Valuing Informal Adultcare in the UK

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Abstract

This article reports on the measurement and valuation of informal adult care. Informal adult care is an output of household production – the unpaid goods and services produced by households for themselves. Household production includes any non-formal care of those aged over 16, this could include care given by household members, relatives or neighbours. This article looks at those being cared for (the number of adults looked after, differentiated by the type and frequency of the care that they receive), rather than the carers. It is the second in a series of articles to update the full Household Satellite Account (HHSA) for the UK. The methodology remains under development and any estimates reported here, or in forthcoming publications, should be considered experimental and interpreted with caution.

Key Points

• The number of adults receiving informal care in the UK remained broadly stable between 2000 and 2010 at just over 2 million people
• The total number of hours of informal adult care received increased by 2.4 billion hours between 1995 and 2010
• Between 2000 and 2010, the number of adults receiving informal continuous care has grown, while those receiving less frequent care has fallen
• In 2010 the value of informal adult care in the UK was £61.7 billion, this is equivalent to 4.2% of GDP
• The total value of informal adult care in the UK has almost tripled in 15 years, from £21.5 billion in 1995 to £61.7 billion in 2010

Introduction to the Household Satellite Account (HHSA)

In 2002 the Office for National Statistics (ONS) published the first Household Satellite Account (HHSA) for the UK, which measured and valued the unpaid goods and services produced by households (ONS, 2002; Holloway, Short & Tamplin, 2002).

Following the publication of the Report by the Commission for the Measurement of Economic Performance and Social Progress (2009), there has been fresh interest in valuing household production. As such, as part of the Measuring National Well-being programme, ONS is currently updating the HHSA which measures household production in the UK. The value of informal adult care is the second of the eight HHSA modules to be updated.
Household production is all unpaid goods and services produced by households in the UK. Conventional National Accounts measurements, such as GDP, do not fully take into account these goods and services. However, if these goods and services are paid for they are included as part of the National Accounts. For example, if I were to iron my own clothes this service would not be included, however if I were to pay someone to do it for me it would.

The HHSA provides a means by which the influence of changing patterns of unpaid work on the economy can be measured. The information will also be of use to policy makers who need to take significant amounts of unpaid work into account.

This work falls outside the scope of the UK National Accounts. This is because the inclusion of all activity which is productive (in the economic sense) but which does not have a monetary value would swamp the monetary flows, obscure what is happening in the markets, and reduce the usefulness of National Accounts data for analysis. HHSA is therefore separate from, but conceptually consistent with, the UK National Accounts.

The HHSA extends the National Accounts boundary to include all activity that could be delegated to another person. This activity is divided into several principal functions; providing housing, transport, nutrition, clothing, laundry services, adult care, child care and voluntary work. The approach being taken by the ONS is to focus on the outputs of these principal functions.

The methodology remains under development and any estimates reported here, or in forthcoming publications, should be considered experimental and interpreted with caution. ONS welcomes comments and feedback on all aspects of the methodology used and the assumptions made, and seek suggestions for further/alternative data sources. A more detailed description of the methodology can be found in the appendices of this article.

**What is informal adult care?**

As most of the adult care carried out by household members or their networks (family members or neighbours) could be delegated to another person, it is deemed to be part of the productive role of households.

Informal adult care is defined in the HHSA as any help received either from members of one's own household, or from members of other households. We shall refer to this group as informal carers. The HHSA does not aim to measure the help provided by members of voluntary organisations, as this will be recorded separately in our estimates households' voluntary activity.

The output of adult care is therefore the number of adults (individuals aged 16 and over) receiving informal care in the UK. There must be some adjustment for the amount, quality and regularity of the care given for it to be relevant to the HHSA. The type of care varies from specialised care, such as lifting or changing dressings, to "keeping an eye" on someone or doing their shopping. The amount of care received also varies from a visit once a week to continuous care. As the cost of providing 24 hour nursing care for an elderly person is very different from the cost of providing a meal once a day or doing the shopping for an elderly neighbour once a week, it is clear why the data needs to be sufficiently adjusted to enable valuation using the market rate of an equivalent service. A full account of the methodology can be found in the appendices of this article.
The output of informal care is therefore the number of adults looked after, differentiated by the type and frequency of the informal care that they receive.

