HELEN BEVAN:
We will be starting in a couple of minutes. In the meantime, while we are waiting, why not check-in in the chat box. You can see it on the right-hand side of the screen. It would be great if you could say who you are and where you are. If you can’t see it at the moment, at the very top of your screen on the right-hand side, there is a symbol that says Chat. If you click on that, it will enable you to chat.

When you are making a comment or checking in, if you could send your comment to all participants, then everybody taking part will be able to see it. We will be starting in a couple of minutes.

Good morning, everyone. Welcome to our Edge Talk, ‘In Search of the Perfect Health System’ with Mark Britnell. What I think we will do, we will start in a minute, because we are just waiting for a few more people. I can see people coming in as we speak. We will start in 1 minute.

I think it is time to start. Good morning, everyone. Welcome to our Edge Talk. We are delighted today to have Mark Britnell with us, the chairman and senior partner for global health practice at KPMG. Mark is going to talk about his book, ‘The Search of the Perfect Health System’.

Mark works across the globe in 60 different countries, and there is no one better to be able to give us an overview of health systems.

Many are watching this live, and many people are watching the recording, so welcome, everybody. We would like everybody to join in today and beyond today. You can see, on the right-hand side of your screen, a chat box. When Mark is talking today, if there are themes you want to expand, or talk to other people about. Or you want to ask questions to Mark, put your contribution into the chat box.

At the same time, we will have a tweet chat going on, using the hashtag, #edgetalks. If you would like to tweet out what you are hearing, we would be delighted. We will stop and pause and see what we have got in the chat box, and we will see what we have got on Twitter as well.

We would love it if you could join our Facebook group. These talks are part of a global knowledge platform that our team runs with regard to the latest thinking and practice around transformational leadership, around being a change activist, so we would love it if you would contribute as part of our Facebook group.

What happens, whenever we have these monthly Edge Talks, what happens is that each Wednesday afterwards, we have a tweet chat about the topics we have talked about. So our next tweet chat will be next Wednesday at 1600-1700 GMT around the themes of today.

Just to tell you who is taking part today, my name is Helen Bevan, and I am chairing the session. I am chief transformation officer of the Horizons Team, which is part of NHS England.

Shortly, I will introduce Mark, who is our presenter. We also have some other colleagues helping us today, Janet Wildman from the Horizons Team is monitoring, or will attempt to monitor, all of
the activity and ideas in the chat room.

Also, we are being joined by Jodi Brown, and Jodi will be monitoring what is happening on Twitter.

Let’s introduce Mark. It is interesting, so I was looking for photos of Mark to introduce him. On the left-hand side, we have the current one. And on the right-hand side is Mark when I first met him.

I don’t know if Mark remembers, but actually, it was 21 years ago. And when I first met Mark, he was actually still in his 20s. He was the project director for an amazing project at Central Middlesex Hospital, which was called the ACAD, the Ambulatory Care and Diagnostic Centre.

What was happening in Central Middlesex at that time was revolutionary. So many of the things that we do now around extended work roles and therapists, and separating out different flows to make life easier, and for patients.

Having single digit concepts, redesigning workflows around the needs of patients, they are the kind of things that, today, every health provider does. But in those days, they were truly revolutionary.

When I met Mark at that time, everybody knew that he was someone that was destined to be a great leader. And I think, the confidence and the wisdom that we saw in Mark then, it made it clear that he was going to do interesting things with his career.

I won’t go through the whole of his career, but he has held a lot of very senior roles in the NHS. He was the chief exec of Queen Elizabeth Hospital in Birmingham, he was the chief exec of South Central Strategic Health Authority, and he was the director-general for Commissioning and System Management for the NHS before he joined KPMG in 2009.

The year before that, in 2008, Mark had prostate cancer, and he is now a trustee of Prostate Cancer UK. I know it is a cause close to his heart.

Nobody has got round the world of healthcare and healthcare systems globally like Mark. We are thrilled he can join us today to talk about his search for the perfect healthcare system. Mark, I am going to make you the presenter. We are looking forward to hearing your talk.

MARK BRITNELL:
Thank you, Helen. That is a gracious introduction. Good morning, good afternoon and good evening to all the callers on this presentation.

HELEN BEVAN:
Can you get closer to the microphone, because there is a bit of distortion.

MARK BRITNELL:
Can you hear me now?
HELEN BEVAN:
That is better.

SPEAKER:
Everyone should go on mute, actually.

MARK BRITNELL:
Perfect. Good morning, good afternoon and good evening to all the listeners and participants today. Let me return Helen’s compliment by saying, first of all, I did not realise it was 21 years. You look even younger than the first day I met you. Secondly, it just shows how time flies.

I had the privilege, as you say, of working at Central Middlesex when we developed the first Ambulatory Care and Diagnostic Centre in 1995. We sought to re-engineer pathways and extend skills, especially for nurses, to standardise care, to look at efficient and lean care and business processes, and here we are now in 2016 talking about the very same things.

I want to start by that. First and foremost, I am a practitioner. Although, I happen to be global chairman for healthcare for KPMG and have been for the last seven years, my heart is in improving care from a patient perspective.

In the last seven years, I have worked in 60 countries on 200 occasions. Just towards the end of last year, I published my first and probably only book called ‘In Search of the Perfect Health System’.

There is a copy of it. I am not trying to get rich out of the royalties. All of my royalties go to Prostate Cancer UK. As Helen said, I survived a radical prostatectomy in 2008, and I talk about patient power and patient vulnerability in my book. There is a chapter dedicated to it. More of that later.

