



Select Committee on the Long-Term Sustainability of the NHS

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

Tuesday 25 October 2016

11.55 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 11

Heard in Public

Questions 118 - 128

Witnesses

I: The Rt Hon Lord Willetts, Chair, Resolution Foundation; The Rt Hon Steve Webb, Director of Policy, Royal London Group; James Lloyd, Associate Fellow, Strategic Society Centre; and Tom Kibasi, Director, Institute for Public Policy Research.

USE OF THE TRANSCRIPT

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

Examination of witnesses

The Rt Hon Lord Willetts, Chair, Resolution Foundation; The Rt Hon Steve Webb, Director of Policy, Royal London Group; James Lloyd, Associate Fellow, Strategic Society Centre; and Tom Kibasi, Director, Institute for Public Policy Research.

Q118 The Chairman: Good morning, gentlemen. Thank you all for coming to assist us with this inquiry today. We are most grateful. First of all, we are broadcasting, so any conversation you have privately might be picked up. Secondly, at the end of the session and subsequently you will be sent the transcript of today's session, and, please, if there are any crucial corrections to be made, let us know. If there is any evidence that you may not have been able to send, or that you feel after the session you would like us to have, please feel free to send it to us later on. If you do not mind, introduce yourselves, and if you want to make an opening statement, please feel free to do so. Can I start with you, Lord Willetts?

Lord Willetts: Thank you very much. It is obviously a great honour to be invited before this Committee. My name is David Willetts; I was a Member of the House of Commons between 1992 and 2015. Now I am a Member of this House and executive chair of the Resolution Foundation.

Steve Webb: I am Steve Webb, director of policy at the mutual insurer Royal London and, as I think of myself, the last but one Pensions Minister.

James Lloyd: I am James Lloyd, associate fellow of a public policy think tank called the Strategic Society Centre, and I have done thinking and writing on the topic of how we pay for an ageing population, social care and interaction with pensions for a number of years.

Tom Kibasi: I am Tom Kibasi; I am the director of the Institute for Public Policy Research. For today's discussion, it might also be worth mentioning that I led on the financial sustainability of health systems for McKinsey for many years, working with the World Economic Forum, the OECD and a number of different national Governments.

The Chairman: Thank you very much. I will kick off with the first questions, which relate to funding. Do you think there is a case for reforming the current funding system for both health and social care? Furthermore, what acceptable and viable alternative models might there be? Is a "free at the point of use" national healthcare system sustainable in the long term? Who would like to start?

Lord Willetts: Shall I set the ball rolling very briefly? On the funding of the NHS I am very cautious, perhaps because of my experience in the past of having been a policy adviser in Margaret Thatcher's policy unit, where health was one of my responsibilities. We did then look at co-payment, private insurance—all those conventional options. We did conclude that a nationwide risk pool to fund healthcare was a perfectly

reasonable arrangement, and that the costs of moving from what we had to some other system were very high.

You also asked about social care, however. It is on social care where I would be much more radical. Interested as I am in a fair deal between the generations, it is social care where we have a real muddle on our hands. I was on the Cabinet Committee that considered Andrew Dilnot's proposals, which of course have now been so watered down as to be barely happening. On social care, there is some scope for a combination of proper and distinctive public financing—perhaps doing as they did in Germany, with some national insurance element dedicated to covering the cost of social care—plus being explicit about private payment on top of that.

That would then open up a wider question as to what we offer pensioners. I would like to see a revised triple lock, which did not cover solely the pension and had some revised promise on the uprating of the pension, but included some commitment on the costs of social care. It would be a combination of a national insurance element plus private payment if you had significant assets on top. In summary, I would be cautious on NHS funding, and radical on social care funding.

Steve Webb: In terms of how we pay for social care, you hear two main arguments. One is that we should all be encouraged to save more; people have talked about a long-term care ISA, or something like that. I think that is ridiculous. I work for an insurance company, but I have always thought that social care is an insurance issue, because most of us will not face catastrophic care costs. The idea that somehow we should all try to put tens of thousands of pounds aside for the minority who end up spending tens of thousands seems ridiculous, and will not happen.

If you want it to be insurance, lots of countries do it through social insurance. I do not sense there is any appetite in the Treasury to go down that road; one could call for it, but it will not happen. The question then is: how do you encourage people to insure, when insurance companies are not willing to offer insurance products? That is partly what the Dilnot report was trying to do. It was trying to say, "We will cap liabilities here", and then the insurance industry says, "Right, we know what we are on the hook for. It is up to this amount. The state will take the tail, and the state is quite good at that kind of thing, because it is still there in a generation", and then you would have had products.

We can argue about the detail, but I talked to Andrew Dilnot recently about this, and he said, "Catastrophic long-term care cost is the last unpooled risk". We pool our car insurance, our home insurance, the risk of unemployment and growing old. This is the one risk that falls catastrophically on a minority of individuals. One of the problems with insuring is that people do not know. They have this slight sense of, "If I need care, the council will provide". They have this vague sense that they will not be on the street, so what is it you are insuring? You are insuring quality and choice, I think. The council will provide something, but it will be in the worst place in the borough, probably, and barely cover the cost

of that. We need to facilitate insurance; we need to be clear what we are insuring; and, critically—this is the answer to all your questions—we need to deal with prevention and early intervention.

I will make one further point, and then I will shut up. The beauty of the Dilnot scheme was not what happens at the end, when you have racked up £70,000-odd worth of care costs. It is what happens on day one, when you open your Dilnot account. The day you open your Dilnot account, you send a signal to the local authority, which hitherto does not know you exist, to say, "I have started to incur significant care costs. I am a person on a journey".

If local authorities were able to intervene at the start of that journey to help you stay in your own home, and all the things that we know help to reduce the catastrophic costs at the end, society would save a huge amount and families would benefit. However, we do not have that trigger. We should start the Dilnot process and get that clock running today, even if the Government do not want to pay at the end, so we get much better information about the people coming into the system, and we can act early to help prevent costs later.

