



HOUSE OF COMMONS

## Treasury Committee

Oral evidence: [Autumn Budget and Spending Review 2021](#), HC 825

Thursday 18 November 2021

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Members present: Mel Stride (Chair); Rushanara Ali; Harriett Baldwin; Anthony Browne; Siobhain McDonagh.

Health and Social Care Committee Member present: Barbara Keeley.

Questions 306 - 387

### Witnesses

I: Sir Andrew Dilnot CBE, Warden, Nuffield College, University of Oxford; Sally Warren, Director of Policy, The King's Fund.



## Examination of witnesses

Witnesses: Sir Andrew Dilnot and Sally Warren.

Q306 **Chair:** Good morning and welcome to the Treasury Committee and our inquiry into the Budget and the comprehensive spending review. Today we are going to be looking closely at social care. I am very pleased to be joined this morning by a member of the Health and Social Care Committee, Barbara Keeley—Barbara, welcome to our Committee—and also by our two witnesses. I am going to ask them to very briefly introduce themselves for the public record.

**Sir Andrew Dilnot:** I am Andrew Dilnot. I was the chair of the Commission on Funding of Care and Support back in 2010-11.

**Sally Warren:** I am Sally Warren, director of policy at the King's Fund. I have been a senior civil servant with responsibility for social care reform at various stages over the last 12 or so years.

Q307 **Chair:** Thank you very much and welcome to the Committee. I am going to start with you, Andrew, and then go to Sally. I am going to ask a very broad question, so do not feel under any time pressure. It would be good for you to set the scene on what is quite a complicated set of moving parts here.

How do you think the Government's current proposals, as we understand them, match up to the kind of recommendations that you were making in your report in 2011? Could I ask you specifically to, among those many things, touch on the very recent announcement that we have had about the contribution from local authorities to care costs not counting towards the cap that the Government are proposing?

**Sir Andrew Dilnot:** Thank you, Chair, and thank you to the Committee for looking at this, which is an extraordinarily important set of issues. As you say, there were some changes announced yesterday that are still very hot off the press and that we are still digesting.

There are five or even six areas where there are differences between what the Government are now proposing and what the commission I chaired proposed in 2011, and was then put into legislation in 2014, so let me take them in order. The first, which is a very important set of issues to remember, is related to working-age adults. There tends to be almost exclusive focus on older people. The social care of older people is extraordinarily important, but the social care of working-age adults is very important too.

The recommendations that we made back in 2011 recommended that the cap for people who entered working age with an already established social care need should be zero. If you already had a social care need when you entered the labour force at 18, we should not expect you to make any contribution to your care, because that was a risk that we felt should be pooled across the population as a whole. We felt that the cap



## HOUSE OF COMMONS

should be zero until age 45 and should then rise in steps until it reached the retirement age level for the whole retired population.

The idea behind that was that it is not unreasonable to expect those who are able to have a normal working life to prepare and make some contribution to their social care costs, but it seems a bit harsh to say to somebody who enters adulthood with an already established social care need that they should be doing that. That felt like a risk that should be pooled across the whole population.

That principle was there in our report. It is not there in the Government's current proposals, which set the cap for working-age adults at the same level as the cap for retired people. That is a significant way in which these recommendations are less generous than those that we suggested.

**Q308 Chair:** Can you quantify the number of people who would be in that category, or can you tell us something about the size of that group?

**Sir Andrew Dilnot:** Roughly half of our social care spending goes on older people, and roughly half on people of working age. The proportion on those of working age has been growing, partly as a result of extremely welcome changes in how successfully we can look after people who have serious illnesses when they are young. This is a very significant group, and that is an important point to make.

Trying to be even-handed, one way in which the current proposals are more generous than those that the commission initially recommended or than was legislated for in 2014 is that our proposal was that the means-tested system should be made significantly more generous for those in residential care, but not necessarily for those still being looked after in their homes. That was because we felt that those who were in residential care whose houses are included in the value of the means test were hit very hard by the existing system, so we suggested raising the upper capital limit—the limit beyond which you get no means-tested support—to £100,000 or more for them, but not necessarily for those still having care in their own homes, because, if you are having care in your own home, the value of your house is excluded.

The Government's proposals increase the upper capital limit—the point beyond which you get no support—to £100,000 for everybody, whether in residential care or having care in their own homes. That is a way in which the system is more generous than what we had proposed.

A second way in which the system is more generous in this case than what was proposed in 2015 is in the context of daily living costs. There is a very clear argument for expecting people to continue to make a contribution to their daily living costs when they are no longer living in their own home. That is what they do when they are living in their home. The proposals were to set a fixed level for that. The level that the Government are proposing now, at £200 a week, is, in real terms, probably about £30 a week more generous to individuals than what was



## HOUSE OF COMMONS

proposed in 2015. Those are the two areas in which the proposals are more generous.

Now let me go through a number of ways in which they are less generous, two of which were known about before yesterday and one of which we found out about only yesterday. The two that were known about before yesterday were that the upper capital limit—this £100,000 threshold beyond which you get no support, which is a big increase compared to the £23,000 that it is at the moment—is less in real terms than we had recommended, and less in real terms than was recommended by the 2015 legislation. That extension of the means test has become a bit less generous than it was in our recommendations.

Perhaps the most clear headline way in which these recommendations are less generous than what we had proposed is in the level of the cap. We said that we thought people should contribute to their own care costs, unless they needed means-tested support, until their lifetime care needs reached somewhere between £25,000 and £50,000. We picked £35,000 as the midpoint. The cap has been set by the Government at £86,000, which is very significantly more and almost twice as high as our central £35,000 in real terms, and about a third higher than the top end of the range that we had suggested.

Q309 **Chair:** Would you not have to take into account inflation?

**Sir Andrew Dilnot:** I have taken inflation into account in that.

Q310 **Chair:** The note that I have here suggests that that means that it is £86,000 versus £62,000. Would that be broadly right in today's money?

**Sir Andrew Dilnot:** That is roughly right. It is a bit more than a third higher than the top end of the range.

All of those things were known before yesterday. Yesterday there was a further announcement made that does merit considerable attention. The recommendation that we had made and that was legislated for, so it exists in primary legislation, suggested that the way that the metering would work would be as follows.

Imagine that, let us say, 25 years from now, I show up, needing to be assessed for a social care need. The assessor says, "Yes, that old running injury of yours, Andrew, means that you now need care and support. You need help to get up in the morning, to be fed at lunchtime and to get back to bed. That would cost us, as a local authority, £860 a week to provide." Let us say that I have enough income and assets that I fail the means test, so I do not get any means-tested support. The local authority is able to say, "In that case, come back to us in 100 weeks." The 100 weeks is the £86,000 cap divided by £860 a week, so, "Come back in 100 weeks and, at that point, we will take on your care."

Let us imagine I have somebody who is my doppelganger but has been financially less fortunate, and so has the same social care need but would



## HOUSE OF COMMONS

get some means-tested support, because his assets are below £100,000. To make this simple, let us imagine that that person would get means-tested support of £430 a week. Under our initial proposals and the existing legislation, that person would hit the cap at exactly the same time, after 100 weeks, having spent only roughly half as much of their own money as I would have done. That is because that is what means-tested systems try to do—they try to support those on low incomes.

The change that the Government propose, about which I am very disappointed, is that, rather than doing it as we had suggested, the metering towards the cap would be of accumulated need minus any means-tested support that the Government deliver. That means that my less well-off doppelganger would hit the cap significantly later in time, having spent exactly the same amount of money as me, his better-off peer.

Essentially, what this change does is that, for those who have long care journeys or significant care needs, the less well-off will not gain any benefit from the cap. The only change as a result of all of these reforms will be that, instead of running your assets down to your last £14,250, you would run your assets down to your last £20,000.

The people who are most harshly affected by this change will be those with assets of exactly £106,000—that is the £86,000 of cap plus £20,000 that is protected by the means-tested system. Everybody with assets of less than £186,000 would do less well under what the Government are proposing than the proposals that we made structurally and those that are legislated for. That is a big change that was announced yesterday, and it is disappointing. It finds savings exclusively from the less well-off group.

Q311 **Chair:** That is a very helpful explanation. Your doppelganger, who is going to be means-tested because their assets are less than £100,000, is, under these very latest proposals, being disadvantaged by the fact that the LA's contribution is not going towards them reaching the cap of £86,000. Nonetheless, just so that I am very clear, they would be receiving some support by virtue of the fact that they have between £20,000 and £100,000 worth of assets.

**Sir Andrew Dilnot:** Yes.

Q312 **Chair:** Can you just talk us through how much that would amount to, using your own example?

**Sir Andrew Dilnot:** In the example I gave, they would be receiving support of £430 a week on average. It would start lower and get higher as their assets decline, probably, but let us say that they are getting £430 a week, so half of the costs paid every week.

Q313 **Chair:** How is that computed?



**Sir Andrew Dilnot:** In the example I am giving you, let us assume they have no income apart from normal state benefits, so it is largely taking account of their asset base. If they are in either domiciliary or residential care, under the new regime they would get support. The amount of support depends on exactly how their assets are composed and exactly what their income is. The means-tested system is being made more generous by what is being proposed.

The challenge, though, is that, if you go on having care needs for a long time, you end up using up all but the last £20,000 of your total wealth, because you are making a contribution each week. The people who are hit hard are those who have long care journeys, go on needing to make a contribution and end up having to spend exactly the same amount as their better-off counterparts. For those who have a substantial and long care need, the means-tested system does not leave them, at the end, any better off because of the cap.

Q314 **Chair:** We have a lot to cover, but these are really important points that you are covering. What would be really helpful would be if you were able to point to something or send something to the Committee, which looks at the impact of these various bits that are moving around—the amount of assets that I have, what income I might have, what my situation is and so on. It would be really useful for us to have a look at that.

**Sir Andrew Dilnot:** Yes, certainly. Both the King's Fund and the Health Foundation—

**Chair:** I am sure you have plenty of stuff.

**Sir Andrew Dilnot:** I have brought copies.

**Chair:** Wonderful.

**Sir Andrew Dilnot:** I was not sure that you would necessarily want me to hand those round.

Q315 **Anthony Browne:** I have a point of clarification. If I have understood correctly, under these proposals the means-testing part goes from being a benefit, which is a grant, to a loan, effectively, which you end up having to repay to the Government over a longer period of time. Is that right?

