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Official Report

FINANCE COMMITTEE

Wednesday 21 November 2012

Session 4

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FINANCE COMMITTEE
30th Meeting 2012, Session 4

CONVENER

*Kenneth Gibson (Cunninghame North) (SNP)

DEPUTY CONVENER

*John Mason (Glasgow Shettleston) (SNP)

COMMITTEE MEMBERS

*Gavin Brown (Lothian) (Con)
*Jamie Hepburn (Cumbernauld and Kilsyth) (SNP)
Michael McMahon (Uddingston and Bellshill) (Lab)
*Elaine Murray (Dumfriesshire) (Lab)
*Jean Urquhart (Highlands and Islands) (Ind)

*attended

THE FOLLOWING ALSO PARTICIPATED:

David Bookbinder (Chartered Institute of Housing in Scotland)
Mike Brown (Association of Directors of Social Work Resources Standing Committee)
Callum Chomczuk (Age Scotland)
Fiona Collie (Carers Scotland)
Nancy Fancott (Coalition of Care and Support Providers in Scotland)
David Ogilvie (Scottish Federation of Housing Associations)

CLERK TO THE COMMITTEE

James Johnston

LOCATION

Committee Room 6

Scottish Parliament

Finance Committee

Wednesday 21 November 2012

[The Convener *opened the meeting at 09:35*]

Decision on Taking Business in Private

The Convener (Kenneth Gibson): Good morning, and welcome to the 30th meeting in 2012 of the Scottish Parliament's Finance Committee.

I apologise for being late. I did not realise that the meeting was to start at 9.30; to be honest, I still do not understand why it was to start then, given our fairly limited agenda. That said, I repeat my apology.

Everyone present should turn off their mobile phones, BlackBerrys and pagers, please. We have received formal apologies from Michael McMahon.

I warmly welcome to our meeting a delegation from the Indonesian Government's Ministry of National Development Planning and Ministry of Finance, and the World Bank. The delegation is in the public gallery.

The first item on the agenda is to decide whether to take item 3, our draft report on improving employability, in private, and further consideration of the draft report in private at future meetings, if necessary. Do members agree to do so?

Members *indicated agreement.*

Demographic Change and Ageing Population Inquiry

09:36

The Convener: Our main item of business is to take further evidence for our inquiry into demographic change and the ageing population. We will take evidence in a round-table format.

I welcome to the meeting Callum Chomczuk of Age Scotland; David Ogilvie of the Scottish Federation of Housing Associations; Fiona Collie from Carers Scotland; Mike Brown from the Association of Directors of Social Work; David Bookbinder from the Chartered Institute of Housing in Scotland; and Nancy Fancott from the Coalition of Care and Support Providers in Scotland.

Two of the most significant challenges that public finances in Scotland face over the coming years are an ageing society and the need to try to increase sustainable economic growth. In its "Fiscal sustainability report" of 2011, the Office for Budget Responsibility stated:

> "Demographic change is a key source of long-term pressure on the public finances."

The issue also has a crossover to other fiscal sustainability work around universal services and employability.

I remind everyone that the remit of our inquiry is:

> "To identify the impacts which demographic change and an ageing population will have primarily on the public finances in respect of the provision of health and social care, housing, and pensions and the labour force, and the planning being undertaken by the Scottish Government and key public bodies to mitigate such impacts."

I thank all the witnesses for their submissions and will ask Callum Chomczuk to kick off once I have quoted a section from Age Scotland's submission. Anyone who then wishes to ask him a question or to make a point should catch my eye. I will take people in the order in which I see them. Please feel free to contribute as often as possible. You do not have to wait until everyone else is asked a question; if you want to say something, please come in, and we will keep the debate moving forward. We have about 90 minutes, but our time is reasonably flexible.

The Age Scotland submission says:

> "While our ageing population is leading to an increase in the overall cost of delivering services, it is our failure to commission appropriate services which has led to 1/3 of the older peoples' health and care budget ... being spent on delayed discharge and unexpected admissions."

Will Callum Chomczuk expand on that a wee bit and tell us what the "appropriate services" should be?

Callum Chomczuk (Age Scotland): Thanks for inviting me to the meeting.

I am sure that most members of the committee saw the Audit Scotland report from earlier this year, which I quoted in my submission. Audit Scotland really took to task local authority commissioners for their inability to plan the appropriate services to meet the health and social care needs of the ageing population.

I also quoted Asthma UK, which drew attention to the failure of local authority commissioners to have the analytical skills to plan appropriately. There is a real concern that local authorities are not working out what services the local community needs, what it will cost to commission services and what the supply of local services is. Until we get a real picture of need and the capacity to deliver, we are never going to procure and deliver the right services for older people.

I hope that the health and social care integration approach will improve the commissioning process. However, we need details: how will we upskill commissioners, improve the process and increase the involvement of the third sector, which knows what services local people need, in the decision-making process? Such measures would lead to better decisions on commissioning and—I hope—a reduction in the £1.5 billion cost of unexpected admissions.

I will leave it there and let other people in.

The Convener: Okay. Does anyone else wish to comment?

John Mason (Glasgow Shettleston) (SNP): Although we have had evidence from different sources, I am still not sure whether the fact that people are living longer automatically means that they need a lot more care and support. Some have suggested that people need most support and care in the last year or year and a half of their lives. However, others might think that somebody who lives to 80 rather than 70 will need intensive care for an extra 10 years. I am not clear how the issues tie together, but I believe that the extra years would have an effect on care and housing. Are people living longer before they need supported accommodation, sheltered housing or that kind of thing, or will they have to be in such accommodation a lot longer because they are living longer?

Callum Chomczuk: Obviously, the ageing population is putting huge pressure on the need for things such as increased housing. Does someone else want to come in?

Nancy Fancott (Coalition of Care and Support Providers in Scotland): I want to pick up on Callum Chomczuck's general point about commissioning. Commissioning is a huge issue for third sector providers, but we are unfortunately not involved in it as much as we could be. The Audit Scotland report "Commissioning social care" noted that only 11 of the 32 local authorities had some form of strategic commissioning plans for social care, which is a concern for all of us.

Our message is that we have a lot of experience and expertise to bring to that table and that we should be involved in the planning for services in local committees from the get-go rather than being brought in as potential providers at the point where services are being procured. I point out that the distinction between commissioning and procurement is that commissioning happens at the planning and development stage, and procurement is about how we are going to provide the services that we have decided we need.

We are keen to get more involved in the commissioning stage. I understand that, in the context of health and social care integration, quite a bit of work is taking place now around joint strategic commissioning, which is being led by the joint improvement team and which is quite promising. What it has developed so far is a national learning and development framework, and guidance is being developed. Quite a lot of work is therefore beginning to take place that will—I hope—improve commissioning. However, until now, it has been difficult for the third sector to get involved in the commissioning stage, which we think is the most important stage and where we need to make our contribution.

09:45

The Convener: Before Mike Brown comments, I notice that his submission states that

> "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."

Perhaps he could also speak to that point.

