White Paper: Nashville Health Care Council's 2017 United Kingdom Study Mission Findings

Healthcare systems in any country are complex, spanning politics, business and public policy, the intersection of which creates the plethora of health systems found globally. This complexity creates a challenge for healthcare companies looking to work across borders. Yet, whilst it is true that each system is specific to its context, many parallels can be drawn across systems, and there are lessons for businesses looking to enter new markets.

It is in this vein that the Nashville Health Care Council, a premier association of healthcare industry leaders, set out to run an international study mission to the UK. Building on the Council's commitment to gather insights from across the globe, the three key objectives for this study mission were:

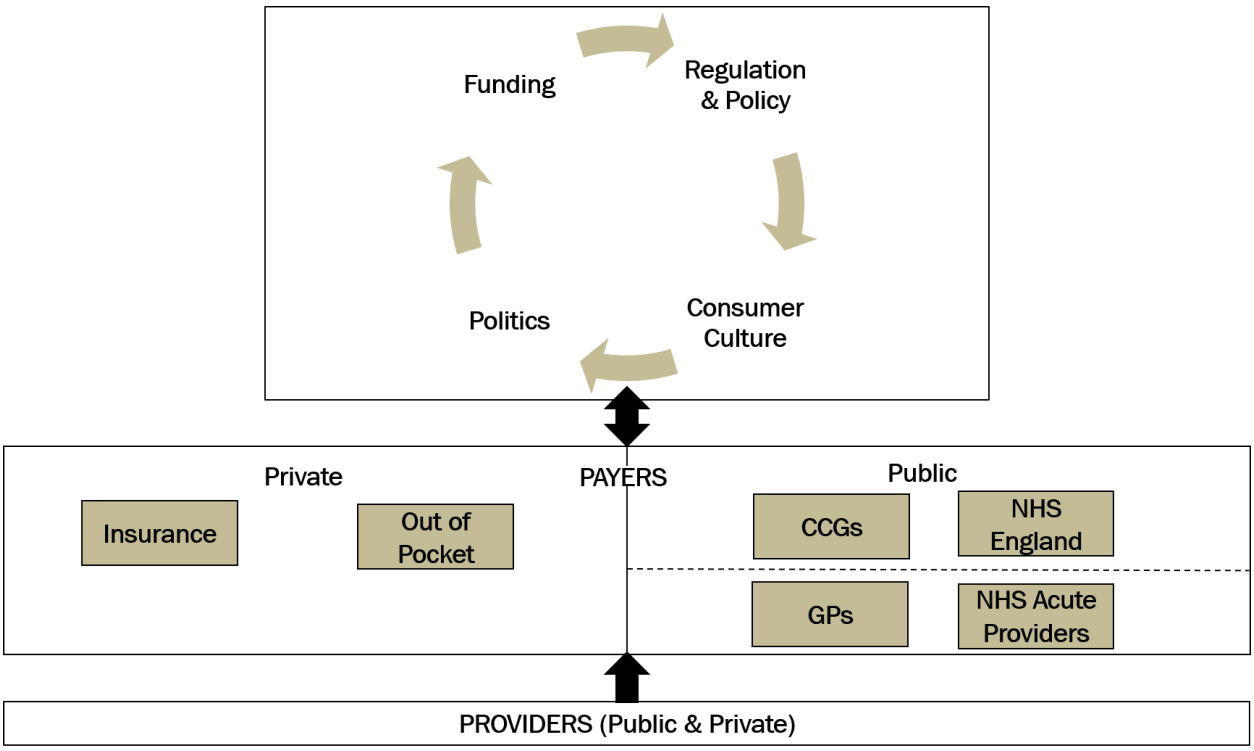
1. To provide trans-Atlantic educational and business opportunities for its members
2. To give its members a chance to develop deeper relationships abroad and with one another
3. To showcase Nashville's healthcare industry on a global stage and establish the region as the healthcare capital of the US

This document developed by the Marwood Group, a healthcare specialist advisory firm, follows this study mission. It seeks to answer the question *'what is the opportunity for international players in the UK healthcare market?'* To do this, the document builds on the diverse dialogue of those who attended the mission, including health system and political experts, business leaders, operators, and individuals from the financial industry. It builds on the content and themes developed through the study mission highlighting the health system's strengths and weaknesses and identifying areas of shared opportunity, including:

1. Supporting the NHS to achieve its efficiency objectives
2. Supporting the NHS to transform services – such as the development of population-based healthcare models
3. Providing a healthcare offering for individual consumers

What's the Nature of the Opportunity for International Players in the English Healthcare Market?

The English Market



Key Factors

The healthcare system in England is dynamic, shaped principally by four factors:

- Funding
- Regulation and Policy
- Consumer Culture
- Politics

These four factors interact, creating evolving opportunities and risks for companies looking to participate in healthcare markets. As stands today, the key factor shaping English healthcare markets is funding. A scarcity of Government funding relative to demand has caused changes in both regulation and policy as well as in consumer culture. Conversely, the impact of politics on healthcare markets is currently static in light of a political focus on wider domestic issues.

Funding

As a result of complex financial pressures, the NHS is experiencing a funding gap of £30bn by 2020. As with many countries, the NHS is experiencing increasing demand for services driven principally by demographic pressures. In England, the pressure is intensified by the complex interaction with the social care system (i.e., personal services, mostly elderly care), which is separate to healthcare, is not free at the point of need and is under significant funding pressure for several years, leading some patients to use healthcare rather than social care services for lack of an alternative.

