HOUSE OF LORDS

USelect Committee on the Long-Term Sustainability of the NHS

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

Tuesday 20 December 2016

10.10 am

Watch the meeting

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

Evidence Session No. 34 Heard in Public Questions 314 - 318

Witness

Dr Mark Britnell, KPMG.

Examination of witness

Dr Mark Britnell.

Q314 **The Chairman:** Good morning, Mr Britnell, and thank you for making time to come and see us today. We are most appreciative. Of course, you did a seminar earlier on, before we started our inquiry. This time a formal evidence session is very useful. You will be sent a transcript after our session. Please feel free to correct it but not to change it. We are on live broadcast today. Please introduce yourself for the record and, if you want to make an opening statement, please feel free to do so.

Dr Mark Britnell: Good morning. Thank you very much indeed for inviting me. It is a real honour and privilege. My name is Mark Britnell. I have dedicated my professional life to healthcare; 20 years in the NHS and the last seven as global chairman for health for KPMG. In that time I have had the privilege, if that is the right word, of working in 66 countries on 230 occasions—sadly, I counted it up last night.

If I may, I would like to make some brief opening remarks. I have six points which I hope will shape the agenda. I have read some of the transcripts of your previous meetings. I will be short and to the point.

Point one: the NHS is fantastic value for money. Having worked in 66 countries, I think we get tremendous value for money from the NHS. We all know that OECD spend over the last two or three decades has been two percentage points higher than economic growth, and we also know that our country compared to our European peers lags by some 2% of GDP behind spend, so I think what we pay for and what we get is fantastic.

Point two: obviously, clearly and axiomatically, the NHS can be more productive, more efficient. The work of Lord Carter suggests that running costs per square metre of a hospital range from £100 to nearly £1,000; infection rates post-hip operations have an eightfold variation. I have seen organisations in the States, India, Singapore and elsewhere where that variation would not be tolerated, and it is a shame, after 27 years working in the healthcare profession, that we are still tolerant of that variation.

Point three: as you know—and I think I sent you my book; if I did not, I am very happy to send it to you—I have spent all my professional life trying to reform and improve healthcare. It is my passion and my profession. In my book I conclude that a single or dominant payer is the best form of payment to keep costs down. There are consequences of that, as you are well aware, but after working in these 66 countries, I conclude a single or dominant payer is best to control costs. How that is funded, through general taxation or social insurance, is a second matter and a secondary matter, but we will no doubt come on to that in due course.

Point four, and I think many of the Peers around the table are aware of this pressing concern: if we do not love our workforce more, if we do not try to motivate and manage our workforce in modern ways, we are in the middle of and approaching a larger crisis. As some of you know, I am one of the 12 members of the World Economic Forum Health Council, and recently we have looked at work, along with the World Health Organization, that suggests the number of doctor and nurse vacancies will be 13 million by 2030. I think your time horizon is to about 2025. One thing I know, and many of you know this better than I, is that there is an emerging global market in the movement of skilled labour, especially in the medical and clinical professions. I know because even last week, when I was working in Jamaica and the Bahamas, visiting the University of West Indies, how influential and sapiential our education and medical education system is globally. I think it is time for us to reinvent ourselves, in producing über-modern doctors and a new form of care worker that transcends health and social care, allied with technology. It is a massive global market and we can lead it. If we do not, the Indians will.

Point five: I say this now not because of the fiscal crisis but, after 27 years of consideration, and working with all sorts of Ministers from different political persuasions, it is my view that we need a new debate, as in 1911 and 1948, on the repurposing of national insurance. I say that not because of the financial crisis we are in now—I consider it pressure, by the way, not crisis, not yet. Looking at the demography and the ageing characteristics of our society, where we know that the work/age dependency ratio will decrease by 20% over the next 20 years, we know that by 2020, just three or four years away, we will have 1 million more people aged over 75, and we know that on average now our life expectancy extends by one year ever 4.5 years, you do not need to be a Member of the House of Lords to work out that we have to find a different form of funding.

I have done some work on this. I am not an expert but I think there is £60 billion at play, give or take—and I can talk about that later—for how we can repurpose national insurance to have a fund which is professionally managed, directed by government, and, dare I say it, much more transparent in the way that funding is supplied to the NHS. I think this new financing and funding model will bring together, quite rightly, and integrate health and social care. In the great reforming traditions of David Lloyd George, Beveridge, the Conservatives with the White Paper in 1942 and the Labour Government that gave us the NHS, it is this sort of cross-party coalescence that we need, which I think you are leading very ably, if I may say so.

Finally, and this is the most important matter, in any great tectonic health change you require three things, and I have seen it happen but not very often. You need tremendous political will and courage, very good managerial skill and time. I believe there are countries that have demonstrated how they can change their health financing, funding and delivery systems by strong political will, great managerial skill and time. I

could name a few at random: Japan in 1961; South Korea after their civil war; Mexico; Brazil as it created SUS; Italy even, in the 1970s; and of course, last but not least, the country that people still look to the most, the great United Kingdom, which led the way in 1948.

