HOUSE OF LORDS

Select Committee on Public Services

Oral evidence: Public services: lessons from coronavirus

Wednesday 23 September 2020

4 pm

Watch the meeting

Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Bourne of Aberystwyth; Lord Davies of Gower; Lord Filkin; Lord Hogan-Howe; Lord Hunt of Kings Heath; Baroness Pinnock; Baroness Pitkeathley; Baroness Tyler of Enfield; Baroness Wyld; Lord Young of Cookham.

Evidence Session No. 19 Virtual Proceeding Questions 156 - 161

Witnesses

I: Rudolf Henke, Member of the German Bundestag (CDU) and Covid-19 lead for CDU/CSU Parliamentary Group in the Bundestag Health Committee; John Kampfner, Author and Journalist.

Examination of witness

Rudolf Henke and John Kampfner.

Q156 **The Chair:** Good afternoon, everyone, and welcome to this almost final public session of the Committee. We are delighted that we have two witnesses today to talk to us about the experience of public services in Germany and the way the pandemic has been tackled with them.

We are very pleased to welcome Rudolf Henke from the Bundestag, and John Kampfner. Many of us will know John as a journalist in the UK, but, as I have discovered, he has a long history of working in Germany and has been writing quite a lot in recent months about the German experience and the British experience of tackling Covid.

Welcome to you both. We have about an hour. Everyone in the Committee is really interested in our international comparisons. We have met with people from Taiwan and New Zealand to hear about their experiences and we really felt that we needed to hear about a European country as well, so we are very pleased that you are able to join us this afternoon. We will ask questions and may well come in with supplementaries, too. I hope you will be okay with that.

I start by asking John Kampfner the first question, but I am sure that Mr Henke will want to come in on the question, too. What fundamental strengths and weaknesses has Covid-19 revealed in the German state's model of public service delivery as compared to the UK's?

John Kampfner: Thank you very much indeed, Chair. It is very good to see you, and various members of the Committee with whom I have had some long history following Parliament, again. I now divide my time between the UK and Germany, and when in Germany I am predominantly, although not exclusively, in Berlin.

First, by way of caveat, I emphatically defer to Mr Henke in the precise health information and detail. Unlike him, with his health, medical and science background, as well as his chairmanship of the Bundestag health committee, I am no health specialist. What I can provide, or hope to provide, the Committee with is perhaps some comparative background. Some of it is as much political as it is policy-making. Some of it may be outside your remit, but that is for you to decide. I hope that as much of it as possible will be helpful.

I would divide the policy-making into three areas: policy, politics, and societal. They all have different elements of facts versus impressions.

Let us start with the politics. Politics here is so fundamentally differently wired. It is wired behaviourally to outcomes and results. Everything I say will obviously always have exceptions, but it is predominantly shorn of rhetoric. The main chamber is rarely the place of great parliamentary occasions. They do happen, but predominantly the work is done in committees, in discussions and in negotiations. It is quite rare to find a great political rhetorical flourish. That can obviously in some ways distance politicians from electorates, because so much is done in a rather

granular way and in a way that is not particularly designed to be viewer-friendly or user-friendly, but it does produce results.

There is very little onus on political point-scoring, even 12 months before a federal election that will be one of the most important federal elections for many a decade, perhaps. One of the reasons for that is the behavioural and procedural one that I have outlined to you, but it is also the relationship between the federal Government and the Länder, the 16 regions.

Every government in Germany is a multiparty coalition and there is probably every possible permutation of coalition available, with the absolute emphatic exception of the far-right AfD. They are all given different colours, slightly bizarre national flags—there is the Jamaica coalition, for example—and all different kinds of names are ascribed to them. So every party has a vested interest in success; no party has a vested interest, really, in settling scores with others, simply because they are all part of it. Particularly on major crises, of which this is one, and on other major topics, many of which are devolved—health and education very much so—there is no point in the Social Democrats—the SPD—attacking the CDU, the Greens, the liberal FDP, or Die Linke, which is the left-wing party that is in power as part of coalitions in a few places, because they are all in it together.

