HOUSE OF LORDS

Select Committee on Economic Affairs

Corrected oral evidence: Social care funding in England

Tuesday 23 October 2018

3.35 pm

Watch the meeting

Members present: Lord Forsyth of Drumlean (Chairman); Lord Burns; Baroness Harding of Winscombe; Lord Kerr of Kinlochard; Lord Lamont of Lerwick; Lord Layard; Lord Livermore; Lord Sharkey; Lord Tugendhat; Lord Turnbull.

Evidence Session No. 2 Heard in Public Questions 14 - 23

Witnesses

I: Warwick Lightfoot, Head of Economics and Social Policy, Policy Exchange; Kathryn Petrie, Senior Economist, Social Market Foundation; Harry Quilter-Pinner, Research Fellow, Institute for Public Policy Research.

Examination of witnesses

Warwick Lightfoot, Kathryn Petrie and Harry Quilter-Pinner.

Q14 **The Chairman:** Thank you very much for coming to the Committee. I am sorry that we kept you waiting for a bit. We had one or two items of business to deal with.

I will begin with an easy question. What is the scale of the social care funding challenge, and how immediate a problem is it to address?

Harry Quilter-Pinner: Thank you for inviting me. The scale of the challenge is as big or as small as we want it to be. It is a political decision about how many people we want to access care and how high quality we want that care to be. There is broad agreement in the sector that the system is inadequate, that too many people do not receive care and that too much care is not of the right quality. If we are looking to deliver a first-class social care system that provides access to all those who need support when they get older, it is clear that we need immediate investment in social care to deal with the immediate crisis, and then there is a longer-term sustainability funding challenge.

The Health Foundation did some modelling and said that to fund the existing system properly as it stands would need an extra £9 billion per year by 2030. If you wanted to make the system more generous, which most people think it should be—it should offer more people access to care—moving to something like free personal care would need around £19 billion a year by 2030. The gap is significant in the context of existing social care spending, but in the context of overall government spending it is very small.

Kathryn Petrie: There is an immediate issue as to whether social care needs fixing today or not. It is not something that can necessarily be fixed within one Parliament. We are talking about very big issues of how we fund social care in a way that is sustainable not just in 2030 but in 2050, because those sorts of decisions cannot be made in a short-term space or have short-term implications. If we are talking about long-term changes to the social care system, we need to make those decisions not quickly and not necessarily within one party. Cross-party consensus is a great place to start. Yes, it is an immediate issue for those in the system today, but actually sustaining it is potentially more important than fixing the problem right now.

Warwick Lightfoot: There are very serious pressures and problems in social care at the moment, but it is worth remembering that in the last 40 years we have travelled a very long way. I began my working life as a general messenger at a big district general hospital called Freedom Fields. Then, much of the social care was carried out in geriatric wards in hospitals, which were most disagreeable places to be in. A whole range of people needing different forms of care would be in the same place, and often people with early onset dementia were in that kind of ward; I think they were called Nightingale wards. We have largely moved away from that.

We should start by recognising that we have travelled a long way and we have had substantial and very welcome improvements in the last 40 years. The Care Quality Commission shows in its latest report that, on the whole, care is quite well carried out, but there are genuine pressures throughout the whole system. The most difficult thing is to work out how much more money needs to be put in the system at the moment to make it work properly.

As I see it, there are two dimensions to the challenge we face. One is that, ever since the foundation of the National Health Service in the late 1940s, the Cinderella in the care continuum has been social care. More than 40 years ago, Sir Keith Joseph, when he was Secretary of State, and perhaps Dick Crossman before him, identified the lack of priority given to social care and to the diseases of a chronic character associated with old age. In relative terms, we have put too much money into the acute sector and too little into chronic conditions; to manage diabetic leg ulcers, for example, or for community nurses and so on. Social care has been a particular Cinderella. That will take a long time to correct and get right. We probably do not want a race to do it, because that would result in a lot of misapplied public expenditure. It is difficult to get a precise finger on the underfunding.

The second part is structural. When we set up the National Health Service in the 1940s, the decision was made that social care would be financed by individuals until they fell into the hands of the social security system and came under the National Assistance Act 1948. We have now got to the stage where many more people have complex and difficult social care needs, and they have to finance themselves until they are cleaned out of their financial assets, yet a whole range of other medical needs are dealt with totally free. If you have good eyesight, you can just about see a ganglion cyst on my palm. I will not allow it to be dealt with, because the physiotherapists say not to. I could happily have that done at St Mary's, Praed Street, and not pay a penny, but if I have a funny turn in front of you, have a very serious stroke, am seriously disabled and need a great deal of social care, I shall have to finance it all myself.

There are all sorts of examples of very odd conditions that are fully funded through the health service but left alone in the social care service, unless you meet the tests of the social security system. To put that right in today's money would really be quite modest in public expenditure and national income terms: about 0.4%, or 0.5% or 0.6% of national income. For self-funders in long-term residential care settings on a UK basis, it would be about £7 billion, and for self-funders in domiciliary care it would probably be another £3 billion or £4 billion, so we are talking about something like £10 billion or £11 billion. Of course, there are substantial pressures in the future, which we should not forget.

The Chairman: Do your numbers take into account the effect of making more resources available for people who are already providing care and not depending on the state? When you come up with a number such as £11 billion, are you taking into account the fact that if more resource is

made available, people who are managing without help from the state will become an additional burden on the state?

Warwick Lightfoot: Before I go into the numbers, it is fair to say that getting a neat taxonomy of numbers that all sum to 100 is very difficult. Most reports that have been written about this have suitable grammatical elisions of meaning, and you can never quite get to the bottom of what is what and where is where.

The best guide to how much is being spent by self-funders in the care system comes from the Competition and Markets Authority study of the care home sector. It is about £7 billion in the UK, including the cross-subsidy for local authority-purchased care in homes. The least tractable number to get hold of is how much is being charged for people who meet the criteria for receiving care, and have assets and get charged in their own home through the domiciliary care system.

There is an issue around whether relaxing the astringent means-testing regime would call forth more demand. I am not so certain of that, because very few people who need care actually want it, even if they can afford to pay for it. How many people do you know who desperately need meals on wheels and a home help, and resist it to the bitter end, way beyond the time when they should be prepared to accommodate such a service in their home, and are very reluctant to go into a residential care setting?

The Chairman: That was not my point. My point was that people may have care in their home, and their families may be paying for it because they cannot get it any other way, but if there was more supply that would be taken up. That was the question.

Warwick Lightfoot: It is very difficult to estimate that.

The Chairman: I know. That is why I asked the question.

Warwick Lightfoot: It is very difficult to estimate, but remember that the criteria before you receive the care are very tightly drawn, and you cannot just volunteer for it.

Harry Quilter-Pinner: The numbers that the Health Foundation produced with the IFS are the most reliable. They estimated that the cost of free personal care would go from what we spend now, which is about £19 billion, to £36 billion in total. They used three different methodologies, all of which assumed that the offer would induce people who are currently not even trying to get care through the state system to get that care. The Scottish experience shows that there is an increase in numbers of people. There, they estimated the cost of introducing free personal care, introduced it and had much higher demand than they thought they would have originally. That was factored into the Health Foundation numbers.

The Chairman: The Scottish experience is that there is free care but you cannot get it, because it has to be rationed.

Harry Quilter-Pinner: Indeed, because it is not funded properly.