Although the Government has responded to this challenge by promising an additional £8bn investment in the NHS between 2015 and 2020, leaving the NHS to find £22bn worth of efficiency savings, NHS funding has been flat or slightly up in real terms since 2010. This is a significant departure from the 6% annual increase seen under the previous Government. This is unlikely to change, even though the Conservative party have promised another £8bn funding in real terms by 2022. The timetable for allocating this additional funding has not been set out, and despite the increase, NHS spending as a share of GDP will continue to contract.

Regulation and Policy

To address the £22bn funding gap, policymakers are focusing on two things:

- Doing the same things better or more efficiently
- Delivering services through new models of care

Doing the Same Things Better or More Efficiently

The efficiency challenge is large. Historically, the NHS has achieved efficiencies of only 0.8% per year. To address the funding gap, the NHS is expected to realize efficiencies of 2-3% per year. To support the NHS to achieve these efficiencies, there have been a number of publications[1] which set out key efficiency targets for both clinical and non-clinical services. Some of the solutions outlined to improve efficiency include:

- Medicines optimization to reduce unnecessary spending on pharmaceuticals
- Improving patient pathways
- Improving workforce productivity
- Addressing costly delayed transfers of care
- Making use of new technology
- Improving procurement processes
- Better management of the NHS estates

Despite this, progress to date has been relatively slow and varies across the country. Several reports, for example from the National Audit Office and of the House of Lords, point to the need for more coordination and clear plans to achieve greater efficiency and minimize performance variation. As mentioned above, one of the ways to improve efficiency is through the use of new technology, as many providers have already done in Nashville. For example, the Center for Medical Interoperability, a Nashville-based cooperative research and development lab founded by health system leaders to simplify and advance data sharing among medical technologies and systems.

[1] The Carter Review of operational productivity and performance in the English NHS acute hospitals, The Naylor Review of NHS property and estates, The Watcher Review of information technology in the NHS

Delivering Services Through New Models of Care

The NHS is looking at developing new models of care to address the funding gap. The *NHS Five Year Forward View* (FYFV), NHS England's vision for healthcare by 2020, outlines five new models of care to change the way of delivering healthcare services. These models are based on partnerships and integration between primary, community and secondary (hospital) care. They build on population-based models similar to those developed in the US by Accountable Care Organizations (ACOs), such as Mission Health Partners in Nashville, which brings together 39 primary and secondary care providers to improve service delivery to their population.

The new models of care are currently being tested through 50 'vanguard' sites. Their experience will act as a benchmark for other areas, and will shape the healthcare provider landscape in the medium and long terms. Vanguard sites have now been in operation for just over two years. Although no thorough evaluation has been carried out yet, some of them are starting to deliver on their objectives. Some examples include reducing avoidable hospital admissions (Neuro Network Vanguard) or expanding access to services (Morecambe and Wakefield).

The NHS's Five New Models of Care

- Integrated primary and acute care systems (PACS) – joining up general practitioner (GP, i.e., primary care physicians), hospital, community and mental health services
- Multispecialty community providers (MCP) – moving specialist care out of hospitals into the community
- Enhanced health in care homes – offering older people better, joined-up health, social care and rehabilitation services
- Urgent and emergency care – new approaches to improve the coordination of services and reduce pressure on A&E departments
- Acute care collaboration

Consumer Culture

The NHS in the UK is often described as a national religion, with 'publicly funded universal access to care' forming part of the country's cultural identity. Whilst the policy response to the NHS funding gap has been addressing some of the challenges, the financial pressures facing the NHS have already begun to impact patients through increased waiting times and restricted access to publicly funded services. This is increasingly leading to wealthier individuals looking to pay for services out of pocket as they need them. A trend that has the potential to be compounded by cultural changes and new expectations, mostly from younger generations. However, this shift from patient to consumer is nascent.

Politics

Politics and healthcare in the UK are inextricably linked. Whilst healthcare is normally a recurrent topic of political debate, the Government is now focused on delivering Brexit. This process has been made more complex following the early general election of June 8th and the loss of the Conservative majority. This means that the funding trajectory and associated implications (such as the increasing role of the private sector) are unlikely to change in the medium term.

Healthcare Markets

There are two healthcare markets in the UK, shaped by the key factors outlined above:

- A large and diverse public market, purchasing the majority of healthcare services
- A smaller private market

Both markets purchase services from two types of providers: NHS providers and private providers.

Public Market

Contrary to common perception of the NHS, there are several payers in the public healthcare market. These payers include commissioners (NHSE and CCGs) and providers outsourcing certain services (NHS acute hospitals and GPs).

Commissioning of healthcare services is split between NHSE's four area teams and 207 CCGs. NHSE purchases specialized services (services that have a high cost and low volume, for example trauma services) and primary care services (GP, dentistry, opticians and community pharmacy). CCGs are clinically led statutory NHS bodies composed of local GPs and other clinicians (nurses, secondary care consultants). They commission other services, from hospital care to non-specialist mental health services. Increasingly, CCGs are also taking the lead in commissioning GP services. CCGs have a degree of discretion in resource allocations and priority definition, even though their plans and spending are overseen by NHSE.