They are my six opening remarks. I remain, as always, an optimist. These problems are solvable, they are not intractable, but we need to think and act with more speed and, dare I say it, more verve and imagination. Thank you for listening to my opening remarks.

The Chairman: Thank you very much for that, Mark. In fact, you have covered a lot of the things I was going to ask, certainly my first question, and maybe others too.

Dr Mark Britnell: Thank you. Can I go now?

The Chairman: Can I add one question on what you have just said? Yes, we have heard that our model is one of the best, free at the point of need, but it is not delivering in a lot of areas, and you have picked out some of them. What do we need to do to make it sustainable by 2025, 2030, and beyond?

Dr Mark Britnell: I think there are two different phases now. Clearly, we live in strange and interesting times globally, and I get to see quite a lot of that first-hand. The first thing to say is thank goodness we have economic growth, and thank goodness we are leading the G7 in our growth numbers at the moment. Of course, they have been revised a little over the last few months, for obvious reasons, but, as you know, since the Second World War every major country has shared the proceeds of its economic growth in healthcare. If you look at our European counterparts—the Dutch, the French, the Germans—they are now spending 2% or 3% more on healthcare.

I would expect, as people have said, including the Secretary of State for Health, that as our country grows—and it will—some of the proceeds of that growth will be invested and further invested in our National Health Service. I see that as a short-term, tactical play, while giving us the next three to four years to have a much bigger debate about the future repurposing of national insurance, as I indicated in my opening remarks. I believe that between those two issues we can create a much more sustainable health and social care system, which recognises the will of the British people, which is, as you know, that the NHS is the most cherished institution, more so than our Olympic team, our Armed Forces and our monarchy. I believe both these things need to happen in parallel but I think both things could and should happen.

Q315 **Lord Warner:** Can I take us back to what you said about a single payer being critical? That fits quite neatly with a tax-funded system. Why are you so enthused about national insurance and what you call repurposing of national insurance, as distinct from continuing with a largely taxation-funded system? What are the arguments? What is the evidence internationally to support that line of argument?

Dr Mark Britnell: First, to make sure I am clear in my argument, and forgive me if I have not been, I am saying that for the next period a gentle increase in taxation or the proceeds of growth is the way to make the NHS and social care more stable, but looking at the demographic pressures over your timescale, I think this debate about national insurance is long overdue.

Let me answer your question specifically. When I say a single payer, I could also mean a dominant payer. Japan, which I know people have mentioned to you, has over 3,000 insurers, so it has many payers, but it only has a single price setter in the Government; the finance ministry sets the prices in consultation with the health ministry, and they do that every two years. That is why I used the word "dominant". In that case many insurers are a dominant payer in the form of the Japanese ministry of finance.

On national insurance, I will be the first to acknowledge that I am not an expert, and the great work you did with Dilnot I think taught us many things. The reason why I say "social insurance", or "national insurance", is that, first of all, it goes with the grain of our British history. It was created by Lloyd George in 1911, with the "nine pence for four pence" quote, where the employee paid four pence, the employer three pence and the Government two pence. I believe that then, obviously, Lloyd George was making sure we were fit, that we had funds when we could not work, that we were fit to fight—he was afraid of the Germans, and I am not saying there is any parallel there of course—and that using something which people understand, which they have paid for, and is called national insurance, helps working people and old people think about national insurance for health and social care, because those two things now, as you know better than I, are a complete nonsense in terms of health or care.

Why do I say national insurance? I am quite open to people cleverer than I having better ideas. It is not quite hypothecated but it is a source of funds which is clearly identifiable. It can be managed more transparently, which I know has been an issue for your Committee. It can also be managed independently by professionals who know how to manage health funds, and there are lots of examples of how you can better manage health funds. Also, I think it allows for us to have a conversation with the country, dare I say it, outwith the political cycle, where of course we lurch from feast to famine, and in my career I have experienced two feasts and two famines. It allows us to take perhaps a seven-year view, and I say seven years deliberately because it is nearly halfway between five and 10, and we can have a conversation with the British people about what they want to pay for.

I got back from the Bahamas and Jamaica on Friday and I have been swatting up this weekend. Thanks to you for that; the Christmas shopping will have to be done later on this afternoon. I was shocked to read in the IFS report of this year that today's pensioners are better off than today's working people on average. Something has to give at some

stage, so when I look at this £60 billion—and I do not want you to shout at me straight away, because these are just sources and applications of funds, and they are all game for a debate as far as I am concerned—we should look at tax relief on pensions; there is £35 billion to £40 billion there. We should look at the triple lock; surely that has had a good run for its money. We should look at who pays and the rate of national insurance contributions. We should perhaps think about national insurance extensions, because the average life expectancy in 1948 was 67 years, and it is now over 80; old people have a direct benefit from what they have paid into, but perhaps we should extend national insurance for people aged over 65. Chris Ham at the King's Fund and Anita and others have talked about prescription charges, and the old chestnut of TV licence and heating.

My argument is that there are funds there that require political choices and managerial decisions, but I think there is enough in there, coupled with the proceeds of growth—thank God our country is growing—that we can have a proper debate over a period about creating something which people see as respecting the will of the people. They love the NHS.

