



Select Committee on the Long-Term Sustainability of the NHS

Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 25 October 2016

10.35 am

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Members present: Lord Patel (The Chairman); Lord Bradley; Baroness Blackstone; Bishop of Carlisle; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Warner; Lord Willis of Knaresborough

Evidence Session No 10

Heard in Public

Questions 105 - 117

Witnesses

I: Ben Page, Chief Executive, Ipsos MORI; Emma Norris, Programme Director, Institute for Government; and The Rt Hon Frank Field MP, Chair, House of Commons Work and Pensions Select Committee.

USE OF THE TRANSCRIPT

1. This is an corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

Ben Page, Chief Executive, Ipsos MORI; Emma Norris, Programme Director, Institute for Government; and The Rt Hon Frank Field MP, Chair, Work and Pensions Select Committee.

Q105 **The Chairman:** Good morning to our witnesses, and thank you very much for coming today to give evidence. We are very keen to hear from you about issues related to public attitudes to healthcare and other issues. We are recording and broadcasting, so I say to Committee members and to you, any private conversation may get picked up, so be careful about that. I will tell you when we stop broadcasting. I would be grateful if you could please introduce yourself, starting from my left, and if you want to make any opening statement, please feel free to do so.

Frank Field: My name is Frank Field. I am the Member of Parliament for Birkenhead. I very much welcome your inquiry and am grateful to be asked to be a witness.

Ben Page: I am Ben Page, Chief Executive of Ipsos MORI, the research company.

Emma Norris: I am Emma Norris, a programme director of the Institute for Government, a not-for-profit organisation working to support more effective government.

The Chairman: Do you want to make any opening statement? No. Okay, we will kick off. The first question may appear targeted particularly to you, Ben Page, but I would like to hear from the others. Are you able to outline the main trends in public attitudes to health services and how are they shifting over time? What issues in public health services are the public most concerned about, particularly currently, and in the future of the health service? Is there any aspect of health policy that has seen a bigger shift in public attitude?

Ben Page: If you look at the last 20 years, the pattern of public attitudes has, in some ways, mirrored funding of the NHS. Back in 1997, nearly 20 years ago, the NHS was top of the list of things that people said, spontaneously, worried them in Britain. As expenditure on the NHS doubled—and we can talk about how effectively that money was spent, and there are many members of this Committee who will have opinions on that—concern about the NHS declined.

It is now back up there again as an issue of public concern. Overall ratings of service standards remain much better than they were in the 1990s, but they have started declining slowly. The key challenge, in a sense, is that the public are completely wedded to the idea of a free, universal NHS. When we ask people which public services should be protected from cuts, which we have done repeatedly since 2010, it is always at the top of the list of the priorities. Aid for the developing world is always at the bottom of the list of priorities.

When you ask people what the biggest problems are in the NHS—and, to be honest, this has been the same ever since we started asking the question at the beginning of the century—it has always been a lack of funding and investment. This was the case even as funding was pouring in and real-terms rises were occurring. At the moment, though, there has been a real swing in the last few years to an anxiety about the future. People have always believed there will be a funding problem, but we now have 55% of people, the highest figure we have ever recorded, saying that the NHS will deteriorate in the future.

On current ratings of individual aspects, such as GP services, people are starting to notice that access is a bit more difficult, but things are still much better than they were 20 years ago. It is certainly under pressure, and the challenge is that people talk about paying a bit more in tax for it, but it will take some brave politicians to do that. Hypothecation, as with the rise in national insurance rates at the beginning of this century, may be a way of packaging it up, but in the fiscal environment we are in, with rising consumer inflation possibly challenging real wages, it will be very difficult.

Finally, as waiting times fall in the NHS, there tends to be a non-linear relationship between public opinion and delivery on the ground, if you like—particularly access, which is often how the public judge it, rather than clinical standards. As waiting times fell, there was not a linear recognition, in line with those falls in waiting times, that things were getting better.

If you read the STPs, you have bed spaces being reduced and things closing. As the service comes under more pressure, with deficits all over the place, and if waiting times do start to rise, it will not be a gradual switch in public opinion. There is likely to be a tipping point. When that will be, I do not know, but it will presumably be in the next few years if it is to occur, and at that point the public will be willing to see perhaps more radical measures.

As we put in the slides that I think were circulated to the Committee, there are some measures that the public tend to favour, but they tend to prefer the idea of other people doing things—other people paying fines if they are late, rather than them paying £10 or so to see a GP. They prefer other people perhaps losing weight before they have an operation, but probably not them and their families. That, I think, is the challenge, but it is certainly the most loved public service in Britain. I will stop there, but I am happy to take questions.

Frank Field: Thank you, Chair. The paradox is that there is no question that the data Ben gives is true about the importance the public attaches to this one great institution that has survived the Attlee era as somehow giving the country a sort of social coherence. Yet, I have a massive postbag, and the question “What are you doing about protecting this service?” almost never occurs in the postbag. I think the main reason for that is that there has been no crystallisation of the debate about what we can be debating for or against. That is why I am so pleased that you are

undertaking this inquiry and that there will be a parliamentary report around which that debate may take place.