Providers, including GPs and NHS acute hospitals, have discretion over outsourcing some of their services to external, typically private, providers. The services they outsource include both clinical services, for example district nursing and community nursing services, and non-clinical services, such as back-office functions.

Private Market

There are two key payers in the private market: private medical insurance (PMI) and individuals.

PMI covers approximately 11% of the UK population, and up-take has remained flat over the past 10 years. The majority of individuals covered by PMI are generally enrolled as part of their corporate benefits program. Although many large firms offer PMI, this is often limited to senior employees. Few individuals subscribe directly to a PMI contract. There are several reasons for this, including a cultural reliance on the NHS and the perception that the cost of PMI is too high.

The out-of-pocket payment segment of the private market has been growing in recent years. This trend is closely linked to restricted or difficult (long waiting times) access to NHS-funded services.

These new consumers are generally over 50 years old, making a one-off payment into their health. A typical example is orthopedic operations.

Providers

Public and private providers of health and care services work across both markets.

NHS providers provide most of the clinical services in the public market. However, some NHS-funded services are being delivered by private providers, especially in the behavioral health sub-sector. About 10% of the total NHS budget is spent on non-NHS providers, which include private but also non-profit providers.

Providers in the private market include mostly private hospitals, as well as some more specialist providers such as Acadia, a Nashville-based behavioral health provider. In addition, NHS providers can offer services to private providers; however they are restricted in how much income they can make from private provision.

Opportunities Created by the Changing Shape of Healthcare Markets

Currently the balance of purchasers and providers in and between all markets is shifting in response to current dynamics created of the four factors. The two key shifts are:

- Public payers increasingly working in partnership with private providers to deliver public services
- Movement of 'users' from the public to private markets

The size and risk of the opportunities inherent in these two shifts will play out differently in different sub-sectors and geographies. Yet at a national level, these two shifts represent a trend that has persisted and will continue to persist in the context of a broadly supportive political environment.

Opportunities in the Public Market

Two opportunities exist in the public healthcare market created through funding pressures and policy changes:

- Supporting the NHS to deliver efficiency savings
- Supporting the NHS to deliver the new models of care

Whilst the funding challenge is creating these opportunities, it is also creating a number of risks for those looking to take up those opportunities. The main risk is the NHS's ability to pay for the services that private providers offer.

Opportunities in Supporting the NHS to Deliver Efficiency Savings

To achieve efficiency savings, the NHS is going to be looking to the private sector for support ranging from the provision of back-office services to delivering care on the NHS's behalf. Opportunities in this area will exist fairly uniformly across the country. Private providers and companies willing to work in partnership with the NHS will need to be able to demonstrate how they can contribute to the efficiency challenge. For example, this may be through making investments in workforce productivity, as Virgin Care has done across the UK.

Virgin Care: Investing in Workforce to Increase Efficiency

Virgin Care provides more than 400 clinical services for NHS commissioners across the country. The company provides a broad range of health services on behalf of the NHS, such as primary care, immediate care, community services, social care services, prison healthcare, and children and young people's health and social care services. Virgin Care's support to the NHS focuses on under-served and rural areas, which were previously receiving patchy and fragmented care.
To increase efficiency, Virgin Care has invested in its workforce in three ways:

- Introduction of new technology solutions
- Training
- Wellbeing

Virgin Care invested a lot of time in working with caregivers and nurses to listen and learn from them. Through this 'bottom-up' approach, the company developed a solid understanding of their workflow patterns and identified the resources and tools nurses needed to be successful and fulfill their mission to make the biggest impact possible on patients. With this knowledge, Virgin Care made smart investments in technology that improved care coordination and empowered their employees to provide the best care possible to patients and make their job easier. This included a mobile app for nurses and an integrated electronic health record.

Virgin Care has also developed a number of training programs to support its workforce. For example, the community nurses' leadership program is an in-house training package to support nurses with management responsibilities to lead effectively.

Finally, Virgin Care has made investments into workforce wellbeing, particularly mental wellbeing and resilience training to support staff in coping with potentially emotionally draining work and reduce stress and sickness absence.

These investments have made a significant difference in Virgin Care's ability to meet the increased demand for community health services, improve the quality of these services from the patients' perspective, and increase productivity. [2]

Opportunities in Supporting the NHS to Deliver the New Models of Care

In the second opportunity deriving from the funding and policy context, public payers will be looking to work in partnership with the private sector to support innovation in their healthcare systems, drawing from international best practice and models of working in other industries, outside of healthcare. Opportunities in this area will exist in a small number of geographies, which are leading healthcare transformation in the UK. For example, several vanguard sites are working in partnership with private providers to achieve their objectives.

[2] These case studies have been written with the support of Molly Cate, founding partner, Jarrard Inc.

Optum: Supporting Modality Partnership's Integration

The US healthcare technology company Optum is working in partnership with Modality Partnership to provide a range of support services, such as health analytics, data and decision-support tools and actuarial services.

The Modality Partnership is one of the 50 vanguard sites testing the new models of care. Its ambition is to create a community-based model of care integrating primary, mental health and social care services.

Opportunities in the Private Market

Opportunities exist to different degrees across the two segments of the private market (out-of-pocket and PMI). However, the British people generally expect to receive healthcare services that are free at the point of need. This cultural element makes them particularly sensitive to price and likely to return to the NHS should the financial position be altered in the future.

