



Select Committee on the Long-Term Sustainability of the NHS

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

Tuesday 20 December 2016

12.10 pm

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Members present: Lord Patel (The Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Warner; and Lord Willis of Knaresborough.

Evidence Session No. 36

Heard in Public

Questions 328 - 333

Witnesses

I: Nicholas Timmins, Senior Fellow, King's Fund and Institute for Government and former Public Policy Editor, *Financial Times*, Denis Campbell, Health Policy Editor, the *Observer*/the *Guardian*, Professor Richard Horton, Editor-in-Chief, the *Lancet*, John McDermott, Public Policy Editor, the *Economist*, and Alastair McLellan, Editor, *Health Service Journal*.

Examination of witnesses

Nicholas Timmins, Denis Campbell, Professor Richard Horton, John McDermott and Alastair McLellan.

Q328 **The Chairman:** Gentlemen, thank you for coming to help us in what I think will be the final session of our evidence taking, but I cannot be sure of that. Thank you for coming today. We are very grateful that you have found time from your busy journalistic duties to come and help us today. To start with, it would be helpful if you could introduce yourselves, starting from my left, and if you wish to make a very brief opening statement, please feel free to do so.

Nicholas Timmins: I am Nick Timmins. I was the public policy editor of the *Financial Times* for many years up to 2012 and I am currently a senior fellow at the King's Fund and the Institute for Government.

Denis Campbell: I am Denis Campbell, health policy editor of the *Guardian* and *Observer* newspapers.

Professor Richard Horton: I am Richard Horton, editor of the *Lancet*, and I have a particular interest in international health systems.

John McDermott: I am John McDermott, public policy editor at the *Economist*.

Alastair McLellan: I am Alastair McLellan, editor of the *Health Service Journal*.

Q329 **The Chairman:** I know that you are all used to having quick-fire questions and quick-fire answers. With five of you and 12 of us, we need to manage the time well and get through the questions, because we need a lot of information from you. Let me start off. With your experience and knowledge of the public's views about health and social care, how do you think the public attitudes to health and social care in all its aspects have changed? How engaged do you think is the public's mind about health service and social care issues? How has this trend changed over time?

Professor Richard Horton: Shall I start off? What we know from the British social attitudes survey, which has documented this very well over the years and has been analysed by the Health Foundation and others, is that there is incredibly strong public support. Nine out of 10 people strongly support a tax-funded free at the point of need health system, but that satisfaction with that system is falling. In 2015-16 satisfaction fell by 5% to 60%, and dissatisfaction rose by 8% to 23%. Satisfaction varies across the different parts of the health service. Some 69% are satisfied with general practice services but only 53% with A&E. We are seeing a very dynamic environment for the way the public view health. While they are very supportive of the NHS, they are also very concerned about the direction it is taking.

Denis Campbell: I was going to mention some of the same statistics. This is a slightly less scientific answer than you might want, but my

anecdotal, impressionistic response is there is a gap between the emerging realities of the condition in which the NHS finds itself and patients' experience of it—missed waiting times, visible lack of funding, running out of paediatric intensive care beds, having to send young people with life-threatening anorexia to Scotland rather than England and so on—public opinion, because it is clearly rising in the index of public opinion, and government action.

Nicholas Timmins: One of the things about the satisfaction figures, particularly the British Social Attitudes Survey, is that there is always quite a long lag between what is objectively going on in the health service and these numbers. For example, in the 2000s, when money was pouring into the NHS and the service was clearly getting better, it took quite a few years for satisfaction levels to start to rise and they come down quite slowly when the service gets worse, so there is an odd time-lag effect that I think you need to take into account.

As to attitudes to health, health is famously the closest thing that we have to religion. There is still incredibly widespread ignorance about how social care works. It is quite stunning, because there has been plenty of debate about it over the years. Lord Warner will know these figures better than I do, but if you look at the Dilnot research, 60% or 70% still think it is free; they do not quite know what is coming until it hits them.

Alastair McLellan: It is almost as if the public do not read newspapers any more, is it not?

John McDermott: I do not think we really know what drives the satisfaction figures, so we should be cautious in assuming that when they are high everyone is happy with the NHS at that point in time. I suggest they perhaps combine a feeling that people have about their experience of the performance of the NHS in practice with their views of the NHS in a more abstract way. There is perhaps some evidence from Scotland, where performance is not that good but the perception is that the NHS as an institution is under threat, that happiness and satisfaction with it and belief in it remain high. I do not think we should just start looking at graphs and say, "This is going up, so everything is okay".