Lord Burns: If I wanted to find out how much was being spent in total by the private and the public sector on social care, would I be able to do that, including money spent on care homes and money spent in the home?

Warwick Lightfoot: It would be quite difficult. From the latest piece of work by the Competition and Markets Authority, you could probably get quite a good sense of what is spent in residential care homes.

Lord Burns: Both private and public?

Warwick Lightfoot: Yes, but remember that there are very few public homes left.

Lord Burns: I meant paid by the individual as opposed to being paid by the local authority.

Warwick Lightfoot: Yes, you can get what local authorities are paying and you can get what private individuals are paying. You can probably get a fair gist of what local authorities are paying for care inside people's own homes. What will be difficult to get easy purchase on is a situation whereby you and I may be at home outwith the care system, paying for our own care and commissioning it ourselves.

Lord Turnbull: Another dimension is the unpaid care that the family provides. One thing that could happen, and you can make up your mind on whether or not you think it is a good thing, is that, if more resources were available, some very hard-pressed families would be able to afford care and to take pressure off themselves. I personally think that would be a good thing rather than a bad thing. There would undoubtedly be some degree of what the Treasury would probably call leakage, but it is one of the variables that has to be taken into account.

Baroness Harding of Winscombe: I presume that the numbers you have all quoted are all gross for incremental cost over time, assuming no changes in efficiency. With my NHS hat on, it is clear that, while demand for healthcare is growing, there is also an enormous opportunity to be more efficient and deliver better outcomes for service users. What are your views on the opportunity to get to a net number that is not so large, through better use of resources?

Harry Quilter-Pinner: Social care is one of the least productive sectors; it is not performing particularly well productivity-wise or compared with social care systems in other countries. That suggests that you could get some efficiency. Having said that, all the numbers done by the Health Foundation and the IFS assume no productivity gain, because the system has been squeezed so far that there is not much more to squeeze out of it. None of the numbers we would cite in an IPPR report, for example, which we would think rigorous enough, would assume productivity on top of that.

Q15 **Lord Sharkey:** What principles do you think should underpin the funding of social care? I notice that the DCLG and Health and Social Care Select Committees in the Commons had a go at this, and they suggested six. How long would your list be?

Kathryn Petrie: This summer, at the Social Market Foundation, we wrote a paper on funding social care, looking at it across a few distributional consequences. We are particularly interested in where the funding is being raised from and how it affects people by level of wealth, income, generation and gender. We know that, predominantly, men tend to pay income tax; it is in the data. Those working over the age of 65 also tend to be men. If we introduced national insurance for those working over the age of 65, we could look at how those policies affect people.

On the other side, if family members could suddenly benefit from not having to provide care that was breaking them in some ways, and could start returning to the labour market, it would predominantly have consequences for females. There are many ways to look at it. As well as wealth and income, how does it affect the different genders and generations? We would suggest that the policy needs to be sustainable over the long term. Those would be our principles.

Lord Sharkey: I was not very clear that the first bit of what you said was a principle. It struck me as being a list of problems.

Kathryn Petrie: Yes, there are distributional consequences, so I would say that there should be fairness.

Lord Sharkey: Would anybody else like to have a go?

Warwick Lightfoot: How I would look at it, and how my colleagues at Policy Exchange would look at it, is where you would choose to intervene. What is the rationale for intervention? My thoughts have been guided substantially by the US healthcare debate of some 25 years ago, when Mrs Clinton was trying to make her healthcare changes. That stimulated an extremely interesting debate, although the result may not have been satisfactory.

You should try to intervene when a person cannot afford to pay for the care themselves, either because they are in a low-income household or just because it is very expensive; when they cannot take out insurance that would realistically cover it; when the nature of the care is so expensive that no insurer would deal with a catastrophic event such as certain forms of cancer, or it is just too difficult; or when there are chronic conditions, where no insurance market would work because the condition is recurrent without insurance.

What is very odd about the UK position is that many of the medical instances that we could pay for ourselves, such as going to see a GP or having certain forms of procedure that could be covered by insurance, we choose to provide collectively for people, and I have no dispute or difficulty with that at all, yet the one area on the continuum of care that

often we cannot pay for ourselves, which could bankrupt you and where insurance markets of a private character simply do not operate, is where we invite you to take full responsibility for yourself.

Harry Quilter-Pinner: We produced an independent inquiry into health and care over the last year, chaired by Lord Darzi; Lord Prior was also involved. We said that, across the health and care system, four principles should underpin reform. Care should be accessible, so you should be able to access it if you need it; it should be joined up between health and care systems and beyond; it should be personalised and not a one-size-fits-all system; and it should be preventive.

The more interesting thing we said was that social care should increasingly be universal. I agree with Warwick's comments. We have tried having a health system and a care system with different principles for access and entitlements, and our view is that it does not work. It does not work morally. Why should a dementia patient be treated differently from a cancer patient?

It does not work economically. We know that the lack of an adequate social care system is leading to delayed transfers of care and increased admissions. Economically, it would make sense to invest more in social care, so we should move to a system of free personal care on the same basis as the NHS. The only difference would be that you would contribute to your housing costs.

Lord Sharkey: The fourth principle that the Commons Select Committee suggested was that we should aspire over time to move towards a system that is free at the point of care. Mr Lightfoot and Ms Petrie, do you agree with that as a fundamental principle?

Kathryn Petrie: Yes, as a fundamental principle, free personal care is the way forward.

Warwick Lightfoot: Yes, it should be free personal care, without a means test but with an assessment of need.

Lord Layard: If you could not have free personal care because it cost too much—and let us assume that that is probably the way things are—you would have to choose between spending what money was available, which is £4 billion or something, on providing for needs not now being met, or protecting some of the people who would otherwise go bankrupt. How would you rank those different ways of spending that money on social care?

Kathryn Petrie: I do not think they have to be mutually exclusive. Yes, at the moment we may not be able both to meet current unmet need and to make sure that nobody faces the catastrophic costs that they face today, but we can look at other ways of raising the money. We should not just assume that because there are difficult political decisions to make, we should not make those decisions. Whether it is a change to the tax system or to wealth-based taxes, there are ways forward through which

we can implement a cap and a floor in greater needs measures or offer free personal care. It does not need to be an either/or situation.

The Chairman: Given that the model you have described is what I understand the Scottish Government have introduced, how do you think it has worked out?

Harry Quilter-Pinner: The evidence from Scotland is interesting. There are a couple of points. The main point is that it has not been funded properly. In an ideal situation, you would fund the system properly and get different outcomes from the ones in Scotland, and some of the challenges that Scotland has faced, such as the rationing you referred to earlier, would be less pronounced. There is a load of lessons to be learned from how it was implemented there. For example, there was no clear definition of free personal care, which led to a whole load of challenges on what people were or were not entitled to.

Broadly, the Scottish evidence shows that, if delivered alongside reform to the delivery of the system, there are areas that have drastically reduced delayed transfers of care, for example. Satisfaction with social care in Scotland is higher than it is in England, and support for free personal care is very high. There are no very good metrics on quality; we have looked closely at whether you can compare quality, and it is very difficult to do, but it would be an interesting comparison. I certainly do not think that Scotland is ideal or that free personal care is the only solution, or the only part of a solution, but it would be a great step forward from where we are the moment.

