ADSW
ASSOCIATION OF DIRECTORS OF SOCIAL WORK

Scottish Parliament Finance Committee: Inquiry into the impact of demographic change and ageing population on public finances

Response from the Association of Directors of Social Work

Introduction and Summary

1. ADSW welcomes the Scottish Parliament Finance Committee's inquiry. Changing demographics – both for older people and for other age-groups – will have a major impact on public finances. The need for a radical shift towards collaborative, outcome-focussed service planning, pooled funding, and pre-emptive, community-orientated preventative services is widely recognised. Even so, the funding situation will remain very challenging.

2. The Association's response covers health and social care issues in Questions 1-6 set out in the call for written evidence and we repeat the Committee's questions for ease of reference.

3. The **main points** we raise in our submission are:

   (1) The ageing population is not new and has already had impacts on local authority finance. The future impacts are significant and are larger for social care expenditure than for the NHS. Social care spending on older people would have to double between 2010 and 2035 on current service models and rates of provision.

   (2) The impact of demography on increasing demand for health and social care services is not restricted to older people. The number of people with disabilities is also increasing in all age cohorts, although less information is available nationally than is the case for older people. There are also recession-linked pressures in relation to increasing numbers of people with mental health problems and probably also addictions.

   (3) Improvements in information about healthy life expectancy, and the changing prevalence of learning disabilities, physical disabilities, dementia, mental health problems, and the provision of unpaid care, are all required and are discussed further under Question 4.

   (4) Public sector budget transparency is important. Annual and three-year budgets should be explicit about the extent that demographic pressures have been recognised. Public clarity is needed about how much is in the annual local government revenue grant settlement for demographic pressures, and in the funding of health boards and other public sector agencies.

   (5) Increased public expenditure on the scale required to meet demographic pressures is challenging, but not necessarily "untenable" The willingness of society and the state to sustain increased spending on health and social care depends on many factors, including:

   - the value placed on the health and wellbeing of people with disabilities, self-care and mobility problems due to old age, dementia, and other chronic health or long-term conditions;
   - the balance between the roles of the state, communities, families and individuals; and
   - the performance of the wider economy, the size of the working population, taxation and public expenditure policies.

   (6) Too much funding is currently locked up in emergency inpatient admissions and in residential care; the rate of increased funding required for demography can be reduced by further planned changes in the balance of care, through increased community health, social care, and third sector services. That will require political leadership and public confidence that planned bed closures are not service cuts.

   (7) There is a growing consensus that much more investment is required to improve support to carers, to fund prevention on the scale required, and to develop community capacity. The key

issue is how to free up funding for investment in prevention to reduce *future* increases in demand when available budgets are under pressure to meet *existing* levels of demand.

(8) Better information on the economic case for prevention would assist decision makers. The Scottish Government could usefully commission a public sector prevention website with links to published evaluation studies of preventative spend in health, social work and social care: this would help disseminate the findings, and build knowledge of "what works" to be translated into practical action on the ground.

