Social Justice & Fairness Commission

Discussion Paper 2: Reform of Social Care

1. Introduction

The aim of the Social Justice and Fairness Commission is to deliver a route map to the real prize of independence. That prize is a fairer Scotland that values and cares for everyone who lives here, from baby box to grave, and in which everyone can fully participate and have the opportunities they need to flourish.

Independence will empower the people of Scotland to build a better society, with wellbeing at its heart. Independence is an opportunity to think afresh about the kind of policies we could pursue, and how we make decisions at every level in Scotland.

Our ambition is constrained only by what we collectively consider is desirable, and the response to the current pandemic has been regarded as a good example of collective effort with public support in response to a crisis, of what we can achieve when we put our minds to it. Change is possible, and very few people want to return to the way things were. As we chart our recovery and rebuild, we must build something better.

No one should be reliant on a food bank to eat. No one should be without the basic human right of a home. No one should be shivering in the depths of our Scottish winters because they can't afford to heat their homes. As we move forward, and look towards a better future, we must accept that no one should be left behind in our new Scotland. We all have a duty to look after one another.

The world is changing, and we must keep pace with that change – all the while harnessing the benefits of progress and protecting that most vital of resources, the planet on which we live.

This paper will look at how we can reform and reimagine the way we deliver social care and support people accessing care services to engage in everyday activities, paid employment, and family and social life. Among the challenges we need to address is how to care for an increasingly ageing population, and how to pay for that care, as faced by governments across the world without any easy answers. Right now, Scotland is no exception in that regard and nor would we be as an independent country. As a Commission, we are considering what action could be taken in the short-term, but also the more transformative changes we could deliver with the full powers of independence.

On the issue of social care, the following matters have been foremost in our considerations.

Firstly, we are taking a human rights approach to this issue, as we are with all the areas we are working on in the Commission. So, at the heart of decision-making must be the

fundamental human rights of those in receipt of all forms of social care and support. People in Scotland have a right to fulfilling lives, and to access services based on dignity, fairness and respect. In reforming our system of social care, we must continually reflect upon what we would expect for ourselves and our own families.

Secondly, we need to build a consensus on what is essential to our individual and collective wellbeing, and build a long-term, sustainable model for social care. How we care for our older and most vulnerable citizens is an issue that transcends party politics and conventional policy-making. This is an issue that requires us to come together as a society to agree the standard of care that is required, and how we collectively deliver that.

Thirdly, we want to ensure that those working in the social care sector are better rewarded and recognised for the valuable work that they do. Providing good employment and investing in staff in the sector are central to delivering the very best in care. Raising the status of the care sector as a career with clear opportunities for progression is a key element of this.

Fourthly, we consider investment in social care as an investment both in our wellbeing and our economy, in the same way that investment in childcare and early years education delivers on multiple outcomes. Care is integral to all our lives at some point and is so important it should always be a key priority for any government.

Finally, we are acutely aware of the funding challenges and the need to build consensus about the fairest way to pay for social care.

2. The Ethical Dimensions of Care

The main ethical principles underpinning medical practice include respect for patient autonomy, beneficence, non-maleficence or “do no harm” and justice - part of a set of principles which all doctors are required to follow in delivering care to patients. Failure to observe these principles can result in a doctor losing the licence to practice.

It is essential that those providing care in a non-clinical setting should be able to articulate the ethical principles which underpin their work. It would be reasonable to suggest that the focus of care of a person’s life should be on protecting and maintaining as good and fulfilling a life as possible. There is an extensive literature on the concepts considered to be important for a good life. These can be summarised as: autonomy and freedom; individuality and lifestyle; relationships and social networks; warmth, safety and familiarity; developing capacities and giving meaning to life; and subjective experience and feelings of well-being.

The four themes of ethical behaviour for doctors can be seen as important to the delivery of social care. However, they are insufficient to ensure that those living in social care settings experience the feelings of wellbeing and respect to which they are entitled.

Further studies of the care sector in Scotland could identify those settings which achieve high levels of wellbeing in residents. By sharing best practice through an improvement approach, quality of life in our care homes could be significantly enhanced.

3. Statement of Principles and Purpose

It is critical that in building a reformed social care system, it has ethical principles at its heart. This requires a human rights-based approach to the realisation of rights to a decent life, with dignity and respect at its core. Our public services should support individuals to have a full and dignified life and must reflect the principles of:

- Focus of care of a person's life should be on protecting and maintaining as good and fulfilling a life as possible.
- Universality - in that it meets the diverse needs of all who require care and support.
- A publicly funded care system, with the need for an open debate with the public about how this is paid for.
- High quality: valued by those who receive it and society more generally.
- Ensure the dignity and respect for everyone - in receipt of care and in providing care and support.
- Decent working conditions including better pay.
- Participation and inclusion in co-produced design and delivery, with flexibility for individual needs and preferences, reflecting local contexts including remote and rural, as well as urban differences.
- Strengthened regulation and inspection to ensure rigour and oversight.

