## The Wanless Review 20 Years on: What can Policymakers Learn?

**Transcript of a witness seminar held on**

**19 October 2022**

**Edited by Richard Sloggett and Sally Sheard**

Acknowledgements: The convenors would like to thank the witnesses for their contributions.

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ISBN: 978-1-9999209-8-2

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**Instructions for Citation**

This document has been published online. References to this Witness Seminar should refer readers to the online version, following the format below: [Witness name], in R. Sloggett and S. Sheard (eds), The Wanless Review 20 years on: What can policymakers learn? held on 19 October 2022, published by the Department of Public Health, Policy and Systems, University of Liverpool, 2023, (page number of reference)

**Introduction**

In 2002 Derek Wanless published his first review into the long-term trends affecting the health service in the UK.[[1]](#footnote-1) The Review was commissioned by the Chancellor of the Exchequer following the announcement by the Prime Minister Tony Blair that the UK would increase health spending to the European average by 2005.[[2]](#footnote-2)

Labour’s 1997 election campaign had argued that there were 24 hours to save the NHS. But the 1999 winter flu outbreak combined with a 15 year high in other respiratory viruses, alongside stories such as those from Lord Winston[[3]](#footnote-3) about his mother’s care and Mavis Skeet – whose cancelled operations made her cancer inoperable – forced the Government to act.[[4]](#footnote-4)

As Timmins notes the spending commitment was ‘enormous’, amounting to 2 percentage points of GDP.[[5]](#footnote-5) At the March 2000 Budget the Chancellor announced spending increases of:

‘6.1 per cent average annual real terms growth over the next four years - the longest period of sustained high growth in the history of the NHS. It compares to an average of 3.3 per cent annual real growth since the foundation of the NHS and 2.9 per cent annual real growth between 1978-79 and 1996-97.’[[6]](#footnote-6)

Alongside this he announced that he was commissioning ‘a long-term assessment of the technological, demographic and medical trends over the next two decades that will affect the health service to report to him in time for the start of the next spending review in 2002.’[[7]](#footnote-7)

**The Wanless proposals – the scenarios and the health service of 2022**

In his pamphlet *The most expensive breakfast in history* Timmins notes that the Review was ‘the first serious attempt by any government in the history of the NHS to have an independent assessment made of the service’s likely future needs, and likely cost over the next 20 years.’[[8]](#footnote-8)

Derek Wanless - a banker - was appointed to chair it and his central argument in the final report was that less had been achieved with regards to health outcomes as the UK had spent less on healthcare and spent it less well.[[9]](#footnote-9)

The Terms of Reference asked Wanless to determine the resources needed for a high-quality service. Wanless defined this high-quality service as one where patients were at its heart, waiting times reduced, buildings modernised, more care provided outside hospital, closer health and social care integration and the service able to recruit and retain the staff it needs.[[10]](#footnote-10)

Wanless supplied three cost-based scenarios for delivering it by 2022, set out in Box 1 below.

**Box 1: Securing Our Future Health – scenarios for health service 2022[[11]](#footnote-11)**

**Scenario 1: solid progress** – people become more engaged in relation to their health. Life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. The health service becomes more responsive, with high rates of technology uptake, extensive use of ICT and more efficient use of resources.

**Scenario 2:** **slow uptake** – there is no change in the level of public engagement. Life expectancy rises, but by the smallest amount in all three scenarios. The health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity.

**Scenario 3:** **fully engaged** – levels of public engagement in relation to their health are high. Life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.

Wanless was clear that resources alone were not sufficient to deliver an improved healthcare system, noting that radical reform was ‘vital’. He argued that such reform should include:

* The National Institute for Health and Care Excellence (NICE) to examine older technologies and practices that may no longer be appropriate or cost-effective
* Extending National Service Frameworks to other areas of care and including resource estimates for delivery
* Investment in ICT and central standards rigorously applied to such budgets
* Adopting evidence based public health expenditure decisions and improving public health information
* Greater diagnosis and treatment in primary care and more self-care
* Incentives to reduce ‘bed-blocking’
* Increased community and patient involvement in local health service governance
* Ensuring that the health structures as they were being re-organised at the time worked effectively and ruling out any further structural changes
* No extension of out of pocket payments for clinical services; but noting that there may be some scope to extend charges for non-clinical services
* Greater co-operation between the NHS and the private sector, building on the concordat of the NHS Plan

The first Wanless Review was followed in 2004 by ‘Securing Good Health for the Whole Population’ focused particularly on prevention and the wider determinants of health. It argued that ‘health services must evolve from dealing with acute problems through more effective control of chronic conditions to promoting the maintenance of good health’.[[12]](#footnote-12) The report produced 21 recommendations with a focus primarily on traditional public health issues such as smoking and obesity, rather than wider social determinants of health.[[13]](#footnote-13)

**20 years on – what progress has been made? And what can be learnt?**

When re-reading both Wanless reviews many of the challenges and ideas feel very familiar to those today, albeit the scale of the difficulties is arguably larger particularly when factoring in the pandemic. Vacancy rates of over 100,000 staff across both health and social care, a capital maintenance backlog of nearly £10 billion, inadequate and fragmented IT, rising obesity rates, waiting time targets being missed and elective waiting lists of nearly 7 million. The health service and the scenarios set out by Wanless would not appear to have been realised.

Timmins sets out two legacies for the original Wanless Review in his work.

The first is that it lingered on, for example being referenced in the 2007 Spending Review where future health funding increases were made. However a 5-year follow-up suggested by Wanless was not commissioned by Government (though a separate exercise was undertaken directly with the King’s Fund) and a further review for social care was not taken forward. Former Health Secretary Patricia Hewitt noted that the pressures in the NHS were ‘inexorable’ and that the Review got put on the shelf as a result. Former Government Special Adviser Paul Corrigan argued that the lack of clear actions within the ‘fully engaged’ scenario meant that it was difficult to know what to practically do with the Review.[[14]](#footnote-14)

The second legacy, supported by former Treasury Adviser Ed Balls, is that the Review was a political mechanism for a centre-left party to raise national insurance to improve the health service. On this Balls argued that delivering this without political fall-out is ‘the thing I am most proud of.’[[15]](#footnote-15)

On the second review Timmins states that ‘for many but not all of our interviewees, the public health report had almost entirely faded from memory.’ The Chief Medical Officer’s (CMO) annual reports made only passing reference to the Review. Though Sally Davies CMO from 2010 to 2019 argues that the Review ‘woke the health community up.’[[16]](#footnote-16)

Contributors

Chair

Nicholas Timmins, Senior Fellow, King’s Fund; Senior Fellow, Institute for Government; Visiting Professor, King’s College London

Convenor

Professor Sally Sheard, Executive Dean, Institute of Population Health, University of Liverpool

Richard Sloggett, PhD candidate, University of Liverpool. Former Special Adviser at the Department of Health and Social Care (2018-2019)

Witnesses

Dr Paul Atkinson, Senior Research Fellow, University of Liverpool (Researcher on Wellcome Trust – The Governance of Health: medical, economic and managerial expertise in Britain since 1948); civil servant, Department of Health, 1988-2006

Rt Hon Ed Balls, former Cabinet Minister and Treasury Special Adviser during the Wanless Review

Professor Iain Buchan, Chair in public health and Clinical Informatics, and Associate Pro Vice Chancellor for Innovation, University of Liverpool

Anita Charlesworth, Director of Research and the REAL Centre (Research and Economic Analysis for the Long term), Health Foundation; Secretariat lead for the first Wanless Review

Professor Siân Griffiths, former President of the UK Faculty of Public Health of the Royal College of Physicians

Patricia Hewitt, former Secretary of State for Health; Chair, Norfolk and Waveney Integrated Care System

Richard Murray, Chief Executive, King’s Fund; former Director of Policy, Department of Health

Barry Tennison, Senior public health official, national and regional (retired)

**Areas for discussion and seminar format**

The aim of this witness seminar was to bring together individuals directly involved in the formulation and implementation of the Wanless review: from politics, the civil service, the NHS, academia and other organisations. The event was chaired by Nick Timmins who invited participants to speak on the main areas of discussion outlined below.

The seminar forms part of Richard Sloggett’s PhD research exploring the question ‘Can health policies build preventative healthcare systems? A study of the NHS in England.’

**Areas for discussion**

1. Origins and development of the first Wanless Review
   1. What was the original objective of the Wanless Review(s)?
   2. How did the Terms of Reference get set? Were there disagreements in finalising them, and, if so how were they resolved?
   3. How and why were the three scenarios developed? What was their motivation?
   4. How did the work of the Reviews align with the existing health policy agenda (e.g. NHS Plan)?
2. Publication and implementation of the first review
   1. How was it received?
   2. How much attention was paid to the additional recommendations for reform?
   3. In particular how much attention did the ‘three scenarios’ attract, and what traction did they gain?
3. The second ‘public health’ review
   1. What were its origins? How did the terms of reference get set? Was it a deliberate attempt to put more flesh on the bones of the ‘three scenarios’. Were there any disagreements about terms of reference? If so, how were they resolved?
   2. How was it run? Any significant difference to the first review?
   3. How was it received? What traction did it gain?
   4. What role did various organisations play in the roll out of its proposals? E.g.: Central Government, NHS management executive, public health community?
   5. If the traction was limited, was this in any way due to it being a Treasury report that was never really ‘owned’ by the Department of Health?
4. The legacies
   1. Aside from lots more money, did the reviews improve the NHS and how?
   2. What did the second review in particular achieve? Why is it much less well remembered?
   3. Did the Reviews have unforeseen consequences and/or benefits?
   4. What lessons can be learnt from the Wanless review processes?
   5. What could be done differently if the exercise was undertaken again?
   6. What are the learnings from the review in regards to delivering policies that ensure a more prevention and patient centred health system?

**Witness Seminar Transcript**

**Sally Sheard**

Welcome everybody. I would just say a few words at the start to set this afternoon’s fascinating conversation in train. I’m Sally Sheard. I’m a Wellcome Senior Investigator and Professor of Modern History at the University of Liverpool. I’m running a seven-year project called ‘The Governance of Health’ which looks at the interface between different types of expertise in health policymaking in Britain since 1945, particularly medical, economic, and managerial.

We have done a number of case studies already in this project: on NHS reorganisations, such as the internal market, the use of health economists, management consultants, the development of policies for waiting lists, genetics and genomics. The one we are currently working on led by my colleague here on my right, Paul Atkinson, is the development of NICE. Richard’s PhD is the latest in our focussed case studies, and Richard will speak as well about how he has chosen this particular case study, Wanless.

So just for those of you who have not been to a witness seminar before, the expectation is that we have an open Chatham House style conversation around the width of the Wanless reviews, that we contribute as directed and invited to by Nick Timmins, our chair this afternoon. The benefits of witness seminars over one-to-one oral history interviews are that we trigger each other, hopefully, to think about how we can collectively analyse and discuss some of these developments.

I am going to stop at that point and hand over to Richard.

Richard Sloggett

Thank you. Hello everyone. Thank you so much for making the time. I am Richard Sloggett, PhD candidate at the University of Liverpool. My PhD topic is ‘Can national health policies build preventative healthcare systems?’ My fascination with prevention came from working in the Department of Health and Social Care during 2018/2019 as a special advisor to the then Secretary of State, particularly on the ‘Prevention Green Paper’ – a white paper for which is still to be published at this point – with the proposition that ‘prevention is better than cure’.

And then I started researching the history of this statement and found that it is a recurring theme in health policy going all the way back to about the mid-1970s and even further. And so, having left the Department, I started talking to Iain and Sally about undertaking a possible academic exercise around this; and I have been working part time on this now for the past two years.

I have found Wanless quite interesting for a couple of reasons. One, is because there was a genuine preventative angle to his work, and also because the year 2022 happens to coincide with his 20-year projection for what the health service should look like. And when you read that projection of what the health service should look like in 2022, a number of the challenges that we face today were still very much in existence back then.

So that is why I think this is such a fascinating time to be doing this research because we have a 20‑year frame from which to look back to see what progress, if any, have we made? And ask why is that the case? And what can we learn moving forward for health and NHS policy? And it is fantastic to have such a range of different expertise – political, academic and public health – around the table to have this discussion, so just a big thank you from me. I am really looking forward to the discussion.

Nicholas Timmins

Thanks. Again, we are really glad you are all here and giving your time for this. We are really grateful. Due mainly to a mix of illness, we have lost four people at very short notice, so Paul Corrigan[[17]](#footnote-17), David Buck[[18]](#footnote-18), Chris Ham[[19]](#footnote-19), and Richard Douglas[[20]](#footnote-20), all of whom are wanting to contribute further later if they can. We are going to do this in three hours and a tea break, so what I shall do is break it into the first hour on the first Wanless report. The second hour on the second Wanless report. The third hour on legacy as to what we might learn and draw from all of this.

I guess nearly everybody knows everybody, but it might just be worth whizzing around the table to see who people are in case someone does not know someone. Siân, do you want to start?

Siân Griffiths

I'm Siân Griffiths. I was once the President of the Faculty of Public Health. In fact, 20 years ago.

Barry Tennison

I'm Barry Tennison, and I was a public health doctor for quite a long time in various positions.

Nicholas Timmins

I’m Nick Timmins, I’m chairing this, and I wrote that (*The most expensive breakfast in history*[[21]](#footnote-21)) for the Health Foundation, which is an account of the Wanless reports.

Patricia Hewitt

Patricia Hewitt. I was once Health Secretary, and I actually cannot remember if I was Health Secretary when all this started off – whether I was in the Treasury, or doing something else – but there we are. I was in government.

Richard Murray

Richard Murray. I am now Chief Executive at the King’s Fund, but through this period I was a civil servant. Most of the time Director of Finance of the spending reviews known as the PSAs – the targets – as they were.[[22]](#footnote-22) But I was not there at the time of Wanless – so I was there for Wanless 2, and the follow on from Wanless.

Paul Atkinson

Paul Atkinson. I’m an academic at Liverpool. I work with Sally on the Governance of Health Project, and mostly on NICE at the moment, as she said.

Sally Sheard

I’ve introduced myself already, Sally Sheard.

Iain Buchan

I’m Iain Buchan. I’m a public health doctor and data scientist at the University of Liverpool where I am Associate Pro Vice Chancellor for Innovation, currently supervising Richard’s PhD with Sally. I have a long-standing interest in how to let the data speak to make prevention more programmable, and at the time of Wanless, I was Barry’s trainee.

Ed Balls

Ed Balls. At the time I had become Chief Economic Advisor to the Treasury, so I was on the management board at this point, and I was very much involved with Anita in the commissioning and landing of Wanless.

Anita Charlesworth

Anita Charlesworth, so my background is as a health economist. I was working at the Treasury when Wanless happened, and I led the team that worked with Derek on the first Wanless review, and then I have worked in the space, either in the Treasury, or now, I work for the Health Foundation, since then.

Richard Sloggett

And I am Richard Sloggett.

Nicholas Timmins

Great, thank you. Now, as Richard has made clear, the essential focus of the day is the public health and prevention aspects of both Wanless reports.[[23]](#footnote-23) The first and the most famous one which produced a huge increase of 7.4% real for five years for the NHS. And the second, a much less well remembered Wanless report, which was specifically on public health. And because of that we do not want to spend too much time on the origins of the first report, so I am going to start with what I hope is a swift but fair and balanced account of its origins before asking if anyone strongly disagrees with that before getting into the questions that are outlined in the briefing paper that you received.

So we begin with Labour’s landslide at the 1997 election. The NHS was, at that time, in a pretty parlous state. Much less data was then available about just how bad it was, but boy it was bad! I mean, there were people literally dying on waiting lists from the condition for which they were waiting. It was serious. New Labour, however, promised to stick to some extremely tight Tory spending plans for its first two years. More money was found for the NHS in part due to an unprecedented £2 billion underspend on social security – which was something of a once in a blue moon.

