

HOUSE OF LORDS

Economic Affairs Committee

---

7th Report of Session 2017–19

# **Social care funding: time to end a national scandal**

---

Ordered to be printed 27 June 2019 and published 4 July 2019

---

Published by the Authority of the House of Lords

HL Paper 392

### *Economic Affairs Committee*

The Economic Affairs Committee was appointed by the House of Lords in this session “to consider economic affairs”.

### *Membership*

The Members of the Economic Affairs Committee are:

<a href="#"><u>Baroness Bowles of Berkhamsted</u></a>	<a href="#"><u>Lord Lamont of Lerwick</u></a>
<a href="#"><u>Lord Burns</u></a>	<a href="#"><u>Lord Layard</u></a>
<a href="#"><u>Lord Darling of Roulanish</u></a>	<a href="#"><u>Lord Livermore</u></a>
<a href="#"><u>Lord Forsyth of Drumlean</u></a> (Chairman)	<a href="#"><u>Lord Sharkey</u></a>
<a href="#"><u>Baroness Harding of Winscombe</u></a>	<a href="#"><u>Lord Tugendhat</u></a>
<a href="#"><u>Lord Kerr of Kinlochard</u></a>	<a href="#"><u>Lord Turnbull</u></a>
<a href="#"><u>Baroness Kingsmill</u></a>	

### *Declaration of interests*

See Appendix 1.

A full list of Members’ interests can be found in the Register of Lords’ Interests:

<http://www.parliament.uk/mps-lords-and-offices/standards-and-interests/register-of-lords-interests>

### *Publications*

All publications of the Committee are available at:

<http://www.parliament.uk/hleconomicaffairs>

### *Parliament Live*

Live coverage of debates and public sessions of the Committee’s meetings are available at:

<http://www.parliamentlive.tv>

### *Further information*

Further information about the House of Lords and its Committees, including guidance to witnesses, details of current inquiries and forthcoming meetings is available at:

<http://www.parliament.uk/business/lords>

### *Committee staff*

The staff who worked on this inquiry were Sam Newhouse (Clerk), Luke Hussey (Clerk until December 2018), Michael Berry (Graduate Trainee Clerk until February 2019), Ben McNamee (Policy Analyst) and Lucy Molloy (Committee Assistant).

### *Contact details*

All correspondence should be addressed to the Economic Affairs Committee, Committee Office, House of Lords, London SW1A 0PW. Telephone 020 7219 5358. Email

[economicaffairs@parliament.uk](mailto:economicaffairs@parliament.uk)

### *Twitter*

You can follow the Committee on Twitter: [@LordsEconCom](https://twitter.com/LordsEconCom).

## CONTENTS

---

	<i>Page</i>
<b>Summary of conclusions and recommendations</b>	<b>3</b>
<b>Chapter 1: Introduction</b>	<b>7</b>
Existing funding arrangements	7
Table 1: Estimated breakdown of gross adult social care funding, 2016/17	8
Box 1: Eligibility for public funding	8
Public funding sources	9
Box 2: New sources of public funding	10
<b>Chapter 2: Challenges</b>	<b>11</b>
Political challenges of reform	11
Box 3: Government reviews and attempted reforms of social care funding since 1999	11
Cross-party consensus	12
Public understanding	12
Funding for adult social care	14
Inadequate funding	14
Figure 1: Adult social care spending, 2010/11 to 2017/18 (adjusted for inflation)	14
Rising demand for adult social care	14
Unmet demand	15
Required additional funding	17
Unpaid carers	17
Table 2: Numbers of unpaid carers in England by amount of care provided, 2011	17
Unfairness	19
The ‘condition lottery’ and catastrophic costs	19
Self-funders, local authority fees and market sustainability	20
Regional differences	22
Workforce	24
Vacancies	25
Pay	26
Care as a profession	27
<b>Chapter 3: Options for reform</b>	<b>30</b>
Principles for reform	30
Public versus private individual funding	30
Cap and floor	30
Free at the point of use	32
Box 4: Free personal care in Scotland	34
Costs	35
Private insurance	35
Options for public funding	40
Hypothecated versus general taxation	40
Box 5: Mandatory social insurance in Germany and Japan	42
Intergenerational fairness	42
Box 6: Recommendations from the Barker Commission for raising additional funding for social care, including money that could be raised	43

National versus local responsibility	44
Appendix 1: List of Members and declarations of interest	46
Appendix 2: List of witnesses	48
Appendix 3: Call for evidence	53
Appendix 4: Private meeting with care workers	54

Evidence is published online at <https://www.parliament.uk/social-care-funding-in-england/publications> and available for inspection at the Parliamentary Archives (020 7219 3074).

Q in footnotes refers to a question in oral evidence.

## SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

---

1. Adult social care in England is inadequately funded. 1.4 million older people (14 per cent of the population) had an unmet care need in 2018. The number of older people and working-age adults requiring care is increasing rapidly, and public funding is not only not keeping pace, but has declined in real terms by 13 per cent between 2009/10 and 2015/16. (see Paragraph 1)

### *Challenges*

2. After decades of reviews and failed reforms, it is not clear how another Green Paper is going to make progress on addressing the challenges in social care funding. With each delay the level of unmet need in the system increases, the pressure on unpaid carers grows stronger, the supply of care providers diminishes and the strain on the care workforce continues. Government action, rather than further consultation, is required. (Paragraph 20)
3. To avoid further delay, the Government should produce a White Paper, not a Green Paper, with clear and plausible proposals for sustainable adult social care funding. (Paragraph 21)

### *Funding for adult social care*

4. As fewer individuals have been able to access local authority funding, greater pressure has fallen on family and friends to provide unpaid care. This may not be sustainable. Restoring access to local authority funding for many individuals could help to relieve this pressure. (Paragraph 40)
5. To restore care quality and access to 2009/10 standards, addressing the increased pressure on unpaid carers and local authorities and the unmet need that has developed since then, around £8 billion a year in additional funding will be required for adult social care. More will be required in subsequent years as the population of older and working-age people with care needs continues to grow. Roughly half of all public funding for social care is spent on the working-age population. (Paragraph 41)

### *Unfairness*

6. Unlike the Secretary of State, we are convinced that the increasing disparity between prices paid by self-funders and those paid by local authorities is unfair to both sides and therefore unsustainable. The effect is to drive care homes to market to self-funders, and so reduce the availability of places for individuals funded by local authorities. (Paragraph 54)
7. Local authorities differ in respect of the cost pressures they face and their ability to raise funds. Some local authorities are therefore able to spend more per head on adult social care than others, leading to a postcode lottery in standards of provision. (Paragraph 65)
8. We share the concerns of many witnesses about the Government's plans to make local authorities more fiscally self-reliant. Demand for social care is often greatest in areas where business is least buoyant. (Paragraph 66)

### *Workforce*

9. Increased funding for adult social care will allow for investment in the care workforce. Higher pay is required for care workers in publicly-funded care providers to allow those providers to compete with other local employers.

The care workforce needs a career structure which better reflects the skills required to be a good care worker and the social importance of the sector. (Paragraph 87)

### Options for reform

#### *Principles*

10. Any long-term funding solution for adult social care should:
  - (a) Put more money into the system through a combination of public and personal funding;
  - (b) Be simple and easy to understand for those accessing public funding;
  - (c) Ensure local authorities can afford to provide care to all those whose needs meet the legal eligibility criteria, which must be interpreted fairly and consistently across local authorities;
  - (d) Quantify and address serious unmet need;
  - (e) Ensure the level of unpaid carers in the system does not suffer a steep decline and is sustainable;
  - (f) Better protect individuals from catastrophic costs;
  - (g) Reduce the disparity between entitlement to help in the National Health Service and the adult social care system, ensuring that entitlement is based on the level of need, not the diagnosis;
  - (h) Allow local authorities to pay care providers a rate that covers the costs of providing care, without the need for cross-subsidy from self-funders;
  - (i) Distribute adult social care funding more fairly across local authorities;
  - (j) Invest in the social care workforce and ensure a more joined up approach to workforce planning with the National Health Service. (Paragraph 90)

#### *Public versus private individual funding*

11. The Government has two categories of challenge: how to fund the system to ensure adequate quality and access; and how to make people's entitlement to public funding fairer. Notwithstanding the latter, which is discussed in our subsequent conclusions, the Government must increase funding to restore levels of quality and access to those observed in 2009/10. This should be its top priority. (Paragraph 127)
12. As most previous inquiries have concluded, the costs of long-term care should not fall solely on the shoulders of individuals and families or on the state. We support a partnership approach, in which the costs of care are shared between individuals and the taxpayer. (Paragraph 128)
13. Free personal care is fair, better aligned with NHS entitlement than the current system and easier to implement than alternative proposals. It may be more expensive than some alternatives, but it could reduce demand for residential care and health care in the long-run by encouraging users to seek domiciliary care early. (Paragraph 129)

14. Free personal care is a partnership approach because it covers only some of the costs of social care. Personal care means essential help with basic activities of daily living, such as washing and bathing, dressing, continence, mobility and help with eating and drinking. It does not include other areas where support might be needed, such as assistance with housework, laundry or shopping. (Paragraph 130)
15. Under free personal care individuals would therefore only receive funding for support with these basic activities of daily living, based on the minimum threshold of eligible needs as defined by the Care Act. Accommodation and living costs, which everyone incurs irrespective of their care needs, would continue to be met by the individual. (Paragraph 131)
16. The Government should introduce a basic entitlement to publicly funded personal care for individuals with substantial and critical levels of need. Accommodation costs and the costs of other help and support should still be incurred by the individual. The Health Foundation and the King's Fund estimate this would cost £7 billion if introduced in 2020/21. (Paragraph 132)
17. Free personal care must be funded properly, otherwise it will result in longer waiting times or restrictions in eligibility criteria. Funding should be reviewed each year to ensure local authorities can afford to meet demand. (Paragraph 133)
18. Some people who need long-term care for many years, particularly in residential and nursing homes, might still face catastrophic accommodation costs. (Paragraph 134)
19. The Government should retain a means test for accommodation costs. To avoid catastrophic accommodation costs, the Government should also explore a cap. (Paragraph 135)
20. No country relies primarily on private insurance to fund adult social care costs. In the current system, establishing a market for long term social care insurance in England would be difficult, even with a cap on lifetime social care costs or accommodation costs or an auto-enrolment scheme. Private insurance cannot provide the amount of funding required by the social care system, not least because roughly half of public social care funding is currently spent on people who are working-age. (Paragraph 136)

### *Options for public funding*

21. Some witnesses said social care funding should reflect the fact that older generations are more likely to benefit from it in the short term. Employees above the state pension age currently pay no national insurance on their earnings, but their employers do. We recommend that those above the state pension age should no longer be exempt from employees' national insurance. They should pay the same rate as other age groups. This could raise more than £1 billion. (Paragraph 155)
22. Social care funding should not be reliant on locally raised revenue which has little connection to local demand for social care. (Paragraph 156)
23. The additional funding needed for adult social care should be provided as a government grant, distributed directly to local authorities according to an appropriate national funding formula which takes into account differences

between local authorities in demand for care and ability to raise funds from local taxation. (Paragraph 157)

24. Funding social care should be approached in the same way as any other funding pressure. We recommend that social care is funded largely from general taxation. (Paragraph 159)
25. The Government should adopt a staged approach to providing the additional funding recommended by this report. It should immediately invest £8 billion in adult social care, which is the amount the Health Foundation and the King's Fund estimate will be required to restore quality and access to 2009/10 levels, funded nationally and distributed according to a fair funding formula. It should then introduce free personal care over the next five years. Free personal care should be available universally by 2025/26. (Paragraph 160)

# Social care funding: time to end a national scandal

## CHAPTER 1: INTRODUCTION

---

1. Adult social care in England is inadequately funded. As a result, many people who need state-funded care are not receiving it. 1.4 million older people (14 per cent of the population) had an unmet care need in 2018.<sup>1</sup> Family and friends, most often women aged 50–64, are taking on an increasing amount of unpaid care, and most carers say this is having a negative impact on their health.<sup>2</sup> Care workers continue to be underpaid and undervalued. The number of older people and working-age adults requiring care is increasing rapidly, and public funding is not only not keeping pace, but has declined in real terms by 13 per cent between 2009/10 and 2015/16.<sup>3</sup>
2. Social care funding is also unfair. People with cancer receive treatment free of charge on the NHS, while many people with dementia have to pay hundreds of thousands of pounds for their social care. National funding for social care is distributed unequally across local authorities. The funding shortfall has meant local authorities are paying care providers a far lower rate for local authority-funded care recipients than self-funded care recipients, and those care providers with a high proportion of local authority-funded care recipients are struggling to survive.
3. This report sets out our conclusions on the challenges for adult social care funding and considers options for reform and ways of achieving it. Our report does not consider issues of quality or the nature of provision of care. Unless otherwise specified, the report refers to care for both older people and those of working age. This chapter gives background on the present funding system for social care.

### Existing funding arrangements

4. Social care in England is funded primarily by local authorities, with contributions from care users, national government, and the NHS. Local authorities contract out services to care providers, who range from large national private companies to smaller local organisations, including charities and voluntary bodies. In 2016/17 local authorities spent £18.15 billion on adult social care, divided roughly equally between care for older people and for those of working-age.<sup>4</sup> Table 1 shows the distribution of sources through which local authorities funded adult care in 2016/17.

---

1 Age UK, *New analysis shows number of older people with unmet care needs soars to record high* (9 July 2018): <https://www.ageuk.org.uk/latest-press/articles/2018/july-2018/new-analysis-shows-number-of-older-people-with-unmet-care-needs-soars-to-record-high/> [accessed 16 May 2019]

2 Written evidence from Carers UK (SOC0046)

3 Written evidence from The Health Foundation (SOC0047)

4 NHS Digital, *Adult Social Care Activity and Finance Report: Detailed Analysis* (23 October 2019): <https://files.digital.nhs.uk/35/6A192B/Activity%20and%20Finance%20Report%20201718.pdf> [accessed 30 May 2019]

**Table 1: Estimated breakdown of gross adult social care funding, 2016/17<sup>5</sup>**

Source	Amount and proportion of funding
Council tax	£8.0 billion (38.6%)
Business rates	£3.8 billion (18.1%)
Other income (predominantly NHS partnerships)	£3.2 billion (15.5%)
Government grants	£3.0 billion (14.7%)
Care user contributions	£2.7 billion (13.1%)

Source: Ministry of Housing, Communities and Local Government, *Local authority revenue expenditure and financing England: 2016 to 2017 individual local authority data: outturn* (24 August 2017): <https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2016-to-2017-individual-local-authority-data-outturn> [accessed 26 June 2019]; Local Government Association, *The lives we want to lead: the LGA Green Paper for adult social care and wellbeing*, July 2018: <https://futureofadultsocialcare.co.uk/wp-content/uploads/2018/07/The-lives-we-want-to-lead-LGA-Green-Paper-July-2018.pdf> [accessed 26 June 2019]

- To be eligible for local authority funding, an individual must pass a needs assessment and a financial assessment. If the individual qualifies for funding, the local authority will determine a “personal budget”, which sets out the total cost of care needs and the distribution between individual and local authority contributions.<sup>6</sup> Any individual with more than £23,250 in assets will not receive public funding. Box 1 describes the assessments in more detail.

