HOUSE OF COMMONS

Health and Social Care Committee

Housing, Communities and Local Government Committee

Oral evidence: Long term funding of adult social care, HC 768

Monday 26 March 2018

Watch the meeting

Ordered by the House of Commons to be published on 26 March 2018.

Members present:

Health Committee: Dr Sarah Wollaston (Chair); Rosie Cooper; Andrew Selous; Dr Paul Williams.

Housing, Communities and Local Government Committee: Mike Amesbury; Bob Blackman; Helen Hayes; Kevin Hollinrake; Andrew Lewer; Jo Platt; Mr Mark Prisk; Liz Twist; Matt Western.

Questions 1 - 61

Witnesses

I: Caroline Abrahams, Charity Director, Age UK; Dominic Carter, Senior Policy Manager, Alzheimer's Society; Neil Heslop, Chief Executive, Leonard Cheshire Disability; and Anna Bird, Executive Director of Policy and Research, Scope.

II: Simon Bottery, Senior Fellow in Social Care, King's Fund; Nick Davies, Associate Director, Institute for Government; Sir Andrew Dilnot, Chairman of 2011 Commission on the Funding of Care and Support; Professor Martin Knapp, Director of Personal Social Services Research Unit, London School of Economics.

Examination of witnesses

Witnesses: Caroline Abrahams, Dominic Carter, Neil Heslop and Anna Bird.

Q1 **Chair:** Good afternoon and thank you for coming to the first session of the joint Select Committee inquiry—the Housing, Communities and Local Government and the Health and Social Care Committees—into social care funding. For those following from outside the room, will you start by introducing yourselves and who you are representing today, starting with Neil Heslop?

Neil Heslop: Thank you. I am Neil Heslop, chief executive of Leonard Cheshire Disability.

Dominic Carter: Good afternoon, everybody. I am Dominic Carter from the Alzheimer's Society.

Caroline Abrahams: Hello. I am Caroline Abrahams, charity director of Age UK. I am also co-chair of the Care and Support Alliance, but I am here representing Age UK. I ought to add that I am one of the so-called expert advisers who has been appointed to support the work of the Green Paper.

Anna Bird: I am Anna Bird. I am executive director of policy and research at Scope.

Chair: Great. Jo Platt is going to open the questioning today.

Q2 **Jo Platt:** This is about the current and future challenges. Will you each briefly summarise the challenges faced by the social care system?

Neil Heslop: The challenges are falling funding, with £6 billion taken out of the system over the last seven years; increased costs across the system of more than £1 billion, predominantly driven by the national living wage, but not exclusively; increasing demand, albeit that now some 400,000 fewer people are in receipt of social care than was the case some seven or eight years ago; a changing supply environment under significant pressure, not least because of skill shortages, especially with regard to nursing; and, in common with other aspects of the economy, the uncertainty associated with Brexit in elements of the workforce. It is all of that combined with a somewhat disjointed and un-joined-up approach from Government across related policy areas.

Dominic Carter: We look at it in terms of a system that is both unfair and inefficient. People with dementia often face a triple challenge around access to care services. Hundreds of thousands of people with dementia are not able to receive good-quality care, partially because of strict eligibility criteria, strict financial thresholds and cherry-picking from providers. This means that people with dementia often do not get the services they need.

That then has an impact on what people pay for care—people often have to pay an additional sum. We are seeing lots of people spending up to £100,000 or £500,000 on the care they need to live well. Often when they can access that care, it is the sort of care that is not good enough—poor-quality care. People with dementia often receive a lower quality of care than the general average, CQC services rating more providers for dementia care as failing than for general support.

There is a growing prevalence of the number of people with complex conditions. Seven in 10 people with dementia are living with a comorbidity. As the population ages, the complexity increases. How do we create a system that supports that and ensures that the care provider market is sustainable and able to take on those challenges in an environment with falling funding, with core budgets that have not changed since 2010? How do we provide support for people who have more complex needs and, in terms of the responsibility that is falling upon them, for family carers and their own health? There are about 700,000 family carers across the UK providing 1.6 billion hours of care and support every year. On the one hand it is great that there is such a tight-knit support network, but on the other hand three in five family carers tell us that their own care is failing because of that. So, how do we ensure that family carers are able to provide support but that it is not all on them?

Caroline Abrahams: I will try not to repeat what my colleagues have already said. Long-term chronic underfunding probably lies at the root of many of the problems that the care system has now, but, unfortunately, that has gone on for such a long time that all sorts of other issues have arisen as a result. The biggest problem is the growing gap between the demand and the supply for social care. That is from older people, but it is also, of course, from disabled people and from people who have mental health problems.

If you talk to older people about what worries them and their families, first, it is very expensive to buy care: £25 per hour for domiciliary care—care in your own home—outside London is not unusual, and it soon adds up. The quality is extremely patchy. There are some great carers out there who do their best, but people complain about lack of continuity, never seeing the same person twice, people with rushed visits—maybe quarter of an hour rushing in and out—with no time to establish a proper relationship, let alone real communication.

As Dominic said, there is not enough support for family carers, many of whom do the right thing and put their interests second but who get very little support. A lot of the support has been cut, we hear, particularly around respite care, and there are very big financial challenges for people who give up work in order to care. That is partly because there are enormous workforce challenges within social care. We know that it is very difficult in some areas to recruit and retain staff. The terms and conditions are roughly comparable with those in retail or hospitality.

Some people have suggested that the introduction of the national living wage has levelled up those three areas so that there is no particular incentive to go into care unless you happen to be very highly motivated. It is easier to earn money stacking shelves, essentially.

In addition, other issues that probably are worth mentioning are the risk, which lots of older people worry about, of incurring catastrophic long-term care costs if they develop a condition that means they need care for a long time. At the moment there is no real way of protecting yourself against that.

Finally, there is, on the whole, rather poor integration with health when it comes to how services actually work. Most older people need care because they are not very well, their health is declining, and, as Dominic said, they may have multiple long-term conditions, so getting things properly joined up makes a real difference.

Anna Bird: I would not disagree with anything that anyone has said but would add from our perspective that for disabled people the care system is there to be the bedrock of support that allows them to be independent, to participate in family life, to contribute to the community, to work and to volunteer—all those things. We see as a result of funding pressures that fewer people are getting care, but those people who are receiving care are people with more complex needs, but they are not receiving the same quantity of care. That means that their support is being restricted to the basics of personal care and it is not allowing the care system to provide what it really should be there to do, which is to promote independence, to allow people to get out and participate in their communities. That is a big problem for disabled people. It also has an impact on our wider systems of support.

Q3 **Jo Platt:** Neil, you spoke of the impact from other services. What do you see as having the greatest impact on the social care system as another public service?

Neil Heslop: The division between health and social care is an obvious one. To build on some of the points that Anna made, if you are an 18-year-old who is looking at a lifespan of 60 or 70 years and maximising your potential in terms of how you live, learn and work and the place of social care relative to the rest of your life—be it transport, the movement into learning or volunteering opportunities on that journey towards independence and, ultimately, work—there are some real systemic disjunctures that militate against individuals achieving their potential.

Q4 **Chair:** Thank you for setting the scene. May I now turn in more detail to the funding challenge and, starting with you, Anna Bird, ask how the funding challenges differ between social care for older adults and for working-age adults?

Anna Bird: The funding challenge is the same funding challenge. We are looking at a social care system that is underfunded, and it impacts both

on older people and working-age disabled adults. We are clear that for disabled people of working age the outcomes of care might sometimes be different, but the funding challenge is the same. We are seeing a squeeze on providers as a result of all the things we have talked about—the apprenticeship levy, the living wage, pension contributions and all that. That is having an impact on providers. It is difficult to provide the same quality of care, the same outcomes for people, but the outcomes for disabled people might be slightly different as disabled people might want to go out, contribute and work. The impact might be felt elsewhere in their lives or in the wider system.

Q5 **Chair:** Thank you. Caroline, do you want to add anything?

Caroline Abrahams: I agree. The funding challenge is the same whoever you are. Where sometimes people get into a different conversation is about the different assets and incomes that older and younger people might have access to and, therefore, whether that suggests that there could be different ways of funding. If people were being asked to contribute more, for example, different people would be in different positions to be able to do so—obviously, very few younger people have housing wealth, for example, but it is more that way round, I think. In terms of the funding challenge, it is very similar.

Q6 **Chair:** Dominic and Neil, do you want to add to those points?

Dominic Carter: I agree with everything my colleagues here have said but would add that it underlines the importance for us of modelling and understanding how things will change over the next few decades and appreciating that not many of these working-age adults will be older people, and what that means for future provision and future systems. When we talk about things at the Alzheimer's Society, it is around the fact that by 2021 we expect there to be 1 million people with the condition and understanding those future trends.

Neil Heslop: All I would add is that, as well as the longevity, individuals at different stages in life have different expectations for what their next 20, 30 or 40 years hold. For younger people living with disability, the implications can mean greater complexity and, therefore, greater cost associated with that complexity, but the core issue—access to funding fundamentally inhibiting one's ability to live as one wants—is the same.

Q7 **Chair:** Controversially, social care for younger adults has been excluded from the Green Paper. Do you feel it should have been included, Neil, and, if so, why?

Neil Heslop: Yes. For organisations such as ours, whose interest is predominantly for younger disabled people, there has over many years been a continual frustration in the great debate of social care about the needs of what is, numerically, the smaller proportion of the population requiring support but financially representing 50%, or, if you look at the longer-term projections, even more than the total issue. The Government's decision to create a twin track fleetingly made us wonder

whether perhaps disability was going to get the specific attention we felt it merited. In the light of what has happened since, there is real concern that splitting them risks not delivering an outcome for both communities appropriately. We absolutely think it should be one integrated approach.

Q8 **Chair:** Thank you. Anna, do you feel the same or differently?

Anna Bird: I agree. The care that is provided to disabled people of working age makes up about 48% of the budget. The funding challenge applies to disabled people just as much as it does to older people. It needs to be looked at in the round. Any sustainable funding solution needs to provide a system that works for all people who need care and support. It needs not to create cliff edges and inadvertently create problems for one group or the other. It is unhelpful to separate by age group the questions that arise.

As I have said a few times, there is a question about how the system of care and support can deliver the outcomes that working-age disabled adults need. We think there is an opportunity for the parallel process to look at how you can create a care and support system that enables disabled people to live independent lives.

As for funding, I do not see how you can separate the challenge by constituency or age group.

Q9 **Chair:** Thank you. Does Dominic or Caroline want to add to that?

Caroline Abrahams: I am very happy to do so. When we heard there was going to be a social care Green Paper but that it was just going to be focused essentially on older people, it was a surprise, I have to say. We would have been completely relaxed about it covering everybody—it would have made more sense to us. The Care and Support Alliance, which I chair, stands for decent care for everybody who needs it, whether they are a younger person, an older person, and indeed support for carers. From that point of view too—and most of us, I think, in the sector are members of the CSA—that has been very much our stance. It would be really unfortunate if in some way people in the disability sector felt that their issues were in some sense second order, because they are not and they do not deserve to be either. We are all in it together, essentially.

