HOUSE OF LORDS

Select Committee on the Long-term Sustainability of the NHS

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

Tuesday 13 September 2016

10.05 am

Watch the meeting

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

Evidence Session No. 6 Heard in Public Questions 69 - 75

Witnesses

I: Professor Alistair McGuire, Chair in Health Economics, London School of Economics, and Ian Forde, Programme Lead, Health Systems Quality and Outcomes, OECD.

USE OF THE TRANSCRIPT

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

Examination of witnesses

Professor Alistair McGuire and Ian Forde

Q69 **The Chairman**: Good morning. I first of all say to everybody, Members and witnesses, that this session is being broadcast, starting now. Thank you for coming; we appreciate very much your coming today to give evidence. As you know, most of this session is to do with funding, different funding models—the pros and cons of different models—and, importantly, the long-term sustainability of the NHS and social work. First of all introduce yourselves. If you want to make an initial statement about anything, please do so.

Professor Alistair McGuire: My name is Alistair McGuire. I am Professor of Health Economics at the London School of Economics. I have been involved in the analysis of healthcare both in the UK and abroad for about 30 years.

Ian Forde: Good morning. My name is Ian Forde. I am one of the senior analysts at the OECD in Paris, responsible for health system performance assessment. I was the lead author of the quality review of the United Kingdom, which was published about six months ago, and I have been involved in performance assessment of various health systems in Europe and Latin America.

The Chairman: Do either of you want to make a statement?

Professor Alistair McGuire: No.

Ian Forde: No.

Q70 **The Chairman**: We will start with the first question then, which is: how does the UK compare with the OECD and other EU healthcare systems in terms of its funding and performance. How are the two things linked and is it likely that the UK will maintain its position over the next 15 to 20 years, so long term, whatever its position is now?

Professor Alistair McGuire: Personally, I think the UK lags behind most northern European countries, if you take them as a comparative group, in terms of expenditure judged by percentage spend per GDP. We are about 8% to 8.1% per GDP currently. Most of the northern European countries—by that I mean France as well as Germany, Denmark and Sweden—are now up at about 11% of their GDP. That comparison becomes slightly better if you do a healthcare expenditure per head of population comparison and take account of prices, exchange ranges and purchasing power parities, so taking account of relative prices, but even then, in comparison to northern European countries the UK is slightly below healthcare expenditure per head, even adjusting for our lower costs within the NHS. Of course, about 70% of the costs are labour costs and therefore we have basically lower wages in the NHS compared to our northern European comparator countries.

In terms of performance, it is difficult to compare, because you are comparing across countries which define health and social care expenditure in different ways, so comparisons are obviously difficult on the expenditure side, but they are very difficult on the performance side because you have different structures and different starting points across countries. Nevertheless, I personally think the performance within the NHS is deteriorating if you look at health outcomes. If you look at cancer survival rates over five and 10 years, we are again lagging behind our northern European comparators. That is pretty well documented by a number of European studies or surveys. There was a fairly well publicised study by Chris Murray et al. I do not always believe his figures but it was published in *The Lancet* and they were looking at how the UK generally in terms of health outcomes compared to other countries in Europe. Again, the UK was in a fairly weak position—not very good performance compared to other countries in terms of age-adjusted mortality rates for a number of diseases, including cancer and cardiovascular disease.

From our own internal performance indicators on the process aspects of the NHS, such as waiting time targets, we know we have been missing them quite badly for a number of years now, going back about three or four years now; in particular, the cancer wait times have not been met for the past two years. I think expenditure is relatively low, in summary, compared to northern European countries, and our performance is deteriorating.

Ian Forde: I would agree broadly with Alistair's summary of the spending picture. The UK historically has relatively underspent compared to OECD averages, and certainly compared to the G7 there is less spent on health in this country than in any of the G7 countries apart from Italy. In relation to the more relative comparators, it would seem the UK NHS slightly underspends. As Alistair said, countries such as France, Germany, Switzerland, Sweden, all spend considerably more.

It is worth noting though that growth in spending is well controlled in the UK, which is a positive aspect. Over the last 10 years, annual rates of growth have only been around 1.8% compared to around 2% across the OECD. That is a positive statement: growth in spending is better controlled in this country than elsewhere.

In terms of performance, I think I would be more optimistic than Alistair's summary. There are some areas where we perform well compared to OECD comparators. Primary care is a good example of that. The OECD publishes various indicators of performance in our *Health at a Glance* publication. The 2016 edition will be out in six or eight weeks. If you look at the indicators of performance across the OECD, in primary care the UK does well. We have fewer hospital admissions for things that should be managed in primary care, conditions like chronic heart failure or CAPD; we prescribe better in primary care compared to other countries in terms of generics, in terms of appropriate medications for diabetes and so on; and we are good at vaccinating elderly people against the flu, for example, so that is reassuring. We are less good on other aspects,

however, particularly secondary care. As Alistair mentioned, our survival rates in this country for cancers are less good compared to OECD comparators, although they are improving and the rate of improvement is promising. We are less good in terms of survival after heart attack or stroke, so people in the UK are less likely to survive a month after having a stroke or heart attack than people elsewhere in the OECD. Unfortunately, we in the UK—I say "we" because I am English, as you will have picked up—are also less good at prevention. Obesity rates are higher than the OECD average, and worsening; alcohol and smoking are going down, but they are still worse than the OECD averages; so we are poor on public health prevention.