As we imagine the kind of country we would like an independent Scotland to be, we need to define what the purpose of our social care system is. It should be an instrument of radically transformative social change, a tool for securing in place the basic human rights of our population to take control of their lives and participate in their community. It must respect human dignity, individual autonomy and personal wellbeing.

4. Lessons from the Pandemic

The pandemic has shone a bright light on the vulnerabilities of the current model of social care. There have been a variety of issues in the ability of care providers to respond, including provision of PPE to staff at the start of the pandemic, the ability to contain the spread of the virus, testing, and staff access to sick pay beyond the statutory, to name but a few. In contrast, the NHS was able to address PPE concerns more quickly and introduce a more standardised approach. The inherent challenges of a system operating a myriad of different providers could not have been more starkly demonstrated.

People in receipt of social care and support, and those working in the social care sector deserve better. Care staff have worked with great dedication to look after the most vulnerable – particularly during this pandemic - and we pay tribute to them. However, they deserve more than our thanks: they deserve a fundamental shift in the value, standing and pay of the care sector. It is important to recognise the progress made in Scotland in encouraging employers

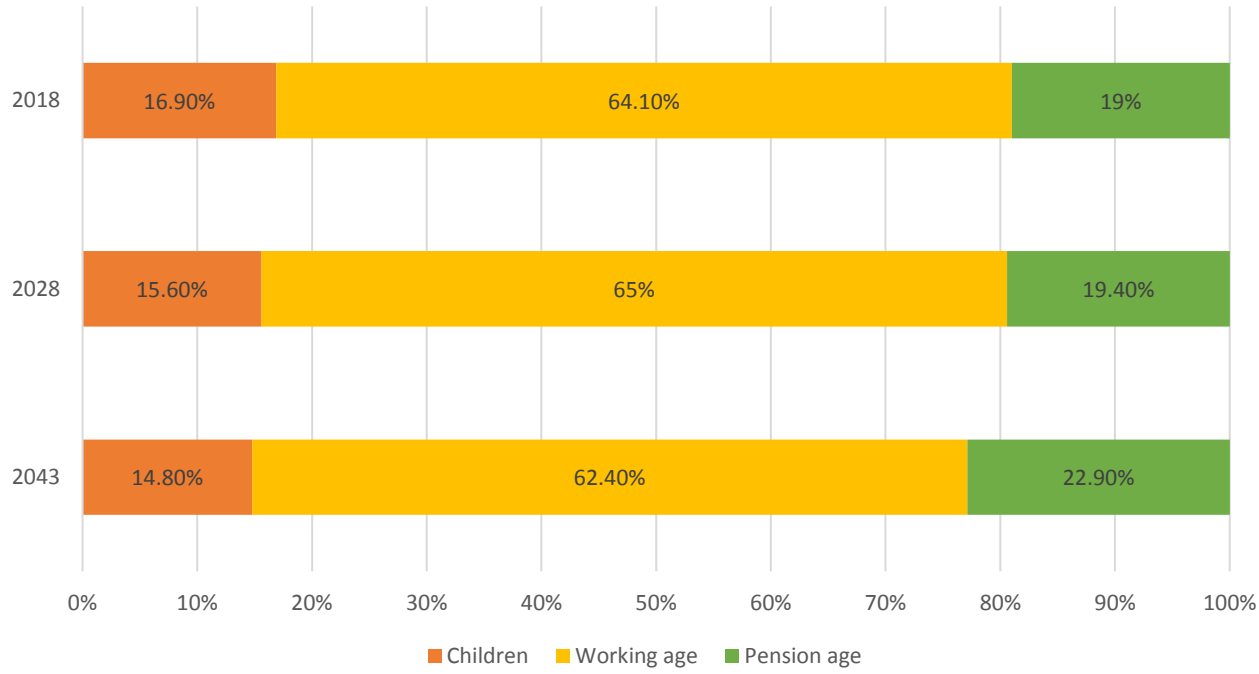
to pay the real living wage, however not all employers in the care sector are paying this as yet.

During the pandemic, measures have been taken by the Scottish Government to strengthen the ability to intervene to protect service users from a failing care service. As we learn lessons from the pandemic, the need for strengthened regulation and oversight is important. Those in receipt of care and their families need to know and have confidence that the services they receive are regularly inspected and are required to meet clear and consistent standards of quality.