But it was too often a case of drip-feeding bits of money in for winter pressures, or sharply rising drug costs, and other crises, and there were some real tensions between Number 10 and Number 11 over that, not to mention with the Department of Health. I mean, recently released cabinet papers illustrate the tension with one note going to Tony Blair[[24]](#footnote-24) from his advisors saying, ‘Classic Treasury. Too little, too late.’ Now, in both Number 10 and Gordon Brown’s[[25]](#footnote-25) Treasury there was a recognition that something bigger and more sustainable needed to be done. Both Ed, here, and Ed Miliband definitely recall conversations to that effect with Chancellor Gordon Brown, however, it is far from clear that thinking was conveyed to Number 10.

Tony Blair becomes increasingly exasperated with what he saw as Gordon’s refusal to do anything big. Brown’s view being that the ground had to be prepared for that, as it was likely to involve tax rises, particularly at a time when the battle needed to be taken to the Conservatives over the nature of the NHS given that their policy at the time was to provide tax breaks for private medical insurance. Indeed Liam Fox[[26]](#footnote-26), their health spokesman, had declared that, philosophically, the Conservatives had ‘moved on’ from a fully comprehensive NHS.

So after a big winter crisis, Blair goes on *Breakfast with Frost* in late January 2000, stunning everyone by declaring that all things being equal the NHS would get extra spending as a share of GDP up to the European average over the next five years. This was in Blairs words, ‘a straightforward pre-emption,’ with the result being what Blair described as, ‘a few days of tin helmet time with Gordon,’ and the Chancellor in the March budget announcing a genuinely big increase of 6% or so in real terms for the NHS over the following three years, and that was double the average historic rate of growth. But that alone would not be enough to get NHS spending up to EU levels.[[27]](#footnote-27)

Brown combined that with the news that he was commissioning, and I quote, ‘a long‑term assessment of the technological, demographic, and medical trends over the next two decades that will affect the health service, with that report in time for the next spending review in 2002.’[[28]](#footnote-28) And this was the Chancellor’s strategy for winning the long-term argument about NHS funding, and it is what became the first Wanless report, although, detailed work on it did not really start until a year later. So before we turn to the questions in the briefing paper, and the terms of reference, does anyone disagree strongly with that broad account of the origins of the review?

If not, well, I suppose the first question is how did the terms of reference get set? And the terms of reference, if you need reminding (were) – the first of them was the phrase I just read out. The second ‘In the light of that (Terms of reference, point 1) to identify the factors which will determine the financial and other resources required to ensure that the NHS can provide a publicly funded, comprehensive, high-quality service on the basis of clinical need, and not the ability to pay.’[[29]](#footnote-29) And, ‘To report to the Chancellor by April 2002 to allow him to consider the possible implications of this analysis for the Government’s wider fiscal and economic strategies in the medium-term, and to inform discussions for the next spending review.’[[30]](#footnote-30)

And if you read those, it is crystal clear that the tax funded nature of the NHS is not up for debate here. And it does not take a genius to read in point 3 that there is an implication here that there might be some tax rises on the way to pay for this. So those were the terms of reference. Was there any debate about what they should be? Ed? Anita?

Ed Balls

So there was not a debate about the terms of reference. I mean, it was pretty consensual. I am not going to disagree with anything in your introduction. But I think (it is important) to understand the context of getting to this point – to get to these terms of reference. I think there was one big thing which we underestimated when we did the terms of reference which leads to the interim report.[[31]](#footnote-31)

The context was you have a Prime Minister and Chancellor who were, I think in this period, very focused on building the public case for growing investment in public services without looking like they were making the mistakes of the past. And making the mistakes of the past would have been seen by Blair and Brown, back to 1994, as looking like the party which instinctively always wanted to raise taxes. Throwing money at problems because that solved them, and then particularly giving into short-term pressures to do so because that looked knee-jerk, and not long‑termist, and best-interest driven.

So how did you show we were not about sectional interests but best-interest in the long-term? And in 1997 the reason why we stuck to these public spending figures in the first two years was partly because it was a good signal, but it was at least as much that we decided that we wanted to move to three-year budgeting in the 1998 spending review to try and cast that more long-term view, and to stop us doing what had happened in the past which was to make continual calls on the reserve. So in 1997, in the first budget, we actually give an extra £1 billion to health, and £1 billion to education – but we were trying to get to this longer-term view.

And part of the reason why there was frustration between Number 10 and the Treasury was once we had said in the 1998 spending review, ‘we are setting these three-year budgets,’ we thought it was really important to stick to them, and the partners should work within them. And so there was this continual thing when Health would say, ‘winter pressures, can we have another £100 million?’ And we would say, ‘It’s quite small amounts of money…’

Nick Timmins

Compared to a drugs bill of £140 million.

Ed Balls

Health would say ‘If we had £150 million, we would solve the problem,’ and we would say, ‘Actually, no, you should work within your budgets because if we simply just throw a little money at problems that is not the strategy.’ And it did cause lots and lots of tensions in that period, but by the time you get to 2000, we all know that the money is not big enough. We all know, therefore, that at the 2000 spending review, we are going to give a lot more money to health and to education. That is clear. My personal view is, I do not think the *Breakfast with Frost* interview made any substantive difference to outcomes, and I think this was a classic piece of Blair-Brownery where, on the fundamentals, they both knew exactly what they were doing.

Tony knew what the plan was. He knew we were going to announce money for health in the budget. We were going to prep the Spending Review for Health. We did not know exactly what the number was going to be, but it was going to big. But they did not tend actually to disagree that often on substance. Sometimes they did, but there was always a bit of competition for who was going to be in the lead, or get the credit, and Tony jumped in, and Gordon was frustrated by that – for two reasons. One, that Tony had been pre-emptive on the case, but also that it looked very input driven – the amount of money rather than the purpose.

We already knew, though, that whatever we did in the 2000 review was not going to be enough, and in the end, you had to get to a tax rise, but that you could not get to a tax rise unless you had really made the case. And we did not want to make that case in the 2001 election campaign. So we can do schools and hospitals first, but we did not want to say, ‘we’re going to raise National Insurance.’ In fact, it was quite hard holding the line on National Insurance, particularly during the election campaign. But Wanless was always supposed to set up a piece of work which we had promised – but it did not really crystallise until the post‑election period.

So you had a mandate from the manifesto to do the work, but when you say, ‘why wasn’t there any terms of reference?’ Well, because nobody wanted to even begin that until after the election because we did not want them (the Opposition) to say, ‘well, you have started this work, is that going to lead to a tax rise?’ But it was absolutely clear that was always what the strategy was.

And so the terms of reference was written essentially rather than, ‘we are going to spend on the NHS to get to the EU average,’ or, ‘the NHS needs more money,’ to instead say, ‘what does a world class health system need for the next 10 years and how much would that be? And then how are we going to pay for it?’ So the tax becomes the consequence of the analysis rather than the other way round. The thing which we underestimated, I think, at that time in 1999 when we come up with a plan – even in the spending review 2000 – was the extent to which the consensus about the ‘free at the point of use’ tax funded NHS was coming under pressure.

So when we wrote those terms of reference, we did not think it was particularly controversial. We thought, ‘that’s what we all believe in,’ a free at the point of use National Health Service, that is what we are going to look at. And we had – as you say in your report – a bit of a kerfuffle because Adair Turner said, ‘I agree with that, but I do think we should ask that question first.’[[32]](#footnote-32) And we thought, ‘why do we even need to raise this issue because we all know that, so let’s not put it in the terms of reference.’

And then what happens over the course of that year with Liam Fox and William Hague – well, actually it was post-William Hague really – but Liam Fox as health started to really ramp up this idea that we are going to a post-NHS world. By the time you get to the autumn, the right-wing papers have got themselves into a real lather about moving to insurance, and we had this Wanless report, which had taken that as a given.

We did not think it was Wanless’ job to win that argument, but what I said to Anita is, ‘could you just – rather than changing the terms of reference, could you just put in a couple of paragraphs which just say, ‘here’s why our starting point was a tax funded free at the point of use NHS’ so that this will then provoke an almighty row with the right-wing papers and the Conservatives’ – which it did – ‘we will then go out and fight that argument for the next two months, and if we can win that – which we believe we can – by the time your report comes back, we will be back to where we thought we were going to be.’

We did not think the argument was necessary because we thought it was done, and when it became clear it was necessary, we thought, ‘if we do not have this argument first, Wanless will be shrouded in a controversy about “is it the right system?”’ So all through that November, December, January, all mixed up with Gordon’s tragedy, as well, was winning the political argument about the best insurance policy in the world, so that by the time that Wanless came out, you could get back to the money. So the reason why there was not a lot of discussion about it is because at that point it was, I think for all of us, a given.

Nicholas Timmins

Sorry, the further evidence of that is when the interim report came out it was not just *The Telegraph* saying, ‘why is the NHS model right?’ *The Independent*, *The Observer* were writing pieces saying ‘well, we should at least look at the alternatives.’

Ed Balls

Well, let us be clear, the health editor of *The Observer* then went off to become the Conservative Advisor to the Conservative Mayor of London. So I think there was undoubtedly a whole thing going on which we had underestimated which was, [[33]](#footnote-33)if we are going to win the argument against a publicly funded free at the point of use NHS, this is our moment. And we suddenly found that mid‑Wanless we were in the middle of it, which I do not think we had quite expected.

Patricia Hewitt

We had not expected it – I do not think anyone expected it. Can I just add something on that because when this was being commissioned, I was actually the Economic Secretary to the Treasury, but I had been involved for years beforehand in the policy review and the modernisation of the Labour party and so on. So I think part of the memory that led to exactly the political strategy that we are describing was the disaster of John Smith’s[[34]](#footnote-34) shadow budget, which was a classic tax and spend, and included lifting the ceiling on National Insurance.[[35]](#footnote-35)

Ed Balls

With no memory of why. I mean, nobody knew what the shadow budget was paying for. They just knew taxes were going up.

Patricia Hewitt

Exactly, and John Smith thought he had pulled off something completely brilliant because he had limited the amount of pension increase he was committing himself to, so there is a whole history about that piece. But I vividly remember Gordon saying while I was Economic Secretary, ‘You never, ever, ever set up an enquiry unless you know exactly the result you want in advance, you know what the report is going to say, and you appoint the person who is going to say that.’ So fine, and by and large I think that is correct, but that is certainly what he did.

And I think also having Wanless, who had no background in health whatsoever (was important). He was a banker – I mean, he was reliable. He was one of Gordon’s people. A bit like Gordon Borrie[[36]](#footnote-36) on the social justice commission earlier on, that was a John Smith one, but he could be relied upon to do and say what Gordon needed. And I think having a banker also was a bit left‑field, and quite interesting. The other thing I was going to say really comes a bit later on when we got to the tax raising budget and the increase in National Insurance contributions, but we can come back to that.

Anita Charlesworth

As an official, I guess the things that I remember coming loud and clear through to me were, initially, the model is not up for grabs. This is about how we secure an NHS for the next 20 years, not whether we are having an NHS. And that was very important in the choice of person who was reviewing because it was really important that they were 100% bought into that. Now, as you say, it meant that I set up the work to answer one question, and we had to do a little bit of retrofitting to answer the second, but there was another thing that came through very loud and clear both from senior officials in the Treasury, and I think it was where senior officials in the Treasury and Gordon and Ed were aligned: this has got to be something for something.

The Treasury were very worried about – I mean really worried, particularly some officials. I mean, the Treasury does not like setting out long-term fiscal commitments, so we were very worried about –

Nick Timmins

Turnbull[[37]](#footnote-37).

Anita Charlesworth

Yes. I mean, lots of people were very, very worried. It quite goes against a lot of Treasury thinking. Just in case you are ever going to need to control spending, you want to keep everything open and not box yourself in with your own numbers, don’t you? But given that, I think everyone could see that you (Ed Balls) were going to have to do something, and do something substantive.

The interest then is can we really, very clearly make sure that we are getting something for the money that we are putting in? And the sense in which, if we are going to spend public money – and this is where – for you (Ed Balls) and your administration this was absolutely critical – we would spend where we are very clear what we are getting for that, and that it is value for money, and that it will really deliver.

And actually the approach of, ‘are we clear what we are going to get?’ I think actually was met with quite a lot of support, almost, in health policymaking circles because we had, of course, come to realise that although there was enormous affection and commitment to the principle of the NHS, we were not doing very well in terms of outcomes.

And Frank Dobson[[38]](#footnote-38) had done all the work, as well, on National Service Frameworks[[39]](#footnote-39), and there was a lot of clinical commitment that the way we were practising medicine – the standards that we were getting – were not achieving what we wanted to, and people were very, very worried about that.

So I think there was a sense that we needed more money, but it was not just money.

Patricia Hewitt

Investment and reform.

Anita Charlesworth

Yes, indeed. But then the other thing that was very clear to me for Alan Milburn[[40]](#footnote-40) accepting this, is that we, the Treasury, were not going to tell him how to run the NHS. And so the terms of reference and the way I crafted the work had to be very careful about getting this, ‘what are we going to get for it?,’ right but leaving scope for the Department of Health, still, to determine how the NHS was run, and that was something that throughout the review I was tiptoeing around. And actually Derek (Wanless) turned out to be a really good choice – because he was actually very good at being very careful in that space and getting people on board. He was very evidence driven, very interested in what people were saying. We had our huge steering group with Nigel Crisp[[41]](#footnote-41) and everyone on it, and very sensibly Clive Smee[[42]](#footnote-42) took the decision to be a very active collaborator. The Department Health sent me some people to check what I was doing –

Nicholas Timmins

I think it helped he (Wanless) was a Newcastle United supporter.

Anita Charlesworth

Yes, indeed. They (Milburn and Wanless) had some chats about that. But there was a tension because we were setting out a vision, if you like, for what the NHS should try to achieve, but then there was this parallel process going on (in the Department of Health) about ‘how do you actually use that money and turn that into practice?’ And no one really, in the system, owned what we had said. Nobody disagreed with it, but there was no gut commitment to it, which is one of the things that is quite difficult. Could you have done this if it had not been Treasury led? No. By being Treasury led, it is quite hard then to have the subsequent real follow through on the detail of it because no one really owned it. It was, for the Department of Health, fundamentally an exercise to get the money.

Nicholas Timmins

Sally, you wanted to –

Sally Sheard

I did. So the terms of reference do not acknowledge the timeframe for this – the 20-year period. So where does that number come from?

Anita Charlesworth

Good question. I cannot remember.

Ed Balls

I think that would have come from Derek Wanless. It did not come from us. We were focussed on the period of the tax rise. But it was about the long term.

Anita Charlesworth

Yes, exactly, and if you were interested in public health, and in particular from the Treasury point of view the question was ‘can we get to something that is sustainable?’ If you only look at five years, or even arguably 10 years, you just look like you are haemorrhaging money. And so we had this whole idea of catch up, and then keep up – two phases to this. I was on the exam question, ‘Okay, if we are going to spend 6-7% for a period, it cannot always be 6-7%, so can you show how there is a glide path here where some of the things that you are doing actually start to reap some of the benefit.’ And if you look at the three options (scenarios), they do not differ very much, even for five years, in terms of spend or what you are getting.[[43]](#footnote-43) It takes a quite a long time to come through. When you get beyond 20 years, your ability – I mean, even at 20 years –

Nicholas Timmins

Even at 20 years, you are guessing.

Anita Charlesworth

You are in the realm of guessing, so I mean, it is just balancing that. There is no great science to it.

Ed Balls

If I could just in a way say the same things about the reviews as Patricia. I agree with Patricia, though am not fully agreeing with her. I did lots and lots of these reviews. We must have done 20, 30, and there was a method to them, and there was a pattern to them. And so you absolutely needed to know what you were trying to achieve at the start, and you needed somebody who wanted to achieve what you were trying to achieve. And normally the reason you do this as a review rather than just happening internally was because – not just the external challenge to the machine, but also because you wanted them to go and find out stuff you did not know.