Opportunities in the Out-of-Pocket Segment

The key opportunity that exists in the private healthcare market is arising from the growth of the role of the consumer. The funding issues impacting the public market have created some barriers in individual access to services. Where these barriers coincide with individuals' ability and willingness to pay for services, they will start to pay privately, shifting from users to consumers. This trend has been historically present in sub-sectors such as in-vitro fertilization (IVF) services and is increasingly being seen in other sub-sectors, such as primary care.

Babylon: Simplifying Access to Primary Care

Access to NHS primary care GP services can be difficult, especially same-day and out-of-hours appointments. Founded by Ali Parsa three years ago, Babylon is a healthcare app addressing this shortfall. The app allows patients to check their symptoms, receive advice on the best solution to their health issue, book video or text GP consultations and book physical GP appointments, at a cost of £5 per month, while a one-off consultation costs £25. The app is used by approximately 250,000 people in the UK.

Earlier this year, the company raised £50m to further develop its online clinical triage tool, which was launched last year. Babylon says its system is 17% more accurate than a nurse and 14% more accurate than a doctor. And, it claims to make diagnoses 80% cheaper. The company also says it has a 95% accuracy rating in predicting diseases and can diagnose 90% of all primary care diseases.[3]

Opportunities in the Private Medical Insurance Segment

Some opportunities exist in the PMI segments; however PMI up-take has been mostly flat over the past 10 years and is likely to remain so in the future for cultural and economic reasons. This segment targets primarily a wealthy population, mostly concentrated in London, seeking access to high-quality, innovative services.

[3] These case studies have been written with the support of Molly Cate, founding partner, Jarrard Inc.

HCA Healthcare: Addressing the High-End London Market

Through its London and Manchester state-of-the-art private hospitals, HCA Healthcare UK provides for privately funded individuals seeking quick access to high-quality services.

To meet this demand, HCA Healthcare UK has invested more than £500m in the last 10 years into in the UK market. With a consumer-facing branding and marketing strategy, HCA Healthcare UK directly targets the population through a results-driven campaign that highlights their achievements.

A good example of HCA Healthcare UK's strategy is their Cancer Service Network, which is one of the only private healthcare providers whose services cover fast access to the entire cancer pathway. HCA is the only private provider in the UK to offer Phase 1 and Phase 2 clinical drug trials for cancer therapies. And, they were the first private hospital group in the UK to use CyberKnife and NanoKnife systems. [4]

About the Nashville Health Care Council

The Nashville Health Care Council is a premier association of health care industry leaders working together to inspire global collaboration to improve health care by serving as a catalyst for leadership and innovation. Since 1995, the Council has served as a trusted source for information on trends and innovations influencing the nation's health care industry. Through regular programs, the Council provides members with unparalleled access to national and international policymakers, industry innovators and thought leaders.

For more information on the Council, please visit www.healthcarecouncil.com

FOLLOW THE COUNCIL ON SOCIAL MEDIA
Twitter
LinkedIn

Marwood Group

For more information on any of the content in this publication or to learn more about Marwood Group Advisory's capabilities, we encourage you to please contact us.

Kayleigh Hartigan
Managing Director, UK and European Healthcare Advisory
Office: +44 (0)20 3443 7052
khartigan@marwoodgroup.com

Jennifer Meyers
Director
Office: (212) 532-3651
jmeyers@marwoodgroup.com

FOLLOW US ON SOCIAL MEDIA
LinkedIn

[4] These case studies have been written with the support of Molly Cate, founding partner, Jarrard Inc.

ANNEX

UK POLITICAL CONTEXT

Current Political Headwinds

- *The UK voted to leave the European Union (EU) on June 23rd 2016: the UK political context is dominated by 'Brexit' (the UK withdrawal from the EU) and will continue to be in the next 2-3 years*
- *Prime Minister Theresa May notified the EU of the UK's intention to leave on March 29th 2017*
- *She subsequently called an early general election on April 18th 2017 in the hope to strengthen her legitimacy as the leader of the country ahead of the withdrawal negotiations*
- *This resulted in the Conservative party losing their majority in the House of Commons*
- *However, the Conservatives won the greatest number of seats and formed a minority government supported by the Democratic Unionist Party (DUP, Northern Ireland)*

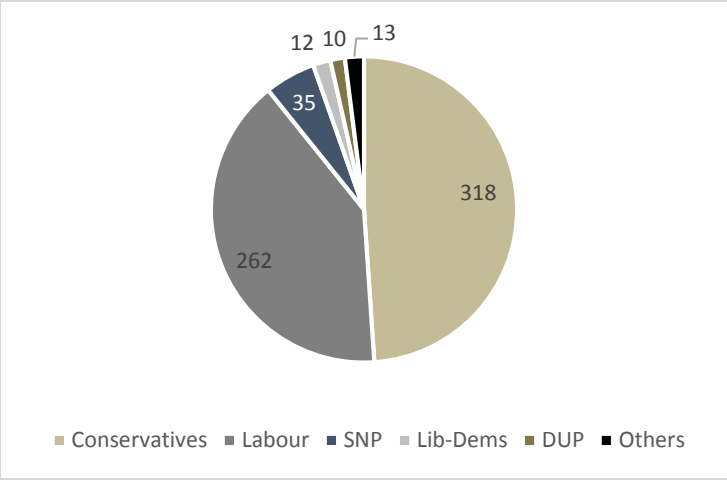
Overview of the UK Political System

Structure

The UK is a constitutional monarchy resting on a bi-cameral parliamentary system. The monarch is the Head of State (currently Queen Elizabeth the Second) but delegates most of their power to the Prime Minister and their Government, who in turn determine the course of national policy.