Warwick Lightfoot: Given the highly constrained choice that Lord Layard presented, I would start by dealing with the iniquity of the self-funders having the transfer payment to publicly provided care that the Competition and Markets Authority exemplified so clearly in its work. I would start with that and try to make the means-testing regime less draconian for everybody who is caught in it, starting with those going into long-term residential care settings.

Lord Layard: And you would not improve the standard of care, not with the first lot of money.

Warwick Lightfoot: I am trying to identify the principal pinch-points that are extremely difficult. Care homes being funded as they are at the moment is simply not sustainable.

Lord Burns: What does free personal care mean for people who continue to live at home? Does it mean that some third party decides what service is appropriate?

Harry Quilter-Pinner: Yes, in the same way as in the current system you would be subject to a needs test and given entitlement based on that test. The difference would be that everybody would be able to access it for free; there would be no charge.

Lord Burns: In the National Health Service, part of the way you take

pressure from something that is free at the point of use is by a queuing system, but I do not see how that would work for social care.

Warwick Lightfoot: It turns on the criteria used for the basis on which you offer care. For example, some local authorities have very tightly drawn criteria before you can access care. I think I am accurate in saying that one of the few authorities that continues to offer moderate care needs is a London borough of which I used to be a member, Kensington and Chelsea. You ration the care; the gatekeepers, who are the social workers, ration care according to their budgets.

Lord Burns: That is what you would expect to happen under a system that was free.

Warwick Lightfoot: If you do not have a pricing mechanism, you would expect an administrative rationing system, done by a gatekeeper.

Lord Turnbull: If someone needs care, they can have it either at home or in a home. At home could mean someone coming in once, twice or three times a day, someone living in or family helping; in a home, you would get all that done in one place. Is there any reason to think that one of those channels over time would be better than the other?

There are pros and cons. People might like to stay in their home, but it is probably an inefficient way of providing care, with people coming in at different times of the day through the traffic. Is there any reason why we should try to nudge people in one direction or another, or should we try to create a level playing field, giving people a choice as to whether they are at home or in a home and making it their decision?

Warwick Lightfoot: I worked for the Treasury as an adviser at the time when the Government accepted the recommendations of the Griffiths report. The important part of that was that there should be no perverse incentive to cause people to be placed in one form of care or another, which they might not choose or need. Working out when an individual should go into a residential care setting is one of the most difficult things for families and professionals working in the field. The step of going into a residential care home is very challenging because, however good the home is today, however nice Matron is, however good Cook is and however nice whoever is in the next room, tomorrow is another day. It would be wrong for public policy to try to direct people to make that decision in a way that is outwith their own judgment.

Kathryn Petrie: The current system tends to favour care within the home, purely because of how it means-tests assets. If you receive care in your home, your home is not included in the valuation of assets you can deplete, so there is a preference to stay at home rather than moving to a residential care home. We already have preferences in policy.

Lord Layard: To go back to the issue of protecting people who would otherwise pay for themselves, the problem is that the private market will not supply insurance. Is an alternative that the state should operate an

insurance scheme? It might not be completely insolvent, as a private one would have to be and therefore not workable. Why can we not have a state insurance scheme whereby people can protect themselves against those costs if they become liable for them?

Warwick Lightfoot: A state insurance system becomes, effectively, a public expenditure and tax regime by another name.

Lord Layard: No, I meant a voluntary state insurance scheme.

Warwick Lightfoot: We would find ourselves getting into the sorts of muddles that so disfigure so much federal government expenditure in the United States, where you have the black lung programme, the trust fund for social security and the trust fund for Medicare. Instead of focusing on which service should be offered, how well focused it is and how well managed it is, whether it conforms to being economy efficient and all the normal stuff you want to be doing, you would spend most of your time asking whether the fund has money in it and whether the levy is just about matching it. It is extremely difficult to make that kind of arrangement work.

Q16 **Lord Lamont of Lerwick:** I apologise for being late; I was listening to the Statement. The question I am scheduled to ask is a rather general one about how social care costs can be fairly distributed, which I guess means between private, public, means-tested or capped. What is a fair distribution of the responsibility?

Harry Quilter-Pinner: As I mentioned earlier, the IPPR has been very clear. To add to the conversation we have been having, we think that the best means is a national system similar to the NHS, where the risk is borne collectively through the state and funded through general taxation.

There are many challenges with a voluntary scheme, and I agree with Warwick's concerns. One challenge is that, unlike healthcare, which everyone is bound to need at some point and therefore has an incentive to save and insure themselves if they can, which is a crucial question, probably only one in five people will need social care. Faced with that choice, a lot of people will decide that it is not worth the cost of saving. It is a very clear area where a collective solution offers the best and most efficient option.

Kathryn Petrie: If we are talking about fairness of funding, changes to tax law on income might be a way to go. We were looking at the fairness of the policy in general. If we increased income taxes to pay for a free social care system, it would fall predominantly on those of working age, because they pay the majority of income tax. The older population pay income tax, but the median amount they pay is not significantly large. It falls on those of working age. Is that distributionally fair and is it generationally fair? We would say no. Income inequality is an issue in this country, in the population, and wealth inequality, particularly between the generations, is quite a stark problem.

The Chairman: We have heard evidence that half the budget goes on

people who are not elderly, on young people. What does that have to do with intergenerational fairness?

Kathryn Petrie: I would raise the funds for elderly and social care very differently from how I would raise them for adult-age social care, particularly for children and those of working age. Those who need care in their 70s and 80s have had a lifetime to build up assets; those of working age who need care at 30, 40 or 50 have not necessarily had the same chances, so I would pay for that through a general taxation system. We need to be clear that they are two very different groups of people with different needs, who have had different lives, so I would separate them as different issues.

Lord Lamont of Lerwick: You did not mention what the Social Market Foundation recommended—a one-off payment. I am surprised that you did not refer to that.

Kathryn Petrie: I was getting there. We have recommended a one-off payment at the age of 65, which could be deferred until death. It would be roughly £30,000, but it would offer free personal care throughout your life. We know that roughly one in 10 people faces charges of around £100,000 and the median is between £20,000 and £25,000, so it is not much larger, but it would cover care costs throughout a lifetime. We would be taking a substantial amount of money away from certain groups of people. Obviously, the threshold would be means-tested; we suggested anything more than £150,000 per household per adult in the household, so for a couple it would be around £300,000. They would each pay £30,000 for free social care for the rest of their life, which could be deferred until death, so we would not be sending people an invoice at 65.

The Chairman: Do you think that is an election winner?

Warwick Lightfoot: My starting point is that, in the end, long-term social care must be provided without charge to cohere with the National Health Service. Baroness Harding asked a very interesting question about efficiencies and synergies. In the costings, I did not include any of the potential savings. I simply do not think that the National Health Service and social care will cohere until we have actually dealt with that complex means-testing question. That will be the only way to make the system work.

If you start from the presumption that it is going to be public expenditure and ask how you would finance it fairly, I would say that it must be through general taxation, and through borrowing when you do borrowing, with a decision being made about how best to collect that general taxation and how to have a balance between deadweight cost, progression, fairness and so on. I would not have any specially directed tax going for one identifiable piece of expenditure. That is the route to mantelpiece economics.

Lord Kerr of Kinlochard: All the answers to each volley of Lord Sharkey's question concerned old age. I am an amateur in this, so could

you explain to us what happens under the present system when special needs children in schools fall out of the school system? I have the impression that a lot of attention is given to them, although it varies with the local authority. We seem to have fewer colleges to help people with physical or mental problems to find a role in the world of work. What happens to those people, and what assessments of their needs are made at 16 or 17, or whenever the school regime, which has to some extent protected them, comes to an end?

