to demand and are correlated with deprivation

The government judges that some living arrangements also lead to more demand for adult social care. The Department of Health and Social Care's (DHSC) technical guidance sets out the expectation that local authorities that have higher proportions of the over-65 population either living alone or living in rented accommodation would require more funding under proposed charging reforms.[9]

Once again, the proportion of the over-65 population living with these arrangements increases as the deprivation in a local authority increases. In local authorities outside London, there is a strong relationship between deprivation and the proportion of the population living in rented accommodation.

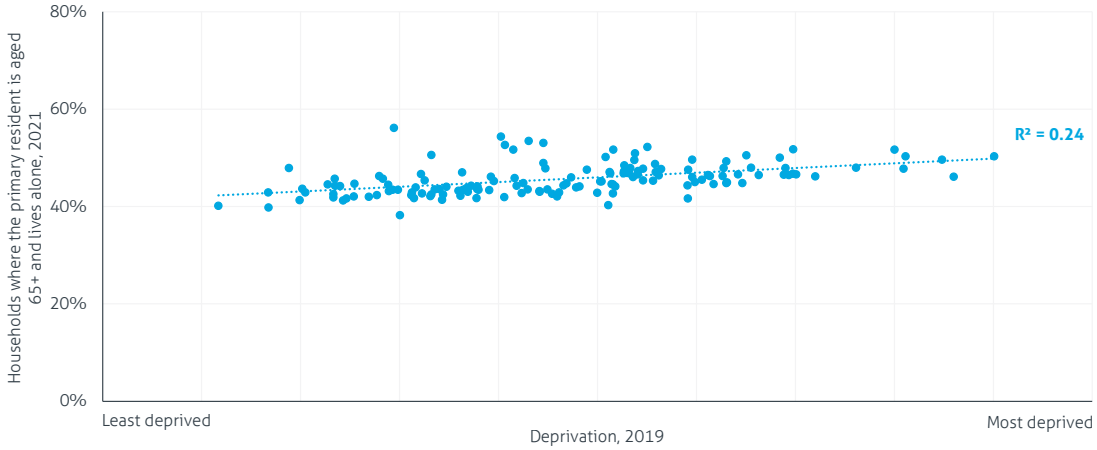
We exclude London from this because ownership and rental patterns are so different to elsewhere in the country. In the more deprived London boroughs, there are some of the highest rates of older adults living in rented accommodation in the country. For example, almost 70% of adults aged 65+ in Hackney and Tower Hamlets (68.5% and 69.6% respectively) live in rented accommodation, compared to the national average of 22.7%. In contrast, the least deprived London boroughs have broadly similar levels of the over-65 population living in rented accommodation as comparably deprived local authorities.

Figure 15 **Households where the household reference person is aged 65+ that rent, 2021, compared to deprivation, 2019, by local authority**



Source: Institute for Government analysis of ONS, 'Census: Household tenure by age', 2021, and MHCLG, 'English indices of deprivation', 2019. Notes: This shows English local authorities only. Deprivation is the average score for each local authority. The ONS defines the household reference person as the household member who owns the property, is responsible for the rent, has the highest income, or is the oldest.

Figure 16 **Households where the household reference person is aged 65+ and lives alone, 2021, compared to deprivation, 2019, by local authority**



Source: Institute for Government analysis of ONS, 'Census: Family composition', 2021, and MHCLG, 'English indices of deprivation', 2019. Notes: This shows English local authorities only. Deprivation is the average score for each local authority. The ONS defines the household reference person as the household member who owns the property, is responsible for the rent, has the highest income, or is the oldest.

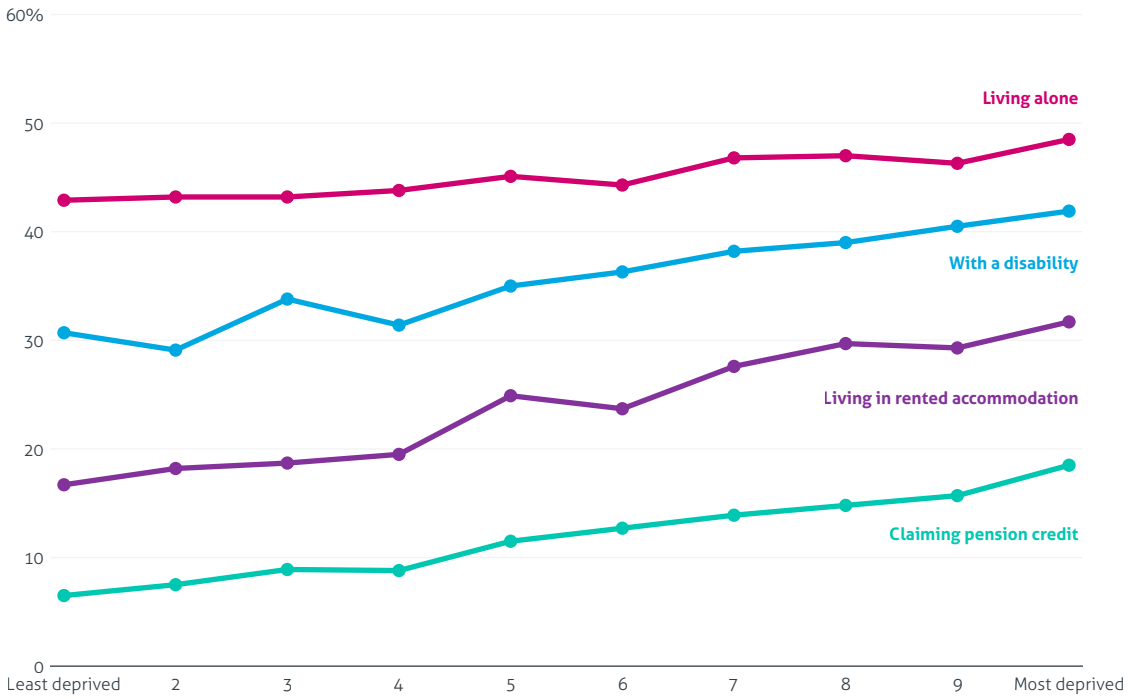
There is a moderate relationship between deprivation and the proportion of over-65 households where the person is living alone. The slope of the line is also not as steep as it is for the rented accommodation line: a 0.19 percentage point increase in the proportion of over-65 households living alone for every one-point increase in the average indices of deprivation (IMD) score, compared to a 0.53 percentage point increase in the proportion of over-65 households living in rented accommodation.

This is an indicator of demand for publicly funded care because when an older adult lives with someone else, they are more likely to receive (unpaid) care from that person, reducing pressure on local authority-provided care.

This indicates much higher need for publicly funded adult social care in more deprived local authorities

All of the factors discussed in this section – disability rates, pension credit claimants, living in rented accommodation and living alone – are higher in more deprived local authorities, indicating that there is a strong relationship between need for care for older adults and deprivation. Put another way, as the deprivation in a local authority increases, so does the likelihood that its residents have a limiting disability, lack sufficient assets to meet the needs test, live alone and/or live in rented accommodation.

Figure 17 **Disability status, pension credit status and living arrangements of adults aged 65+, by decile of deprivation, 2021**



Source: Institute for Government analysis of ONS, 'Census: Disability by age, sex and deprivation', 'Tenure by age' and 'Tenure by household composition', 2021; and DWP, 'Pension credit data', 2023/24. Notes: The 'living alone' and 'living in rented accommodation' lines show the proportion of households with someone aged over 65 living in them. The 'living with a disability' and 'pension credit' lines show the proportion of individuals aged over 65 living with a self-reported disability or claiming pension credit. This is shown at a local authority level.

Box 2: How to interpret multivariate regression analysis in this report

Below this point in this report, we use multivariate regression analysis to explore relationships between the characteristics of local authorities. This allows us to assess the relationship between two variables while 'controlling' for other factors. This does not let us say that one characteristic causes an outcome, but it does let us see if a high level in one variable tends to go along with a high or low level in the other.

We show the variables we control for and the results from all our regressions in Appendix 1. The 'coefficient' in those tables shows the change in the dependent variable that is associated with a one-unit increase in the independent variable. For example, in regression 4, an additional one percentage point of people aged 65+ that report living with a disability is associated with a 0.22 percentage point increase in the proportion of the population providing unpaid care. When we discuss effects in this report, the reader should assume that we are holding all other variables equal.

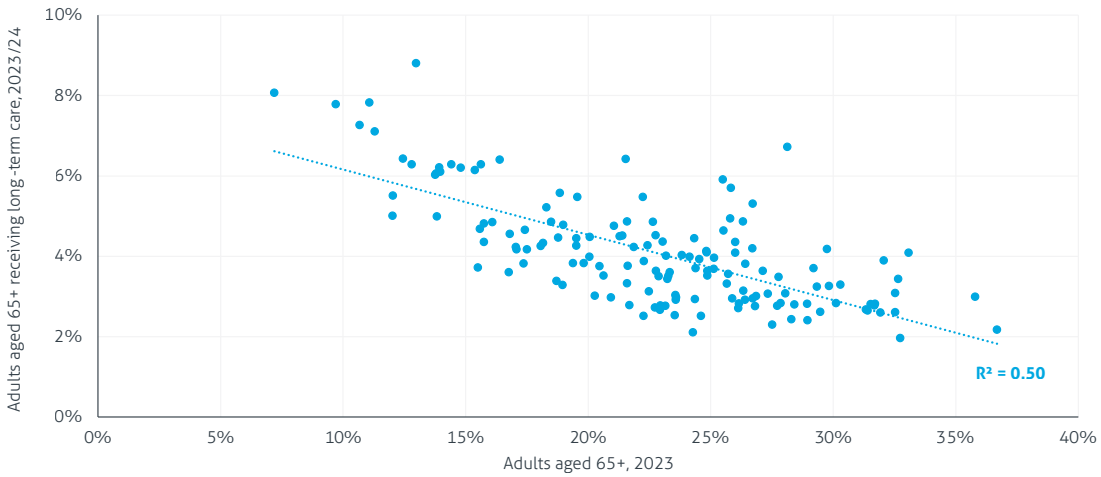
The regression analysis also shows us the likelihood that there is a statistically significant relationship between the independent variables and the dependent variables. This is shown in the 'p-value' column. The p-value shows the probability that we would observe an effect in the direction that we do, if there was in fact no relationship between the variables. The smaller the p-value, the more likely it is there is a real relationship between the variables. Throughout this report we refer to the significance of the relationship. We say there is a 'statistically significant relationship' when a p-value is under 0.05.