### Box 1: Eligibility for public funding

The **needs assessment** is conducted by a local authority employee, such as a social worker or occupational therapist, who considers whether the individual has eligible needs for care and support such as help with “managing everyday tasks like washing, dressing and cooking” or wider social needs. The assessment can happen over the phone or in person.<sup>7</sup>

In the **financial assessment**, the local authority determines how much an individual can afford to pay towards their care. If an individual's assets value higher than £23,250, they will receive no funding. Where assets value lower than £14,250, individuals will pay “only what they can afford from their income”. Individuals falling between the two thresholds will pay an affordable amount (as assessed by the local authority) from their income, and a means-tested contribution from their assets.<sup>8</sup>

5 Since 2016/17, government grants have increased with the improved Better Care Fund. This totalled £1.84 billion in 2019/20, which, as an indication of magnitude, would have increased government grants in 2016/17 figures to 23.6 per cent of gross adult social care funding.

6 Age UK, *Paying for permanent residential care* (April 2019): [https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs10\\_paying\\_for\\_permanent\\_residential\\_care\\_fcs.pdf](https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs10_paying_for_permanent_residential_care_fcs.pdf) [accessed 29 May 2019]

7 NHS, ‘Getting a needs assessment’, (31 July 2018): <https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/getting-a-needs-assessment/> [accessed 29 May 2019]

8 The means-tested contribution is calculated as £1 per week for every £250 of capital between the capital limits. Department for Health and Social Care, *Social care: charging for care and support* (January 2019): [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/772969/Social\\_care\\_charging\\_for\\_care\\_and\\_support\\_-\\_LAC\\_2019.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772969/Social_care_charging_for_care_and_support_-_LAC_2019.pdf) [accessed 29 May 2019]

If the individual is receiving care in their own home (domiciliary care), the value of the individual's home is not included in the financial assessment. If they are living in a care home, the value of their house is included. Any outstanding mortgage debt is deducted from the value.<sup>9</sup>

Income is calculated on a weekly basis. Individuals are expected to pay a large proportion of their income towards care costs, but they will always be left with a minimum of £24.90 a week (a Personal Expenses Allowance). The assessment assumes that individuals claim all social security benefits for which they are eligible.<sup>10</sup>

### *Public funding sources*

6. Traditionally, as shown by Table 1, social care funding has come from local authority budgets, which are themselves comprised mostly from central government grants and receipts from council tax and business rates. Most is not ring-fenced for social care, meaning local authorities are free to allocate funding according to their views of needs and priorities in their area.<sup>11</sup> Unlike the National Health Service, budget decisions are therefore made at a local rather than national level.
7. Box 2 describes actions taken by the Government to make more funding available for social care in response to the challenges set out in Chapter 2 of this report.

9 NHS, 'Getting a needs assessment', (31 July 2018): <https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/getting-a-needs-assessment/> [accessed 29 May 2019]

10 Age UK, *Paying for permanent residential care* (April 2019): [https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/large-print-factsheets/fs10\\_lp\\_paying\\_for\\_permanent\\_residential\\_care\\_fcs.pdf](https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/large-print-factsheets/fs10_lp_paying_for_permanent_residential_care_fcs.pdf) [accessed 29 May 2019]

11 House of Commons Library, *Adult Social Care Funding* (England), Briefing Paper, [CBP07903](#) 12 February 2019

**Box 2: New sources of public funding**

From 2016/17 to 2019/20 local authorities have been allowed to add a **social care precept** to council tax of two per cent in each of the four years, up to a total of eight per cent. From 2017/18, local authorities were permitted to raise the precept by up to three per cent for that year and 2018/19, but without an increase in the eight per cent maximum. Forty-four per cent of local authorities chose to bring the precept forward by increasing it by three per cent in both 2017/18 and 2018/19, and will therefore not be able to raise a further precept in 2019/20.<sup>12</sup>

Originally introduced in 2013, the **Better Care Fund** (BCF) pooled money already due to be allocated to clinical commissioning groups and transferred to social care from NHS funding. In 2015, the Government pledged additional national funding for the BCF, known as the **improved Better Care Fund**.

An additional £240 million was added to the Better Care Fund for 2018/19 and 2019–20 to invest in social care to alleviate pressures on the NHS over the winter.

The **Adult Social Care Support Grant** was announced in 2017/18 as a one-off £240 million grant for social care funding, distributed according to the relative needs of local authorities. It was extended in 2018/19, but only with £150 million. For 2019/20 it was expanded to include children's social care and increased to £410 million.

---

<sup>12</sup> Local Government Association, 'Council tax will fail to protect adult social care services this year', (6 March 2019): <https://www.local.gov.uk/about/news/council-tax-will-fail-protect-adult-social-care-services-year> [accessed 16 May 2019]

## CHAPTER 2: CHALLENGES

---

8. This chapter examines political and policy challenges within the social care system. It considers Government attempts to reform social care funding and why they have proved difficult, before moving onto those issues of underfunding and unfairness identified in the previous chapter.

### Political challenges of reform

9. There have been numerous attempts by governments to address the funding of social care in the last 20 years. The Voluntary Organisations Disability Group said that since 1998 there had been “12 green papers, white papers, other consultations, and five independent reviews” that attempted to solve the issues of social care funding. Some of these attempts are summarised in Box 3.

### Box 3: Government reviews and attempted reforms of social care funding since 1999

- 1999: A Government-appointed Royal Commission published proposals for reform. These included a more generous means-test and free personal and nursing care. The proposals were accepted in part by the then Labour Government (free personal and nursing care was introduced subsequently by the Scottish Government, citing the Royal Commission’s recommendations).
- 2009: A Green Paper by the Labour Government proposed a National Care Service, and a subsequent White Paper proposed a two-year cap on social care charges initially, followed by free social care after 2015.
- 2011: The Coalition Government established the Commission on the Funding of Care and Support (the ‘Dilnot Commission’). This Commission proposed a cap on lifetime social care charges and a more generous means-test.
- 2014: The Coalition Government legislated to implement the Dilnot Commission’s proposals with cross-party support, but the newly-elected Conservative Government in July 2015 postponed their introduction from April 2016, citing funding pressures and a lack of preparedness by local authorities. In 2017 the implementation of the proposals was postponed indefinitely.
- 2017: The Conservative Government committed to publishing a Green Paper on social care in the March 2017 Budget, a commitment reiterated in the Conservative Party manifesto for the 2017 general election, which also included proposals to introduce a floor on the costs an individual could incur. The Green Paper has been delayed numerous times: the latest revised date for publication was April 2019 but the Secretary of State blamed “Brexit and the need for bandwidth” for the missed deadline.<sup>13</sup>

*Source: House of Commons Library, Social care: forthcoming Green Paper (England), Briefing Paper, [8002](#), 13 May 2019*

10. These attempts have not succeeded in addressing the challenges. Care England said they were “frustrated by the lack of progress” despite all the reviews, “all of which seem to come to similar conclusions—the system needs

---

13 [Q 96](#) (Matt Hancock MP)

to be properly funded.” The Institute for Government explained how some of the proposals became contentious politically:

“Proposals included in a government discussion paper in 2010 on how to fund free social care were quickly dubbed a ‘death tax’ by the Conservative opposition and dogged the Labour Party throughout that year’s election. During the 2017 election campaign the shoe was on the other foot. The Conservatives’ social care manifesto commitment quickly became known as the ‘dementia tax’ and is widely seen as contributing to the Government losing its majority ... Painful precedents such as these mean that political parties are reluctant to discuss how to raise money to fund health and social care.”<sup>14</sup>

11. The Local Government Association said “national governments past and present have tended to put political prospects ahead of difficult but necessary decision-making.”<sup>15</sup>

#### *Cross-party consensus*

12. Witnesses called for a cross-party consensus on any solution. The Institute for Government said: “a minority government muddling through or acting decisively on its own is highly unlikely to achieve a long-term sustainable funding solution.”<sup>16</sup>
13. The Secretary of State acknowledged this was one of the main reasons a solution had not yet been found: “The main political parties have not yet come together across the divide to agree this” and that it would be wise for a discussion between parties to take place “outside the immediacy of an election cycle.”<sup>17</sup> The Nuffield Trust said that new proposals “are often put forward as part of election campaigns at a point in the electoral cycle when there is minimal incentive for cross-party cooperation.”<sup>18</sup>

#### *Public understanding*

14. Some witnesses believed a lack of public understanding of the social care system was hindering reform. Care England said there was “a hesitancy by politicians to increase funding for a system that is not well understood by the public”.<sup>19</sup> The Health Foundation said that one of the “political challenges” was that the Government needed to raise awareness of the problems with the current system: “raising awareness of these problems is a risky thing to do ... But you can’t have a conversation about solutions to the social care challenges unless the public is informed.”<sup>20</sup>
15. Iain MacBeath, Director of Adult Services at Hertfordshire County Council, said there was a need to ask “some urgent questions” about the gap between people’s needs and expectations and have a “transparent conversation with the public about what is available from the state and what is not”.<sup>21</sup>

---

14 Written evidence from the Institute for Government ([SOC0061](#))

15 Written evidence from the Local Government Association ([SOC0033](#))

16 Written evidence from the Institute for Government ([SOC0061](#))

17 [Q 97](#) (Matt Hancock MP)

18 Written evidence from The Nuffield Trust ([SOC0031](#))

19 Written evidence from Care England ([SOC0039](#))

20 Written evidence from The Health Foundation ([SOC0047](#))

21 [Q 66](#) (Iain McBeath)

*Complexity of the present system*

16. The complexity of the present system was cited by witnesses as a barrier to public understanding. A Local Government Association survey found that 48 per cent of English adults said they had “little to no understanding of what the term ‘social care’ means”, 44 per cent thought social care was provided by the NHS and 28 per cent thought social care was free at the point of access.<sup>22</sup>
17. The King’s Fund and the Health Foundation published a joint report into public attitudes to social care in 2018. The Health Foundation said that the reaction to the current funding model “was unanimously negative. People were often shocked when the details of the means test were explained to them.”<sup>23</sup>
18. Kari Gerstheimer, Director of Information and Advice at Mencap, said the system was “confusing”; even people working for the charity’s information and advice service struggled “to help people navigate that extraordinary complex system.”<sup>24</sup> Caroline Abrahams, Charity Director at Age UK, believed that reforms such as that proposed by the Dilnot Commission “would have been almost impossible to communicate to the public. I am not sure that you would ever succeed in raising public awareness.”
19. **Cross-party cooperation will be necessary if progress is to be made on reforms to social care funding. It will be easier to achieve if reforms make the system easier to understand. Evidence shows that people who have not had direct exposure to the social care system do not appreciate the extent to which people are responsible for paying for their own care, and that the system is too complex. This inhibits discussion around reform, as proved by the ‘death tax’ and ‘dementia tax’ refrains in recent election campaigns.**
20. **After decades of reviews and failed reforms, it is not clear how another Green Paper is going to make progress on addressing the challenges in social care funding. With each delay the level of unmet need in the system increases, the pressure on unpaid carers grows stronger, the supply of care providers diminishes and the strain on the care workforce continues. Government action, rather than further consultation, is required.**
21. *To avoid further delay, the Government should produce a White Paper, not a Green Paper, with clear and plausible proposals for sustainable adult social care funding.*
22. Our inquiry found that there were three main challenges within the social care system: a lack of funding, unfair outcomes for individuals using the care system and workforce retention and recruitment.

---

22 Local Government Association, ‘Majority of people unprepared for adult social care costs’, (26 October 2018): <https://www.local.gov.uk/about/news/majority-people-unprepared-adult-social-care-costs> [accessed June 2019]. The Health Foundation highlighted polling on behalf of Deloitte which found that 47 per cent of people believed social care was free at the point of need. Written evidence from the Health Foundation (SOC0047)

23 Written evidence from The Health Foundation (SOC0047)

24 Q 44 (Kari Gerstheimer)

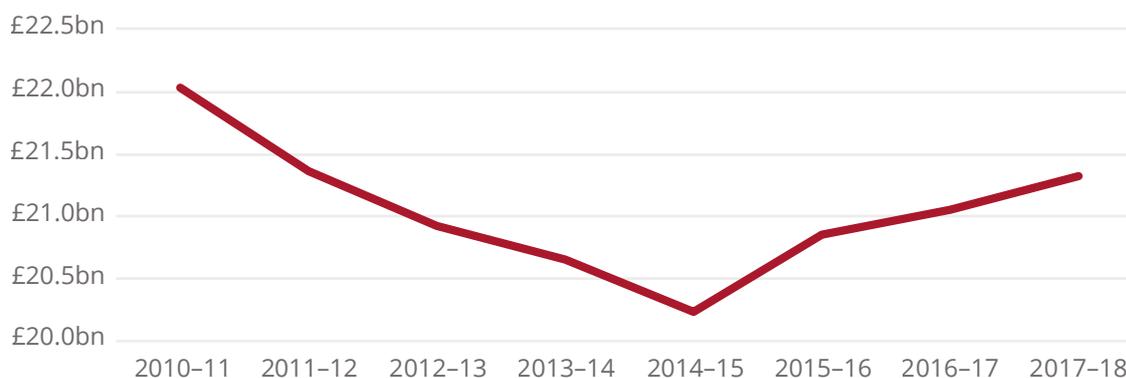
### Funding for adult social care

23. Witnesses were agreed that there was inadequate funding for adult social care and that increases in the proportion of working age people with care needs and an ageing population would increase this ‘funding gap’. We also heard there were substantial unmet care needs and that the system was dependent on a large number of unpaid carers.

#### *Inadequate funding*

24. Local authorities spent around £18 billion gross on adult social care costs in 2017/18.<sup>25</sup> Over half of local authorities overspent against their adult social care budgets in 2017/18 and just under half financed that overspending from their reserves.<sup>26</sup> While short-term injections of funding have increased funding since 2015/16, Figure 1 shows that funding was still £700 million lower in 2017/18 than in 2010/11. This does not account for increases in care demand in the intervening period, meaning funding per head is even lower.