Lord Warner: Can I bring you back to feast or famine? We have had a fair amount of evidence saying that the volatility of the allocation of resources to the NHS has been very poor, up and down, up and down, and no synchronisation with social care. Is there any evidence from overseas that there are countries that take a longer-term view and smooth out what Simon Stevens called lumpiness, so they take five-year, seven-year, 10-year views?

Dr Mark Britnell: They do, and of course, they have a particular form of democracy. There are three countries, two of which you will be very familiar with, and one which you will know about but I think is able to plan over a longer time period for different reasons. Of the three countries I would like to talk about briefly, the most resilient I have seen is Singapore. It scores very high on the World Economic Forum competitiveness rankings and innovation rankings; it is a highly tech-savvy country; it is a small country, with a particular form of democracy. I have worked with their Government and their major clients for years. They are planning out to 2025. After their independence from the British in the late 1950s, like every developing country, they wanted to build great big pyramids of prowess, big teaching hospitals; their ageing problems are significant, and they realise that; they have now shifted gears, moved hospitals into clusters of care homes, GPs, all connected by information technology; 4.9 % of GDP, 83 years of life expectancy. It is a smart and clever system. They plan, because they tend to have one political party in power for a long period of time—they have elections of course. They are planning up to 2025, and they are planning massive investments in technology, in care homes, but also, as you know, tax incentives for people like me to look after my parents. They are using a combination of law, policy, planning and economic prowess, so that is one example.

The second is China, of course. GDP growth has been constant at 7% for some time now, but in 2009 they realised how disturbing patients were becoming with their doctors—there were fights, arguments—they wanted to share more of the economic proceeds of growth into healthcare. They launched the largest single movement in universal healthcare that the planet has ever seen, with 800 million people covered through universal health insurance—broad but shallow. They are planning out now to 2025, 2030 as well.

Perhaps they are not the same as our country but what underlines both—

Lord Warner: What was the third one?

Dr Mark Britnell: The third one is where I am coming back into territory which we feel more comfortable about, and that is Australia and to a certain extent Switzerland. I say both, because Australia has just celebrated its 26th year of consecutive economic growth, and although its political system, as you know, is very fractious, and it can be very hard politically, they have people planning over a parliamentary cycle, partly because those parliamentary cycles are so volatile, and they are basing that on economic growth. The Swiss, of course, once again, score very high in innovation, education, teaching and flexible labour relations between employers and employees. Their health system, as I say in my book, is the least disturbed I have ever seen. They do that because they simply spend $9,500 per head, something we cannot do—it is up there with the States—but they do it because their economy is strong.

The answer to your question is yes, I am aware of countries that plan longer. All are predicated on a strong economic base, and all have elections of sorts, some more democratic than others. If you forgive me for saying two more things, and I do not wish to be provocative, but I run a multibillion dollar business, and no one tells me whether I am going to be plus 5, plus 10, minus 5 or minus 20. In one sense we can still plan in the NHS; it is just a lower number than most people want. I do not think it should stop us doing things because we do not know what is coming from year to year, but smoothing out those cycles, as we do in the private sector, is something the Government should encourage in the NHS and for health and social care as well.

That is why I come back to national insurance as being one way in which the Government are still in control but the fund would be managed in a slightly different way, because, as you well know, being a former Minister, and I know, being a former director-general, in that great scrummage called the spending review, when all the departments put in their pet projects, most of which of course are good, it goes into that big back box called Her Majesty's Treasury and something comes out saying "Do all of it with less money". That is one way of going about business but it demotivates professionals, it lacks transparency and, worst of all, it avoids a conversation with the public, who love, as we do, the NHS. We are grown-up politicians, we have led the world in the creation of universal healthcare, and we can lead the world again with a new social

fund which looks at health and social care together. Our time is now, and I am glad that you are looking at this matter.

The Chairman: I am going to have to have to manage the time a bit better. I have several hands up. I need quick-fire questions and quick-fire answers, otherwise I will run out of time and we will not get all the questions in.

Baroness Redfern: You mentioned Japan. Roughly half the long-term care financing comes through taxation but extra premiums are paid by people over 40. You mentioned that employers are paying—is it compulsory for employers to pay?

Dr Mark Britnell: Yes. It comes back to my point about political courage. As you know, the Japanese health economy has been flat-lining for 30 years. I do not know whether you know, but it is depopulating at an enormous rate, from 122 million to 90 million, in the next 30 years. I was there two months ago. That political system is fractious, as you well know, and quite fragile. I admire the Japanese. In fact, they are acknowledged in my book because they had the political courage to have an awfully difficult debate—

Baroness Redfern: That is dual funding as such, rather than single funding.

Dr Mark Britnell: Yes, in 2000 they decided to introduce a mandatory social insurance tax of between 1% of income on anybody over 40, while running 3,500 insurance companies across 47 prefectures. They did it. It was not popular. It did not work at first. It has bought them time. It is a good system. It is always under pressure, but they took that difficult political decision.

Baroness Redfern: Is it compulsory for employers to contribute or not?

