HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Social care: funding and workforce, HC 206

Tuesday 14 July 2020

Ordered by the House of Commons to be published on 14 July 2020.

Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell.

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Witnesses

I: Kevin Caulfield; Pamela King, former carer; and Deborah Gray, care user.

II: Lord Forsyth of Drumlean.

III: Yasuhisa Shiozaki, former Minister for Health, Labour and Welfare, Japan; and Sir Andrew Dilnot.

Examination of witnesses

Witnesses: Kevin Caulfield, Pamela King and Deborah Gray.

Q102 **Chair:** Good morning, and welcome to the House of Commons Health and Social Care Select Committee inquiry into funding and workforce issues in the social care system. Coronavirus has shone a spotlight on the fragility of the social care system. Today, we are going to consider some of the longer-term solutions.

We are delighted to welcome some very distinguished witnesses, who have made significant contributions to the debate, including Sir Andrew Dilnot, who was chairman of the Commission on Funding of Care and Support, which, amazingly, reported back in 2011, was adopted by the Government in 2014, then dropped, but it may be about to be resurrected.

We will hear from Lord Forsyth of Drumlean, Chairman of the Lords Economic Affairs Committee, whose influential report on social care funding was published last July and recommended free personal care for the elderly. We are going to hear from the former Japanese Health and Welfare Minister, Yasuhisa Shiozaki, about how Japan has already solved some of the problems that we still face.

Before that, to make sure that we have our discussions in a fair context, we are going to hear from some of the people who have suffered because of the problems in our current system. I welcome our first panel.

On that panel is Pamela King from Leicester. Her sister, Diana, had a huge stroke and has had enormous battles to get the care that she needed. Kevin Caulfield is from Hammersmith. He has a neurological condition that means he has been using a wheelchair for over 20 years. Deborah Gray is from Wiltshire. Her husband, Atherton, has early onset Alzheimer's. She is paying over £50,000 a year for his care.

We are going to start with Pamela. Thank you so much for joining us.

Q103 **Dr Evans:** Pamela, thank you so much for joining the Committee today. I would be grateful if you could outline a little what happened in your case and where things are at the moment.

Pamela King: My sister had her stroke in July 2018. She was in the Leicester Royal Infirmary for four weeks, and then she was transferred to a community hospital. In the meantime, I had a holiday booked, and I did not realise that they try to get people out within four weeks; there is a four-week turnaround in a community hospital, and it coincided with when I was going away. It was all very stressful; they were saying, "What are we going to do? We have to get her out of here, and you are not here to organise things." They actually kept her for six weeks.

Apparently, the turnaround used to be six weeks, but they have reduced it to four weeks. They kept her for six weeks, basically because I insisted on going away because everything had been paid for and booked months in advance.

It was down to me to try to find her a care home. This was also a very difficult obstacle. She hadn't got any property and she was renting, and all the money she had was in pension pots, but they said that because she had more than £23,250, she would have to pay for her own care. She was paying in full for her own care until very recently, but I was advised not to find somewhere too expensive because when the time came that we needed to get social services to pay any difference, if we had chosen somewhere too expensive, they would probably ask me to move her out into a cheaper home.

I had to try to find somewhere. It was all very difficult. There is a directory of care homes that social services give you, but there is no pricing in it. They say they cannot put pricing in because obviously the prices change all the time, but there was not even any idea of the pricing, so that was very difficult as well. I needed to find somewhere close to home for visiting.

Q104 **Dr Evans:** Can you tell me what Diana was like before the stroke? Was she in good health? What was she left with afterwards?

Pamela King: The stroke was very severe. She had been fine, but she had a DVT and was treated for the DVT with some medication. Apparently, it is a new medication that does not need monitoring. It was not Warfarin. It was a tablet type; I think it is an American drug. She was on that for probably about three weeks. Then she got a tummy bug, which we both had actually, and she was just getting over the tummy bug when she had a really bad stroke. It was a bleed on the brain. It was in the centre of the brain, so they could not relieve the pressure because it was too much in the centre of the brain. They could not do anything. They just had to hope that the bleeding stopped.

It left her with paralysis. They tried to get her to stand up and to walk in the community hospital, but she was too affected by the stroke and had been too weak prior to the stroke. She has always been underweight anyway, and with the other things that had happened to her—the DVT and tummy bug—she was just too weak. She could not stand by herself or walk the way they hoped that she would.

It has affected her bladder and bowels as well, so she has to wear pads, and she is completely paralysed all down the left side. She has to be hoisted in and out of bed. She only has the use of her right arm. She can feed herself with a fork and a spoon, but she needs help with everything.

Q105 **Dr Evans:** When that all happened, did you have any understanding about the crossover between the NHS and social care? How easy was the signposting of what needed to be done? It sounds like you had to do a lot.

Pamela King: Yes. They wanted her to go home. They were pushing for her to go home. I thought, "If she goes home, how is she going to cope?" They said they could supply a hospital bed and all the things that she would require, and that she would have four carers coming in every day. I said, "What about in the night?" They said, "Well, we can't provide night care." They said that potentially she could go 12 hours without any carers because from the last call in the evening, depending on the last time, to the first call in the morning it could be as long as 12 hours. It could be less. It could be 10, but, even so, that is a long time for somebody to be left on their own if they can't do anything for themselves. It is hard.

Q106 **Dr Evans:** What did you expect to happen, and what was the reality of what happened? You have touched on it a little bit, but could you talk about when the stroke happened and what you thought might happen, and where you actually got to?

Pamela King: The social workers talked to her and they wanted her to go home. They were pushing for her to go home. She was involved in all the meetings. It has not affected her mind. It has affected her speech slightly, but it has not affected her mind. They wanted her to make all the decisions because she still had her mental capacity. They were leaving it to her to decide, and she said she wanted to go home. She only has my brother and me. We talked through the impracticalities of that and had to persuade her that it was not the best thing for her to do. If we paid for someone to come in during the night, it would potentially cost quite a lot of money every night, seven nights a week, to have carers in the night. They would have to be private. Social services would not provide them. Is that what you mean?

Q107 **Dr Evans:** It is just to understand what you expected to happen, what the reality was and where that has left you. We are now almost two years on. How have things settled at the moment?

Pamela King: There was another stressful time when her money was running down to the £23,250. I contacted social services and said that her money was going to run down any time, and could they now come in and help. They asked if my brother or I could pay the top-up fee. The difference was £109 a week. I said, "I'm on a pension and I am retired. My brother is on a pension and he is retired. We are only on modest pensions. We have a bit of a private pension but not a very big one, so no, we can't really afford to pay that." They said it would have to go to a review board.

My main concern was her being moved from the home into a cheaper home. There aren't many cheaper homes about. I found from experience that the cheapest home I could find in our Leicestershire area was £650 a week. Hers is currently £712. There are many more at £800 or £1,000 a week. The one she wanted to go to, and asked to go to, was between £1,000 and £1,100 a week. I had to say to her, "I'm sorry, but you can't."

Q108 **Dr Evans:** What is the one thing you would hope for in the future? With everything you have been through, what is the one thing from a patient and relative perspective that you would hope to see in the future?

Pamela King: She has now been told that she can stay there. The decision was that they are going to pay the difference and that she can stay in the care home. That has been a big relief. I cannot really see any better future for her than that at the moment. She is no better. She is no worse, but she is no better either. She still needs care 24/7, so I cannot see how anything could be any better. She likes it in the care home. It is a small care home, so it is a bit more personal.

Dr Evans: Thank you very much. My regards to your sister and thank you for coming today.

Chair: Thank you very much, Pamela. It sounds like it took quite a long time to get to the right solution from the way you describe it, but it is excellent that your sister has now got into the care home she wants to be in. We are going to go on to Kevin Caulfield from Hammersmith.

Q109 **Neale Hanvey:** Good morning, Kevin. Thank you very much for coming along today. What has been your experience of paying for care and support and what impact has it had on you?