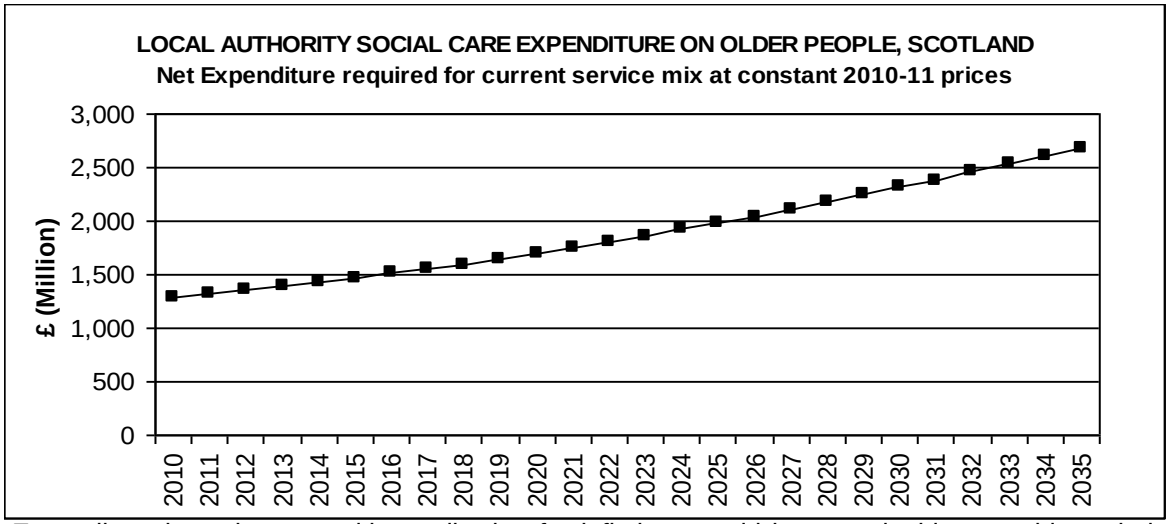
(9) Politicians face difficult choices. There is a clear need for a fuller and more informed public debate about the funding of health and social care in the future. Ultimately this is a question about values and priorities.

General issues – budgeting for demographic change, and data sources

Question 1*: What is your view of the effects of demographic change and an ageing population on the sustainability of funding for (a) health and social care and (b) housing services and (c) public pensions and the labour force? What public services will individuals increasingly call on and in what way?*

4. The financial impact of demographic change is already here, and has been for some years, although not at the level entailed by future population projections. Many councils have not been able to increase spending on health and social care in line with increasing demand, resulting in tighter application of eligibility criteria. The best evidence available is that the need to spend more on health and social care will continue at an accelerated pace into the future. "Demographic change is a key long-term pressure on the public finances" (Office of Budget Responsibility 2012: page 6).

5. ADSW has calculated the impact of the latest (2010-based) population projections for Scotland (NRS 2012) on council spending on **social care for older people** between 2010-11 and 2035-6, holding service utilisation rates constant at 2010-11 levels (for each age group 65-69, 70-74, …, 90+):



6. Expenditure in real terms, without allowing for inflation, would have to double over this period, from £1.3 billion to £2.7 billion. The methodology makes no allowance for current levels of unmet need which are assumed to grow in the same proportion. Equally, the method of using constant service utilisation rates (reflecting needs met at current eligibility criteria) assumes that future rates are not lowered by increasing Healthy Life Expectancy.

7. The most recent Scottish Government projections of the impact of demography on **adult health and social care** expenditure requirements are graphed on page 68 of the consultation paper on the *Integration of Adult Health and Social Care in Scotland*, published on 8 May 2012. Revised data, kindly supplied to ADSW by the Scottish Government, are shown in **Table 1** overleaf, for three variant "scenarios" relating to whether additional years of life are healthy or years of chronic illness and disability:

HLE constant.	This is the **worst case scenario**: Life Expectancy (LE) increases but Healthy Life Expectancy (HLE) stays the same, so the additional years gained are years of ill-health and disability.
Change HLE = Change LE	This is the **best case scenario**. Each additional year of life expectancy (as projected for Scotland by the Office for National Statistics life expectancy projections to 2030) is assumed to be healthy.
Change HLE = 0.5 change LE	This is the **mid-point scenario**: Healthy Life Expectancy (HLE) increases by half the increase in Life Expectancy (LE).

Table 1: Scottish Government: Health and Social Care Demand Projections, £ million 2009-10 prices

Scenarios	2010	2015	2020	2025	2030
	£M	£M	£M	£M	£M
Scenario1: Projections with HLE constant					
Total Health and Social Care	**11,012**	**11,630**	**12,387**	**13,249**	**14,169**
Average % change per year		1.1%	1.3%	1.4%	1.4%
Scenario 2: Change HLE = Change LE					
Total Health and Social Care	**11,012**	**11,439**	**11,954**	**12,507**	**13,040**
Average % change per year		0.8%	0.9%	0.9%	0.8%
Scenario 3: Change HLE = 0.5 change LE					
Total Health and Social Care	**11,012**	**11,529**	**12,160**	**12,860**	**13,579**
Average % change per year		0.9%	1.1%	1.1%	1.1%

Source: Scottish Government Analytical Services Division – Health (supplied 1.8.12)
Note: Average annual percentage increases over each 5 year period calculated by ADSW.

