



Select Committee on the Long-term Sustainability of the NHS

Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 18 October 2016

11.30 am

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Members present: Lord Patel (The Chairman); Lord Bradley; Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Lord Mawhinney; Baroness Redfern; and Lord Warner.

Evidence Session No. 9

Heard in Public

Questions 98 - 104

Witnesses

I: Dame Kate Barker, Chair, Commission on the Future of Health and Social Care in England, Professor Julien Forder, Professor of Economics of Social Policy and Director, Personal Services Research Unit, University of Kent, and Sir Andrew Dilnot, Chair of the Commission on Funding of Care and Support.

USE OF THE TRANSCRIPT

1. This is an corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.



Examination of witnesses

Dame Kate Barker, Chair, Commission on the Future of Health and Social Care in England, Professor Julien Forder, Professor of Economics of Social Policy and Director, Personal Social Services Research Unit, University of Kent and Sir Andrew Dilnot, Chair of The Commission on Funding of Care and Support.

Q98 The Chairman: Welcome, and thank you for coming. My apologies for keeping you waiting; we, unfortunately, got too excited with our previous witnesses. I have no doubt that will happen equally in this session because you are very distinguished witnesses and we want to explore key issues with you. First, we are being broadcast, so any conversation you have will be recorded. Secondly, at the end of the session, during the week, you will be sent the record of our session to make any pertinent corrections. You cannot add to or subtract from it but you can edit it. Please feel free to send any additional material you think may be useful as a result of the session today.

Would you introduce yourselves and say who you represent, if you do? Also, if you wish to make any opening statement, please feel free to do so. Can I start with you, Dame Barker?

Dame Kate Barker: I am Kate Barker. I think here I am mostly representing myself but I am here because I chaired a commission for the King's Fund a couple of years ago. In that regard I should say that since I completed that work I have not really stayed in touch with this issue.

The Chairman: It was a very important report.

Dame Kate Barker: It is very kind of you to say so. I still think it is a very important issue, but I wanted to say I have not really followed the ins and outs of the debate. We face very difficult issues here: how far, as a nation, we want to share the financial burden of illness and ageing is the first one, and the second one is how on earth do we deal with a huge bureaucracy such as the NHS and make it efficient without losing what is so important to it? I assume that those are two questions you will want to address today.

Professor Julien Forder: Hello. I am Julien Forder. I direct a research unit at the University of Kent called the Personal Social Services Research Unit and I have worked for over 20 years now on social care and social care issues, more recently looking at health and health outcomes.

Sir Andrew Dilnot: I am Andrew Dilnot. I am warden of Nuffield College, Oxford, and I was the chair of the committee on the funding of care and support back in 2010 and 2011. I have been thinking about these things for many, many decades. It seems to me the big challenge we face and that your Committee needs to address is that in this country, as in almost all parts of the world, the demand for healthcare, broadly construed, including social care, rises more quickly than the economy grows. In this country for the last 60 years the average rate of increase



in health service spending has been 1.6% a year—more rapid than the growth of the economy. That is the challenge we face. I do not think it is in any sense an insuperable challenge. We spend less as a share of national income in this country on healthcare than many other comparable countries: indeed, probably less than half of what is spent in the United States. So I am not at all tolerant of those who say we cannot afford anything very particular, but we have some choices to make and getting the public debate to engage with those choices has been a struggle.

The Chairman: Thank you very much.

Q99 **Lord Lipsey:** An easy, a medium-easy and a hard question. The easy: do we need to spend more on social care? Harder: how much more? Hardest of all: how do we divide any extra we spend between helping people—perhaps better-off people—to pay for the care they receive and the alternative, which is spending more on services themselves?

Sir Andrew Dilnot: I am happy to have a go. The answer to the easy question, “Do we need to spend more?”, is yes—and nothing more needs to be said on that. We face what looks like a critical situation in social care across the country at the moment. Of course, that has been said before but it does look critical at the moment. We see things such as the closure of large numbers of care homes and we have challenges such as the living wage coming down the track at us, so the answer is yes. How much more? I do not think that is at all an easy question to answer. My own view is the answer to that depends very much on the answer to the third question: how do we split the responsibility between individuals and the community? It will come as no surprise to this Committee that my view is that it is perfectly reasonable to split this between individuals and the community, and certainly the work that we did on the care commission, of which Lord Warner was a noble and distinguished member, showed that most people think it is entirely legitimate that they should pay something towards their care costs.

The principal argument we put forward was that in the split between the individual and the community it was the catastrophic costs that should be borne by the community; that is why we argued for a cap. There are all kinds of arguments that can be brought forward for that. Precisely where that cap should be placed is, in the end, a political judgment: the further towards the left and to the universalist position you are, the lower you would tend to argue the cap should be; the further towards a more self-responsibility, libertarian position, the higher the cap should be—but it seems absolutely that there should be a cap. Until there is a cap, so that we take away the gross fear of disaster from individuals, we will not get a better care structure where individuals are willing to spend more of their own money and where the private sector can provide something that is not always ground down towards the lowest possible level of quality.