The UK Parliament is made of two chambers: the House of Commons (HoC), elected directly every five years in a general election, and the House of Lords (HoL) appointed. Members of the HoL are appointed by the Queen on the recommendation of the Prime Minister and leaders of the main political parties. The role of the UK Parliament is to discuss, amend and pass legislation.

Political Parties



Historically, there have been two main political parties: the Labour party on the center-left and the Conservative party (Tories) on the center-right. The Prime Minister is normally the leader of the political party that hold most of the 650 seats in the HoC, and since the end of the Second World War, all Prime Ministers have come from either the Labour or the Conservative party. Currently, the Conservative party holds most of the seats (318), but not the majority of them (326). Labour is the second biggest party, with 262 seats.

Current Government

Current Majority

Following the June 8th general election, the Conservative party won 318 seats in the HoC, just short of a majority. Theresa May remained Prime Minister with the support of the DUP, a center-right Northern Irish party. Despite the loss of majority, Theresa May has confirmed that her main priority will be on delivering Brexit and starting negotiations with the EU as planned.

Opposition

The Labour party is the main opposition to the Conservative party. Labour, led by left-wing Jeremy Corbyn, failed to win a majority in the HoC in the general election. However, it significantly increased its number of seats, winning 30 more seats than in 2015, and totaling 261 MPs.

Political Interaction with Healthcare

The UK National Health System (NHS) was founded in 1948 on the principle that everybody should be able to access healthcare regardless of their financial means. The British people are very attached to their NHS and their local services in particular. Politicians of all parties are keen to be seen as protecting it. For example, it became a major argument during the campaign on the EU referendum. Those in favor of remaining in the EU argued that, to be sustainable, the NHS needed a strong UK economy, dependent on the UK's membership of the EU. Those in favor of leaving suggested that UK contributions to the EU budget could instead be used to finance the NHS.

Overview of the European Union

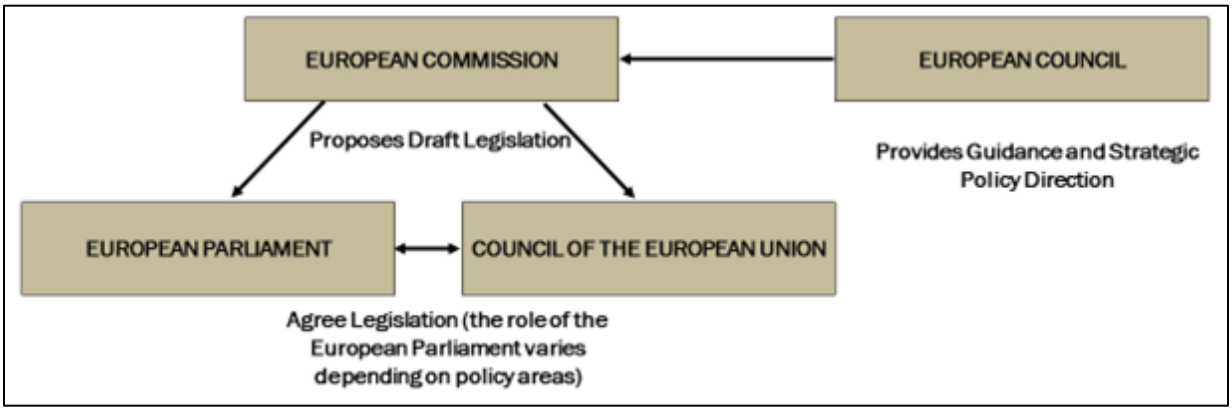
Structure

The EU is a supra-national political and economic union, currently formed of 28 Member States (MS)[5]. The EU was established as a legal entity in 1992, with the adoption of the Treaty of Maastricht. Before that, it was known as the European Economic Community (EEC), which was established by Germany, France, Italy, Luxembourg, Belgium and the Netherlands in 1957 with the Treaty of Rome, and which the UK joined in 1973.

MS delegate some (but not all) of their national prerogatives (competencies) to the EU. One of the key elements of the EU is the single market, an area of free trade across the 28 EU countries plus Norway, Iceland, Liechtenstein and Switzerland. Giving access to 500m consumers, the single market allows for goods, services, capital and persons to move freely across the 32 countries as if there were no borders.

Institutions

There are four key institutions:



The European Commission's role is to propose EU legislation and ensure that EU Treaties (the legal framework of the EU) are applied by all MS. The European Commission takes advice on overall policy direction from the European Council, which is made up of the 28 Heads of State and Government and is led by a President, appointed by the same Heads of State and Government.