**Figure 1: Adult social care spending, 2010/11 to 2017/18 (adjusted for inflation)**



Source: *Adult Social Care Activity and Finance Report, NHS Digital, cited by the King's Fund*: <https://www.kingsfund.org.uk/publications/social-care-360/expenditure> [accessed 22 May 2019]

#### *Rising demand for adult social care*

25. At the same time as funding has been under pressure, demand for care services has been increasing and is expected to continue rising. The Nuffield Trust said:

“by 2040, around one quarter of the UK population is projected to be over 65 years old and 8 per cent will be 80 years old or more. Based on current spending and population projections, a funding gap of £18 billion will open up by 2030/2031. The implications for the funding

25 NHS, *Adult Social Care Activity and Finance Report, England 2017–18* (23 October 2018): <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2017-18> [accessed 30 May 2019]

26 Written evidence from the Association of Directors of Adult Social Services (ADASS) ([SOC0052](https://www.adass.org.uk)). A 2018 report from the Chartered Institute for Public Finance and Accountancy (CIPFA) showed that 10 to 15 per cent of local authorities showed signs of being financially unstable, primarily because they were depleting their reserves. They suggested adult social care funding was at least responsible in part for the vulnerability of some local authorities. CIPFA, *Measured resilience in English authorities* (December 2018) <https://www.cipfa.org/policy-and-guidance/reports/measured-resilience-in-english-authorities> [accessed 26 June 2019]

challenge are stark: by 2040, for every 2 working-age adults in the UK, there will be almost 1 person over 65 years of age.<sup>27</sup>

Researchers from the University of East Anglia, London School of Economics and Pensions Policy Institute estimated that the costs of care for older people would double between 2020 and 2035.<sup>28</sup>

26. The proportion of the working-age population with disabilities is also expected to increase. The Voluntary Organisations Disability Group (VODG) told the Committee that by 2025 there would be 150,000 more working age adults with moderate or severe physical disabilities, and 16,000 more with learning disabilities.<sup>29</sup> Hft, a charity which supports people with learning disabilities, said people with learning disabilities “are living longer and displaying increasingly complex support needs.”<sup>30</sup>

#### *A ‘tipping point’?*

27. The combination of funding pressures and increased demand led the Care Quality Commission to warn in 2016 that adult social care was approaching a “tipping point”:

“The fragility of the adult social care market is now beginning to impact both on the people who rely on these services and on the performance of NHS care. The combination of a growing and ageing population, more people with long-term conditions, and a challenging economic climate means greater demand on services and more problems for people in accessing care.”<sup>31</sup>

28. Care England said similarly that:

“time was running out for social care ... Relentless pressures on funding, increases in the level and complexity of need and widespread challenges in the retention and recruitment of the workforce required are compounding at an exponential rate, putting the continuity of care of thousands of vulnerable people at great risk.”<sup>32</sup>

#### *Unmet demand*

29. Many witnesses told us that substantial numbers of people who need care are not being provided it. Age UK estimate 1.4 million older people, 14 per cent of those over 65, have unmet care needs.<sup>33</sup> Iain MacBeath said: “councils are really only meeting the needs of people who have substantial or critical needs”.<sup>34</sup> He said the number of people receiving social care had “massively

27 Written evidence from The Nuffield Trust ([SOC0031](#))

28 Written evidence from Care and State Pensions Reform (CASPeR) ([SOC0073](#))

29 Written evidence from Voluntary Organisations Disability Group ([SOC0068](#))

30 Written evidence from Hft ([SOC0038](#))

31 Care Quality Commission, *Adult social care ‘approaching tipping point’, warns quality regulator* (13 October 2016): <https://www.cqc.org.uk/news/releases/adult-social-care-%E2%80%99approaching-tipping-point%E2%80%99-warns-quality-regulator> [accessed 28 February 2019]

32 Written evidence from Care England ([SOC0039](#))

33 Age UK, ‘New analysis shows number of older people with unmet care needs soars to record high’, (9 July 2018): <https://www.ageuk.org.uk/latest-press/articles/2018/july-2018/new-analysis-shows-number-of-older-people-with-unmet-care-needs-soars-to-record-high/> [accessed 16 May 2019]

34 [Q 66](#) (Iain MacBeath)

reduced over the period of austerity.”<sup>35</sup> Inclusion London, a disability equality organisation, described the impact on disabled people:

“Disabled people are receiving an extremely basic ‘clean and feed’ model of care. The most basic choices such as when to get up, go to bed or use the toilet, when and what to eat, and the choice to leave the house are no longer in the hands of disabled people but subject to local authority budget allocations which are becoming ever more restricted.”<sup>36</sup>

30. A 2018 survey by the Care and Support Alliance found that as a result of a lack of support:

- “Over a quarter of respondents reported being unable to maintain the basics like washing, dressing and/or visiting the toilet.
- 1 in 5 respondents felt unsafe moving around their home, and over a third didn’t leave their homes.
- 1 in 5 respondents said they went without meals.
- 1 in 4 respondents said they needed hospital treatment and 1 in 8 told us they’ve been delayed leaving hospital.”<sup>37</sup>

*Reduced eligibility for public support*

31. The number of people who are eligible for publicly-funded care has reduced in recent years as the threshold used in the means test to determine whether a person becomes eligible—if they have assets worth £23,250 or below—has not increased with inflation, and therefore decreased by 12 per cent in real terms.<sup>38</sup> If the means test had increased annually with inflation since it was last increased in 2010/11, it would now be £2,811 higher.<sup>39</sup> The Health Foundation said this had allowed the Government to “go unnoticed in making fiscal savings.” They said over 400,000 fewer older people accessed publicly-funded social care in England in 2013/14 than in 2009/10, a 26 per cent fall despite the rise in the population of older people over the same period.<sup>40</sup>

32. Shaping Our Lives, a national network of service users and disabled people, argued local authorities were also making it harder for individuals to pass the needs assessment for public funding:

“If a council deems a need to be ‘eligible’ the need must be met as a matter of legal duty without delay. However, councils have carte blanche to define ‘need’ in whatever way they want. There are national eligibility criteria, but these are so loose as to be virtually meaningless ... In this way councils can meet their fiduciary duty to spend within budget.

35 *Ibid.*

36 Written evidence from Inclusion London (SOC0024)

37 Written evidence from Care and Support Alliance (CSA) (SOC0028). Care and Support Alliance conducted a survey of 3,915 self-selecting older and working age individuals with self-identified care needs.

38 The Health Foundation, *NHS at 70: What’s the problem with social care, and why do we need to do better?* (June 2018): <https://www.health.org.uk/publications/nhs-at-70-what%E2%80%99s-the-problem-with-social-care-and-why-do-we-need-to-do-better> [accessed 16 May 2019]

39 The King’s Fund, *Social care 360*: <https://www.kingsfund.org.uk/publications/social-care-360/access> [accessed 30 May 2019]

40 Written evidence from the Health Foundation (SOC0047)

In effect, it is significance of impact on budget, not wellbeing, that determines whether needs will be deemed ‘eligible’.<sup>41</sup>

### *Required additional funding*

33. To maintain existing levels of provision, the King’s Fund and the Health Foundation estimated adult social care will require an increase in annual funding of £1.5 billion by 2020/21 (to maintain 2015/16 levels of provision).<sup>42</sup> ADASS estimate local authorities will require £2.4 billion of additional funding for 2019/20.<sup>43</sup> Such additions would stop the funding gap widening but would not relieve substantially unmet care needs or pressure on carers.
34. The King’s Fund and Health Foundation estimate that to restore provision to 2009/10 standards of care, adult social care would require £8 billion in extra funding.<sup>44</sup> Age UK estimated that there were still more than 800,000 people living with unmet care needs in 2010.<sup>45</sup>

### *Unpaid carers*

35. These funding estimates assume that the level of unpaid care that is provided presently by carers is sustainable. Increasing pressure is being placed on friends or family members to provide informal care. According to the 2011 census, there were 5.4 million unpaid carers in England. Nearly a quarter of them provided 50 or more hours of care a week, as shown in Table 2.<sup>46</sup>

**Table 2: Numbers of unpaid carers in England by amount of care provided, 2011**

Number of unpaid care hours provided a week	Number of people
1 to 19	3,452,636
20 to 49	721,143
50 or more	1,256,237
Total	5,430,016

Source: Office for National Statistics, 2011 Census

36. Some witnesses told us that with reduced local authority funding, informal carers were doing more, and with less support. Carers UK said:

41 Written evidence from Shaping Our Lives (SOC0017)

42 Written evidence from the King’s Fund (SOC0057)

43 Written evidence from the Association of Directors of Adult Social Services (ADASS) (SOC0052). This uses the King’s Fund and Health Foundation estimate of £1.5 billion, and adds £500 million of savings ADASS estimates directors would otherwise be asked to find from their budgets in 2019/20, £358 million in response to overspends and spending of local authority reserves on adult social care in 2017/18.

44 Written evidence from the Health Foundation (SOC0047). This is the additional amount required if local authorities had been able to increase their spending by 3.7 per cent every year since 2009/10. 3.7 per cent is the Health Foundation’s estimate of the average annual growth in social care cost pressures until 2030/31, caused by a growing and ageing population, more people living longer with long-term conditions and the rising costs of providing care.

45 Age UK, ‘1.2 million older people don’t get the social care they need’, (17 November 2016): <https://www.ageuk.org.uk/latest-news/archive/12m-older-people-dont-get-the-social-care-they-need/> [accessed 26 June 2019]

46 Office for National Statistics, 2011 Census (27 March 2019): <https://www.nomisweb.co.uk/census/2011/QS301UK/view/2092957699?cols=measures> [accessed 30 May 2019]

“The rationing of social care services due to funding cuts is resulting in extreme and unsustainable pressure being placed on carers, who are providing more care, for more hours than ever before. Since 2001, the growth in the number of carers has outstripped population growth by 16.5 per cent and the number of people providing 20–49 hours of care a week has increased by 43 per cent.”<sup>47</sup>

Eighty-one per cent of people answering the Care and Support Alliance’s survey mentioned above said family and friends are being expected to provide more care as local authority funding has been restricted.<sup>48</sup> The Alzheimer’s Society told us that unpaid carers “bear the brunt of the social care funding crisis”.<sup>49</sup>

37. Carers UK said unpaid carers were receiving less support. As the care packages the person supported receives decrease, carers “are finding it harder to access the breaks they need to look after their own health and well-being”.<sup>50</sup> They noted that spending on carers decreased by 6 per cent between 2017 and 2018, and the number of carers getting support or being assessed by local authorities decreased by five per cent.<sup>51</sup>
38. A 2018 survey by Carers UK found a large proportion of carers reported that their health had declined as a result of caring: 72 per cent mentally and 61 per cent physically.<sup>52</sup> Thirty-seven per cent of respondents said they were “struggling to make ends meet” financially.<sup>53</sup> Carers UK argued that, given this impact on carers, any long-term adult social care solution should not assume that current levels of unpaid care can continue:

“Our evidence from carers shows that any economic modelling which is predicated on the unpaid support of families and friends continuing to care in good health, or being able provide the same level of care in the future, would be deeply flawed.”<sup>54</sup>

39. Fifty-eight per cent of unpaid carers are women, with those aged 50–64 particularly likely to have care responsibilities. 63 per cent of female carers aged 50–64 provide care for at least 50 hours a week. The Women’s Budget Group said that as more women entered the workplace, this supply of unpaid carers was likely to fall.<sup>55</sup>
40. **As fewer individuals have been able to access local authority funding, greater pressure has fallen on family and friends to provide unpaid care. This may not be sustainable. Restoring access to local authority funding for many individuals could help to relieve this pressure.**
41. **To restore care quality and access to 2009/10 standards, addressing the increased pressure on unpaid carers and local authorities and the unmet need that has developed since then, around £8 billion a year in**

---

47 Written evidence from Carers UK (SOC0046)

48 Written evidence from Care and Support Alliance (SOC0028)

49 Written evidence from the Alzheimer’s Society (SOC0050)

50 Written evidence from Carers UK (SOC0046)

51 *Ibid.*

52 Written evidence from Carers UK (SOC0046). The survey was UK-wide and 75 per cent of respondents were from England—Carers UK, *State of Caring 2018* (July 2018): <https://www.carersuk.org/images/Downloads/SoC2018/State-of-Caring-report-2018.pdf> [accessed 27 May 2019]

53 Written evidence from Carers UK (SOC0046)

54 *Ibid.*

55 Written evidence from The Women’s Budget Group (SOC0051)

**additional funding will be required for adult social care. More will be required in subsequent years as the population of older and working-age people with care needs continues to grow.**

### Unfairness

42. Witnesses to our inquiry were in broad agreement that the present social care system in England is unfair. The Health and Social Care Secretary said: “there is a whole series of ways in which the existing system is unfair, and it is hard to see a single solution that solves all those injustices.”<sup>56</sup> Witnesses mentioned three main types of unfairness: disparities between adult social care and the National Health Service, those who fund their own care and those who receive local authority funding, and between different local authorities.

### *The ‘condition lottery’ and catastrophic costs*

43. Several witnesses pointed out the disparity between conditions for which people receive health care, which is free at the point of use, and those for which people receive social care, for which users usually make a substantial contribution (as detailed in Chapter 1). Dominic Carter, Policy Manager at the Alzheimer’s Society, said:

“there is a growing and angry understanding that if you develop many different conditions you will get free support through the NHS, but if, like many, you develop dementia most of the responsibility for paying for care will fall on you and your family, meaning that of the £26 billion that dementia costs every year, two-thirds is being shouldered by the individuals concerned.”<sup>57</sup>

44. Warwick Lightfoot, Head of Economics and Social Policy at Policy Exchange, described how the disparity between health and social care came about:

“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.”<sup>58</sup>

45. Dementia was cited by several witnesses as an example of this disparity.<sup>59</sup> The costs of caring for this condition and the fact that the costs can be incurred over a long period can involve “catastrophic costs” to individuals, which can lead to them being forced to sell their home. The Alzheimer’s Society estimate typical dementia care costs to be roughly £100,000, rising to £500,000 in some cases.<sup>60</sup> Sir Andrew Dilnot, who chaired a Government-commissioned review which reported in 2011, said:

“One way of describing the current system is that it is a very high inheritance tax, but only on people who have high social care needs.

---

56 [Q 96](#) (Matt Hancock MP)

57 [Q 43](#) (Dominic Carter)

58 [Q 14](#) (Warwick Lightfoot)

59 [Q 33](#) (John Godfrey), [Q 42](#) (Dominic Carter), [Q 66](#) (Iain MacBeath) and written evidence from The Nuffield Trust ([SOC0031](#))

60 Written evidence from the Alzheimer’s Society ([SOC0050](#))

That is the unfairness. If we want the inheritance tax regime to take more money away from the person with £2.5 million than it does from the individual with £500,000, let us do it for 100 per cent of those in that circumstance, not for 10 per cent of them ... the person with £2.5 million who has no social care needs [is] completely untouched by anything. It is only the very small subset of people with high social care needs who get hit.”<sup>61</sup>

46. The Health and Social Care Secretary said: “the threat that people might lose their home because of something they cannot do anything about or insure against is one of the injustices of the system.”<sup>62</sup>

*Self-funders, local authority fees and market sustainability*

47. Individuals who pay the full cost of their care (known as self-funders) often pay higher rates for care homes than those whose costs are funded by the local authority. Witnesses told us this was unfair both for self-funders, because they were paying higher fees, and for local authority-funded individuals, because it gave care providers an incentive to focus on self-funders to the detriment of other provision.

48. The Competition and Markets Authority estimated in their study of the care homes market that self-funders paid 41 per cent higher fees than the local authority rate in 2016.<sup>63</sup> They found that this differential had increased substantially since 2005, when only one in five care homes charged different prices for the two groups.<sup>64</sup> The report concluded:

“The consequence is that self-funded residents in mixed homes are meeting a much greater proportion of homes’ fixed costs than LA-funded residents. This is often referred to in the industry as a ‘cross-subsidy’.”<sup>65</sup>

49. Sarah Pickup, Deputy Chief Executive of the Local Government Association, said the cross-subsidy was “not fair” to self-funders.<sup>66</sup> Professor Jill Manthorpe, Director of the National Institute for Health Research Health and Social Care Workforce Research Unit, described it as “taxation by other means”.<sup>67</sup>

50. Professor Martin Green OBE, Chief Executive of care provider representative Care England, argued the disparity resulted from low local authority fees, not overcharging of self-funders:

“We should not see it as a cross-subsidy; we should see it as one lot of people probably paying the real costs of care, and local authorities not doing so. I do not think that people realise how low those figures are.

61 [Q 11](#) (Sir Andrew Dilnot)

62 [Q 102](#) (Matt Hancock MP)

63 Competition and Markets Authority, *Care homes market study: final report* (30 November 2017): <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> [accessed 26 June 2019]. This applies only in care homes which accommodated both local authority and self-funded residents. Care homes which focused exclusively on one of the two groups were excluded.

