





## A new ideology for UK healthcare THE FUTURE OF THE HEALTHCARE SERVICE AND THE INDEPENDENT SECTOR'S INVOLVEMENT





14 November 2006

### Today's discussion



#### OVERVIEW



- Government policy since '97 has addressed historic problems within the NHS
- However, future challenges will create new and intense pressures
- As funding increases slow, the NHS will need to address the breadth and depth of the service it provides
- The independent sector has not yet restructured to meet the changing nature of the NHS
- There will be opportunities for both the insurers and providers to reinvent themselves

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### Government policy since 1997

#### UK healthcare in 1997:

- Waiting lists over 1 million with 5% waiting over 12 months
- Expenditure c £45bn p.a.
- Health expenditure per capita lower than most EU and OECD countries
- Health expenditure as % of GDP lower than EU and OECD countries
- UK health outcomes poor
- 30% of NHS estate pre-dates 1948
- Fewer doctors and other healthcare professionals per head of population
- Low investment in health care technologies
- Poor morale amongst staff and staff shortages

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### Government policy since 1997

#### Framework for reform

Money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve (transactional reforms)

More choice and a stronger voice for patients (demand-side reforms)

BETTER CARE  
BETTER PATIENT EXPERIENCE  
BETTER VALUE FOR MONEY

More diverse providers, with more freedom to innovate and improve services (supply-side reforms)

A framework of systems, management, regulation and decision making which guarantees safety, quality and value for money (system management reforms)

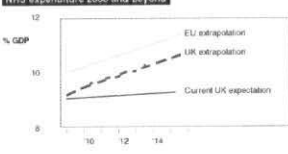
#### Main Reforms

- Foundation Trusts (devolved decision making)
- Plurality of providers (introduction of independent sector)
- PCTs as commissioners (restructuring of PCTs)
- Practiced based commission (indicative commissioning budgets)
- Payment by results (Money follows the patient and providers are reward for the activity they undertake)
- Public and patient choice (choice of elective provider)
- New regulatory regime (Monitor, Healthcare Commission)
- Modernising Primary Care (GP access, long term conditions support, prevention, and integrating service with social care)

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### New and intense future pressures

#### NHS expenditure 2008 and beyond



The first ever evidence-based assessment of the long-term resource requirements for the NHS in 2002: 'Securing Our Future Health: Taking A Long-Term View' (the Wanless report)

**Conclusions:**  
In order to meet people's expectations and to deliver the highest quality over the next 20 years, the UK will need to devote more resources to healthcare, and that this must be matched by reform to ensure that these resources are used effectively.

**Spending growth beyond 2008 likely to be below current NHS inflation:**

- Spending growth 2002 - 2008 approx +7% p.a. real
- Likely envelope beyond 2008 below 3% real
- Pay and prices inflation around 6% p.a
- Implies activity growth around zero, possibly negative, vs around 2% to 3% currently to meet demand

**Obstacles to further significant increases:**

- Public resistance to further tax rises
- Competing demands (schools funding aspiration, climate change, policing...)

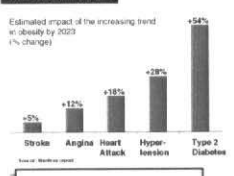
**The gap is supposed to be covered by NHS productivity increase - but 2% target probably not being met**

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### New and intense future pressures

#### Healthcare demand drivers

Estimated impact of the increasing trend in obesity by 2023 (1% change)



- Increase in prevalence of conditions associated with modern lifestyles - eg obesity
- Availability of new and expensive drugs
- Demographics - over 60s account for >50% of costs and their population is increasing significantly
- Medical technology - reduced lengths of stay but more things can be treated
- Consumer expectation
- Increasing availability increases demand
- The 18 week target


**Major new treatments introduced 2000 - 2010 e.g.**

- Herceptin (Cancer)
- Ebixa (Alzheimer's)
- Relenza (Flu)
- Taxol (Cancer)
- Interferon Beta (MS)

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### Addressing the breadth and depth of NHS services

#### The NHS in 2015 - scope



Availability criteria...? ← Treatments subject to restrictions...?