Kevin Caulfield: Good morning, everyone. I hope that you can hear me. I have been invited to make personal comments. I actually work for the London Borough of Hammersmith and Fulham, but I am not here today representing the council.

Many of you know that Hammersmith and Fulham is the only local authority in England that currently does not charge for essential support and care services for people living independently in the community. I have had my condition for over 22 years, so in the bad old days there was tremendous negative psychological impact in having a financial assessment and receiving an invoice just based on who you are. I am a disabled person, and I have significant support needs. I had a neurological brain condition 22 years ago, so there is a fundamental issue about the psychological impact of being charged on the basis of who you are.

The other point I want to make is that, obviously taking into account different charging regimes, charges generally increase in relation to the barriers you have in accessing society. The greater your health condition or your impairment and the more your support needs, the more the costs increase. That cannot be right.

The financial assessment process is often demeaning. It comes at a point in people’s lives when they need support and peace and tranquillity. Instead, what happens is that you move further and further away from that. Overnight, my life changed in terms of me needing state support to live independently. I cannot survive without that support, but then you start on a whole process of taking you further away in terms of the additional burdens that are placed on you as an individual to navigate the system and deal with the assessment and charging process.

It reinforces the sense of you being other and different. The underlying message is of being a burden and expensive. These are all negative messages. If we are really interested in developing a national care and support service that meets people’s needs, those things have to be taken into consideration. They are all issues that disabled people have been raising for 20 years or more. They are not new.

Around 2008, we did some work writing the “Charging into poverty?” report produced by the Coalition on Charging. Charging plays a huge part in the decision by many people to end using services. People often stop support if care charges rise. That has a negative equality impact on unwaged family carers, particularly women—often disabled women—and people from black and minority ethnic communities who are also disproportionately disadvantaged by the results of charging regimes.

We have the issue of debt and people falling into debt. It absolutely cannot be acceptable in the 21st century that people are falling into debt to pay for the support that they need and end up in the legal system as a result. That is a fundamental issue that needs to be addressed.

For my last point, I am going to steal the words of Baroness Jane Campbell, who chairs the Independent Living Strategy Group. She said: “Support provided under the Care Act is meant to improve the wellbeing and independence of disabled people. By charging many for that support, the system is making a mockery of the spirit of the legislation and causing worry, stress and poverty. Charging raises a relatively small sum of money which is pushing up costs elsewhere.”

If you do not frontload the social care system, the financial impact of personal care—neglect, such as pressure sores, kidney infections, falls and stress-related illnesses—means finding extra resources for the NHS. I think we all understand that. If independent living and social care is not working, the demands on the NHS are greater.

Q110 **Neale Hanvey:** Thank you, Kevin. I think you have touched on this quite a bit already. As a disabled person, what are the specific challenges that you have faced in paying for and accessing the support that you need? Can you give us some examples?

Kevin Caulfield: Happily, with the current situation in Hammersmith and Fulham, there are not too many specific challenges for me in paying because there is no charging. My contribution to society comes in other ways. That is a really important message. It came about from disabled residents campaigning in the borough and keeping the issue of charging disabled people for essential services high up on the agenda. One of our slogans was “£12.40 an hour for a shower.” It brings home the message that that is what you are doing. You are charging somebody that amount of money for basic access to have their human rights met.

What is key for us locally is that the leader of the council, Councillor Stephen Cowan, understands the barriers that charging presents to local disabled residents. There is recognition that, if disabled people are to get anywhere near the starting line of being valued and having the best life they can, charging for independent living and homecare support is not going to help any of us meet that ambition.

Chair: Kevin, thank you very much indeed for that. It is a very important reminder that the social care debate is not just about older people. We are very grateful to you for your testimony.

We are now going to hear from our third witness in the first panel, Deborah Gray from Wiltshire, whose husband Atherton has early onset Alzheimer's. She is paying a huge amount of money every year for his care. Thank you so much for joining us, Deborah. We really appreciate it.

Q111 **Sarah Owen:** Deborah, thank you for coming to speak to us today. It is really appreciated by all of us on the Select Committee. Could you start by telling us, please, a bit about your and your husband's situation, and the impact that the cost of care is having on you both?

Deborah Gray: In a word, the impact on us all is enormous. If my husband had had a tumour or needed dialysis, the NHS would pay for his care, but because he has dementia, it does not.

Care homes recognise that dementia is a disease, and they charge us an extra 15% to look after him because he has dementia and because that involves additional needs. Consequently, when he went into a care home, we had to find £1,000 a week. That is £52,000 a year for his care. It seems like a lot of money, but I always say to my friends when I talk about it that it is extortionately expensive, but it is good value for money. It costs that much to give people good care.

My husband was a doctor in the NHS. He was really proud to be a doctor in the NHS. He spent his whole life paying his national insurance, in the knowledge that when it was his turn the NHS would take care of him, but it hasn't. He is now 68. He retired at 62 in good physical health, but he was aware that something was not right with his once very brilliant brain. He was a poet. He had vigorous interests in astronomy, the arts and philosophy. Now, he is unable to utter a couple of words at a time. He has seizures and falls. He is doubly incontinent. He doesn't recognise his own children. It is screamingly clear that something is wrong with him, and it is a disease.

Dementia is not just a matter of ageing. Liver failure is not like that. Cancer is not like that. It is the unfairness of the treatment of somebody with dementia that makes me really angry. It is like picking up a random card from a pack and saying, "Oh, you've got this particular one. Tough. That's the disease the NHS isn't going to pay for."

We had an assessment recently for continuing healthcare. We were told that he does not have a primary healthcare need. If you saw him, you would not believe that. I wept when I got that letter. It was just another cruel blow, and it seems like we have one after another. How could that not be a primary healthcare need?

We have psychological costs. When I tried to find out about how dementia care is funded, I found the information confusing and hard to find. When I did find it, it was often contradictory. I am IT literate and I have English as my first language. I feel for people who do not have that advantage. I found it impossible. It was impossible to plan ahead. I still have sleepless nights.

The whole thing was very stressful. My children ended up being more concerned about me almost than about my husband, because I was not only having the burden of his care but also the stress of trying to navigate the system or, more accurately, the lack of a system.

Q112 **Sarah Owen:** I was going to ask a question about how this Government's policy makes you feel. It is like, as you say, a random deck of cards and picking out Alzheimer's and dementia as ones that you have to pay for, but you have already answered that.

I want to ask about the impact on you and your family. I know that Atherton is now in a home, but before that you were providing care. Did you have adequate access to respite care and support for yourself?

Deborah Gray: From the moment of diagnosis through to the moment he went into the home, I can honestly say that there was no signposting for anything. Everything I found for myself and for Atherton, I discovered. I trawled the internet and I found somewhere that people with early onset dementia could go for a walk. I organised his going there and paid the costs of the transport. We live in a rural area and it is 26 miles to the centre that wonderfully provided his care. In fact, they took him sailing once a week, and it was definitely the highlight of his week. I found that. Nobody else found it for me.

I got to a point when I desperately needed a break. I went to the nearest care home, which is seven minutes away by foot. I said, "Would you be willing to do some care for him?" They said, "Oh, we don't like doing care for somebody we don't have in our day centre." I said, "What day centre?" I did not know there was a day centre seven minutes away from my home, and I had been dealing with this for several years by then. There is no signposting and the whole thing is a quagmire.

Q113 **Sarah Owen:** In terms of this crisis and the current pandemic, there are reports that many people with Alzheimer's and dementia have increased symptoms or a worsening of symptoms. Do you think there should have been extra support available for people living with Alzheimer's and dementia in their families during the pandemic?

Deborah Gray: I am one of the lucky ones. My husband is very well cared for in a home that is well staffed and well managed. It would have been wrong for me to have gone in there and taken the possibility of disease from the community into the care home. That would have been irresponsible, but I have not seen Atherton since 1 March.