5. Our Current System and its challenges

Scotland's population is ageing. As illustrated by figure 1, Scotland's pension age population is projected to grow by nearly 3% over the next two decades, reaching 22.9% by 2043. A larger older population will require a social care system that is capable of not just fulfilling this increasing need but enabling that population to live fulfilling lives.

Figure 1: population breakdown by age projections for Scotland 2018-2043, %



(Figure 1 data taken from National Records of Scotland, 2018)

The current care system has been based on a mixed model of care for many decades. Reforms have taken place over the years, such as the integration of health and social care and the introduction of a national care home contract which have led to some improvements in the system. However, more fundamental changes are now required.

Many local authorities have reduced their involvement as direct providers of care both in care home and care at home sectors, resulting in the private care sector increasing its role over the years and the public sector retreating from direct provision of care. This has been largely driven by resource considerations. Just under 75% of care home capacity is now provided by the private sector with the remaining being a mix of council and third sector provision.

The third sector also plays a highly regarded role in the provision of specialised care, often for younger adults with complex needs. These services tend to have a very different ethos from large scale private operators.

It is also worth noting that Scotland was the first nation in the UK to move to a system of free personal and nursing care (FPNC), which has been a ground-breaking change in the funding of care. This has been built upon further with the more recent extension of this policy to under 65s, meaning those with early onset dementia will now also receive FPNC. Another important development has been the retention of the Independent Living Fund in Scotland while this has been removed in England.

The promotion of the Scottish Living Wage in the care sector in Scotland has also been an important attempt to improve pay, however it is fair to say that there are still too many care sector employers who are yet to take this step.

While these measures have contributed to a measure of fairer funding for service users, greater consistency and cooperation, and have helped avoid confusing contract negotiations, they have not solved the fundamental issues of the standing of the sector, quality of provision, terms and conditions for staff, career progression, and other systemic problems. It is time therefore to consider more radical change of the care system.

Such change is not to question the quality of care in individual care environments, which should be of the highest quality and not the lowest price. The question is a broader one of what model best serves the most vulnerable people in our society, particularly at times of crisis, when the current model looks increasingly unsustainable.

Larger conglomerates have increasingly dominated the care market, often at the expense of smaller providers that have found it difficult to sustain their businesses and so have been pushed out of care provision. These larger conglomerates are often seen as unresponsive to local needs: for instance, HC1 have come under criticism during the pandemic for transferring staff from one part of the country to rural Scotland due to staff shortages.

The increasing domination of the sector by the larger organisations has also had a negative effect on its staff. Takeovers can be unsettling for staff, residents and families and morally we need to reflect that when ownership transfers, we are talking about care of our most vulnerable, not products on a shelf. There is a fundamental moral question to be asked about

whether a sector whose purpose is caring for the most vulnerable should also have to make a profit for its shareholders.

Recruitment and retention issues have been an ongoing challenge for the sector which has a poor reputation for pay and status and therefore not surprisingly struggles to attract staff. Despite the commitment to the Scottish Living Wage, it is often not seen as a career where someone can progress, and it can be poorly paid for extremely hard and challenging work and long hours. There is also a clear gender dimension to this also given this is a mainly female and often part time workforce with little union representation.

There is little doubt that more funding is required for the care sector to address many of the problems, but a fundamental question is where that funding should go, and on which priorities and outcomes. If public funding is partly used to provide shareholders dividends within the private sector it will not be available to improve quality, or address pay in the sector.

There is also a need to think about new ways of providing a spectrum of services that can adapt to meet a person's changing needs. Our care system is currently fragmented into different sectors such as nursing and care home provision, care at home, respite and day care services. There could be new models developed that blend these sectors and more effectively integrate services and facilities in order to provide more holistic care for the person and their carers.

It is clear then that there must be a major rethink on care models and an increase in resources. The key question we are therefore facing is this: is it wise or desirable to increase the resources available for the existing care model, or should we utilise these resources to fundamentally change the nature of provision of social care services? Which option helps us achieve the aim of building a strong social care network, capable of enabling our population to take control of their lives, participate in public life as a recognised member of their community and be treated with respect and dignity?

6 Reforming Care: Our Options

Central to our conversation must be the discussion of new ownership and provider models for care services and whether the Scottish Government and its public agencies should regard themselves as key stakeholders in the provision of care and, if so, consider the best way to establish and shift to a new model.

A National Care Service

There has been much discussion in public and by different political parties and other groups about a national care service - a singular service for the provision of care across the country.

An integrated care service is a way of understanding that care services comprise adult social care, specialist residential care, eldercare, childcare, which should work to the same standards of quality across Scotland and be delivered in a way that meets the needs of individuals and specific local contexts.

