



## The Future of Health and Care in an Ageing Population

Note of expert meeting: London, 23<sup>rd</sup> September 2015

*This document reflects the discussions in a meeting held to gather the views of a sample of people with experience in the issues raised by the ageing population. The content has not been peer reviewed and any statements are not necessarily findings of the project*

### Executive Summary

1. Large birth cohorts coinciding with increasing life expectancy has, and will continue to, result in an increase in the numbers of people and the proportion of the population in the last few years before death. Conventionally these are the adult years with highest health care costs. There is also evidence that while we may be pushing back the onset of disability, healthy life expectancy is not increasing as fast as life expectancy after age 65. There may be a compression of morbidity across the whole life, but an expansion post 65.
2. The separation of health and social care has significant implications for a growing proportion of the population as the structure ages. Health care plays a smaller part of disease management as we age, whereas chronic diseases and co-morbidity need social care. There is a need to consider the balance of funding between health and social care and how we can ensure that use of services is not focussed on the NHS which is free at point of care.
3. The provision of informal care may change as family structures change, for example through increasing childlessness, divorce, female employment and geographical mobility.
4. Local networks and communities may become more important and should be integrated into future policy initiatives at both the macro-and micro-levels.
5. Technology has huge potential but at present is hitting many barriers mostly around the suitability of available healthcare technology and the interface of these technologies (for example tele-health and telecare) with professionals and public.
6. The role of public health across the life course is still uncertain, undefined and needs to be fully integrated into public policy.
7. Modern medicine is still driven by diagnosis and intervention and not wellbeing. This will need to change as UK population ages and thus has different needs
8. Cross-departmental intervention is essential to allow us to adapt to the needs of an ageing population, and to allow improvements in health and wellbeing to be maximised. For example, changes in transport and housing can impact on health.

9. Inequalities play an important role in many of the health and care issues. For example, social inequalities are associated with health conditions such as obesity, financial resources to be able to procure care and access to technological advances such as telecare.
10. Individual responsibility is increasing but there is insufficient evidence about the risks and implications of this.
11. Research involving analysis of large data sets may allow more targeted use of limited resources such as medicines (via personalised medicine) and public health interventions.

## **Key trends and the evidence for them**

### **Demographic and social change**

- The demographic shift towards an older population is causing an increase in the number of chronic diseases.
- In the future there will be fewer workers to provide formal and informal care.
- The relationship between life expectancy and healthy life expectancy will be key in understanding the health and care needs of the population in the future.
- As people live longer there will be a delay in life transitions such as becoming a parent or grandparent, or losing your parents.
- The actions of people aged 20/30 will impact on their health in 2040, and there is a shift of risk and responsibility for health on to individuals.
- As we improve wellbeing at all ages this will impact on inter-generational resource transfers.
- There is an increasing role for the home as a place of care.
- Technology will play an increasing role in health and care.

### **Changing health needs and demands**

- There is an issue around prevention and how this can impact on both the prevalence of disease and the use of services.
- There may be a role for social care, including community-based social care in preventing more intensive residential care. There is an interdependency between social care and health care, but it is unclear exactly how much spending on social care can reduce spending on health care. One study suggests that for every pound spent on social care, there is a saving of 20p in the pound of healthcare costs.
- Personalised care may improve quality of life and well-being, but there is little evidence on the longer-term health benefits and costs/savings. Some studies suggest personalised care may be neutral in terms of cost, but that some interventions may be cost-effective if you consider quality of life.

- There is a question about how you measure the outcome of interventions (for example do you value health as an outcome?), as cost-neutral interventions may improve quality of life and generate social capital.
- New models of care such as vanguard care and multi-specialist community care aim to be person-centred and preventative.
- Technological advances, for example sending results to patients by text, could free up resources and funding that would otherwise be spent on hospital-based services. These resources could then be spent on GP or community-based care.
- Behaviour change has caused a move towards vaping. The health implications of this are currently unclear.
- While obesity is still rising in UK as a whole, it is flattening in some populations and there are clear inequalities involved in this. Conversely, some less well-off groups may be malnourished towards the end of their lives.
- Compression of morbidity is not taking place so all of us will require more health and social care as we age.
- There may be an impact of reduced vaccine uptake in some groups on public health.
- More research needs to be carried out to allow limited resources (medicines, public health messages etc.) to be focussed in the most efficient way possible.