The legislative power is shared between the Council of the EU and the European Parliament. The Council of the EU meets in 10 different configurations (covering all policy areas). It is made up of the relevant 28 national Ministers depending on discussion topic (for example, the UK Secretary of State for Health sits in the Employment, Social Policy, Health and Consumer Affairs Council configuration). The European Parliament's 751 members (MEPs) are directly elected every five years, and each MS has a number of MEPs that is proportional to its population. Together, the Council of the EU and the European Parliament amend, negotiate and pass legislation. In some cases, such as trade agreements or exit of an MS, the European Parliament's role is limited to approval or rejection of agreements without amendment. However, its decision is binding on the Council of the EU.

EU Interaction with Healthcare

For healthcare, the EU is mostly relevant for pharmaceutical and medical devices regulation, research and development funding, labor, and to some extent, competition and procurement.

The EU has limited powers on healthcare services. Each MS is responsible for funding and organizing healthcare services and priorities as it sees fit. In this regard, the role of the EU is limited to

[5] Including the UK. Once the UK withdrawal is effective, there will be 27 Member States.

overseeing and setting the legal framework for cross-border healthcare services – for example, a British hospital agreed a contract with a French hospital to deliver some of its elective care and reduce waiting lists. However, these services remain exceptions rather than the rule.

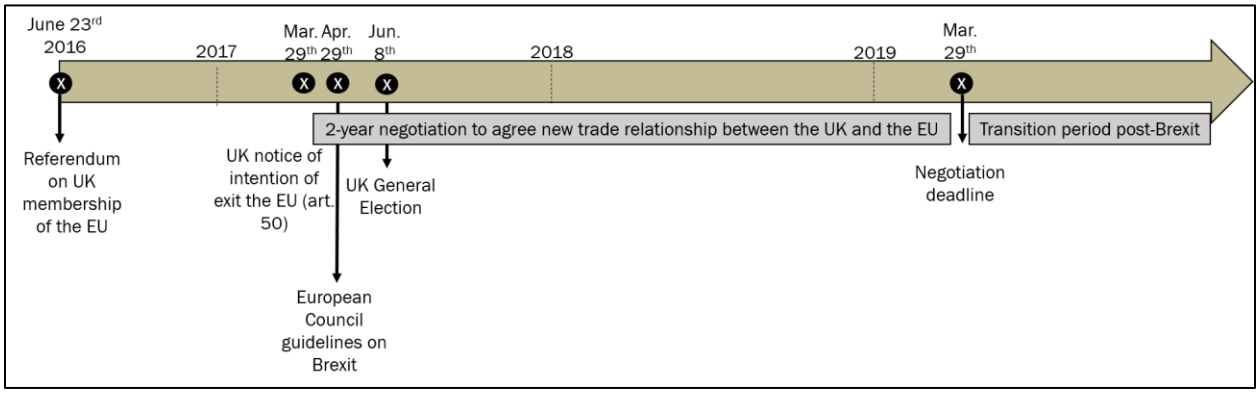
UK Relationship with the EU

History

The UK joined the European Economic Community (EEC, the predecessor of the EU) in 1973. The relationship with the EU was never straightforward. After declining to take part in early economic cooperation initiatives with Germany, France, Italy, the Netherlands, Belgium and Luxembourg in the 1950s, the UK applied to join the EEC in 1963. This move was vetoed by the French President, Charles de Gaulle, and the UK had to wait until after his death to reapply, this time successfully. However, membership was challenged, mostly from the Labour party at that time. The UK held a first referendum on its membership of the EEC in 1975, resulting in 67% of votes in favor of remaining. The following 40 years were marked by numerous UK opt-outs from several European policies, such as participation in the Schengen Area (an area of passport-free travel between EU countries) and participation in the single currency, the Euro. In the 1990s and 2000s, most critics of the UK's membership of the EU ('Eurosceptics') came from the Conservative party. After the Conservative win in 2015, David Cameron attempted renegotiating the UK's terms of membership with his 27 partners to secure further opt-outs and concessions, including on the free movement of workers from other EU countries to the UK and British sovereignty. An agreement was found in February 2016. David Cameron subsequently sought approval through the June 2016 referendum, which he did not get.

Brexit Timeline

The process for an MS to leave the EU is outlined in article 50 of the first part of the Treaty of Lisbon, the current legislative framework of the EU, in force since 2009. It sets out a two-year negotiation period between the UK Government and the EU for exiting.



The negotiations will be led by the European Commission, on behalf of the remaining MS. The process for leaving the EU is most likely to unfold in two steps. First, the UK and the EU will negotiate the high-level terms of exit for the UK. One of the main issues to be resolved is the payment of the UK's financial commitments to the EU budget. The second phase will be more detailed and will consider sector-specific issues. For example, this is when discussions on pharmaceutical regulation are likely to happen. The final agreement will require to be signed off by the Council of the EU, with the approval of the European Parliament.

It is likely that there will be a transition period post-Brexit to allow for phased implementation of the changes. It is also possible if no deal is found at the end of the two years to extend the negotiation period, but it would require approval of all remaining EU countries.

Brexit Scenarios

No MS has made use of article 50 before, and it is still unclear how it will work in practice. There are different scenarios for the UK outside of the EU.