64 Competition and Markets Authority, *Care homes market study: final report* (30 November 2017): <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> [accessed 26 June 2019].

65 *Ibid.* “Mixed homes” means homes which house both self-funded and local authority-funded residents.

66 [Q 63](#) (Sarah Pickup)

67 [Q 72](#) (Professor Jill Manthorpe)

In Windsor and Maidenhead, for example, they pay £2.48 an hour to deliver care to people who have several health problems, many of whom are living with dementia. Those figures are totally unsustainable ... How is anybody supposed to deliver a quality service on that level of funding? It is not possible.”<sup>68</sup>

51. There were also concerns that low local authority fees threatened the overall sustainability of the market. Professor Green said that some smaller providers which could not “make economies of scale” were exiting the market.<sup>69</sup> Larger providers have also faced difficulties. Home care provider Allied Healthcare was sold in late 2018 after announcing it was selling or transferring all of its contracts,<sup>70</sup> and in April 2019 care home operator Four Seasons Health Care, which houses 22,000 people in 322 homes, went into administration.<sup>71</sup> The 2018 ADASS Budget Survey stated that providers had handed back contracts to more than 60 local authorities, impacting just under 3,000 people in 2018/19.<sup>72</sup>
52. Some witnesses were concerned that a “two-tier” care homes market was emerging.<sup>73</sup> Witnesses suggested more care providers were choosing to market services predominantly at self-funders in order to remain sustainable. Douglas Cooper, Project Director of the Competition and Market Authority’s care homes market study, said:

“There are strong incentives for homes in a local market where they can rely solely on self-funders. Without the cross-subsidy element, they can offer better deals, better value and better quality for the self-funded residents. The consequence will be that local authority-funded residents will be pushed out and the quality of care, if any care is provided to them, is likely to diminish over time.”<sup>74</sup>

Iain MacBeath, Director of Adult Social Care Services at Hertfordshire County Council, said that one care home in his area focused predominantly on self-funders cost £2,500 a week, while the local authority paid care homes £560 a per resident.<sup>75</sup>

53. The Health and Social Care Secretary suggested he did not think the situation was unsustainable:

“You ask if it is sustainable. It has been going on for quite a long time. If you were designing a perfect system, of course you would not have such a disparity. At the same time, local authorities buy in bulk and can predict the amount of demand they are going to have. I look at it as a feature of the system rather than something that anybody designing this system from scratch would put in place.”<sup>76</sup>

---

68 [Q 82](#) (Professor Martin Green OBE)

69 [Q 86](#) (Professor Martin Green OBE)

70 Public Sector Executive, ‘Home care provider Allied Healthcare saved from bankruptcy’, (3 December 2018): <http://www.publicsectorexecutive.com/Public-Sector-News/home-care-provider-allied-healthcare-saved-from-bankruptcy-> [accessed 28 May 2019]

71 ‘Four Seasons: Care home operator goes into administration, raising fears for elderly residents’, *The Independent* (30 April 2019): <https://www.independent.co.uk/news/business/news/four-seasons-care-home-operator-administration-residents-a8892731.html> [accessed 11 May 2019]

72 Written evidence from ADASS ([SOC0052](#))

73 [Q 63](#) (Iain MacBeath)

74 [Q 82](#) (Douglas Cooper)

75 [Q 63](#) (Iain MacBeath)

76 [Q 101](#) (Matt Hancock MP)

54. **Unlike the Secretary of State, we are convinced that the increasing disparity between prices paid by self-funders and those paid by local authorities is unfair to both sides and therefore unsustainable. The effect is to drive care homes to market to self-funders, and so reduce the availability of places for individuals funded by local authorities.**

*Regional differences*

55. Witnesses agreed that the impact of the disparity between care costs for self-funders and local authorities was greater in areas with a higher proportion of local authority-funded care users. The Health and Social Care Secretary acknowledged that higher numbers of self-funders in some areas “undoubtedly has an impact regionally”.<sup>77</sup> Warwick Lightfoot said:

“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’.”<sup>78</sup>

56. The trade union UNISON agreed:

“Financial constraints are further entrenching inequalities of provision and a north-south divide, with a risk that care companies focus on places where there are more high-paying self-funders of care (such as the south east), creating a shortage of care home places in other parts.”<sup>79</sup>

57. Professor Martin Green OBE said the system was “walking towards a postcode lottery”.<sup>80</sup> He continued:

“If you look at the State of Social Care report, which the Care Quality Commission delivers to Parliament, you will see that there is a reduction in the overall number of beds. Underlying that, there is also the issue that the new beds are all in particular areas. There is attrition in areas that are predominantly publicly funded and new services are being developed in areas where there is more affluence and private funding.”<sup>81</sup>

*Unequal demand for care*

58. Some local authorities have higher populations of older people than others, leading to higher care costs. West Sussex County Council told us the population of West Sussex over 65 was projected to rise more than 53 per cent in the next 20 years.<sup>82</sup> South East Councils said the population of those aged over 75 was higher in the south east than anywhere else in the country, and projected to double by 2041.<sup>83</sup> Essex County Council said that 21 per

---

77 [Q 101](#) (Matt Hancock MP)

78 [Q 18](#) (Warwick Lightfoot)

79 Written evidence from UNISON ([SOC0026](#))

80 [Q 83](#) (Professor Martin Green OBE)

81 *Ibid.*

82 Written evidence from West Sussex County Council ([SOC0010](#))

83 Written evidence from South East England Leaders and South East England Councils ([SOC0018](#))

cent of their population were over 65.<sup>84</sup> Some areas will incur higher costs because a higher proportion of their population qualifies for public funding through the means test.

59. Despite attempts at national standardisation in the Care Act 2014, witnesses told us that there were differences in local authorities' interpretation of what constituted a social care need. Warwick Lightfoot said:

“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 ... Kensington and Chelsea. You ration the care; the gatekeepers, who are the social workers, ration care according to their budgets.”<sup>85</sup>

*Unequal ability to raise funds*

60. The amount local authorities can raise for social care through the Social Care Precept, normal council tax and business rates depends on the strength of their local economies. Sarah Pickup said:

“business rates and council tax cannot be the only solution for services like adult social care and children's services, exactly because the pattern of growth in need does not reflect the pattern of growth in business rates.”<sup>86</sup>

61. The Institute for Fiscal Studies found that between 2009/10 and 2017/18 adult social care funding per head was more likely to have decreased in more deprived areas. In the most deprived areas, funding per head decreased by 17 per cent.<sup>87</sup>

62. The Government plans to increase the amount that local authorities retain from business rates from 50 per cent to 75 per cent from 2020/21 onwards,<sup>88</sup> in exchange for the removal of several government grants. This includes the Revenue Support Grant, which can be spent on adult social care. Local authorities who raise less in business rates revenue may see a decrease in funds available for adult social care. In a recent report, the Institute for Fiscal Studies said adult social care could account for more than half of revenue from council tax and business rates by the mid-2030s, with little left over for other services such as children's social care or housing.<sup>89</sup> The Care and Support Alliance said:

“There are outstanding concerns both about variations in the amount different local authorities will be able to raise from business rates and whether business rates will replace the revenue support grants as a sustainable source of income to enable them to meet their social care responsibilities.”<sup>90</sup>

---

84 Written evidence from Essex County Council ([SOC0025](#))

85 [Q 15](#) (Warwick Lightfoot)

86 [Q 61](#) (Sarah Pickup)

87 The Institute for Fiscal Studies, *Changes in councils' adult social care and overall service spending in England, 2009–10 to 2017–18*, (13 June 2018) p 5: <https://www.ifs.org.uk/uploads/BN240.pdf> [accessed 30 May 2019]

88 HC Deb, 29 January 2019 [HCWS1282](#)

89 The Institute for Fiscal Studies, *English council funding: what's happened and what's next?* (29 May 2019): <https://www.ifs.org.uk/uploads/publications/bns/BN250.pdf> [accessed 6 June 2019]

90 Written evidence from Care and Support Alliance ([SOC0028](#))

63. The Care Quality Commission's 2018 State of Care report raised concerns about regional variation in the quality of care provision.<sup>91</sup> The Department of Health and Social Care acknowledged regional differences in quality and committed to consider this as part of its forthcoming Green Paper.<sup>92</sup>
64. Jonathan Marron, Director General for Community and Social Care at the department, told the Committee that the Government already attempts to redistribute funds according to need:
- “Some of the money in the £10 billion that the Secretary of State has talked about comes from the improved better care fund (iBCF), a grant from government to local authorities. That was set up to try to have a further redistributive effect. Areas less likely to raise money from the precept were given more from the iBCF, so the details of the arrangement were quite complicated, but we were trying to address exactly your point about some local authorities having less spending power.”<sup>93</sup>
65. **Local authorities differ in respect of the cost pressures they face and their ability to raise funds. Some local authorities are therefore able to spend more per head on adult social care than others, leading to a postcode lottery in standards of provision.**
66. **We share the concerns of many witnesses about the Government's plans to make local authorities more fiscally self-reliant. Demand for social care is often greatest in areas where business is least buoyant.**

### Workforce

67. Many witnesses praised the work ethic and integrity of staff in the care sector. Sir Andrew Dilnot said:
- “It is easy to neglect how wonderful the people providing this care are and, by and large, they are fabulous people working in circumstances that many people would not find desirable.”<sup>94</sup>
68. Sharon Allen OBE, chief executive officer of Skills for Care, said:
- “The other reason why we have not seen things fall over completely is the dedication and commitment of the 1.47 million people working in the sector. People in the sector develop long-term relationships with people they provide care and support to. During the “Beast from the East” last winter, for example, we saw social care workers working in residential care staying on for one or two nights extra, and we saw people going out on foot because they would not leave people without care and support.”<sup>95</sup>

---

91 Care Quality Commission, *State of Care 2017/18* (October 2018): <https://www.cqc.org.uk/publications/major-report/state-care> [accessed 26 June 2019]

92 Written evidence from the Department of Health and Social Care ([SOC0060](#))

93 [Q 92](#) (Jonathan Marron)

94 [Q 5](#) (Sir Andrew Dilnot)

95 [Q6 8](#) (Sharon Allen OBE)

*Vacancies*

69. The National Audit Office estimated there were 1.3 million people employed in the care workforce in 2016/17 with a 6.6 per cent vacancy rate.<sup>96</sup> The Centre for Workforce Intelligence estimated in 2016 that an additional 660,000 jobs would be needed by 2035, if the care workforce was to grow at the same rate as the demand for care in that period.<sup>97</sup>
70. Skills for Care estimate staff turnover in the sector during 2017/18 was 31 per cent, rising to 38 per cent for care workers and 42 per cent for care workers in domiciliary providers. Turnover had increased by nearly 8 per cent since 2012/13. While much of this turnover was movement within the sector, a “large proportion” of that turnover was attributed to “people leaving the sector soon after joining”.<sup>98</sup> The Care Quality Commission said that this turnover “has a detrimental impact on the continuity of care for people and their ability to develop meaningful relationships with the staff who support them”.<sup>99</sup>
71. Caroline Abrahams, Charity Director at Age UK, described this as a “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.”<sup>100</sup>
72. ADASS noted that the vacancy rate in 2017/18 was highest for registered nurses, at 12 per cent.<sup>101</sup>
- “Recruitment and retention issues have led to some care homes deregistering from nursing care provision, instead refocusing on residential provision. This in turn leads to a shortage of nursing care provision. There is also competition for registered nurses from the NHS, which further exacerbates the situation.”<sup>102</sup>

---

96 National Audit Office, *The adult social care workforce in England*, HC714 Session 2017–19 (8 February 2018): <https://www.nao.org.uk/wp-content/uploads/2018/02/The-adult-social-care-workforce-in-England.pdf> [accessed 30 May 2019]. Skills for Care estimated the vacancy rate was 8 per cent in 2017/18, Skills for Care, *The state of the adult social care sector and workforce in England* (September 2018): <https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf> [accessed 1 June 2019]

97 Centre for Workforce Intelligence, *Forecasting the adult social care workforce to 2035* (July 2016): [https://www.basw.co.uk/system/files/resources/basw\\_22641-9\\_0.pdf](https://www.basw.co.uk/system/files/resources/basw_22641-9_0.pdf) [accessed 26 June 2019]

98 Skills for Care, *The state of the adult social care sector and workforce in England* (September 2018): <https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf> [accessed 1 June 2019]

99 Written evidence from the Care Quality Commission (SOC0055)

100 Q 54 (Caroline Abrahams)

101 Skills for Care, *The state of the adult social care sector and workforce in England* (September 2018): <https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf> [accessed 1 June 2019]

102 Written evidence from ADASS (SOC0052)

73. The Royal College of Nursing were concerned about the impact of high nurse vacancy rates on nurses and the quality of care:

“There are not enough registered nurses and healthcare support workers to deliver safe and effective care in adult social care settings such as nursing homes and residential care homes. Registered nurses report working unpaid overtime to fill gaps, additional stress caused by a high-pressure environment, and describe occasions when vital care is left undone. Data shows that while the number of registered nurses is declining, the number of care workers is increasing. We are concerned that inappropriate substitution of skills leads to poorer outcomes for people using these services.”<sup>103</sup>

*Brexit and care workers*

74. Some witnesses were concerned about the impact of the UK’s exit from the European Union on recruitment of care workers. The Nuffield Trust estimated this would increase vacancies in the workforce by 70,000.<sup>104</sup> Caroline Abrahams said this would most affect London as around one in six care workers in London were from elsewhere in the EU.<sup>105</sup>
75. Kathryn Petrie, Senior Economist at the Social Market Foundation, noted that:

“... the social care workforce is around 10 per cent non-UK and non-EU and about 8 per cent 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.”<sup>106</sup>

*Pay*

76. Many witnesses blamed low pay for difficulties in recruitment. UNISON described the threat of competition from other sectors:

“Low pay has forced too many good workers to leave the sector because they cannot afford to stay; with care homes facing a recruitment crisis as competing employers, such as discount supermarkets, are actively recruiting and offering more attractive pay rates.”<sup>107</sup>

Iain MacBeath noted that the lowest-paid workers in the NHS were due pay rises of between 9 and 29 per cent over the next three years, which could encourage care staff to move to the health sector.<sup>108</sup>

77. In January 2019, we held a private roundtable discussion with care workers from an Oxfordshire care home. They agreed that competition from supermarkets was a problem, particularly in urban areas. They also highlighted competition within the sector for workers in care homes. Care homes which relied more on self-funders could afford to pay more than

---

103 Written evidence from The Royal College of Nursing ([SOC0049](#))

104 Written evidence from The Nuffield Trust ([SOC0031](#))

105 [Q 59](#) (Caroline Abrahams)

106 [Q 21](#) (Kathryn Petrie)

107 Written evidence from UNISON ([SOC0026](#))

108 [Q 62](#) (Iain MacBeath)

those predominantly reliant on local authority funding. In the participants' care home, care workers were paid between £8 and £10 per hour, while self-funder homes could afford to pay between £15 and £17 per hour.<sup>109</sup>

78. The Health and Social Care Secretary told us that pay for care workers had increased in line with recent minimum wage increases:

“We have seen some very sharp rises, in percentage terms, in the pay of people working in social care. The national living wage has had a big impact on people working in care, because there is a higher proportion of people who were previously on the minimum wage in social care than in many professions. Part of the increase in funding that has gone in has been to ensure that pay has gone up.”<sup>110</sup>