**Sir Andrew Dilnot:** That would be one way of characterising it. If you have a long care journey, you end up—

Q316 **Anthony Browne:** With means-testing, you pay less at the beginning but you end up paying more later. It is, basically, an interest-free loan rather than a benefit.

**Sir Andrew Dilnot:** You end up paying just as much as your better-off counterpart.

Q317 **Siobhain McDonagh:** I know it is very recent, but has there been any calculation of the optimal wealth that you would have to get the most



benefit out of the system?

**Sir Andrew Dilnot:** The people who are unaffected by this change are those with wealth of more than £186,000. If you have wealth, including your house, of more than £186,000, this change does not make any difference to you.

Q318 **Siobhain McDonagh:** But if you have wealth and assets of less than £106,000, it does.

**Sir Andrew Dilnot:** It does. Let me just point to an exhibit. This red line is the current system—how much of your assets you lose. This blue line is what it would be under the existing legislation. This orange line is what it would be under the Government's proposals. The gap is biggest and the greatest hit for people comes at exactly £106,000. It reduces somewhat as you get down towards the bottom and reduces as you go up towards the top. There are descriptions that we can send that put all of that more clearly.

I should emphasise that this is the position that faces somebody who has a long care journey. For somebody who has a shorter care journey of perhaps only a year, they get the benefit from the means-tested system. They were never going to hit the cap under any regime, so the means test helps them. It is just that, in terms of cover for those who are hardest hit, they are the group that are losing.

Q319 **Harriett Baldwin:** Can I just ask a clarifying question on the chart, please? What is your Y axis here—"the share of assets depleted"?

**Sir Andrew Dilnot:** It is how much of your wealth you lose.

Q320 **Harriett Baldwin:** Is the top line 100% or 1%?

**Sir Andrew Dilnot:** It is 100%. The red line shows that, under the current system and facing a very long care journey, you risk losing almost all of your wealth. That is the challenge that successive generations of politicians and the Prime Minister have been seeking to address. Under the current regime, if you have less than £14,000, you lose nothing, because the state pays for everything. It rises very quickly. Under the Care Act proposals, it peaks at a much smaller proportion and nobody loses more than 50% of their assets.

**Harriett Baldwin:** That is the blue line.

**Sir Andrew Dilnot:** That is the blue line. Under what the Government have proposed, which is the amber line—

**Harriett Baldwin:** That is the announcement yesterday.

**Sir Andrew Dilnot:** That is the announcement yesterday. You can see that, for those with assets of £106,000 or less, this is almost exactly the same as the current system. The only way it is different is that you get down to your last £20,000 rather than your last £14,000.



Q321 **Harriett Baldwin:** For everybody, the orange line is a better outcome than the current red line.

**Sir Andrew Dilnot:** Yes, and that is because of the increase in the lower capital limit—the limit below which you get everything paid for—from £14,000 to £20,000.

Q322 **Chair:** Looking at your chart here, what is interesting is the gap between the orange line and the blue line. Is it maximised at £106,000?

**Sir Andrew Dilnot:** It is at its greatest at £106,000.

Q323 **Chair:** That is the pivot point. Either side, it is fairly substantial. Once you get much over £25,000, you are getting into a reasonable gap.

**Sir Andrew Dilnot:** The other thing to ask, to set this in context, is how many people there are at these sorts of levels. About 60% of older people who end up needing social care have assets of less than £186,000. Probably about 30% or 40% have assets of less than £106,000. There is a geographical distribution of this. On the whole, this will tend to hit less well-off people harder; it will tend to hit people in regions of the country with lower house prices harder than it does those in regions with higher house prices, so there is a north-south axis to this. People living in northern and other less high house price areas are likely to be hit harder than this on average than people in better-off parts of the country.

Q324 **Chair:** Could I just add to my request for information after the Committee? Any distributional analysis of that type that you can point us to would be really helpful.

**Sir Andrew Dilnot:** Again, there is a very good Health Foundation document that sets that out.

Q325 **Barbara Keeley:** You were giving us a good example, Sir Andrew, in terms of the costs you and your doppelganger might have to pay on long care journeys. Looking at the 60%, and 30% to 40% split that you have just talked about, how long will yesterday's announcement add to the time to reach the cap on your care journey? Are you talking about two to four years? Is it three to six years?

**Sir Andrew Dilnot:** It varies, depending on exactly where you are, but it is perfectly plausible to imagine it doubling the time it takes some people to get to the cap.

Q326 **Barbara Keeley:** Broadly, this is people with dementia and those sorts of conditions.

**Sir Andrew Dilnot:** Dementia is one of the common causes, but it is not just dementia. Dementia is one of the things that tends to lead people to end up in residential care or needing dom care for a very long time, but it could be severe arthritis or some other orthopaedic or physical concern.

Q327 **Chair:** This is a very helpful chart. Are you happy for us to take this as



evidence today?

**Sir Andrew Dilnot:** Yes. We can be in touch with the Clerk to send that electronically.

**Chair:** Yes, indeed, and that other stuff.

Q328 **Siobhain McDonagh:** You said that 60% of older people having care have income and assets of less than £186,000. How many do you say have less than £106,000?

**Sir Andrew Dilnot:** It is 30% to 40%. It is not very easy to get very good numbers on this, but it is that kind of scale. Of course, some of those 30% to 40% are not terribly hard hit because they are the people right at the bottom who were never going to be affected by the cap, because the means-tested system comes in and helps. Not all of that group will be hard hit.

Q329 **Chair:** Getting back to the broader question that I set at the beginning, are there any other areas where you want to discuss different distinctions between your proposals, existing legislation and the Government's proposals?

**Sir Andrew Dilnot:** I do not think that there are any other big distinctions. I would like to say, because this is important, having just expanded at great length on some concerns I have, that this set of proposals still takes us to a much better place than where we are at the moment. The cap is less generous than I wanted it to be. The upper cap is a bit lower. Nonetheless, it moves us from a world where we are now, where this is an entirely means-tested regime that exposes the whole population to catastrophic costs, to, for the first time, a national risk pool for social care. These things are to be noted and welcomed. The particular way in which they are being done, and particularly what was announced yesterday, is less than the best way.

Q330 **Chair:** Overall, are you sitting there, thinking, "I am reasonably comfortable with what has been put forward"? Can I press you on that? What is the overall mood music that you feel?

**Sir Andrew Dilnot:** Overall, I have a very strongly positive feeling about the fact that change has come and that we are moving to a national risk pool for social care, which is critical not just for the recipients of social care but also for the providers. I regret the levels of the main parameters, and particularly the announcement that was made yesterday, which removes a central element of progressivity, which we thought was an important part of the structure.

Q331 **Anthony Browne:** You have pointed out various ways in which the Government's proposals are less generous than yours. Maybe wearing your old IFS hat, do you have a fiscal estimate of the benefit to the Treasury between the different costs of what you proposed and what the Government are proposing?



**Sir Andrew Dilnot:** I am afraid I do not, partly because the metering thing has happened very recently. I also pointed out that there are a couple of ways in which it is more generous, and we should not forget those. If I could put my old IFS hat on, one of the things that I would be expecting this Committee to say is that one would expect, very quickly, some good costings of all these things. I welcome the fact that this has been announced, but it was announced quickly and we do not yet have very much detail, so I am afraid that I cannot give you an answer on that.

The metering change in particular is, I would have thought, unlikely to be a very significant sum of money, which is also what partly makes me regret the decision, because I do not think that it will be a very large share of the total cost. Therefore, it seems to me one that I would like to see dealt with in a different way.

Q332 **Rushanara Ali:** Sir Andrew, I just wanted to ask you a question about those who are in work and the burden that is going to fall on them. How do you see the implications of that playing out?

Also, given that much of the ageing that is going to happen is not going to be disability-free—I am relying on old data but it is probably still relevant—how does that play out in terms of distributional impact? It would be really helpful to know. I appreciate you might not want to or be able to answer those questions, but it would be really interesting to understand how that plays out in terms of equity considerations.

The very disturbing point that you were making is around the regional distribution effects and the impact from the north-south divide being exacerbated, which seems to be completely contradictory to the Government's talk about levelling up. We had transport announcements yesterday about HS2 and last night we got this, which seems to be doing the opposite of what the Government talk about. Do you have a view on that?

**Sir Andrew Dilnot:** Forgive me; some of that goes beyond my legitimate remit, but it certainly is the case that there is a distributional and regional impact, particularly from this latest change. One of the things that was in our minds 10 or 11 years ago, and was in the mind of the legislation that many of you may have voted for in 2014, was that the way of bringing together the means-tested and the cap system was a way of providing progressivity and of in part addressing regional as well as income and wealth disparities. That is an important issue.

On those of working age, it would be sensible for me to turn almost immediately to Sally, who is much more expert on this than I am, but my immediate sense is that this metering change is also very significant for those of working age, because more of those of working age needing social care tend to have lower assets and income and, therefore, are more likely to be within the means-tested system. It is the combination



## HOUSE OF COMMONS

of not setting a zero cap for them at entry and this metering change, but Sally is probably better placed.

Q333 **Chair:** That is a marvellous moment to pass over to Sally on that question, as well as for any observations that you have on anything that we have covered or anything else you would like to share with us.

**Sally Warren:** Thank you very much. I will come back to the question about working-age adults, if that is okay. In terms of additional reflections on what Andrew said on the assessment of the scheme, I have four main points to make.

One is around the structure of the capped costs and the means-tested system. From my and the King's Fund's perspective, the capped cost model with the extended means test is the right structural way to help to protect people against that catastrophic cost and to do risk pooling. It is the right overall structure, but there are a couple of key elements of how the Government are now proposing to build that structure that we would have concerns about. One is it not being zero for working-age adults when they enter adulthood. The second is the change to how the cap and the means test interact with that metering change, which Andrew has gone into a lot of detail about. Those structural issues are very significant, because those are the things that you set once and set at the start of a scheme.

My second point is that there are a number of parameters, where Andrew has taken us through what is more and less generous; it is six of one and half a dozen of the other. I see those parameters as being much more likely to change over time, so the lower capital levels and the cap level could be made more generous over time. In terms of those parameters, it is quite a mix as to where it is more generous or not, but if the structure is the right thing, the parameters are something that can be debated and that different Governments would be able to improve over time.

The third point is that the original Dilnot commission did much more than just talk about a capped cost and a means test. It is just worth remembering that there were a whole host of other recommendations—for example, on the need for a public information campaign, so that individuals understand what their liabilities were, to help them plan and prepare; recommendations about working with the financial services industry to make sure that different products would emerge to support individuals; and better support for carers.