In a conversation with his manager, I think we have both agreed that any recognition that he had of me as an individual who was friendly—I don't think he recognised me as his wife—will have gone after this long gap. It is the people who are a stage behind me who have really suffered. I cannot tell you how many times I have been grateful that he is in a home. If this had happened while I was looking after him in the family home, I don't know how I would have coped. Trying to keep somebody inside who has a tendency, let's say, to wander is hard. It is hard to keep somebody with dementia enclosed within four walls. I do not know how I could have done that without support and without the days when he went to the day centre or went walking. To spend day after day with somebody with dementia—I just do not know how people have done it.

Q114 **Sarah Owen:** What difference would it make to your life and Atherton's life and his care if you did not have the worry of having to pay over £1,000 a week for his care?

Deborah Gray: We are now in receipt of some local authority care because he has gone down. I echo what I heard earlier. My biggest worry once he went into the home was, would he then have to be removed from that home because the local authority would no longer pay for it? In fact, he had an assessment by a social worker who decided it was in his best interests to stay in that home because his level of need is such that he would not be able to make relationships with a new place or with new people.

It is all about the matter of stress. One of the things that always bothered me more than anything else was the fact that, if you are under 60 and you require local authority support, they can request that you sell your home. I was 55 when he was diagnosed. I thought that, if things went very rapidly and I needed help, I could be asked to sell my home at a time in my life when I was trying to cope with so many other things. That would have been one burden too many.

In fact, it is downright cruel to do that to people. I beg the Committee to take that requirement out of any further legislation. I feel passionately that it is an unfair burden. Anybody who is a carer of somebody with advanced dementia, or moderate dementia as it was then, gives up their job. You give up with that not only your own earning capacity, so your family budget goes down, but your future wealth because you are not paying into a workplace pension. The knock-on effects for the carer will go on forever.

I have always been very worried—selfishly worried—about how I am going to fund my future if I am funding Atherton's to such an extent that it diminishes my assets. My parents are in their late 80s. I could last another 30 years. I do not want to end up being a burden on the state because he wasn't.

Sarah Owen: Thank you, Deborah.

Q115 **Chair:** I have a quick follow-up question, Deborah. It has obviously been a very stressful period for you, going through lockdown, thinking that at the start of the lockdown Atherton recognised you, but by the end, when you get to see him, he may not. When you think about the people who are looking after Atherton in his home, what message do you want the Government to take away from the coronavirus crisis with respect to the social care sector?

Deborah Gray: I would like you to recognise that care workers are professionals. One of the reasons why we have not had continuing healthcare funding, as I understand it, is that the very highly trained professionals looking after him are able to give him his medication, to anticipate his needs and look after him properly. It seems that, because they are not nurses, they are just described as care workers who give social care, and that is that. Those people need specialised management, and the care workers are very highly trained to do that. They need to be integrated into the system. The NHS should be able to make payments to care homes for the care of people like my husband who have dementia. They are skilled professionals.

Chair: Thank you. That is a very important answer. A very big thank you to you, Deborah, and also to Kevin and Pamela, for giving us your evidence this morning. I think you are going to stay on the line and watch the rest of the session. Thank you very much for sharing those experiences with us. I know I speak for all of the Committee when we say that we hear from all the great experts, but the bit that means the most to us is when we hear from ordinary people who sometimes bear the brunt of policies that have not gone as well as people hoped. Thank you very much for your evidence.

Examination of witness

Witness: Lord Forsyth of Drumlean.

Q116 **Chair:** Our next panel has one witness: Lord Forsyth, Michael Forsyth, who is Chairman of the Lords Economic Affairs Committee, and a Conservative peer. The Committee published a cross-party report last July recommending free personal care for the elderly.

Thank you very much for joining us, Lord Forsyth. Could I ask you to kick off by outlining the key conclusions in your report?

Lord Forsyth: They are very much reflected by what you have just heard from the witnesses. It is a system that is grossly underfunded. It is very unfair in the way it operates, and it undervalues the people who do a magnificent job in providing social care.

I left the Cabinet and Government in 1997. Since then, there have been 12 Green Papers, White Papers, consultations, five independent reviews and a Royal Commission. There has even been legislation passed, but, like Billy Bunter's postal order, the money never comes.

We felt that two things need to be done. First, we need to put right the money that was taken out of social care. The budget has fallen very considerably in real terms while demand has gone up very considerably. Secondly, we need to deal with the issue that basic care is being charged for certain types of condition and not for others, as you have just heard. If you have dementia or motor neurone disease, you get no free care. If you have cancer, you get free care.

The system is absolutely incomprehensible to follow. I have had some personal experience of it. I looked at the guidance on the Care Act, which runs to pages and pages, and even for a skilled legislator it is very difficult to follow and understand. The burden on local authorities now is immense. Instead of providing care according to need and diagnosis, they are having to deliver according to budget.

We think that the Treasury must have its dead hand removed from it and get on with what everyone has been saying for the best part of 20 years in a situation that has got very much worse.

Q117 **Chair:** In your report you talk about an £8 billion increase in the annual budget for the social care sector. I want to ask you about the detail of that. We heard from the Health Foundation, which said that if you just looked at demographic changes over the next four years, and the increases in the national living wage that the Government have promised—no increase in the capacity of the system or the care we provide but just looking at the demographic changes and the national living wage—that is an extra £3.9 billion. Does your £8 billion include those demographic changes and the increases in the national living wage, or is it on top of those?

Lord Forsyth: Our £8 billion was based on figures that we also got from the Health Foundation and the King's Fund, but as you say, our report is more than a year old and we are still waiting on a response from the Government.

The Health Foundation, you are right, has upgraded its figures. The latest figures I have are £10 billion a year, and, as you say, one has to allow for future demand. There is no going away from this: the costs of dealing with it properly are broadly equivalent to what Dominic Cummings put on the side of that bus. It is very substantial, but all of us got into politics because we believe that there should be a net and a ladder. In this case, people cannot find the ladder and there is a very big hole in the net. It is a net that has to be filled.

My Committee consisted of two former Chancellors of the Exchequer, three former permanent secretaries—one was a Treasury secretary—and a very distinguished economist. We were all able to take evidence and listen to the kind of testimony that you heard this morning, and conclude as we did. There is no ideology. There is an urgent need that is fundamental to all the principles on which the national health service and our society operate.

Q118 **Chair:** You said that you have not had a formal response from the Government to your report, but you have had the Chancellor in front of your Committee. What sense did you get as to the way the Government are thinking and whether they are receptive to the kinds of things you are proposing?

Lord Forsyth: I know, Chairman, that you did an enormous amount when you were responsible for these matters. You got an extra £20 billion for the health service. Many people do not realise that the entire local authority spending on social care is less than the £20 billion that you got. I know you also got a promise of more money.

I put to the Chancellor, when he was before my Committee a few weeks ago—I accept that he has a lot on his plate at the moment, but he was also spending quite big sums of money—that I had heard on the grapevine, and everyone I talked to tells me, that what has blocked it is not the Ministers responsible for delivering the services, but the Treasury that does not want to spend the money, and had he read our report? He replied, "My briefing tells me it could cost £15 billion." That just sums it up. He said there is no consensus about that.

I have now had a letter from the healthcare Minister, because I have been complaining about the lack of response to our report, saying, "Well, we need to get a cross-party consensus on this." That was one of the recommendations for the long term, but we do not need cross-party consensus for what is needed now in the short term, which is very substantial additional resource. I very much hope that your Committee will come to the same conclusions as us. It is certainly more than £10 billion.

Q119 **Chair:** There are a lot of members of the Committee who want to ask questions, Lord Forsyth. I have one slightly more personal question, if I may. You have always described yourself as a Thatcherite. That is normally associated with a belief in a small state, but obviously a recommendation for free personal care for the elderly is an expansion of the role of the state. Why are you making an exception in this case?

