

## **Engender response to *Integration of Adult Health and Social Care in Scotland: Partial Equality Impact Assessment***

Engender is a membership organisation working on anti-sexist agendas in Scotland and Europe to increase women's power and influence and make visible the impact of sexism on women, men and society. We provide a wide range of information and support to individuals, organisations and institutions who seek to achieve equality and justice.

We welcome the opportunity to comment on the partial EQIA of integrated adult health and social care proposals in Scotland. Specific responses are below; we would also like to emphasise the following broad points:

- The evolving backdrop of welfare reform, NHS reform, major public sector cuts, funding cuts to third sector services and related impacts on informal support networks are not well understood.
- Intersections between protected characteristics under equalities legislation must also be adequately taken into account. For instance, gender and age, gender and disability, gender and disability and income bracket.
- Care in the 'community' predominantly equates to care by women. This has enormous impacts on earning potential which must be linked into debates on women's / children's poverty and increasing vulnerabilities.
- Views from carers must be proactively sought and made more central to the process, particularly in rural areas and where input to date is lacking. This should include support and facilitation where needed.
- Insufficient disaggregated data by gender limits understanding of impacts. As the process advances, M&E should include disaggregated data on gender.
- The shift to care in the community could be used as a platform to highlight gender biases within the system, such as the undervaluation of care professionals, and to promote the unrecognised work of unpaid carers.

- The partial EQIA only name-checks ways in which women are likely to experience impacts. Engender recommends that the gender concerns identified are fully explored at next stages of the process.
- Strong gendered analysis and resultant policy responses are not only about gender justice and equality imperatives, but also further a broad range of Scottish Government National Outcomes, targets and agendas.

## Partial Equality Impact Assessment

### Introduction

- D.4. *“Findings are based on the knowledge and experience of those present at the workshop.”*

Whilst we recognise that this was an initial stakeholder meeting and that participation from the women’s sector may have been sought, there is a notable lack of expert input from a gender perspective in this initial document.

As three broad ways in which proposals will have a greater and differing impact on women have been identified, specific input from gender experts should be incorporated at the next stage of the EQIA.

- D.4. *“This report...presents possible impacts that may require further consideration.”*

The partial EQIA recognises that women will be more significantly affected across three entry points for analysis: women’s occupational dominance in social care roles, women’s role as unpaid carers and women’s longevity.

It is vital that these and other gendered impacts are analysed and understood more fully, and wider implications taken into account. This will feed squarely into all four stated aims of the EQIA.

### Rationale and aims of policy

- D.5. *“We recognise, however, that we should go further to ensure consistently good outcomes for patients, service users, **carers** and **families**”*

This will not be possible without due consideration of gender inequality, women's time poverty and discrimination faced by women. For instance, as the shift to increased 'care in the community' is implemented, development of support for carers, must take account of women's higher incidence of poverty and their roles as managers of poverty, increasing unemployment, and the gendered impacts of welfare reform.

Women carers should be proactively consulted in next steps of policy and service development, in the context of other gendered responsibilities and changing demographics (e.g. childcare for grandchildren), as well as structural gender issues such as those outlined above.

- D.7. *"Problems often arise in providing for the needs of people who access many services over prolonged periods, such as people with long term conditions, **older people**, and people with complex needs."*

As identified by the partial EQIA, a majority of older people are women. Gender analysis of differing needs should be undertaken, to ensure that older women's experiences of primary and secondary care, and the disconnects between them are taken into account.

- D.9. *"The changes in demography will vary in scale depending on location, with predictions suggesting that **rural areas** will be affected to a greater degree than urban areas."*

There are gendered implications for women carers and service users in rural areas of Scotland, such as limited informal support networks and mental health issues associated with isolation.

In some rural areas, travel constitutes a major strain on women's time and budgets. For example, it has come to our attention that elderly people from Argyll and Bute who can no longer be cared for in the home are taken away from their families on the Islands and put into care homes in Greenock and Paisley.

Strategic planning around demographic change must include gender perspectives.

- D.10. *"Our current system of health and social care incorporates within it barriers in terms of **structures, professional territories, governance arrangements and financial management** that not only have no helpful bearing on the needs of the large, growing group of older service users, but in many cases work against the general aspiration of efficiency and clinical/care quality."*

Governance is at the root and heart of gender inequality and structural changes provide an opportunity to address major issues, such as women's participation and leadership, access to decision-making structures, inclusion and gender power relations.