One area where the UK is outstanding is in the policies and institutions which are put in place to improve performance, efficiency and sustainability. Across the OECD it is very rare to see the level of transparency and accountability, the depth of data, the granularity of data, that is available in the UK; that is rarely replicated across other OECD countries—the institutions in place such as the National Institute for Health and Care Excellence, the incentives in place and so on and so forth. Therein lies a slight paradox: although the UK is outstanding in terms of its policies and institutions to drive performance and efficiency, somehow its performance is average at best.

The Chairman: You said we are better than some OECD countries in terms of preventing admissions to hospital and that primary care was better, yet our hospitals are chock-a-block, full.

Ian Forde: That is a question of resources. The UK has fewer hospital beds than the OECD average; it has fewer doctors and nurses than the OECD average as well.

The Chairman: Also, we often hear stories about our access to primary care not being that good; people cannot get an appointment to primary care.

Ian Forde: That is not borne out by international comparison. If you look at data on unmet healthcare needs, the UK does very well; it is well below the OECD average. Also, in terms of equity, if you measure that indicator by wealth quintile, for example, there is a very narrow distribution, so we are very good at making sure people with fewer resources as well as those who are better off have the same level of access. On an international comparison, I would not say the UK health system struggles on access.

Lord Mawhinney: Out of the average for northern European countries of 11% of GDP, what proportion comes through the Government spending taxpayers' money and what proportion comes from taxpayers paying themselves, either through insurance or directly? What are the comparable figures for this country?

Professor Alistair McGuire: As I said, it is difficult to compare. Health in most countries in northern Europe is publicly funded, so the vast

majority of the funding will come from public funding. For example, in Germany public funding is about 95% of the expenditure, with a very small private sector, for example. However, it is a completely different funding model. It is funded through social insurance, which is employer contribution-led rather than tax-based. A group of countries have followed that German model of social insurance rather than a public tax-based model, as it were, but the vast majority are public expenditure-dominated. The comparison is not like for like on taxation but I think the idea that we have a tax-based system is quite important, for example.

To pick up on something Ian said, the UK has been relatively good at constraining expenditure growth. I use the term "good" in a pejorative sense because, obviously, if expenditure is too low, constraining the growth of the expenditure is not necessarily a good thing. Over the past few years, for example, the Government has ring-fenced the NHS spend and said that the real resourcing going into the NHS will be level funding but, to acquire that level funding, the NHS has to maintain between 3% to 4% of what they call productivity savings—we can come back to the term "productivity" if you want—or efficiency savings per annum over the next five years. Historically, the UK NHS has really only attained at best 1% and on average 0.5% productivity savings per annum over the life's course of the NHS. This 3% to 4% is a big ask, just to stand still, and in standing still, that is the constraint element in terms of keeping the expenditure level. But note that our expenditure is tax-based, and we have a number of expenditure departments that have a claim on the taxation that is raised by primarily income and other, indirect forms of tax. Assuming that this Government hold to their public sector borrowing requirements—we have extended those requirements and targets a bit—taxation will have to fund partly the public sector borrowing, but with the NHS being held at the level form of expenditure, even incorporating the productivity/efficiency savings, other government expenditure departments will lose out by about 6% per annum in expenditure. That is a hard choice.

Lord Mawhinney: If we as a Committee were to ask you for your advice on how we go from 8% to 11%, would you reply that we should simply increase taxation, or should there be more individual payments and, if so, on what? I would be interested in both of you answering that.

Professor Alistair McGuire: I am not a big fan of co-payments, of individual payments. I think the responsiveness of the volume of services to co-payments is inelastic; in other words, you can put co-payments up by 10% but utilisation only increases by about 2%, because it is a very inelastic response, so I am not a big fan of that. I think there has to be a political will among politicians and others to increase expenditure in the UK. You have to have something like Tony Blair's expensive breakfast, where he announced on breakfast TV without any discussion with his Cabinet, it appears, that they were going to move from under the OECD average to the OECD average expenditure level. There is nothing great about averages. We could ask everybody in this room to stand up and obtain the average height. It does not really mean much; some are

below, some are above, but it was a political will to move us to that average, and they funded that by an increase in national insurance taxation. It was not a hypothecated tax at all but it was an increase in national insurance.

We would probably have to raise taxes, but let me emphasise that there is no true figure in this game; it is a normative statement about how much people in the country want to spend on healthcare. The Americans spend about 20% of their GDP on healthcare and are also a fairly bankrupt country—in other words, they have a big public sector borrowing requirement and debt requirement on the private sector as well—but their citizens seem to want to spend that high level of expenditure on health. It is a normative question; there is no fixed level which is true and good, but I believe currently we are underspending. If we are going to increase our spending, it is best done through taxation.

The Chairman: Mr Forde?

Ian Forde: I broadly agree. There are various options if you want to raise national levels of spending on health. One option is to ask people to pay for it directly out of their pocket when they see a GP or when they purchase medication. The evidence does not support that as a policy option. It is bad for equity, because it damages people on lower incomes, and it is bad for health, because in the long run it increases health costs because people forgo primary care and preventive care when they need it and wait till they are sicker further down the line and end up costing more money. There is good evidence that increasing dependence on out-of-pocket payments is not a good option.