We show the results of one of these regressions in Figure 26. The dots on the chart show the coefficient from the regression and the bars around the dot show the 95% confidence intervals for our results. This means that there is a 95% chance that the true value lies within this range. We consider results statistically significant where this range does not cross zero. Where a result is not statistically significant, it may still be informative, but could just reflect random chance, so should be interpreted with caution.

Older people are less likely to receive care if they live among people of similar age

In theory, local authorities provide care according to need and whether someone meets the means test only. This means that, all else being equal, we would expect there to be no relationship between the proportion of the adult population that is aged over 65 and the proportion of that population that receives long-term care. This, however, is not what our research found.

Figure 18 **Proportion of adults aged 65+ receiving long-term care compared to proportion of the adult population aged 65+, by local authority, 2023/24**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, and ONS, 'Mid-year population estimates', 2023. Notes: This shows English local authorities only. It shows long-term care at the end of the year.

There is a strong negative relationship between the proportion of the adult population aged over-65 and the proportion of that population that receives long-term care – though this does not control for any other characteristics of local authorities. For each additional percentage point of the adult population that is over 65, there is a 0.16 percentage point decline in the share of over-65s who receive long-term care on average.

One reason why we might observe this relationship is if demand for publicly funded care was different in authorities with a higher share of over-65s and those with fewer. A multivariate regression allows for observation of the relationship while controlling for those other demand characteristics. To account for demand, regression 1 also controls for:

- deprivation
- disability rates of the over-65s
- local authority spending power per resident
- the proportion of over-65 households living alone and living in rented accommodation

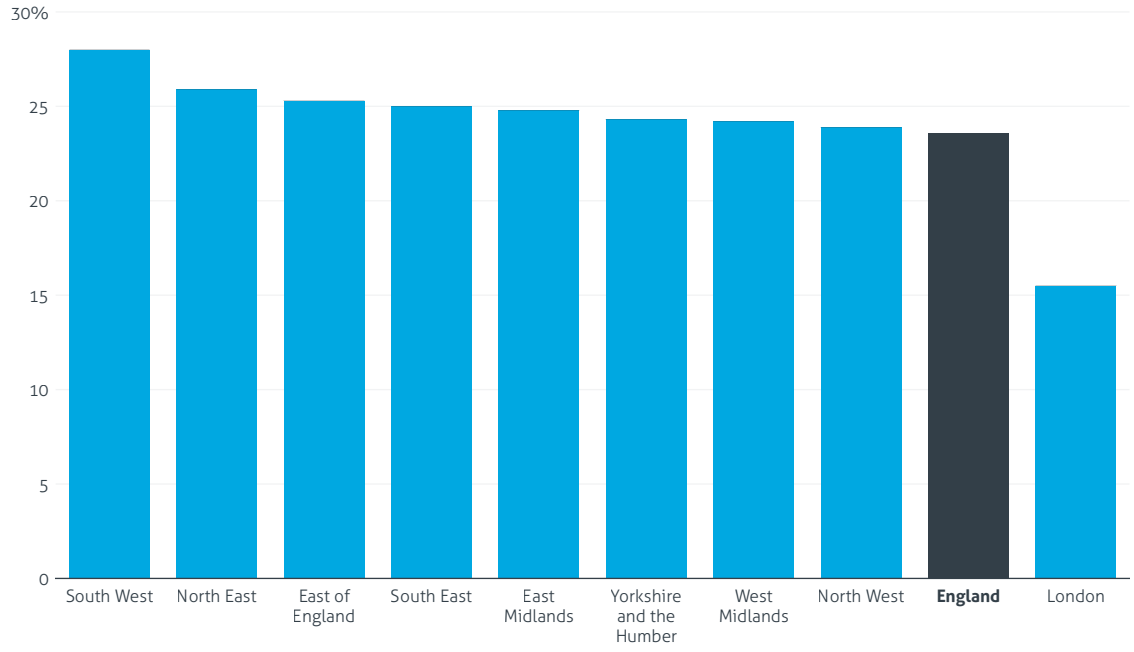
- the proportion of over-65s claiming pension credit
- the proportion of the population living rurally*
- the proportion of the 65+ population aged over 80
- the vacancy rate of direct care staff.

After controlling for those variables, the relationship between the proportion of the population aged over 65 and the share of over-65s receiving care remained statistically significant: the regression implies that a one percentage point increase in the adult population aged over 65 is associated with a 0.08 percentage point reduction in the proportion of the over-65 population that receive care.

This finding also goes some way to explaining the regional variation in access to care for over-65s. Of all the regions in England, London has by far the smallest over-65 population: only 15.5% of adults are above that threshold, compared to 23.6% across all England and 25.1% in local authorities outside London. In two London local authorities (Newham and Tower Hamlets), less than 10% of the adult population is aged over 65 (9.7% and 7.2% respectively).

But though smaller in number, this group receives proportionately more long-term care; London is also the region with the highest proportion of the over-65 population receiving long-term care at 4.9%, compared to an average in England of 3.6%.

Figure 19 **Adults aged 65+, by region, 2023**



Source: Institute for Government analysis of ONS, 'Annual mid-year population estimates', 2023.

* This control was suggested by an interviewee who argued that because populations in rural local authorities are less transient, someone in need of care may be more likely to have a family member living within the authority who can provide some unpaid care.

At the other end of the spectrum, 28.0% of adults in the South West are 65 or older. That region also has the lowest rates of access to care for the over-65 population, with 2.8%.

Using the estimate from regression 1, the difference in the proportion of adults aged 65+ in London and the South West would explain 1.0 percentage point of the 2.1 percentage point difference in the proportion of the over-65 population that access care in those regions.

Given the large difference in rates of access in London compared to other local authorities, it is reasonable to think that London local authorities might be accounting for most of the relationship identified in regression 1. But the relationship is still significant even without London, though the size of the effect is smaller: there is a 0.05 percentage point reduction in the proportion of older adults receiving care for every additional 1 percentage point increase in the proportion of adults over 65, compared to 0.08 when London is included.

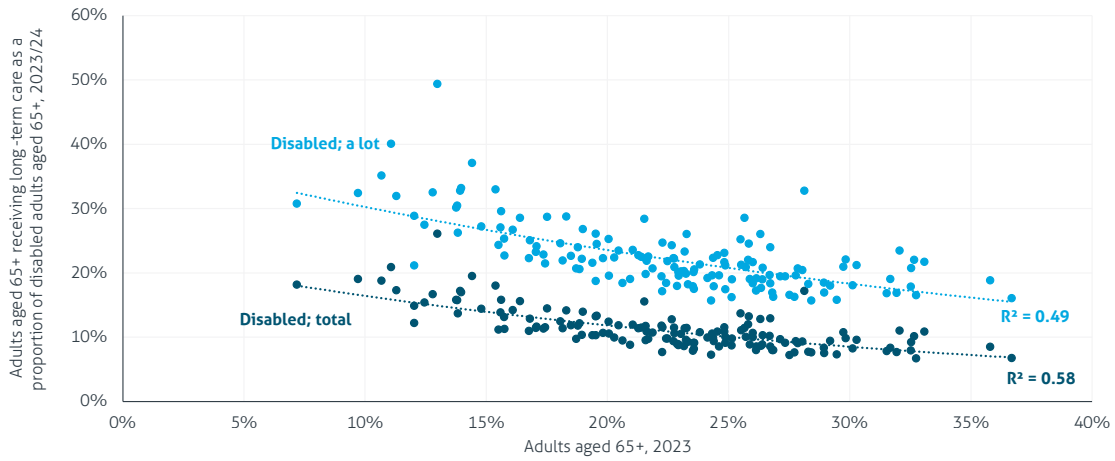
While this analysis attempts to control for 'demand', there are likely other factors that drive need. So, it is possible that this relationship is a result of other differences in the over-65 population across these authorities. However, one interpretation of these regression results is that local authorities struggle to meet the higher demand for adult social care services that come with large older populations. Given budgetary constraints, local authorities with larger over-65 populations are unable to provide every person over the age of 65 with the care they need, reducing the likelihood that an individual will receive the care they need.

This is both an unfair and ineffective way of allocating care to people over the age of 65.

A lower proportion of older adults with a disability receive care in local authorities with larger older populations

Another indicator of whether local authorities are meeting the needs of older adults is to look at the proportion of the population that report living with a disability that receive long-term care. This is not a statistic that is directly observable. Instead, we can reach an estimate by dividing the number of adults aged 65+ receiving long-term care by the number of adults aged 65+ that reported being disabled in the 2021 census.

Figure 20 **Adults aged 65+ that receive long-term care as a proportion of adults aged 65+ reporting a disability compared to the proportion of adults aged 65+, by local authority, 2023/24**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023, and ONS, 'Census: Disability by age, sex, and deprivation', 2021. Notes: This shows English local authorities only. It shows long-term care at the end of the year. The y-axis measure does not show data that is directly observed but rather is imputed by dividing the number of older adults receiving long-term care by the number of older adults that report being disabled.

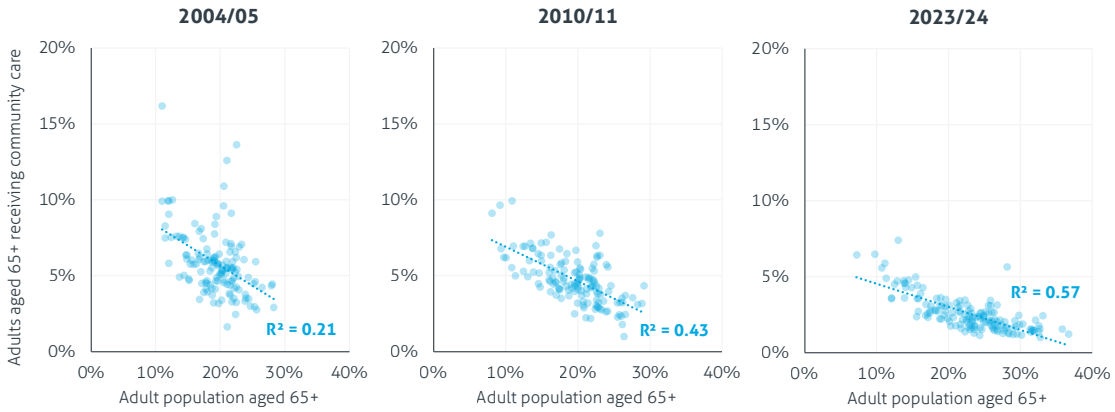
The larger the proportion of adults that are aged over 65, the lower the proportion of the disabled over-65 population that receive publicly funded long-term care. This is a strong relationship for both the proportion of the total disabled population and the heavily disabled population.