For instance, targets could be set for women's representation at all levels in new decision-making bodies/ posts, and policies put in place to engage a wide range of female stakeholders in design and delivery of integrated services (including service users, carers, women from BME groups, disabled women, older women etc.)

There is also overlap between professional territories and both horizontal and vertical occupational segregation. Women are underrepresented in managerial and other senior positions within health and social care structures, and overrepresented in professions which are culturally undervalued and underpaid, such as care.

This means that women are more vulnerable to impacts of the economic crisis, government austerity measures, welfare reform and cuts to third sector service providers, both as service users and as employees. In turn, this may mean that increasing numbers of women with caring responsibilities are under new and evolving pressures, which undermine resilience and ability to adapt to restructured caring networks.

Analysis of "barriers in terms of structures, professional territories, governance arrangements and financial management" should include this range of gender concerns. Otherwise, strategies to address these limitations will fall short of both serving the needs of older service users, carers, families and staff, and of ticking efficiency boxes.

- *D.11. "We know **from clinicians and other professionals who provide health and social care support** that, as far as possible, it is better for people's wellbeing if they are supported in their own homes or another homely setting in the community, rather than being admitted unnecessarily to hospital. The integration agenda will be key in continuing to drive forward **the shift in the balance of care from institutional care to services provided in the community.**"*

Over-reliance on the views of healthcare professionals risks a one dimensional picture, which does not adequately take stock of wider health and wellbeing implications for carers and families. Their views and those of third and independent sector service providers should be sought in monitoring and evaluation of this process.

As policies are implemented, steps must be taken to ensure that adequate practical and emotional support is provided for carers and families. In 2011,

Engender supported a group of women carers from Inverness to produce *Preparing to Care: Woman to Woman*.<sup>1</sup> Key messages to emerge were that 'carers need care' and women lack communication channels to access information and support.

Dialogue must remain open, in order to flexibly respond to wider impacts that emerge. The cost of (women's) 'care in the community' in rural areas, coupled with public sector budget cuts may mean that people are denied services and care.

On a more fundamental level, these structural changes could be harnessed to address and highlight inherent gender inequalities in health and social care systems. This could provide an opportunity for step-change towards policies, economic models and cultural norms which recognise and value the unpaid and underpaid care work of women.

There is also a fine line between increased care in the community and elements of the Coalition government's 'Big Society' which undermine the role of the welfare state and the rights and needs of marginalised and vulnerable groups. The implications of UK welfare reform and cuts to services must be comprehensively integrated into impact assessments.

### Objectives

- *"Clear accountability for delivering agreed national outcomes"*

"Tackl[ing] the significant inequalities in Scottish society" is a Scottish Government national outcome. This process should be used to advance gender equality objectives.

### People present

The partial EQIA would have benefitted from input from specific gender perspectives from the outset. Participation from gender experts could have been actively sought.

### Population groups

- *D.17. "Women tend to work in social care roles more than men; proportionally there tends to be more female carers; and women are more likely to live longer and outlive male partners so they are more likely to access services later in life."*

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<sup>1</sup> <http://www.engender.org.uk/wp-content/uploads/2012/03/Preparing-to-Care-A51.pdf>

There is a clear need to work through the implications of these three identified areas. For instance:

#### Carers:

- In terms of capacity, what exactly will be demanded of carers and will this be sufficiently flexible to ensure no negative intersections with increased female unemployment/ high rate of female job losses in (flexible) public sector?
- Will forms of support reflect other demands on women's time? Time poverty amongst women is a global phenomenon, which should be addressed in this EQIA. How will the so-called 'double dip' into women's time (to care for children and again to care for the sick and elderly) be addressed.
- Mental health and wellbeing of carers and their families should be of paramount consideration, especially in light of parallel funding cuts. How will this be integrated and monitored?
- Caring responsibilities often mean that children lose out. What support models would work best to mitigate this with built-in 'family time'?
- Our work with carers in Inverness reflected trends such as:
  - carers of partners who had suffered strokes 'guilted' into care roles.
  - female relatives assuming caring roles, rather than male partners
  - assumptions from professional staff that a) carers will be women and that b) caring comes naturally to them.
  - concerns about the needs of older men caring for their partners not replicated for women
  - women are bullied into taking on the caring role by health professionals

#### Social care roles:

- What are the implications for flexible working patterns? This needs to be linked into wider SG discussion on flexible working and loss of income.
- Are there opportunities to highlight the undervaluation of caring professions, from a public awareness/ engagement perspective?

