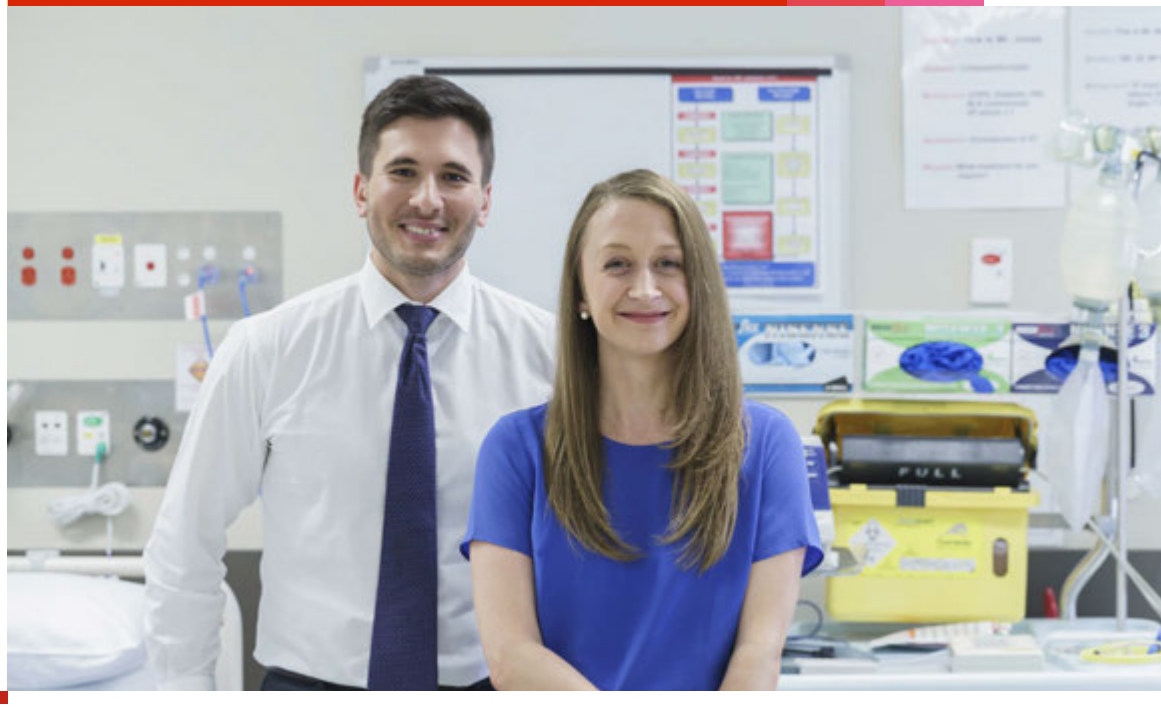
www.pwc.com

Health Matters

Spring 2016



pwc

Welcome to the first edition of Health Matters, our new quarterly bulletin looking at some of the key issues facing health industries.

The health landscape is changing at record speed. Whether it be structural changes in the NHS, financial pressures putting strain on drug pricing or technological and scientific breakthroughs disrupting traditional ways of doing things, health is at an infection point both in the UK and worldwide. Change is the agenda - in the pharma and medtech industries as much as in public sector healthcare.