Dominic Carter: We welcomed the seven principles laid out by the Secretary of State last week. The things that are in there are just as relevant across the board for people of working age and older adults. In order to get to that point, in order to change the system as much as we want and is needed, it has to look at both sides.

Chair: Thank you. We are going to explore in more detail how the extra funding should be raised and I turn now to Mark Prisk.

Q10 **Mr Prisk:** Thank you very much for that. At the heart of this debate is who pays. In your personal views, what proportion of the money for

social care should come from the Government and what should come from individuals? Perhaps I may start with Caroline.

Caroline Abrahams: Thank you very much.

Mr Prisk: It can be on a zero to 100 scale.

Caroline Abrahams: Absolutely. We talked to older people in the system very recently and on Wednesday we are launching a report that sets out the findings. To give you a sneak preview—and I tried to do that a bit in our written evidence—the view of older people, essentially, was that many of them are already paying quite a lot. If you are in the state-funded system, that sounds great—it sounds as though all your costs are already being paid—but in practice very often families, or the older person, are topping up that amount because it is not enough to buy a good care home place somewhere in your area. Top-ups are quite common among people in the state-funded system. That is the first point.

Secondly, as the means test has got tighter and less generous and the state-funded system has retracted over time, more people have become self-funders, paying all or most of their own care fees, whether that is at home or indeed in a care home. As I have already explained, that £25 an hour soon adds up. Those sums are quite significant.

The first thing is that older people are already paying quite a lot. When we talked to older people in the system and their families about whether they would be prepared to pay more, they said, yes, they might be prepared to pay more—they did not reject it out of hand—as long as it was affordable and if what they got back in return was worth while. In particular, they wanted to make clear that for them that meant a service that was qualitatively better than what they receive now, where people turn up, it was not someone different every time, they were not just rushing in and out, and they had time to make a proper relationship with them.

Most people accept that everybody has to contribute. A lot of people were very keen to say that social care is there as a system for everybody, so, while they might be prepared to pay some more, they thought everybody should pay into the system in some way, just as they felt they did for the NHS. It is something that we all share in common because, who knows, one of you might fall down the stairs—I hope you do not—going out of the building and suffer a serious brain injury and then have a need for social care. We never know, any of us, when that is going to happen.

Q11 **Mr Prisk:** You are saying that the current system does involve individuals and you recognise and your members feel that that system would continue.

Caroline Abrahams: Yes. I think people are happy to say that they put in some money but the Government should as well. There was something like 98% approval overall in our focus groups that the Government

should be putting more in, but, of course, then we get into the nitty-gritty question of where the money comes from.

Q12 **Mr Prisk:** Of course. Neil, Leonard Cheshire is a different group, in some senses, but is the view that Caroline just expressed—that individuals should continue to contribute—shared?

Neil Heslop: Both communities get very similar feedback if something is fair, sustainable and good quality. The challenge becomes that, by definition, the individuals who are looking through the lens of that question are at different stages of life and have had different life experiences. For somebody who perhaps has had a full career and has built up personal wealth and assets, particularly in housing, the view looks very different from someone in their mid-20s without employment, perhaps living with poverty. Both communities answered the core question very similarly, but what they mean by an appropriate balance between individual contribution and the state is radically and dramatically different. At its heart, in order properly to square that circle, this whole principle about some element, to whatever degree, of pooling of risk is at the heart of the discussion.

Q13 **Mr Prisk:** Anna, is that your take on the situation, particularly the point Neil has just raised about the different perspectives of different age groups?

Anna Bird: Yes, absolutely. We know from research we have done into the extra cost that disabled people face that, on average, over their lifetime disabled people are likely to acquire £108,000 less in assets and wealth. We know some disabled people will be less able to contribute to their own care costs over the course of their lives. The Dilnot proposal included a zero cap for those who acquired an impairment under the age of 40 to recognise the fact that younger disabled people are not in a position where they are able to acquire that wealth and contribute in the same way. We think that is a helpful starting point, but I agree.

Q14 **Mr Prisk:** Dominic, does that reflect your view—that individuals should contribute but that there should be a distinction between people at different stages in their lives?

Dominic Carter: Yes, I think so. The challenge is the balance of responsibility, which we believe at the moment is off. You mentioned the scale of zero to 100. We talk about the typical cost of dementia care being about £100,000. At the moment, too often people end up paying all of that, if not more. We need to move to a point where the balance of responsibility is clearer, is more obvious to people, but is also fairer between the individual and the state. We estimate that the costs of dementia are about £26 billion per year, of which two thirds are shouldered by the individuals affected, whether that is through family support or individuals purchasing social care.

Caroline mentioned the number of people paying top-ups. We find that people with dementia often face additional costs—that care for somebody

with dementia, possibly just for having a diagnosis, has an additional price than potentially the same care for somebody without the condition. This means that they have intense support needs, rack up costs very quickly and face spending a lot of their assets.

A lot of people who face these care needs are quite asset rich and cash poor. We did some public polling and found that less than a third of people felt that the Government should be fully responsible for paying for everything, for support, and a high percentage agreed that there should be some form of balance between the two. At the moment that is some way off being the reality, and a clear conversation with the public to help the initial understanding around the fact that care does actually cost in the first place is a key start—that there is a bit of an agreement between Government, society, state and individuals that care is there. The challenges we see are the people who are put off accessing care, because of the costs associated and the challenges around understanding the system and how expensive it is, to a stage where they need hospital support.

Q15 **Kevin Hollinrake:** Everybody concedes that we are going to need to raise some more money to pay for this. I am going to give you the wonderful opportunity to be Chancellor for the day. We have heard lots of different ideas and you have talked about a few of them in your submissions so far—more general taxation, social insurance, inheritance tax or using the equity in people's homes. Which funding solutions are you most in favour of?

Neil Heslop: To state the blindingly obvious, there is no easy answer. We have looked at each of those options through the lens of what has happened over the last 20 years, which is more of a recognition of the political division. All the options of general taxation, what have been called wealth taxes or redirecting existing spending through reforms around the triple lock and so forth appear to lie at the heart of why we as a society have failed to come up with a solution over the last 20 years. Fundamentally, what happened with the death tax in the run-up to the 2010 election or the dementia tax in the 2017 election goes to the heart of political priorities. As a principle, therefore, although some form of hypothecated tax, whether it be the development of national insurance, presents all sorts of challenges, given our country's history on this topic, it and the evolution of some form of social insurance balance offer the greatest prospect of political and public consensus. We as an organisation have not taken a stance to advocate a particular funding solution.

Q16 **Kevin Hollinrake:** That is very useful; thank you. Are there any other thoughts?

Dominic Carter: The question in our submission was, what is funding needed for? The Green Paper and the general process will be most useful in identifying what it is we are trying to do and achieve as a society to determine the money we need and therefore how much money we need and how to raise it.

In ending catastrophic care costs, looking at the Dilnot Commission and putting in a cap, when it comes down to working out what that sum is and how we do it, we see there being no one-size-fits-all solution but that there are step changes to make and different options to approach. In the short term, we believe more funding should be found from general taxation. Compared with other similar nations, perhaps there is more wiggle room there.

At the same time, the benefits system could in certain ways support people with things that already exist. If you have dementia, in many cases you can get reductions on your council tax, but a lot of people are not aware of that and do not access it. There are things around pension credits and personal independence payments. We could be making a smoother, clearer system that enables people to get some of that support where the funding already exists.

As for integration and smoother working between health and social care, the Alzheimer's Society did some work around delayed transfers of care and found that the number of people spending Christmas in hospital who had dementia was around 1,400. This was largely because of the lack of social care in the community to help them out—

Q17 **Kevin Hollinrake:** I am sorry to interrupt. I am looking at where you are going to get the money from. You are talking about general taxation. Is that your answer?

Dominic Carter: Certainly in the short term, and in the medium term being able to create a system that is a bit more sustainable and has the platform to be able to innovate means that you can start to look at things around the private insurance market to give people options and to get the public into a space and a sense where they are feeling that a hypothecated tax or more of a pooled approach to risk is more achievable. I think it is about looking at it as a step change and of providing options for people.

Caroline Abrahams: We have just run listening events with older people and their families. What came out of those essentially was that the least unpopular ways of raising more money, if I can put it like that, were some kind of increase in general taxation, which could be national insurance or income tax, plus a 5% levy on people's estates after their deaths. To unpack that a little, clearly you might say, "They would say that, wouldn't they, because a lot of them do not pay income tax and do not pay national insurance?" There are things you could do about that as a Government if you were minded to do so. That is a matter for other people to be thinking about, but it is not—

Q18 **Kevin Hollinrake:** Your constituents in this survey were people who—

Caroline Abrahams: They were older people who are in the system at the moment and their families, so the next generation down.

When it came to the 5% levy on estates, the reasoning was that people thought it was fair for people, if they had some assets, to be able to contribute; it felt fair to people because everybody would be affected, and 5% sounded like it would be a fair whack but would not wipe them out.

The third point was that there was a lot of support for suggesting that whatever money was raised should be put into some kind of ring-fenced fund for social care. People worried that if, for example, it went to councils it could end up in potholes. They also worried that if it went to the NHS and social care the NHS would take the lion's share, because it usually does. They had a strong preference for knowing, if they were going to pay some more money, where it was going to go.

Anna Bird: The only thing to add is that, from a disabled person's point of view, the one method about which we are really concerned is any voluntary private insurance route, which would make it very difficult for disabled people to save and pay. We agree with everything that has been said around general taxation.

Similar to what others have said, there is also a point about whether people are willing to pay for a system that does not deliver the outcomes that disabled people want. Are people willing to pay more in taxation or any other means for a system that is letting people down and is not delivering on the right outcomes? We need to tie any future funding to a genuine conversation about what the system is there to achieve for people and make sure that it really delivers. That is about delivering independence and all the outcomes that I discussed before.

Q19 **Chair:** May I follow up on the point about intergenerational fairness? Caroline, you said that those whom you surveyed could see the point about the older generation who are not paying tax or national insurance making a contribution. Did you also explore other issues such as pensioner benefits and, for example, paying national insurance after retirement, or even taxing pensioner benefits, if not means-testing them?

Caroline Abrahams: There are three things, I think. We have just done another bit of research with older people that found that most older people had no idea what intergenerational fairness was and saw it as a London "chateratti" issue—the man on the Clapham omnibus is not talking about intergenerational fairness.

Having said that, the older people we have talked to are really worried about what is going on for young people in their families or other young people they know. It is not that they are not sympathetic to the position lots of young people are finding themselves in, but they do not think it is their fault—the intergenerational narrative at its purest tends to suggest that it is their fault. Nor do they feel that they are a particularly favoured bunch. Their view—and this comes out over and over again if you do research with older people—is that they have worked hard during their lives, paid their taxes, paid into the system and it ought to be there for

them when they need it in later life, which perhaps brings us on to the pensioner benefits view.