That produces, again, a sense of buy-in to decision-making and results, which does not mean, of course, that the decision-making is identical. The Länder, the 16 regions, have quite considerable autonomy on health policy and education, and on Covid, and Mr Henke will talk more, I am sure, about that. Different decisions are being taken all the time. At the moment, Bavaria is taking tougher decisions than other regions because the numbers are worse.

I just wanted, first of all, to paint that picture to you. It is not just a question of national emergency in which we must suspend normal practice. This is normal practice in Germany. This is the way politics operates. That is on the political front.

On the policy front, again we can go into the specifics of Covid perhaps in a second, but as I say there is a strong sense of buy-in on policy. The regions have almost complete autonomy on health and education, as I said, and on other areas that are not necessarily relevant to us now, such as culture, but there are always mechanisms for co-ordination with the centre. Sometimes it is frustrating for the centre, but it is generally well co-ordinated.

Finally, I suppose the most impressionistic side of things in my introductory remarks is the behavioural. One can get terribly stereotyped and clichéd about this kind of thing, and every positive also brings with it a downside, but there is, I would say, a much more communautaire approach to many social issues in Germany.

The negatives are that sometimes it can feel meddling. The rugged individualism that some like to talk about in the UK, which may be exaggerated and may not be, is not necessarily put on a pedestal here in Germany as it is in Britain. The idea that people would almost be praised for taking a stand against conforming to Covid restrictions would—with the exception of the far right, which has been organising demonstrations here—be deemed to be completely unacceptable. There is always a residents' association in apartment blocks, and if people make noise at the wrong time, get up to troublemaking or whatever—or even, in some regions, do not get involved with the weekly cleaning—residents get quite annoyed with each other.

They have the word "mitmachen", which literally means "do it with us"—in football terms, you would call it "get stuck in"—and is the sense that everyone has a vested interest in a harmonious community. As I say, that can be annoying, it can be overbearing, but in situations such as this, where social trust of government, both national and regional, is at a premium, it comes in handy.

Just one final point on rules before we get to the point about specific rules and regulations: there is a far greater onus on everybody sensibly abiding by them. Unlike, famously, Dominic Cummings or the Irish commissioner, Commissioner Hogan, there have been, as far as I am aware, no well-known violations, people taking shortcuts or that kind of thing. When Angela Merkel was required to quarantine, she just did it, no questions asked. So I would say that there is that sense of greater social trust in the competence but also the adherence to these difficult rules.

I would just add that it is not as if people are particularly enjoying them. Everybody grumbles about the rules, about not being able to meet their friends and about wearing masks, just as much as anywhere else.

Rudolf Henke: I agree with many of the things that John has mentioned, but I'd like to concentrate upon the most important point. We are organised as a federal state in Germany, which means that the 16 member states of the Federal Republic own the Federal Republic and the Federal Republic can only decide things that have been handed out for regulation to the federal level. Mainly, all decisions are made in the Länder or federal states, and only the things that are definitely handed over to the federal Government and the federal Parliament in Berlin are decided there. Public health is a question for the Länder. Education is a question for the Länder. Prevention of disease is a question for the Länder.

Now, it is quite clear that a crisis like the one we are facing in Covid-19 demands co-ordination and co-operation at the national level, so after we noticed the dangers of Covid-19 there was a rather fast transfer of many parliamentary decisions to the federal Government. We had that statement that we were in an epidemic situation of national relevance. First, the Government wanted to announce that the epidemic was a situation of national relevance, but then the parliament blocked it and said, "Either we do it or nobody does. It is us who takes that decision,

and by doing so we hand certain decisions of Parliament to the Health Minister and the federal Government. They may be able to take government decisions in this topic on their own until the end of March 2021". That was discussed twice in the federal parliament. It was very harsh, but there was a huge majority for keeping this rule.

