BSG Ageism Special Interest Group

Ageism and Social Care

Submission to the Casey Commission Independent Commission on Adult Social Care

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Ageism and Social Care:
Submission from the Ageism Special Interest Group, British Society of Gerontology (BSG), to the Casey Commission - the Independent Commission on Adult Social Care

Summary

The BSG Ageism Special Interest Group's aim is to strengthen the links between research, policy, and practice to challenge ageism, as defined and evidenced in the World Health Organisation's report on ageism 2021. We have a particular focus on ageism in adult social care because of its prevalence and impact. The issue of ageism is highly relevant to the Casey Commission's work both in terms of how the Commission frames the issues in adult social care and how it identifies solutions and makes recommendations.

This paper sets out the key issues arising from both deliberate and inadvertent ageism in adult social care. It argues that the Commission must avoid negative discrimination on the grounds of chronological age which is a poor proxy for individual need because people age differently (both as individuals and as members of different cohorts). It then makes recommendations for how ageism can be tackled and how these considerations should inform the Commission's recommendations.

We do not make specific recommendations on the funding system for public social care beyond recognising that the current system of capital limits and thresholds has a disproportionately negative impact on older people who are less likely to be eligible for public support. We believe that any reformed

system should be non-ageist in intent and consequences. Transparency in how the system operates for people of all ages would demonstrate people's legal rights and provide clarity about expectations that they may need to plan around.

We strongly believe that distinguishing between adults of different ages in terms of their eligibility for care and support would be highly regrettable. There are multiple reasons why this two-tier system would be undesirable, not least because of the 'cliff-edge' between 'working age' adults and 'older people' that would be hard to justify and complex to administer. However, if the Commission were to be minded to adopt this model, it is vital that it does so in full awareness of the implementation and administrative challenges and recognising the difficulties of avoiding negative ageist outcomes and reduced well-being for older people.

We hope that our comments and advice will be helpful to the Commission's deliberations and would be very happy to provide further information or to discuss this paper in greater detail.

1 Introduction

1.1 The Ageism Special Interest Group (SIG) of the British Society of Gerontology was established in April 2025 to strengthen the links between research, policy, and practice to combat ageism. The SIG is led by a Steering Group that brings together expertise and experience (including lived experience) from academics, researchers, policy analysts, practitioners, and older people.

1.2 We believe that ageism (how we think, feel and act towards ourselves and others based on age) blights people's lives, throughout their lifetime and has a cumulative impact. Ageism, in common with all forms of discrimination, is often invisible and unconscious; it is embedded in society, in institutions and our culture. It can be inherent in policies, practices, and decision-making across all aspects of life. Ageism can manifest in direct discrimination where people are treated differently solely based on their chronological age. More often it is subtle and almost invisible in the assumptions and beliefs about age that reduce or remove the opportunities available to people in all areas of life. Ageism is evident in assertions and beliefs about what people "should expect" at specific ages, which may contribute to a more limited and constricted life than should be possible.

1.3 Ageism is also reflected in the societal culture and style which perceives ageing (from a very early age) in negative terms – something to be denied and overcome. This is the world, for example, of cosmetic surgery and interventions that seek to remove the natural signs of ageing and to view these as a personal flaw. The impact of this negative thinking is to render older people as less visible, less attractive, and ultimately less valued in society.

1.4 In relation to social care, assumptions that ageing always entails irreversible decline, deficit and dependency can have pernicious consequences that deny older people opportunities for meaningful quality of life. There is growing evidence that many older people can be supported to return home after serious illness and hospitalisation given targeted rehabilitation and recovery interventions at the right time, and it seems likely that many thousands of older people have moved prematurely into permanent residential care because of outdated assumptions that recovery was not possible, denying them time-sensitive opportunities to regain independence.

1.5 As a SIG we are dedicated to highlighting the impact of ageism, challenging its adverse effects, and promoting effective strategies to combat ageism. We are following the framework established by the World Health Organisation (WHO) in its Global Campaign to Combat Ageism that identifies three strategies:

- **Policy and Law:** strengthening policies and the law at local, national, and international levels.
- **Education:** interventions across all levels and types of both formal and informal education.
- **Intergenerational:** fostering interaction and connection between different generations.

