Social Care for Older People: A Sustainable Future

16 November 2018, at the Scottish Parliament

Event report by Scotland's Futures Forum

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Welcome and introduction

Lewis Macdonald MSP, Convener of the Health and Sport Committee

Lewis Macdonald MSP welcomed participants to the seminar, which he described as tackling one of the major issues facing Scotland.

With an ageing population, challenges in public finances and changes in aspirations and expectations for our later years, the future of social care in Scotland is a critical question for the Scottish Parliament and people throughout Scotland.

The event involved three presentations, a workshop session on potential scenarios for the future, and feedback. This report captures the main points arising in each section.

Social care for older people: future challenges

Professor Carol Jagger, Newcastle University

Professor Jagger's presentation concentrated on predicted levels of dependency among the population and the predicted care needs that they would bring. Her work focuses on England, and although there may be some slight differences between the two countries in terms of baseline population characteristics, the picture is likely to be much the same in Scotland.

More information on the work Professor Jagger referred to can be found on the MODEM website.

Future levels of dependency

Professor Jagger's measure of dependency includes the activities of daily living with which a person needs help, severe cognitive impairment, and incontinence, and is based on the interval of need which reflects the time between periods when an individual needs help.

Dependency is categorised as follows:

High Dependency Person requires 24-hour care	Person is bedbound or chair-bound; is unable to get to or use the toilet without help; needs help feeding; is often incontinent and needs help dressing; or has severe cognitive impairment.
Medium Dependency Person requires help at regular times every day	Person needs help preparing a meal, dressing or taking medication.
Low Dependency Person requires help less often than daily	Person needs help to wash all over or bath, to cut toenails, to shop, or to do light or heavy housework.
Independent Person is deemed to require no help	Person does not require help with any of the above activities (although they may still have difficulty).

Professor Jagger then shared the forecasts of future numbers of dependent older people:

There will be an increase in the number of people aged 65 and over at all levels of dependency, including independent, but the numbers requiring 24-hour care will rise by about a third by 2035.

The number of those aged 85 and over (the fastest-growing section of the population) who will require 24-hour care will almost double.

The time that people spend in each dependency state is also worth noting:

A man aged 65 in 2035 will live 3.5 years longer than a man aged 65 in 2015 and, of that lifespan, four more years will be independent. That means that, on average, men will spend less time in medium or high dependency in the future.

However, women, who already live longer than men, will see smaller increases in life expectancy, and most of those extra years will be with low dependency. Furthermore, a woman aged 65 in 2035 will live for one more year in high dependency than a woman aged 65 in 2015.

Effect of dementia

Professor Jagger referred to the effect of dementia, noting that, of all people aged 65 and over who have substantial (medium or high) dependency, about a third have dementia. By 2035, there will be a 200% increase in the number of over 65s who have both substantial dependency, dementia and two and more diseases, and an increase in the number of those who also have four or more diseases.

Care needs will therefore be much more complex, which has implications for carers – both family and professional – and their training and support.

Who cares for older people?

Professor Jagger referred to a study of nearly 1,000 85-year-olds in 2006. For all levels of dependency, the predominant carer – the person who helped with the activities – was a child. The child was generally female, as women do most of the caring, and these women would have been around 60 years old – the women whose state pension age is increasing and who therefore are having to work longer. As care needs will be more complex, Professor Jagger pointed out that there be implications for people who remain in the workforce and become carers.

Future challenges

Professor Jagger summarised the future challenges:

- The numbers of older people requiring substantial care (daily or 24-hour care) will increase – particularly driven by the growth in those aged 85+
- Increasing life expectancy will mean more years from age 65 are spent requiring care - at least for women
- Care will be more complex as prevalence of (and numbers of people with) four or more diseases increases. This will require more training for family carers and the care workforce
- Care breaks and flexible working will be necessary for those carers also in employment

Finally, Professor Jagger emphasised that the current crisis will not go away: it needs long-term cross-party and cross-society planning.

Social Care for Older People – Future Funding

Professor David Bell, University of Stirling

Professor Bell provided a brief history of long-term care policy in Scotland, noting the 2001 work of the Care Development Group, the introduction in 2002 of Free Personal Care and the Sutherland Review in 2008. However, he stated, not much has been done since then to look at the overall funding of care.

