Mark Britnell: how will we pay for the next 50 years of care?

We hadn’t prepared our presentations together but I think mine builds on beautifully to Dan’s. I’d like to thank Chris for inviting me here today. I’m a Senior Fellow of The King’s Fund so I declare that conflict of interest.

Because the title is about the next 50 years, the main message I want to give you today is that I feel very optimistic about the future of the NHS and our country. I say that for two reasons: the first reason is for the last three-and-a-half years as Global Chairman I’ve worked in 40 countries on 130 occasions so I know quite a bit now about global health care. The second reason I say it, because the title is about the next 50 years, is I’ve looked at the audience and very few of us will be around to prove or disprove my point!

The reason why, having worked in 40 countries with public and private organisations, with government ministers and NGOs, is when you look at efficiency, equity and effectiveness, when you put all those three things together, the NHS I think stands as one of the best if not the best in the world. It’s important that I tell you that today because in a sense we are in a moment in the UK with a flat-lining economy, with a big efficiency challenge in the NHS, but it is possible to make our great NHS even greater. I think fundamentally we’ve got the broad structure of the way we are organised right. I want to suggest one or two things at the end and they actually touched on the last slide, but bear with me.

I am not going to pick all 40 countries but I am going to pick some countries which you might think are high-performing and some countries which you may not have heard too much about. So given that the World Health Organisation dropped its world league ranking tables back in 2000 because it was too politically contentious, and as you probably remember, put the French as number one. By the way they have been dining out on that for the last 13 years - seriously, and I’ll come back to that in a moment or two. But as far as I can tell now any decent independent think-tank, and let’s call it the Commonwealth Fund from the US, puts – do you know which country is number one? I’ve got a pound in my pocket. Anybody like to guess? Not Nigel Edwards; he always gets it right. It’s The Netherlands.

Now, let me just spend a few minutes on The Netherlands. I’m just going to canter through a few countries. Three or four years ago I recruited the Deputy Prime Minister of The Netherlands and the Chief Finance Minister, Wouter Bos. He’s now our Head of Health and Public Services in The Netherlands. The Netherlands was rated number one by the Commonwealth Fund. It spends 11.8 per cent of its GDP on health care, so that’s two percentage points higher than ours. It has, as you know, competing commissioners; six large commissioners, and the state has largely got out of managing directly providers. So in a sense, they’ve spent 20 or 30 years thinking about these market principles. They were introduced in 2006 and, guess what? The coalition that Wouter just helped to put together, its first act was to try to increase the co-insurance by €425. There was revolution in the streets of Amsterdam. The government fell back but has still increased the patient deductible which is the amount you have to pay before your insurance kicks in.

The point I want to make – and when I speak and we do work with the insurers – they say it is a terribly fragmented system; we can’t control the pathways of care; our GPs
are paid separately from our hospital specialists; the organisations don’t really want to think about a bigger picture, and we can’t control costs. Now this is the highest performing health system in the world that spends 2 per cent more of its GDP than we do.

Now let’s go to Canada. We spend a lot of time in Canada – a very good country; beautiful, beautiful people; on the right side of the world; great resources in terms of shale gas and oil and pretty prosperous, but some of its provinces like Ontario are looking at very big, deep deficit reductions. As you may know, their NHS was established in the Canada Health Act of 1946. The second question for a pound, do you know who set up the Canada Health Service which is very similar to our own National Health Service? Do you know who that person was? He was a Scottish GP. I can’t remember his name but it’s true; he is a Scottish GP. Now the Canadians love the Queen and their NHS almost as much as we love our Queen and our NHS. We’ve been doing a lot of work in Ontario which has a significant budget deficit because it is not where oil is produced.

What’s interesting about Canada is in Ontario they recruited one of their most respected economists, a guy called Don Drummond. If you get a chance, go onto the Ontarian Government website and look at Don Drummond’s report. It’s about 200 pages. He is a leading economist advising all the banks and, as you know, Canada sailed through the banking crisis because it had sensible banks. It spends 11.4 per cent of its GDP on health. I’m not going to go through the Drummond report but I want you to read it. It has 153 recommendations. It’s a bit ‘busy’. That’s why I guess he was never a manager: 153 things can’t be implemented.

Let me just read some of them out: cap health spending growth 2.5 per cent per year; don’t increase health over the rate of country GDP growth; shift resources away from hospitals to home care; shift resources from acute care to chronic care; put more resources towards prevention in self-care; continue to organise the delivery of health care around local health integrated networks, they used to be called PCTs or CCGs to me and you. Then he says, cap doctor pay.