So many of the decisions that have been made—for example, the rules for the public to obey and how we deal with people returning to Germany from high-risk countries—have been decided very quickly with no advance parliamentary debate. I do not completely disagree with John that this has all been worked out in committees or negotiations, but it has been prepared in the Government, not in the parties.

Secondly, there has been a very intensive form of debating between the Chancellor, Angela Merkel, and the Prime Ministers of the Länder. After a few weeks of the pandemic, we had a highly co-ordinated line that was shared by all those responsible in any of the governments. I think that has created huge credibility among the German public, because the German public usually expect the parties to be divided, to exaggerate different political approaches and to find reasons for blaming the others.

However, in this phase, all came together. Around Angela Merkel was the competence of all 16 Prime Ministers in the Länder, and they all spoke—on some occasions even jointly—to the press and communicated in a similar way. Therefore, right from the beginning, we had the huge credibility of all those governing advocating for the same rules.

Lastly, we all know the phrase "evidence-based medicine"—you probably all know that phrase—which is used to differentiate between medical measurements that have proof and medical measurements that do not have proof. At this time, this sort of evidence-based medicine is being transferred to politics in the demand for evidence-based politics. I have never seen a time like this where scientists have such huge influence on the recommended political path.

This did not come about by accident or just by luck. Since 2006, we have had a scientific platform on zoonotic diseases in Germany on which the best known advisers to the Government are organised and which, since 2016, has even added energy to their work. There are now 1,000 scientists on this platform for evaluation and findings on zoonotic diseases. That explains why, at the beginning of the pandemic, the science scene in Germany was prepared to contribute knowledge and techniques.

One of the lucky circumstances was that we had very many, very early test opportunities. We could test right from the beginning. The first thing we noticed with Covid-19 was that there were people with positive tests but perhaps with no symptoms or very few symptoms. I come from the city of Aachen on the borders of the Netherlands and Belgium, and just in the north of the city of Aachen there happened this well-known carnival session at which the first explosion of Covid-19 infections in Germany

occurred. They were all found, not because they died but because of positive testing.

We had several weeks of preparing, because if you die from Covid-19 usually you were infected five to 10 weeks before, I would say. In many other parts of the world, the first thing the public noticed was that people died, and then they noticed that there was a crisis, but we noticed it just by testing, testing, testing. That is, I believe, one of the reasons why we were lucky: because we had more time to prepare.

The Chair: Thank you, Mr Henke. I will bring in Lord Hogan-Howe now. Even though you have begun to stray into some of his question, I am sure he wants to follow up on it.

Q157 **Lord Hogan-Howe:** Thank you, John and Mr Henke. I agree with the Chair that you have addressed the first part of the question very well.

The second part of my question is this. You have talked, as we have encouraged you to do, about the positives of the arrangements in Germany, but what are the downsides of this localisation of decision-making within the Länder and the service delivery? Are there downsides that you would recognise and warn us about? Perhaps this question is for John initially and then Mr Henke.

John Kampfner: I would rather do it the other way around. Mr Henke is better informed on some of these. I have one point to make, but I will wait until he has given you a probably more comprehensive overview.

Lord Hogan-Howe: Okay. Mr Henke, could you address that?

Rudolf Henke: We have less clear knowledge about the situation with services. We have statistical numbers, of course—we know that we have 375 health offices, or Gesundheitsamt as we call them—in the municipal surroundings. But up to the present date, because of that decentralisation we do not have national statistics on manpower and the qualifications of these people. Even today, it is still not possible to guarantee that any information will get sent electronically. You still need telephone calls, and you still need written information, which gets sent by letter.

During the Covid-19 epidemic, we have created the legal obligation that any information that arrives at the municipal level has to be handed up to the Robert Koch Institute, the central health office in Berlin. We did not have that obligation before; we expected it, but there was no obligation. So we noticed a lot of the shortcuts. When you are in charge of everything it is very difficult to collect all the information, and I am quite sure that the public health service in Britain will know much better than we do who works in the public health service and with what qualifications.