1.6 The WHO recommends that these strategies be approached in evidence-based developments, together with improving data and research to gain a better understanding of ageism and how to reduce and prevent it, and to build a movement to change the narrative around age and ageing. We are committed to this approach.

1.7 Our initial strategy and objectives for 2025-2028 have identified two key inter-related areas that we are prioritising: social care policy and practice, and internalised ageism (the limiting beliefs that people hold about the implications of ageing for themselves and others). We are using this opportunity to engage with the Casey Commission: Independent Commission on Adult Social Care. The aim is for our comments and advice to assist the Commission in understanding how ageism affects the current social care environment, and to guide both immediate and longer-term recommendations to avoid ageist outcomes. We would be very happy to provide additional information and to discuss our conclusions and recommendations in greater detail.

1.8 In preparing this submission for the Commission, we engaged with our SIG membership via an online event and panel discussion, and through in-depth discussions with other interested experts. The perspectives shared here represent the collective views of the Ageism SIG Steering Group.

2 The Commission's Terms of Reference

2.1 The Terms of Reference for the Casey Commission include the following:

"The commission should start a national conversation about what adult social care should deliver for citizens and build consensus with the public on how best to meet the current and future needs of the population. It will consider older people's care and support for working age disabled adults separately, recognising that these services meet different needs.

The commission should produce tangible, pragmatic recommendations that can be implemented in a phased way over a decade. It will aim to make adult social care more productive, preventative and to give people

who draw on care, and their families and carers, more power in the system."

2.2 We welcome the 'national conversation,' and we urge the Commission to ensure they engage directly with the diverse voices of older citizens, including the seldom heard and often stigmatised voices of people living with dementia and older people living in permanent residential care. Consulting 'the public' about the future of adult social care without directly engaging with all the groups of people who rely on care and support risks the debate being dominated by ageist and ableist perspectives. While it is possible to build consensus on the need for reform in adult social care, it is much harder to achieve this around what a new system might look like. This is a highly contested area and finding a fair solution will require transparency about potential winners and losers.

2.3 Despite being major users of social care services, the voices of older people are frequently unheard in the discourse around the current experience of the social care system and aspirations for the future. Where these voices *are* captured, it is usually through carers or others acting as proxies; we believe this is inadequate and emphasise that the Commission must engage directly with older people with firsthand experience. It is also crucial to recognise the intersectionality of older people; those who experience poverty or who are marginalised because of where they live, or because they are also part of the black and global majority population, or whose lives do not conform to heteronormative expectations, are at higher risk of experiencing the compounded effects of ageism. The experience of older age is also gendered with women likely to live longer than men on average, and to have more years of poor health, while also being more likely to be poor because of having

lower lifetime chances of benefiting from pensions and savings because of interrupted employment histories.

2.4 We are also aware of the history and context of the Commission and recognise that it is the latest in a series of independent enquiries and reviews in this contested territory that have taken place over the last three decades. We are therefore also concerned that this latest Commission may re-tread familiar ground and make similar recommendations to its predecessors. The Commission's terms of reference also state that:

"The commission should seek to understand the current adult social care landscape and identify a commonly agreed picture of the problems faced."

We do not believe there is a lack of knowledge about the current problems in the existing social care system, and as we highlight in this paper many of the current shortcomings disproportionately affect older people.

2.5 We believe that the current impasse and the repeated failures of successive governments to introduce meaningful and equitable reform to adult social care cannot be allowed to continue and must finally be resolved. Any outcomes from the Commission's work could have significant, far-reaching consequences; this might be a once in a generation opportunity for reform and it is vital to get it right. With this in mind we are especially concerned that the way the Commission is framing 'adult social care' could mislead understanding and lead to unforeseen negative effects for both older and younger people.

2.6 Our analysis is relevant to both phases of the Commission, and we start by questioning some of the underlying assumptions inherent in the terms of reference cited above.