English ideas

Professor Bell referred to previous reviews in England, including the Barker Commission, which suggested making social care free at the point of use for those with "critical" needs, extending to those with substantial needs as the economy improved and to those with moderate needs by 2025.

The Commission also floated four different ways of funding these changes:

- remove exemptions for prescription charges, while making them cheaper;
- restructure National Insurance to collect more from those aged over 40 and high earners;
- increase contributions from older people such as by limiting winter fuel payments to those on low incomes; and
- review wealth and property taxes

What do we mean by fairness?

Professor Bell suggested that decisions on funding come down to what we mean by "fairness" in the context of long-term care, and he pointed to these areas for consideration.

- Condition: is it fair that there is free care for people with cancer but not for people with dementia?
- Income: what share of cost should be borne by low or high-income households and families? Does the prospect of high care costs cause a disincentive to save?
- Wealth: should we use wealth rather than income when considering ability to pay?
- Place: how far should local communities be able to set their own levels of long-term care support?
- Generational: will subsidies to care for the baby boomers adversely affect following generations?

Spatial equality in Scotland

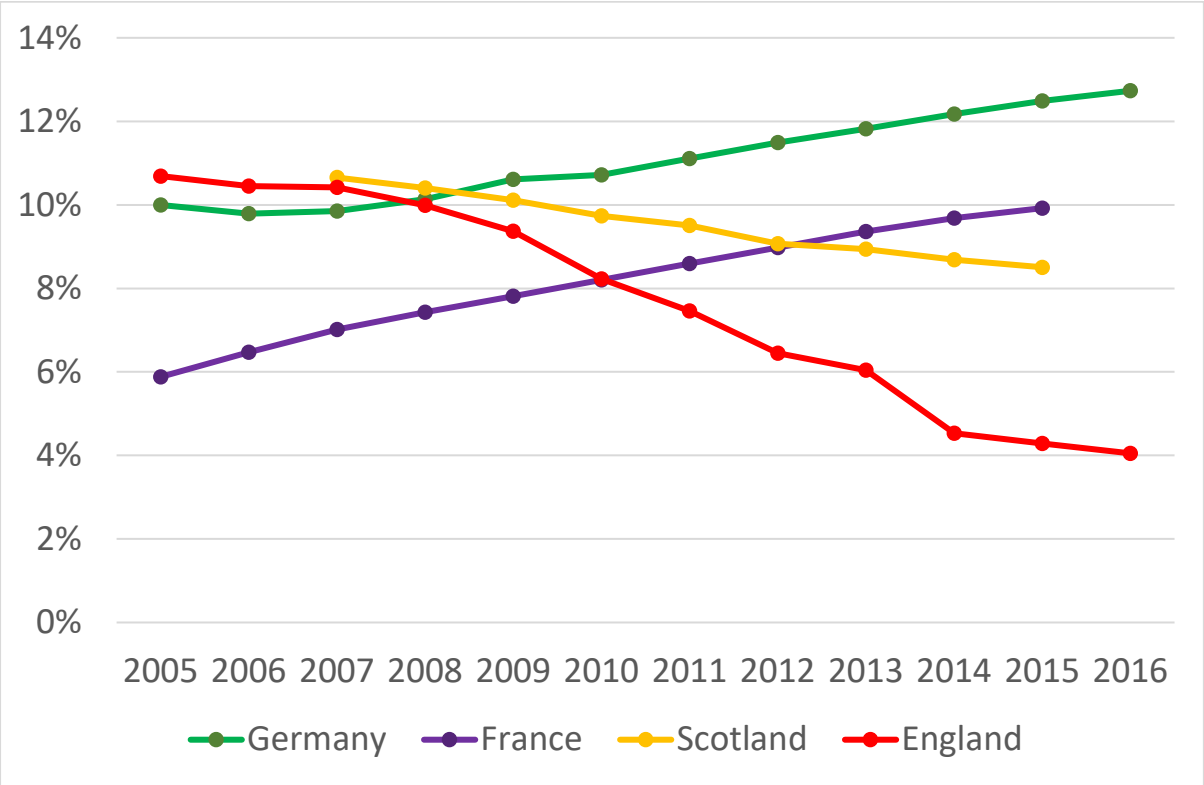
Professor Bell took one of the questions – that of space – and examined the proportion of people aged 65 and over who are receiving free care across Scottish local authorities. He noted a large variation, from 3.5% in Highland Council area to almost 8% in Inverclyde and Dundee.