You have the option of voluntary health insurance, as widely adopted in France, for example, where you encourage people to take out their own private health insurance plans, which could top up or supplement what is offered by the national health insurance. There is not particularly good evidence that that is a good idea either. It is inefficient, and it can damage equity. That is not a broadly recommended option.

Finally, you have the choice of either raising contributions from employment-linked insurance, the German model, or general taxation. The OECD has a clear position that the best option is to finance spending on health or growth in spending through general taxation. We think that is better than employment-linked contributions, for two reasons. First, as you know, the population is ageing and there will be fewer people in work compared to those working in the future, so the base for revenues if you go for employment-linked contributions will be shrinking. Second, there is this notion of the "Uberisation" of the economy, with the economy shifting to a more informal basis—the "gig" economy, whatever you want to call it—so the revenue base in that sense is also likely to shrink or certainly become less stable. The OECD's general position is to go to general taxation for increased funding of health and social care.

Lord McColl of Dulwich: You mentioned the figure of 8.1% of GDP, but if that were adjusted it is better. What is the figure?

Professor Alistair McGuire: Adjusted for what? Roughly 8%, just over 8% of GDP of our healthcare expenditure, so adjusted for what?

Lord McColl of Dulwich: You said if you adjust it for all the other variables, it is better. In terms of what?

Professor Alistair McGuire: Ian, do you know that?

Ian Forde: The OECD figures are UK figures. I do not know whether it is quoting English figures but for the UK spending as a fraction of GDP is something like 9.8% of GDP.

Lord McColl of Dulwich: Thank you.

Lord Warner: Can you go back to this issue of employer-based systems for raising the money? Is there any evidence that they become a tax on jobs, and unemployment shifts disadvantageously? I am thinking in particular of the experience of General Motors in America, which went down the tube not just because it made lousy cars but because of its healthcare costs.

Professor Alistair McGuire: That was a private insurance base. The employer was buying private insurance as a secondary base. The German system is completely different from that; it is not based on any actuarial basis of insurance, which the premiums were for General Motors when it contracted with its private insurers. It is a social insurance scheme which has fairly large cross-subsidies built into it to overcome problems associated with high-end users. It is slightly different and does not operate so much as a tax on employers, but obviously there is an additional cost embodied in that. The cost is partly passed through to the employee, because there is an employee contribution as well. It is not a full cost to the employer.

Lord Willis of Knaresborough: I am more interested in what you get for your bucks rather than the total amount, though I accept that that is important. We saw a huge amount of money put in during the last Labour Government and, in terms of productivity, what resulted in terms of patient outcomes was not significant. I wonder if there are any indices anywhere which correlate the amount that is spent with actual outcomes in a set of principal areas of care. Is there such a table? The second part of this question is: on public health, how do we fare compared with our OECD partners, or even G7 partners, on the amount we put into preventing poor health rather than pouring money in to mend it when it has gone wrong?

Professor Alistair McGuire: Can I pick up on your first observation, which was that we did not obtain very much through the last Labour Government? Remember that it takes five to six years to train a doctor and about four to five years to train a nurse. Essentially they doubled expenditure over an eight-year period, but it takes five to six years to train a doctor, so it takes at least that time to start seeing the return. You are not going to see a very quick return. I would suggest that there is

evidence to say that for a very short time there were some promising indications that that money was being put to good use in the system, around 2011-12, 2012-13. That is debatable. That is my perception.

In terms of expenditure, we know there is good correlation regardless of what it means between expenditure and GDP levels—national income levels. We know there are certain confounding elements which help to explain that relationship between GDP and expenditure. There is a less well correlated association statistically between expenditure and mortality rates, and that is partly because you have to wait some time before the expenditure returns a benefit on mortality. There is some—better than 50%—correlation between a range of indicators on mortality that public health would have to regain.

Ian Forde: The question you ask is a very basic one: can you demonstrate health gain per pound spent? Unfortunately, that is extremely difficult to do. There have been myriad studies trying to develop indicators of productivity efficiency, and not one has taken hold as an internationally validated benchmark or comparator across systems, so although the question is an obvious and a simple one, it is not something which is in common currency. There is a correlation at lower levels of spend—you can see a clear correlation between spending levels and life expectancy, for example—but in the G7 or the European Union that relationship is completely flat. It is hard to demonstrate an important correlation between spending levels and health outcomes.

In terms of the level we spend in the UK on preventive health, the OECD measure breaks down how money is spent within a health system. There is a category called "collective services", which covers public health but also captures other things such as administration and governance costs. It is not a precise measure of what you were asking, but on that indicator the UK spends 9% of its health budget on these collective services, which is the same as the EU, the 27.

I would like to make an important point that on prevention we should not just think about classic public health, vaccination, health promotion campaigns, and so on. It would be important for this Committee also to consider spending on social care and long-term care, because that is often left out of the equation, and if the spending in that domain is cut, there is an immediate impact on greater demand and pressure in the health service.

Professor Alistair McGuire: As there has been in the UK, quite dramatically.

Q71 **Lord Lipsey**: Across the OECD there is quite a range of spending on health as a percentage of GDP. There is also a great variety of systems: Bismarck in Germany; Bevan here; Adam Smith, if you like to call it that, in the US, although curiously American public spending on health is comparable with that in the rest of the OECD; the Americans just do a lot of private spending on top. My question to you is this: if you think about the variety of different systems, is there any evidence that one of those

systems is systemically better than the other systems, or are other factors much more important in determining the efficiency of health gains for a given level of spending?