3 Older people and working age adults

3.1 We believe that distinguishing between older people and working age adults in the Commission's Terms of Reference is at best unhelpful, and at worst damaging. It reflects some inherent ageist bias in its framing and expression. In particular it:

- Introduces age to differentiate between different adult categories.
- Separates older individuals needing 'care' from working age disabled individuals needing 'support.'
- Claims that considering these two groups separately is justified because "these services meet different needs."

3.2 We argue that the framing of this understanding is fundamentally flawed and could have highly negative consequences particularly for older people. We explore the main issues below.

The age criterion

3.3 At present the social care system *does not* distinguish in policy between adults of different ages; rather, 'adult social care' has a remit for all adults aged over eighteen who have needs for care and support. If the Commission is exploring the situation of older people and working age adults separately, their recommendations for reform might similarly envisage separate solutions and systems. We wish to highlight the risks of such an approach which could be divisive and treat people differently solely based on their age.

3.4 We would also underline that any such approach would not be consistent with either the letter of the law or the spirit of the legislation as set out in both the 2010 Equalities Act, and the 2014 Care Act. The latter is explicit in stating that local authorities:

"need to ensure that decisions about the individual are made having regard to all the individual's circumstances (and are not based only on the individual's age or appearance or any condition of the individual's or aspects of the individual's behaviour which might lead others to make unjustified assumptions about the individual's well-being)."

3.5 It is not clear from the Commission's terms of reference precisely what is meant either by 'older people' or by 'working age' adults. Both of these terms are ambiguous and indeed have overlapping definitions; many older people continue to participate in paid and voluntary employment (both full and part time), and the concept of 'working age' has shifted considerably in recent years not least because of changes in the state pension age that have made retirement ages later.

3.6 Focusing on 'working age' adults overlooks the unpaid contributions of many older people in caring for a partner, adult child or other relative or friend. It also disregards the ongoing employment histories and the practical and financial support they provide younger generations, potentially framing older people who are no longer employed as unproductive.

3.7 Whether or not there is any direct intention in the terms of reference to draw a negative distinction between different age groups, separating older people in this way reflects many familiar cultural tropes that portray older people as passive, dependent, and a 'burden.' This approach 'others' older people and treats them as a homogenous group rather than as individuals with different needs, experiences, and preferences. Of course, some older people will need high levels of support including permanent residential care (the same is true of some younger people). But defining 'older people' as an undifferentiated group makes potentially misleading and negative assumptions about people's vulnerability and dependency.

3.8 Related to the above uncertainty of definition is the issue that is potentially created at the transition point between working age and older person status. In policy analysis this is typically identified as a 'cliff edge' issue where people can move overnight from one classification to another simply based on their chronological age. At other stages of the adult social care system, it is well documented that transition points create significant impediments to continuity of care. The poor experience of many children and young people with disabilities, or who have been identified with Special Education Needs and Disabilities (SEND) moving from children's to adults' services is particularly relevant.

3.9 The impact of an age distinction in adult social care could have negative consequences both for adults who are ageing with an existing need for care and support, as well as for those who develop such needs after they have passed a defined age threshold. How would access and eligibility be determined for people at these transition points? Potentially an older person might lose their entitlement to the package of support they had received before their latest birthday, or someone becoming eligible for support just before or after such a threshold could have very different experiences and opportunities. This would not be a system based on individual need but reflecting the arbitrary impact of a crude age qualification.

3.10 It is unclear what would happen in practice if eligibility to parallel systems of adult social care were determined by age, but it is highly likely that as well as being seen as inequitable and creating a hierarchy of rights, such a system would be administratively cumbersome and costly to manage. Creating separate systems for working age and older people would involve significant changes in organisational and administrative policies, processes, structures, and systems at a time of parallel reorganisation in the structures of local government and the

NHS. This would distract from the primary purpose of reform which is to secure better care and support for people who need it.

