

FREE PERSONAL CARE FOR OLDER PEOPLE: IS THIS SCOTLAND'S BID FOR DISTRIBUTIVE JUSTICE IN LATER LIFE?

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INTRODUCTION

Older people have always featured in social policy debates but this has not ensured greater equity or justice, and erosion of state responsibility has been a characteristic of the last twenty years. Since the inception of the National Health Service in the UK, debates in this area have revolved around the relationship between the state and individual responsibility, intergenerational tensions and the marginalisation of older people. As researchers in health policy, Player and Pollock (2001) note with alarm the neo-liberal assault on the welfare state and, in particular, the shift towards private responsibility for long term care with sparse debate at any level of government in the UK. Also, across the OECD countries there has been a demographic rise in the numbers of people who are aged eighty and above. This raises fiscal, economic and social policy issues. While many older people live in their own homes remaining fit and active contributors to society, the possibility of long term care increases in this age group and until recently few countries had a specific policy concerning long term care OECD (1996, p. 59). This can be understood as part of the 'invisibleness' of later life and an abdication of social responsibility.

More recently, Lynch (2001) studied the age orientation of social policy regimes across OECD countries and explored distributive equity in relation to welfare reform. Her thorough economic and intergenerational analysis of

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twenty-one countries revealed differences in the extent to which they support older people, but that the notion of a 'selfish generation' of older people cornering welfare policy was not endorsed. She concluded that an understanding of how and why public resources are directed towards different age groups is 'of critical importance for future welfare politics' Lynch (2001, p. 434). Politically, there remains ambivalence about the compromises that chronic ill-health imposes on the individual. In an analysis of Giddens's account of agency and social policy, Hoggett (2001, p. 44) raises the problematic issue of 'hatred of the very idea of dependency' and the refusal to comprehend that some people need continuing support. Frail older people challenge the upbeat notion of cure/rehabilitation and care is not afforded the same kudos. His view is that social policy requires to be more sensitive to the spectrum of the human condition and to develop alternative accounts of agency.

The inception of the Scottish Parliament in July 1999 offered an opportunity to initiate and implement new policies within a coalition framework. Under the Scotland Act (1998) the health service was devolved to Scotland with a minister and deputy minister for health and community care. In the first two years of operation, there was a distinctive emphasis on patient and public involvement, as noted by Kennedy (2001) in his analysis of the NHS Plan for Scotland. As part of an open, democratic and accessible parliamentary structure, pressure groups were an important part of the policy process as Lynch (2001) outlines. In terms of championing the case of older people in Scotland, Age Concern Scotland has been particularly active in support of the findings of the Royal Commission on Long Term Care (1999).

The aim of this article is to explore issues concerning ageing and social policy through analysis of the Royal Commission on Long Term Care (1999) and to offer an insight from one group of senior healthcare practitioners - occupational therapists - concerning aspects of implementation. Attempts will be made to situate the report alongside other policy initiatives affecting older people in Scotland (Appendix 1). Although John (1999) regards the sequential model of social policy as over simplistic, structural coherence for this analysis will be sought through the stages of the policy making process - initiation, formulation and implementation as outlined by Jones et al (1994). It is accepted that the policy on long-term care is still in a pre-legislative stage and will not now meet the original implementation deadline of April 2002; however, attempts to understand the ideological prompts, formulation dynamics and practical issues in implementation are offered.

SOCIAL POLICY AND OLDER PEOPLE – FACTORS PROMPTING THE INITIATION OF MORE EQUABLE POLICY

Social inclusion and equity are part of the proclaimed intention of the present Labour government but there remains accompanying reserve about the growth of demand on welfare noticeable within many policies. Rhetoric about empowerment and enablement may fail to appreciate the difficulties which that entails for marginalised groups in society such as frail older people. In attempting to analyse the intentions which underpinned the commissioning of a report on the long term needs of older people by the Labour government in 1997, it is clear that there was a financial agenda. However, it was also a response to public concern and a growing realisation that older people and their carers felt fearful and insecure about the future. This section of the analysis will explore two issues which seem to have acted as an impetus for the Royal Commission on Long Term Care chaired by the theologian and philosopher, Sir Stewart Sutherland. One is the contribution of prevailing ageism and the other is the difficulty encountered by older people which is caused by the health/social care divide in relation to community care.

