

FINANCE COMMITTEE

DEMOGRAPHIC CHANGE AND AGEING POPULATION INQUIRY

SUBMISSION FROM NHS HIGHLAND

Background

1. Demographic change and an aging society will continue to present very significant and increasing challenges to NHS Highland over the coming years. Demographic predictions do not tell us what *will* happen, but they give some foresight into the *likely* configuration of future populations in order that we can plan effectively to provide optimum levels of health and care into the future.

The effects of demographic change and an ageing population on the sustainability of funding for health and social care.

2. The impact of demographic change will be augmented or diminished by a wide variety of other factors including disease patterns, social and economic factors, technological advances, government policy and changes in lifestyle risk factors.

3. [General Register Office \(GRO\) data](#) show a projected increase in NHS Highland's population of 9% from 2010 to 2035. While the increase in people in working age groups is projected as being around 2%, the projected increase in those in pensionable age groups is 28% and the increase in those aged 75 and over is projected as 98%. In 2010 people over 64 constituted just under 20% of NHS Highland's population; by 2035 it is projected that they will constitute just under 30%. In 2010 people aged 16 to 64 formed 63% of NHS Highland's population; by 2035, that may slip to just under 54%.

4. At an individual level an older person may be healthier than someone half their age but at a population level frailty and the prevalence of a number of limiting health conditions increase significantly with age. The health and social care needs of the population of older adults are, therefore, much greater than those of the younger population.

5. Demographic change may affect sustainability of NHS Highland's funding in three ways:

- Increasing demand for health and care services due to an aging population
- Additional costs arising from the lower proportion of working age people due to:
 - A relatively smaller pool of people in economically active age groups with a likelihood of greater wage competition
 - A potentially smaller proportion of unpaid carers
- A reducing proportion of taxpayers within the population limiting the Scottish Government's capacity to increase health spending in line with increasing demand.

6. The Scottish Parliament Information Centre has modelled the [impact of ageing on health service costs](#). The most conservative primary care scenario, assuming a 20% decrease in primary care consultation rates every five years, results in a one-third increase in primary care consultation costs for people aged 65 years and over by 2033. Other scenarios show cost increases of between two-thirds and 150%.

7. In 2011 NHS Highland's Health Intelligence and Knowledge Team modelled The Impact of Demographic Change on Hospital Services in NHS Highland's area to 2022. The resulting report highlights the uncertainties inherent in prediction, particularly long-term prediction, and is presented as a snapshot of "what might be", rather than "what will be".

8. If current age-specific admission rates and lengths of stay remain constant, projected demographic change would see an increase in General Hospital bed days by 2022, including over a third more occupied bed days for emergency admission compared to 2010, mostly in relation to people aged 75 years and over.

9. Given the size and nature of predicted demographic change and effects on service demand, it is our view that NHS Highland's best endeavours are likely only to moderate, rather than eliminate, the additional cost pressures arising.

10. The other side of the sustainable funding equation is the level and longer-term predictability of the resource NHS Highland receives from the Scottish Government. If funding does not increase in real terms, then the situation is unlikely to be sustainable. Short-term funding arrangements also reduce NHS Highland's capacity to develop and implement effective long-term plans and, therefore, reduce sustainability.

NHS Highland's planning to address demographic change

11. NHS Highland and the Highland Council have long factored demographic change into planning. The [Highland Single Outcome Agreement](#) and [Argyll and Bute Single Outcome Agreement](#) both identify demographic change as a challenge and outline health and care of older people as a priority area for action.

12. The work carried out within NHS Highland in relation to the Impact of Demographic Change in Hospital Services (described above) illustrates the specific use of demographic information in relation to financial planning and service redesign.

13. The most far-reaching current example of planning to address demographic change is the joint NHS Highland/Highland Council [Integrating Care in the Highlands](#) project. This innovative, solution-focussed initiative was born from a recognition of the demographic challenges facing the organisations and the need to deliver services in the most efficient, effective and quality-rich manner achievable, eliminating the discontinuities which arise when a person's care is divided between different organisational structures.

14. Other examples include NHS Highland's Change Fund initiatives, including reablement strategies, the development of virtual wards, anticipatory care planning, development of unscheduled care/A&E responses, increased care at home services, telecare/medicine, memory clinics, step up/step down beds in care homes and supported living accommodation, support for end of life choices, out of hours sitting, home-from-hospital services, referral/diagnostic management through primary care, promotion of self-care, effective partnership working across the public, private and voluntary sectors, co-production, community resilience and community development approaches, etc.

Weight given during the annual budget process to demographic trends/projections

15. Demographic change will present a major challenge to NHS Highland's delivery of health and care in years to come. Our population has already begun to age and we are seeing higher numbers of older people using our services. We have budgeted for service adjustments to accommodate this. However, if population predictions are correct, this is simply the first gentle lapping of what will eventually become a tidal wave.

16. Financial planning for demographic change cannot be undertaken effectively during annual budgeting processes. Predicted changes are cumulative and long-term, unsuited to consideration within the constraints of annual budgeting cycles which tend to push organisations down a largely reactive route. A wider, more enduring view is required.