### *Care as a profession*

79. Care workers at the Committee's private roundtable discussion emphasised that pay was not the only reason for high turnover rates in the social care workforce. One participant described two types of people who worked in the care sector. One type saw care work as a vocation and remained in the sector for decades. The other, a more recent entrant to the sector, was looking for short-term work to fill a gap in their career or pay the bills. The participant said: “It is not a vocation for them, it just fits their lifestyle. Something is missing ... it is not seen as an attractive role anymore.”<sup>111</sup>

80. One participant said: “It is not all about money ... care work is a profession and needs to be seen as such. Nurses are highly respected, highly regarded ... we need to be on the same platform but are seen as second-class citizens.” Another participant noted that they had too often heard people describe themselves or others as “just a carer”.<sup>112</sup>

81. Kari Gerstheimer, Director of Information and Advice at Mencap, said:

“Our position is, first, that the phrase “low-skilled worker” should not be used in relation to care staff. We think that that perception needs to be challenged. There needs to be a greater emphasis on professional structures, career development and appropriate reward.”<sup>113</sup>

82. Harry Quilter-Pinner, Research Fellow at the Institute for Public Policy Research (IPPR), argued that care should be treated as a profession akin to nursing:

“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?”<sup>114</sup>

---

109 Appendix 4: Private meeting with care workers, 8 January 2019

110 [Q 98](#) (Matt Hancock MP)

111 Appendix 4: Private meeting with care workers, 8 January 2019

112 *Ibid.*

113 [Q 44](#) (Kari Gerstheimer)

114 [Q 21](#) (Harry Quilter-Pinner)

83. In response, Warwick Lightfoot warned about imposing too many qualification requirements on the sector:

“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 ... 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.”<sup>115</sup>

84. UNISON said the adult social care workforce was not taken seriously enough by the Government:

“the 142-page draft [Health and Care Workforce] strategy allocated just five pages to social care. The lack of importance attached to the development of the social care workforce is related to the wider failing to seek engagement from staff, amply illustrated by the fact that the expert panel set up to inform the green paper includes no care workers and no representatives of care workers.”<sup>116</sup>

85. The draft Health and Care Workforce Strategy, published for consultation by Health Education England in 2017, made few suggestions for reform. One section however discussed the potential introduction of professional regulation for care workers:

“Professional regulation supports the delivery of safe and high quality care through setting standards and ensuring continuing fitness to practise. Greater regulatory oversight of social care workers might be an option. A regulatory framework could also support the development of clearer roles linked to competencies, building on the Care Certificate.

While this is an opportunity, it would be more challenging to deliver in social care than the similar new role of nursing associates in health. There are fewer levers in social care to drive consistent changes in the workforce, not least the large number of small private or third-party employers in the sector.”<sup>117</sup>

86. The draft strategy suggested that, through the Government’s Green Paper, “experts, stakeholders and people using care and support services will have the opportunity to shape the long-term reform needed.”<sup>118</sup> The Health and Social Care Secretary agreed that care work should be treated as a profession, and suggested it was an issue the department can “just get on with” notwithstanding the Green Paper.<sup>119</sup>

87. **Increased funding for adult social care will allow for investment in the care workforce. Higher pay is required for care workers in publicly-**

---

115 [Q 21](#) (Warwick Lightfoot)

116 Written evidence from UNISON ([SOC0026](#))

117 NHS, *Facing the Facts, Shaping the Future A draft health and care workforce strategy for England to 2027* (December 2017): <https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%2C%20Shaping%20the%20Future%20%E2%80%93%20a%20draft%20health%20and%20care%20workforce%20strategy%20for%20England%20to%202027.pdf> [accessed 7 June 2019]

118 *Ibid.*

119 [Q 98](#) (Matt Hancock MP)

**funded care providers to allow those providers to compete with other local employers. The care workforce needs a career structure which better reflects the skills required to be a good care worker and the social importance of the sector.**

### CHAPTER 3: OPTIONS FOR REFORM

---

88. This chapter considers who should receive publicly-funded social care and how it can be funded sustainably.

#### Principles for reform

89. The following principles will govern our recommended reforms in this chapter, based on the evidence presented in Chapter 2.

90. **Any long-term funding solution for adult social care should:**
- (a) **Put more money into the system through a combination of public and personal funding;**
  - (b) **Be simple and easy to understand for those accessing public funding;**
  - (c) **Ensure local authorities can afford to provide care to all those whose needs meet the legal eligibility criteria, which must be interpreted fairly and consistently across local authorities;**
  - (d) **Quantify and address serious unmet need;**
  - (e) **Ensure the level of unpaid carers in the system does not suffer a steep decline and is sustainable;**
  - (f) **Better protect individuals from catastrophic costs;**
  - (g) **Reduce the disparity between entitlement to help in the National Health Service and the adult social care system, ensuring that entitlement is based on the level of need, not the diagnosis;**
  - (h) **Allow local authorities to pay care providers a rate that covers the costs of providing care, without the need for cross-subsidy from self-funders;**
  - (i) **Distribute adult social care funding more fairly across local authorities;**
  - (j) **Invest in the social care workforce and ensure a more joined up approach to workforce planning with the National Health Service.**

#### Public versus private individual funding

91. How much should individuals be required to pay towards their care costs? Recent proposals have divided roughly into three categories: a “cap and floor” model, where care costs are publicly funded for those whose income and savings fall below a certain point (the “floor”) and after they have already paid a certain amount of care costs (the “cap”), universal provision of some form of free social care, and those who believe that financial products can help people avoid catastrophic costs.

#### *Cap and floor*

92. This model was proposed in the 2011 Dilnot Commission. Sir Andrew Dilnot, chair of the Commission, told our inquiry that any system should

fund care for “those who cannot provide it themselves” and “let those who can afford to look after themselves do so if they possibly can”, intervening in the market to enable the latter if necessary.<sup>120</sup> This model, he argued, “take[s] the catastrophic risk away”.<sup>121</sup>

93. The Dilnot Commission proposed increasing the upper capital threshold for the means test from £23,250 to £100,000. It proposed a cap of £35,000. In the 2013 Budget the Government broadly accepted both recommendations, proposing an upper capital threshold of £118,000 (slightly less than £100,000 in 2010–11 prices) and a cap of £72,000.<sup>122</sup> The cap would cover only the costs of care services; people would pay a contribution towards their living costs while in residential care. The Care Act 2014 made provision for the introduction of a cap by regulations, but no such regulations have been introduced.
94. Sir Andrew Dilnot described the model as “social insurance with a large excess, and the excess is the cap”.<sup>123</sup> By limiting the risk for insurers, he argued a cap could help provide a sustainable market for private social care insurance.<sup>124</sup> This argument is explored in more detail later in this chapter. The Care and Support Alliance said a cap would “enable people to make earlier, more informed choices about their care, prevent self-rationing on cost grounds, and enable those with the means to save towards care costs to do so.”<sup>125</sup>
95. Harry Quilter-Pinner thought the cap and floor model was too complicated:
 

“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.”<sup>126</sup>
96. The Health Foundation said a cap would create “winners and losers”: “more people would receive state-funded residential care but fewer would receive funding for domiciliary care.”<sup>127</sup> Their 2018 report with the King’s Fund estimated that the number receiving domiciliary care would decrease by roughly a third if the Government’s proposed cap and floor model were introduced, due to the Government’s proposal at the time to include property in the means test for domiciliary care.<sup>128</sup>
97. The Health and Social Care Secretary said a cap “is not a magic bullet”.<sup>129</sup> He raised practical concerns about implementing a cap:

---

120 [Q 1](#) (Sir Andrew Dilnot)

121 [Q 5](#) (Sir Andrew Dilnot)

122 HM Treasury, *Budget 2013* (HC 1033, March 2013): [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/221885/budget2013\\_complete.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/221885/budget2013_complete.pdf) [accessed 22 May 2019]

123 [Q 6](#) (Sir Andrew Dilnot)

124 *Ibid.*

125 Written evidence from Care and Support Alliance ([SOC0028](#))

126 [Q 19](#) (Harry Quilter-Pinner)

127 Written evidence from the Health Foundation ([SOC0047](#))

128 Assuming a cap of £75,000 and a floor of £100,000. The King’s Fund, *A fork in the road: Next steps for social care funding reform* (May 2018): <https://www.kingsfund.org.uk/sites/default/files/2018-05/A-fork-in-the-road-next-steps-for-social-care-funding-reform-May-2018.pdf> [accessed 23 May 2019]

129 [Q 102](#) (Matt Hancock MP)

“measuring the cap is difficult, because the proposed cap is on lifetime care costs ... Lifetime care costs are extremely hard to measure. Even if you measured care costs after retirement age, notwithstanding the fact that retirement age is moving, to have a cap policy for people who are already in retirement you would have to know how much they had spent on care before the policy was introduced. That is a logistical challenge in the cap policy.”<sup>130</sup>

In measuring the cap, distinguishing between spending on care which meets basic needs and spending which is discretionary to secure greater comfort or amenity also presents difficulties. Under the Dilnot proposal, local authorities would calculate the spending of individuals in relation to the cap based on what local authorities would have spent on their care, not on what individuals actually spend.<sup>131</sup>

*Free at the point of use*

98. Harry Quilter-Pinner from the IPPR said there was a “consensus growing behind free personal care”.<sup>132</sup> The Policy Exchange, Social Market Foundation, Mencap, UNISON, Independent Age and the King’s Fund all voiced support for providing some form of social care free at the point of use in evidence to our inquiry.<sup>133</sup> Warwick Lightfoot from the Policy Exchange said: “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.”<sup>134</sup>
99. UNISON said delivering the “vast majority of social care through public funding” would address “glaring inequality around access to care ... built into the current care system” and “enable care providers to have greater certainty over their funding streams and therefore plan better for future needs, particularly in terms of workforce.”<sup>135</sup> Independent Age said it would encourage older people “to seek help earlier rather than waiting for a point of crisis” and “enable them to live in their own homes for longer”.<sup>136</sup> They joined the IPPR in praising the simplicity and clarity of providing care free at the point of need.<sup>137</sup>
100. The most popular proposal for free social care was “free personal care”. In this model, individuals receive free assistance with essential daily tasks, such as washing, cooking, mobility or dressing. Other needs, such as housework

---

130 [Q 103](#) (Matt Hancock MP)

131 Commission on Funding of Care and Support, *Fairer Care Funding* (July 2011): <https://webarchive.nationalarchives.gov.uk/20130221121529/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf> [accessed 26 June 2019]

132 [Q 23](#) (Harry Quilter-Pinner). Personal care is defined by the CQC as supporting people with things like washing, bathing or cleaning themselves, getting dressed or going to the toilet. Care Quality Commission, *Personal care* (5 February 2019): <https://www.cqc.org.uk/guidance-providers/registration/personal-care> [accessed 16 May 2019]

133 [Q 15](#) (Kathryn Petrie), [Q 44](#) (Kari Gerstheimer); written evidence from UNISON ([SOC0069](#)), Independent Age ([SOC0034](#)) and The King’s Fund ([SOC0057](#)). The King’s Fund wrote that the Barker Commission measures should be pursued as a means to make social care free at the point of use in the long-term.

134 [Q 22](#) (Warwick Lightfoot)

135 Written evidence from UNISON ([SOC0069](#))

136 Written evidence from Independent Age ([SOC0034](#))

137 [Q19](#) (Harry Quilter-Pinner)

and shopping, would not be included in the entitlement. In Scotland, personal care is defined as help with:<sup>138</sup>

- Personal Hygiene: bathing, showering, hair washing, shaving, oral hygiene, nail care;
- Continence Management: toileting, catheter/stoma care, skin care, incontinence laundry, bed changing;
- Food and Diet: assistance with the preparation of food and assistance with the fulfilment of special dietary needs;
- Problems with Immobility: dealing with the consequences of being immobile or substantially immobile;
- Counselling and Support: behaviour management, psychological support, reminding devices;
- Simple Treatments: assistance with medication (including eye drops), application of creams and lotions, simple dressings, oxygen therapy;
- Personal Assistance: assistance with dressing, surgical appliances, prostheses, mechanical and manual aids. Assistance to get up and go to bed. Transfers including the use of a hoist.

101. Individuals would also still have to pay for those accommodation and living costs that they would incur regardless of their care needs. In practice, this makes domiciliary personal care free, while residential care still involves paying care homes for the accommodation element.
102. Accommodation costs could still face the same problems on a smaller scale; those requiring long-term care could still face catastrophic accommodation costs. The average stay for older people in care homes is 30 months,<sup>139</sup> though some with complex needs could stay for many years. A 2017 study estimated average accommodation costs for older people in residential care were £178 per week.<sup>140</sup>
103. This could be addressed by means-testing or introducing a cap on accommodation costs. The Dilnot Commission proposed an annual cap on accommodation costs of between £7,000 and £10,000, based on the minimum and median income of those above state retirement age at the time.<sup>141</sup> A cap could also be measured in terms of time spent in residential care, with accommodation costs funded publicly for those who have spent more than a certain number of months or years in residential care. In Scotland, accommodation costs are means-tested.

---

138 Scottish Government, 'Free Personal and Nursing Care': <https://www2.gov.scot/Topics/Health/Support-Social-Care/Support/Adult-Social-Care/Free-Personal-Nursing-Care> [accessed 26 June 2019]

139 Independent Age, 'Cost of average length of stay in a residential care home is equivalent to 26 years' worth of family holidays' (26 October 2017): <https://www.independentage.org/news-media/press-releases/cost-of-average-length-of-stay-a-residential-care-home-equivalent-to-26> [accessed 26 June 2019]

140 Personal Social Services Research Unit, *Unit Costs of Health and Social Care 2017*: <https://www.pssru.ac.uk/pub/uc/uc2017/services.pdf> [accessed 26 June 2019]

141 Commission on Funding of Care and Support, *Fairer Care Funding* (July 2011): <https://webarchive.nationalarchives.gov.uk/20130221121529/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf> [accessed 26 June 2019]

### Box 4: Free personal care in Scotland

Since 2002 Scotland has offered free personal care for over 65s. It was extended to the working-age population in April 2019. The Scottish Government defines personal care as including assistance with tasks such as washing, cooking, mobility or dressing.<sup>142</sup> Local authorities do not charge for personal care delivered in a person’s home. Self-funders in care homes are paid £180 per week by local authorities as a contribution towards their personal care, and £80 per week for nursing care.<sup>145</sup> The latter is aimed to fund care costs but not accommodation costs.