James Lloyd: We have moved very quickly, have we not, into the detail of what is a fair partnership to pay for social care in England? I presume this Committee is covering the whole of the UK, but I will focus on England nevertheless. Obviously, in broad terms, social care is a special case, because there is now total recognition, politically and in terms of local authorities, care providers and so forth, that we are absolutely at the cliff edge. We simply cannot go on as we are. There is also widespread recognition that the underfunding of the local authority social care system is now resulting in clear and explicit, and indeed higher, costs for the NHS.

If you look across the social care system, what is also clear is that in a way there are no efficiencies left. There is not much scope to do things better, so to speak. The demand, or the expenditure required of local authorities for social care, is reduced. The care fees that providers charge to local authorities have been pushed down as far as they will go, and are now reaching points that naturally incur implications for people receiving care. There has been a confluence of other factors, which are putting pressures on the care system, not least the national living wage, and the implications for a very low-paid care workforce.

On the first question of how we fund care and fund a sustainable system—the question of whether we can do things better within the current system—I would say all the low-hanging fruit, and indeed the fruit above those fruit, have been picked. We are left with some very difficult choices. Typically, you might then think, "Where else within public spending can we find this money? Can we reallocate funding from the NHS or from other areas of, for example, benefit spending? Is there a case for targeting public expenditure on the state pension in a different way, so that that would release money to transfer into the social care system?".

Obviously, we have already had mentioned the possibility of looking again at the triple lock and perhaps the uprating process that is attached to that. In addition, we can get into discussions of fiscal measures associated not with reallocating public spending but with increasing the tax take, and what might be appropriate new specific taxes for social care. For years, we were told that tax rises for social care were not possible, but of course last year the Government announced the social care precept, which gives local authorities the option to raise council tax specifically for the purposes of social care.

There are also other options that could be considered in the context of tax rises and fiscal discussion. Inevitably, having participated in this discussion for about 10 years now, at some point we will get to talking about the fact that the cohort that is coming through, which is putting such pressure on the social care system, displays a very high rate of home ownership, and unprecedentedly high levels of housing wealth. For the large part, this is completely untaxed. That might be a question the Committee wants to explore.

All that is completely separate from a different policy question, which is: what is the fair partnership between the individual and the state in paying for care? What should people expect from the state—from local authorities or from whatever arm of the state is going to support them in their care costs—and what should people have to pay for privately? This, again, is a question that has been explored over a number of years, and I can see people around this table who have participated in multiple commissions on this question.

The most recent attempt was, of course, the Dilnot Commission on Funding of Care and Support. The Government in 2014 adopted its recommendations, but then chose to delay implementation from 2016 in an announcement made in July 2015, despite having previously, in their manifesto, committed to implementing it in 2016. The Government said that the principal reasons for that were associated with the fiscal outlook, which obviously has become worse and more uncertain in light of the referendum vote this year. On top of that, there was no evidence of the insurance market coming forward with products that would sit alongside the Dilnot cap.

Where I would disagree slightly with the previous comments is that, having looked at the Dilnot proposals throughout their process of development, publication and adoption by the Government, I have never been convinced that they would lead to any kind of pre-funded insurance market. Indeed, I know of no insurance company that thinks they will lead to a pre-funded insurance market. The reasons for that are complicated, and maybe something that the Committee would like to think about in another session. In very simple terms, the liability with which individuals are left under the Dilnot cap is uninsurable for a private sector insurance company.

Why is that? People's liability, when their meter starts and when they reach the cap are determined by individual local authorities' positions at

some point in the future. Insurance companies cannot incorporate that uncertainty into the actuarial projections that they undertake. To put it another way, the insurance company cannot be sure when your meter, under the capped cost model, will start, and when it will finish. That is just one reason why the Dilnot proposals, specifically, would never unlock a pre-funded insurance market.

It is worth observing, around that issue, that there is no country in the world that has a functioning pre-funded insurance market in the way that we might expect to see one. The barriers to the development of an insurance market are many, and they exist on the demand side and the supply side. If you wanted to go through them we can, but they are long and detailed. I will stop there.

Q119 The Chairman: That has been put to us through other evidence and, Lord Willetts, you might wish to comment on that—although I hear you clearly say that in terms of funding for healthcare, after all the discussion and investigation, you came to the conclusion that the current tax-funded model for healthcare is the right model. The problem is that currently how much money healthcare gets varies, depending on what is affordable and how the Department of Health and the Treasury feel about it. How could that model work in a sustainable way, year on year, looking ahead to 2025, 2030 and beyond?

It has also been put to us that not an insurance model that is run by insurance companies, but a national insurance that pays towards social care, might be one way of going. That would include those who are claiming pensions paying towards it. Do any of you have a comment on that?

Lord Willetts: Ironically, that is historically how the system began, in the first part of the 20th century. It was national insurance for healthcare, and it was Beveridge who shifted it all around and shifted it to national insurance for pensions, with the NHS taken out of the social insurance model. We looked at all these options, and of course it is right to look at them again; maybe the arguments have changed. However, is a contributions requirement intended? Is it a contributory principle in that sense—you are entitled to healthcare if you or other members of your family have paid contributions for X year or in X circumstances?

I can see in the current mood of anxiety about migration that that has some advantages. On the other hand, you may find there are people who then are not entitled to care for whom you need to provide care. We have sometimes looked at trying to define rigorously whether you can have a more limited list of available publicly funded treatments, and say that you have to pay for treatments on top of that. By the time you have got to tattoo removal and perhaps vasectomy reversal, you rapidly run out of these things that you are not willing to pay for. It becomes trivial. We were never able to crack it.