Notes

1. In the HHSA voluntary activity is defined as unpaid work undertaken for or on behalf of an organisation or group which benefits other people or the environment

People receiving informal adult care

The number of adults receiving informal care in the UK has remained relatively stable since 2000 at around 2 million, following a period of growth between 1995 and 2000 (Chart 1). In spite of this the total number of hours of informal care received has increased, and was up by 2.4 billion hours in 2010 when compared with 1995.

Chart 1: Total number of adults and hours 1995-2010

United Kingdom

The divergence between the growth in the number of adults receiving care and the number of hours they receive can be explained by changes in the frequency of care over the period. Chart 2 shows
the growth in the number of people receiving informal continuous care relative to non-continuous care. Continuous care is classified in this case as full-time care given by a household member.

Chart 2: Number of adults receiving care by frequency
United Kingdom

Between 1995 and 2010, the number of adults receiving informal continuous care has grown by 252,000. In comparison, the number of adults receiving non-continuous care increased between 1995 and 2000, but has since fallen from 1.6 million to 1.4 million. Chart 2 shows that despite this fall the number of adults receiving non-continuous care is much higher than those in need of continuous care.

This has resulted in a change in the proportion of informal adult care which can be attributed to each frequency between 2000 and 2010 (Chart 3). In line with the trend in Chart 2, continuous care accounts for a greater proportion of total care in 2010 than 2000. None of the other frequencies have seen a rise in their share of total care. In 2000 approximately 1 in 4 people that were receiving care were being looked after continuously (27%), a similar proportion to those receiving care several times a week. In 2010, the number of people receiving continuous care had increased to approximately 1 in 3 (35%). That increase is equivalent to over a billion hours of informal care.
Chart 3: Proportion of people receiving care by frequency - 2000 and 2010

United Kingdom

2000
- Once a week: 11%
- Several times a week: 19%
- Once or twice a day: 18%
- Several times a day: 25%
- Continuous: 27%

2010
- Once a week: 8%
- Several times a week: 16%
- Once or twice a day: 16%
- Several times a day: 25%
- Continuous: 35%


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This change in the proportions could be as a result of either relatively stronger growth in continuous care or a decline in demand for the other frequencies of care. Therefore it is important to look at the number of people being looked after by the frequency. Chart 4 shows that the growth in continuous care is supported by movement away from less frequent care - the number of people receiving less frequent care has decreased, rather than just experiencing low growth in comparison to continuous care.
The UK population has grown over the decade and in 2010 was 6% bigger than in 2000. As the UK population has increased, the proportion of the adults receiving care has gone down. Chart 5 shows how the number adults receiving informal care has changed, and 2010 stood at 4.4% of the adult population. However the chart also shows that even though the number of adults has increased, the proportion of UK adults receiving continuous care has gone up.
Those receiving informal care by age

The population of the UK is ageing: the number of adults has grown relative to the population as a whole and four in every five people in the UK are now adults. This can be seen in Chart 6 as the population share of the older three age groups increases over the period.
An aging population is likely to have an impact on adult care, as those who are over 70 years old make up just under half of all of those receiving informal adult care in the UK (Chart 7). It is not surprising that the over 70s receive the most care, however it is interesting to see that the same group’s share of care has not increased as their share of the population has increased.
Chart 7: Adults receiving care by age group - 1995-2010

United Kingdom


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Chart 8 shows the split between continuous and non-continuous care, for all four age groups, between 1995 and 2010. The resulting chart shows that as the age of the group increases, the share of their care that is non-continuous also increases.

In 1995 approximately two in three people receiving care between the ages of 16 and 29 needed continuous care. This has fallen to just over half in 2010. In comparison, the proportion of those in the over 70s age group that receive continuous care has risen.
Hours of informal care

Having considered the number of people receiving care, we will now turn to look at the number of hours of care that are received. The total number of hours of informal care received has increased and, as shown by Chart 1, was up by 2.4 billion hours in 2010 when compared with 1995.

As continuous care counts for 168 hours per week (24 hours a day multiplied by 7 days), movements in the number of people receiving continuous care can have huge effects on the number of hours of informal care received. This is clear in Chart 9, which shows the proportion of total care hours that can be attributed to each frequency. Continuous care makes up 89% of total hours of informal care in the UK in 2010.
Chart 9: Total hours of care by frequency - 2010

United Kingdom


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Chart 10 shows the total number of hours of care received by adults in the UK split into non-continuous and continuous care from 1995 to 2010. This split shows that the change in total hours has followed the rise in continuous care hours. Non-continuous care hours have remained low in comparison, at just under 1 billion hours for the whole period. It is clear that continuous care has seen the most change over the period and that this change has had the greatest affect on total care.
Chart 10: Total hours of care by frequency - 1995-2010

United Kingdom


Download chart

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Notes

1. HHSA assumes that any household member caring for an adult 112 hours a week is also passively caring for that adult, so the hours are made up to 168. See methodology section for further details.