The subject of ageing is seldom met with a neutral or non-committal response by ordinary citizens, but social policy also plays a pivotal role in the construction of later life. Older people are frequently defined and discussed in reports by using the psychological distance of demography, deficit and economics. This obscures individuality and the reality that two thirds of older people are negotiating later life with minimal help from the state. Such an imbalanced view has provided the impetus for social gerontologists, and voluntary groups such as Age Concern and the Centre for Policy on Ageing, to promote a more positive view of growing older. Indeed the prevailing values of the Royal Commission on Long Term Care were stated early in the report and it repudiated negative representations of older people in society. Nevertheless, the discourse in many previous reports concerning older people such as **The Rising Tide** (1982) and in subsequent strategies for action were inherently pessimistic and continued to conceptualise later life as entirely problematic.

Ageism is as invidious, endemic and destructive as racism or sexism and has often been considered as more difficult to eradicate. As a specific construct concerning prejudicial and negative perceptions of older people, it was initially described by Butler (1969) and Comfort (1977) within an American medical context and more recently by Bytheway (1995), a social

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gerontologist, in the UK. The nature and pervasiveness of discrimination at all levels of society has been analysed by Bytheway (1995, p. 58) who draws particular attention to the semantics and the impact of language in various policy documents. Emotive words such as the 'burden of age' used in some government reports to emphasise the cost of ageing result in heightened public anxiety, and have led writers such as Walker (1990, p. 378) to state that 'the cost of ageing has been amplified artificially in order to legitimate policies aimed at diminishing the state's role in financial and social support for older people'. This pejorative position leads to intergenerational tension and the possibility of rationalisation of resources on the basis of age.

Social policy analysts such as Townsend (1986, p. 119) have been tireless commentators on the structured dependency imposed on older people. He argues that ideology, values and some theories of later life have shaped policies which 'legitimise ageism in practice'. From a prevailing interest in poverty, his key concern was the exclusion of older people from the labour market and provision of a pensionable income of less than the accepted poverty level. It remains the case in 2001 that the majority of older people are poorer than other members of society. Bytheway's (1995) analysis also includes the extent to which a 'them and us' analysis pervades even the disciplines of social gerontology and research into later life which is 'done to rather than done with' older people.

Ageism is also prevalent in the way that power is exercised upon older people particularly when they are regarded as a drain on resources. In the quest to reduce the cost of care, successive governments have sought more of a financial contribution from older people and their carers. Understandably, this provoked anger and a sense of injustice from people who had contributed to the welfare state and believed that they would receive assistance in later life as a result. This became evident in the gathering of evidence for the Royal Commission Report on Long term Care concerning public attitudes towards paying for long term care, with the majority view being that long term care should be a public responsibility. The recorded messages in the final report from the Commission (1999, p. 5) are heartening in this respect and acknowledge the need for a more positive and inclusive climate for older people whereby notions of burden and decline are morally intolerable. Recently, there has been lively debate between geriatricians and policy makers concerning the perceived mismatch between the NHS plan for England, which explicitly claims to remove ageism from the NHS, and the failure to offer free personal care for older people in nursing homes. Knight

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(2001, p. 337), speaking from his position as policy committee chairman for the British Geriatrics Society, considered that this is potentially an ageist position and had all the 'hallmarks of covert rationing at the expense of a highly vulnerable sector of the community'. Interestingly, policy documents such as **Better Government for Older People** (1998) the **National Framework for Older People** (2000), and **All Our Futures** (2001) have made explicit statements to eradicate age discrimination and ageism.

Another issue which acted as a spur to action for the initiation of a different kind of policy for older people was the existing problems concerning community care and the living arrangements of older people. Health policy in the 1990s was dominated by the NHS and Community Care Act which was supposed to create greater partnerships between health and social care, but for many older people and their families it resulted in fragmentation and delay. This policy was described by Bond (1993, p. 221) as one of a raft of anti-collectivist policies, characteristic of this political era, whereby there was a 'distribution of health and welfare resources throughout the free market with a minimal role for the state'. Long term care was not given priority and implicit privatisation was evident within the policies.