Harry Quilter-Pinner: It is not an area we have done a huge amount of work on.

Warwick Lightfoot: I may be able to help you. What normally happens is that there is an awkward overlap between the family and children's services and the adult services. In general, the service available for family and children's services in unit cost terms is somewhat more generous than for adult care. The guardians and parents of a learning-disabled young adult may become very anxious and nervous in the transition period.

The adult social care service has responsibility for doing an assessment and finding appropriate placements, appropriate places to live and work, and so on. Of course, that does not always work. I am no longer a member of a local authority, but 10 days ago I helped some very anxious parents when, at the very last minute, a particular authority failed to deliver on the care it had promised them all the way through, until it was time to go to the college three weeks later. It is a very real problem.

If you speak to the Association of Directors of Adult Social Services, you find that the fastest-growing component of social care spending at the moment, as I understand it, is for young adults carrying on into middle age who, in the past, might have had a curtailed life expectancy. That is quite a challenge.

There is a further point about young adults, old age and social care. We have a tendency to think that all this social care stuff is about someone like my mother, who is 91 and a half, but there are a lot of people who are much younger—in their 50s and 60s—and even younger, if you are unlucky enough to have a stroke when you are 37. Sometimes you can be brought into the disabled care regime, which can be quite generous, but you will be surprised how many people do not qualify under that regime, and fall under the wider social care regime, despite being below 65. The other thing that can happen is that if one of two people in a household has early onset dementia or early Parkinson's, with behavioural problems that need complex social care, and they eventually die, the partner left behind finds that the household balance sheet is very different from what she was expecting, because of the social care costs.

Harry Quilter-Pinner: I have a point on the taxation question that Lord Lamont asked. It is crucial that we disaggregate the conversation about social care and wealth taxation, which have obviously been joined for quite a while in the policy and public conversations, and I understand the

logic of that and the intergenerational fairness issues. The challenge is that both fit into the category of "too difficult". Politicians see them as too difficult, so you are tying together two issues that are too difficult.

No country in the world has managed to get the wealth taxation question right. If we set the bar to solving social care at getting wealth taxation right, we will never solve it. We would not look at Trident and say that we could not go ahead with a decision until we work out how we solve wealth taxation, and we should not do the same for social care. It is really important that we disaggregate those two questions.

Kathryn Petrie: Because my idea is on a wealth taxation basis, one reason why we came out with the flat-rate charge is that we want innovation in the market, and we believe that financial service providers could play a role. There is potential for people to prepare for a flat fee that they understand is coming, and there is a place for financial service providers to know that there is a flat fee coming and insure against that risk throughout your lifetime.

The Chairman: How much notice would they get?

Kathryn Petrie: If we implemented it in the Budget on Monday, a couple of years or a year.

The Chairman: No, I meant how much notice do they get to build up the money they have to pay?

Kathryn Petrie: You would know that it was coming, although you might not know the exact amount, because that would depend on demand.

The Chairman: But when would you know that it was coming?

Kathryn Petrie: We would have it at 65, so let us say that we implemented it for everybody who was 50 today.

The Chairman: At what age would you be told, and what notice would be given, that you were going to have to find this £30,000, or whatever it was?

Kathryn Petrie: That would be flexible, but let us say that we decided that in 15 years those who are 50 today would have to pay the £30,000.

The Chairman: Fifteen years is your proposal.

Kathryn Petrie: Yes.

Lord Burns: I was just imagining that I was sitting across the table from Lord Lamont doing a Budget, and that I was looking at this measure and the income distributional consequences of moving from the present situation to free care for all. It would show enormous gains for people on very high incomes and relatively little gain for people on very low incomes. I have to say that I would expect the Chancellor of the day to think very hard about that, when presented with that picture.

Harry Quilter-Pinner: You could say the same about the NHS; we could have that conversation now about the NHS.

Lord Burns: But that has been going for many years. Customarily, you look at the position as of today and compare it with what the change is going to be, and the impact of the change when you make and introduce your new policy. That is the picture you would be faced with, and I put it to you that it would look pretty scary when you had to present the income-distribution consequences of your Budget.

The Chairman: It would be interesting to hear the IPPR response to the suggestion that you are proposing a big transfer of wealth towards some of the richest people.

Harry Quilter-Pinner: If you look at any of the options on the table, the only genuinely progressive option would be to increase the means test. Even Dilnot's proposal protects the wealthiest people from paying the full cost of their care. Most of the conversation that we are having here is, in the purest sense, regressive.

How do we get a system that is fair and effective? The challenge we have at the moment is that, for anything that is not free personal care and not completing the welfare state or the NHS, to use the phrase you used earlier, we struggle to get a political conversation that leads to an outcome; we struggle to make a case for it. The challenge we face is how to have a public conversation that leads the public to say, "Yes, we will allow you to put up tax to fund social care". Free personal care would allow us to do that in a way that made sure that the most vulnerable people had access to social care.

Warwick Lightfoot: Many of the people getting free care will not be hugely well off; they will be people on quite modest incomes. I was chairman of the social services committee in Kensington and Chelsea, and you would be surprised by how much resource seems to have disappeared for many people in the later parts of their lives, when they need care in their own home and go into a care setting. It is not because they are being clever and tax planning, or anything like that; it is due to the real vicissitudes of life. Funnily enough, people do not save as much as they think they do, particularly those who have not worked in a final salary scheme, such as in the public service. It is a very different story for people who were once very successful barristers, for example. I have been quite surprised by the people I have tried to help with housing benefit and all sorts of things at that part of their life.

The Chairman: Okay, point taken.

Q17 **Lord Layard:** I want to move to the role of local authorities. When there is such variety in the scale of need across local authorities and in the funding base across local authorities, does it really make sense that the local authority is doing the funding? That is the first question.

Secondly, if you move to national funding, you could more or less combine it with the NHS, which is sort of what has been done in

Manchester. Does that make a lot of difference? Are there a lot of savings to be made, on avoiding bed-blocking and so on, by combining the two budgets? There are two questions: local authority versus national, and combining with the NHS to avoid the costs of bed-blocking, and so on.

Kathryn Petrie: I can talk about the first part of the question. I am not an expert on the situation in Manchester, unfortunately. At the moment, we have a large issue about the amount of capacity a local area has to raise funds and the amount of need in the area, particularly if we start to look at council tax precepts. It just does not correlate with the need or the ability to raise the funds. A national fundraiser and distribution based on need is the way forward, in my opinion. I cannot speak about the joining of the NHS and social care, unfortunately.

Harry Quilter-Pinner: I agree entirely with that point, so I shall move on to the second point. To start with Manchester, the evidence that integrating health and social care is the right thing to do for the patient as regards quality and experience is well established. The evidence that it saves huge amounts of money is shakier. There are examples where it would save money, and things that you can identify where there definitely could be a saving. For example, there could be a reduction in delayed transfers of care, but the actual cost of delayed transfers of care is absolutely minute compared with the NHS budget; it would be about £1 billion rather than multiple billions. The case for it is about the quality and experience and, potentially, the financial savings, but I do not think they are massive.