We always advised them to say nothing quickly because you will make a mistake, but to do an interim report because that is where you have your row, and then, when you do your final report, as far as possible we should be aligned. And then you should come back in a year’s time to report on whether you have done what you said – we are delivering on what you are saying. And the civil servants never want to be on ‘one year on’ reports, and I would always say, ‘you have got to do it.’ So a classic example is John Vickers[[44]](#footnote-44) with the Vickers Commission on Banking. John wanted to get out by that point, and he just did not want a ‘one year on’ review, and I kept saying to him, ‘you really should demand that if you want to really see this delivered.’

In the case of Wanless, we did not expect the row to be what the row was, but we knew the interim report was going to be a row. I think we thought the row would be about quantum rather than about the underlying principle, and it would be raising the question, ‘how are you going to pay for this?’ As opposed to whether you should be paying for it. But when you go to things like the time period, the three scenarios, the focus on prevention, I do not think any of that was mandated by the terms of reference, or in any of our conversations. I mean, I think from the moment we set the terms of reference, you went off for months and did this whole thing, and when you came back to us and said, ‘this is where we are going,’ we said, ‘Fine. That sounds really interesting.’ It was not like we said –

Patricia Hewitt

Do that.

Ed Balls

‘Do this. This time period – any of these focusses.’ What we wanted to do was get to an interim report in the autumn where we could have a row about spending more money. That was our plan, and that was really it. And so in that sense this was never about the Treasury or the Chancellor trying to re-engineer the health service to the extent that Wanless had a vision. That was his vision. And I think part of the challenge was, as we both know, Number 10 and the Treasury had different relationships with different Secretaries of State, and there were times when Gordon would have some Secretary of State relationships where it was very close and common, even though there would be arguments along the way, and it tended to be like that with Patricia at Department for Trade and Industry – lots of common work. Alistair Darling[[45]](#footnote-45) at Transport, John Prescott[[46]](#footnote-46) at Regions.

There were some departments where you had a duality, so the Treasury would tell Education what we wanted, and Number 10 would say what they wanted, and they would end up having to do both. So in education they would do academies, and money for head teachers or school building. In health, it was unusual in the sense that the whole content relationship was mediated through Number 10. There was really no Treasury - Number 10 content relationship. So in a way, what you did on Wanless was you went and established this whole Treasury - Health department commonality about the substance of this, which actually happened outside the political process. I do not think any of us knew about it or got involved in it because that was not how it was done.

And I think the truth is that Alan Milburn probably always foresaw it as a political threat.

Patricia Hewitt

Of course, he did.

Ed Balls

From the beginning, but actually, in a way in which was, I think, a misinterpretation of our motive because actually I do not think it was ever intended to be. Going forward two or three years, suddenly there are big rows about the content of health policy. At that point, the Treasury is quite keen in having rows with Alan Milburn about who borrows what, and who sets up what. In 2001 with Wanless, that was just so far from what we were thinking, so actually, I do not think there would have been any political push behind the content of the work on the interim report.

Anita Charlesworth

No, there was none. I had been a Department of Health civil servant for the first five years of my career working for Clive Smee, who was really, really influential and important, so I knew a lot of the people, and we had goodwill and relationships.

Derek was very interested – I mean, he was a really good choice because he was interested in evidence and the details, so he wanted to go out and understand all of that. Actually, there was quite a strong, I think, consensus in health policy, which actually Frank Dobson also deserves a lot of credit for in building all these National Service Frameworks, which had done immense painstaking work on what should happen in the big disease areas, which meant that actually, for us in the Wanless review, when we start to look at what sort of system do we want, what problems are we fixing, what are we going to try and achieve, all of that very careful work and consensus building on what that meant had been done and we could tap into that. But I guess what I knew though, as well, was that – and Derek felt that because he was a banker – is we wanted to do all of that, but with a really strong focus on value for money, as well, and being very clear that we get something.

So it is that classic thing that when you pick the reviewer, you pick a reviewer who understands what you are trying to achieve but has the approach to it that means you do not have to think –

Ed Balls

He’s a reviewer and a team leader. If you take someone like Higgs on corporate governance[[47]](#footnote-47), Myners on city[[48]](#footnote-48), Cruickshank[[49]](#footnote-49), which was a bit of a nightmare I could go on and on. I would have been having – me or Ed Miliband – would have been having weekly meetings with the team leader throughout the period, trying to make sure that we had a grip on what was going on. Whereas, I do not think we had a meeting with you between the budget and two weeks before the pre-budget report because that was not what was going on. You were charged, really.

Anita Charlesworth

Yes

Iain Buchan

If I could just press a little more on the choice of time horizon. I am interested in the strength of the public health voice in the room when selecting how far out you go. The economic uncertainties increase when you are estimating return on investment, particularly social return on investment that has got a large amount of transactional NHS cost. But for the prevention agenda, there is always that short-termism bias where you do not see a potential return on investment because you have a hard stop. So what was the public health discussion when you were saying, ‘how far can we go out on the economic projections?’

Ed Balls

There is almost a prior question actually, where did the real focus on prevention at the centre of Wanless in the interim report come from? Because as I say, it did not come from the Chancellor. Did it come from you (Anita), or from health, or from Derek? Which is a prior question to your 20 years. I mean, why be in this space at all?

Anita Charlesworth

Well, if you had worked on health policy throughout that period, you would (be in this space). I assembled experts and people like Clive Smee had thought about this for an entire career. To some extent Wanless was a moment that a lot of people had been – I mean, they would not have thought about it in this form – but it was a moment that they to some extent through a lot of their work had been almost preparing for. To a large extent the art of this was just being a vessel for that to come together in a reasonably orderly way. But I would not underestimate the importance of Derek’s background in this. So there is public health, but the other reason he was interested in the longer timeframe from a value for money point of view was the productivity and the transformation agenda.

He had come to this having just converted NatWest into an online and digital bank, and he had seen the potential of that to transform the business. I mean, one of the reasons why to some extent you picked some of these reviewers is if they are good, they provide a counterbalance to some of the weaknesses in a traditional government policy making machine, which is that we are not by and large very good at understanding what is involved in transformative change and the timescales that make a return. And that is why he was interested in public health but also really saw the opportunities, the inefficiency of, and the opportunity to modernise and transform the system. But you could only really explore that if you had that longer term perspective.

Ed Balls

So where did the 20 years come from?

Anita Charlesworth

So we did sit around, and Clive (Smee) had input in that, as well. Technology is a very big factor and innovation is a very big part of that, it is 15 years to train up a doctor, and it is 10 years roughly speaking for drug developments – there is no exact science to it. What seems long enough to start to be able to show how we might get some real payback from these different types of intervention – public health and the IT and modernisation – but not so far that we are in the world of fantasy and fiction about what sort of health needs, what sort of system would you be needing with drugs innovation and stuff like that.

Nicholas Timmins

And when we were talking for this[[50]](#footnote-50), you said also part of the public health and prevention agenda was to get to these three scenarios where spending was not always going on at 7%. And if you want to see a reduction, prevention and public health are a route to the trend not staying like that forever.

Siân Griffiths

Can I just pick up two points? One, is about having the National Service Frameworks. They were very important. The second is having a Minister for Public Health, so the public health community start to feel that we are a community. But what does that actually mean? All that work on the NSFs, which had a huge emphasis on prevention – was a framework for prevention was already there so when Wanless comes along, it fits into the same agenda and that helps to unify because it brings along the Treasury, which hardly ever talks to public health because the timescales are not right.

The timescale of 20 years is a sensible approach. If you take children, if you take pre-birth care, in 20 years, you can start to see some impact from interventions. It is soft, but it is the right sort of discussion because you cannot see change in generations otherwise.

Ed Balls

My sense – Patricia can say if this is right – is that I do not think this is where the political conversation was at that time. I think that there were places where politics was ahead on some of these prevention things, so all the stuff around Sure Start, and childcare, and early intervention with children, that was quite politically driven. That was quite Blair and Brown throughout that period. You talked a lot about prevention when you (Patricia) became Secretary of State for Health later, but actually, in this period there was not a lot of enthusiasm in Number 10 for public health. Nobody talked much about prevention. It was all about, ‘oh my God, the waits are too long. More capacity, now.’ So actually the focus in the interim report on the prevention stuff, that was something which came out of the experts and the machine. It was not imposed by the political process.

Patricia Hewitt

No, no, no. I think you are missing one thing there – I mean, the galvanising of the public health community certainly felt very real and very important in the sense that, ‘oh, somebody was finally taking some notice of it.’

Siân Griffiths

Yes, Derek had dinner with us. No one else did.

Patricia Hewitt

Exactly, so that was a very important catalyst, but if I have got it right, Tessa Jowell[[51]](#footnote-51) became public Health Minister in 1997, 1998, I cannot remember.

**Sally Sheard**

Straight away in ’97.

Patricia Hewitt

It was 1997 because she went right in as a junior minister to Frank, and she did – somewhere in the following year or two – our first public health white paper, green paper, whatever it was[[52]](#footnote-52). I was at Treasury, and then at DTI doing technology and digital, so I was very involved in Sure Start because I was the Treasury Minister for that, but my recollection of that public health green/white paper was a lot of public engagement, as well as obviously engagement with the public health community. That was what laid the basis for the smoking ban and the obesity strategy.

But at a political level, what it did was give us a narrative about, ‘people want to be healthier,’ and the government’s job is to support them in making healthier choices. Give them the information. Make it easier, labelling it or whatever, but avoid the nanny state like the plague because Tony was completely terrified of that: not very ‘New Labour’. That re-emerged a bit later down the line in the smoking ban arguments. So actually there was quite a lot of work being done quietly on public health in the first term.

Ed Balls

That is true.

Patricia Hewitt

Even though the big focus from Number 10. and from Tony, and from the public was, ‘sort the waiting list, get in the extra capacity.’ And –

Ed Balls

Because Yvette (Cooper)[[53]](#footnote-53) was Public Health Minister straight after Tessa.

Patricia Hewitt

I’m sorry?

Ed Balls

Yvette was Public Health Minister straight after Tessa in that period.

Patricia Hewitt

Of course she was.

Ed Balls

So you are absolutely right. There was this big public health agenda, and there was this real tightrope about nanny state. My point is I think that it was quite disconnected from the Department (of Health), the Treasury, and in Number 10 from what people thought was the big NHS agenda. It was a public health agenda which was about Sure Start, children and parents and all of that, but the NHS was something else.

Patricia Hewitt

It is. It is. It was waiting lists.

Ed Balls

And when we were focussed on the Wanless, we were not thinking, ‘well, this is going to solve a preventative public health agenda.’ We thought, ‘what is it going to do to get waiting times down?’ And that is what –

Participant

And give us more money.

Ed Balls

And if you said to Tony, ‘Wanless is going to propose spending loads of money in public health.’ He would have gone, ‘Oh my God, why? He is supposed to be sorting out the NHS.’

Siân Griffiths

It is always like that.

Ed Balls

But I think Wanless helped to shift that for us.

Sally Sheard

Just before we move on, the other thing we must not forget is that Donald Acheson had been commissioned to do an enquiry on health inequalities.[[54]](#footnote-54)

Paul Atkinson

In 1998.

Sally Sheard

And inequalities was now back on the agenda. It no longer had to be called ‘health variations’. It was back to ‘inequalities’ and that enquiry, I think, provided a lot of the evidence that said, ‘this is a political problem that we need to address as well as the NHS.’

Nicholas Timmins

It actually did that but, a bit like the Black report[[55]](#footnote-55), in terms of the recommendations of what should happen, they were just huge amounts of money and pie-in-the-sky and very little evidence that if you had done what it wanted you to do, it would have any impact. So it definitely put health inequalities and prevention on the agenda, but it did not have any teeth.

Anita Charlesworth

There are two important things I would emphasise.

One, is I had been involved in the margins of the Sure Start work and Norman Glass’s[[56]](#footnote-56) brilliant work in scoping some of that out, and I had seen how he used and brigaded that evidence and brought that community along. He helped align it with political ambitions and priorities and create something which was in a model that fitted a New Labour way of doing things. So he helped take what you were trying to achieve, understand that, bring experts together, get alignment and support for that, and produce something that fitted with the way that you as a government wanted to work. And I thought very much that I needed to do something which is similar to what Norman did then.

But you have very little time with these things, so the other thing which is just great is that there was lots of evidence already published. You forget people can do huge amounts of this work, and it feels like it goes nowhere at that moment in time, but if it is all there, then you can use it. And so we did not come up with lots of new evidence. We did not do that at all, but what we did was we took the evidence, and we brought it together in a way which aligned with what New Labour were. The way New Labour thought about the world and then tried to produce something that could be acted upon in a New Labour way. And that is often the bit that gets missed out, and I would say to the public health community often there were moments that were not seized because people did not know how to seize it.

Nicholas Timmins

I want to keep us moving on for a bit, so can we go to the publication. A short question, how was it received? Well, with the exception of Iain Duncan Smith[[57]](#footnote-57), who was completely isolated, it proved to be the most popular budget since the 1970s – Mori has been doing these things [public opinion polls] since the 1970s – despite the tax rise. Huge percentages were in favour of a National Insurance increase. You could not have asked for a better reception basically.

Patricia Hewitt

The CBI were very unhappy.

Nicholas Timmins

I did not even notice that.

Patricia Hewitt

No, I am sure. I remember going along. I was due to speak there.

Ed Balls

It was employers and employees.

Patricia Hewitt

It was employees and employers, and they quite accurately said, ‘great you are spending more money on the health service. Do not make it a tax on jobs.’ And then I felt I was on a strong wicket because we had a very strong case for doing it, but a less strong wicket when it came to the nature of National Insurance contributions, as it is regressive, and a tax on jobs. So there was a big CBI employers event which –

**Ed Balls**

The problem was the polling which at the time had basic rate 35% support, VAT 35% support, National Insurance 75%. It was so powerful as an example of what people thought National Insurance was – independent of what it actually is.

**Nicholas Timmins**

Let me get onto some of the recommendations, which again, I will try do a quick summary. There are three big scenarios to talk about most, but there were a number of specific recommendations which I will just skip through. NICE to examine all technologies – well, NICE tried – it did not really work. Actually for quite good reasons as it is difficult. Where do you start? So that had already happened. Extending the NSFs to other areas. That did not really happen.

**Richard Murray**

It did. There was a whole series of them. They were not as successful. There was one for neurological conditions. There was a long series. They just were not as iconic as cancer, but they were there. There was a whole suite, which usually then meant they had a National Clinical Director which the NHS still has now, so it survived. They were not like cancer, CVD and mental health, which were the three giants, I suppose. Diabetes was quite big, but and it is partly funding and it is partly that the first three were so dominant in terms of both lives lost and mortality, that they had a huge impact. After that there was like a second door, the others were in there I am afraid to say, but they were there.

**Nicholas Timmins**

Right. The recommendation for a big investment in ICT, which most certainly did happen, had some pretty disappointing results.

**Patricia Hewitt**

It did happen with rather better, albeit mixed results, but better results than is generally the case. It drove me up the wall when I was health secretary, by which time a staggeringly large investment had been written off, not financially, but written off politically, as it were, and in the public mind. Why (now) do we have email? Why do we have it across the whole of the NHS? Why do we have e-prescribing? Why do we have digital imaging? Why do we have all those things? Because of the national IT programme. There were other things about it which were a complete screw up. It was very badly commissioned, frankly, by the commercial director who was brought it in to apply best practice and procurement.

**Nicholas Timmins**

It was meant to get us electronic patient records–

**Patricia Hewitt**

It did not give us the platform for the digital transformation of healthcare, I would say.

**Nicholas Timmins**

So that happened. Adopting evidence-based public health expenditure decisions and improving public health information. We will come on to that in a minute. Greater diagnosis and treatment in primary care and self-care. Increased community and patient involvement in local health service governance. So those are the sort of specifics, but behind all that is the three scenarios. The question is, I suppose, how much attention did they attract, what traction did they gain?

**Richard Murray**

They were not the subject of conversation in the Department. I came in shortly after it (Wanless review) was published and it is just not the way either you framed things – and Patricia did not ask us to either. So we did not feel we were doing something wrong, so they (the scenarios) did not (get traction).