Dame Kate Barker: I certainly agree on the first point. It is clear to me that we need to spend more on social care, and I echo what Andrew said



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about the fact that the system looks as though it is closer to crisis now than it has ever been. We have this tremendous fall in the number of people who receive public support and we see real pressure on care homes. We know that, even when you take the new 2% precept and the Better Care Fund, it is still hardly going to help the care system out with meeting the costs of the national living wage, which in other respects is a worthwhile proposition. It will lead to much greater pressure on care homes, and we have just had the Care Quality Commission report pointing out that care homes have not improved very much since the last time they went around—which is a rather sad conclusion.

So we need to spend more and the question is whether the “more” is going to come largely from the public or the private sector. Part of one’s response to this is one’s sense of morality and what is right, and seeing poorer, frail elderly people getting very poor-quality care is something we should be ashamed of. The other thing which should give us pause for thought is that we are asking people who are paying for their care, people who pay privately, to effectively cross-subsidise other people because we do not fund those other people adequately. It means that those individuals are doubly hit: first, they are not well or they would not be in care in the first place; and, second, they are having to pay for themselves and a little bit for somebody else. I feel that that is a very profound injustice in the system.

I agree with Andrew that a cap is absolutely vital, and I agree with him that people who can afford it are going to have to find some money towards their care. Although we talk about the NHS being free at the point of use, there are a lot of things impacting health you have to pay for: teeth, prescriptions and other things. If you break your leg, the health service will mend your leg but they will not move you from A to B when you need it to go to work; you have to work out how to do that yourself. So we have to recognise that not every need can possibly be met, and should not be met, by the public sector.

One of the points that came out of my work when I was at the King’s Fund was that this is not just about funding but about how people work their way through the system and the difficulties people have in working their way through the system and the oddities that arise within it. A big point of the work was not about what people are entitled to and how that might be funded but about a system that would work better for people, suggesting that when people had fairly low-level needs they should have a small, non-means-targeted benefit that, as their needs grew and the help became more extensive, would have to be means tested—but, at a rather lower level than today, people should be able to have more free care from the state, and, in particular, trying to move away from the cliff edge that exists with regard to continuing healthcare. It is truly heart-breaking to think of families who are suddenly told their relative is a little bit better—and that is great—and now they have to pay a large bill because they have come off continuing healthcare, but obviously their care is still very expensive. To have that difficulty in the system, so that



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in some ways you would quite like your relative to be a bit more ill again, also seems to me profoundly morally difficult.

The Chairman: Is that what you meant in your report when you suggested that the various forms of wealth taxation should be explored further?

Dame Kate Barker: Talking about wealth taxation here I am thinking about inheritance tax, which I am aware is a deeply unpopular subject. I remain a bit baffled by a world in which we do not want to tax people's family homes when they die because, quite rightly, we know that people want to pass on the value of their home to their children—I want to pass on the value of my home to my children and I recognise that that is a very natural human desire—but that if they need social care the whole thing gets wiped away. That, again, feels uncomfortable. I do not quite see why we would not want to tax inheritance a bit more to enable there to be some money so that individuals who do have social care may still enable their children to inherit. People will then say that that is what the cap is about; it is enabling rich people to pass things down. Of course, family housing is not just among the rich, it is pretty widely spread throughout the population.

The Chairman: Professor Forder—on the original question from Lord Lipsey.

Professor Julien Forder: Yes, certainly. The two questions are intertwined. One way of looking at them is to consider some of the problems. The two main ones are underconsumption in the current system and underinsurance. Underconsumption stems from two things: the way in which the needs threshold for eligibility has been set and has recently been increased, so that we have seen considerably fewer people being eligible for support in the social care system, particularly older people. The other is around the charges that people face and the disincentive effect that charges have. Those people who are below the threshold for eligibility are likely to be in a poor situation. I say "likely" because we do not know a great deal about their situation. Those people who are still eligible have a reasonable level of support, and more work should be done to determine whether that is an appropriate level. But for those people who are not eligible we really need to consider their situation.

On the underinsurance issue, Andrew tackled the issue around trying to provide insurance for people at the tail end of risk. Those people who fall outside the means test are in a situation where they could well face catastrophic costs. It has always struck me as something you would want to insure against. There is very little provision for insurance. The private market for insurance clearly does not work. Voluntary insurance has not worked in any country. It does not work in the US. In fact, the few providers of voluntary insurance in the US are now departing the market—and if it does not work in the US it seems very unlikely that it will work anywhere else. With that market failure in mind, there seems to



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be an important solution for the state and some role for statutory insurance.