Mike Brown (Association of Directors of Social Work Resources Standing Committee): First, let me respond to earlier questions on whether increasing longevity means that the additional years are healthy or unhealthy and what the fiscal implications or consequences of that demographic change might be. Unfortunately, the evidence on whether life expectancy is increasing at a greater or lesser rate than healthy life expectancy is somewhat mixed. Indeed, there was a recent change to the measurement of healthy life expectancy, which basically depends on survey information.

I tried to address the question in paragraph 33 of my submission, where I quote from the Scottish Government's 2010 report "Demographic Change in Scotland". That report states:

"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"—

those are the years of long-term conditions in particular—

"has, for men, actually been widening."

I think that academic contributors to the committee's previous evidence sessions said pretty much the same thing, which is that the jury is out on that one.

On page 3 of the ADSW submission, I provide data that I acquired from the Scottish Government about the fiscal implications for expenditure on the national health service and social care together for all adults—I think that the cut-off was 16, so this is not just expenditure on older people. The Scottish Government modelled several variant scenarios where there were greater improvements in healthy life expectancy than current data might indicate, but the impact on the funding required for the future is less than you might think. For example, on the most favourable analysis of healthy life expectancy, the average annual increase required for all demographic change—including among the non-elderly—was 0.8 per cent per year by 2030, which is not a huge amount. On the worst scenario, the average annual increase was 1.4 per cent per year. Those percentage increases are not huge.

We make the point in our submission that, obviously, much will depend on what the economic growth rates are in the future. They are pretty grim now, but all previous economic slumps have come to an end after a while. If we return to the average growth rates of the recent past, those increases are not really unaffordable on economic grounds. That may be a big if, but that is the case. However, it may be that the way that we are managing the services is unsustainable for other reasons.

That brings me to the question whether we have too much expenditure locked up. For example, of the roughly £4.5 billion that is spent on NHS and social care for older people, £1.5 billion is locked up in emergency admissions. As Callum Chomczuk mentioned in his submission, that is one third locked up in a very reactive service, and we all want to see the investment downstream in prevention.

However, I disagree with the analysis that Callum Chomczuk and Nancy Fancott have put forward that the problems are to do with local authority social care commissioning. I do not doubt that things could be better—there are examples of good practice involving the third sector and joint commissioning, and there are examples of bad practice—and, like all parts of the public sector, local authorities are sincerely trying to improve what they do. However, that is not really the problem. The problem is not poor commissioning but that there is not any spare money to put into preventative services because it is all locked up in dealing with the current levels of need.

Generally speaking, budgets—certainly in social care—have not kept pace with demographic changes in the past 10 years, so eligibility criteria have become tighter and tighter. Budgets are locked up in current service models that are dealing with high levels of need. Finding spare capacity to free up money for prevention is a major problem. That is why we have the change fund, which is a very welcome development and a step in the right direction.

The NHS contribution of £80 million a year and the local authority contribution of £20 million a year—£100 million a year—is quite a small percentage of the £4.5 billion for older people's NHS and social care services. Unless we can find ways to free up money for more prevention, it will be difficult to meet all our aspirations for the quality, volume and availability of services, not only for older people but for other groups—such as people below the age of 65 with learning disabilities—that are also increasing in numbers and in their level of need.

John Mason: If I understand you correctly, you are saying that the difficulty is that we do not have extra money to put into preventative expenditure. Are there areas in the budget that you think that we could cut back on to free up more money?

Mike Brown: If we can fund some double-running costs, we can start to invest in the services that reduce the higher cost. For example, hospitals want more funding in community health, community social care, home helps, telecare, adaptations to housing and so on, which we know will be cheaper in the medium to long term.

In addition, we need to provide much more support for carers and to look at building community capacity in other sorts of prevention. At the moment, we do not have the means to fund a lot of that, so we need to find some way of increasing the size of change funds. I do not have a solution apart from the fact that more cash needs to be put into this area. It is ultimately a question of political priorities.

We have to remember that in the past five or six years, the NHS, and local authorities in particular, have done a huge amount to change the way in which they operate in order to provide efficiency savings. They have had to do that simply to balance the budget. Those savings have not been available for investment and prevention; they have been taken in order to have balanced budgets.

Until we crack the question of how we resource prevention, we will be toiling.

There are some low-cost things that could be done. In the ADSW submission I quoted David Bell, who said something that my association said when we were here back in 2010 for the committee's inquiry into prevention, which is that there is no one-stop shop for prevention solutions. Lots of academic institutes, such as the Institute for Research and Innovation in Social Services in Scotland, the Social Care Institute for Excellence down south and the Nuffield Foundation, and lots of academics, are looking at what works in prevention and coming forward with really good research that shows the benefits of various solutions and what is necessary to deliver them. Although it is quite difficult to get a handle on that wealth of information when it is not all in one place, it would be quite simple to commission the relevant agency, at low cost, to come up with a website with links and some kind of analysis of what works in prevention. We are all looking for opportunities to change what we are doing and learn from the growing evidence base in prevention.

Elaine Murray (Dumfriesshire) (Lab): I want to ask for comments on the role of housing in prevention and whether we are making the right investments and going in the right direction. In appropriate housing, older people can remain independent longer, will require fewer care services and are less likely to need emergency admission to hospital. However, anecdotally, I hear that properties that were built for pensioners and disabled people are often having to be allocated to single people, partly because of pressures resulting from long waiting lists and our homelessness targets. I imagine that that will get worse with welfare reform and that the bedroom tax will increase the pressures on those properties and possibly make them less available to older people. I wonder what we can do to tackle that.

I wonder, too, whether even in the private sector we have the correct standards for constructing properties so that they remain accessible to older people as they get older. Over the years, there has been a bit of a retreat from sheltered housing, and even where there is sheltered housing it is often being renamed as retirement accommodation. That seems to be being accompanied by a reduction in the level of support that people are getting, with premises not having live-in wardens and people having care-call instead of somebody on the premises who can assist. Is housing going in the wrong direction at the moment in terms of the preventative agenda for older people?

David Bookbinder (Chartered Institute of Housing in Scotland): Elaine Murray is completely right that there has been a significant degree of pull-back from a focus that was probably there mostly in the 1980s and 1990s—maybe into the 2000s—on specialist housing or housing with support or care, moving away from sheltered housing up the way, if you like, towards housing-based alternatives to residential care.

The reality goes back to John Mason's question about the implications of people living longer. The vast majority of older people always did live in ordinary housing and stayed in ordinary housing, but the proportions are going to become even more acute. However frail they become, only the tiniest minority of older people will leave to go into sheltered housing, extra-care housing or residential and nursing care. The proportion of older people who do that will become ever smaller, so all the things that are important about the mainstream housing system, as opposed to a specialist housing system, will become even more crucial. Mike Brown mentioned one of those, which was always going to come up today, when he talked about adaptations. I will return to that in a second.

