PODCAST TRANSCRIPT

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Intro: WORLD: we got this.

The podcast talking big global challenges with the experts taking them on.

Brought to you by the School of Global Affairs at King's College London.

Throughout this series, we will be discussing some of the major global challenges we face – deforestation to global pandemics.

In our first season of WORLD: we got this, we'll be speaking with experts about the factors at play during a global pandemic, the differing global perspectives and ultimately the way in which we can meet this challenge.

This podcast was being planned long before the outbreak of COVID-19 but all that changed just a couple of weeks ago.

Now of course, I'm recording this from home and everyone we speak to in the coming episodes is also going to be working from home.

But the key thing is that they're still working, they're still researching, they're still teaching and they're still trying to understand how we can wrestle with this global pandemic.

Because that is what the podcast is all about.

So here we go.

James: Hello and welcome to the podcast.

I'm James Baggaley from the School of Global Affairs at King's College London.

Social care policy has for decades been an area of deep discussion amongst researchers and policymakers.

With its direction, we are told, key to understanding the future of an aging society.

These discussions are not always made front page news and perhaps in that complex nature we can see why.

Yet in the last few weeks social care policy has come to the very centre of this global pandemic.

If we didn't know before, we've certainly learnt in this COVID-19 outbreak just how important it is and how many rely on those that work within it.

In today's episode we speak with experts from the Institute of Gerontology as well as colleagues from Global Health & Social Medicine about social care.

We seek to define what it is; we also look at the unique challenges posed by COVID-19; why we are seeing increased levels of mortality within some social care settings; and critically what we can do to improve our response.

We go on to discuss how this crisis may demonstrate the need for a radically different form of social care and what lessons we can learn from other countries.

Our guests include Professor Karen Glaser, Head of Global Health & Social Medicine at King's College London, Dr Ludovico Carrino, Research Fellow at Global Health & Social Medicine and Professor Mauricio Avendano Pabon, Director for the Institute of Gerontology at King's College London.

I started by asking them all how the lockdown was going.

So I mean we're going to start the today's episode like we start all our episodes and that's to ask how you're doing and how you're lockdown's going?

Karen, if you want to go first.

Karen: Well, first of all thank you so much for inviting me on this podcast.

And we're now five weeks into the lockdown and fortunately I'm well and I'm getting used to working from home.

Although, it has been harder than I thought to work in this way, it's been harder than expected.

Ludovico?

Ludovico: Hi everyone.

Thanks, I'm very happy to have been invited to this podcast.

I'm also working from home.

Of course, I'm in Italy in my home town in Trieste with parents and my girlfriend.

It's been tough but we hang on.

Mauricio: Hi, hello.

Thank you James for inviting me again to this podcast.

I'm very happy to be here.

My lockdown is going generally well.

I'm spending less time traveling and more time homeschooling my children, reading and cooking on the oven, so it's been difficult but also good to have time to do other things.

James: So today we're going to be talking about social care and the critical role it's playing in helping tackle COVID-19.

I guess we're all quickly becoming aware of the different ways public health and the NHS is playing a role in dealing with this crisis, I want to start by asking perhaps an obvious question but just in order to kind of set out the boundaries of what we're talking about in this episode, and I just want to ask what we mean when we say social care.

Perhaps Mauricio, if you'd like to give us an outline.

Mauricio: Yes, thank you James for this question.

So, people use different terms when they refer to these issues.

They refer to long-term care.

Essentially social care refers really to any service and support that is provided usually by a local authority in the UK but in other countries, it may be private, it may be organised by the national government and it really has a name to help all the people usually with some level of limitation to maintain good quality of life and to maintain functioning.

Now this usually, it's important to understand that social care really is very much targeted to often vulnerable people, so really it sort of, it is often sort of something that is triggered after an assessment of people's ability to function.

Another different distinctions, obviously this is not only about caring in nursing homes.

Actually the majority of caring happens at home, as I think Ludovico and Karen will explain to us.

So, I'll keep it there but just to sort of understand this as the general principles of social care.

James: Ludovico, Mauricio mentioned there the fact there are different ways in which it is delivered.

We've heard a lot about care homes in this COVID-19 outbreak but there is two forms of care and I guess that's home care and institutional care.

Is that right or is there always a strict difference between the two or is there often a mixture of both for many?

Ludovico: Yes James, you're right.

The two main forms are home care and institutional care.

And although relatively more people receive care at home and we will discuss also this later, institutional care is the most expensive part and the relevant for the public budget, the long-term care budget.