Dr Mark Britnell: I would have to go back to my book. I cannot remember off the top of my head. Could I get back to you on that?

The Chairman: Would you write to us and clarify the contribution from the employer?

Lord Lipsey: I am struggling with this debate on national insurance. National insurance is essentially an employment-based tax, where you have it. You said something about extending it to older people, but if you extend it to older people's employment, all you get is an extra £100 million a year, which is not material. If what you are saying in the rest of your remarks is correct, that old people are doing rather well compared with employed people, why are we turning to a tax on employment to fund this when we have another thing which affects everybody equally, namely the taxation system in general?

Dr Mark Britnell: First of all, I respect your greater authority on this matter than mine. I am trying to give you an example of a fund that could be managed over a period of time. The money comes from

somewhere; whether it is general taxation or national insurance, it is either one pocket or the other. If there is a way to have a more transparent give and get between taxation and the spend on health and social care, and a conversation with the population, you would know better than I how to do that.

On the issue of a taxation for national insurance on employers, employees and older people, if you push me, I think the NHS is fantastic value for money for this country, but also great for our business. I have worked in many countries that have social insurance. You know that great, apocryphal cliché about $1 in $4 from General Motors being spent on healthcare. There are companies around the world that have a double whammy, paying for health insurance for their employees and through taxation. I think having a more discrete fund where employers, employees and, dare I say it, older people pay into a fund because of the benefits they have enjoyed, they will enjoy and they continue to enjoy from extended life expectancy—there may be a better way to do it, because I am not an economist; I am a jobbing health service manager—is a debate through your line of inquiry that should be scrutinised further.

Lord Scriven: A very quick question. You have talked about this discrete fund, wherever it comes from—an integrated health and social care fund. You have talked about a dominant payer. In the British context, who would you see as the dominant payer? At the moment there are a number of dominant payers, and this could be quite tricky. In future, going forward, if we have this fund, who is the dominant payer?

Dr Mark Britnell: In the national insurance scenario that I painted? Many countries have—

Lord Scriven: Just your view of the UK, going forward.

Dr Mark Britnell: Following my scenario, you would have a publicly managed national health and care fund that would be managed by professionals. It would be part of government but not necessarily part of the Department of Health.

Lord Scriven: You would take it away from local authorities as well.

Dr Mark Britnell: I realise the difficulties there about what we do with health and social care but, if you push me, in the final analysis, the dog should wag the tail and not the tail the dog when it comes to expenditure, if that is not being too cryptic.

Lord Willis of Knaresborough: There is a major flaw I can see, and it is probably because I have misunderstood it. Social care is in fact funded through a whole set of different sources. Are you suggesting that all those sources are abandoned for a single source which comes through this system? It means that everything would then be free at the point of delivery, whether it was social care or healthcare. That is a fundamental difference.

Dr Mark Britnell: As you know, there are about five sources of funds that flow into social care at the moment, which gives complexity and problems. Forgive me for a second if I just say that, unfortunately, my mother passed away six weeks ago. She had lived in a care home for three years, with fantastic care by English, Indian and eastern European carers. I have read many of the transcripts over the weekend and lots of them narrate the problem. All I am trying to do in your last session today is hint at a possible line of inquiry for a solution. I do not think I can defend my argument completely but, yes, these sources of funds should go into a consolidated fund. We should then look at how we can best deploy that fund, and which sources and applications of funds go into it and where it goes. I am calling for that debate to be had and for that line of inquiry to be pursued.

To answer your direct question, yes, I am assuming that all the sources of funds that at the moment go into health and social care may be consolidated into this fund. Whether people would have to pay more into that or not is a matter of the projections which I would expect people to take over a seven to 10-year period. That is the sort of arrangement I am trying to etch out.

Q316 **Lord Kakkar:** I would like to turn to the question of workforce. You mentioned the impending workforce crisis globally, the huge demands that all health economies now have for a trained workforce. Can I ask you whether, first, you have seen other health systems that are able to better demonstrate the value they place upon their workforce, and are also better positioned to deliver planning for the development of a workforce over time, recognising potentially the different requirements for skills mix and the need to provide flexibility for members of the healthcare workforce to develop and change over time in their professional careers? Do you think that, again, there are models elsewhere in the world that have answered that question and, in particular, have been able to address the skills mix in a way that has been acceptable both to professionals and to meeting the needs of the health economy, and whether we, in our own system here, find ourselves with a more demoralised workforce, experiencing more pressure than in other parts of the world?

Dr Mark Britnell: Two opening remarks. First, in my considered opinion from my global travels, the quality of our medical and clinical education and training is second to none. It is something we have given the world that we should be proud of, and that we should exploit and, as I have said, we should export. I will come on to that in a moment. We should be very proud of what we built up in the 19th, 20th and 21st centuries.

The second thing to say is that there is indeed a global crisis now in work. It is not only the 13 million that I referred to for the World Health Organization but something which I do not think is being covered, reading the transcripts. Many of you will be aware of the sustainable development goals that require all countries to achieve universal healthcare by 2030. Think of all the countries we have been taking from and what they will need to stand up their own universal healthcare. Last

week I was in Jamaica. They have a doctor and nursing crisis. They have sent many of their best over the years to this country. The point is that we need to wake up, and wake up now, and I am glad this Committee is taking the lead on this.

