



Select Committee on Economic Affairs

Uncorrected oral evidence: Social care funding in England

Tuesday 11 December 2018

3.35 pm

Watch the meeting

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

Evidence Session No. 6

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Questions 50 - 59

Witnesses

I: Caroline Abrahams, Charity Director, Age UK; Jules Constantinou, President, Institute and Faculty of Actuaries.

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Examination of witnesses

Caroline Abrahams and Jules Constantinou.

Q50 The Chairman: Ms Abrahams and Mr Constantinou, thank you very much for coming to the Committee. We have quite a lot of questions and not a lot of time, so I will get on with it by asking the first question.

Sir Andrew Dilnot told us that the means test for social care had “the worst cliff edge” in the British welfare state and required reform. Do you agree, and what changes, if any, would you make to the means test? Who wants to go first?

Jules Constantinou: I will go first. I am sure that Caroline will be able to comment on whether it is the worst means test we have seen in the welfare system.

We have done some technical work to look at the means test that is currently in place, and that proposed under the Care Act 2014. We find that there is a cliff edge, and that the incentive to save is not being encouraged by the means test. We did some technical work that showed that, under the existing means test, if people with between £20,000 and £40,000 of assets were able to accumulate or save an additional £10,000 pounds, their personal contribution to social care might encompass that whole amount, or at best £8,000 of it, so they would have only £2,000 of that £10,000 saving to enhance the level of care they might receive.

Under the Care Act, the statistics are slightly different, and for every £10,000 that the same group might save, £5,000 would be available to them to enhance the level of care they might receive. We have not looked at anything further. The only improvement might be to look at the French system. That also operates with the means test but it is universal, so everybody will get something. At the top end, people might get only 10% of the allowance that might come through, but everyone gets something.

Caroline Abrahams: The fact that it is set so low and you have free care only if you have less than £40,000 is pretty bonkers and screens almost everybody out.

The other thing is that, even if you are lucky enough to fall into that category, quite often people end up paying something anyway because of top-ups in the industry, where family members are often asked to top up, even if theoretically you get your care for free.

Another thing to remember is just how expensive care is. As a self-funder, £25 per hour outside London is not unusual, certainly in Oxfordshire. In London it is about £18 for something that is half decent. Even I can do that maths; basically, even if you had some savings, you would go through them awfully fast.

The Chairman: Neither of you answered the question: what changes would you like to see to the means test?

Jules Constantinou: We have not done any technical work in the IFoA. My suggestion, as I said, was possibly a graduation where there was something for everybody under the means test, which might reduce the sharp cliff edge that you alluded to earlier.

Caroline Abrahams: At Age UK we think it should just be a lot more generous, but we did not focus on the means test or the cap as such. We want to see better care for everybody, and the current system does not work in those terms.

The Chairman: So are you in favour of or against the cap?

Caroline Abrahams: A cap would be quite nice, but it is not our top priority.

The Chairman: Set at what level?

Caroline Abrahams: As low as it could be, to help as many people as possible. Our view about what matters most comes from talking to older people, who tell us that they want to see improvements; they want everyone who has a care need to be able to get care, which is absolutely not where we are at the moment when 1.2 million people with a care do not get it met. If there is more money to go into something other than a cap, they would rather it went into improving quality and expanding the service that is available to people.

Lord Darling of Roulanish: You mentioned France. What happens there? What do you get? What is covered by the care provision that you referred to?

Jules Constantinou: I am not sure about the exact detail of it. It is by no means a fully funded system, so even for people who are getting "100%" of the tariff, it would be no more than—I am guessing now—between a third and a half of what it might cost.

Lord Darling of Roulanish: Is this for older people or for people throughout their life, depending on what condition they have?

Jules Constantinou: No. It is focused specifically on older people.

Lord Turnbull: I am interested in your saying that it is a means testing on wealth. Most means tests in Britain are based on income.

Caroline Abrahams: Yes, but it depends how your wealth is taken into account, which it is, is it not, in both of the means tests? A complicated calculation is done to try to work out where you are in your income by looking at how much money you are supposed to make on the back of your savings, which becomes part of the calculation as well.

Lord Turnbull: If you have income that does not have any savings, such as a pension, how do they deal with that?

Caroline Abrahams: That is just straightforward, is it not?

Jules Constantinou: Yes. It is included in the calculation.

Q51 **Lord Sharkey:** I want to ask about intergenerational fairness. Whatever systems of reform we propose, how can we make certain that we account fairly for each generation? In particular, to what extent should housing wealth form part of the reforms that can acknowledge or take account of intergenerational fairness?

In addition, since the use of housing wealth to pay for care appears to be highly unpopular politically, how do we go about this practically if we are to take a fair account of wealth?

Jules Constantinou: The key question here, as you point out, is that it appears to be almost a political question as opposed to one about fairness. People sometimes choose to put money into their pension fund, and through the freedom and choice agenda they now have access to those liquid funds if they need them. Other people have made a choice in their life let us say to repay their mortgage as opposed to doing that.