There is increasing public awareness and use of the term a National Care Service, as the experience of Covid-19 has laid bare our reliance and dependence on care and how undervalued care and those working in care services and providing care at home have been. A National Care Service cannot simply be about bringing care provision back within state control, or an issue to be traded-off between political parties. Care and carer organisations, disabled people's organisations, political parties, feminist and other advocacy organisations have talked about a National Care Service for a long time. It is not the preserve or idea of any one organisation.

An Integrated National Care Service is an ambition to ensure universal quality, local flexibility, and transparency and accountability in the governance and finance arrangements, delivering care and support in appropriate forms to individuals in Scotland.

As part of the recently published Scottish Government Programme for Government, a review of social care was announced. The independent review is to consider the idea of a National Care Service. The Social Justice and Fairness Commission is keen to contribute to that review and will provide a submission based on the responses to our consultation.

A National Care Service could have several advantages, such as the assurance of better quality and standardised terms and conditions. Such integration would also have to be coupled with better pay and conditions and opportunity for career progression and the commitment to the Scottish Living Wage will be an important part of this.

However, it would be important to recognise the need for local flexibility in the delivery of services in communities, given what works in parts of remote and rural Scotland may look different to that in urban parts of the country. What will be important is that all services form part of a trusted approach, where consistently high-quality services are provided no matter where the person lives. This could be a system which builds on the National Care Standards already in existence.

There are various options for developing this model, such as through the integrated joint boards, NHS, councils, third sector or a hybrid of these models. Central to any model is a need for transparency and accountability of decision making, and participation of service users and local people in decision-making.

A national care system under the existing integrated health and social care partnerships (H&SCPs) is one option.

- This promotes cooperation and partnership between public services.
- However, this model may not be able to resolve some of the issues that exist in the current system, such as delayed discharge issues, which have remained a problem even under integrated arrangements.
- The staff would also have to be employed by one of the key partners (either councils or the NHS) as the H&SCPs are not the employing body under these arrangements.
- Integrated partnership structures must also ensure compliance with national standards and the Public Sector Equality Duty and the requirements for equality impact assessments to inform service and spending decisions.

Another option is for councils to become more involved as direct care providers, building on the care services they already provide.

- The primary advantage is that most councils already have experience of care at home and care home provision, so administratively this model would be familiar to both councils and communities.
- The disadvantage is that the lack of a direct incentive to councils to do this could result in all 32 of Scotland's councils trying to do this in different ways at a different pace risking issues such as delayed discharge remaining, making the system inefficient and not delivering the change required.

Another alternative could be to establish a national care system, sitting alongside and inter-related with the NHS. The advantages would include:

- Expanding an existing national system with consistency of terms and conditions and consistency of approach.
- A one system approach which would help to eradicate, for instance, issues with delayed discharge, and bringing a greater focus on the social aspects of care beyond healthcare services.
- Benefitting both parts of the system without privilege or hierarchy, potentially helping resolve recruitment and retention problems.
- Allowing staff, the ability to enter the joint health-and-care service and be promoted to posts across care, community and acute settings.
- Providing care through a trusted brand of a National Care Service (NCS), or an Integrated National Care Service (INCS) - an important assurance to those who would be cared for and their families. However, this may lead to a system that does not enable the local flexibility required and consideration would need to be given to how the third sector would be involved in such a system.
- A national commissioning model could be a way of allowing third sector providers to provide care under a NCS brand provided they meet the required regulations and standards, in a similar way to GPs and community pharmacists which are independent contractors but are a key part of the NHS, delivering NHS services

All the above options have merits and challenges, but it will be important that any national system remains integrated with local flexibility at the point of delivery of services. A National Integrated Care System with local flexibility, is not an easy balance to strike. Keeping the involvement of not for profit third sector organisations and charities that provide critical local services will also be important, so some local flexibility will be required. Avoiding them feeling subsumed into a NCS, and avoiding them losing the important ethos they have developed over many years, will be important.

It will also ensure that individuals always remain the focus, and the person is at the centre of the care provided. This also means that models like self-directed support, where the person themselves is the employer of personal assistants, must be improved and supported. This can be empowering for those requiring care while also providing the flexibility to be able to live life as they would wish to do, rather than fitting into more rigid care models. It can also be a

source of additional stress and unnecessary complexity when multiple agencies and processes are involved.

A blended care service: quality provision that reflects local needs and possibilities

A blended care system needs to be responsive to the changing needs of individuals across the life stages. That's why care needs to feature in our housing policy, our infrastructure planning, and as a core element of community participation and decision-making. Local community level decisions on care hubs and other settings of non-domiciliary care are an essential part of co-production of care services and funding pathways, as well as decisions on the use of space and facilities locally. Current mechanisms need to be more transparent and more inclusive of local people and particularly of service users, especially disabled people and others accessing care support whether to live independently or using care services to stay at home or be looked after in residential settings.