Having said that, I am really struggling. Where we talked about the disagreements between Gordon Brown and Tony Blair - a lot of things that the Department came up with, Derek must have questioned. So the NSFs figured as they were a massive focus, and a lot of the NSFs were about prevention, about tobacco, about basically secondary prevention in CVD.

The pure public health elements were quite small, and yes there was, an enormous push on waiting times, but we (the Department of Health) have got a period when growth is going to be high, if we are ever going to get it (the money), we have got to do it now. And slightly, that thinking is having your cake now, and then thinking, ‘I will worry about public health in future years’. But there was a view you had four or five years in which the money would be secure, to get the workforce, to get waiting times off the table, and then turn your attention to the other things. But the nature of those three scenarios, no, they did not get traction.

**Patricia Hewitt**

I became health secretary in 2005 and we did not say, ‘right, how far are we along the road to fully engaged?’ It was just not part of the conversation. We had sort of moved on. It was seen as a rhetorical device and it was a very clever one, actually, and it had real substance behind it, and the whole analysis was correct.

**Ed Balls**

That was the choice of the Secretary of State for Health at the time, and to a lesser extent, Number 10. It was not something the Treasury could decide.

**Patricia Hewitt**

It was a strange call.

**Ed Balls**

In the end, I would have wanted –

**Richard Murray**

Alan had gone, by the time –

**Ed Balls**

My point is, on day one this is announced, there is no sense in which the Secretary of State wants to use this as a galvanising frame for health policy. If it does not happen then, there is no way the Secretary of State is going to come back three years later and say, ‘oh, and by the way,’.

I think, to be honest, the Treasury sort of shrugged its shoulders and thought, ‘well, you have got this big rise in money, I hope you are going to spend it well. Why are you giving it all to these GPs? But let us hope these NSFs really deliver what we want.’ Because what we cared about was, fundamentally, the public seeing that this was delivering better outcomes and that was consensual. But in terms of the framing narrative, from the day of the budget, there was no sense in which the Department of Health were going to make that the framing narrative, and that was the end of it.

**Nicholas Timmins**

The day after the final report was published, you get the big document from Milburn, which has payment by results, foundation trusts, all the market reforms which have nothing to do with public health.

**Richard Sloggett**

There are two references to all of this (Wanless) in that document[[58]](#footnote-58). They are both on hospital discharge. If you think about where the focus of the Wanless report ends up, it is quite telling that actually the NHS Plan is at the very other end of the health spectrum.

**Nicholas Timmins**

I think I am right in that within all that Milburn announced, there was not at the time a battle over financial freedoms for Trusts; even though it became battle over foundation trusts later. I mean, that was all done by Health.

**Ed Balls**

No, that is not entirely true. Go back to Anita’s point earlier. I think the sense of there being strings and ties, and a focus on performance. I mean, in that period, actually, we were quite worried about the scale of money and whether we were sure it was going to deliver results.

So if you take, for example, Foundation Trusts. That was something in that three or four weeks before, we were all really enthusiastic about. The nature of the relationship meant that we were having no conversations with Health, because that was just not the way it worked. What happened was, the whole health relationship was mediated through Number 10, so me and Anita would have been there, at the time, but with Jeremy Heywood[[59]](#footnote-59) and Robert Hill[[60]](#footnote-60). We would all be talking about, what is needed to do to make sure we can show there is going to be a focus on outcomes. So for example, with regards to Foundation Trusts, we saw that in the same context, at the time, as high performing councils.

So councils who were higher up the Audit Commission assessment would get extra freedom and flexibility, and similarly, you would have Trusts, who, if they were clearly performing well and getting good outcomes, we would be willing to give them more freedoms and flexibility. So it was a message that outcomes matters.

You may think, understandably, that the Wanless report was all about the long-term prevention agenda and public health. I think, even on the day of Wanless being published, we were more focussed on, ‘are we going to spend this money well in the next five years?’ And that means trusts have really got to drive this into behavioural change, so we get waiting times down. ‘Is that going to happen, and how can we signal that?’ Once we are doing that, with freedom and flexibility, we did not think they needed to be privatised, or borrow, or budget, or go bankrupt. We just thought they would be like councils. They would get more flexibility if they were doing well, so in that sense I think we saw those parts of the statement the day after as quite consistent with what we were wanting to achieve.

**Nicholas Timmins**

One tiny point, by that stage, Simon Stevens**[[61]](#footnote-61)** was in Number 10, but also – a pity Paul’s (Corrigan) not here, but Paul says he remembers going to talk to you –

**Ed Balls**

In that period. We were not rowing at that time –

**Nicholas Timmins**

Corrigan was saying ‘We are doing this; we are doing that.’ And, if anything, you at the Treasury were saying ‘great’.

**Ed Balls**

It shifts in the following year, so we are suddenly into this bitter foundation hospitals dispute. There was no sense, at all, that that was about to happen on the day of 2002 budget – we had no idea. At the time, there was no row going on.

**Nicholas Timmins**

And we do not need to get into that.

**Anita Charlesworth**

And I think it is really important to understand what the fully engaged scenario is, because there are two elements that really drive the sustainability. So, one is a shift towards population health, but the other is incredibly aggressive productivity assumptions, and the reason why he (Wanless) ringfences the IT spend is that he felt that was the route to a much more efficient health service.

And the third thing about fully engaged, is he is always quite tough on people taking more responsibility (for their own health) as well. From an official’s point of view, in the Treasury at the time, what the Department of Health was doing did not look like it was at all in conflict with that. What I think is a critical issue over that first five years is the attention on the immediate performance transformation, which everyone wants, and everyone is agreed on. There is a big argument, obviously, about Foundation Trusts – which is the only thing that feels like it happened for a number of years. And an underlying focus on transformation.

What Wanless talked about was needing to operate on these two tracks at the same time.

So you deliver on the current business while you build the new business underneath, which is what he felt he had done at NatWest. You keep your existing business going. You try really hard to improve it, because if you do not do that, you will lose your customer base. You cannot not do that. But at the same time, you build your new business. There is enough money in this, he is arguing, in this first phase, for you to do both. What there is not, though, is senior official bandwidth or, arguably, ministerial and political bandwidth, or actually a delivery system that really knows how to do it. And I think what I observed increasingly was, a delivery system that got all the money and just went, ‘Oh my God, what do we do?’ People did not know how to spend the money well. They struggled.

**Patricia Hewitt**

That is certainly true.

**Richard Murray**

It is true that it is much easier to see the impact on waiting times than it is on anything else. I would not lose the fact that that period is the only time in the entire history of the NHS that brought, sustainably, waiting times down in a way that the public noticed, and it did. And it showed up in the satisfaction surveys, which reached a peak and stayed there for years so that we turned around that net negative into an enormous net positive, in 2007/2008.

That did squeeze out, I think, some of the public health perspective. The department became incredibly focussed on delivery. It hit all its PSAs. It hit public health PSAs. I think, if I was mimicking David Nicholson[[62]](#footnote-62), I would say, ‘I did what you asked me to do, what’s the problem?’

And life expectancy rose faster in that decade probably than ever in British history, and a lot of that is CVD [cardio-vascular disease].

**Ed Balls**

But if you take the delivery unit meetings, which were hugely important in this period, and, actually, Treasury, Number 10 were all involved. In no sense, in the delivery unit, was Michael Barber[[63]](#footnote-63) or Tony saying to Alan, ‘are you working on the long-term Wanless preventative agenda?’ This was not part of the conversation at all.

**Patricia Hewitt**

Can I just make a few observations on this. First of all, just a very quick point, Anita, on your very interesting point about Sure Start, because I remember the first time as Economic Secretary when I was briefed on Sure Start, I thought, ‘Good God, I had no idea the Treasury did anything like this, how fabulous.’ But the difference was that the content of Sure Start, was essentially conceptualised, built and driven from Treasury.

The content on Health was absolutely not. And largely, I am guessing, due to the politics, Treasury kept a million miles away from it – this was certainly true by the time I became Health Secretary but it was also true earlier.

I would say you had a whole series of completely overlapping but different agendas. You had Treasury and Gordon, who, with the help of Wanless, had poured some money in, in a way that was massively politically popular. Tick. Tax rises into the health service, wonderful. You had at Number 10 and in the Department of Health at the top of the office for NHS and ministers the number one priority was waiting lists, and all of that. But, in order to do waiting lists sustainably and to get productivity up, which was fundamental for that to happen, there was an increasingly clear view from Number 10, shared by Alan Milburn and myself, that choice and competition were the route.

Now, this was not a sort of fully formed view, although it absolutely built on the internal market. This was a continuation of fundamental, well-established policy direction, but it was emerging, I would have said, as we went into the 2001 election. It was not fully formed. Ed, you are absolutely right, and that is why Alan’s plan and the Wanless report were two sides of the same coin. Within a year or so, Foundation Trusts had come up and that was the hospital version of an academy, and the thinking was, ‘give them much more autonomy and they will innovate and they will do all kinds of things, get some competition.’

We all know the arguments, but Number 10, and let us put it crudely, for Blairite ministers choice and competition was the key route to productivity. As a Secretary of State, probably more committed to productivity than any other Health Secretary, and knowing a bit about it because I have had at least a brief acquaintance with the private sector and exactly that Wanless-type analysis and process, the frustration for me with Treasury, was that actually they just had no interest whatsoever in productivity or value for money at the NHS.

And whereas, my DTI budget of £5billion including ring-fenced science spending, had been pored over by Treasury officials that could tell me precisely which line with £10million in it was going to be raided in order to stop councils putting up council tax, the health service budget of £100 billion had been handed over to the Department of Health, who, a few months after I became health secretary walked in – all top 13 officials – and said, ‘we have just discovered the NHS overspent last year,’ which of course – from talking to a previous Economic Secretary, they are not allowed to do, so we had to get a grip on it.

So that was the productivity piece, but that was linked to Tony’s public service reform agenda, which was emphatically not Gordon’s public service reform agenda, and hence you got into all the arguments about choice of competition, marketisation, foundation trusts, etc.

Meanwhile, at the Department of Health, and, I would say, with Alan – maybe less with John (Reid[[64]](#footnote-64)) – but with myself as well there was still work going on, on public health. Now, that took us to smoke-free legislation. It was the single biggest legislation we did in my term for health, but what we had also been doing was building the Primary Care Trusts, and their job, was to work on the fully engaged piece, though not described in those terms. That is about local partnerships, prevention, keeping people at home, and enabling them to be independent, and all that stuff, and there was some really good work going on there which we needed to build on.

But the basic problem of the Blair/Brown divisions in the Government meant that an agenda that could and should have been jointly owned by Gordon and Alan, and then remained jointly owned across government, fell afoul of the fact that anything Gordon owned Blairites were not going to own, and Tony, as Prime Minister, was not interested in health inequalities or the broader agenda. He was interested in a highly efficient, digital NHS system, without waiting lists, that would meet people’s needs and give them a real sense of being treated like proper consumers instead of grateful supplicants. Sorry, Sally –

**Sally Sheard**

I just wanted for us to note that the other thing that is happening in the health arena at this time is on health research, and this does touch on productivity and it is the Cooksey Review of 2006, which I think does demonstrate that health is something that is on the agenda of other government departments[[65]](#footnote-65). It is not just siloed.

**Patricia Hewitt**

Which review?

**Sally Sheard**

The Cooksey Review. David Cooksey. He was brought in – I think he was brought in by Treasury, wasn’t he? To look at the ‘Health as Wealth’ as agenda.

**Patricia Hewitt**

I do not remember that at all.

**Nicholas Timmins**

Now, where you have just finished goes into your time, which is 2005.

No, this is actually the moment – it would be the perfect moment to transfer from report one to report two, but before we do, Siân, is there anything that you want to say about the reception of the first one which was reported.

**Siân Griffiths**

I think, as I said, it probably helped – having a Minister of Public Health was hugely important, then a strategy, then NSFs and other initiatives. But we did not only work in health, so you are right about that. We worked across the piece– with environment, with industry, the whole philosophy of Health in All Policies. All of that meant that our activity was not actually focussed just on the Department of Health.

That is where it becomes quite complex as we did not have an adequate workforce. Alan Milburn then created the 300 PCTs just like that, and we had to find Directors of Public Health, and we had to change the whole public health infrastructure to try to provide public health into each of the PCTs, because that was the new structure.

So there was a sort of diversion at that point which meant that people who were very committed and very enthused by the idea that there was a very seminal report – in terms of Wanless recognising the long term public health agenda – actually had structural problems of trying to just survive. They had to get the whole profession reorganised, change the training programmes, change all sorts of things all at once, at the same time, as this report.

So therefore, I think that it probably comes to why when you bring out the second Wanless report, there was actually some sort of dissipation of some of the focus. And we have discussed NSFs and productivity. I mean, all the specialists, every single NSF group required public health specialists, so the specialist resource was very stretched, and although the philosophy is that everyone can be in public health, the infrastructure was not there as the profession had not been adequately developed.

So there was a set of factors – you had a workforce issue in public health, you had the structural changes going on, you had a great agenda, and we had a Department of Health not interested in us because we were not delivering on the short-term agenda. We were looking long term. And so things like Sure Start, things like the New Opportunities Fund, were much more relevant to us as a public health community. And of course, then, there is also the Chief Medical Officer[[66]](#footnote-66) who was not hugely engaged in the Wanless report, and I think that is important too, because his role in the profession is important. So I think there is a whole set of factors there – I had not really thought of that for years.

**Ed Balls**

Everything which has just been described about the situation which then happened subsequently is true. The Treasury was completely focussed on the NSFs and public investment in the capacity of the health service with contestability was going to deliver the outcome. If we needed to win the tax argument, we thought all the stuff about choice and market and prioritisation was a total distraction and irrelevance and was going to make absolutely no difference in healthcare. If anything, it would cost us more money, it was the opposite of productivity.

Andrew Lansley[[67]](#footnote-67) tried to do it in 2011, failed, and ever since then, nobody has ever mentioned choice, diversity, and market pressures in the health service. My personal view is it is a historical aberration, which was a mistake of Tony, because actually it diverted him from the real agenda, but luckily the NHS did not get diverted and carried on delivering real outcomes. That is a fundamental difference of view. I know that was the one point when the people around Tony just lost the place. But luckily the NHS delivered anyway, because we put loads of money in. But that is a difference. A fundamental difference.

**Richard Murray**

We are about to publish for the Government a paper on ways to reduce waiting times, and this is the only period in history where the NHS has ever done it and largely the evidence backs you up: money, staffing.

**Ed Balls**

We looked at America, and thought, ‘we do not want it (their system).’ Politically, why did we have this massive row? But luckily it did not make a difference to anything. It just caused lots of grief.

**Nicholas Timmins**

Okay. Second report. So this is the public health one that comes out in 2004. So again, what were its origins? Apparently, according to both Alan Milburn and Simon Stevens, the original proposal was to look at things like efficiency and productivity, and, in Alan’s words, he went ballistic with both the Chancellor and Tony about that, and Simon helped ensure that it became about public health rather than efficiency and productivity. I do not know any other versions of its origin.

**Anita Charlesworth**

I was not in the room for those conversations, so I do not know. What I do remember very strongly was that Derek was very worried about the ability to deliver. He was a really intelligent man. He felt that, to some extent, it (the review) created a bit of a window and a moment for public health.

**Ed Balls**

Did he instigate the second report? I do not think it came from us. We had already done Wanless.

**Anita Charlesworth**

No, it did not come from you. He instigated it.

**Ed Balls**

He had been very exposed and felt quite in the frame, and he sort of wanted a second go, didn’t he?

**Anita Charlesworth**

Yes, and he felt very much that a moment had been created, but that the infrastructure and the approach, as it were, to actually seize that moment and make it happen was not there. It’s not so much a political thing on how to get there. He of course had all the conversations with senior people. He was worried about taxpayers’ money as much as he worried about his own money, and he was very worried that actually the money was going to go in, but that longer-term transformation was not going to happen.

That was why he argued so strongly for ring-fencing the capital, but also why he wanted very much to have a look at what to do for public health. But of course that review really struggled because actually there was no political imperative for it. There was no ownership.