Elaine Murray mentioned the design of all the houses that we are building today in the mainstream housing programme. What are the accessibility standards? Even if they are decent in terms of the general standard—the building regulations and what, in the jargon of the housing field, we call the housing for varying needs standards—and have enhanced general accessibility, we are not building many houses that are suitable for people who use wheelchairs. It costs more to do that, so that sector gets squeezed when we are trying to build as many units as possible for the least amount of money. Wheelchair housing is a mainstream housing issue; it is not specialist, it is just housing that a wheelchair user can live in. Dementia awareness is also an issue not only when we design new houses but when we retrofit existing homes. There is an increasing awareness of the often quite modest changes that can be made to an existing home to make it more user friendly for somebody who has dementia.

The issue of adaptations has a higher profile than it used to—everyone on both the health and social care and the housing sides would admit that—but there is still something grudging about adaptations on both sides. Most of the legal obligations relating to adaptations are in the health and social care world, often going back to legislation from the 1970s, but a lot of the money for adaptations is on the housing side and the issue has always fallen between the two. To be fair, the Scottish Government has been looking at it and we are waiting for what we hope will be quite a radical report about the way forward on adaptations. However, whatever the way forward

is structurally—whoever has the lead responsibility, whether health and social care, housing or the individual funding their own support—more money will need to be spent on adaptations. There is a long way to go on that journey for adaptations—some of which can cost £1,000 or £2,000—for the profile to be where it should be.

The important thing is to think mainstream. Even five years ago, not much specialist provision was being built, but at the moment the process of aligning housing capital and health and social care capital, building stock and then aligning that with forward commitments on providing care in that specialist housing and care setting, is a really difficult call. The focus is almost inevitably on how we can make the mainstream housing stock suitable.

10:00

David Ogilvie (Scottish Federation of Housing Associations): Thank you for inviting us to give evidence.

Elaine Murray asked whether investment in housing is going in the wrong direction and whether we are doing enough to achieve a shift to preventative spend. I will invite Nancy Fancott to give you evidence about our work with the CCPS, under the auspices of the Housing Support Enabling Unit, to conduct a provider optimism survey of housing support providers.

Providers are reporting a significant downturn in the investment that they receive from local authorities. When the budget comes to the pinch, local authorities are doing exactly what we thought they would do, which is to cover the base—that is, their statutory responsibilities—and not look at the bigger picture. I have a degree of sympathy with local authorities, because they are in an inauspicious position. However, we need to achieve the shift, because doing so is essential to fiscal sustainability in the longer term.

I want to cover a range of issues in the context of the SFHA's input. I will ensure that members receive a copy of the report that we produced earlier this year through joint improvement team funding, "Supporting older people to live at home: the contribution of housing associations and cooperatives in Scotland"—I will send a copy to the clerks for distribution. We wanted to put on record the offer that we can make to the change fund process and to health and social care providers and commissioners, to help them to see the role that housing associations and co-operatives in Scotland can play.

Currently, less than a third of change fund applications made by housing associations are successful. Far too often, I hear anecdotal evidence that major players in the sector—I think that the committee will take evidence from Bield Housing Association, Hanover Housing Association and Trust Housing Association—are extremely frustrated because they are not getting the opportunity to provide services or to help in the shift towards preventative spend.

Elaine Murray said that there is a retreat from sheltered housing. That is a historic trend. Before my time at the SFHA, the Scottish Executive—as it was—undertook a review of older people's housing, which showed that, because of the European working time directive and the squeeze on housing support funding, it was becoming increasingly difficult for sheltered housing providers to make the warden model of sheltered housing stack up.

I am sure that, whenever there is a reconfiguration, members get mail about it in their constituency postbags. I will leave it to the providers that you will hear from in your next meeting to give their perspective, but I can say on behalf of the sector that there was never a conscious decision to cut services. Provision stacks up only as the funding dictates. The European working time directive made it unwieldy and difficult to manage the sheltered housing model and pushed things over the edge.

It makes more sense to move towards a telecare model. If, after consultation with tenants, such a model stacks up and is acceptable, that is fine. I fully appreciate that there are delicate issues to do with the transition from one model to another. However, in general, the sector does what it can to keep support in place.

The answer to Elaine Murray's question is yes, overall we are probably going in the wrong direction in terms of preventative spending, because there are indications that spending is getting squeezed. However, I would not want the committee not to appreciate the full range of services that the sector offers.

We are involved in making adaptations to homes. We help owner-occupiers to fund and undertake repair schemes. Housing associations underpin most of the care and repair schemes in Scotland. We provide information and advice on housing options through housing options hubs, and we also organise various different low-level support services such as visiting, befriending, stair cleaning, snow clearing, and what have you. Housing associations can therefore play a role as community anchors. I could quote some brilliant examples such as the Cassiltoun Housing Association and the Elderpark Housing Association project, which is a craft cafe in its stables property in Castlemilk. That provides a unique opportunity for local people to engage and maintain a mentally healthy and active life. That

sort of thing helps to prevent admissions to health and social care.

We are determined to force our way into the integration of health and social care. Along with the Scottish Council for Voluntary Organisations delegation, we went to meet the Deputy First Minister earlier this year when she was overseeing the health brief. We wanted to make known our concern that housing was not really mentioned in the health and social care integration consultation. The committee should be mindful of how important it is to include housing. How can we shift the balance of care into the community if we do not have appropriate home settings? Our sector is more than able to provide those settings.

Callum Chomczuk: The Scottish Government and Parliament have recognised the pressures that there are on older people's housing stock through the ageing population, and I welcome the committee looking at the issue today. In the evidence session that I was at a couple of weeks ago, I mentioned that the Government conducted a review in 2010 and modelled what the pressures would be exactly. It said that the number of pensioner households that would require adaptations would rise from 66,000 in 2008 to 106,000 in 2033, and the number of sheltered housing units would need to rise from 38,000 in 2008 to 61,000 in 2033.

We can therefore see that the ageing population is putting a huge amount of pressure on that type of housing stock alone. The question is how we are placed to meet that challenge. Last year, the Scottish Government published its older people's housing strategy, which was a welcome document that set out a framework that showed that the Scottish Government recognises the challenge of housing older people within the community, and set out how it is working with partners in the third and private sectors, housing associations and local authorities, to help to supply that housing stock. That framework is really valuable, but the problem from Age Scotland's point of view was that there were no targets or benchmarking within the document. The strategy seeks a plan for older people's housing in 10 years, but there are no expected outcomes. If we can work towards a better housing outcome for older people, that would seem to be a satisfactory outcome.

What is more disappointing is the fact that no resources are attached to the budget. Local authorities have no funding incentive from the Scottish Government to act, so there is no reason for them to follow through on the actions detailed in the older people's housing strategy.

The bigger challenge is for local authorities to start to map their local housing stock. I think that only one local authority in Scotland—North Ayrshire, which includes your constituency, convener—has started to map its housing stock, how useful it is, and how susceptible it might be to being adapted. Budgets are decreasing so we will have to depend much more on adapting existing housing stock. We will not have the capital to build brand new houses for older people, so we must make sure that the existing stock can be adapted. However, until local authorities are in a position to undertake a fairly extensive review of what they have available, we will always be one step behind.

The framework is there and it is important, and we have touched on the preventative spending in adaptations. The evidence from Bield and Hanover is that spending £3,000 on adaptations can save in excess of £10,000 in health and social care costs. Those are clear examples of why we should invest but, so far, local authorities do not have the resources to focus on such investment as a priority.