We have not seen much information from Government on any of those wider things, which are desperately required to make the system work. If this is going to help people plan and prepare, they need to know about it. It is not something that they should find out about only when they first get a care need.

That leads me to my final point, which is a really important one that I am sure we will keep coming back to. This is about how you change the



balance between the individual and the state, but it is building on an existing means-tested system that has been underfunded for over a decade and remains underfunded. This year's spending review does not provide enough funding for us to be confident that the social care system can continue to meet needs as the population ages.

It is really critical that Andrew's first report back in 2011 talked about the importance of the first thing you do is strengthen the foundations of the means-tested system and then you make these changes to the structure. We have not seen that happening at the same time as these cap proposals. As I say, I am sure we will come on to the spending review shortly.

Q334 **Chair:** How big is the underfunding, as you term it?

**Sally Warren:** It is quite difficult to give a precise number, because it depends on your ambitions about how much unmet need you want to tackle. There are high levels of unmet need. Age UK assesses that there could be as many as 1.5 million older people with an unmet care need. It also depends on how you want to tackle the workforce crisis in terms of whether you want to see care workers being paid more in order to be able to attract and retain them, and what level you think there should be. It is hard to come up with an absolute, direct number.

Q335 **Chair:** Can you give us some sort of order of magnitude or range?

**Sally Warren:** The Association of Directors of Adult Social Services says that £10 billion a year is needed to stabilise the adult social care system.

Q336 **Chair:** Is that in addition to that which the Government have brought forward through the levy?

**Sally Warren:** Yes. How I look at it is to think that the spending review has provided an increase in spending power of 1.8% a year. Normally, in social care, demographic pressures are around 1.8% to 2% a year. We then have additional cost pressures through the increase in the national minimum wage and national insurance contributions, and changes in things like energy costs, which will hit care homes quite hard. All of those mean that we think that social care will need considerably more than the 1.8% that has been provided each year in the spending review.

I will briefly come on to the working-age point. It was a really good question and a really important one. Working-age adults with disabilities will normally have a very long care pathway, partly because of the nature of their disabilities but also their age. What that means is that they will face catastrophic costs over their lifetime. They get support through the means test, which, as Andrew has said, becomes more generous, so more people will get some support. Because that support will not count towards the cap, they will find that the cap takes a long time for them to reach.



What that will mean is that, until they hit the cap, they lose all of their income down to a minimum income guarantee. The Government have now confirmed that they will unfreeze the level of the minimum income guarantee, which has been frozen for a number of years. What you end up creating with working-age adults is a Catch-22, where they have very little. If they are working, all of their money is going into care provision, and that will keep on happening until the cap is hit, so there are quite considerable implications for working-age adults. It is harder to do an analysis on numbers of those, because it is not as clear what their current asset bases are. It is more difficult to do those numbers.

**Q337 Rushanara Ali:** Would it, in effect, be a massive disincentive for people to go back to work, and potentially discriminatory, if you have a disability and are trying to enter the labour market, compared to wealthy people? Sir Andrew was talking earlier about them being better off. There are issues around productivity when the Government are wanting to increase productivity and get the population back into work. There are wider economic implications, are there not?

**Sally Warren:** If you want disabled people to be contributing to our economy and society, as we all should, you would want them to feel that they are able to work and to make provisions for their own later life. Disabled people will age as well, so if all of their money is being taken from the system to pay for care, they are not able to start to plan and prepare for their own retirement. It does create some difficult incentives.

**Q338 Rushanara Ali:** In summary, this change is going to hit disabled people much harder, it is going to hit poorer people harder and it is going to hit people in the north much harder. It is regressive, is it not?

**Sally Warren:** It is much harder than the Care Act proposals about how the cap scheme worked, based on Andrew's original report. For all of those groups, it is still better than the current system, because of the changes to the means-test thresholds, but it is not as good as current legislation would suggest.

**Chair:** On this distributional point, you are going to come back to the Committee, because this is something that we want to look at the detail of. I know that it is all out there, but it is just a question of sending it through to us.

**Q339 Barbara Keeley:** The point about working-age adults is so often forgotten and you end up with a discussion about older people. How can this be changed? You talked about setting up the structure of the new system and the different building blocks, which I understand, but if we start off with getting this wrong, will it be hard to change for working-age adults? It seems like a very important point that they have been left out.

**Sally Warren:** How you would change it would be to set different cap levels for different age bands. The Care Act does allow that, because this was the original set of proposals that was legislated for, and the coalition Government's implementation plan was to have a tiered approach; it was



not quite as many tiers as Andrew might have recommended, but a couple of steps. The Care Act legislation would allow you to be able to introduce that concept of a zero entry and a tier over time. It is a reasonable question to debate in terms of how many tiers are appropriate during working age and what the benefit is. I think Andrew would be happy with the principle of a tier rather than it needing to be precisely the tiers that he recommended, without putting words in his mouth.

**Sir Andrew Dilnot:** No, completely. We just thought that the central point was that it does seem reasonable to expect older people who have had a flourishing working age to make some contribution to their care needs. It does not seem reasonable to say to a young adult entering working age with a pre-existing social care need that she should have to provide for herself. That does feel like a risk that we would want to pool across society as a whole. I am very open to ideas about precisely how you get from zero to the full cap.

Q340 **Anthony Browne:** My questions are a bit high level, about how much we should be funding out of taxation and how much out of co-payment. The national health service is fundamentally based on the principle of free at the point of use. Although there are clearly exceptions in terms of dentistry, eye tests and prescriptions, it is largely free at the point of use. There has been discussion in the past about a national care service, funded totally through taxation. What are the arguments for and against that? Why is there an argument for having a large amount of co-payment in the care service, but not in the health service?

**Sir Andrew Dilnot:** My guess is that there are probably two big sets of arguments in favour of co-payment, rather than making it free. The first is an entirely pragmatic one; the second is one of principle. The pragmatic one is just cost. To make it entirely free would have a significantly greater cost. Effectively, it would be setting the cap at zero for everybody.

In the face of fiscal constraints and a worry that if you ended up saying a service will be free, you are also worried about overall spending, you may end up delivering a quality of service that is less generous than it should be. That is a challenge that faces some of the countries that have gone down this route. It is all provided out of taxation or social contributions, but the taxation and social contributions are not set at a high enough level to deliver a service, so there is a set of pragmatic arguments.

Then there is a set of arguments of principle. Some element of social care need is predictable in older age. Probably close to 80% of us will need social care badly enough that we pass a local authority assessment when we are in old age, which is foreseeable. Because it is foreseeable, asking people to make some contribution does not seem unreasonable, as long as they are not exposed, as they are under the current regime, to the possibility of catastrophe.



## HOUSE OF COMMONS

One of the things that we did in our initial report was we went out and did focus group-type stuff, and the majority of people felt it was not unreasonable to make some contribution to their care needs. They just did not want to be exposed to the full range.

There is one other argument that lies somewhere between principle and pragmatism, which is that, if you make almost anything free, you will tend to see a very significant increase in demand. One of the things that I am told we have seen in Scotland is that, when personal care—the very first part of care—was made free in Scotland, it led to a very significant increase in both demand and supply. That meant that there was a lot of resource going to the first part of social care need, which still left those with the catastrophic and greatest needs rather exposed.

**Sally Warren:** I will just add a couple of points to Andrew's explanation. One is just thinking about public views and opinions. You can go back as far as the 2006 Wanless report into social care, which first started to talk about a partnership between the individual and the state. Ever since then, various bits of public consultation and focus groups have tended to confirm that the public do think that this should be a partnership. They think that, particularly because some of this is about how you plan for your own quality of life in later life, there should be that shared partnership.

At the King's Fund, we did a joint report with the Health Foundation in 2008 called *A fork in the road*, and we did public engagement on that. Most people—55%—favoured costs being shared; 41% favoured it being a tax-funded system, free at the point of use. The public do understand that, particularly for care needs in later life, it is reasonable to share the cost and the burden between the individual and their family and the taxpayer.

The other thing to think about is eligibility and the definition of a system that is free at the point of use. Quite often, people suggest it both because they think it is fairest, and also because it would be simplest, but you do then get into what the level of need eligibility is for care and, in particular, what the definition of care is. In Scotland, they introduced a free personal care scheme, but since that was introduced almost 20 years ago, they have started to expand the definition of personal care into a broader set of services. It has still left a sense of, "We do not understand why this is free," and this is not free in the Scottish system.

You can see that across other international systems as well—that sense of eligibility and criteria being much more challenging in social care than it might be, for example, in the NHS, where we tend to trust. We go to our GP, an A&E consultant or a nurse, who determines what health services our needs are eligible for us to access. Quite a lot of social care is very personal to your particular life circumstance and the quality of life that you want to lead, so it is much harder to pinpoint whether you are eligible for this or for that. That is also where that sense of partnership is



really important, because it is a core, ongoing part of your life, not just a single episode of treatment, which is more what you would be getting with the NHS.

**Q341 Anthony Browne:** The boundaries are less clear. In your report, Andrew, you looked at other countries a bit. What is the evidence from other countries about this? Some countries have comprehensive, taxpayer-funded social care systems. Are there lessons to be learned from other countries about what the best system is?

**Sir Andrew Dilnot** This is complicated. Systems tend to be very embedded in individual cultures and histories. You might look at countries such as Germany and Japan, both of which have larger and clearly identified tax or social contribution streams that are directed at social care.

If we take the example of Germany, in many ways that has been relatively successful for many years, but it is now facing problems that are quite similar to those faced here, in that there simply is not adequate funding. The amount of money that is raised by the contributions is not enough to deliver universal, comprehensive and free social care. It is sort of an analogue of the challenge we face in the NHS.

Back in 1955, NHS spending was 3% or 3.5% of GDP, and it has risen by roughly one percentage point of GDP each decade and looks set to continue. That challenge exists also in the social care context and may even be, at the moment, an even greater challenge because of demographic change, which, by the way, we should welcome. It is fantastic and fabulous that we are living longer. Something that I used to say 10 years ago was that, if I heard somebody else say "the burden of ageing", I would scream and scream until I was sick. The alternative to ageing is being dead and, by and large, we would rather not be. It is wonderful that people are living longer, but that is creating particularly rapid pressures in this space.

