

Health

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Roundtable debate: Future of healthcare

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In search of a lasting solution



When Sir Derek Wanless published his report on the future of the NHS in 2002, he told the government that spending on healthcare would have to double over the next 20 years.

But, as the next government spending review – already delayed – approaches in 2007, it seems that the money might already be beginning to run out.

There seems little question that the amounts spent over recent years have led to dramatic falls in some NHS waiting lists.

But last month the government effectively conceded that it will be unable to sustain this level of spending on healthcare if it is to meet its responsibilities in other priority areas such as education and pensions.

It seems likely, then, that slower rates of growth than those predicted by Sir Derek will be ordered by the Treasury after 2008.

But as the debate continues over just how much should be spent on the NHS, there have been calls for a more radical investigation into the way healthcare is delivered in this country.

Our assembled panel of health insurance specialists, who we invited to lend their weight to the debate on how healthcare should evolve in the 21st century are spearheading those calls.

As you will read, they are concerned that simply throwing money at the NHS – more than £100bn a year by 2008 – in its current form is not a lasting solution.

All of the main political parties seem to agree that private sector healthcare providers should play an increasing role in delivering care to ever-more demanding NHS patients in the future.

That is something, too, that our invited health insurance specialists seem to concur is the right way forward for our health service.

They seem in agreement, too, that businesses should play an increasing role in providing healthcare for their employees.

But, moreover, there is a consensus among the participants in this month's roundtable discussion that the debate over how healthcare is funded in the coming years needs to focus not simply on levels of spending, but on how the money is spent – and how it is raised.

I am sure that their stimulating and provocative thoughts will persuade you to play your role in that debate. To have your say, please, as always, email us at news@hi-mag.com.

Richard Banks
Editor, *Health Insurance*

Produced in association with





Tim Baker was appointed director of business development at Norwich Union Healthcare in 1993. He is responsible for a wide range of strategic initiatives and the development of clinical and management care services. Tim has a degree in economics and a

post-graduate qualification in management.



Hazel Gregory is managing director of Medical Insurance Services and secretary to the Association of Medical Insurance Intermediaries. Having spent 14 years in the PMI industry, her experience ranges from underwriting and claims through to

product development, marketing and PR. She has also been involved in a number of working party projects.



Linda Cooper joined Premier Choice in March 2005 to develop its large corporate healthcare and group risk portfolio. Previously, Linda worked for 10 years with the PMI Health Group as a senior healthcare consultant, advising corporate clients

on related insurances, occupational health and general employee health management strategy. Linda recently took on a new role within the Premier Choice Group to manage the strategic development within Premier Choice Employee Benefits Limited.



Nick Lipczynski founded independent healthcare specialists IHC in 1993, having gained experience both with Gartmore Fund Managers and at BUPA, where he was national sales manager. He has an MBA and extensive knowledge of a variety of health insurance

products, including PMI, expat, dental, life and group risk.



Carolyn Derrington is marketing director at HSA, joining in November of last year. She is currently leading the strategic development and launch of HSA's modular healthcare solutions for companies and individuals. She is also closely involved with HSA

Group initiatives such as the integration of Adastral Health and the development of an occupational health proposition.



Paul Lynes is head of corporate affairs at Standard Life Healthcare where he has worked for the last two and a half years. Prior to that, Paul worked for over 10 years in communications consultancy advising clients on public affairs and public

relations campaigns in a range of areas including the health, food and drink, charity, energy and public sectors.

Richard Banks (RB): Is it time for a re-think of NHS funding? Or is the current system sustainable?

Tim Baker (TB): It's difficult to see how the current funding system can be sustained without substantial tax rises. Such rises are certain to be politically unpopular and may be a form of electoral suicide. You only have to look at other western economies to see that they do spend more on healthcare because private spending is usually significantly higher than in the UK.

Paul Lynes (PL): I think there are a number of long-term issues facing the government at the moment. The Wanless Report said that basically if people don't change the way they live - if they don't get healthy, they don't eat more healthily or exercise more - by 2025 it's going to cost the NHS an extra £30bn. So, essentially the message was get fit or it goes bust. Then the funding that currently exists runs out in 2008. What happens after that? We've seen suggestions that even Wanless's projections after 2008 perhaps are a bit too much for the Treasury and therefore they're going to look again at extending the timescale in which those funding prices will come through. I think the biggest problem the government's got is in fact a demographic issue, the fact that in years to come there will be more people over 65 than we have at the moment. In 2000, 25% of the population were over 65 and by 2025 that's going to be 33% and by 2050 that's going to be 40%. That creates two problems: one is that you've got more elderly people who need more hip operations, living longer, more cataracts etc. But more importantly you have fewer people paying tax and the portion of people paying tax will decline as people get older. So who is going to pay for all these increased costs? I think the other big issue we've got which has never been addressed by Wanless or anyone else is the costs of these new emerging therapies like the new class of wonder drugs which are going to transform conditions like cancer.

focus on health and wellbeing, but not a strong enough one certainly from the government or from any political party. The question is whether health and wellbeing enables us not only to live longer but to be more healthy through old age and therefore by default less costly. We've talked a lot about the Wanless Report but we haven't really focused on health and wellbeing.