Jamie Hepburn (Cumbernauld and Kilsyth) (SNP): I want to turn to the role of carers because I would imagine that, as the proportion of the population that is older increases, there will be increased demand not so much on the statutory sector but for private carers and familial support. Are we geared up to support such people? I note that, in its submission, the Association of Directors of Social Work suggests:

> "There is a growing consensus that much more investment is required to improve support to carers".

What are the needs in that respect and what might they be in the future? Moreover, how does self-directed support, which we are moving towards, fit in with this agenda?

The Convener: I call John Mason, to be followed by Jean Urquhart.

John Mason: Is it okay if I go back to housing, convener?

The Convener: Of course it is.

John Mason: Taking a slightly different angle from Jamie Hepburn and returning for a moment to housing, I took from Callum Chomczuk's comments that, because money is tight, we will have to emphasise adaptations rather than build specially designed sheltered housing or whatever. I wonder whether that is what everyone is actually saying, because some of the evidence seemed to suggest that it was the other way round.

Secondly, is the current mix right? Should we just stop building new houses and put all the money into adaptations? I cannot imagine that that is the answer, but should there be some kind of switch or move in that respect?

Thirdly, in its submission, the CIHS seems to suggest that, although equity for private home owners cannot be released at the moment, it

should be. Could people get some kind of loan on which, say, the public sector paid the interest and under the terms of which the house would be sold when no longer required and the loan itself repaid? There would be no risk in such a move. When I was a councillor, I heard of people paying tens of thousands of pounds for an extension to a house, a downstairs toilet and so on, and such things can require huge input from one family.

The Convener: I think that that question was directed at David Bookbinder.

David Bookbinder: Perhaps I should answer the housing question rather than the carers question that was asked.

The Convener: I will bring in Fiona Collie in a wee minute. That is why I did not ask her to respond directly to Jamie Hepburn's question.

David Bookbinder: John Mason has raised a number of points. On the question of specialist versus adapted housing, there will always be a need for some highly specialist new-build provision, but the danger is that there might well be little or none of that. Even if only 1 per cent of older people have to move at some point in later life because, for one reason or other, it is not possible for them to be cared for at home, we are still talking about a reasonable amount of specialist housing based in what might be described as homely housing and care settings that one would hope will be an alternative to what we have come to see over the years as residential care. At the moment, it is very hard to see much, if any, of that coming. Even five years ago, before the economic climate worsened, there was relatively little of that kind of specialist provision being built. We are facing a bit of a time bomb in that respect. However much we rightly focus on adapting existing stock, there will always be a need for some highly specialist provision and it is very hard to see where that is going to come from.

Mr Mason is right to focus on the equity release issue, given that so many of the older population are home owners. Indeed, it was very telling that you asked whether the public sector could make provision in that respect. When, years ago, I was lucky enough to work for what was then known as Age Concern down south, equity release was very close to our hearts. In the 1980s, however, there were some scams and schemes that were not very good for older people and which gave it a bad name. The ideal scenario would be to invent a product that would be relevant for repairs or the adaptations that Mr Mason mentioned, particularly larger ones such as extensions, and which would allow someone to borrow 10 per cent of the value of their home without having to pay interest and to repay that sum as an equity share when the property was sold. No commercial outfit will ever do that because they want to give you 10 per cent and take 20 per cent on the sale. They know that that does not look good and they will not go into it. They did not go into it in the days when the housing market was good and they are certainly not going to go into it now.

10:15

That begs the question whether there is a role for the public sector. A few years ago, when, understandably, grants for home owners were starting to be withdrawn, the Scottish Government looked at something called a national lending unit to see whether some kind of equity loan could be offered by what would effectively be a state bank on the basis that commercial outfits would not go into that area. However, quite apart from the fact that the credit crunch did not help that kind of initiative, some of us believe that there was perhaps an element of cold feet from a Government that was not really confident that it wanted to be a bank or a lender. Only the public sector will be able to provide a reasonable and appetising equity release model for older home owners. It will never come from the commercial sector.

David Ogilvie: On the back of what Mr Bookbinder said, without naming any names, I am aware of some in our sector who have looked at whether they could develop an equity release model, almost as an adjunct to their factoring offer. If the committee is interested, I would be happy to write to it separately about that. However, because I have not consulted those individuals, it would not be appropriate for me to say more at the moment.

The social enterprise model or equity release provision would be far preferable to the commercial scenario, purely because of the reasons that David Bookbinder has stated. There have previously been some pretty bad horror stories.

I take the opportunity to build on Callum Chomczuk's point about the strategy not having sufficient resources. I would tie that to John Mason's point about whether we should stop building houses—please God no. We have a huge housing crisis in this country and one of the biggest points that the Finance Committee needs to take on board is the evidence that my director, Maureen Watson, gave the committee on a previous occasion. From our perspective, housing is one of the key drivers for economic growth. More money should go into housing, and not just in terms of capital investment for mainstream housing. Picking up on the evidence from the CIHS about wheelchair housing, I believe that if we fail to invest in specialist housing and affordable rented housing for all household types, we will pay for it in future in high health and social

care costs that we will not be able to accommodate in a budget that is set to reduce.

Jean Urquhart (Highlands and Islands) (Ind): Do all the agencies have an influence on, or work together with, local authorities on new houses that are built? Given that it is easier to build one house in every so many for a wheelchair user, that we know the percentage of people who are likely to need such housing and that someone who is not a wheelchair user could live in such housing, is it better to think of that in advance rather than to do adaptations? How do you engage with all the other agencies, social work departments, local authorities, health boards and so on—and private sector companies such as Bield, I guess—that have a vested interest in making that happen?

David Ogilvie: We have adaptations because we can go forward only from where we are; we cannot reinvent the housing stock that we have inherited. Over many years, we have developed a housing stock that may not be compliant with wheelchair housing needs or indeed housing for varying needs, which Mr Bookbinder mentioned earlier.

If we are to be truly preventative, we need all sectors—whether it is the private rented sector, the private sale sector or the social rented sector—to build to a wheelchair-compliant standard. That will cost much more in the private developer sector. There will probably be some feedback from Homes for Scotland on that point, but it is the only way that I can see of achieving the objective.

David Bookbinder: You are right to focus on influencing local authorities because, as you have identified, they are now the lead agencies in the affordable housing supply programme, which is overseen by the Scottish Government nationally.

The way in which local authorities estimate the housing needs of older people leaves a lot to be desired. However, I have some sympathy with them. Back in the 1980s, and even into the 1990s, the housing needs of older people were estimated by the use of an automatic prevalence rate, which said that for every 1,000 of the population we needed 21.6 sheltered houses. It seems very old fashioned now to say that it is sheltered housing or nothing, and that nothing else matters.

With the current focus on mainstream housing, there is uncertainty in local authorities about exactly what to seek and to commission in the way of a housing programme when we have to consider mainstream issues such as a percentage of new houses being built for wheelchair use.