**Q342 Anthony Browne:** Sally, do you have any lessons from international comparisons?

**Sally Warren:** Broadly, international systems all use a combination of some core ways of funding. There is normally some aspect of tax-funded and of a co-payment of some description, and quite often a cap. The key dilemma is what the right balance is between those, and most of the international experience would say that countries are tweaking the balance in the face of an ageing population to be really sure about how they can fund it, so either taxpayer contributions going up or the co-payment expectations increasing.

We are different in England because we have failed for a long time to introduce a new system, whereas other countries such as Japan and Germany have been able to. That new system still needs to grow and evolve as your population grows and evolves as well, so I do not see



there being one country that has sorted this and that we can just pick up and copy here.

Q343 **Anthony Browne:** One assumption is that, if it was a totally taxpayer-funded model, it would lead to providers ending up, at some point, being the state sector, whereas at the moment it is partly state sector and partly private sector. Do you think that the model that is proposed now will have an impact on the type of provision? Will it lead to, effectively, the nationalisation of care homes? I am not sure whether that is a good or a bad thing, but I am just wondering whether you think it will have an impact.

**Sally Warren:** There are two answers to this. One is that it should not have an impact on the nature of providers. We have a very large and diverse provider market, with more than 18,000 providers providing care. That diversity is important to be able to meet lots of people's needs in different ways. It is a fragile market at the moment, because of the underfunding, so it does need to be supported. I do not think that the structure of how you share the payment will change the provider make-up because, in effect, the individual is still receiving and buying care, whether that is with local authority money or their own money, so that will stay.

There is a big "but" to this—apologies for making this even more complicated—which is that section 18(3) of the Care Act allows self-funders to ask the local authority to access care at the local authority rate. It is an attempt to remove the cross-subsidy, which has been growing over the last decade. If you get that wrong in removing the cross-subsidy by not setting the Government rate high enough, that could see very high levels of instability for providers, and you could see providers removing themselves from the market. In that case, the only option you may be left with would be for local authorities to step in, definitely in the short term and possibly in the long term, to provide care.

The simple answer is to say that I see no reason why, structurally, these reforms should change, but implementation and transition might mean that there is quite a lot of turbulence. Section 18(3) is something that will be debated a lot.

Q344 **Anthony Browne:** I have one last question for Andrew—Sally, you might have a view—with your old IFS hat on, about the new health and social care levy. The Treasury famously does not like hypothecated taxes, and this is what one would probably call a political hypothecation. I just wondered what you thought about that, and the pros and cons. Clearly, it makes it politically easier to sell a tax increase, but it is not real hypothecation, is it?

**Sir Andrew Dilnot:** It is not real hypothecation, in the sense that there is no explicit link between the amount that an individual pays and the amount of benefit that she or he will subsequently get. There is also no explicit link between the amount that is raised in aggregate and the



## HOUSE OF COMMONS

amount that will be spent. That will still be a decision that will, I think properly, be made by Parliament on the advice of the Treasury, fully informed at all times.

There are two riders to that that are worth mentioning. First, I think and hope that, by having a tax with social care's name on it, we will help to move away from the long-standing tradition of social care being the relatively poor orphan that has had very little attention paid to it. It is the case—Sally has already mentioned it and we may come back to this—that there has been historical underfunding.

Whatever we think the optimal level of aggregate spending on health and social care is—people with different political views will have different views about that—it is almost impossible to think that the split in the aggregate spend between NHS spending and social care spending is optimal. It just is not.

Whatever level you think the aggregate should be, whether you are on the libertarian end and you think the state should be rather small, or on the more communitarian end and you think it should be big, the share of the total that has gone to social care has been crazily low. That is not a very technical way of putting it for a former director of the IFS, but it is very hard. That is important. The fact of having a tax with a name on will help.

The only other thing I would say is that the cap or social insurance element of this really is the state playing an insurance role. The reason for the state to play an insurance role is that the private sector cannot, in this particular case, because of the adverse selection and aggregate shock risk. To that extent, it seems that there is a stronger argument for at least an in-principle link between a payment and a benefit, because this is really the state acting as an insurer, in a certain way. There is a stronger case in this particular area for a tax linked in some vague, general way to a particular form of spending, because it is really the state substituting for an activity that the private sector cannot deliver.

**Chair:** We are going to come back to this insurance point because I know Harriett is going to talk about it, but Rushanara is sticking with whether we are spending enough.

Q345 **Rushanara Ali:** Yes, are we spending enough? We have established that what the Government are going to raise is still not going to be sufficient. According to the NAO report in March, publicly funded social care costs are projected to be £25.5 billion a year by 2028 and £34.7 billion by 2038. Despite what is being done, and leaving aside the equity considerations and so on, it is still scandalously low for the challenge we face, is it not? What else should be done to really meet the challenge that faces an ageing population in this country?

**Sir Andrew Dilnot:** There is no doubt that is lower than we need. My main reflection on this is that, for quite a few years now, every year the



## HOUSE OF COMMONS

Treasury has had to announce additional funds for social care. It seems to me it would be much better to be honest about this, and to recognise that further funds will be needed for social care and that this is a central part of our role as a community, and, therefore, to announce them in advance.

Social care would have a much better chance of being well managed at the local authority level if we were to say to local authorities, "We recognise that we need to spend more on this and, rather than handing that out each year as we go along, let us be honest about it". My biggest regret about the SR this year is that there is not a settlement for the core existing means-tested social care regime that any of us has real confidence will be robust over the next three or four years. I am absolutely confident that the Treasury will have to add more money in each year of the spending review period, which just does not seem like a very rational way of doing things.

Even if you take a relatively parsimonious view of how much money should be spent, the Government are going to end up spending more than they said so far, so that does not seem like a sensible way of proceeding. It would be much better to be honest about this. There is a contrast here between social care and the NHS. The position that I described for social care was the position we had for the NHS for many years. There have been periods when a long settlement has been announced, but also many that I can remember in the last 40 years when it has been clear that the amount was not going to be sufficient, and so there has been more.

That does not contribute to good planning. We are already asking our colleagues working in local authority social services to make extraordinarily difficult decisions about who to fund, and not being able to give them a stable and plausible series of budgets does not seem sensible. Of course, these are very large amounts of money for any of us as individuals, but relative to the overall level of Government budget or, say, the NHS budget, they are really rather small. Our total current level of spending on elderly adult social care is less than £10 billion a year out of total public spending of £800 billion a year. It is dwarfed by that and by the NHS. Somehow, it seems to me that we do not have a good perspective on all of this.

**Sally Warren:** I would just add a couple of points to that. Particularly if we are looking at the very long term—to 2038, for example—there is a really important thing about how we consider the balance of spend across health and social care needs. I absolutely echo Andrew's point about local government needing a realistic settlement now. I was speaking to a council at the beginning of the week, which was saying that it assesses its cost pressures in social care to be 6% for next year, and they are getting 1.8%, so we see that we are not quite on track there.



## HOUSE OF COMMONS

There is something really important when we look at how much we spend as a country on healthcare and social care. We know that that will increase every year, because, as a wealthy country, it will. What we have tended to have is a spending pattern that prioritises the acute end of people's needs and is not being spent on public health, prevention, social care or support in the community.

For me, the push towards an integrated care system, with the new Health and Care Bill creating new statutory organisations, is really important, not to save money but to spend our money in a different way and to really have local integrated care system being able to think about population health, how you can change the demand profile, and how you can work with communities and use the assets in communities and in public services to shift that.

There is a potential with integration of health and care services, with a real focus on population health and on inequalities, to rethink that balance of spend and to stop what has tended to be a case of social care and public health feeling very much like the poor relation when it comes to overall spending. What then ends up happening, as Andrew said, is that, at the last minute, bungs of money have to be given to social care. Over the last 18 months, when we say "last minute", we really mean one-minute-to-midnight announcements that grants or specific pots of money will be extended. It is extremely difficult for local authorities and providers to be able to cope with that kind of last-minute decision making.

**Q346 Rushanara Ali:** On these points about prevention, public health, integration, collaboration and so on, there have been lots of different attempts in different areas, over many decades, to try to do that, and it seems to elude Governments of all colours. I know that prevention and public health are certainly big issues in areas such as mine. What needs to happen tangibly to make that happen, so that we get out of that characterisation of last minute that both of you provided? What needs to change in terms of incentive structures for Government to do it? It has not happened, really. It has a little bit in some Governments of one colour more than others, but not to the extent that we need it.

**Sally Warren:** That is the \$64 million question: how to fix it. From my point of view, there are a few things here. One is that what has tended to happen before with integration is the concept of one size fits all. Whitehall determines what it thinks integration looks like and says to everybody, "You must do this." With integrated care systems, there is a huge amount of local flexibility proposed in the Bill. There are some minimum requirements about an integrated care system, but also a lot of flexibility about how integrated care systems then work with the places and communities within their footprint. We at the King's Fund think that flexibility is really important, because what is going to work in south-east London is not going to work in Cornwall. We really want to see that



flexibility; it is an important signal of maturity in a health and care system that you can trust local.

The really important thing that needs to happen is about what we consider success to mean for integrated care systems. If we focus only on waiting times and A&E waits, the system will shift all of its resource, people and focus to that. If what we have is a properly integrated performance framework that looks at long-term trends in life expectancy, quality of life or mortality, alongside the patient experience of more immediate access to care, that is really important. A lot of this will come from local leadership, but it will, critically, be set by the tone from Whitehall and NHS England about what matters.

**Q347 Rushanara Ali:** Over the last decade, what we have seen is a tendency for national Government to talk a good game about localisation and devolution, and then to pass on the responsibility but not the appropriate funding. In social care, the Government have already said in their plan, "We expect demographic and unit cost pressures will be met through local council tax, social care precept and long-term efficiencies". Is it reasonable to expect the spending pressures from changing demographics to be met from these sources, given what we know about different wealth levels, regional inequality and the cuts that local authorities have faced over the last decade?

My local authority has had £200 million taken out of its budget. That is just one local authority. Up and down the country, Conservative, Labour and whichever colour local authorities have really struggled. What would you say to this passing on of responsibility but not the appropriate resources and thinking through that equitably? What is the implication of that on the care agenda?

**Sally Warren:** I do not think that council tax is an appropriate base to pay for social care, because where you can raise the most council tax does not tally to where there is the most social care need. Yes, it is a locally delivered service, so it is reasonable to think that local government should be trying to ensure as good value for money as possible, but we need to see more grants from central Government to local government around social care. We have a few of those. We also have some arrangements where the NHS contributes to social care costs through the Better Care Fund.