We have done a lot of work on what is happening in Manchester. The evidence supports what I have just said, but I think in Manchester they would say that they cannot go further without the funding system being integrated in the way we have discussed and, crucially, without it being funded, which is probably more important. Finally, in joining up the two systems, they are struggling against the Lansley legislation.

A crucial point is that, even if the funding mechanisms were aligned, as we have discussed, there would be huge accountability differences. Local government would argue that the thing that makes it uniquely placed to deliver social care is that it is democratically accountable and the NHS is not. The NHS would say that local government does not have targets or the infrastructure to deliver social care at scale.

If you can do all that, how do you go about merging the systems? Again, I would look at Manchester and Scotland where, essentially, joint boards of local government and NHS leaders manage those systems. Scotland is more formalised and it is put into legislation, whereas Manchester is very informal, but that is probably how you have to go about it.

Warwick Lightfoot: Many years ago, when I first took an interest in this, I thought that a priori it made sense to have social care and health together. Someone I got to know very well had been a director of social services in Northern Ireland, where the systems are effectively together, and he said that we should be careful what we wish for. The problem of

the acute service taking a disproportionate amount of the resource, and the incoherence between free at the point of use and the astringent means test, made it very difficult for the services to cohere. He said that merely integrating local government with health on social care would not deliver what we wanted because of those structural issues. When the head of the National Health Service in England gave evidence to the House of Commons Select Committee, he more or less referred to the early origins of the service.

Until recently, that would have been where I drew stumps and stopped, but I am conscious that there are very big changes in local authority finance at the moment. Having had one of the most sophisticated grant regimes, whereby two-thirds or more of local authority finance came from grant that was very carefully calibrated to relative need, we are moving to a much clumsier system, where grant will play a smaller part. The needs assessment will be much less frequent and less precisely honed, and there will be greater expectations that local authorities rely on expanding their revenue from their council tax and business tax base, which are non-buoyant sources of taxation.

Over the last 15 years, education, a very important service, has effectively been bypassed from local government, so there is not the same depth of finance officers, lawyers or change managers working in a local authority setting as when I was first a councillor 30 years ago. One has to ask some quite probing questions about whether social care in the long term should be located in a local authority setting. I do not have an answer to your question, but I would certainly say that it is something one has to probe quite hard.

Q18 **Baroness Harding of Winscombe:** Could we talk about the provision of social care, and the provider sector? How would you define the social care market? Is it local or national? What is not working in it and why?

Warwick Lightfoot: Essentially, it is a combination of national and local. The national story is the means test and social security rule set, which guides what someone will have to pay if they do not have the money. Then there is the national grant provision to local authorities that has resulted in spending on social care falling by some 11%, more than almost any other service provided by local government over the last seven or eight years.

The market will vary greatly depending on where you commission the services, whether it is a company providing homecare services or you are commissioning places in a residential care setting. For the people providing the homes, it will turn on how expensive it is to set up a home, with property prices and things like that. It will depend on the people coming into your home who are selling their home; they could have quite a lot of money from the sale of a house in Surrey, but it is different if you are selling a flat in Knowsley.

We see evidence that, because care providers cannot get enough from local authority-commissioned places, they are beginning to withdraw from

areas where there is an insufficient number of self-funders. In some places, where property prices have gone up a great deal, and against an increasingly challenging expectation of service, regulation and inspection, some people who have run rather good homes say, "I have a substantial capital gain on this premises and, in an orderly way, I would like to move out of the market, call it a day and cash in the capital gain and convert it into flats, or whatever".

That is an unfortunate dynamic in the market. Quite often, some of the larger homes, which always have spare capacity, may say, "We got through the last inspection, it was a near-miss but there you go. We're still in business, and we can accommodate some more". The smaller homes, which are the ones we might like to live in, withdraw from the market. There are limited economies of scale, but larger homes of around 60 people tend to be more viable and smaller homes are less viable. This is anecdotal, but people tend to prefer the smaller homes, and there is some evidence from the Care Quality Commission that inspection reports on those smaller homes are rather better on satisfaction than on the larger ones. A lot is going on there.

I am neutral on whether the service should be commissioned in a private home or publicly commissioned by the local authority owning the home. If you commission all your services with another body and, for some reason, that market atrophies, you will have to pay some very high costs to put people in those places, and you have no control over the cost or management of the cost base you face. We see that particularly in expensive children's services of the sort that Lord Kerr was asking about, where some very challenging unit costs arise because there is a shortage of service and the people running it can name their own price.

The reason why local authorities have withdrawn from direct provision of the service is that they face inspection, which they did not face until 1993, when the National Health Service and Community Care Act took effect. Many homes did not meet inspection standards, not because they were being run in a bad way but because the rooms were not big enough or the bathrooms not nice enough. At that time, as I am sure Lord Burns, Lord Turnbull and Lord Lamont will remember, local authority access to borrowing through the Public Works Loan Board was highly constrained, so they did not have the capital to modernise the homes. In addition, a national England local authority cost base means that it is very expensive to own and manage the home yourself, so, nine times out of 10, it makes sense, when you can, to pass the management to somebody else, whereby you lose control of it all. I do not know whether that helps.

Kathryn Petrie: I have nothing to add on the care home point, but one issue for local authorities when they commission in-home care workers, those who visit once or twice a day, is that they have a restricted amount of money to pay for that service and often go to those who provide it at the cheapest rate. That does not always provide the best in-home care, which is not to say that the workers are not doing their absolute best

with the limited resources they have, but we do not necessarily judge a service on its outcomes to patients in the in-home care service.

Baroness Harding of Winscombe: Are you all arguing that if there was more money, the social care market would function just fine? Is there any evidence to believe that that is the case—that if we just increased the money we would have a better range of providers and a more functioning market?

Warwick Lightfoot: It is a significant factor, but, in commissioning care and where it is, there are issues to do with how the homes are managed and the national terms and conditions of local authority employees that give a bias to commissioning from the private sector, when it might be better on many occasions for a local or public authority to commission the home directly itself, manage it and have more control over it.

Q19 **Lord Turnbull:** Can we explore a couple of the sources of funding? Attendance allowance is hardly ever mentioned, but it comes to £5 billion or £6 billion. Is it means-tested? Effectively, does it mean that the family of anyone who needs care, and continues to need it when they move into a home, will get attendance allowance?

Warwick Lightfoot: Not necessarily, because getting through the gatekeeper to get the two levels—and the enhanced one is what you want—is increasingly difficult.

Lord Turnbull: Are there plans to drop attendance allowance? Will it still be a feature of the system?

Warwick Lightfoot: If there was care free at the point of delivery, there would be much less need for something like attendance allowance because the state would be doing it.

Lord Turnbull: Oddly enough, it is a bit like a voucher. Vouchers are underestimated in their value. You could pay someone a sum of money and someone who wanted to be in a slightly more luxurious home could top it up. We do not seem to have that provision: you are either a self-funder or at the local authority rate.

Harry Quilter-Pinner: I would need to check properly, but my understanding is that in Scotland you cannot claim free personal care and attendance allowance simultaneously. If we were thinking about introducing free personal care in the UK, we would have to think about what we wanted to do with the attendance allowance and what entitlements we wanted. We would need to have the same conversation on free personal care about NHS continuing care and how free personal care would sit alongside that, as well as a range of other benefits, potentially.

Lord Turnbull: Another variable in the system is the going rate, the rate that local authorities pay care homes. Is that set nationally?