Cowen (1999, p. 112), in his evaluation of community care, has endorsed the view expressed earlier in this article, that older people continue to be seen as a homogenous group in this context and that the 'issues of caring for older people are tightly bound to ideological constructions of their particular social importance'. People who are over eighty are the largest group affected by community care policies and they are frequently the victims of the procedural muddle caused by the division between health and social care.

In terms of locating the issue of free personal care within long term care, Twigg (2000, p. 120) has argued that it lies on the medical-social 'fault line' which presents specific problems for western welfare systems. The phenomenon also contains inherent power differentials whereby medicine is revered and social care has a comparatively lower status. This is then instituted through funding arrangements, professional orientations and approach to knowledge generation. In an important paradigm shift, Twigg (2000) has recently sought to alter the prosaic ethos of community care and expose it to a more thorough academic analysis - particularly in the area of intimate caring activity. She seeks to explain some of the tensions concerning provision and also the division between acute and chronic care whereby 'chronic care is increasingly re-categorised as social care' Twigg (2000, p.

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112). Her belief is that social policy needs to refocus more sharply on the experience of older people in this respect. With the first and most widely discussed recommendation of the Commission referring to free personal care for older people, this work is of particular relevance and raises the profile of a previously neglected area for more rigorous academic and political debate.

Cowan (1999) also acknowledges the issue of gender and the plight of older women within community care. According to the population statistics from Age Concern 2001 – 2002, a clear picture is drawn of the larger numbers of women over sixty-five in Scotland and the likelihood of financial hardship. They are also the group most likely to receive long term care. This issue has become a specific area of policy critique, and Bernard et al (2000) adopt a critical feminist analysis to reveal sustained gendered approaches to policy making in later life. While there is general disquiet amongst contemporary gerontologists that the 'voice' of older people is seldom heard in research or policy reports, attempts to gather the views of older women are even more rare. The writers argue for the distinctiveness of women's perspective on caring, welfare and social justice to influence policy.

The initiation of an inquiry into long term care is noteworthy and reasserts important values about social inclusion. In exploring the financial issues concerning new approaches to the welfare state, Le Grand (1998) has sought to offer a partnership model of funding which he argues is consistent with the Third Way ideology. However, the Scottish response seems to be part of a more 'older people friendly' stance, which perhaps retains some ideological commitment to universalism concerning welfare provision.

FORMULATING A POTENTIALLY RESPECTFUL POLICY ON LONG-TERM CARE FOR OLDER PEOPLE

The intention of this section of the article is to explore some of the dynamics involved in formulating a potentially respectful policy on long term care based on the findings of the Royal Commission on Long Term Care 1997 with a particular focus on Scotland. Three volumes of published evidence plus additional material accessible on the web site support the final document. Given the tight timescale, the commissioners, many of whom were eminent social activists, consulted widely and produced a report which is focussed, coherent and unequivocal about the key message. This relates to the first recommendation that 'free personal care should be available after assessment

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according to need and paid for from taxation' (Royal Commission on Long Term Care 1999, p. xvii). Thus, the central value and principle characterising the report is that older people require personal care – not because of their age, but due to disabling conditions. Very clear efforts were made throughout the report to resist a view of later life as a deficit state requiring specific management of such perceived decline.

The main recommendations and accompanying rationales are preceded by an introduction from the chairman which sets a respectful tone for the document and balances the financial remit with recognition that older people requiring long term care should 'have a reasonable hope of a just and socially inclusive provision' (Royal Commission on Long Term Care 1999, p. xi). Appreciating the magnitude of the task and the timescale leads to a certain scepticism that the Labour government may have appeared democratic in commissioning such an independent inquiry – but did so in the covert belief that it would fail to find a solution to such a complex and unpredictable phenomenon. Certainly, the rapid rejection of the proposals by the Westminster government on the grounds of financial concerns and the attendant 'funnel of doubt' appears to have been more on the basis of dissent within the ranks of the commissioners – notably from the Labour peer David Lipsey. This note of dissent is published in full and has been followed up in the popular press with a vitriolic attack on the Scottish Executive and the former first minister in particular, describing the decision to implement the recommendations as a 'populist wheeze' and ill considered in the long term (Lipsey 2001)

The final report of ten chapters devotes more than half to the considerations of current expenditure, analysis of risk, the scope of the private sector and an evaluation of the possible scale of public provision. Evidence to support this came largely from Volumes 1 and 2 of the accompanying research documents and was drawn from the projections of the Government Actuary Department, previous research by Wittenberg et al (1998) concerning demand for long term care and publications concerning health economics dating from the 1990s. Interestingly, few specific Scottish studies are apparent from this body of evidence and only Adams and Wilson (1997), Petch (1996) and Petch et al (1996), who write about mental health, housing and care management in Scotland, stand out in this respect.