There are steps on those, but they tend to be at the margins of the overall budget, whereas local government needs to have more support from central Government, so that we are confident that the right money is going to the right places to pay for care needs, rather than thinking that, overall, we can raise money through council tax, because it will end up in the wrong places.

**Sir Andrew Dilnot:** All that Sally says is correct. I would just like to step back and repeat that it looks as though this Government will deliver a significant increase in long-run spending on social care. That will be the



first time that that has happened in the 40 years that I have been working in this general area. As we have already discussed, there is a whole set of areas—particularly yesterday’s announcement—about which I feel very uncomfortable, but it is striking that that is the first time that this has happened over a very long time. What that points to is that social care—we all have to recognise responsibility here—simply has not attracted political, public or media interest and support in a way that is proportionate to its needs.

The current funding settlement is inadequate. It is inadequate to deliver appropriate integration, because integration is the kind of structural reform that relies on people having some flexibility and slack, but that is a problem that we need to recognise implies criticism of all of our institutions and all of us.

Although I am critical of some aspects of what is being done at the moment, I also want to give credit to this Government for having the courage to try to increase spending in this critical area. We all need to reflect on why something as important and central to our lives and to what kind of community we are as social care simply has not had the kind of political, public and media support that it needs if it is to be done well. We will not, for example, do integration well until we have the right levels of budgets.

**Q348 Rushanara Ali:** That is a very important and well-made point. Successive Governments have tried to bring this debate to the fore, but for different reasons have not, despite the fact that the grey vote has so much clout and power, which is interesting.

Looking into the future, this is a good place to start from. Those of us on the left would want to see much more equality across regions, populations and so on, in terms of those distribution points that were made earlier.

If you were to build these proposals into being something better and sustainable for the future, so that we do not run into this difficulty 40 years hence and we are still having these debates about neglecting adult and elder social care and so on, what would you do systemically in terms of budgets to address these equity considerations, and particularly the regional ones? We are going in the wrong direction, frankly, and what we are seeing is that people who are poorer and who are going to need care are going to be hit even harder, regardless of these changes. As you say, it is better to have them than not, but how do we get to a better place as a society, where we can solve this crisis rather than having to do this incrementally?

**Sir Andrew Dilnot:** This may sound like a counsel of despair, but I do not think that this is a crisis capable of solution, because the trends and pressures will continue in perpetuity, just as they have in the NHS. What we can hope, expect and require ourselves to do is to do much better—serve people’s social care needs much better and serve the needs of



## HOUSE OF COMMONS

providers in this space much better. The immediate step that we need to take is to provide an adequate level of funding through the existing means-tested system. Until we can do that, we will be asking employees in social services departments around the country to make decisions that would try Solomon, but we simply do not have enough resource going in to make reasonable decisions. That is critical.

There is an impact that we need to deliver but we also need to deliver a promise of reasonable budgetary availability over enough time for people to be able to plan. The structures that are being put in place can be really effective. We have a chance with this structure, which removes catastrophic risk from people. The providers will, for the first time, have a structure within which they can innovate and invest. Our best chance for doing better in all of this is a combination of adequate budgeting and innovation. This sector has not changed very radically in the way it delivers care, despite significant technological feasibility, which at the moment is not being brought in, because there simply is not the money.

I am not despairing about the future, but to get there we all have to recognise how important this is. We have to deliver appropriate resources and then we need all public and private sector to work very hard at doing it better. That can be done, but to achieve all of that the sector and the activity needs a different kind of profile. There are all kinds of interesting questions about why we do not talk about this very much.

It could be to do with fear—that we can see this coming at us. The fear can somewhat be tackled by pointing out that, if you ask people receiving social care how they feel about their lives, their self-reported life satisfaction is, in many cases, very high. Needing social care does not mean that you are condemned to a miserable life; it is quite the reverse. We need to point out that this can be a good thing, but there are, of course, aspects of social care that people do find unpalatable. We do not like talking about incontinence. We need to do better at addressing, head on, some of the challenges that are to do with social care in order to give it a higher and better profile.

**Sally Warren:** To give a practical example, if your ambition is that we more consistently fund the social care system well, one key issue at the moment is the lack of data that we have about the social care system. If you compare social care with the NHS, we have very little data, which can make it very hard to make a case to Treasury about what you get in return for this money, but it is also very hard to then articulate the benefits and value of the adult social care system.

Just as a couple of examples, we know very little about self-funders at the moment. We will start to know more about them. Because of the capped cost system, they will now start to interact with the state, so that is a really good opportunity to understand what is going on with those people's needs and how they and providers are meeting them. We also know very little about unmet need. We know how many people come to a



council to ask for help and how many of those get turned away and are given absolutely nothing, but we do not know what they then do and how they meet their needs. We do not know how many people might never have even come to the council. There is a whole set of unknowns that are really challenging in terms of being clear about what you are investing in when you are investing in social care.

We can too often be doom and gloom and say that it is a problem and there is a funding gap, but there are also huge opportunities. Some 1.5 million people work in the social care sector, which makes a massive contribution to local economies up and down the country. There is huge innovation in some parts of the market. There is huge value in social care, but we do not always have the data to be able to show the potential for that, and therefore, show why it should be prioritised among other competing pressures at a spending review.

**Q349 Chair:** I want to come back to one point that you made, Andrew, which I totally understand. You said we need more money; £10 billion, for example, in the context of overall public spending of £850 billion or whatever it may be, is a relatively small amount. If the Chancellor was sitting here, he might say, "But it is the amount at the margin. I have a bit of fiscal headroom in my fiscal targets, and £10 billion would take a huge chunk out of that in one go." What is your response to that?

**Sir Andrew Dilnot:** The £10 billion that I was talking about was what we currently spend. We are currently spending £10 billion a year on adult social care for older people. That is to be compared to the £130 billion or so that we are spending on the NHS.

There was another £10 billion that was mentioned earlier on, which was the additional amount that ADASS said we need. If we were to add £10 billion now, it could not be spent properly, but it would be a reasonable ambition. This goes back to something that your sister Committee, the Health and Social Care Committee, said earlier this year, which is that, as a result of the reforms, we needed an extra £7 billion to £10 billion a year in the long run. That is a reasonable ambition.

If we were to have the Treasury commit to increasing social care spending by £2 billion a year for each of the next few years, that would put us on a path to a level of activity and funding in local authorities that would give them a reasonable chance of delivering good care to all who needed it. It would give us a basis for these reforms, which are essentially an extension of that, that could work.

If I were the Chancellor, I would still say, "There are many competing calls on an extra £2 billion a year," and, of course, there are—education across the country as a whole amongst those who are more deprived, dealing with acute healthcare challenges or rebuilding public infrastructure. Of course, there are always trade-offs to be made, but my own sense—although, of course, I would say this, would I not?—is that the marginal benefit from increased spending in this area in terms of



## HOUSE OF COMMONS

social but also wider economic good is pretty high relative to some of the other calls on Government, which are endless, as you will remember from your time. It is difficult to balance where the greatest need is, but it does seem to me that this is an area where, relative to our current spend, the marginal benefit of increase would be particularly significant.

**Sally Warren:** It might also be worth briefly saying that it is also how the marginal spend impacts on how effectively you can spend the bulk of money that we are already spending on health and social care. If you really want to shift population health, early intervention or support in the community or to reduce demand for hospital care, you need to have a fully functioning social care system. We are, right now, seeing up and down the country what happens to hospitals if social care is not there. It is one of those where, if the Chancellor wants to see better value from NHS spending, that has to be part of seeing health and social care and public health together, and trying to shift incentives to mean that we are looking after people in a different way, in order to stop as much crisis and as many acute episodes as possible.

Q350 **Harriett Baldwin:** Thank you so much for this brilliant explanation. I particularly value this chart, because that really helps me understand that everyone in the country sees some sort of benefit from the announcement, although you have made it very clear in terms of what the curve looks like. I really want to try to understand this in retail terms, because all of us as MPs have this in our advice surgeries the whole time, and I want to be able to explain it clearly to my constituents. It is complicated.

What people have heard is, "You will no longer need to sell your house to pay for care." Can you elaborate, in terms of this chart, on how many people are still having to sell their house to pay for care?

**Sir Andrew Dilnot:** Let us imagine that you have a house that is worth £500,000, so you are right up at this end. This new regime will help you very significantly there. Let us imagine that you have such a house and you were facing 10 years in residential care. Under the current regime, you would lose almost everything. You would be up on this red line. Under the new regime, you lose a very small proportion—a bit less than 10% of your assets. That probably means you are not going to have to sell your house. You will be able to retain it.

I should say that the selling of the house has always seemed to me a proxy for what matters, rather than the critical thing that matters.

Q351 **Harriett Baldwin:** But it is what people have heard on the retail offer.

**Sir Andrew Dilnot:** I know that is what they are looking at. If your total assets are £100,000, at the moment you are in a very serious position and you would lose 85%, which would mean that you almost certainly would have to sell your house. Under the Care Act proposals, you would lose between 40% and 50% of your assets, which might well mean that you would be able to retain your house, one way or another. You could



take a deferred payment. Under what the Government are currently proposing, you would lose 80% of it.

Q352 **Harriett Baldwin:** Can you give an estimate to the Committee of how many, in terms of numbers, will still be selling their house to pay for care, once this is implemented?

**Sir Andrew Dilnot:** That is a very hard thing to do, particularly on the hoof.

Q353 **Harriett Baldwin:** It is not zero.

**Sir Andrew Dilnot:** No, it is certainly not zero. About 30% or 40% of the pensioner population is below this point, and about another 20% is between that point and that point. A very large proportion of the pensioner population needing care will find itself materially less protected by the proposals the Government have announced than they would have been without the amendment that has just been proposed.

Q354 **Harriett Baldwin:** They are more protected than they are now.

**Sir Andrew Dilnot:** They are a little more protected than they are now, because they face going down only to £20,000 instead of £14,250, but those people with less valuable houses but facing significant care journeys will be much less protected against catastrophic risk and the sale of their house if this amendment is made than without it.

Q355 **Harriett Baldwin:** It is going to be really interesting to the Committee to have a sense of how many people will still find themselves faced with that potential outcome.

**Sir Andrew Dilnot:** It will be tens of thousands. Of course, there are two very different numbers. There is how many people in any one year will be faced by that catastrophe, and then there is the much larger number of those who are faced with the risk of that catastrophe. The point I always make in this area is that, when we think of the benefit of having our houses insured, we do not think that the people who benefit from home insurance are those whose houses burn down. We think that it is all of us, as we leave our flat or house in the morning, knowing that, in the very unlikely event that it burns down, we are not facing catastrophe. That is the critical thing.

