The Effect of Financial Incentives and Access to Services on Self-Funded Admissions to Long-Term Care

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Abstract

With the growth in the numbers and proportion of older people in the population the funding and incentive structures around long-term care are of international concern. A study of the circumstances of self-funded admissions to care homes allowed the comparison of self-funders with publicly-funded admissions to care homes in the UK, the influences on self-funders in their decision to move into a care home and resources on which they were able to draw. These findings contribute to our understanding of the impact of current policy on self-funders and our thinking about the way that future policy and practice changes could improve the way we use society's resources in the provision of long-term care.

Keywords

Long-term care, Self-funded residents, Care homes for older people, Access to services.

Background

For older people the path into formal long-term care is dependent on factors such as medical needs, impairment and availability of informal care support. However, as the long-running and international debates around funding long-term care have illustrated, funding and policy structures and incentives are fundamentally important in determining what happens to people and how they feel about it. Ideally we want to move towards systems where information and incentives combine to maximise the production of welfare and minimise the use of resources in this process.

One of the objectives of the funding reforms introduced in the UK by the 1990 NHS and Community Care Act was to remove the perverse incentive identified by the Audit Commission (1986) for people to be admitted to care homes rather than be cared for in the community. Prior to the Act local authorities bore the cost of community care services but not of independently provided residential or nursing home care. For a substantial group of people, however, the perverse incentive continued. These were people with a certain level of assets (£19,000 in 2002/2003, including the value of their home if they were home-owners (Department of Health, 2002a)) who were expected to meet the costs of their own care. Since April 2001 the value of the individual's home has been disregarded from means testing for the first three months (Department of Health, 2001). For those falling outside these means testing limits the local authority bears no costs if they are admitted to care homes. However, if they receive care services in their home the authority will bear a proportion of the costs, quite how much depending on the local authority charging

system. Charges for home care services vary considerably, both between and within authorities (Audit Commission, 2000).

However, authorities do bear the costs for those people who reduce their assets below these levels while staying in long-term care, so they should have a financial interest in who is admitted and to what type of home. Moreover, despite the widespread adoption of the care management approach, social workers responsible for undertaking assessments rarely hold budgets and are not known for being dominated by financial considerations in their decisions (Baldwin and Lunt, 1996). Thus it could be hypothesised that a more important influence on the decision of self-funders (or their relatives) will be their access to assessment and services, than incentives that prevail once they are "in the system".

Current policy moves are widening the net of those who will need to be assessed prior to admission to a care home. In Scotland, everybody admitted to care homes will receive public funding because of the commitment to free personal care. In England, only those admitted to nursing homes will need their nursing needs professionally assessed (Department of Health, 2002b). While the intention is that this is to be incorporated into the single care assessment process, it is not entirely clear at present whether this means that all those self-funders who propose to enter a nursing home will receive a full assessment prior to admission. Although the new care standards require self-funders entering care homes providing residential care to be assessed, this only has to be by the care home provider and not by an independent professional (Department of Health, 2003).

A study funded by the Department for Work and Pensions (formerly DSS) provided us with an opportunity to investigate the circumstances of self-funded admissions to care homes (Netten et al., 2002). This was designed to be directly comparable with a previous study of publicly-funded admissions (Bebbington et al., 2001). We outline the method adopted by the studies before describing how self-funders compare with publicly-funded people admitted to homes, the influences on self-funders in their decision to move into a care home and the resources on which they were able to draw. We discuss how these findings can contribute to our understanding of the impact of current policy changes on self-funders, and our thinking about the way that future policy and practice changes could improve the way we use society's resources in the provision of long-term care.

Method

There are major methodological difficulties in establishing the financial and other circumstances of self-funded admissions (Darton et al., 2000). Establishing appropriate sources of information and achieving a reasonable response rate is problematic at a time in their lives when older people themselves are very vulnerable, and relatives and home managers are likely to be very defensive. Moreover, in the survey of publicly-funded admissions, 80 per cent of older people showed some signs of cognitive impairment and 35 per cent were severely cognitively impaired (Bebbington et al., 2001). In addition, there are always difficulties in identifying reliable financial information under any circumstances.