So let's say that the formal care at home can come when a nurse comes to your house let's say, the house of a dependent person, to provide the injections, to provide help with medications.

Other forms of nursing care or social care are help and support with the limitations that people may have with activities of daily living like dressing, feeding, bathing, for example.

When these limitations are expected to last for let's say a rather extensive amount of time.

There are other types of social care like community care services like Baker Centre, Meals on Wheels, or cash benefits.

For example in the UK, we have one of these cash benefits, the attendance allowance for example.

So the formal home care is very important and the other main pillar is institutional care.

James: And Karen, for this podcast, I was going back and reading some of the work that you've done, that Mauricio has done, that Ludovico has done, and I know you've focused on care given by family as well, and looking at for various different reasons; families also play a role in this.

This isn't just the state.

Karen: Yeah families do.

In fact the majority of care in most countries is provided by families.

So I think part of what this crisis has highlighted is if social care, care workers, disappears you're seeing you know greater of family involvement in this type care and there are huge variations across countries in the level of involvement in family care.

And one of the things that I think we'll go on to talk about is that also shapes the nature of the social care system.

Whether you get involvement of the state or of the market or more of families involved in it.

James: And Ludovico, if I can ask, so we've kind of set out what the bounds of social care is but again this may be an obvious question but I think it's important to make clear the beginning of this conversation, which is why is social care important during a pandemic and what critical role does it play?

What kind of purpose does it play in particular during a health crisis like this?

Ludovico: Well I would say at least two main reasons for the importance of social care in this context.

One is the fact that we know that care in care homes has become a critical issue during this crisis.

We know that COVID-19 affects older people disproportionately and so also that the majority of deaths from COVID-19 are due to that of older people and that an important part of these deaths are coming from people, related to people that live in care homes.

So this has really put the attention, the policy attention, the spotlight on care homes.

We want to understand why the death rates in these settings are so high.

The other question, the other motive let's say, the other reason for importance for social care I think relies on the availability of care during social distancing policies, when people in need of care may have more difficulties in receiving the care that they need regardless of whether this is from informal carers like relatives or friends, or from formal carers.

Because of the social distancing policies.

James: And Karen, we know there's been varied results in terms of infection rates across Europe and we know there are different types of health care systems that operate across Europe.

Do we also see a difference between different countries in terms of their social care policies as well?

Karen: Yeah, there are huge differences.

Even within Europe not all countries have, kind of, developed social care systems and I guess the way, and this is I'm grateful to Ludovico for providing a kind of easy way to think about it, is the kind of differences across countries can really be summarised with four kind of w-type questions: who can get it?

So that depends on you know access and the rules around access, so how strict countries are in determining who gets it based on the number and types of conditions and disability, and who pays for it.

So for example if you look at Germany the focus is really on severe and lighter kinds of disability limitations and it's not means tested, whereas in England it is means tested.

So services are means tested although for example in Scotland you get free universal care.

And then it's what you get, so countries are really divided in terms of cash versus in kind services.

So in England, in Italy, a lot of it is cash based and then you can use that to purchase services.

In other countries like Sweden it is actually the provisions of the services and often publicly provided services.

And then you know related to what we've been talking about the far is where you get it, either at home or an institution.

Always more at home and I think we'll talk about this a bit more because the kind of policies has been to reduce care in care homes but countries vary in this in terms of the percentage of people in care homes and older people.

And then who has responsibility for it and this gets back to the role of the family, the state and the market.

Whether it's families who are thought to be more responsible for it or whether it should be state.

James: You mentioned Germany and Sweden, have they got a more encompassing state system, at least not necessarily at a federal level but generally in terms of the public sector, is this a slight difference between say UK and Italy and perhaps the Nordic countries and Germany?

Karen: Yeah, the Nordic countries do have a more publicly funded state system of social care.

In Germany, they have social care insurance and in England, it's a mixture of both.

Ludovico: What I would add to what Karen said is that it's very interesting to see how are the same kind of services that are provided in countries that are relatively close and that for example in Sweden, in the Netherlands, the emphasis is on services.

And in Sweden, there are a lot of people that are going into institutions and in the Netherlands as well.

Whereas for example in Germany and especially in Italy and also England, the role of home care is relatively more important and in particular in Italy the role of family is very important in providing home care, and the state perhaps gives some compensation to informal care givers through some national programmes.

James: When we discussed this episode, Mauricio kindly sent over some notes that I know you've all contributed to.