Seven sites in Scotland were visited by the commissioners with a public hearing in Dundee and a seminar in Edinburgh. The north west, far north and western isles and the borders were not visited. Scottish organisations which

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gave evidence included Alzheimers Scotland/Action on Dementia, and at least four Scottish based organisations such as Disability Scotland were included in the Reference Group. While acknowledging the transferability of certain economic and geographical evidence, proportionately Scotland was not particularly well represented. This begs the question of the grounds and evidence upon which the decision to provide free personal care in Scotland was based. It has led Eccles (2001), in one of the first critiques of the process, to postulate that the Scottish decision may have had less to do with a wish to represent older people more fairly than a symptom of convoluted political dynamics north of the border. His analysis supports the scepticism about a sequential model of social policy and reveals the unpredictable nature of decision making in politics together with the influence of unforeseen events which render the process more reactive than carefully planned. This was clearly the situation on the Mound in January 2001, when a change of policy occurred within twenty-four hours. Nevertheless, the criticism fails to take account of the prevailing attitudinal differences between Scotland and England in this respect. In Scotland, there has been a dominant mood of support for any government initiative which would improve the standards of living for older people as noted by Paterson (2001). It may also reveal that policies are powerfully shaped by public opinion and that democratic politicians respond accordingly to that phenomena.

Apart from the two main recommendations concerning personal care and the establishment of a National Care Commission, twenty three further recommendations concerning funding, services, help for carers, information gathering and help for younger disabled people were offered. Most of these required no additional legal initiatives but predictably they have paled into insignificance alongside the financial imperative of free personal care. South of the border, the health secretary sought to implement some uncontroversial proposals, but according to Hirst (2000, p. 15) considerable antagonism and even attempts to 'rubbish' the report had occurred. Her revealing account notes liaison between Labour government advisors and dissenting commissioners in a possible conspiracy to delay any response. Whether this reflected Treasury panic, a retreat from the seemingly bold step of mounting a Royal Commission instead of an internal inquiry or a disregard for the plight of older people it is difficult to determine. However, Hirst's view (2000, p. 16) is scathing and considers it scurrilous that 'a mere 0.1% of GDP' could not be devoted to easing the lives of older people. Likewise, Player and Pollock (2001, p. 253) view the situation as part of 'new liberal ideologies of New Labour's third way prevailing and severing the 1948 social contract'.

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The difference in response between Scotland and England led journalists writing for the **Economist** (2001, p. 39) to whimsically propose that Westminster may have to recapitulate or risk another instance of the 'Scottish dog wagging the English tail'. Another possibility is that the Commission was no more than a symbolic gesture as Hills (1993) suggests in his analysis of the difficulty of implementation of social policy.

However, in the formulating of a distinctively Scottish response to the findings of the Royal Commission, it is useful to track the chronology and context of the issues related to the decision to implement the main recommendations, originally as from April 2002. (Appendix 1). Initially, the Scottish position had been in accordance with Westminster, with the then first minister of the Scottish parliament baulking at the cost, which he believed was unsustainable. In October 2000, the then health minister, Susan Deacon, gave a response offering some measures to support older people in their own home but did not concur with free personal care. Changes in the Scottish Executive caused by the death of Donald Dewar and the appointment of Henry McLeish led to an unforeseen review of all policies. As noted earlier, a very public change of heart occurred in January 2001 when a Care Development Group was established to explore issues related to implementation of free personal care. Again a very tight time schedule of six months was allowed. The composition of this group was interesting with continuity provided by one of the commissioners, and some others had given evidence. Upon reporting of their findings in September 2001, their deliberations endorsed the Royal Commission, clarified the definition of personal care, agreed with the proposal to use a single shared assessment and suggested that new money should be ring fenced to ensure that appropriate finance was allocated for services to older people in Scotland. Running parallel to this work was a strong lobby from Age Concern Scotland to uphold the findings of the Royal Commission. The campaign entitled 'We Care' presented the largest petition of over 10,000 signatures to the Scottish Parliament. Public opinion, voluntary organisations and professional groups all continued to exert pressure.