Q100 **Lord Warner:** I ought to declare my interest as a member of Sir Andrew's distinguished commission. I have a question mainly for Kate Barker but perhaps for both groups. Have you changed your views in any way since the publication of your report? Are those still the recommendations you would like to make? Could you also say something about a situation which has occurred both since the Barker report and particularly since the Dilnot report, which is that the synchronisation between the uprating of NHS health and social care has got worse—it has got more out of sync—in the sense that the real-terms supplement each year for both those services is now very much out of sync? How do you think the Committee should address that issue as well, given its impact on the sustainability of the NHS?

Dame Kate Barker: I explained right at the beginning that since I wrote the report I have not stayed closely in touch with the debate, which means that I have not spent a huge amount of time reflecting on whether I would reach the same conclusions again. When I look back, my sense is that I would reach broadly the same conclusions again. I think—Professor Forder made this point—that there should be better entitlement to state support for people at a lower assessed level of needs than today; it seems that you have to have quite a high needs test to get over to be entitled to state support.

If there is anything I have changed my mind on, again, as Professor Forder said, it is probably insurance. We did not suggest insurance. The proposals we made were largely about raising a little bit more tax today from the whole of the pensioner population and their wealth; after all, we have old people needing social care today and insurance is potentially more a solution for tomorrow. If I were rewriting it today I might think harder about whether, in the long run, we needed to have some form of insurance for social care. We commented in the report that the lack of understanding in the population of how the social care system works is still very significant, and we ought to do something to address that.

On the variants in the public budget, yes, I absolutely agree, and have already made the point, that the extra money that has gone to social care will not be sufficient to do more than offset the impact of the national living wage, so we are facing a situation in which care beds, which we badly need, are not likely to be supplied in the right number. That will add to the pressure on the health service. At the same time, and since I think it should be part of the same budget, local authorities' ability to invest in health prevention has been affected by the cutbacks. All that, as you rightly say, is adding to pressure on the National Health Service.

The failure to think of this as a system means that we then continue to have what I found the most extraordinary and saddest feature—I know in some parts of the country people are progressing with integration—which was people who had been stuck in hospital or in some other way because



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while the health and social care system felt they were entitled to something, they could not decide who they were entitled to it from. That is a terrible thing to happen and we have to work out a way of making that work better, not because it saves money—that is not my primary reason—but because it is fundamentally wrong that people should be left in that situation.

Professor Julien Forder: Dame Barker's report was very good and covered many of the issues. I, too, think that perhaps we should be moving more toward a statutory insurance model and this question of hypothecation, which I know was looked at in detail. In preparation for this meeting I was thinking: why argue for hypothecation in social care but not in healthcare? That remains a knotty issue for me, but I would say that it is partly to do with two things. One is the age relationship in social care. If you were to move to a hypothecated system having some age-related elements to that would be important. You can see examples of that in the Japanese system, for example. Their long-term care insurance has a 40-plus contribution; people over 40 make contributions. In the German system, although there is no specific age threshold it is certainly true that pensioners make contributions all the way through, and families without children make differential contributions as well. So there is some distinction between that and the health service.

There is also a role for informal care and where we are on social care and long-term care, coming very much from a tradition of it being a family responsibility, which also changes the equation somewhat. So I would argue for some form of partial hypothecation and some form of insurance system for long-term care as a way of more closely linking the idea of people making contributions with the care they receive.

The Chairman: In the German and the Japanese systems of insurance, what is the level of contribution?

Professor Julien Forder: The German system, I think, is around 1.9% of income. The Japanese system is quite complicated because some of it comes from income tax and some of it comes from a specific, earmarked contribution—but it is quite a generous system so it would be slightly more expensive than the German system. So you are probably looking in the order of around 2% of income, but that would cover, certainly in the Japanese system, quite a generous system; in the German system, not quite so much.

The Chairman: Sir Andrew, on the question that Lord Warner posed.

Sir Andrew Dilnot: Most of that question was really a question for Kate and not for me to trespass into. It is perhaps worth saying that in the five years now since we finished our review, I certainly have not changed my view about what the ideal system would be. I have changed my view about how bad the position that we are in now is. The position we are in now is much, much worse. It was bad then; it is much, much worse now. I think it is pressing and urgent. It is pressing and urgent for



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government, because if government does not act there is a risk of a very bad crisis. But I am much more interested in why it is pressing and urgent for people. It is pressing and urgent for the population because we live in a country that is now, by historical and international standards, extremely well-off, yet we live in a country where it is an issue that is likely to face most of us. I used to say repeatedly that the probability of needing social care was higher than the probability of falling pregnant, because half of us are never going to fall pregnant and about three-quarters of us will need social care, and need it badly. So this is a widespread issue facing most of us and the system is inefficient, ineffective and at risk of becoming defunct. We really need to get on with it and we would need to get on with it even if it was not causing problems for the rest of the healthcare system. It is causing problems for the rest of the healthcare system because of bed blocking and associated matters. So I am still honestly puzzled as to why we have not managed to take a bit more action.