8. The difference between best and worst case scenarios (1 and 2) is over £1 billion by 2030 –- the difference between an 18.4% increase in costs (excluding inflation) or a 28.7% increase between 2010 and 2030. This highlights the importance for planning of reliable data on Healthy Life Expectancy (further discussed in 33).

9. **Table 2** shows that population ageing has a greater impact on social care than on NHS spending (a finding also from the Office of Budget Responsibility – see para 22 below).

Table 2: Scottish Government: Health and Social Care Demand Projections, £ million 2009-10 prices

Scenarios	2010	2015	2020	2025	2030
	£M	£M	£M	£M	£M
Scenario1: Projections with HLE constant					
NHS services (for adults)	9,375	9,805	10,310	10,852	11,389
Average % change per year		0.9%	1.0%	1.0%	1.0%
Residential care and home care for adults	1,637	1,825	2,077	2,396	2,780
Average % change per year		2.2%	2.6%	2.9%	3.0%

10. This is because the probability of service need by age-group has a steeper gradient for social care than for health. In England, the Dilnot Commission (2011a) drew the conclusion that that social care funding requires larger percentage increases than those being provided to the NHS. In Scotland, Professor Bell, in his paper *Fiscal Sustainability: Issues for the Finance Committee Work Programme 2012*, also notes that:

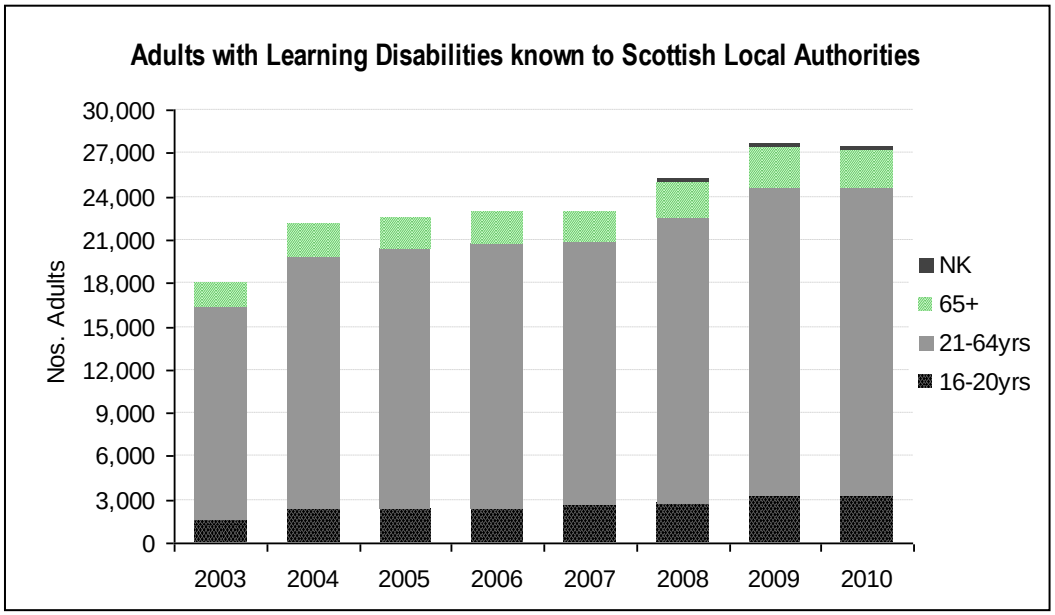
> The demographic data suggest that there will be a more rapid expansion of demand for chronic care relative to acute care. Older people will be living with long-run illnesses, such as dementia. The attempt to reallocate resources from acute care to long-term care, which has been entrusted to Community Health Partnerships (CHPs), has not been entirely successful. (Page 19).