As a commentator on this process, Eccles (2001, p. 10) believes that the Scottish decision illuminates the 'fragmented and competing nature of government'. Far from a rational, well argued and rigorous debate about the specific issues surrounding free personal care for older people, he considers that political expediency proved the greatest catalyst. He forecasts that implementation will be problematic and that it sets precedents, which will

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alarm Westminster. However, this criticism merits a rejoinder which challenges the notion of political expediency as the sole motivating factor. Public opinion and all party support exists concerning the responsibility of government to maintain standards of living for older people in Scotland (Paterson 2001). Predictably, pressure groups such as Age Concern Scotland perceive the situation differently and maintain that the Scottish parliament has matured and shown the facility for setting clear priorities concerning social justice, according to Dunion (2001). That concurs with the closing statements in the Royal Commission Report (1999, p. 109) which state that the basic principle of permitting older people to live without fear 'is something beyond price'.

Older people are a potentially powerful political force. They vote more consistently than younger people and have vocal and energetic advocates in Scotland who lobby tirelessly on their behalf. Nevertheless, the challenge to formulate coherent and co-ordinated social policy concerning older people remains. It has prompted the Scottish Executive to quietly establish an Older People's Unit to raise the profile within the executive. However, in terms of formulation of future policy, the independent Royal Commission may have backfired as a delaying strategy for the Westminster government. What becomes apparent from an exploration of the Scottish political process is the interplay of public opinion, input from a political champion, media involvement and the near collapse of the coalition prior to the historic decision. However, the next stage of implementation before the parliamentary elections in 2003 is not straightforward and prey to competing interpretations of the recommendations regardless of any other unforeseen events.

ISSUES CONCERNING THE IMPLEMENTATION OF A POLICY CONCERNING FREE PERSONAL CARE FOR OLDER PEOPLE

As the deadline for implementation of free personal care for older people draws closer, various professional groups have published their reaction to it which seem to endorse Ham and Hill's (1993) analysis of discretion in the policy making process. Responses from social work, for example from Sutherland (2001) and McKinnon (2001), are wholeheartedly in support but both voice cautious reserve about how it will be funded. Commentators on the political process such as Eccles (2001, p. 10) consider that the costs have been underestimated and that while 'Scotland offers an enhanced policy commitment towards older people, it simultaneously faces fiscal stress'. The

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possibility of raising taxes may be a necessary but unpopular action especially in the prelude to Scottish parliamentary elections. This worry about financial underpinning is endorsed by health economists whose concerns are with the efficient allocation of resources, opportunity costs and the finite nature of resources available to pay for free personal care. There are also still issues surrounding the differentiation between nursing and personal care and Ford and McCormack (2000, p. 43) seek to clarify the difference according to the Royal College of Nursing guidelines. Basically, the argument surrounds the pivotal distinction between the intention to care or cure. It is acknowledged that many individuals can provide personal care but nursing care is bound by a 'duty of care that registered practitioners accept' within a theoretical framework of enablement. This has prompted responses from nurses such as Caulfield (2001) to raise the issue of delegation to health care assistants and how this would affect funding, all of which reveals the extent to which professional discretion is a feature of implementation complexity.