The Chairman: Why do you think that is so?

Sir Andrew Dilnot: I do not know, because I am not part of the decision-making group. It is worth noting that I do not think that this is a simply a matter for the current Government; I do not see it being very high on the priority lists of any of the major political parties. It may be because the group affected is not a very noisy group, and that when the crisis comes, as it comes in many families, it is not a time when people have a great deal of time and energy available for campaigning. I am puzzled because I think it is a major problem. It is a major problem in itself and it is a major problem for the wider health service, and it would be great if as a result of the travails of your Committee more were to be done.

The Chairman: We will come back to that. Lady Redfern, you have a supplementary.

Baroness Redfern: Just very quickly, Sir Andrew. We mentioned about funding and extra funding, possibly before 2020. Do you think it should be targeted to social care? You alluded earlier to the closure of residential homes. I like to think that local authorities have played their part in helping people live in their own homes much longer with extra support, and therefore that they benefit by that, particularly with the introduction of the well-being helpers as well, where people can go and not feel isolated, et cetera, and looked after in the community. If there is any extra targeting of funding, do you think that it should go to social care?

Sir Andrew Dilnot: By "social care", do you mean domiciliary care as opposed to residential care?

Baroness Redfern: Yes.

Sir Andrew Dilnot: Honestly, I would not claim to be in a position to assert what the proportion should be. Certainly there are huge merits in



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both domiciliary and residential care, and it would be very surprising to me if, in the case that there were extra funding, all of it should go to one or the other. The appropriate settings are different for different people.

Baroness Redfern: Some of the closure in residential settings is because people are looked after in their own homes—so it is just not the funding issue.

Sir Andrew Dilnot: That is certainly true. To the extent that residential care homes are shutting because demand is falling because people prefer to be looked after in their own homes, that should be entirely supported—but I do not think that that is the whole story, by any means. Some of the closures are being driven by some of the processes that Kate and Julien described, where the funding available simply is not enough to keep homes going.

Baroness Redfern: Thank you.

Q101 **Lord Bradley:** Can we turn to the integration issue, which Dame Kate Barker mentioned? By that I mean the integration of health and social care but in the context of the wide integration of physical and mental health and wider public sector services reform being integrated into that programme. Do you think that is achievable? Have you done any assessment of where integration is working successfully, or where there are barriers to successful integration? Do you think savings can be made out of such integration? What key drivers should be put in place, if you think it is an appropriate direction of travel, to achieve it more quickly?

Dame Kate Barker: The fundamental difficulty with integration, which is apparent, is that the NHS has a ring-fenced budget, and, of course, social care comes from local authorities and is not ring-fenced. It is also means tested and the National Health Service is not. However, I do not think that that should necessarily prevent integration if the relevant local authority and local health service can be persuaded to put their pots of money together so that they are able to take more rational decisions across it. Of course, that requires both of them to give up some degree of autonomy, which they are often very reluctant to do. That is one of the problems that arises in the system.

Another problem with full integration is that they have grown up with two different workforces, and you might need a rather different workforce if you are going to use people to try to combine some of the social care and health functions. Of course that happens today, but you would be doing it much more explicitly, and it is not easy to get there.

Do I think this would save money? I am sure it would save some money. However, if it were to save money, I would wish to see it staying in that system. But the primary reason that I believe it to be desirable is not because it would save money, but, as I said earlier, because it would be better for the people involved if they did not have a system where they had to battle with two different organisations at a very painful time.



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Andrew rightly raised the point that the reason people do not shout about this so much is they are too busy getting on with it. It would be much better for individuals and their families if the system was more easily understood, was delivered to them more effectively and was not so bureaucratic. That must be the real reason for integration, alongside the points that have already been made about reducing bed blocking and maybe getting a bit more money back into prevention. People are a bundle of needs and we know that, and we are responding to that bundle of needs ineffectually.

Professor Julien Forder: I would certainly say it was possible; however, I do not know of any country that has a truly fully integrated health and social care system. Some of the Scandinavian countries come pretty close. Finland in particular is one example that springs to mind. I think there are still some differences between healthcare and long-term care that are important to be clear about. Informal care is the key part of that equation. Informal care and family play an important role. There is also the range of skills that Kate alluded to, and the potential for the substitution for some of the lower-skilled tasks involved with caring that informal carers do. So there are some differences but there are clearly some benefits as well.