Professor Bell and colleagues had tried to explain this variation in many ways, including by examining the proportion of people in receipt of Attendance Allowance, but the patterns do not align. There is, he said, something that we cannot explain in the provision of free personal care across Scotland in local authorities.

International comparisons

Professor Bell showed the following graph, which outlines the proportion of older people supported by the national long-term care system in England, Scotland,

Germany and France. He suggested that the policy of austerity has seen the levels of people supported decrease in England, leading to a real crisis south of the border.



Long-term care demand and supply

Using population projections from the National Records of Scotland, the Social Care Census and Care Home Census from Information Services Division Scotland, the Scottish Social Services Workforce Data from the Scottish Social Services Council, and levels of dementia prevalence and the costs of dementia care from the Alzheimer's Society, Professor Bell and his colleagues had produced a macro model of demand for long-term care and the resource requirements in Scotland.

The findings included:

Age group growth

For every 100 people aged 80 or over in 2016, there will be about 185 in 2041 in Scotland. The numbers of those between 65 and 79 will increase and then see a slight decrease, while the number of those aged 0 to 64 will stay roughly the same.

There are regional variations: in Glasgow, for every 100 people aged 80 or over in 2016, in 2036 there will be about 130; in West Lothian and Clackmannanshire, there will be 180.

Care home growth

Assuming the same proportion of the population stay in care homes, the growth in the number of self-funded care home places will be from 10,000 to 16,000. As background, we have not seen such a big increase in recent years, due to the policy of shifting the balance of care and challenges to the profitability of care homes.

There are again regional variations, largely driven by population changes, with East and West Lothian seeing the biggest proportional increase.

Costs of dementia

Professor Bell set out predicted costs for both residential and home care of dementia in 2021 and 2036, assuming similar prevalence levels apply. Breaking down the costs into health care, social care, unpaid care and other, he noted that, for residential care, the main costs are social care costs and, for home care, the main costs are to the unpaid carers themselves.

Conclusion

Professor Bell shared the following conclusions:

- Free personal care has served Scotland well, but there is still a debate to be had about whether it is fair.
- Free personal care was also introduced prior to the ageing of the baby boomers: much greater challenges lie ahead, particularly in respect of dementia.
- These challenges can be met only with a co-ordinated response from the public, private and voluntary sectors.
- Despite having excellent data and a separate healthcare system, Scotland does not have the same level of research and evidence to support policy making that has been collected in England.

Social Care for Older People: Future Commissioning

Dee Fraser, Deputy Director, Coalition for Care and Support Providers in Scotland

Ms Fraser opened by noting that, although there is a lot of talk about demand and the drain on public services, the value of the care sector to the economy has been judged to be £3.4 billion. She stated that, while she would not deny that there is crisis, we have to remember that the care sector is a big employer and an economic driver for Scotland.

Context

As context, Ms Fraser noted that 80% of social care is delivered by non-statutory partners in the voluntary and private sectors, with 69% of social care workers in those sectors. The fact that the majority of work is done under contract rather than directly by public authorities is the reason why commissioning is so important.

Not a market

Although we talk about a market for social care, Ms Fraser noted that we really have a monopsony, where there are lots of providers but only one purchaser. In such a situation, the purchaser has a lot of control, over price for example, but the long-term effect can be toxic. Providers unable to meet the requirements drop out, leaving only one large provider, and a monopoly emerges.

Given that situation, and the fact that the opportunities under self-directed support are not being used by much of older population, Ms Fraser suggested that we end up with an overly bureaucratic system that provides decreased availability and choice of care.

A new mindset

In response, Ms Fraser called for a new commissioning mindset. Rather than let commissioning be led by finance, purchasing and practice of procurement, we should fit services around people and consider the whole system rather than just the parts.

With that in mind, Ms Fraser suggested five areas to consider for the future.

1: Pay attention to effects

Ms Fraser provided an example from a local authority in Scotland – although simplified, it showed how reaching a quick fix can cause more problems.

Social care expenditure was increasing, so the authority's reaction was to re-tender with a lower, capped hourly rate. Providers withdrew as the rate was not financially viable, meaning that the external providers market reduced. The statutory duty to provide support lay with the local authority, which had to buy in agency staff to cope with the demand. This, in turn, increased the social care expenditure.

A better solution would have been to develop an understanding of cross-sectoral expenditure, with collaborative allocation leading to a better use of resources.