In Scotland, the Scottish Executive have stipulated that nursing and personal care would be free for all older people, and the Care Development Group was established to explore service provision, financial implications, a common assessment process and to provide a clear definition of what was meant by free personal care. This encapsulated non-medical services involving close personal contact, which also included psychological support for older people with dementia. A number of small studies designed to gain feedback emerged from the work of the Care Development Group, including a study by Dewar, O'May and Walker (2001) which sought to explore the perspectives of older people already receiving residential and community care on free personal care and other service provision. Focus group methodology was used to gather views from forty-nine older people in seven sites. Findings revealed that many of the actual needs of older people were not neatly covered by the existing definitions and that provision of more services by the state did not address the essence of their experience. The researchers concluded that the artificial division of services might negate a holistic approach. Using a similar methodology, Jones, Ridley and Robson (2001, p. 47) attempted to gather public opinion by working with six groups including older people, carers and people aged thirty-five to fifty. Considerable confusion existed about what personal care meant, and this led the researchers to reiterate their concern that it was an imperfectly understood term. Interestingly, this group were more interested in 'free entitlement to packages of personal care tailored to individual need, properly assessed and extending to whatever kinds of support were necessary' to help the person maintain independence. Those

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selected examples from empirical inquiry reveal the need for feedback at the pre-legislative stage of any policy initiative.

As a group of health professionals, occupational therapists have been considered dilatory in making their voice heard in health and social policy debates. This tunnel vision, whereby the profession was perceived as diffident about wider sociopolitical issues, caused Cameron and Masterson (1998, p. 556) to challenge occupational therapists to acknowledge more publicly that their work existed in a wider social context. This was prompted by the fact that they were excluded as a named group from the white paper – **The New NHS – Modern, Dependable** (1997) and the doubts over continued contribution by various professional groups voiced by the Health Services Management Unit (1996). Nevertheless, those writers are supportive of the contribution made by occupational therapists towards social progress and believe that they should be helping to analyse, formulate and implement health and social policy.

In an attempt to gain insight into issues concerning implementation of the recommendations of the Royal Commission on Long Term Care (1999) with particular reference to occupational therapy, a small pilot study was carried out. Four senior occupational therapists, two from local authority backgrounds and two from NHS backgrounds who would have responsibility for interpreting social policy with regard to their service were interviewed by telephone (on 26 October 2001 and 31 October 2001). One was located in a rural area of Scotland and one represented work with older people with mental health problems. This convenience sample was chosen to represent salient professional issues and the implications of various locations for the delivery of services to older people. Each interview took forty minutes. The interview schedule of ten questions was sent to participants one week before the interview together with a copy of the main recommendations and summary from the main report of the Royal Commission. Notes were taken during the interview and a summary was reflected back to the interviewers to ensure accuracy.

An interesting consensus was apparent concerning the noticeable gathering of pace in the last six months of policy initiatives, some of which required more immediate professional responses than the recommendations of the Royal Commission. All concurred that services were patchy, with those older people who were in most need catered for reasonably well but with little preventative work possible within available resources. All acknowledged the importance

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of the Joint Futures initiative which had direct impact upon occupational therapy whereas the Royal Commission had a minimal effect upon discussion or decision making at this point in its evolution. However, there was disquiet about how assessment would occur and who would carry this out. Older people with dementia were considered to be at a disadvantage despite specific mention within the report. On the issue of what could or should be provided free, the interviewees could quickly provide a rationale for small pieces of rehabilitation equipment and adaptations. Finally, all wished to see the appointment of an implementations officer or a commissioner for older people who would act in a proactive manner and ensure common interpretation of the findings of reports concerning older people.

Within the profession, a concern about the insidious phasing out of a welfare society alerted Runge (1999, p. 11) within a Scandinavian context, to note the resulting competition between professions that this brings which, in turn, causes disintegration of collective approaches to care so needed by older people. This view was endorsed by senior practitioners working within a local authority. In the UK, care management approaches were intended to prevent this and, in the opinion of the interviewees, this is a positive outcome of working with complex situations where arguably the need is greatest. Nevertheless, all interviewees could identify specific areas where older people were not served well and the attempt to employ community rehabilitation teams for preventative purposes had yet to be evaluated.

The four interviewees were aware of a quickening pace and drive towards social change in the last two years, and while some practitioners were described as 'change weary' an underlying optimism was apparent. This concerned the greater accessibility to the Scottish parliament: 'MSP's can be seen at conferences' reported one interviewee. Democratic ideals, which were embedded in partnership forums and elder councils (**Better Government for Older People**) were attributed not only to a change in political ideology but to a local will to implement positive change. This theme of 'joined up' thinking, budgets and services was prevalent throughout the policies concerning older people, and resonated through the responses of the four senior occupational therapists who have to operationalise policy initiatives on a daily basis. However, the need for co-ordination was considered urgent. All interviewees were confident that older people with complex needs were being serviced effectively but that many others had to wait for non-essential services such as bathing. Many issues of unfairness existed, particularly concerning the health and social care divide. Social care, as Twigg (2000, p.