The politest way of putting it is that we detect no appetite among older people to want to give up any of their current benefits. One reason for that is that people think they have earned them and have already paid for them. Therefore, if any political party decides it might be a good idea to suggest taking them away, it will feel to older people as though they are being cheated of something they have already paid for.

The contributory principle is very firmly believed by many people in this country even though, if you do the maths, it is obvious that we are only paying a bit towards some of those benefits and they are topped up by Government. People do not know that. They think they have paid into a fund, it is there and then you pull out afterwards.

There is clearly a debate going on in the sector around the edges of the Green Paper and in other forums about national insurance and older people. The traditional argument against imposing national insurance on people who are working past their state pension age is that it would disincentivise them from working and that it is a good thing for people to keep working. The Treasury likes it because they pay their taxes and a lot of older people get lots of benefit from working.

Where we are now, of course, is that many more people are choosing to work past state pension age or deciding they cannot afford not to, so, to some extent, the incentive argument is less strong than it used to be. It would be fair to say that there are different views across different older people's organisations and older people's stakeholder organisations about whether it is fair for older people who are still working to pay national insurance.

Q20 **Kevin Hollinrake:** May I come back on one thing? Neil, you mentioned social insurance. One thing in the evidence we have heard is that insurance companies are not particularly interested unless there is sufficient market size that they can pool or blend the risk, which I think you referred to earlier. That raises the prospect of making social insurance compulsory. Would you advocate that?

Neil Heslop: No. I do not think—

Kevin Hollinrake: It does happen in Germany.

Neil Heslop: We have not done sufficient work to determine whether that is the right answer. If one looks at what has gone on in Japan and—

Kevin Hollinrake: In Germany as well it is mandatory.

Neil Heslop: It is similar but with a slightly different approach. In those systems, notwithstanding their challenges, that mandatory component exists. I mentioned the two areas around hypothecation of tax—a fundamental evolution of our view and perhaps less general taxation and

more national insurance. A lot more work needs to be done on either of those and we have not come to a firm view. However, the intergenerational point is really important and speaks to some of the fundamental differences for people at different stages of life. Caroline made the point that people do not talk about the intergenerational point. The underlying problem is that there is a whole generation of people who have paid their dues and are now taking out of the system who have believed since 1948 that social care was, like the national health service, free at the point of use. That is at the heart of the belief. We all know that that was never the case, but in dealing with that population that is an issue, particularly in a Brexit world of socially divisive points of view about what the 20 to 40-year-olds feel about that relative to the over-60s. If you are a young person who has gone through tertiary education, you are living in a world effectively where you have signed up to a graduate tax as well, so there is quite a complicated backdrop to all of this.

Q21 **Liz Twist:** We have talked a bit about what services we should have, which seems to be at the heart of it. If extra money was available, how do you think the extra spending on social care should be directed? Should we be looking at the means-test threshold or increasing eligibility for free personal care? What do you think the money should be spent on, assuming there is some?

Neil Heslop: Who is the question directed at?

Liz Twist: It is to any of you who would like to offer an opinion.

Neil Heslop: From a Leonard Cheshire point of view, one real concern is threshold of eligibility. The practical, on-the-ground experience of the threshold being substantial means that the impact for many thousands of disabled people is that they are not in the system at all, which is having quite profound implications for daily living. From our point of view, while recognising that the means-testing threshold clearly is a whole set of different questions, eligibility would be an important thing to look at.

Dominic Carter: We would look at a number of things. We talked about intergenerational fairness, but there is also fairness within generations themselves. We see the idea that somebody with a condition such as dementia would need to pay for the care and support that people with many other conditions get through the NHS for free as a significant challenge. Greater support should be provided to people through new models of funding.

We would like to see money put towards implementing different parts of the Care Act. The sector was very supportive of a number of different parts of that legislation, including those around the Dilnot Commission. The legislation provides us with an opportunity to do quite a bit of what we are talking about here today, but the local authorities that we speak to across the country quite often say that they cannot afford to do carers assessments or information and advocacy at the moment.

Therefore, perhaps we need to get what we have in law in order first and then look at where the next steps are, and certainly that would be around the threshold. The threshold of £23,250 has now not changed in eight years. At the same time inflation has gone up by more than 20% and house prices have skyrocketed to a point that buying a house is a dim and distant dream for me, so, on that basis, there is some quite clear and commonly held ground on which we could make progress with new money.

Caroline Abrahams: Age UK would be very keen on widening eligibility, or bringing it back to perhaps more like what it used to be. We know there are at least a million older people at the moment with an unmet need for care. That is just too high.

Secondly, we would want the money to improve quality, which would be both the duration of care visits and support for informal family carers. Some of that money would have to go into long-term workforce reform because we need a long-term workforce plan for the social care workforce.

We are very supportive of the point of view of our friends at the Alzheimer's Society's. We need a better deal for people with dementia, period, which needs better support from the NHS in the community as well as enhanced social care access.

When we talked to older people at these events about a cap, people with assets were quite keen on there being some way to be able to cap their catastrophic costs, should they experience them, but even they felt that it would not be enough on its own to justify them paying more. Their preference was for enhanced quality, both for themselves and for their families if they were providing family support.

Anna Bird: Like others, our concern is about unmet need. It is hard to put a number on the disabled people who do not receive care. We know that two thirds of people who apply for funding for care from their local authority are turned away or signposted to other services, but it is difficult to put good numbers on it. We know that lots of disabled people who require support to help them to get into work, to volunteer or to participate are not getting that support, so we would like to see funding diverted to those people.

Equally, we know that many people who receive care packages are already seeing those care packages squeezed, and that is the difference between people living, contributing and participating.

We think that the support needs to go in both directions. As I have said before, equally we need to have a conversation about how to reform the system in a wider way because putting money here or there in a system that is not delivering is not going to do the trick, ultimately.

Chair: May we turn now to health and social care integration? Andrew is

going to lead on this.

Q22 **Andrew Lewer:** Health and social care integration is an expression that is often thrown around and cited as the answer somehow, but how are health and social care linked and what impact do those two systems have on one another?

Dominic Carter: For people and their families who live with dementia, the web of care that they access often carries across from health to social care without people necessarily wanting to know the difference or knowing that they are going from one to the other. People will often want good care, understanding, and a friendly face, and a knowledgeable face, regardless of where they see that. We believe that someone with dementia might come across 50 different professions as part of the support that they might need, many of which will cover both sides.

As I mentioned before, we did some work that looked at the number of people who were stuck in hospital over Christmas on the basis of a lack of social care, and you can see the direct impact that that has on the hospitals and the number of beds that are occupied over Christmas. I think there is a similar issue in terms of the number of people who are ending up at the front door of A&E in the first place on the basis that many admissions that could have been avoided are leading to people being unwell enough to require hospital care.

That is the kind of interchanging use of budgets that we are seeing, where actually in reality health is paying for a lot of the gaps in social care at the moment. We are not necessarily acknowledging that. I do not think we are necessarily looking at how we could create better use of that spend, yet it has been interesting to us to see how social care has become the less popular sibling to receiving some of the attention it needs. People with dementia take about 60% of home care services, we believe, and about 70% of care home places, and those interchanging with primary care and healthcare often occur for everybody with the condition.

Anna Bird: We published a report on integration, which we are happy to share, a couple of years ago and we are supportive of the idea of integration between health and social care. For working-age disabled adults, some of the touch points are different. It is not about keeping people out of hospital necessarily; it might well be about preventing isolation, which might then have a knock-on impact on mental health care, for example.

We see there is a relationship and it is helpful to explore a more integrated approach, but, from a Scope point of view, we are also interested in integration that looks a bit beyond the health system. We know that some of the relationship of integration should be with the employment system and the housing system, and those things need also to be looked at because disabled people need holistic support to be independent in the way they would like to be.

Neil Heslop: I would echo some of those sentiments. The opportunity for interventions that really make a difference to people living with a disability is very often lost. Certainly, we have research on those people who believe they should be receiving some form of social care; some 40% are not.

The points that Anna made about isolation, about the effect on both mental and physical health, of some of the weaknesses where people are receiving social care are clearly pretty material. The expansion of getting people out of their homes and into volunteering opportunities and on through the system into employment, where that is appropriate, when one looks at the whole work capability system, is fundamentally broken for people living with a disability in terms of those points of transition. One can also look at elements of where learning and education opportunities are similarly compromised. Of course, for people at a later stage of life, they are very much focusing on living and the personal care generally that is associated with that. The prominence of their learning and working agenda is dramatically different from someone much earlier in life.

Caroline Abrahams: I agree very much with what Dominic said in so far as older people are concerned. Clearly, older people generally develop social care needs alongside declining health and development of various health conditions, so in practice they need both medical and care interventions. The more joined up that is around individuals and their families such that there is a team approach, the easier it is for everybody and the more effective it is, whether that is somebody who is living in a care home—we know there have traditionally been quite a lot of difficulties getting good healthcare into care homes, although it appears some progress is being made—or for older people living at home, who often are, crucially, dependent not only on the quality of the care service they can or cannot get but on those very unsung heroes, the unfashionable community health services such as district nurses, coming in and tending to things like pressure sores and ulcers, which in and of themselves, if not treated properly, can end up precipitating someone into hospital.

The best practice I have seen in these areas is where there are multidisciplinary teams—for example, ones that are there to prevent admission to hospital to try to keep people of all ages fit and well at home. A really good one operates in south London that is consultant led: it is genuinely multidisciplinary; they all work together; the care workers are not treated as second-order citizens and their insights are respected. Everybody works together to try to keep an older person fit and well.

Q23 **Andrew Lewer:** May I build on that and ask you all about the idea of combined budgets and combined commissioning authorities for health and social care? Is there more to be done, and would it have a positive impact on the sector?

Dominic Carter: From our point of view, we would look at the challenges that commissioning faces in the social care sector currently and how far apart we are from being able to commission in the way that perhaps we do in health. The services that are being commissioned—home care support or care homes, or anything else for that matter—quite often are a long way away from being the true cost of care. Until we are able to provide that and to make sure that the market is stable, it is going to be difficult to integrate those budgets and the commissioning process behind it.

Anna Bird: There is a risk of medicalising the care system and of a dominant approach of the medical system, so we are keen that the outcomes of the social care system are seen as separate and important in their own right and that any commissioning allows those things to co-exist, with both having the same value. I do not have a view on that particular model, but I wonder whether we are close enough to being able to do that and whether it is the right model for disabled people, who might need a more holistic package than just health and social care together.

Neil Heslop: Because the system is in silos and that is how Government is organised, the debate about merging budgets is a little seductive. On the point that Anna made, and Jeremy Hunt's statement of principles, I think you have to start with the life experience of individuals as a customer because we as individuals and none of these people whom we are talking about define themselves as "at the moment I am interacting with the health service, the social care system or the education system." It is just life. If this is rooted in the experience that we in society feel is right and proper in the 21st century, the tactic at an appropriate level of bringing together budgets, from a practical point of view, is highly likely to be a necessary but insufficient part of the change that we all want. I get a little bit cautious for some of the reasons that Anna described about being sucked into thinking that that was some kind of magic Nirvana solution.