Linda Cooper (LC): I think industry can play its part in that by encouraging the older workforce to take more responsibility for health and wellbeing and helping them through early intervention measures and health screening. But 30% of NHS spending is on the over 75s and 46% on the over 64s so it's a really serious issue that's got to be addressed. And I think there's got to be some sort of cross fertilisation between the public and the private sectors as well. There are areas where we do well, so I think there's got to be a sharing of ideas.

NL: I'm amazed that more isn't being done about wellbeing because if you create wellbeing with a workforce you have a more content, happier, more productive workforce. Though I sometimes think nowadays in society if you create a healthier workforce then people just look for something else to complain about.

RB: It's very easy to point to the problems and difficulties but what about the solutions? Are there things that should be done in the short term?

Hazel Gregory (HG): There has been some discussion suggesting the Chancellor has delivered the spending [on the NHS] but not the reforms. There's been no real change, it's still the big sort of monster NHS that it's been for the last 15, 20 years and I think if we go back to what the NHS was intended to be and now consider what we want from the NHS I think we have to change course and that doesn't seem to be happening.

NL: I'd endorse that. Without wanting to sound political, the 1980s were defined by major changes in society. What you seem to have in the last five to 10 years is a stagnation about delivery of these services. The government seems very happy to put the money in - funding it through direct or indirect taxation - but they seem very loath to actually make real changes to the way things are delivered. They're happy to throw the money at it to keep people happy. But the will to take contentious decisions on major changes about delivery and about the NHS itself doesn't seem to be there. We seemed to reach a stage in the '90s and into the millennium where that isn't happening. We are stagnating and in fact, in some ways, we're arguably going backwards. We're not making those changes we should to enhance the delivery. We're just throwing money at it.

TB: Short-term fixes are unlikely to be sufficient to fix such a complex issue. Evidence from other countries suggest that people are prepared to spend more on healthcare where funding is more transparent, consumers are given choices and there is competition (between providers and payers). This leads me to a conclusion that a form of social or stakeholder insurance is an economically sustainable way of preserving the underlying principles of the NHS.

HG: The NHS is not evolving and we are. What we want from the NHS is simply not there because it hasn't actually kept up with our needs and I think that's for political reasons.

"The government seems very happy to put the money in but they seem very loath to actually make real changes"

Nick Lipczynski
IHC



Nick Lipczynski (NL): All these new drugs are great, but all you're doing is just deferring the ultimate cost again of that person dying, all you're doing is identifying that they will die of another disease not the one they would have. So all you're doing is putting off by five or 10 years the cost of death and that cost is still something that has to be borne through the NHS. So sometimes people will get caught up in thinking all these new developments are going to save the NHS money, but ultimately you're still going to die and you're still going to die of something quite nasty, it just may not be the thing that the drug treats. So the cost will still be there and I don't think any of this is actually going to save the NHS money in the long term. The problem is that in those additional years that people are living they're not actually contributing anything to the coffers because they tend to be elderly and have stopped paying taxes.

Carolyn Derrington (CD): It brings us back to the other part of the Wanless Report around the health and wellbeing concept. There is a

NL: To evolve you've got to make change, you've got to upset people which is going back to what we did in the '80s. Society had to change in the way we worked, which is what we did. They were very painful changes. But the last five, 10 years just seems to be a case of treading water.

CD: It's not really a vote winner is it?

NL: To make changes, to upset people and to get people taking sides for and against you is a very risky thing for a government that is committed to just retaining its power. I think they've successfully generated the money very cleverly but they haven't been prepared to take on the NHS head on. They've just seemed happy to keep throwing money into it.

PL: I think it depends who you talk to. People in the NHS actually say there's too much reform going on at the moment. You've got this new payment by results system. You've got the national tariff, which will standardise costs for hospital procedures, and you've got consultant contracts coming through and you've got a lot of reform happening on the hospital side. The government is now spending more money with private hospitals than it ever was before and that trend is likely to continue. If you speak to people working in the NHS they will actually say: "Hold on a minute, there's too much reform going on." Whereas the perception in the private sector is actually there's not enough or it's not going far enough.

CD: Or it's not delivering results.

NL: But I don't see reform being spending money on the private sector. That to me is not reform that is spending money that you've created and taken off people. That isn't reform, that's just taking the money elsewhere.

PL: I'm not disagreeing with you at all. I think what the government is now saying is: "We have thrown all this money at it, what we're going to do is not throw as much money at it but try to reform the way in which the NHS works." One of the ways in which they'll try to do that is to say the NHS isn't the only delivery mechanism for healthcare and the private sector can be a delivery mechanism for healthcare.

NL: But the NHS is effectively a government organisation and it's fine to introduce so-called competition but the hospitals and the people who work in those units will still be with their jobs in the next five to 10 years even if the private sector does more treatment. The government will introduce a smokescreen of more private treatment, which is good because it means people are getting the treatment they want. But it still comes back to the fact that it is not reform. It's saying we have a bigger pot of money, let's throw it somewhere else now. But they're not actually going to change the way the hospital or the profession actually works because that's a contentious issue.

PL: It does depend who you speak to. If you speak to any of the unions, like UNISON, they say there's too much reform; we're basically saying there's not enough reform.