One of the things that was mentioned was the high level propensity of deaths within care homes and I think it's important to say that as we record this podcast, the picture continues to change and I know that we've seen figures released recently that show that there has been an increased level of deaths within UK care homes but we're still waiting for further figures and obviously each individual case is perhaps different.

Why are we seeing more deaths in care homes than we are perhaps in other parts of the NHS or care system?

Mauricio: So that's an absolutely key question and one that's being asked around the world is why are we seeing so many deaths in care homes and the first reason may be because in a care home you have high risk populations in a high risk settings.

So I mentioned before that it's important to remember that those in care homes are often the oldest of the old, so those 85 and over, and a lot of what we've seen so far shows that age is a really significant risk factor for COVID-19.

So those, and you know, care homes are also amongst the most medically vulnerable so they are those with long term comorbid conditions, that's multiple complex health conditions, so the really seriously ill.

And of course we've also seen that evidence suggests that those with underlying conditions are at higher risk of COVID.

Karen: And Karen, what are the kinds of things we can do to help reduce risks with care homes?

Well there's been some discussion and I guess this relates to your later question about you know what type of care might be better in this kind of epidemic, that you know the possibility of if you introduce certain

protocols, you know so social distancing measures, extensive and earlier testing, that those might be ways to actually be able to control the disease within care homes and that really relates to the kind of nature of, one thing is you know why are infection rates so high and death rates so high in care homes so the kind of, the composition of those who are in care homes and the other reason, they lie in the role of social care itself.

So, you know because you have such close proximity between residents, between residents and workers, you know people visiting patients and also workers working across multiple care homes, so all of this puts people at greater risk and also these facilities weren't designed or equipped to really treat patients with serious COVID-19.

James: And Mauricio, Karen mentioned the staff that work within care homes, I know in previous conversations we've spoken about the way in which our healthcare is structured, in particular the mixture of private and public sector delivery, one striking thing has been to hear of some of those care workers, the hours they work, the pay that they receive, and due to that, the fact that at least here in the UK they may work across multiple sites and I've heard similar stories, I was reading before this episode about similar cases in the US where you've got care workers who are working across multiple sites because they need to due to economics, so has that perhaps played a role in this pandemic and is that something we're going to have to look at in terms of managing it long-term?

Mauricio: That's a very critical question, James and as Karen was saying, I think that the second sort of component of what are the social care structure may have a role.

It's important in those two ways: first, what are the structures within the social care homes such as for example the level of crowding, the fact that there is a sharing of bathroom facilities and you know gathering in common areas and the level of preparedness for infection control.

Those are aspects within the social care system that might be important but as you well point out there may be also issues about the particular staffing issues in care homes that are important.

For example we know that workers in caring home settings, they have a very high turnover.

This is a population very much rotating and working in different institutions, relatively low population.

There is also a very high residence of staff ratio.

These modules of housing units that are very high.

There's relatively low levels in some setting of preparation in terms of prevention and control.

and you mentioned the spread of the epidemic.

Now one potential constrain as well is that much of the emphasis on the use of equipment to protect workers has focused on NHS workers, so workers in the healthcare setting and that absolutely makes sense but there has been much less emphasis on the need for protective equipment for staff in care homes, which is absolutely essential because as you know and perhaps this didn't get mentioned at the beginning but the case fatality ratio, probability of people dying and being hospitalised as well, the probability of dying for someone who is above the age of 70, which is the majority of the population in care homes, is much higher than for the rest of the population.

This is a variable figure but estimates speak of around 13 to 14 percent case fatality ratio for the population 80 years and older, as opposed to around 8 percent for those 65-69 and somewhere around 0.06 for the 50-54 and they're much lower part of the younger age groups.

So this is a critical population and basic nursing homes essentially would have needed to prepare much better for responding to staffing issues.

Now you were asking before also this question of what kind of lessons we can learn, what kind of actions nursing homes can take in order to prevent the spread of the epidemic, and I think sort of Karen pointed to some important issues but I think the level of preparedness across nursing homes is a critical issue that might need to be addressed because there are huge variations across the institutions and there's also huge variations in the level to which it is possible for them to carry out some of the recommendations such as the need for isolation, separate rooms or having a quarantine area.

This is not always possible for others.

As I mentioned the availability of personal protective equipment was not something that many nursing homes were prepared for and in general the level of preparations to contain COVID-19 was really very variable and that's sort what comes out from our research around the world, from Singapore and as well the UK and the US.