These relationships appear to be growing more pronounced

The relationship between the proportion of adults aged over 65 and access to long-term care for that population seems to have existed for a relatively long time. In 2004/05 (the earliest year for which there is local authority level data), areas with larger older adult populations were less likely to provide long-term community care to any individual* – though they were more likely to provide care overall than in subsequent years. But the closeness of the relationship was lower than in subsequent years: an R-squared of 0.21, compared to 0.43 in 2010/11 and 0.57 in 2023/24.

* We use community care here rather than all long-term care (which includes nursing and residential care in addition to community care) because many local authorities returned incomplete data for nursing and residential care in 2010/11. Community care makes up between 61% and 67% of all long-term care between 2003/04 and 2023/24. Roughly the same relationship as depicted in Figure 21 exists for long-term care in 2004/05 and 2023/24.

Figure 21 **Proportion of adults aged 65+ receiving community care compared to proportion of adults aged 65+, 2004/05, 2010/11 and 2023/24**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'P2s.1' - 2004/05, 'Provisional council level activity' - 2010/11 and 'T38' - 2023/24), and ONS, 'Mid-year population estimates', 2023. Notes: This shows English local authorities only. It shows community care rather than all long-term care because there is no reliable data for nursing and residential care in 2010/11. Community care accounts for between 60% and 70% of all long-term care, depending on the year.

As previously discussed, some of the decline is for good reason. Self-reported disability rates among older adults fell between the 2011 and 2021 Censuses. But access declined further than disability for that age group. There was a 41.9% reduction in the proportion of older adults receiving care between 2010/11 and 2020/21, compared to a 34.0% fall in the rates of self-reported disability.

The magnitude of the relationship has also declined over time. In 2004/05, a one percentage point increase in the proportion of the adult population aged 65 and over was associated with a 0.26 percentage point decline in the proportion of older adults receiving community care. The same number was 0.23 and 0.15 in 2010/11 and 2023/24 respectively.

That is partly because the largest reductions in access to community care between 2004/05 and 2023/24 happened in the local authorities that were providing the highest proportion of the older adult population with community care in the first place, as shown in Figure 22. Only one local authority – Surrey County Council – increased the proportion of older adults receiving community care over that period.

Figure 22 **Change in proportion of adults aged 65+ receiving community care between 2004/05 and 2023/24 compared to the proportion of adults aged 65+ receiving community care in 2004/05**

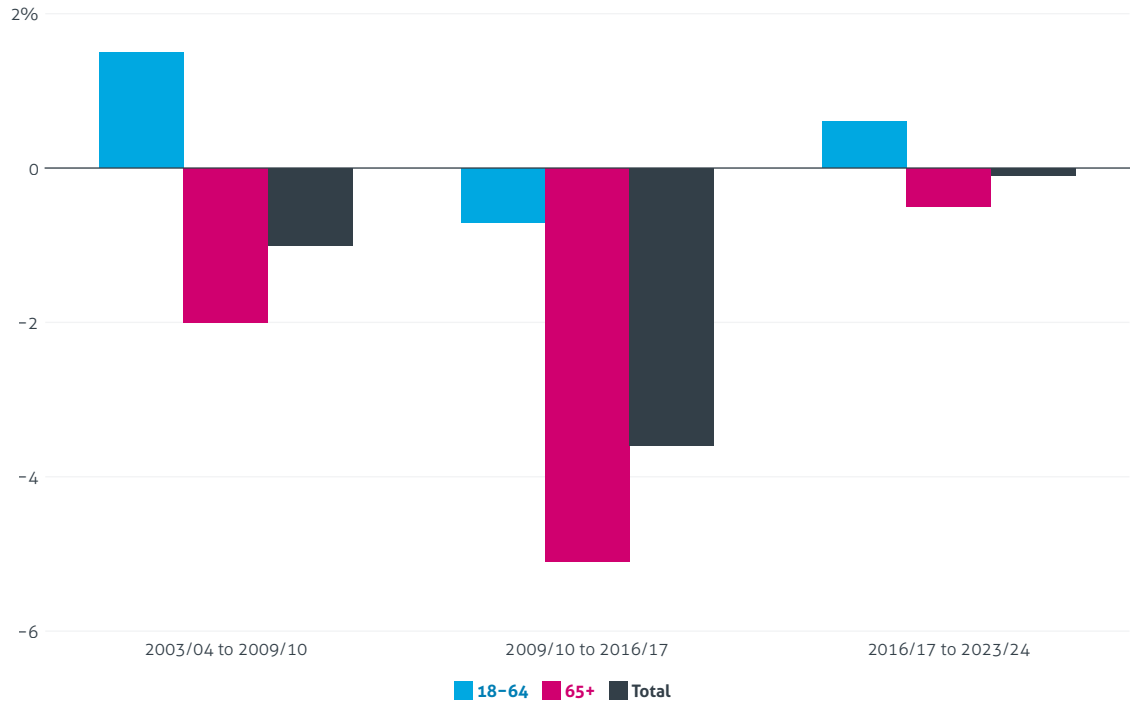
Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'P2s.1' – 2004/05, 'Provisional council level activity' – 2010/11 and 'T38' – 2023/24), and ONS, 'Mid-year population estimates', 2023. Notes: This shows English local authorities only. It shows community care rather than all long-term care because there is no reliable data for nursing and residential care in 2010/11. Community care accounts for between 60% and 70% of all long-term care, depending on the year.

Taken together, this implies that there was some rationing in 2004/05, though the relationship between access and size of the older adult population was nowhere near as strong as in later years. There was also far more variation in rates of access in 2004/05, which would make sense in a financial context where local authorities had more flexibility to choose to provide more care to older adults if they wanted. By 2023/24, the variation had been compressed substantially.

There is no comparable data for local authority funding before 2010, but there is other evidence from the time that local authorities were beginning to ration care in response to budgetary pressures. Derek Wanless's review of the sector from 2006 said that "there is evidence of significant unmet need", that the proportion of people receiving the care they needed had been falling, and that budget constraints were to blame.[10] This is supported by polling carried out by *Community Care* (a trade publication for social care workers) in 2007, which showed that there was wide variation in the eligibility thresholds that local authorities used for care, and that many had raised the threshold in the previous few years, making it more difficult for people to access care.[11] The article claims "across England evidence is emerging that cash-strapped councils are being forced to restrict access to adult care services".[12]

In that context, the coalition-era cuts to local authority grant funding turbocharged the rate at which local authorities rationed care. Those local authorities that had provided the highest proportion of their older adult residents with care in 2004/05 made the largest cuts to access between then and 2023/24.

Figure 23 **Average annual change in the number of adults receiving long-term care, by age, 2003/04–2023/24**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' ('Appendix D: User numbers time series' table), 2023/24. Notes: This shows the number of people receiving care at the end of the financial year. This shows publicly funded care only.

Between 2003/04 and 2009/10, the number of older adults receiving care fell by 2.0% per year on average. Between 2009/10 and 2016/17 – the years when local authorities' spending power dropped the most[13] – the number of older adults accessing care fell by 5.1% per year. The decline continued until 2022/23, since when there has been an uptick in access for the over-65 population, driven at least in part by a large increase in spending on adult social care after the government redirected funding that was initially intended to reform how adult social care is funded.[14]

An interviewee also claimed that the continued decline in access between 2016/17 and 2021/22 could be for good reasons. They argued that following the implementation of the Care Act in 2014, many local authorities recognised that some long-term care could be disabling and instead looked to improve preventative work that negated the need to provide someone with a care package. This is plausible, and is an approach that we would support, but is at present difficult to prove from available data. The decline in the rate of disability among older adults – as discussed above – could also be a legitimate cause of some of the decline in the number of older adults receiving long-term care.

The same pattern does not hold for working-age adults

A larger older adult population might also then lead to local authorities reducing the amount of care that they provide to working-age adults. There is almost no relationship between the proportion of working-age adults that receive long-term care and the proportion of adults aged 65+, as shown in Figure 24.

Figure 24 **Proportion of adults aged 18–64 receiving long-term care, 2023/24, compared to proportion of the adult population aged 65+, 2023**

Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, and ONS, 'Mid-year population estimates', 2023. Notes: This shows English local authorities only. It shows long-term care at the end of the year.

This finding is supported by regression analysis. There is no significant relationship between the proportion of the adult population aged over 65 and the proportion of the 18 to 64 population that receive care (regression 2) after controlling for other population and local authority characteristics. Combined with the finding that there is lower variation in the proportion of the working-age population that draws on long-term care, this indicates that a working-age adult with need for adult social care has a similar likelihood of receiving care wherever they live in the country.

One possible explanation could be that younger adults have more complex needs, meaning that it is harder for local authorities to ration care. But interviewees argued that this is not the case; an older adult with advanced dementia may, for example, have needs as complex as a young adult with severe learning disabilities. Instead, interviewees said that there are a couple of factors that could explain the lower variation in access to care among younger adults.

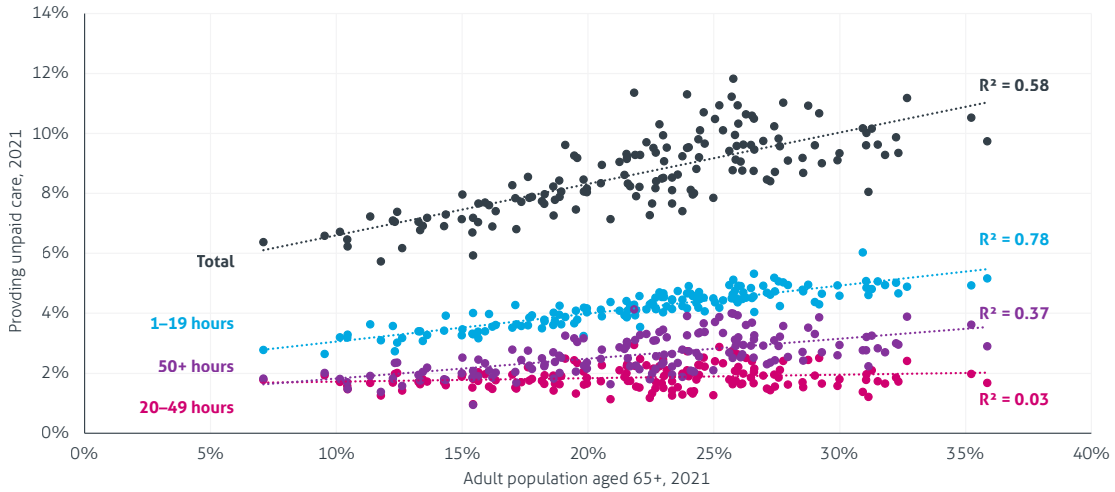
The first is that they often have relatives who are better able to advocate on their behalf and 'fight their corner' with the local authority as compared to an older adult who lives alone and has few – or no – close family. Second, and potentially more controversially, is the view that there are different social expectations about the level of care that a younger and older adult should receive. Interviewees said that it is more socially acceptable to pay a higher amount of money to support a younger adult than an older adult. They attributed that to "ageism".