<ul style="list-style-type: none"> <li>• Not available</li> <li>• Means tested</li> <li>• Co-payments required</li> <li>• Rationed</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic</li> <li>• Bariatrics</li> <li>• Infertility</li> <li>• Laser eye surgery</li> <li>• Varicose vein clinics</li> <li>• Sports injuries</li> <li>• Vasectomy, etc</li> </ul>
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**Rapidly evolving view of: what the NHS does how it does it**

- **Different structures for provision**
  - National policy
    - Quasi-independence (Bank of England model)
    - NICE
    - Royal Colleges
  - Local flexibility
    - Mix of provision – district generals, foundation trusts, IS
    - PCT as commissioners
- **Different scope of service**
  - ‘Lifestyle’ treatments means tested
- **Different culture**
  - Patient centred
  - Accountable
  - Commercial, marketing competence


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### Addressing the breadth and depth of NHS services

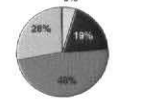
#### The NHS in 2015 - choice


Q: "If more patient choice was introduced into the NHS do you think the standard of patient care will improve, stay the same or get worse?"

**General Public**



**GPs**



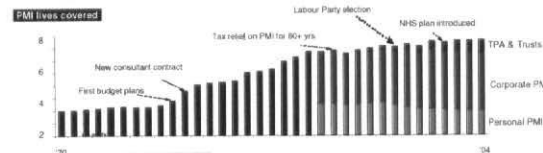


Source: MORI 2003

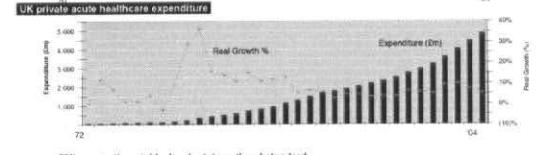
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### The independent sector has not yet restructured

#### PMI lives covered



#### UK private acute healthcare expenditure




- PMI penetration stable, low by international standard
- Switch from individual to corporate / trusts
- Over 85% of private acute hospital income from insured patients

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### The independent sector has not yet restructured

#### Q: how does the independent sector position itself in relation to ISTCs...?




*ISTCs: Low cost, high efficiency and provable quality*

- Move from guaranteed volumes contracts to patient choice
- Efficient and customer focused service
- Clean, functional environment
- Standardised offering to reduce costs
- Staffing & new medical training
- Ability to demonstrate quality
- Integration with Choose & Book
- Relationships with local SHAs, PCTs and GPs
- Brand development


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### Opportunities for insurers and providers to reinvent themselves

National Health Service



Health Insurance



Independent Providers

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### Opportunities for insurers and providers to reinvent themselves


#### PRIVATE HEALTHCARE

High quality, highly differentiated, private provision

- Move from 'hotel chain' to more sophisticated brand and proposition differentiation
- Investment in patient experience, surgical techniques and clinical outcomes
- Consultant chambers
  - Hospital as healthcare improvement centre
  - Clinical excellence
- New services for treatment excluded by NHS eg:
  - Cosmetic
  - Bariatrics
  - Infertility
  - Laser eye surgery
  - Varicose vein clinics
  - Sports injuries
- Partnership with NHS

#### Cosmetic surgery

Your new look couldn't be in better hands



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## Opportunities for insurers and providers to reinvent themselves

### PM

Innovation, diversity and cost management

- Less focus on waiting lists (although 18 weeks still too long for many)
- More sophisticated pricing & underwriting
- New products for 'excluded' treatments – selection issues
- Wellness
- Disease management
- Genetics



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## Summary

- Pace of change in NHS has been dramatic
  - Will accelerate beyond '08 due to financial and social pressures
- New NHS may threaten the independent sector – but only if it remains in a 20<sup>th</sup> century mindset
- Independent sector must anticipate the NHS of 2015, and the opportunities this will offer for:
  - New products and services
  - Branding and positioning
  - Distribution
  - Partnerships

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Q&A

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