James: And without going into...

we're going to come on to discuss a wider discussion perhaps about what kind of social care policy and system a country might want going forward to try and help deal with the situation but have there been any countries that have demonstrated real success in how they've delivered social care during this crisis?

Ludovico: There were some articles in March that were documenting how in Singapore the nursing homes had zero, very low, actually zero number of COVID-19 patients affected, residents affected by COVID-19 and one of the reasons for this is that they managed and succeeded in implementing higher precautionary procedures and protocols.

Also caring a lot for the post hospitalisation phase, when patients come back from the hospital and they implemented repeated testing and also strict isolation policies that may also have undesirable consequences on the wellbeing of patients, but what I wanted to say is that actually then in Singapore I think the first infections in nursing homes happened around mid-April.

They had some COVID-19 positive residents in Singapore's nursing homes but they managed to delay a lot the onset of these first infections and hopefully in the numbers are much lower.

So, that might be an interesting case study.

Mauricio: Sorry, just to add to Ludovico's point.

Yes, absolutely because there are some countries that indeed have had a lower proportion of deaths and so far with the temporary data we have, and Singapore is one of them; Australia is potentially one of the countries has also had relatively lower proportions of deaths in nursing homes.

Now one of a lessons more in general from this epidemic is that many of the East Asian countries and actually, I'm involved at the moment in a report that covers COVID-19 mortality numbers, that many lessons East Asia learnt from the prior epidemic have actually in general led to a better implementation of many control measures in that part of the world.

Now this includes partly with China but it's also with you know Taiwan, Singapore.

Many of these countries were able to prevent measures much earlier and generally responded.

So much of their better morality rate relates to overall more effective measures rather than very specific interventions within the home care setting.

James: So we've spoken about what we mean when we're talking about social care, we've spoken about how the particular adverse impact this crisis has had on social care, I now want to just turn to actually thinking about what we may want to look to improve both in terms of meeting this crisis, COVID-19, trying to reduce some of the mortality within care homes and in social care settings but also in terms of long term about improving social care.

I know one of the things that you'd want to discuss today and one of the things we might want to think about in terms of perhaps a next stage in the development of our social care system was an integrated care model, so perhaps Ludovico, you could let us know and give us a bit more information about what we mean when we say integrated care.

Ludovico: Yes, James, I am happy to talk about integrated care, which I read is about like a Rorschach test, so it's a very nice word which people mean very different but coherent, consistent things.

Integrated care, the need for integrated care stems from I think two key critical characteristics of our current systems.

The fragmentation, which is like, you can imagine, that blurred lines between various aspects of care that people can receive.

The famous, infamous distinction and overlap between social and health care for example and then the fact that we have service centre care provisions, so that many times the left hand doesn't know what the right hand is doing in providing care and help to people.

In the UK, as in most other countries this is exactly because we have a separation between health care and social care.

In the UK social care is often considered as the sort of a Cinderella service with respect to NHS and also some raised discussion also related to availability for example of PPE, also during the COVID crisis.

So, in a way that when we talk about integrated care we're talking about a horizontal integration, a sort of integrated system, let's say integration across different systems.

So to bring social and health care under one umbrella.

I would say it will be a person centred approach compared to the services centred approach.

So a person service approach where individuals needs are assessed and a comprehensive care plan is delivered around the needs of the individual to maintain his or her wellbeing and capacity.

This may involve for example a single point of entry into the system, a single care manager for assessment, integrated systems for sharing information across services and the coordination of services.

And it has been shown that this is especially important for people with multiple conditions.

James: And Karen, is the anywhere currently that does have an integrated care system in this way that Ludovico has outlined?

Karen: There are few but there are countries that have integrated care systems.

Canada is one of these.

So what you're trying to do as Ludovico said is build closer connections between health and social care.

The idea that we'll not only provide a kind of a better service and outcomes for in this case older people, disabled or vulnerable older people, but also the idea behind it, and this is where we know less, is that the workforce within social care or health care would be treated more equitably.

And this is part of the problem that Mauricio was referring to before about there has been this idea that you know those who are working in the NHS got personal protective equipment and that care workers have been more exposed.

Although you know this is being addressed now, but I think a key problem with the integrated care and something that we really don't know a lot about, is whether health or social care separated or not, there is an emphasis now on keeping people at home as much as possible and that policy would suggest a reduction in diseases like COVID-19 because people are less likely to end up in A&E, and that's a major outcome and studies in Canada have suggested that people are more likely to stay at home and not end up in A&E.