Areas with poorer access to care often see greater reliance on 'unpaid care'

Often when someone is not able to access the publicly funded care they need, a friend or family member steps in to provide care – known as 'unpaid care' – although there is little data about this. The most regular source is the census. While there are limitations with this data (see the Methodology for more details), there is evidence that the proportion of people providing unpaid care is higher in the local authorities in which there is lower access to long-term care.

People provide more unpaid care in local authorities with older adult populations

Figure 25 **Proportion of the population who provide unpaid care compared to the proportion of adults aged 65+, by weekly hours of unpaid care, 2021**



Source: Institute for Government analysis of ONS, 'Census: Unpaid care', 2021, ONS, 'Mid-year population estimates', 2023, and ONS, 'Census: Disability by age, sex, and deprivation', 2021. Notes: This shows English local authorities only.

There is a strong relationship between the proportion of the adult population aged 65 and over and the proportion of the population that provide unpaid care.

When disaggregating the total into buckets with the number of hours provided per week, we can see that the proportion of the adult population aged over 65 explains more of the variation in the 1–19 hours category than either of the others. There appears to be no relationship between the proportion of the adult population aged 65+ and the number of people providing 20–49 hours of unpaid care.

The size of the effect is also largest for the 1–19 hours category. On average, an additional percentage point of the adult population aged 65+ is associated with an additional 0.09 percentage points of the population providing 1–19 hours of unpaid care per week, though this does not control for any other characteristics of local authorities.

More people provide unpaid care in local authorities that provide the least care to older adults

As discussed earlier, local authorities with the largest proportion of adults aged over 65 provide the lowest levels of care to older adults. So it follows that more people provide unpaid care in these areas.

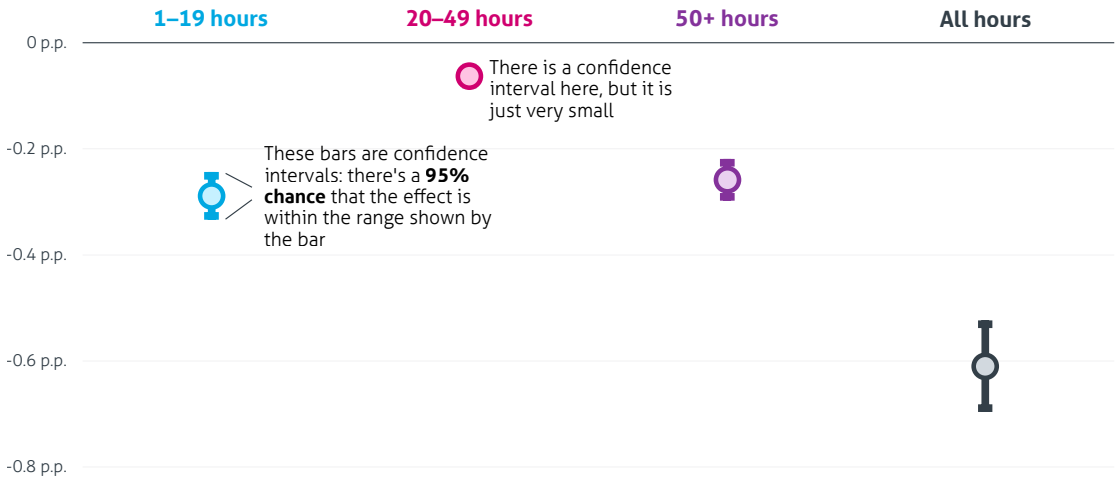
This could, however, be due to other unobserved factors that explain the relationship. But the relationship is still statistically significant even when controlling for other factors that might drive demand for care such as deprivation, the proportion of older adults that report being disabled, or the proportion of the population that requested support from their local authority, among others (for details see regression 4 in Appendix 1). That shows that three variables have a statistically significant relationship with the proportion of the population that provide unpaid care.

The higher the rates of disability and people living rurally in a local authority, the more likely it is that someone will provide unpaid care. In contrast, the higher the proportion of older people receiving long-term care, the lower is the likelihood of people providing unpaid care. For each additional percentage point of the 65+ population that receives long-term care, 0.61 percentage points fewer people provide unpaid care, as shown in Figure 26.

The proportion of older people receiving long-term care is also significant when looking at the proportion of the population providing 1–19 hours, 20–49 hours, and 50+ hours per week of unpaid care (regression 4 in Appendix 1).

The magnitude of the effect is different, however, for each of the dependent variables. As Figure 26 shows, the proportion of 65+ population receiving long-term care has the largest effect on the proportion of the population that provide 1–19 hours and 50+ hours per week of unpaid care. A one percentage point increase in the proportion of people aged 65+ receiving long-term care is associated with a 0.29 and 0.26 percentage reduction in the proportion of people providing 1–19 hours and 50+ hours per week of unpaid care respectively.

Figure 26 **Implied effect of a one percentage point increase in the proportion of the 65+ population receiving long-term care on the proportion of the population providing unpaid care, by amount of unpaid care per week**



Source: Institute for Government analysis of ONS, 'Census: Unpaid care', 2021, NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023. Notes: This is based on the results from a multivariate regression, which controls for other local authority characteristics. For details of the regression results, see regression 4 in Appendix 1.

There are a couple of ways to interpret this result. The first could be that in some areas of the country people prefer to care for their relatives and friends themselves. In those instances, the local authority is not obligated to provide care. In those cases, you would expect to see both a lower rate of access to publicly funded care and a higher rate of unpaid care provision, but the former does not cause the latter.

The second explanation is that as local authorities provide less care, friends and relatives step in to provide support instead. This could also explain why the relationship and effect is strongest for the 1–19 hours category: it is generally easier to ration care to those on the margin of the needs test. Those people, by definition, have lower need for care. You would expect friends and family to have to step in with some – though not intensive – levels of support.

While both effects are likely happening to some extent, interviewees indicated that they thought the latter is more prevalent. If this is the case, it means that the government subsidises lower access to care with unpaid labour from friends and family.

Local authorities with more older adults spend more on adult social care

The final question is the impact these patterns have on local authorities' finances. As Figure 27 shows, there is a strong relationship between the proportion of the adult population aged 65 and over and the proportion of local authority spending that goes on long-term care for this group.

Regression 6 (see Appendix 1) shows that that there is a statistically significant relationship between the proportion of the adult population aged 65+ and the proportion of spending on long-term care for that age group, after controlling for other variables. A one percentage point increase in the proportion of the adult population aged 65+ is associated with a 0.65 percentage point increase in the proportion of local authority spending* going on long-term care for the 65+ population across all local authorities. This relationship holds for local authorities both inside and outside London.

Figure 27 **Proportion of local authority spending that goes on long-term care for adults aged 65+ compared to the proportion of adults aged 65+, by local authority, 2023/24**

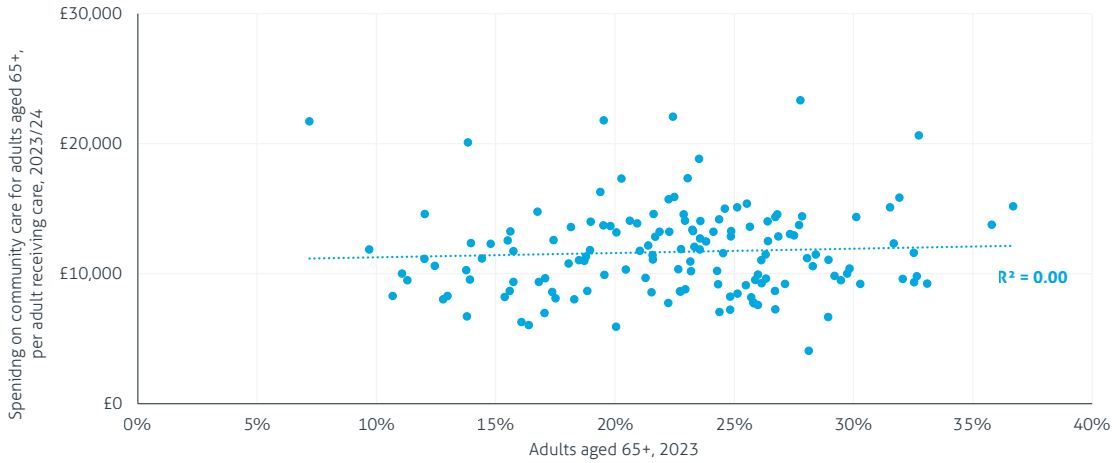
Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023, and MHCLG, 'Local authority revenue outturn', 2023/24.
Notes: This shows English local authorities only. 'Local authority spending' excludes spending on education, police and fire services.

This indicates that rationing can take a local authority only so far. There is a certain level of need above which it is very difficult to deny an individual care. At that point, the size of the over-65 population is a key determinant of how much the local authority will have to spend and those with larger over-65 populations will have to spend more of their budget on care.

* "Local authority spending" refers to net current service expenditure, excluding spending on education, police, and fire services. For more details of this metric, please see the Methodology

This relationship is not because local authorities with larger older adult populations spend more on each person in care. There is no relationship between the size of the older adult population and the amount that local authorities spend per person receiving long-term community care,* as Figure 28 shows.

Figure 28 **Spending on community care for adults aged 65+ per person receiving community care compared to the proportion of adults aged 65+, by local authority, 2023/24**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T34'), 2023/24, ONS, 'Mid-year population estimates', 2023, and MHCLG, 'Local authority revenue outturn', 2023/24.
Notes: This shows English local authorities only. Spending is adjusted for the relative cost of delivering services. This shows the number of people receiving long-term care throughout the year, to better match spending with activity.

Some drivers of demand are associated with local authorities spending more per person receiving care

When looking at the factors that are associated with higher spending per adult aged 65+ receiving community care (regression 5 in Appendix 1) there are three characteristics that have a statistically significant relationship with that variable. Those are the proportion of the 65+ population reporting a disability in the 2021 census, the proportion of the population living rurally, and the proportion of the over-65 population that are aged 90+. An additional percentage point of each is associated with a local authority spending £415, £65 and £1,013 more per person receiving community care respectively, compared to a national average of £11,721 per older adult receiving community care.