Value of informal adult care

We value informal adult hours using the wage rate for an equivalent service – how much it would cost if you had to employ someone else to do it for you. This differs between personal and practical care, and the frequency of care. For a full explanation of the valuation method used, please see the methodology section of the paper.

In 1995 the total value of UK adult care was £21.5 billion, or equivalent to 2.9% of GDP. This has almost tripled over 15 years: taking the value to £61.7 billion or the equivalent of 4.2% of GDP.
Chart 11 shows growth in both the hours and the value of informal adult care from 1995 to 2010. Both hours and the value follow an upward trend over the 15 years, however the total value of UK adult care has grown at a faster rate than total hours.

**Chart 11: Total hours received and valuation of informal adult care - 1995-2010**

United Kingdom

This indicates that while the growth in the value of UK adult care can be partially attributed to the increase in hours, it is also as a result of increases in the cost of UK adult care over the period.

**Annex 1: Methodology**

The main data source used for the estimation of informal adult care is the Family Resource Survey (FRS) (commissioned by the Department for Work and Pensions, DWP) which collects information on the number of adults receiving care and whether this care is on a weekly, daily or continuous basis. The FRS is currently the best data source available for the estimation of the household production of adult care, but is known to underestimate the number of adults receiving care.

The FRS defines adults as the members of the population who are over 16 years of age and care as all help or assistance given to others because of physical or mental need. It ranges from odd jobs
e.g. helping an elderly neighbour/relative with shopping or gardening, to full-time nursing care of the sick, disabled or elderly.

The questions provide information on the number of adults receiving help and give the respondent’s perception of the help received. This perception may include active care (direct interaction or supervision) or passive care (i.e. available on call if needed).

The total number of adults receiving help includes those who are helped by people working for organisations, e.g. visiting social workers, nurses, specialist teachers and volunteers. For simplicity, we will refer to this group as formal carers. For HHSA purposes, we exclude any episodes of care which are provided by formal carers. For this reason our estimates will differ from those published in the FRS report, which give an overall valuation of care.

We can also identify the number of cases where an adult is helped exclusively formally or informally. In the cases were there is only informal care, people tend to be helped by spouses, their children, neighbours, friends and other relatives. These cases are valued by our estimates, whereas the cases that are exclusively formal care are not.

However, there are cases where an adult receives both formal and informal care. In some cases an adult is being cared for by an outside helper and the informal carer is supplementing this help, e.g. an adult may be attending a day care home for the majority of the day and receive informal help from a neighbour when they get home. In other cases an adult could be predominantly cared for by a household member, but could receive more specialised care, such as changing a dressing etc, from an outside helper. For the HHSA it is important that we include all adults who are helped by an informal carer, even if they are also receiving help from a formal care provider. In order to include these cases, we need to adjust the type and length of the help received. This will enable estimation the help from informal carers only.

**Frequency of help received**

For valuation purposes we need to differentiate between continuous and less frequent episodes of care, as these are associated with different market rates. Using the FRS, we have some information on how often the adult receives help. The frequencies are broken down into the following categories:

1. Continuously
2. Several times a day
3. Several times a week
4. Once or twice a week
5. Once a week

However, this is dependent on the respondent’s perception of what constitutes each frequency type.

The equivalent market price of informal care is based on an hourly rate rather than on an episode of care or an independent measure of the output, e.g. bathing an elderly person. Therefore we have had to make an assumption about the approximate the number of hours in each episode of care.

**Estimating the number of hours in each frequency type**
To estimate the number of hours that correspond to each frequency, we examined the cases where an adult is helped by informal carers only. When we examined the hours of help given and the frequency of help received, there was a considerable range in the total number of hours helped and the frequency type. This suggests a difference in respondents’ perception of frequency. This can be accounted for by the fact that frequencies are undefined and that no distinction is made in the question between active and passive care. The modal number of hours was used to approximate the number of hours, which correspond to each frequency. Sensitivity tests have been calculated to see the effect of using the mean number of hours for each frequency. The discrepancy between reported care given and care received is not ideal for creating relevant and reliable estimates. Our experimental statistics are attempting to create estimates to gauge the magnitude of the value of informal adult care.