11. Not all demography-related pressures have been included in the Scottish Government projections in Tables1 and 2. In particular, increases in numbers of **people with learning disabilities** have not had the same recognition by politicians, government, media, or the public, as have the increases in numbers of older people. This partly reflects inadequate information.

12. In 2004, NHS Health Scotland's *Health Needs Assessment for People with Learning Disabilities in Scotland* confirmed that:

> "The life expectancy of people with learning disabilities is increasing and in future there will be more people with learning disabilities, more older persons with learning disabilities, and more persons with the most severe learning disabilities in all age cohorts". (NHSHS 2004:iv)

13. Unfortunately, this report did not estimate future numbers or the rate of increase that could be expected for different age-groups. Some work on future needs has been done by the University of Lancaster for the Department of Health in England, although this is based only on projecting forward into adulthood the numbers of currently known children and young people with a learning disability. The NHS Health Scotland report had stated that "The eSAY project co-ordinated by the Scottish Consortium for Learning Disability will lead to better information in future" (NHSHS 2004:vi) — information from this source is shown below:



14. In Scotland, the total numbers of people with learning disabilities known to local authorities increased by an average of 3.6% per year from 2004-2010 (ignoring the low value in the initial year), although a change in methods of data collection in 2008 may affect the time-series.

15. ADSW is also aware of evidence from individual local authorities that the numbers of school leavers with learning disabilities who require adult social care have been increasing in recent years. For example, the City of Edinburgh Council's Long Term Financial Plan projects additional spending of £13.4 million over the next five years on social care for adults with learning disabilities, compared to £10.5 million more on older people (2016-17 expenditure compared with 2011-12, at constant 2009-10 prices). These figures reflect in part the higher unit costs of learning disability services compared to those for older people.

16. The numbers of **children** and **adults with physical disabilities** have been increasing for similar reasons to those set out above for learning disabilities, due to increased survival of very premature and low weight babies, and of people surviving strokes, road accidents and other trauma; and also reflects the factors responsible for increased life expectancy in the general population. However, information on changes in the age-sex prevalence of physical disability over time is difficult to obtain and does not appear to be well-studied academically.

17. There is also considerable evidence that **mental health problems** increase during economic downturns. "*Demand for mental health services is likely to increase as a result of unemployment, personal debt, home repossession and other fallout from the recession*" (Royal College of Psychiatrists 2009). A recent academic review – "Economic Recession and Mental Health: An Overview" (Cooper 2011) – concluded that "*Economic downturns raise population levels of unemployment, poverty and distress, and this in turn tends to increase suicide rates and the prevalence of psychiatric disorders*". The European Office of the World Health Organisation (WHO) also published papers in 2011 on the "Impact of economic crises on mental health" which contain similar findings and argued for investment in mental health services. In Scotland, a recent NHS Scotland paper took a similar view (NMHIN, 2011).

18. The impact of these pressures on health and social care spending in future is not known, and further research is required. They will increase the demographic cost estimates shown in Tables 1 and 2, particularly in the early future, but we do not know by how much.

19. The conclusion drawn by the Scottish Government from their projections of increased health and social care spending (in Table 1) is that "***the projected increase in costs will be untenable***" on all three scenarios (SG 2012, page 68). This is, perhaps, a surprising conclusion to draw from annual cost increases of between 0.8% and 1.4% per year in real terms, and needs to be set alongside other large cost drivers such as the NHS drugs bill, which on recent years will be a bigger driver of increased spend than age-related demography.

20. Certainly, increased expenditure on this scale is *challenging*, but it is far from certain that it is really "untenable". **The willingness of society and the state to sustain increased spending on health and social care depends on many factors**, including:

- the value placed on the health and wellbeing of people with disabilities, self-care and mobility problems due to old age, dementia, and other chronic health or long-term conditions;
- the balance between the roles of the state, communities, families and individuals; and
- the performance of the wider economy, the size of the working population, taxation and public expenditure policies.