**Ed Balls**

Your description of the Alan paranoia may be totally accurate, but I think it was entirely misplaced. In no sense did we think Wanless should come back and do a second review. It is not going to help the health service at all – but Alan saw conspiracy over every shoulder.

**Anita Charlesworth**

Derek felt very strongly that the things that he had put in the review which were about how you were going to get to the sustainable growth and really deliver the value for money were not in place.

**Nicholas Timmins**

It was return on investment stuff.

**Anita Charlesworth**

It was. It was very much his desire to –

**Ed Balls**

Did you lead it?

**Anita Charlesworth**

No. Natasha Jones.[[68]](#footnote-68)

**Ed Balls**

Right.

**Anita Charlesworth**

And they were locked in a cupboard in the Treasury. Nick Macpherson[[69]](#footnote-69) occasionally said, ‘Hi, how are you?’ She’s a fantastic person, but there was no oomph behind it.

**Nicholas Timmins**

When I spoke to you (Anita) for this (‘Most Expensive Breakfast in History’ report) and I said, ‘What about the Wanless 2?’ You sat there and said, ‘I cannot even remember it.’

**Patricia Hewitt**

No, exactly.

**Anita Charlesworth**

No, I had moved on.

**Patricia Hewitt**

I know I have completely forgotten all this too.

**Iain Buchan**

At that time, was the home for the primary prevention agenda and the parenting of it ever discussed – the government department home? The economy in terms of work and productivity, social capital and local communities, those departments feel the effects of better primary prevention before it ever hits the health service. The NHS is never going to be a good parent for the primary prevention agenda.

**Anita Charlesworth**

So there were discussions going on – not specifically on the back of Wanless – but generally. PSAs were a really important part of government at the time. A lot of public health things went into cross-department PSAs. Now, there was a social exclusion unit that picked up bits of cabinet machinery around it. We were all discovering that it was bloody hard and it was easier to write them than genuinely make them happen and work.

Sometimes you have got some officials and ministers in different departments who both saw the advantage (of a joint agenda) and one would run. There was a deep ambivalence, I think, about what the role of local government was and how much more we gave local government and whether local government was to be expanded, developed, supported or not. And often a lot of the cross departmental PSAs ended up in the more prevention public health agenda, which took us back to local government. Then you get the question, ‘Are we going to do this with local government?’ John Reid did a big review – was it in 2004? – on how to get PSAs to work genuinely across government and it was difficult.

**Richard Murray**

And the Department, which had a formal lead on the public health PSAs, such as they existed, always struggled a bit because of the data. They were not so easy to define. I remember two: the health inequalities one and the teenage pregnancy one, and you would try and have conversations with other departments. The tendency that came back was usually, ‘You run off with all the money and now you are coming to ask us to contribute to your PSA.’ And they would say ‘No.’ I have to say when they would then ask the Department (of Health) to contribute to theirs, we would also say ‘No.’

So the structure of that cross-government bit did not work unless there was a crosscutting review, and there were some that triggered it. I remember the one on older people. They would work if you set it up with the infrastructure around them. With the ones that the Department led on, I remember the public health work. We looked at it and thought, ‘We can treat our way out of this. We do not need to do it through public health.’ If we have any inequalities, ‘I can do that through statins. Statins and blood pressure drugs.’

And so what happened was, the NHS went, ‘I can kind of do that. With teenage pregnancy too. You do not need local government. We will have a go at doing that,’ and we performance managed it. The problem is, that does not work very much in most public health. You cannot use the NHS, doctors and nurses sitting in hospital as your primary tool.

And that goes back to your PCTs point that the hope then was that PCTs would be the people that would reach out to local government and that is where that would begin to come from, but foundation trusts –

**Nick Timmins**

There are some wry smiles in front of me. I would love to know what people are actually thinking about. Come on, somebody.

**Siân Griffiths**

No, I was just thinking when you were talking about the working with local government issue. I mean, it is very live at the moment. Where is public health within local government and where is it going to be as the squeeze gets tighter ?and where is the voice of public health? You move public health out of the NHS and then where is the voice of public health in the NHS and in secondary care? There are some huge issues sitting there and it feels that this is just a re-run now of some of the same issues.

But we were in a better place before. I do not think we are in a good place with local government now despite the fact that public health people are in local government, because of the complexity that we have created for public health.

And we have not been clear enough about public health goals. So public health directors take on the education brief, they take on the social care brief, they take on the environment brief. They take on all the briefs because of the squeeze. And it all gets very muddled again. We need some clearer public health goals.

**Patricia Hewitt**

I have a slightly different perspective on that. I mean, my sense was back when I was Health Secretary with the PCTs I could see the top third of them, really building effective relationships in their local communities with local government. And you were getting much more in the way of joint appointments, shared budgets, more of a focus on those public health goals, as well as simply sorting out whichever bit of the health service was causing problems in that area. Some of the stuff going on in parts of Birmingham, for instance. There were a number of different things Lansley[[70]](#footnote-70) could have built on, rather than throwing it all up in the air.

But, I mean, Richard (Murray) is absolutely right. The NHS is the last place to be putting all that primary work, wider determinants of health, the 80% of health that does not depend on the statins and the operations and the rest of it. And there was not an institutional vehicle at a national level to be connecting this – the PSAs, the cross-departmental committees, and so on. We struggled with all of those. Family policy was another one trying to join up across government. But the PCTs were a very embryonic thing.

But now fast-forward – because I chair the Integrated Care Board in Norfolk and Waveney. I have been chairing the Integrated Care System, non-statutory, for the last five years. Now, it is very interesting. Our Director of Public Health sits in our County Councils. Covid, of course, has absolutely put her up in lights and turbocharged the relationship between our two tiers of local government – because the district councils are key in this for a two-tier area – and the NHS, the voluntary sector and primary care. And, although it is a desperately complex institutional structure that has been created for the new ICBs, we do now have 42 ICSs which join local government and the NHS, and the wider voluntary second-line partners. It is imperfect, but it is a vehicle.

And final point, when Simon Stevens set up the Sustainability and Transformation Partnerships, now six years ago, they were simply drawn on health authority boundaries. And it was increasingly clear – I was one of the first chairs – that NHS England did not begin to understand local government. They would say: “Where are they (local government)? Who are they? What does two tier mean?”. They have been on a learning journey. NHS England have got a much better sense now and the Department of what local government is about. There is still too much of the NHS saying, ‘Oh, right now we are going to do population health management. Right, here is the committee. Everyone will come to it.’ Rather than actually recognising that everybody else has been doing this for quite some time. The NHS could come along and be supportive but…

**Sally Sheard**

I do think Covid is useful as an example but Covid is a pandemic in an atypical situation. The question is can you maintain that (collaboration)? Can you maintain it and can you institutionalise that for public health goals for the future?

**Patricia Hewitt**

That’s what we have to do now.

[Crosstalk]

**Anita Charlesworth**

Can I rewind a little bit?

**Nicholas Timmins**

I was going to say: can I take us back a bit, yes.

**Anita Charlesworth**

Yes. I want to argue that I do not think the problem in the eight years after Wanless 1 was published was that the social determinants of health were not being addressed. So ‘Welfare to work’ that we worked on, ending child poverty, legislating to end child poverty, all of that work was happening. Trying to narrow the attainment gap in education, it was happening.

There were not countervailing and opposing agendas. I did not feel the problem on Wanless was because we were sitting in a Government that was not committed and was not trying to improve social determinants of health because everything else I worked on was exactly focused on that set of issues. It just did not describe them in those ways.

**Ed Balls**

But it was a government which, like the Thatcher government and the Major government and the Cameron government in economic policy and in health policy was just quite local government sceptic.

**Anita Charlesworth**

Yes.

**Patricia Hewitt**

I think we were very local government sceptic.

**Ed Balls**

We were very local government sceptic. And so, the problem with the whole preventative agenda – is there is not the belief in local government. There would be this sort of sense of scepticism – whereas actually if the NHS is going to do it, people think, ‘Well, that is okay,’ or actually, ‘Well, maybe the employment service is going to sort it out,’ or, ‘The schools are going to sort it out.’

And it is a huge problem. I have been doing a separate history project. We have conducted interviews about levelling up. And we have interviewed Patricia. We have interviewed all the Prime Ministers, Chancellors, everybody – 80 people from the last 40 years. One of the things that comes through consistently is people saying, ‘We were so distrustful of local government and their capacity and their ability to deliver.’ So when it came to the margin, if you wanted a preventative health agenda and it was going to go to local government, well, there would have been less enthusiasm and resource allocation. The political process would have thought the NHS was better placed. And actually public health outside the NHS has always been, in this 50-year period, a big problem.

**Patricia Hewitt**

It is a big problem, yes.

**Paul Atkinson**

And this goes to an absolutely decades-long problem about the governance of health.

**Ed Balls**

Yes it totally does.

**Nicholas Timmins**

This is a complete aside: I have never understood why both parties are always so sceptical. On one level, there’s always –

**Ed Balls**

I interviewed Tony Blair last week who said it was because Durham County Council were so rubbish. It’s micro to macro.

**Nicholas Timmins**

Yes. Yes.

**Ed Balls**

It is quite personal.

**Patricia Hewitt**

Yes, Yes. I am afraid I have been doing the same thing – because bits of Camden Council were rubbish, you know. And bits of Leicester Council were a bit dodgy.

**Ed Balls**

I was Children’s Secretary for three years. They do a really, really good job in Hull, say on preventative interventions on children’s policy. But if you live in Bristol, the fact they are doing well in Hull does not really help you. And if you are a Secretary of State, you get much more grief from Bristol failing than Hull succeeding. You have 150 centres, of which one failure is really bad. It is decentralisation in a world in which public accountability happens through Westminster because that is where the taxes are raised. That is such a problem –

**Patricia Hewitt**

So centralised.

**Ed Balls**

– to deal with the risk of local government delivery. We could all come up with examples of great local government capacity doing great leadership, but they were never the thing which causes a problem. Whereas with the NHS you thought, ‘Well, at least the NHS can grip it at the centre,’ which I know is bad, but it is the truth.

**Nicholas Timmins**

Richard, you wanted to…

**Richard Sloggett**

Yes, I wanted to come in on the context for the second report, particularly the political context because it lands in February. It was interesting that you said you do not remember because at the time of course we are in peak Iraq war time.

**Patricia Hewitt**

When was it – sorry.

**Richard Sloggett**

February 2004

**Patricia Hewitt**

Oh, of course.

**Richard Sloggett**

So there is a question of Wanless –

**Ed Balls**

Post-invasion.

**Richard Sloggett**

Post invasion, yes. So there is this thing when Wanless 1 lands where you have got the NHS under huge amounts of pressure. And there is this question about money. When Wanless 2 lands and it does not feel like there is anywhere near the same sort of driving factors around the discussion, which then politically means it does not have a home. And we have talked about the delivery but it just does not have the same kind of environment as a first report. Is that a fair characterisation?

**Participant**

Yes, no absolutely.

**Ed Balls**

Well, we need somebody to tell us we are wrong. I think this was a thing which Wanless wanted and therefore it was easy for him to do it. And that is fine. But those are not the reviews which deliver anything. Do not forget, in retrospect, the massive achievement in my view – I think it is a big policy and political achievement – is to get to the point where you re-establish the consensus about tax-funded free at the point of use health service. By 2010 it has become consensual again. But in 2004 it is not yet.

**Patricia Hewitt**

It was not, absolutely.

**Ed Balls**

And we have not (won the argument yet). The 2005 election, the Tories are still going to fight on the patient’s passport, and so you are still in this world. And the measures of public satisfaction had not come through at that point.

**Participant**

No, they had not.

**Patricia Hewitt**

No.

**Ed Balls**

And so therefore you have got this vulnerability. And in this vulnerability there is this guy called Wanless, who is a banker –

**Patricia Hewitt**

– who wants to do a report.

**Ed Balls**

– who did a first report, which we all relied upon. If he suddenly appears on the Today programme three months before the election and says, ‘My report was rubbish. The health service is failing. This is terrible’ that is a big problem. So the truth was there would have been a big Wanless-handling process. It was basically you have got to keep Wanless in the tent. And if he wants a review, give him a review. If he wants a knighthood, give him a knighthood. I am not saying that that was the case, but do you know what I mean?

So I think this would have been much more about keeping Wanless on side than anything to do with a policy imperative or political imperative.

**Patricia Hewitt**

Absolutely. Absolutely.

**Richard Sloggett**

And, as you are saying on the handling of Wanless, I have just thought about Andrew Dilnot.[[71]](#footnote-71) Because the thing about the Dilnot review of social care, as soon as there was any backtrack – Andrew would go on the Today programme and say, ‘I did this review. It is really sensible. It does not cost that much money. It needs to happen.’ And there is an interesting comparison there between someone who has been commissioned to do a government review in health policy, who has then felt that he had been ignored in his proposals, whereas, actually, maybe the political decision was taken, ‘Actually let’s keep Derek doing it. Do another one.’ And he does one in 2006 with the King’s Fund.[[72]](#footnote-72)

**Anita Charlesworth**

He does the 2006 one because one of the things he was not been allowed to do is social care, which he realised quite early on was his biggest error in the terms of reference. And you probably thought that it – I mean, we all probably think with hindsight –

**Richard Sloggett**

– with where things are, of course we do.

**Anita Charlesworth**

Yes, and the reason why was because it was all the backwash of the Royal Commission. And it was a hard enough thing to do anyway.

**Ed Balls**

Once it gets to 2006, Wanless is no longer going to blow things up.

**Anita Charlesworth**

No.

**Ed Balls**

But in 2004, there is this quite big risk and he is not being looked at by any of the NHS or by the Department (of Health). Number 10 sort of do not really want him and we have created this monster –

**Patricia Hewitt**

He was your child. He was yours.

**Ed Balls**

So therefore he wants another review. And he probably wrote the first terms of reference to be really wide. And Health are going bonkers, when I said, ‘Anita, oh my God, sort this out. Get him onto something he can do.’ I think the idea that there was some big piece of political Machiavelli here is mistaken. It was the opposite of that. It was that we just wanted to make sure that Derek was still okay. He had made his contribution massively but he probably himself was not fully appreciating quite the scale of what he had already achieved.

**Anita Charlesworth**

So can I raise one other thing, which I do not understand fully and feels like a big, missed opportunity. So, alongside public health, if we had been delivering quite fast on the vision of fully engaged, we would have been putting a lot more resources into a primary care system that would have probably looked a lot more like the Ara Darzi[[73]](#footnote-73) model. And it took a very long time comparatively to get to that. That seemed really aligned with the goals, and it went kind of nowhere for polyclinics.

And Primary Care policy has felt like one of the biggest failures.

**Patricia Hewitt**

Absolutely.

**Anita Charlesworth**

And I am on the board of an ICS as well and nothing that we can achieve – that we would want to achieve – is possible without primary care at scale, sustainable, with a much more fluid model. And one of the things that obviously was really important, coming out with all the money, was the investment in the workforce, but that did not happen – we grew the specialist workforce much faster than the primary care workforce. When you look at the workforce mix that emerges through that period, you have cognitive dissonance with what policy was and what the Wanless review said was the workforce that you needed.

But I am interested to hear why that bit proved so problematic to move forward with. We are still living with that now and it remains the case. And it is one of those examples where no one disagrees. One of the interesting things about some of the failures where we made limited progress against the objectives was not that there was outright opposition. There was not a row, ‘No, no, no, we’re not willing to invest in Primary Care. We do not want to grow the number of GPs. We do not think that that is right.’ But somehow, even with people being broadly supportive and signing on with policy statements, we have struggled to deliver.

**Nicholas Timmins**

Yes, [inaudible].

**Anita Charlesworth**

Oh, do you think?

**Nicholas Timmins**

We will come back here in just a second because when you get to Ara, well, a) he called them polyclinics –

**Patricia Hewitt**

Exactly.

**Anita Charlesworth**

Yes, that was an error.

**Nicholas Timmins**

– that was a terrible mistake. And b) the BMA did oppose them.

