

# Let's demand supply

Ed Smith - former Chair NHSI

Clever people tell... it's always necessary to investigate both demand and supply drivers to achieve optimal efficiency in economic analysis, *blah, blah!* Well maybe, but in our NHS the dominant driver has to be supply.



We broadly know demand at the aggregate level - it's an ageing population with multiple morbidities, and forecastable increases in illness from cancer and obesity in particular.

Of course there are other illnesses and there are many horizons of innovative treatments and preventions which may, over 15 to 30 years, shift the demand - but probably not by that much. In addition to which some of these treatments are expensive in resources and in the science of discovery. And, then there are pandemics, much forecast over the last 15 years but much more nebulous in their timeframe as we have seen.

A degree of disaggregated demand is also a relevant factor. It is necessary to look at population dispersal - age, ethnicity, economic and social inequality being the more likely population characteristics to drive the variance in demand.

And then, geographic demand driven by population density and other factors.

But, we shouldn't really be worried by detailed disaggregated demand analysis, as a supply driven system will automatically rebalance to ease and release supply mobility across

those geographies and segments.

In the next 10 years, we may as well be honest, life is economically going to be quite tough.

Businesses will fail, unemployment will rise, government borrowing will be high and international trade will be less navigable.

The solution is investing in our much overlooked infrastructure (physical and digital), investing in education and skills, and reinventing the UK digital landscape - becoming more self-reliant in goods and services and more balanced across our nations.

Personally, I wouldn't over worry about government borrowing at close to zero interest rates and with lowish inflation for a long time to come.. but then I'm not really qualified unlike the army of Treasury experts.

I just think Keynesian economics fits our time - and in terms of our NHS should have done so since it's birth in 1948.

What do I mean by looking at the supply drivers? Basically, for our NHS supply is key to health prosperity which is, in turn, key to economic and social prosperity. We have to break the circle of a

constrained demand mentality which has funded this public service so that in 10, 20 and 30 years we are creating the virtuous circle of healthier people, healthier economics, and healthier social equalities.

Again, let's be honest, that means higher taxation to change the starvation diet the NHS has been on, once the three card tricks of the last decade have been

cannot contribute themselves. Let's start with the most important supply side resource for our NHS by some margin which is our clinicians -doctors, nurses and associated professions.

Why on earth were (and are) UK medical student numbers so constrained until finally in, 2018/19 they rose by 1,500, to 7,500 entrants year?

At the same time we

locations for their placements and practical experience. I think the line "*we cannot afford it*" would ring hollow in every household across our land.

Of course, any excess supply (*if that was ever to happen*) would be absorbed across the global health estate or lead to cost efficiencies.

Given that 62% of student loans are now being written off, as a student loan system becomes substantively a graduate contribution scheme, it's fairly easy for policy

*'...before we spend £4 billion on 40 hospitals, let's have the benefit from insights into how we have provided services differently over the last year...'*

outed. In my view it also requires hypothecated tax for health and care along with a Defined Contribution Care Scheme; which incentivises people to save for their own future later life care needs, with a tax incentive to do so and inheritance tax-lite intergenerational transfer of unused funds.

However, that is only ever incremental to a fully state funded care system for those who

were Brexiting, had already seen a decline in doctors coming to the UK.

There was a political belief we could just grow our own. Oh dear, oh dear!

Of course there should be no limit on appropriately qualified applicants training as doctors.

Adjustments simply have to be made in our hospitals and health

makers to design a system which both sustains a contribution during a working life and creates a lower and higher contribution band for the doctors who work in the NHS and for those who choose not to.

I suspect history will also look back on the move from bursaries to student loans for nurses as a rerun of the three card trick, created by the overall student loan system.

It saved money in year 1 due to government accounting, but was a ticking bomb.

Fortunately, that has been outed in revised government accounting but too late to redress lower nursing-graduate applications over the period that loans applied and to avoid creating a nursing debt burden for 35 years of their lives for

not new but rebuilds of some of the worst of our decrepit estate.

As we do that, the Better in Build Back Better has to be the dominant focus. It should be linked to ICS service configurations and must be future proofed for a digital century.

I'm sure it's been done (*maybe*) but before we

discounts, just-in-time manufacturing delivery, scaled-up production efficiencies.

Management consultants flogged these for years and in many parts of economic life, it has real value. But not in our NHS. Some smart person will one day analyse the savings made by the NHS in driving down the "*consultancy wisdom road*" compared with the cost of shortages in 2020 and the priceless value of people's

lives, including some amongst our brilliant NHS staff. We probably don't need to wait for a "smartie" to tell us the answer.

**Following Jim's lead of locally sourced, close at hand, fit for purpose PPE is not only smart - especially when done in an ICS and group of ICSs context, but plays strongly to UK economic recovery from COVID by investing in and supplying home-produced consumables.**

## *'... let's talk about the supply-side driver for PPE and other consumables...'*

those who graduated in the period.

Oh dear, oh dear!

Another supply-side driver is Estates. Much more tricky to constrain in the way described above. That said, we know the direction of travel - it is away from monolithic hospitals to distributed and digitally connected ecosystems. Fortunately when getting into the detail of the PM's "40 hospitals", it is apparent that most are

spend £4 billion on 40 hospitals, let's have the benefit from insights into how we have provided services differently over the last year, as well as analysing the real cold spots of our geographical hospital configurations.

And, in deference to one of the many excellent NHS Trust leaders, let me mention Sir Jim Mackey, and let's talk about the supply-side driver for PPE and other consumables. Some will remember the days of volume

What plays out on vaccine production and distribution, across geographies, might prompt me, further, to comment, about the brilliance of University, business and NHS collaborations across our nation!