Emma Norris: As Ben has said, the public place huge importance on the NHS. They are wedded to the idea of a free NHS, but we know that funding pressures are likely to result at some point in radical changes, whether that is continued and expanded reconfiguration of services, changes in the breadth of service provision or rises in income tax. Given how passionately the public feels about the NHS, I think that the only way to pursue change, whether increased taxes, reconfiguration or whatever it might be, is to involve citizens in that conversation. Otherwise, we are likely to see that conversation and any policy change being derailed. I can talk a little more about what a national conversation on the NHS might look like.

The Chairman: Ben Page, what effect are the problems in social care having on public attitudes?

Ben Page: The point about social care is, of course, that it is very complicated. I speak as somebody who has just nursed my mother and stepfather to death at home, on the other side of the river, in Lambeth. Trying to navigate the system is incredibly difficult. The issue of the problems in social care is clearly there in that, if you look across the public sector, there are two areas where people have noticed the impact of cuts. One is road maintenance, which we will quickly put to one side. The other is adult social care, which people have noticed.

It is still not a majority of users who say that they think it has deteriorated, but it is the largest proportion, pretty much, of any public service. The point is that such a small proportion of people directly receive it and the accountability for it is so confused, as opposed to the straight line in theory to NHS England and the Department of Health, that the public has not clocked. In a way, to be honest, I am quite surprised, given the demographics. Back at the beginning of the century I was expecting that by now there would be a very active pensioners' party. There would be people saying, "I cannot cope with my mother any more", and dropping her off somewhere.

Instead, people like me have ended up doing domiciliary care at the weekends; it is our parents. Society has proved, in some ways, more flexible, but the pressures are undoubtedly there. In a way, what we are doing—the way the system is set up at the moment without integration—of course, hides that. If I were a politician, quite frankly, I would probably want that to continue, rather than ending up being made to take responsibility for it. What it would do, of course, is highlight the massive shortfall in supply.

Q106 **Lord Warner:** Ben, I am quite influenced by a bit of work that you did for us when I was on the Dilnot commission, the interest I declare. Sticking with social care for the moment, what data is there around whether people think social care is part of the NHS, and whether they think they and families should be paying more, or saving more, or paying

for this service? They separate out in their minds social care from the "free at the point of use". That is a paradox, because there are two views. One is that it is all in the NHS anyway, and the other is that it is not the state's responsibility; it is much more mine. What is the data showing on that now?

Ben Page: From memory, it is still showing confusion. People are not aware; some people think local government delivers social care, which, of course, in theory in part it does. There is much more confusion about that than there is for, say, acute services. In terms of taking responsibility, about four in 10 people say, "Yes, I recognise that I will need to save up money for my care when I am older", but a large proportion will take the view, "I pay taxes". In particular, older people who are coming closer to the event are saying, "I have paid taxes and national insurance all my life; why on earth should I pay?"

When we ran large-scale consultations to look at paying for social care, we found that everything was fine, even with the idea of the Japanese system of introducing extra national insurance payments at the age of 40. We found that broadly the public might go along with that. With the idea of the state getting a bit of your house when you died, however, at this point there were rebellions. People are not rational about it, and they are also divided. If it were simple and easy, any Government of any colour would have done something about it a long time ago.

Lord Warner: Is that all static? Is it changing?

Ben Page: It is fairly flat, to be honest, apart from people noticing a deterioration. There is a bit more recognition in the data that people know that austerity is here, that prioritisation needs to happen, but it is not moving anywhere near as quickly as we would need it to.

Frank Field: Can I just add to Ben's comments, in a sense, a note of dissent? On his idea about his weekends being given to look after his parents, we downplay the strength of families still, and families still expect and want to carry out that role if they can. If they have additional support, they are grateful for that, and they come to their MP only when they are almost worn out, at the end of their tether, when they do not know, and they ache with pain wondering what the next move is. If you are in that state, you are not in a very good state to form a new political party; you want a rest.

Q107 **Lord Mawhinney:** Frank, nice to see you again. I would be interested in your views about people saving for social care, which is being tossed around here already. Specifically, how would you react, as a former Minister, to the idea of attaching some function to national insurance payments that were designated specifically for social care as a first step in starting to address this?

Frank Field: Brian, I much welcome that, and maybe I could develop the ideas now, or a bit later. If one were starting again, one would not come up with an NHS. Naturally, then, they did not care as much about social care, because it was not a big issue. If we were designing a system

now, the two would be combined. How do we make the transition from where we were to where we might be?

I hope the Committee, if it is considering any financial reform proposals, makes the point that we need to be using that transition of raising additional funds to change the nature of the service, so it is an NHS social care service. That means, of course, that group that at the moment does not pay national insurance, which is pensioners, would come into the scheme and start to pay for it.

You could have a transition by saying, "If you want to play around, you may have to lose your house. You may have to get this terrible lottery by your local authority about whether there is any help available to you. That is fine; but if you take a model that you will be in, you get the whole package". That would be part of the transition. At some stage in this Parliament there will be a God almighty eruption over the funding of the NHS. The exercise on trying to get savings is a good thing to do; we all should be conscious about worrying not just about how much we put in but what we are getting for the outcomes. We should be looking at that as well.

This offers the Committee a real opportunity to try to bring the debate together and suggest which way forward we might go. Might I, Chairman, suggest what I would like to see here, or should I do that later on? May I? We should follow Gordon Brown's model, possibly in two stages. One is that he was terrified introducing the increase in national insurance; he thought it was almost going to be the end, and was then surprised by the cheering he got in the streets. He could not have been more popular as a Minister after he did this.