While reforming our care system requires us to look at who provides the care, even more importance should be placed on what care is provided and how that care is provided. We need to be bold and innovative in looking at new models of care delivery. One area we are keen to explore in this consultation paper and in conversations around the reform of social care, and future models of local provision is the idea of care hubs or care villages.

Care hubs/villages

A model based around care "hubs" or "villages" could provide a blend of the care provided. The hubs could be in one or several physical locations or could be virtual given the differing needs of more remote parts of Scotland where services would need to be delivered differently. Although having a focus on care, other intergenerational services could also be provided in the hub such as nursery provision. There have been some good examples of this with co-location enabling older citizens the opportunity to interact with some of the youngest, providing a stimulating environment for service users, and local sharing of resources and facilities such as kitchens, transport, etc.

A care hub or village could include a sheltered or very sheltered housing complex that has care provided on a scale that can increase or decrease as the needs of the person changes. It could also include permanent care and/or nursing home beds for those with more complex needs. Respite provision could provide much needed breaks for those people still living within their own homes and their carers who need regular breaks to continue to live independently. Day care services could also be located within the hub, which would provide much needed social contact for people who are socially isolated and lonely and suffering poor mental health. The care village could provide much needed social interaction for many, improving their quality of life while enabling people to live independently for longer.

Those providing care at home services could also be co-located within the care village ensuring that services are joined up and staff working within each care setting are interacting

and working closely together. This model would also provide a variety of career opportunities and richness of experience in different settings for those working in the care sector.

The concept of the "20-minute neighbourhood" has attracted huge global interest, with the concept that people in any part of a town or city should be able to find shops, public services, leisure facilities, green space and employment opportunities within 20 minutes' walk of a good affordable home. Care should be a core part of this vision and the care hub or village would fit in well to this concept.

Integrating unpaid care and carers in a vision for social care

Locally accessible facilities such as a care hub, that combines social activity, opportunities for socialising and combatting isolation for carers and people accessing care services, as well as access to health and other support, potentially offer greater support to unpaid carers. Our reliance on unpaid care by partners and family members is consistently overlooked and undervalued. The economic, social, and personal costs to individuals who reduce or give up paid employment to care for family members or friends are hugely significant to the individual, to our economy, and to our systems of social care and support which have come to rely hugely on unpaid care.

Any future vision of care in Scotland must integrate the experience of unpaid carers and their contribution to the wellbeing of others and must protect the wellbeing and economic security of carers. There have been some recent developments to support carers in Scotland through additional social security payments, something which could be expanded upon to provide greater support. There is still much work to do to ensure carers feel valued and are genuinely listened to – despite legislation intended to support them, and the engagement and advocacy of individual carers and highly effective carers organisations.

A future integrated care system must be based on the inclusive participation of service users, carers, and providers in developing a range of social care services and delivery mechanisms that ensure the dignity and respect of all recipients and providers.

7 Investing in Care: the Social and Economic Case

The care economy is a significant economic sector in Scotland and we need to think about it as such. According to the Scottish Government, there are 200,000+ people employed in a sector with a value of £3.4bn. Scotland is committed to a wellbeing economy. A care economy therefore must be at the heart of that ambition. We need to be bold about care and put it front and centre of our vision for Scotland - now and for the future.

There is a common attitude towards state-provided public services, be they health, education, care or others, that they do not produce economic value as such. They are generally recognised as necessary for the functioning of society, and their provision universally and for free is usually recognised as necessary for the more financially disadvantaged to access them,

but their economic value is primarily seen in terms of a 'sacrifice' we all make through general taxation for those who need it.

This is a viewpoint that has come into sharp criticism for its narrowness. Just as we see education as an investment into the future of our young, as a method to foster skills and talents our society needs to ensure its future prosperity, we need to see social care in all its forms as part of a system of cradle-to-grave support for our citizens to foster their full participation in our public life.

Investment in care is not a drag on our resources or a revenue cost, but rather it generates significantly more economic return that investment in other sectors. Investing in care should be given an equivalence to investment in any other key sector, and should therefore feature prominently in economic policy, not only in post-Covid economic and social recovery, but as an appropriate focus of investment supported through organisations like the Scottish National Investment Bank and economic development funding.