At the moment, we probably have about 350,000 people in residential care out of the total elderly population of well in excess of 10 million, but most of those 10 million people are looking forward to what would happen if it turned out that they needed residential care for a long period, and that distinction between those who hit catastrophe and all of us worrying about catastrophe is very important.

Q356 **Harriett Baldwin:** I am going to get on to the insurance issue in a minute. From what point in time is it? Is it from enactment of the legislation or a specific date in the future?



## HOUSE OF COMMONS

**Sir Andrew Dilnot:** It is a specific date: October 2023.

Q357 **Harriett Baldwin:** For my constituent who is currently paying for care, is there any retrospective element of this, or is it literally that the clock starts in October 2023?

**Sir Andrew Dilnot:** The proposal, as clarified yesterday, is that the clock starts in October 2023.

Q358 **Harriett Baldwin:** So there is absolutely no impact on anyone who is currently paying for care.

**Sir Andrew Dilnot:** Unless they are still paying for care in October 2023.

Q359 **Harriett Baldwin:** There are no changes proposed to attendance allowance, so the eligibility continues to remain exactly the same as it is now. We might want to table some questions about the impact assessment of particularly yesterday's changes, because it feels like that has made quite a big shift in terms of the number of people who face the risk. We have heard a little from you today about the health and social care tax. In terms of the cost to the taxpayer of making these changes, does the health and social care tax fund 100% of that cost? I know it is hard to say without knowing what the cost is, but does it probably cover all of that?

**Sir Andrew Dilnot:** The health and social care levy will raise north of £10 billion a year.

**Harriett Baldwin:** Starting from next April.

**Sir Andrew Dilnot:** Starting from next April. The figures that have been given so far suggest that the cost of these structural reforms will, over the three years of the spending review, be £5.4 billion in aggregate, so about £1.8 billion a year. The health and social care levy much more than raises enough money to pay for this. As we all know, much of the health and social care levy funding is being allocated towards the health service, but the health and social care levy massively more than raises enough money for this. I suspect that the wider public may, at the moment, think that a large part of the health and social care levy is going towards social care, but it looks, at the moment, as though it will be less than 20% of the fund, certainly in the first three years. Beyond that, there is less clarity.

Q360 **Harriett Baldwin:** There will be people starting on a care journey between now and October 2023, who will still have to sell their homes to pay for care.

**Sir Andrew Dilnot:** Yes.

Q361 **Harriett Baldwin:** How quickly is the average person going into a care home going to exhaust that £86,000 cap?

**Sir Andrew Dilnot:** If your care journey starts with going into a residential care home and you have not had any domiciliary care to begin



## HOUSE OF COMMONS

with, a bit more than three years would be the typical length of time before you would hit the cap.

**Sally Warren:** It is also worth saying that the average person entering a care home will probably never hit the cap.

Q362 **Harriett Baldwin:** The average is about six months, is it not?

**Sally Warren:** Yes. The point about the cap is that it is set to protect people from very catastrophic costs, if you are unlucky enough to be one of the people facing that. In his report in 2011, Andrew talked about one in 10 people facing costs of over £100,000. That has since been relooked at and we think it is one in seven. This is not everybody and it certainly is not the idea that the cap is your target and that you want to spend on social care to get your cap. It is very much that two or three of us in this room may be unlucky enough to have those very long care journeys that mean we are faced with those catastrophic costs. On average, most people starting their care journey will not be spending that level.

Q363 **Harriett Baldwin:** That is why it makes it a perfect insurance market product, it seems to me, because you have an amount—the £86,000—that you need to aim for to avoid having this. For the insurers, you have a probability of the people who will have to pay that. Most people would want to have bought an insurance policy that covers that first £86,000, which would seem to me to be a quantifiable goal that the market might be able to provide. I just wondered what you are hearing about this idea of a working group that you proposed between regulators and the industry to consider how to enable the development of that insurance market.

**Sir Andrew Dilnot:** My sense is that the Government are very keen to work with the financial services industry to get that going. My own reflection is the financial services industry may be a little wary for a while, because they feel they had their fingers slightly burned in 2014-15, because the Government had said they would introduce measures like this from April 2016, bits of the financial services industry spent some money on product development and then, after the 2015 election, the plug was pulled.

I have been approached by bits of the industry to ask if I am happy to talk to them about what they might do, so there is interest. You are right that one potential market is people who might want insurance up to the cap. I do not think that that will be an enormous market, because many people will say that they are happy to have that taken out of their estate. Certainly those further up the income and wealth distribution might say that, but there is a market there. I have had conversations with some bits of the industry that think that that is something that they could provide. In technical terms, it would look a bit like a funeral policy. You would pay a certain amount of money each month.

Q364 **Harriett Baldwin:** Those funeral policies are awful, aren't they? Sorry to



the industry.

**Sir Andrew Dilnot:** They are. They would pay a certain amount each month, which would deliver a fixed amount under certain circumstances.

There is another area that is potentially even larger and where there might be more excitement. Many people will say to themselves, "It is great that the state will cover my catastrophic risk, but I do not necessarily want to have residential care provision that is only of the quality that the state would be willing to provide, and so I would like to be able to top up". One of the welcome aspects of the announcements yesterday is the clarity that that will be feasible.

We could see a world where people's pension or other savings providers might be engaged in providing policies such that, in the quite unlikely circumstances that somebody ends up needing social care for a long period, their annuity would increase in value. This would, effectively, be a disability-linked annuity, and they can be quite cheap and attractive, because the probability of living for a very long time is negatively correlated with the probability of needing social care. There is a way of putting those two risks together, where a provider might be able to say, "You can have either a flat annuity of £10,000 or an annuity of £9,000, which will treble to £27,000 if you end up needing residential care". There is scope in both those bits of the market for the financial services industry to get going.

My own experience of the financial services industry is that it tends to be remarkably conservative, until it makes a change. I think back to the 1980s and the abolition of life assurance premium relief. I fear I may be the only person in this room old enough to remember that, but in the run-up to the Budget that announced the abolition of tax relief for life assurance premiums, the industry said, "No, we could not possibly unbundle products." By midday the day after the Budget, new policies were available, so there is scope here for parts of the financial services industry to get involved. I am not terribly optimistic that they will move very quickly, until the legislation has been enacted, because they feel that their fingers have been burned.

**Sally Warren:** I would just add two really quick points on that. The first is just to reinforce that it is financial services rather than insurance in terms of the overall potential here. The other really important thing to say is that the capped cost scheme does not rely on the emergence of these products for it to work.

In 2015, one of the reasons given for delaying and then abandoning the reforms was the lack of products, but it was never the case that you had to have these products. It was more that, once you have the scheme, it creates the conditions where products might emerge, which will increase choices that individuals have about how to plan and prepare for their own life. It is really important that we do not think that one success criterion is that there must be product on the market in October 2023.



## HOUSE OF COMMONS

I do not think that that will happen, for the reasons Andrew said. Also, there will not be any demand for it until the public start to know about it. It is something that will mature over time rather than being something that appears right on day one of the new system.

**Q365 Harriett Baldwin:** Are there any insurance companies that currently have policies outstanding and who will benefit, effectively, from the fact that that catastrophic risk has been taken away?

**Sir Andrew Dilnot:** The principal policy that is available at the moment is something called an immediate needs annuity. At the point where you need social care, you can go to an annuity provider and ask them to sell you an annuity that will provide X thousand pounds or the cost of your care until your death. That is a bit like the only insurance available to car drivers being that, in the split second where you have a car crash, you are given the opportunity to share your risk with everybody else who has a car crash at the same time. It is better than nothing but not a great deal better.

Those annuity providers will want to look at what they are providing and would, in the future, be providing annuities that would be somewhat different, in that they would probably fall by about £25,000 a year, once people hit the cap. They would be a bit cheaper and a bit more attractive.

**Q366 Harriett Baldwin:** Sally, in terms of the interaction between all of this and the NHS continuing care packages, we all get a lot of casework about where that line is drawn. Do you see this having any impact on that?

**Sally Warren:** As we understand the current Government proposals, there are no explicit changes to the continuing healthcare system, so those rules would apply. What the overall changes to the cap and the means test mean is that, at the moment, if you apply for continuing healthcare and do not get it, you are left facing those catastrophic costs completely by yourself. What this will do is make that cliff edge between "Is this a continuing healthcare need, where everything is paid for by the NHS, or are you needing to pay for yourself?" less of an extreme one, because you have the protection of the cap, which you have not had before. It will not change the rules, but it might change the impact on people as they experience that decision point.

**Q367 Siobhain McDonagh:** I want to look at the intergenerational impact of the proposed changes. Sir Andrew, there have been criticisms that the Government's proposals represent a transfer of wealth from the young, who have to pay national insurance, to the old, who do not and who will benefit from the new levy regardless. Do you agree?

**Sir Andrew Dilnot:** The levy is essentially like national insurance contributions, but with two differences. One is the dividend payment, which I welcome. The other is that people over retirement age in work will, for the first time, pay something like national insurance contributions, and I welcome that too. The state of the world where national insurance contributions were not paid by those over retirement



## HOUSE OF COMMONS

age is, essentially, something that harks back to 1948, when it made perfect sense. In 1948, the correlation between old age and poverty was very high. Now, the distribution of income for those over retirement age looks very much like the distribution of income for those under retirement age, and it is an anomaly in the tax system that those over retirement age do not pay national insurance contributions.

What we have ended up with is something that, in terms of its impact, looks remarkably like raising all income tax rates by 2.5%. If you compare the distribution impact of raising all income tax rates by 2.5% with those who pay the two lots of 1.25%, it looks very similar.

How should we think about this intergenerationally? The first critical point I would make is that social care is not just about old people. Half of the spending that we already do is on young people, or people of working age, and there is another slice on children. There is sometimes a category error here that people assume that all social care is for the older generation. In that context, a funding regime where a significant amount was contributed by those of working age might seem less fair, but half of the spending does go on people of working age, and that is important.