What we did not realise then, but do realise now, is that while that one penny was a very useful way of bringing us up to the European average, Gordon, clever as ever, diverted half of that money to his other pet schemes. Certainly, there will be enough in the campaign leading up to that to make sure the public realise that, and they would want a separate scheme. Therefore, it would allow you to begin to develop a different form of governance.

Stage one could be to accept the system as we have it now, and follow the Gordon line of a penny on national insurance on employers and employees, without a ceiling. That would fill the gap that will develop, if the efficiency savings are achieved. However, there is a longer-term objective here, in that as now, increasingly, people cease to believe in God, our public religion, as Nigel Lawson said, is the NHS. It gives us a real chance of rethinking that position, particularly as we are bringing social care in. I hope the Committee will seriously consider looking at a national insurance base. I say that because Ben and others have done surveys that show that the public see a difference between a tax and what they regard as a contribution.

Lord Mawhinney: Can I just be clear: I asked you about national insurance as a fund for social care; do I detect that you are broadening it

to be NHS and social care?

Frank Field: Brian, I am, in the sense that the Government are already trying to get local authorities with their funding to work with local trusts so that the bed blocking, as it is rather cruelly called, is lessened. There is an attempt to come together locally, and anything you propose, I hope, would reinforce that trend rather than ignore it.

The Chairman: We will have an opportunity to expand on this when we come to it in the questioning, but Baroness Redfern will carry on with the original line.

Q108 **Baroness Redfern:** From a local authority's perspective, obviously we have raised an increased 2% that is targeted towards health and social care. Ben made a broad statement that 55% said the service was deteriorating. Can I just tease a little out of that? Is that regional? Is it well people or ill people? You can make a broad statement—

Ben Page: Sure. That is the population as a whole, just expecting it to get worse. If you look at the very detailed data that NHS England collects on patient experience, it is not the case that 55% currently are dissatisfied.

Baroness Redfern: That is what I wanted to tease out.

Ben Page: We need to be very clear about it. This is the point. The NHS, partly by raising its deficits, is holding the line. Waiting times are increasing, but they have not hit a tipping point where they are on the front page of the *Sun* every day. However, and this is the point of what I was trying to say, there is a non-linear relationship. If the trend continues, at some point the pressures will feed through.

At the moment, patients are not rioting in the streets about standards and it is generally, as I say, about access. It is a slow deterioration, but the point is that it will not go on. The evidence suggests that there will be a tipping point when suddenly people notice, but at the moment it is holding together. It is fascinating that the press coverage of junior doctors' troubles et cetera has not led to a more marked fall.

Baroness Redfern: Is it focused mainly on the acute sector?

Ben Page: Yes, and GP access. The acute data is still reasonably good. There has been a rise in mortality in the last year, which nobody quite understands, and if that trend continues, that will be interesting. I started to think that was the canary in the mine and possibly was partly related to social care, but no. Satisfaction is holding up; it is drifting down slowly, but there is anxiety about the future.

Q109 **Lord McColl of Dulwich:** Ben, from your surveys do you get any sense of whether the public understand that half the illnesses are self-induced and that the obesity epidemic is the worst epidemic for 100 years? Do they have any sense that they could do something themselves about this? You see old people constantly being blamed for getting older, but

they have always been getting older. It is the young people who are getting fatter and fatter.

Ben Page: People estimate that 45% of the population is obese. Obviously, they do not think they are, but the actual figure is about 62%. There is some recognition of the public health dimension of the problem. People recognise that obesity, drinking too much, lack of exercise et cetera are a problem. The challenge is changing behaviour. The NHS has talked about moving from being an illness service to a wellness service, certainly since the 1990s, when I first became involved in measuring it, and obviously probably for longer. However, the cultural shift that we need to achieve is enormous, and we are nowhere near it yet.

Baroness Blackstone: I wanted to ask Ben whether, in any of your surveys, you have asked the question: "Should more money be spent on the NHS or on social care?" If you have, what do you get as a result? Can I just follow up on Frank's suggestion that pensioners should pay national insurance? Have you also asked the public whether it would be a good idea to introduce national insurance for pensioners, since they are by far the heaviest users of the health service, and if you could in some way link that with improving the services that they will get?

Ben Page: The short answer is that I do not think that we have asked—I have not seen it, but it may exist out there somewhere—about basically charging pensioners more somehow. Obviously, people massively underestimate the rise in DWP's expenditure on pensioners over the last 10 years.

On social care versus the NHS, the only thing I can give you is that when you ask people to prioritise the NHS versus care of the elderly, or however you want to define it, the NHS massively outstrips it. Of course, that is in a sense the culture we have inside the NHS, which is always blue flashing lights and surgeons, rather than some of these slow and creeping problems that we face.

Q110 **Bishop of Carlisle:** You have made it clear that everybody wants additional funding for the NHS; they are clear that there needs to be additional funding. You have made a couple of very interesting comments. You said, Ben, that everybody basically wants somebody else to pay for it. Frank, you said that there is likely to be an eruption fairly soon about the public funding.

Could I ask a question that is very much about what you think the public would find most acceptable? This is not for your views but what you think the public would go for best. I note that one of your slides says that six in 10 say they are prepared to pay more taxes to help the NHS. That is quite a high proportion, but if you are taking into account things such as direct taxation, statutory insurance, national insurance and so on, which of those do you think the public would favour most—that is likely to be the thing that politicians will go for—and does it matter?