In order to identify the feasibility of a full-scale survey, a small-scale study was undertaken prior to the main survey. This identified the data that needed to be collected, devised a broad methodology for data collection and identified the size of the sample required to answer the aims of the survey. Residents themselves were rarely clear about their financial circumstances on admission, so any information that was gathered from this source was likely to need to be verified. Often nobody at the care home knew anything about finances. The most reliable and informed sources were the relatives, who were usually very involved in making decisions. This finding was confirmed by the findings of a project funded by the Office of Fair Trading that ran concurrently with the feasibility study. In that study, approximately 80 per cent of the people who were identified as having helped the older person make a choice about a particular home were members of the family (Wigley et al., 1998). However, some information was regularly available at homes about all admissions (such as age, gender, marital status and previous address).

In the light of the findings of the feasibility study, it was decided not to collect any information directly from older people, although their permission for participation was sought. Instead, attempts were made to interview a relative or other person familiar with the older person's circumstances, wherever one could be identified. Where there was no relative, home managers would be asked a limited number of questions about the resident's finances, to mirror the questions in the interview conducted with relatives. Relatives were approached for an interview four to six weeks after the time of admission, as homes and local authorities use this period of time as a settling-in period and to determine whether the placement should be considered to be permanent.

A sample of homes in England, Scotland and Wales was selected in order to identify recent and future self-funded admissions. 481 homes, 96 per cent of those approached, agreed to participate. They were asked to identify all self-funded admissions over the previous six months and then contacted on three more occasions to identify all new admissions between July 1999 and March 2000. By the end of the study, 292 of the homes had generated 921 self-funded admissions over a period of 14 months.

Basic demographic information was collected about all self-funded admissions. Information about dependency characteristics was collected for those admitted within the previous two months at each contact with the home (402 cases). Relatives or, in a few instances, friends or professionals such as solicitors, were interviewed about the current financial resources available and the circumstances immediately prior to admission (331 cases). Although not everybody interviewed was in fact a relative this term is used below to refer to this group of informants.

Wherever possible, information was collected about residents on the same basis as information in the previous survey of publicly-funded admissions (Bebbington et al., 2001). This survey of 2,500 admissions took place in 18 local authorities in England in 1995. Information was collected about demographic characteristics, dependency, and service receipt, together with basic information about the fees paid and type of home to which the individual was admitted.

In both studies dependency was measured using a number of items, and a combination of these was used to compile the Barthel Index of Activities of Daily Living (Collin et

al., 1988), a measure of abilities to perform activities of daily living and continence. In this index a maximum score of 20 indicates high functional ability and a score of zero indicates extreme dependence on others. Cognitive impairment and challenging behaviour were measured by using items from the Minimum Data Set (MDS), a structured approach to assessment and problem identification (Morris et al., 1990; Carpenter et al., 1997). A seven-point scale, the Minimum Data Set Cognitive Performance Scale (MDS CPS) (Morris et al., 1994) was compiled from these items. Using these hierarchical categories provided an overview of problems in the areas of memory, functioning and communication. An additional question derived from the MDS concerned the frequency of problem behaviour such as wandering, physical or verbal abuse and antisocial acts. Behavioural symptoms of depression were excluded.

Results

Type of admission

Overall, 65 per cent of self-funded admissions were to residential places (as opposed to nursing places). This reflected the rate of admission to the homes in the study, in which there was a slight bias towards residential rather than nursing places. Once the relative number of places was adjusted to match the national proportions, the proportion admitted to residential places was 61 per cent, still significantly higher than among publicly-funded admissions (54 per cent, $p < 0.001$).

Of the 331 people for whom we had information from a relative, 69 per cent were admitted to a residential place. We would expect a tendency to over-represent admissions to residential places among this sample as people admitted to nursing homes are more likely to die shortly after admission. In this study 20 per cent of our sample in nursing homes had died prior to the interview with home managers (so no relative was contacted), compared with 7 per cent of people admitted to a residential place.

Marital status

Just 15 per cent of the self-funders' sample were married at the point of admission, rather less than among publicly-funded residents, where 20 per cent were married on admission. This is to be expected as those who are married homeowners will be entitled to public support at a lower level of assets, as the value of the home is not taken into consideration unless the partner no longer needs the property. This also explains why a relatively high proportion, 35 (or 26 per cent) of the 133 married people, were moving into a home at the same time as their spouse, or to join their spouse.

As with publicly-funded residents, significantly more people admitted to a nursing place were married (21 per cent) than those admitted to a residential place (11 per cent) ($p < 0.001$). Among publicly-funded residents the proportions were 29 per cent and 18 per cent respectively (Bebbington et al., 1996). However, those married

couples that were admitted together were significantly more likely to move into a residential home than a nursing or dual registered home ($p < 0.001$).