Measuring passive care

In the HHSA we define productive activity as anything that could be delegated to another person - the “third party criterion” developed by Margaret Reid (1934). The important point is that if no unpaid carer were available, someone would have to be paid to take his or her place. We should therefore measure passive as well as active care wherever possible. This could just be keeping an eye on an elderly parent, or being available to help during the night.

In the FRS, an adult has the option of reporting that they receive continuous care. We assume this is 168 hours per week: 24 hours a day multiplied by 7 days.

There are cases where an adult reports that they need continuous help (active plus passive care), but the total number of hours of help given by informal carers is only a few hours a week (active care only). Similarly, there are cases where a helper reports giving care 168 hours a week (active and passive care), yet the frequency of help received is reported as several times a week (active care only).

In order to include passive care, whether it is reported or not, we have re-coded the frequency of help received. This now includes not only those cases where the recipient records a need for continuous care, but also those cases where at least one household member gives more than 112 hours a week (or 100 hours a week in the later years of the estimates due to changes in the FRS questionnaire). Our underlying assumption is that, if a household member is caring for an adult 16 hours a day (the average waking day), 7 days a week (112 hours) then they are also likely to be caring for the adult at night - even if this is passive care. This is not the case when the informal carer is not a member of the same household as the adult receiving care, in which case they must be giving 168 hours of care for it to be considered continuous.

Reclassify the frequency of help received by those adults who have both formal and informal carers

All formal care needs to be excluded, whether provided by paid carers or by volunteers working on behalf of an organisation. We have information on the total number of hours of help given by just formal carers or informal carers and can exclude the number of hours given formally. We can use this estimate of informal hours of help given as a proxy for the frequency of help received. By using our earlier assumption about the number of hours which correspond to each frequency, we can then reclassify the frequency of help received.
There are limitations in this approach, as the number of hours of help given will not always correspond to the frequency of help received. This could be due to different perceptions of what constitutes care (passive or active), different perceptions of what constitutes each frequency type, two or more carers helping simultaneously or reporting errors in the survey itself. However, to reclassify this help an assumption has to be made about the relationship of the frequency of help received to the hours of help given.

In order to inform this assumption, we examined the cases where adults receive help only from informal carers and compared the total number of hours given by those carers with the reported frequency of help received. We calculated an average of the modal values of hours given corresponding to each frequency category. We used this in order to re-categorise the frequency of help received once formal care hours were excluded. As before, an adult is considered to be receiving continuous help only if 112 hours or more are given by one household member.

Examples of this reclassification follow. An adult may report they receive continuous help and a total of 168 hours of help are given. This could be provided equally by a volunteer and a relative. By removing the hours of help given by the volunteer, the total number of hours given by the relative is reduced to 84. This corresponds with the several times a day category, and so the frequency of help received is re-categorised. Similarly an adult could report they receive continuous help and a total of 132 hours are given. This could be provided by a spouse who gives 112 hours and a relative who gives 20 hours a week. Because one household member is giving 112 hours we assume that this person is receiving continuous care.

Other cases also need to be re-categorised. For example, an adult could receive 10 hours of help and report that the frequency of help is several times a week. If 8 of these 10 hours of help are provided by a district nurse, then we would re-categorise the frequency to once a week, as only 2 hours of help are being provided by an informal carer.

There are many cases where the number of hours given do not correspond to the frequency of help the person reports they receive. Only in the cases of re-categorising help received from both formal and informal carers do we use the number of hours giving help, rather than the reported frequency of help received.