From a fairness perspective, the question might be about the difference between those two assets, and whether it is not perfectly legitimate to say that that is a good measure of your wealth and it should be taken into account.

Caroline Abrahams: Our view at Age UK is that you can develop a social care need at any age—including young people, and so on—so everyone has a role to play in paying for it. You might well end up with different options for people to pay, depending on how old they are. For us and a lot of other people, to move more to the kind of approach they have in Japan or Germany with regard to long-term social insurance might be a good idea for the future, but it does not account for what are going to do over the next little while.

We have talked to older people about whether they would be prepared to pay more, and they said that yes, they would, as long as it was fair and they could afford it, and we talked about a number of ways of doing that. We found when we asked them, as has almost every other organisation that has done the same sort of thing, that some form of general taxation or national insurance was the most popular.

However, we also talked to them about housing wealth, and their view was that they were prepared to pay something like, say, a 5% levy on their house if it was fair and everybody had to do it, and if—this was absolutely crucial—they got something better for it in return. Just expecting people to pay more for more of the same when it is not very good is clearly not a runner. But if this was part of getting the care system to a much better place, you would have more of a chance of winning that sort of argument with people.

Lord Sharkey: Did you talk to young people about this? The differences in the levels of home ownership—

Caroline Abrahams: The Alzheimer's Society certainly did.

Lord Sharkey: What was its view?

Caroline Abrahams: If you are a young person and you do not have any housing wealth, you do not have particular view about it—it is not for you. Generally speaking, younger people are quite supportive of older people's need to have a decent care system. However, the idea that people of that age might need to start saving and put money aside to help fund a proposed social insurance scheme so that we can have decent social care in this country is certainly something that some organisations have talked to young people about.

Q52 **Lord Lamont of Lerwick:** I wonder if I could ask you about the balance between an individual paying for it and state funding. We have had evidence from Simon Bottery of the King's Fund, who, referring to consultations or perhaps a conference they had had, said that most people thought that the balance of responsibility should lie with the state; they did not think that the pooling of risk could be done other than in that way. Indeed, that was rather confirmed by evidence that we had from the insurance sector.

Jules Constantinou: That is a good question. The difficulty, particularly for younger ages, is that currently there is no voluntary market and there appears to be no demand or interest from young people in thinking about social insurance off their own bat. So in some respects one could argue that a basic social insurance scheme that started funding earlier, as we have seen in other parts of the world, might create the momentum for people to actually start considering and understanding the fact that they need to make a contribution towards their social care costs.

There is a fine line between "Should there be insurance?" and "Should we be encouraging people to save more so that when they retire they have sufficient funding both to fund their normal retirement and to fund whatever care costs they might have later in life?" Those vehicles are available currently, and it might make more sense to create some kind of encouragement to increase savings as opposed to insurance, but I think both models can work alongside each other.

Lord Lamont of Lerwick: If you were going down that road and wanted to encourage more individual or private provision, there are certain principles that you would have to observe, which were put to us by the Nuffield Trust, to do with transparency. First, there would need to be clarity about what entitlement and access was actually being offered to people, transparency about what you were contributing and what exactly you would get out of it, and consistency across different areas of the country. Leaving the last one aside, is it not very difficult to get precision on the first two objectives?

Jules Constantinou: That is absolutely correct. Currently, the system shows the regional variations across the piece. From an intergenerational fairness perspective, asking young people to make a contribution today to fund the care costs of today's people requiring care could be deemed to be unfair.

Think about the demographic change that is going through the population: the number of people over 85 is going to double in the next 20 years, while the number of people over 65 is going to be 50% more, while the working-age population is increasing by only roughly 2% per annum. The mathematics basically mean that if we ask the younger generation to pay for their care, the amount they have to pay will increase and be leveraged up over time.

If we are thinking about some kind of insurance scheme, we should probably think about those of working age, and then think about those people who are currently in retirement or needing care separately from a funding perspective.

Q53 Lord Layard: We are talking about a condition that affects less than half the population. Insurance is obviously the issue: you do not want general savings, you want insurance against your turning out to be that kind of person. You could imagine a sort of automatic state provision with this tax, starting at 40 or whenever, but people do not like to impose taxes.

What do you think about a scheme where you have a state-run or state-organised insurance scheme with an opt-out? It would be voluntary—you could opt out of it—but it would be there. It would deal with the problem of different standards and so on. It would simply be a financial insurance scheme that would insure you up to a maximum tariff according to your state. Does that not more or less square all the corners of the circle?

Jules Constantinou: Yes, it does, and it has worked in other parts of the world. The Singapore system, for example, operated on an opt-out basis for a number of years. Initially when it instituted the system there was quite a large proportion of people who did not join the scheme, but only about 8% of each cohort that turned 40 from time to time opted out. So the idea that you have proposed there has actually worked.

However, Singapore has turned around and thought about healthcare and social care in the round. It has taken large steps to promote healthy living and to bring through prevention not only in the ageing population but in the working population. It has accepted that social care has to be universal and that it has a responsibility to provide its citizens with the necessary services.