Home ownership

Table 1 shows information on household tenure and composition separately by the type of place occupied by the resident. The small number of individuals that owned property that had not been their accommodation prior to admission were classified as owner-occupiers.

81 per cent of the 848 self-funding residents for whom information was available were homeowners prior to admission. This is rather lower than might be anticipated for this group. Over two-thirds of people admitted to care homes are publicly funded and only those living in owner-occupied accommodation with low financial assets who were living with others on admission would be eligible for public funding. In the general population, 66 per cent of all people aged 65 and over in private households, and just over half of those living on their own, were living in owner-occupied accommodation in 1994/1995 (Wittenberg et al., 1998). 51 per cent of owner-occupiers had sold their property by the time of the interview with their relatives. In 75 per cent of these cases the property had been sold to pay for the resident's care. The majority of the remaining 25 per cent had sufficient savings and income to cover their care fees (21 per cent), and for the other 4 per cent of cases the financial information was incomplete.

Overall, 58 per cent of the individuals for whom information was available had been owner-occupiers, living alone. However, the proportion was higher for those admitted to a residential place (62 per cent) than for those admitted to a nursing place (49 per cent). Conversely, individuals admitted to a nursing place were more likely to have been owner-occupiers and living with other people (34 per cent) than those admitted to a residential place (18 per cent). Among the owner-occupiers living with other people, approximately two-thirds were living with a spouse only.

Income and assets

Relatives and home managers supplied information about the value of the home where this was available and the council tax band of the property. This information was combined with information about shared ownership to identify the value of assets tied up in property prior to admission. Table 2 shows the distribution of the value of financial assets alone and the total value of assets when property was included.

Although the majority of self-funders' assets were tied up in their home prior to admission, over 60 per cent had more than £20,000 in financial assets other than property prior to admission. However, 6 per cent of people had total assets less than £16,000 and were entitled to public funding and thus an assessment at the point of admission at the time of the study.

Information about income was provided both in bands and actual levels when this was available. Table 3 shows the distribution across income bands. In the 212 cases where

actual income was available, mean income was £184 and median income was £150 per week. This is considerably less than standard fees for residential homes. Only in 16 per cent of instances did weekly income exceed the fees being charged by the home.

In our sample, the people who would have become eligible for public funding for the first three months of residence in a care home under the criteria introduced in April 2001 are those:

- who were homeowners at the point of admission,
- whose weekly income would not meet the fees, and
- who had savings and investments below £18,500 (since April 2002, £19,000).

The data collection process means that the closest cut-off point that we can reliably identify corresponds to savings and investments of less than £20,000. This group (80 individuals) constituted 28 per cent of the admissions for which information was available.

Source of admission

Table 4 shows where people were immediately prior to admission. A lower proportion was admitted directly from hospital (43 per cent), compared with publicly-funded residents (52 per cent). A similar proportion was admitted from hospital to residential homes (about 40 per cent); it is amongst those admitted to nursing places where the difference is most marked. Less than half of the self-funders were admitted

from hospital, compared with nearly two-thirds of publicly-funded admissions ($p < 0.001$).

As with publicly-funded admissions, the majority of self-funded residents (69 per cent of the 872 for whom information was available) had lived alone prior to their admission to the home or their hospital stay immediately before admission. Among publicly-funded residents for whom this information was available (a sample of 1,982), the proportion was 63 per cent. A significantly lower proportion was admitted from single-person households to nursing homes, both among self-funded (58 per cent) and publicly-funded admissions (52 per cent).

Dependency

Table 5 shows that in almost all instances there was evidence of lower level of physical dependency among self-funded residents than among publicly-funded residents. This was true in terms of mobility, activities of daily living, and continence.

Self-funded admissions to residential homes were significantly less dependent than publicly-funded residents (average Barthel score = 14.1, compared with 12.5, $p < 0.001$), although those admitted to nursing homes were similar (Barthel score = 7.1, compared with 6.7). The overall difference in level of dependency reflected both the difference within home type and the higher proportion of self-funded people admitted to residential places.

There was a similar finding with respect to cognitive impairment (see table 6). A significantly higher proportion of self-funded residents in both residential and nursing homes were identified as entirely cognitively intact (27 per cent overall) and a lower proportion severely impaired (25 per cent overall) than publicly-funded admissions (20 and 35 per cent respectively) ($p < 0.01$).