Investment in care encourages job creation and provides economic stimulus. The commitment in Scotland to the living wage will be an important aspect of ensuring the jobs created are fairly paid. Especially in post-crisis contexts like the world we will enter with the end of the coronavirus pandemic, this is an urgent and relevant concern. Research into the effect of investing in care has found that in both developing and developed economies investment in care stimulates a creation of far more jobs than in construction, which is the usual target of Keynesian stimulus packages.

Research in 2016 found that an extra 2% of GDP invested in care would see the increase in overall employment in several OECD economies range from 2.4% to 6.1% depending on the country, with accompanying dramatic drops in the gender gap in employment, from as much as half in the US to 10% in Japan and Italy (De Henau et al, 2016: 25-26). Updated data has revealed that besides the direct stimulus of job creation, investing in care infrastructure has long-term benefits for the economy such as a reduction in the need for expenditure on care through prevention. This can essentially reduce its net fiscal costs over time.

Considering care as central to economic recovery and social renewal following the pandemic, means putting care and investment in care on an equal footing with other sectors of the economy and plans for investment in economic development. That means that investment in building care facilities should be an eligible and attractive proposition for the Scottish National Investment Bank and other funding streams. De Henau and Himmelweit in their most recent analysis demonstrate the multiple benefits of investing in care, which additionally speak to Scotland's ambitions for a wellbeing economy and our ambitions in responding to climate change. The data in Table 1 below are from the UK Women's Budget Group, but can be modified for Scotland.

Investing in care would create 2.7 times as many jobs as the same investment in construction: 6.3 as many for women and 10% more for men.

Increasing the numbers working in care to 10% of the employed population, as in Sweden and Denmark, and giving all care workers a pay rise to the real living wage would create 2 million jobs, increasing overall employment rates by 5% points and decreasing the gender employment gap by 4% points.

50% more can be recouped by the Treasury in direct and indirect tax revenue from investment in care than in construction.

Investment in care is greener than in construction, producing 30% less greenhouse gas emissions. A care-led recovery is a green led recovery.

'A Care-Led Recovery from Coronavirus', DeHenau, J., and Himmelweit, S. (2020)

8 Investing in Care: Our Funding Options

Every government of every political colour will be faced with political choices over whether or not to increase resources in care and, if so, by how much and how to achieve this in the fairest way. While not increasing resources in care is of course an option for any government, it is difficult to see how this would be sustainable given the obvious weaknesses of the current system. It also appears to be a time when public support for investing in care services it at an all time high, perhaps making that political choice a more palatable one. It is self-evident that if we want a healthier care system, let alone a national care system, we need to discuss ways to redirect resources tied up in poor models of care while also recognising the need for a substantial increase in public funding for a new improved system. To that end it is pertinent to explore several possible models of funding investment in care.

a. General taxation

Raising funds for the care system out of general taxation, the same way the NHS is funded, is a generally popular proposition. Research into the preferences of the UK population regarding funding for care generally finds this is their preferred option for more funding for care (The Health Foundation, 2019: 3; 7; 59-60). People tend to also prefer funding such provision via progressive taxation where those on higher incomes pay more, but even models largely identical to the current system of funding for the NHS, which is not predominantly funded from progressive taxes are generally preferred to models that emphasise co-payment (The Health Foundation, 2019: 58-61).

General taxation is relatively rarely the predominant source of funding for extensive social care systems globally. High-income countries tend to fund healthcare primarily from public sources, while social care more often relies on individuals paying privately.

b. Hypothecated taxation

Hypothecation is when a tax is created for the singular purpose of funding a service or project. The funds raised from hypothecation are earmarked for this end, ring-fenced and unavailable to other purposes. This can be either:

1) partial hypothecation (where *other* sources of income than the hypothecated tax can supplement the income acquired from hypothecation) or
2) full hypothecation, where the hypothecated income pays for the whole cost of the service or project.

Two reasons are usually provided for hypothecated taxation. One is that it can be easier to make the public case that a tax is necessary. Indeed, in the context of care, the public generally seems even more supportive of general taxation models when these include an element of hypothecation, where funds raised out of general contribution are ring-fenced for the purpose of funding care alone (The Health Foundation, 2019: 58). The second is that such a measure can address a common problem, where the growth of health spending experiences prolonged swings below and above its average level of growth. The argument goes that if a proportion of funding is guaranteed securely via hypothecation, this cycle may be overcome (The King's Fund, 2018: 2).

Full hypothecation is controversial, even unpopular in orthodox policymaking practice. The primary issue with the proposition is that it severely restricts the flexibility a government has in making spending decisions. For many public services, such as the NHS, implementing a system of funding through full hypothecation could be challenging as tax revenues are forecast, only generally become clear at the end of the year, long after salaries and medicine bills have been paid. In addition, it makes little logical sense in a public service like health or social care: there is no real guarantee that increases in tax revenue would necessarily match increases in demand for health services.