Caroline Abrahams: Where things seem to be going quite well around the country, quite often either the local authority or the NHS is in practice the lead commissioner while the other is playing second fiddle. That seems to be working quite well. Whether it is going to drive enough change quickly enough is a moot point. At Age UK we are quite supportive of the idea that for older people who have quite pronounced care needs and who are at risk of being in and out of hospital, when hospitals are taking a bit more responsibility for organising social care around the hospital, sometimes that seems to work really well. I do not think quite the same issues arise for older people as absolutely understandably they do for younger disabled people in that context.

The other thing I would reflect on is that people have been talking about improvements in commissioning being the answer in this and other spaces for at least the last 20 years. If it was easy, we would have done

it by now. I am not quite sure how that is really going to crack it. Workforce and culture and multidisciplinary teams might need to be part of the agenda as well rather than just expecting commissioners to be able to sort it out.

Q24 **Jo Platt:** I am from Leigh in Greater Manchester, which has a devolved health and social care budget. Will you give an opinion on what should happen or on whether it should be kept separate. How do you think that will work with Greater Manchester's devolved budget?

Neil Heslop: Manchester has a terrific opportunity, and we are doing some work with Andy Burnham and the team to look at how their joined-up approach might give the opportunity for some quite innovative approaches. That work is relatively early, certainly from our point of view, but, in what has felt like a bit of a paralysed system nationally, the devolution to Manchester genuinely gives all of us the opportunity to try some stuff and see what does and does not work.

Chair: No one has any follow-up questions on that point, so may we move on to the issue of building a political and public consensus? Mike is going to lead on that.

Q25 **Mike Amesbury:** How important is public understanding in achieving consensus on social care funding? I will start with Anna.

Anna Bird: It is important, as I have said, that we are really clear and can articulate the value and purpose of social care if we are going to build a public consensus and, ultimately, get some money into the system. That is important. I would not say much more than that.

Caroline Abrahams: It is important but it is really, really tricky. The problem with social care is that, if you need it or know someone who needs it, then you care passionately about it and realise its value, but it is the sort of thing that most of the population just does not want to think about because it is associated with getting older—with bad things happening. I think some polling from Ipsos MORI just last week showed that two thirds of the population assumes that it is part of the NHS anyway. To be honest, I think it is near impossible for any Government to try to get these messages across in a very busy world where there are lots of messages about everything else going on. I am quite pessimistic about the chances of being able to do it.

Dominic Carter: The public polling we have done has suggested that people are passionate about it, that when they do engage they feel quite strongly about it but not necessarily about what needs to happen. Many people are experiencing this across the country; they see it daily. As we see the number of people accessing, using and seeing their grandparents using care and support increasing, we are witnessing a lot more people engaging with the third sector but also with newspapers. It would be fair to say that the public are not naive. As I say, we have reached a situation where around 80% of people told us that they would be angry, worried or

frightened if the Government did not choose to tackle this as a key issue in the very foreseeable future. At the same time, maybe we struggle because the sector has soaked up a lot of the pressure—the social care sector and the local authority budgets have done their very best to make sure that things have not completely fallen off a cliff edge. We have seen the CQC come out and talk about it being a tipping point. I think a lot of the campaigns that the Alzheimer's Society, Age UK, Leonard Cheshire and Scope have done highlight that there are big problems, but that perhaps as a society, if we are talking about this as a society issue, we need to own up to it a bit more, and some of the problems that are happening, as a group.

Neil Heslop: I am, like Caroline, a bit pessimistic about this because there is a conceptual answer to that question and there is a 2018 answer. Conceptually, given what I said about what most people believe and have believed since 1948, if you want to deliver change you have to change what people believe. The time for us effectively to do that has timed out. That is the kind of debate that other industrialised economies have been having with their populations over the last 20 years. The reality for us as a society is that we have got ourselves into a place, either through poor media, poor interest or poor political leadership, where all our organisations have banged on about the crisis in this space ad nauseam and it is just not shifting.

On the ability to engage with people, we are starting from a long way back, but it is a massively important thing for us at least to attempt to do. That cannot become an excuse for a failure to act because our sector, among others, has a great and glorious history of perhaps crying wolf on stuff. I do not think that is what is going on here.

Q26 **Mike Amesbury:** What are the key questions on which we need to develop consensus? Good public services might require increased taxation.

Neil Heslop: It is the fundamental balance of priorities between the state and the individual, which is massively loaded, particularly at this time of Brexit, in an extraordinarily febrile conversation. I cannot pretend that they will have some magic answer to it, but I think somehow we have to cut through and move at a pace. We as an organisation have called historically for some form of independent commission to get to a solution, not because we are massively enthusiastic about it but because we recognise that unless there is some cross-party consensus it ain't going to work—but that tactic that we call for we feel has timed out.

Q27 **Mike Amesbury:** Do you think it would be necessary to develop some key principles around social care funding for that public consensus?

Neil Heslop: Yes, I think principles help you break out of impasses if you can build consensus around those principles. What Jeremy Hunt did, I think, similar to Dominic, is interesting if it can rapidly form the basis of

building some political alignments and that kind of engagement with the public.

There is one principle from a pure disability point of view that I did not think quite featured, in that people with disabilities often talk about "Nothing about us without us." If you ask most people who are experiencing social care today what the options are for many of them, they do not feel engaged and have lost a sense of belief in organisations such as ours and, with respect, the politicians.

Q28 **Mike Amesbury:** Does anybody else want to comment on that?

Anna Bird: What are we talking about having public consensus about? From our perspective, we are talking about people who do not get to speak to someone from one day to the next or someone who has to choose between having a shower or getting their meds collected from the pharmacy. We are talking about people who could work, who could contribute, who could spend time with their families but are not able to do so because the system does not provide the support that they need day in, day out.

Sometimes we hide behind a language of social care in the system and the funding arrangements, but as a society we are all agreed that that is not acceptable and that we need to get out of a place where we think we do not have a consensus because perhaps we do about what we think a decent society should look like. If we start talking in real language about what disabled people and older people want, we would probably get closer to what we hope for, which is an agreement that we have to sort the system out and have to find a funding solution that works.

Caroline Abrahams: The bit that is really difficult—and this is going to be true for any Government or political party trying to have this conversation—is that, if people start off by thinking they have already paid for it through their taxes, the first thing you have to say to people is, "You have to pay for some things and not for others." Explaining the rationale for that—and dementia is a very good example—is really difficult, because, largely, these are historical accidents. I think most people agree that if we were starting again— if we did not have what we have now—we would have a fully joined-up system from the start and we would be funding both in the same way rather than separating them off.

What has happened over time is a social construct. Some things you now have to pay for that are called social care used to be called health some years ago and are called health in some other countries. We have reached where we are through a whole range of decisions made by Governments over a long period. Politically, having to say to people, "Well, you know that thing you thought was free, here is the bad news: you are going to have to pay something towards it. But here is the good news: it is not quite as much as you might otherwise would," is a tremendously hard argument to get across, I think.

Q29 **Liz Twist:** My question follows on from that. Before we get consensus on social care funding, do we need to get consensus on what we want from social care?

Dominic Carter: That would be the ideal. It is clearly a challenge, but even across this panel there have been several things on which we have all agreed and which I think over the last few years the third sector, but also others working in this environment, have agreed on and have suggested would be a very positive step forward. I think we are at the stage now where we could list three or four things from thresholds, caps and eligibility criteria to making sure that there is funding behind that. The seven principles that were laid out are great in principle, but actually the one thing they all come back to is money, the thing for which we are here today, to make sure that is the big push. That is where the big difference could be made.

Q30 **Liz Twist:** Anna, I think you talked about establishing what it is we are trying to do first of all.

Anna Bird: That is really important. What is the purpose of social care? Is it about independent living? Is that what we are all talking about here, and therefore the money follows? Let us be really clear about what we expect from the system and then we can talk about the funding that goes behind that.

Q31 **Liz Twist:** If people knew what to expect from the system, would that help to explain it?

Caroline Abrahams: At the moment it might frighten them, actually. That is the problem. It would need quite careful handling. This is where the argument slightly diverges because it fulfils a slightly different purpose for a number of younger people than it does for older people. This is sometimes true for younger people as well, but they are, as has been pointed out, at different stages of their life, so it looks a bit different.

Q32 **Matt Western:** Neil, you said that 20 years ago maybe we should have grasped the nettle—got to grips with this issue—but that politicians or others did not face the challenge. I think Caroline was talking about other countries. Will you name one country that you think has actually got this sorted—that did face up to it 20 years ago?

Neil Heslop: If you were in Munich or Tokyo, I do not think either would say they have got it perfectly right, but I think Germany and Japan have a system closer to a better place than we have.

Dominic Carter: I will go for something slightly different. We see quite a bit of innovation and, I guess, faith in the system as well as some financial backing within Holland—the Netherlands—in some of the work that they do to support people with dementia to live fairly independent lives and to make sure that it is focused around the person and what they want individually. We could learn from that and take it forward.

Caroline Abrahams: We have commissioned some research on this externally. We get the report back in about three weeks' time. I think we have asked the researchers to look at what goes on in Japan, Germany—and I am going to get this wrong now—Spain, Italy and somewhere else. I cannot remember where the somewhere else is, but I think we are expecting to find that if you do not spend any money you do not get very good outcomes. That is going to be one of the big messages coming back. I do not think there is any country in the world that has quite got it right, or, as Neil says, thinks it has quite got it right. To some extent, these are new challenges.

Anna Bird: I do not have any additional points.

Q33 **Chair:** Does anyone have any further points? Are there any points that you wanted to make today that you have not been asked about?

Caroline Abrahams: I suspect we would all agree but none of us quite got round to saying that one big problem in the system is that it is almost impossible to navigate. For people who have to organise care, trying to find out what is available, where it is available, how much it costs, how you get it and actually getting through the labyrinth of local authority assessments and stuff like that is an absolute nightmare. It definitely makes an already very difficult, stressful system even worse for people. There is a lot of agreement among everyone in the sector that that is an area that definitely needs looking at. If we end up with a system that is even more complicated than the one we have now, I think we will probably have failed and we will never communicate it to the public anyway.

Neil Heslop: In my opening remarks, we talked a little bit about a slightly un-joined-up approach from Government on certain issues. One area that I think is incredibly live and an example of that is the whole sleep-in night challenge. I am really quite concerned. We have talked about long-term structural issues in the core system and the sleep-in night issue is a little bit of the tail on the dog. The fragmented supply system includes a large number of not-for-profit charity providers, particularly in the learning disability space. Depending on where the whole sleep-in night thing finishes, there are many organisations that will be in a great deal of trouble this side of Christmas.