If we assume that self-funders can be maintained in the community to the same level of dependency as publicly-funded residents, then we can estimate the proportion of residents who need not have been admitted. Thus if we reduce the proportion in the lowest dependency group from 50 per cent to 34 per cent, the proportion of publicly-funded admissions falling in this category, 24 per cent of self-funders would not have been admitted, although this reduces to 21 per cent if we use the data weighted to reflect the national picture. While this could be due to a positive decision to enter a home for specific perceived benefits, the question is raised whether it is due to lack of access to adequate assessment and support.

Local authority role in the decision to enter a care home

The majority, just under 60 per cent of 314 residents for whom information was available, had seen a social worker or care manager prior to admission. A full assessment had been conducted in 54 per cent of cases. Out of the 171 people assessed, care managers had recommended admission to 158. In about half of the cases that were not assessed there was no evidence of contact with social services at all. Only in two instances did respondents report that social services had directly

refused to assess the older person. Of those that would have been eligible for local authority funding for the first three months, so would need to be assessed under the new arrangements, just 27 people, or 11 per cent of admissions, had not been assessed prior to admission.

People who had been admitted from hospital were much more likely to have been assessed as requiring admission than those who were admitted from their own home (64 per cent compared with 40 per cent, $p < 0.001$). There was no statistically significant difference in terms of the type of place to which people were admitted. Of 98 people admitted to a nursing bed, 58 per cent had been assessed by social services. Of 217 admitted to a residential bed, 52 per cent had been assessed. Those in the lowest dependency category shown in table 5 were slightly less likely to have been assessed as needing to be admitted than those at higher levels of dependency (46 per cent compared with 58 per cent), although this difference did not reach statistical significance.

The assessment role was not seen as necessarily part of the final decision. Only 30 per cent of respondents identified social services as being part of the decision to admit the older person to a home. In 9 per cent of cases social services were identified as the only party involved in the decision.

In just 13 cases (4 per cent of the sample, 8 per cent of those assessed) residents and relatives had not followed the social services' recommendation that the person should stay in their own home with services. Five were admitted to a nursing place and eight

to a residential place. Out of these 13 cases the older person was involved in the decision in ten instances.

Overall, just 15 per cent of the residents had made the decision to move into a home alone. The resident made the decision jointly with someone else in just over a quarter of cases, and in 58 per cent of cases someone other than the elderly person made the decision. This was primarily sons and daughters: in 44 per cent of all cases children of the older person were involved in the decision.

Support services

Table 7 shows the proportions of people receiving services by whether they were admitted to a residential or nursing place. In all, 21 per cent of older people for whom the information was available (318 people) did not receive any of the named services. Of those receiving services, the vast majority received them weekly or more often. Perhaps surprisingly, there was no relationship between receipt of services prior to admission and the probability of having received an assessment by social services.

Home care services, which provide personal care, are of particular importance in maintaining people at home. Less than half (46 per cent) of the sample was receiving local authority-organised home care. On average, these people were receiving eight hours per week, compared with 24 hours per week among the 21 per cent of cases receiving privately-organised care. The difference was largely due to a few cases that had a very high level of private care: two cases were full-time (168 hours per week)

and a further four received 70 or more hours per week. The maximum local authority-organised provision was 30 hours per week. However, it was clear that the difference was not just due to a few extreme cases: the median level of privately-funded care was eight hours per week, compared with six local authority-organised hours per week.

Twenty-five people, 19 per cent of those receiving local authority-organised services at least weekly, topped this up with privately-organised care at least weekly. In 19 cases they had organised additional home care on a daily basis. The average level of home care amongst all cases that received care from both sources was 32 hours per week. The average total amount of home care among all cases that received either or both local authority or privately-organised care was 14 hours per week.

This evidence tends to suggest that people were not satisfied with the level of home care organised by local authorities. This was supported by a number of comments made by respondents. Although relatives were not asked directly about their views on services, a number took the opportunity to express their views at the open-ended question at the end of the interview. A typical comment was:

> "I feel I needed more advice about what my father needed…no-one seemed at all interested".

Discussion

The study was concerned with a difficult-to-reach group of people. As a result, some of the sub-groups were quite small. Nevertheless the study gives us an insight into a particularly vulnerable population at a critical stage in their care careers.