The Chairman: Something else brings happiness to the Scots.

Lord Kakkar: Is there any evidence that the satisfaction rating makes it easier for Governments to direct more funding into the provision of health services through increased taxation, or is there no relationship between them; or, as a corollary, that if there is less satisfaction people want to pay more?

Professor Richard Horton: I am not sure there is true cause and effect, but it is interesting to look back to 1997 and see that public dissatisfaction with the NHS was then 50%. Now it is in the lower 20 per cents, so you wonder whether that very high level of public dissatisfaction in 1997 was a cause of greater investment in the NHS by the Government at the time. We have to go back and look at the history of

what shaped those decisions. I am sure there is a relationship, but it will be very complex and likely non-linear.

Alastair McLellan: When I talk to policymakers about decisions they make about funding, they do not talk a lot about the social attitudes survey; it is not very prominent on their radar. Perhaps it should be, but in the job I do I tend to judge it as much by what people do not talk to me about as what they do talk to me about. I would not say that in the social attitudes survey public concern about the NHS in general is very influential on policy. There is concern about specific issues—A&E waiting times is a classic example, and GP access is another, although they are very different factors—but I would not say that general attitudes towards the health or otherwise of the NHS prove to be a very big influence on health policy, as far as I have seen.

Lord Willis of Knaresborough: I have two very brief questions. First, is it clear to you who is driving change and improvement in the NHS? Secondly, do you think the NHS is too big to succeed?

Professor Richard Horton: I do not think it is at all clear who is driving it, because we have such a fragmented crazy system. We have what feels like dozens of royal colleges multiplying almost every year. We have outsourced a lot of work from the Department of Health to independent organisations, many of which do a great job, but we have no overall governance. For many of us close to the system we have not seen NHS England become a wild success in being able to co-ordinate those different fragmented elements together into a unified strategy, despite the best efforts of Simon Stevens.

Alastair McLellan: I disagree a little with Richard. There is an awful lot of innovation and endeavour going on, and the fact that it is not as directed by the centre as it was in the noughties is a good thing. I think there is more innovation going on at the present, despite the lack of money—certainly, lack of money is not a good thing—than there was in the noughties. In the noughties they were back-filling decades of underinvestment, so there are reasons for that.

On the question whether the NHS is too large. There is a criticism that it is too large but also that it is too fragmented and broken up into too small parts. Having heard this debate over and over again in many different forms, it strikes me that it will always be so and it is about getting the balance right and central bodies as well as local ones taking the appropriate actions.

This morning we have been talking about investment in technology. It strikes me that there are two things that drive change in technology. In the private sector it is the profit margin. If Tesco introduces a new form of till technology, Sainsbury has to move very quickly to respond; otherwise, it will lose business instantly. I do not think we want to be introducing the profit margin in the NHS. The other thing is to have some kind of national programme for IT. It did not work so well last time, so there is no simple answer here. As I think a lot of people have said this

morning, it is a management problem; it is something you have to manage week in, week out, month in, month out, and make the appropriate decisions. NHS England is still a relatively young body, but it is getting better at that.

John McDermott: I am not a full-time NHS reporter. I cover education as well and in countries outside the UK, but whenever I do report on the NHS I am struck by how the name is such a misnomer. This is an utterly fragmented system. I do not think that is a bad thing per se; it is a bad thing only when people get confused. When there is an assumption on the hospital floor that this is a simple command and control system, or one of markets, in that confusion bad policy is made. Following what Alastair was saying, NHS England is effective when it knows what it is responsible for and what it can achieve and what it does not.

One other thing I am always struck by is the degree to which, even when there is very little relationship between what NHS England can do and the effect on the ground, there is belief in what it can do. Often, you will find hospital officials or doctors and nurses almost waiting for an announcement from on high, even when the means of achieving that are not there. Planning is okay, but you cannot expect them to plan absolutely everything.

Q330 **Bishop of Carlisle:** I would like to return to the question of funding. Almost everybody seems to agree that it would be good if more money went into the NHS, but not everybody wants to find that money themselves; they feel it should be coming from somewhere else. Various witnesses we have seen over the past few weeks have suggested different ways of funding the NHS, including direct taxation, hypothecated taxes, statutory insurance and so on. From your experience and what you have picked up about what the public generally feel, which funding system do you think would be most acceptable?