From 2020, Singapore is adjusting its scheme. It will now be compulsory for all people turning aged 30 to contribute, and it is allowing the people in the existing system to buy back protection for the years for which they have not contributed. The only issue that Singapore is finding, which we will find not only here but in other parts of the world, is that it does not really have enough money to be fully funded. It recognises that either through familial support or independent care there is a gap that people will have to fill, maybe through private insurance or savings. That is a large financial problem in all parts of the world.

Caroline Abrahams: As Jules has said, we have talked about health for the first time. In a way, that is such an important part of this debate. Most of the public think they have already paid for their social care,

because they think it is something that comes through the NHS. Recent polling shows that that is still a widely held view. To be honest, quite often you cannot put a fag paper between what the two things definitely are—there is an incredibly artificial divide between them—and that holds back a lot of this discussion.

We looked at what has happened in Singapore. The point there is that it has a totally different system for funding its healthcare. What is difficult about our country is that we supposedly have healthcare free at the point of use, funded through general taxation, and then we have a totally different system, a very arbitrary one, for social care. There are all sorts of reasons why that is problematic, but it is also quite difficult if you are trying to reform it along the lines that you have been discussing.

Lord Layard: You could more or less keep the present system but add on the individual's ability to ensure themselves against their own costs. That seems a natural way, without totally throwing everything up in the air, to make the existing system work better.

Caroline Abrahams: We think that lots of people would opt out. That would be our worry. The reverse of that is that all the evidence so far is that there is very little appetite for people to privately insure against social care. It is not just that there are no products; there are no products is because there is no appetite. There is no appetite because your chances of developing a social care need are actually quite small, but if you do then it can absolutely wipe you out.

That is why Andrew Dilnot says it is a classic case for risk pooling, for example. Everyone hopes that it will be not them but someone else. Maybe two or three of us in this room will develop a serious social care need, but there is no way of knowing in advance who it will be. It is not necessarily about those of us who have fantastically healthy lifestyles as opposed to someone who does not; you could fall down the stairs tomorrow and develop a serious social care need. It is such a lottery, and that is the difficulty.

The Chairman: You are depressing us.

Caroline Abrahams: Sorry.

Lord Turnbull: He is not on this Committee with us, but a Member of the House of Lords, David Lipsey, argued to us that if you ask people to insure against a one-in-five chance, they will not do it. He came up with the idea of post-event annuities: in other words, you wait until you need care and then insure yourself against how long you will need it for, so you eliminate one set of risks. However, he also admitted that no one had really taken up that variant either. Could that be made to work, do you think?

Jules Constantinou: The point is absolutely correct. I was going to say that those are the only long-term social care products that are available in the market today, although that is not 100% true; since the Care Act,

there have been insurers who have tried to innovate around traditional insurance products and whether you could add additional benefits to those to fund social care. However, you are describing the immediate-needs annuity market. Currently only 1,000 or maybe 1,500 people are actually buying these products on an annual basis.

Good work has been done by the PSSRU which says that 40% of self-funders who go into care homes could benefit from getting an immediate-needs annuity. It is a question that goes back to the fact that few people know that they exist. They are accessible only through financial advisers, and unless you have been signposted to that you do not know that they exist. But they provide strong protection for people against their own longevity.

Lord Turnbull: One way in which Governments have traditionally broken through that apathy or myopia is to provide a tax incentive. It does not need to be large, but it is the idea that if you buy this annuity, you are getting it at less than the full cost. Would that be worth doing?

Jules Constantinou: There is a tax incentive associated with the immediate-needs annuity, which is that the income from the annuity is not taxed as income if it is paid directly to the care provider or the care home. Therefore an incentive is attached to it. Again, thinking laterally here, in some respects if care home providers were obliged to signpost people coming into their care homes to take financial advice, pointing to the fact that there is a tax advantage if they take these policies, it is possible that that market might grow up.

Lord Darling of Roulanish: Ms Abrahams, you made an important point about what, if you had some sort of scheme, it would cover. Have you or anyone else done any work for example on what, if you had a national care scheme as opposed to a National Health Service, it would cover: bed, care or other help, or simply a sum of money that is means-tested to a greater or lesser extent?

One of the difficulties I have is that you can see that there is a need, but unlike with the health service, where it is fairly clear what you get and you will basically get treatment for whatever you need, care covers such a multitude of possibilities that I cannot see how you could ever get a scheme that could possibly deliver everything and be at all sellable.

Caroline Abrahams: The typical difference that people point to is that you can either have a national care scheme of some kind that meant that you just got your care costs paid, or you could have your care costs and what are known as your hotel costs paid—the board and lodging element, for example, if you are in a care home, which typically accounts for about a third of the overall cost. Obviously, it is much cheaper just to have the kind of provision that just covers your care costs, but that is much harder to sell to the public.