Lord Forsyth: What an odd question. I am quite convinced that if Margaret Thatcher had been on my Committee, she would have come to exactly the same conclusions. The evidence leads inexorably in that direction. I believe in the principles of the health service, which are that you should be able to get care according to need regardless of ability to pay. I do not understand how it can be right that someone with motor neurone disease is not treated in exactly the same way as someone with cancer. I understand why the Treasury would not want that to be the case, because it involves cost, but it is about whether you believe that for health it is necessary to have some kind of system that enables us to pool risk.

In the case of people who require long-term care, the risks are unknown. It could happen to any of us. We know that we are going to die. We know that we are going to get old, and we can insure for that. It is extremely difficult to find a system based on insurance or something else, and therefore we have to rely on the principles of the health service. The false distinction, and the hardship and stress it causes to families, is something I find intolerable.

Q120 **Paul Bristow:** We go from one Thatcherite Conservative to another. The headline recommendation from your report was free personal care. Would you outline the advantages in your mind of free personal care and then perhaps the disadvantages?

Lord Forsyth: The coalition Government took up the Dilnot proposals, which were to have a cap on what people would pay. By the time it had gone through the Treasury, the cap had gone up from £35,000 to £73,000 and was limited only to care services.

The effect of such a system would be to bias people, in terms of support, towards going into residential care instead of being cared for in their own home. When we looked at the evidence, and I commend the report to you if you have not had a chance to look at it, we came to the conclusion that the difference in cost between having free personal care—the basics like washing, cleaning, continence and feeding—as they have in Scotland, and the Dilnot proposals did not represent a very substantial increase in funding. It just meant that it was simple and was aligned with the principles of the health service.

There are problems if you have a capping system in trying to get insurance. The evidence we got from the insurance industry was that they did not think they could sell such a policy because people would not know whether they would have to draw on the policy or could opt out of the policy. You would end up thinking it had to be compulsory, and that is simply a tax, and the last thing we need are new taxes.

Q121 **Paul Bristow:** There have been some examples from Scotland where they offer free personal care and there is still a degree of confusion locally about what is free and what is not free; what will be paid for and what is going to be offered free of charge. Do you want to comment on that? Do you think that is a considerable risk, especially with the fragmented system that we have in England?

Lord Forsyth: I live in Scotland, and I am very familiar with the Scottish system. The Scottish Government claim that they have free personal care. Indeed they have, but, because they do not have the money, what is happening is exactly what is happening in England: it is not your need that determines the resource that is available to you; it is the resource available to the local authority. It is budgets that determine the need.

Therefore, people wait for a very long time for care, and there are arguments about their need for care. You heard from Pamela King, who said that there was an argument that her sister could be left for 12 hours on her own overnight. Those kinds of things apply. We have rationing because of lack of resource.

I did not think shopping, cleaning and things of that kind should be covered, but very basic services—help for people who are doubly incontinent, with the changing of beds, and help with feeding. All of those basic things should be provided free according to need. People should not have the complexity and worry that arises as they run out of money. They see their savings run down to the last £14,250, and even then they are asked to make a contribution. If they cannot afford to pay, "Couldn't you get some of your relatives to pay?" It is a most debilitating system and difficult to defend.

Q122 **Barbara Keeley:** I have a question about the cross-party consensus that you were told, Lord Forsyth, by the Care Minister that we need to have. You did a great job of building that consensus in your own Committee for the report. In terms of what has happened since then, the Labour party had a policy to introduce free personal care, and I understand that Conservative MPs like Jacob Rees-Mogg have been persuaded of the need for it. What do you think about the issue of cross-party consensus? How can we move forward to the point where we get it?

Lord Forsyth: I think it is there. I was astonished. Our report was universally welcomed in the House of Lords, and indeed in the House of Commons. We had lots of support. It is the only time in my life that I have actually had a favourable interview with *The Guardian*. For anyone who looks at it, the evidence leads inexorably to the conclusion. Frankly, the problem—people on your Committee will have experience of it—is that the Treasury does not want to commit itself to the resource.

Even on the more free market side of the Conservative party, people realise that it is not something that can be avoided. It is not something that can be done other than by meeting the costs out of the revenue from taxation.

Q123 **Dean Russell:** Lord Forsyth, thank you for your evidence. It has been interesting to hear about the Committee and the group that you got together. I was interested in your view about the barriers. You obviously have an incredible wealth of experience, going way back beyond 20 years, of people who would have been involved in decisions around the funding. Why do you think it is so difficult to get agreement? I wondered whether any exploration had been done of the cost savings, with regard to the impact on the NHS and on the economy more broadly, of helping people in that way around social care.

Lord Forsyth: I think you are absolutely right on the latter point. We have people sitting in beds in hospitals who could be looked after at home if we had a proper support system. There are savings. There are also savings in people's conditions not worsening, as you heard from some of your witnesses earlier. I absolutely agree with that.

There is legislation on the statute book to bring in Dilnot. When the present Secretary of State, Matt Hancock, came and gave evidence to us, he argued that the Dilnot proposals were unworkable because in assessing the cap it would be difficult to work out what people's costs could be.

I took the opportunity to talk to Andrew Dilnot while we were waiting to go online. He said that was just rewriting history, and we were very clear. All that legislation was subject to free legislative scrutiny. I am not against going down the Dilnot route, but that is not going to deal with the problem we have now. We suggested free care over a five-year period as a second stage. The important thing now is that a very large sum of money needs to be put into local government, ideally ring-fenced, in order to cope with social care.

It is difficult. It is a very expensive undertaking, but at the end of the day politics should be about reaching out to the most vulnerable people. One of the things that people forget, as was pointed out earlier, is that half the people requiring support from social care are of working age. They are not going to be able to operate an insurance scheme or something of that kind.

The most astonishing evidence that we got was from the Local Government Association, which did a survey of people's knowledge of social care. It discovered that an enormous number, the majority of people, did not actually know what social care was. One of the reasons, and the Covid outbreak has now highlighted it, is that most people's experience of the deficiencies in social care only arises when they have a very elderly relative or a very severely disabled youngster to look after, and they realise the pressures that are on them. It is a kind of hidden thing that is going on in our society, where people are being stretched to breaking point. I mean families and I mean care workers.

That is the other thing that came out very clearly. We take those people for granted. They are not treated as a profession, and they should be. They should be supported and given care. I know that Sarah Owen has had experience as a care worker and would be able to tell the Committee about that. Certainly for myself, it is only as a result of dealing with a mother-in-law, who died recently, who had dementia over a period of 10 years, that I have been able to see the pressures and the immense skills and dedication with which local authorities try to cope with trying to fit a pint into a half-pint pot.

Chair: That echoes what Deborah was telling us earlier.

Q124 **Dr Evans:** Thank you very much, Lord Forsyth. With all your experience and all you have seen across the sector, are you hopeful that we will solve the problem? If so, why or why not?

Lord Forsyth: I think it is down to you, Luke. You are a doctor. You know these things. You have experienced them day to day. You are in the House of Commons. I am in the House of Lords. As far as some people in No. 10 are concerned, the House of Lords should be sent to York and be seen and not heard. In the House of Commons, you have the votes. I believe that within all the major parties now there is consensus that the Government should find the money.

The Prime Minister has promised to do it. He promised it in the election campaign. He promised that he would fix social care. Fine. Let's fix it, and let's do it now.

Q125 **Rosie Cooper:** Lord Forsyth, you have essentially addressed in your remarks to Luke the comment I was going to make. In your answer to Barbara, you said there is great consensus about the social care problem, but, when political parties suggest solutions, the Opposition—whichever party it is—tears them apart. How can we get to a solution that is forged in the interests of patients, people and users and is not just protecting politicians in the run-up to elections? We surely need to take this decision now, as far away from a general election as possible.

Lord Forsyth: I couldn't agree more. Indeed, in our report, which of course was before the election, we said, "Whatever happens, don't raise this as an issue in the general election because people play games." We accused Labour of wanting to introduce a death tax. Labour accused us of wanting to introduce a dementia tax. Anyone who looks at the evidence will realise that it is a matter that needs to be dealt with.