In some of the work that I have been involved with, we have seen benefits that I have loosely placed into two categories. The first is prevention effects. For example, if you do a bit more social care, it helps people with nutrition, with mobility, with prevention of falls, which has a preventive effect on their need for healthcare. If you supply the right configuration of social care, that allows a more timely transfer of care, of people out of hospital, for example. Those preventative co-ordination activities are there.

There is also a lot of duplication. Needs overlap to a certain extent and you get two sets of professionals doing very similar tasks in trying to assess those needs and plan around an individual.

I think that there is some scope for cost savings and/or improvements in outcomes; in fact, probably more of the latter. It is very difficult to put a figure on this. If pushed, I would say that there are certainly cost savings to be had, but I think that they would be relatively modest. Again, I think that if there was a greater level of co-ordination and integration it would improve the way that people experience the system and the outcomes that they achieve. Of course, how you do that is another question.

Sir Andrew Dilnot: I think integration is probably a good thing. Of course, it has been in existence in Northern Ireland for a very long time and I do not think it has been shown to be any kind of silver bullet. It is a good thing, for the reasons that Kate and Julien have described, and we should do it—but it is absolutely not a way of addressing the fundamental pressures on either the healthcare or the social care system.



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The number of people aged 85 and over should double over the 20 years from 2011. It is absolutely fantastic that people are living longer, but if there are twice as many people aged over 85, the pressures are simply going to continue to grow. Instrumental reform such as integration might help us at the margins address the pressures, but it will not address the key question in social care, which is that there are many, many more of us living much longer—and that is wonderful—and, by and large, living slightly longer healthy lives. But we need to look after ourselves as we get older and we have a system that fails to do that. Nor does it help us address the fundamental question for the wider healthcare system, which is that demand grows more quickly than the economy, so we are going to have to work out who is going to pay and how. Integration is an important issue and something of which I am fully supportive—but, in the context of the questions you are facing, it is a distraction.

Baroness Blackstone: Do we have to think more radically about this, given that the barriers to integration are partly caused by two completely separate systems: a nationally organised top-down NHS and a local government system which provides social care? Would it not be better to try to devolve some of the NHS spending and some of its services—or, indeed, maybe a great deal of them—to local government, so that you could create a more integrated system of social policy more generally and get the kind of integration that one needs and a more sensible allocation of funding than we have at the moment, where basically we have a silo system?

Sir Andrew Dilnot: You have to give the money to either the health service or local authorities. One or other has to take responsibility. The question as to who it should be, if you are to get a fully integrated system, is one over which we could spend a great deal of time. In some parts of the country I suspect you would like it to be the local NHS and in some parts of the country you would like it to be the local authority. I am not sure whether there is an answer that would work across the whole country. Certainly it needs to be radical and there are some signs of experimentation in some parts of the country at the moment where either the local authority or the local NHS is willing to give greater delegated authority to its counterpart. I am not deeply pessimistic about it, but I do not think that it is going to answer the core question that this Committee is trying to answer, which is how we can move to a more sustainable system in the long run.

Professor Julien Forder: When you talked about devolution, one thing that struck me was taking it all the way down to the individual in some form of personal budget. A few years ago we did a large evaluation of personal health budgets and my colleagues have worked on personal budgets in social care. At that level, you saw two things: people engaging with their personal budgets and a shift in what they used their personal budgets for. You saw more social care, if you want to use that term. You saw more well-being services and perhaps less of the traditional



mainstream services. Where this seems to have had some traction is where it has been pushed all the way down to individuals. I agree completely with your point. At the moment their organisation, funding and culture are different. So it is not surprising that we have not seen as much integration over the years as I think people had expected to see when first looking at this issue.

The Chairman: Dame Kate, do you have any comments?

Dame Kate Barker: No, it has been very eloquently covered. I would like to support the comment about personal budgets because I suspect that means that money gets spent better in terms of the outcomes for individuals. But administering personal budgets puts some cost back into the system and on to the individual and their family—but it seems a desirable thing to do.

I want to go back and pick up some points other people have made. One of the things that perhaps we have not talked about so far in this session is how we think about carers in the voluntary sector. None of us wants to feel that we do not wish to be responsible for our elderly relatives, but the fact is that many of us live a very long way away from them—which, frankly, makes it much more difficult. Julien referred to this obliquely when he talked about family circumstances changing. If you look back at the post-war settlement, first, people did not live so long with needs such as dementia, and I imagine that the assumption was that they would be cared for within families where there were fewer working women. That is no longer the case.

So we need also to make sure that we try to make a better offer to carers. My understanding is that, following the Care Act, that has not really happened as much as people had hoped. Carers do not feel any better supported. Supporting carers better so they were clearer about how much they could expect to have the burden lifted from them in a physical sense might make people more willing to undertake it in the first place. Caring must feel terribly lonely for a lot of people. We must not lose sight of that, because we all know that lots and lots of informal and voluntary care goes on. Ensuring we are able to get the best out of that seems to me very important.