CD: What they're really saying is that the reform that is there people can't keep up with.

PL: Well possibly. I think you put your finger on the nub of the

problem which is political. Which government wants to start charging for NHS treatment?

CD: We say that we don't pay for NHS treatment but we do. We pay for our dentistry, pay for prescriptions. There's a statement that Tony Blair made about "we shall not charge for treatment" but there's no definition of treatment anywhere. How do you interpret that?

PL: We pay for it through our National Insurance.



"It's clouded in mystery, isn't it? You don't really know exactly where your contributions are going and how it's divided up. I think it would be interesting for people to know that"

Linda Cooper
Premier Choice Healthcare

LC: But it's clouded in mystery isn't it? You don't really know exactly where your contributions are going and how it's divided up. I think it would be interesting for people to know that. Maybe be better informed about the costs of treatment.

NL: I get the impression the NHS complains about too much reporting, too much targeting which actually still is not developing or contributing to reform. It's giving a whole load of information but again not much seems to be done with it. I get the impression when people complain about reform they're just complaining about the level of reporting and the level of information they must report upwards. I question whether there is actual reform happening. I don't believe we're actually delivering better value.

PL: What the government is really talking about at the moment is waiting lists. That's what they're talking about when they talk about improving the NHS: bringing [waiting lists] down to 18 weeks which to me is still a long time to wait. But what about the experience of patients? The government isn't really addressing that. It's not enough to say to people: "We're going to bring the waiting times down." It's actually what about the experience when you walk in the hospital. You know when you go private you buy an experience, that's what you're buying.

NL: It's also the experience of the first time you're ill of actually trying to get to see the GP to begin with. The government has this great global set of targets that it touts around which nobody hits. In reality we all know it doesn't happen. So the experiences start at the point you're ill so there is still a massive gap in the expectation and the actual delivery.

CD: When you say there hasn't been any reform, that's partly because it tackles specific areas in complete, splendid isolation without actually looking at how the whole system works.

LC: The out-of-hours service that GPs are supposed to deliver is quite pathetic so that puts an added burden on accident and emergency because people are having to go to casualty when they can't get to see a doctor with non-urgent conditions.

NL: What's the one service that all the insurers have introduced in the last few years – GP telephone helplines. Why? Because people want to speak to someone. And NHS Direct fails in a number of cases. You can't get to see your GP anyway so this is why all the insurers have gone down this route of introducing these free services because there is a demand for these things.

HG: I think any government that wants to actually change the NHS has got to go to the public and explain fully that it's just simply not going to work. We need to re-think it. The other thing is that I think the fact that health insurance is such a rude word. I think we have to dispel that myth and I certainly think that from an industry perspective we need to go forward and say: "It's actually freeing up a space on the NHS rather than actually taking funds out."

NL: I can't understand the reluctance of the Labour Government to encourage additional funding into the NHS or into the private sector by whatever means, whether it's tax relief or whatever. I just don't see why they won't embrace it more and say: "We know there's a role for the private hospitals, because we're going to use them more, there must be a role for the private insurance market." It may not necessarily be insurance but we all know that the big banks are looking at these savings schemes entering the market and I'm fairly certain we'll see at least three or four this year, if not next year, come into the market that will be looking to use savings more realistically to fund some form of private healthcare. I think the government should take a lead on it and they could make a stand and say: "Okay, we will encourage more investment." People do want to invest in health, everybody wants to be healthy and everybody wants wellbeing so there's a demand out there for people to put money into something, it may not be insurance, but they'll put money into some form of healthcare.

CD: There's an onus on us as an industry to do something about that as well isn't there? We've not, generally, been particularly good as an industry at actually coming together. We've taken our own needs more as a priority and – particularly from an insurance perspective – we have taken our company developments forward, we haven't really worked together as an industry. In fact, over the last five to 10 years there have probably been only two or three occasions when we've actually found ourselves sat around a table having to work together. There is more that we could potentially do.

HG: There's this idea that if we actually promote ourselves we're attacking the NHS and I think that it doesn't have to be like that. I cannot understand where that has actually come from because I see us working hand in hand with the NHS and I think that you could perhaps see the NHS as providing sort of primary and chronic cover and the private sector dealing with the acute situations.

LC: There are definitely areas where both sides can contribute and share resources that we have, I don't see any problem with that.

NL: I still think that the health insurance industry has a lot to answer for. We still have very little product development in the insurance market. We've still no real development in terms of what sort of products you can actually buy and I think we still have a fairly static insurance market. We're still selling the same products that we developed 25 years ago with a few additional whistles and bells. But I don't see any real PR activity, any real development coming out of the insurers.

CD: Which is potentially why we still have the image of elitism. In the private medical insurance sector we're seen as elitist and it's very hard to position an elitist product alongside the NHS. Private schools don't need to position themselves against state schools in the same way whereas we all try to position ourselves as complementary to the NHS don't we – whatever products we're working with we're ultimately still seen very much as elitist.