**Anita Charlesworth**

Yes. That is the power of the BMA.

**Nicholas Timmins**

I mean, the BMA fought like hell. And the Stalinist connotations, just the name kind of sank them from the beginning. They did not want their world changed.

**Anita Charlesworth**

Well, yes…

**Patricia Hewitt**

Well, absolutely, because this primary care agenda and rooting things in communities, which was prevention and early intervention, all of that (was a change). I mean, one of the very first things I did, which was actually suggested by some of my officials was a full-day workshop with a fabulous bunch of GPs. And the thinking was they were all – the GPs and the BMA GP committee –really grumpy, despite vast sums of money having been poured in courtesy of the Treasury in different contracts.

**Ed Balls**

Hadn’t we just given them a massive pay rise?

**Anita Charlesworth**

Yes.

**Patricia Hewitt**

Exactly.

**Ed Balls**

Despite our best efforts.

**Patricia Hewitt**

Yes. Well, indeed. I am sure we –

**Ed Balls**

Why did we spend it all on these GPs and consultants?

**Patricia Hewitt**

Yes, poured it into them. Grumpy as hell. So this was a sort of charm offensive: get them around the table. We had this wonderful workshop, full of these intelligent, creative people coming up with all kinds of good ideas. But, at the end of it, I said, ‘Do you know what? I was dreading this because I have been told how cross you were.’ So that was very, very interesting.

And then we sort of morphed from that into our Healthcare white paper[[74]](#footnote-74). The idea was to have a really serious piece of properly constructive, deliberative democracy to see how we would win public understanding and support for an agenda that put acute hospitals in their place and reshaped them to do what only they can do, but recognise that medicine is taking you towards much more specialist regional and hyper-regional centres, and much more local Primary Care - chemotherapy in the home, etc. And so that was the political thinking around, *Our health, our care, our say*.

And meanwhile we were really trying to engage with the primary care community and, therefore, particularly GPs around it. But you had the BMA who said nothing is going to change regarding the private partnership model. You had the national contract. Here there was some progress, this was the time of QOF (Quality and Outcomes Framework) points and that was all quite early and starting to get some traction. We were desperate to get – as everybody always is – more GPs into the underserved areas, which are the poorest areas with the worst outcomes in the country. And the only way we could do it, essentially, was this to say: ‘Right, here is the money. This is where we want the Practice. Who will do it? And if a decent NHS GP will not do it, we do not care. Virgin come on in.’ Whoever. Anybody who would provide primary care in deprived communities.

So what then happens? The BMA goes hysterical. The chairman of the committee who opposed it actually had to resign to the committee because his Partners in their practice won a contract under a tender process that he was personally opposing. We had all of the ultra-left having hysterics about the alleged privatisation of the health service. And when we say, ‘Excuse me, GP practices are private.’ The response was: ‘No, they are not private businesses. They are part of the NHS. Public Good. Private Evil.’

So we had all of this nonsense going on. Fast-forward to where we are now, and we have got (in Norfolk and Waveney) – and this would be fairly typical – we have got some fabulous GPs in very rural areas. We have got more GP partners and fewer salaried than perhaps London. But we have got some fabulous, highly innovative pretty much at scale, GP practices, running multiple surgeries with big, multi-professional teams, by and large doing the kind of thing you would want them to do. We have got a soggy middle and we have got a small number of horror stories. But, getting the ones who are overprescribing opiates and leaving their patients to go to A&E to change – unless they are actually damned by the CQC – and most of them are not because they are not bad enough – to leave is virtually impossible. We can scarcely get them to talk to us. I mean, we can go and see them. They will not come to any meeting, however easy we make it.

So the leaders are not there and I had high hopes that Sajid Javid was actually going to look at the GP contract.[[75]](#footnote-75)But sadly, that was two Health Secretaries ago and well off the agenda now.

**Richard Sloggett**

I think they got pretty close but they did not push it over the line.

**Nicholas Timmins**

Can I just drag us back slightly to one of my complete frustrations when I was doing this and today is we could not get Liam Donaldson to engage because he was the CMO at the time of all this.

**Patricia Hewitt**

Not his thing.

**Nicholas Timmins**

And I did go through his annual reports and it barely gets a mention. I mean, it is almost as if it never happened.

**Patricia Hewitt**

Not his thing.

**Nicholas Timmins**

I am just sitting there thinking that we talked about ownership at the Department. We have talked about what the Department tries to do. The Chief Medical Officer appears just not to engage.

**Richard Murray**

A couple of things about primary care and the attention it gets. Yes, it did not get enough attention in the period that we are talking about now, but look at it now. I mean, the thing has fallen of a cliff. By no standards in history has primary care ever been anything like this – even in 1997 it was not this bad. So one of the reasons why I think the Department sometimes look the other way is public satisfaction for GP services was incredibly high. And public loyalty to their GP. Harold Shipman[[76]](#footnote-76) was an extremely popular GP. It did not cause the grief. And I think for too long, it has been a bit of a cottage industry within the Department and it gets tracked into point-to-point negotiations with the single professional body.

**Patricia Hewitt**

Correct.

**Richard Murray**

And everything ends up being a pay negotiation.

**Patricia Hewitt**

True. The rate card.

**Richard Murray**

Exactly. Exactly. And it is kind of trapped in that mindset. I am not surprised Liam did not really talk about it, neither did his predecessor and neither did his successor. So it is not that odd; there is a more permanent problem there. The only other thing – I’m beginning to sound like I have been sent –

[Crosstalk]

**Ed Balls**

When you said ‘Liam did not talk about it.’ And by ‘it’, you mean –

**Richard Murray**

– General Practice and the role of primary care within communities and public health.

**Paul Atkinson**

Do not forget that Liam’s big, big, big focus was patient safety, wasn’t it?

**Patricia Hewitt**

Exactly. Exactly. My first meeting with Liam. He came in. He sat down. We said, ‘Hello.’ And he puts 10 cards, like dealing a pack of cards on my table. And each one has a photo on it. And he is sitting here and he puts them so that I can see the photo. I an looking at these photos. And he says, ‘These are all people whom the NHS has killed in the last year.’ That is what he cared about. And we brought him in – what’s his name? Berwick?

[Crosstalk]

**Patricia Hewitt**

Don Berwick[[77]](#footnote-77). That was his big thing and the other thing was medical training, which was a complete screw-up. And do not forget the other thing about GPs: not only are they at that point full of public satisfaction. But they are looked down on as public health consultants tended to be by acute consultants. And, therefore, you have got all that medical hierarchy stuff –

**Barry Tennison**

– much less than they were in the 1950s or the 1960s. So things have changed a lot right now.

**Patricia Hewitt**

Well, I am glad to hear it.

**Barry Tennison**

Could I just say about the CMOs. I mean, the CMOs are incredibly different. They all have their own special interests and places that they come from and it is an extremely hard job for them to actually take the breadth of view that some people outside their realm might expect. It is sometimes very frustrating for those of us who are public health people because they are not necessarily very public healthy. That may come as a surprise to you, but it is not to us.

**Patricia Hewitt**

To be fair, Liam did smoking.[[78]](#footnote-78)

[Crosstalk]

**Barry Tennison**

They did do some good things.

**Siân Griffiths**

He also created the Health Protection Agency (HPA). He had a sequence of reports. There is a sort of sense of which sort of engagement the CMO will have in the health and social care agenda in Nick’s pamphlet. And that’s actually historic because the CMO is supposed to be separate and across the whole of government. So I think – and Liam was particularly aware of that – that he would choose very specifically what to engage in. I thought it was unfortunate he did not engage with Wanless more. But he was very clear about being independent.

**Nicholas Timmins**

Oh yes, sure. And, as you say, he did some other very good things.

**Siân Griffiths**

Yeah. The HPA – I don’t remember what that one was called – but it was actually very good in analysis in moving things forward.

**Barry Tennison**

And Sally Davies[[79]](#footnote-79) came out of a research background. Her focus was absolutely on research and some of us (in public health) felt no backwash at all.

**Iain Buchan**

Given enough cover from the Cabinet Office, could a Chief Medical Officer go to Treasury and say, ‘We think you are the absent parent in prevention and early intervention,’ because all of the power, control and influence is vested in the highest cost centres and the managers in the NHS, who will be looking at that as any reform vehicle, so everything else will be marginal. The only way we can disrupt this to deliver prevention and early intervention is by having a national parent agency with enough power to allow the network of public health professionals to work across agencies. So this does not fall between stools and dilute to impotence.

So could you envisage a CMO holding that mirror back and saying, ‘Look, National Insurance is a lifetime and a population-wide price and we are not delivering on that in prevention and early intervention. We need a different cross-government relationship here, and we need someone to be a parent.’

**Richard Sloggett**

And just building on that: if you think the Department is basically managing the NHS in its focus, if we talk about the two delivery vehicles – local government and GPs – both having challenges in terms of their ability to deliver on this agenda, one of the proposals or solutions that you could then propose is that we build some sort of central agency or central convening body that brings together the relevant people to make decisions. Now, that feels like the gap to fill. Practically, that raises a whole range of questions about how you can do it. And I think it is an interesting space in which to try and find solutions.

**Nicholas Timmins**

Could I pause this point and say we are now getting into sort of Section three, which is legacy. And right now would be a good time to break and have a cup of tea and then come back.

**Ed Balls**

Let’s do that.

**Nicholas Timmins**

In a sense come back with that as the opening concern.

**Ed Balls**

Yes, it is a good idea.

[Crosstalk]

[Break]

**Nicholas Timmins**

So let us just start with where you got to, Iain. Is there some way that, if the Treasury took control of this agenda we could change all the balances of power?

Iain Buchan

Yes, the promise of National Insurance being a lifetime investment on a whole population, and not just the rescue bit at the very end. How do we maximise the return on investment for the whole of society? Is Treasury the only natural parent for prevention, early intervention? If we are always going to have the short-termism bias, understandably, with huge pressures in a sickness service and most of the power, control and influence surrounding those managers who stick around and build really quite persistent lobbying mechanisms, centred on acute trusts. If we have concluded that the locus of power and prevention and early intervention is too dilute across public health and primary care, what big parent is going to give that the concentration it needs?

**Ed Balls**

I am a bit confused by this. Who is it who is turning up? Whether it is the Treasury or the Prime Minister, or the Health Secretary, in a way it is slightly second order. Let us say, rather than the Treasury, say the centre. So say that the centre is cohesive, which generally, actually, it is, who is it who turns up and says, ‘You have got to do this?’ When you said the CMO, I thought, ‘is that really the CMO’s job?’ I mean the Chief of Defence Staff is never going to turn up to see the Prime Minister and the Chancellor and say, ‘Sort out a better way to run defence’. That is his job. So the CMO’s not going to turn up and say, ‘I need you to impose upon the new structures’.

**Nicholas Timmins**

And CMOs are no longer as powerful as they once were.

**Anita Charlesworth**

No.

**Nicholas Timmins**

I mean, they once were absolutely –

**Ed Balls**

But it might go to your point, which is that there is not a leader of this service. But I sort of think, ‘Who is it?’ I was not quite sure who it was turning up and asking for it. Who at the moment would say, ‘Sort this out’?

**Patricia Hewitt**

I think there is a bigger issue here. I think it comes back to a point Anita was making, which was that, actually, when we were in Government, we were absolutely acting on the wider determinants of health, but we were not calling it wider determinants of health, or public health, or population health management. What we were calling it was child poverty, unemployment, lousy outcomes for kids in poor schools, and that is what we were acting on, and that is what made a difference and helped to drive lives. I mean, there were other reasons for it, but things like the whole reshaping of tax credits, and family tax credits on my massively disadvantaged council estates. I was seeing and hearing the difference from family after family, lone mother after lone mother. So we were making that difference.

So that is wider determinants of health and health inequality. That is politics. That is not owned by Treasury or CMO, or some organisational thing. That is the government’s commitment, if that is what the political party in power wants. That is the ‘levelling up’ agenda, except it is rhetorical, rather than real. At a local level, I have been very pleasantly surprised. I am in not only a two-tier area, but an area that is almost entirely Conservative, in local government. I thought I was going to have to avoid talking about health inequalities, but instead talk about fairness and people who are disadvantaged. Not a bit of it. They are absolutely committed to tackling health inequalities. Tory councillors are passionate about this stuff, and they absolutely want to make a difference to their particular communities. That is a much wider political agenda.

If you are talking about public health and prevention in a sort of narrower, more health kind of way, and you are more focused on vaccinations, or an obesity strategy, I think an anti-obesity strategy straddles a whole set of much wider things, but also absolutely brings in the NHS, and particularly primary care. Then there might be a role at the national level for a more effective cross-departmental working. It is sort of back to your point about the PSAs being a real attempt at this, but not quite working. At the local level, this is what the integrated care systems are meant to do, and are busy getting on with.

**Iain Buchan**

If you get the Integrated Care Boards (ICBs) to increase their acuity on prevention, early intervention, it will have an economic impact.

**Patricia Hewitt**

Of course.

**Iain Buchan**

So there is a Treasury interest in the work of productivity, in social cohesion, the civic resilience, that is intangible at the edges, but you have got a bit in the middle that no one is owning. You have got wider determinants of health separate too; but (as you have said) that is politics. But as we have said, if we say that is politics, it falls between the stools. No one owns it.

**Patricia Hewitt**

No it is not. I mean, child poverty is owned. Education is owned. But they are not owned by the NHS, and they should not be. The NHS are the last people who should be doing that.

**Ed Balls**

It is why measuring the accountability is important. If you take something like, for example, I was Secretary of State (for Children, Schools and Families), with teenage pregnancies for three years. My memory of teenage pregnancies was that there was variation across the country, which was not really related to what you might think was a conventional measure. So it was not actually area by area, correlated with income, or religion, or any other kind of characteristic. But when you dug into it, the conclusion of the teenage pregnancy team in the Department, was it fundamentally came down to leadership.

If the teenage pregnancy objective was owned by the PCT, or the NHS, or the local authority, and it was being led by a medium ranking official, nothing would happen. Whereas, if the Chief Executive of the local authority and the PCT both thought that this was really important, and they thought being accountable for the outcome was important, and they sent a signal to the system, ‘We both care about this’, that was the thing that got teenage pregnancies down. Because it actually changed the de facto practice of school advice and social work advice and –

**Patricia Hewitt**

Housing advice, probably.

**Ed Balls**

Housing advice, but also the way GPs operated. But it was all fundamentally about leadership. So it was not about putting a service in charge, because actually it was necessarily crosscutting. It was fundamentally about leadership, but the leadership only mattered if there was accountability. And then we had another issue, which was non-accidental injuries in children, and we had this big problem. How did you galvanise? Because, again, non-accidental injuries in children is actually much more complicated than social workers, because by the time it has got to the social worker, they have probably already been injured, and how are we spotting this early? Does the school care, and does the NHS care?

So the measure we came up with at the time was children presented at A&E with a non-accidental injury, where we required data to be collected, and then there was a conversation with the Children’s Trust, about why is it the case we have more children going to A&E with non-accidental injuries in this place, compared to place *y* and place *z*? It becomes then a conversation about, ‘Oh, well it turned out there were calls going to the police about people who were worried, but they were not routing it to social work’, or there were things being spotted in the NHS, but they were not tipping people off. So it actually became a systems issue which came back to leadership. So the fundamental thing is people feeling locally, one, they are accountable for an outcome which is crosscutting, and then the leaders thinking that sorting it out is a good thing. If you get both those things, things start to work. You cannot solve that by an agency. It is not actually going to happen nationally. Nationally, you have to care about whether or not things improve. So you have to publish, nationally, the outcomes or non-accidental injuries or teenage pregnancies, but then demand local accountability, which is not an agency.

**Iain Buchan**

I think we have hit a really important point about granularity. If you say nationally you need to own the National Grid, but locally you will manage those power stations for health and society, it is only manageable for a defined population that is small enough to see all the moving parts, but big enough to have some economies of scale. So there is an optimisation problem.