#### Older women:

- Do older women access and use services differently, and what are the implications for planning, budgeting and staffing?
- What gender patterns emerge regarding hospital admissions/ types of treatment once changes are implemented?

- Distances and costs undermine care in the community approaches in rural areas. How will funding be adjusted to reflect this?

Gender disaggregated data from local authorities and public bodies will be vital in fully understanding the gendered implications of these proposals. Changes in employment patterns should be monitored at local level.

The perspectives of carers, families, older women, young people, women living in rural areas, and women directly affected by the approaching introduction of Universal Credit must be proactively sought, as well as those of women within other groups protected by equalities legislation. This input should be channelled into shaping service design and delivery in due course.

- *D.17. [Minority ethnic people] “What are the levels of health and social care service uptake from minority ethnic communities? Current evidence indicates the numbers of minority ethnic people accessing services is low.”*

To understand these trends, data disaggregated by gender is of key importance. There are many factors which dictate how, where, when and why BME women access support, including cultural norms, socio-economic circumstances and practical barriers such as language, transport or childcare.

- *D.17. [Minority ethnic people] “Need to bring together workforce development on understanding of cultural outcomes.”*

This would be a welcome initiative. Equally important and insightful, however, would be a parallel process to understand the depth and complexity of gender outcomes. Engender strongly recommends that a gender-specific assessment is undertaken.

- *D.17. [Refugees and asylum seekers] “There is an ongoing need for staff to have a cultural understanding of outcomes for individuals.”*

It is certainly important for health and social care staff to have a cultural understanding of individuals needs. It is also vitally important that staff increasingly understand the discrimination and injustice faced collectively by women refugees and asylum seekers within UK public services.

For instance, women often seek asylum having fled gendered persecution, violence or torture, often suffer from PTSD, and face multiple systemic and practical barriers to accessing basic needs, adequate housing, legal representation, healthcare and many other services. Engender strongly recommends training for service providers, and urges the Scottish Government to assert influence at UK level.

- *D.17. [Lesbian, gay, bisexual and heterosexual people] “No impacts identified.”*

Perspectives from LGB groups should be actively sought.

- *D.17. [People in different socio-economic groups] “This could impact on people from poorer areas where life expectancy is lower and the burden of disease higher. The policy could thus impact disproportionately in deprived areas in terms of the costs associated with the cared for.”*

A central element of equalities impact assessment is the intersections between marginalised groups. The dynamics between low income and gender, are multiple, diverse and particularly relevant to health outcomes.

Poverty is highly gendered and Scottish Government anti-poverty measures lack adequate integrated gender analysis. Insufficient data, disaggregated only by household and area, masks the extent of women’s relative poverty, lack of recourse to economic independence, the gender pay gap and other discriminatory employment practices. Women tend to fulfil roles as ‘managers of poverty’, as well as primary caregivers for children and relatives, and 90% of lone parents in Scotland are women.

In short, extreme pressures on women’s time, especially in low income households, is not recognised or factored into policymaking.

Women living in poverty in Scotland should be a priority demographic for the full EQIA. Understanding implications of integrated health and social care from the analytical baseline of women’s time as a (finite) resource will be a key part of this, as well as interplay with the evolving landscape of UK-level cuts and the introduction of Universal Credit from 2013.

- *D.17. [Carers] “If there is a single point of access to services it will be easier and simpler for carers as they will not have to contact multiple service delivery organisations.”*

Engender welcomes the prospect of relieved pressure on carers’ time in this respect. It is also clear, however, that the shift to increased care in the home and community will have enormous implications for carers and their time.

In close consultation with carers and families, the full EQIA should include fuller consideration of these impacts. Issues such as increased demand on respite services, interplay with women’s domestic responsibilities and the increasing role of grandparents in providing childcare must be understood. In due course, carers



should be actively supported to input into the implementation phase of new policies.

To reiterate, the process could also be used as a platform to promote the work, time and value of unpaid carers in Scotland’s society and economic system.

- *D.17. [Staff, includes people with **different work patterns, e.g. part-/ full-time, short-term, job share, seasonal**] “Issues relating to differing terms and conditions in Health Boards and Local Authorities were noted, with potential for consequential impact on staff and their respective representative bodies.”*

This is a key point. Women are more likely to work different patterns and in less secure jobs, to accommodate other responsibilities and as a result of discriminatory employment culture. Given the pressures on public sector budgets and highly gendered job losses in Scotland over recent years, it is extremely important that impacts on all working patterns are understood and that flexibility is maintained.