Lord Darling of Roulanish: That would mean that if I paid more taxes or took out an insurance policy, if I went into a care home I would either

get free care or free care and hotel costs. But suppose I wanted to stay at home, which is in everyone's interests. I will get nothing. That does not seem right.

Caroline Abrahams: No. I think the idea was that it would also fund the domiciliary care for you. As you rightly say, most people want to stay at home for as long as possible, and there is some evidence that some people, particularly those who are better off, sometimes go into care homes too early and then blow through their resources and run out of money, which is a problem at the moment, but also become more dependent than they needed to be. Domiciliary care is important.

Q54 **Baroness Harding of Winscombe:** I should begin by declaring my interest as chair of NHS Improvement.

Perhaps we can change the subject slightly. Do you think that the current social care system is delivering value for money, and what should we do to improve its ability to deliver value for money to taxpayers?

Caroline Abrahams: It is a total and utter disaster, if that is what you mean.

The Chairman: Not another one.

Baroness Harding of Winscombe: Yes. We have a few of those here.

Caroline Abrahams: Lack of money might lie at the root of the problem, but the fact that that has gone on for such a long time has produced all sorts of other issues and problems which it will now take more than money just to solve and which will take a long time to solve.

The most obvious one, which is not so different from what you will have seen at NHS Improvement, is the chronic workforce shortage. There is a very high turnover, and lots of people do not want to do this job, so there are places where, even if you have some money, as a self-funder you cannot buy care because there is no one there to provide it, typically in better off areas, where there are easier ways for people to earn a living.

Do the public get their money's worth? I have heard two directors of social services say within the last little while that as far as they are concerned, they have so little money to play with that success for them is getting someone over the threshold and making sure that someone is going into someone's home. They cannot commission for quality, so as lots of older people and families say to us, even if they are lucky enough to get state-funded care, it is so rushed that it does not help them, it is impersonal, and it is no fun for the employees, let alone for the person who is in receipt of care.

From that point of view, we appear to be paying quite a lot of money. You can be lucky: there are some marvellous people out there, who do a fantastic job, but that is despite the context in which they work rather than because of it. That suggests that there is a need for absolutely

fundamental reform. Let us all hope that the Green Paper will help us with that, but I am not entirely convinced that it will.

Baroness Harding of Winscombe: If you had significantly more money, and fundamental reform was possible, what would you do? What would you prioritise?

Caroline Abrahams: Age UK's position is that we would prioritise reach, so we would try to get more care for the 1.2 million older people who are not getting it at the moment, for example. We would also try to give people more care; even people within the state-funded system have often had cuts to their packages, and it is exactly the same for disabled people. So we would try to give people more care.

But really, we would want to look at it in the round, looking at quality and the workforce, and you cannot do any of that without also looking at the role of the NHS. Slightly different issues apply for different groups in the population, but frail older people typically need health as well as care.

The way the system currently cuts those things up makes absolutely no sense at all. In a way, I am sorry that we do not have an ageing population Green Paper rather than a social care one, simply because it would have allowed us to look at some of those pros and cons a bit more easily across health and care.

The Chairman: You say "fundamental reform". Could you be more specific?

Caroline Abrahams: Lord Darling mentioned the national care service, and there is quite a lot of interest in what is going on in Scotland. It is fair to say that no country in the world has completely cracked this problem. It is interesting to look at what is happening in Germany and Japan. You were asking a question about France earlier. We commissioned some research from Incisive Health, which compared our system with that in France, Spain, Japan, Germany and Italy, which I am happy to send you. Basically, it says that ours is the worst. That is because it has taken us so long to get round to doing anything about it. Most other countries looked at this a generation ago. Unfortunately, we have an unreformed system, coupled with a system that has fallen into significant repair.

The Chairman: It would be helpful to have that information. I am pressing you on the specific things. You are using the phrases that always irritate me when I hear Ministers say them: "We will look at" something and "We will review" something. What are the specific things that you think need to be changed?

Caroline Abrahams: I would change the line between health and care. You might want to look at a completely different way of dealing with frail older people, some of which is anticipated in the NHS plan, which you know lots about. I am leading one of the work streams there, where we

met before. We are moving towards health and care coming much closer together for frail older people.

Different issues arise for younger disabled people, who have their whole lives ahead of them, hopefully, and who need lots of independent help, so there are different issues there. Then we have lots of people who have just been pushed out of the system as it has been increasingly rationed over the last few years. We have to have a proper workforce strategy, which has to work across health and care, otherwise health takes people out of care, which just robs Peter to pay Paul.

Baroness Harding of Winscombe: You have mentioned a number of different international models of funding—Scotland, Germany and Japan, which are all different—and have said that your assessment is that ours is the worst. Which should we move to, if you were the one making the recommendations?

Caroline Abrahams: The market leaders are Germany and Japan, which essentially have different sorts of systems of social insurance, do they not, Jules? But that will deal only with the future. Obviously, I work with Age UK, and we are worried about what will happen over the next 10 years. Even if we get that sort of approach and start to build up some funding, what do we do in the meantime, and how do we first stop the system completely falling over and start to put it on a much firmer financial footing for the future?