Alastair McLellan: I imagine it is the one that has the smallest impact on an individual's income.

Bishop of Carlisle: Which would be what?

Alastair McLellan: It is different for different people. The system of funding for the NHS is not broken; it needs good stewardship. The system of funding for social care is broken and needs reforms, and you have heard during the course of your inquiry from many people more knowledgeable than me, and if I may say so my colleagues, on what needs to be done on that front.

Professor Richard Horton: I completely agree with Alastair. It is instructive to look, on the social care side—I know you have heard evidence about this on many occasions and I will not repeat it—at the political challenge Japan faced in the late 1990s. How did it build public consensus for greater investment in social care? They could not do it through a tax-funded system, but they went for the model of long-term care insurance and were able to bring the public with them, solve an

acute political challenge, given the demographics, and implement a system—do not get me wrong; they had to modify it along the way—that has been extremely successful in bringing more money into social care and enable planning in the long term. I submitted an article to you which we published in 2011 on an evaluation of the Japanese experience. It might be well worthwhile looking at that experience and thinking about that.

Bishop of Carlisle: That is helpful. One of the other questions I wanted to ask was about how we best engage with the public and have exactly the kind of discussion you are mentioning. You are reckon there are lessons we could learn from the Japanese model.

Professor Richard Horton: Very much so. This is a very carefully planned and implemented model. It was not done quickly; it was done with a great deal of thought and with course corrections along the way, as they understood that it was 20% more expensive when they introduced it than they had originally planned. They had to make adaptations, but they have done it with remarkable public consensus.

Bishop of Carlisle: Was that done primarily through the media? How did they set about it?

Professor Richard Horton: The Government tried to create a national conversation by talking about the challenge: an increasingly aging population and a declining cohort of people coming in to provide the tax base. By that political leadership they were able to build a consensus when they implemented it in 2000.

Nicholas Timmins: Looking at the health side, I would urge the Committee not to go down the road of saying that we should replace it all with social insurance, because frankly, at a very high level there is very little difference between general taxation and social insurance, and it would be a huge distraction. The great advantage of general taxation is that you have the widest possible tax base, whereas with classic social insurance you have employers and employees and you are making it more expensive to create jobs. By and large, in a globalised world you should make it as cheap as possible to create jobs and tax the wealth they produce. Social insurance tends to move against that. That does not mean that there might not be a role for some form of social insurance to tackle some of the social care stuff, but I would not go down that road for the entire health and social care system.

Baroness Redfern: Going back to Richard, we cannot compare like with like with Japan, because it does not have such an elderly population and it is declining as such. I think 40 year-old people pay an extra amount.

Professor Richard Horton: It is 1% of their earnings.

Baroness Redfern: Yes, and there is a 50:50 split with employers. That is how their system works, but they do not have the growing elderly population that we are going to face.

Professor Richard Horton: They do have an elderly population.

Baroness Redfern: But it is dropping.

Professor Richard Horton: Yes, but they introduced it in 2000. It is seen as a very fair system. You have to fill in a 74-question form. You are then categorised into one of seven levels to see what your eligibility criteria are and the services you get out. All of it goes to an expert committee that makes the final decision. There is a very fair process. The public feel that it is broadly a fair process. It has strengthened social solidarity in Japan, because you become eligible when you are 65 and people start at 40. It has built a sense of community and commitment around the points that are taken into account.

Baroness Redfern: Do you think the general public would welcome that type of funding?

Professor Richard Horton: You have to be careful about cross-cultural comparisons. The Japanese family-based value system is different from the UK's, but they were able to build that political consensus.

Lord Lipsey: When we tried to build a political consensus here there were all-party talks. They were close to agreement, and then the Conservative Party put up a lot of posters referring to a death tax and that was the end of the consensus on social care. I think there was a consensus among politicians that social care is jolly difficult, because only one in three or four people will ever cash in for it, unlike health which we all use, and nobody wants to pay money in now to get something they may not benefit from in 20, 30 or 40 years' time. Therefore, it is not a natural solution to social care, but the consequences are absolutely frightening. We are guaranteeing aid, which is the most unpopular form of public expenditure. We spent £4 million on a girl band, if we believe yesterday's *Daily Mail*, and yet there is a 25% drop in people getting social care at home. How can we crack this completely disastrous failure to provide for the most essential social service you can imagine?