People say, "Where is the money coming from?" Politics is about priorities. This year, I become of pensionable age, which means that I do not have to pay national insurance charges from my income. Why should that be? There is revenue there. There are other possibilities. When we are dealing with people under severe stress and with severe difficulties, I think it has to be made a priority.

Chair: Thank you very much indeed, Lord Forsyth, for your very powerful testimony. We have taken your entire report. We are going to look through it and treat it as evidence to us when we do our report, so that we do not try to reinvent the wheel. We are very grateful to you for giving us your time this morning, and for the wisdom of the experience you have gained having been in the process and thinking about it very hard.

Examination of witnesses

Witnesses: Yasuhisa Shiozaki and Sir Andrew Dilnot.

Q126 **Chair:** We now move to our final panel this morning. I give a very warm welcome to a former colleague of mine, Yasuhisa Shiozaki, who was Minister for Health and Welfare when I was Health Secretary. We did a lot of work together on patient safety and worked closely on a number of issues to do with global health security.

I was always very conscious of the fact that Japan had bitten the bullet ahead of us on social care. They have been debating the challenges of an ageing population for longer than we have, and they introduced major reforms in the year 2000. We are very grateful to have Mr Shiozaki, who was also Cabinet Secretary in Japan and is a very experienced Government Minister.

We also have Sir Andrew Dilnot, who has been hovering over today's proceedings like Banquo at the feast. His proposals have been much debated and, indeed, legislated on. We are very grateful to him.

Minister Shiozaki, thank you very much for joining us. We are extremely grateful. You have been grappling for much longer than the UK has with the challenges of an ageing population. Could you start by outlining the major changes that you have made in Japan since 2000?

Yasuhisa Shiozaki: Thank you very much, Jeremy, for inviting me to join your Committee meeting online. I am very happy to be here to talk about our elderly care insurance scheme in Japan.

We introduced it in 2000. I will start by explaining why we introduced it. The major reason for the introduction of long-term care in 2000 was increased demand for nursing services due to demographic and socioeconomic changes. The demography is, obviously, that people were starting to live longer. The second thing is that women started to join the labour market from the 1990s. By that time, many housewives who tried to work in the labour market were trapped in their home giving elderly care to their husband's parents. A phrase often used at the time was "elderly care, infernal hell," for women trapped in elderly care services in the home. We decided to introduce a public insurance scheme in 2000.

What changes have been brought about by the insurance scheme? There are three major points. The first is that it expanded the number and variety of nursing care services that should be affordable and accessible to all. As a result, the elderly and their families have a choice. They have a choice about whether they supply elderly care services by family members or by nursing care services coming from outside.

The second point is that it has mitigated the financial burden arising from out-of-pocket payments by each household. The third point is the reduction of hospitalisation without due clinical need. It propped up the cost of medical care and solved the problem of so-called social hospitalisation at the time. That is why we introduced it, and those are the changes that it brought about.

Q127 **Chair:** Thank you. As I understand it, you have a 10% cap on how much people have to pay. That means that the Government have a very big bill to pay because they pay 90% of the cost. How do you raise the money for that? Is the extra tax unpopular with the Japanese people, or is it accepted by the Japanese people?

Yasuhisa Shiozaki: You are right. Co-payment is usually 10%. The remaining costs are financed by tax and an insurance premium. The tax and the premium is divided 50-50. The national Government contributes 50% of it, while prefectures and municipalities—cities, villages and towns—pay a 25% share each. The amount of national expenditure in 2020 is about 2.7 trillion Japanese Yen, or £20 billion. Among various categories of tax we mainly allocate consumption tax, VAT, to maintain the long-term care insurance scheme.

We also issue deficit financing bonds to fill the gap, as our consumption tax revenues are less than 50% of social security costs. Regarding the insurance premium, in Japan all citizens over 40 must pay the premium. The premium rate differs by each municipality. It gradually increases. The current monthly premium among the senior population is approximately £40 to £50.

As to whether people accept the cost burden or not, nobody loves being taxed. We introduced consumption tax in 1989, starting at 3%. Now we have a 10% consumption tax rate. We have experienced a hike in consumption tax three times, and each time we had big political battles. Some Prime Ministers lost their seat as Prime Minister.

People are starting to recognise the importance of tax for financing the costs of social security. That is getting more and more recognition among taxpayers. The same is true for the insurance premium. When long-term insurance was introduced in 2000, the monthly premium among seniors was around £20 on average. Now it is about £40 to £50.

We started out with five price tiers in the premium in 2000, and we now have nine tiers according to income level. That is a fairly substantial burden for each individual. It is a reflection of wider usage that currently 5 million people use the services, which is about 14% of seniors, so I would say that the public insurance scheme for elderly care has now been accepted as indispensable social infrastructure.

Q128 **Chair:** We, too, have experiences of Prime Ministers losing elections on the social care issue. That is a similarity with Japan. It is interesting that there is no big popular movement to get rid of what is actually quite a big tax now on the over-40s. It varies with income, but it is around £40 to £50 a month. The reforms started in 2000, 20 years ago. As you look back on them now, have they stood the test of time? Are you happy that older people in Japan today are looked after with dignity and respect?

Yasuhisa Shiozaki: I would say that there are three pros and two cons. The first pro is that the family burden has decreased quite a bit. As I said, elderly care, the inferno type of burden, is no longer in each household. Secondly, suddenly a nursing care market was created. There is greater efficiency, and wider variety and flexibility of services now. Thirdly, as we change the fee schedule every three years, we can consider what the correct policy is to fit into the new fee schedule. It is adjustable nationwide, according to whatever changes are happening.

There are two cons, I would say. Financial sustainability is always a big challenge. The second is the labour shortage of care givers. I would not say that we would seek another system than the present one we have now. I think we are going in the right direction, but we always need maintenance according to the changes that are happening, and to keep price, quality and better access. With innovation, we should be able to keep maintaining the system to improve the quality of the services we supply through the public insurance scheme.

Q129 **Neale Hanvey:** Thank you for your contribution, Mr Shiozaki. You have just mentioned quality, which is what I wanted to explore. How do you monitor and measure quality to ensure that you have a consistent level of provision nationally? How is that provided? Who are the providers of that quality care?

Yasuhisa Shiozaki: As I said, the insurance scheme is run by each municipality. They have what we call care managers, who write up the care plan for each individual. Of course, we have standard services for elderly care nationally, but they are the ones who assess the condition of each individual person who needs care. They write up the right combination of services he or she needs. The Ministry of Health, Labour and Welfare is always looking into the quality of the plans and the services supplied nationally. We check nationally, and to start with, in municipalities, the check is run by local government at prefecture level. All of that is decided by the municipalities, including the premium they collect.

Q130 **Dr Davies:** Further to that, Minister Shiozaki, I wondered whether you feel that the setting of the cost of care nationally is a key determinant in providing quality—in other words, to ensure that there is always sufficient money to fund the services you are looking for.

Yasuhisa Shiozaki: The Ministry of Health, Labour and Welfare is always watching what kinds of services are increasing and decreasing. We also check the profitability of the care service providers. We can manage the whole cost and the quality by setting the correct price for each individual service to have the right budget for the next three years. As I said, we change the cost structure; the premium and service prices are changed every three years. It is for the Ministry of Health, Labour and Welfare to decide what kinds of services they should have in the coming three years.

Q131 **Dr Davies:** You mentioned future challenges. What makes you so certain that the demographic change that Japan is seeing, as many of us are, with an increasing elderly population, and even more so, will allow the current policy to continue into the future, including, for instance, increased tax on those of working age?

Yasuhisa Shiozaki: As I said, our demography is always changing towards a more ageing population. That really complicates the problems, as you can easily understand. At the same time, the change in the age structure, especially for younger generations, changes the whole cost structure for people over 40 paying the premium.

At the same time, we think about the cost of services. We go to innovation and using IT and robotics in order to make services more productive. Productivity improvement is always needed to have sound, healthy financial stability in the whole structure of the public insurance scheme.