To answer your question directly, Lord Kakkar, there is no country that I think is the panacea for workforce education and training, but there are plenty of systems and organisations that are working more smartly than we are. They do three things simultaneously, and I am thinking about India, the States but also the Netherlands—I could go on. First, they are intolerant of clinical variation, and therefore they standardise, consensually through clinicians and international experts, best clinical practice over care pathways, both within organisations and across organisations. Why is this important? The standardisation allows you to self-police, regulate less, and motivate more. It also encourages clinical professionals to hold each other to account, as opposed to a top-down, central diktat.

When those protocols and pathways have been agreed, they become an iron law. It is not cookbook medicine; you can vary and go off the norm, as long as you can explain, but that enables you to put technology in which is completely supportive, which is cognitive, and now increasingly, if you look at the case of Israel, is based on the best algorithms in artificial intelligence for population health. There are clear pathways and strong information technology. What does that enable you to do? Leverage skills to the highest point possible. That means—I do not like the word down-skilling; I think it is incredibly pejorative—that it allows people to work to the limits of their practice. This means, as you know, in India, with cataracts, they are 12 times more productive than we are in the United Kingdom, and I think five or six times more productive in cardiac surgery. They have managed to reskill and remotivate the workforce. They even—and we have not heard a lot about patients today—encourage families to share care. I am not suggesting that today, before anyone jumps down my throat. As you know, Dev Shetty has a great quote from Narayana: "Who knows the patients best? The family". There is room there for patient activation and support.

Organisations I am thinking of—Geisinger, Virginia Mason, Intermountain you will be familiar with, Apollo, Narayana, Buurtzorg in the Netherlands—all re-profile the skills they need based on the clinical pathways that have been agreed, and they heavily leverage technology to make sure you have support when you need it.

What does this mean in the UK context? I am not an expert in workforce planning and, sadly, I do not know many people who are in our country. There are two things that are clear to me about taking this global export potential to market and winning—and I think we can win because of the strength of our university system. I think we need to train some doctors more quickly, and I think we need to create a new movement of what I call care workers and care givers, and that is nurses and nurse assistants. I do not think we would go wrong if we overtrained, with more

doctors and more nurses and care givers; we will need them in our country. As we know, it also stimulates local economies, and it draws people from local economies that look just like me and you when you are being cared for in your moment of need.

Those are two areas I would major on: a massive explosion in care workers, supported by technology, and I would want us to be the first country in the world that has thought about training some doctors more quickly, perhaps using the physician assistant model as a basis on which to build. The reason I say that is, in my experience of 27 years, people are great at getting into little huddles locally and saying, "This pathway here, from this A&E to this old care ward to this community hospital; let's have a care pathway", and they spend two years agreeing that care pathway, only to conclude they need a generic health worker. We have been too specific. Regulation has played its part in slowing down innovation but I think we have to think and act in a different way now. I genuinely believe there is another economic case for demonstrating that we can not only serve our own country but export that prowess to the rest of the world.

Lord Kakkar: May I follow that up? You are saying that in many of the countries where you have worked there is no national planning approach to workforce. You gave examples of health systems that clearly have an approach to developing their workforce. Does that mean that potentially in our own country regulation stifles the ability for an individual health economy to start developing the workforce that it needs?

Dr Mark Britnell: I think it does to a certain extent, although it is easy for healthcare practitioners and educators to always blame regulators, which are not, in my opinion, the root cause of the problem. Yes, it has a role; yes, it would be nice if pharmacists could do more; and, yes, it would be nice if, say, physicians' assistants could prescribe. All that is helpful, but I do not think it is the root cause of the problem, so I would want to go where the action is, not just try to dump blame on regulators. They are used to it, of course, but I do not think that is the sole source of the problem. It needs to be addressed, but I think there is a much bigger issue about education, training and re-profiling skills dependent on technology.

Also, as you know, in our country, unfortunately, the technologists are a million miles away from the educators. This is not tolerated in any other industry. It is not tolerated in my business, and we are across 157 countries. We need to become a lot smarter at doing that in this country, and I genuinely believe we can rule the world; we can lead the world in a new form of training and education for healthcare givers, carers and workers.

Lord Ribeiro: When the Secretary of State gave evidence the other day he echoed your thought that no Government has done workforce well, and he threw down the challenge that Brexit might well be the catalyst to address this thorny problem. Britain, like America, has for years relied on overseas workers to staff nursing doctors, the lot. What is your vision for

what we will see post Brexit?

Dr Mark Britnell: There are many visions, as you know, of post-Brexit scenarios. Before I answer your question directly, I would like to remind you—I do not know whether you are aware of the statistic. Do you know how many more healthcare workers the US employed between 2008, the global financial crisis, and 2013, so when they were going through their tough times? Would anyone like to guess?

The Chairman: Please give us the number.