Jules Constantinou: To answer your question about the international systems, even though, as Caroline said, the systems all started a generation ago, in the late 1990s to the early 2000s, most of them have been through three or five-yearly reviews. In the Singapore system they worked out that the contributions were more than enough to pay for the level of benefit they were providing, so they enhanced benefits. The German system actually started off at 1% contribution from employees and employers. It is now at 2.75% from employees and employers.

Almost the best system is one that starts somewhere. I would almost say that it is imperative for us to put something in place from a funding perspective, and everyone will understand that we will review as we go forward. It is just a question of creating awareness about people's individual responsibility and the state's responsibility, which is the question that the Chair raised earlier.

Caroline Abrahams: Can I make one other point that we have not talked about yet: the role of informal care as families and so forth? The amount of care that they provide vastly dwarfs anything that the state or indeed the private sector provides. They are crucial in keeping people going, but we are nowhere on that either; people are not even paid the value of the jobseeker's allowance in order to be carers.

There are a lot of people in midlife, for example; increasingly even professional women feel that they have to come out of the labour market in midlife, although they are in good careers, because they cannot source

good enough care for their parents. That is basically an economic hit and one that the Treasury ought to start getting a bit worried about. So part of this means thinking about what we can do to support people in combining caring and working, which is about flexible working and so on, and giving people a bit more money if they completely leave the labour market in order to care.

Q55 Lord Turnbull: We have spoken about a national care service, which seems to imply a convergence between the NHS and the care system. It implies to me that, first, there would be a widening of the conditions that are assisted. At the moment, a medical condition is paid in full, but something long-term is not.

Secondly, you are converging on a service that has no patient contribution. The problem that we have to face is the cost of this. You have just mentioned, correctly, that the contribution by self-funders and their families is five to 10 times more than the state is paying. If you make the system wider and more generous, there must be some behavioural consequences of that, and the first consequence is that Mrs X will say, "Well, I can go back to work now that my mother is being better looked after".

That might be good for the economy, but it is not very good for the taxpayer. Is it realistic to expect to be able to afford a system in which the behavioural incentives are to expand the service? That is pretty much what happened in 1948 when the National Health Service was created: lots of people who had never gone anywhere near a doctor thought, "That's fine, I can get treatment". The costs would be a lot greater and the informal family contribution would be backed out.

Caroline Abrahams: The evidence is contrary in other countries where they are more generous. I will see if I can dig it out for you, but I am pretty sure that we have had that conversation. If you provide people with a bit more support, they are more inclined to want to care informally. For example, neighbours and friends are often terrified that if they start doing help for someone, they will suddenly be landed with it—they will carry all the responsibility themselves and be left holding the baby, as it were—but if they thought there was better support around them, they would be more inclined to help. That is my understanding.

After all, at the moment there are loads of people in this country—I would get the numbers wrong, but it is an enormous quantity of people—who are providing care on a pretty intensive basis for nothing or virtually nothing, and they do it because they want to. Sometimes they do it because they cannot find anything else, but they are deeply committed to their family members. They often do not view themselves as carers, because they are just doing what you do for your husband, your wife, your mum, your wife or whoever it might happen to be.

That is a strong human motivation, and I do not think it would suddenly be changed by whatever we did in this way. However, it would mean that people who did not have that—for example, there are growing numbers

of people in our society who do not have children—would not be left in the pretty desperate position that they are now.

Lord Turnbull: I am not sure I share your optimism, but it would be nice if it were like that.

Jules Constantinou: There are one or two things I would like to jump in on. First, we have recently had a relevant number: the Demos report talked about 8 million people who are providing informal care.

The other dimension to this is healthy living. Statistics talk about the old-age dependency ratio, which basically means workforce versus people in retirement. As you push the state pension age up, you expect that dynamic to change and that you could legitimately tax more people in order to fund people's elderly care. The fact is that more and more ageing people in the population are not fully economically productive.

One of the areas that need to be focused on, although it is difficult to see how you could bring extra money into the system in order to do it, is changing the incentives for both working-age people and the elderly to prevent illness and disease. Again from a demographic perspective, the statistics are that men can expect to live for around 16 years in ill health before they die, and the figure for women is 19. So part of every year that we add from a longevity perspective is being spent in ill health. If we can change that dynamic, it might change the funding that you were talking about.

Lord Turnbull: We do not talk much about an attendance allowance. That would be a different way of funding this: if you need care, basically you get this money and it is yours. It is a contribution to your costs, and then you top it up as much as you like or can afford. Do you think we could make more use of that method as opposed to the direct funding of care costs?

Caroline Abrahams: First, it is there to pay for the costs of disability, not the costs of care. That is what it was originated for, if you read the small print.

Secondly, people do not just get it, they have to claim it, and there is a long form. We know that an awful lot of people who are entitled to it do not get it. Research that we at Age UK carried out shows that it is predominantly spent on the things that it ought to be spent on. Increasingly over the last few years, more of it has been spent on transport, for example to doctors and hospitals, because other services have melted away, so some of the things that you used to get free are no longer available.