During the epidemic, we have also created a statistical register for intensive care beds in hospitals and opportunities for ventilation treatment. We did not have that before. We are now noticing from our to do list that we will be able to use such knowledge even when the pandemic has gone, because it would be good to know how many

ventilation opportunities you have in your hospitals and how many intensive care beds are free. We did not know that.

It was the same when the personal protective equipment issue hit us. When it all started, we knew from the tests that plenty of people were infected, but it was only a fortnight before hospitals and private practices ran into a shortage of personal protective equipment. What we had in stock was for perhaps two years' use in a normal epidemic. This, too, highlighted the weaknesses of the system. I do not believe that we would have been able to know these things without the pandemic.

We are now handing out a lot of money to the health services and hospitals, and we are doing a lot to stabilise the personnel and the technical situation of the Gesundheitsamt. That made us aware of a lot of things. You do not change the rules too much during a crisis, but when the crisis is over we will certainly have a debate about the competencies of the central Robert Koch Institute and decentralised decisions. We have very great differences in the reactions of the local governments in the municipal surroundings to special situations. Not everybody does the same when 50 out of 100,000 inhabitants locally have been infected in the previous seven days.

Lord Hogan-Howe: John, you said you had a particular point to make.

John Kampfner: Yes, I had a couple of quick points to make following on from that. The first is not about weakness but about strength.

The health offices that Mr Henke has pointed to are quite remarkable in that they would speak to a country that was a bit behind the times, a bit slow, dusty and fusty, not much happening, officials just sitting around. They were there to protect public health in case of a pandemic such as one caused by water treatment problems, the possibility of swine flu, this or that. It is the very classic German thing of insuring yourself—Germans take out more insurance policies individually than any other country—as a nation, as a region, against things that might happen, rather than paring things down to the bone because they do not pay their way. It is quite a different philosophy. They had these 375 offices that were underfunded, that were not really doing things, but they were there. They had an infrastructure there.

What was remarkable in the early period of Covid was that they then sprung into action. People were seconded from across the public sector, from across the municipalities: people who worked in forestry departments, in museums or at swimming pools; traffic wardens; anybody who was doing work that was not really needed at the time. They were not forced to do it but were invited to do it, and of course you could refuse if you wanted to. They just set up desks in these offices and began track and trace, literally with a telephone, a laptop and emails. In some ways it speaks to a quaintness. In another way, it speaks to a country that thinks ahead on the basis of what possible crises might befall us.

That also speaks to the issue of bed provision in hospitals, for example, which we will come to later, I am sure. The NHS had bed provision down almost to an algorithm for the minimum possible needed to shift people through. In Germany, they saw surplus capacity as not necessarily a bad thing. It is a slightly different philosophical point.

The data point demonstrates another great difference between the two countries. Because of Germany's history, not just the Nazi time but the Stasi time, it has incredibly strong data protection rules. That means that a lot of public services are deliberately analogue, which also means health records. No doctor will go tip-tap and be able to download everything that has possibly happened to you in your personal history, because that would be seen as an invasion of privacy. Those two forces are now coming up against each other, and that is a very interesting ongoing debate.

Lord Hogan-Howe: Just to follow up on what Mr Henke and John have both mentioned in slightly different ways, as a general approach—I think John has written about this—there is something about Germany's thoroughness. Mr Henke talked about an evidence-based approach, and certainly my experience has been that there is always a commitment to quality, which can contradict value for money at times. John has just given the very clear example of beds, but you can go right through public contracting. You can either buy the cheapest or you can buy what you need.

Is there evidence, in either of your experiences, that it is embedded somewhere in a statutory or constitutional requirement that quality, based on evidence, is a fundamental aspect of how you approach problem-solving?