John McDermott: Going back to Nick's point, so long as there is profound ignorance about what you can expect in social care you can start proposing all the different solutions you like, but when nobody knows or believes there is a problem there will not be the political will to do it. One of the benefits that Committees like this can bring is to be a bit more specific about the problem, as opposed to a generic bemoaning of the unsustainability of the NHS. It is not really about the NHS; it is about healthcare more broadly and, in this particular instance, about social care.

Alastair McLellan: Indeed. The report from the OBR, shows that funding for the NHS is entirely sustainable. The NHS does not have a sustainability problem, if I may say so—a dangerous thing to say, given the nature of this inquiry—but the health and social care system in its totality definitely does have one.

Lord Warner: Can I bring you back to the Bishop's question? When I was a jobbing Minister there were two kinds of truths on which you could rely. One was that the public were totally preoccupied with ease of access to the NHS, and the other was that, if you were bold enough to raise extra taxation, it was easier to raise another pound for the NHS than for any other public service. I am not sure whether those truths still hold, which makes it quite difficult for politicians, because certainly the public seem much more critical of the efficiency and effectiveness of the NHS than they were back in my day. Do you pick up any changes around public mood and nervousness among politicians about those sorts of issues?

Alastair McLellan: I think that asking journalists about the public mood is a pretty dangerous thing.

Lord Warner: I have some belief in experts, but carry on.

Nicholas Timmins: I think you are slightly forgetting the past. We tend to wipe out all the horrible bits.

Lord Warner: There were lots of horrible bits.

Nicholas Timmins: If you go back to the late 1990s, there was complete turmoil around the NHS. There were people demanding a rationing unit at the centre, including people from the NHS, so you had to have a rationing body and rationing menus. The whole place was in turmoil. There was huge public dissatisfaction and worry about all of it. Blair had the most expensive breakfast in the world and pledged a lot of money and all that went away. Now we are coming round to another cycle of the same thing.

Professor Richard Horton: The public often have contradictory views about this when you ask. Half the public think that there is an enormous amount of waste in the NHS, but half the public are willing to pay more tax if you ask them to invest in the NHS. I am not sure you get a very clear answer to that question.

Lord Warner: Does that come out in your interviews with politicians? You are the people who are talking to politicians and trying to get their take on the world.

Alastair McLellan: You asked about access. It is interesting that yesterday NHS Improvement effectively downgraded the four-hour waiting time for A&E targets. It is still in there but it is now wrapped in with loads of other indicators. It is a pretty sensible move in my view, but you will know that in your day everybody fixated on the four-hour A&E target. Politicians in general are not quite as focused in a laser-like way on access issues as was certainly the case when you were a Minister. I think they remain fixated on patient experience, not necessarily patient outcome, because patients can measure their experience, but it is a lot harder for them to measure their outcome, because how do they compare it? They can compare their experience; they cannot compare

their outcome. They are not as closely fixated on access in that narrow definition we had in the new Labour years, but it is very much around patient experience. You see a lot of the Hunt approach to safety and quality and his redefining of the Health Secretary's role as being responsible largely for safety and quality, letting somebody else worry about the money.

Professor Richard Horton: I think they are also focused on money. When I speak to health politicians they always blame their Treasury spokesman. They would love to do a million things but they cannot, and they cannot talk about it because they are not allowed to speak about those things. That raises an important point about the role of health in our broader economy. I think we have the argument wrong. I heard Simon Stevens and Jeremy Hunt say in your last evidence session, "Thank goodness we have a growing economy to support the NHS". I think that is entirely the wrong way round. The latest economic evidence shows that investing in health, particularly the health workforce, which is the key here, drives the economy in multiple different ways. It is not just about a healthy and productive workforce; it has an effect beyond that. The caveat to saying that you invest in the health workforce is that it is not more of the same; it is not doctors and nurses but thinking about a completely different skills mix in the health workforce and new cadres of health workers. This evidence has come out since September, which I submitted to you, but a real revolution has taken place in the economic thinking around the role of the health economy.