Chair: Thank you. That was a very important point. Thank you, all of you, for coming this afternoon.

Examination of witnesses

Witnesses: Simon Bottery, Nick Davies, Sir Andrew Dilnot and Professor Martin Knapp.

Q34 **Chair:** Good afternoon and welcome to our second panel. Will you start by introducing yourselves to those following from outside the room, starting with Sir Andrew?

Sir Andrew Dilnot: I am Andrew Dilnot and I was chair of the Commission on Funding of Care and Support between 2010 and 2011. I am the warden of Nuffield College, Oxford.

Simon Bottery: I am Simon Bottery. I am senior fellow in social care at the King's Fund.

Professor Knapp: I am Martin Knapp, a professor of social policy at the London School of Economics and I am also a director of the NIHR School for Social Care Research.

Nick Davies: I am Nick Davies. I am an associate director at the Institute for Government.

Q35 **Matt Western:** You listened to the previous panel. Will you all summarise the challenges facing the social care system, and perhaps identify whether there are any differences between the challenges for social care for older people versus those who are of working age?

Sir Andrew Dilnot: There are two big challenges. The first is that the means-tested system that is meant to provide support for those who have no resources or little resource of their own is simply underfunded. The real level of funding has declined significantly since 2010 at a time when, both among the working-age population and the older population, demand has grown. That core of a decent system looking after those who cannot look after themselves is not funded.

There is a second problem, which goes beyond it and also desperately needs to be resolved: the structures we have at the moment mean that the population as a whole have no capacity to plan and manage their own lives in this space. That was an important part of what we said. I heard much of what was said in the first session and do not have much to add.

There is one area that I would add. We did not hear much conversation in the first session about providers of care. It is really important to recognise that providers of care are put into an extraordinarily difficult position by the lack of a coherent funding structure. I often liken being a consumer of care to being in a shop with no prices. Although you know what the price will be per week or month, you do not know for how many weeks or months you are going to go on having to pay, so you do not actually know the price of what you are being asked to pay for.

The consequence of that is that, with the exception of a very small group of very wealthy people, almost all consumers are seeking to buy the cheapest they possibly can. That means that the market does not work, that it is very difficult for providers to invest and innovate, which means we get much less innovation than we should do; and that we have a sector where almost everybody employed in the sector is paid at the minimum wage.

The sector does not work as an industry very well, despite the wonderful care that is provided by many of the people working in it, so I think we

do not have enough money for the means test; the structure does not work for any of us and does not allow people to take control of their own lives; and, as a result of all of that, we have a sector that is hamstrung in being innovative and providing better services.

Simon Bottery: Like Sir Andrew, I heard the previous debate and agree with much of what was said. If I had to sum it up in a paragraph, the fundamental problem is around rising need/demand for services, both from older people and from the working-age population, rising cost of delivery of social care services, and, against a context of cuts in state-funded social care over the last few years, within the context of a lack of public understanding of what their entitlement is or is not and within the context of a failure by successive Governments to address this in terms of policy reform.

Professor Knapp: Not to repeat what others have said, I would add that we have this very large, rapidly growing and almost completely uncharted sector of self-funders, so particularly older people, people who do not qualify for local-authority-brokered support, who are having to find their way through the system and who then hit many of the problems that Andrew talked about. That is one.

Secondly, in the context of this fiscal tightening, we also have the challenge that the number of people who are willing and able to be unpaid family carers is not keeping pace with the growth in the need for that support.

Thirdly, I would say that the sector has not been terribly innovative in developing new forms of care. We see this in two areas where we have seen disappointment. One is in the housing-with-care area, where there is a big gap in the market; and, secondly, in relation to technology—I do not mean robots but fairly basic technology—we do not see very much take-up of quite simple technologies that could improve the lives of people and particularly of carers.

Nick Davies: I will largely restrict myself to the Committee's second main question about the mechanisms for change, but reiterate a couple of points: first, demand has risen and is continuing to rise; and, secondly, the two principal strategies that local authorities have adopted for trying to do more, or the same with less, are now starting to have a negative impact—or from 2013 onwards the data suggest are having a negative impact—on outputs and outcomes.

I know that two particular strategies have been: first, reduction in the service provided, and it is unclear, unfortunately, from the data what has happened to all those people who used to be providing services but are no longer, and I do not think the Department for Health and Social Care has a clear answer to that, either; secondly, to hold down costs by squeezing the amount paid to care providers. Average fees have fallen by about 6% over the last five years. At the same time there has been a new national minimum wage, which is pushing up costs for those

providers. I think there is a big question about the sustainability of the provider market.

Q36 **Matt Western:** I come back to a point you, Martin, were making about housing with care. Have all of you been feeding that back into various channels? With an ageing population and a need for housing capacity, we are not actually facing that challenge where there is a significant need. That could be a very effective way of delivering this sort of care in old age.

Professor Knapp: I would say two things. There is a danger that some older people, particularly now, as their needs for some support grow, make the leap, if I can call it that, from living in their own home into a care home without going through some intermediate step, which would be quite appropriate to meet their needs. The market is just not there. If I can give you a personal anecdote, my mother lives in Eastbourne, which you would expect to have a wonderfully developed housing-with-care market. It has been incredibly difficult for her to find something that is that step up from living on her own in her own home. Fortunately, she does not have much in the way of care needs but she needs some kind of reasonably sheltered setting, I would say, and it has been surprisingly difficult in that context. The market for housing with care—and there is a whole range of different products, if you like, potentially out there—just has not kept pace with demand or need for that sort of service.

Q37 **Matt Western:** I have one final point about the Green Paper, which does not cover social care for working-age adults. Do you think it should have been included, Sir Andrew?

Sir Andrew Dilnot: That is a slightly tricky question to answer because there might be strategic and tactical questions about the Green Paper that are for politicians, not for me. Do I think that the two groups should be thought of together? The answer is absolutely yes. We can only produce a coherent answer to why particular forms of help should be made available by the state for one group if it is coherent with the way we think about the other group. Our own view—and the Commission on Funding of Care and Support was explicit about both working-age and older adults—was that most people think it is not unreasonable that older people should make some contribution to their own care. After all, a random draw of 65-year-olds would probably show that three quarters of us will need some social care before dying, so it is not unreasonable to prepare for that. It seems pretty unreasonable to say to an 18-year-old who is entering adulthood with an already established care need, "Well, you really should have prepared for that earlier."

Our argument in the Commission on Funding of Care and Support was that it was reasonable to set a cap that was not zero for how much older people should contribute to their care if they had resource, but for people who entered adulthood with an already established care need it seemed natural that the cap should be zero—that we should pool that risk across the whole of society.

One does need to think together about these things to make sure that whatever responses one has are consistent across the piece. Whether the Green Paper itself should have included that I think is a matter for Government and Parliament.

Professor Knapp: The support for working age and older people comes from the same pot. I think that the working-age group is now constituting about half of public spending on social care, so it is a substantial element and will grow relative to older people's public spending on current arrangements. I think not to include those in the same discussion would be to miss a challenge that is being faced locally by local authorities in their whole-budget decisions.

Q38 **Helen Hayes:** From the research that each of you with your respective organisations has undertaken, how much extra funding is needed in the short term—let us say to 2020—to tackle the current challenges with the funding of social care? Is there a consensus between you about that figure?

Simon Bottery: I doubt we have a consensus, but there was a consensus at least between ourselves, the Health Foundation and the Nuffield Trust. Our estimate of the spending gap by 2020 is £2.5 billion. That is based on assumptions about the rising demand we have already talked about and on Martin and the PSSRU's figures about demand. It is based on recognising the additional costs coming into the sector, particularly from the national living wage but also to pay for sleep-ins, for example. It is based on an assumption that local authorities maintain the current percentage spend against overall spend on social care.

Q39 **Helen Hayes:** That figure does not address current unmet need.

Simon Bottery: No. All that figure is doing is recognising the gap for the existing demographic that is receiving care and following that forward to 2020.

Sir Andrew Dilnot: I do not have anything to add. The work done at the King's Fund was a very sensible piece of work. It looks like the right kind of number. All I would say is it is important to have that number in some kind of context. That is about one tenth of 1% of national income. It is a very small number relative to the size of the economy or for our overall public spending of in excess of £700 billion a year or our spending on the health service of well in excess of £100 billion a year. It is a significant amount of the adult social care budget, and in particular of the older adult social care budget, but it is a very small number relative to the overall economy or other big bits of public spending.

Professor Knapp: We certainly were happy with the calculations that the King's Fund and other groups pulled together. When we look forward, the danger is that you just look at today's system and say, "What would be the cost of maintaining that level of support?" —forgetting that today's system is missing a large number of people, particularly those with

so-called lower-level needs who in the past would have got support from local authorities but are now no longer getting that. That takes us back to the point I made earlier about the self-funders. We just do not know how much funding is going into the system from people privately because it is simply an uncharted, unknown sector.

Nick Davies: Similarly, we have not done our own research, but the analysis by the three health think-tanks looks sensible and credible to us.

Q40 **Helen Hayes:** That brings me to my next question: how do you anticipate the need for social care changing in the longer term, and what impact do you anticipate it will have on the funding need?

Sir Andrew Dilnot: It will go up. It will go up by quite a lot and that reflects the single biggest change of the last 100 years that we should be delighted about, which is that we are living longer. I am fed up with people talking about the burden of ageing as though it is a bad thing. It is fabulous. We are living longer. It is the thing that most of us most want. One side-effect is that the cost of social care for older people is going to rise. The cost of care for people of working age is also going to rise for similar but perhaps in some ways even more dramatic reasons, because people who 20, 30 or 40 years ago might have died before reaching adulthood are, again as a result of technological progress, now living and are able to have, in many cases, a good quality of life but with significant support.

The costs are going to rise. This is going to become a more important sector in this country and around the world than it is now, and that is a great opportunity for us to do it better. It is a great opportunity for innovations, for the kind of technological changes that Martin and others have spoken about to become established. The UK could be a world leader. We just need to face up to it and do it.

Simon Bottery: We do not have an additional figure. I think the OBR has said that the cost of delivering care could rise from about 1.1% of GDP up to about 2.5% of GDP by 2060, so it will be a significant increase and clearly that money needs to come from somewhere. In addition to the obvious costs, there are some potential underlying costs that may rise more quickly. By 2030 we may need up to another 700,000 care workers simply to keep pace with the existing demand, and you have to wonder whether we can recruit an additional 700,000 care workers and continue to pay them at the national minimum wage. Can we get enough people who want to work in care at that sort of level? There are some quite challenging issues that lie beneath the surface of some of the broader concerns that we have all shared about the fantastic additional costs of having a successfully ageing population.

Professor Knapp: You have some evidence—I saw written evidence—from the CASPeR project, which involves colleagues of mine from the LSE. They have done these projections for many years of future demand. They feed the cost of meeting that future demand into the OBR estimates

and so on. Their estimates are that under current arrangements long-term care for older people will have to rise by 40% between 2020 and 2030, and by a further 26% between 2030 and 2035 just to keep pace with demographic change and expected earnings increases. This is a substantial cost at the same time as we are celebrating the substantial achievement that Andrew was talking about.