The short answer is, therefore, as part of the political process, people are choosing Governments who will decide how much they spend on

healthcare. It is fascinating how we have all so rapidly moved to social care—both because that is so clearly in a much greater state of flux, and, as Steve said, it is the area where the pressures on healthcare look as if they could be relieved. I am sorry to be so cautious, but I never found a private health insurance model, a contributory model or a limited list model that seemed so manifestly superior to what we have. Governments have to decide how much they spend.

Tom Kibasi: I wonder if I could come in on that question of structure and how you look at different countries. An extraordinary thing has been achieved, which is that ministries of finance around the world have been utterly persuaded that you invest in education and you get a return, and that is a worthwhile investment, and the more you spend, the better it is for society. However, healthcare—you are doing this with the way you have asked the question from this Committee—is framed as a burden, something that is imposed on us and something that we should be seeking to minimise.

The short answer to your question, “Is the NHS sustainable?” is: it is as sustainable as you choose it to be. There is a conflation between financing on the one hand, which is whether you are putting in enough money compared with your expectations of what you want. That is one set of questions. A different question is whether you are doing it in as productive and efficient a way as you possibly could. Those two questions get conflated, and get a different answer. On sustainability alone, the answer is surely that it is as sustainable as you choose it to be.

This issue is not a uniquely British one. We look at this and say that it is somehow something to do with the NHS. The reality is that in all advanced countries, healthcare expenditure growth is growing, typically, at GDP growth plus two percentage points. This is an issue across different health systems.

I have always found it striking in these kinds of conversations that there are people who argue, “Does that mean we need to move away from our tax-funded system?”. If we are concerned about the level of expenditure that we have at the moment, and we are in the cheapest possible way of financing healthcare, it surely makes no logical sense to ask whether we should be moving away from that to private insurance, co-payments, any sort of health savings accounts, or any of those systems that are more expensive. In terms of how you start to think about the question, the first bit is to take away the question of whether we should be moving from the most efficient way of financing a system, and into a discussion about how you finance it at the correct level, which is a more important and difficult issue to debate.

There is also a unique thing that we have in Britain, compared with other countries, and there are two aspects to the debate that are quite interesting here and very different from elsewhere. One is that the debate is utterly dominated by the supply side. It is all about how you fix the hospitals and how you fix primary care, and everyone has a point of view on clinical commissioning groups, or whatever it is. The reality is,

however, that the 90% of the economy that is everything else drives the 10%. You need a discussion about that.

The second bit is that we do not talk about capital in the NHS, and the accumulated capital stock that we have, and take expenditure over a 30-year period, when if you look over a 30-year period, we are well behind other comparable countries. Let me leave it there, but that is a bit of framing that is quite important in this whole debate on the sustainability of the NHS.

Q120 Lord Willis of Knaresborough: What I found interesting about all your responses, particularly those from the two former politicians, is that despite the fact that all major political parties are committed to having an integrated health and social care system, you do not see that. You see the way forward as perpetuating a separately funded NHS, and separately funded, by some method, social care. I would like you perhaps to turn your brainpower to that question. If we had an integrated model, would they have to change?

Steve Webb: I certainly think integrating budgets is essential. I well recall visiting my local acute hospital and going on the elderly care ward, and all the patients had red, amber and green stickers against their name. Most had green stickers, and I said, "What does that mean?" and they said, "Ready to be discharged, but there is nowhere for them to go".

In my view, it is essential that we have joined-up budgets, which gets you part of the way there. My point about setting the Dilnot clock running is precisely that. If you have combined health and social care budgets, spending some money early on someone who is showing the first signs of needing care saves you bucketloads on health and social care later. I absolutely would say that.

Just coming back to this question about whether we just put national insurance up or hypothecate, social care funding is an area that, as we all know, is littered with commissions and reviews that got nowhere. The sine qua non for what you come up with seems to be, "Fine, if you want to write a report that says 'Put national insurance up', it will go on the shelf with all the others". I would suggest that you find something that the Treasury will buy into.

What will the Treasury buy into? It would be keen on more people self-funding, to take the pressure off local authorities. If you can find a mechanism that will encourage the people who can afford to do so to self-fund, the Treasury will be in listening mode. The one thing we miss in these discussions is that we always talk about care, and I think we should talk about inheritance. That is what a lot of people care about.

I am in my 50s, along with my brother. My parents are in their 80s. My brother came to me recently and said, "We need to think about the family home. If my dad goes into care, it doesn't matter, because my mum is still in the house; it does not count. If my mum goes into care as the last

person, the family home is on the hook. What can we do to protect the value of the family home?"

If we talk to people about insuring their inheritance, rather than talking to them about being old and infirm, which no one wants to think about, then you would have a product people could sell, and people would be motivated to buy it. That would take the pressure of local authorities, who could then concentrate on the people who really need it.

- Q121 **Baroness Redfern:** To James, first, who mentioned prevention: I find prevention sometimes very difficult to measure. To put him on the spot a little, does he think that budgets from the acute sector should be transferred to health and social care, getting people out of those expensive beds? Would local authorities working with intermediate care be better for the patient and save money at the same time?

James Lloyd: Where it could happen, it should, clearly. The Better Care Fund that the Government have set up has been put in place to make that happen and provide the upfront funding for the health system and local authorities to be able to do that. In a way, this relates back to Lord Willis's question on integration. Integrated care, as we all know, has been around as a concept for 50 years. It means different things to different people, but I generally take it to mean the integration of health and care funding streams, assessments and/or delivery.

What has been interesting to observe over the last five years is that the interest in integrated care models, and real money coming through the system to achieve integrated care, is now happening in a way that it was not, despite decades of talk, previously. This poses a challenge for related debates on how we finance health and social care, particularly social care. For years, I have participated in discussions of how we finance and fund social care as a society.