2: Alliance contracting

Alliance contracting (a process used in places such the oil and airline industries) is a vehicle to share risks, responsibilities and opportunities. It is not a legal entity, so there is no need to merge any bodies; it is an alignment based on outcomes and a commitment to principles and behaviours.

Traditional contracting involves one commissioner and several providers, with separate contracts with each party. In it, there are separate drivers for each party, performance is individually judged and does not drive collaboration, the commissioner is the co-ordinator, provision is made for dispute and contracts are based on tight specifications. As such, change can not be easily accommodated and the process is not responsive to changing demand.

Under alliance contracting, the public body is commissioner but is also part of the contract – this gives it a greater involvement in the outcomes. Under one agreement and performance framework, with aligned objectives and shared risks, success is judged on overall performance, with shared co-ordination and collective accountability. There is an expectation of trust and an agreement which describes outcomes, and change and innovation in delivery are expected.

3: Confident collaboration in a competitive context

Ms Fraser's third area to consider was an example from a local authority that, seeing massive gaps in provision, invited all the providers to breakfast meetings over six months to discuss the situation. Following a process of collaborative allocation, they encouraged providers to work together to fill gaps, rather than compete (or not compete) for provision. This has worked well, including by helping the providers come together to meet the requirement for the living wage to be paid for overnight support.

4: Systemic planning

Ms Fraser suggested that public authorities suffer from both bureaucratic redundancy (asking staff to do unnecessary work) and failure demand – where they create demand for services by failing to meet people's needs earlier. If we can help people who do not need to be in the system to stay out of the system, that leaves more resources to support those who need it.

5: Self-directed support

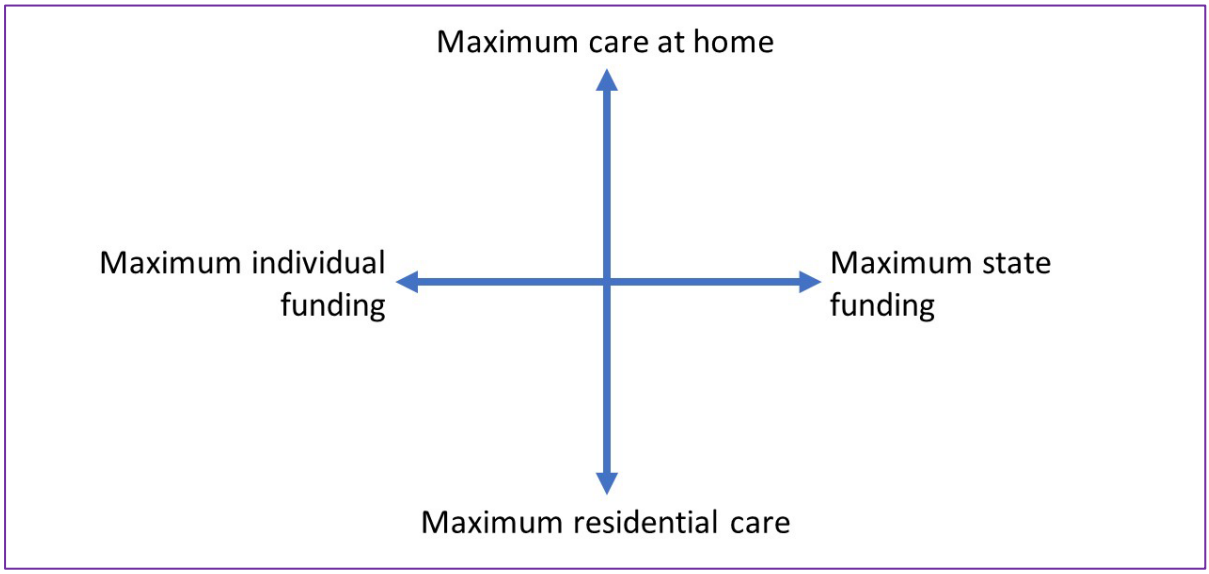
Finally, Ms Fraser noted that that if there were a real move to people taking control of their own budget, it would unlock the social care market, bringing it closer to a real market with individuals making own choices and services growing to meet that demand.

Conclusion

In conclusion, Ms Fraser suggested that we need to stop doing the wrong thing a bit better and, instead, we need to do the right thing, even if it takes some time to do it properly. In particular, we need a change in mindset and courageous cross-sectoral systems leadership.