Rudolf Henke: I will comment from the health point of view. We, of course, have also had phases of arguing that competition is the most important instrument for creating an economical way of dealing with foreign money. After all, in the German health system most of the money that is spent by the social insurances is foreign money, which they get only because the state decides that they have to give the money to the insurances. It is not deliberately given. The state's money is taxpayers' money, which comes from laws, so we have to be sure that the money is used for advantage. We should not spend money with no increase in use.

On the other hand, because we have an insurance system and not a state system, the insurance gives people a promise. The promise is that you will get all the goods that you need for your health. If it is notwendig, necessary, ausreichend, sufficient, zweckmäßig, reasonable, and wirtschaftlich, economical, you can make a claim to get the delivery of a certain service or a certain good. There is no room for refusing somebody an operation that he needs or a pharmaceutical drug that she needs for financial reasons. There are certain limits on an overwhelming economic approach.

We should not spend money for nothing, but there is no place in the German health system for refusing money because somebody is 90 years-old and has a life expectancy of only seven more years. In that case, you would say that if they need a hip replacement that lasts for seven years, and if they can cope with it—if it does not medically kill them and they can stand the operation—then go for it, and the finance system has to follow that.

We believe that this comes because you pay a contribution to your own insurance, even if it is statutory insurance. It is not taxpayers' money and politicians cannot decide where it goes. The money for the health social insurance can be spent only in the healthcare system. It cannot be spent on traffic, education or for defence reasons. We think that is an important point. It is very difficult for the state to interfere in this relationship between the person being insured and the insurance fulfilling a promise to the person who is insured.

Q158 **Lord Filkin:** Thank you very much to both witnesses. Can I just play back what I have understood to check whether it is accurate? It seems of potentially enormous help to us.

We are clearly reflecting on some of the areas where we have had difficulty as well as on our successes, and one of those areas has been testing, and track and trace. It appears that we are at the other end of the spectrum in that, by and large, testing, track and trace has been run, set and delivered nationally, whereas testing and track and trace has, as I understand it, been fundamentally led from 375 locally based public health agencies in the municipalities in the Länder. Am I right?

I also hear Rudolf Henke's assertion that because those bodies had the responsibility for public health, they had the ability to test and then to track in place before the coronavirus epidemic got out of control. Have I understood correctly?

Rudolf Henke: Yes, that is completely correct for tracking. It is not completely correct for testing, because, especially at the beginning, testing was also done on the basis of the decisions of 120,000 privately run practices. The doctors there met the patient. In Germany, six in seven patients with Covid-19 were dealt with by private doctors in their private practices and they did not go to a hospital. Only one in seven went to hospital.

We have 170 privately run laboratories, which adopted this technique of testing: the doctor took the material from the back of your throat for the test, sent it to a laboratory, and that laboratory provided the test. They have increased their capacity enormously in the last six months. Yes, it was these 375 local authorities doing the tracking in the circumstances that John described, but the testing was done through an even more granular system of providing services.

John Kampfner: I have nothing to add on that point. I will just finish answering Lord Hogan-Howe's question about spending.

Health and social care has been ringfenced for some time, partly because it is insurance-based, as has been described to you. It has increased steadily, even during a long period of German-style austerity. It is 12% of GDP, which is higher than pretty much anywhere else. I think Switzerland is the only other country where it is higher.

Just to slightly adapt the record, it is not as if Germany has been splashing the cash on public services in general. It has had the so-called black zero rule, which has been blown away by Covid, which is neutral or budget surplus not just for the federal Government but for all state governments. That has seen underinvestment and problems in railways and in education—school buildings falling apart a bit, and that kind of thing—but health and social care have always been put to one side.

Q159 **Lord Hunt of Kings Heath:** Thank you very much. I want to just follow up this question of the balance between national government and state and local government.

Mr Henke, as you are probably aware, our own public health agency, Public Health England, is being abolished and replaced with a new body, the National Institute for Health Protection, which is really modelled on the Robert Koch Institute, which you have already referred to. One of the reasons for the abolition of Public Health England has been the perceived breakdown in relationship between it as a central body and local authorities, which is replicated more generally in the way government and local government work or do not work together.