PL: I think there are two issues. One is how do we get the government to start debating this issue honestly, because I don't think that's happening at the moment, and I think the other issue is: "What are potential solutions?" On the first point, undoubtedly as an industry we could do more. I think the problem we will always have in the private health industry is that we'll get accused of "Well you would say that, wouldn't you?" So it's actually not us who needs to be saying it; we need other people to do so. When you get the President of the Royal College of Surgeons standing up and saying: "Perhaps we should move to social insurance," that helps because that's not us saying it, it's someone else saying it. And part of the work that we're trying to do is get some of the think-tanks to say it so it's not just us calling for reform, it's professionals, it's outside commentators, commentators who know the business.

CD: That will work if we work together better as an industry I think.

PL: Absolutely. We don't necessarily have all of the solutions but part of the solution might be that people are willing to spend more money on health and wellbeing products. There was a Mintel report a couple of years ago that said tens of millions of pounds are being spent on these products every day by people walking into Boots. So there are people out there who can afford it and are willing to pay more towards their health and wellbeing. We did a survey and asked people:



“Where do you think funding for future healthcare should come from?” And we gave them a number of options, one of which was an increase in tax, that’s basically the current system, and about a quarter said that’s the way we should go. Twice as many, nearly half, said they’d be willing to fund some treatments out of their own pocket direct. So some form of co-payment may be a solution. I think the problem with coming up with solutions is that we haven’t had the debate and until you have the debate about some of these solutions it becomes a moot issue. We’ve got to concentrate on the first one, getting more people to call for a debate and then we can start to speak about some of the solutions. And again we should certainly do more to promote that.

NL: We still have a static individual purchase population of 11%. We are not growing that part of the market. The corporate market is burdened by the cost increases and we know most corporates still afford it every year but there’s always the danger that eventually somebody will say, “Enough is enough.” We have different funding arrangements, whether it’s trusts or whatever but we are still only playing around with 5% or 10% of the costs each year, so again, going down the trust route just defers that cost increase for maybe a year or so until next year. I just think we’ll have to look at getting better value and better delivery out of the money that’s being spent. Clearly people don’t perceive, in most cases, insurance is giving them something. You know, they pay their premium every year and they get nothing for it.

PL: I think you’ve put your finger on it for me, it’s political and – to be controversial – I think the government needs help with this issue. It’s not good enough for us just to be saying it, because what will happen is all of the unions will jump up and down and all the NHS will jump up and down, basically saying we’re in the pocket of the private sector which is what happened at the recent Labour

Conference. So it does need others to help us take the debate forward. If you take a parallel with pensions they’re realistically now talking about making pension contribution compulsory – 10 years ago you wouldn’t have been able to say that politically. We need to be in the situation where this honest debate about the future of health funding is happening because at the moment it’s not happening because the government – any government, any political party – is absolutely petrified of being the government to change the way this sacred cow, the NHS, is funded – and meanwhile everyone is suffering because the debate is not happening.



“Any government, any political party, is absolutely petrified of being the government to change the way this sacred cow, the NHS, is funded”

Paul Lynes
Standard Life Healthcare

RB: Do enough people appreciate the seriousness of what potentially we’re facing?

NL: I don’t think the debate really can happen for the time being because the economy has done sufficiently well for the government to be able to find money, to throw money at this situation.

LC: But that’s not going to continue for much longer.

TB: It’s no use pretending that the politicians don’t understand the difficulty of the position we are facing – they do, only too well. Of course we have to accept that there is a difference between what they say in public and what they might admit in private. One thing for sure is that if the private funding sector is going to have a larger role to play in the future it needs to come up with politically acceptable solutions. At its most basic, this means we need inclusive and socially cohesive solutions that work for everyone and not just the few, or relatively few, that can afford the private option.

NL: People are not really feeling that much discomfort. It’s only when they do that the debate will happen but of course it then happens too late. But trying to get people to debate it at the moment is the difficult thing. There is a big inertia against changing things because it’s just status quo.

HG: We’re talking about the population en masse here. Yes, there are problems at the moment but generally things still happen. When you look to the future it’s a very, very different world. People don’t think that far ahead and social change means that we think here and now or we think about our own lifetime. We are quite self-centred in that sense, people automatically think about themselves.

NL: I sometimes wonder whether, in the last 10 years, the government has created this view in society that things will happen for them – that things will be taken care of for them. In a way we’ve created a very smug society where people just expect the government will deal with it. And it’s only at the point when you are ill, then you realise all the promises that have been made actually can’t be delivered. I think again, there is a need to create that debate where



people realise that this situation can't continue indefinitely. There will be funding problems in the next five, 10, 15 years. You can't raise that much money.

CD: It's about taking responsibility though isn't it? I do think that was a big social change. I mean the pension analogy is interesting because we've been through stakeholder pensions which everybody has now forgotten. It just didn't happen, did it? Everyone was offered one though. So if the next step is compulsion and you ask: could the health industry move towards stakeholder healthcare? Could we get to the point where there is a rule that says the employer must offer employees the opportunity to take out some sort of healthcare provision? Would that actually address some issues and if it did, is that something that we think politically would work?

LC: I think we can look to our what our European neighbours are doing as well where private spending on healthcare is so much higher in France, Germany. They seem to have got it half way right.

CD: They have. But even if you look at all those statistics and where the projections are going currently by the year 2008 or 2009, spending will be approaching the same percentage GDP that it is in France. In France they can't comprehend the idea of waiting 18 weeks for treatment. So we have a situation where France spends less than 10% GDP on healthcare and everybody is very satisfied. We are not going to get to that stage are we? There's something fundamentally wrong with our system because when we get to that stage it just doesn't happen does it?