Nicholas Timmins: We talk a lot about the NHS and whether we can afford it—that it is a burden because it is public expenditure. Let us do this thought exercise. Supposing it was entirely privately provided and financed—it was in the private sector of the economy and it was growing. We would see that as a good thing; it would be a growing industry that was doing well. So if people choose to spend more on it, why do we say that because it happens to be publicly funded it is a bad thing and a burden? It is worth thinking about it like that. If it was an entirely private sector business, more was being spent on it and we were getting more for it and employing more people, we would say, "What a success!"

Professor Richard Horton: For every job you create in the health economy you create two jobs outside it. That was work released by the International Labour Organization that looked specifically at the UK.

Lord Scriven: I am unusually suspicious of journalists, but I am warming to you guys. You have said that basically a paradigm shift has to take place here, and a question like "How do you save the NHS?" will not work. You have absolutely hit the nail on the head. If that is the case, what do you think is going to be needed, not just in funding but in policy, particularly where you are experts, and engagement and discussion with the public to get that paradigm shift, rather than a short term "We have to save the NHS"?

John McDermott: Let us remember the political context. You have a Government whose existence will be defined by getting out of the

European Union and the desire to mutualise the National Health Service, which they have done since 2010. The difficulty facing those who would want to persuade the Government about the importance of tackling the social care funding crisis is that the Government will be aware that by raising the salience of the issue they potentially attract criticism at a time when they believe that they do not have a lot of money and are busy trying to extricate themselves from the biggest mess in British political history since Suez. It is important to remember that context. Given the bind politicians will feel themselves to be in—that they are only ever being attacked on the basis that it is their fault for this and their fault for that—they might be more inclined to bury the issue than tackle it.

Alastair McLellan: To build on what John says, for the first time in 20 years we have a Government and a Prime Minister who do not consider the NHS to be a priority. There are perfectly legitimate reasons, including practical political reasons, for that. This is a Government who do not prioritise the NHS and are slightly irritated by the NHS's sense of self-entitlement that it has grown used over the past 20 years since new Labour came in. The Government have said, "On the one hand, we can put more money into the NHS because we realise it is an important topic, but we have no idea whether we will get any return on our investment, because it seems to us you can put a lot of money into the NHS and some good things happen but not everything does. What it does not do is stop people asking for more money—they carry on asking for more money—and we are not very confident in the NHS space; it is not our area of skills and expertise. Therefore, we will put our chips into Brexit and deal with immigration and concerns about that and the economy, because we are more likely to take that action and get this result"—that may be foolish, but that is what they think—"and it is also our skill set; we know our way round that". In summary, the debate that we are talking about, as John was saying, will probably not come from the Government.

Lord Scriven: We can put things in a report that will hopefully kick-start it, or at least light a fire. It is those kinds of issues that I am interested in, because clearly you are on that page in your understanding. What are the key issues or messages?

Professor Richard Horton: Can I give you one example of where it works very well but not in the context of the UK health system? I refer to the sustainable development goals for 2030 mentioned earlier this morning. That has transformed, as the MDGs for 2015 did, the entire global conversation about human development, specifically health, because of specific targets that have been set. All countries—194 nations—have signed up to those targets, and they have to be delivered. Suddenly, you have all these agencies and Governments running around thinking about how they are going to meet those targets, because you have league tables that show where you are and you do not want to be shamed in front of your neighbours.

In the UK context we have fantastic data. We can do forecasting, but we do not do long-term forecasting; it is very, very short term. Why can we not have a national SDG for health? Why can we not think out to 2030? There are all these nations that disagree about so many things, yet we cannot do it within our nation. There must be a way to do that. I do not think you can do it easily from the Department of Health; it is not independent enough. But why can we not create an organisation that has technical credibility and can set those long-term goals and keep a running commentary, and in the public mind, even when, as may well be right, Governments do not want to talk about it. The Institute for Fiscal Studies does an incredible job in being able to keep issues in the public consciousness because it is independent, credible and technical. Why can we not do that for health?

Q331 Baroness Blackstone: Can I come to the whole question of long-term planning? A lot of the people who have given us evidence have suggested that one of the current failures is that there is no long-term planning. We do not know what is going to happen after 2020.