Dr Mark Britnell: It is 1.4 million people, the size of the NHS. There is a clear and present danger and problem when a country of that magnitude decides to embrace Obamacare, extend coverage, and employ 1.4 million more people. Time is against us, but two things strike me. I genuinely believe, as I just said, that we can train and care for lots more people by employing and training people in different ways, and we should not be scared of that; we should walk forward with purpose, because I genuinely think we can lead the world in that.

On the Brexit situation, clearly, there are about 140,000 people from outside the UK in health and social care. I am not a politician, but I think these people have to stay in our system. We have to cherish them and thank them for their contribution, while now planning to create new healthcare workers linked to technology. I do not see that as a contradiction in terms. I see it as something we can build on concurrently and also consecutively. That is what I will be trying to do.

Bishop of Carlisle: One of your initial six points was about valuing and caring for the health and social care workforce, and you have talked about cherishing. What do you see as the key to that valuation? Is it training, as you were suggesting; is it thanking; or do we need to pay them more?

Dr Mark Britnell: It is all of those things, as you know, and, depending on where you are and who you are working with, some are more important than others. One of the nice things about a single funded system of course is that pay rates normally rise and fall with the fortunes of our GDP and our economy, and that is quite a sensible regulator. It is Christmas, I am not calling for massive pay rises, but I think there is only so long you can keep your wage restraint. It bounces back eventually, as we have seen over feast and famine. It is a part of it, certainly, but I think the motivation and recognition in training to enable people to give their best in clinical practice is important. I had the privilege of leading University Hospitals Birmingham for six or seven years, and built the largest hospital in the history of the NHS, with staff satisfaction rates of 85%. We did that through professional appraisal, where we listened; we had an honest conversation about what was expected, the give, and the get, and then we mobilised our training and recognition programmes around that appraisal.

Work I have done globally suggests you can get 15% more motivation and productivity out of the workforce by valuing them properly through professional appraisal and development. I would start there. By the way, anywhere I go in the world I play a game at the conferences I speak at. I say, "What percentage of your staff have meaningful appraisal?" I have never been to a country or a conference where more than 30% of hands go up, and in this country it is about that, if not a bit lower. I would start there.

Baroness Redfern: You mentioned the workforce and how regulators can probably get in the way of motivating and collaboration of certain services. What do you think is holding it up? Do you think we have poor management, or are people saying one thing and holding back? Are they nervous, not confident to move and take on new skills and roles? The second part of my question is: can you hold up a country that is an exemplar in health and social care?

Dr Mark Britnell: They are three big questions. The first thing I would want to place on record, having said I am a jobbing manager, is that I think the managers in the NHS and social care do a tremendous and fantastic job. I know they are maligned by some but, with the resources that we are given, and for what we get, they should be thanked every day, along with our great doctors, nurses, allied health professionals and ancillary staff. They do a great job in difficult circumstances. That is the first point I want to make.

Second, in terms of the regulation, as you have said, and the lack of workforce planning, having worked in the NHS for 20 years at local, regional and national level, I think that what stops better workforce planning is that no one really thinks they are in control of it.

Baroness Redfern: Should we have fewer regulators?

Dr Mark Britnell: It is almost axiomatic that we need fewer regulators, we need fewer providers, and we need fewer payers locally. It is not possible to do what we are trying to do, to transform the NHS, with 200-plus CCGs and so many providers. There is not enough skill on the planet to make that work. It is not just about the English NHS.

Baroness Redfern: A country that could be an exemplar?

Dr Mark Britnell: The ones I cite in my book are the Nordics.

Baroness Redfern: I have read your book.

Dr Mark Britnell: Thank you. If you pushed me today, the Nordics are similar to us, they are north European, higher taxation base, better integration between health and social care—sometimes that is misconstrued by people who do not understand the systems. They have their problems—they tend to plan longer, have less national directives, and have clinically-driven databases which they use for improvement. We have an overactive policy thyroid in our country, as I talk about in my book; every two years we get another national vision for healthcare, but

in the Nordics they seem to go about their job much more quietly and thoroughly, and they plan more collaboratively. They are not brilliant; if you look at the last OECD report, it still talks about fragmented care and co-ordinated care, but if you were pushing me today, which you are, I would say the Nordics. Are you pushing me further? Do you want which one of the five countries in the Nordics? It is Norway, but do not tell Iceland because they are doing well as well, and Sweden, and Denmark, and Finland.

Lord Scriven: On this integration of health and social care, a couple of questions: first, do you see in the future it being one body as an integration? If so, how will we get there? Integration has been spoken about for about 30 years. It is a nice word but we do not seem to be able to get there. What will be the key to get us there? The other issue, coming back to what Lord Willis said on your approach to this one fund in an integrated health and social care system going forward, is whether you see, in this new world of integration, a system that is free at the point of need for both health and social care, or would there be co-payments or extra payments for services which were not within an agreed bloc of services that were being paid for under this system?