"Could we get to the point where a rule says the employer must offer employees the opportunity to take out some sort of healthcare provision?"

Carolyn Derrington
HSA



LC: Well apparently half of the extra spending recently has gone on pay rises, staff costs in the NHS. It's not actually getting through to the patient.

CD: It's all about tangibility of product isn't it? If you look at what people spend money on, it comes down to something tangible they can actually grab hold of: they've taken that tablet, they've measured their blood pressure and they're okay. They do a lot of things like that.

NL: There are certain insurance companies that have at least been slightly innovative and have tried different ideas and we know there's some in the market at the moment. The jury's out on whether they're going to succeed or not but at least somebody's trying something. There must be something that can be thrown into this mix that takes it away from insurance and gives people a return for what they're buying. But it's amazing how many people just don't value it.

LC: I think we have to take note of the increase that there's been on the self-pay option as well. We've got to maybe come up with some more innovative products that would harness that.

CD: Although there are some recent stats that suggest it's now dropping.

LC: I suppose if waiting lists improve, if people are not waiting they're not going to have the need to pay. So there's got to be some sort of counterbalance system to offset that because you start getting those people who have opted to pay themselves, coming back, and they're going to be an added burden that the NHS just can't afford to take on.

HG: Anyone who has actually used their policy does stick with it. The people who are dropping out are the healthy ones who haven't seen any value. And that's one of things that I think is a problem for insurance companies.

PL: In our recent survey we asked people: "Does the NHS need more money or less?" And two thirds of people think the NHS does need more money, even now. But I don't think people see the whole, picture so what you're getting is pockets of problems which are all related to funding but not this all-encompassing debate which enables people to piece it together and say: "Actually there is a massive problem here."

HG: No, they're judging the NHS by their own experiences actually. Where people have had a bad experience they really do begin to see where the holes are. For instance, actually having to phone on the morning that you're supposed to be going in to have the operation to find out whether there's a bed for you is absolutely appalling.

RB: Is there a sense that the funding issues that the NHS is facing are shared by the insurance industry generally?

TB: I think there is a consensus that the NHS will face a much tougher fiscal backdrop from 2008 onwards. As to the solutions it has proven very difficult for the industry to agree. Without solutions there is little for the industry to talk to government about. That was one of the reasons why NUHC developed a potential solution in the Stakeholder Healthcare model.

PL: One of the reforms that has come in which I think will benefit the private sector is the government shaking up the hospital groups. Some of the costs associated with PMI are actually costs of the private hospitals – what they charge us as insurers. And because of this idea of making them compete with the NHS to work in a different and more efficient way, I think we, in the private sector, will see the benefits of that and I think it will start to come through within the next year to 18 months. Credit where credit's due, I think the government has shaken up the private hospital groups somewhat and most of them are now changing the way they work. I think that will reduce some of their costs and therefore some of our costs that we can then pass on to the consumer. So I think costs are a big issue but I think it's beginning to be addressed.

NL: I find that quite interesting because you could take the opposite view that because there are large amounts of government money being made available some of the private hospitals will rush into these contracts for prices that are virtually unsustainable because the government, if it's doing the purchasing correctly, will purchase at a very keen rate that the private sector would not normally offer anybody. The net result is the hospitals are being squeezed because of the delivery of their NHS throughput and they

will have to look to the private sector to make that up. I've got the impression that the hospitals will have to start to drive up the cost of the private delivery which is where they'll need to make the profit because what they'll be getting from the government is very small. They'll get stacks of volume but the profit they'll make out of it will be virtually negligible.

CD: The whole theory is if your hospital's 60% full with your private patients, you've got 40% [capacity] there but I think potentially what's going to happen is the hospital groups are going to work like businesses. There's a risk of greed, isn't there? And, I think, potentially, that they're going to look to fill the 40%. What's that going to mean to the private sector then? Because in a true private sector you would always have extra capacity in those hospitals. If you don't have the capacity in the hospitals you can't guarantee the promise that's being made to the customer that they can go in at a time that suits them. And that's what they're buying it for. So there has to be some over-capacity and my fear is that we will go too far in taking up that over-capacity and when we get to that stage we're going to end up with private hospital groups whose business model is dependent upon funding from the NHS.

NL: If I was a private hospital I would take the NHS funding with both hands because you've got a guaranteed number of people at a guaranteed price. Why wait for the vagaries of the private sector to push patients through to you?

PL: I agree. I guess where I take a different line is that I don't think it's a question of one or the other. I think what they're trying to do now is build their model where they do get the volume. And discussions we're having with them suggest PMI will cost less than it does now and that can only be a good thing. If there's more money to be spent, I think what you'll see is more providers coming into the market and not just British providers. The Americans are eyeing up the market and there was a recent story in the press of a group of consultants, backed by a venture capitalist, who hope to open a new £100m hospital with private capital that's going to go for NHS contracts and will probably, in time, go for private contracts. So in the future we may, as insurers, have many, many more providers than the BUPAs and the BMIs to which to send our patients if our patients wish to go there.