Partial hypothecation is much more frequent in policymaking practice. It avoids a lot of the pitfalls of full hypothecation but suffers from the issue that it can be difficult to tell what its effect on the funding of a given service was. For instance, in 2002, Gordon Brown as Chancellor of the Exchequer introduced an increase in National Insurance contributions directly linked to a very generous five-year package for the English NHS, but it is impossible to tell what the effects of the counterfactual – where the NHS remained funded exclusively from general taxation – would have been. Partial hypothecation has therefore been described as "fundamentally dishonest" (The King's Fund, 2018: 7) as it cannot demonstrate that it has increased expenditure in the areas it is intended for. Recent reforms to the Scottish Budget process were intended to improve parliamentary and public scrutiny on the relationship between spending and outcomes, processes and practices which could be further strengthened.

c. Social insurance, co-payment and mixed models

As mentioned before, most high-income countries in the world generally do not cover social care out of general taxation. However, several models exist that rely on social insurance (like the predominant share of the UK pension system) or co-payment.

Germany operates a national "risk-pooling" social insurance scheme, where contributions to the scheme are levied on income and cannot be diverted elsewhere. Everyone pays in a fixed proportion of their income into the funding for this system, the funding is strictly ring-fenced, and a national framework assesses eligibility for care.

While this is not direct taxation and therefore cannot, for instance, levy a higher contribution percentage-wise on those with higher incomes, there is a sense of fairness as everyone is equally entitled to these funds upon being deemed eligible. The costs of the social care system have in this way also been contained. On the other hand, the system is unable to cover the full cost of social care and individuals have increasingly found themselves facing rising costs for the remaining share. It is also a system that relies heavily on the support of informal carers and suffers from a workforce shortage.

9 Scottish Government Review of Social Care

As part of the recently published Scottish Government Programme for Government, a review of social care was announced. The independent review is to consider the idea of a National Care Service.

The review will aim to ensure Scotland provides consistently excellent support for people who use these services, as well as their carers and their families.

The review will cover a wide array of services and non-clinical support in a range of settings, involving care homes, care at home, day services, and community support for people with a range of needs, supporting those with disabilities, older people, people with mental health problems and those with drug and alcohol problems.

The review will consider the experiences of those supported by, and who work, in social care, as well as looking at funding, governance, administration and delivery and will consider the needs, rights and preferences of people who use services, their families, and their carers.

The review will be chaired by Derek Feeley, former director general of Health and Social Care in the Scottish Government and will report by January 2021.

The review wants to hear the views of stakeholders, service users, carers, those who work in the sector and members of the public, so it is timely that the Social Justice and Fairness Commission is publishing this paper and launching our consultation. We will provide a full response to the independent review from the feedback to our consultation.

10 Questions for consideration

Principles

1. What should be the key guiding principles of our social care system?
2. Do you support the values and purpose contained in the consultation paper?
3. How should the social care system promote and deliver these?

Public/private/third sector balance

4. Should the public sector take a more leading role in the social care system, especially sectors such as residential care?
5. What role should be played in the provision of social care by third sector initiatives, i.e. charities and non-profit organisations? Should the private sector continue to have a role in the delivery of care services in the future?

Structural reform and new models

6. Do you support the concept of a National Care Service for Scotland?
7. What role should the Scottish Government, NHS, local government and not for profit third sector bodies have in the delivery of a National Care Service?
8. What do you think of the concept of a National Commissioning Model for a National Care Service as described in the paper, similar to that operating in the NHS? What changes would be required to ensure that quality not price is paramount in the commissioning/tendering processes?
9. What do you think of the concept of blended care with different care settings being co-located in a care hub or village?
10. How do we better attract people to work in the care sector and improve career progression for those working in care?

Additional funding

11. Should there be additional investment in care? If so, in order to invest additional funds in Scotland's social care system, which of the following options for sourcing additional funding would you prefer:
    a. An increase in one of the taxes that currently exist (e.g. National Insurance or Income Tax)?
    b. A new tax ring-fenced (hypothecated) for the sole purpose of funding the social care system?
    c. The introduction of a social insurance system, contributions to which are split between you and your employer (as with pension insurance)?
12. What powers, if any, which are currently reserved, do you think are required by the Scottish Government in order to deliver new funding models for care?

The Commission would like your views on the above questions, and any other issues you think are vital in considering the reform of our social care system.

11 Conclusion

An examination of the prospects for social care reform is a crucial part of the Commission's work in developing proposals for a more socially just Scotland, both now and in an independent Scotland. Some of the options described in this paper would of course require full control over the tax and benefits system. The coronavirus crisis has starkly highlighted many of the shortcomings of the society we currently live in with regards to how we engage in the delivery of social care and support, how we show our respect for the hard work of the people who provide it, and our aspirations for care as a social and economic driver for a wellbeing economy. This is a moment to reimagine care and support on a radical scale.