3.11 Although in principle, and in law, all adults have the same rights and entitlement to care and support from social care, it is also a common experience that in practice older people are often treated differently by the system. Formalising such a difference in approach would reinforce existing disparities and disadvantage older people relative to other adults. Older people who use adult social care typically experience:

- Lower levels of public spending (the average cost of local authority funded residential care in 2023/24 for adults aged over 65 was £951 a week, and for working age adults £1,540). [1]
- Less likelihood of long-term support in the community: local authorities spend similar amounts on long term support for working age and older adults. However, for the former two-thirds is spent on community-based support, and for the latter two-thirds is spent on residential care.[2]
- Fewer options in support to maintain social engagement and participation.
- Reduced likelihood of having access to a social worker compared to younger adults.
- Greater likelihood as self-funders to be left to find their own way through a confusing system. [3] [4]

[1] https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-adult-social-care
[2] https://www.gov.uk/government/statistics/adult-social-care-activity-report-england-2024-to-2025/adult-social-care-activity-report-2024-to-2025-commentary#long-term-support-1
[3] https://basw.co.uk/sites/default/files/2025-05/No%20Older%20Person.pdf
[4] https://careconfidence.org.uk/

Distinction between 'care' and 'support'

3.12 The framing in the Terms of Reference of older people needing *care* and working age disabled adults needing *support* is problematic. By contrast, the phrasing of the 2014 Care Act refers to adults' needs both for 'care and support', and the Act defines this widely in terms of the duty of local authorities to promote an individual's well-being:

"Well-being," in relation to an individual, means that individual's well-being so far as relating to any of the following—

(a) personal dignity (including treatment of the individual with respect);

(b) physical and mental health and emotional well-being;

(c) protection from abuse and neglect;

(d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);

(e) participation in work, education, training or recreation;

(f) social and economic well-being;

(g) domestic, family, and personal relationships;

(h) suitability of living accommodation;

(i) the individual's contribution to society." [5]

3.13 Parallel legislation in Wales – the Social Services and Well-being (Wales) Act 2014 – places similar emphasis on well-being. Both statutory frameworks adopt a much wider remit than a focus simply on 'care' for older people might entail. The importance of promoting well-being, prevention and early intervention across the lifespan could be significantly diluted by a focus on 'care' for older people that is distinguished from a more active approach to 'support' for working age

[5] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/general-responsibilities-of-local-authorities

adults. The well-being principle is an inclusive and proactive concept that is concerned with maximising people's independence, choice and control, and social participation. It is unclear how such values would be reflected in a system that emphasises, respectively, care *or* support depending on age.

Meeting 'different needs'

3.14 We are not convinced that distinguishing between 'care' and 'support,' and between older adults and working age disabled adults is useful or beneficial, and we disagree that this distinction meets essentially different needs. The importance of focusing on individual well-being is that it starts with the person and the principle embedded in the Care Act that individuals are best placed to understand their own needs, considering their views, wishes, feelings and beliefs. We recognise for example, that younger disabled adults may wish to have more support to participate in education, training or employment than would be sought by most older adults. However, addressing different needs such as these is inherent within a personalised approach for every individual of any age. Treating all 'older adults' as a separate and homogenous group needing 'care' contradicts the principle of personalisation and assumes all individuals above a certain age are essentially the same.

3.15 Despite the intentions of the Care Act and the importance of the values and principles around supporting well-being, we recognise that implementation has often fallen short and has offered more limited support than was envisaged. It is likely that for older adults, this would be further compounded by a narrow approach to reframing needs only in terms of 'care.' We believe this is a question of recognising the human rights of *all citizens* and the importance of valuing people equally.

3.16 It is widely stated in the policy discourse that the purpose of social care support is to provide "a life not a service." The Think Local Act Personal (TLAP) partnership starts from the premise that:

"Everyone should have the care and support they need to be able to live their life their way. Too many people are denied this." [6]

3.17 Importantly, this approach to enabling tailored support that is co-produced with the people using support, applies to people of *all* ages and with all different needs. Social Care Future has further developed the ideas and vision for what social care and support should deliver with the statement that:

"We all want to live in the place we call home, with the people and things we love, in communities where we look out for each other, doing the things that matter to us." [7]

3.18 The House of Lords Adult Social Care Committee[8] has also stated its commitment to the vision of "a gloriously ordinary life" while recognising the reality that the persistent underfunding and lack of resources in adult social care and support hinder individuals having an equal opportunity to lead meaningful and fulfilling lives. If a narrow focus on 'care' is concerned only with keeping older people alive and meeting their basic needs, it reinforces a view that older lives lack value and are not worth living well. The positive framing of social care and support for *people of all ages* is one we support and would like the Commission on Adult Social Care to endorse. We do not believe this will be served by drawing an age-based distinction between the needs of different cohorts.