Nicholas Timmins: I think long-term planning sounds great; it is very warming and all that sort of stuff. It is incredibly difficult to do because stuff happens. I am not saying that you should not do it. You should try to do a bit of it. You have to recognise that you will be wrong all the time. Look back at NHS history. If you had been trying to do long-term planning in the 1950s, it would never have occurred to you that over 30 years we would shut all the lunatic asylums because the drugs were not available to allow us to do that. If you do long-term planning in the 1980s, along come day surgery and keyhole surgery. You would need to be a genius to see these things coming. Clearly, it is sensible to do some broad forecasts about where we are going and what it looks like, but you need to be very wary about being deluded that you will get it right. Good stuff happens, bad stuff happens. Think about dementia for a moment. If someone comes up with a new drug that makes a significant difference but is not a cure, that will be incredibly expensive because of the numbers. Supposing someone comes up with something that halts it in its tracks. That will be incredibly cheap. It could be either; we do not know.

Lord Willis of Knaresborough: To follow that up, every major corporation in the world, including major supermarkets in Britain, works by having a database that is swift enough to move for market trends. Surely, a starting point in long-term planning has to be the sophisticated use of data that is fast and responsive so that whatever comes along, be it new disruptive technologies or whatever, you can respond to it because you have all your data there. Surely, we could all fight for that one.

Nicholas Timmins: I am not saying that you should not do it at all. I worry about putting too much faith in where it says it is going.

Professor Richard Horton: I broadly agree with that. It is absolutely true that there are new things that come along very quickly.

Lord Willis of Knaresborough: And you do not need data for it.

Professor Richard Horton: I am thinking of discoveries: new drugs or techniques that come through the pipeline.

Lord Willis of Knaresborough: But they will apply to people.

Professor Richard Horton: I absolutely agree, but there is planning that you can do. We have known since 1990 that we were building up multimorbidity in both mental and physical health. We have known since 1990 that dementia would become a huge crisis for us. Did we start planning for in 1990? No, we did not. Why are we talking only now about parity of esteem? Why are we talking now about dementia? We knew this a generation ago. The point is that there is no long-term planning, and we do not use the data we have because nobody is charged with it; nobody is given the locus of responsibility to do something with it. Nick is right: things come along, but for a lot of stuff we do know today where we will be in 2030.

Lord Willis of Knaresborough: The first question is: who should be doing that?

Professor Richard Horton: It should be Public Health England; it should be the Department of Health. Multiple bodies should be doing it, but they are so locked into short-termism and not given the political responsibility to do that. They should be doing it, but I do not know why they are not.

Baroness Blackstone: When you have a workforce, some take many years to be trained, but you do need to have some long-term planning to think through how you are going to divide up roles in the workforce and think through different ways of approaching how you prepare them for their jobs in the longer term.

John McDermott: You clearly want to think about what is going to happen in the long term when it comes to health needs, but that is different from having a plan to address individual policies. That can be dangerous, because sometimes if you have a plan and it is not a very good one sticking to it becomes more important than meeting the objective. I think a lot about how technology could change the health labour force. Like Nick, I do not know what is going to happen in 10 or 20 years, but even if a modicum of what some of the more techno-evangelists say will happen does happen, for example with diagnostic intelligence, it could utterly transform the role of the general practitioner—in essence, it could make its current form redundant—so we do not want to get into a long-term plan for X thousand number of GPs and prioritising that over a more efficient technology that could bring benefits to patients in the future.

Lord Warner: Is not what Richard was saying right? You do know what the demographic and disease profile will be in 20 and 30 years, and you know what your workforce does now, and you could make some reasonably intelligent judgments about whether, if you carry on that

workforce trajectory, it is likely to be a practicable or an inexpensive or very expensive way of dealing with your disease profile. We do not see anyone doing that and telling the public they are on the wrong trajectory for what is now inevitable. There is something pretty inevitable about the disease profile and demographics—they are going to happen, so that is a reliable area you can start from—and your point about goals seems to me important. Would you guys be writing about that if there was another body? You write about the OBR; you are interested in what it is saying and the Government are doing. Would you be interested in writing about whether an informed body was talking about this and whether governments were on the right trajectory to meet those goals?