**Type of help received**

For non-continuous care (several times a day, once or twice a day, several times a week, and once a week) it is important to distinguish between the types of help received, so that we can value the care at different appropriate market prices. Respondents are asked "what kind of things does [X] usually receive help with?", the responses include "getting into and out of bed" (physical help), "keeping an eye on them" (other physical help), and "giving medicines" (other personal help). Respondents are given a show card to help prompt their answers, and can respond with one or more of the following:

- Help with personal care e.g. dressing, bathing, washing, shaving, feeding, using the toilet
- Physical help e.g. walking, getting up and down the stairs getting into and out of bed
- Other sorts of personal help e.g. preparing meals, giving medicines change dressings
- Help with paperwork or financial matters e.g. writing letters dealing with bills handling money, banking filling in forms
• Other practical help e.g. shopping, laundry, housework, gardening, doing odd-jobs, taking out for a walk, keeping an eye on him/her

Due to small sample sizes in each category, we have reclassified this help into three categories:

• personal help (help with personal care, other sorts of personal help),
• practical help (physical help, help with paper work or financial matters and other practical help)
• both personal and practical help

Reclassifying the type of help received by those adults who have both formal and informal carers

Analysis shows formal and informal carers give different types of help. When adults are helped by informal carers only, approximately 60% receive both personal and practical help. In contrast, in cases where adults are helped by formal carers only, approximately 60% receive help with personal tasks only and only 30% with both personal and practical tasks. The proportion receiving help with practical tasks is similar in both cases. This seems to suggest that formal carers help more often with only one specific type of task, while informal carers provide are more likely to help with a range of activities.

The majority of adults who receive help from both formal and informal carers also are helped with both practical and personal tasks. However, it is hard to come to any conclusion about whether these adults use formal carers to support the help given by household members (e.g. an extra pair of hands to lift, bath etc.) or to provide additional, more specialised help. In cases where we have excluded the help by formal carers, adjustments have been made to the number of hours received using the gender of the individual and the frequency of care.

Grossing to the UK population

Data was not available on a UK basis before the end of 2002. Therefore we needed to gross the data for England, Scotland and Wales to account for Northern Ireland as well. A UK total allows the estimates to be consistent with the rest of the HHSA. Post 2002, the FRS includes Northern Ireland and therefore no grossing has been necessary.

Valuation

In order to value informal care, we need to use the cost of the nearest equivalent service provided by the market. As already noted it is important to try and encapsulate the different types of help received, taking into account how often the care is received and the type of care given.

Non-continuous personal care includes help with dressing, bathing, changing dressings and feeding. We have chosen the average wage of an assistant nurse or nursing auxiliary as the most appropriate market rate for valuing this care, as they would usually provide this type of specialised care outside the home.

For non-continuous practical care we have used the hourly rate of care assistants and attendants in health and related occupations. The wage rates used are median hourly wages from the Annual
Survey of Hours and Earnings. Data from this survey is not available for 1995 and 1996, so these figures have been imputed.

In 2002, the valuation of continuous care was estimated using the residential care weekly fee from the Care of Elderly People Market Survey 2001, conducted by Laing and Buisson. Given the experimental nature of the HHSA estimates published in 2002, the process of consultation remained ongoing. Following publication of the estimates, the use of this valuation approach for continuous care was reconsidered. Using the cost of a nursing home as a market equivalent ignores the economies of scale in a nursing home, which result in it not being a market equivalent to informal care at home. (Hirst, 2002). In these estimates we have therefore used the same valuation technique as practical care, but for all 168 hours. This is considered to be a more appropriate market equivalent.

This has an impact on the magnitude of the value of informal care, and therefore we have conducted sensitivity analysis to show the difference.

**Data Sources**

**Family Resources Survey**

The FRS is a continuous survey that consults households in the UK using a stratified multi-stage probability sample. The questions and answers that we are interested in appear in the care module:

1. In some households, there are people who receive help or being looked after, for example because they are sick, disabled or elderly. Is there anyone in this household who receives any of these kinds of help or looking after? This could be from outside or anyone who lives here.  
   Yes / No

2. How frequently does (X) receive such help?  
   1 - Continuously  
   2 - Several times a day  
   3 - Once or twice a day  
   4 - Several times a week  
   5 - Once a week  
   6 - Less frequently

3. Who looks after, or provides help for (X)? Anyone else?  
   14 - Named person  
   15 - Relative  
   16 - Friend  
   17 - Helpers
4. About how many hours a week, on average does (name of helper) spend actually providing help for or looking after (X)?

Number of hours given.