CD: And I think that is a positive out of it. I can see the concerns both ways. I think though that people in the UK have absolutely no idea of the cost of the NHS and the cost of treatment. I don't think people have got any idea of the costs of drugs, for instance.

PL: It comes back to the funding doesn't it? At the moment money goes into this big pot called National Insurance, out of which everything comes – education, transport, and environment. Apparently [healthcare] is free, but of course it's not free. We just pay for it in a convoluted way.

RB: What about the concept of health tourism? We've heard examples recently of people travelling to the continent for treatment that is quicker and cheaper than in the UK?

NL: The insurance companies have been very slow on this. The idea that you can take your insurance outside of these borders should be encouraged. Those of us that represent corporate

schemes know how hard it is to get an insurance company to acknowledge if somebody wants to go outside these borders and have treatment that will save them money. The insurance companies just shut up shop, they don't want to know unless you've got an international policy that is designed for that but the UK policies just look inward at the UK and that's all their interested in.

RB: Has the government led people to believe that they're actually entitled to too much from the public health service at the moment?

NL: I think the government has created an environment where people are too spoon-fed, too looked-after and people are less likely to take responsibility for things nowadays. That's one of the situations the government has created over the last number of years, so people do look for the state to do more than it can actually deliver. Then people go looking for scapegoats and looking for people to blame.



“If we can re-assemble our market proposition and work with government on their agenda for health in the workplace we could get to a ‘win-win’ position”

Tim Baker
Norwich Union Healthcare

TB: Expectations have certainly been raised and once the genie is out of the bottle there's no going back. However, for how long would consumers be prepared to continue putting up with an inferior NHS service? You could argue that the public have been very, perhaps too, patient for too long.

CD: I think there certainly is an over dominance of regulation. Everything is checked for you so you don't have to take ownership and responsibility and you look back and say, “Where does it come from?” Part of it is about protecting those that aren't able to take ownership and responsibility.

NL: The drug industry is still only 60 or 70 years as a real science phenomenon and yet people expect these drugs just to cure everything. It can't happen and I think people need to appreciate that. You have to take responsibility and management for your own health.

RB: And what role do risk professionals have to play in that?

LC: There are lots of good things that we're doing in our industry, particularly when you look at what's happening with sickness absence management.

TB: The biggest opportunity is in the corporate space right now and probably will remain so until at least 2008. If we can re-assemble our market proposition and work with government on their agenda for health in the workplace it feels like we could over time get to a ‘win-win’ position. Fiscal incentives may have a role to play here and we need to articulate the case for that carefully.

NL: You can see companies starting to pay more attention to it. But interestingly you speak to a corporate entity and they'll have an IT budget, they'll have a budget for a number of things. But if you ask them what their healthcare budget is, very few people can put their fingers on it and say what the total cost to their business is. They'll tell you they have a PMI bill or they have an income protection bill but very few companies actually have the mechanics or the means to quantify the total cost of health within their workforce. And we all have enlightened clients who are moving that way but they're in a minority. So I think we have to create a debate with corporate clients to try to look at the value they're getting, what they're buying and why they're buying it.

HG: I think there should be tax breaks for people, for companies and individuals. Apart from the insurance premium tax of 5%, there should be more emphasis on people who are helping themselves, people who are taking the pressure off the state and then perhaps that way people who are not helping themselves can see that there are benefits in doing so. I think you've got to try and turn the tables. I think there's too much weight on helping those who don't help themselves and not helping those who are genuinely making an effort to provide for themselves.

LC: But there is a very heavy burden on employers and employees. Not only the P11D aspect, also but higher National Insurance contributions. So they're being expected to carry the burden.

"There's too much weight on helping those who don't help themselves and not helping those who are making an effort to provide for themselves"

Hazel Gregory
AMII



PL: If we have an honest debate about the future of health funding, I suspect people will begin to understand that if they want to live longer, which we all do, there has to be a cost in that. The current system is not sustainable and I think society is mature and intelligent enough to understand that dilemma and to try and talk about ways in which we might get round that. I think the barrier at the moment is that politicians are too frightened to tackle it. And I think having some sort of debate about it which gives them the sense that it's not just them doing it, and that it's actually coming from people who realise there's a problem, I think that's one of the ways around it and we can play a part in that I'm sure.

CD: Probably the only way to revive that sense of community again is to promote health and wellbeing via the workplace and, in this sense, there is a big burden on companies.

PL: We have suggested that perhaps employers should do something similar to Investors in People. A voluntary scheme where to be the best employer not only do you have to show excellence in training and personnel development and be an Investor in People, you would also have a workplace health accreditation. It wouldn't be mandatory, you'd only get the best companies wanting to do it and it would bring health into the workplace – which is where most people in this country spend most of their life.

CD: And hopefully from a positive point of view because most of it at the moment is about employers managing their risks, in terms of their duty of care.

PL: The government accepted it last year. Investors in People have actually been tasked with running it and we are working with them to try to develop what the standard might look like. A plus of the standard might be that the company has PMI, which is obviously in all of our interests as well.

LC: And maybe the government should look to subsidise companies that want to do that who maybe can't afford otherwise to put these benefits in.

CD: It's about looking at longer terms strategies isn't it?