21. Until the banking crisis and recession, UK GDP per capita grew by 43% from 1995, the middle of the last recession, until 2008: an average annual increase of 2.8%, well above the OECD average (Portes 2012). Many economists believe that UK and European government economic policies that prioritise deficit repayment over investment are prolonging the recession; however, when the recession ends, GDP growth rates are likely to be larger than the health and social care public expenditure increases required for demographic reasons alone (between 0.8% and 1.4% on Scottish Government figures). The Office for Budgetary Responsibility assumes a return to an average UK annual growth of 2.2% (OBR 2102: 7).

22. The problem is rather the future gap between projected tax revenues and public spending –- "Public Sector Net Debt" (PSND). The 2012 *Fiscal Sustainability Report* by the Office for Budgetary Responsibility makes 50-year projections of all UK public spending and revenues. The impact of population ageing is projected to increase UK public expenditure (other than debt interest) from 35.6% of GDP in 2016-17 to 40.8% by 2061-62, an increase of 5.2% of GDP or £80 billion at current prices (OBR 2012: 8). The report states:

> The main drivers are upward pressures on key items of age-related spending:
>
> - health spending rises from 6.8 per cent of GDP in 2016-17 to 9.1 per cent of GDP in 2061-62, rising smoothly as the population ages […]
> - state pension costs increase from 5.6 per cent of GDP to 8.3 per cent of GDP as the population structure ages and State Second Pension entitlements mature. […]
> - social care costs rise from 1.1 per cent of GDP in 2016-17 to 2 per cent of GDP in 2061-62. […]
>
> These increases are partially offset by a fall in gross public service pension payments from 2.2 per cent of GDP in 2016-17 to 1.3 per cent in 2061-62. (OBR 2012, page 8).

23. The impact of these drivers very much depends on the future tax base, and therefore the size of the working population, future levels of net migration, and taxation rates. On **migration**, for example, the OBR report acknowledges that:

> > Higher net inward migration than in our central projection – closer to the levels we have seen in recent years, for example – would put downward pressure on borrowing and PSND, as net immigrants are more likely to be of working age than the population in general. This effect would reverse over a longer time horizon, when those immigrants who remain in the UK reach old age. (*ibid*, page 12).

24. The Chief Executive of NRS noted during the Finance Committee's session on demography on 11 January that "immigration is the big thing that is pushing up Scotland's population" (Official Report, column 475). Professor Jeffery's comment on this key issue is worth repeating: *"It is important for the Scottish Parliament to continue to press the UK institutions to be imaginative about immigration and to reflect the different understanding of the issue in Scotland*" (ibid, 477).

25. The policy options posed in the OBR report amount to **tax increases** or further **fiscal tightening** to bridge the future gap between projected public expenditure and tax revenues. Professor Bell's paper for the Finance Committee notes that UK tax revenue as a share of GDP is below average in the OECD, ranking 8th highest out of 18 OECD countries in 2010 (Bell 2012: 10). The difficulties politicians face are well summed up in a recent article by the Director of the National Institute of Economic and Social Research:

> It so happens that the British want good-quality health and education, largely provided free at the point of use by the public sector; decent state pensions and social care, and for old people to be able to leave their houses to their children, not to have to sell them; and they don't want to pay the taxes necessary to fund all this. This combination doesn't add up and poses a significant political challenge… (Portes 2012).

26. **This further reinforces the need for a fuller and more informed public debate about the funding of health and social care in the future. Ultimately this is a question about values and priorities**.

Question 2*: Further, what planning is being done, or should be done, to address this?*

27. **First**, national and local methodologies for estimating the scale of demographic impacts over the short, medium and longer term need to be improved, not just for the health and social care service needs of older people, but also for other age-groups, including people with learning disabilities, physical disabilities, mental health problems and addictions. (We identify some of the research and data requirements in our answer to Question 3).