Q102 **Lord Warner:** This is a question particularly for Julien Forder. Have we made a mess of the boundary between health and social care? Are we out of step with international opinion in similar countries in having nursing homes not part of the healthcare system? How much out of step are we with that? If we then turn that on its head, are we fighting a losing battle in keeping continuing care in the NHS? Should we not transfer it clearly to social care and cap individual liability? At the moment we have neither fish nor fowl; it seems a bit of a muddle. What are your views on trying to straighten out that muddle?

Professor Julien Forder: My first response is there will always be a boundary issue wherever you draw the boundary. It has been helpful to



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break the type of care down into its various components. Broadly speaking, you have acute healthcare intervention, nursing care, personal care and then practical or long-term and well-being type services. It seems to me that if you can get your fault line at the junction of those components of care, it would work better. Certainly if you try to draw the fault line in the middle of what constitutes personal care, it is going to be incredibly difficult to sort out.

I agree that the way in which NHS continuing care works is difficult and has proven there are some significant boundary issues. On the other hand, I am not sure that those would improve necessarily if you pushed the boundary one way or the other. It might even be more difficult if you pushed it to a greater degree into what people consider to be personal care. Currently there are some issues around the way those services are funded. I think both Kate and Andrew have picked up in their reports, as I did previously when I worked with Derek Wanless, the accommodation issues with NHS continuing care. I think that is an issue that could and should be addressed.

Lord Warner: Are we out of line with international opinion on nursing homes?

Professor Julien Forder: In some respects we are. Baroness Redfern made the point earlier that it is not necessarily a bad thing to be moving away from residential care. If people want to live in their own home and can be supported to do so, that is a good outcome. Taking one form of care with a residential component—nursing homes or care homes—and putting it into one system and leaving home care in another system could create perverse incentives in that regard.

Baroness Blackstone: What happens in Scandinavia? You said that there was a more integrated system there.

Professor Julien Forder: It is closer.

Baroness Blackstone: Can you tell us a bit about how it works? Surely it is relevant to Norman's question, too.

Professor Julien Forder: Yes. If you take Finland, at the moment most of health and social care is organised at the municipality/local authority level. More specialist hospital care is distinct. There is closer integration in that respect. Getting this balance right between residential and home care is important. It would concern me if that was where the boundary line was drawn, because, although a person is in an institutional setting if they are in a nursing home, their combination of needs is not necessarily different from those of a person who is supported intensively at home. So it strikes me that if you take a needs focus or an outcomes focus, that is an artificial distinction to make. I do not think anywhere has got this absolutely sorted out. I would certainly look at the experience of the Scandinavian countries, but, there again, lots of the other countries I



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mentioned earlier—France, Germany and other places—maintain a distinction between their health and social care systems.

Lord Warner: The health service is now taking the law into its own hands. It is buying and is even being encouraged by Lord Carter to build nursing homes to get people out of hospital. Are we fighting a losing battle here? If you have a collapse of publicly funded social care, do you end up, force majeure, with a nursing home being a better option in the NHS than keeping people in the medical wards of acute hospitals?

Professor Julien Forder: Certainly you would want to see greater co-ordination. People began to talk about different models for that and the accountable care organisation is one where you see responsibility for a greater part of the spectrum of care needs being afforded to one organisation. It seems likely that there are some gains to be had by improving co-ordination between the systems. Delayed transfers of care is a very topical issue at the moment and an improved level of co-ordination seems to have produced benefits. That would seem to be a good solution. How you achieve that, though—whether it is health assuming some social care or personal care responsibilities, or whether it is vice versa—is a complex question which many people would struggle with.

Q103 **The Chairman:** Does the whole discussion that we have been having for the last half an hour or more come down to one thing: appropriate funding of the social care sector? Would you agree that if we do not do that now, it will have an impact on the long-term sustainability of the NHS, including the acute sector? What do we need to do now?

Sir Andrew Dilnot: I think the answer to your question is yes. It is already having an effect on the sustainability of the wider NHS. We need to act, and the need to act is growing more pressing month by month. At the moment there is inadequate funding to deliver acceptable levels of social care provision in England, and that is having an effect on the NHS itself. Some of the developments that Lord Warner talked about are a reflection of that. We are now seeing some major acute hospitals trying to organise the funding of care homes because that is the only way they can imagine getting people out of acute beds into more appropriate care.

The Chairman: So is it your view that the NHS is currently suffering because of lack of social care?

Sir Andrew Dilnot: Yes.

The Chairman: And that the lack of long-term sustainability in social care is more important to make the NHS more sustainable in the long term?

Sir Andrew Dilnot: Yes.