The Scottish Government, which rightly still oversees the affordable housing supply programme, has a critical influence on how local authorities deal with housing need. It is down to the Scottish Government to ensure that the outputs are not so squeezed by trying to get as many houses for £30,000 or £40,000 a unit as possible; the Government should not be so keen to get the numbers right that it misses some of the breadth and variety of the provision that is needed. As David Ogilvie said, doing that could lead us into trouble in the future because we will have new houses but they will not be of the right type.

Jean Urquhart: Is your sector making that recommendation? I am not suggesting that every house should be built to accommodate wheelchairs, but who decides? If we are realistic, it is a spend-to-save issue; £4.5 billion is spent on health and social care for older people and a third of that sum, or £1.5 billion, goes on emergency admissions for elderly people who do not have the right facilities. Adapting one house in 20 cannot dramatically increase the cost.

David Bookbinder: That is why Horizon Housing produced a report a couple of weeks ago to help local authorities to estimate and make provision for housing for wheelchair users when they are commissioning new housing. We are trying to support local authorities and we are seeking leadership from the Scottish Government on that.

We are saying that roughly 5 per cent of new housing should be built to wheelchair standard. That is not happening at the moment. As Jean Urquhart said, that should be affordable, even in the current economic climate.

David Ogilvie: Our submission makes the clear point that, although there is a high-level strategic review of the structure of adaptations funding to ensure that, in future, it will be a tenure-fair, person-centred funding system, we have witnessed cuts to that budget in the past financial year of about 25 per cent.

Returning to the theme that Elaine Murray developed about the funding and the strategy, I suggest that we are going in the wrong direction when it comes to preventative spending. At the very least, we need to maintain the amount of funding that is going into our sector. Last year, it was £8 million and now it is £6 million. We cannot afford to see that budget reduce any further. In fact, it needs to be pushed up. If that means tweaking other areas, we should look at that, but the investment in housing must be increased from its current level. Capital investment has to rise, as does investment in adaptations.

The Convener: Thank you. Fiona Collie has been very patient.

Fiona Collie (Carers Scotland): I want to say a few things about carers. The main point is that if we do not involve carers and older people, the plans that we make are not likely to work. We

need to support carers in the future, because there will be 1 million by 2037.

The Convener: Is that in the UK?

Fiona Collie: That is in Scotland. There are already 660,000 unpaid carers in Scotland, who provide varying levels of care. Of that number, 110,000 are intensive carers who work 50 hours a week or more. If we do not provide support for them, in the first instance, there will be an immediate effect on their health and there will be costs to face in managing the poor levels of health that will have been created by that lack of support.

We believe that it is cost effective to support carers and to shape services and support to provide intervention. It reduces the costs of admission or readmission to hospital. If we stop that happening in the first place by supporting the carers, we will reduce costs. Supporting carers also helps in allowing people to remain independent for longer and reduces the need for them to go into more expensive residential care. As I mentioned, it is important that carers continue to care in good health. It is important to remember that if we place all our eggs in the one basket of families and carers providing care, there will be a very big cost to those people, and it will come to the state in the long run.

In our submission, we argued a few points, one of which was about sustaining carers to allow them to remain in employment. As I have said, we will need more carers in the next 20 years, but we will also need more people in the workplace. If we do not support carers so that they can continue to work, they will fall out of employment and that will be another cost to the state. The London School of Economics and Political Science did some research recently and worked out that the public expenditure cost of carers leaving employment was £1.3 billion per year in England. We can imagine a comparative percentage in Scotland. That figure is made up of lost tax revenues and the cost of carers allowance and the other benefits that carers get, such as income support, but it does not include national insurance contributions.

The cost to families also needs to be considered. Approximately 250,000 carers in Scotland are already juggling work with care responsibilities, and they have to absorb the cost of reducing hours, or of not being able to take a promotion or develop their career. In the long run, that will cost an individual about £11,000 a year. Carers tend to retire earlier, their employment rates are lower, and the loss of income means that they cannot build up pensions and savings for the future, which then impacts on their future retirement and chances of a healthy old age.

We need to bring employers into the equation because they can do a lot to support their employees by restructuring the way in which they work. For example, BT allowed a large proportion of its employees to work flexibly through, for example, home working. That has saved BT an awful lot of money—it saved £5 million on recruitment—and it has much more productive workers. It increased revenues by £5 million to £6 million, and saved £1 billion in back-office functions because it did not have to have people working in an office. British Gas reported making similar savings by allowing home working. We should therefore work with employers to create the conditions in which carers can work and care at the same time.

We should also remember for the future that families move further apart. Someone's work might be in London while their mum is in Scotland—how can they provide care for her? More people are providing care at a distance and going up and down the country at weekends, and things like telecare are important because they give people the confidence that the person for whom they are caring is safe. There is a danger that people put all their eggs in the community alarms basket and forget that telecare is much bigger and that there are many other options. Not all local authorities are connecting with the different equipment that is available. There are fall detectors, for example, which bring savings by helping to prevent falls. Carers find it difficult when they ask for a telecare assessment for the person for whom they are caring and are offered—if anything—a community alarm.

10:30

There will be more very old people, so there will be many older carers who are retired or nearing retirement. People will provide care into their later lives. We need to build that into the equation.

We should support carers who are in employment in the same way as we support parents. We have developed a mixed economy in childcare, so that parents—particularly women—can combine their work and parental responsibilities. More and more, people will combine all those responsibilities with caring responsibilities.

The Convener: You talked about there being 1 million carers by 2037, in a population of 5 million. What funding support will they require from the state? Employers might not be willing or able to provide support. It might not be practical to provide support, given that 96 per cent of businesses are small businesses. What is the state's role? We want to consider how services can be more effectively and efficiently provided.

Fiona Collie: It is about flexibility of services. One of the few things that a carer is asked at a

carers assessment is whether they want to retain their job. Caring responsibilities can develop progressively but they sometimes come suddenly and people have to make a decision about whether to care. Indeed, people are often not even given a choice about the decision. They are told, “We’re discharging your mum from hospital”, and the situation is right in front of them.

Carers say time and time again that they have to give up work because services are not flexible enough and are not delivered at the time when they need them to be delivered. People need to be confident that if someone says that they will come in at 9 o’clock, that will happen.

Self-directed support is a major development, which will give individuals more opportunities to lead independent lives and which will enable carers to have more choices and more quality of life outside their caring role. Those choices might include employment or further education.

For some carers, it is not possible to combine work with caring, because of the extent of their caring role. Those carers will require additional support. Sometimes small interventions and pieces of support can make all the difference.

Mike Brown: ADSW is in complete agreement with what you said about the centrality of carers’ roles and the importance of increasing support to carers, through a preventative strategy that is worthy of its name. People who work in social care departments are well aware that carer breakdown is a major cause of admission to hospital, a care home, or high-intensity support at home, so it is essential on economic as well as moral grounds that we provide more support for carers.

I think that I am right in saying that the current legislation gives local authorities the power but not the duty to undertake assessments of carers’ needs as carers. The Social Care (Self-directed Support) (Scotland) Bill might provide an opportunity to look at that. I say that—perhaps I am going slightly off script—because, generally speaking, local authorities do not like additional duties being imposed on them by the Scottish Government unless the financial consequences are funded, but I strongly believe that the support that is given to carers is currently insufficient and that it needs to increase. That is very much a part of prevention and the demographic sustainability agenda, and the issue needs to be looked at again.