I was there in November. They were having a right old ‘ding-dong’ with doctors because doctors - and just in case you don’t know – are paid separately to hospitals. So basically they are driven by fee for service, cost and volume contracts. Did you know in Canada – a dirty little secret here in Ontario - 20 per cent of the total health care costs in Canada go into doctors’ pockets, and they’ve just frozen pay for two years.

Now let’s swing to the East: Singapore which I’ve got a great deal of respect for. When it became independent from us in 1959, the first thing it did – it’s a very small country as you know; no natural resources; only 5 million people – if a country could be a professional services firm, it’s Singapore. Basically, obviously you know, through the war, a deep-seated paranoia about the instability in that part of Asia, what they did is they sent their best and their very highly paid civil servants by the way (and they are excellent) to study all the systems in the world. Basically they came up with a different system which I think in terms of innovation – I don’t think we can do it in Britain, but I do think it’s pretty innovative - for those of you who don’t know it’s called the ‘3M’ system. It’s a medi-save, medi-shield and medi-fund. Basically it’s compulsory. It believes in the principles of social solidarity like we do. You pay in and you take out.
You can top up your paying in with another fund and in 2002 it introduced a new fund called ElderShield.

Now 25 per cent of the population has already taken out compulsory long-term care and age-care insurance. Basically there is now a big debate in Singapore. It spends 4 per cent of its GDP on health and do you know what its average life expectancy is? I’ve got one more pound in my pocket somewhere. It’s the third highest in the world at 83 years of age. Now some people say when they look at Singapore, “Ah, that’s because they are all very young.” Actually by 2030 25 per cent of their population will be aged over 65. That’s another little dirty secret in parts of Asia: a massive explosion of long-term conditions and an aging population.

The point about Singapore is that it has an interesting governing structure which you probably know. The PAP, the People’s Action Party, have never been unelected from power since 1959. Their share of the popular vote dropped for the first time to under 60 per cent – imagine that in the West: under 60 per cent! The government got very scared, so guess what it has decided to do? We work a lot with the government. Last year it announced it is going to double the amount of money it spends on health in seven years: from four billion to eight billion – something like that – from 4 per cent of GDP up to about 7.5 per cent of GDP. It’s going to build 30 per cent more hospital beds but we are trying our best to advise them that they shouldn’t replicate the 20th century model of western care. So they are also in public-private partnerships investing in, increasing the supply of community and age care facilities by 100 per cent. They have promised their health care workers a pay rise in excess of 20 per cent. Can you imagine how the rest of Asia feels about little old Singapore? Very happy or a bit ‘cheesed off’?

Japan – I spend a lot of time in Japan. I think Japan has an amazing system. It’s a universal system which was created in 1961. You know that Japan has the oldest inhabitants on the planet. Do you know what their average life expectancy is - my final 5p? - 84.5 years of age. They spend 8.5 per cent of GDP; they have thousands of health insurers; they have thousands and thousands of doctor-owned and corporation-owned hospitals, but they have a single price-setting authority.

Now my love for the NHS is on record. A single payer system in times of recession is the most sensible thing in the world to have. Single payer systems are not the same as single pricing systems. In Japan they have a single pricing system. So – this is the truth – the Cabinet every two years sits around the table and decides how much money is going into health and social care and then tells the thousands of insurers that is the rate of increase. That’s it. So they have a very, very detailed costing methodology and pricing methodology and they go, “Right. That’s all interesting. It’s 0.5 per cent.”

What Japan has done, however, and I think this is worth studying - if there was more time today we would talk about Korea: that’s a very interesting country to study - what Japan did in 2000, because as you know they’ve got the largest number of old people on the planet. I don’t know if you also knew that it’s depopulating. Its size will reduce from 122 million by 32 million people over the next 20 years. Its economy is sclerotic. So they are fighting hard here to try and reinvent themselves.

There are two points on Japan that I want you to remember. The first one is: in spite of their economic difficulties they took a big decision in 2000 to introduce compulsory age care insurance for everybody over 40. People moaned; they griped but guess what?
They love that system now. That system cost their economy as far as I can tell (I’m not an economist) somewhere between 1.2 and 1.5 per cent more of their GDP but they did it and people are happy. The problem with the pricing approach by the way is do you know what percentage of hospitals in Japan are running a deficit? Sixty per cent! But the point is, we can study Singapore and we can study Japan to see how we can model our own responses to what will be a pressing problem in the next few years.