Could you say a bit more about the Robert Koch Institute and the way it relates both to the Länder and to the municipalities to work effectively?

Rudolf Henke: Thank you for this question, Lord Hunt. As far as I am aware, the Robert Koch Institute advised the federal Government very closely. For example, from the middle of March until at least the end of May, they held daily press conferences to inform the public. By informing the public, they of course also informed the local authorities, because all their material was available on the internet.

Nevertheless, the institute has been accused of changing its assessment of the potential benefits of mask-wearing, for example, at a very late stage. They had long defended the idea that there was no need to wear masks in public. Nowadays, we think something else, and the Robert Koch Institute argues that masks covering the nose and mouth do help to protect against infecting other people.

Especially at critical stages, it was evident that many people had difficulties dealing with scientific uncertainty and with preliminary assumptions. The problem of such a prominent institute as the Robert Koch Institute is that it has to deal with things according to preliminary assumptions. Remember that last January or February we did not expect what was coming and nor did most of the scientists. The Robert Koch Institute, despite being a neutral institution, was judged in some cases as a political authority, both positively and negatively. My impression is that the attitude of most of the local authorities would be to have more

precise and binding guidance from the Robert Koch Institute. In fact, the guidance of the Robert Koch Institute is sometimes very close to precaution or insurance: "Do not risk too much, be careful".

Lord Hunt of Kings Heath: You mentioned that its advice has changed and that came in for criticism, but would you say that generally the institute enjoys credibility with the public because of its independence?

Rudolf Henke: Very much so, yes, but as the controversies about changing scientific recommendations developed, people then said, "Four weeks before, you said something contrary to what you are saying today. I don't take that as scientific process and additional knowledge, I take that as you just deciding what you want: one day this, and tomorrow the other thing". That has, to a certain extent, challenged the credibility of the institute, but I do not think that this goes for most of the public in Germany. About 10%, perhaps 15%, of the population consider the institute to be not independent but an instrument of government to get their points of view through.

The Chair: Thank you. Baroness Pinnock's question has partly been asked, but I am sure she has something else to ask.

Q160 **Baroness Pinnock:** Yes, thank you. The question really is to Mr Henke, and thank you so much for the detailed picture you have painted about the local delivery of services for testing via local doctors and tracing, which was described earlier in our conversation.

I am interested to learn how these were co-ordinated across the country. With a very devolved system and a very localised way of doing it, how was it made sure that every doctor in every local area was able to perform testing accurately and effectively? I say this knowing the considerable criticisms that have been levelled at England's test, track and trace system. Mr Henke, are you able to throw some light on it?

Rudolf Henke: I am not sure. I am a delegate to the World Medical Association, and even if we did not meet this year in physical terms I know a lot of colleagues from the British Medical Association, and usually they are beacons of evidence-based medicine. We always think that in Germany we are still on the path to evidence-based medicine and that there is much more eminence-based medicine in Germany than in Britain. I am not sure whether that is really true, but that is the impression I get from discussions with people from the British Medical Association.

Of course, a lot of knowledge had to be reactivated, and one of the crucial elements in that was one of the leading scientists on zoonotic diseases, Professor Drosten, from Berlin University. We publicly broadcast Corona-updates by this scientist so that people other than doctors could understand. He is a virologist and a specialist on zoonotic diseases. He was one of the great scientists on SARS-1, and right from the beginning he was active on SARS-2.

The floor was given to him in radio stations and he had a daily programme of 30 to 60 minutes updating the public on what we knew

about Covid-19. Many colleagues I know listened to him when they returned from work in the evening, because you could listen on demand. I believe that has contributed a lot. Precise scientific education was available for everybody and many doctors used that.