The Chairman: Will your recommendations, if adopted, achieve the long-term sustainability of social care?



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Sir Andrew Dilnot: I think putting a cap in place would certainly help, but one of the things we were extremely clear about is you also have to have adequate funding of the means testing system. There are two separate questions. The first is how we can make a social care system that will function and take away the fear and anxiety that affects the whole of the population. The second question is how we can make sure that those who have no or very few resources of their own are adequately looked after. To deal with that second question, you have to have a means-test system that is adequately funded.

To deal with the first question, which I think is crucial for long-term sustainability, we have to take away from people the fear that they will face catastrophic costs over which they have absolutely no control. Social care is the last big risk that we all face over which we can do nothing but shut our eyes, put our fingers in our ears and whistle bravely—and that does not seem a very sensible place to be in 2016.

The Chairman: Are you saying that the key thing about the long-term sustainability of the NHS is a proper level of funding for social care?

Sir Andrew Dilnot: No, I am certainly not saying it is sufficient. It is nothing like sufficient. I am saying it is necessary: if we do not sort out the social care system, the NHS will continue to face this constant problem. For the long-term sustainability of the NHS, the issue is how we balance the way in which demand grows much more quickly than the economy. It is a separate question, but we will not be able to answer it adequately unless we tackle the social care problem.

Lord Warner: Can we take the logic of that through, Andrew, and possibly with the other members of the panel? As a country, if we do not fund adequately means-tested social care and we do not cap catastrophic costs for people, do we end up with a situation in which the demands on the NHS become so large that you have to tackle the issue of whether it can continue as a tax-funded, free at the point of need system? Is that where this logic takes you?

Sir Andrew Dilnot: In extremis, yes, but there are other pressures facing the NHS that are hitting it even more quickly on the grand scale than this. But, yes, if we do not have an adequately funded means-test system, we will continue to have bed blocking, which is getting to be increasingly serious. If we do not have some system that allows all of us to help take control of our own social care needs, we will have many more people ending up in the NHS with falls that could have been prevented, for example, than we otherwise would need.

The wider problem for the NHS is that in 1955 we spent 2.9% of GDP on the NHS; 10 years later it was 3.4%; 10 years later it was 4.6%; 10 years later it was 4.5%; 10 years later it was 5.2%; and 10 years later it was 6.7%; and 10 years later it was 7.4%. It goes up and up. It is rising at 1.6% a year more quickly than the economy. There have been two occasions in the past 30 years when Governments have tried to stop that



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increase. One was in the middle years of the 1980s and after that in the late years of the 1980s, when Mrs Thatcher's Government substantially decreased spending on the health service because they felt it was unsustainable. The second was in the middle years of the 1990s, after which we saw the very substantial Blair/Brown increases. These pressures are seen throughout the developed world. I do not see any reason to think they will go away. Of course we can have better integration; we can try to make the system more efficient. There will always be ways of making it more efficient, but there is a long-run, upward trend in the amount we want to spend on health services, including social care.

We change the allocation of our spending very readily in the private sector. We have gone from spending 4% to 12% of consumption on transport as private individuals. We want to do the same with health. We have not yet found a way of doing that. Essentially, there are two options: either we can go on with a tax-funded, free at the point of use healthcare system covering it all, in which case taxes will have to go on rising, or we can try to find some other way. It seems to me that the central challenge facing your Committee is: if you do not believe that taxes will continue to rise, how are you going to square the circle?

Dame Kate Barker: That is right. I think the way you put the question was a bit odd. I completely agree with Andrew that in some sense you are asking a question about both systems together to ask: if we do not fund the social care system better, will we find that the NHS funding falls over? Implicit in that is that we have to fund both social care and the NHS better to meet a decent standard. The money has to come from somewhere. In a way, in social care I find it more compelling in some sense than in the NHS. In the NHS we could always choose not to take fancy new technologies or more expensive drugs and let people die. In the social care system people with dementia will carry on living pretty much regardless of what we do to them and ought to be dealt with decently. That sounds terribly hard—I know it does—but these are the kinds of choices that you have to think about.

I am never quite sure what is meant by "sustainability". If you are asking whether I think the NHS, as people would like to have it—free at the point of use with the present level of GDP going to it—is sustainable for the next 20 years, I agree absolutely with Andrew: it is not. We will be able to have an NHS free at the point of use that meets what people would really want out of it only if more money goes in, which means either that we have to introduce charges in some way or that we raise taxation. This seems to me a very profound political choice.

This is made more difficult for the NHS if we do not fund social care adequately. But the reason we should fund social care adequately is because it is not decent and humane not to. The side effects on the NHS are, of course, undesirable. It is very inefficient to have people in acute hospitals when they could be looked after probably better—and they



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would probably prefer it—in a less expensive way. The tragedy of having people stuck in acute hospitals is that it is neither good for them nor the hospital—it is doubly awful, and clearly we should get rid of that. But the problems of funding will persist even when we have removed that issue.