Nick Davies: I would add that the research suggests that, as both individuals and societies get wealthier, they place greater importance on health. In the abstract it is one thing to say that people are willing to spend more of their own money or more of society's wealth on keeping people healthy, but the challenge is turning that into practicalities of where you raise that money from.

Q41 **Helen Hayes:** Is it right to say that your fairly sketchy, if I may say, assessments of future need and cost are about the increase in numbers of people, not a transformation in the level or type of care that those individuals might be receiving? You are making assessments and assumptions on the basis of the current thresholds and eligibility criteria and those sorts of things, not, "What is the best possible care system that we could imagine that all of us would want to be able to receive when we reach that point in time?" Is that fair?

Sir Andrew Dilnot: That is certainly my position, partly because it is genuinely very uncertain. We could see—and let us hope that we do—technological change that means that the demand for care for our particular cohort is reduced. We are seeing, for example, a decline in the incidence of dementia that we expected 10 years ago.

Forecasting is a mug's game—I am an economist, so I should know—but forecasting with any degree of precision what the demand might be even 10 years from now is intensely difficult. The demographic change is so bold and dramatic, we can be confident that almost in any scenario the overall cost is going to rise—the pure numbers are rising so quickly. But you are quite right: either on the upside or the downside, the numbers could end up looking rather different.

Q42 **Andrew Selous:** Drawing together Sir Andrew's comments about the lack of innovation because of the way the system is funded and Simon's forecast of an extra 700,000 care workers being needed by 2030, I was wondering whether, if innovation is possible within the system, because the funding does flow, that projected labour demand could be helped by using technology. What is the scope for that coming to the aid of this issue?

Sir Andrew Dilnot: I suspect others will have more to say on that than I do, but my own view is that, yes, there is a big change in resource required, but not big relative to what we see, for example, in health where we have gone from 3% of GDP in 1955 to 8% now and social security from 4% to 12%. These are substantial changes but they are not changes on a scale that an economy of our size and flexibility cannot

cope with as long as there are mechanisms that allow people to respond carefully. Others may have more to say on the specifics of the innovation.

Simon Bottery: Yes. We should be cautious about assuming or hoping that there are technological changes around the corner that will fundamentally change the way we deliver care. Care is fundamentally a people business and the people receiving care by and large want to receive it from people. If you look at countries that are ahead of us on the demographic curve, you cannot see massive changes in the way they are delivering care. The fundamental patterns are still the same. There may be some efficiency gains there, but we should not look to it as a salvation.

Professor Knapp: I have a couple of quick points. One would be, to go to Helen Hayes's point about the projections, that we did some work for the Government, published four years ago, looking specifically at dementia and what would happen if, instead of today's system, we gave everybody the best evidence-based care and support. We looked at medication, psychosocial support, carer support, case management and something else. We found that it would not change the total cost of the system very much—it would bring it down a little, so there would be efficiency gains as a result—but it would improve the quality of life for people with dementia and their carers.

We could do better in making the technologies, if I may use that term more generally—the treatments, the care and the support arrangements we have today—available to people who would benefit from them. It will not do a lot to contain the future costs of care, but it will do a lot to improve lives, I think.

Q43 **Chair:** Thank you. May I come on to how we should be raising this money? Sir Andrew, you have pointed out that relative to our economy we are talking about small sums. Nevertheless, the difficult question is who should pay and how that is balanced between the state and the individual. Will you set out for us your thinking about where that balance should lie?

Sir Andrew Dilnot: Ultimately, this is quite a political judgment, but I would distinguish between where we might expect to look for the funds for a means-tested system and where we might look for funds for anything that goes beyond that. The funding of the core means-tested system should not look very different from the way in which we fund the health service. A natural source would be general taxation. The reason for that is that the means-tested system is about looking after people who are not in a position to look after themselves, so it does not seem to make sense to expect them to do it.

Let us imagine that we went beyond a means-tested system and, for example, that the proposals from the Care Act 2014 were influencing proposals that bore some relation to what we had initially proposed. There, what you are saying is that there is a market failure in the private

sector. Individuals can do nothing to pool their risk, so the state should come in and pool some of that risk for them by providing a care cap.

It seems clear that the group that will benefit from that is older people, and it is benefiting because Government want to address a market failure. It seems perfectly legitimate to expect that population to pay for some of the costs of that themselves.

Whereas I think general taxation seems the natural source for the means-tested system, if we are going to extend beyond the means-tested system—I strongly advocate that we should—there is an argument for looking to the recipient population, the beneficiary population, to pay. The natural thing there is to think, in these circumstances, it would be reasonable to expect older people to make some contribution.

One way of characterising that kind of change is as an extension of the benefits of social insurance. At the moment the main benefit of social insurance in the UK social security system is the pension; in the non-social security system, it is the healthcare system. This would be introducing a new benefit, introducing a contribution from older people. There are a number of possibilities, one of which would be taking some money out of people's estates, but a more natural thing in this context would be to say, "Let us have something akin to a national insurance contribution." This looks like an extension of the ideas that were behind the introduction of, first, unemployment insurance and then the healthcare system.

It is anomalous that older people do not pay any national insurance contributions and pay a lower rate of tax on their incomes than younger people. That goes to some of the questions about intergenerational justice. So, my argument, I think, would be that if we were to extend, as I hope we will, the benefits of social care to new groups in new circumstances, it is not unreasonable that we should ask them to pay. After all, the only reason we are doing it is that the private sector will not. If there were a private sector solution here, if there were a private insurance market, we would expect people to pay their own contributions. We might make them compulsory, as we do in the case of driving. Neither of those routes is possible, so I think we should be willing to think about older people paying. There are other ways than national insurance contributions—changes to inheritance tax, changes to the entitlement to the winter fuel allowance and so on—but I do think it is reasonable to think of charging older people in this circumstance.

Q44 **Chair:** May I go back to your point about insurance products not coming forward? The theory behind having a threshold and a cap is that the insurance market would develop, but no companies came forward with proposals to do that.

Sir Andrew Dilnot: That was not actually what we said in our report.

Q45 **Chair:** Will you clarify that?

Sir Andrew Dilnot: Yes. Let me step back a bit. Why on earth should the Government get involved in social care for people who have enough money? After all, the Government do not get involved in the provision of food, housing or transport. The answer is that social care, like healthcare, is something where there is—a horrible piece of terminology—highly skewed risk probability distribution. Most of us will not face really high social care costs, but a small number of us will. We cannot predict now which of us it will be.

Faced with that kind of thing, where some of us will face a high risk and some not, what we like to do as people is to pool the risk—we do not face the financial consequences of a car crash. In fact, it is illegal to face the financial consequences of a car crash. You have to buy insurance. We do not face the financial consequences of extreme ill health because in this country that risk is pooled through the state. In some other countries it is pooled through private insurance. We do not face the financial consequences of our house burning down because most of us buy insurance.

Why do we not just buy social care insurance? It is because we cannot. The reason we cannot is the same reason that, while we could buy health insurance for next year, we cannot buy health insurance for 10 years from now. Insurers will sell it to you only a year in advance. That is precisely not what we want here. There is nowhere in the world where you can buy private insurance against the social care risk. There are a few products in the States, most of which run out after a small number of years or a certain number of hundreds of thousands of dollars, which is precisely what you do not want.

Therefore, I do think that there is an argument for the state stepping in here because there is an inherent market failure that means that the private sector cannot insure this risk. If the state were to step in and insure that risk for people, guaranteeing through a cap, then I think the private sector could come in and start providing additional services.

There are two sorts of things that would happen. The first is that you could see a market where people would say, "Well, if the cap is set at £75,000, I want some cover for that £75,000." I think most people would say they were perfectly happy for it just to come out of their estate, but some people might want a product that would cover that first £75,000. That could be done.

The market would be likely to develop more quickly and more largely where people might say, "I am delighted that the catastrophic risk is covered, but, if I need to go into a residential care home or need domiciliary care, I want to spend more on it than the state will provide, so I want a top-up." That is a market on which the insurance industry can deliver because they would not be exposed to the total cost of whatever

it cost; they would be committing to, let us say, an extra £10,000 a year if you fail three activities of daily living.

So there are products that would become available, but I think they will become available only once the state has come up with an offer, and they are not pure insurance products because I do not think a pure insurance product will ever work for the private sector.

Q46 **Chair:** Thank you. Simon, would you like to go back to that point about commenting on the balance between the state and the individual and where you think that should be?

Simon Bottery: Yes. As you heard from Caroline Abrahams, who has done some work recently, we have been doing similar work with the Health Foundation, doing large-scale deliberative events in London, King's Lynn and Leigh to try to take people through the social care system and the options for funding it.

We have found, quite similar to Caroline, which is reassuring, that there is a very strong feeling that the state should pay, that it should not be about the individual. We found a very strong sentiment among people that they have already paid; they have already contributed. In many cases they believe that that is on a hypothecated basis. They say NI has been a hypothecated tax that will cover their health and care needs in old age.

If we are going to increase funding, they see income tax or NI as being the most obvious route. We have found that there is quite strong opposition to the idea of tapping into housing wealth. That is not to say that you should not or could not do that but merely, if you were going to go down that route, you would need to work and try to take people with you, I think.

That is broadly what we found, but we also found that people do not want to think about their individual care costs because that is not an area where they want to go. Someone said to me, "Well, there is no point because you might just die of old age anyway, mightn't you?" People have this idea—probably all of us have—that we are going to live to 85 and then drop off suddenly, whereas the recognition of increasing morbidities and comorbidities is not something that we want to face and therefore we do not want to think about how we plan for it financially.

Q47 **Chair:** Thank you. May I clarify that these deliberative events were with older people or with a cross-section?

Simon Bottery: It was a cross-section, both in terms of ages and all the other things that you would expect, but it was not just older people, no.

Q48 **Chair:** So it included young people who are not care users at the moment.

Simon Bottery: Yes, absolutely.

Q49 **Chair:** Did even young people in your deliberative groups feel it should be pooled through national insurance and the tax system?

Simon Bottery: That was the general feeling, yes, that the tax system was the fairest way of raising additional income.

Q50 **Chair:** Thank you. Martin, do you want to add to that?

Professor Knapp: Two difficulties with this kind of exercise are, first, that people do not understand their personal risk of needing social care services, although perhaps that understanding grows with age; and, secondly, people do not understand the social care system, so when they discuss options for the way the system might be organised and financed they do so from a position of, often, quite a surprisingly limited understanding of what is going on. In the events that the King's Fund and Age UK have held, they have had to invest quite a bit of time in explaining the system before then going on to understand what the options might be for the future.

Nick Davies: We do not have a particular view on either the balance or which taxes might be better used, but if you are going to raise taxes, or indeed if you are going to make tax policy more generally, we certainly do have views on how you would do that effectively.