However, if we genuinely think that the future is to bring the two much closer together, we clearly, in a way, have to pause and think, "How will the decision that we make around funding what we think of as social care affect our ability to integrate health and social care, and the different models of integrated care?" To put this in practical terms, if you were to implement the capped cost model proposed by the Dilnot commission or some other similar model such as the Wanless model, which rely on local authority assessments of your social care needs—personal care needs in the home for example—

Baroness Redfern: Do you agree that there is more money going into the acute sector that should be diverted to—

James Lloyd: Yes, but just to make this point, it does—

Baroness Redfern: Tom is shaking his head.

James Lloyd: Okay, I will let him answer.

Tom Kibasi: We have to be very careful with this, because a mythology is emerging that we somehow have far too many hospital beds and that we should just be pushing money over to other parts of the health and care system. That is not quite true. If you look at the number of beds that we have, we have a very low number of beds compared with many other comparable countries. With growing demand, the reality is it is a question of how we keep our bed base stable, rather than having to grow it with growing demand.

Regarding this idea that we can just rip all this money out of the acute sector, I have not been to any hospitals where there is dust gathering and there is not enough to do.

Baroness Redfern: They were not my words.

Tom Kibasi: I think it is worth just being clear about that. The principal problem with integrated care, and the real reason why it does not happen, is that it is not as simple as trying to integrate the NHS with social care. As a one-to-one interface, that ought to be relatively straightforward. The problem is the byzantine complexity of the NHS system makes it next to impossible to integrate health and social care, because the health side is far too complicated and completely disjointed.

To answer that question of integration between health and social care, the first step has to be a dramatic simplification on the NHS side. One of the big problems with the Health and Social Care Act 2012—one of the many problems—was the explosion in bureaucracy and complexity within the NHS, which makes actual integration next to impossible. For the local authorities, the first question is, “Who am I integrating with about what?”. In a world that is incredibly complicated and messy, at the moment it is simply not possible to give a serious answer to that question.

The other bit that I would add to this is that there is a little misdirection going on here. If you look at the breakdown in what needs to happen to meet the productivity requirements within the health service, the vast majority is people getting more efficient in their existing models, in their existing organisations, and reducing the variation between them. It is a classic response to say, “I will point at the boundary and this issue that no one is really accountable for; I will apply 100% of the blame on to that specific area”. Integration is really important—I am not saying it is not—but it is also a bit of misdirection by everyone pointing at the thing for which no one is really responsible.

The Chairman: Some of the answers have gone on to your questions. Do you want to pursue it further?

Baroness Redfern: They have, yes. No, it was just about the challenges facing the implementation of health and social care.

Q122 **Baroness Blackstone:** Can I pursue this just a little further? I just wonder if you are going to get the genuine integration that you are

talking about, in funding, delivery and the provision of services. Do we not have to devolve and have a proper system of devolution, so that we get away from a top-down NHS and create regional and local systems of NHS, where you can much more easily integrate those systems properly?

Tom Kibasi: Except in theory, that is what we have done. We have had a fragmentation of commissioning: it has gone from 152 commissioners in 2010 to over 200 commissioners now. If anything, we have over-devolved, in the sense that it has been more fragmented down to a local level. The other thing I would just say is that, if you take a step back and think about what activities are involved in health and social care, and where there is a crossover, we are talking about a relatively small number of people who are receiving multiple services in their own home that could be consolidated.

It is where the social worker is coming in one day, and the COPD or cardiac nurse is coming in the next. Could those activities be consolidated? In terms of the core expenditure on health—doing hip and knee replacements, cancer therapies, out-patient appointments, in-patient surgery, day-case surgery and GP appointments—the vast majority of what is going on in the health service has nothing to do with social care. Yes, at the boundaries there are some ways that you could create additional value, by keeping people in their homes better and for longer.

I would argue, however, that financially integration makes a very small difference, and the big difference that you get from integration is an improvement in quality of care and experience. That is valuable and we should do it, but it is a red herring to focus too much of the sustainability conversation on the integration between health and social care. The economics just do not stack up on that.

Baroness Blackstone: Can I just question that? I think you slightly misunderstood what I was asking. I was not suggesting that within the NHS there should be more devolution to yet more commissioners and yet more bureaucracy. I was suggesting something much more radical, along the Scandinavian lines, where there should be local health provision, done through local or regional authorities, whichever is the best. Can I just also comment on the other thing you said—that there are all these different forms of treatment in the NHS that have nothing to do with social care? You have to set that against the fact that a very high proportion of people being treated by the NHS are elderly, and they need a mixture of social care and health provision.

Tom Kibasi: I absolutely agree, which is why I say it is about quality. On the Scandinavian point, however, because it is a really important example, I worked with the Government of Denmark for many years. They made me a Danish healthcare ambassador as a result of my association with them for many years. I am not sure what that consisted of, but they did that because I worked with their Ministry of Finance, their Health Minister and Health Ministry.

The reality was that when they pushed the financing of the hospital over to the local municipalities, they found that instead of prompting the municipality to solve the social care issue, all it did was push taxes up at a local level. If anything, they would argue that their experience was that it reduced hospital efficiency, because the local hospital could make a direct emotional appeal to local people, saying, "Put the taxes up because otherwise services will be compromised". In fact, it did not have the improvement on integration that it was expected to deliver, and they were largely quite disappointed by the impact of that act of devolution.

In Denmark, though, they consolidated from 21 health regions down to five, while we went from 152 up to 211. Norway went from 14 down to one; Alberta in Canada went from 13 down to one. Every other country in the world has gone in the opposite direction from us by consolidating, and we have gone to fragmenting and making it much more complicated.

Q123 Lord Warner: Can we come back to this issue of integrating the funding, which Steve Webb raised? I should declare my interest as a member of the Dilnot commission. The Dilnot commission was a real live test case: we tried to persuade the insurance industry to produce products for insuring social care, if we capped the risk. It was a total failure; they showed no interest whatsoever in that, so we know about that bit. We tried to persuade the Government to do the right and proper thing about publicly funded social care, and failed again. We have some real historical evidence about trying to do those things.