Professor Alistair McGuire: I would say no, but Ian might differ.

Ian Forde: No, I would say no as well. The first point to make is that although the distinction you make between different types of funding structure used to be very real, nowadays functionally those types of systems are very similar. Even within an NHS-type, tax-based system, you have competition between providers and you have division in to purchasing and providing, geographic units and so on; and even within the Bismarckian model that you described, you have national values, national guidelines and so on. Functionally they look very similar. If you stack up OECD health systems, the ones that tend to have a higher spend as a share of GDP tend to be the Bismarckian-type systems, to use your terminology—the social insurance type models. We think that is simply because they are more complicated. You have lots of insurers; people can choose between them, choose which one they want to join. That generates a lot more administrative costs, so they cost more if you rank the OECD health systems up. They seem to have perhaps slightly better health outcomes. That may be because more money is going in or it may be because they have better developed competition between providers. It is very ball-park stuff and it is a very simple glance at a set of bar charts which leads to that conclusion; it is not a sophisticated analysis by any means. My bottom line would be to agree with Alistair that you could not confidently say that a tax-based system is more efficient than a social insurance-based system.

The Chairman: Although you seem to be in favour of a tax-based system, saying that it is as good as any of the others, or better, is it not a problem that a tax-based system can be manipulated in how much the Government from year to year will allocate to health expenditure, as opposed to other systems which might increase with an increase in costs and therefore are more sustainable?

Professor Alistair McGuire: A tax-based system is good for raising funding, I would say. I think private insurance is completely inefficient, for a whole host of reasons. Social insurance can work as well but, as Ian points out, there are maybe more administrative costs in that. It is very difficult to measure the administrative costs, of course. Because tax-based systems move away from an actuarial base and allow explicit cross-subsidisation across populations, they are very efficient in raising funds. In terms of what happens to these funds and what level of funding is attained, they are obviously open to political manipulation and, as I said, if we continue with this level funding based on productivity savings, somebody else loses in the public pot somewhere unless we put up taxes, which nobody likes. So yes, it is open to those manipulations and those political decisions but I believe political decisions have to be faced up to.

Ian Forde: I think it is an advantage in fact if a tax-based system is open to political manipulation, which is the word that you used. As I said,

an employment-linked basis for funding carries risks going into the future because of the worsening dependency ratio with an ageing population and the way the economy is shifting to a more informal basis. As we face the future, a tax-based system is probably a more sensible choice. A point Alistair made earlier on is that populations tolerate higher spending on health through tax; whether it is Sweden or Switzerland, populations, through political process and through political agreement, have shown themselves to be happy to spend more on health. That can only be negotiated through a tax-based system as opposed to an employment-linked system.

Lord Bradley: Very briefly, Mr Forde, I may have misheard you. I think you said at the beginning that we are poor in preventive work compared to other countries. What are the key features of where we are poor? What are the major weaknesses in our system in preventive care?

Ian Forde: On activities or on the outcomes that result?

Lord Bradley: Both, very briefly.

Ian Forde: On the outcomes, as I mentioned, obesity is worse than the average, and worsening. Alcohol and smoking are improving but still worse than OECD averages, so we have a less healthy population.

Lord Bradley: What are the drivers that make them better?

Ian Forde: Primary care is very important, and the OECD has shown that the most effective intervention is quite resource-intensive. It is a one-to-one discussion between an individual and a clinician, a nurse or a doctor. That is the most cost-effective way of tackling these risk factors, but it is an expensive intervention. More broadly, there are public health measures, such as increasing taxes on alcohol or sugar, or minimum unit pricing, for example, or stronger regulations around labelling. The UK's preferred model has been for responsibility deals with industry to achieve those public health goals. It is still too early to decide whether that is an effective approach or not.

Professor Alistair McGuire: There are a lot of differences across countries in tastes and behaviour of course, which are difficult to control, so you need to put in place incentives. On expenditure, it is not just levels; it is what you do with that expenditure. Some systems have started operating bundled payments to try to promote co-ordinated care, particularly for things like obesity or diabetes, and give a payment to a chosen medic, usually, to try to co-ordinate across a range of services that these people with chronic diseases need. There are incentive mechanisms you may put in place as well.

Baroness Redfern: You mentioned outcomes on cancer. Do you think it is because people present themselves late, and do you think more money should go into public health, particularly with obesity? My area has very high rates of children with obesity. Obviously, that is linked to cancer and cancer outcomes as such. Do you think more money should go into public

health and health and social care to try to prevent that?

Professor Alistair McGuire: I definitely think there is scope for improvement in screening programmes, for example, particularly for cancer, but of course, cancer is partly led by other issues. It is one of these diseases that is becoming more and more specialised across the disease spectrum, with very rare cancers being picked up now as well. The screening programmes themselves have to be considered in a cost-effective manner.

Baroness Redfern: Do you think we should have more screening programmes?

Professor Alistair McGuire: Yes, but we have to have cost-effectiveness tests to say whether these programmes are appropriate or not, because some are very ineffective, with very high false positive rates, for example.

The Chairman: Yes, you have to make sure that screening programmes are cost-effective, otherwise it costs a lot. Secondly, with the ageing population, the numbers of people with cancer will be rising. Also, people with cancer will live longer because they will be able to manage. That has to be costed in.