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133) has intimated, is regarded as less important, less academically interesting and always raises the fact that personal care is located in a 'zone of contention' which is experienced by key workers but seldom debated. All interviewees were aware of the plethora of new policy initiatives concerning older people, and, in particular, **Joint Futures** was considered the most salient for the practice of occupational therapy. In contrast to the Royal Commission on Long Term Care, which was considered as media and political fodder by two of the interviewees, the **Joint Futures** report demanded accountability and transparency and had mentioned occupational therapy specifically.

Similar to the concern of nurses, the definition of personal care had practical consequences for who might conduct the assessment and where this may be carried out. However, the central issue was the method and mode of assessment that would act as the screening tool, with concerns raised that rationing would still occur. The axiomatic issue in the report is the assessment of need, which as a construct has often been used to justify social policy. Theoretically, the seminal work of Doyal and Gough (1991) is relevant in this context and has substantiated the concept that objective human needs do exist. Their ideas reject both market individualism and state collectivism and proffer an alternative theory of human need, which draws on liberal and socialist thought. They used the theories of Habermas (1976) and Rawls (1972) who both searched for models of democracy and distributive justice which listened to the voices of all concerned and avoided the power of vested interests. Currently, confusion confounds this pivotal aspect of assessment regarding which single instrument may be used, and unless this is clarified within the next few months the potential for disarray and local anomaly is great. Debate concerning who would carry out the assessment highlighted the issue that Twigg (2000) had raised in her theoretical overview of the nature of care/bodywork. At present, this is afforded low status and likely to be allocated to low paid careworkers. In turn, this led to concerns particularly about training which might be offered by qualified occupational therapists but would have to occur within already curtailed budgets. Two of the interviewees considered that small scale adaptations and some assistive devices could also be provided free within the spirit of maintaining independence. They all shared some common concerns with social workers and nurses but sought to contextualise the report within a raft of measures since 1998, which had the potential to improve services for older people. All participants conveyed a critical political awareness and reflexivity concerning how to operationalise their services.

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In summary, John (1999) considers that implementation problems often cause decision makers to rethink policy. It rests on the nature, amount and quality of feedback since the formulation phase. Equally, as Lipsky (1971) revealed, service providers (such as occupational therapists and nurses) have the opportunity to affect the successful implementation of policy initiatives. Since this policy is in the pre-legislation phase, policy analysts will be considering probability factors, which will include a more macro evaluation of current global sociopolitical situations. The policy making process is indeed multi-causal, but, in the Scottish context, implementation will be powerfully shaped by the appointment of the new first minister, financial imperatives, how service providers interpret the report and the forthcoming elections.

CONCLUSION

Considerable challenges face social democratic governments in relation to welfare provision and efforts were made by the commissioners to learn from international experience. However, devolution meant doing things differently in Scotland and ageing appears to remain a priority for the parliament with a drive to make health and social services more responsive. In terms of distribution of resources, the key issue in all policy contexts is co-ordination and integration with other policies, which Begg (2001) is particularly concerned about in the Scottish context. The Report on Long Term Care (1999) has had an interesting relationship with the Scottish parliament. It has been the vehicle for disagreement between ministers, the catalyst for a near disaster in the coalition and the eventual stimulus for a popular decision, which has public support. Within a period of inertia, the report was also used to petition the parliament by Age Concern. While Lynch and Birrell (2001) note that the intention of the petition committee was not to provide a forum for major pressure groups, it was certainly part of the process which seemed to mobilise a decision and represents how feedback can influence policy.

From the moral high ground of social justice, free personal care seems the very least that could be offered to older people with enduring ill-health and thus an incremental step in the right direction according to the pressure groups involved with later life. However, practitioners working in resource-starved situations are preoccupied with the need for clarity in the definition of personal care and how to assess this. Their view is that the impact of the report is greater when seen as part of a number of initiatives designed to improve services for older people – notably the **Joint Futures** report. Some

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counteracting of policy pessimism is apparent in this respect together with an increased theoretical interest in the area of personal care.