28. **Secondly**, despite progress in long-standing policies to shift the "balance of care" from hospital and long-stay care home admission to care at home in the community, huge sums remain locked into funding emergency inpatient admissions and residential care. The rate of increased funding required for demography can be reduced by further planned changes in the balance of care.

29. **Thirdly**, there is a growing consensus that much more investment is required to improve support to carers, to fund prevention on the scale required, and to develop community capacity. We discuss this further in our answer to Question 5 but here highlight the key issue, which is how to free up funding for investment in prevention to reduce *future* increases in demand when available budgets are under pressure to meet *existing* levels of demand. It would appear that investment in prevention on the scale required can only be funded by ceasing or reducing some existing services: these are difficult choices that call for greater political and public debate.

Question 3*: What weight should be given during the annual budget process to demographic trends and projections?*

30. Demographic pressures are in competition with other budgetary priorities; nevertheless the scale of the challenge requires that demographic trends and projections should be recognised as fully as possible. This will require the development of long term financial plans, and their continual improvement as data sources and projection methodologies improve.

31. Budget transparency is important. Annual and three-year budgets of local authorities, health boards, other public sector agencies, and the Scottish Government, should be explicit as to the extent that demographic pressures have been recognised for older people, and for other groups whose numbers are increasing, such as people with learning disabilities, physical disabilities, or mental health problems. For local government, this does not mean a return to ring-fenced or earmarked funding, but does mean public clarity about how much is in the annual local government revenue grant settlement for demographic pressures.

Question 4*: What data is collected (and what should be collected) with respect to (a) health and social care and (b) housing services and (c) public pensions and the labour force, and what use is made of this (or should be made) to forecast what funding will be needed?*

32. The **data currently collected on health and social care** by the Scottish Government (including NHS data collected by ISD) is largely concerned with service usage, and is broadly fit for that purpose. Statistical policy already supports moves to collect information on a person basis, where possible, and this will greatly increase the scope for record-linkage, subject to the appropriate data protection, security and confidentiality safeguards. We agree with the remarks that George MacKenzie (Chief Executive of National Records of Scotland) made to the Committee at the 11 January 2012 session: "*Data linkage will be crucial to our better use of evidence in the future*" (column 474), but also note what he said about the legal and ethical challenges.

33. Going forward, our response to **Question 1** highlights many areas where the information base is insufficient:

(1) Will the longer-living future elderly population will be healthier than currently? The available research evidence on **healthy life expectancy** is mixed: Professor Jagger's evidence to the Committee on 11 January 2012 was that at UK level there was evidence of a compression of morbidity for men but not for women. Conversely, the Scottish Government's *Demographic Change* report stated that "*Healthy life expectancy in Scotland has also been increasing, but not at the same rate as life expectancy and the gap between life expectancy and healthy life expectancy has, for men, actually been widening*" (SG 2010: 26). Since then, a change in survey questions has interrupted the time-series.

(2) Further research is also needed on **age/sex differences in the willingness to report health problems** and limiting long-term illness in the surveys on which estimates of healthy life expectancy currently are based.

(3) A closely related question is **whether improvements in healthy life expectancy will significantly reduce *health* expenditure**. Professor Bell's paper for the Committee in January 2012 suggested otherwise, based on US evidence (Bell 2012:18), lending some support for the argument that "that health expenditure is concentrated towards the end of life and that the relationship between age and health expenditure is not all that strong once proximity to death is allowed for". This point is also made in the Scottish Government's research overview on *Demographic Change in Scotland* (2010: 28). All these issues require further work.

(4) Another question is whether the increasing numbers of older people with **dementia** is due entirely to the ageing population and increased longevity, and not in part due to other causal factors (such as diet or pollution) operating alongside age. In relation to dementia, research is required to assess whether there are changes in age/sex-group specific prevalence over time.

(5) While there is sufficient evidence that numbers of people with **learning disabilities** or **physical disabilities** are increasing in all age-groups, there is a lack of good epidemiological data for future service planning. As a result government estimates of future public expenditure largely ignore disability trends for age-groups under 65 years.