The monk St Augustine says, "The world is a book and he does not travel, he reads only one page." I spent 20 years working in the NHS. And often, the limit or the extension of my interest and ability to think Whiteley was limited to the outer edges of Birmingham or London when I worked in those two great cities.

It is difficult to lift one's eyes when you are turning the soil day in, day out. But I have come to believe and accept that this quote is absolutely true. If you don't want to read my book. If you haven't got the time to read my book, although I should say, each chapter is written in such a way that you can read it in the time that it takes to drink a cup of coffee, I would say there are three things that you should hold onto.

Everybody has something to teach and learn. There are more similarities than differences in global health, and imagine the power of potential for human good if we spent as much time collaborating as, dare I say it, the communications industry, the financial sector, the defence sector, and the life science sector. All of those compete and collaborate simultaneously. There is more that we can do, and that is why I am delighted to speak today. I do very much pay honour and give respect to Helen Bevan, because she has been planning this particular foray for over
Let me go into the presentation itself. I should say also that I have recently, at the end of January, the privilege - if that is the right word - of speaking a truth to power at Davos as part of one of the 15 people that sit on the World Economic Forum Global Health Council.

I haven't got time today to talk about the paper we presented with the Harvard School of Public health, but it talks about misalignment between providers and patients. The punchlines are that we can actually extend globally, human life, by five years, on current global levels of expenditure in healthcare if we transformed more effectively.

We also estimate that healthcare is a $9 trillion industry. And about 11%-12% of that money is being misaligned quite considerably.

In the NHS, we are dealing with an unprecedented decade of austerity. There is still, as we know, efficiencies to be gained, and more importantly, better patient pathways and better patient care.

The 60 countries you can see before you, I know them pretty well. I accept that I am a little light on parts of Africa, but all these countries I visited on a number of occasions, 200 or so. So I am working in about 30 countries a year. And because I was a former NHS management trainee back in 1990, I started my career working with the porters, the cleaners and the cooks. And I do feel that my experience over the last 27 years have been brought to bear in this book. And of course, the hundreds of clients I now work with - public, private and not-for-profit.

The book itself is an easy read. I don't go through all 60 countries that I have worked in. I pick 25 countries. It is actually 29, because I aggregate the Nordics. And the book is really not an academic book. It is written by a practitioner for a practitioner, and I also know that it has been read by politicians, and also most pleasingly for me, patient groups as well.

I am told by our global communications team based in Toronto that we have now sold out of the books. We sold 10,000 books in the first three months, so we are reprinting now. Also, I have been told that I have received over 2 billion media impressions. I am not sure what that means between me and you, but it sounds quite impressive.

The insights of the book are obviously a product of my 27 years in healthcare, as I say, working with hundreds of different types of organisation, and also my own personal experience of running the University Hospital Birmingham, where we build, as you probably know, the single largest hospital in the history of the NHS.

We were one of the highest performing hospitals in the United Kingdom, and also as I mentioned, my experience as a patient, and many of you know, you do see the health system in a completely different way when you are lying on your back.

Let me now turn to the presentation itself.
The first part of the book asks if there is a perfect health system. There are brilliant examples from around the world where we can all learn from each other.

The second part of the book looks at 25 countries in detail. The third part looks at seven forces, that I think are at play globally, ranging from climate change to workforce.

The fourth part of the book, entitled 'It Wouldn't Start From Here', talks about the shift from healthcare, in the 20th century, to the issue of health in the 21st century – that is the structure of the book.

Having said there is no such thing as the perfect health system, what I do is talk about 12 facets of high performing systems.

It is a subjective view, backed up by a tremendous amount of research. Let me say a word on the way I developed the book. This week I was working with the government of the Bahamas, helping them build universal healthcare for the first time since they gained independence from the British.

Next week I will be working with the Healthy Ministry in Israel. Get briefed in five ways, the social and political situation, health policy and strategy, the health system of the organisations we are working with, verbal briefing on the characters involved, and the solutions we can offer our clients.

Where ever I have gone in the world, on trains, planes and automobiles, I have been living notes all over the place. Two friends suggested I should capture my scribbles and thoughts into a book.

I am grateful for them and Jonty Roland, my global executive, for helping me draft and write this book. The perfect health system would have the values and universal healthcare of the United Kingdom, the primary care of Israel, the community services of Brazil, the mental health and well-being of Australia, the health promotion of the Nordics, the patient and community empowerment of parts of Africa, it would have the guile, flair and speed of India, the ICT of Singapore, and would encourage choice, like France, have the funding of Switzerland and the age care system of Japan.

Before I go into these in detail, I have to say these are subjective observations, dealing with many clients in each of these countries. There is a lot of information on world league tables, but as I say in my book, when you look at the WHO, the Economist, the World Health Fund, each has different ratings, methodologies and rankings.

I think it is bizarre that there is no global standards for patient experience, patient satisfaction and patient value.

As a member of the World Economic Forum Health Council, but in the same way we think the economy is important and we created GDP, as an indicator, we need to get together and construct meaningful patient experience and outcome scores.
I call for this in the book, and as far as possible, we have a table that shows some of the high level performance indicators of countries.

Let me dive in to each of these countries. I am proud of our National Health Service and I am not the only one. In the 2012 Olympics, studies and poles took place, 73% of the British population defined the NHS as the quintessential feature that made them proud to be British – higher than the monarchy, higher than Dr Who, higher than the Beatles, the Armed Forces and Football Association.

Many people are proud of their own health systems, but I have never come across a country that so closely identifies its well-being and sense of purpose with the health system. Nigel Lawson once said the NHS was the closest thing the British had to a national religion.