Ben Page: It probably matters, in the sense that you want to get elected, although the nature of politics at the moment is somewhat

lopsided. To be honest—and Frank and I might agree on this, although we do not agree on everything—some sort of hypothecated national insurance rise that is very clearly badged as for, in positioning terms, the NHS as much as social care. Because social care is so complicated and people become so confused about the range of providers and responsibilities, the NHS brand is much stronger than social care.

Anyway, some type of hypothecated taxation is probably the easiest way out. Of course, the NHS is already trying demand management; it is doing it, trying to charge for extras. We charge massively for car parks; it is very expensive. There are some options, and you will have other people who are better on the detailed economics of the NHS than I am, but it would appear that only something like that will get us out of the hole we are in. It is probably easier to do that than a rise in VAT or in taxation generally. That would be my take on it.

The Chairman: In terms of what this inquiry is about, which is the long-term sustainability of the NHS beyond 2025 or 2030, so that we do not have yearly or five-yearly cycles, what kind of funding will the public find acceptable for long-term sustainability? It will have to grow year-on-year.

Ben Page: I will pass the buck on this one, Chairman. John Appleby of the King's Fund has done some interesting work on this. I do not know if he also presenting to this Committee. If you ask him about it, he says, "If you look at Germany, the Germans spend a lot more on their health services than Britain. It is just a matter of choice". I will give it to other people to consider that. I would also urge us to look at investment in public health. This, of course, is part of the NHS's current troubles, as I understand it.

The difficulty is the need to re-engineer the service with a surge in demand that is in some ways even beyond what would have been anticipated with the change in the profile of the population. It is a bit like changing the engine in a ship while the ship is moving along. However, we need to make that investment in public health. Probably, that is part of it, but we do not operate on those sorts of cycles as politicians in this country.

Bishop of Carlisle: Thank you, that is very helpful. I know there are other questions that people want to ask on this.

Q111 **Lord Bradley:** Could I just pick up, Ben, on your point about the integration of health and social care having political consequences? I have to declare an interest as a non-exec on a trust board in Greater Manchester. The direction of travel is to push those budgets down, to integrate those budgets—Frank mentioned joint commissioning between local authorities and public health as part of that, and the trust et cetera.

You are suggesting that the political consequences, when the pressure comes even further on, from those decisions could be found at the local level as opposed to the national level, where you are trying to get a national system in place to mitigate that. What are your further views on

that issue?

Ben Page: It is clearly sensible to integrate things at a local level. There is massive duplication, inefficiency and confusion. Will the Secretary of State suddenly become responsible for my mum's bedpan in her house in Clapham? To be honest, that is the direction we are going in. I am not clear what the new Government's view is on devolution, however, because we seem to have such a patchwork quilt of different deals and options.

To a certain extent we will need to go to that model, and there will be differences between different parts of the country, but this is where we run into the central problem that 81% of people want the NHS to be the same everywhere. It may be a fantasy, but that is what they want. They do not want, for example, Herceptin to be available in one part of the country and not in another. The fantasy of the NHS, which is an enduring fantasy for the British public, is that basically clinical care is the same everywhere, and you are guaranteed, as a taxpayer in Britain, to get a certain thing.

Devolution is probably necessary, and it is more efficient. The Scandinavians have great examples of it working, as far as I can see. However, there will potentially be some fallout, yes, because suddenly it will be, "Why are we not getting this here? Who made these decisions not to give us this in Greater Manchester, when over in—"

Frank Field: Birkenhead.

Ben Page: "—Birkenhead, on the other side of the river, they get it?"

Lord Bradley: It is heading your way.

Ben Page: That is the challenge.

Lord Bradley: Just a quick supplementary: within the question of the integration of physical and mental health, is there a growing recognition among the public of the need to develop services around that?

Ben Page: Yes. Obviously, mental health still has a massive stigma and massive misunderstanding. If you ask people the question, they do not sit in the pub talking about this, and we saw that again. When given the choice, they will say, "Make those investments".

The Chairman: Frank, you wanted to come in.

Frank Field: I did. Could I just pick up a couple of points, Chairman? On Baroness Redfern's issue, we have seen this Parliament part of the NHS bowing to public pressure. It was not by politicians, but it was by opinion polls. The junior doctors were not beaten by the rhetoric of politicians, but the polls were showing it swinging against them. Although, in a sense, it was not an immediate, "I am looking after my mum and I should not", there was a real anxiety growing that the standard of service would suffer and waiting lists would grow even further

if this strike went ahead. This was reflected in the polls, and very sensibly the junior doctors withdrew.

On Keith's point, when we are talking about reform it is important that we are talking about both kinds of reform. We need to start to educate the public that maybe, particularly in this age of devolution, the role of government is the Webbian one of laying national minimum standards, but there will be other bodies that will improve on that. The Webbs always saw that, because some authorities would do better than others, that would be one of the stimuli for driving up what the national level should be.

On the Bishop's point, speaking as a politician who likes getting elected and wants to get elected again, it would be a more choppy campaign if we were vaguely talking, although we had not even done it, about there being some increase somehow in the next Parliament, but we could not tell you what it was. It would be a real opportunity lost if we tried to make the hospital sector raise more money by these charges, because it is quite arbitrary if you compare what you can charge for parking in London hospitals with that in Birkenhead hospitals.