Q72 **Lord Warner**: Can you move us on to the evidence about different funding models for health and care? The OECD seems to have changed its definition of healthcare to include in effect some things which were previously regarded as social care. Is there any evidence that different funding models improve the performance or sustainability of the system? What I mean by that is: is there any linkage between the way you collect the money and the way it ends up being distributed? Could collection systems affect the way you use the money?

Professor Alistair McGuire: Let me preface this by saying that we are obtaining more and better data on health outcomes all the time but we do not have the ideal datasets to answer these questions yet, particularly on measuring morbidity, because a lot of long-term care is associated with morbidity rather than mortality. It is easy to count the dead but it is difficult to count chronic illness in a morbid sense. The short answer would be, no, I do not think there is any evidence to show that different funding typologies lead to better outcomes or even that the funding itself is more or less efficient.

Let me backtrack and defend the OECD. The OECD did not redefine health and social care; a number of individual countries have redefined what is in their pot for health and social care and so on. Some of the social care elements have gone into health in the OECD definitions. The British Government through the ONS tried to follow the OECD definitions but found it very difficult, both because there are four constituent countries in the UK and because different local authorities were measuring social care in different ways. There is a vast variety of measuring of social care in the UK at this point in time; there is no

standard measure as such, but we know that the level of expenditure on long-term care in the UK is about half of the OECD average, and we also know that it is worsening by the moment, as local authority budgets have been cut by about 25% over the past five years.

Lord Warner: Can I just be sure I have understood that? Are you saying that the method of collecting money for social care can have an adverse effect on the outcomes for the healthcare system?

Professor Alistair McGuire: The measures of how the money flows are going can have an adverse effect but, more importantly, the measures of need, and need in long-term and social care, and how you measure that, can have an adverse effect. As people grow older and more chronically sick, their needs go up, but the local authorities are also adjusting the needs base on which the entry criteria for people to come in to the system to use the money is defined.

Ian Forde: I just emphasise the point that there is very little evidence that the way you choose to collect the money makes any difference to performance and sustainability. It would be a mistake, I think, for this Committee to focus too much on that. Much more important is how you spend the money once you have collected it, which really determines performance and sustainability. In that regard, there is good evidence that a health system needs things in place like a health technology assessment agency such as NICE; it needs price control in place, like national tariffs; it needs lots of transparency and data in place to look at variation across the country in rates of hip replacement and so on; and it needs close performance management at the clinical level, so that units and doctors and nurses can see how they are performing day to day. It is much more important what you do with the money and how you spend it than how you raise it.

The Chairman: Currently we hear every day about crises in the health service. We hear of crises on the public health side and on the social care side, and it all seems to be about money. If we are spending what you say we are spending, clearly something is not working.

Professor Alistair McGuire: Yes. Let us take a look at this money issue in another way. Roughly 70% of healthcare spend is labour costs. Let us assume you all have a real job.

The Chairman: Are you suggesting we do not?

Professor Alistair McGuire: I am just making an assumption. Let us assume we all have a real job. How would your wage be determined? It would be determined by your productivity, your add-on output to that firm or whatever job it was. In terms of productivity—and remember I used that term earlier—the productivity/efficiency estimates are part of the levelling off of the expenditure in the NHS. They have to make a 3% to 4% productivity gain just to stand still. Also, part of that productivity gain has been essentially a fall in real wages. We are in a time of depression generally, so I do not have a huge problem with that, but we

have seen falling real wages. It is becoming more and more difficult to attract people in to the NHS, the 70%, let alone social care, and so the volume of people going through, having to service this higher productivity need just to stand still, is currently, I would suggest, not in equilibrium. I think there are probably all sorts of pressures in the system, because we do not have enough people in the system to service the system. One of the problems with that statement is it is very hard to go back to the data and prove it, because the data and labour statistics in the NHS are not widely publicly available.

The Chairman: Why not?

Professor Alistair McGuire: There is all sorts of confidentiality. If I asked you how much you earned, you would not be very happy about that question. It might be that you would put it in the public domain but not everybody wants to do so, and so there are confidentiality issues in getting people to report. We could get around that through anonymity IDs, but to do that and then to go through all the security issues is not a trivial task. My suggestion would be that labour costs should be tracked to productivity outcomes rather than the productivity/efficiency savings being used to keep our expenditure lid down. In that way we may see more volume. I think we have a real volume crisis in staffing in the NHS just now.

Ian Forde: The NHS is broadly efficient. It delivers broadly the same outcomes of other health systems with fewer doctors, fewer nurses and fewer beds. If there are reports of crises in the papers, a lot of that could be due to the cuts in the social care sector impacting directly on hospital A&E departments and GPs' waiting rooms. We know that in the UK, as a result of austerity, local authority funding dropped by around a fifth or a quarter for old peoples' services, and that will directly impact on the health service. It would be an interesting study to try to quantify that and to explain to what extent these reports of crises or this perception of crisis originates from outside the health sector.

Professor Alistair McGuire: I should add that some studies have said somewhere between 10% and 30% of the growth in expenditure on healthcare is attributable to new technologies. Usually in a sector a new technology would come in if it lowered the unit cost. That happens in healthcare. So PTCA, angioplasty for heart disease, is about a third of the open heart surgery, the old coronary artery bypass grafting. It is about a third lower and you would expect that to save money but it did not; it raised money in that group of patients who were just on the cusp of getting open heart surgery. Once the lesser intervention came in, it widened the patient group who could have surgery, and therefore the costs increased. The use of technologies is quite important in terms of servicing the patients as well. We have some evidence that there is a lower uptake and a lower rate of diffusion of new technologies across the NHS, and therefore the outcomes are suffering because of that, so we are in a catch-up.