Scenarios	Implications
UK joins the European Economic Area (EEA)	Members of the EEA have full access to the single market and are subject to freedom of movement for workers. As such, this option would make little difference to the current relationship.
Comprehensive Free Trade Agreement (FTA) between the UK and the EU	The objective of an FTA would be to eliminate trade barriers (tariffs and regulations) between the EU and the UK. However, it would not extend to free movement of workers between the two parties.
Bilateral Agreements between the UK and the EU	Instead of a comprehensive FTA, the UK could negotiate bilateral agreements with the EU in specific areas, such as pharmaceuticals for example. They would eliminate trade barriers only for products or services covered by the agreements.
No agreement	World Trade Organization (WTO) rules apply by default.

Impact on Healthcare

Healthcare policy is a national competency. The EU has no power in decisions relating to healthcare financing, planning and priorities. However, healthcare policy interacts with other policy areas that are directly controlled by the EU.

The main concern is access to health and social care workforce. It is estimated that 55,000 or 5% of NHS staff come from the EU (out of 1.2m staff). Theresa May has already announced that the UK would not seek to remain a member of the single market, effectively ending automatic free movement of workers. Although it is unclear how the UK intends to control EU migration, there are concerns that the health and social care systems will find it harder to recruit EU workers post-Brexit.

The second area of uncertainty is pharmaceutical products regulation. The EU and the single market have created a single market for pharmaceutical products with certain products being approved centrally by the European Medicines Agency (EMA) and others being approved at the national level but benefiting from mutual recognition across the single market. It is unlikely that the approval procedure will change post-Brexit, but it is possible that the UK will be less influential in shaping regulatory decisions.

UK research institutes and universities are currently the first recipient of EU research funding. Although the Government has pledged to match prospective EU funding already secured, there are concerns about the UK's future attractiveness as a major place for research and life sciences. Finally, in the run-up to the 2015 general election, the Labour party promised to repeal the Health and Social Care Act 2012[6] if elected to repeal competition clauses. However, it turned out that repeal was not possible under EU legislation. The withdrawal from the EU may reopen this prospect in the upcoming general election.

[6] The Health and Social Care Act 2012 came into force in 2013 and introduced substantial changes to healthcare organization in the UK. Among others, it introduced Clinical Commissioning Groups (CCGs), which are clinically led, strengthened patient choice and competition (on quality) among providers, and established Monitor (now NHS Improvement) to oversee financial sustainability of providers of NHS services.

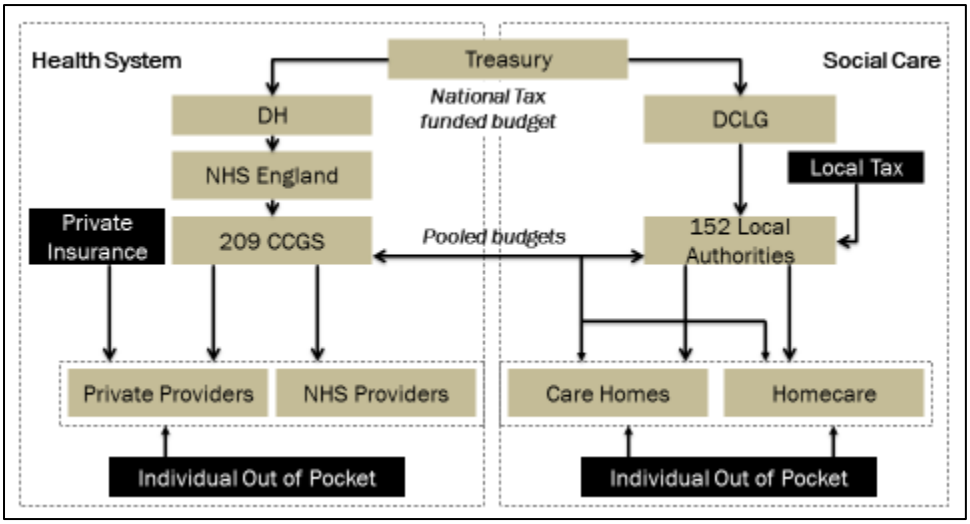
HEALTH AND CARE SYSTEM IN THE UK

Snapshots

- Responsibility for health and care in the UK is devolved to the four constituent countries: England, Wales, Scotland and Northern Ireland
- In 2015/16 the UK spent 7.4% of its GDP on healthcare
- There are some similarities in the way the systems are organized, such as universal, tax-funded, free at the point of need healthcare
- Systems are structured and operate as autonomous systems
- Most importantly, there are multiple payers, which vary across the four countries

The English Health and Social Care System

Healthcare in the UK is distinct from elderly care (support for activities of daily living), known as social care in the UK. In England, funding flows as follows:



Healthcare

Public Funding

Public healthcare in England is funded through general taxation. Services are mostly free at the point of need; however, there are a number of patient charges for dentistry and optical services.

The Treasury provides funding to the Department of Health (DH) on the basis of the Spending Review, a multiannual plan outlining how public funding will be allocated. The last Spending Review took place in November 2015, covering five financial years until 2020/21[7]. Most of the DH funding is subsequently allocated to NHS England (NHSE), and the DH sets out an annual list of broad goals for improvement in the Mandate. For 2017/18, the total healthcare budget is £123.5bn. Of this, the NHS budget is £109.96bn. About a third of the funding is used by NHSE to directly purchase certain

[7] In the UK, the financial year starts on April 1st and ends on March 31st. The Spending Review 2015 covers five financial years, from 2016/17 until 2020/21

services. The remaining budget is allocated to the 209 Clinical Commissioning Groups (CCGs) on a weighted capitation basis. The CCGs' total budget for 2017/18 is just over £72bn.