Q132 **Taiwo Owatemi:** Minister Shiozaki, a similarity that Japan has with the UK is the workforce shortage in its care system. How is that affecting Japan's current care system, and how does it plan to address it in the long term?

Yasuhisa Shiozaki: For the past 10 years or so, we have started to introduce potential care givers from outside Japan. Since the supply of a new Japanese workforce is shrinking, with fewer babies, we must ask for labour from outside. We decided to introduce foreign labour, mainly from Asian countries. We are trying to increase it, but the number in our workforce from abroad is still limited. Our big headache is how to tackle that labour shortage. We will definitely increase the foreign labour force from abroad in the care giver market.

Q133 **Dr Evans:** Minister Shiozaki, how did you build political co-operation from parties on both sides? What tips could we learn in the UK about building political consensus to drive through change?

Yasuhisa Shiozaki: We had a long and extensive discussion about what to do about the ageing problem, especially the elderly care issue. It was at the time when Germany decided to introduce an insurance scheme type of elderly care plan. We looked into that, too. At that time, we had a coalition Government. Our party, the Liberal Democrat party, the biggest political party, had a three-way coalition with the Socialist party and the Progressive party. We had fairly extensive and long discussions to come up with the present scheme.

Now we are not in coalition with the Socialist party, but basically they support the insurance scheme. The number of services that should be provided is the main interest of opposition parties. The question of elderly care is not an unsolvable problem for us, but the cost burden and the number of services supplied is the main focus of discussion in Parliament.

Chair: Thank you very much, Minister Shiozaki. That is fascinating testimony, and we will use it in our report. We may leave out the bit about Prime Ministers in Japan losing their job because of the tax increases they had to introduce to pay for improvements to the social care system, but certainly what Japan has done is a very inspiring example. Thank you very much for your time; we really appreciate it.

Our final witness this morning, Sir Andrew Dilnot, needs no introduction to this Committee. Indeed, we were discussing his proposals earlier this morning. Thank you very much for joining us, Sir Andrew. Barbara Keeley has some questions for you.

Q134 **Barbara Keeley:** Sir Andrew, the first question is on why now. Given the focus on our care system after the severe stresses that the system has been through during the Covid-19 pandemic, what do you think are the most compelling reasons now for reforming the current funding system for care?

Sir Andrew Dilnot: We just don't spend enough money on care. We want to be a country where those who are most in need are looked after well. We have seen the tragedy of what has happened in the last few months that has affected people receiving care, both in care homes and in their own home. We want to be a society that looks after people.

Right now, the funding of social care is inadequate. It is inadequate for the means-tested system that simply looks after those who cannot look after themselves—we are not putting enough money into that—and that is a stain on us as a nation. We also have a social care funding system that does not help the rest of the population who have some resource to prepare and look after themselves well. It is not only that. We have a system staffed, almost without exception, by wonderful people doing great work but not adequately supported. The managers and investors who should be providing a great industry are also working in an industry where it is very difficult to be a provider of support.

In all kinds of ways, we have a system that does not work, does not look after the people who need it well, does not look after those who are providing the care well and does not provide an industry that is attractive to move into. Reform is due now. It has been due for many years, but now seems like a really appropriate time to act.

Q135 **Barbara Keeley:** Yes, I think we would all agree. An important part of what we look at today is options. Why do you think a cap on care costs is the best option? Should that go alongside bringing in free personal care, as we have just discussed with Lord Forsyth? In fact, do we need a package of reforms? Should there be other options? You talked about the pay and conditions for care staff. Should we also be looking at restoring eligibility for care packages to the 2009-10 levels?

Sir Andrew Dilnot: There is a variety of things we need to do. The first thing, and the most urgent priority, is to make sure that the means-tested system is adequately funded. A whole succession of Governments have put extra bits of money in, recognising that there was not enough, but we need to do more of that now. The overall level of funding of the means-tested system is lower now than it was in 2010-11 despite there being many more people using it. The first essential step is to put more money in for the means test.

I would argue that a second step is to reform the means test itself because, at the moment, there is a horrible cliff edge in the means test at £23,250. That causes a great sense of unfairness, and inefficiency, incentives to cheat and all kinds of problems.

The next question is, why should we do something for people other than those who do not have any resource of their own with which they can pay for care? Should we do something for the population as a whole? I would argue strongly that we should. We have, in most parts of the British welfare state, a sense of social insurance; we pool risks and we do things together. We see that in our healthcare system and in our social security system. That has a long and wonderful history. Way back in 1911, when he was introducing social insurance, Winston Churchill said that he thought social insurance brought the magic of averages to the rescue of millions. Not all of us will need a great deal of social care, but some of us will. We heard from Pamela about her sister. We heard Deborah talking about her husband, Atherton. We heard from Kevin, who has experienced something that is not likely but when it happens we want to help out.

Why a cap on care costs? The answer is that I think the people we should be most concerned about are those who have the worst luck and who end up with really high care needs. The best way of tackling that is to take away the catastrophic risk altogether and to say, "You live in a country where, if you are unlucky enough to have high care needs, after a certain period the state will just come in and take the burden of that away."

The best way of describing a cap on care costs is that it is like having social insurance with an excess. The excess is the amount you have to pay for yourself, and beyond the cap the state comes in. That is important because free personal care, which would also be a nice thing to have, covers the first part of the costs, but not a catastrophic need.

The Scottish free personal care system, effectively, covers the first £200 a week of your care costs. If your care costs are less than £200 a week, it means that all of your costs are being covered for basic needs. If your costs are more than £200 a week—say, the £712 a week that Pamela was paying in the care home for her sister, or the £1,000 a week that is needed for Atherton's care costs—free personal care does not help you very much. It pays for the first slice, but it still leaves you exposed to the much higher costs. I think a cap is the most efficient way of spending money to help the people who are in the greatest need. It takes away the fear that otherwise people face.

Q136 **Barbara Keeley:** There is a question about the level of the cap. Although the Government accepted the principle of a cap—we do not have it yet, but the principle was accepted—which I think you set at £35,000, the Government did not go ahead with that. That was not the level they were recommending. Could you explain the differences, and who would benefit at certain levels of the cap? What would you recommend today as the right level to set the cap?

Sir Andrew Dilnot: When we reported in July 2011, nine years ago, we said we thought the cap should be set somewhere between £25,000 a year and £50,000 a year in 2010-11 prices. We picked £35,000 as the level we thought it should be set at. In current prices, that would be in the mid-40s, so a cap of about £45,000.

The reason we argued for that is that we felt that, if it went much higher, for those with lower wealth it did not seem to be providing very generous support or cover. If you went much below that, you would be paying money to a much larger group of the population. If there is a budget constraint, that gets much more expensive. We thought it should be at a level that in current prices would be about £45,000.

The legislation that was passed in 2014, and was due to be implemented in 2016, would have set the cap at a level of £72,000. That is significantly less generous. My feeling about that was that while I welcomed the introduction of a cap, because at least you are taking away the really catastrophic risk, it was at a level that was less generous than would be much better. I would like to see the cap much lower. If I were Chancellor of the Exchequer or Prime Minister today, I would be saying that the recommendation we made in 2011 would, in current prices, be £45,000 roughly, so let's set the cap at that level. That way, you are giving real assurance to most people who are not covered by the means-tested system that they are not going to lose everything. You are taking the fear away. A cap much higher than that does not work so well.

Q137 **Barbara Keeley:** One criticism about the cap model is that it would be complicated and perhaps leave people paying unexpected bills. How did you envisage—this is quite some time ago now—local authorities keeping track of what self-funders spent on their eligible care services over a period that is often several years? If we are back to looking at a care model, we have to take on board that they have those issues.

Sir Andrew Dilnot: Yes. There has been some confusion, and I take responsibility for perhaps not explaining as clearly as we should have done what was needed.