Denis Campbell: I want to make a point about the potential of creating an OBR-style body to set goals and targets and monitor progress towards agreed health goals, acting as an honest broker with the NHS England, already atomised as it is, more so since 2012. I am loath to suggest the creation of a new body to add to the baffling, confusing array that we have already, but a body like the IFS that has clout, credibility and complete independence could also go alongside the great investment in more public funding, wherever it comes from, that Jeremy Hunt has said repeatedly will be necessary after 2020. That could all be part of the mission of renewing and repurposing the NHS for the times that we know we are soon coming into.

Alastair McLellan: I cannot think of a system that has as much scrutiny as the NHS already. You have Anita as your adviser; she produces incredibly good work on the long-term funding needs for the NHS. We know the answer; we do not need another body to create the answer. It is there; you have been presented with the evidence over and over again.

One of the advantages of the world in which we now operate is that we can see which articles get most read. We would all write articles about a health OBR. They probably would not be that well read, apart from a relatively small bunch of health policy geeks. I do not think it would have an enormous impact on policy decision making because of the political nature of the NHS. I realise that might not be an answer you feel comfortable with, but that is what I think the impact would be.

The Chairman: Surely, there must be a difference if an opinion given by a body set up through legislation and is independent rather than very efficient think tanks.

Alastair McLellan: You would think so, would you not? Just because something is created by legislation does not mean that anybody pays any attention to it. I refer to the Health and Social Care Act passed only a few years ago and now widely ignored by everybody, including the Government that created it.

Professor Richard Horton: I do not agree with this.

Alastair McLellan: I thought you might not.

Professor Richard Horton: This has to be framed with the word “accountability”. What is accountability for the NHS? There are three parts to accountability. First, you need to have accurate monitoring and reliable data, metrics and indicators to be able to track progress in various dimensions of what we say our NHS is. It is true that we have multifarious sources of that data, but there is no one place—an independent, authoritative technical body—where it is pulled together, so we do need an institution that is for monitoring. Secondly, there has to be transparent and participatory democratic discussion about what the data means. We do not do that because we do not have that monitoring centre. Thirdly, we have to act and do something about it, which is a remedy function. The three dimensions of accountability are: monitoring, reviewing and acting. We can start with the monitoring bit.

Lord Lipsey: The discussion about long-term planning is very interesting. I am thinking about what this body would have done 15 years before the Black Death. Would it have seen that coming? To take a perfectly realistic example, in 10 or 15 years’ time we may well as a society opt for widespread voluntary euthanasia. Some people think that is a good thing, some think it would be a bad thing, but given that two-thirds of health expenditure is incurred in the two years before death, it would clearly make an enormous difference to the economics of the health service. Do you not think that some of this planning idealism should be taken with a very large pinch of salt, because very large disruptive forces can come along and turn this into nonsense?

Professor Richard Horton: But if we are planning for, say, more people living with dementia in 2030, 1,500 extra doctors a year is not going to solve that problem, as wonderful as that might be. We have to train a completely different cadre of people who will be able to respond to the physical and mental health needs of that group of people. We should be planning for that now because we know it will hit us. It has already hit us. Are we planning for it? Nowhere near enough.

Q332 **Lord Bradley:** Do you see that as the biggest threat to the long-term sustainability of the NHS and social care, or are there other factors that you would want to put on the table? Can I abuse my position by asking you, as we are coming to the end, whether you see devolution, such as in Greater Manchester, as an added fragmentation of the NHS and social care, or an opportunity to reconnect and make coherence out of a fragmented system?

Alastair McLellan: If you look at what is happening across the NHS through the lens of the STPs, although not a perfect lens, there are parts of the country forging ahead. Manchester is one of them and there are various other parts of the country where that is happening. I will not list all of them. They are parts of the country that always seem to do well under any kind of system, and it is good. Therefore, for those parts of the country you should devolve to them as much as you can to. If you do not mind my saying so, that is not the problem. The problem is those parts of the country—take the M25 ring for example—that are not high-performing health or social care economies, and never have been.

Devolution is unlikely to be the answer in that particular case, because effectively you are likely to be endorsing poor practice.

I think that for the best and most high-functioning healthcare economies devolution is the answer and we are seeing that happen now, but the really difficult question is what you do with those areas like the M25 ring which are not high-performing where devolution is not the answer because you are not starting from a good place.

Q333 Baroness Blackstone: If you had to pick out one proposal for change that this Committee might make, which would support the sustainability of not just the NHS but, to use Alastair's earlier phrase, the health and social care system, what would it be?