* We use community care here rather than all long-term care to avoid seeing variation caused by the higher unit costs associated with nursing and residential care meaning that spending per person is skewed by the mix of community, nursing, and residential care. Community care accounted for 61.8% of adults aged 65+ who received long-term care in 2023/24 and 36.4% of spending on long-term care for adults aged 65+.

Part 2. What should the government take away from these findings?

Part 2. What should the government take away from these findings?

This report has shown that there is substantial variation in the proportion of the over-65 population that receives publicly funded long-term care from England's 153 upper- and single-tier local authorities. It also shows that the range in access is much narrower among the working-age adult population. Some of the factors that affect this – disability, deprivation and living alone – are in line with what we would expect. But not all are.

That an older adult living in a local authority with a higher proportion of older adults is *less* likely to receive care should give the government pause. This goes against how the needs-based system should operate, at least in theory: an individual's likelihood of receiving care should not be related to the characteristics of where they live.

Similarly, that areas with lower rates of access to care for older people see far higher rates of 'unpaid care' – as friends and family step in to provide the care not given by government – also suggests a system not working for all people equally.

Finally, local authorities spend a higher proportion of their budgets on long-term care for older adults when there is a large proportion of older adults living in their area. But local authorities with the largest older adult populations are able to stop the cost overwhelming their budgets by providing a lower proportion of the older adult population with care.

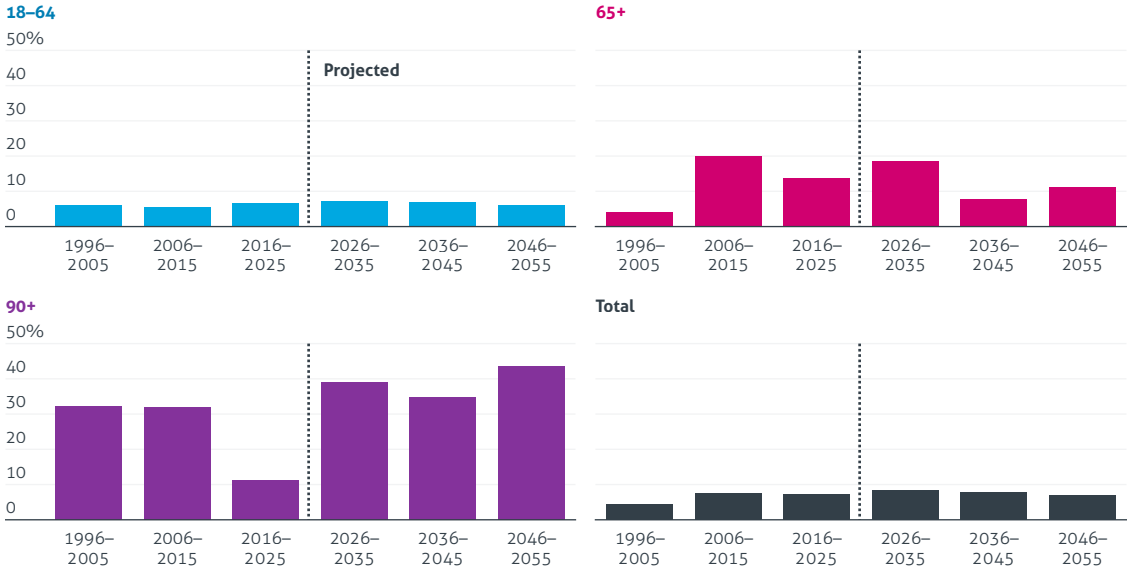
The government should find some of these conclusions particularly concerning. And while it has acknowledged the need for reform, its principal review into this, Louise Casey's adult social care commission, is not due to report until the very end of this parliament on current plans, in effect leaving the sector largely unreformed for years to come.

Demographic pressures will continue to strain local authority finances

This work shows that local authorities spend more on adult social care when a larger proportion of their population is aged over 65. This suggests that, all else being equal, more and more of local authority budgets will need to be spent on care for older adults – and particularly in areas that cut provision so much since 2003/04 that only those whose need is more acute receive care.

The over-65 population is due to grow faster than the total population over the coming years. Between 2026 and 2035, the total population in England is forecasted to grow by 8.4% (an average of 0.9% per year). In comparison, the over-65 population will grow by almost a fifth: 18.6% or 1.9% per year. This is faster than the previous decade (13.9%), if not as much as seen between 2006 and 2015 (19.9%). Beyond 2035, the rate of growth slows compared to the previous 30 years.

Figure 29 **Population growth in England, by decade and age group, 1996–2055**



Source: Institute for Government analysis of ONS, 'Mid-year population estimates 1838 to 2023' ('Table 11'), and ONS, 'England population projections', 2025. Notes: Population projections start from 2023.

There is set to be an even larger growth in the number of adults aged 90 and over. Between 2026 and 2035, that age group is forecast to grow by 39.0% compared to 31.9% in the 10 years before 2015 (change in the number of adults aged 90+ was likely affected by the Covid-19 pandemic). As shown in the analysis about variation in unit cost, a larger proportion of adults aged 90 and over equates to much higher spending per person receiving care.

On the other hand, there is evidence of a decline in the level of need among older adults. Fewer older adults reported living with a disability in the 2021 census than in 2011, despite the growth in that population. There were also 2.8% fewer people aged 65+ requesting adult social care support from their local authority in 2022/23 than in 2016/17, despite that population growing 7.5% in that time.

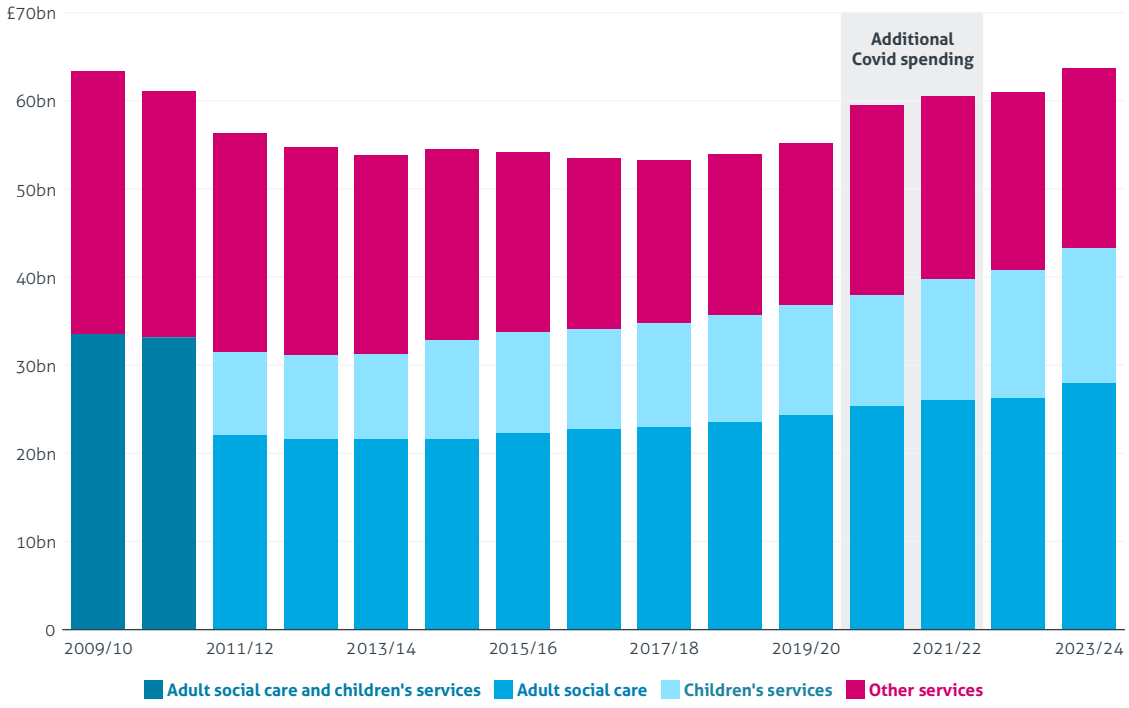
It is difficult to know if these trends in disability rates will continue and what effect they will have on demand for adult social care. The Care Policy and Evaluation Centre estimates that the number of disabled older people in England will rise from 3.5 million in 2018 to 5.2 million in 2038, and that this will translate into higher need for publicly funded care.[1] But this projection assumes that disability rates among older adults will remain unchanged, an assumption that could be questioned, given the decline in self-reported disability in the decade to 2021.

Among working-age adults, there is also evidence of growing demand for care. This could be driven by rising rates of disability among younger adults, as this report has shown. It is more expensive for local authorities to support working-age adults than older adults, with long-term support averaging £1,696 per week for younger adults compared to £951 for older adults.[2]

These trends raise questions about the sustainability of local authority finances and the quality and accessibility of non-social care services.

When funding does not rise in line with demand and local authorities spend a higher proportion of their budget on adult social care, they cut spending on other, non-social care services. This has been an observable pattern in local authority spending since at least 2009/10.

Figure 30 **Spending by local authorities in England, by type, 2009/10–2023/24 (2025/26 prices)**



Source: Institute for Government analysis of MHCLG, 'Local authority revenue outturns' 2009/10-2023/24. Notes: Excludes spending on education services, police and public health. Separate spending data for adult social care and children's services is not available before 2011/12.

In 2009/10, local authorities spent 53.0% of their budgets on adult and children's social care. By 2023/24, this had increased to 71.5%. Across the same period, local authorities cut spending on libraries by just under 50% in real terms, and on youth services by slightly less than 60% in real terms.[3] Local authorities even cut spending on planning – a relatively well-protected service – by 16.5% between 2009/10 and 2023/24.

Without a substantial increase in income, a new approach to funding local authorities, or in managing demand for adult social care, this trend seems likely to continue.

The government should ensure that people have similar access to care regardless of where they live

There is enormous variation in the rate at which those over 65 access long-term care in England. At the lowest end of the distribution, only 2.0% of the over-65s in Rutland accessed publicly funded long-term care at the end of 2023/24. Some of that is for good reason. Rutland is a relatively wealthy area, meaning that proportionately fewer residents will meet the means test. It also has some of the lowest rates of disability among the over-65 population. But, as we have shown, that only tells some of the story.