[6] https://thinklocalactpersonal.org.uk/about-us/what-we-do/
[7] https://socialcarefuture.org.uk/
[8] https://ukparliament.shorthandstories.com/new-deal-adult-social-care-committee-report/index.html

The central importance of carers

3.19 The Commission's terms of reference briefly acknowledge the families and carers of people who rely on care, but their contribution must be fully recognised and placed at the heart of any new framework for adult social care. In England approximately 10% of women and 7.6% of men provide unpaid care.[9] The highest prevalence of caring in England and Wales occurs among people aged 55 – 59 (16.5%). Older carers often provide significantly more hours of care every week, particularly when supporting a spouse or partner. For example, women aged 75-79 (5.6%) and men aged 85-89 (7.4%) provide more than 50 hours caring per week.

3.20 Older people are less likely to self-identify as carers and may not be recognised as carers by others particularly when they are caring for their spouse or partner. Beliefs about 'just looking after each other' can distort carer identification and are also internalised by older people who do not view what they do as *caring* but just as part of their relationship. This can leave older carers highly isolated and vulnerable as any change in their own health and well-being can lead to a rapid deterioration in the ability to care for themselves and others.

Ageing without children

3.21 The importance of supporting carers and recognising the impact of caring in terms of physical, emotional, and financial pressures must be fully recognised. Valuing carers *must* be about more than paying lip service to the 'wonderful work' they do. It is also important to acknowledge that demographic shifts mean more people are ageing without children.[10] This

[9] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021

[10] https://awoc.org.uk/

reinforces the importance of not assuming that everyone has family and friends available to offer care and support.

4 Medium and longer-term change

4.1 The ways in which adult social care is framed fundamentally shapes the policy and practice that follows. This is why we have focused on the importance of understanding the potential impact of ageism in separating the needs of older people from those of all other adults. These are not our only concerns however, and in looking to the medium - and longer-term - changes that need to be put in place to transform social care, we recognise that the agenda for the Commission is substantial and that change must be both meaningful and affordable.

4.2 The combined impact of the means-test and local authority underfunding that currently characterises social care results in publicly funded support only for people with the lowest means *and* the highest needs. The outcome is a system which offers very limited social protection, irrespective of age, compared to most other advanced countries. This has a disproportionate impact on older people who are more likely to have amassed lifetime savings and capital above the means-testing threshold and therefore are less likely to meet eligibility criteria for publicly funded support. This can leave self-funders having to navigate their way around a confusing system and make major decisions with little or no support. In the context of universal health care through the NHS, this is unhelpful and does not support the wider objectives of promoting prevention or continued independence. The Ten-Year Plan for the NHS [11] envisages three strategic shifts in the way the NHS operates:

[11] https://www.england.nhs.uk/long-term-plan/

- From hospital to community: more care available to people locally and in their own homes.
- From analogue to digital: more technology will reduce administration and enable people to manage more of their own care themselves.
- From sickness to prevention: improving healthy life expectancy for everyone.

4.3 We recognise the importance of aligning health, social care and other related agendas (notably housing), and enabling social care to contribute to prevention and early intervention. However, social care should not be viewed primarily as a mechanism to improve NHS efficiency. Efforts to reduce hospital admissions and address delayed discharges – typically of older people - must avoid simply shifting additional pressures onto adult social care. Gains in efficiency and productivity must not come at the expense of people (and disproportionately older people) who rely on care and support, or on unpaid carers. Rapid hospital discharges are not a positive outcome if they lead to increased anxiety for individuals, reduced independence, or higher rates of readmissions.

5 Conclusions and Recommendations

5.1 The Casey Commission has a unique opportunity to shape a long-term plan for reform that will influence policy and practice for generations to come. Expectations are high after years of inaction and repeated failures of successive governments to address this critical challenge. As the Commission examines evidence and explores potential solutions, we urge it to be bold and ambitious, while remaining grounded in realism.