Lord Kakkar: If I may just return to the point of the relationship

between what is provided in social care and the ultimate effectiveness and efficiency of healthcare, would it therefore seem most intuitive to have a single mechanism of funding that is driven principally by focusing on the population need across those two domains and defining it in that way? Would that ultimately lead to a more effective and efficient delivery of healthcare?

Professor Alistair McGuire: That is partly what these bundled payments which have been tried in some of the northern European countries, mainly France and Germany, are trying to do, to try to integrate through financial incentive those pathways across different providers. They are not using it in Germany for social care but there is no reason why they could not. Certainly what you do not want is to take money out of the NHS budget and give it to the local authority, as was done in the past, and say "Get on with it". In short, yes, I think you can use financial incentives in a better way.

Ian Forde: A priori, your suggestion is absolutely correct because, at least from a patient point of view, there is very little distinction between health and social care. When someone falls over and breaks their hip, their need for immediate medical care and ongoing rehabilitation and social care and adaptations to the home and so on and so forth, to them, it is the same episode of care. A priori, it absolutely makes sense and, as Alistair said, there are some experiments to try to bring those two streams of funding the services together. The challenge is that historically they are very distinct sectors. The social care sector in particular is much less used to performance management, to accountability, to transparency, and so on and so forth, simply for historical reasons and because of the professional culture in place. That is not to say it cannot adapt and become more like healthcare. Indeed, that I think would be a very ambitious and challenging but very pertinent recommendation for this Committee to make.

Lord Kakkar: I have just one further question, Lord Chairman, if I may. You talk about these experiments—has anybody in the world been able to demonstrate that in an objective way?

Ian Forde: Do you mean reduction in costs?

Lord Kakkar: And more effective delivery of care across that spectrum, considering the whole.

Ian Forde: Yes, there are some examples, particularly in Germany. Germany and the Netherlands are the most advanced in terms of integrated care models. The most famous is called the Kinzigtal integrated care model, in a small valley in Germany, small enough that they could integrate further services relatively easily. That was shown to have reduced costs and improved outcomes. Also in the States there are some moves towards integrated care models, bundled payments and so on, which have been shown to be more efficient and to deliver better patient outcomes.

Lord Kakkar: I should declare my interest as Chairman of UCLPartners.

Q73 **Bishop of Carlisle**: I think you may have just answered my question in the question that was asked of you a moment ago. We have talked about different funding models, and you have made it clear that it is not always easy to make comparisons between different countries. You have also said that in terms of sustainability what really matters is how you spend the money you have, and we have talked a bit about the linking with social care, but is there any particular country which you would want to single out when it comes to sustainability, which is what we are talking about in this Committee, where there have been particular reforms or the performance has been really outstanding, that we can learn from? If so, what have they done? You have mentioned Germany and the United States but I wonder whether you want to stick with those or mention anybody else.

Ian Forde: Within the OECD, two countries, at least for me personally, really stand out in terms of their reforms, and that is Portugal and Israel. They are much less studied than the classic examples but they are both extremely dynamic, ambitious, responsive systems capable of fairly far-reaching reform. In each case what you will see is, again, a deep investment in data, and in transparency and accountability. In Portugal, anybody—a doctor or patient—can go on to a website and find a whole range of indicators for their local health service, benchmarked against all the other peers in Portugal over time, to see how it is performing. They have done lots on integration, they have done lots of reforms on strengthening primary care, reducing dependency on the hospital sector, and lots of innovation on financial incentives as well. Israel, particularly the Clalit insurance model, is another example. One thing that the OECD is very keen on is learning from other systems. In fact, that is the raison d'être of the OECD. If you were interested in looking at systems to compare the English system to, I would definitely recommend Portugal and Israel.

Lord Bradley: I declare my interest with Pennine Care. Would you extend the integration model to the integration of physical and mental health as well as health and social care?

Ian Forde: Again, a priori, yes. There should be no distinction between a person's needs for care and we know there is a very close correlation between physical well-being and mental health well-being. The two drive each other. Again, the reason that they have not been more closely integrated is probably historical more than anything else. It is probably a result of historical legacy rather than intentional design, which is just to say that I think integration will be difficult but a priori should be sought.

Lord Bradley: Are there good examples elsewhere where that has been done?

Professor Alistair McGuire: No.

Ian Forde: Few spring to mind. Mental health is still seen as a very distinct system, for better or worse.

Professor Alistair McGuire: There is a general rise in payment for performance but that of course means you have to define performance, and that means defining both the indicators and the timescale over which you are working. Some of these chronic diseases are not easily managed within an annual budget setting. That is a problem. For sure, you can shift your financial incentives in terms of payment structures within systems, and I think we have done that very successfully within England with the HRG payments for hospitals—case payments, basically—and for some of the GP practice payments, for their standards of care, which were a one-off payment for upping their screening activities essentially. But to get performance indicators and to get the appropriate timescale for mental health is extremely challenging.