John McDermott: Before answering that, can I return to the question about whether we want an OBR for health? I implore you to think that analogy through properly. It sounds nice and reminds me a little of what people tend to do when it comes to a problem, which is to say, "Let the schools deal with it". If we are saying, "Let us hive it off into an independent technocratic body"—at a time when, by the way, the public seem to be getting quite annoyed with such bodies—it would seem to me quite an odd thing. Experts propose more experts.

On the OBR analogy in particular, it is an annual almost falsifiable judgment on decisions that are made and can be quickly interpreted as right or wrong, or dangerous or not. If we are talking about health, what is the equivalent of estimates of the deficit here? What is that body going to do? Saying we should have an OBR for health might make a nice headline for three people to read, but what does it mean?

On what this Committee can do, if there is one good thing it can do is probably be specific and raise the salience of the crisis of ignorance and funding in social care and not repeat the same clichés about there being a sustainability problem in the NHS more broadly.

The Chairman: Nick, let us start with you.

Nicholas Timmins: On the "OBR" bit?

The Chairman: We have probably killed that cat.

Nicholas Timmins: If you have killed it, I will shut up.

The Chairman: What would you like to say quickly about OBR?

Nicholas Timmins: On sustainability, I would echo a lot of what the previous witnesses have said. The big drivers around cost in the NHS do not lie within the NHS but within exercise, obesity and all the things the NHS picks up the pieces for without being responsible for getting it right in the first place. If you want to make the healthcare system more affordable, clearly one of the most important drivers lies outside the health and social care system.

The Chairman: As it is Christmas, what were you going to say about

OBR?

Nicholas Timmins: You have to be very clear about its remit. Someone mentioned setting targets. First, politicians will not let an independent body set targets for health and social care. Secondly, I worry about its actual influence. Can I give a parallel? Take NICE; its remit is that when it says that the NHS should adopt a new technology, it has to. Therefore, there is a direct connection between what NICE recommends and something happening on the ground. It also has responsibility for social care. It produces guidance on social care. It has no mechanism for implementing its guidance; it just sounds nice. In its previous report it said that we should not have 15-minute visits, which we should not, but there is no mechanism to translate what NICE says about social care into action.

If you take all the big issues that we have been talking about, we know what they are. The problem is getting people to do it. Clearly, it is a huge challenge. We have known about the social care problem for 20 years; we have known about mental illness. One goes back to Barbara Castle and the Cinderella services in 1975. The problem is getting something done about them. It is not that we do not know about them, so I am not quite sure what another body adding all this up would bring to the party.

The Chairman: Denis, what do you say in response to Baroness Blackstone's question?

Denis Campbell: There needs to be a recognition among politicians of all parties that ill health is starting to overwhelm the health service. Therefore, the prevention of that should self-evidently be regarded as an absolute key priority of government, whoever happens to be in power, and should be treated as such. The gap between the evidence and necessity for provision is wide and growing in the wrong direction. That should be the No. 1 priority. The NHS is visibly, almost on a weekly basis now, straining uncomfortably to keep up with the demand. We know from the demographic projections and so on that trends in COPD, obesity, cancer, diabetes and the whole slew of things we know about will continue, and yet the NHS's capacity to give people what they need when they need it, and as good as they need it, is, sadly, increasingly found wanting. We need to make the prevention of ill health an absolute national priority. I am not going to propose a body, but we need someone in government to progress chase it and assess almost every government policy. Will this improve the prevention of ill health? Otherwise, we will be overwhelmed.

Professor Richard Horton: Do not give up on a post-fact world. Facts are still important. More importantly, we need radically to change the economic arguments about health and social care. Health and social care are not costs to the economy; they are investment opportunities. Use the new economic evidence to show that by investing in the NHS and social care you will accelerate inclusive economic growth for the whole population. The best way to build sustainability is by making the direct link with the economy.

Alastair McLellan: I agree with all my colleagues. I make one plea. I am sure you will not do it, but please do not produce a report that bashes the NHS. Produce a report that recognises that, while the NHS faces many challenges, there is also an enormous amount of innovation, endeavour and improvement going on within the service.

The Chairman: We are not here to bash the NHS. Remember, we are the Lords Committee. We are here to help.

Alastair McLellan: Like us journalists. We are health journalists who are here to help.

The Chairman: Thank you all very much for coming today. We very much appreciate it.