**Ed Balls**

The Audit Commission have to collect the data and publish reports, and you have to have output targets which are set, and then you have to resource them, and all those three things were in place when we were in government, and then the Audit Commission was abolished, the PSAs were abolished. You moved away from joint, collective accountability of your outcomes, and in that world, nobody is forced to do the collective leadership unless they choose to, which is a bit random, and you do not solve it by a local agency. You solve it by going back to the accountability, I always say. Is that wrong?

**Anita Charlesworth**

Two things which happened at this time which partly play into this debate. So not because of Wanless, but during this time, another thing that happened in Government, championed by Gus O’Donnell[[80]](#footnote-80) and Richard Layard[[81]](#footnote-81), were the development of wellbeing measures alongside GDP. This was thinking that as a nation, we need to think about what success looks like in a broader sense. This allows us to begin a national conversation about that, and also then as we are thinking about assessing policies, we start to look at them more broadly. A really interesting case study where policy changed is Richard Layard’s championing of IAPT (Improved Access to Psychological Therapies) which came out of him saying, exactly your point. For labour market goals, we have got a whole load of people now who are not in the labour market because of their poor mental health. And there are a whole series of things which if you do them, that are really cost-effective, really well evidenced and could help people get back into work.

So we need to make that a priority for the system, and then we need to drive through delivery of that. You could argue about the detail, but the reality is that we have ring-fenced just shy of £1 billion of NHS funding to create IAPT services. We created a new class of healthcare worker, which is the IAPT professionals. We created national standards. We measured the effect of the health outcome by whether people were engaged in work, by employment outcomes. So there is quite an interesting case study in that; and then obviously now morphing in Wales into the health of future generations thinking, and then in New Zealand about the four kinds of capital.

It partly links in here. I have worked in the Treasury. There are many things you can do in the Treasury, but if you have had experience with Treasury for quite a while, you have to be very humble about the limits of what you can do, and the harm you can do if you try to do too much. But Treasury can influence some of the frameworks, context and thinking.

**Iain Buchan**

Let us just take ownership of mental health, because this is a really difficult exam question for an integrated care system, as they are formed at the moment. Who owns mental health? If you optimise that nationally, you have a one‑size‑fits‑all problem. IAPT just does not work on the national modelling, particularly in some of the most challenged and complex areas where the greatest needs are. But where is the management quality locally? We have got ICBs that have third rate managers managing first and second-rate managers, if I am being brutally honest. They are failing to appoint the quality of chief executive to ICBs, that can hold some influence –

**Richard Murray**

Just to be clear, they have only been in place since 1 July, so watch and see. I am not necessarily disagreeing with you, but they have been in place for about three or four months.

**Iain Buchan**

Okay, so I have talked to candidates for three different integrated care systems who really wanted to do the job. They did not want to leave their big trust job, with tens of thousands of employees, because they thought that their power base for having greater influence for something they cared about was greater if they stayed in their trust, than going to something that might be ‘fly-by-night’. The politics says create a really good integrated care system, but the existing power base cannot be moved in the NHS. How do we get across that?

**Nicholas Timmins**

Well, I mean I think I would say to that you only need 42 of these people, and I mean, it is not as though –

**Patricia Hewitt**

Can I make a few comments on all of this? First of all, just coming back to Ed’s description of teenage pregnancies and then safeguarding, effectively non‑accidental injuries. I think that what you were describing was exactly right and it moved the dial, and it was that combination of national focus, local leadership, accountability, transparency, data, and that is a really powerful mechanism. But if you do it on too many objectives, it gets weaker and weaker on all of them, and there is a real risk of that, and, of course, that is the story of NHS targets as well.

I think in the context of ICSs, or any attempt at local partnerships and local change, you also need some room for some local priorities. I mean, we have a very centralised state, and I would not leave it to the centre to say these are the top 10, 20, things that local leaders will be measured on. Because, actually, local leaders, who include local government, elected by their local population, will say, ‘Well, actually, either for this area as a whole, or for parts of our area, the really important thing is something a bit different’. So you need just a little bit of flex there.

**Ed Balls**

Well, you know how hard that is. If you are the Secretary of State, and you have to answer a question in Parliament, but the question is, ‘Why is teenage pregnancy not a priority in Leicester?’

**Patricia Hewitt**

Yes, but not everything can be a priority at the same time.

**Ed Balls**

That is true.

**Patricia Hewitt**

So teenage pregnancies at the time –

**Ed Balls**

But as a minister you never want to answer that question.

**Patricia Hewitt**

Excuse me. This is part of the art of politics, Ed, as you know, and the skill set of politicians to be able to waffle.

**Ed Balls**

So you allow the flexibility for the ‘how’, but the ‘whether’ is quite difficult.

**Patricia Hewitt**

It is, but if you promise to make everything a priority, and set up a programme, and hold people accountable, and publish a meeting, which is where we ended up and what too many ministers do that is no good. So I would say a sensible number of national priorities, with space for a bit of local, additional stuff, and all that local multi-agency leadership, absolutely.

Now, Iain raised this issue of scale, and that bedevils this conversation – Nick and I were just having it. So I inherited, I do not know, 132 PCTs, something like that, and 25 SHAs, and it was very obvious to me, and I suspect would be to anyone who came from the private sector, there is no question to which 132 and 25 is the right answer because I could not have a meeting with 25 SHA chairs, and even remember who they all were. I mean, please. Ridiculous. So we moved it to nine or 10, which was almost, but not quite, coterminous with our new regions, and, we had a reorganisation. But what it meant was you could get your arms around it. You can have a sensible conversation with the SHAs, and they could have a sensible conversation with the PCTs.

We are now in a situation where you have got 42 ICBs and we have got nine, I think regions, and there is a real danger that all we have done is create another layer of management and regulation.[[82]](#footnote-82) Now, we are desperately trying to avoid that, but it is a real problem. There is a tendency in the Department and NHS to say, ‘Oh, we have got too many ICSs. Let’s merge them’, and then they look at the map and say, ‘Oh, Norfolk and Suffolk, you could be one’. I think actually trying to drive, or take a bus from one to the other would show how difficult that would be.

So that issue of scale, and what you do within a system, what you do at place level – very different between unitary and two‑tier – and what you do at the neighbourhood level, which is where a lot of your social and community assets are, and a lot of your deprivation is in an area like ours. It is at neighbourhood. It is not spread in a larger area as it might be in Birmingham or Manchester. You actually have to be very sensitive to those local circumstances.

**Ed Balls**

I cannot remember what you said when we asked you this, but actually one of the things which comes out of the economic work we are doing around levelling-up is that (and Heseltine makes this point really strongly) is that we have ducked the big issue of 1972, when we rejected the committee of local government organisation[[83]](#footnote-83). Your problem is if you are looking for effective partnership, in which local government is one of the partners, but you take the local government map as a given, it is a catastrophe because 150 is even bigger than 42 –

**Patricia Hewitt**

Indeed.

**Ed Balls**

– and then you add on top of that tiers – and, actually, of course you would not merge Norfolk and Suffolk, but a sensible world would have a sensible number of one tier Mets (Metropolitan councils) and if you did that, and the NHS aligned, suddenly you would have something workable. And, actually, the NHS, as you know, because it has done it quite a number of times, the NHS is quite good at reorganising. There have been a few times –

**Patricia Hewitt**

We are very bad at it.

**Ed Balls**

No, no.

**Patricia Hewitt**

We do it all the time.

**Ed Balls**

We do not mind doing it regularly, but at local government we never do it, and even if we try and do it, we then tend to duck it. But actually maybe the answer to this point is that unless you actually reorganise local government properly –

**Patricia Hewitt**

Ed, now, I would have totally agreed with you when we were in government? I lived in London for years. I was an MP in Leicester and lived there. Now that I live in Norfolk, and I am getting to understand rural, large geographies and two-tier systems. Norfolk has argued about local government structures and unitary for at least 35 years.

In the five years that I have been chair of the system, we have been round the course at least twice on unitary, because some of the Tory leaders want two unitaries. One capital King’s Lynn, one capital Norwich. County council Tories have said no chance. So they are confrontational. I simply observe they are now like this all over again about the devolution regarding the county deal, the idea of the rural mayors. This is a blue‑on‑blue fight, and I just say, ‘Fine, I will work with whatever local government boundaries you give me’. Meanwhile, we wasted six months, a great deal of money, time and effort having an argument about whether we change the boundary of the ICS to make it coterminous with the two counties. Matt Hancock[[84]](#footnote-84) absolutely wanted it, and would have done it if he had stayed. Javid took a more, in my view, intelligent approach and said ‘no’. That may resurface, who knows?

I am afraid I think you have to go with the grain of what is possible in different places, and give them incentives.

**Ed Balls**

But it is kind of why you end up – if you care about policy outcomes, you tend to think – ‘Let’s do it from the centre’.

**Patricia Hewitt**

I know.

**Ed Balls**

Because trusting local government and trying to reorganise it is such a nightmare –

**Nicholas Timmins**

There has been quite a lot of local government (organisational change) that goes on, over the years, bit by bit. I mean in Dorset it has changed completely. They are re-designing Cumbria and Lancashire at the moment.

**Patricia Hewitt**

Devolution deals, county deals, I think that is the right to do it.

**Ed Balls**

It is fundamentally politics.

**Nicholas Timmins**

And if you want to reorganise local government, remember Rutland.

**Ed Balls**

If Patricia thinks 25 is too many to have in a room, then how do you manage to align sensibly, locally, for crosscutting objectives, not over 25, but over 150 plus?

**Richard Murray**

As a longstanding national person, I am slightly more of a convert to Patricia’s point of view now. You cannot performance manage, you cannot oversee that many objectives. There is a very limited number, and what the NHS has always done, because it is the most easy thing to do, is it has ended up with too many – way too many – which means you also cannot performance manage them properly. One of the things that Alan and his successors, Patricia, did is cut that list down.

I mean, Alan started with about 100, and it came down to fewer targets, a bit of inequalities, and then you can hold people to account. I think the centre keeps on falling into the belief, that if I can monitor all these things, I can make them do it locally, without thinking, ‘What resources have they got? Have they got the staff or the money to be able to do it?’ And so although I agree absolutely on accountability and responsibility on a limited number of things do not exaggerate how similar areas like Cornwall and Croydon are. They are facing a very different demographic, and in five years time it will be even more different.

The bit I would not want to lose is that we are in a natural experiment about how ICBs work – can they pull this off? – and I would not mess around with that now. They have only been doing it for a couple of months.

That still leaves the national level. Every time as a person from the Department of Health I went to Treasury and tried to talk about taxation policy, regulation policy, tobacco the answer was, ‘That’s none of your business. That’s reserved to Her Majesty’s Treasury. Go away.’

**Patricia Hewitt**

Indeed.

**Richard Murray**

And you could not get the door open. So you can do all the great things that local government and the NHS might be able to do at local level. But if you want to ban –

**Patricia Hewitt**

Alcohol taxes.

**Richard Murray**

Alcohol taxes –

**Patricia Hewitt**

Sugar taxes.

**Richard Murray**

And we have seen it just recently. So the obesity strategy has been dumped. So things about banning unhealthy foods before the watershed, buy one get one free is dead, the tobacco strategy that Sajid Javid was going to do, dead, and the inequalities strategy all gone, because Thérèse Coffey[[85]](#footnote-85) does not want to do it.

**Ed Balls**

But is that not what the CMO should be going into –

**Richard Murray**

What are the only things that national government can do? And, let’s face it, on things like tobacco, they are crushingly powerful, and they would be on obesity, if we did them (the policies) as well. You cannot expect each local authority to try and legislate over local taxation and closing chicken shop stands. It is torture. So I do accept there is a gap somewhere there at national level. Actually I would not say it was Treasury, because, to be honest most Treasury officials view of taxation policies are ‘It’s to do with us, and if you come up with an idea we will reject it out of hand’. I think it needs to be somewhere closer to Number 10. That is where it would need to be.

**Anita Charlesworth**

But those things are Number 10. I mean, you cannot structure your way out of needing to win political arguments. In the end what got the smoking ban was political action – there is a very good OECD paper from I think it is 2010, that looked across eight or 10 countries, at where structural reform had happened. They looked at reform of product markets, reform of labour market, and pensions reform. Now, pensions reform in hindsight might not have gone quite as well as initially in some cases we thought.

And there are some really interesting things that are seen (in that paper). One, how long it takes to get to a place for change. But there is pitch‑rolling that systems can do. Having really good evidence in place, in ways that is really usable, with the right people fronting that evidence, using that voice, which may point to CMO and things like that, so trusted people and those who are active in public debate, because that needs to happen.

But leadership, leadership, leadership – continuous leadership, politicians engaging with the public about it, playing the field and then being prepared sometimes to get a little bit ahead. There is no country that does big, major change without that. When I dip into the public health world, there is often a sense in which there is a kind of structural solution, a bit of a shift or something like that ‘and we will be free’, and those things can help, but unless there is – and the same is true from having been on the board of PCT and then a provider, and now on an ICS – unless and until you can convince a local population that actually what you are offering is better for them, really credibly, you can have all this in place but you will not drive through your change.

**Siân Griffiths**

Yes, I think you are absolutely right about that and I think we have not really touched on this public engagement, public voice. People talk a lot about patient engagement, patient‑wise. It is the public voice, the groups of mums at the school gates ,who can make the big difference, about whether the chip shop is there or not. There is a sense in which you need to, in classic public health, go local, regional, national, global. That is the classic way of public health thinking that would say, ‘You need top-down and bottom‑up to come together.’ You need your leadership and you need your evidence. You need your leadership, and you need your engagement locally, or in whichever size community you choose, and you need that combination.

I just wondered whether Iain was raising the fact that sometimes at the centre, the public health community, needs to feel there is a point where priorities can be agreed or passed down. Because if you are going to have somebody in every local government, organisation then that person needs to be able to work. They will know their community, like we found from Covid. The local public health people know the communities they work with. But sometimes it helps to have someone to go to nationally. I am not sure government is necessarily what public health people are looking for, because they (public health) need to think long term. Not the short-term – the short-term is fine, but if you are going to talk about literacy rates for example, you are not going to see much difference if you do not put any more (resource) into it and do not take a long term view.

**Richard Sloggett**

So there has always been this tension, hasn’t there, with the public health director role at local government level, and what that relationship is with the centre? So Public Health England (PHE) never felt that their role was to manage local government either. That was always very clear. But then I think through the pandemic. Chris Whitty made a real effort to reach out to Directors of Public Health and bring them in during Covid-19, and to get them providing on those calls insight and updates on what they were doing and what was working.

And the new role for the Office for Health Improvement and Disparities (OHID) is really interesting, because that is only a year old. So you grew from a kind of semi‑independent agency, to one which is now sat in the centre, but it is reporting into the Department. There is this tension, I think now, which is the CMO is independent, but oversees an agency which reports into the Department, and I think there is a conflict in that. One of the things you could do, I think Anita you made this point, is an OBR-type model, which, Ed, you were obviously critical to setting up. Some function, which is a data‑led function in government, which publishes the data, on public –

**Ed Balls**

Isn’t that a thing for PHE?

**Siân Griffiths**

No, it has been abolished.

**Ed Balls**

And replaced by?

**Siân Griffiths**

Two bits, and a split public health function – actually, three bits.

**Ed Balls**

If we have a public health voice and they do not say anything then they are easy to abolish.

**Siân Griffiths**

They could not do it because PHE was an agency in government, and they were told that –

**Ed Balls**

But Chris Whitty had a voice.

**Siân Griffiths**

Chris Whitty[[86]](#footnote-86) was the CMO.

**Patricia Hewitt**

I am not sure it is a useful route to go down. PHE had had its budget slashed to pieces.

**Ed Balls**

The question I was asking was who is the public – let’s say that –

**Patricia Hewitt**

Well, it was Chris Whitty, as the CMO.

**Ed Balls**

So if you take the Wanless story, I would say that the fundamental story of Wanless, and actually the fundamental story of the delivery of government outcomes is, fundamentally, if Chancellor and the Prime Minister align, they agree on the priority, things tend to work. But sometimes they argue and that can be quite constructive because they stop each other doing stupid things, but fundamentally where they align, it works. But, of course, the pressure put on to them by external agencies is really important.