Baroness Blackstone: Just now, when you picked out Portugal and Israel, you mainly focused on primary care. Am I right in assuming that both those countries stand out because their primary care is so good, but is their secondary care equally good, or is there a tendency for some countries to focus on one sector, primary, and not so much on secondary, and vice versa in other countries? If that is the case, which countries have really good secondary care?

Ian Forde: You are right. Portugal and Israel are particularly good in their primary care reforms, but that is not to say that they have left their secondary care sector alone. In both countries there have been several initiatives to improve performance sustainability in secondary care. They are worth studying across both sectors.

On countries' general tendency to focus on one sector or the other, in fact the general tendency is to focus on hospitals and primary care is often forgotten. That is because it is much more difficult to understand primary care. Hospitals are much more visible in what they do; they are much more procedural and things can be counted much more easily in secondary care. The things we value in primary care are continuity, comprehensiveness and co-ordination, and these tend to be invisible to data systems, which means they tend to be forgotten by reformers and planners. When I talk about leading countries in health reform, the most challenging reforms to achieve are in primary care. That is why, again, Portugal and Israel sprang to mind. If countries have a preference for reform, it is always in the hospital sector. It is more grip-able.

Lord Warner: Can I bring us back to the answer Dr Forde gave a little while ago about Germany and the Netherlands being in the lead on trying to integrate systems of health and social care? Is there an issue around the way you collect the money for those two systems that is very difficult to align if you collect the money for those two systems in fundamentally different ways? At the moment we seem to have a totally different budgetary system for raising the dosh for social care and for the health service. They do not all come out of general taxation. How have those two countries grappled with that? Have they unified their way of

collecting the money for the services?

Professor Alistair McGuire: They are both very different, but yes, Germany has bundled it into its social insurance system, tax system, and the Dutch have an experiment going on in private insurance and public provision where the public provision contracts with the funders. I would suggest that the private insurance experiment is not really working. There is not enough cross-subsidisation, but that is a different question. I think the contracts are specifying much more complete crossovers between hospital and social care. However, it is not working particularly well because their hospital sector is in deficit at present. There are other problems. Every system in every country has problems, unfortunately.

Lord Warner: If your two funding systems for raising the money are diverging—in social care we now have local authorities raising precepts—this is going to make integration intrinsically more difficult.

Professor Alistair McGuire: It does not make it easier, that is for sure. Also, I think that the annual budgeting process does not help within the NHS. If you are dealing with chronic care over a long period of time, and trusts are focused on balancing their books at the end of March, as are local authorities, it does not help address these issues.

The Chairman: Mr Forde, did you have any comment?

Ian Forde: Yes. In Netherlands and Germany both health and social care are funded broadly from employment-based revenues, so there is an immediate coherence, as you mentioned in terms of the funding base, without the kind of complication that would exist in this country.

Q74 **Lord McColl of Dulwich**: Based on international experience, what should the UK focus on to make the health and care systems sustainable?

Professor Alistair McGuire: I was not really clear on the term "sustainability". That is quite easily answered: £380 million a week, is it not? I was not really sure what "sustainability" meant. If you meant broadly achieving given targets and objectives, that is one thing, but if you meant dealing with the rising demands and costs within the NHS system, that is another thing. The IFS came out with a fairly good report a few years ago saying that, even if we were keeping our expenditure level in real terms, the demand increase associated with chronic morbid conditions would add about 1.5% per annum to expenditure, and new technologies would add a further 2% to our expenditure in predicting out the per annum cost. If you take their figures as real, you are looking at a 3% increase in current budget per annum to keep matching their predictions of demand and technology uplift. That is even beyond the Simon Stevens figures that say just to keep still by 2020 we need £20 billion if we are going back to historic 0.5% per annum productivity increases.

Ian Forde: We have already discussed many options for putting the NHS on more sustainable funding. The option to rebalance to private sources of funding we have already crossed out. There is an option clearly to

rebalance the public, government budget more towards health, and that has been historically done over recent years by spending less on defence, for example, less on infrastructure, and more on health. That is clearly an option which could be pursued further.

The main answer on the spending side of the equation has to be about striving for greater efficiency with the money that you have. The UK does a great deal in that sphere already but there is still more that could be done, in particular around variation of care across the country. We know that, for example, hip replacement or procedures on the heart after a heart attack, CABG and PCI and so on, can vary threefold across the country in ways unrelated to need. Despite having national guidelines, despite having national tariffs, despite doing our best to have a national health system, there are still these variations across the country. That is clearly one area to tackle.

There are lots of other areas of waste in health services that need to be tackled as well. Beyond efficiency, there are still other steps and recommendations which I think would be important. Paying adequate attention to social care spend is clearly fundamental, and we have discussed that at some length. The other element that is often forgotten in this conversation as well as social care is the role of the patient him or herself. It would be a useful recommendation to try to bring patients more into the conversation, to try to orientate more information to the user of the health service about how much things cost so they are slightly more aware of these things, and also, where care is low value, to try to moderate demand. There is a very good initiative called Choosing Wisely, which has been rolled out across Canada, the United States and some other countries, where they take national guidelines, the things produced by NICE, for example, which run to several hundred pages, and reduce them to a single side of A4, and they are written for the patient, so that the patient in conversation with his or her doctor can understand what care is appropriate and what care will be effective and what will not. For example, Choosing Wisely tries to discourage patients from asking for scans of their back when they have simple back pain. It tries to discourage patients from asking for antibiotics when they have a cough or a cold. It is trying to move the conversation in the patient's direction so that it is not about cuts, the Government saying no or the NHS saying no or the doctor being difficult; it is about what is good for you and what is good for the health system in the long run. Bringing the patient into the conversation I think is something we have not done sufficiently and should be explored more. The final area is around prevention, which we have also discussed at some length.