Warwick Lightfoot: It is not by home, but sometimes it is placement by placement. Effectively, they use their bulk purchase opportunity to get it down as low as possible. Quite often, they do not take up all the places. It is almost a bilateral thing.

Lord Turnbull: But the pressure on local authority budgets is driving that figure down and down, and I suspect that it is now beginning to affect supply, with the minimum wage coming their way.

Warwick Lightfoot: Absolutely.

Lord Turnbull: Another point, which Lord Burns raised, is how you could possibly sell a Dilnot cap. With the Dilnot cap, someone who is reasonably well off, who might otherwise have paid £1 million on care, until they get down to some very low number, say £23,000, would be relieved of that and never pay more than X. Let us call X £100,000. On the one hand, we could say that we have been incredibly generous to that family, which would have paid £1 million but is now going to pay only £100,000. Or we could say that for a class of people, the way the funding is set up means that although individual families in the group have that windfall, as a class, well-off people would pay more than they were otherwise doing. How do you make it clear to people that that is in fact the bargain? If you cannot do that, as Nick Timothy found with the Tory manifesto, people will always point to the few families that apparently get a very large gain.

Harry Quilter-Pinner: The main problem we have had with social care, and one reason why we have not achieved more, is that people do not understand the existing system.

Lord Burns: Join the club.

Harry Quilter-Pinner: Indeed. That was partly what happened in the 2017 election. Once the cap was introduced, the proposal put forward by the Conservative Party was actually very generous; it was not actually that much cheaper than free personal care. But people perceived that they were being asked to pay for something that they thought they were already getting for free.

The key challenge for anybody who wants to solve this problem is that there needs to be an educational campaign about what the existing system is and what the proposal is. We have talked about a race to solve social care. I do not think anyone could claim that there has been a race; we have been at this for years and years. We cannot rush it, because first we have to explain it. Then the challenge comes; I am increasingly not convinced that you can sell Dilnot. By the time you have gone into explanations of the detail of it, you will have lost the general public anyway. That is partly why we are advocating free personal care.

Lord Turnbull: There are two benefits for better-off people. One is that they will not be eroded down to £23,000—it will be some other number—and they will never pay more than X. To make it fair, what is there on the other side? Housing could be brought into the calculation, and it could be

offset against the estate, but it looks like a one-sided bargain. There must be some way of juggling the variables to demonstrate that everyone is paying a bit more and the better-off are paying rather more. No one has yet seemed to come up with that solution.

Harry Quilter-Pinner: Having a political conversation to explain that during an election, even if you came up with a solution, is unrealistic. That is partly why I came down on the position I did: make care free at the point of need and find a progressive way to tax it. The rich pay more, in progressive taxation, and everyone will get care free.

Lord Turnbull: Is it more difficult than the long battle to persuade people that the pension age had to go up?

Warwick Lightfoot: Much more difficult. People can roughly understand that they get their pension money a year or two years later, or whatever it is, but I would not want to be the person to go out and sell these proposals. I have a colleague back at Policy Exchange who, during the general election, invented the soubriquet "dementia tax". Lord Forsyth asked, "Would you want to sell that?" I would hide under the table.

The Chairman: Lord Burns, get us out from under the table.

Lord Burns: You have explained that at the moment the general public do not really understand the present position, so, presumably, the general public do not have strong views on how social care should be funded, other than that there should be more of it, or are there any clear signals about what people think should happen?

Kathryn Petrie: We could look at the research. The King's Fund has done some great work on public perceptions of social care funding. At the moment, the majority of the public think that the Government pay for it and that it is free, that it is just like the NHS and that it will be there when they need it, which is not necessarily the case. I am not an expert on this because it was not my work. They tested people's attitudes on who they thought should pay for social care in future, and, predominantly, there was favour for shared risk between the individual and the state. There were two options for sharing and, when they were added together, they were more popular than the option for free personal care by the Government, but as a single option it was the most favoured.

Lord Burns: What do you mean by sharing?

Kathryn Petrie: People being able to pay until they cannot pay. I cannot remember the second option off the top of my head, because it is not my research, but there was a favourable opinion towards sharing risk between the Government and the individual.

Harry Quilter-Pinner: That is the art of polling. Who would trust polls after the last few years? Independent Age, a charity for older people, polled on free personal care and found 75% in favour. Read into that what you will. Choose which poll you want to use, and use it as evidence.

Warwick Lightfoot: The public do not fully understand how social care is funded, because they assume that it is like healthcare. In the main, those who have assets want to protect them, and some of them will kid themselves that you can extract wealth from other people, which might actually enable all difficult issues to be evaded.

We were talking about the role of wealth taxes and taxation. We have to have recurrent taxes on recurrent sources of income, and wealth is not the way to fund recurrent expenditure. We have to be realistic about it. You may want to go after wealth, but do not kid yourself that you can get the revenue in to pay for current public spending. The late Tony Crosland put it very well when, in a vivid expression, he said that we have revenue taxes, such as the standard rate of income tax, in his day—that takes you back a long while—and purchase tax, and we have political taxes, such as capital gains tax, inheritance tax and estate duty, but they are not there to bring revenue in.

Q20 **Lord Burns:** The Dilnot proposal put a lot of emphasis on insurance and the potential for an insurance-based system, if you took away unlikely but huge-impact events on people's lives. If the state could take care of that, there would be a possibility of moving towards an insurance system. What are your feelings about that?

Warwick Lightfoot: I am very sceptical about making insurance work. Trying to find an artificial set of arrangements to make an insurance market work is something I am very sceptical about. An example is the Affordable Care Act in the United States, which tried to make insurance work where it cannot do so, because of low-income households. They are trying to create artificial circumstances to avoid carrying out the public expenditure that they need to do. The one bit of the Affordable Care Act that has worked quite well was extending Medicaid, but the convoluted insurances people are taking out, and the very high co-payments before they can use them at all, makes it extremely difficult. Your Lordships would spend a lot of time investigating complaints about how the insurance had gone wrong. If you think about all the mis-selling that took place over so many years, you would have a busy time.

Lord Layard: Is it not the case that upper-income households would be doing the insuring? It would not be the lower-income households, which would get it free anyway.

Warwick Lightfoot: Yes, but how do you deal with the small print about pre-existing conditions, and so on? Lord Layard, I defer to you, because you know more about this than I do: adverse selection, asymmetric information, moral hazard, and Nobel Prizes right, left and centre for some very distinguished people. We know why it does not work.

Kathryn Petrie: The reason why it would not work at the moment is that there is no cap on the amount people can pay for their care. The insurance provider would be taking on their longevity risk and their catastrophic cost risks. If you changed the system to reduce the catastrophic risk and said that there was an insurance market that would

cover people up to X, and that was where the state would step in to take the catastrophic risk, there would be potential to start working around that. Actuaries can do great things.

Harry Quilter-Pinner: I agree with everything that Warwick said. I do not think there is much evidence that an insurance system is particularly feasible. There was no great clamouring from the insurance sector over the Dilnot proposals. I am also not sure that it is desirable. The evidence that Beveridge-style systems are more efficient, ultimately, is clear. As we discussed, if there was a voluntary insurance system and your chance of needing it was one in five, would you take that bet? A lot of people would not take it.

The Chairman: What if it was compulsory?

Harry Quilter-Pinner: If it was compulsory and state-provided, I agree with Warwick that you would end up, essentially, with a statutory system that could be done through general taxation anyway. You would end up in the same place.