The results confirm earlier work that suggested that self-funders tend to be admitted at lower levels of dependency than publicly-funded residents (Netten et al., 2001a). This could reflect preferences, with those who have control over their own resources choosing to be admitted to homes, a choice denied to those dependent on public funding. However, the weight of previous evidence suggests that people prefer to remain in their own homes if at all possible (Warburton, 1994). Very few people were admitted in the face of a local authority assessment that recommended they remain at home, and in even fewer cases was it clear that it was the older person's preference rather than relatives' concerns for their welfare. It is more likely that people are being admitted to homes unnecessarily through lack of access to alternative modes of care.

There is a very strong financial disincentive for self-funded residents to be admitted. The fees usually exceed their income, so they will need to draw on financial assets to meet the costs of living and care. These incentives clearly have an effect on decisions. Other work has identified how they were more likely to be living in lower cost residential homes than in nursing homes, than publicly-funded residents at a similar level of cognitive impairment (Netten et al., 2001b). It is possible that financial incentives explain the lower proportion of self-funders admitted to nursing

homes from hospital. Nevertheless, the evidence above suggests that nearly one in four self-funded residents are being admitted to care homes who need not be.

This raises the question whether we are observing the effect of the perverse incentive on local authorities to place those people who will fund their own care rather than support them in the community. There are two places at which we might observe this perverse incentive in action: at the point of decision to enter care, and access to service packages as an alternative to admission.

Our source of information about the decision-making process was the relative or carer of the older person. As a result, our sample is biased against those without an "advocate or representative to act on the individual's behalf" where local authorities are obliged to "make the arrangements and to contract for the person's care" (Department of Health, 1998, paragraph 10). However, Department of Health guidance is that, even if people are able to pay the full cost of any service or make their own arrangements, they should be advised about what type of care they require and informed about services available (Department of Health, 1998, paragraph 8). Wright (2002) identified that in 1999 it was still common practice for local authorities to deploy a number of tactics to avoid carrying out needs assessments of people with assets above the capital limit. In practice, only just over half of our sample received an assessment. Very few people were directly refused an assessment, although they could have been discouraged from asking. It is most likely that those people who were not in touch with social services were not aware that they could ask for an assessment if the older person was able to fund their own care. There was no evidence that the assessments themselves were biased towards admitting self-funders

at lower levels of dependency. However, there clearly is a group of people who are not receiving assessments who could have been supported in their own homes.

In terms of packages of care, self-funders were receiving less in the way of community care than their publicly-funded counterparts (Netten et al., 2002). Those who were assessed as needing to be admitted were no more likely to be receiving services, but from this study we cannot observe those over the capital limit who were assessed and provided with a community care package as an alternative to admission to a care home. However, as Wright (2000) also found in her smaller scale study of self-funders, the evidence suggests considerable dissatisfaction with the level of access to support provided in the community prior to admission.

It was argued above that more self-funders would be assessed as a result of policy changes that have happened since the time of the study. In total, 86 people, 30 per cent of the sample for which we had full information, would have been affected by the policy changes. The vast majority of these, 80, or 28 per cent of the sample, would have benefited from the three-month exclusion of the value of their home from entitlement to support, an entitlement that was not available at the time of the study. Nearly two-thirds of those that would have been affected by the policy changes were assessed by social services prior to admission. As a result, in England just 11 per cent more of self-funders would be assessed as a result of the three month exclusion.

However, the major policy impact will result from the changes to funding personal and nursing care. As a result of the new funding arrangements in Scotland all admissions would now be assessed, twice the number assessed in our study.

Moreover, the meeting of all personal care and nursing costs should ensure greater incentives to provide packages of care in the community rather than admit people to care homes. In England, however, only 13 per cent more of self-funded admissions would be assessed because of the funding of nursing care. Whether this assessment would facilitate access to services that might prevent admission is not at all clear. Moreover, these assessments will be targeted on those least likely to be diverted to community-based care.

In the introduction we suggested that, ideally, we want to move towards systems where information and incentives combine to maximise the production of welfare and minimise the use of resources in this process. The results suggest that, while current policies are moving us in the right direction, there are still important perverse incentives and evidence of lack of access affecting self-funders' decisions about long-term care.