Summary of key impacts, research questions and evidence sources

- *D.23. Evidence-informed recommendations are key to a robust impact assessment; however, ‘evidence’ to support the development of recommendations can be thought of more widely than just formal research. Furthermore, a lack of available robust evidence should not lead to the impact assessment process being delayed or stopping altogether. **Often there is poor or insufficient evidence** about the links between a proposal and health; there may, **however, be plausible theoretical grounds to expect an impact.***

As above, lack of adequate disaggregated data by gender is a major issue. However, there is ample theoretical and anecdotal evidence to anticipate gendered impacts of these proposals.

Please see some additional comments and recommendations below.

Area of impact	Research questions	Possible evidence sources
Increased payments made for and by people who access these services.	Could there be an increased number of social care payments made for and by people who access these services, particularly disabled people, and over	Explore further with appropriate stakeholders.

	65s? <b>and women (see comments on women's poverty.)</b>	
Accessibility to services for people from ethnic minorities.	How can workforce development teams be brought together to develop an understanding of cultural outcomes for individuals?	
Potential implications for trade union and staff-side bodies representing health and social care staff.	How will differing terms and conditions of employment between Health Boards and Local Authorities, particularly if staff move between them or are within integrated teams, be managed?  <b>What are the implications for flexible working patterns?</b>  <b>Are there opportunities to highlight the undervaluation of caring professions, from a public awareness/engagement perspective?</b>	Seek advice from relevant stakeholders including Scottish Government Health Workforce and Performance Management Director, Personnel Directors and Trade Unions. <b>Close the Gap is another key stakeholder.</b>
Promoting positive attitudes in communities and service users.	What evidence exists of effective approaches for promoting positive attitudes? <b>Valuing unpaid and professional care work is part of this picture.</b>	Census; Scottish Household Survey
Maximising available income for older people.	How will the policy maximise the income for older people?  <b>Must be analysed in</b>	Census; Scottish Household Survey

	<b>context of gendered poverty, welfare reform and UK government plans for pensions reform.</b>	
Create better networks between health and social care providers and carers.	How can data be shared between NHS, social care providers and carers?	Data sharing work under development by Scottish Government.  <b>Opportunity to push for comprehensive disaggregated data collection by Local Authorities and Health Boards, including by gender.</b>
Improve patient safety: with minimum unnecessary movement from home. <b>Vulnerability to domestic abuse must be carefully monitored.</b> Impact of change on homecare capacity. <b>This is vital- the capacity and time of carers will be severely impacted.</b>	What are the hours of care per client or numbers of clients? <b>Must be understood in context of other commitments: e.g. childcare, work patterns.</b>	Homecare statistics publication; Scottish Health Survey
Services would be provided in a person centred framework.	What would the experience be for the patient receiving the service? <b>Opportunity to monitor differing experiences of women, men and transgender people.</b>	GP/local NHS services patient experience survey
Adult protection.	Adult protection: There is a need to continue to ensure adequate provision and capacity of staff to provide support and information to enable patients <b>and carers</b> to	Care home statistics; census. Scottish Health Survey

	manage medication and stay safe in a homely setting.	
Older people.	Will the policy increase the system's ability to keep >65 year olds out of hospital?  <b>What are drivers of differences by gender and deprivation?</b>	> 65 emergency bed day rate per 100,000 population by Health Board (HEAT target) stratified by gender, age and deprivation.
Carers.	What is the potential impact on respite care admissions?  <b>What is the potential impact on health and wellbeing of carers?</b>  <b>Will forms of support reflect other demands on women's time?</b>  <b>Will demands on carers intersect with implications of increased female unemployment/ high rate of female job losses in (flexible) public sector?</b>	Scottish Government health and social community care publications.  <b>Ongoing dialogue with carers.</b>
<b>Gender.</b>	<b>Do women access and use services differently, and what are the implications for planning, budgeting and staffing?</b>  <b>What gender patterns emerge regarding hospital admissions/ types of treatment once changes are implemented?</b>	<b>Explore further with broad range of service users, care professionals, carers and NGOs.</b>

Who else needs to be consulted?

- *D.24. A range of key partners, relevant and interested parties were invited to the scoping workshop to support the assessment of the impacts of the policy and contribute to the development of the partial EQIA scoping report. After consultation the group identified no further parties for inclusion in the scoping workshop, or to assist with the scoping report*

Engender strongly recommends expert gendered input at the next stage of the EQIA and throughout the implementation phase of proposals.