At the other end of the spectrum is Lambeth, a local authority in which 7.8% of the over-65 population receives long-term care, the third highest level in the country, behind only Tower Hamlets, and Hammersmith and Fulham, both of which have slightly unusual adult social care policies.* Lambeth is neither particularly deprived (61st most deprived out of 145 local authorities for which we have data about deprivation) nor does it have particularly high rates of disability among the over-65 population (54th). The distinguishing feature of Lambeth is that is has a relatively young adult population: only 11.1% of its adults are aged over 65, compared to an England average of 23.6%, giving it the fourth lowest proportion in the country.

Even when controlling for a range of variables that act as proxies for need, there is still a statistically significant relationship between the proportion of the adult population aged over 65 and the proportion of those adults receiving care. That implies that an older adult that requires care is more likely to receive publicly funded care in a local authority with fewer older residents.

This is a poor and unjust means of determining who accesses care that could substantially improve people's quality of life.

* Hammersmith and Fulham has provided free home care for older and disabled residents since 2014 and Tower Hamlets has attempted to implement free home care for multiple years before finally doing so in April 2025.

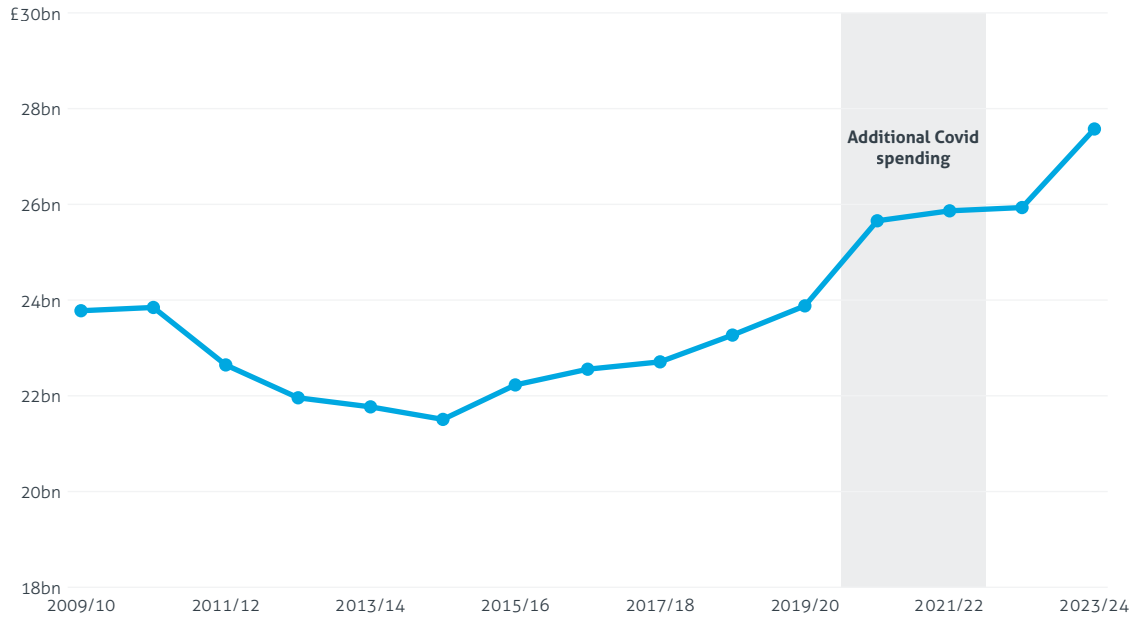
The government should ensure that funding for local authorities reflects its priorities

This report also found that there is a statistically significant relationship between local authority funding and access to adult social care for local authorities outside London: higher core spending power (CSP, the government's measure of the amount of money available to local authorities to spend on service provision) per resident is associated with higher rates of access to long-term care in a local authority, though this is partly because the funding formula for local authorities accounts for drivers of need for adult social care. Areas with larger older adult populations also spend a greater proportion of their budgets on care for those adults.

Nationally, we saw the effect of declining local authority funding on access to adult social care during the 2010s. In response to reductions in central government grant funding from 2010 onwards, local authorities rationed care to residents, resulting in falling rates of access to adult social care. This report shows that that trend appears to have started before 2010, even as early as 2004/05, though it accelerated under the coalition and subsequent Conservative governments.

In recent years, we have seen the opposite trend. It does not seem to be a coincidence that the increase in adult social care spending since 2020 has coincided with an increase in the share of people over the age of 65 accessing care in 2022/23 and 2023/24.

Figure 31 **Spending on adult social care, 2009/10–2023/24 (2025/26 prices)**



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report, England 2023-24' ('Appendix C, Table 5').

However, simply increasing spending on adult social care faster than economywide inflation may not be sufficient to increase the number of people receiving care. Rapidly rising costs of delivering care – particularly the rise in the national living wage[4] – means that even large increases in funding are not translating into substantial

increases in access. Costs in adult social care seem likely to continue rising in the coming years. The national living wage (NLW, which determines the salary of a large proportion of the adult social care workforce) increased again in April 2025, by 6.7%[5] – well ahead of the 3.2% forecasted CPI inflation for 2025/26. The increase in employers' National Insurance contributions announced at the 2024 autumn budget will also likely increase the fees providers charge, further denting the purchasing power of local authorities' adult social care budgets.[6]

On top of this, the government's recent pivot on immigration policy included its white paper announcing an immediate end to overseas recruitment for social care visas,[7] cutting off one of the most important recent sources of staff for the care sector. The prime minister said he wanted to attract British staff to do these jobs, but this would almost certainly require providers to increase wages, which would in turn require local authorities to pay higher fees for publicly funded care.

Local authority core spending power is set to increase by 2.6% per year in real terms between 2025/26 and 2028/29.[8] That is above the projected average annual increase in England's population (0.9%), just above the forecast growth in the over-65 population (2.1%) but below the over-90 population (3.3%). If funding increases for local authorities fail to keep pace with cost pressures in the coming years, it is likely that current spending plans could further restrict access to care by the end of this parliament.

Labour used the 2025/26 local government finance settlement to redistribute funding from the least to the most deprived local authorities.[9] This is an understandable decision, given the disproportionate cuts those authorities have received since 2010 and the association between demand for services and deprivation.[10] But the analysis in this report shows that if it intends to improve access to adult social care, that may not be the right approach because deprivation fails to capture one important aspect of need for care identified in this report: the size of the older adult population living in a local authority. Excluding London local authorities, the government increased core spending power more in local authorities that already provide a greater proportion of older adults with adult social care, as Figure 32 shows.

Figure 32 **Real terms change in core spending power, 2025/26, compared to the proportion of adults aged 65+ receiving long-term care, 2023/24, by local authority**

Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report' (Table 'T38'), 2023/24, ONS, 'Mid-year population estimates', 2023, and MHCLG, 'Local government finance settlement – final', 2025/26. Notes: This shows English local authorities only. Core spending power is central government's measure of the money available to local authorities to fund service delivery.

It is welcome that the government announced long-awaited reforms to the local government funding formula in June 2025. Part of that announcement was an update to the formula which determines the allocation of funding for adult care.[11]

Overall, these reforms are a positive step towards more equitable matching of needs and funding for local authorities. But it is still unclear whether these changes will re-balance some of the disparities in access for older adults that this report has identified. The government should monitor the implementation from April 2026 and ensure they are supporting consistent access across the country.

The burden of rationing falls on friends and family

Rationing social care is an understandable response by local authorities to tightening budgets, but it is not cost-free. In many cases, rationing shifts the cost of care away from the state and on to the friends and family of those who need support.

As with access to long-term care, this report shows that higher rates of unpaid care provision are associated with larger over-65 populations. This means that there is also a postcode lottery for unpaid care.

Often friends and family want to care for their loved ones. Unpaid care is not always a burden. But it can be when it is imposed on people when they have little choice and the degree to which a person's local authority has deemed appropriate to ration care is not a decision in their hands, meaning for many the choice will be made for them.

There are also distributional implications with unpaid care. Wealthier people are more able to pay for private care, while the less wealthy have to rely on unpaid care. In the 10% of most deprived local authorities, 5.2% of the population provide more than 20 hours of care per week, compared to 3.5% in the least deprived 10%. Women are also more likely than men to provide unpaid care.[12] In the 2021 census, 59.2% of those that reported providing unpaid care were women.[13]

Finally, there is an opportunity cost to those hours spent caring for loved ones. When people provide unpaid care, they often leave the workforce. Work from the London School of Economics (LSE) estimates that in 2015/16 there were 345,000 people who had left the workforce at some point over previous years to provide unpaid care.[14] Of those, 205,000 (59.4%) were women.

The Health Foundation found that four in ten unpaid carers under retirement age were not working as much as they would do otherwise due to their caring responsibilities[15] – there were 3.7million working-age adults that reported providing some level of unpaid care in the 2021 census,[16] so if this reporting scales up some 1.5million people will have been reducing their working hours to provide care not offered by local authorities. This means rationing of care at the local government level is creating something of a false economy and could be frustrating central government's objective of having 80% of people in work.

Conclusion

For those who need it, access to the appropriate level of care is a crucial enabler of living a fulfilled life. There are good reasons why people should not be able to draw on publicly funded care; the government has set both a need and means threshold for publicly funded support. But the system is failing when someone is denied care purely because they live in an area with a larger older population. That failure is compounded if it is friends and family who have to step in to provide the care that the state will not.

Appendix – Regression tables

Significance thresholds

In the following regression tables, we use asterisks to demonstrate the level of significance of an independent variable, as determined by the p-value from our regressions. Three asterisks signify the highest level of significance and one asterisk the lowest. The thresholds are as follows, and includes the word we use to describe these results in the body of the text:

* Weak relationship: 0.01<p<0.05

** Moderate relationship: 0.001<p<0.01

*** Strong relationship: p<0.001

Regression 1: Proportion of the 65+ population receiving publicly funded long-term care

Variables	All local authorities	Local authorities outside London	Local authorities in London
Average score on the English indices of deprivation (low is less deprived, high is more deprived)	-0.00860	0.00139	0.06773
	(0.02532)	(0.02075)	(0.09844)
Proportion of adults aged 65+ reporting high disability	0.10728	0.08142	0.07714
	(0.0627)	(0.04855)	(0.25022)
Proportion of adults aged 65+	-0.08162*	-0.04692*	-0.59534*
	(0.03246)	(0.02307)	(0.22301)
Core spending power per resident (£)	0.00157	0.00203*	0.00302
	(0.00098)	(0.00078)	(0.00323)
Proportion of 65+ households living alone	-0.00206	0.01402	-0.08543
	(0.04642)	(0.03823)	(0.16397)
Proportion of 65+ households living in rented accommodation	-0.00675	-0.00700	0.00530
	(0.0257)	(0.02171)	(0.10138)
Proportion of adults aged 65+ receiving pension credit	0.06995	0.06397	-0.13966
	(0.05223)	(0.04539)	(0.20972)
Proportion of the population living rurally	-0.00238	-0.00547	N/A
	(0.00828)	(0.00569)	N/A
Proportion of adults aged 65+ that are aged 80+	0.01200	-0.00110	0.48316
	(0.02918)	(0.01842)	(0.30388)
Vacancy rate of direct care staff	-0.04284	0.01093	-0.13592*
	(0.02246)	(0.01897)	(0.06243)

Notes: Dependent variable: proportion of the 65+ population receiving long-term care. Level of analysis: upper- and single-tier local authorities in England. The coefficient shows the percentage point change in the proportion of the 65+ population receiving care from a one-unit increase in the independent variable.