Table 1: Household tenure and composition, by type of place occupied

Household tenure and composition	*Residential place*		*Nursing place*		*All places*	
	No.	*%*	*No.*	*%*	*No.*	*%*
Owner-occupier, living alone	350	58	125	39	475	52
Owner-occupier, living with others	100	17	87	27	187	20
Not owner-occupier	107	18	43	13	150	16
Information incomplete	32	5	52	16	84	9
Not applicable	10	2	15	5	25	3
Total number of residents	599	100	322	100	921	100

Table 2: Value of assets owned by resident

Value of assets	*Savings and investments*		*All Assets*	
	No.	*%*	*No.*	*%*
Less than £16,000	90	28	18	6
£16,000–20,000	35	11	10	3
£20,000–30,000	52	16	30	10
£30,000–40,000	24	8	18	6
£40,000–50,000	22	7	21	7
£50,000–100,000	53	17	95	31
£100,000 or more	40	13	113	37
Number of residents	316	100	305	100

Table 3: Average weekly income of resident from all sources, by type of place occupied

Average weekly income	*Residential place*		*Nursing place*		*All places*	
	No.	*%*	*No.*	*%*	*No.*	*%*
Less than £75	19	9	5	5	24	8
£75–99	23	11	11	11	34	11
£100–124	28	13	14	14	42	14
£125–149	24	11	9	9	33	11
£150–174	20	10	15	15	35	11
£175–199	16	8	5	5	21	7
£200–224	17	8	8	8	25	8
£225–249	12	6	5	5	17	6
£250–299	21	10	10	10	31	10
£300–349	10	5	5	5	15	5
£350–399	7	3	1	1	8	3
£400–499	5	2	6	6	11	4
£500 or more	8	4	5	5	13	4
Number of residents	210	100	99	100	309	100

Table 4: Source of admission, by type of place occupied

Source of admission	*Self-funded*			*Publicly-funded*		
	Residential	*Nursing*	*All*	*Residential*	*Nursing*	*All*
	%	*%*	*%*	*%*	*%*	*%*
Private household	52	44	49	46	20	34
Care home	7	5	7	11	16	13
Hospital	40	48	43	42	63	52
Other	1	2	2	1	2	1
Number of residents	599	322	921	1310	1123	2433

Table 5: Dependency characteristics, by type of place occupied

Dependency characteristics	*Self-funded*			*Publicly-funded*		
	Residential	*Nursing*	*All*	*Residential*	*Nursing*	*All*
	%	*%*	*%*	*%*	*%*	*%*
Self care (need assistance)						
Wash face and hands	18	58	31	34	67	49
Bath or wash all over	80	91	84	86	95	90
Dress	46	83	58	58	88	72
Feed self	4	38	16	11	38	23
Use WC	17	60	32	28	73	49
Transfer (bed/chair)	25	73	41	32	76	52
Continence						
Continent	60	35	52	53	24	40
Occasional accidents	24	23	24	32	30	31
Incontinent	16	42	25	15	46	29
Barthel Index (grouped)						
Low dependence (Score 13–20)	66	19	50	52	12	34
Moderate dep (Score 9–12)	18	18	18	28	19	24
Severe dep (Score 5–8)	11	26	16	15	32	23
Total dependence (Score 0–4)	4	37	15	4	37	19
Number of residents	261	135	396	1310	1124	2434

Table 6: Cognitive impairment and behavioural problems, by type of place occupied

Cognitive impairment/ behavioural problems	*Self-funded*			*Publicly-funded*		
	Residential	*Nursing*	*All*	*Residential*	*Nursing*	*All*
	%	*%*	*%*	*%*	*%*	*%*
MDS CPS categories						
Intact (0)	27	28	27	22	18	20
Mild impairment (1–3)	52	40	48	52	36	45
Severe impairment (4–6)	21	32	25	26	46	35
Frequency of problem behaviour						
Never/very unusual	70	70	70	67	65	66
Sometimes (>weekly)	12	16	14	21	20	20
Frequently (daily)	18	14	17	13	16	14
Number of residents	261	136	397	1261	1025	2286

Table 7: Proportion of people receiving services, by type of place occupied

Services	*Residential place*	*Nursing place*	*All places*
	%	*%*	*%*
Local authority-organised home care	45	47	46
Privately-organised home care	20	24	21
Any type of home care	55	56	55
Domestic help	37	41	38
NHS nursing care	15	33	21
Day hospital	8	8	8
Day centre	18	11	16
Meals on wheels	24	24	24
Number of residents	217	99	316

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