So if you take Wanless, they (Prime Minister and Chancellor) actually fundamentally aligned on a few key things, but on this sort of public health prevention stuff, they clearly did not collectively prioritise it. But who should have been the advocate, other than Wanless, demanding what should be done? Is that the Secretary of State?

**Patricia Hewitt**

The Secretary of State for Health and the CMO, ideally.

**Ed Balls**

And the Secretary of State for Health necessarily, in our system, tends to become more – often becomes more NHS‑focussed for the reasons we have talked about. But you are saying it is not the director of PHE, because that is not their role.

**Siân Griffiths**

No. Well, it does not exist anymore, but the CMO technically – and there has been an argument in this –

**Ed Balls**

That our CMOs do not tend to advocate for this?

**Patricia Hewitt**

Some do. A lot do not.

**Siân Griffiths**

It depends. What you need to do is tie the CMO to a system, and have a public health system, and I think what is missing is a public health system that allows the CMO to actually raise questions independently and be protected.

**Ed Balls**

All of the individuals in public health in local areas are talking, but there is no collective voice at the centre.

**Siân Griffiths**

But the CMO could say things, if you create the role that there is a system that he is head of, that he can then help to shape.

**Richard Murray**

The CMO is independent.

**Siân Griffiths**

You do not want it to be a managerial system.

**Richard Murray**

I mean, I have been in the room with the Secretary of State when the CMO spoke up, and the Secretary of State said, ‘If you do not be quiet, you will be never invited to another meeting again’. So do not exaggerate the independence of the CMO in the current form – it is sort of theoretically independent.

**Ed Balls**

Well, you would not say that to the Governor of the Bank of England.

[Crosstalk]

**Iain Buchan**

There is a mechanism there, for independent accountability for government on the delivery of –

**Ed Balls**

We know the OBR did not do a forecast (of the mini Budget 2022) because they issued a statement saying, ‘We offered a forecast and it was turned down’. So I mean, an independent person does that.

**Anita Charlesworth**

I have argued for an OBR for health. I have argued in the select committee in the House of Lords, that the point is not that it should be decision‑making. I think part of the problem with PHE is they were both an agency for delivery, and they had lots of different things all muddled in together, for reasons I understand.

But really the thing that I think is missing, I have argued, is that all these decisions are political, and there is a technocratic solution to it. You can help to allow politics and prod politicians to think about the long term, when you have got good data and good analysis in the public domain. Essentially the parallel with the OBR is that you can make short-term economic decisions that undermine the longer-term. Elected governments have the right to make bad short-term decisions. They are elected governments. But what you want to do, is for that to be open and transparent, and therefore then there to be a proper debate about it, and so you do not want them to control that. Just as you think about the economic sustainability, the health sustainability essentially is what are we doing for our long-term health, for the long-term sustainability of our healthcare system. That is a political decision. It must be a political decision. All of it is, but to have a body with some rigour and independence, that just enables us to see what is happening there.

One of my reflections back is that Wanless was absolutely fantastic – I am so proud. I am so proud of it, and I think its huge impact was to settle for almost 20 years the argument about a tax‑funded NHS, and to focus on how we deliver that and how we make that happen as well as possible. But actually, if you want to have something where we are actually improving the health of the nation, are we really addressing the underlying dynamics of our system, and its sustainability. You cannot do that by an event, however good. That is an endeavour that never ends, isn’t it? So you need a slightly different approach. So the review was really good for addressing that argument, helping to create that window for you to step into and act on the funding. But actually some of the things that we tried do in the report, in the work of Wanless, you cannot actually do through a one-off review.

**Nicholas Timmins**

You are right. I mean one of my – this is smaller than what you are just suggesting – but one thing I would definitely do for this, and for other reasons, is bring back the Audit Commission. And if you cannot get it to happen nationally, get some local initiative in some of those areas. So I would bring back the Audit Commission. Governments can get ahead of this and lead it. If you think about both drink-driving legislation, seatbelt legislation, they were massively unpopular, but government did it, because the evidence was there.

**Patricia Hewitt**

Because, actually, with smoking, government was behind. All the push had come from the public, from ASH, from the doctors, the BMA for once doing something useful. They were really good on that issue. The CMO actually infuriating John Reid by going well beyond the manifesto commitment that John was proposing. So the consensus for it was really built up outside. Then you had a not entirely satisfactory manifesto commitment, and then you had some bumps on the road, but we got to the right place, so that was fine, but it was not government leading.

I just, if I may, I really just want to come back to Iain’s dismissal of the entire ICB leadership, because that really will not do.

**Ed Balls**

You might have to dismiss them.

**Nicholas Timmins**

Second rate is nearly third rate. It sounds quite dismissive.

**Patricia Hewitt**

Just a bit. Now, you have a point which is that the executive leadership on the commissioning side, by and large, has never been as strong as the executive leadership on the trust side. And there are some chairs and boards of the big teaching hospitals, some who absolutely get system working and want to make it work, others who say, ‘We are the big hospital on the hill. We are far too important. What is this thing called a system? Not my problem.’

But Treasury, interestingly, forced through what many of us regarded as an unnecessary pay rise for CEOs of ICBs. But the reason for doing it was the belief that if you put the salary up to where the big trusts were, you could tempt across more of the CEOs – it was Treasury and then NHS England who did it.

What has actually happened, of course, is the bulk of the jobs have gone to the people who were previously the accountable officers, for the larger CCGs, and there are some very good people amongst them. Four – I cannot remember the exact number – a few have been tempted across from Trusts. Some quite interesting people have come in from local government. We (in Norfolk and Waveney) have either the only one, or one of the only two, that we have brought over from the voluntary sector, and she is superb. But the other thing to recognise is the new ICBs also have a medical director and we have got, I think, a really strong executive leadership team, which is more than a match for the calibre of our executive leaders in the provider trusts. The issue is getting everyone on the same page and doing stuff. But having a medical director as well as a nursing director is proving really powerful.

**Iain Buchan**

That was my provocation about the power of the cabinet. Currently, we have a technical and political landscape that is great at escalating a single issue, that can get behind one thing and get behind smoking cessation, for example, but we have no way of escalating a system issue. We do these four or six things in an integrated care system, and we hit a roadblock. It needs fixing up here. Three or four integrated care systems coming together as an effective cabinet? Maybe if they were coterminous between the civic and the NHS boundaries, and there was a standard way that you could escalate a system issue, and the way that those cabinets worked, was that they could talk to other cabinets, and they could escalate.

At the moment, if you hit a really big roadblock – it might be mental health, with complex lines, something where multiple agencies have to work together, and they have some block that cannot just be fixed within that system; it has to be fixed within these two or three departments above. There is no easy way of saying, ‘This we need to escalate as a system’.

**Nicholas Timmins**

But it is not easy, because it is not easy.

**Anita Charlesworth**

I mean, aside from things like fiscal instruments for risk factors, and the regulatory framework.

Now, I am on the board of an integrated care system. Two things that strike me. One is, I was just wondering, in other countries where this is about improving population health, why is it we have got no public health directors.

**Siân Griffiths**

I was going to ask. Where have they gone?

**Anita Charlesworth**

Where? ICSs are not being run by public health directors. We have got medical directors, not Directors of Public Health. Actually it is quite difficult to get some of the public health community, to engage in them. I do not quite understand that, and I have not heard the public health profession agitate for being in a leadership role in them. But you would think if what we are now doing is saying we are going to actually have these organisations in the NHS who are charged with improving the health of a community, and a place, is not that public health? So that is a bit strange.

But then the second thing is that actually in most of this, you do now have a lot of the people in the room. You have all the local government people, the voluntary sector people, the NHS people, both the big acutes and the community mental health sector. The key to moving things is not asking upwards for someone to change it. It is working out how to work together, and work in different ways. And part of the things you see that NHS colleagues are struggling with, is that most of the ways in which we make a change, is not a contractual model. It is not a performance management system. It is a relational brokering role, and people are not trained and equipped for how to deal with this. It is particularly – and I think local government leadership often get more development in this – working out how to make things work, so that it can work politically in a locality as well.

**Paul Atkinson**

This is what I am trying to teach my public health postgrads. Three forms of governance.

**Anita Charlesworth**

Yes. Someone mentioned Tessa Jowell. Tessa Jowell had this incredible ability to find a space to make change and to act. Even when she did not necessarily have the formal levers. She was one of those people I thought that every job that she left, something had happened that had moved it on, and she found the space to move, to get things moving. Wes Streeting[[87]](#footnote-87) said he has that above his calendar. He has a picture of her above his desk, to kind of remind him of that.

I was thinking back when we were having a conversation about how to help for winter, and how to get people out of hospital, and kind of everyone who could do something about it is in our room, and everyone is looking at everybody else. No one quite knows how to step into that space, lead in that space, and make it happen.

**Iain Buchan**

If we say it is in Treasury’s interest to have a Director of Public Health putting the whole population resilience agenda, and keeping it on the ball, prevention over intervention, system cohesion in an ICB. Why is it not happening? Why is there not a Director of Public Health?

**Patricia Hewitt**

Iain, the institutional architecture that has been created is very different from what was intended two or three years ago. The original plan was that you would take ICSs, put them on a statutory basis and the existing partnership boards would morph into the board of the new setup. But it would be a single board. We and every other system spent quite a lot of time designing that and working through who would be on it, and how did you balance a size that would enable you to make some decisions with inclusiveness? And that produced the white paper, I think, of early 2020, was it?[[88]](#footnote-88) Local government, LGA, then did a very effective piece of lobbying, and said there is not enough space in here for local government, and the upshot of that was NHS England and the Department suddenly decided we were going to have two boards.

So you have an ICS, which is a statutory construct, and you have two statutory organisations, the ICB and the Integrated Care Partnership (ICP), with overlapping roles (and it is a Venn diagram). The NHS ICB has a job to do in the NHS, and with social care. Then the ICP has the wider job, and, as I said, it is a Venn diagram and we have got quite enough in the Act as it is, particularly regarding board representation. Constructing a board is another thing. Certainly with a single board, the Director of Public Health would be on it. She is not in fact on our ICB board and she is not running the ICP, and that is to do with the politics and leadership of our county council, where the Director of Public Health reports to the Director of People Services, or adult services. But the Director of Public Health and her team are hugely important in all of this because they are driving all the analysis. They are shaping the population health, public health agenda, the Core20PLUS5 framework we agreed, which is underpinning the strategy that we are building in the ICP, but also the priorities of the ICB.

Meanwhile, of course, we have our ABCD priorities.[[89]](#footnote-89) We are being performance managed to sort out the ambulance queues, and the truth is, if we cannot, as a ICB, show that we can work with the system and sort this out sufficiently so that the NHS does not fall over, before next Easter, we will lose our licence to operate. So we have got to do those two things, but, let us not have any more structural change, or telling us who to –

**Nicholas Timmins**

There really is no such thing as an ICS. There are two boards.

**Richard Murray**

There are two boards. Somebody has to be responsible for NHS spending. You make it the ICB. You cannot then sack a local authority chief executive because you put them on the ICB, nor could you sack the local representative of Age UK who happens to be on the board. So part of that has forced that separation, which is based on needing someone formally accountable for NHS spending, and it cannot be local government.

**Patricia Hewitt**

That was Treasury absolutely seeing ICBs as the way they could stop the money disappearing into a black hole.

**Richard Murray**

Exactly. If you do that, you end up handing the NHS to local government, and that is a bigger political decision. The only other thing I would say is, I was the lead for the relationship with Treasury for a decade (for the Department of Health). I think they never, ever talked to me about public health. They talked to me about NHS overspending, and whether we were going to hit our PSA targets. In the coalition era, they only asked about spending. That is the only thing they talk about. There was no interest whatsoever in public health. Briefly at the time of Wanless it popped up, and briefly at the time of PSAs, there was an interest in the Brown era for inequalities – but apart from that, that was not the nature of the conversation at all.

**Ed Balls**

Not with the NHS.

**Richard Murray**

With Treasury. So the idea that Treasury’s going to push it –

**Ed Balls**

So Treasury was not talking to the NHS about inequalities, and at the time, Tony was allergic to talk about inequalities in that period. But Gordon spent a huge amount of time more widely working on inequalities.

But I think if Gordon had said to me, ‘What do I want the NHS to do’, it would have been ‘get waiting times down’. It slightly goes to your point, you would not have thought that was the NHS’s priority, but you can put it as a priority for the country.

**Patricia Hewitt**

2005. Okay, (I am the) new health secretary – and I go to the first of Tony’s whatever they were called –

**Ed Balls**

Stock deliveries.

**Patricia Hewitt**

Stocktakes. He had been persuaded by whoever, that Gordon should be there. This did not work and did not last for very long. But anyway, there I was at my first one. Anyway, fine. We discuss. The second one, which I think Gordon was not at, we come to health inequalities. I think I said something like, ‘It is in the manifesto’. But, basically, what he (Blair) wanted to hear about was the waiting list. And it was because of Gordon that health inequalities were there.

**Ed Balls**

You mentioned the stocktakes. In the meetings we had, because I used to go twice‑weekly with Jeremy (Heywood) and the two of them. In no sense did that report (Wanless) persuade Tony that this was a good idea. In fact, Tony, was totally anathema. We went through a period, having some rows about health inequalities, and in the end it was just draining. So we shifted our focus elsewhere. So it was all about how do you use Sure Start to try and drive health outcomes. But just not in a conversation with Tony and the NHS, because he did not want to go there.

**Patricia Hewitt**

It is about child poverty.

**Ed Balls**

He associated health inequalities, and public health, and local government all in the same bin.

[Crosstalk]

**Nicholas Timmins**

In a sense is that not the point, in that the NHS is required, and should care about health inequalities, but what drives health inequalities are things like Sure Start, welfare to work, all these other policies.

**Ed Balls**

The Treasury and Number 10 are really focused on health inequalities. They just did not want it to be called health inequalities, and they did not think they should talk to the NHS about it.

**Anita Charlesworth**

That is largely true, but it is also the case that one of the things that Labour did do, which was very good, is when it got the money, it did actually allocate the money, differentially, to more deprived areas. Liverpool colleagues have shown this. I think they gave differential allocation to the spearhead PCTs. And actually mortality improved more in the areas that got the extra resource, and that money went into the NHS for things like earlier detection.

**Patricia Hewitt**

But Anita, that was PCTs, where you had a powerful relationship with local government.

**Ed Balls**

Did you hear of a thing called the Sure Start maternity grant?

**Anita Charlesworth**

There was a Sure Start maternity grant.

**Iain Buchan**

We live in an increasingly connected world, and some of us have been talking quite a lot about the sentiments you say, about the cross-fertilisation, the advocacy. You can encode quite a lot of that. Back to Derek Wanless’ point, if you can measure it, you can manage it in these areas. You do not measure consistently at the moment, because you do not connect the relevant data. This is an agent-based public health strategy that moves into that connected world, and I do think it could be politically very powerful in programmable prevention. My serious points about integrated care systems, is that there is an opportunity to put agents in a system but they need to be allowed to touch the metrics of the performance units of that system, and be allowed to travel because they have a public health mandate in a connected world. I guess that is for another roundtable.

**Nicholas Timmins**

Is there more people want to say, or have we covered the ground?

**Sally Sheard**

Have you been through the list of questions?

**Nicholas Timmins**

Well, I have kind of abandoned the list of questions, because in a sense we did quite a lot better than we thought. So the questions are aside from lots more money, did the reviews improve the NHS and how? We know that they did. What did the second review in particular achieve? Why is it much less well‑remembered? Did the reviews have unforeseen consequences, or benefits? What lessons can be learned from the Wanless review process? Which is what we spent the last hour talking about. What can be done differently? Which is what we have been talking about. What are the learnings from the reviews in regards to the…? I think we have kind of done that. Just we have not done them quite like that.

**Richard Sloggett**

I might pick individuals up for a follow‑up chat.

**Nicholas Timmins**

So unless something wants to raise something else, can I just say thank you very much?

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