Lord Warner: The oddity of my question, just to be clear, is that I was trying to provoke you to say what you have said, because I am a sceptic about politicians' willingness to actually increase taxes, with the demand increasing from the NHS.

Dame Kate Barker: I recognise that.

Lord Warner: I successfully provoked you.

Dame Kate Barker: Yes, that was a result for both of us.

Baroness Redfern: To pick up on Andrew's point about the funding and its increase year on year, nevertheless, the ageing population is growing and we want to see people living well without any major concerns, which there are at the moment. Targeting funding on social care is really important because it helps the acute trusts get people out of those beds as quickly as possible. The local authority, with its intermediate care, is a step to help them get out very quickly and then on to their own home. So there is a three-stage process and it is vitally important that we treat people as individuals.

I am very pleased that we have personal budgets. Last night we debated disability and helping people with a disability have real choice with their personal budgets so they are helped to integrate into the system as much as able-bodied people. Going back from there, with funding to social care, it would be interesting to see what happens when we get people out of acute as soon as possible, because we all know people who are in acute beds for longer lose their confidence to go home eventually. Intermediate care is the real help that we want to focus on and improve.

Sir Andrew Dilnot: When we are looking at that particular set of issues, yes—but, of course, social care is not just about taking people out of hospitals and getting them back into their homes. A lot of social care, at its best, will be about helping people take control of their own lives so that they do not end up in hospital. The optimal mix is a delicate term or question of art and I would certainly defer to Julien who these days is much more expert on that than I am.

Professor Julien Forder: I think that was a very important point to make. Recently we have been doing research on trying to measure the impact of social care in its own right. I think that is a crucially important part of the debate. A lot of the focus of the discussion recently has been on the interface between health and social care, but I think it is very important to think about social care in its own right, as well as the fact that these additional benefits come from greater co-ordination. A lot of people rely on that. It improves people's quality of life. We have a body



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of research now showing that social care does that, so it is important to keep that in mind. It is also important to link it with informal care, as we have mentioned before. If we are talking about integration and about social care in its broadest definition, we are talking about housing, criminal justice and the benefits system. All these things need to be considered, not just the interface between the health and social care systems.

The Chairman: Thank you very much. Baroness Blackstone, you have a question.

Q104 **Baroness Blackstone:** Do you have a key suggestion for change that the Committee could recommend that would support a sustainable NHS?

Sir Andrew Dilnot: I have two—I am cheating. The first is to try to create a serious debate about this. I have been working in this area for 35 years. I first gave evidence to a parliamentary Committee—the Treasury and Civil Service Select Committee—about this sort of issue in 1983. I think we are lacking a serious debate about the kinds of choices that the three of us have tried to describe, and that is going to be crucial. The second thing we ought to do is make sure that the Government introduce a cap on social care while at the same time properly funding the means-testing system. Those things were agreed, legislated for and in the Government's manifesto, so I am very much looking forward to seeing them done in 2020.

Dame Kate Barker: It is pretty difficult to say anything after that, so I will not. I completely agree with that. I think Andrew is correct: it is not just about the cap, it is also about entitlements. We argued very strongly in the report that the entitlements between social care and healthcare are, bizarrely, different, and that is a problem. We have to accept, as I say, that we probably cannot fund everything out of general taxation. People are going to have to cope with some of the ups and downs in their lives with social care, as they do with other things, but they should not have to cope with catastrophic costs, and people who do not have the resources to cope should not be left without any, as I think is happening too much today. Julien referred to this earlier and the fact we do not really know what has happened to all these people who are no longer getting local authority care. We do not quite know how they are coping. I think that is terrible. I completely agree with Andrew that the main thing we have to do is have a bigger and honest debate to develop a sensible longer-term plan for this and stop producing little bits of sticking plaster that paper over the cracks. We cannot just keep doing that.

Professor Julien Forder: Can I indulge in two? The first is certainly about the funding of social care. As I think I said at the beginning, it is time to look more seriously at statutory insurance and some form of hypothecation. Since the royal commission in 1999, there have been many attempts to reform social care. I think now is the time to look at statutory insurance very closely.



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The other point is co-ordination. Obviously, they are linked as we have been discussing, but I think there is a lot of co-ordination activity that could be done, not least much better information sharing between the health service and long-term care, which has become very difficult recently, along with joint care planning and assessment. There are lots of organisational and delivery-type things that can still be done that will improve that, even if we operate within the same envelope of funding.

The Chairman: Thank you, Dame Kate, Professor Forder and Sir Andrew, for coming today and giving us your time in a very important session. If you think of any further information, please send it in and we will include it as evidence.