Also, there is something terribly important about the NHS as the last great institution binding us together as citizens. Rather than start dividing us over, "Oh God, is it not unfair? Look at those hospital charges", we should say, "We bit the bullet, and we have done it together. It has been done in a progressive way. We support this move. We feel it belongs even more to us as a community than before". The latter offers not just a way out of the funding for the NHS, but plays a crucial part in adding to social cohesion. It is a strange phrase, but we are all aware when social cohesion begins to collapse, and we are then at a loss about what we do about it.

Q112 Lord Warner: Can I just pursue this issue of efficiency and productivity and where the public are? This Government has put quite a lot of pressure, through the media, on improving productivity and efficiency in the NHS and the wider public services. The present Prime Minister had a pretty good go at another sacred cow, which was the police. Where are the public on this? Where are the public on the NHS in the context of greater efficiency in the public services?

Ben Page: Every year we have asked people what the biggest problems facing the NHS are. Obviously, some of the booking procedures are nowhere near where they should be. People can see inefficiency. Three-quarters of people agree that there is a lot of waste and inefficiency in the NHS, but simultaneously believe it should have more money. Spontaneous anxiety about bureaucracy and inefficient management has declined since 10 years ago, so I do not know whether they have noticed that it has become a bit more productive.

The main shift in public opinion over the past six years has been an acceptance of austerity, which is interesting. One of the things we have seen is the proportion of people who believe that the amount of cuts that

have been done has fallen from 40% in 2012 to 28% in 2015. There is a recognition—you can argue about whether it is right or wrong—that austerity is necessary, and that there is more of it to come. We believe that in many public services there are people rowing back their expectations.

In the past I have had chief executives of councils saying, “If I offered a free nose-blowing service down at the town hall, there would be a queue of people waiting for it”. Now people have bought the rhetoric that money has to be saved.

Frank Field: In Birkenhead, Chair, they have been working out what the code is for nose-blowing.

Q113 **Baroness Blackstone:** A lot has been said by you and by previous people from whom we have taken evidence on the need for a big public debate about the NHS and the future of our health services. We have been told that people need to have better understanding, and they need to be able to express their views about what they want. Emma, in particular, can you start on the question of how this should be done? This is a big ask; it is not an easy thing to do and it has to be got right if it is to be reliable and valid.

Emma Norris: On how, it is worth pointing out that there is a lot of nervousness at the moment about talking to citizens about the challenges and the future sustainability of the NHS. The STPs are perhaps a case in point, where citizens were not engaged as early as they might have been. If citizens are not involved in a big national conversation, however, it will make change even harder, whether that is financial reform or something else.

We have seen examples many times in the past of citizens derailing, sometimes for good reason, policies when they have not been involved in big conversations to begin with. It could be opposing hospital reconfigurations, opposing long-term storage solutions for nuclear waste, or scrapping plans for nationwide road pricing. If citizens are not involved in these big conversations up-front, it is very hard to make policy progress.

In terms of how, there are many international and domestic examples that we could learn from. For instance, in Canada, about five years ago, a national dialogue was held on the future of their healthcare system, what a good-value healthcare system looked like, and, crucially, what the responsibilities of citizens were in helping to achieve that good-value system. Just a few months ago Canada launched another dialogue, this time on electoral reform. Even in the UK, back in 2006, the “Our Health, Our Care, Our Say” listening exercise was run to look at out-of-hospital care and how it could be improved. There are international and domestic examples of how to hold big national dialogues.

This was also something that we looked at on a slightly smaller scale at the institute quite recently. We were very interested in how you involve

citizens in difficult policy decisions that we know people feel strongly about but have very divided views. Our research told us a couple of things. We looked at examples of citizens' juries that were run by PwC and BritainThinks, on how to create the right criteria for a spending review. We looked at examples from abroad of when the public have been asked to deliberate on how to expand airports. We looked at local councils that were implementing budget cuts and were trying to involve citizens in the choices they needed to make.

A couple of things came out about how to run those conversations effectively. The first was about being transparent about what is and is not up for grabs: taking Redbridge Council as an example, where it was talking to citizens about cuts, it was very clear about what citizens could decide on and what they could not. There was no room to reject the requirement to make £25 million of savings; budget deliberations could only occur within that envelope. Similarly, any conversation on the future sustainability of the NHS would need to be clear about what was up for discussion and what was not.

There is also a point about timing, and not leaving it too late to involve the public in these conversations. The examples we have looked at have been most effective when people have been involved from day one on deliberating about future options. For NHS England, the timing of engagement on sustainability and transformation plans has not perhaps worked as effectively as it might have. One of the first times that citizens heard about the plans was, I think, through media coverage. In a bigger national conversation about the future funding of the NHS, getting that timing right and making sure citizens are involved as early as possible is crucial.

Ben Page: I am a huge fan of consultations, because that is how my company makes its living. The challenge is the scale: to make a nation of 60-plus million people feel that they have all had a say is a huge communications challenge. However, there are some interesting examples in our recent history of difficult policy choices that Britain has done without too much trouble, and we could maybe look at those. One is pensions: basically, the parties, and these Houses here, have agreed that everybody will pay in more and work longer, and there is no big debate about that. We are doing it with social care, and it does not seem to work there.

My worry about a consultation, or an engagement exercise, is that you would need to be very transparent about the choices. The difficulty will come when experts start arguing with the choices, or saying they are fake choices, or something like that. Somehow, in the pensions debate, that did not become as incendiary. I am all for doing it, because it is the right thing to do, but in getting people to feel that they have definitely had a say, I wish everybody a huge amount of luck.