In 1942, the Beveridge Report was considered revolutionary. It laid the foundation for the creation of the creation of the Welfare State and the NHS which were considered revolutionary at the time and marked a reimagining of the social contract between the citizen and the state. We need that kind of ambition now, and a reset of the relationship between governments and the people they are there to serve. Radical reform of the care system should begin now under devolution, although independence offers an even greater opportunity to consider different funding models with full control over the tax and benefits system.

As we begin the road to recovery from this pandemic and securing a brighter future for Scotland now and with independence, our focus must be on building something better than our old normal. Please join our discussion about how to make that happen.

If you would like to contribute to our consultation, our website is:

www.socialjustice.scot

You can also keep up to date with our work via:

Twitter- @SJFCommission

Facebook - @socialjusticeandfairnesscommission

Appendix A: Statistics on care homes in Scotland

Figure 2: Number of care homes and occupancy rate per council area, 2017 (data taken from statistics.gov.scot and statistics.gov.scot)

COUNCIL AREA	CARE HOMES N/O	OCCUPANCY RATE
ABERDEEN CITY	58	93%
ABERDEENSHIRE	72	89%
ANGUS	31	90%
ARGYLL AND BUTE	22	90%
CITY OF EDINBURGH	79	89%
CLACKMANNANSHIRE	11	94%
DUMFRIES AND GALLOWAY	36	91%
DUNDEE CITY	34	87%
EAST AYRSHIRE	26	86%
EAST DUNBARTONSHIRE	18	91%
EAST LOTHIAN	19	89%
EAST RENFREWSHIRE	16	81%
FALKIRK	34	84%
FIFE	85	88%
GLASGOW CITY	117	84%
HIGHLAND	71	90%
INVERCLYDE	26	86%
MIDLOTHIAN	15	93%
MORAY	22	86%
NA H-EILEANAN SIAR	11	101%
NORTH AYRSHIRE	28	86%
NORTH LANARKSHIRE	35	85%
ORKNEY	8	90%
PERTH AND KINROSS	45	84%
RENFREWSHIRE	25	88%
SCOTTISH BORDERS	24	88%
SHETLAND	10	98%
SOUTH AYRSHIRE	30	88%
SOUTH LANARKSHIRE	61	88%
STIRLING	24	88%
WEST DUNBARTONSHIRE	14	89%
WEST LOTHIAN	35	94%
SCOTLAND	1,142	88%

Figure 3. Breakdown of care homes in local authorities by sector, 2017 (data taken from statistics.gov.scot)

REFERENCE AREA	ALL SECTORS	LOCAL AUTHORITY AND NHS SECTOR	PRIVATE SECTOR	VOLUNTARY SECTOR
ABERDEEN CITY	58	0	30	28
ABERDEENSHIRE	72	11	37	24
ANGUS	31	4	26	1
ARGYLL AND BUTE	22	6	13	3
CITY OF EDINBURGH	79	12	40	27
CLACKMANNANSHIRE	11	2	6	3
DUMFRIES AND GALLOWAY	36	1	26	9
DUNDEE CITY	34	6	25	3
EAST AYRSHIRE	26	1	25	0
EAST DUNBARTONSHIRE	18	1	14	3
EAST LOTHIAN	19	4	13	2
EAST RENFREWSHIRE	16	1	10	5
FALKIRK	34	7	21	6
FIFE	85	11	65	9
GLASGOW CITY	117	10	56	51
HIGHLAND	71	17	41	13
INVERCLYDE	26	1	9	16
MIDLOTHIAN	15	2	8	5
MORAY	22	3	13	6
NA H-EILEANAN SIAR	11	7	1	3
NORTH AYRSHIRE	28	2	21	5
NORTH LANARKSHIRE	35	2	31	2
ORKNEY ISLANDS	8	7	0	1
PERTH AND KINROSS	45	3	34	8
RENFREWSHIRE	25	4	16	5
SCOTTISH BORDERS	24	0	20	4
SHETLAND ISLANDS	10	9	0	1
SOUTH AYRSHIRE	30	3	20	7
SOUTH LANARKSHIRE	61	8	37	16
STIRLING	24	3	13	8
WEST DUNBARTONSHIRE	14	6	7	1
WEST LOTHIAN	35	6	13	16
SCOTLAND	1,142	160	691	291

Bibliography and Further Resources

A number of extremely helpful research reports and articles were used in the writing of this summary, and these can be found below.

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