Workshops

Following the presentations, participants were asked to look to 2030 and explore potential future scenarios for the delivery of social care, considering two major policy decisions: where care will be provided and who will pay for it. These drivers were considered together using the following matrix:



Each workshop group considered a different future scenario for social care:

- Maximum care at home with maximum state funding
- Maximum care at home with maximum individual funding
- Maximum residential care with maximum state funding
- Maximum residential care with maximum individual funding

Participants were also invited to consider potential trends that would affect Scotland in 2030:

- Scotland experiences a higher number of extreme weather events, including frequent storms and high winds, regular flooding and colder winters.
- Technology has developed in all aspects of life, with driverless cars and drones common across the country, decisions on public services taken by artificial intelligence, and miniaturised robotics revolutionising our home and working lives.
- The job market in Scotland has changed, with a greater number of people working part-time or with portfolio careers in which they move frequently between short-term contracts.
- Medical science continues to develop with a greater understanding of neurological conditions. But, unless things change, 40% of people in Scotland are obese.
- In line with other developed economies, economic growth, and the tax revenue it is based on, continues to be slow – although other measures of success beyond GDP form a greater part of political discussion.

In the discussion, participants were asked to explore the scenario and its implications, and consider the action we should take to embrace the positives and avoid the negatives.

The main points of the discussion are captured below.

Scenarios

Maximum care at home with maximum state funding

It was felt the scenario worked for what most people wanted for their care: this is the ambition that we should aim for. That said, there were many concerns about how achievable and affordable it is, given the changes in demography and wider society.

In particular, concerns were raised about the tax implications of such a scenario, with funding a major issue. The growth in part-time work, both generally and in the care sector, was seen as a challenge - fewer full-time workers may mean that less tax is paid, while carers working part-time can compromise the continuity of care, which is hugely important to those receiving care. Furthermore, a shift to part-time working could be seen to undermine the value of social care as a career.

Indeed, it was agreed that the status of social care needs to increase: caring should be seen as a valued and rewarding job. The sector would need to be innovative to deal with people on short-term contracts, although if carers are supported and trained properly, it would not matter if they left one organisation, as long as they moved within the same sector.

Looking at the context, participants noted that the increase in poor weather events would cause problems. Particularly in remote and rural areas, most careers will not live near the people they care for, so they will be unable to get to them. Technology-enabled options would be useful (and will become ever more commonplace), although older people can struggle with new technology and so they have to be supported.

Participants also suggested that the high levels of obesity in Scotland could prove a practical problem in the future. It was agreed that enabling a healthy and active lifestyle is vital, with engagement in the community a part of that. Better designed community spaces, with things like benches for older people to rest on when they are out, are key to supporting that.

One potential negative to maximum state funding was that it might disincentivise people from taking ownership of their care. It was suggested that that would happen, but that it needn't.

Maximum care at home with maximum individual funding

Participants in this group wondered whether maximum care at home would suggest limitations to institutional care – would it be a deliberate policy to limit the places, or the consequence of other policies?

It was suggested that individual funding of social care could create an opportunity to discuss and address wider issues with regards to inequality in society. Older people would not be a "burden on the state", and inequality would be tackled as property wealth and capital assets that would otherwise be inherited would be used to pay for care. One participant asked: "How can you not raid that bank?" However, they also noted that property wealth is not income that can easily be spent. Capital assets would have to be used in a different way, through equity release schemes for example.

One potential solution under this scenario would be the creation of a small community-based village model: a community supported by technologies, with buildings that can change to match the shifting needs of individuals and families.

It was suggested this aspirational approach would be hard to deliver in 12 years: instead, we need to build on the communities already in existence. Indeed, we would need more community empowerment if responsibility for the provision of care is taken away from state. While that might individualise the system, leading to more loneliness and isolation, equally it could encourage social cohesiveness as communities fill the gap.

Looking at the context, participants noted the need to ensure that technology does not isolate further those who do not use it: 60% of over 80s do not use the Internet, for example. Participants also noted that obesity rates may inhibit the ability of younger generations to care for older people.

Overall, this scenario was seen as an opportunity to create a different dialogue. It was argued that the approach since 1948 has created a sense of entitlement and dependency, but people do not realise that their taxes pay for the NHS and not for social care. If we got people to recognise that they will have to fund their social care, it would open up a discussion of wider issues.