There is no need to monitor what people actually spend. The cap is not a cap on what people actually spend. It is a cap of accumulated need. Imagine that 20 years from now I go along to be assessed and an old sporting injury means that I need help getting out of bed in the morning, being given lunch and then getting to bed in the evening. The local authority assesses me and says, "Well, yes, you need that support. It would cost us £1,000 a week to provide that care for you." Let's say there is a cap in place that at the moment is £45,000. All they say is, "I'm afraid you have failed a means test, so you are on your own for now until you hit the cap. It would cost us £1,000 a week to provide your care. Come back in 45 weeks." They do not have to monitor what I spend or do not spend. All they are saying is, "Until your accumulated need is at the level of the cap, you are on your own. Once you have got to that point, we will take over."

There is an initial assessment required. That assessment has to work out what the local authority would spend if they took responsibility immediately. Then you simply work out how many weeks it would be at that level of spending until you hit the cap. Once you have got to that point, the local authority takes on the financial responsibility. Of course, if the severity of need increases during that time, there could be a reassessment and that would bring forward the point at which the cap would come into play. There is no need to monitor what is actually spent by anybody. All you are monitoring is accumulated need as assessed by the type of assessment that has to take place already.

Q138 **Barbara Keeley:** It is worth saying that people would still end up paying hotel costs after they had hit the cap on care costs. In your commission, did you do work on modelling how much that would be, and could you give us an idea of how much it would translate into these days?

Sir Andrew Dilnot: Yes. It is important to be clear about that. People would still be expected to pay their basic living costs. There are two reasons for that. One, of course, is that with a Treasury hat on you always want to save money. Another important reason is that if you are receiving care in your own home then, of course, you pay your own housing costs and food costs. If you did not pay housing costs and food costs in residential care, there could be an incentive to move into residential care and out of care in people's own home. There is increasing evidence that, by and large, where it is feasible, it is better for people to be looked after in their own home.

I would suggest being more generous than we were at the time of our initial report in 2011. We thought in 2011 that there should be a fixed level of hotel costs of £10,000 a year. The risk is that some people would have needed to pay some money beyond their pension entitlement to achieve that. If I were introducing the system now, I would be inclined to set a fixed hotel charge at the level of the basic state pension, about £8,000 a year. We can be confident that everybody will have that amount of money that they can pay out of their income. That would make the system clearer and it would feel a bit fairer.

Barbara Keeley: Thank you. That is all really helpful.

Q139 **Chair:** Lord Forsyth said earlier that one of the disadvantages with your proposals is that they can create an incentive for people to want to opt for residential care rather than being cared for at home. Is that fair?

Sir Andrew Dilnot: I don't think so. The way the system would work is that you are assessed, and the local authority decides what it would need to spend if you were looking after your own care. You hit the cap when you have accumulated a certain amount of care. Whether you are in residential care or domiciliary care, if you are making that choice yourself, has no impact on the speed at which you move towards the cap. You move towards the cap at whatever rate the local authority says it would spend on you if it had responsibility for you, so there should be no impact on that choice.

Q140 **Chair:** There is what is now called the Dilnot route, and there is the free personal care route. I do not want to put words into your mouth, but I think what you are saying is that free personal care is a very worthy thing to do, but if resources are constrained, the most socially equitable thing is a cap so that you help the people with the most catastrophic costs. Is that a fair reflection of your view?

Sir Andrew Dilnot: I think that is exactly right. I would be very happy if the Treasury would come up with money for free personal care too. The analogy I draw is that if we imagine that the health service was entirely means-tested, as the social care system is now, free personal care would be a bit like saying, "Let's move to making GP services free." That would be a good thing to do, but it would still leave somebody who contracted a serious cancer or a chronic disease very exposed to the much more catastrophic costs of a catastrophic illness.

In social care, free personal care would help everybody who had social care needs, but the people it would help the most would be the people with low needs, all of whose costs would be met, whereas somebody like Atherton, or Pamela's sister Diana, would still be left exposed to very substantial costs. It seems to me that, when we introduce a social insurance system, the people we want to help most are the people who face the highest needs and the greatest category of problems.

Q141 **Chair:** Lots of colleagues want to ask you questions, Sir Andrew, but I want to ask a final question about costs. The Health Foundation came to our Committee. It said that if you just look at demographic costs and the planned increases in the national living wage, with a little supplement to allow for the shortages in the labour market, that alone is an extra £4 billion by the last year of the Parliament. The total budget goes up by £4 billion a year. How much would your proposals cost on top of that £4 billion?

Sir Andrew Dilnot: On top of that, in steady state—I will use Health Foundation numbers so that we have comparable numbers—if you set the cap at the mid-40 thousands, which would correspond to the £35,000 that we set in 2010-11, the Health Foundation thinks it would add an extra £3.1 billion a year. That is the cap and also the reform of the means test that we suggested, which would take the upper capital limit down, from £23,250 where it is now, to £120,000 to make that means-tested system fairer. With both of those reforms, on top of demographic change, there is an extra £3.1 billion a year if we set the cap at £46,000.

Chair: Thank you. A number of people want to come in. First, Rosie Cooper.

Sir Andrew Dilnot: I can't hear Rosie.

Chair: I can't hear Rosie either, so we will move on. If we get Rosie back, we will come back to her.

Q142 **Dean Russell:** I have two or three very brief questions. I am conscious of everyone's time. First, with regard to your report, Sir Andrew, obviously it was a fair few years ago and it has been in discussion over that time repeatedly. I am interested to know if you had any thoughts on what you might add that is different now, that you have learned over the past few years, and would update the report.

The second question is from a productivity and economic perspective. If the measures were put into place, how much do you think that would save the economy in terms of people being able to work or not having to sell their house and therefore being able to accrue interest, wealth and so on?

The third question is about efficiencies. One of the issues we have repeatedly talked about in these Committees is the inefficiency between the NHS and social care with regard to patient pathways and single customer views, or patient views. Has that been looked into, especially with the rise of technology that has happened quite dramatically over the past 10 years?

Sir Andrew Dilnot: What would I add? I have already mentioned it in response to a question from Barbara Keeley. I think I would want the hotel accommodation costs, the fixed costs, to be slightly lower than we said at the time of our commission. Setting it at the level of the current basic state pension would give people assurance that they would be able to pay those costs.

The second thing I would add is that at the time of the commission we did not emphasise enough how difficult it is to be a provider in that market. That is intimately related to the funding model. At the moment, the funding model means that if you have to buy social care, as Pamela, Kevin and Deborah all do, it is a bit like being in a shop with no prices. Although you know how much the price is per week or per month, you have no idea how long it will carry on, so you do not know what the overall cost will be. That makes it very difficult as a provider to invest and innovate.

Forgive me for being an economist for a moment. Instead of there being a nice downward sloping demand curve, there is, effectively, a flat demand curve at whatever the cost of the minimum level of provision will be. That makes it very hard to innovate or invest. I would emphasise that the funding model not only creates fear, unfairness and anxiety for individual consumers, but also makes it a very difficult market in which to be a provider and contributes to the low and very consistent level of wages.

On productivity and efficiency and how much we could save the economy, it is very hard to know the answers. The answer is certainly something positive. One of the consequences is that if we had the kind of model that I have described, or that Lord Forsyth has described, I hope that people would spend more of their own money. Rather than holding on to their wealth just in case they are one of the unlucky ones, they would know that they would be covered if they were one of the unlucky ones. I very much hope not that that would protect people’s inheritances but that they would spend their inheritance on themselves rather than giving it to their children because they would not have the anxiety that they might need it for care.

The boundaries between the NHS and social care are certainly problematic. We have seen that again in the last few months. We hear a lot of discussion about delayed transfers of care. It is certainly the case that delayed transfers of care are inefficient for the system. They increase costs in the NHS, but they are also inefficient for the potential care recipient. By and large, you can have a much better quality of life and much better care, if it is social care that you need, outside the health service than in a hospital. Improving things there will certainly help the NHS as well as helping individual consumers.

Dean Russell: Thank you.