Lord Lipsey: Were you all for doing it the day after the Brexit referendum, where we had a great national debate?

Frank Field: Chairman, on this point, if, in working on your proposal, you are working with the grain of human nature, you get support very quickly. I have given one example of Gordon being surprised. There was another where Healey challenged the trade unions to maintain the pay freeze, and he said, "If you do not maintain it there will be tax increases. If you do, you will get tax allowance increases".

From the second poll onwards, it showed that the public understood what the choice was and which they wanted to choose. If you were having a national conversation about trying to persuade people to dismantle the health service, it is a different conversation from one about how we strengthen it.

Baroness Redfern: Following on from Lord Bradley on mental health issues, Frank, would you advocate a closer working relationship with local authorities and GPs? We have talked about mental health issues; we can talk about isolation, depression et cetera. Would you see a closer working relationships with GPs?

Frank Field: They are pivotal, as are the support services they are building up. In the area that I represent, they are losing those under pressure as the hospital budgets try to suck money out of primary care. When we are making these changes, we ought to be thinking about the regional aspect of this, which has been referred to, but there is also very much the local aspect of this—having services to which people can walk, particularly if they are poor. It does not mean that all doctors would be good on mental health services, and again their budgets might be structured in a way that would encourage them to be so.

However, to be able to refer patients in my constituency by all doctors, not just the best ones, as quickly as those who, for example, got secondary services in their GP surgeries would be a tremendous breakthrough. One does not want to underestimate the difficulties of somebody going to another person outside the family and saying that they have real mental health problems.

Lord Warner: We have not had much luck with representative democracy in recent times. Is there any evidence that getting the elected representatives, local and national, engaged in the conversation has worked? That is probably for Emma as much as anybody.

Emma Norris: Yes, absolutely. We looked quite a lot at infrastructure, another area where obviously there are incredibly difficult policy decisions being made, and citizens have a big interest in them. It is something that some of our European neighbours have perhaps been slightly more successful in having conversations about than us. The expansion of Schiphol Airport in the Netherlands is a good example. They created a deliberative forum to have conversations about how to expand that airport after there had been a lot of public backlash against the initial proposals.

It involved citizens, but one of the most effective things that was used in that deliberative forum was bringing together local and national representatives to try to deliberate on their respective evidence bases about what was and was not going to work. It was important for citizens to see that local and national representatives had been given an opportunity to come together to hash out some of those details.

I think you are right that sometimes just showing, definitively, to the public that there is space to look at national versus local interests, and to have conversations about the evidence base, is enough to take some of those conversations forward. That is just one example of how.

Q114 Lord Willis of Knaresborough: Mr Chairman, I am always slightly amused when I am talking about public consultations, being a member of the National Environment Research Council. We have just recovered from Boaty McBoatface as a result of that, so I would hate for us to get into that space. I wonder if we could come back to Frank Field. I always enjoyed, Frank, your commitment to finding a long-term funding solution when I was in the Commons. You have often been a lone voice in suggesting hypothecated taxes for that.

There were three things you mentioned in the earlier discourse. I do not think we need to go back over that, but there are issues with your proposal, first of all about hypothecation and ring-fencing it. I would be very interested if you could add to your idea of an NHS mutual as to how you keep it retained. You are quite right that Gordon Brown's one penny quickly became half a penny in that sense. How do you stop that? There is a sense that at the moment the contributions simply go into the pot and are spent by the Treasury.

Secondly, if income is attached to a source that cannot remain constant and economic disactivity results in a significant downturn in tax revenues, you would then get a shortfall. What would you do with that?

The third point, which is crucial, is that if you do not have a mechanism that ties your spending to productivity and efficiency, which Lord Warner was talking about earlier, we end up with a situation where you pour a lot of money in, having won that argument, but you are no better off. I wonder if you could start perhaps with the NHS mutual, and give us the solutions to tackling those problems—including, of course, taxing the elderly, because in this room we are cash-rich. The Chair is, anyhow.

Frank Field: I have three points, one about hypothecation. I genuinely think the Government could get away with quite a major restructuring without hypothecation, given that the wish of the electorate will be to see the NHS through to its next stage of life. However, if it did that, it would be a real lost opportunity. It may have to do an interim increase, and then spell out what that longer-term reform is about. I would be very happy to submit a paper, if I may, through you, Chair, to that.

I would link it to a mutual so that the Government was the post office, collecting the money from the reformed national insurance base to go to that mutual for that mutual to spend. It would be transparent, it would be

very clear and it would stop any of this sleight of hand that somehow says "There is a large sum of money here, and I would like half of it, or even more of it, to go to some of my other pet projects". It would strengthen the NHS's place in the affection of the country, and it would strengthen democracy in that it would be another great bulwark both in helping lead the debate that you have been talking about, and protecting revenues and making sure they go where they should.

Secondly, you raise the question about a downturn. You would not want to make this change without giving the mutual power to build up balances so that over the cycle—whatever we regard now as the cycle—there would be enough in the bank to offset. Certainly, one would not want, when there is a downturn, for the contributions to go up and therefore, in a sense, restrict individual spending. We would want that as a period where you could reflate. Even Beveridge proposed that in his schemes, but that was one aspect that was ignored. The mutual would have the powers to build up balances to deal with the very point that you raise.