That brings strength and also a potential weakness in its ability to change quickly. We were, after World War II, the first universal health system, the Germans had the first social insurance health system in 1883 with Otto von Bismarck, but we were the first universal health system.

Now that all 192 countries have signed up to the sustainable development goals, every country needs to have universal healthcare by 2030.

Think of the battle for talent that will ensue over the next 15 years. We have to love, treasure, nurture, and respect our workforce because it is the only workforce we have.

In terms of the primary care of Israel, where I will go next week, I believe if Israel was based in the US, the world will have heard of its health system. One of the best kept secrets in the world, they only spend 7.3% of GDP on healthcare. Its life expectancy is over 83 – why and how does it do this?

Back in the 1920s, before Israel was created, the labour movement organised for health maintenance organisations that pay and provide care. It's real trick to success is that it has built a primary health led system. It has fantastic IT, brilliant outcome measures for primary care, and great community services.

I was told by the medical director of Kalish, the largest health maintenance organisation in Israel, that 50% of all paediatric consultations take place on a smart phone.

Given the conversation, argument and discussion we have had in the UK over 111, I know that HMO-style care, rooted in the community, based on a strong primary care platform with brilliant ICT, is the way forward.

I know it is easier said than done, but Israel is a great place to study. It has got its problems, it has some of the lowest bed per thousand population rates across the OECD, but it is a country one should study more carefully.

In Brazil, they are experiencing big economic and political challenges. When they created their
universal health system, SUS, in 1988, they knew they did not have enough doctors and nurses.

They have leveraged the assets of the community. They have a highly geared and leverage model where one doctor, two or three nurses, and members of the community trade in certain conditions, look after about 4000 people.

They visit those people irrespective of health or wealth. They proactively prevent and treat. They have incredibly good statistics in terms of lowering hospital admission rates and improving long-term conditions including mental health.

They are the Che Guevara of healthcare, as far as I am concerned. They are not perfect, but they are a phenomenal example of a low to middle income country doing the best it can to serve all of its people through limited human resources.

We know how difficult it is, in the Western world, to activate the community, Brazil gives us great hope, techniques and tools to plug back into the developed world.

Mental health is often considered to be a Cinderella service. We struggle to say that one country is the best. The paucity of data in mental health is quite obvious.

The Dutch provide good mental health services, and also in the UK we provide good services as well. But in a recent OECD report of 2014, Australia is doing the best.

They are going through another series of reforms for their mental health service, but what is striking is their policy has not changed since 1992 despite their fractious, knockabout political system, they have stayed true to the course in decanting from mental health institutions and grounding care in communities, and at home.

There have been substantial investment in public promotion campaigns, great early intervention plants and improving access through technology.

They topped the OECD Better Life Index, a much broader assessment, they all contribute to the Better Life Index. There is more to do we can learn a lot from the staying power and consistency of Australia’s attempt to improve mental health amongst its citizens.

The Nordics, Scandinavia, are great examples of another form of staying power. Ever since the Helsinki declaration in 1987, where all the Nordic countries came together, they have consistently set about baking in and prioritising health promotion and prevention.

Their smoking reduction rates, in real terms per annum, was 2% per annum over 20 years, a stunning achievement. They have great ordination between state and local authorities, between local authorities and local municipalities, and given that in the developed world, roughly one in five is a public sector jobs and four in five comes from the private sector, in the Nordic countries they had mobilised employers, public and private, to take control and help people live healthier lives.
This balance of public and private involvement is known as status individualism in the Nordics. If you have bought the book, I encourage you to read the chapter on that. They don't have a lot of public health people just talking to one another and feeling better because they violently agree with one another's points. They take the argument out to the employers, citizens and workers in the country.

It is a brilliant example of what you can do if a society decides to take it seriously.

Choosing Africa for patient and community empowerment may seem odd. Africa has 25% of the world's diseased burden, but it is because of the fact that, quite simply put, empowering patients, and helping communities become carers is simply a matter of life and death.

I found this in Kenya, Nigeria and South Africa, where I was two weeks ago, they train patients and members of the community in basic skills to help them face and fight both communicable diseases and also noncommunicable diseases as well.

If you look at South Africa in the last 10 years, as they try to defeat or arrest the development of HIV and AIDS, it is not just the introduction of retrovirals, all antiretrovirals, it is the empowerment of communities and patients.

Recently, I had the privilege to see leaders in Durban fighting HIV and AIDS, and I asked them a question about what the principles are that can be applied to all long-term conditions from HIV and AIDS, and they said, "They can all be applied to long-term conditions."

We sometimes need to learn from others that we think we have, on the face of it, nothing to learn from. We all have something to teach and something to learn.

I am not recommending the fragmented health system of the United States, but it is fair to recognise it is the biggest centre for research and development in the world. It invests more in research and development than all of Europe combined, it spending subsidises discoveries and we can all benefit from them across the world, it has more noble laureates for medical devices, and some great examples of care process innovations, such as Virginia Mason, and Guisinger.

But the point is, although America spends nearly 80% of its GDP on healthcare and its life expectancy is two years less than the OECD average, we are dependent on the research in the US to provide cost-effective drugs.

Having said that, and this is an interesting juxtaposition, I want to talk about the innovation in India. When I was there in October, speaking to the government, I had no doubt that India will become the generic cradle for drugs of the world.

And as that happens, there will be more affordable and universal access to drugs across the world. Just one example of course, how India took on and helped the Africans reduce and lower the price of HIV medications, for example.

In India, the word for innovation is 'jugaad', and that means to make do and mend. It is a classic
example in India of how they do three things very well, from which the rest of the work and learn.