We would like more people to get attendance allowance than actually do. An awful lot of people do not know it exists; it is a best-kept secret. As you rightly say, it makes an enormous difference to people when they get it.

Q56 **Lord Burns:** How easy is the health and social care funding system to

understand? What kind of advice is available for those who are planning their social care needs? In the sessions that we have had, I have learned an enormous amount. I wonder about the state of knowledge among people who are facing this situation.

Jules Constantinou: Caroline is at the coalface on this. Looking at it objectively, I guess there are three agencies that you could approach to help to fund your care. We have spoken about attendance allowance, which is non-means-tested and is via the Department for Work and Pensions; you have to apply to your local authority for potential housing support or care support, which is means-tested; and you have to go to the NHS for NHS-funded nursing care, which is not means-tested.

I think that results in a fundamental paralysis. Most people look for advice only when they are actually in the moment of crisis, when something bad has happened—someone has fallen or had some accident and they need to access the care system. Many people really do not know where to go.

Caroline Abrahams: The honest truth is that it is baffling. It is almost impossible to make sense of. There are some good websites out there that you can access, but the truth is that all these different, clunky systems do not interact with each other. Obviously organisations such as local authorities and the NHS are trying to defray costs. They are both under a lot of financial pressure. A lot of people never get past ringing up the council and getting fobbed off at the first phone call, because basically these organisations do not have enough money and are desperately trying to keep their liabilities down.

Exactly the same applies to continuing healthcare funding, which is the NHS funding and is highly controversial because of how it is framed, deliberately excluding things like dementia, which is the cause of the dementia tax issue, but not only because of that. It is also because it is difficult to apply for, and lots of people cannot manage it.

Lord Burns: What do you think the greatest unfairnesses are under the system? By that, I mean how people are treated in very different ways so that some people really suffer from the system while others do not.

Caroline Abrahams: There is quite a long list, to be honest. There is the postcode lottery unfairness. Although we have national systems, they are interpreted differently, certainly by local authorities, but that is true of the NHS as well, which is quite localised in the way that it behaves in relation to some of these things.

Then there is the whole unfairness in whether you develop a need in the first place. Other people would point to the unfairness in someone who has saved all their lives finding themselves just over the means test and getting excluded, while feckless Joe down the road who has spent all his money is now getting something for free. That is a different sort of unfairness again. The system is quite rife with it, to be honest.

Lord Burns: Do you find that many people deliberately take action to

avoid paying for their social care? Is there much avoidance, evasion, or whatever you want to call it?

Caroline Abrahams: There are some examples of that. If you have some assets to protect, you are more likely to be thinking along those lines, but of course a lot of people do not have any assets to protect.

The fundamental point about all this is that the evidence shows that most people never think about social care—they do not give it a minute's thought—until, as Jules says, disaster strikes and maybe someone has a fall and end up in hospital, and then for the first time it becomes apparent that they need some help at home.

Separating out the decisions about how you pay for it and the need to organise it from the humane point of view, from an old person's perspective, would make a lot of sense. Otherwise people are suddenly confronted with something bad happening to them and needing to work out how to pay for it all at the same time. It is a lot for people to take on.

Q57 **Lord Tugendhat:** I have a quick question on that point. From time to time, the Government have launched public awareness campaigns. I particularly remember one about heart attacks, for instance. In the light of what you have just said, do you think it would be helpful for the Government to launch a public awareness campaign along the lines of, "Have you thought about social care?"

Caroline Abrahams: I suppose it would depend on what they were trying to raise awareness of. If there were a strong offer from the Government, a new offer that would give you better social care, that might be worth trying to get across to people. Otherwise, the problem is that the existing system is so complicated that some of the reforms suggested, such as the Dilnot system, would have been almost impossible to communicate to the public.

I am not sure that you would ever succeed in raising public awareness. As I say, the research we have carried out, partly on the financial side, shows that if you talk to people in midlife about planning for later life, you say the words "social care" and the shutters come down, because it is terrifying. It is associated with decline, death and all the things you do not want to think about. We need a totally different way. If we want to ask people to think more constructively about the future, we have to talk to them in a very different sort of way.

Baroness Harding of Winscombe: What would that be?

Caroline Abrahams: It is about saying to people, "How can we make sure that you get to live the life that you want for as long as possible on your own terms?" We should probably talk much more generically about all the elements of people's health and their care. We are suggesting a review for people at age 50, partly about their finances, that would be another opportunity to start thinking a bit about their health: "Is there more you could be doing?" "If something went wrong, what would you do about it?" "Do you have power of attorney sorted?", and that kind of

stuff. It has to be done much more subtly and gently, because the evidence is that people just shut off when you try to talk to them about care.

Lord Sharkey: I think you mentioned earlier that there is a basic misconception anyway, which is that it is free. It is difficult to attract people's attention to a complicated scheme if their going-in point is that it is free.