**Q368 Siobhain McDonagh:** The levy is going to go on older people, unless I have misunderstood.

**Sir Andrew Dilnot:** The answer to that is that it is not at all clear.

**Q369 Siobhain McDonagh:** At the moment, it looks like it will not include people of working age.

**Sir Andrew Dilnot:** The £5.4 billion is for those over working age. In the end, I am not very persuaded by these intergenerational arguments, partly because the main feature of national insurance, as of all direct taxes, is that the main difference in payments is between those of higher and lower incomes. As the Government have said, half of the extra levy will be paid by the top 14%, I think, of payers by income. The main redistribution that will go on as a result of this will be a redistribution from better-off people to less well-off people, and older people needing social care are, on the whole, less well off rather than better off.

From a purist perspective, it would have been neater to have done this through a 2.5% increase in all income tax rates. That was not done, and the principle established by imposing national insurance contributions for the first time on those over retirement age will make, over time, a contribution to intergenerational fairness, rather than the reverse.

**Q370 Siobhain McDonagh:** Sally, even with the social care levy being applied to those over state pension age, only about 2% of the overall tax rise comes from pensioner families, with about two thirds coming from families aged under 50. This is because pensioners get the majority of their income from private or state pensions, which the new levy will not be applied to. How might the proposals have been funded in a way that was fairer across generations?



**Sally Warren:** The King's Fund is not a fiscal think-tank, so I may well pass some of that over to Andrew. There are other routes through the taxation system—inheritance tax or changes to some benefits that older people have—that could have been possible. What I would say is that, having lived through social care reform for not far off 20 years, we have never before had a reform proposal and a source of funding for it. There is a bit of me that says, pragmatically, if this was the time to get it over the line, that is good enough, in that it is supporting the system.

The other point on intergenerational fairness that I want to make from a human point of view rather than being a fiscal expert in the room is that our generations are not independent of each other. They are interdependent of each other. For example, if you think about how many people leave the workforce every year because they cannot balance their caring responsibilities for a family member with their role, that is because the social care system is not of sufficient quality. There is not enough of it and it cannot be relied on. If using the levy to improve social care means that fewer working-age adults need to leave employment, that would be a really good thing and helps with intergenerational fairness.

I know that that is not how we quite often see tax and spend in an intergenerational way, but I feel it is important that we recognise that there are complications and consequences of some of the current decisions on individuals, particularly in terms of balancing that work. I do not know if Andrew would have more to say about the different sources.

**Sir Andrew Dilnot:** I would perhaps add two other things. The first is to recall that we all hope to be older.

Q371 **Siobhain McDonagh:** A lot of young people hope to own a house, and they are not going to.

**Sir Andrew Dilnot:** Yes. The second thing I would say is that, in general, intergenerational issues are best thought about in the context of the whole activity of Government, both taxation and public spending. One of the other things that was done by the Government around this time was freezing the triple lock. One of the things that made it possible politically to freeze the triple lock may have been these things, and the freezing of the triple lock made a very significant short-term impact on intergenerational fairness. Had the triple lock not been frozen, retired people this year would have received a very much larger increase in their pension. It is important to take that into consideration as well.

These intergenerational issues are very thorny. They are not best thought of in very narrow terms. We want to take the whole activity of Government into account.

Q372 **Siobhain McDonagh:** According to the IFS, a working-age person with average pre-pandemic earnings of about £28,000 will now pay 20% of their income in income tax, national insurance contributions and the new levy. By comparison, a pensioner receiving the same amount in pension



income will pay just 11%—almost half the rate of the working-age employee. In Germany, the tax base for social care contributions also applies to pension income, so that pensioners continue to pay for a risk that they continue to face. Is this something the Government should consider introducing to reduce the burden on the working-age population?

**Sir Andrew Dilnot:** It is something that we should all consider as a matter of fairness. As I said earlier, the fact that retired people have historically not paid national insurance contributions has been something of an anomaly. It is important to recognise that changing the rules for already retired people is something to do with considerable care. While I would be very happy to see this considered for future generations of retired people, including me—it is perfectly reasonable to say to people who are coming up towards retirement that this is something that they will need to consider—one of the characteristics of retirement is that people plan for it and tend to have less scope to adjust their plans post retirement.

As I have said, there is an anomaly in the current tax system that the direct tax rate paid by pensioners is lower than that paid by others. This increase of 1% is, therefore, a welcome structural change. I would expect, over the next 20 years, that that 1% will steadily move towards the rate that is paid by those of working age, but careful consideration needs to be given to the phasing of that, so as not to treat unfairly people who have made their retirement plans in the context of one set of rules and are not now able easily to change them.

Q373 **Siobhain McDonagh:** Would it have been intergenerationally fairer to ask those with the ability to pay, such as homeowners, to pay more towards their care needs, rather than increasing taxes for those who may not yet be on the housing ladder or may well never be in a position to buy their own home?

**Sir Andrew Dilnot:** I do not think I have anything more to say about that.

Q374 **Siobhain McDonagh:** Could I ask you a question about landlords? Torsten Bell, who is a person who regularly gives evidence at our Committee and who we all enjoy when he comes, has tweeted, “The good news for landlords: you don’t pay towards the health and social care levy, your tenants do. The great news for landlords: you will get almost all your assets protected by the social care cap (unlike homeowners with just the one, relatively cheap property)”. Is that a fair point?

**Sir Andrew Dilnot:** I certainly think that one of the ways in which the social care levy differs from a 2.5% increase in all income tax rates is that this is a category of income that in many cases, though not all, will escape that. The point about protection is the metering point that we discussed at great length earlier on. It is the case that the change in the



## HOUSE OF COMMONS

proposed metering proposed yesterday will not have a significant impact on the better off, and will have a significant impact on the less well off.

**Q375 Barbara Keeley:** Thanks for the Committee including me today. What you have covered with the Committee so far this morning has been very useful, and it is really good timing in terms of the debate around these things.

My questions are initially about whether the NHS and social care are on an equal footing. Can I return to the point about the level of the Government's ambition for social care? You have both said that the system is underfunded. Sir Andrew, you said we need to serve people better with social care. I will read out what the Government's ambition is in their plan: supporting the NHS, reforming adult social care and creating a new integrated system between health and social care. How do you think the measures announced so far meet that ambition, which is quite a high ambition?

**Sally Warren:** If we look particularly at the social care part of that ambition, how I look at it is we have had two of three critical parts of the jigsaw puzzle announced by the Government. The first is the capped cost model, which we have discussed a lot today and which we see as a positive step. The second is adequacy of funding of the means-tested system, which, as we have discussed, we do not feel is adequate for the ambitions we would have in the system. The third is a promised White Paper on reform of the system, which is about Government recognising that fixing social care is not just about the cap; it is about a wider set of challenges around innovation, our workforce and how to improve and have better joined-up care.

We have not yet seen that White Paper, and that would help us understand what the Government's vision is and how ambitious it is. I will be honest and say that my concern is that we know that social care was allocated only £5.4 billion from the levy funding. The vast majority of that will go to funding the changes to the means test and the capped cost model. Based on the figures the Government have provided so far, less than £2 billion of that over three years is going to be for reform to the social care system. That does not feel like an ambitious pace and scale of reform and change in a sector that has been waiting for a reform programme for five or six years now.

My concern will be that, when we see the White Paper, it will not fulfil the ambitions that many of us working in the sector have for those who need to draw on social care, because all this comes back to what the quality of life and support that people who need to draw on social care receive, and whether we are living up to the standards that we would want for all of us and our families.

**Q376 Barbara Keeley:** Sir Andrew, we have mentioned figures in this Committee session of £7 billion, which the Health and Social Care Committee talked about. The Lords Economic Affairs Committee figure



was also something like £10 billion. You have mentioned that ADASS think it is £10 billion. This is £2 billion, compared to that.

**Sir Andrew Dilnot:** We are some considerable way short. The three-way categories that Sally described are extremely helpful. I will say it again because I have said a number of critical things today: the structural reforms to both the means-tested system and the introduction of the cap are really welcome, and the Government deserve credit. Albeit they are less generous than I would like them to be, they have done it, or nearly done it, and other Governments over the last 40 years have not. That is something to mark, to note and to celebrate.

On adequacy of funding, we are a long way from where we need to be. I am absolutely sure that this will mean that the Treasury has to add more money each year over the next three years, which just does not seem like a very mature or sensible way of carrying on. It would be much better to say now, "This is what is going to be done over the next three years," and give people a chance.

On the White Papers, we just do not know yet. They are not published. I hope that they are being put together with great care and ambition, but some of the issues that need to be raised there also require funding. If there is not funding, it is going to be hard to see how they will be delivered.

Q377 **Barbara Keeley:** Sally, you have written that, rather than putting the NHS and social care on an equal footing, as it stands the plan leaves social care to wait in line behind the NHS. Can you elaborate on that? You have talked in this session about 1.5 million people with unmet needs; the demographics that are not being funded, apart from through council tax; pay for care staff; personal care; and support for carers. Could you just elaborate on that point about social care waiting in line?

**Sally Warren:** What that comment was relating to was how the health and care levy was going to be shared out amongst different parts of the health and care system. The £5.4 billion, which is the total over three years, is quite backloaded for social care. They get very little money next year—just £200 million—from that reform pack, and then it grows over time to considerably more in the final year.

That profile of spend is right for implementing a capped cost model, because one of the things about a capped cost model is that you do not have to be spending a lot of money as a Government on day one, because people are accruing their own costs. That profile is right for a new finance system. It is not right if you want to be making changes right now to the rest of the social care system, to improve the workforce, to be able to think about innovation or to support improvements in different housing models.

In particular, if we look at the current workforce challenge that we have in the social care system, we have had a non-recurrent pot of money



## HOUSE OF COMMONS

provided at one minute to midnight, equivalent to last month on helping them through this winter. We have a £500 million commitment as part of that £5.4 billion on workforce recruitment and retention, professional development and well-being, but nothing on pay. We have to be honest with ourselves that, until we can start to reward our workers in social care, who are doing fabulous and really important work every day that can be transformative for people's lives, with more than they can get paid in retail and hospitality, we are going to keep losing staff. We have a vacancy rate that is increasing quite dramatically this year. That is where I worry. Social care is waiting in line to get serious funds that would meet its problems.

What I would say, though, is that the NHS also needs funding. It has a very considerable problem with the backlog. We know that we can get carried away a bit by talking about the numbers, but we have to remember that all of those numbers—the 5.8 million people waiting—are people. They are us. They are in pain. They are anxious. They are concerned. This is not about saying, "We do not think the NHS needs financial support to be able to meet its challenges," but it is about saying that, if you are serious about a health and care system that is going to work well together, it should not always be that social care is waiting for three years before it gets a considerable investment.