Jamie Hepburn: I want to pick up on some things that Fiona Collie mentioned. The issue of a flexible approach by employers is quite interesting. We heard about BT. Are there other examples? Is there evidence that suggests that employers are being flexible on a wider basis? If not, is there a requirement to put that approach on a more statutory footing?

It has been suggested that how we support carers needs to be improved; I think that the convener tried to get at that as well. Are we talking about the financial support that is provided and the carers allowance? If the carers allowance is not thought to be adequate, what should it be?

That begets another question. I think that Elaine Murray touched on the issue of welfare reform in a different context. How might the welfare reform process be affecting carers specifically?

Jean Urquhart: I want to go back to the figures that Fiona Collie mentioned. The figure of 1 million carers seems very dramatic. By when will there be that number?

Fiona Collie: By 2037.

Jean Urquhart: We currently have 600,000 carers.

Fiona Collie: There are 660,000.

Jean Urquhart: I presume that that is across the whole spectrum. The figure seems incredibly high. It does not cover only old people; I presume that people who care for children are included.

Fiona Collie: Yes—that is across the spectrum of carers. Currently, there are probably around 100,000 carers who are 60 or over, and around 40,000 of them provide intensive care. The number of carers is certainly increasing as the number of people who require care is increasing. It is not only older people who require care; people with a learning disability and children who in the past might not have been expected to live into adulthood, for example, require it.

Gavin Brown (Lothian) (Con): My question is on a slightly different subject. Is that okay, convener?

The Convener: Of course.

Gavin Brown: A number of organisations—primarily the Scottish Federation of Housing Associations and the Coalition of Care and Support Providers in Scotland—have commented on the change funds. The sentiment that I got from the submissions is that the change funds were a good first step and were welcomed but that there are questions about what is happening on the ground. It was said that there has not been enough change and that change is a little bit patchy, depending on where you are. Do any of our panellists want to expand on that and give us some insights into the change funds?

The Convener: Nancy, the Coalition of Care and Support Providers in Scotland’s submission says:

“we have concerns that the execution”

of the change funds

"has been problematic."

Nancy Fancott: That is right. We think that the change funds are a wonderful idea on the basis that they provide resources to assist institutional change and the kinds of projects that are needed to begin to shift the orientation of organisations away from acute care and towards prevention. I am sure that everyone agrees with that. We believe that the third sector can provide an especially positive contribution to that overall agenda, but we have concerns that we have not been as involved with the various change funds as we would have liked.

I know that Age Scotland has done a fair bit of work on what has happened with the first series of change funds and the types of things that the resources have been put towards. Our specific concern is that not very much of the money has gone towards what all of us would normally consider to be prevention and that not very much of it either has come or is coming to the third sector.

We have been trying to put forward our member organisations as being perfectly placed to assist with transition services. However, as David Ogilvie of SFHA has pointed out, only a relatively small proportion of housing associations that applied to the fund were successful, and we have heard anecdotal evidence directly from our members that they either do not know anything about the fund or have not been successful in engaging with it.

There are practical problems for us, because we represent national provider organisations and the change funds are happening at a local level. As a result, links need to be made between large providers and local decisions and planning with regard to the provision of services.

Callum Chomczuk: I echo much of what Nancy Fancott has said. In its snapshot analysis of the first six months of last year's change fund, the JIT has said that only 19 per cent of the first £70 million was for preventative spending, which, to be honest, is pretty paltry. Despite the expectation that the percentage will increase over the four years, we probably all feel that instead of that kind of progress there should have been an absolute commitment to prevention at the heart of the change fund from the very beginning.

As Nancy Fancott has said, we have done some analysis on the matter. When we got feedback from local authorities and health boards about where the money was being spent, we found that it was being spent on communications officers and other things that, from a layperson's point of view, we could not see were delivering a real preventative outcome. Key services that actually focus on prevention, such as care and repair and community transport organisations, have told us that they are finding it really difficult to access change fund moneys.

Again to echo Nancy Fancott's comments, I think that the change fund is a great model and that we must get it right. However, some of the restrictions on the spend are too specific. If an organisation already has a model of delivery, it cannot access the money; it will get money only if it wants to introduce something new and innovative. At the same time, new projects that do not have a preventative focus are getting access to the fund. In some ways, the guidance is too strict; in others, it is too loose. We need to improve the way partnerships allocate the money to ensure that the focus is on real preventative outcomes.

Finally, with regard to transport, one issue for older people that we have missed out is the national concessionary fares scheme. If we are looking at the impact of an ageing population, we also need to examine not just the current scheme's sustainability but its appropriateness. As members from rural constituencies know, community transport plays a vital role for older people across the country, but people have to pay for it. There is a case for including such services in the scheme.

The Convener: I understand your point, but one of the issues that the Scottish Parliament has to face is that over three years there will be an 11.6 per cent reduction in our resource budget and a 33 per cent reduction in our capital budget. In many of these evidence sessions, people say that we need to spend more money here or there. If this were an ideal world, we would agree with them, but not many people are telling us where we need to spend less money so that we can spend more on this or that particular group. On which group should we spend less money so that we can fund your proposal?

Callum Chomczuk: Having engaged with many of our members with regard to community transport, we feel that in order to extend the scheme to cover community transport we should look again at the age of eligibility. The state pension age has already risen to 67 and, more likely than not, will rise to 68. I believe that Audit Scotland or the independent budget review has suggested that increasing the age of eligibility for the concessionary scheme to 65 will save around £40 million. That money would make a huge difference in the ability to extend the scheme and to invest in preventative spending that stops people from having to go into residential accommodation or hospital. That is the approach that we should take.

10:45

The Convener: That is a helpful suggestion—whether we agree with it or not—because it presents a choice. I welcome what Callum Chomczuk has said, because it is important that when folk come to the committee they say, “Yes, we think that money should be spent here, but less should be spent there.” It is then up to politicians to take decisions based on the input that we get.

Fiona Collie: I want to respond to Jamie Hepburn’s questions about what is happening and whether there are other examples of employers taking a flexible approach to carers.

The Scottish Government is introducing a carer-friendly kitemark for employers. With the minister, we held an initial meeting with a range of employers—including the Federation of Small Businesses in Scotland—to look at what we can do with employers in Scotland in providing other routes. For example, where a small business operates in the supply chain of an organisation such as Sainsbury’s, we need to look at how they can support each other in supporting carers. That work is on-going.

Another organisation that also works with small businesses is Employers for Carers, which covers the whole of the UK. For a small business, it can be very damaging to lose one of its most experienced employees. The peak age of caring is between 44 and 54, which is when people may have been in an organisation for a long time and know it inside out. Bringing in someone new and training them up is always expensive, but it can be even more expensive for a smaller business.

Jamie Hepburn also asked about what other support carers want. Carers need practical and emotional support and need to able to have a break but, given that financial support was mentioned, I cannot fail to mention the level of carers allowance. At just over £58 a week, the carers allowance works out at about £1.67 an hour for a 35-hour week. Carers have consistently said that they want carers allowance to be increased at least to the level of other benefits such as jobseekers allowance. We have campaigned for that for a long time and we have been told on more than one occasion that the allowance would be reviewed.