Professor Alistair McGuire: I broadly agree but I think the pinch points in the NHS now are the volumes of staffing levels. I think there are concerns over those. The NHS is often compared as an employer to the Red Army in terms of size, but the Red Army has one in six at the front line, and there are six behind them doing all the administration and other tasks. There is a very great need to improve management within the NHS. The management structures and management intake are poor.

Whilst there is variability of outcomes across the UK—quite marked variations—the variations in management are appalling.

Lord McColl of Dulwich: I like very much this Choosing Wisely. Is it having any effect on the gross obesity epidemic?

Ian Forde: It is a very new initiative, having been up and running for three to five years. There are some studies, and they show that it has an effect on the things which they try to disincentivise—for example, antibiotics for coughs and colds. There is no study looking at the effect on obesity yet but it has been shown to be an effective programme in other areas.

Lord Ribeiro: You both said earlier that general taxation in your view was a better way to achieve sustainability in the NHS, but if public funding was limited, what evidence is there that private funding can fill the gap? Given the objections you have both raised to co-payments, even though we have evidence that the public have accepted prescription charges and dental charges, how do you see this being taken forward?

Professor Alistair McGuire: If you have a capacity-constrained system, which leads to waiting times, for example, for elective surgery, there is some evidence that a complementary system of private funding can take some relief out of that system, but it may be it is only temporary relief, because it may be that capacity grows in the other sectors, so it is a dynamic question. Generally speaking, it is the same surgeons and clinicians operating both systems, so it may be that you have to regulate the system quite extensively if you introduce complementary private funding. I have less of a problem with private healthcare provision being allowed to compete for resources which are financed publicly. I think that can, under certain circumstances, with suitable regulation, also be used to improve efficiency, but with the funding you have to be careful that you are regulating the two systems appropriately, and of course there is a massive issue about equity.

Ian Forde: Apologies if I was over-simplistic when I said that we had discussed rebalancing to private sources and we had crossed that one out. I did not mean to be over-simplistic. Clearly, every health system has a blended source of revenues, and clearly there is a place for private sources of funding within that. The UK currently has around 15% coming from out-of-pocket sources. It is an option to expand that to try to shift more of the costs on to private individuals but, as we said, there are risks associated with that. It is an option but one that should be taken carefully. It is not really being pursued by other health systems.

Lord Ribeiro: On that basis, do you think that the introduction of the concept of independent sector treatment centres, which initially was introduced so that NHS surgeons and anaesthetists would not be taken out of the system to work in it, was a success or not?

Professor Alistair McGuire: Broadly speaking, I would say they have been, but you have to be aware that first of all the treatment centres

have largely been merged into the NHS now, as a source of revenue generation. I think initially they were largely broadly a success to increase the efficiency within the system, but that was at a time when money was growing quite markedly. Also, you have to have, as there was, considerable regulation to ensure that there is no cream-skimming.

Q75 **Baroness Blackstone**: If you were to make one key recommendation or suggestion for change that the Committee might recommend which would promote the long-term sustainability of the NHS, what would it be?

Professor Alistair McGuire: There were always going to be two bites at this cherry. My main recommendation would be improved management in the NHS. The second one would be improved data. I have to come back to the labour data, because it is not just about the cost of that data. We have very poor data of who does what and the turnover rates, for example, of nursing staff within the NHS. So data but primarily management.

Baroness Blackstone: Can I just ask you what you mean by management? What level are you talking about—central government, NHS England, hospital trusts or what?

Professor Alistair McGuire: Picking up on something that Ian said right at the beginning, I think the regulatory structures within the NHS are, broadly speaking, very efficient and very good. At the central level, particularly NHS England but also NHS Improvement, as Monitor now is, I think that there are excellent people there. The centralised structures are fine. Where you have much more variability is within the hospital trust sector, within the CCGs, as it were, and probably as are going to be but in a different manifestation, and at GP practice level. We have no history in this country of promoting management as a career structure within the NHS. We have been very lucky with some of the NHS managers who are outstanding, but the variability is massive.

The Chairman: Mr Forde?

Ian Forde: I completely agree with Alistair, so I will take the opportunity to build on his response by saying two different things. My two responses would be, first, to be ambitious on prevention. Seventy per cent of NHS spend is on long-term, communicable, lifestyle diseases. This country is not healthy, and in some respects is becoming unhealthier over time, so there is a need to be ambitious on prevention through legislation, taxation, advertising and regulation, as well as the clinical one-to-one stuff. The second recommendation would be around the health and social care budget, to take that difficult step to unify the service. That would be more patient-centred as well as being more efficient, and would better match the needs of the population going forward. It is an extremely difficult thing to do. However, that is not to say that this Committee should not make a difficult recommendation.

The Chairman: Thank you both very much. We have taken a lot of your time. Thank you for coming. If you have any additional material or

something you may think about that you would have liked to answer but you did not have a chance, I encourage you to send that in.

Ian Forde: When I said lots of things were above and below average, and so on, the data itself is in this document, so I will leave this with you. You will find the numbers in there.

The Chairman: Thank you very much indeed.