(6) Evidence that **mental health problems** (and **addictions**) are increasing appears to be mainly related to the impact of the recession. Here we need research models that quantify changes in demand for health and social care services in relation to indices of recession (e.g. changes in unemployment or GDP).

(7) The prevalence of **unpaid care** is affected by such factors as the age/sex structure of the population, the divorce and separation rate, mobility (especially, geographical distance between adult children and their aged parents), and more generally by social expectations and customs. We are not aware of studies that have successfully modelled these factors against demographic trends, in order to assess whether the prevalence of unpaid care will increase or decrease in the future. This is another area where more research is required.

34. Notwithstanding the above points, **practical evidence of "what works" in prevention is arguably the most important information need currently**. There is growing national and inter-national evidence as a wide range of preventive services, projects and initiatives are evaluated by governmental agencies and academics. But as Professor Bell pointed out in his evidence to the Committee's session on demographic change and financial sustainability on 11 January 2012:

> It seems to me that evaluation is very important. There is no centralised location or repository for evaluative evidence in Scotland. […] If we want to know what works, we must have a system that will enable us to evaluate the evidence coherently. (Official Report, 11.1.12, column 472).

35. It is essential that budget decision makers have available good enough information on which to base investment in prevention decisions, preferably with reasonable data on the cashable and non-cashable benefits and the timescales when these might be realised. The Scottish Government could usefully commission a **public sector prevention website** with links to published studies of preventative spend in health, social work and social care: this would help disseminate the findings, and build knowledge of "what works" to be translated into practical action on the ground. It would also help identify major gaps in the knowledge base.

***Question 5**: To what extent are preventative policies such as the Change Fund key to addressing demographic pressures on the provision of health and social care?*

36. Preventative policies such as the Change Funds (Older People and Early Years) are essential to reducing demographic pressures and are being used typically to fund social care, community health and third sector services that will prevent or delay admission to hospital and support earlier discharge, to improve support to carers and to develop community capacity.

37. Increasing investment in support to carers is absolutely central to any preventative strategy worthy of the name. In volume terms, more "social care" is provided by carers (mainly partners and other family members), than by employees of local government, the NHS, or private and voluntary care sectors. "Carer breakdown" remains a major cause of admission to hospital, care homes, or high intensity support at home. Increased funding for support to carers is therefore an important strategic policy objective for the Scottish Government, local authorities and the NHS in Scotland. Equally, there is a need to continue and deepen measures to build community capacity for self-care and resilience.

38. New services funded by the Change Fund for Older People are financially sustainable only if they support a shift in resources from acute, emergency inpatient bed use to community- and home-based health and social care, thus allowing some hospital resources to close. That will require political leadership and public confidence that such closures are not service cuts. During the period of transition, the need for double running costs for hospital services and increased community and home based services is likely to be larger than the total Change Funds made available, which currently are largely top-sliced from NHS budgets.

39. While current preventative strategies and change funds will reduce but are unlikely to eliminate the financial impact of demographic change. Prevention – based on clear evidence of what works over various timescales, many of which will be long-term – is absolutely necessary to fiscal sustainability, but increasing spend on health and social care will still be necessary, at lower levels that would otherwise be the case.

***Question 6**: To what extent are the pressures on health and social care a consequence of an ageing population as opposed to other health challenges such as obesity?*

40. As explained in our answers to the earlier questions, demographic pressures are wider than the ageing population and also include increases in the numbers of people with disabilities at all ages. Numbers of people with mental health problems are also increasing, and this is likely to increase with the economic recession, as may be the case with addictions, although the alcohol pricing policy should offset that. For older people, we also do not know whether the increase in the prevalence of dementia is only an age-effect.

41. Both the recession and the UK Government's welfare reforms will increase poverty and widen income and wealth inequalities, and those health inequalities for which social inequality is an increasingly well-evidenced driver.

42. ADSW is aware of future pressures on health and social care from other social and environmental changes, such as obesity or air quality, but believes that more research on these is needed to assess their impact of future fiscal sustainability.

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