The Robert Koch Institute provided a report every day. It still produces a report every day, and everything that is new you can find on the Robert Koch Institute pages. I would like the Robert Koch Institute website to be reframed, perhaps not now during the crisis but later. It would have been better organised if the innovation had been made before. Nevertheless, you find everything there.

We do, of course, have compulsory organisations for all active physicians on the Länder space who have a contract with social insurance—the so-called Kassenarzt or Alle Kassen system. Everybody has to be on that and they give you a lot of information. We have the Chambers of Physicians, the German Medical Association in the 16 Länder, and membership of every doctor in Germany is compulsory. Therefore, there is a continuous flow of information to the doctors. This information does not come primarily from the state but from the profession, so there is greater credibility. I think that is a way of educating and bringing in new information.

At the same time, we have a credit points system for doctors. When you have passed one hour, you get one point for updating. That was dispensed for this Covid year so that every doctor could concentrate on Covid and did not need to make points on other items.

The Chair: I am afraid I am going to have to move to the last question because we are running out of time.

Q161 **Baroness Pitkeathley:** Thank you very much to our panellists. It is an absolutely fascinating session and your knowledge not only of German health systems but of our own is very impressive. I want to ask you about that and would like a comment from both of you.

As you know, the Committee is suggesting redesigning public services in order to make them more effective. What is the most important lesson the UK Government could take from Germany's experience of Covid-19? In view of time, I will be very harsh and ask each of you for just one suggestion to the UK Government. Perhaps Mr Henke would like to start.

Rudolf Henke: I am not able to give such advice. I remember being invited by Sir Douglas-Hurd to London to give a speech to pupils in 1979. I was there before 500 pupils in London, and I advised them to fight for continuing Britain's membership to the European Union. That was something that I thought I could made a judgment about, but I cannot judge the British health system.

If I had one comment about one of our strengths, I would say that we have a decentralised delivery system with 2,000 independent hospitals that take their own decisions, 140,000 independent doctors who take their own decisions, and 375 local authorities taking their own decisions,

and it is more or less the provision of rules of funding or remuneration of these services that is decided by the state. That is perhaps one idea I could help to debate.

Baroness Pitkeathley: That will be a very valuable contribution for our Committee and I thank you very much. I am sorry you thought it was an insensitive question. John Kampfner, would you like to make a suggestion?

John Kampfner: As Mr Henke was reluctant to give one, I will, exceedingly briefly, give you two. The first, which we have discussed briefly, is long-term planning and provision for future crises rather than salami slicing. Now, that is not an exhortation for a spending free-for-all, but it is about building slack into any health and social care system on the basis of a rainy day principle, which we have not done for reasons of fiscal prudence but which has come back to bite us.

The other one, which we have talked about briefly, is the whole division of power between the centre and the regions. That is done effectively in Germany because everybody roughly knows the codification, which is basically the boundaries between the regions and the centre. It has been long established, for 75 years, and has been tampered with only in bits and pieces through the written constitution.

The regions—broadly speaking, not completely—have equal powers, unlike in the UK where Manchester has considerably more and some small local authority has virtually none at all. There is a broad sweep among the 16 that they know what they are doing and they know what their relationship is. It is one thing to advocate the devolution of powers within England to local authorities; it is quite another to be able to deliver that within the patchwork quilt of local government that we have at the moment, which in my view is really not fit for purpose to deal with a crisis like this, as distinct from what exists in Germany.

Baroness Pitkeathley: That will also be a very valuable contribution for us. Thank you very much to both witnesses.

The Chair: I echo Baroness Pitkeathley's thanks to both of you. Mr Henke, I was concerned that we did not ask you to do things that you would not be comfortable with, but you have given us some very valuable insights and I thank you very much indeed. We shall continue to watch with interest how you develop things on your committee and what your committee is doing on all this. Thank you too, John Kampfner. It is good to hear from you again, because you have direct experience of both countries, which has been very useful to us too. That brings our formal session to an end. Thank you very much indeed.