Dr Mark Britnell: You have asked me three different questions. The global evidence suggests that the best integration is that integration that is wrapped around the patient. All of those pathways need to come together in a care plan between health and social care and different agencies, including education. I know it is easy to say but all the global evidence suggests that you need a unified care plan. The second thing you need, which we do not have, and we have not talked yet about investment in the NHS—and I will answer the question but you have not asked it yet—is an investment fund. There are billions of yen, dollars, euros, sterling, waiting to come into healthcare. It is a very resilient industry, as you know. The consulting industry globally is growing at 8% per annum, larger than financial services and agriculture. Why is it resilient? There is always more demand than supply, capacity and capability.

I am going to answer your question. The second thing is you have an integrated information system that makes it very easy for self-care, for extended care, and for clinicians, between health and social care, to focus on that care plan.

I would think about a much bolder investment portfolio for information technology, because we cannot train people, and upskill to the very highest level, unless we are leveraging technology, and we are not doing that. That is the second thing I would say. They use information technology very well. Look at Singapore, where they now have these clusters. We helped them create that system: teaching hospitals, care homes, GPs, integrated IT system. It took them about 12 years. It was not one big bang, by the way. They learned from us, as they usually do in Singapore, and did not go the same way we did.

The third thing is this, and I would like to emphasise it. I have tried to come today with a new idea. It may not be the best idea, it may not be the freshest idea, but I am saying we need a debate about this, because demography, not just finance, is forcing us to a different place. I cannot answer your question today. It is the old politician's trick of "Show me the structure and I will reform it". I think form should follow function, and I think what is great about your group, truly, is that I find it surprising that an industry which is £130 billion to £140 billion does not have a capability to forecast over 10, 15, 20 years. It is a dirty word in healthcare. It is probably a dirty word in local government. We are 140 years old, we operate in 157 countries, we live on a quarterly basis, but we are always planning 10, 15 years out. Any good business needs to do that. Frankly, I am glad that you are doing this work. In a sense, I am surprised that you are doing this work and others are not. I am glad you are, and I am sorry to say this, but you are better placed than I am to answer the question you have asked me. I will happily play a part as a member of the public, as somebody who loves the NHS.

Lord Warner: Dementia care and nursing homes by historical accident have ended up on the social care side of the boundary. Is that an exception, or is that usually the position in most other countries?

Dr Mark Britnell: That is a good question. Broadly speaking, from my memory, we are not an exception, unfortunately. The Dutch do it better, as do the Austrians, with their dementia-friendly care homes. They are starting to move into a completely different socialised model of care, which is less medicalised. I know that was not your question but I do not think many other people have embraced it either. All of this is hitting countries at roughly the same time, at the same velocity.

Lord Willis of Knaresborough: One of the common threads throughout your book, and you have mentioned it a few times today, is that you need to have an integrated technology platform to handle data across health and social care. It is interesting that in your book there is no system, including in the United States, that is the size of the UK's NHS; they are all much smaller. The Netherlands is a classic example, as indeed are the Nordic countries. Is it not time that we accepted that the NHS is too big an organisation to develop the sorts of processes you want to see, and that integral to doing so is to break it up into smaller modules?

Dr Mark Britnell: Yes. Singapore, Denmark, and the Nordics, have very good systems, built over time, with a population base of 5 to 10 million. I think there is a different way of going about what we need to procure. Clearly, we have learned a lot of lessons from Connecting for Health. It did some good about the national spine but no, I am not suggesting, for the avoidance of any doubt, that we have another national programme for health. From the GPs—I read the Secretary of State's transcript—you know there is lots of local innovation. It is great, it works for the practice, but it needs to be joined up. There is a wall of investment waiting to come in for education and skills development and the application of IT to

leverage skills. Why should we not be the first country in the world to take it?

Lord Willis of Knaresborough: We heard last week from the Secretary of State that all GPs are now fully computerised, whatever that means—I do not know—and that tertiary care is not, yet we spent £2 billion on a centralised system, which absolutely failed. I do not know where we go unless we break the thing up, but you have agreed that it should be broken up into a smaller number of units.

Dr Mark Britnell: Smaller, more manageable, public-private joint venture partnerships.

Lord Bradley: Very quickly, one of the drivers for integration, another idea, has been the devolution model, such as in Greater Manchester, backed up by locality planning and technological development across that footprint. What are your views on that?

Dr Mark Britnell: I think where there is a great history of collaboration, we should proceed. As you know, I spent many years in Birmingham. I always hoped that we might get our act together but sometimes people are not built that way and relationships are not made that way. I think the Greater Manchester model is fantastic. I do not know whether it is for everyone.

I know you want to move on, Chairman, but there are five facets of high-performing, low-cost systems, and your question touches on one. The first is integrated primary community and secondary care, and I cite Israel, with its technology. Why am I saying that? That can work in Manchester. The second is hospitals as health systems, so you unpack health systems and they run clusters. That can happen in Singapore; for that you could read Birmingham. The third is standardise, digitise and leverage skills. I have mentioned that. The fourth is do not forget social care, and the fifth is a dominant single payer.

Why am I saying all of that? Because Manchester and, let us say, Birmingham, if Birmingham goes a different route, are equally valid models; we are a big and a small country simultaneously, paradoxically. Both deserve to be tried out. That is why I think what Simon Stevens is trying to do in NHS England along with his partners is the right way to do it: not a thousand flowers blooming but four or five models that should be tested. I think we need to move the pace on, and the scale, dare I say.