RB: Would it be fair to say that if insurers demonstrated an ability to be more innovative, then the powers that be might be more willing to consider some more radical reforms of the public services system?

TB: It isn't really about being innovative it's more about coming up with solutions that are good for UK plc and not just UK insurers and our customers. The government doesn't owe us anything and hardly sees us as relevant. You've only got to look at the provision sector.

PL: The focus on health and wellbeing is quite innovative in the government's mind because their agenda is not just about the NHS it's actually stopping people going to the NHS in the first place. So there could be more innovation. But going forward, the fundamental funding mechanism has to change and then we'll get real innovation and change. Because you could get to a situation where the NHS pays for a certain amount of treatment but over and above that a system of co-payment would kick in and you're going to need insurance to cover it. So in the future, top up insurance products is where the real innovation lies.

NL: Going back a number of years there were attempts from the investment industry to bring out joint products that were part investment, part medical insurance. It was in the days of PEPS. There must be products out there which are a combination of these two things, where people are putting money in now and if they don't claim anything in five years, it gives them a small return. People coming into their mid-20s who have paid off their student loans and now have reasonable jobs would buy things like that. They really don't see there's going to be a need over the next five or 10 years, but they get a return on the money they're putting in and they have some insurance as well. I can't think of really any products that have come out in that area in the last number of years. There was an attempt, I know, but it seems to have all gone very quiet. It's either insurance or it isn't.

LC: Lots of people newly coming into the job market in their early 20s are pretty sophisticated consumers already.

NL: People will put more and more money into health because everybody wants to be healthy and well and live better. It's just finding ways of taking that money and you're right, it is competing with your mortgages and everything else. But there's a challenge out there.

HG: The cost of health insurance is all based fundamentally around what hospitals are actually charging us. Perhaps in time we could

have some influence there perhaps and we would see a TravelLodge-style hospital.

NL: Well, there's these independent treatment centres (ITCs), specialist centres dealing with specialist conditions where the efficacy of the treatment, the quality, the success is going to be very high because you're having somebody that's doing the same operation 30 times a day. I can see that's where improvements will be made.

PL: This is where some of the reforms in the public sector will actually have a beneficial effect on the private sector. The government has opened up a market and the ITCs and some of the hospital groups are changing the business model. I think only that will bring down prices.

RB: People around the table seem to think that there are opportunities to be grasped and there seems to be some confidence.

NL: I think there is confidence but it is important not to get complacent. Corporates have it built into budgets and therefore carry the cost each year. For a time we did get complacent about these corporate bodies and we need to be careful that we develop with people all the time so they don't lose track of why they've got these arrangements and they can see there is value being delivered for what now are very extensive costs. The industry has constantly got to get across the value of why people are doing this. It's not just new products it's also the future of funding, making sure people appreciate why they're doing it and they're going to continue to do it.

TB: This is the most exciting time for the industry in decades. Undoubtedly the NHS reforms will lead to a restructuring of our sector and that has to be good news for consumers. We have a great opportunity to re-shape the market, which will lead to different propositions with a broader appeal to consumer groups. New players will emerge, the boundary between private and public sector will blur and insurers may have a key role to play in helping the NHS on issues such as commissioning.

CD: Certainly there are a huge amount of opportunities out there so from that point of view, yes, I am very optimistic. But I think we have to be able to change. Where do we go with the NHS? We could all agree that just carrying on doing what we're doing isn't going to work. Even with some of the reform and the changes, it's not going to be enough. I'm not really sure that we do have a solution with which we could all lobby government.

RB: Is there more that the industry could be doing to actually sit alongside the situation that the NHS is in at the moment and actually complement it?

CD: Yes, I think there is more that we can do. For a long time we worked purely as adversaries, we never actually came together and we never did anything about positive PR. If there was an issue then we'd take a different stance on it almost to see who won. So I think we have made a lot of steps forward in the last five to 10 years. But we're not at a point – possibly because our market is small as well – where the government or the opposition would come to us to talk

about healthcare and healthcare reform. If you look at the pension industry, that kind of conversation is taking place all the time.

PL: The debate on the NHS hasn't been as advanced as the debate in pensions. That's one of the biggest challenges for us as an industry – how do we get the government to enter into an honest debate? If we can do that I think we will go the same way as the pensions industry. They're open and talking about it. So I think we need to help with that process. When that happens I don't know but in terms of confidence for the future, I'm sure it will happen. That debate has to happen because it can't go on the way it has been going on. Irrespective of that I think I'm confident about the industry because I see change coming through on the provider side and I think that will bring down prices. I think the challenge for us is not to get complacent, to constantly show the corporates and the individuals the value of PMI, which is both peace of mind health and wellbeing. A big challenge is to keep on innovating in that area and to show the value of the product in the short term. In the longer term it's getting the government to address this key issue which may lead to a situation of co-payment and where top up insurance products are the norm.



“The boundary between private and public sector will blur and insurers may have a key role to play in helping the NHS on issues such as commissioning”

Tim Baker
Norwich Union Healthcare

NL: Somehow we need to try to take the government and the politics out of health. We need to take the health debate away from politics and politicians because you immediately get entrenched in positions that you're expected to take. Labour, Tory, Liberal, whatever are expected to take positions and it's very difficult to have those open debates about the future when you're taking political sides.