But what we don't know is whether how these kinds of systems would affect care in care homes.

So, if we look at data that we've got for Canada and you see similar proportions, with the data we have about half of COVID related deaths are in care homes, and you still see even in Canada, so that it might be beneficial in reducing the number of deaths from COVID-19 because you've got less people going into care homes or hospitals, but the proportion of deaths is pretty similar at about 50/60 percent.

So while it might be that such a systems are better at helping frail older people remain at home, a large share of deaths is still occurring in care homes and what we don't know, and this is bringing it back to what we've discussed before, is whether it's just that these are kind of high risk settings with you know very medically vulnerable populations or is it about how the care is delivered, and you know whether they're really differences in how care is delivered in care homes in an integrated care system.

James: We've heard some of the advantages of an integrated care system and Karen, you mentioned there some of the advantages of care at home, although we're not quite sure the moment in this pandemic whether that is necessarily better.

Karen: What are the reasons why this hasn't happened, why don't we have an integrated system in the UK for example?

Well that's a tough question.

There is a movement.

You know to integrate the two systems but it's very service-lead, so this all dates back to the kind of foundation of the NHS.

So the NHS was clearly set up to deliver health care that was going to be free at the point of delivery.

Social care was also within initial thinking but this was always devolved down to local government versus the kind of national level.

And so initially it was about vulnerable older people, you know the kind of how to protect them in care homes.

A lot of that was to with care homes even though you had an emphasis on community care, that's always been there, and that has been emphasised more recently, and really the movement has been a way for moving people away from care homes and into the kind of care in the community and the best way to support people at home.

Ludovico: I just may add a very small thing.

So the NHS is already the fifth I think largest employer in the world.

It employs around 1.7 million people and the social care sector in the UK employs I think around 1.5, 1.6 million people.

Everything considered, so that would easily become the largest employer in the world, more than the Chinese army and the US department of defence.

So it needs careful of course careful planning.

Mauricio: So thinking ahead in terms of what might happen as a result of this crisis and the COVID-19 outbreak, what do we think might change in a social care setting?

So, Ludovico if you could kick us off.

Ludovico: Well James, for example, I think that tele health and telemedicine might be boosted by this.

And we might see an increase in the type of services that are provided remotely to older people at home or in nursing homes.

This may provide an opportunity to improve care for people that have difficulties in accessing care or even increase the contacts between people and their practitioners for example.

Karen: Yeah what I can see, which is definitely changing, is the increasing recognition of the importance of social care and in terms of big changes, we've actually seeing that funding of social care and the number of people getting social, actually the number of people getting social care has actually been declining of older people, and what I'd like to see in the future is that increasing because there is a suggestion there's a lot of unmet need and this is likely to have important implications.

So, increased numbers getting, receiving social care would be great.

James: And Mauricio.

Mauricio: Thank you James.

I think procedural changes I think are going to become increasingly important; the development of protocols, the increasing coordination perhaps between public health agencies and care homes.

There's definitely an increasing awareness, as Karen was saying, and potentially one would hope also that the stockpiling of personal protection equipment, masks, all that is needed for caring for old people will come, as well as training; potentially some thinking about how to address the issue of isolation that we have these crises.

Now the second question to larger changes, I think that really taps into more political decisions that are harder to think about, for example the question about the working conditions of social care workers.

As Karen was describing, this really sort of relates to broader trends of a very precarious working population not only within social care but in many different sectors in the economy and that actually have been particularly hit very strongly by the lockdown as we have seen in the European countries including the UK.

So I think one would hope that one might raise bigger questions about the working conditions of precarious employer, employees and the role that the government and the states come play regulating their employment conditions.

James: Mauricio, you're the director of the Institute of Gerontology here at King's which we know is playing a massive role in understanding aging and social care, could you just tell us a little bit more about the Institute.

Mauricio: So the Institute of Gerontology at King's really aims to investigate the major challenges of health and social care but also the social economic and policy consequences of ageing populations; the fact that all countries in the world, including the UK, are becoming older.

And this is happening in both developed, in both low, as well as high and middle income countries.

The Institute was founded in 1986 and really sort of has over the decades focused on different issues.

We look at the issues of how we think about ageing across the life course but also long term care, employment in older age, social participation, how do we design cities and how do we design sort of environments, social housing and how generations relate to each other and how their wellbeing can be improved by policies and by governments.

James: As always, a big thank you to all our guests on today's episode: Karen, Ludovico and Mauricio.

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