104. The Kings Fund and Health Foundation 2018 report *A fork in the road: next steps for social care funding reform* said the introduction of free personal care in Scotland (see Box 4) had “created unexpected levels of increased demand for domiciliary care which we might also expect to occur in England”. They estimated that with free personal care the number of people receiving publicly-funded domiciliary care in England would almost double.<sup>144</sup> But the report said the Scottish Government may have saved money overall:

“by supporting older people to live at home, helping to prevent costly hospital admissions, and delaying the need for residential care, the system may have resulted in lower total government expenditure as compared with no policy being in place.”<sup>145</sup>

105. John Godfrey, Corporate Affairs Director at Legal and General, said that some of the costs of unpaid care might shift to the state if free personal care were introduced, as unpaid carers decided to let the state undertake their caring duties.<sup>146</sup> However, Caroline Abrahams said unpaid care might increase:

“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.”<sup>147</sup>

106. There may be a deadweight cost to the introduction of free personal care. Unlike a cap and floor model, under free personal care many individuals with neither relatively high care costs nor limited assets would receive public funding. Sir Andrew Dilnot said: “for those who can afford [social care] it should not be free”.<sup>148</sup> Dominic Carter, Policy Manager at the Alzheimer’s Society, said he thought this money would be better spent on a “complex

---

142 Scottish Government, ‘Free Personal and Nursing Care’: <https://www2.gov.scot/Topics/Health/Support-Social-Care/Support/Adult-Social-Care/Free-Personal-Nursing-Care> [accessed 26 June 2019]

143 Written evidence from the Scottish Government ([SOC0074](#))

144 The King’s Fund and the Health Foundation, *A fork in the road: Next steps for social care funding reform* (May 2018): <https://www.kingsfund.org.uk/sites/default/files/2018-05/A-fork-in-the-road-next-steps-for-social-care-funding-reform-May-2018.pdf> [accessed 26 June 2019]

145 *Ibid.*

146 [Q 36](#) (John Godfrey)

147 [Q 55](#) (Caroline Abrahams)

148 [Q 3](#) (Sir Andrew Dilnot) He did however argue that social care for working-age adults below a certain age should be free because they would not have had a chance to prepare for the possibility of needing social care.

care fund” to support individuals who required “that extra bit of help and support”.<sup>149</sup>

107. Some countries that provide care free at the point of use also struggle to manage demand effectively. Japan caps care home places at 3 per cent of the over-65 population, which has resulted in long waiting times, and reviews the system every three years to ensure funding is keeping pace with demand, often resulting in increased social insurance premiums.<sup>150</sup> There have also been reports of long waiting times in Scotland. Age Scotland said in May 2019 that more than 4 in 10 older people with critical or substantial needs wait more than 6 weeks for social care.<sup>151</sup> Harry Quilter-Pinner from the IPPR said Scotland’s system “has not been funded properly”.<sup>152</sup>

### *Costs*

108. The Health Foundation and the King’s Fund estimate that introducing free personal care would cost £7 billion. Introducing the cap and floor model proposed during the 2017 general election campaign in 2020/21 would cost £5 billion.<sup>153</sup>
109. The Rt Hon Damian Green MP proposed a “Universal Care Entitlement” in a recent report written with the Centre for Policy Studies.<sup>154</sup> The entitlement, which he describes as “copying the state pension,” would “guarantee a decent level of care in both homecare and residential settings, and basic accommodation costs if residential care is needed” subject to the same needs test as currently. Individuals could purchase a “Care Supplement” financial product provided privately, which would insure them for a higher level of care, including “larger rooms, better food, more trips, additional entertainment and so on.”<sup>155</sup>
110. Damian Green’s report estimated that a Universal Care Entitlement for England would cost £2.5 billion. This was based on extrapolating the cost of the Scottish system. He described this as “a fairly rough and ready figure” which local authorities and care providers he had spoken to would find “satisfactory to get them to a reasonable baseline”.<sup>156</sup> The Pensions Policy Institute estimated that introducing free personal care only for older people would cost £3.9 billion.<sup>157</sup>

### *Private insurance*

111. Some witnesses suggested the private sector could help individuals fund their own care by offering insurance products. These could take the form of traditional insurance paid regularly through the individual’s life or a one-off payment at retirement age. Products were mostly aimed at care

149 [Q 45](#) (Dominic Carter)

150 Written evidence from The Nuffield Trust ([SOC0031](#))

151 Age Scotland, ‘43% waiting too long for social care’, (28 May 2019): <https://www.ageuk.org.uk/scotland/media-press/2019/may/43-waiting-too-long-for-social-care/> [accessed 26 June 2019]

152 [Q 15](#) (Harry Quilter-Pinner)

153 Written evidence from the Health Foundation ([SOC0047](#))

154 Damian Green MP and Centre for Policy Studies, *Fixing the Care Crisis* (29 April 2019): <https://www.cps.org.uk/files/reports/original/190426143506-DamianGreenSocialCareFinal.pdf> [accessed 26 June 2019]

155 *Ibid.*

156 [Q 104](#) (Damian Green MP)

157 Care and State Pension Reform, *Interactions between state pension and long-term care reforms: a summary of further findings* (December 2018): <https://www.pensionspolicyinstitute.org.uk/media/3002/20181212-casper-interactions-further-findings-summary-report-final.pdf> [accessed 26 June 2019]

for older people rather than those of working-age. The Rt Hon Sir Steve Webb, Director of Policy at Royal London Group and a former Pensions Minister, said the new ability to withdraw pensions pots as cash created new possibilities:

“In the past, people would retire with a stream of income ... Increasingly in the future they will retire with a pot of money ... In the past two years, 200,000 people have transferred from final salary pensions into pots of money, averaging £200,000 ... When I am 60, 65, that sort of age, I would pay a chunk of that pot to make sure that my kids got the family home.”<sup>158</sup>

112. The Health and Social Care Secretary told us:

“I am quite attracted to the idea that the state might back an insurer to cause this market to come into effect, in a similar way to what we did with pensions.”<sup>159</sup>

113. Other witnesses said that both demand and supply of products were too low to create a sustainable market for care insurance. John Godfrey said the market had “limited scope for growth”<sup>160</sup> and Dr Jonathan Cylus, Research Fellow at the European Observatory on Health Systems and Policies and London School of Economics Health department, said only two countries had significant voluntary private insurance sectors.<sup>161</sup>

*Demand for insurance products*

114. Rob Yuille from the Association of British Insurers said: “on the demand side, it is not really a risk that people like to think about.”<sup>162</sup> John Godfrey said:

“Most people find it difficult enough to save for retirement. We all expect to grow old. The expectation of growing old and sick is harder to envisage. Therefore, it is harder to sell those products.”<sup>163</sup>

115. Sir Steve Webb disagreed that there were insurmountable demand problems:

“People do not want to think about care, but they do want to think about insuring the family home—a lump sum at retirement out of a pension pot that buys an insurance that says that when you are 85 or whatever the policy pays for your care and the kids get the home.”<sup>164</sup>

116. He suggested adding a tax advantage, to allow the premium to go untaxed from the pension pot to the insurer in the same manner as an immediate needs care annuity. In this way, the Government could make a contribution to the costs of care gradually:

---

158 [Q 37](#) (Sir Steve Webb)

159 [Q 95](#) (Matt Hancock MP)

160 [Q 24](#) (John Godfrey)

161 Written evidence from Dr Jonathan Cylus ([SOC0071](#))

162 [Q 25](#) (Rob Yuille)

163 [Q 24](#) (John Godfrey)

164 [Q 37](#) (Sir Steve Webb)

“There is no asking the Treasury for a big bundle on day one, but it gives the financial adviser a reason to say to the client, “Actually, you can take money and the Government will pay 20 per cent or whatever of it”.”<sup>165</sup>

117. The Association of British Insurers said the Government should lead an “awareness campaign for social care” to help the public understand their potential future social care costs.<sup>166</sup> The Health and Social Care Secretary agreed that a lack of understanding was “a big challenge both to making progress in the policy ... and to the substantive rollout of it.”<sup>167</sup> However Bupa, a health insurer and care provider who have previously offered long-term care insurance products, said “financial products are unlikely to be viable in the short term” regardless of efforts to increase public understanding.<sup>168</sup>

“behaviour research shows that even if people are better informed about how the social care system works, the choices they may face and the costs they may incur, they see products and services which are specifically marketed towards ‘the elderly’ negatively and are reluctant to invest.”<sup>169</sup>

*Supply of insurance products*

118. Rob Yuille said long-term uncertainty made offering care insurance unattractive for providers:

“Just as there is uncertainty for the individual, there is uncertainty for the provider as well in terms of the risk and what the state will offer ... It is expensive to hold capital against such a long-term risk, and the provider will be uncertain about what the state offers.”<sup>170</sup>

119. John Godfrey added that voluntary insurance encourages “adverse selection”:

“the only people who want to buy it are those who think they are going to use it. So it is a bit different from pet cover or mobile phone cover or those types of things.”<sup>171</sup>

120. Kathryn Petrie said the introduction of a cap on care costs, as recommended by the Dilnot Commission, could encourage more providers to offer products:

“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.”<sup>172</sup>

121. Sir Andrew Dilnot said insurers could offer two different kinds of products. One would insure individuals for any costs incurred up to the cap. The other, larger, market would be for those who wanted a higher quality of care than the state could provide.<sup>173</sup>

---

165 [Q 37](#) (Sir Steve Webb)

166 Written evidence from the Association of British Insurers ([SOC0054](#))

167 [Q 95](#) (Matt Hancock MP)

168 Written evidence from Bupa ([SOC0066](#))

169 *Ibid.*

170 [Q 25](#) (Rob Yuille)

171 [Q 26](#) (John Godfrey)

172 [Q 20](#) (Kathryn Petrie)

173 [Q 3](#) (Sir Andrew Dilnot)

122. The Association of British Insurers said:

“our sector is agnostic about a cap. In itself, a cap will not create a market, nor is the absence of a cap what is limiting a market, as this is due to the many other factors in addition to a cap, such as awareness of an individual’s personal liability for meeting care costs, and the options for helping individuals meet those costs.”<sup>174</sup>

123. They added that a cap could reduce demand by making the system more complicated:

“Unless carefully designed, a cap on total care costs has the potential to add complexity to the care funding landscape, reduce consumer understanding of the extent of their responsibility to fund their own care, and therefore would not prompt people to make their own provision to pay for care. Any cap must therefore be designed with the need to ensure simplicity and understanding as a high priority.”<sup>175</sup>

#### *Auto-enrolment*

124. Auto-enrolment of individuals in long-term care insurance schemes has been suggested as a way to boost demand. The Health and Social Care Secretary told the Committee he was “attracted to auto-enrolment because it has worked so well in pensions.”<sup>176</sup> The Association of British Insurers (ABI) said in written evidence: “the success of automatic enrolment [in pensions] has shown the potential of soft-compelling individuals to save, and given this, it is sensible that the Government explores compulsion”.<sup>177</sup>

125. However, Rob Yuille from the ABI questioned the analogy with pensions when he met with the Committee:

“ who is automatically enrolling into what, and can they opt out? With pensions it is very clear, and there is a long-standing relationship between employers and pensions. That is not the case with long-term care in this country. Pension saving will be right for most people but not for everyone, so it would seem sensible for there to be an opt-out system. If there was an opt-out system here, that would create moral hazard issues around what the state provides for people who have opted out.”<sup>178</sup>

126. Daniela Silcock, Head of Policy Research at the Pensions Policy Institute, said that more money “coming out of their pay cheque” could encourage people on lower incomes to opt out of any such scheme.<sup>179</sup> Sir Steve Webb said he would opt out:

“I am baffled as to how auto-enrolment would work in this context. If there was soft compulsion and if I am 30 years old and could opt out of something that might pay something in 55 years’ time, I would opt out like a shot. You would be mad not to, because the policy will change 15 times before you get there.”<sup>180</sup>

---

174 Written evidence from the Association of British Insurers ([SOC0054](#))

175 *Ibid.*

176 [Q 96](#) (Matt Hancock MP)

177 Written evidence from the Association of British Insurers ([SOC0054](#))

178 [Q 28](#) (Rob Yuille)

179 [Q 37](#) (Daniela Silcock)

180 [Q 39](#) (Sir Steve Webb)

127. *The Government has two categories of challenge: how to fund the system to ensure adequate quality and access; and how to make people's entitlement to public funding fairer. Notwithstanding the latter, which is discussed in our subsequent conclusions, the Government must increase funding to restore levels of quality and access to those observed in 2009/10. This should be its top priority.*
128. **As most previous inquiries have concluded, the costs of long-term care should not fall solely on the shoulders of individuals and families or on the state. We support a partnership approach, in which the costs of care are shared between individuals and the taxpayer.**
129. **Free personal care is fair, better aligned with NHS entitlement than the current system and easier to implement than alternative proposals. It may be more expensive than some alternatives, but it could reduce demand for residential care and health care in the long-run by encouraging users to seek domiciliary care early.**
130. **Free personal care is a partnership approach because it covers only some of the costs of social care. Personal care means essential help with basic activities of daily living, such as washing and bathing, dressing, continence, mobility and help with eating and drinking. It does not include other areas where support might be needed, such as assistance with housework, laundry or shopping.**
131. **Under free personal care individuals would therefore only receive funding for support with these basic activities of daily living, based on the minimum threshold of eligible needs as defined by the Care Act. Accommodation and living costs, which everyone incurs irrespective of their care needs, would continue to be met by the individual.**
132. *The Government should introduce a basic entitlement to publicly funded personal care for individuals with substantial and critical levels of need. Accommodation costs and the costs of other help and support should still be incurred by the individual. The Health Foundation and the King's Fund estimate this would cost £7 billion if introduced in 2020/21.*
133. *Free personal care must be funded properly, otherwise it will result in longer waiting times or restrictions in eligibility criteria. Funding should be reviewed each year to ensure local authorities can afford to meet demand.*
134. **Some people who need long-term care for many years, particularly in residential and nursing homes, might still face catastrophic accommodation costs.**
135. *The Government should retain a means test for accommodation costs. To avoid catastrophic accommodation costs, the Government should also explore a cap.*
136. **No country relies primarily on private insurance to fund adult social care costs. In the current system, establishing a market for long term social care insurance in England would be difficult, even with a cap on lifetime social care costs or accommodation costs or an auto-enrolment scheme. Private insurance cannot provide the amount of**

**funding required by the social care system, not least because roughly half of public social care funding is currently spent on people who are working-age.**

137. **The analogy between social care, national insurance and the state pension is weak. Most people will expect to need a pension, while the proportion needing care is unknown and may be even further away in time than retirement.**
138. **A market for private care insurance may be more likely to develop in a system where personal care costs are funded by the state. Products might emerge offering individuals the ability to insure against accommodation costs, other care needs or to access more expensive private care provision.**

### **Options for public funding**

139. As discussed in Chapter 2, the King’s Fund and Health Foundation estimated that to return levels of quality and access observed in adult social care to 2009/10 levels the Government would need to spend £8 billion.<sup>181</sup> In addition, to implement our recommendations above by 2020/21, the Government would require £7 billion (estimated by the King’s Fund and the Health Foundation as the cost of introducing free personal care).<sup>182</sup>
140. There are two main options for raising this money: funding through general taxation or funding through a hypothecated tax, which ties the funds raised to the provision of social care.