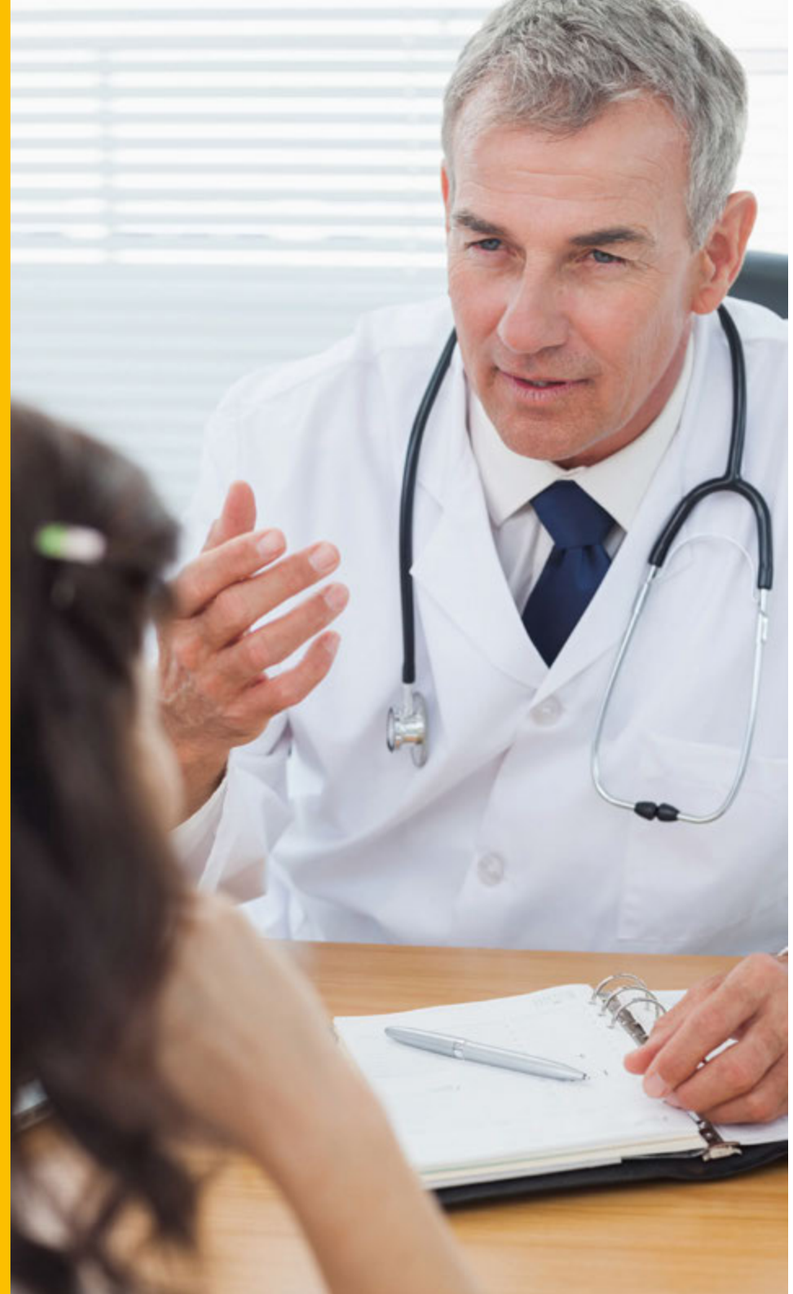
That creates huge uncertainty. But it also creates real opportunities to shape a new health paradigm of better health outcomes, contained financial costs and more empowered patients. A new market in solutions is emerging. The time is ripe for new ideas – how to better organise the care system to deliver; how to help new entrants to challenge the status quo; how to support the Pharmaceutical and Life Science industry in innovating new services and not just new products.

PwC is at the forefront of addressing these issues and this issue of Health Matters offers thoughts as well as concrete propositions and strategies that could help our clients deal with the challenges and seize the opportunities of the new health landscape that is now emerging.

Feel free to share Health Matters with your colleagues and contact newhealth@uk.pwc.com if you would like to join our mailing list.

Rt Hon Alan Milburn
Health Industries Oversight Board Chair

alan.milburn@uk.pwc.com



Contents

The outlook is far from rosy inside the ring-fence: Budget 2016 and NHS finances

Quentin Cole, Health Industries Leader, explains how, despite increased Government spending, the pressures on the NHS mean we need to look more seriously at encouraging people to take responsibility for their own health.

With the ring-fence still firmly intact, there were no great expectations for the health sector from this week's Budget. While the longer term health challenges the population is facing were acknowledged through the attempt to tackle child obesity through a sugar levy, with NHS finances continuing to deteriorate, the picture is far from rosy inside the ring-fence.

The Spending Review acknowledged the scale of the challenge facing the NHS, announcing a £10 billion real terms increase in NHS funding in England by 2020-21, of which £6 billion will be delivered by the end of 2016-17. While this investment is welcome, at 8.5% the UK's healthcare spending as a proportion of GDP is lower than in comparable countries - Netherlands, Switzerland, Sweden, France and Germany all hover around the 11% mark - or the OECD average of 8.9%. With an ageing population, suffering increasingly from complex conditions, can we afford not to invest more in the future of healthcare? There has been something of a trend in the UK of the public wanting Scandinavian-style high-quality public services with low American-style taxes, but while it is clear the public want better healthcare services and for the NHS to remain free at the point of need, it is not clear that they are prepared to pay for it.