You were saying, Steve, that you could envisage integration of budgets. I am struggling with how you do this. How are you going to integrate budgets that are largely budgets for publicly funded social care, on a means-tested basis, with the NHS budgets? Let us take Manchester. How is this going to happen in Manchester? How will you integrate those budgets in real terms?

Steve Webb: If you take the analogy with the pension system that we have now, you have a role for the state and a role for the individual. The state is providing a baseline level of provision, but most people would not be satisfied with the baseline level of provision, so we have auto-enrolment to workplace pensions, which enables most people to do more and get something better in retirement. We all expect acute healthcare to be there and not be means tested, et cetera. We expect a basic level of social care to be there for the destitute and so forth.

However, we might also want individuals who want something better, who want choice of provision, and maybe want to access it earlier than the state will allow them to, to self-provide. The state is providing the safety net, which is pretty comprehensive for acute healthcare, but the private market is buying you quality and choice. That is analogous to what we have in pensions. We can bring in another pot of money here, which is one that we have not mentioned so far, which is attendance allowance. Were I still trying to get elected, I would not say this, but attendance allowance is a complete nonsense, as you know.

The Chairman: Is that honesty on the part of a politician?

Steve Webb: It is the honesty of an ex-politician. I think of an elderly member of my family who got a few thousand quid a year of attendance allowance and did not spend anything on care. He qualified because he was not very well, but he was not spending anything on care. That was pure transfer. It is ridiculous that the DWP has that funding stream when local authorities and health could do a lot more with it. That might be a useful place to find some money that the Treasury might be interested in.

On your point about the insurance sector not being willing to come up with products, it is because they did not believe you, and they were right. You said, "We will do this thing, cap this thing, come up with some products", and they said, without moving their lips, "We do not believe you". You got the law through Parliament, and it still has not happened, so they were right. Do it, implement it, and the products will follow, but they do not trust you.

Lord Warner: They do not trust George Osborne, rather than—

Steve Webb: Sorry. Yes, "you" corporately, my Lord.

Q124 **Bishop of Carlisle:** Could I put a question to you, Lord Willets about generational equity? You mentioned that earlier, and it is obviously something you feel strongly about and it is important. How do we begin to ensure that in paying for health and social care?

Lord Willetts: The health service is disproportionately used by older people, and so be it: that is understandable and natural. It is social care where the issues are most explicit, and where we will either have to have higher taxes to pay for it, or draw on money that would otherwise pass on to children as inheritance. People want to discharge their obligation to the younger generation individually, by their own inheritance pot being passed on, but that is not the only way we should do it.

I personally think that the accumulated wealth of the baby boomers is now so substantial, in housing equity and other forms, that it is reasonable to use that to help fund social care. I, like Lord Warner, have observed over decades attempts at creating insurance products in this area. There were glimmerings: I think Norwich Union had one for a time, and then it pulled out of the market. It has proved very difficult.

I would look instead at easier ways in which housing equity can be used as a financing model for social care. It might even be that this is a role for Government in providing some kind of wider scheme, because that seems a way in which you would harness the wealth that this generation has built up.

Bishop of Carlisle: Thank you. Is that something you feel that we as a Committee ought to be pursuing in what we are suggesting here?

Lord Willetts: It is for the Committee to decide, but it would be a very useful line of inquiry, because this stock of housing wealth is very

considerable, and so far different schemes for housing equity withdrawal and mortgage schemes have had relatively modest effect. Whereas I am a pessimist about ever getting an insurance model going for social care, I am more of an optimist about accessing housing wealth if the right kind of model can be constructed.

There is a role for government in helping to promote that. There is a big issue of trust, and people not knowing what terms they will get from mortgage providers or other equity providers.

- Q125 **Lord Willis of Knaresborough:** One of the biggest issues this Committee is facing is not simply how can you get sufficient resources to meet sustainability over the next 10-15 years, but, given the variations that there may well be in economic activity, how do we ensure that that is consistent and that you can get funding certainty? Providers want more than anything else to know that there will be funding certainty, particularly for manpower, over a significant period.

On pensions, Steve, you were able to deal with a very tricky issue and, by creating the triple lock in terms of pension policy, were able to get some certainty, which then encouraged, for instance, the new comprehensive pension policy. I wondered if you could transfer your mind to the NHS and say whether that same approach is possible with the NHS and with social care funding. Irrespective of where the money comes from, could you put those mechanisms in to create certainty over a period of time?

Steve Webb: You certainly hear the plea for policy certainty in the pensions world all the time, particularly with regard to tax relief, where every six months we get speculation about change. Pensions and health are long-term businesses: how can you have policy certainty? It is funny that in pensions, commissions seem to have worked, and in long-term care they seem to have failed, for various reasons. I have asked myself repeatedly why. The Turner commission, which led to auto-enrolment and so on, was a triumph, in my view. What was it that it did that the royal commission did not do—that Andrew, Lord Lipsey, Lord Warner and their colleagues did not? Why did that not fly?

The thing about getting long-term stability of policy in pensions was that there was something in it for everyone. If I think about automatic enrolment, the trade unions were happy because they were getting mass membership of lower-paid workers. The CBI liked it because most of its members were already paying in and were competing with smaller firms who were not. The Treasury did not like paying tax relief, but was potentially saving itself long-term costs, because if we all retire poor, the state picks it up.

You saw all the different players, and there was something for everybody. Auto-enrolment was a dirty great compromise: everyone had to give something, but everyone got something. Whatever you come up with on your Committee, if it is just going to the Treasury for money, you are wasting your time. However, if the Treasury can see something in this,

you have a chance of buy-in from the Treasury and of something happening. You need something that would encourage more self-provision: quality provision for those who cannot, but enabling and encouraging people who could provide for themselves to do so.