Caroline Abrahams: Exactly. I would be inclined to start from where they are and make it free, but you would have to pull back the money in another way. That is the point.

Q58 **Lord Layard:** Why do you think this problem has just gone on and on without any Government managing to address it? I have a few thoughts. Is it because of the split between the NHS and local authorities that no one has any idea how to handle it? Is one way around that to put the whole thing together as a single service: NHS and social care? Some people have said that that would be disastrous, because the hospitals would take all the money and social care would get even less. I would like your views on that. Also, do you have any ideas about what might be coming in the Green Paper?

Caroline Abrahams: We have not seen it, have we, Jules? I think that, as ever, there are a whole bunch of reasons why it has taken so long. It is partly bad luck. Gordon Brown's Administration came up with an idea right at the end of his tenure as Prime Minister—actually a very sensible idea, a lot of people in the sector think—of some form of tax on your assets, but basically it all became part of the politics. Even this Green Paper has been a chapter of accidents. We have had a succession of different people leading it as Cabinet Ministers have come and gone for one reason and another, which has not been terribly helpful.

Also, the issue is very complicated. The problem, which you alluded to at the beginning, is that people think it is free, so the first thing that you as a politician have to be able to say to the public is: "You know that thing you thought was free? Here's the bad news: it's not free. But here's the good news: we're going to make it slightly less expensive than it otherwise would have been". In the end, that is what bedevils this issue: well-intentioned policy people in different government departments work out stuff but then it gets to the Commons people and they say, "How are we going to sell that?", and it falters at that point.

The only way to get over that, I am afraid, is to grasp the nettle and jump to a different place. That is my advice to any Government: you have to get to a totally different place and completely reform it, because gradualist reforms, which are still going to cost members of the public more, are a very hard sell. However, successive Governments have had plenty of things to worry about and have not got around to it.

There are few advocates for older people; those 8 million carers are exhausted. As someone said to me, it is quite interesting that if you have

a child who is ill, whether hopefully they get better or even if they do not, you probably become an advocate for that condition. People who care, for example, for ageing parents or partners dying of a neurological disease are usually heartbroken when it finishes, and then they want to get on with their lives because it takes over. They tend not to be, certainly while it is going on, the people who are jumping up and down, so there is an advocacy issue as well.

There are lots of reasons. I think you are right that there is a split between councils and the NHS. We have been through periods of history where each has had a bit of a pop at the other and there has been a bit of a division, although actually it is in both their interest to get this sorted. If the NHS plan is going to deliver, it absolutely needs social care to be able to be in a better place than it is at the moment.

The Chairman: Is that really true about people who are—perhaps I should declare an interest—looking after or caring for elderly parents and family? Does it not make them more aware of the shortcomings in the system, make them more articulate about obtaining change and make them think about what is going to happen to us? Is that not what is happening now?

Caroline Abrahams: I know what you mean. I am perhaps in the same position that you are.

The Chairman: You are much younger than me.

Caroline Abrahams: I mean that I am caring for my mum part-time and she is in the system, so I am mystery-shopping it, which is fascinating. I think you are partly right, but what typically happens with people is that you care for them and they die, so they are not around to be able to advocate in the same way as, for example, a cancer survivor might be.

I think there is a bit of a different dynamic around the issue. A lot of people are very sad and think it is just them; it is a routine, private sadness that we do not talk about very much in our society. It is much less commonly discussed. Still, more people now have direct experience themselves or as a family member or neighbour.

The Chairman: In answer to Lord Layard, you said that the communication was so difficult that we just had to make a journey to another place. Could you try to articulate what that place is like and how much the fare is to get there?

Caroline Abrahams: It is a jolly expensive fare. That is the first thing. I do not think there is any doubt at all that this is so grossly underfunded that we are talking about having to raise an awful lot of money one way or another.

The Chairman: At the moment it is about £20 billion.

Caroline Abrahams: Yes.

The Chairman: So what do you think it should be?

Caroline Abrahams: My friend here is probably better equipped to answer that than me, actually.

The Chairman: It was a hospital pass.

Caroline Abrahams: He is the money man, not me.

It is a fair old chunk more, partly in order to get those 1.2 million people, or at least a good proportion of them, into the system, and to do something about the appalling, or variable, quality, which means in part doing something about the terms and conditions of staff. This is a people job, really. The technology might help a bit, but essentially it is a people job, and that is where a lot of the expense goes. That is not only expensive but it will take a long time.

My sense is that if you want people to pay more for this—we have to ask people to pay more—they have to see that they will get something better in return. That is why you have to jump to a different place. The hardest sell of all is saying to people, “You’ve got to pay more, but it’s going to go on being as bad as it is at the moment”, because that is an impossible argument to win.

Jules Constantinou: I guess the only number that you could lob in is that the 8 million informal carers are calculated to be saving the economy about £140 billion a year. That must create some context for what the bill might look like.