I am personally disappointed in the progress made in the implementation of healthcare, just a year and a half ago, Modi declared it would be incremented by 2018 and I doubt that will happen.

We encouraged the government to do more want universal health care, but there are pockets, often in private hospitals, and also in public hospitals, where they do three things really well.

Firstly, they standardise the clinical care process. And because they standardise the clinical care process, they can then deploy ICT in a meaningful way to roll shift and encourage the flexible deployment of skills in the workforce, which of course, is limited.

But those three things, care standardisation, clarity of care pathways, building information communication processes on top of that, which enables the right staff with the right skills to do the right thing at the right time, that often means that India, even when you compare in real terms costs, I can operate at 20% compared to the developed world.

Singapore is a very tech savvy state. It is also a small state of just 6-7 million people. It is probably the best country in the world that has fully embraced integrated technology.

when I was in Singapore in September of last year, I saw how their clustered approach linking hospitals with GP practices, with nurses homes, with residential homes, it is all linked and glued together with their ICT platform.

They started this journey in 2004. In 2011, they rolled out a single care record. And now, over 40% of all their patients have direct access and control of their medical records.

We hope the same in the UK, but I have to say that at the moment, the UK is significantly lagging behind other tech savvy states, whether it is Singapore, Hong Kong, the United States of America, or indeed India.

But Singapore is a very good example of how a full electronic health system and record can help shift care to lower cost and better settings for patients.

Choice of France. France has high levels of patient satisfaction. It spends a lot of money, over 11% of its GDP and has financial difficulties. A third of its hospitals are private, a third of its hospitals are run by the state, and a third of the hospitals are run by religious orders. Patients have the freedom to choose.

They pay a small co-payment or deductible, which is reimbursed in many cases, the Carte Vitale allows them to move quickly between general and specialist care.

In 2000, the first and only World Health Organisation league table for healthcare placed France on top.
It would be wrong to say that everything is perfect in France. It has a fairly fragmented system, but the choice of France enables patients to take control of their health care.

In the choice between different settings of care, France can provide examples of what we can do when you allow patients to become more empowered.

When I talk about the funding of Switzerland, I would accept that this can be criticised. In Switzerland, they spend nearly as much as the United States of America. They spend 11.5% of their GDP on healthcare. And my title for the chapter on Switzerland is ‘You Get What You Pay For’.

Why do I mention Switzerland? It is a truism. In the last decade, healthcare was expanding at 6% per annum, the global economy was expanding at a rate of 3% per annum, at some point there will be a reckoning. And people in the NHS are facing this decade of austerity.

The reason Switzerland can fund its healthcare so well, and by the way, I consider Switzerland to be the least distressed healthcare nation I have ever worked in, is because as the World Economic Forum concludes, it leads the world competitiveness table. How does it do that? These other factors help healthcare.

It has world-class education, it has brilliant labour and workforce flexibility, it is highly effective and transparent in well governed institutions, apart from FIFA, of course, and has excellent infrastructure.

Read the chapter on Switzerland if you want to see how a strong economy can provide a good basis for a strong health system as well.

Finally, Japan. We know it is the world's oldest society with over 25% of its population being 65 or over. I don’t know how many of you know that the population of Japan is 122 million. It is depopulating, it will depopulate to 95 million in the next 20 years.

It has laboured under stagnant economic growth over the last three decades. Its political system has been unstable because of changes in prime minister, but this is the big point, and we know this very well in the United Kingdom.

Japan's politicians back in 2000 had the courage to realise that unless they spend more on their age care, their society and health system would fall apart and be swamped with the so-called ageing tsunami.

They introduced a compulsory long-term care insurance by placing an extra 1% income tax on the over 40s. And let me tell you, it has worked. Their health systems are now much more like health communities. Their hospitals run nursing homes in residential homes.

There are still big problems, they have more hospital beds in any developed country in the world, but their politicians saw what was coming, and we can forecast what percentage of our population will be over 65 by a certain date, and in spite of their economic difficulties, they
decided to spend more on their aged population.

They showed great respect and reverence to their elders. I have been amazed by their determination.

The service is not perfect, but they did something which other politicians around the world, including the UK, need to seriously address. As I say in my book, "We have 15 years at most to get on top of this issue, and you have to tackle the problem now if you have any chance of providing a solution later on."

They are the 12 facets.

HELEN BEVAN:
Mark, can you hear me?

MARK BRITNELL:
I can hear you.

HELEN BEVAN:
That was like a tour de force. I think it might be a good time now, if that is OK, to stop and reflect.

We are getting fantastic feedback for this talk, both in the chat box and Twitter. And lots of people are enjoying it. One nice thing that is happening is that people are starting to share their experiences in the chat box. There's a parallel conversations that you are sparking. It is getting people to think about things.

And there are lots and lots of questions. So what I will do, just to give you a moment to get your breath, is to hear back from Janet and Jodi, and I have written lots of questions down as well that people are asking. Is that OK?

MARK BRITNELL:
Great.

HELEN BEVAN:
Janet, would you like to go first? Can you hear me, Janet?

JANET WILDMAN:
I can hear you, can you hear me?

HELEN BEVAN:
Loud and clear. Tell us what is going on in the chat box.

JANET WILDMAN:
First, everybody is in awe of the book. The reviews have been fantastic. Everybody will be buying it. Some people have already bought it and read it and have said in the chat room that it is a
must-read for quality and improvement professionals. That is the number one.

But there are a number of other questions that have come up, Nina Mayhill, who has worked with us in the past asks, "How do you address the GP recruitment crisis, and what has been done in Israel to attract people to work in primary care?" She is interested in learning from the experience you have got around what has worked in Israel.