#### **Ability to provide or procure care**

- The scale of voluntary care is much bigger than formal care. One study suggested that in one town only 10% of care costs were caused by spending on formal care.
- There have been radical cuts to spending on social care, and there is a debate about whether the social care system is being more inefficient or not.
- We should move away from framing this discussion around the procurement of care, as the majority of care is provided by families and communities.
- In Scotland since the introduction of free social care at the point of use, levels of informal care have not been reduced. Conversely there has been a rise in informal care and more people have been supported to stay at home.
- Personalisation of care budgets provides people with an overview of what resources are available to them so that families can better assess what additional care needs to be brought in.
- We have an increasingly mobile society and children may not live near their parents limiting their ability to provide informal care.
- There is a question around what is meant by 'care'. Should we talk about 'social health', or the 'well-being system'?
- The consequences of private market involvement in the provision of nursing home care, particularly venture capital and other corporate financing schemes, needs to be assessed.
- Innovations to products used in everyday care (for example incontinence pads and peg feeding) could change the nature of the care that needs to be provided. There has been very little innovation in these products over the past 25 years.

## Changes in the ability of medicine

- The nature of illness or need has been changing and may change further in the future. There has been an increase in the numbers of conditions needing health or care services. Research and practice is better at picking up co-morbidities.
- There has been an increased understanding of how genetics interacts with the effectiveness of drug treatments. This has led to personalised/precision medicine where the use of drugs is targeted based on genomic information. Targeting of medicines in this way requires data from large numbers of people to determine how drugs can be most effectively targeted. Public perception of risks around data sharing and data use could be an impediment in progressing these types of treatments.
- The regulation of genomic profiling may be lagging behind the technology.
- There is no evidence that telecare and telemedicine are effective as they are currently used. They may be more effective when individually targeted.
- There is a question around who should bear the costs of telehealth and telecare.
- With individuals having increasing access to information about health and diseases this is changing the relationship between individuals and healthcare professionals. Healthcare professionals are increasingly becoming interpreters of data rather than data providers.
- An increased number of disabled people in 2040 will have implications for health and care needs.

## Politics of health and care

- The political focus is currently on the baby boomer generation, and the generation immediately following that. These generations have a growing awareness of their likelihood of encountering long term health conditions such as Alzheimer's or Parkinson's disease. They are also coping with their parents suffering from long-term conditions and coming to terms with the impact that this will have on them both in terms of burden of care and the financial implications of care. There is resentment about the demands placed upon them and the perceived inability of the state to help. There are two potential reactions to this: either to place responsibility for care onto families, or to ensure people have an equal entitlement to care.
- Care of older people is unregulated relative to childcare. Is there a need to move towards more professionalisation of care for older and vulnerable people?
- There is a tension between movement towards personalisation and self-management and inequalities in understanding information, using technologies and in the very risk factors and diseases themselves.
- Local authorities now have responsibility for public health but their ability to deal with public health messages is limited.
- A public health strategy on ageing needs cross-government input. Public health implications should be considered across all policy areas, for example transport and the built environment. Most public health changes are bought about by cultural changes and legislation.

## Policy issues and ideas

1. What is the role of the state in brokering informal care? How can the state facilitate this?
2. How can we have a more informed public debate about social care, and the role of families and communities in providing this?

3. How can we find a sustainable mechanism of funding social care which doesn't incentivise the use of more expensive, free at the point of use NHS services. Could social care be made free at point of use? How could this be funded? For example, could it be made more income based and included it as a taxable benefit under income tax?
4. How is the narrative about taxation presented to younger people and how should we change those messages? Should we take into account attitudes towards redistribution of resources?
5. Should control of social care budgets sit with individuals or the state?
6. Should there be integrated commissioning of health and social care, and potentially public health as well?
7. What are the opportunities for local innovation and engagement?
8. What is the role of commercial organisations in providing care and should this be altered?

### Evidence gaps

*The following areas were identified as needing further research, evidence or thinking*

- Further research is needed into which public health interventions are effective allowing limited resources to be most effectively deployed.
- Innovations to products used in every day care (for example incontinence pads and peg feeding) could change the nature of the care that needs to be provided. There has been very little innovation in these products over the past 25 years.
- As people live longer there will be a delay in life transitions such as becoming a parent or grandparent, or losing your parents. We need to understand the health implications of these life transitions.
- The long-term health implications of the move towards vaping are currently unknown.
- Research to allow limited resources such as medicines to be targeted in the most effective way possible, for example using genomics.
- Need to understand more about how health and care costs change through the lifecourse and what drives these changes.