Planning and Commissioning Structures

Responsibility for health legislation and general policy in England falls under the jurisdiction of Parliament, the Secretary of State for Health (SoSH), and the DH. The SoSH has overall responsibility for the NHS and for promoting health and social care. The DH provides stewardship for the overall health system. Its key responsibilities include setting overall health policy and strategy, negotiating funding for the NHS with the Treasury, and allocating resources to the NHS.

NHSE sets budgets and planning guidelines for national and local commissioning of health services. NHSE, in conjunction with NHS Improvement (NHSI), determines the national tariff, a set of prices and rules to help commissioners work with healthcare providers and identify which services offer the best value.

CCGs are clinically led statutory NHS bodies composed of local General Practitioners (GPs) and other clinicians (nurses, secondary care consultants) and are responsible for commissioning most healthcare services across primary and secondary (hospital) care.

Provision

NHS organizations provide a wide range of primary and secondary care services. Primary care providers include GPs, dentists, community pharmacists and opticians. GPs ensure the majority of primary care provision. They are the first point of contact for most patients and have a gate-keeping role in referring patients to specialist services. Patients are required to register with a local practice of their choice and are free to change at any time. The secondary care provision landscape is mainly composed of public hospitals (Trusts). Services are provided by consultants (specialist doctors), nurses and other healthcare professionals such as radiotherapists and physiotherapists who are employed by the Trusts. There are two types of Trusts: Foundation Trusts (FT), who have the freedom to invest and disinvest and are separate from the capital regime of the NHS, and NHS Trusts, who have not yet been able to demonstrate the conditions to become FT.

Although the vast majority of healthcare services are public, there is some private provision as well. Private providers work either in parallel to NHS services or in partnership with them. Those working in parallel focus on offering high-quality, state-of-the-art treatments to patients paying out of pocket or covered by private medical insurance (PMI). About 11% of the UK population subscribes to some form of PMI, generally through their employer. This segment of the private market is mostly concentrated in London. Private providers can also work in partnership with the NHS. They contract with commissioners to deliver services on behalf of the NHS and are paid through public budgets. Some providers, for example dental chains, offer a mix of NHS services, for which they have a contract with the NHS, and private services, paid out of pocket.

Regulation

There are a number of healthcare regulators in England. The main regulator overseeing quality of care is the Care Quality Commission (CQC). The CQC carries out inspections of all healthcare providers (NHS and private) in England and rate them from outstanding to inadequate. Overall, private providers' ratings tend to be better than NHS providers.

Financial sustainability of NHS providers and private providers delivering NHS services is the responsibility of NHS Improvement (NHSI), a merger of Monitor and the NHS Trust Development Authority (TDA). It also oversees leadership and ensures that competition rules are applied across the NHS.

Guidance and standards on health and social care procedures are developed by the National Institute for Health and Care Excellence (NICE).

Finally, medicines and medical products are regulated by the Medicines and Healthcare Products Regulatory Agency (MHRA).

Social Care

Funding

Social care services are services supporting individuals in their activities of daily living either at home or in specific settings, such as care homes. The funding system for social care is complex, involving multiple sources of funding. Government funding provides a safety net for individuals with savings and capital below £23,250. Above this threshold, individuals are required to contribute to the cost of their care as services are not free at the point of need.

There are two sources of Government funding. One source is national allocations from the Department for Communities and Local Government (DCLG) to Local Authorities (LAs). LAs are local governments (equivalents to states in the US, though much smaller) which are responsible for funding a range of local services, including social care. In addition to national funding, LAs raise a number of local taxes, mostly Council Tax (levied on domestic property) and business rates (levied on commercial property). Within that budget, LAs are responsible for funding a number of local public services, including social care, but also education and housing. For social care, LAs also receive a grant from the DH.

Planning and Commissioning Structures

There are 152 LAs responsible for organising social care services. The Care Act 2014 placed a new responsibility on LAs to assess the needs of any individual who appears to have care needs and provide information and assistance to those who have been assessed as needing care. LAs carry out financial assessments to determine whether an individual is eligible for public funding.

LAs remain the main commissioner of social care. They agree contracts with local providers which are negotiated every year. In recent years, LA prices have mostly decreased or, at best, increased by about 1% annually for care homes; but they have not kept pace with the increase in costs (made worse by the introduction of the National Living Wage from April 1st 2016). In addition, as social care is not free at the point of need, there is a substantial proportion of private payers who cover the full or partial cost of their care. Providers charge higher prices for them, and increasingly, this is used to make up for low LA prices.

Providers

Contrary to healthcare, social care services are primarily provided by private operators. LAs also offer some direct provision, but this is very limited. The provision of social care services in England is diverse.

Services may be provided in care homes, generally for older people (over 65) who need various degrees of constant support in either residential or nursing settings. However, there are also care homes for adults (aged 18-64) and children living with a learning disability and presenting challenging behaviours.

Increasingly, commissioners and health and social care professionals try to keep individuals in their own home as long as possible. These individuals receive non-clinical, home care or domiciliary care

services provided by home care agencies and their carers. Most of these services are delivered to older people.

Regulation

The main regulator of social care services is the CQC. They inspect social care providers on the basis of the same criteria as healthcare providers and rate services from outstanding to inadequate.