Thirdly, if we had lots of new money slushing around, it raises the whole debate about efficiency and how we look at outcomes rather than just inputs. How do we put patients at the centre, and staff—whom we should not forget about—second but still crucially important? Undermining staff morale, whether teachers or NHS workers, is very good for politicians short-term to gain headlines, but long-term it starts to make the culture even more inward-looking and even more difficult to change.

One of the aspects noted by people who use the NHS, and we all do and we see the inefficiencies, is that there needs to be a massive cultural change in how they approach their individual functions—the cog within the wheels. I, again, think it is the role of the mutual to lead the national debate on the change in culture, what we are expecting and what we want from increased productivity. We also, however, need to start debating publicly whether there are limits at all to what you are prepared to pay for, and the conditions for which you are prepared to pay in the future, given our projections. They would be like those that the Office for Budget Responsibility produces; they would produce the same: "If, in fact, we are going to quickly incorporate, thank goodness, all the latest drugs and all the latest equipment, this is where we will land up". Going back to the previous question, is there not a duty on you to perform in a certain way so that you are not "abusing" the health service? Here, from the word go, are courses that you could be on or become part of, which would reduce obesity, understanding the difficulties there are if you are poor in engaging in those.

Thirdly, this would be a great body whose responsibility would be to guarantee transparency, but to have a constant duty to seek out at every opportunity to lead a public debate. The debate would consist of defending what we have, why it is being reformed, why it continues to be reformed and why your contribution, which we are now debating with you, is clearly linked to the sort of service that you wish to continue.

That service, I think, will increasingly be one that demands an end to this mess-up between hospitals and social care.

Lord Willis of Knaresborough: Could I just follow up, very quickly? The one flaw, when I read your earlier work, seemed to me that you were advocating a hypothecated national insurance contribution over and above existing national insurance contributions. Somehow you have to interrelate both of those, which means you have to recognise where the current money from the contribution is being spent. If you do not do that, you end up then with a set of services that are hypothecated for this money to be spent on, without a relationship to the whole.

I could not work out how, in fact, you unpack the current contribution to say how much of that is the NHS spending, unless you link the whole thing together, in which case you cannot fund the lot.

Frank Field: No, there are two stages. One is that we must have an emergency package, and that we would have a Gordon Brown approach stage one, linked to the establishment of a new body that guaranteed they got the money. Secondly, we would need to convince the public that almost none of their National Insurance contribution goes to the health service, although I think Ben's surveys show that everybody thinks all their National Insurance contribution goes there. It actually goes to pay pensions. We need to think about that.

I would like, as the third stage of the reform, over time to transfer the whole cost of the NHS and social care budget to the new mutual, and the new mutual's job would be to say, "That therefore allows the Government to make tax cuts". It would not use this transfer of a budget that people are already paying for generally through taxation, to pay for it again in the reform and by sleight of hand get away with huge increases in revenue, but without saying, "We will not charge you twice". I hope nobody would even try the double taxation trick, and be very popular for sloshing money all over the place.

Lord Willis of Knaresborough: The increase in the NI contribution would be quite significant. We are not talking about a penny; we are talking about a significant amount, if you were going to remove the NHS spending from the tax base to reduce taxes, and therefore make that a sweetener. For those who are not earning, and particularly for elderly people who have incomes that are coming in where they are not working, that shift is monumental.

Frank Field: The shift would be, but they would get a guarantee that they would keep their house. We may not understand it, but move one is: maybe we just do the increase in national insurance. We then think about the longer term, as you are suggesting—and I agree—and we take the whole of the health and social care budget to this new funding basis, which becomes progressive rather than regressive, as it is at the moment. There is then a clear commitment that, for each billion that is moved over from the existing health budget and general taxation to the new progressive base for the mutual, that money would come up and be

earmarked for tax cuts. It would not be used by sleight of hand to get tax increases on people, because the whole thing would blow up in the face of whoever was trying such a foolish move.

- Q115 **Lord Lipsey:** Frank, I just want to home in on your proposal on national insurance, which you earlier described as a progressive way of funding it. Is it a progressive way when national insurance falls entirely on working people, who, as the Resolution Foundation and others have shown, have done very badly in recent years, and the benefits of improved healthcare disproportionately accumulate to people like me? We older people who do not pay national insurance will now get, as well as the triple lock and the cornucopia of goodies that have been heaped on us, even more money spent on their health.

Frank Field: I have tried to stress a couple of times, David, that this package would be accompanied by bringing pensioners into the scheme, and they would be paying national insurance along with the rest of us. There may be a case for asking pensioners to pay national insurance contributions now on their income. Certainly there is no case for a reform package that would generally most benefit older people, and for those who could not pay most—pensioners who are exempted from national insurance contributions—not to be included within the scheme.

The Chairman: Ben, you mentioned the Japanese system of paying national insurance specifically for social care. Do you want to comment on that?

Ben Page: I am not an expert on it, but it was certainly one of the things we looked at in a consultation on paying for social care, a while back. It was certainly pre-2010. It was interesting; we did not go into the mechanics with the public, but the idea is that you have reached the age of 40 and it is therefore quite likely now that you will live on et cetera, and now you will pay a bit more. Of course, by the time you are 40 you are earning a lot more than you would have done in your 20s anyway, so it is more affordable. Of many of the things that we looked at, that idea was broadly accepted as a principle.