5.2 We emphasise that all proposed solutions and recommendations must promote intergenerational solidarity and avoid any framing that is

inadvertently ageist or reinforces existing disadvantage and intersectionality. Reforms should not create further barriers to good care and support by introducing a potential two-tier system defined by chronological age.

5.3 We present the following conclusions and recommendations and express our commitment to working closely with the Commission to ensure that any future system is explicitly anti-ageist. Such an approach would not only create a fairer system but benefit society as a whole by challenging and reducing negative attitudes toward ageing.

- The Commission should make an explicit commitment to anti-ageist policy and practice, ensuring that the adult social care system does not intentionally or unintentionally perpetuate ageism. We urge the Commission to deliberately adopt an anti-ageism perspective when reviewing evidence and developing recommendations, critically examining how proposed reforms might affect older people and what underlying assumptions or beliefs they reflect.

- This should include an understanding of the need to monitor the impact of reforms and ensure they actively reduce or prevent ageism. Better data collection and analysis are required to document the impact of social care policy and practice on different populations and cohorts.

- Preparing for ageing and later life should be approached positively and throughout the entire life course. Too often decisions about social care are made in haste and in a crisis with insufficient information. Supporting people to plan realistically about care and support before they need it would benefit everyone.

- Valuing people who draw on social care and support only happens when those services are valued in society. This principle has direct

implications for the care and support workforce which is often low paid and perceived as low-skilled. A clear statement from the Commission affirming the importance of care work and outlining what valuing it should mean in practice would establish a vital foundation for reform.

- Systems must be fair and not impact disproportionately on younger or older adults. This includes ensuring that access to social care is never based principally on age criteria. The Commission should build on both the letter and spirit of the 2014 Care Act that provides the same rights to all adults regardless of age.

- The rights that are enshrined in existing care legislation and in any future reforms need to be backed with clear and enforceable entitlements for people of all ages. Meaningful choices and options in care and support require a range of different provisions. Encouraging appropriate commissioning in social care is essential in developing a flexible menu of services for adults of all ages and life stages.

- Innovation in models of care and support must accelerate and be developed through co-production with people who draw on services or may do so in future. While technology can play an important role, it is not a substitute for the relational nature of care. New technological developments must take into account the high numbers of older people who do not have online access or are not digitally confident. Support must be personal and human, not merely transactional. We need to ask what do people truly want from care and support? And how can we balance these aspirations with the realities of limited public and private resources?

- Care and health, and other related areas of support (including education and training, financial support, housing, infrastructure, and

the built environment etc) must be genuinely joined up. Social care is only one part of a much bigger system and cannot operate effectively without this wider coherence.

- Social work support and advocacy must be more available and accessible to ensure people of all ages have the best opportunities to identify the support they need and want. This includes improving access to social work for older people who are less likely to be offered such input. [12] This is particularly valuable at first point of contact with services and when older people are at risk of not having a voice or control of what happens to them.

- Information and advice for people navigating care and support needs to be much improved and not limited to signposting.[13] Older people who are particularly likely to be self-funding often need to make life-changing decisions about how and where to live or what alternatives there might be and rarely get the necessary support to make meaningful and informed choices.

[12] https://basw.co.uk/sites/default/files/2025-05/No%20Older%20Person.pdf
[13] https://careconfidence.org.uk/

About the BSG Ageism Special Interest Group

The BSG Ageism Special Interest Group (SIG) was established in April 2025 to strengthen the links between research, policy and practice to combat ageism.

It is led by a Steering Group which brings expertise and experience (including lived experience) and includes academics, researchers, policy analysts, practitioners and older people.

It is a Special Interest Group of the British Society of Gerontology and has collaboration at its heart.

The BSG Ageism SIG is free to join and open to anyone with an interest in ageism. We are a growing network with members from across the UK as well as international colleagues. To find out more or to get involved please contact us at BSGAgeismSIG@BritishGerontology.org

LinkedIn BSG Ageism SIG

The British Society of Gerontology provides a multidisciplinary forum for researchers and other individuals interested in the situations of older people, and in how knowledge about ageing and later life can be enhanced and improved. BSG is a registered charitable company and is the professional organisation representing gerontologists in Britain.