I think that welfare reform will have a significant effect on carers because it will have a significant effect on disabled people. I do not think that we should underestimate what that effect will be across the board. I do not think that any of the organisations around this table—from local authorities to voluntary sector organisations to individuals—will be unaffected.

Mike Brown: I want to make some comments in response to what has been said about the change fund.

Obviously, third sector involvement will vary from area to area, but right from the beginning the change fund documents that partnerships are required to submit to the Scottish Government have had to be countersigned by not just the NHS but the third sector and the independent sector. Obviously, the third sector does not always speak with one voice and there are sometimes issues about who is representing whom, but there has been an attempt right from the beginning to involve the third sector directly in the governance of the change fund.

I think that there is acknowledgement nationally that the input of the housing dimension of community care has not been as strong as it ought to be. I agree with the comments that have been made on that front. The template for submission of the joint strategic commissioning plan for older people—which is replacing the document that partnerships had to send to the Scottish Government to ensure that they were spending their change fund money properly—now has a housing contribution template, which is an attempt to get partnerships to focus on the housing support and other housing elements of community care. That will not solve the problem, but it is a step in the right direction.

I turn to the question of how much of the change fund is being spent on prevention. I have not yet read the JIT report, so I do not know what the 19 per cent figure that was cited amounts to, but there is an issue about how we define prevention.

We need to remember that this is only the second year of the change fund. Last year, it was £70 million; currently, it is £100 million. Most of those funds come from the growth moneys that the Scottish Government has—rightly, in my view—made available to health boards. The change fund has therefore been top-sliced, and health boards obviously want the fund to focus on their agendas.

The services that are currently funded by change fund moneys are intended to be self-financing in the medium term, although quite when that will be is another matter. Those services can be self-financing only if they free up beds in hospitals, which in some areas would mean hospital closures—a subject that has been debated at previous evidence sessions. I remember one person making the quip that there was no greater driver for building community capacity and getting people to think on a community basis than the threat of their local hospital being closed. It will require quite a bit of political courage to accept that, with changing

models of care, in future we will not need the same investment in acute in-patient beds.

That brings me back to the issue of what prevention is. From the point of view of reducing the size of the acute sector in the NHS, prevention means community health services, care homes, more home care, more adaptations of properties and so forth; it involves the entire range of existing service models. If we define prevention as falling into primary, secondary and tertiary categories, such services would be at the tertiary end. In the middle, the change fund is funding more investment in intermediate care, rehabilitation and—in some areas—home-care reablement. All those things are intended to help a person with long-term conditions manage their own care, be more active and improve their abilities. They will defer the need for more intensive packages of care further downstream.

Primary prevention—which is perhaps what the 19 per cent figure relates to—is much more to do with people with lower-level needs, who currently would not meet the eligibility criteria because they are too tight, and with building community capacity, community development projects, use of volunteers, wellbeing projects and things such as healthy eating initiatives. Those are very important but, because their impacts are further downstream, they might not be seen as achieving a reduction in the number of acute in-patient beds or the better use of the current beds through reductions in length of stay and delayed discharge, which alone offer the opportunity for some self-financing of the change agenda. I hope that I have explained that clearly.

I think that the picture on prevention is more mixed than is being presented. A lot depends on what you mean by prevention and what the priorities are.

Nancy Fancott: I want to come back to the convener's point about where we find the money. I do not have an easy answer, but I know that poor-quality care is not what we are aiming for as, ultimately, it will cost us more in the long run. A tension is emerging in a practical and real sense between the agenda for improving the quality of care and improving outcomes for people, which is what integration is all about, and the need to balance budgets.

I agree and disagree with Mike Brown's point that the issue is not poor-quality commissioning but the need for more money to be put into the system. There are big issues with commissioning.

The problem is that we do not have the proper information to assess what we need, what it will cost and what the outcomes will be, and we are not linking the strategic aims with the investment decisions that local authorities are making. We see that quite often when our members provide evidence of the effectiveness of their services and yet find that their funding is cut. We also saw that in the research that we did on single outcome agreements, which showed that a lot of strategic-level objectives were not supported by investment decisions—it was quite the contrary in some areas.

Recently, we did some freedom of information research on hourly rates for social care across local authorities. That brought out some interesting information about the comparison between rates in the private, voluntary and public sectors. It showed that in many cases public sector rates are quite a bit higher, yet the funding is being cut for voluntary sector providers. There are some gains to be made in improving some of the processes.

Having said that, I also agree with Mike Brown about putting more money into the system. We need a wider debate on our collective aims, as a society, in relation to the public services and the quality of care that we want. We need to be open about how we would get that, what it would cost and how the different players—communities, the Government, the private sector and the voluntary sector—would contribute. We need to have that debate in order to answer the convener's question about where we are going to find the money.

The Convener: That goes to the heart of what we are doing. We will have a debate on the subject in the chamber and ministers will respond to the report that we publish when we conclude our inquiry.

The issue is that we have to balance budgets and every area, whether it is education, health, local government or whatever, considers itself to be the priority. Everyone suggests that, if more money is spent in their area, it will save money down the line. As a Parliament, we have to make political decisions based on the evidence that we get. That is why it is vital that people such as you are able to come here and give us that information to help to steer the Scottish Government and the Scottish Parliament along the right paths, so to speak.

Mike Brown wants to come back in.

Mike Brown: There is concern that the unit cost of services that councils purchase from private and voluntary sector providers has been driven down too low by the financial problems that councils have, and that, as a consequence, there is a risk to quality. I think that that is true. Although in the CCSPS work on the issue there is sometimes a lack of sympathy for the predicament that local authorities are in, many things that are stated in the reports are the case and need public recognition.

I will give some figures so that we get a sense of the scale of the issue. Before I came to the committee today, I looked at the latest available local authority financial returns, which are for 2010-11. Of the total spend by councils on social care for older people and adults, which was £2.7 billion, third-party payments—that is, purchased services—accounted for 54 per cent, so it is very much a mixed economy of care. More spend is now with the private and voluntary sector than with councils' own services, according to those figures.

The figure for third-party payments that went to private companies, many of which are for-profit companies, is £1 billion. That is the 2010-11 figure for purchasing by councils of private care services, many of which are delivered in private residential care. Obviously, negotiations for the national care home contract are done nationally. The lack of visibility on the profits that private care homes make is a bit of a problem for the local authority side. The funding support to the voluntary sector is much smaller, at £217 million.

11:00

Coming back to the difference between the unit costs of in-house and purchased services, I think that it is true that in the vast majority of cases, but not universally, unit costs for in-house services are higher, because staff are entitled to local authority pensions and they are not generally on minimum pay rates, whereas the workforce in the private sector often has a pretty difficult experience in terms of their pension rights and their rates of pay. In some areas, the private care industry has had recruitment problems because people can sometimes get a better deal by stacking shelves in supermarkets, for example.