I would echo exactly what Caroline is saying: that it is not going to get any better. I gave the example of the other markets; the bill will increase unless at some point we take interventions such as allowing people or giving them the facilities to live better and healthier lives. That might be part of the education that needs to be put through, but we cannot hesitate to start funding and make people aware of the current deal, or maybe, as Caroline is saying, an improved deal for them to buy into.

Q59 **Lord Tugendhat:** My question follows on from what you are saying. To what extent are the working conditions of care workers an issue? Where and why do the problems arise, and how can they be addressed? That is an omnibus question.

Jules Constantinou: Absolutely. I am now going give back the hospital pass. Caroline is closer to this.

Caroline Abrahams: There are not enough staff. That is the first thing. As the amount of money that has gone to councils has reduced, they have less money to purchase care with. Therefore they depress the amount of money going to care companies, which in turn are trying to juggle a lot of need with not enough people.

If you look at the workforce stats on care, there is a hard core of really dedicated people who have been in care for a while who are a bit older.

They are holding it together. It is difficult to keep young people in the profession; they tend to move in and out. That is a problem for the future. The problem with the older people in this profession is that sooner or later they will want to retire. Some people do it because they love it and because they get a buzz back from helping people, but there are just not enough of them. They are inclined, if we are not careful, to think that going into the NHS is a better career path, which is what some of them do. We need to make care attractive enough that people want to say there.

Lord Tugendhat: To what extent are we dependent on people from elsewhere in the European Union and from the BME community?

Caroline Abrahams: Obviously it varies by geography. I should know these numbers off the top of my head, because we have been doing some work on this. Essentially, London is quite dependent on people from the EU, and there are different types of care that are quite dependent on them. Generally speaking, London and the south are where the EU workers tend to come—except for Manchester; there are also quite a few in Manchester. But they are concentrated in the south and London. There are about one in six in London, and Brexit is undoubtedly a threat to that.

There are some forms of care, such as live-in care, which are growing in popularity because they allow people to stay at home for longer, and they have quite a few EU nationals working in them. Because of the way that works, they can fly in and out to work—say, three weeks on, three weeks off—and it is cheaper to fly over on a cheap flight from Spain than it is to take the train from Newcastle if you are coming to provide care for someone in London. I know this, because it is happening to me. Those arrangements are dependent on a flow of labour around the place.

There are definitely people who come from other parts of the world to do this job, such as South Africans. A retired Singaporean doctor is coming to be a live-in carer for my mum in a week's time, for example. People come in and out to do this. Of course, there are Brits who do this too, but particularly in London and the other cities in the south we are quite dependent on people from other countries.

Lord Tugendhat: If it therefore becomes very much more difficult to attract people into this country from elsewhere in Europe, what would your suggestion be for remedying that deficiency?

The Chairman: Without mentioning Brexit.

Caroline Abrahams: Well, what can we do? We are already seeing shortages of staff in different parts of the country anyway, particularly in more affluent areas, where people can earn more money doing something else. One can only see that getting worse. Typically people go into care from retail or hospitality; those are the sectors that they tend to come from, which are also quite dependent on people from abroad, including the EU. Therefore there could well be more competition for exactly the same staff.

What would I think about? I would think particularly about being much more generous to informal carers, because it is hard to see where else to look in the shorter term.

Lord Tugendhat: How could informal, unpaid carers be better supported?

Caroline Abrahams: You would pay them a bit more, for a start. You would allow them to claim more money; they do not get paid even as much as jobseeker's allowance at the moment. You would help people to balance work and caring, so that they could care part time and continue to stay in the labour market, which is good for the economy and good for them.

The Chairman: But given that we have just heard that this informal caring is worth £140 billion, I think you said, if you started paying people for that care, would that not result in an enormous bill and no additional benefit?

Caroline Abrahams: We are paying them already; they get carer's allowance. It is just set terribly low, that is all. We need to up it a bit.

The Chairman: Yes, but my point is this. The wrong impression is given in the phrase, but an economist would describe it as the "deadweight cost", which would be very high, and you would end up paying a lot of money, which would not actually improve the quality of care. What is your answer to that?

Caroline Abrahams: If we are talking about a situation in which significant numbers of EU nationals are no longer here to provide care and there is a big hole, people will be faced with really difficult choices. In that situation, it would make sense. It is a moral question as well as an economic one.

The Chairman: Why would they no longer be here if they still have a right to stay?

Caroline Abrahams: First, there is anecdotal evidence that some of them are giving up already because they do not feel welcome any more. We are certainly hearing that from some care providers.

Secondly, under the recommendation made by the Migration Advisory Committee, as I understand it, people will no longer have preferential access to the UK labour market. Therefore we are turning off the tap of future people from the EU.

The Chairman: Right. I can see that we are going off the rails now.

Caroline Abrahams: I am sorry we looked at it.

The Chairman: That is okay. Actually, we have run out of time, but we are extremely grateful to you. We have packed a lot into this session. Thank you very much for coming along. We would be very grateful if that

information on overseas examples could be provided to the Committee.