Once it has happened, the momentum keeps it going and gives you a chance of policy stability, but until you can get something where there is something for all the parties, you will just have another initiative, another report and not get anywhere. Give each party something to gain out of this, and build people to advocate for your package: "Local government likes it because of this; the NHS likes it because of this; the Treasury likes it because of that". There has to be something for everyone in it.

Lord Willis of Knaresborough: David Willetts, you seemed to indicate in your introductory remarks that there was a way of linking the triple lock on pensions, with this issue of long-term care, at least, and to be able to do something in a combined way. Could you just perhaps expand on that?

Lord Willetts: My thinking there was that the triple lock is extraordinarily generous to pensioners. When I look at what is happening to the value of the benefits for working families, compared with what is happening to pension income through the triple lock, it is a conspicuous example of unfairness between the generations. However, politics is politics, and you cannot expect our successors, as democratically elected politicians, to be kamikaze pilots.

Lord Willis of Knaresborough: I thought that was the rule now.

Lord Willetts: How do we make it rational for a politician to go into the next election without repeating the triple lock in its current form? We are looking into this at the intergenerational commission at Resolution that I am chairing: can you have some other kind of triple lock, where you reduce the extreme generosity on the pension income, and offer some other feature instead? I think the biggest anxiety is around social care, so you would offer something around social care, which would be Dilnot-type. We got quite close to implementing Dilnot. The problem with Dilnot was that there were some political anxieties that the cap would be exploited by opposition parties and would be thought to be very tough on older people.

We got quite close then. I was trying to think of a way in which a politician would say, "We may not quite be able to afford the full-blown three-part triple lock for the value of your pension. We will still give you something there—earnings or prices—but in addition this is our promise on social care". The promise on social care is that if your income is below a certain amount, you will get help. Who knows what the alignment of political forces is? But if you were trying to avoid making that pledge in the next manifesto in its current form, this might be an alternative pledge that was sellable. I am trying to think of a political model that would work.

Q126 Lord Lipsey: The trouble with that is most people think social care is free anyway, so the offer is not a very good one. In a similar vein, on the idea that you get quality if you pay for it yourself and not quality if you get local authority: these are usually the same homes. You might get a slightly smaller room if you are paid for by the council than if you are a private payer, but you get the same people looking after you. What you are paying for is a whacking great subsidy from the self-funders to the council, not improved quality. These are not as clearly attractive, politically and to individuals, as you perhaps think.

Lord Willetts: May I make a quick comment on that? I would be open to seeing the opinion survey evidence. However, one of the advantages, and one of the reasons why it should be possible to make progress on social care, is that people, I thought, contrary to Lord Lipsey, do understand that it is a mixed market. That is why there is a fair amount of private payment for it already. It is one of the reasons why I do not want to integrate it into the classic NHS model. There is already a fair amount of private spending, and people are very aware that they may have to use up resources to pay for it. We are halfway there.

Steve Webb: Can I just chip in very briefly? Something that astonishes me about this issue is that we are always told the over-85s are the fastest growing section of the population. You might imagine, pro rata, there would be a surge in the number of people in long-term care, but it is static. It has not gone up at all. Clearly access is being rationed more and more toughly. Another thing that self-funding buys you is earlier access. The council is now setting the barrier right up here; it must be, because there are far more people potentially accessing the system, and yet no extra people getting into it.

The bar is being set higher, so, again, self-funding gets you in sooner. While it is clearly true that there are homes where there are those who are council-funded and self-funders, I think that is breaking down. We have people who had council contracts handing them back, and care homes now not taking local authority. That division is growing.

James Lloyd: I certainly like David's overall political strategy of saying, "Is there flexibility in future around the triple lock, if we take off the 2.5% guarantee but replace it with some other guarantee?" Having worked on social care policy, I suppose I can see many limitations to linking that guarantee to the social care system. There is no one social care system in England; there are 152. There is massive variation across local authority areas. People do not understand the social care system or the concept of needs assessments.

It is also very tricky, because, as Lord Lipsey has alluded to, if you are going to try to insert in there some improved partnership offer, such as a Dilnot model, around the balance between the state and the individual in paying for care, you are up against people's ignorance of the current system. As alluded to, most people think it is free. Any other model that we might come to will still be quite tricky for people to understand. The

Government announced the cost-cap reforms, but it was never clear to me how many members of the public understood them.

If you wanted to think about what else might be the third component, or the new third component, of some sort of triple lock, you need to look across the full gamut of public spending on health and disability in the older population, and think, "What reaches far more people than the social care system? What is consistent, understandable, popular and navigable?" That is the attendance allowance system. I know that the attendance allowance system has its critics; we had some comments from Steve earlier.

However, it is far and away the most popular bit of public spending on social care and disability. It reaches significantly more people, and people understand it; it is consistent. Many people do not spend it on social care, because it is not for social care. It is to assist with the cost of living with a disability, and to take your quality of life up, in theory, to the level that somebody else would have if they did not have your level of disability. It strikes me that that, in some rebranded form, perhaps, could form the basis of a new triple lock.

That does, in a way, take you into another discussion that might be worth exploring, which is around the state pension and whether or not we have, if you like, a disability-linked component of the state pension, which effectively is what attendance allowance is, by another name.

Lord Bradley: With the new triple lock, would that be regardless of other income from other sources?

Lord Willetts: The short answer is that for the social care element, if that were the third part of the triple lock, I do not think it could be. You would have to have some element of a Dilnot-style means test. You would be saying that if your income had fallen below a certain amount, at that point you would be helped. It could not be universal.

Lord Bradley: With pension freedom, would there be an incentive to reduce your pot to get into the new triple lock at an appropriate point to get access to better social care?

Steve Webb: That was an argument with the pension freedoms themselves under the current system. The trouble is, if you are 55 or 58 or 63 and you are not going to incur catastrophic care costs until you are 80-odd, are you going to blow your average?