Maximum residential care with maximum state funding

Participants were uncomfortable with the idea of maximising the number of people in traditional residential care, particularly given the current care home model which was described as soulless.

It was therefore suggested that the traditional model of residential care should be expanded to include alternative models of housing such as very sheltered housing and supported living. For this, a very different regulatory framework would be needed as the current one-size-fits-all regime does not allow for flexibility.

One participant also provided data to question the feasibility of increasing state funded residential care. He highlighted that there are currently 30,000 people in care homes and each place costs about £1,000 per week. This equates to £1.5 billion per annum, out of Scottish income tax revenue of roughly £13 billion. Another 20,000 people in care would require additional investment of £1 billion, which would mean that about one in six tax pounds would be spent on care homes

One positive of this scenario is that it would be equitable, and enable better management of care: eligibility criteria for accessing care would be tighter, which could enable a focus on end-of-life care or earlier intervention to prevent problems further on. It would also enable society to have the right people in the right places – with less variety comes greater control – and potentially better continuity of care through better staff retention.

On the negatives, as well as the general discomfort with the approach, it was suggested that preventative methods would not get the appropriate focus. The scenario would also do nothing to address gender justice and shift the informal balance of care away from women.

Finally, it was noted that such a scenario could leave families and other informal carers isolated from their loved ones.

Maximum residential care with maximum individual funding

All participants in this group agreed that this scenario was iniquitous in its extreme form, and no one considered it a desirable situation. Indeed, there would be a high degree of resistance in the population to any sort of compulsion in terms of

residential care: what would happen to those who could not afford residential care, or the residential care of their choice?

As context, a participant reminded the group that, if all things remain the same, there will be a requirement of 30% more care home places by 2030. A growth in the proportion of people going into residential care would bring an even bigger increase.

There was a consensus that residential care would need to look very different from how it looks today, with a mixed range of options available to address different needs and differing personal outcomes and aspirations.

Maximum residential care could mean that choice is limited for the people who need it. The barriers created by remoteness and rurality were mentioned. Particularly if residential care was centralised to any degree, people would be isolated at a distance from their families and friends.

On the positive side, participants noted that, for the wealthy, this scenario would increase the choice of care available. It would also relieve the burden on unpaid carers and, potentially, make family roles more evident. Indeed, the group felt that unpaid care remains virtually invisible in all the calculations and considerations of the cost of care to the state. Could the potential of existing carers be unlocked if they were paid?

On the negative side, the group was clear that, for those who are poor, there would be no choice in this scenario. It would also require a huge level of resourcing, with a bigger workforce required to replace the informal and unpaid care that takes place at the moment.

Participants also noted a ballpark figure for costs similar to the one shared in another group: if the current provision is simply expanded, a total of 50,000 care home places at a cost of £1,000 per week would mean an annual cost to the state of £2.5 billion, which is about a sixth of income tax revenue. A large amount of capital would also be required for building extra care homes and expanding existing care homes. If not from taxation, where will the funding come from?

What action should we take to achieve the positives and avoid the negatives?

People

One focus for action was how we support the people involved in the system: those with care needs, their family and other informal carers, and those in the care workforce.

More should be done to enable those with care needs to look after themselves in their own homes. The adaptation of homes (through the installation of grab rails etc) must be more of a priority to keep people moving themselves. These are cheap, preventative options compared to providing care, but they are not a priority for local authorities.

Linked to that, **there needs to be smarter planning of homes and public spaces**: we need accessible housing that can be adapted to last a lifetime, and to maintain accessible community spaces to support communities and prevent loneliness among older people.

We also need to support those who provide care, both as part of the care workforce and informally as part of the "support force". **We have to consider the wider implications of someone having to care** – financial, psychological and physical – and provide more support for those taking on the role. Those providing informal care need access to flexible working and caring leave, and early support will be cost-effective as it prevents problems later on.

We also need to **recognise the gender inequality in the current situation**: care in the community is currently done mostly by women. How can we bring about a cultural shift in the role's importance to value the work of women appropriately and increase male uptake?

Equally, there are concerns that the care workforce has been overprofessionalised. **How do we get the balance between care being a good career option for some and simply a caring job for others?** Is there a similarity with classroom and leadership teaching in education?

Finally, **people should not feel shame for needing support**. It was suggested that some people cut the cord for emergency support in a house because of the stigma attached to having it in your home. People should not feel shame at requiring help in their lives.