Warwick Lightfoot: I will give the IPPR a plug, if I may. In its report, Lord Darzi produced a very nice picture. I do not know how he constructed it, but it was a very nice picture, in which he showed that the Beveridge systems are in the end more economically efficient in terms of resources deployed for a result than other insurance-based systems, including social insurance. Given where we are, where we started from in 1948 and the risks that we choose to cover collectively through taxation, it would be going into a cul-de-sac on the one bit where it would never work to pretend to ourselves that it could be made to work.

The Chairman: Lord Tugendhat?

Lord Tugendhat: Oh, sorry.

The Chairman: You are stunned by that consensus between the IPPR and Policy Exchange.

Q21 **Lord Tugendhat:** The King's Fund has talked about 700,000 more care workers being needed in the next few years. To what extent does that address the problem? It is a very impressive figure, but to what extent do you see it as addressing the problem we are talking about?

Warwick Lightfoot: I do not know whether the figure is accurate or sensible, but I know that you have to pay people realistically to attract them to do that kind of work and stay in it, and get training and do all the kinds of things that you want them to do. That will mean more money going into the system. What we are doing at the moment is probably below efficiency wages. More will be needed, and we will probably have to pay more for it.

Lord Tugendhat: Obviously, we have to pay people properly, but to press you further, to what extent is it an area where more flexible working methods and flexible time, and all that sort of thing, would make

a difference? I imagine that social care is an activity, in some respects, where people could work unsocial hours, and there would be a market for people doing that.

Warwick Lightfoot: One important thing we have not mentioned is the role of technology. If you had asked me 18 months ago, I would not even have bothered with it. In monitoring not just whether someone has fallen over but things such as incontinence and so on, we could be much more ambitious about what can be achieved through technical innovation. We should not kid ourselves that we can put huge stresses on families to carry on doing some of the care they are doing at the moment. That is a source of huge strain.

Lord Tugendhat: I have to ask you about Brexit and the impact of changes in immigration rules. What do you have to say on that?

Warwick Lightfoot: I am a member of the CIPFA commission on the future of public services post Brexit. That is something that my fellow commissioners from the National Health Service and local government have expressed concern about, although sometimes some of the participants slightly overestimate the difficulties of recruiting care workers and the reliance on people from outside the United Kingdom.

Kathryn Petrie: Geographically, across the UK, the social care workforce tends predominantly to be British, particularly in the north-east and north-west. I was looking at the figures before I came and was quite surprised to see that the social care workforce is around 10% non-UK and non-EU and about 8% EU workers, so our dependence on non-EU workers is heavier than it is on EU workers. That does not necessarily mean that, with skills changes, there will not be issues, but the EU issue is not necessarily the be-all and end-all of the workforce issues. There are much more important things going on in the industry, such as attraction and retention.

Warwick Lightfoot: It is also fair to say that lots of heads of service in health and local government expressed concerns about it, but when you look at the detailed numbers in that way it is quite hard to see what they are getting at.

Harry Quilter-Pinner: The workforce question is key and probably the second most important issue after the funding question. Quality in social care is largely determined by the quality of the workforce. There is lots of evidence that staffing turnover leads to poorer-quality care, and huge amounts of evidence that it is linked to pay. There is evidence that some care homes are not paying the minimum wage, but we should be having a conversation about why they are not paying the real living wage.

There has to be a conversation about skills, training and development. Health Education England's budget is approaching £6 billion, but the Skills for Care & Development budget is less than £100 million, and the social care workforce is bigger than the NHS workforce. We need opportunities for staff in social care to get training and development, and

to stay in the sector. At the moment, care workers are leaving to work in shops and retail. Unless we solve that, we are not going to solve the problem.

Lord Tugendhat: In care homes, what proportion or order of magnitude of the staff are from BME groups?

Warwick Lightfoot: My hometown is Plymouth, where I still have a house and my domestic life. If you went into a residential care home there, you would find that most of the staff were local ladies, very much a feminine workforce. In central London, many of the people being cared for are of the host native community, and a disproportionate number of people are from minority communities. Several people have said that there is a most unfortunate balance in both those who are being looked after and the staff taking care of them. That would not be what we would aim to do.

The Chairman: I am conscious that we are running out of time.

Lord Layard: You talked about the relationship between pay and turnover, but on skills do we have evidence from other European countries, where the skill levels are generally higher, that that means there can be fewer staff per patient, at a lower cost, even if there are more highly skilled staff on a higher wage? How do we mount the argument in favour of higher skills?

Harry Quilter-Pinner: I do not know the answer to the exact question about comparisons with other countries. The argument has to be about quality. The only way we are going to get high-quality care is by investing in the workforce. We accept that argument in other sectors. One challenge in this sector is that there is an underpaid group of staff, very weak unionisation, no professional bodies and very limited professional qualifications.

Do we need a royal college equivalent to represent care workers, or a more significant skills qualification to get into the sector? I am thinking about the transformation in nursing over the past 10 or 20 years to a more professional and highly qualified role. We have to take a similar journey on social care. The argument to take to the public and politicians is to ask who we want to look after our elderly grandparents and family when they are older. Should that person have no qualifications and no support and be very low paid? Do we think that is fair?

Warwick Lightfoot: I slightly disagree. We have to be very careful that we do not go down the same route as we have with nurses, because care is everything. I have certainly experienced care settings where there has been very good leadership in a particular home, with what we would call unskilled people, who have had very few opportunities to have education. They can actually manage. I have seen pain relief given through pillows, which is simply not given in an NHS setting, with every kind of palliative drug available. The people managing the home have very real skill and know what they are doing. Often, they are quite badly paid compared

with the people working in the hospital across the road. We talk about head teachers needing leadership, but it is the people who run the homes who often need leadership.

Harry Quilter-Pinner: Just as a clarification, I was not advocating the medicalisation of care in care homes; I was arguing for proper esteem, respect, pay and training opportunities for care workers.

Baroness Harding of Winscombe: You made a comment earlier about other countries' care systems being more productive. In my experience as a retailer and in the NHS, quality and productivity go hand in hand. Higher-quality institutions are usually more productive, and vice versa. I wondered whether you had any evidence that you could share with the Committee, although not now, on the statement that other social care systems are more productive, and on what they are doing that we are not.

Harry Quilter-Pinner: I can certainly share stuff, although I do not have the detail in my head at the moment.

The Chairman: Perhaps you could drop us a note.

Harry Quilter-Pinner: I would be happy to.

Lord Lamont of Lerwick: On quality, one point that has not been raised but which I have read a bit about is the inspection system and the Care Quality Commission. Are you satisfied that the system of inspection is really what it ought to be? I have read reports that it is very haphazard and sometimes rather cursory. Do you think the Care Quality Commission is the right body to do it?

Warwick Lightfoot: There has been transformation by having an inspection service, which started in 1993, and having all care settings inspected, which they were not before. That is my first observation.

As for how the commission goes about its work, it is inconsistent, and sometimes the things it focuses on seem to be irrelevant to the welfare of the people who live in the home. I have come across examples of what we might call theoretical tick-boxing about what a nurse does when she visits, rather than looking at the genuine welfare and well-being of the people living in the home. We should probably ask some questions about how it carries out its inspections. Whether it is right to have that organisation doing it, I do not know.