Q317 **Lord McColl of Dulwich:** My question is on preventive medicine, and the question is: can we reduce demand and need? Half the NHS expenditure, as you know, is involved in treating patients with complications of the obesity epidemic, and some of us, including the Secretary of State for Health and the Minister of Health, are keen for us to focus on a big drive of preventive medicine, an all-out, nationwide campaign, involving every man, woman and child, not telling them what to eat but informing them of the stark facts. Of course, we were very successful in the 1980s in

dealing with the AIDS epidemic, and you remember the tombstone. We told them the facts, and it worked. How do you respond to that?

Dr Mark Britnell: When I was a nipper, I was on the management training scheme in the late 1980s at St Mary's Hospital, which, as you know, had a fantastic HIV unit. There has been HIV, seat belts, smoking, obesity. Obesity's time has come. I certainly support what you are implying. It is a silent killer, and it is something the population are not sufficiently aware of, so in the same way we talked about seat belts for trauma and smoking for cancer, I think we need to up our game on obesity.

I sense in our country, as in many others now, a willingness to have that debate. Of course, it has to be more than a campaign but certainly, in the Nordics, for example, they have realised that it is schoolchildren, and roughly 70% to 80% of workers are employed in the private sector, so we need to find a way to get employers also to take this seriously. There are good wellness programmes now, from South Africa to the States to Italy and Germany and so on, where the wellness programmes have given employers incentives to pick up the cudgels. Although it is half-baked at the moment, when we had this debate about national insurance and what you put in and what you get out, I would like to see wellness hardwired into schools, and also the responsibility of employers. We have missed that through our system over the last period.

Lord McColl of Dulwich: There are many parents who do not think their children are fat. In fact, if their ribs are showing, they think they are malnourished. The amount of ignorance is extraordinary.

Lord Scriven: What are the issues for moving from an illness care model to a more wellness care model, which we will need in the future? You mentioned wiring things. Is there anything else you want to add on what we need to do?

Dr Mark Britnell: Not really. I am not an expert but I think hitting it hard at school and working with employers, because that is where a lot of people spend their time, are two areas. I know we do great school work through our school visitors but I think we can do more. They would be the two areas of focus for the campaign.

Lord Scriven: In our care system, social and health, how would you unlock the funds in buildings, in the acute sector? Is there anything you can do over the long term to begin to do that? It has been talked about for a long time but it still reinforces going into the illness rather than wellness.

Dr Mark Britnell: The obvious answer is what I have seen in Israel. They are so tech-savvy. They have four HMOs, combined payer-provider-hospitals-community. Clalit is the largest—I was speaking to them two weeks ago—with 48% market share, so it is a dominant payer. By the way, we can do this because our system is even simpler; we have a purchaser and a provider. They use technology, and they leverage that

through motivation, through empowerment, through activation, and we know through work we have done along with others that, as patients get up to level 4 in their patient activation, their consumption of care drops by between 8% and 21%. We are nowhere near that.

Another one of my clients—I hope they forgive me for saying this—is Discovery in South Africa and their product vitality now is all around the world. They use algorithms and artificial intelligence to look at at-risk groups, population health, and they drill in through coaching in navigation with apps and also incentives. In my dream world, with this new fund, whether it is NHS tax-financed or national insurance, the fund would manage benefits: discounted greens, discounted sports goods. It would actively use the weight and the power of our muscle, our purchasing power, to get a better deal for working-class families and others for their basic daily living, which makes it easier for them to live healthy lives.

I think we can be so much more imaginative about what we can do if we start to think about this fund being an active fund, not a passive payer. That is what we have been stuck in for the last 60 years, dare I say it. It has served our country brilliantly, but every 10 years, as you know, give or take—we are overdue a debate at the moment because it is 16 years now since 2000—each developed country spends 1% more of its GDP on healthcare. We have not done that, so the debate is coming and you are leading that debate. I think you should not flinch from drawing some bold conclusions, because the country will thank you for it. Whether other people do or not I do not know. Merry Christmas.

Q318 **Baroness Blackstone:** You spoke passionately about a number of things this morning, but what key suggestion for change should the Committee recommend that would sustain the NHS?

Dr Mark Britnell: There are two: love your workforce and motivate and direct it properly, and think big and long about new sources and applications of funds. If you do those two things, you will have served the country well.

The Chairman: Mark, thank you very much indeed. I know we could have gone on for much longer, because you are full of information. Of course we will read it in the book you talked about. Thank you for coming, and thank you also for coming to do the seminar. If there is any other information you would like us to have based on the questions we asked that would help, please do so. There is one thing you promised to send in reply to the question from Baroness Redfern. Thank you for coming today.

Dr Mark Britnell: Thank you, and merry Christmas to you all.

The Chairman: The same to you.

Dr Mark Britnell: I have the answer to the question of who pays: Japan's 2000 long-term care insurance was split 50-50 between employees and employers. I thank Jonty Roland for that advice.

The Chairman: Thank you very much.