Baroness Redfern: For pensioners paying towards that care, would that have to be means tested and therefore would that be very complicated?

Frank Field: It would be means tested only in the sense that if you were below the threshold, wherever you set it, you would not be paying through the national insurance scheme. However, it is not a special means test.

Baroness Redfern: It would be interesting to know where you would set the threshold.

Frank Field: Again, that is a matter for debate. In the Japanese system, Chairman, it comes in at 40. There has been a big change in my lifetime. One left university expecting to get a job, a house, a pension, and to save. Now at 40 you would be lucky if you have maintained a job, and you may well be thinking about a family and trying to acquire a house.

There will not be a good point in the life cycle to introduce these contributions. Again, as with all great reforms, the bullet has to be bitten.

Baroness Blackstone: Maybe 40 is a bit too young. Maybe it would be better if you said 50.

Frank Field: I agree. When we left university, we were invited to pay our back national insurance contributions, which most of us did, thinking that was likely to affect our pensions, and that we would not be working all that long. It is easier to bring in contributions when you start paying contributions, rather than hiking it up later.

Q116 **Lord Warner:** Can I carry on from this a bit with my question? It has been very difficult over time to get political commitment to addressing the question of longer-term sustainability of public services, including the NHS. The Chairman has said that we are set up here to look at the longer term, not the immediate problems, although the immediate problems can, of course, affect that longer term. You, Frank, have identified an external force, which you called the national mutual fund. Is there a more fundamental case, without getting into how you raise the money, for trying to get some better assessment over time, independently of government, about what these systems need?

We have done that a bit with the OBR. Is there a fundamental problem or flaw in the present system, whereby politicians wait until the crisis occurs and we then have a dose of catch-up money? Is there a danger, Frank, that your proposal will be just another catch-up proposal, and we will never get to stage two? Is there a case for at least trying to see where the direction of travel should be for these services, outside direct political control?

Frank Field: I think there is. As I said, the model of the Office for Budget Responsibility is one that one might follow—although initially, given its standing, one might commission the King's Fund to undertake that function for it. You seemed to suggest earlier, Lord Warner, how poor our representative Government is. In the Labour Party, most MPs now represent constituents who overwhelmingly wish to leave Europe. I almost got crushed in the rush of Labour MPs adopting a new position once they realised where their constituents were.

We are sensitive in that: representation and representativeness do not just come from general elections. MPs do try to pick it up in other ways. The sort of debate that you are initiating might well be one of those factors that helps clarify their minds, so that they are cheerleaders for it in their local communities and beyond.

Ben Page: Could I just add that depoliticisation is obviously desirable, but the people doing it will not necessarily be popular. One of the things we might need to confront the public with is, I think—somebody will correct me—the current amount we spend on maintaining somebody for a year is about £35,000, and if your treatment will cost a lot more than that, it is not available. People do not want to be faced with this. They

sort of know it, but one of the things about Britain is that so many things are left unsaid.

We like fairness, but we do not like to confront the fact that people in certain parts of the country live 20 to 30 years longer than those in other parts of the country. If we are told that, it is outrageous, but then we do not want to do what is necessary to stop that happening. If we try to depoliticise it, we want to have that very honest conversation with the public—"How much are you prepared to pay for? What treatments are not available?"—rather than having it obfuscated through our various processes at the moment. Somebody will have to be pretty brave to have that conversation, but it is worth doing.

Lord Warner: Exciting to do, as well.

Ben Page: Yes.

The Chairman: Lady Blackstone, with her golden question.

Q117 **Baroness Blackstone:** What key change would you each recommend, which we in turn can recommend, to make a more sustainable NHS?

Frank Field: I merely summarise, Tessa, what I have been saying: there is going to come a point at which the public will be even more open to radical reform. I would like to see that focusing on both a new progressive funding basis and a real strengthening of people's sense of ownership of the NHS. Some of us might—others might not—be surprised by just how popular that was. One would need to do it in stages, and one would need something like a report that you are going to produce, which is not "the Tories" or "the Labour Party, up to their tricks with something we love, which we want strengthened". Then they, in a sense, are coming behind you to lead the debate, rather than them, in desperation, kicking off the debate themselves.

The Chairman: You have suggested previously establishing some sort of commission.

Frank Field: You are the commission, are you not?

The Chairman: We thought we were, but we are not.

Frank Field: You are doing that work, and therefore if it is possible for you to report unanimously, the report will be even stronger. You will be sowing on fertile and not on stony ground, when your report is ready.

Ben Page: My shopping list would be some form of hypothecated charge, probably through national insurance, but at the same time a new Government closing all the hospitals that are uneconomic, which we do not close because it is difficult, and a massive investment in public health.

Emma Norris: Mine would be the instigation of a national conversation on the future of the NHS, and critically that should include establishing an independent evidence base about options to support that conversation.

The Chairman: Thank you, all three of you, for coming today. If you have any further information—Frank, you mentioned something—please feel free to provide it, and we will include your slides as part of the evidence.

Frank Field: I will, indeed. Chairman, might I also make a suggestion that for you to commission polling on this would be helpful? There is one person not very far to my left who—

Ben Page: Last time he got me to do it for nothing.

Frank Field: I do not know whether you have a research budget, but you might like to ask him to pose certain questions for you, for your research.

Ben Page: Happy to consider it.

The Chairman: Thank you very much. Thank you, indeed.