5. What kind of things does (X) usually receive help with?
1. Personal care (dressing, bathing, washing, shaving, feeding, using the toilet)
2. Physical care (walking, getting into and out of bed, and getting up and down stairs)
3. Other sorts of personal care (preparing meals, giving medicines, changing dressings)
4. Help with paper works or financial matters (writing letters, dealing with bills, handling money, and banking)
5. Other practical help (shopping, laundry, housework, gardening, doing odd jobs, taking out for walks, visiting, talking to, keeping an eye on)

‘Care of the Elderly: People Market Survey’

This is a postal survey 42 of all for-profit homes with 4 or more places in the UK. The homes were asked to give their minimum and maximum single and sharing fees for nursing and residential care. The average was calculated as the mean of the minimum and maximum fees, weighted by bed numbers. The response rate for 2000 was 24% of all for-profit homes. The residential rate was chosen because the services provided by a residential home involve daily help with personal and practical care, as well as being on call.

Annual Survey of Hours and Earnings

The Annual Survey of Hours and Earnings replaced the New Earnings Survey in 2004, and back dated the series using the new methodology to 1997. The Annual Survey of Hours and Earnings (ASHE) provides information about the levels, distribution and make-up of earnings and hours worked for employees in all industries and occupations. ASHE is based on a one per cent sample of employee jobs taken from HM Revenue & Customs (HMRC) PAYE records.

Annex 2: Sensitivity Analysis

The estimates of adult care are subject to a number of assumptions. This section of the article considers some alternatives to the assumptions made, and the resulting changes on the value of adult care.

Estimating the number of hours in each frequency type

As discussed in the methodology, the frequency of care that individuals receive is recategorised and then the modal number of hours for each frequency is applied to estimate the number of hours of informal care. Sensitivity tests have been calculated to see the effect of using the mean number of hours for each frequency (see table 1).
Table 1: Sensitivity to hours assumption

United Kingdom

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Table source: Office for National Statistics

Download table

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This sensitivity analysis shows that using the mean reported hours rather than the modal reported hours results in a higher value of adult care for the UK in all years between 1995 and 2010. The extent of this difference varies from year-to-year, in 2000 using mean hours gave an estimate that was 11.6% higher.

Valuation

In the 2002 estimates, weekly residential home fees were used to value continuous care. After methodological consultation, the HHSA now uses the hourly wage of a care assistant, or home carer, to value the 168 hour week. Included below are the estimations for the value of informal adult
care using the weekly cost of residential care. For this we use the average of all weekly residential care.

Table 2: Sensitivity to valuation approach

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<td>32,534</td>
</tr>
<tr>
<td>2007</td>
<td>33,966</td>
</tr>
<tr>
<td>2008</td>
<td>43,243</td>
</tr>
<tr>
<td>2009</td>
<td>45,615</td>
</tr>
<tr>
<td>2010</td>
<td>47,467</td>
</tr>
</tbody>
</table>

Table source: Office for National Statistics

Download table

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The hourly wage of a care assistant has been included as the value of continuous care as it is deemed as the most appropriate alternative to home care. Residential care, although full-time, has many economies of scale that enable the providers to offer it a cheaper rate than it would be on an individual level. As a result, this has not been chosen as the market alternative rate used for valuation.
Notes

1. Average weekly residential care data are provided by the National Health Service.

About the ONS Measuring National Well-being Programme

National well-being

This article is published as part of the ONS Measuring National Well-being Programme.

The programme aims to produce accepted and trusted measures of the well-being of the nation - how the UK as a whole is doing.

Measuring National Well-being is about looking at 'GDP and beyond'. It includes headline indicators in areas such as health, relationships, job satisfaction, economic security, education, environmental conditions and measures of 'subjective well-being' (individuals' assessment of their own well-being). Find out more on the Measuring National Well-being website pages.

Background notes

1. Revisions

   The data in 2002 HHSA (1995 -2000) have undergone some revisions. These revisions come from:

   • The use of a more recent estimate of the grossing factor from the Family Resources Survey, which grosses up the sample to represent the whole population. This has changed to reflect the availability of more recent and accurate population estimates.
   • Methodological improvements in the valuation of adult care.

   Although these revisions make subtle changes to each individual year, the long term trend implied by the data remains the same.
2. Details of the policy governing the release of new data are available by visiting www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html or from the Media Relations Office email: media.relations@ons.gsi.gov.uk

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This document is also available on our website at www.ons.gov.uk.

Supporting Information

Further information

About the Household Satellite Account
The purpose and intended uses of the HSSA.

Household Satellite Accounts
The value of unpaid childcare in the UK in 2010 was £343 billion, equivalent to 23% of GDP. There has been an increasing preference for paid childcare since 1995.

References


