Written submission: Health, Care and Sport Committee, Scottish Parliament, 28 Oct Session – Professor Martin Knapp, London School of Economics and Political Science

Decision makers in social care systems face challenging economic realities: needs and aspirations are growing, public resources are shrinking, while private resources are very unequally distributed.[1] Difficult decisions are faced about how to use available resources to meet needs in a timely fashion, respond to the preferences of people who draw on care and enhance their wellbeing, support carers and the paid workforce, whilst also investing for the future through capital spending and seeking to prevent needs emerging in the first place.

Achieving a financially sustainable social care system that improves population wellbeing means paying attention to what works in terms of better outcomes, what it costs to achieve those outcomes, and whether the balance between costs and achievement is 'worth it'.

Evidence from economics studies – often couched in terms of cost-effectiveness or cost-benefit – can support that quest by informing decisions in several different contexts. These include decisions by central government finance and spending departments, local authorities (as both commissioners and service providers), guideline developers (such as the Scottish Intercollegiate Guidelines Network (SIGN)), organisations in the public, private and voluntary sectors that deliver care and support, people who pay for their own care, family and other unpaid carers, and the manufacturers and sellers of products such as new care technologies. All these groups make decisions about how to use their available budgets and other resources, and all will want to make sure those decisions produce the best outcomes.

There is less cost-effectiveness evidence in social care compared to health care, but it is accumulating and it can be employed to good effect.[2] The term 'cost-effectiveness' does not mean that something is cheap or necessarily saves money; a cost-effective service model is one that achieves a socially acceptable balance between outcomes – how is quality of life improved, for example – and costs. A new service model might cost *more* than what is currently provided, but it could still be considered cost-effective if it generates much better outcomes.

As an example, consider the policy and practice responses to **dementia**, a rapidly growing challenge for health and social care, and more widely. The number of people with dementia has increased rapidly over recent decades and is projected to grow even faster.[3] Dementia is a health issue with substantial impacts on the NHS. But the social care costs of dementia dwarf healthcare costs (comprising 38% of the total in 2024), while costs associated with unpaid care (out-of-pocket payments, lost employment and opportunity costs) are higher still (47% of the total).[4] Effects on family and other unpaid carers are actually much greater than those costs imply, because many dementia carers are themselves of an age where their own health needs are substantial, and where caring can have a heavy toll, including on their own dementia risk.[5]

There are both short and long-term potential responses: prevention, cure and care. A long-term strategy is to address the known early life and mid-life risk factors for dementia to reduce the number of people with the condition in future decades. Supporting smoking cessation, reformulating food products to reduce salt and sugar intake, improving treatment of diabetes

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[1] McKee M et al. (2021) The changing health needs of the UK population. *Lancet* 397, 1979-1991.

[2] With funding from NIHR, a compendium has been compiled of evidence on cost-effectiveness of social care service models and interventions in the UK. This online resource (ESSENCE) is freely accessible: https://essenceproject.uk/.

[3] GBD 2019 Dementia Forecasting Collaborators (2022) Estimation of the global prevalence of dementia in 2019 and forecasted prevalence in 2050. *Lancet Public Health* 7(2):e105-e125.

[4] Alzheimer's Society. The economic impact of dementia. Module 1: the annual costs of dementia. 2024 https://www.alzheimers.org.uk/sites/default/files/2024-05/the-annual-costs-of-dementia.pdf.

[5] Xue B et al (2026) Association between becoming a carer in later life and changes in the trajectory of cognitive function. *Age and Ageing* May 4;55(5):afag132.

and hypertension, reducing alcohol use through minimum unit pricing, tackling air pollution through low emission zones, encouraging people with hearing impairments to wear aids, and legislating for compulsory bicycle helmets – all these actions not only have immediate health benefits but also reduce future dementia prevalence. In their effects on *dementia alone*, each is cost-effective and will substantially reduce future social care costs and carer burden.[6]

But action is needed to achieve more immediate gains. There are already symptomatic medications that can slow down cognitive decline for a short while and improve quality of life for some people with Alzheimer's disease. There are also newer medications (lecanemab and donanemab) which may slow down the actual progression of the disease, although those currently licensed in the UK have only modest impacts and are not recommended by the Scottish Medicines Consortium because of cost-effectiveness and clinical uncertainties.

Expanding the availability of effective, cost-effective post-diagnostic support would contribute *now* to quality of life of people with dementia (and help them to stay living safely in their own homes for longer) and of their carers. Four examples can be given. Cognitive stimulation therapy – delivered in small groups – improves memory and thinking skills, and quality of life, does not cost more than usual care, and is cost-effective.[7] Supporting family carers of people with dementia through a structured programme can substantially improve carer mental health and health-related quality of life over a 6-year period, reduces the likelihood of care home admission and is cost-saving.[8] A personalised care and support intervention is cost-effective from the perspective of the quality of life of the person with dementia as well as clinical effectiveness.[9] Non-clinical dementia navigators can help people find their way around care systems, coordinate services and improve access, while generating substantial NHS savings.[10] These are all effective, cost-effective service models but they are not widely implemented.

What stops these service models being delivered? Budgets are organised in silos and incentives may not align across health, social care, welfare benefits and other sectors. Impacts on carers are often ignored when public expenditure decisions are taken, even though supporting carers can help grow the economy by allowing some to return to work. Investing now for effects some years in the future is unattractive to decision makers trying to balance their books today. Service commissioners often seem to discount evidence that is not generated locally. Service providers often struggle to introduce new care arrangements because of high staff turnover.

Dementia has been used here to illustrate some of today's major social care-related challenges – rapidly growing needs, interdependency between health and social care, heavy reliance on families, and high and increasing public and private costs. These challenges can be addressed in ways that improve wellbeing whilst using resources efficiently, but this requires public bodies to collaborate better, to be prepared to invest for the longer term, to recognise the relevance of evidence generated elsewhere, and to listen to people with lived experience.

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[6] Mukadam N et al (2020) Effective interventions for potentially modifiable risk factors for late-onset dementia: a costs and cost-effectiveness modelling study. *Lancet Healthy Longevity* 1(1):e13-e20; Mukadam N et al (2024) Benefits of population-level interventions for dementia risk factors: an economic modelling study for England. Lancet Healthy Longevity 5(9):100611; Knapp M et al (2026) Examining the economic case for risk-reduction interventions for dementia and Parkinson's disease. NIHR Policy Research Unit in Dementia and Neurodegeneration.

[7] Spector A et al (2003) Efficacy of an evidence-based cognitive stimulation therapy programme for people with dementia: randomised controlled trial. *British Journal of Psychiatry* 183:248-54; Knapp et al (2006) Cognitive stimulation therapy for people with dementia: cost-effectiveness analysis. *British Journal of Psychiatry* 188:574-580.

[8] Livingston G et al (2020) Clinical effectiveness of the START (STrAtegies for RelaTives) psychological intervention for family carers and the effects on the cost of care for people with dementia. *British Journal of Psychiatry* 216(1):35-42.

[9] Isaaq A et al (2025) Cost-utility of a new psychosocial goal-setting and manualised support intervention for independence in dementia (NIDUS-Family) versus goal setting and routine care. *Lancet Healthy Longevity*, 6

[10] Walbaum M et al (2026) Primary care-based post diagnostic dementia care in England: modelling and scaling up evidence-based models for efficient future care, *Age and Ageing* 55:afag232.