### *Hypothecated versus general taxation*

141. Several witnesses suggested some form of hypothecated taxation, whether through a new tax on income, a ring-fenced increase in national insurance contributions or a mandatory social insurance system. A common argument for hypothecation is that it could increase public support for a tax rise. The House of Commons Health and Social Care and Housing, Communities and Local Government Committees concluded:

“People are generally willing to contribute more to pay for social care if they can be assured that the money will be spent on this purpose. ‘Earmarking’ taxation can help to give confidence and accountability over spending.”<sup>183</sup>

142. Involve, who ran a citizen’s assembly for the joint Commons Committees report noted above, said the assembly felt hypothecation would “create clarity and assurance about how the money would be spent.”<sup>184</sup> Scope said disabled people they had consulted ahead as part of their written evidence submission expressed support for hypothecated taxation.<sup>185</sup>
143. The Nuffield Trust said a mandatory social insurance system “offers a high degree of transparency and clarity to citizens as it is clear where their

---

181 Written evidence from the Health Foundation ([SOC0047](#))

182 Written evidence from the Health Foundation ([SOC0047](#))

183 Health and Social Care and Housing, Communities and Local Government Committees, *Long-term funding of adult social care* (First Joint Report, Session 2017–19, HC 768)

184 Written evidence from Involve ([SOC0035](#))

185 Written evidence from Scope ([SOC0008](#))

contributions are going.”<sup>186</sup> But they noted that Germany and Japan, where such systems have been successful (see Box 5 below):

“built on the social insurance mechanisms they already had established for health. England has no precedent of health insurance so adopting such a system ... may not be so readily accepted by the population.”<sup>187</sup>

144. Dr Jonathan Cylus said that even mandatory long-term care insurance systems abroad usually receive “substantial resources” from general taxation.<sup>188</sup> He called mandatory insurance the “least resilient source of funding for social care”:

“... contributions fall as people age and increasingly leave the labour force; at a population level, relying on mandatory contributions will mean fewer resources for social care in the future, requiring new funding sources or transfers from general tax revenues ... Periods of high unemployment or slowdowns in wage growth will also adversely affect the ability to generate revenues from mandatory contributions (as well as taxes to a lesser extent). This may lead to budget deficits that need to be addressed by using funds from previous surplus years, taking on debt or drawing funds from general taxation. If poorly administered, this may mean that expenditures will fluctuate with the peaks and troughs of the economy ...”<sup>189</sup>

The Nuffield Trust said however that Japan’s system (see Box 5), which blends hypothecated and general taxation, “offers a degree of flexibility”.<sup>190</sup>

145. Sir Andrew Dilnot, Warwick Lightfoot and Harry Quilter-Pinner all suggested that funds be raised primarily from general taxation. Kathryn Petrie also recommended it for working-age care.<sup>191</sup> David Phillips, Associate Director at the Institute for Fiscal Studies, suggested general taxation or a “set of broader tax increases” in order to “spread the burden across different groups and tax bases.”<sup>192</sup>
146. Harry Quilter-Pinner argued that the issue of fairness of taxation should be “disaggregated” from the issue of funding social care: “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.”<sup>193</sup> Sir Andrew Dilnot suggested that the question of how to raise funds was not uniquely difficult:

“I have heard members of political parties on both the left and the right describe this as an incredibly difficult problem, and my response is that it is not a terribly difficult problem. There are huge amounts of money involved in the healthcare system, in pensions, in education—the amounts of money involved here are much smaller”.<sup>194</sup>

---

186 Written evidence from The Nuffield Trust ([SOC0031](#))

187 *Ibid.*

188 Written evidence from Dr Jonathan Cylus ([SOC0071](#))

189 *Ibid.*

190 Written evidence from The Nuffield Trust ([SOC0031](#))

191 [Q 3](#) (Sir Andrew Dilnot) and [Q 16](#) (Harry Quilter-Pinner, Kathryn Petrie, Warwick Lightfoot)

192 [Q 64](#) (David Phillips)

193 [Q 16](#) (Harry Quilter-Pinner)

194 [Q 4](#) (Sir Andrew Dilnot)

### Box 5: Mandatory social insurance in Germany and Japan

In **Germany**, any individual in work or receiving a pension contributes to a fund throughout their adult lives. The current rate is 3.05 per cent of income. Employed people over the age of 23 without children pay an additional 0.25 per cent.

While in work, the individual pays for 50 per cent of the contribution and their employer covers the additional 50 per cent. Once retired, they pay the full premium themselves. Those who are self-employed are expected to pay the full premium.

Both older and working-age individuals receive a basic level of publicly-funded provision. Overall, care insurance covers 58 per cent of the average costs of care, with individuals expected to cover remaining costs, such as accommodation, themselves. Individuals are encouraged to take out private insurance for this purpose.

In **Japan**, those over the age of 40 are required to pay for state care insurance, with 50 per cent of the contribution covered by the employer and the other 50 per cent met by the employee. Premiums vary, but are typically an additional one per cent on top of health care insurance premiums. Over-65s are required to make contributions which are deducted from their pension.

Like Germany, the system offers only a basic level of care. Individuals pay direct co-payments of 10 per cent of care costs, which are means tested and capped at £75 per month for lower earners. Residential care home places are capped at 3 per cent of the over-65 population.

Overall, half of the funds for Japan's social care system come from the mandatory insurance system, and the other half from general taxation.

Source: Written evidence from RAND Europe and PSSRU ([SOC0072](#)), Nuffield Trust ([SOC0031](#)) and ([SOC0062](#)), Centre for Policy on Ageing ([SOC0032](#)) and [Q 30](#) (John Godfrey)

#### *Intergenerational fairness*

147. Some witnesses suggested finding the money from funding that has already been allocated to older people, either by reducing existing benefits or tax advantages or introducing age-specific taxation. Kathryn Petrie argued that without discriminating according to age, working-age people would be disproportionately burdened:

“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.”<sup>195</sup>

148. Sir Andrew Dilnot suggested making those above pension age pay national insurance contributions.<sup>196</sup> Their current exemption was “quite wrong” and a “major distortion in the tax system”.<sup>197</sup> The Treasury told us in answer to a written question that removing the exemption completely could raise

195 [Q 16](#) (Kathryn Petrie)

196 [Q 3](#) (Sir Andrew Dilnot)

197 *Ibid.*

£1.1 billion.<sup>198</sup> Alongside increases in taxation, the King’s Fund supported this and a range of recommendations by the Barker Commission (listed in Box 6) aimed at asking “older generations, who would gain most from the reforms, and wealthier people” to make “a more significant contribution”.<sup>199</sup> The House of Lords Intergenerational Fairness and Provision Committee recommended a similar removal of benefits aimed at older generations, including restrictions to free bus passes, free television licenses, and the winter fuel payment.<sup>200</sup>

**Box 6: Recommendations from the Barker Commission for raising additional funding for social care, including money that could be raised**

- Restricting winter fuel payments and free TV licences for those over 75 to the least affluent in this age group (£1.4 billion)<sup>201</sup>
- Ending the existing exemption from 12 per cent employees’ national insurance contributions for those who work past state pension age, requiring them to pay 6 per cent instead (£475 million)
- Significantly reducing exemptions from NHS prescription charges (£1 billion)
- An additional percentage point of employees’ national insurance contribution for those aged over 40 (£2 billion)
- An increase to 3 per cent in the additional rate of national insurance for those above the upper earnings limit, timed to match extensions of free social care (£800 million)
- A comprehensive review of wealth taxation to include possible reforms to inheritance tax, a wealth transfer tax and changes to capital gains and property taxation.

Source: Commission on the Future of Health and Social Care in England, *A new settlement for health and social care* (4 September 2014): [https://www.kingsfund.org.uk/sites/default/files/field/field\\_publication\\_file/Commission%20Final%20%20interactive.pdf](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Commission%20Final%20%20interactive.pdf) [accessed 26 June 2019]

149. The joint Health and Social Care and Housing, Communities and Local Government Committees report recommended establishing a “Social Care Premium”, an “additional earmarked contribution” to social care which is paid only by those aged over 40 (including those aged over 65).<sup>202</sup> This received support from the citizens’ assembly which informed that inquiry.<sup>203</sup>
150. This recommendation has also surfaced as an increase to national insurance contributions. The Barker Commission recommended an increase of one per cent in employee’s National Insurance contributions for those aged over 40 (see Box 6). Damian Green recommended a one per cent increase to

198 Written Answer [HL15920](#), Session 2017–19

199 Written evidence from The King’s Fund ([SOC0057](#))

200 Select Committee on Intergenerational Fairness and Provision, *Tackling intergenerational unfairness* (Report of Session 2017–19, HL Paper 329)

201 Estimate made before responsibility for funding free licenses was passed from central government to the BBC.

202 Health and Social Care and Housing, Communities and Local Government Committees, *Long-term funding of adult social care* (First Joint Report, Session 2017–19, HC 768)

203 Written evidence from Involve ([SOC0035](#))

national insurance contributions for those over 50 “as a last resort” in his report with the Centre for Policy Studies.<sup>204</sup>

### National versus local responsibility

151. As well as finding new funding sources, the system needs to distribute the funding more equally to local authorities. We heard evidence on proposals to centralise the funding of social care. Sir Andrew Dilnot described the problem:

“We should recognise that there is an element of pure chance here. Why is this a local authority financial responsibility? Because it was left there in 1948, because in 1948 it was tiny. When we took almost everything else into the centre, we left this bit—which is a kind of hangover from the Poor Law, really—with local authorities. I think that is a historical accident. One question we should ask going forward is: should financial revenue-raising responsibility for this stay at local level?”<sup>205</sup>

152. David Phillips said the question rested on “who you think has better knowledge about what local people want and need” and whether central government’s assessment of needs around the country was accurate.<sup>206</sup> Natasha Curry, Senior Fellow at the Nuffield Trust, said funding should be centralised:

“the funding piece has to sit at the national level if we are to have true risk pooling, but local authorities can still have autonomy to administer the system and to do the linking with the NHS. There is a precedent in other countries, where they have a clear national framework for funding, eligibility and benefits, but it is administered at a local level. That gives the local authority the autonomy to shape services according to need.”<sup>207</sup>

153. Essex County Council called for “a funding distribution formula that accurately reflects the level of need in each area.”<sup>208</sup> Sarah Pickup said a “funding formula” could remove inequalities without resorting to a national system:

“You can deal with distribution issues if you can get a good, fair funding formula in place ... It does not mean that you need to have a national system; historically, we kept all business rates and council tax in local areas and had government grant, which was used to redistribute. It did not mean that services were not organised and delivered locally.”<sup>209</sup>

154. The Health and Social Care Secretary said the Government was not considering centralising the funding of adult social care:

“we are not looking at changing the 1948 settlement in which it was decided that the NHS would be a national body and social care would be funded by local authorities ... It is true that an awful lot of taxes are paid to the national Exchequer and then redistributed out, but not entirely. In fact, we have moved slightly in the other direction with the

---

204 Damian Green MP and Centre for Policy Studies, *Fixing the Care Crisis* (29 April 2019): <https://www.cps.org.uk/files/reports/original/190426143506-DamianGreenSocialCareFinal.pdf> [accessed 26 June 2019]

205 Q 7 (Sir Andrew Dilnot)

206 Q 62 (David Phillips)

207 Q 7 (Natasha Curry)

208 Written evidence from Essex County Council (SOC0025)

209 Q 61 (Sarah Pickup)

introduction of the social care precept, but that itself has an equalisation formula on top.”<sup>210</sup>

155. *Some witnesses said social care funding should reflect the fact that older generations are more likely to benefit from it in the short term. Employees above the state pension age currently pay no national insurance on their earnings, but their employers do. We recommend that those above the state pension age should no longer be exempt from employees’ national insurance. They should pay the same rate as other age groups. This could raise more than £1 billion.*
156. **Social care funding should not be reliant on locally raised revenue which has little connection to local demand for social care.**
157. *The additional funding needed for adult social care should be provided as a government grant, distributed directly to local authorities according to an appropriate national funding formula which takes into account differences between local authorities in demand for care and ability to raise funds from local taxation.*
158. **We do not support the introduction of a hypothecated tax or a mandatory social insurance system. While some witnesses said that this could help the public trust that extra taxation will be spent on social care, hypothecation could leave the amount of funding available more sensitive to the performance of the economy.**
159. *Funding social care should be approached in the same way as any other funding pressure. We recommend that social care is funded largely from general taxation.*
160. *The Government should adopt a staged approach to providing the additional funding recommended by this report. It should immediately invest £8 billion in adult social care, which is the amount the Health Foundation and the King’s Fund estimate will be required to restore quality and access to 2009/10 levels, funded nationally and distributed according to a fair funding formula. It should then introduce free personal care over the next five years. Free personal care should be available universally by 2025/26.*

## APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

---

### Members

Baroness Bowles of Berkhamsted  
 Lord Burns  
 Lord Darling of Roulanish  
 Lord Forsyth of Drumlean (Chairman)  
 Baroness Harding of Winscombe  
 Lord Kerr of Kinlochard  
 Baroness Kingsmill  
 Lord Lamont of Lerwick  
 Lord Layard  
 Lord Livermore  
 Lord Sharkey  
 Lord Tugendhat  
 Lord Turnbull

### Declarations of interest

Baroness Bowles of Berkhamsted  
*No relevant interests*

Lord Burns  
*No relevant interests*

Lord Darling of Roulanish  
*Director of Standard Life Foundation, Board of Trustees, Standard Life Foundation*

Lord Forsyth of Drumlean (Chairman)  
*No relevant interests*

Baroness Harding of Winscombe  
*Chair, NHS Improvement*

Lord Kerr of Kinlochard  
*No relevant interests*

Baroness Kingsmill  
*No relevant interests*

Lord Lamont of Lerwick  
*No relevant interests*

Lord Layard  
*No relevant interests*

Lord Livermore  
*No relevant interests*

Lord Sharkey  
*Trustee of Turn2Us Charity, funded largely from revenue from owned care homes.*

Lord Tugendhat  
*No relevant interests*

Lord Turnbull  
*No relevant interests*

A full list of Members' interests can be found in the Register of Lords' Interests:

<http://www.parliament.uk/mps-lords-and-offices/standards-and-interests/register-of-lords-interests/>

**Specialist Adviser**

Richard Humphries

*Provides advisory services to the King's Fund, Health Foundation, ADASS and the Social Care Institute for Excellence.*

## APPENDIX 2: LIST OF WITNESSES

---

Evidence is published online at: <https://www.parliament.uk/social-care-funding-in-england> and available for inspection at the Parliamentary Archives (020 7219 3074).

Evidence received by the Committee is listed below in chronological order of oral evidence session and in alphabetical order. Those witnesses marked with \*\* gave both oral and written evidence. Those marked with \* gave oral evidence and did not submit any written evidence. All other witnesses submitted written evidence only.