CD: It's also an acceptance of private provision in some way coming into the healthcare market. The big change in the pensions market is that it's moving away from the welfare state. You actually have to take responsibility for your own pension. Until we can get away from the idea that the NHS can provide everything and we get an acceptance from people that they need to be helped by [our] industry, then it is difficult to have that same hearing. To some extent I believe that partly we can achieve that through lobbying and we'll achieve it better through lobbying if we co-ordinate ourselves as an industry. And that doesn't just mean the PMI industry either, it has to be all forms of health insurance. But it's also about us changing the perception of our market place with consumers and with corporates. So more innovation would certainly help and to be seen as providing a valuable product. At the moment it's just too small a percentage of the population that see it as a valuable product proposition.

NL: I think we need to take the 'Ps' out – take the politics out and take the private out. And it's about trying to re-position it so that people

don't see it as them buying into something, but more that it becomes part of their way of life, their way of thinking. As I say, the population is too small to support what we want so we might try and change the debate accordingly.

RB: We've talked a lot about a centralised voice, which is as good a term as any. How can we make progress towards getting that? We've got a trade association for intermediaries and the ABI is out there but is that effective as a voice?

TB: The industry has come more together in recent years and there are signs that that will continue. Recently seven leading providers – hospital groups and insurers – have come together to support an industry advertising campaign under the banner “Making Britain Healthier”. This is another first and another sign of the co-operation that there is between insurers and providers.

“If the government lessens the legislation they're putting through, there might be a bit more room in people's workdays to pay more attention to this.”

Nick Lipczynski, IHC



PL: Yes, I agree we need some co-ordinated, centralised voice which bangs the drum but I do also think that in tandem with that we need to be influencing others who can speak on our behalf. It's absolutely key to this because unless we get that we'll always get the accusation: “You would say that wouldn't you?”

LC: In any kind of forum, whether it's a PR forum or a PMI committee, it would always be better if there was someone independent actually chairing those forums as well.

PL: It's less important if publicly the PMI industry is seen to be doing anything about it. What I prefer to happen is the PMI industry actually to be lobbying behind the scenes to get others to be talking about it. That's when you'll start to get a proper debate. I think there's more we can do on that front together.

NL: In surveys MRSA comes out as one of the key reasons that people buy private insurance. It's because they believe that private hospitals are less susceptible to MRSA. There's an adversity that has created a demand – people saying that's why I want to go private, so I don't have to be exposed to MRSA.

HG: Once upon a time it was a sort of a bit of a snob thing – “I want a private room” – and it was actually marketed on the basis that it was a good view from the window and you got flowers on arrival and a very honeyed approach. But through these last 15 or 16 years that I've been in the industry I have seen things change and it is actually driven by what's going on in the newspapers.

PL: Getting employers to talk about a change in health funding may be a step too far because what's in it for them? I think perhaps getting employers to think about corporate healthcare is the thing that definitely needs to happen more and that's part of our drive to try and

create this workplace health scheme alongside Investors in People. It's where you're not forcing people to do it, because as soon as you force people to do it they immediately say: “No thank you, I don't need it”. What the corporates are saying is a) they want to get their people back to work quickly; and b) they want to stop them being ill in the first place, so they want to tackle things like sickness absence which is costing billions of pounds each year. What better way to do that than to create a benefit which then keeps their people happy and healthy and makes people want to work for them? And I think you'll see a snowball effect.

NL: To some extent I agree that corporates could do more but you also then see the pressure that they are under, the amount of legislation they have to deal with. If it's not age discrimination then it's disability discrimination and if it's not disability it's mental wellbeing. Organisations have as much responsibility for mental health as they do physical health. They've spent the last 40 years dealing with physical ailments, asbestosis, VDU screens, RSI and here's another whole new range of legislation they have to deal with, looking at the mental wellbeing of people. So corporates could do more but they're just absolutely drowned in what the government has been piling on top of them.

PL: You're right and that's why a voluntary approach is perhaps a better way because if you get companies actually believing that the product they're buying is helping their bottom line, which is what we're talking about here, then I think you'll see a willingness to start to go down that route. I think if you start beating them with a stick they will just say: “No thanks, I've got these other things I have to do.”

NL: When we're with corporates we at least try and get them to the baseline where they actually finally identify what it is that's costing them. If you're developing a strategy you can't develop one until you know where you are. Only when you know that can you then develop where you want to get to. What we're trying to do with a lot of corporates is to get them to think about “where are we, what is the cost at the moment?”

CD: They don't know.

NL: They don't know. Everybody uses the CBI statistics about how much hundred odd pounds per person per year it cost. You can ask a company what their IT budget is and they'll know how much they spend on computers. But ask them what their wellbeing and healthcare budget is and they can't quantify it because it's all in different areas. It's sits in different silos within the organisation. It sits in procurement, in HR, in benefits. Bits sit in IT, bits in health and safety.

CD: They might just about know the absence but they don't know how much is sickness and how much is absence.

NL: I think corporates could do more but trying to get them to look at the obvious and do more about it is difficult.

CD: That's where we can help them.

NL: And hopefully if the government lessens the legislation they're putting through, there might be a bit more room in people's workdays to pay more attention to this.