**Q378 Barbara Keeley:** I have a couple of questions about workforce and pay. The Government's plan frequently references recruiting 50,000 more nurses, but there is no similar target for additional care staff—only a focus on developing care as a career, which, as you mentioned, has £500 million attached. Last month, the Care Quality Commission published a report describing the social care workforce as "exhausted and depleted" and "drained" in terms of resilience and capacity, because, of course, they have been hit so very hard by the Covid pandemic. Clearly, that is going to have an impact on the quality of care that those people can deliver. Why do the Government not seem to have the same ambitions for social care staff as for NHS staff? Why are we in this situation?

**Sally Warren:** This goes back to how the Government see their role with a provider sector that is predominantly a mixed market or a private sector-delivered market versus a public sector market. The Department of Health and Social Care has always seen that it has a responsibility for the NHS workforce, predominantly because it requires a training pipeline. Having said that it sees its responsibilities, we have not had a workforce plan in the NHS since 2003. We still now, despite the workforce crisis in the NHS, do not have a workforce plan.

Where I see the difference with social care is that Governments of all colours over the last 15 or 20 years have tended to see that the workforce is something for private providers to fix. They need to be thinking about the standards they want to recruit to. They need to be thinking about their terms and conditions. That is right and reasonable, but only to a certain point. The space that providers have to be able to



think about terms and conditions and about pay is heavily limited by the price Government will pay for care. What we have seen over recent years is that, because fee rates have not been rising in line with overall cost pressures, it has meant that social care providers have had less flexibility to be able to respond and to pay their staff more.

To give a specific example, while the increases to the national minimum wage were really positive, all that social care providers have really been able to do is to increase that for people at the bottom. They have not been able to increase wages for others, so you have seen a differential between brand new entrants into the sector and more experienced people really reduce. It is a difference of 6p per hour if you have five years' experience. That is not a way to encourage people to stay and keep their career in social care. In retail and hospitality, we have seen them be more able to increase the pay for those at the beginning of their careers, but also keep the differential. We have seen some real-life examples where providers have not been able to respond as agilely as other sectors, because of just how important the Government fee rate is in determining what investment they can make in their workforce.

**Q379 Barbara Keeley:** I have another question about pay, which seems a pretty important point. The Government's plan references a 3% pay rise for NHS workers, but for care staff, as you have touched on, Sally, it says about making "care work a more rewarding vocation, offering a career where people can develop new skills and take on new challenges as they become more experienced". That is wonderful, is it not, but you have just mentioned that the difference in pay is only 6p an hour between the bottom and the people with all that experience. Could you comment on that? Why no pay rise for care staff? Why is it that all they are getting is coming through the national minimum wage or the national living wage increases?

**Sally Warren:** One of the reasons is a structural one. The NHS is a public sector workforce. The pay rise is determined by a public sector pay body. Government are required to set that, because it is national terms and conditions. In social care, we have 18,000 providers. Everybody is on different terms and conditions with those 18,000 providers, so it is less easy for the Government to be able to say, "This is the pay rise across the board."

What does need to be reflected is that the fee rate that local authorities pay providers needs to be enough to be able to support appropriate pay in response. There will be pay rises for people who are working in the social care system. Most of that will be driven by the national minimum wage changes, rather than any changes in addition to that. Because the workforce is not employed as a public sector workforce, it is harder to have a single pay-lift figure that is shared, because it will be different in every single one of those employing organisations.

**Q380 Barbara Keeley:** With the level of skill, responsibility and regulation that workers have, should that be a minimum wage job?



**Sally Warren:** No, it should not. It is a job that is hugely challenging and, as I have said, hugely rewarding, and makes such a huge contribution to our economy and our society. No, I do not think it should be. We have to be honest with ourselves about why this is the case. Some of this is about social care being quite hidden. It is quite invisible. It happens in people's homes or in institutions that are quite often not at the heart of our communities. Because it is a really great career but people do not have degree qualifications, it is sometimes not seen as important or as significant as being a nurse in the NHS, but it absolutely is a contribution to our health and care system in an equally important way.

We have not recognised those broader skills and that this is a skilled workforce. It might not be a professionally regulated workforce or one that requires certain qualifications, but it is a hugely skilled workforce that certainly deserves to be recognised and rewarded in a different way than it is.

Q381 **Barbara Keeley:** Let me come back to the point that was touched on by my colleague, Rushanara, about the issue of paying for changing demographics in social care through existing taxes. Clearly, that is a small base of taxation that is raised locally and, as we know, varies significantly from region to region. Sir Andrew, would the NHS ever be asked to deal with things in such a way? I am an MP in Salford. The situation of what funding is raised is different in Salford than it is in Surrey. That is a comparison that is often made.

**Sir Andrew Dilnot:** If we were starting with a clean sheet of paper, it would be very unlikely that we would decide that the finance for social care should be raised locally. There are very strong arguments for local variation in delivery, because what is appropriate in Guildford will be different to what is appropriate in the Brecon Beacons or the Highlands of Scotland. There is appropriate variation in exactly how and what is delivered, but it is surprising and, essentially, a historical artefact that the finance is raised locally. That is because, in 1948, when the rest of our welfare state institutions were largely centralised, social care, as a hangover from the workhouse, local provision and even, in some senses, from Speenhamland, was left with the local authorities at a time when it was a rather small-scale activity, and we have not moved on from that.

To centralise the finance now would be a major upheaval, so it does not surprise me that the Government have not chosen to do that. If we are not to centralise it, relying on locally raised finance certainly raises very major questions about equalisation across the country. The amounts of money that are now being drawn down from local authority precepts mean that at least we need to look very closely at equalisation procedures, because, in the absence of doing that, we end up with a situation that just does not seem defensible.

Q382 **Barbara Keeley:** Sally, you mentioned the possibility of using grants as a way of achieving that equalisation.



## HOUSE OF COMMONS

**Sally Warren:** Yes, absolutely. We have always had this balance of some of it being locally raised and some of it being from central Government. What has happened since 2010 is that the scale of the grants has got much smaller, so the potential to equalise has become more challenging.

It is also just worth mentioning, in the context of locally raised revenue, that it is not just council tax but also business rates. In that regard, it is quite positive that the Government have hinted at, rather than officially announced, that they are going to move away from increasing the amount of business rates that could be retained locally. Similarly with council tax, our concern there was that the potential to grow your business rates base would not correspond to where your social care needs were. As social care is now such a dominant part of a local authority's budget, we were concerned that that could restrict some local authorities' ability to meet their statutory duties. It sounds positive that they are not going to be pushing for more local retention of business rates.

**Q383 Barbara Keeley:** Can we turn again to what the Government announced yesterday and the metering? We are going to have to debate and vote on that fairly soon, from the sound of things. Only the amount that the individual contributes towards the cost will count towards the cap. Your review ruled that out, Sir Andrew. How much is going to be saved by that? If this becomes very controversial, how much would it cost to reverse that?

**Sir Andrew Dilnot:** I am afraid I do not know the answer to that, because there are no figures in the public domain about that.

**Q384 Barbara Keeley:** How much roughly, do you think?

**Sir Andrew Dilnot:** My guess is that it would be a sum per year of hundreds of millions but less than £1 billion. Given what we know the overall cost of the package is, it looks like a sum like £500 million a year, but it could be half of that or 150%. I do not know, but it is not going to be billions. I suspect it will be somewhere around £500 million a year, although, of course, in the next three years, it is nothing at all. In the current spending review, this has no consequence at all, because the reforms do not come into play until October 2023, and then it takes a while for anybody to hit the cap anyway. In the current spending review, which I would argue is the period that Treasury, Treasury Ministers and perhaps former Treasury Ministers are most concerned about, the effect will, effectively, be zero. It will only be in the next spending review that funds will be needed for this.

**Q385 Barbara Keeley:** You answered an earlier question by saying that something like 30% or 40% of people are in that bracket of those who are going to be affected by what was announced yesterday. We all find it quite difficult to get across to people, when they come to us as their MP, how this works. Is your take that the Government should look at reversing this? Would it proportionately, for that amount of money, make



## HOUSE OF COMMONS

such a big difference to this package?

**Sir Andrew Dilnot:** Ultimately, of course, these are political decisions. I am an analyst and an economist. I have proper respect and regard for the difficult work that politicians do. I can say that I am pretty sure that, if I were a politician, this would not be a change that I would be suggesting. It seems to me that it makes the system more complicated and more difficult to understand, and the savings that it creates will all be taken from, it seems to me, the most vulnerable group—the least well off, who have the highest care needs. I am disappointed at the proposal and I would, of course, be delighted were the proposal not to be taken forward.

Q386 **Barbara Keeley:** Finally from me, the Government have proposed a notional level of daily costs at £200 a week. You proposed a maximum of £190 a week. What do you think of the Government's proposal?

**Sir Andrew Dilnot:** We proposed £190 a week, but that was a long time ago, so the Government's proposal is more generous than the proposal that we came up with, and I welcome that. The daily living cost proposal is one of the areas where the Government's current proposals are more generous than the 2015 system would have been, which is to be welcomed. Setting it at £200 a week is broadly appropriate, given the level of the basic state pension and the pension guarantee. It means that almost everybody should be able to cover that cost out of their own income.

Q387 **Barbara Keeley:** But to make it fairer, look again at that metering. Sally, you would advocate looking again at working-age adults and the way they are treated.

**Sally Warren:** Yes. They feel like the two structural questions about the system that could make it fairer for all people of different wealth levels and of different care need.

**Harriett Baldwin:** That was going to be my follow-up, and you have just answered it. It was around that £200 a week. Most people of retirement age will be getting the basic state pension. Many of them will also be eligible for the attendance allowance, so it is not as if there is no money coming in for those most vulnerable people that can help to address some of this issue. What you have said today has come across loud and clear, so I just wanted to clarify that.

**Chair:** We have come to the end. What a shame, because this has been such a fascinating and interesting conversation, apart from anything else. Can I thank you both very much indeed? I will probably, if I may, write to you both with some follow-up questions, because there is such a rich series of things that we have looked at that we will probably have further questions. That would be really helpful if you are happy to respond to that.

Can I also say that evidence of deep understanding of complicated matters is often provided when people are able to explain them in fairly



## HOUSE OF COMMONS

simple terms to those who do not understand them? If I may say, you have done that admirably today, so thank you for demystifying a lot of complexity for us, and for all that you have done. That concludes this session.