Given the low level of understanding, both of the social care system and where the money comes from, there are three things in particular I would say.

First, we should be engaging the public early in these discussions. Often there is a sense that consultations are done quite late in the process and a broad decision has already been made about the best way forward.

Secondly, particularly given the lack of understanding, I would want the Government to be taking some deliberative approaches. The evidence suggests, both in this and in other areas, that, given sufficient support, and particularly if there is an indication of political will to follow through on what comes from deliberative events, people can be supported to understand and think about some quite complex trade-offs.

The third point, particularly relevant in the light of today's letter calling for a parliamentary commission, is to try to prepare the ground. Independent inquiries have been used successfully here, though not for tax-raising, but they have been successfully used elsewhere. Both in Australia and in New Zealand, independent commissions have been used. That can be an effective way, through public engagement, to demonstrate that arguments can be won and by engaging with the public to develop better policy as a result of that, preparing the ground for what would otherwise be potentially quite controversial and politically unpopular decisions.

Q51 **Chair:** Thank you for supporting the letter. I would say that, wouldn't I?

May I go further into the point about intergenerational fairness? I am interested, Simon, in your saying that you engaged with younger people and that they were apparently in favour of a model that would essentially focus more, as time goes by, on to a relatively smaller group of working-age adults compared with the population in need of support.

Simon Bottery: What came out for us quite strongly was that there is a very strong sense that we need to look after older people properly. That is very strong across all age cohorts, so getting a system that can do that effectively and spending the money that is required to do that effectively trumps any intergenerational issues. That is why people come back to tax and NI because that is the system that they know and understand already as the most obvious way of raising money.

Q52 **Chair:** Does anyone else want to add any points about intergenerational fairness? No. Are there any methods of raising this extra money other than tax and national insurance and the points that Sir Andrew has raised that anybody wants to add in?

Nick Davies: I can quickly add that one thing that has been raised quite recently is the use of a hypothecated tax to resolve that. I worry that that is sometimes quite overtly done for political reasons inasmuch as people do not really understand the tax system. Actually, a soft hypothecation is quite an easy way to get it past the public without them really understanding that that is not going to pay directly. I would worry that using something like that is going to build distrust and is, at best, only going to provide a short-term solution, and that a more open, honest and engaged dialogue about it would be a much better approach to take.

Q53 **Chair:** But of course a hard hypothecation would mean it could go down or up.

Nick Davies: Indeed. I do not really have a view on whether hypothecation is likely to be effective for meeting ongoing needs. As you say, it is unlikely to, which is I think why what tends to be suggested is quite a soft hypothecation. Therefore, the argument might be made about it probably not being fully open and honest with the public about why it is being used. You might cite national insurance because people think there is a contributory mechanism that does not really exist, and I would not want to add to misinformation. As I say, that is only likely to be a short-term solution.

Q54 **Dr Williams:** If there were extra revenue for social care, should it be directed on raising the means threshold, introducing a cap or increasing eligibility? We can start with Nick.

Nick Davies: It is not something on which we have done a huge amount of research. I do not have a particular point to add on that.

Professor Knapp: There are a few areas that I could mention. In relation to the eligibility criteria, as I said earlier, many older people

would in the past have qualified for some support through the local authority but have not been getting it. There are big concerns about what that means in terms of the secondary prevention benefits of those often relatively low levels of support. Surprisingly, we have not seen the crisis emerge that perhaps might have been expected, but I would put resources into the prevention end of things by changing eligibility criteria or whatever it would be.

Secondly, and not far removed from that, would be unpaid family and other carers who bear this huge, generally hidden burden of responsibility. I think we forget how much we rely on them in the current system and how much we will have to rely on them in the future, so putting resources into supporting them in various ways—and there are evidence-based ways that would work—will be important.

Wherever we target this money, particularly if we are looking to get some efficiency gains, please, please, in social care, let us do it on things where there is an evidence base. Social care has not been terribly good in learning from where there is evidence about what works compared with, for example, the healthcare sector. We are beginning to get a better understanding of that, and if we can do that it would be much better.

Simon Bottery: There are two areas that we have supported in the past. One is around the cap on catastrophic care costs, which we think is a sensible response to those issues. If you are going to introduce a cap, it is important that you are clear with people about what it does and does not cover. There is an issue. If you try to introduce a cap within an underfunded system, there is a risk that the rate at which people will run up their care costs will not be the same as the costs they are actually paying in the marketplace. There is a fundamental or potential problem there.

We commissioned the Barker Commission, which reported in 2014. Barker argued very strongly for free critical needs cover, bringing NHS continuing healthcare into that pot and essentially into the social care system. There is a case to argue for that as well.

Sir Andrew Dilnot: There are two very separate needs. There is no doubt that we need to spend more on the means-tested system, which is creaking in various parts of the country at the moment. We see evidence of that in all kinds of ways, not least in some areas an extraordinary gap between what self-funders are paying and what local authorities are paying in the reduction in the number of people receiving care, so the means-tested system needs more money.

I also argue passionately that we need to do something for the structure as a whole, so I would certainly want to see a cap introduced. Until a cap is introduced, the population as a whole faces no opportunity to pool its risks, so everybody is facing what is, I think, terrifying for them and leads to people feeling very frightened, and because they feel so frightened and have so little control they are not taking the opportunity to control their

risk in ways that could be helpful not just for them but for the system as a whole. Yes, we need more into the means test but I also think we need a capped system, which could perfectly legitimately be funded through taxation or increasing charges for the affected population.

Q55 **Dr Williams:** If we look at the evidence on the underfunding of the means-tested system, many people who do not get means-tested care are paying higher rates and the providers say that they are subsidising the means-tested care with the self-funders. Is that right?

Sir Andrew Dilnot: That is what they say. That is quite a delicate argument because the local authorities might also say, "We are paying less because we are guaranteeing to take the first 'X number'," and that is not unreasonable. It is just that, when the gap between what the self-funders are paying and what the local authority-funded are being charged grows, the system becomes one that attracts an enormous amount of opprobrium and a sense of unfairness.

In domestic care we are seeing providers handing back their contracts. The system is under very great strain. Of course, we have all been saying that for years, but it really is under great strain now, and there is a risk of fairly significant disaster.

Chair: Andrew has a supplementary point.

Q56 **Andrew Selous:** I have a question for Sir Andrew on trying to incentivise people to do the right thing, but I welcome contributions from the whole panel. Family care was referred to in the earlier session as a good thing, but I very much understand the pressures that family carers are under. In terms of personal responsibility and people trying to do the right thing by putting some money away for their own care so that we try to minimise the amount that falls on the state and the general taxpayer—although, of course, accepting the need for that as well—how do we get a system that encourages people to try to do the right thing while being mindful of looking after them properly if they are family carers?

Sir Andrew Dilnot: For people to do the right thing, we want them to have some choices. At the moment they do not have much in the way of choice because there is not a private sector option. Take the driving analogy. We really want people to be insured. In the case of driving, we make it compulsory. Here we want people to be able to manage their own lives, so I think we want them to be able to pool the risk. The only way we can do that is by the state offering to pool some of the risk for them. I do not think the state needs to offer to pool all the risk and people will, even with a cap in place, be left with some risk—the first part of the risk that they will have to cover themselves.

In that world, it makes much more sense for them to take decisions that might reduce their risk of needing care than it does in a world where there is no pooling available. I want people to be able to say, "Let us take some of our accumulated wealth and spend it on a stairlift, a downstairs

loo or getting somebody to come in and help us once a day." At the moment, with the catastrophic risk still available, there is very little sense of that being worth while.

Once we give people back some control, we can encourage people. By and large, people are pretty responsible in this area. They want to do the right thing—family carers want to do the right thing. The worst that we see at the moment is the position that families can find themselves in where they are all worried about what is happening to the inheritance. They just see it running away and there is nothing that anybody can do about that. That does not reflect terribly well on anybody, and we want to reduce that probability.

Professor Knapp: I will add something in relation to family carers. There are a lot of people who would like to provide more in the way of unpaid care and support, but, for all sorts of reasons, including their employment and the stresses and strains of being a carer, do not feel able to do so, which is why I said earlier that an important priority for this area is to do more to recognise what carers do, and can do, and to support them. We know some of the things that will support them—flexible working, statutory carer's leave or better support through psychosocial interventions for people with dementia, for example. All those things have been shown to work. We just need to commit to supporting those very key people within the social care sector.

Q57 **Andrew Lewer:** We have talked about health and social care integration being regarded as a panacea by some people, but without necessarily having a full understanding of what health and social integration is. How would you describe health and social care as being linked, and what impact do the two systems currently have on each other?

Simon Bottery: They are inextricably linked and they need to be joined up and integrated around the individual, so a good system would be one where people were not aware they were receiving healthcare or social care; they were just getting really good care. You would avoid some of the boundary disputes that happen, such as, for example, the arguments about whether a district nurse needs to apply E45 cream or whether that can be done by a care worker. Those sorts of issues simply would not happen.

You would also be able to integrate and co-ordinate care delivery so you would not have three or four people going to see someone at different times of the day to carry out different tasks. You would create a much smoother system for the individual.

Going back to the Barker Commission, Barker argued very strongly for local integration of health and care budgets while including in that pot attendance allowance, so linking in the benefits system or a chunk of the benefits system along with health and social care. The aim is to create a smooth pathway through care for individuals, structured around what they want and how they want it delivered, so heavily focused around

things like personal budgets so that individuals have that strong sense of a seamless system meeting their individual needs.

Professor Knapp: I do not disagree with any of that. If we are to have this closer integration or closer working between health and social care, we need to make sure that the values, principles and professional ethos of the different groups are protected. People in social care often worry about healthcare coming in, taking over and imposing more of a medical model, but I do not think that is the intention of any of the efforts being made locally. Protecting those, and what Simon was describing, would be the way I would support.

Nick Davies: I do not disagree with any of that. I note that what local integration looks like might differ depending on the area. We have quite a complex local system, particularly with the devolution of some health responsibilities to combined authority level. As an example, the boundaries of CCGs, local authorities and so on are not necessarily coterminous. I do not think there will necessarily be one solution to exactly how that integration will work in different areas.

Sir Andrew Dilnot: I do not have much to add. Certainly there are some efficiency gains to be had here, but those efficiency gains cannot wipe out the fundamental challenge that in the UK we have a health system that makes all healthcare free and a social care system that does not. While that boundary exists, there will be wrinkles. I think we can improve efficiency by getting better integration. We have some great examples of that working in some parts of the country, but I do not think it is a response to the fundamental questions that the Committee is asking.

Q58 **Andrew Lewer:** It seems to me that it is the usual problem of the postcode lottery being an enemy of innovation. Somebody tries something and someone says, "Why haven't I got that?", but unless you try something how do you know whether it is going to work any better?

You have partly answered this question, but do you think we should have combined budgets and combined commissioning authorities for health and social care, or is that not necessarily the answer?