HELEN BEVAN:
Should we ask Mark to answer that one? Yeah?

JANET WILDMAN:
Yeah.

MARK BRITNELL:
What has helped Israel is that a large number of Russian Jewish immigrants came back to Israel when the state was created. They have found, up until now, that they have not struggled to find general practitioners, but the age profile now of those practitioners is such that they are all coming up to retirement.

It is time to do three things, it is time to encourage more people to come back, the medical diaspora, to come back. Secondly of course, they are adopting technology to leverage doctor time and doctor capability. Thirdly, on the back of being tech savvy, they are extending roles to other people. Especially nurses.

They are trying to bring people back to Israel, but they see their solution as the leverage of medical capability through technology. They have already grasped that there are not enough people in their country to provide all the services they need with an ageing population.

JANET WILDMAN:
Thanks for that. And there is an accompanying question from Mark, “You mention the assets of many countries, innovation and service delivery in India, and harnessing industry to the cause of public health in the Nordics, great primary care in Israel, which of these attributes do you think the UK should prioritise to make progress on?”

MARK BRITNELL:
It would be tempting to say all of them. But right now, given the pressures in primary care, I would try to invest more in primary care. But I wouldn’t do that as a sideline.

The technology in primary care is absolutely pivotal, because through patient stratification, dedicating more time to the patients that need that care, in some parts of the country, that is what I would prioritise.

JANET WILDMAN:
One more question, is that OK?

HELEN BEVAN:
One more, good.

JANET WILDMAN:
Steve asks, “You can't change culture and healthy lifestyles overnight, but are there any quick wins when it comes to delivering care more effectively and efficiently?” This taps back into the things you mentioned before, but is there anything, like top tips?

MARK BRITNELL:
Hi, Steve. I have been saying this since I was chief executive at Birmingham. I would hold commissions to account for implementation into care processes that is the single thing we can do with the NHS. We do it better than anyone else in the world. (inaudible). That is what I would concentrate on. As Steve has been doing since I worked with him at South-Central.

Come on, Steve, try harder!

JANET WILDMAN:
Thanks a lot. That is it from the chat room now.

HELEN BEVAN:
Very good. Just a couple more. One more from John Hunt, who says, "what is the reaction of UK politicians to the Japanese approach? Could this approach ever happen in the UK?"

MARK BRITNELL:
That is a good question. As some of you may know I was on The Economist podcast last week and I had the chance to discuss this with Jeremy Hunt, and I have had the chance over two decades to talk about the integration of health and social care.

What can I say, it is like motherhood and apple pie, everyone agrees with it, but (inaudible) but I have talked about the need to do this in our country.

I say in the book, there have been three failed attempts, the last was (inaudible), which was a pretty good year. We will have to grasp the mettle. Most people like me, my mother has been in a care home for the last four years, at only 71, most people understand we cannot go on the way we are.

The population of the UK will thank any politician honest enough to grasp that nettle. I would think about creating a new integrated health and social care fund, a hypothecated insurance tax to fund that – I hope someone is strong and visionary enough to call for that.

HELEN BEVAN:
Can we move on to the Twitter chat? There have been a lot of questions. Kate, what has been happening in the Twittersphere?

KATE POUND:
Before we even started the presentation, people thought this was a timely presentation with the news today and the pressures on the whole hospital system, with beds, and patient throughput through the care system – I just wanted to bring that up.
There has been some discussion around commissioning – do we think the current system for commissioning is a major problem? I don't know if everyone wants to think about that before I move on to the others?

HELEN BEVAN:
Mark, given what you have seen around the world, do you think the way health services are commissioned in England is a major problem, and what can the world teach us?

MARK BRITNELL:
I don't talk about my clients, all our engagement are confidential and commercial. With the permission of Glenn Steel, I go into detail about Guisinger. I think England has the perfect condition conditions to create Guisingers all across our country.

There are three parts, it is an integrated provider, it integrates hospitals with primary care doctors, and it has standardised clinical processes, and trademarked information system that looks at 80% of the highest volumes of care, and ensures – in real time – that doctors are held to account with performance that has been benchmarked against best clinical and medical performance.

That would be my answer without passing comment on the current state of commissioning. I see no reason why we can't do that. To be fair to NHS England, through the innovations and the Five Year Forward view, we are trying to create those systems that my good friend Sam Jones is leading.

In 2008, I tried to set up a five-year program to develop the confidence of commissioners then another government came along and prioritised something else.

That is the problem with the UK. The NHS is increasingly being driven by a small base in Westminster and Whitehall. You don't get change by dictating change that way.

I think I have indirectly answered your question. I see no reason why we cannot be leading the world in creating a UK-style Guisingers.

HELEN BEVAN:
thank you for answering that in the way that you did. Kate, there are some more questions? I know there are because I have seen them.

KATE POUND:
the next one leads into the last statement.

“What are your thoughts on the need to for transformational change versus pressures to achieve cost savings?” It is a hard place when people are trying to deliver transformation but have the pressure of saving money.

MARK BRITNELL:
I don’t want to plug my article in the Harvard Business Review, a quick definition, transact means do things better, transform means do better things.

We are getting to the bottom of the barrel in terms of things we can squeeze out in terms of efficiency.

I think the target of 5 billion is largely achievable but the real issue is the 22 billion (inaudible) – I question whether the country should do that or (inaudible).

I believe it is possible to become more efficient and effective, but at the moment, the way our focus is so short term... We recently did a survey of 3000 executives around the world, in healthcare we find that 85% of any executive’s time is focused on today and not tomorrow.