Regression 2: Proportion of the 18–64 population receiving publicly funded long-term care, 2023/24

Variables	All local authorities	Local authorities outside London	Local authorities in London
Average score on the English indices of deprivation (low is less deprived, high is more deprived)	0.00590	0.00920	-0.00377
	(0.00492)	(0.00564)	(0.01352)
Proportion of adults aged 20–64 reporting high disability	0.11860*	0.14687**	0.18354
	(0.05035)	(0.05234)	(0.15554)
Proportion of adults aged 65+	0.00770	0.01141	0.00078
	(0.00604)	(0.00639)	(0.01711)
Core spending power per resident (£)	0.00007	0.00024	-0.00059
	(0.00015)	(0.00019)	(0.00033)
Proportion of 18–64 households living in rented accommodation	-0.00237	-0.00580	0.00153
	(0.00254)	(0.00312)	(0.00611)
Proportion of the population living rurally	-0.00143	-0.00143	N/A
	(0.0012)	(0.00124)	N/A
Proportion of adults aged 18–64 claiming personal independence payments	-0.06872	-0.09801**	-0.00709
	(0.03611)	(0.03662)	(0.11864)
Vacancy rate of direct care staff	-0.00148	0.00247	-0.01346
	(0.00366)	(0.00468)	(0.00696)

Notes: Dependent variable: proportion of the 18 to 64 population receiving long-term care. Level of analysis: upper- and single-tier local authorities in England. The coefficient shows the percentage point change in the proportion of the 18 to 64 population receiving care from a one-unit increase in the independent variable.

Regression 3: Proportion of the total adult population receiving publicly funded long-term care, 2023/24

Variables	All local authorities	Local authorities outside London	Local authorities in London
Average score on the English indices of deprivation (low is less deprived, high is more deprived)	-0.00095	0.00213	0.03232
	(0.0079)	(0.00835)	(0.02715)
Proportion of all adults reporting high disability	-0.02802	-0.04153	0.30619
	(0.06124)	(0.05915)	(0.19341)
Proportion of adults aged 65+	0.00477	0.01370	-0.12164*
	(0.01117)	(0.01063)	(0.04672)
Core spending power per resident (£)	0.00059*	0.00068*	0.00092
	(0.00025)	(0.00027)	(0.00062)
Proportion of 65+ households living alone	0.00160	0.00736	-0.00495
	(0.01169)	(0.01278)	(0.03314)
Proportion of 65+ households living in rented accommodation	-0.01430	-0.01470	-0.01490
	(0.0065)	(0.00714)	(0.01992)
Proportion of adults aged 65+ receiving pension credit	0.02011	0.01573	-0.03341
	(0.01308)	(0.01556)	(0.03642)
Proportion of the population living rurally	-0.00226	-0.00264	N/A
	(0.00214)	(0.00195)	N/A
Proportion of adults aged 65+ that are aged 80+	-0.00123	-0.00460	0.11006
	(0.00741)	(0.00631)	(0.06201)
Proportion of adults aged 18–64 claiming personal independence payments	0.09074	0.09535	-0.21432
	(0.05254)	(0.05029)	(0.18463)
Vacancy rate of direct care staff	-0.00851	-0.00106	-0.03109
	(0.00564)	(0.00641)	(0.01245)

Notes: Dependent variable: proportion of the total adult population receiving long-term care. Level of analysis: upper- and single-tier local authorities in England. The coefficient shows the percentage point change in the proportion of the total adult population receiving care from a one-unit increase in the independent variable.

Regression 4: Proportion of the population providing unpaid care, by number of hours per week, 2021

Variables	1–19 hours	20–49 hours	50+ hours	Total hours
Average score on the English indices of deprivation (low is less deprived, high is more deprived)	-0.02618*	0.02795***	0.03235***	0.03412
	(0.01027)	(0.00437)	(0.00875)	(0.02135)
Proportion of adults aged 65+ reporting a disability	0.07185***	0.04775***	0.10478***	0.22438***
	(0.02014)	(0.00857)	(0.01717)	(0.04187)
Proportion of adults aged 65+ receiving publicly funded long-term care	-0.28866***	-0.06288***	-0.25841***	-0.60995***
	(0.03797)	(0.01616)	(0.03237)	(0.07894)
Proportion of 65+ households living alone	0.01568	-0.03289***	-0.02845*	-0.04566
	(0.01506)	(0.00641)	(0.01283)	(0.0313)
Proportion of the 65+ population requesting support from their local authority	-0.00195	0.00035	-0.00372	-0.00532
	(0.01161)	(0.00494)	(0.0099)	(0.02415)
Proportion of the population living rurally	0.00936***	-0.00083	0.00697**	0.01549**
	(0.0027)	(0.00115)	(0.0023)	(0.00561)

Notes: Dependent variable: proportion of the population providing unpaid care in 2021. Level of analysis: upper- and single-tier local authorities in England. The coefficient shows the percentage point change in the proportion of population providing unpaid care from a one-unit increase in the independent variable.

Regression 5: Average cost of providing community care per person receiving long-term community care, 2023/24

Variables	All local authorities	Local authorities outside London	Local authorities in London
Average score on the English indices of deprivation (low is less deprived, high is more deprived)	-105.24	-23.37	-391.57
	(95.64)	(126.16)	(187.49)
Proportion of adults aged 65+ reporting a disability	415.28*	115.79	398.97
	(166.63)	(227.75)	(276.6)
Proportion of adults aged 65+	-104.76	-66.82	343.15
	(123.27)	(139.21)	(444.14)
Core spending power per resident (£)	-3.43	-4.6	-1.88
	(3.69)	(4.64)	(5.83)
Proportion of 65+ households living alone	-92.66	-326.32	257.55
	(176.86)	(231.2)	(294.13)
Proportion of 65+ households living in rented accommodation	69.28	223.78	-188.06
	(100.88)	(131.01)	(186.84)
Proportion of adults aged 65+ receiving pension credit	-107.46	-75.42	852.76
	(197.32)	(271.74)	(361.16)
Proportion of the population living rurally	65.32*	35.35	N/A
	(30.04)	(32.67)	N/A
Proportion of adults aged 65+ that are aged 90+	1013.03*	993.46	2074.68
	(478.07)	(511.45)	(1535.9)
Vacancy rate of direct care staff	57.65	262.55	-66.75
	(86.47)	(112.65)	(127.03)

Notes: Dependent variable: average cost of providing community care per person receiving long-term community care from their local authority. Level of analysis: upper- and single-tier local authorities in England. The coefficient shows the percentage point change in the average per-person cost of providing community care from a one-unit change in the independent variable.

Regression 6: Proportion of local authority spending going on long-term care for adults aged 65+, 2023/24

Variables	All local authorities	Local authorities outside London	Local authorities in London
Average score on the English indices of deprivation (low is less deprived, high is more deprived)	-0.13064	-0.23309*	-0.05046
	(0.08613)	(0.11619)	(0.16152)
Proportion of adults aged 65+ reporting a disability	0.48112***	0.39653	0.20607
	(0.14153)	(0.20525)	(0.23968)
Proportion of adults aged 65+	0.65429***	0.69358***	0.75656*
	(0.09045)	(0.11068)	(0.32819)
Proportion of 65+ households living alone	0.0904	0.11669	0.26812
	(0.14878)	(0.2064)	(0.25762)
Proportion of 65+ households living in rented accommodation	0.04884	0.1563	-0.13782
	(0.08353)	(0.11692)	(0.15415)
Proportion of adults aged 65+ receiving pension credit	0.04652	0.14977	0.55396
	(0.16464)	(0.24086)	(0.30981)
Proportion of the population living rurally	0.00968	-0.006	N/A
	(0.02581)	(0.02963)	N/A
Proportion of adults aged 65+ that are aged 80+	0.37999	0.29461	0.62931
	(0.4117)	(0.46182)	(1.32669)
Local authority spending per resident (£)	-0.01242***	-0.0123***	-0.01151*
	(0.00205)	(0.00239)	(0.00423)

Notes: Dependent variable: proportion of local authority spending that is spent on long-term care for the 65+ population. Level of analysis: upper- and single-tier local authorities in England. The coefficient shows the percentage point change in the proportion of spending on adult social care from a one-unit change in the independent variable.

Methodology

Choice of metrics

The quality of data in adult social care is poor. It is therefore difficult to make judgments about a wide range of factors that are important in determining the level of need for care and the extent to which a local authority meets that need.

That necessitates us to use imperfect datasets as proxies for a wide range of metrics. Multiple reviewers pointed this out. We acknowledge the imperfections of the data. But also think that it is better to conduct analysis using imperfect data than it is to do nothing.

This section explains the reasons why we use datasets and explains the difficulties and shortcomings with each one.

Requests for support

One measure of demand for adult social care is the number of requests for support from local authorities, as reported in NHS Digital's Adult Social Care Activity and Finance Report (ASCAFR). Within that, we can look at the number of requests for support from new clients (Table 8 in ASCAFR 2023/24). One issue with this metric is that it does not show how many times each new client requests support.

Instead, the NHS published data on the number of unique clients requesting support in the years between 2017/18 and 2022/23 (Table 13 in ASCAFR 2022/23). We chose to use this metric as we believe that it is a better indicator of actual demand on local authorities than the total number of requests. It is unfortunate that the NHS has chosen to stop publishing that data in 2023/24.