Q143 **Dr Evans:** To pick up on Dean's point and the Chair's point, and you have hinted at it, there have been 10 years to put a cap in place. I would be interested to know if you think this is just a temporary solution. Once it was in place, and as you have had almost 10 years to think about what would be the next step, is it the stepping stone for something else? What would it look like in the future, providing that tomorrow the Government said, "Yes, we will put a cap in place"? Where do we go next?

Sir Andrew Dilnot: In terms of the funding model, I think a cap and the reformed means-tested system, and more money in the means-tested system, would be a stable funding system. What was very encouraging to hear from the Japanese Minister was that, with a stable funding system in place, there is a great deal of increased variety and flexibility from the providers. One of the things that we could turn our attention to once we had a stable funding system in place would be encouraging and supporting providers in being innovative.

The UK is a wonderfully innovative society and economy. We see a great deal of innovation in the medical sector. We have seen rather too little innovation and investment in social care. My great hope and expectation, once we have a stable funding regime in place, is that we would see providers coming to the market and providing new sorts of care. It is hard for us to imagine, but I think they would rely much more on various forms of telecare and technology that could assess people.

I also hope that we would see intervention from the private sector financial service industry, who would come in to provide mainly top-ups to the state system. Once we had the financial services sector involved, they would have a very strong incentive to keep us all fit and well and to reduce demand for social care. Yes, I think the kind of model I have described will be stable from a funding model perspective. Then what we hope to see would be innovation in developments in care.

Q144 **Dr Evans:** Leading on from that, one of the successes you could argue for the previous Government was auto-enrolment for pensions. Do you see a similar scheme working on top of what you have suggested as a stepping stone? What advantages and disadvantages would there be, given your experience?

Sir Andrew Dilnot: Auto-enrolment in pensions has indeed been a great success in increasing saving in pensions. What I would be interested in is thinking about using people's pension pots as a way of topping up their social care provision, if they would like provision that is more expensive than what the state would provide.

Forgive me for some horrible acronyms, but there is a thing called the disability linked annuity, where your pension provider could say to you, "You could have a pension from your pension pot of, say, £10,000 a year, or you could have £9,000 a year, but it would treble to £27,000 a year if you fail three activities of daily living." It would be using the pension pot not just to provide a flat income throughout retirement, but possibly to provide a higher income if your needs increase. Those kinds of products could be quite cheap because of the way the risks relate to one another.

Q145 **Sarah Owen:** I have a couple of questions on the care workforce. There are over 100,000 vacancies and there is very high turnover of staff. Do you think we can address the shortage of carers if the Government stick with their current policy on care workers not qualifying for health visas post Brexit?

Sir Andrew Dilnot: It is an enormous challenge. One of the things about the social care sector is that it is often invisible. We do not realise that we have roughly the same number of people working in social care as we have in the NHS. There are huge numbers of wonderful and dedicated people, many of them very long-standing residents of the UK, but many of them newer residents of the UK, doing a fabulous job.

There is potentially an enormous challenge. We are going to need more people. We have more funding, and I hope we will have more people drawn in. I could not claim to be expert on how it has worked in the last two or three years, but I would certainly be anxious that we could end up with constraints in that area. It is something we will have to look at very carefully over the next few years.

Q146 **Sarah Owen:** It is not just the recent announcement around health visas that has been an issue when it comes to care work. We have low pay and poorer terms and conditions than those of NHS or other healthcare staff. We had delays in the correct protection of care workers during the pandemic.

Lord Forsyth said, rightly so, that it is a question of priorities. How do we get policymakers and Government to raise the status of care work and see it as a priority, when there are so many other competing priorities as well?

Sir Andrew Dilnot: I wholeheartedly agree. Something I have often said when talking about it is that we hear a great deal about the burden of ageing, but actually we should be celebrating the extraordinary triumph that people are living longer lives. We should be very clear that quality of life is not necessarily low when you need social care. People can make great contributions while needing social care and can have quite high quality of life—not in all circumstances, but in many—while receiving social care. We should be celebrating that. We should be looking at it and talking about it more. There is no doubt; we need a change in society's attitudes towards old age, towards the experience of disability and towards those who are caring for those who are old and need support because of their disabilities.

It is not something that just Government can do. We all have to be a part of celebrating ageing and caring. At the moment, there is a tendency to look away from it, and that has been true of successive Governments of all political persuasions, partly because we have not had a system of which we could be proud. I hope that if we make some reforms that make the system better, rather than thinking of it as something that we do not want to pay attention to, we can all start paying attention to it and celebrating not just the people who are being looked after but the great work of the people who are doing the looking after. Maybe one of the silver linings of the cloud of the last four months could be greater awareness and acceptance of the fantastic job that is done, of course by the NHS but also by this other bit of our caring structures.

Q147 **Barbara Keeley:** Deborah gave us very compelling evidence earlier. She urged us not to make family members sell their homes to pay for care. I have heard that from other spouses since 2017, because then there was a social care policy proposal from the Conservative party to take the family home into the means test. I have had people since then who have been terrified that it is still somehow being thought about and is on the books.

The current guidance is that you do not count the home if the person's spouse is still living there, regardless of age. I believe that was the recommendation of your review as well. Could you confirm that, because I think it is probably important to people like Deborah?

Sir Andrew Dilnot: Absolutely. If any family member is still living in the home, it seems very difficult to take the value of the home into the means test, in particular as the means test stands now, without a cap in place. In our initial report, we made the same point.

Q148 **Chair:** Sir Andrew, there is a question from Deborah Gray whom we heard we heard from earlier. She wants me to ask you if the charge for general living costs is included in the cap, or does it run alongside it?

Sir Andrew Dilnot: No. The cap would be a cap on care costs and not living costs. When we made our initial report in 2011, we suggested that the charge for general living costs should be £10,000 a year. As I said in response to one of the Members, my view now would be that I would set the charge for general living costs at a fixed level of the state pension, about £8,000 a year. The cap would not cover that £8,000 a year, which of course you would be paying if you were being cared for in your own home; you would be charged that if living in residential care.

Q149 **Chair:** Thank you. It has been a fascinating session. I have one final question. You have been championing this for nearly a decade now. I do not know when you started your report. You reported in 2011, so you have probably been doing it for over a decade when you take account of the time you took to write the original report. What has persuaded you to keep at it? There must have been a lot of times when you wanted to throw your hands in the air and give up. What has motivated you to keep going?

Sir Andrew Dilnot: It is really important. You could multiply the stories we heard from Pamela, Deborah and Kevin thousands and hundreds of thousands of times. There is so much about the way we do things together in the UK that we celebrate, such as our schooling system, our health system and our transport system. There is so much that is good. This is one bit of our welfare provision that has not been brought in.

In 1948, when the rest of the welfare state was created, it was a very small issue. It is now a huge issue. There is political consensus to be achieved. There is good will. We just need to get it across the line. I am absolutely persuaded that the ideas we had back in 2010-11 framed the problem in a way that we can resolve it. We just need to do it.

We need to look to the Prime Minister, to the Treasury, to all parties in Government and to our wider society and say, "This is a really important challenge for us. There is an opportunity to do something really good that can help people who are receiving care and those who love them to have a much better life than they have at the moment, and to make the economy work more efficiently, so let's just do it."

Chair: Thank you very much indeed for your fascinating evidence. That brings our session this morning to a conclusion.

Thank you, Sir Andrew, for your evidence. I thank former Japanese Health Minister Shiozaki for joining us from Japan and Lord Forsyth for joining us from Scotland. I particularly thank the members of the public who joined us to tell us about their experiences of the social care system. Pamela King talked about her sister Diana. We heard from Kevin Caulfield and from Deborah Gray, who talked about her husband Atherton. It has made our session much more real and worth while to have you coming before us. I know that it can be a daunting thing to come before a House of Commons Committee, so thank you very much for joining us. Thank you too to the House of Commons and Select Committee technical teams. That concludes this morning's session.