I started with the NHS in 1989, you can get so far with efficiency. Really, giving our ageing profile is what we need to spend more time on. We need more unified executives with unified objectives. If we focus on three or four things that really matter.

Secondly, we need a transformation plan, Simon has done really well to get 4.8 billion. Thirdly, you need to give time. (Inaudible).

It will need to be the case, I’m sorry there is no magic bullet for an answer, but that is my impression from experiences around the world.

HELEN BEVAN: what was great about the answer you gave, Mark, was we actually had another question come in about Lord Carter’s review so you just answered two questions for one.

Can someone put the link for Mark’s article in the chat box, so that people can see that?

There is one more question we should talk about that came into Twitter, which is, “With so many social determinants of health, do you think the model for care is still fit for the purpose?”

MARK BRITNELL: That is a great question. I was pleased the model for care worked on my prostate, for example. But the real shift, if you look at the 19th century war on public health, in terms of disease (inaudible) healthcare, and the 21st century will be the age of the individual and health, I think it is important to continue to provide treatments, which are effective at cost-effective and clinically effective.

This shift to health, and healthy ageing, will define the 21st century. Are we doing enough? Probably not. Will technology help us in ways we cannot yet understand – it probably will.

Going back to the English NHS, I know my old friend is doing a sterling job. We need to invest in technology to promote health.

I have seen employers take health much more seriously. Recently, in Australia we looked at
performance clinics, which work with organisations, industrial organisations to improve employee motivation and the results have been absolutely fantastic, much more we can do there.

HELEN BEVAN:
there were loads of questions that we haven't answered, but we should cool things there. The link to Mark's article in the Harvard Business Review is in chat – thank you for answering those questions, they were quite tough.

Would you like to carry on with your talk?

MARK BRITNELL:
I am mindful of everyone's time. I won't talk through all 10 slides. The purpose of this slide is threefold. In the earlier part of my conversation, if there is one thing I can do, I would like to create a global NHS IQ where we collaborate to show, and develop and spread, what works.

These 10 things, basically, in whichever country I go, whichever health strategy I read, I play buzzword management bingo to myself and see how many 10 things I can tick off.

Most plans tick most of them off. It is not conceptualising stage C that is difficult, it is moving from state A to state B.

that is my joke, wide didn't the Daleks rule the world? It was the first step that killed them. If we work together and start to train and develop our staff, and hold the staff to account through the organisations they work in, and for, there is a much better chance of a global shift in terms of transformative capability.

I won't read through it each of these, if there is time at the end, I am happy to take questions. Helen, you have been talking about many of these for a long time, there is good evidence behind most of these which the world should start to collaborate on.

Why can the world collaborate on defence systems are not help systems? Why can the earth collaborate on moving global finance around and not healthcare ideas? It is crazy and does not make sense.

Seven global challenges, there are many more. I bump into these seven the most when I am talking or working with clients and systems around the world. The first is the quest for universal healthcare.

As I mentioned, the sustainable development goals require or all 192 or 194 countries in the world to adopt universal healthcare. What we can achieve, as the cradle for universal healthcare, if we work and can indicate together.

Think about the downside, think about what the global battle for talent is going to be like in the next 20 years.

Two, innovation of scale. I have a chapter called the paradox of changes continuity.

Three, this idea of being restless for improvement and bringing quality under control – the more I know, the less I sleep.
Four, the value of the workforce.

Five, patient power. I will talk about how when you elevate patients to level for, the highest level of activation, their consumption of care can reduce by 8%-21%.

There is no country in the world that will remain sustainable if they do not harness healthcare. Six, climate change. Seven, ageing.
I want to briefly skip through each of these. I know most of our listeners are from the UK, we should feel proud that we established the universal health system in 1948.

For people who are less fortunate, three things are needed. The most important is political will, the second is managerial and clinical skill, and the third is time.

I look at countries and systems and how universal healthcare has been, or not been achieved. One thing I do think is going to be important working in Africa, and also India and China, is the growing need realisation that universal healthcare will be provided through the telephone, through telehealth, through links to local pharmacies and having highly leveraged doctors and nurses in a call centre or care centre – and I think this is going to happen fairly quickly.

I have been in the Bahamas this week and got back last night, they have 750 islands, the population is small, they cannot have a doctor and nurse on each island – they will provide universal healthcare through telehealth and telecare and leverage telephonic capability with local network providers. We will see a lot more of that in the decades that followed.

Two, this is the business review, and the question I ask is, why do people think it is so difficult to do?

I come up with three answers. The first is most organisations think they are better than the sector they work in. Most spend more time transacting then transforming, and there is a paucity of vision (inaudible) meaningful period of time, 5 to 7 years, to enable change to happen.

18 months to go we got together 65 health leaders from 30 countries around the world and crowd sourced clinical directors and middle managers from 50 countries. We ask a lot of questions at this slide is interesting.

We asked the clinical directors, general managers and ward sisters what the standard of change that was required in your country? They said it is fundamental, the health system is going to the dogs.

You can see there, they were much more equivocal, unless you have the locus of changed internalised in human beings and unless you move the focus of change to broader transformation – you will do what you have always done.

My chapter on change says the paradox of change is continuity and consistency of approach.
For those that read my book, I say that England takes the gold medal in management disorganisation

Thirdly, I think we are being too liberal and laissez-faire in acknowledging and accepting the wide scale variation we know exists globally, and within our own country.

KPMG did some work, and the title was called 'The More I Know the Less I Sleep'. We convened global conferences and caucuses around the world, got together some of the biggest organisations with good reputations, such as the Mayo.

I don’t have to tell this audience, the more hand office you have the greater freedom you allow, the greater the chance of things going wrong. This movement is not something we hear much about, it is flavour of the month in the US and Canada.