Access to long-term care

There is no perfect metric to compare access to publicly funded adult social care. It is not possible to compare only the number of people accessing care in each local authority, because this does not take account of population size. We therefore chose to normalise this by looking at the proportion of the adult population accessing long-term care at the end of the year. Higher rates of access to long-term care are not always better. There are legitimate reasons why access is lower in some local authorities, as we discuss in the body of the report. It is legitimate that there are lower rates of access in wealthier local authorities with populations that report lower rates of disability, for example.

Long-term care is also not the only way that a local authority can meet residents' needs. They may also take a 'strengths-based approach' to care, in which a local authority uses the 'strengths' of individuals, the community and their social networks to support that individual. This is often proffered as a reason why there has been a decline in access to long-term care, rather than local authorities rationing care. The difficulty with this explanation is that there is no data collected on how many people receive strengths-based support or evidence that it has materially replaced long-term care.

There are two metrics of long-term care in ASCAFR: the number of people accessing long-term support throughout the year (T34 in the 2032/24 ASCAFR report) and the number of people accessing long-term support at the end of the year (T38). We chose to use the latter as it provides a snapshot of the amount of care provided in each local authority at a point in time, which would hopefully be more comparable than the former metric, which might capture things like high turnover of people accessing care in a local authority.

As a robustness check, we also tested our results using access to long-term care throughout the year and found broadly similar results.

There are also difficulties using the total population as the denominator in this metric. As one reviewer pointed out to us, local authorities have very different deprivation profiles. For example, they may have a lot of very wealthy people and a lot of people who are not very wealthy in one local authority, while another might have people who are all moderately wealthy. There would be different patterns of need for adult social care in each of these authorities. This is a good point, but we hope that we capture some of the variation in need by controlling for deprivation in our regressions.

Long-term care data before 2014/15

ASCAFR data starts in 2014/15. That means that until recently we have had to start time series of long-term care in that year. As part of the 2023/24 ASCAFR publication (appendix D),[17] the NHS published a time series of long-term care going back to 2003/04. Combining that national level data with population estimates, we were able to construct a longer term access time series.

The NHS described which datasets it stitched together to make that time series. We were able to find data at a local authority level to replicate their methodology for some years. Using this, we created a time series of long-term care at a local authority level between 2004/05 and 2007/08 (we could not find data for 2003/04). For the years 2008/09 to 2010/11, the quality of nursing and residential care data at a local authority level was patchy, with many local authorities reporting null values. This made it difficult to create a reliable estimate of long-term care for those years.

The data for community care was complete, however, for those years. That means that we have broadly comparable community care data for 2004/05, 2010/11 and every year after 2014/15. We used this to create the three charts in Figure 21.

Need for care

It is impossible to observe the level of need for adult social care in a local authority. We can observe the amount of care that local authorities provide, but not whether this is sufficient to meet the demand for publicly funded care. There are, however, some proxies for need that we use and which are examined in more detail below.

Self-reported disability

One metric of need for social care is the extent of disability. To capture this, we used the disability data collected in the census by the Office for National Statistics (ONS) in both 2011 and 2021.

In the 2021 census, the ONS asked respondents: "Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?"[18]

If they answered "Yes" to that question, the ONS then asked: "Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?"

The response options were:

- "Yes, a lot"
- "Yes, a little"
- "Not at all".

Given that the question specifically asks if someone is limited in their daily activity, we think that this is at least a proxy for a need for some level of adult social care support.

We also compare census survey responses between the 2011 and 2021 censuses. There are therefore some caveats about comparing responses between these two years.

First, the ONS changed the question between the two years. In 2011, it asked: "Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age."

In 2021, the ONS removed any reference to old age and added a reference to mental health conditions in the question. The former could explain some of the decline in the number of older adults identifying as disabled and the latter – combined with wider discussion and understanding about mental health conditions now than in 2011 – could partly explain the number of younger adults identifying as disabled.

The second issue is that the census was conducted in March 2021, during the Covid-19 pandemic. This could have affected responses; people could have been living with long Covid, for example.

Despite these caveats, we think there is still benefit from using the data. First, the ONS describes the two years results as being "broadly comparable" and encourages policy makers to make comparisons.[19] Second, we use the 2021 results for our cross-sectional regression analysis. So, while there may be issues about the effect of Covid on the results, we are not using a variable in any regression that shows the change in disability rates. It therefore seems legitimate to use the 2021 data in cross-sectional analysis.

Unpaid care

There are few consistent sources of the amount of unpaid care that people provide. The most regular (though infrequent) source is the census.

In the 2021 census, the Office for National Statistics asked: "Do you look after, or give any help or support to, anyone because they have long-term physical or mental health conditions or illnesses, or problems related to old age?"[20] People could respond by saying "No", or by responding with a range of answers to indicate the number of hours of care that they provide per week.[21]

The 2021 unpaid carer census data has a couple of shortcomings for our purposes. The first is that it was asked during the Covid pandemic, when people's caring responsibilities might have changed. This may have been because friends' or relatives' usual carers could not visit them due to social distancing rules, or because friends and family may have suffered from worse mental health during the pandemic, meaning they required more support than they would do outside the pandemic.

There is also no way to determine who respondents care for. They could be caring for older relatives, working-age siblings or children. That means it is harder to test the relationship between the authorities that provide less care to the over-65 population and the rates at which people provide unpaid care to that population.

Deprivation

Deprivation is an important metric of demand for local authority-provided adult social care services for two primary reasons. First, because it is an indicator of how many people in a local authority are likely to meet the means test for publicly funded care. And second, because there is a strong relationship between deprivation and poor health, as outlined in the body of the report.

English indices of deprivation (IMD)

The primary indicator of deprivation that we use throughout this report is MHCLG's 'English indices of deprivation' (IMD), from 2019. Within this, we use the average score across all domains for each local authority.

Some reviewers argued that IMD scores alone are an incomplete indicator of deprivation in a local authority, particularly when disaggregating adult social care into different age groups. Because of this, we included other indicators of deprivation that we think more accurately capture age-specific deprivation. Those are discussed in more detail below.

Another reviewer pointed out that average IMD score captures the average deprivation in a local authority, but does not show the distribution and that, for example, a local authority may have a population that is split between being very wealthy and very deprived. This is a legitimate critique of this metric. But we think it is still broadly indicative of the extent of deprivation.

Pension credit

To better capture deprivation among the older adult population, we calculated the proportion of adults aged 65+ that claim pension credit in a local authority. We used the average number of pension credit claimants in the quarters ending May 2023, August 2023, November 2023 and February 2024. This is not quite matched to the 2023/24 financial year, but DWP only provides its data in that time format. We think it is close enough to be usable.

Personal independence payment (PIP)

To better capture deprivation among working-age adults, we calculated the proportion of adults aged 18 to 64 that claim PIP in a local authority. We took the average throughout 2023/24 as the metric for the numerator of this calculation.

Other drivers of demand

We also controlled for other indicators of demand for adult social care. Many of these align with the metrics identified as demand drivers in work that DHSC commissioned the Adult Social Care Research Unit (ASCRU) at the Personal Social Services Research Unit (PSSRU) at the University of Kent to carry out.[22]

Older adults living alone

To calculate the proportion of older adults living alone, we summed the number of households that were classified as 'One-person household: Aged 66 years and over' in the family composition dataset from the ONS's 2021 census and divided this by the total number of households in which someone aged 65 and over was the 'Household representative person' (HRP). We did this for each local authority.

The ONS defines a HRP as "the householder, who is the household member who owns the accommodation; is legally responsible for the rent; or occupies the accommodation as reward of their employment, or through some relationship to its owner who is not a member of the household. If there are joint householders, the one with the highest income is the HRP. If their income is the same, then the eldest one is the HRP."[23]

This means we may miss households in which the HRP is not someone aged 65 and over, but in which there is someone aged 65 and over.

Older adults living in rented accommodation

We used the same denominator as for the older adults living alone metric. For the numerator, we summed the households in which the HRP is aged 65 years and over and where they report living in either social rented or private rented accommodation. This data comes from the 'Household characteristics by tenure' dataset in the 2021 census.

Inflation

Throughout the report, we adjust all money values for inflation by putting them into 2025/26 prices. We use the GDP deflator for all spending and funding that is related to the government, and we use CPI for any figures – for example: income, value of assets, or means test thresholds – that relate to an individual.

Choice of local authorities

There were 153 upper- and single-tier local authorities in England in 2023/24. From these, we excluded the City of London and the Isles of Scilly because they have very small, atypical populations and are unusual in their patterns of service provision. There was also no data for the London borough of Hackney in the 2023/24 Adult Social Care Activity and Finance Report. We therefore have data for long-term access to care for 150 upper- and single-tier local authorities in England.

The coverage of data is, however, different for different metrics. For example, the English indices of deprivation (IMD) were published in 2019. Since then, some local authorities have reorganised, creating new unitary authorities. There is therefore no IMD data for those local authorities and they are excluded from the analysis when we compare access and other metrics to deprivation.

In all instances, we have included as many local authorities as possible in the analysis, with the exception of the City of London and the Isles of Scilly.

Approach to regression analysis

Throughout the report, we use multivariate regression analysis to identify associations between different characteristics of a local authority and outputs and outcomes that we are interested in, such as access to long-term care, extent of unpaid care provision, and proportion of local authority spending that goes on long-term care. Throughout, we use ordinary least squares regressions.

As outlined in Box 2, when we describe a relationship, we are not assigning causality between the variables. It is possible that the relationship would disappear if other variables were added to the controls. We have tried to be thorough with the variables that we have controlled for and have included as many as possible that reviewers have suggested to check the robustness of findings.

Other methodological notes

Figure 27: Proportion of local authority spending going on long-term adult social care

For the denominator of this calculation, we calculate local authority spending in 2023/24 as the sum of local authorities' net current expenditure on highways and transport services, public health, adult social care, children's social care, housing services, cultural and related services, environmental and regulatory services, planning and development services, central services, and other services from the local authority revenue outturn service expenditure summary. We exclude education spending because the majority of this is passed through funding for schools, meaning that local authorities do not have any control over it. We exclude police and fire services for similar reasons.

For the numerator of this calculation, we use the sum of expenditure on long-term care for clients aged 65 and over (Table T44 in ASCAFR 2023/24). We use this because it most closely matches the type of activity that we have conducted analysis for: long-term care for adults aged 65+. Even though it comes from a different dataset to the numerator, we believe it shows a strong indication of how much local authority spending goes on long-term care for that age group.

Figure 30: Spending by local authorities in England, by type

The measure of local authority spending in this chart differs slightly from the measure used in Figure 27. We exclude public health spending from the denominator because that service only became a local authority duty from 2013/14 onwards and we wanted to make the number comparable from 2010.

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