Lord Bradley: That is the unknown factor.

Steve Webb: It is peripheral.

Tom Kibasi: The issue that we are getting into here with the discussion on the triple lock is that the true driver of the intergenerational inequity is wealth inequality rather than income inequality. That is the bigger element in all this: the extraordinary rise in house prices and the inability of young people to get on to the housing ladder. As we have the

discussion, our pensions, from an international perspective, are not excessively generous. There are a lot of people for whom getting old meant growing poor. We should be a little more focused on where the real inequity is, and it feels to me that that is in wealth rather than in income.

We should be coming up with models that are more around releasing some of the accumulated wealth of that generation, rather than trying to unpick a triple lock that politically, with the differential voting rates between my generation and perhaps the generation of many of the people on this Committee, would be rather tricky. On the NHS side of funding, I am broadly supportive of what Frank Field has talked about regarding using the national insurance system. I would quibble with some of the details, but broadly that direction of travel, so that the NHS has a more guaranteed income, would be important.

On the stability point, it is not the total aggregate spending of the NHS that providers are worried about in terms of the settlement. What makes it very difficult for providers is not whether the NHS budget as a whole goes up year on year. It is the arbitrary nature of commissioning decisions. The more disaggregated the commissioning is, and the more you have a completely amateurish approach to commissioning, which is the system that was created by the gentleman amateur of GPs doing this, the more you have completely arbitrary decision-making. I am on the board of a mental health trust. Every year there is a huge fight about the total amount of expenditure, because of the arbitrary imposition of saying, "You have a block contract, so we thought we would cut it 5%". It is much more about how you have a rules-based system within NHS funding streams, and a bit less about the predictability of the aggregate spending figure. The big issue, as you heard evidence on earlier, is how, in total, the NHS funding evolves in a pattern that is less moving forward in jerks, where you artificially suppress it and then the case becomes overwhelming to address the suppression of expenditure. It lurches back up, and moving in those lurching cycles is something that Frank's proposal might go some way to addressing.

The Chairman: Lord Warner, your question might have been partly answered, but do you want to ask it?

Q127 **Lord Warner:** I do. I want to pursue this a bit more. I have been writing down bright ideas for cracking social care funding. We have on the list: attendance allowance, housing assets of the baby boomers, and I have written down whether auto-enrolment can be made to work for social care, and the Japanese Government's levy from a given age for social care. We are fishing around for sources, in a market where there is already a degree of public acceptance of meeting some of the costs if you can afford it. They all seem to require some kind of cap on catastrophic costs to go in that direction. That seems a given.

What about auto-enrolment? People have got used to it; can it deliver some social care money? What about the Government taking money off people from a given point in the age cycle to fund future social care?

Baroness Blackstone: Can I just add a question that relates to what Norman has just asked? We have been told by some other witnesses that introducing national insurance payments for pensioners, which is a form of government levy, to contribute towards social care costs and indeed health costs for the elderly might be a way through some of this.

Lord Willetts: It is a very peculiar feature of the current system that working pensioners are not paying employee national insurance. It is not a massive sum, but it would be an obvious way of tackling several problems and inequity in the current arrangements. It would be a source of some public funding that you could use. Lord Warner mentioned Japan; I was not aware of the Japan model, but something along these lines was done in Germany. You need an input of public funding; you need an explicit recognition that you will expect people to use some of their housing wealth.

You could imagine some rewards of larger amounts being passed on tax-free to heirs if the rest is made available for housing. You have a Dilnot-type structure, and you put all this within the framework of an updated triple lock, and you begin to see something. It is not neat but it incorporates several different factors, and you could have a deliverable proposition there.

Steve Webb: On levying national insurance, on the pension levy, one can see the anomaly, but the other bit of my brain is telling me we want people to work longer—we want to encourage not discourage. Just at the point when the Government are saying, “Voluntarily work beyond the state pension age”, and all that, to then say, “But if you do, we’ll take another 12% out of your pay”, for me sends the wrong message.

You do not get a huge amount of money; you get some money, but just at the point where pension ages will be rising and rising. If you do put pension ages up to the late 60s, which is where we are heading, you will not get much money from NI on pensioners in their 70s anyway. On the politics relative to the revenue, that score seems completely wrong to me. I am not convinced by that. Auto-enrolment is a fantastic mechanism, and there are probably about seven things you might want to have in the queue to graft on to it.

Probably, if I did not work for my present employers, I would put life insurance first, because you can do it for 10 million people just like that, and it costs threepence-halfpenny. That would probably be the first thing I would do. Long-term care: you could, but you would have to be an awful lot clearer what on earth you were insuring. Okay, I now have cover, but what is this thing? I am 51; I might not need this thing until I am 87, so you are telling me that you will just take some more money out of my pay packet, and in 36 years’ time I will get something.

I am absolutely convinced that what you have to do is play to my selfishness. I am a very selfish individual. I care about not losing my parents’ home. I do not care about my care costs in 36 years’ time; I

want my share of my parents' home. If you ensure that, I will vote for you, if I could.

Lord Warner: What about starting taking the money at 60, not 40?

Tom Kibasi: I rather like this idea of an age-related levy that kicks in at a certain point in life, so long as it is a levy that applies to wealth rather than income. If it were just an additional tax, people would see it as an additional form of income tax if it were applied to income. However, you could say, "From 40 or 50"—I am not sure what the right point would be—"your assets over a certain sum will be taxed at 0.5% or 1%, and that will go into a fund to pay for social care".

I am not saying it would be easy, but compared with a vision of people saying, "Will I lose my whole home?", having to contribute a bit of the assets every year would be, in equity terms, far preferable, and it might just open up for the first time that discussion that we need to have as a country, which is about inequality not just being about income but about wealth, and it ties it to a very particular issue. It is one that is definitely worthy of being explored further.