I believe we are talking about it in our own country, or some people are talking about it, but I hope NHS improvement lives up to its name and title by concentrating on improvement as much as cost reduction.

This is something we can do very well. I would make sure all staff are trained in these techniques and held to account. I don’t believe that is mission impossible.

For those of you that have heard this before, I apologise, but one of my greatest clichés is if change is a human contact sport, we best contact human beings. We are not doing enough of that.

Why we should contact human beings is if we don’t love or nurture them, they will leave or retire.

Already in the World Health Organisation, they have a vacancy rate of 7.2 million workers rising to 13 million by 2035.

There are only 44 countries in the world out of the 192 that have universal health care. Do you know America have 1.5 million more workers, more than the entire workforce of the NHS.

There is going to be a global talent for healthcare, meaning we have to treasure, nurture and direct, and support, and it means we have to think about robotics, telehealth and telecare, in a fundamentally different way. There won’t be enough people in the world working in healthcare to care for all the citizens and patients that need caring for in the next 20 years.

at KPMG, we looked at the five most important factors in high performing workforce or staff organisations. There are five habits. One, a strategic focus on patient value. Two, they liberate and empower professionals. Three, they tool up and task people with business process redesign skills. Four, they look at outcomes, not the minutia. Five, they are pretty active in managing staff performance, which means that people have objectives.

The efforts are prioritised at work, the skills are applied to the objectives, and basically, that is how you get staff highly motivated. When you do, guess what happens, you find productivity
improving by 15%.

We can do a lot more caring for staff and motivating them properly and directing them.

Patient power. I have mentioned this, this is work other people have done. Obviously, the reference here to that great seminal piece in current affairs.

Paul Corrigan makes this point very well. If I was going to ask a question and play a game, how many hours are there in a year? How many, on average, was the average European spent on a healthcare professional? I can play this game, but I would be able to give you any prizes. The average European spends just four hours a year with a healthcare professional. If you think about the number of hours that people are awake the vast majority of their time is healthcare. It is a funny industry to concentrate on the four hours, rather than the 5800 waking hours a year. This is what I mean about the shift to healthcare, to health and well-being. We need to think more seriously about how we connect.

Going back to Israel, they do this well. Health makes this organisation, they have every incentive and responsibility to invest in patient wellness. They do that through technology. And access to healthcare professionals.

Climate change, I just got back from the Bahamas and managed to read an old copy of the Health Service Channel, two things about efficiency in the States. I don't know if you know this, but there are 5% emissions in Europe and 8% in the United States that are caused by the healthcare sector. We are creating the alignment in which we try to kill people with respiratory illness.

I don't know if you know this, if we modernise our heat and power facilities, into combined heat and power facilities that are greener and cleaner, we would save a considerable amount of money.

This is a great opportunity for the public and private sector to get together. in the NHS, we can do remarkable things if we could reduce the supply chain, if we can think about telehealth, we can play our part in healthcare to reduce emissions which cause illness.

I am a jobbing manager, but I have seen the consequences of climate change and I know healthcare can do a lot more to step up. I know the problems of RTT times and waiting lists is something we should lead in, globally.

Finally, ageing. You need to read the chapter on this because there is not a silver bullet.

These statistics which came from my good colleague Lord (inaudible). Our work in ageing, which was commended by and run from Singapore, called An Uncertain Agent looks at four facets across the world: boosting informal care and people power, harnessing technology, seeking whole of society solutions and turning hospitals and health systems.

I believe ageing is a great sign of success in health care. It is also a vibrant industry, an
enormous industry, I talk in the book about a conference in the Netherlands that we had with bankers, industrialists, insurers, financiers, health insurers, tech pioneers, discussing possibilities for the future.

One example of good practice I have seen recently in Singapore, they have created tax breaks for children to go and live near their relatives, and vice versa.

In Taiwan, I mentioned in the book, I am sure people in England wouldn't like this, but children cannot inherit their parents’ fortune unless they have cared for them later in life – I would like to hear what people think about that being the idea of the day? Moving on quickly…

This is my chapter on leadership, I talked about the 85% of leaders who direct their attention to operational matters. Board leaders focus on short-term pressures.

If you look at any system in the world, can you think of anyone in the health system that has (inaudible) that has made the change more sustainable across the health system? What I saw in Norway and Sweden, where there is a lot of policy and politics, but in some regions I saw health and social care chief executives and boards and organisations would have five or six objectives each.

They were forced to collaborate and held to account. They came from different organisations but organisations were held to account by how well they collaborated.

I am not a futureologist, but these five things I see already are evenly distributed around the world and will undoubtedly play a significant role in health care.

I will briefly call about mobile health and genomics, the retail revolution, wearables and, on a happy note, dignity in dying.

We all know about the move from average to individual medicine to (inaudible) medicine, it provides great promise. Some predict that when genetic tests dropped to under $1000, there will be a bigger take-up.

At the moment, in my global travels, genomics is largely the preserve of the rich. Many people believe you can only have a universal health system that supports genomics (inaudible) manipulation of risk (inaudible), in the sense of what you have to know about pre-determination of a specific disease, but the jury is out (inaudible).

We know we are at the forefront of this, as we should be, it is a country that has a powerful collaboration between health and life sciences.

We work with clients in India and Africa where the model is really simple. One or two dollars a month allows them to have access to a doctor or nurse call centre. It is run by algorithms but has clinicians working in the call centre.

They get advice and scripts are sent electronically to local pharmacies that provide the vast
majority of primary care – they are coming out primary care and GPs in hospitals.