Structure

The structure and provision of current services was also seen as needing to change.

Can we remove the bureaucratic boundaries and the massive structures in the system? We have 32 local authorities, 31 integration authorities (who are not in charge of purchasing), and 14 health boards. This leads to a diffusion of accountability. Should we have three health boards that match the cancer care regions, give the integration joint boards to councils and simplify the landscape?

How can we also include other important functions such as housing and public health? Should we move commissioning out of health and social care and embed in the wider community through community planning? We could locate facilities in spaces which facilitate 'incidental' contact, such as in community cafes

and libraries, and give community planning in less well-off areas more help to develop what people need locally.

We have to improve the agility of current services, enabling us to move occupational therapy professionals into the community and social workers into primary care, for example.

Finance

The funding question was felt to be the biggest conundrum: it is clear that, in any new models of care, the financial system must be fully considered.

There are undoubtedly questions of intergenerational fairness. The capital and property wealth of certain parts of the population have to be considered when deciding how to fund social care, and younger people do not have the same property assets to access.

Although some property assets may be inherited (and there may be ways for families to release capital without selling a property), those assets may not be available to people in the future. To ensure an equitable approach, therefore, **long-term funding needs to be based on increasing taxation rather than relying solely on individual contributions**.

Ambition

As this crisis will not go away, Scotland needs to show some ambition in tackling the problems in social care for older people.

People need to engage with the issues early and plan for requiring social care as they get older. How can we support these discussions among families and friends? Should this be part of the consideration of citizenship at school?

Although it may be a difficult to talk about, it shouldn't be a taboo discussion. We need to change perception that old age is negative and that requiring care is something to be ashamed of. **We should tackle the stigma and develop a more positive and open approach to care in society.**

Older people should be a priority for public health in Scotland. Unlike the early years, older age is not listed as one of the functions or priorities of Health Scotland, and this suggests a lack of focus on or interest in older people in government.

We have also to improve the information on which we make our decisions, investing in academic work to provide evidence and measuring outcomes rather than process.

Conclusions

We have to plan for the future of social care by taking a whole system and community approach. An expansion of current provision to match the expected demographic changes could see care home costs accounting for one sixth of income tax revenue by 2030. We have to engage local communities and wider society in a proper public discussion on how social care operates in Scotland and how we can pay for it. This includes examining the policy of free personal care.

We need to reconnect people, including those providing care, with their communities. People with care needs want to be a part of their communities as much as anyone else; services should therefore be built around communities and people rather than vice versa.

We must put older people firmly on public health agenda and match the commitment made to the early years through Getting It Right For Every Child. That includes considering the whole family when helping older people, rather than thinking of them in isolation, and potentially signing up the World Health Organization "Decade of Active Ageing".

We have to change society's value of older people, those who care for them and social care in general. Many of us will need care in our older years. We should accept that as a result of increasing life expectancy and plan for it actively and positively.

Event pictures: Andrew Cowan © Scottish Parliamentary Corporate Body, 2018

Participant list

First Name	Surname	Organisation
Lorna	Ascroft	Scottish Government
Richard	Baker	Royal Blind and Scottish War Blinded
David	Bell	University of Stirling
Sarah	Boyack	Scottish Federation of Housing Associations
Caroline	Clark	Scottish Older People's Assembly
Anne	Connor	Outside the Box
Douglas	Cooper	Competition and Markets Authority
Jude	Currie	Generations Working Together
Viv	Dickenson	Crossreach
Elaine	Douglas	HAGIS
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Diana	Findley	Scottish Older People's Assembly
Margaret	Follon	Housing Options Scotland
Dee	Fraser	Coalition of Care and Support Providers in Scotland
Heather	Galway	Health and Sport Committee clerk
Nina	Hemmings	Nuffield Trust
Deidre	Henderson	Inclusion Scotland
Anne	Hendry	International Foundation for Integrated Care
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Carol	Jagger	Newcastle University
Anne	Jepson	Scottish Parliament Information Centre
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Douglas	McKelvie	Symmetric
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Carla	Plasberg-Hill	Scottish Government
Gerry	Power	The Alliance Scotland
Kathryn	Ray	Scottish Government
Emma	Ritch	Engender
Kathleen	Robson	Scottish Parliament Information Centre
Donny	Scott	Symmetric
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