There are national initiatives on the minimum wage and the new working wage—I am sorry; I do not have the right wording for that—which, if extended into purchasing, would obviously increase unit costs, but they would provide the people who do the work with a living wage. Those initiatives need to be looked at sympathetically, although they have an affordability aspect.

It is clear to me that we cannot continue as we are, because we are sitting on situations in which the quality of care being provided or purchased is questionable, which means that people are at risk. It comes back to the difficult question, which we keep skirting around, of how much is enough. As I said, there is not enough cash in the social care system and the wider health and social care system. That was the finding of the Dilnot commission down south when it looked into the issue, and it is a finding that has been reinforced by others, such as the Nuffield Foundation.

The convener is quite right to say that we cannot just keep coming with a begging bowl to the Scottish Government without saying what has to give. There needs to be a much bigger debate than has taken place in Scotland so far on the current and future costs of care and where the funding comes from. At the moment, the public has contradictory ambitions in that regard. In the ADSW submission I quoted something that I came across recently by Jonathan Portes, director of the National Institute of Economic and Social Research, on the British situation, but it also applies to the Scottish one. He said:

> "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".

In the submission, we also looked at the evidence that Professor David Bell gave about tax rates in the UK being below the average of those of countries in the Organisation of Economic Co-operation and Development. There has to be a proper public discussion, which we look to the politicians to lead, on what sort of society people want to live in and what we are prepared to do to pay for it.

Finally, I will say something about welfare reform, which I know is a UK Government policy—I do not want to get into issues around the independence debate.

The UK Government intends to take absolutely staggering amounts of money out of the benefits system. In evidence that the Department for Work and Pensions submitted to the Scottish Parliament, it was estimated that the impact on Scotland would be a £2.5 billion reduction in welfare benefits by 2015 out of a total reduction for the UK of £18 billion. Moreover, at the Conservative Party conference in October, the Chancellor of the Exchequer said that the UK Government would implement a further £10 billion of welfare savings by the first year of the next Parliament—assuming, obviously, that that particular party is successful at the next election. If the same proportions hold, that would mean another £1.4 billion reduction for Scotland—or a total of £3.9 billion coming out of the purses of poor people. The effect further downstream will be a further widening of already wide health inequalities, which are largely—although not entirely—driven by income inequalities.

All this brings us back to the debate about the sort of society that we want. Do we want a more equal and fairer society in which old people no longer live in fear of not being able to look after themselves? If so, we will all have to pay for it—if necessary, through additional taxation.

The Convener: Thank you. We have gone over the 90 minutes that we had allocated for this session and no one else has put themselves forward to speak. However, I am willing to give folk an opportunity to make some final comments before we wind up the session.

David Ogilvie: An issue that I want to highlight in this conversation is fuel poverty, particularly given what is happening with domestic fuel prices and what they are forecast to do. The committee cannot disregard that; indeed, it should be added to the balance, particularly when we are looking at the health and wellbeing of the older sector of the population. We must examine not only how the issue will be funded in future but how it is being tackled at the moment.

Nancy Fancott: I want to re-emphasise our belief that the voluntary sector has a tremendous amount to contribute to this agenda. However, the fact is that we are close to being on our knees as far as our ability to provide good-quality services is concerned. The relentless downward pressure on costs has put huge pressure on the workforce, which is, we think, the key to providing such services. Research that we carried out in 2011 showed that none of the employment terms or conditions in the voluntary sector was comparable to or on a par with those in the public sector. The two-tier workforce that is clearly developing will be tremendously problematic with regard to our ability to help with the prevention agenda, and the issue must be considered in the context of our involvement in strategic commissioning and local authority decision making on service provision.

As has been mentioned, there is potential for the self-directed support agenda to contribute to prevention. Although we strongly believe that self-directed support has nothing to do with saving money and is all about improving outcomes, I think that it has the potential to make some quite significant improvements in service provision and outcomes for individuals that have, in turn, been proven to make additional financial savings. In that respect, I should quickly mention an Alzheimer Scotland study in which piloting work on self-directed support was recently carried out with dementia sufferers in Scotland. That led not only to quite remarkable improved outcomes for those individuals but to some cost savings, and I think that the committee might want to consider the contribution that such an approach can make.

David Bookbinder: Given the convener's understandable concern that we should not all just be asking for more money for everything, and the importance of building the right types of houses, there is one thing that the housing sector would broadly accept. It might be appropriate to reduce the target in the new-build programme slightly in order to build the right kind of houses. Let us say that in the next three-year programme, from 2015 onwards, the Government target was to build 6,500 houses of any type. I suggest that it might be better if it was 6,300 houses of the right type. Those are probably the numbers that we are talking about—they are not huge. It may be that slightly reducing the overall output to get the right kind of output on things such as housing suitable for wheelchair users is the right thing to do. Broadly, the housing sector would have a lot of sympathy with that.

Callum Chomczuk: We have a lot of the important pillars in place to plan for an ageing population. The change fund is a positive development. Free concessionary travel is really important, and health and social care integration can make a big difference. While extra resources will make a big difference, some of it is just about managing these programmes better and more effectively and ensuring that we focus on the outcomes that we want.

To finish on a more positive note, I think that it is important to remember the massive contribution that older people make in their communities, be it volunteering, childcare or the economy. A WRVS report last year said that throughout the UK older people were net contributors to the UK economy of around £40 billion a year; about 9 per cent of that would be in Scotland. Although there are undoubtedly challenges, older people are a hugely important part of communities and the economy. We should not always focus just on the potential costs of an ageing population.

Fiona Collie: I very much agree. We need to think about what we want to develop and what we want to pay for. It is important to remember that people are already paying for care, not through the state but privately. Our organisations need to explore what the future of care might look like and how that could be funded—for example, how employers can support individuals. Also, we need to explore how we can put in place the structure to improve care, and we need to look at things like insurance. We already plan for life insurance and funeral care. Do we need to start planning for the fact that we may become a carer or require care in future?

The Convener: Mike Brown, I know that you spoke a few minutes ago, but that was before I said that everyone had a few minutes to make any final points. Please feel free to add anything, if you wish.

Mike Brown: I have already set out the views of my association. There is a lot more agreement among the witnesses than disagreement, although we have disagreed on some things.

It is quite important to up the public debate on these issues. That is quite difficult because there

are lots of things going in the wrong direction. For example, the line taken by the popular press in relation to welfare reform very much highlights alleged benefit scroungers and so on. Such representations do not help rational argument on the issues.

There has been quite a lot of work in England on insurance-based solutions and shifting the balance of funding responsibility for care between the state, the individual and the family and so forth. Whether or not we want to go down that road, we certainly need to look at the options. There ought to be some kind of commission in Scotland, a bit like the Dilnot commission down south, that can help to provide a focus for raising public debate on these crucial questions about the future funding of care, not just for older people but for other groups in the community, particularly adults with disabilities, where numbers and the complexity of needs have been growing as a result of greater longevity.

The Convener: Thank you. I thank all the witnesses and members for useful and informed contributions, which will help to determine our final report.

At the start of the meeting, the committee agreed to take the next item in private.

11:15

Meeting continued in private until 12:09.

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