I am not saying it is right or wrong but it is happening in Africa and India and China as well.

Speaking to people in India, they believe they can be the cradle of innovation for generic drugs and e-health as well.

I don’t think we are doing enough about this and think we need to reduce tariffs that allow patients to consult with clinicians on the phone.

We need to make much better sense of 111 it seems to be a series of missed opportunities.

The retail revolution, the apothecary is back. The first apothecaries existed in 2600 BC, they sold wine, food and medication and treated you, sometimes with leeches.

The retail chain is offering highly accessible, relatively cost-effective, quick and convenient treatments, and a growing rapidly.

I wonder how long it will be before... And I know supermarkets are already thinking about providing healthcare... This is one way to encourage people to think about what they buy, what they spend and (inaudible) their lives..

I don’t know how many people have a wearable, I am determined to get to make 10,000 steps, it works for me – is it a fad for the very well? Yes and no.

We know tracking devices are helping people with cardiac problems. The market is worth seven 37,000,000,000 by 2018.

I am cautiously sceptical about (inaudible) wearables. It makes people powered care a reality.

I have one more slide, and we know (inaudible) that recently came out by the OECD and the WHO, Britain does (inaudible) dignity in death.

It is about (inaudible) and not at the periphery. I say in my concluding chapter that how we care for the dying is the litmus test for a good health system and a responsible society.

We can do much more, our use of additives is poor and (inaudible). I talk about (inaudible) being mortal.

I conclude by saying, deaf, like life, requires a collaboration of the (inaudible) and living, societies, and providers as well.

I believe and hope it is possible to draw inspiration from different examples of health and healthcare around the world – it is all about the context.

As I say in my conclusion, from the first female Nobel laureate, Marie Curie, (inaudible) by
(inaudible) we can forge better collaborations and together we can improve population health, patient care, and have better value as well.

It is now 10:52 AM, I know we are closing the session at 11 AM, that is all I would like to say. I hope you buy my book, it goes to a good cause, Prostate Cancer UK.

Helen, I am grateful to you for inviting me this morning and looking forward to questions – thank you very much indeed.

HELEN BEVAN:
That was amazing, a tour de force. I said we would stop every 20 minutes or so for questions but I did not want to stop it. People were so engaged and it takes a great orator to be able to do that, and do it virtually.

Really quickly I wanted to ask Janet for a review of what is happening in the chat and the Tweet box – get one or two more questions in? Kate, what has been happening on Twitter?

KATE POUND:
A lot of conversation has shifted to the chat box, we have some questions about the site about solutions and how much can be applied to the UK health system.

I don't know if you want to answer that first?

HELEN BEVAN:
In terms of what you have seen around the world, Mark, how much of it is truly relevant to the UK system?

MARK BRITNELL:
Nearly all of it, we are all human beings that died of the same things, it is a matter of when. Anything from ICT, design, the motivation of clinicians, the education and development – there is so much that unites us.

Of course the challenges are different in Africa to America but there are so many things we can collaborate on.

Then you do your best to bring the global community together. I hope that I can get people to say (inaudible) we should have a World Change Organisation or a healthcare change organisation.

HELEN BEVAN:
In the same way you talk about the opportunities that technological advancement gives us in health and care, the same advancements allow us to connect with one another and learn.

Because we did the call at 9:30 AM, we have not got people live from the US, Canada, Australia or New Zealand, but a lot of people will listen to the recording, and we can connect, all over the world.
JANET WILDMAN:
A bit quieter than before but people are really tuning into the slides and content – thank you, that has been really helpful.

Given the challenges, how can we incentivise the world to collaborate on a system? You try to answer that all the way through this presentation but I don’t know if you have any final thoughts on that, Mark?

MARK BRITNELL:
First of all, I had the privilege to go to (inaudible) this year. The World Economic Forum was created in the 1970s, to put money into a pot, didn’t look at economic challenges.

If you think about countries now, the WHO, or the World Bank, countries are quite happy to put money together (inaudible) disease, because all health systems are struggling, with the exception of Switzerland (laughs).

We can design, adapt and adopt very quickly. I think we should keep pressing industry, government and NGOs to make sure (inaudible).

JANET WILDMAN:
People have talked about the way of connecting people through technology, and valuing people (inaudible) you mentioned beforehand – there is great insights shared in the chat room and a lot of activity there.

HELEN BEVAN:
What we will do is make the chat available. Mark, we would love you to see the chat, and what people are saying.

I think we should draw things to an end now. Mark, that was an absolute tour de force, keeping people engaged as a virtual speaker, for 90 minutes, is really tough, and yet you did that.

You will see how positive, how much people enjoyed things. It was interesting, before we had to talk today, we were publicising that the talk would happen on social media and one of the comments we got was from Lee Spokes, who said about your book, other than Lego, this book was my favourite Christmas present.

What you have given us today is a real gift, insight and wisdom and reflection. And an even greater determination, we had to learn from each other.

85% we spend on transactions but would we spent a little bit of that time connecting with each other, learning and sharing, we could move things forward.

I want to thank Mark and his team at KPMG, and the Horizon team, and everyone that took part today, and made it a lively and interesting talk.

We will be making the recording available later, look out for that, we will advertise that on social
media and on The Edge.

We have a talk on this topic at four on Wednesday next week. Have a great weekend everybody, and I hope we can connect again soon.

MARK BRITNELL:
Thank you, Helen, lots of love, good-bye everybody.

HELEN BEVAN:
Bye.

Lots of comments coming in, people really enjoyed that, it set the bar high for the next one – fantastic, thanks.

I think it is just me, Paul and Kate on the line. We can stop the recording now.