On the anomaly of national insurance, I have to say I rather agree with David rather than with Steve. I would correct it, because it is a pot that you could access. The way that things are currently done seems pretty unfair. I do not think it would be vastly controversial, because the inequity of it is pretty blindingly obvious. I do not think there is a real disincentive. My dad has worked until he is 75, and he keeps promising my mum that he will retire this year. He has said that every other year for the last 10 years.

I do not think it will be a real disincentive for people to continue working. I do not think at the moment it factors very much into the conversation as to whether people continue to work or not. It feels like a modest and reasonable thing to do, which I do not think would be politically impossible. It might cause a bit of noise, but it would be very marginal. It would raise a very modest amount of money, but that is the way it goes—not a huge amount of money, not a huge amount of noise but probably something that you should do.

Steve Webb: If your Lordships remember the omnishambles budget of 2012, there was the granny tax. Do you remember what the granny tax was? It was simply not putting pensioner tax-free allowances up in line with very low inflation. There was an outrage: "The Granny Tax!" I remember being harangued in the streets about it. You are suggesting that we can just dib 12% of the income of the working pensioners and get away with it.

Tom Kibasi: Were we to decide that we cannot do anything and that this is a portion of the population that do not need to contribute, and meanwhile there is a whole generation of people who are saying, "I do not have any job security, I cannot buy my own home and I cannot start a family because politicians do not have the guts to take simple, small

measures", why not just give up and go home? I cannot comprehend how a small, modest change is something that we decide is politically impossible. In which case, why did we decide that we are in this discussion on public policy, full stop?

Lord Willetts: I would rather do that than get rid of the attendance allowance.

James Lloyd: When the issue of older people's housing wealth has come up in the debate over the last decade, inevitably we have discussed it generally in terms of taking the tax, hypothecated for social care or otherwise, at the point of a transaction. It is not saying to people that because they are retired and own their own home, which is worth more than £200,000, we will add a social care levy to their income. It would effectively put up income tax. I do not think that would be politically tenable, but when people die and pass it on they could pay an additional form of inheritance tax for social care.

That is why it has featured in debates so much. Of course, when homes are sold and people downsize and so forth, there may be scope for some sort of capital gains levy for social care there, for people in retirement.

The Chairman: Baroness Blackstone, we had better get to your golden question, because I know some people have to leave.

Q128 **Baroness Blackstone:** Can you each suggest a single change that the Committee could recommend that would help the sustainability of the National Health Service?

Lord Willetts: One thing we have not talked about, and which I care about, partly from my background as the Science Minister, is the difficulty of getting innovation into the NHS. It was deeply frustrating that people with smart ideas, when they wanted to get into a healthcare system, moved to Boston or to the west coast. The NHS is a slow, late adopter of innovation. It seems to be a management challenge: shifting to a new way of doing things is hard to organise.

Even with social care, I look at some of the extraordinary advances in technology, where they can literally track your pattern of electrical use. They can work out when you are turning on a particular device, and register that this person is turning on a kettle between 9.30 and 10 and she has not turned it on and it is 11, just by monitoring the electricity supply. We need to use technology and embrace the capacity of innovation. We experimented, and one way of making it happen is a list of required innovations that healthcare providers are expected to introduce.

The Chairman: That was a good way of fudging the issue about funding.

Lord Willetts: It is not a bad answer. I am standing by it.

Steve Webb: I would start the Dilnot clock running now, not because we are worried about people spending £70,000-odd on care in 10 years' time, but because we need to know when people start having care needs. We need to intervene early. Prevention, prevention, prevention is the answer to all this stuff. We are obsessed with the glossy acute stuff, and it is on the telly all the time, but getting in early—early intervention and prevention—is the only way to have a sustainable health and social care system.

James Lloyd: I will not speak to the NHS but to the social care system. Where can savings be made? I will give you one idea. I would digitise the attendance allowance records for the entire country, and I would share that information with local authorities. Why would I do that? At present we have a couple of hundred thousand people in the social care system in England. There are well over 1 million who receive attendance allowance. At the moment, we take their information; we require them to complete a form and provide details of what conditions and what support they have.

Having obtained that useful really information that could be used particularly for preventive interventions, we apparently—the last time I checked—take those forms, put them on a shelf in Blackburn and leave them there. A very simple thing to do to make better use of the attendance allowance system, to significantly extract more value for it, would be to digitise those records. You would have to put in the relevant necessary data protection safeguards and so forth, but I think most people would be happy for their data to be shared in return for some money that they will get each week when they apply for attendance allowance.

You could hand that information to local authorities, so that we can stop finding out who receives AA only when they turn up at A&E, which tends to be the case for local authorities at the moment.

Tom Kibasi: On the financing question, I would move to a hypothecated NHS tax, by moving national insurance on the overall financing. In terms of the sustainability side of your question, which effectively is how you can slow the growth in demand, and how you can ensure you have the most efficient supply, I would pay for innovation, and use big data to change the equation in care.

The way you do that is to pay for best practice. That means you also have to stop paying for poor practice. We need a fundamental reinvention of the delivery model. We have had 1,000 years of hospitals and doctors' offices, and it is about time we changed that. We need to spend a huge amount to rebuild the infrastructure, particularly in primary and community care. Thirdly, we ought to invest in healthy cities and, as you do your report, I would encourage you to have a look at the *Better Health for London* report of the London Health Commission in 2014, which starts to look at how you can use cities to drive better health in the population.

You have to disentangle these two things: how you provide financing for the NHS, which I would say is moving to a more automatic basis by using

NI on a hypothecated basis; and how you make it sustainable, which is lower rates of demand and more efficient supply. You should look at those things quite separately.

The Chairman: Thank you very much for coming today to give evidence. You have been most helpful, and if you have any further material you would like us to have, please feel free to send it. Thank you.