### Oral evidence in chronological order

**	Simon Bottery, Senior Fellow, The King's Fund	<a href="#">QQ 1–13</a>
**	Natasha Curry, Senior Fellow, Nuffield Trust	<a href="#">QQ 1–13</a>
*	Sir Andrew Dilnot CBE, Chair, Commission on Funding of Care and Support (2010–11)	<a href="#">QQ 1–13</a>
*	Warwick Lightfoot, Head of Economics and Social Policy, Policy Exchange	<a href="#">QQ 14–23</a>
*	Kathryn Petrie, Senior Economist, Social Market Foundation	<a href="#">QQ 14–23</a>
*	Harry Quilter-Pinner, Research Fellow, Institute for Public Policy Research	<a href="#">QQ 14–23</a>
*	John Godfrey, Corporate Affairs Director, Legal & General Group	<a href="#">QQ 24–36</a>
**	Rob Yuille, Head of Retirement Policy, Association of British Insurers	<a href="#">QQ 24–36</a>
*	Steven Cameron, Pensions Director, Aegon UK	<a href="#">QQ 37–41</a>
*	Daniela Silcock, Head of Policy Research, Pensions Policy Institute	<a href="#">QQ 37–41</a>
**	Sir Steven Webb PC, Director of Policy, Royal London Group	<a href="#">QQ 37–41</a>
**	Dominic Carter, Policy Manager, Alzheimer's Society	<a href="#">QQ 42–50</a>
*	Kari Gerstheimer, Director of Information and Advice, Royal Mencap Society	<a href="#">QQ 42–50</a>
**	Tracey Loftis, Head of Policy and Public Affairs, Versus Arthritis	<a href="#">QQ 42–50</a>
*	Caroline Abrahams, Charity Director, Age UK	<a href="#">QQ 50–59</a>
**	Jules Constantinou, President, Institute and Faculty of Actuaries	<a href="#">QQ 50–59</a>
**	Iain MacBeath, Resources Co-Lead, Association of Directors of Adult Social Services (ADASS) and Director of Adult Care Services Hertfordshire County Council	<a href="#">QQ 60–67</a>

*	David Phillips, Associate Director, Institute for Fiscal Studies (IFS)	<a href="#">QQ 60–67</a>
**	Sarah Pickup OBE, Deputy Chief Executive, Local Government Association (LGA)	<a href="#">QQ 60–67</a>
**	Sharon Allen OBE, Chief Executive, Skills for Care	<a href="#">QQ 68–80</a>
**	Guy Collis, Policy Officer UNISON	<a href="#">QQ 68–80</a>
*	Professor Jill Manthorpe, Director, NIHR Social Care Workforce Research Unit	<a href="#">QQ 68–80</a>
**	Colin Angel, Policy and Campaigns Director, United Kingdom Homecare Association	<a href="#">QQ 81–90</a>
*	Douglas Cooper, Project Director, Competition and Markets Authority	<a href="#">QQ 81–90</a>
**	Professor Martin Green OBE, Chief Executive, Care England	<a href="#">QQ 81–90</a>
**	Rt Hon Matt Hancock MP, Secretary of State, Department of Health and Social Care	<a href="#">QQ 91–103</a>
**	Mr Jonathan Marron, Director General of Community and Social Care, Department of Health and Social Care	<a href="#">QQ 91–103</a>
*	Rt Hon Damian Green MP	<a href="#">QQ104–114</a>

#### **Alphabetical list of all witnesses**

*	Caroline Abrahams, Charity Director, Age UK ( <a href="#">QQ 50–59</a> )	
	Action for Children	<a href="#">SOC0019</a>
	Action on Hearing Loss	<a href="#">SOC0064</a>
	Alive	<a href="#">SOC0011</a>
**	Sharon Allen OBE, Chief Executive, Skills for Care ( <a href="#">QQ 68–80</a> )	<a href="#">SOC0070</a>
**	Colin Angel, Policy and Campaigns Director, United Kingdom Homecare Association ( <a href="#">QQ 81–90</a> )	
	Associated Retirement Community Operators (ARCO)	<a href="#">SOC0044</a>
	Association of Accounting Technicians (AAT)	<a href="#">SOC0005</a>
**	Simon Bottery, Senior Fellow, The King’s Fund ( <a href="#">QQ 1–13</a> )	<a href="#">SOC0057</a>
	British Healthcare Trades Association (BHTA)	<a href="#">SOC0045</a>
	Paul Bunting	<a href="#">SOC0001</a>
	BUPA	<a href="#">SOC0066</a>
*	Steven Cameron, Pensions Director, Aegon UK ( <a href="#">QQ 37–41</a> )	
	Care & Repair England	<a href="#">SOC0009</a>

	Care and State Pensions Reform (CASPeR)	<a href="#">SOC0073</a>
	Care and Support Alliance	<a href="#">SOC0028</a>
	Care Quality Commission (CQC)	<a href="#">SOC0055</a>
	Carers Support Centre Bristol	<a href="#">SOC0023</a>
	Carers UK	<a href="#">SOC0046</a>
**	Dominic Carter, Policy Manager, Alzheimer's Society ( <a href="#">QQ 42-50</a> )	<a href="#">SOC0050</a>
	Centre for Policy on Ageing	<a href="#">SOC0032</a>
	Chartered Institute of Public Finance and Accountancy (CIPFA)	<a href="#">SOC0014</a>
	Children England	<a href="#">SOC0041</a>
**	Guy Collis, Policy Officer UNISON ( <a href="#">QQ 68-80</a> )	<a href="#">SOC0026</a> <a href="#">SOC0069</a>
*	Jules Constantinou, President, Institute and Faculty of Actuaries ( <a href="#">QQ 50-59</a> )	
*	Douglas Cooper, Project Director, Competition and Markets Authority ( <a href="#">QQ 81-90</a> )	
	County Councils Network (CCN)	<a href="#">SOC0029</a>
**	Natasha Curry, Senior Fellow, Nuffield Trust ( <a href="#">QQ 1-13</a> )	<a href="#">SOC0031</a> <a href="#">SOC0062</a>
*	Sir Andrew Dilnot CBE, Chair, Commission on Funding of Care and Support (2010-11) ( <a href="#">QQ 1-13</a> )	
	Dimensions	<a href="#">SOC0015</a>
	Disabled Children's Partnership	<a href="#">SOC0043</a>
	Essex County Council	<a href="#">SOC0025</a>
*	Kari Gerstheimer, Director of Information and Advice, Royal Mencap Society ( <a href="#">QQ 42-50</a> )	
	Professor Jon Glasby	<a href="#">SOC0007</a>
*	John Godfrey, Corporate Affairs Director, Legal & General Group ( <a href="#">QQ 24-36</a> )	
*	Rt Hon Damian Green MP ( <a href="#">QQ 104-114</a> )	
*	Professor Jill Manthorpe, Director, NIHR Social Care Workforce Research Unit ( <a href="#">QQ 68-80</a> )	
**	Professor Martin Green OBE, Chief Executive, Care England ( <a href="#">QQ 81-90</a> )	<a href="#">SOC0039</a>
**	Rt Hon Matt Hancock MP, Secretary of State, Department of Health and Social Care ( <a href="#">QQ 91-103</a> )	<a href="#">SOC0060</a>
	Healthwatch	<a href="#">SOC0075</a>
	Hft	<a href="#">SOC0038</a>
	Homeless Link	<a href="#">SOC0030</a>

	Horizon Senior Care Ltd	<a href="#">SOC0012</a>
	Inclusion London	<a href="#">SOC0024</a>
	Independent Age	<a href="#">SOC0034</a>
	Institute and Faculty of Actuaries	<a href="#">SOC0013</a>
	Institute for Government (IFG)	<a href="#">SOC0061</a>
	Involve	<a href="#">SOC0035</a>
	Later Life Ambitions	<a href="#">SOC0058</a>
*	Warwick Lightfoot, Head of Economics and Social Policy, Policy Exchange ( <a href="#">QQ 14-23</a> )	
	Lord Lipsey	<a href="#">SOC0059</a>
**	Tracey Loftis, Head of Policy and Public Affairs, Versus Arthritis ( <a href="#">QQ 42-50</a> )	
**	Iain MacBeath, Resources Co-Lead, Association of Directors of Adult Social Services (ADASS) and Director of Adult Care Services Hertfordshire County Council ( <a href="#">QQ 60-67</a> )	<a href="#">SOC0052</a>
**	Mr Jonathan Marron, Director General of Community and Social Care, Department of Health and Social Care ( <a href="#">QQ 91-103</a> )	
	National Care Association	<a href="#">SOC0063</a>
	National Care Forum (NCF)	<a href="#">SOC0040</a>
	National Institute of Health and Care Excellence	<a href="#">S0C0048</a>
	Newcastle Council for Voluntary Service	<a href="#">S0C0020</a>
*	Kathryn Petrie, Senior Economist, Social Market Foundation ( <a href="#">QQ 14-23</a> )	
*	David Phillips, Associate Director, Institute for Fiscal Studies (IFS) ( <a href="#">QQ 60-67</a> )	
**	Sarah Pickup OBE, Deputy Chief Executive, Local Government Association (LGA) ( <a href="#">QQ 60-67</a> )	<a href="#">SOC0033</a>
*	Harry Quilter-Pinner, Research Fellow, Institute for Public Policy Research ( <a href="#">QQ 14-23</a> )	
	RAND Europe and Personal Social Services Research Unit (PSSRU)	<a href="#">SOC0072</a>
	Royal College of Nursing	<a href="#">SOC0049</a>
	Scope	<a href="#">SOC0008</a>
	Scottish Government	<a href="#">SOC0074</a>
	Shaping our lives	<a href="#">SOC0017</a>
*	Daniela Silcock, Head of Policy Research, Pensions Policy Institute ( <a href="#">QQ 37-41</a> )	
	Social Policy Research Unit, University of York	<a href="#">SOC0021</a>

	South East England Leaders and South East England Councils	<a href="#"><u>SOC0018</u></a>
	The Children's Services Development Group (CSDG)	<a href="#"><u>SOC0042</u></a>
	The Health Foundation	<a href="#"><u>SOC0047</u></a>
	The Inclusion Project	<a href="#"><u>SOC0002</u></a>
	The Independent Living Strategy Group	<a href="#"><u>SOC0036</u></a>
	The National Deaf Children's Society	<a href="#"><u>SOC0053</u></a>
	United for All Ages	<a href="#"><u>SOC0004</u></a>
	United Kingdom Homecare Association	<a href="#"><u>SOC0016</u></a>
**	Versus Arthritis	<a href="#"><u>SOC0065</u></a>
	Voluntary Organisations Disability Group (VODG)	<a href="#"><u>SOC0068</u></a>
	Voscur	<a href="#"><u>SOC0022</u></a>
**	Sir Steven Webb PC, Director of Policy, Royal London Group ( <a href="#"><u>QQ 37-41</u></a> )	<a href="#"><u>SOC0037</u></a>
	West Sussex County Council	<a href="#"><u>SOC0010</u></a>
	Women's Budget Group	<a href="#"><u>SOC0051</u></a>
**	Rob Yuille, Head of Retirement Policy, Association of British Insurers ( <a href="#"><u>QQ 24-36</u></a> )	<a href="#"><u>SOC0054</u></a>

### APPENDIX 3: CALL FOR EVIDENCE

---

The House of Lords Economic Affairs Committee, chaired by the Rt Hon. the Lord Forsyth of Drumlean, is investigating the funding challenges for social care in England.

#### Evidence sought

The Committee is seeking evidence to address the following questions:

- What are the funding challenges for social care in England, and how can they be overcome?
- Why have successive governments been reluctant to address challenges in the delivery of social care?
- How can a sustainable funding model for social care supported by a diverse and stable market be created?
- How can the cost of the provision of social care be fairly distributed?
- What lessons can be learnt from elsewhere in the United Kingdom, or from other countries, in how they approach social care?

This is a public call for written evidence to be submitted to the Committee. The deadline is 9 October 2018.

We are looking to hear from as diverse a range of views as possible—if you think someone you know would have an interest in contributing to the inquiry, please do pass this on to them.

House of Lords reports make recommendations to Her Majesty's Government. Social care is a devolved area for Scotland, Wales and Northern Ireland. As such this inquiry is focusing on social care in England. However, the Committee is interested in the lessons that can be learnt from the other nations in the United Kingdom.

13 September 2018

## APPENDIX 4: PRIVATE MEETING WITH CARE WORKERS

---

The Economic Affairs Committee hosted a private meeting with care workers on 8 January to discuss the social care workforce. Five members of the Committee were in attendance, as was Richard Humphries, Specialist Adviser to the Committee. The session was attended by three representatives from The Orders of St John Care Trust, two who directly work in a care home in Oxfordshire and one Area Operations Manager.

This note summarises the discussion.

### Recruitment

Participants raised recruitment as a challenge for care homes. One participant described a constant fluctuating increase in resident needs. For example, in any one week the dependency needs could be met with a certain number of employees however, as soon as one resident's needs change, and this may be to double-handed care, then the staffing level becomes stretched. The problem being this is unpredictable and difficult at times to manage. Most or all of these staff could be required to help with one complex need.

Competition for staff was high both with other care home providers and organisations outside the care sector such as supermarkets. The recruitment process for care homes was lengthier than for competitors outside of the sector, sometimes taking up to three months due to requirements like Disclosure and Barring Service checks. In general, participants felt prospective care workers chose employers primarily on the basis of pay rates.

On the suggestion of a national recruitment campaign, participants were sceptical. One said: "If we sold the truth, although it would be attractive on some days, on others I'm not sure it would be that attractive because of the demands, responsibility and pressures of the role."

Participants spoke of the importance of exposing men to the care sector to dispel myths about its working conditions. Men were represented in the sector mainly in roles viewed as more professional. Participants noted that amongst different community engagement they held sessions with nursery-age children, and volunteering programmes, that had been relatively successful for recruiting and attracting employees of varying ages.

### Turnover and working conditions

Turnover constituted not only of people leaving the sector, but also carers moving to care homes that could offer better rates. The participants' care home often lost staff to other facilities with a higher proportion of self-funders who could consequently offer a much higher rate of pay. While the participants' care home, which relied primarily on local authority funding, paid between £8 and £10 per hour, those with more self-funders could afford to pay between £15 and £17 per hour. Care workers would also leave the social care sector to work at supermarkets offering higher pay rates, particularly in urban areas. These roles carry much less responsibility also.

Participants agreed that pay was an important factor in turnover in the social care workforce, but not the only reason. In particular, they argued that many left, or did not join, because they felt undervalued by society. As a result, there needed to be a shift in society's view of care workers. Care work was a skilled profession,

which should be recognised as such. One participant said: “It is not all about money ... care work is a profession and needs to be seen as such. Nurses are highly respected, highly regarded ... we need to be on the same platform but are seen as second-class citizens.” Another participant noted that they had too often heard people describe themselves or others as “just a carer”.

Some care workers, particularly in rural areas, lived long distances away from their care home. One participant spoke of a care worker who would take three trains to get to work, leaving home at half 4 in the morning and working 15- or 16-hour days as a result. This contributed to care workers “burning out” and leaving the sector.

One participant described two types of people who applied to work in care homes. One type was looking for short-term work to fill a gap in their career or pay the bills, often attracted by adverts of ‘no experience necessary and training provided’. The participant said: “It is not a vocation for them, it just fits their lifestyle. Something is missing ... it is not seen as an attractive role anymore.”

The other type saw care work as a vocation, remaining in the sector for decades. There were rarely, it was suggested, people who did not fit either category.

### Qualifications

Participants explained that the Care certificate was a nationally approved induction programme. They noted, however, that there was no external validation of the certificate. This meant that, while the participants’ care homes used the certificate to design its own induction programme, it could not be sure that care workers who had achieved the certificate elsewhere had been adequately trained. They would therefore make them repeat the induction programme, and some employees would note differences between the difficulty of achieving the certificate at their current care home compared to other homes outside of the organisation. One participant concluded: “Do we think the transferable Care Certificate is valuable overall? Not really, because of the lack of external validation, however the standards have enabled us to create a robust Induction for all of our employees, sadly this is not the same for all providers.

Participants also discussed National Vocation Qualifications (NVQs). These were externally validated and required for progression to senior roles in the participants’ care homes. The home would support employees in obtaining NVQs, using funding from a variety of partners including local authorities, colleges, and Skills for Care. This funding was sometimes unreliable.

NVQs were not seen as a solution to need to view social care as a profession on its own. One participant said: “NVQs are sometimes seen as ‘something I’ve got to do’ to a care worker, rather than career development.

Participants discussed the likely consequences of local authorities funding care more widely. In this circumstance, one participant suggested that only a minority of families would continue to care for their relatives instead of using the state-funded care. Another participant suggested that greater access to domiciliary care and/or Extra Care Housing could help family members sustain caring for their relatives in their own homes for longer.