17. NHS Highland's ability to take a longer-term, sustainable fiscal position in relation to demographic change is heavily constrained by uncertainty over the financial envelope within which we will be required to operate in the medium and longer terms.

18. Ideally, Government would work with NHS boards to develop long-term financial planning mechanisms. These would look much farther into the future than is currently the case and give boards confidence in the financial sustainability of future planning. Because predictions are uncertain, regular adjustment cycles would be necessary to modify the long-term view to changing demographic (and other) circumstances.

19. NHS boards would then be in a position to evaluate likely activity against likely resource and develop long-term service plans accordingly with a degree of confidence and assurance. At NHS board level, medium and long-term plans would be regularly modified and adjusted in the light of new information which alters projections.

Health and Social Care data collection and use to forecast funding requirements

20. General information on available health data is provided by colleagues at ISD.

21. NHS Highland receives regular Scottish population projections and works with local councils to produce smaller area projections. When combined with activity rates by age and gender, these are useful in estimating future activity. Combining these with trend estimates allows the possible impact of different population changes to be assessed.

22. In future, further linkage between primary and secondary care data, including community activity, would be of great benefit, as it would allow better estimation of the totality of care required. Hospital data is readily available, and partly because of this the impact on hospital services tends to dominate discussions. Improving community care information, and information on use of and movement between primary and secondary care, would obviate this inadvertent focus. Much of current funding allocation is based on hospital data, and including information on the volume and costs of community service provision should aid national agreement on funding allocation. Including information on service costs in rural and urban areas, and the relative impacts of deprivation, rurality and remoteness, should be of national assistance.

23. The integration of health and social care services, such as that in the Highland Council area, will provide very useful information on total service use, and this type of data, if available, would be of wide use across Scotland.

The role of preventative policies such as the Change Fund in addressing demographic pressures on the provision of health and social care

24. The focus of prevention should be widened to reduce vulnerability to ill-health which builds up over an individual's life and largely determines subsequent health status. This type of prevention does not begin when someone becomes ill; it seeks, as far as possible, to prevent illness in the first place. There is clear evidence of the importance of addressing the wider determinants of health. In particular, increasing preventative spend aimed at the early years can provide children with a much better start in life and a greater likelihood of a healthy old-age.

25. The evidence around ill-health and inequalities illustrates the need to extend the preventative approach to public policy in areas not traditionally regarded as Health (for example, housing, jobs, education etc.) This indicates the need for a continued and enhanced drive towards multi-agency working on a range of issues which are likely to affect health in the longer term.

26. Much has already been done to tackle such major risk factors as obesity, smoking and alcohol misuse. In NHS Highland's area, [smoking rates have reduced](#) over recent years. However [alcohol-related harm has remained broadly unchanged](#) while [obesity levels continue to rise](#). If the pressures arising from demographic change are to be effectively ameliorated, it is important that efforts to tackle these issues are intensified.

27. Reductions in premature deaths including those from Coronary Heart Disease (CHD) and cancer have contributed to the demographic pressures we now face. Many people successfully treated for such conditions will regain excellent health.

For some, however, health will remain compromised in the longer term. As survival rates improve, there will be a need to increase the resource available to manage long-term conditions, preventing recurring health crises in those affected.

28. Preventative measures introduced under the Change Fund have been effective in, for example, reducing occupied bed days in for people over 64. The requirement to demonstrate a 3:1 return on investment has been viewed as crucial in this respect. However, while successful in enabling greater independence in those who are already carrying a burden of ill-health, Change Fund initiatives have yet to address the factors that lead to people's health becoming compromised in the first place.

29. In continuing to progress the changes required, there should be a permanent, rolling Change Fund to drive long-term planning of a wider range of preventative policies.

A wider view of pressures on health and social care

30. There is no single source of future pressure on health and social care and not all pressures on health and social care are "health" problems in nature or origin. There is, instead, a range of pressures many of which are fundamentally interlinked.

31. One of the greatest financial pressures facing health and social care (other than demographic change) lies in technological development. Many conditions regarded as untreatable in the past are now amenable to treatment thanks to developments in diagnostics, surgical interventions, drug regimes, etc. It is to be anticipated that such developments are likely to continue in the future and will increase costs significantly. Technology can also help to reduce costs. The development of keyhole surgery has enabled a reduction in the time people need to spend in hospital and telehealth and telecare can enable people to be cared for and treated effectively in their own homes and have the potential to help reduce the need for emergency or unplanned care. When these are taken as a whole, technological advances add significant financial pressures rather than leading to cost reductions.

32. Government policies also serve to vary pressures on health and social care. Through reducing incomes and increasing income inequalities and housing/food insecurity, the UK Government's Welfare Reform Act and other associated changes to benefits are likely to undermine health for those affected by them. Though there is ample evidence within the literature that such policies are likely to reduce health status, the extent to which people will be affected remains unclear and the associated financial pressures, though considered potentially very significant, are nevertheless largely unquantifiable.

33. On the other hand recent legislation on Smoking in Public Places has already served to improve health and these improvements will be cumulative. The introduction of alcohol minimum unit pricing is also likely to improve population health. Meanwhile, increasing rates of obesity present a significant potential source of future pressure on health and care budgets.