Simon Bottery: Yes. As I have already said, I think that is important. That could be within the context of a move to a more population-based health system, so you are looking 10 or 15 years in advance and looking to spend the money in a way not just that meets the immediate needs but is also focused on how you prevent needs from arising. That system would be the ideal that we would be looking at.

Professor Knapp: Part of the challenge would be this 1940s-established difference between a nationally driven and co-ordinated health system and a locally driven and co-ordinated social care system. A lot of people in the social care world worry about that loss of local responsibility, so the solution Simon is talking about where these are locally combined efforts, if you like, would help to preserve that. I am in favour of some

sort of combined effort, but I do not quite see out there any evidence of something that is clearly the best solution. Lots of things have been tried, but they have all been struggling to achieve the successes that Simon is suggesting we need.

Nick Davies: We do not have a particular view on it, but certainly what Simon suggested sounds relatively sensible. I suppose we would just caution that there is a history of being overly optimistic about the efficiencies that can be achieved by system change and trying to bank those efficiencies before they have actually been realised. Yes, we should be quite cautious about what could be achieved, particularly in the short term.

Sir Andrew Dilnot: I agree with much of that. The challenge of working out whether this is a locally provided and/or financed service is tricky. We can all agree that it needs to be locally provided—that the type of care that is going to be sensible in the highlands and islands is going to be rather different from the type of care that is going to be sensible in Camden—but at the moment we still have, at least in large part, local finance coming through the local finance system, and that is a struggle.

It is hard to imagine that, if we were sitting down with a clean sheet of paper today as opposed to in 1948, we would have the difference in the financing arrangements that we have for health and social care in terms of central and local, let alone anything else.

Q59 **Chair:** In other words we would not start from here. One of the previous panel members flagged up the problem you can sometimes get with pooled budgets—that health has all the power and that you suck more into health. How would you guard against that, Simon, with a genuinely pooled budget?

Simon Bottery: That would be by having genuinely jointly agreed plans, so you may have one commissioner but you have jointly agreed principles about what you are commissioning and what you are trying to deliver. Health and wellbeing boards were, I think, intended to provide that population-based overview.

But you are absolutely right, and certainly the public are not daft. In our deliberative events, when we talked about pooled budgets, they had a similar concern that money would be dragged into the acute sector when demand was high and social care would not get its fair share.

Chair: Certainly an issue that Rosie consistently raised on the Health Committee was the powerlessness of health and wellbeing boards, and in fact we will come to you for your questions next, Rosie.

Q60 **Rosie Cooper:** Thank you. This is almost a wrap-up question, and I will resist the temptation to talk about health and wellbeing boards.

My question comes in three parts. Do we need another royal commission on social care policy? After all, we have had five independent reviews on

social care funding since 1999, at least 12 Green Papers and a number of consultation documents. ADASS and the King's Fund would say that it just adds delay and it is difficult to see what value it would add. Do you agree with that?

Part two would be whether you think there are other organisations that might help develop public and political consensus—moving towards cross-party commissions, on which I was delighted to be able to sign that letter, or perhaps the Office for Budget Responsibility.

The third part is, if you were to go with an option like that, how would you ensure continuity to make sure that you get, and that we can implement, long-term reform over a number of Parliaments?

Sir Andrew Dilnot: Do we need another commission? I think we have probably had too many commissions. I thought the 2010-11 one was particularly difficult and bad. I really do not think we need another commission. Apart from anything else, we are in the strange world now where all three of England's political parties are committed to a cap. One could reasonably ask, "But all three of England's political parties passed an Act in 2014 to deliver it, so why has it not been delivered?" I do not think we need another commission.

There is quite a lot of consensus on what money should be spent on. Where there is not consensus is where the money should come from. That is what is always politically most toxic for Governments. The debate is much more now about where the money should come from than about what the money should be spent on. My advice for any institution trying to build consensus would be try to focus on that—to try to bank what everybody agrees on, because I think almost everybody agrees that the means-tested system is underfunded and there is an argument for doing something more. All three of England's main political parties are committed to doing a version of them or what was in the 2014 Act and in the 2011 commission, supported, I think, by and large, by the Barker Commission.

Let us not spend too much more time thinking about what it is that we want to spend money on. If the sticking point is, "Where should the money come from?", let us face up to and tackle that. My own feeling is that it is up to Governments to come up with proposals and put them—quite possibly privately, initially—to opposition parties to see whether they can get them to agree. Asking opposition parties to buy in when they are not in charge is asking quite a lot, but that is probably something for the Institute for Government rather than for an economist.

How do you get continuity over Parliament? You make sure that it is a sufficiently good idea, that people like it enough and then you cross your fingers.

Nick Davies: As I said earlier, the evidence suggests that inquiries can be an effective way to build cross-party agreement and take decisions on what are otherwise politically controversial issues. Clearly, there are also

a lot of examples of inquiries and commissions that have not been effective, so I would say there are a number of things that any commission would need to have in place in order to maximise the chances of it doing its job.

First, it effectively needs to be commissioned by the Government and there really needs to be buy-in from at least one, but ideally both—and I mean active buy-in—from the Prime Minister and the Chancellor, because in previous cases one or two of those not being on board, or at least not fully committed to it, has meant that when recommendations have been made they have not been implemented. Ideally, I think there also needs to be a proactive attempt to at least reach out to the Opposition. Clearly, it can be quite difficult at times to do that, but, for example, on the Parliamentary Commission on Banking Standards, which has been cited, that was commissioned by the Government and at least initially there was some scepticism in the Opposition about whether to support that process. Once it did get under way, I think partly due to the skilful chairing of Andrew Tyrie, it was able to build and bind in the Opposition to that.

On the type of inquiry, people talk about royal commissions. There have been two in the last two decades, neither of which has been implemented. A royal commission is probably an unnecessarily onerous way of going about this. A parliamentary commission or a commission along the lines of the Turner review into pensions would be more effective and could probably report in a sensible timeframe.

Timing is quite critical. Past commissions that have been successful often have been commissioned shortly before an election and effectively have parked the issue for an election and then reported shortly afterwards. That has then given a mandate to implement them.

The other issue is that, if they report at the beginning of a Parliament, sometimes it can be easier to make controversial decisions at the beginning of a Parliament. Clearly, that is not where we are now and there is a critical need, but I think a commission reporting within nine months or a year could be done either as a parliamentary commission or, as I say, in a Turneresque way.

If it is to be done, it clearly needs to be properly resourced. All the commissions that we have looked at have either had very effective and high-calibre civil service support or, as in the example of the Parliamentary Commission on Banking Standards, were able to draw on the expertise of Clerks within the House and to second external experts, including the use of counsel. I do not think counsel would be necessary for this inquiry because it is not investigating a particular incident that has gone wrong, but, clearly, the fact that Government were willing to underwrite the additional costs incurred by the Parliamentary Commission on Banking Standards was very important to its success.

I have touched on it already, but clearly the leadership of that commission is critically important. It needs to be someone who has the respect of both sides of the House and can get not just the policy but the politics right. I do not think there is any single right solution, but there are a number of solutions that could garner sufficient public and political support. They therefore need to be sold effectively.

As I previously mentioned, public engagement is absolutely critical. One reason why the Turner review, for example, into pensions was so successful is that they put a huge amount of work into public engagement, including an event with over 1,000 people in different parts of the country. They also started that early, were quite open minded about their potential solutions, and their recommendations were genuinely guided by what they heard from the public. Critically, they also showed that their recommendations, or the argument for them, could be won with the public, and that was really important in getting on board, I guess what you might call, elite stakeholders—representative bodies who might otherwise have been cautious about supporting things that, for example, suggested raising the pension age, but because it had been shown that the argument could be won they supported them.

Finally, in terms of the resourcing, there needs to be some follow-up. Again, with successful commissions, the risk is that they just stop immediately after the recommendations are made, and unless there is any threat of following up on them there is less incentive for the civil service and Government to get on with implementing them. That is clearly one advantage of using a parliamentary commission, particularly if it involves people from relevant Select Committees, because those people would obviously then be interested in following up and holding Government to account for any commitments they had made.

In terms of the role—I am sorry I am talking quite a lot—of a potential and independent body, you have to consider the different types of roles that different independent institutions play. To bring in two that are sometimes referenced, the National Infrastructure Commission and the OBR have quite different roles. The National Infrastructure Commission is effectively, for its main job, a rolling five-year review publishing an assessment of the 30-year needs of the country in infrastructure and making policy recommendations. That sort of offshoring of highly political issues is probably possible in infrastructure, although we have yet to have the first NIA published.

I am unsure whether an independent institution could do that for something as politically contentious as health and social care. A more likely model for success is the OBR, which is effectively providing forecasts and holding the Government to account, assessing the validity of their forecast and their spending plans. I suspect if you were to have an independent institution, it would be that sort of auditing role that it could play more effectively, potentially providing a solid base of data on

which a discussion could be held rather than making policy recommendations.

Professor Knapp: Very briefly, I took the opportunity to talk to one of my colleagues at LSE, John Hills, who was one of the pensions commissioners, and Nick's characterisation of what they did was exactly what he recalled. This area could learn a lot from the successes of the Pensions Commission in engaging the public in the difficult issues, in engaging civil servants, in engaging, in different order, the Chancellor and the Prime Minister, with interesting background stories there, and I think it had exemplary leadership. There are some key elements, which I think we could learn from in relation to social care financing.

Simon Bottery: Our approach is along the lines of that broader question about how we engage the public in this debate. Based on the conversations we had at the deliberative events, my strong sense is that we might be better off talking about the burning platform—the ageing population and how we create a decent, affordable social care system for that ageing population rather than trying to unpick what is wrong with the current system, which we know most people do not understand and, having spent a lot of time with it, is extraordinarily difficult to explain to people. I would start at the point of: we know have an ageing population, we want a decent social care system that is affordable and it is going to cost a lot of money. I would start at that end rather than what is wrong with the current system and why it needs to change.

Chair: Thank you. It has been really helpful to have your thoughts. Does anyone have any further questions?

Q61 **Andrew Selous:** I have a brief supplementary. We have already legislated to bring in your proposals, Sir Andrew. They come in anyway in April 2020 if we do nothing. How would you revise your proposals, if at all? Would you bring the date forward? What has significantly changed since 2010-11?

Sir Andrew Dilnot: The Care Act implements a version of our proposals. It did most of what we suggested on the means-tested system and introduced a cap at a significantly higher level than we suggested. I do not think my views have changed very much since 2011, except to say that the system faces more strain now. In 2011 I underestimated the importance of the market failure for providers as well as for individuals. I am now more interested in how important funding reform is to make working and investing in the sector feel better than I realised then. Otherwise, I do not think I have changed my position.

Andrew Selous: That is very helpful, thank you.

Chair: Thank you. Are there any points that you were hoping to be asked or points you would like to make? No. Thank you all for coming this afternoon.

HOUSE OF COMMONS