There are just two or three more points if I may, if I’ve got time, that I want to talk about. The first one relates directly to John’s point about growth. Now in KPMG we have been doing a lot of work on workforce. There’s an article today in the Health Service Journal from me on it; there’s a piece in The Times this week about workforce. The point that I want to mention on this is when you look at growth in OECD countries since the Second World War it is too easy to fall into this mantra, this self-pitying mantra that our country is ‘on the rocks’; we’ve got an aging population; an unproductive workforce and we are not competitive. That’s true in part but it’s not true in Toto. The reason why I say that is when you look at the rising health care costs since 1945, 60 per cent of them, perhaps 70 per cent of them, have been what economists call autonomous growth. Do you know what autonomous growth means? We did it to ourselves. These are not controlled by God, these forces. They are controlled by mere mortal human beings like me and you. Therefore the issue about productivity is a very important issue which we can control if we want to.

My penultimate point – to go back to my favourite subject, the French – is that last year we had a big debate – there’s a big debate in Chamonix every year – where the 200 leaders of the French system, from philosophers to ethicists with a couple of grubbing hospital managers and lots of politicians meet to debate the pressing issues of the French health system. Perhaps it’s only the French that could ask...so I had to debate against Sarkozy’s brother which is quite interesting: very smooth. Not me, him! Basically the debate was, “Is wellness more important than Gross Domestic Product?” Now the reason why the French wanted to debate this is because Sarkozy’s brother, the President, had launched this as a big European Union issue in 2008. Of course David Cameron in this government had carried on with this.

Now on the last slide from Dan I want basically to reaffirm something which is blindingly obvious but if you think about it for just a bit more you will see it’s humanly profound. The obvious thing from the wellness surveys is that 80 per cent of those reporting good health were happy but only 20 per cent of those that didn’t have good health were happy. The point is, I know we always say politicians are very sensitised to health because it’s the most important issue for people, and yours was a great slide. But this issue about wellness – wellness being bigger than Gross Domestic Product because it measures all sorts of things: the state of our governance; the state of our communities; the state of our education system; how we deal with old people in dignity and compassionate care – a big issue for this week. I think the reason why health is the most important sector on the planet is because it’s the most important thing that makes people happy or unhappy as they live their lives; greater than economic transactions which are monitored through GDP.

So I’m going to end up with a question and a research ‘itch’ that I would like to scratch. If you buy that the NHS is, I still think, the highest performing system in equity, efficiency and effectiveness, of course we need to do things about the way we control
productivity and growth; if you look over 50 years and if you’ve read Ridley’s – what’s it called? – *The Rational Optimist*, of course our economy is going to grow over the next 50 years and of course we can afford to spend an extra one or two percentage points on GDP. All of this – and once again it’s not ordained by God, or your god – it’s controlled by human beings.

Here’s my question: In 1911 when Lloyd George introduced the first ever National Insurance Act which was the forerunner to the National Health Service, then three people paid – because you know the employers, the employees and the government. Do you know why Lloyd George introduced the National Insurance Act of 1911? We could debate about this all day. There were two principal reasons – you are going to love this – or I hope you’ll love it! The first reason is he was scared about Germans having a higher life expectancy in the run up to war. Secondly he was scared about Germany being so strong economically that he understood that a healthy workforce was a productive workforce.

Now, it’s interesting when you look at the total sum of what we now bring in receipts in National Insurance – I could be corrected because I’m not an economist – but it’s about 130-140 billion. If you add up health and social care, what does it come to? Now I’m not saying that we should go back to 1911; I am saying we need the political strength, as they did in 1911, to think about the next 20 or 30 years. We all know that if you leave a problem to fester, that problem is more difficult to solve. The Government is right to make sensible steps now to cap the amount that people pay for their care. I believe in this room just last week Andy Burnham has launched a very interesting consultation about the future of health and care.

But to answer the exam question that I was asked to respond to today, we are a great country. We have a great NHS. It is fundamentally sound. We need principles of social solidarity but also principles of organisational agility on the supply side. I think it is possible for us to do all these things. My comment about every system at the moment – and it’s funny as I travel the world and forgive me for this small scare word – people say to me, “What was it like in so-and-so? What was it like in so-and-so?” I have a one-liner now which I hope you will find amusing. I say, “Same s**t, different country,” because we are all facing the same issues but we can learn from other people, but I think our system is fundamentally sound.

To conclude, it is possible for us to decide to spend more of our GDP on health and care. I think the separation of health and care is a 19th/mid-20th century anomaly which needs to be corrected. I think this debate about which is the best way to raise funds between social solidarity or at point of need when you are facing difficulties in your old age is something we can debate to and fro. But I genuinely think that if we can control autonomous growth, we can have a system that spends more of our GDP as our GDP grows and we can demonstrate to the world that we are the most effective, efficient and equitable system in the world.

Thanks very much indeed.