Harry Quilter-Pinner: The IPPR has been very clear that the CQC is probably the right body to do it, as a joint integrated health and care regulator. There is emerging consensus that at times the CQC has potentially leaned too heavily on punitive action and not enough towards support and improvement. It has also been quite an expensive, time-consuming and repetitive process. There is growing recognition that we need to move to what we call in the Darzi review an intelligence-led and risk-driven system. Once you had done one round of all providers, instead of just starting again and going around everyone again, you

would rely a lot more on data to predict where there are going to be problems and intervene more in areas where you are concerned that there are risks of failure.

There is a massive disconnect in the health and the social care systems. The CQC regulates on a fixed standard of quality and safety, which is obviously correct, but it does not look at finances, so it is regulating despite the financial pressures on the system. A lot of people say, "That's all well and good if you fund the system properly, but if you are not funding it properly it is very hard for you to hold us to those standards". I do not have an answer to that challenge but I know it is a concern in the sector.

Warwick Lightfoot: That point is absolutely crucial. In the last 25 years, a set of standards has gone up, often quite unrealistically, and the funding has not gone up in a remotely proportionate way. Of course, over the last seven or eight years, as part of the uncomfortable adjustment in public expenditure, funding has actually gone down. The disconnect between inspection and provision of funding has been a very real problem, and many quite good homes have gone because they did not meet the criteria, while other homes that do not meet the criteria very well are able to carry on in business, as I said before. That is a most unfortunate result.

Q22 **Lord Livermore:** What one recommendation would you like to see this Committee make in addressing the challenge of social care funding?

Harry Quilter-Pinner: The IPPR would say that the first priority is funding, and the recommendation would be a managed move towards free personal care, funded by general taxation. Apologies for not answering your question correctly, but you also have to talk about workforce. Those are the two levers that you have to solve to get a high-quality care system: funding and the workforce question.

Kathryn Petrie: Leaving my potentially unpopular wealth-based tax to the side, our biggest problem in social care in selling any forward policy is lack of understanding. I do not necessarily want to recommend that we have a conversation about that, but one of the most important things that we have to do is to have a conversation about it and make people understand what is going on the system and the ways forward. You cannot sell higher taxes if people do not understand what they are paying for.

Warwick Lightfoot: My recommendation would be very much along the lines of Harry's. You have to move to financing complex long-term care that is consistent with the National Health Service so that it is free at the point of use. I would do two immediate things. I would end the arrangement whereby self-funders have to subsidise local authority purchased care in homes, which is iniquitous. I would exempt the main home from the means test so that, effectively, we do what Medicaid does in the United States, where the main home is taken out of it. We should

go in a comprehensive way to funding on the same basis as the National Health Service.

Lord Lamont of Lerwick: Why would you take the main home out?

Warwick Lightfoot: At the moment, that is the route by which households can effectively be bankrupted, because their final assets can be brought down to £23,000. It is quite extraordinary, when you look at health and social care in the United States, that in social care the means test is so much more generous, and in Medicaid the main home is exempted, along, I think, with your automobile and $2,000 of assets.

Q23 **The Chairman:** I have one last question. This subject is obviously very complex, and we are grateful to the IPPR for sending its report, which we will study with interest. There have been endless reports on this subject by lots of very skilled people. What would your advice be to the Committee as to how we should focus our report? Should it be on identifying the various groups and their needs to try to get across the nature of the problem, as you suggested? It is quite remarkable how many people see it as being just about care for the elderly, for example. Should we focus on the funding issue? How do you suggest that we approach this in order to move the Government to do something?

Harry Quilter-Pinner: That is the million dollar question.

The Chairman: Actually, it is several billion dollars.

Harry Quilter-Pinner: Indeed. This is more about politics than it is about policy, to be honest. We do not need more policy papers. The approach that we took with the IPPR report was that we did not need another policy paper, and we were using it as a way to engage in a political conversation, because that is where we have to find a solution.

What would I recommend? We have to move closer to consensus. One challenge is that lots of options have been set out, and for too long we have had lots of papers that have weighed up the options and then left it by saying that we need a conversation. Apologies to Kathryn.

We need consensus, and I feel that there is one growing behind free personal care. The King's Fund is moving in that direction, and the Barker commission was for free personal care. I am really intrigued that Policy Exchange has landed in a similar place to the IPPR. I was not expecting that, so that is very welcome. There needs to be something about consensus-building.

Secondly, I would focus on the funding question. We have the Green Paper coming up, although I am not particularly hopeful that it will resolve much. The spending review is obviously the bigger window of opportunity. The more pressure we can put on politicians not to duck this again, the better. That has to be the priority, because we cannot solve any problems that sit below that, such as the provider and workforce problems we discussed, without a funding solution.

Kathryn Petrie: Alongside the consensus that free personal care is the way forward, how you fund it is a difficult discussion to have with the electorate, particularly in the middle of a general election. Let us not have this conversation in manifestos; let us have it between parliamentarians during Parliament, in the five-year period, and not necessarily in May.

Lord Burns: If you are going to push that argument, do you not think that you should set out exactly what the implications would be for taxation and for individual taxpayers? To make the statement that it should be free at the point of use and funded by general taxation is really to avoid the issue. If you are going to give somebody the choice, you have to tell them what is on offer and what the bill is, surely. That means setting out precisely the sums of money that you are going to raise, how you propose to raise them, and who they would fall upon.

Kathryn Petrie: I shall plug my paper. We looked at eight ways to raise the funds. As the Social Market Foundation, we did not set out to conclude that free personal care was the way forward, and we did not necessarily think that we would propose a tax at 65, or a wealth tax.

We went through the eight options, some of which were income-based and some wealth-based, and decided that the wealth-based policies were the ones we felt most comfortable recommending. We went through the demographics. We looked at age, gender and region. We looked at whether it should be those paying national insurance, and whether it was progressive or regressive. We did that analysis for eight different options and concluded that a wealth-based policy was the way forward. Yes, we can say that it should be based on general taxation, but we need to look at that in detail. Who pays tax today and who will pay it tomorrow? How sustainable will that method of taxation be in future?

Harry Quilter-Pinner: The Darzi review recommends exactly how you would fund it. You can fund free personal care—we included the NHS settlement, which was 3.5% on the whole of the Department of Health and NHS England—until 2022, if my memory serves me correctly, with one penny on national insurance, on both employers and employees. Beyond that, you would have to think about how you continued to fund it.

The Chairman: You get the last word, Mr Lightfoot.

Warwick Lightfoot: If I were you, I would go to first principles. What are you trying to achieve? Where should the public intervention be? Where do we intervene at the moment? What makes sense and what does not make sense? I would approach it in that way. I understand Lord Burns's point that this is a significant piece of expenditure in relation to social care and, to a lesser extent, to health spending overall, but we are not going to see more large discretionary public expenditure over the years that takes place without the agonising and anxiety that we have had collectively this afternoon. There were very large increases in spending set out in 1986, 1988, 1989 and 1991, and we had a glimpse of similar expenditure that started in 1997 and 1998. It must be possible, if

you look back to how spending has evolved over the last 30 years in the United Kingdom, to do this. Andrew Dilnot has himself said that it is a matter of priority. It is a matter of political choice; it is sustainable and affordable, and I would approach it on that basis.

The Chairman: Thank you very much. It has been a very interesting afternoon. We are extremely grateful for the written evidence you have given. We look forward to wrestling with the arguments. Thank you very much.