Research for this article included literature searches which produced sparse critical debate on the issue of personal care in peer reviewed journals, but did reveal a growing interest in sociological perspectives on the ageing body. Conversations with older people, their carers, representatives from the policy section of pressure groups, other social activists for older people and latterly a more systematic interview with a small sample of senior occupational therapists all revealed a cautious optimism about social policy initiatives in Scotland. From an overview of the first year of the parliament, Paterson (2000, p. 60) analyses the hopefulness of 'utopian inclination' that seems to be prompting a more radical social reform, and perhaps the distinctive Scottish decision on long term care is a feature of that movement. Certainly, the decision to uphold the main recommendation concerning free personal care produces a reaction of pride in a small nation making another distinctive political choice. Equally, there appears to be a sustained drive since 1998 to facilitate distributive social justice for older people in Scotland detectable in the policies which predated the Royal Commission on Long Term Care (1999) and indeed in the reports from subsequent initiatives outlined in Appendix 1. However, the unpredictability of the policy making process was further reflected in the resignation of Henry McLeish who was seen as a champion of this report and who had been instrumental in mobilising energy and resources towards implementation.

His departure produced a hiatus within the parliament, and while political will still exists within the coalition to counteract ageism and promote social inclusion for older people, the result of the ballot from the electoral college in choosing Jack McConnell as a successor will have an impact on policies at the pre-legislative stage. In this respect, the words of one of the interviewees who hoped that 'Scotland as an entity can get it's act together for older people' are prophetic. Implicitly it acknowledges the problematic nature of implementation of any social policy. However, it may also give voice to a combined professional, public and political view that human need has priority over political goals and that distributive justice is required for older people with chronic ill health in Scotland.

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APPENDIX 1: IMPORTANT EVENTS AND PROCESSES LEADING TO A POLICY THAT COULD IMPLEMENT FREE PERSONAL CARE FOR OLDER PEOPLE

- 1997 Labour party elected – older people a key issue in the manifesto
- 1998 Better Government for Older People – pilots launched (July)
Royal Commission on Long Term Care constituted (Dec)
Royal Commission gathering evidence within the UK and abroad
Modernising Community Care – agenda for joint working, organisation and delivery of services within agencies
- 1999 Working Together for Scotland: a Programme for Government (March)
Royal Commission on Long Term Care published (March)
Scottish Executive formed (May)
Scottish Parliament formed (July)
Age Concern launches “We Care” campaign
The Joint Futures Group – set up by Susan Deacon, chaired by Ian Gray, Deputy Minister for Community Care (Nov)
- 2000 Petition of 10,000 signatures to the Scottish Parliament to support Royal Commission on Long Term Care (Jan)
Group of Charities and Pensioners lobby Scottish Parliament (March)
State pensions controversially increased by only 75p (April)
Better Government for Older People : All Our Futures Report (June)
Westminster rejects recommendations of the Royal Commission on Long Term Care (July)
Protest March by The Confederation of Scotland’s Elderly (Sept)
Minister for Health and Community Care rejects free personal care as a recommendation (Oct)
Newly appointed First Minister – Henry McLeish and review of all policies (Nov)
Cross Party Support for delivery of free personal care (Dec)
- 2001 Agreement in Scottish Parliament to implement free personal care (Jan)
Expert Development Group appointed
All Our Futures – Report from Scottish pilots
National Service Framework for Older People (March)
The Future for Care Homes in Scotland – a consultation paper (April)

Free Personal Care for Older People

Scottish Executive pledges one hundred and twenty five million to evaluate introduction of free nursing and personal care (June)

Regulation of Care (Scotland) Act (July)

Care Development Group reports endorsing the Royal Commission – all charges for personal and nursing care to cease from April 2002 (Sept)

Health care and social care professions seek ways of implementing Joint Futures and Royal Commission – particularly in relation to a single shared assessment. The agenda for re-establishing rehabilitation as an alternative to care provision is being explored and is likely to be addressed by the Chief Medical Officers Group. At Scottish Executive level, the lead occupational therapist involvement is around equipment and adaptations and how free personal care (and nursing care) relates to this.

Henry McLeish resigns as First Minister (Nov)

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