At the other end of the spectrum, much focus has been on how efficiently NHS providers are delivering. International reports consistently rank the NHS highly in terms of quality, access and efficiency. Yet, NHS Trusts in England reported a deficit of £2.26 billion in the first nine months of 2015-16. This compares with a total deficit of £843m in 2014-15. Whereas 48% of Trusts forecast a deficit at the end of the last financial year, over 70% reported a deficit in Q3 2015-16. Furthermore, far from being a trade-off between finances and quality, the NHS provider sector also missed the A&E waiting time target of seeing 95% patients within 4 hours between October and December 2015 and failed the referral to treatment healthcare standard for the first time.

continued overleaf

"Today's Budget may not have raised new challenges, but neither did it provide the answers to the questions the NHS so desperately needs to address."

Quentin Cole
Partner, UK Health Industries Lead

T: +44 (0)20 7212 6784
E: quentin.r.cole@uk.pwc.com

Against this backdrop, is the challenge of finding £22 billion of efficiency savings by 2021 unrealistic, as the Public Accounts Committee recently claimed? The Carter Review sets out a comprehensive starting point, and there are undoubtedly efficiency savings to be made within the vast majority of NHS trusts. Each provider needs to get a good grip on the causes of their deficit, and identify what's within their control, as well as what is not. Addressing operational efficiencies, rationalising estates, improving workforce productivity and embracing digital will all be critical components for future sustainability.

The final question therefore must be around how funding is allocated in the health and care system. With such a large proportion of providers across the sector in deficit, and social care and public health also under pressure, surely systemic issues are at play. Today's NHS was largely designed for a time when demands on healthcare services were very different.

Delivering tomorrow's NHS, through the new models of care set out in the Five Year Forward View, with a focus on prevention and delivering population outcomes, will require a re-examination of how finances flow through the health and care system and the wider determinants of good health.

The Budget may not have raised new challenges, but neither did it provide the answers to the questions the NHS so desperately needs to address. The Chancellor has called on us to 'act now to make sure we don't pay later'. With an ageing population, an increase in chronic conditions, and growing health risks around obesity, smoking and alcohol, nowhere does this ring truer than in the health sector. Developing a long term delivery plan, seriously focusing on how to intervene upstream to promote good health and providing clarity about what can be achieved by 2020 would be a good place to start.

A starter for Carter

Digital Health Lead, Brian Pomering, sets out why Lord Carter's report is a good one and outlines how it could be taken further with a stronger focus on increasing the skills and capabilities of the work-force.

The long-awaited Carter Review has been well received but the emphasis now has to shift to implementation. Has the NHS got the capabilities it needs to get Carter done?

The Carter report started as a piece of gap analysis: how can the NHS bridge the gap between the £55.6 billion it spends on hospitals now, and the £22 billion of savings it needs to find by 2020. Lord Carter has assessed this in terms of 'variations' – in effect, another gap, this time between the best and the rest. Or, to use his eye-catching phrase, between what's currently being achieved, and what a 'model hospital' could deliver. Elements of this model hospital already exist in pockets across the country, but they're fragmented and fragile, and there's no real understanding about how to scale up from one-off excellence to system-wide improvement. But the very fact that a nascent model hospital does exist proves that it is possible to deliver excellence and efficiency – in other words, that quality and cost are not mutually exclusive. Busting this myth is one of the single most important aspects of the Carter report. The challenge is doing this all the time, and everywhere.

So what's the answer? In our view, Lord Carter's recommendations are sensible, feasible, and achievable, but only if their implementation focuses on another, absolutely crucial gap, and that's capabilities. You can't ask overworked Trust CEOs and NHS staff to improve efficiency and productivity unless you give them the skills to do that. Part of the reason those skills are lacking is because they form no part of medical training in this country: doctors and nurses aren't taught how to run complex departments and manage costs against budgets. Those Trusts which are managing to deliver elements of the model hospital are probably doing it because they've developed those skills and capabilities in their people.

Bridging the huge capability gap will be a task for NHS Improvement (NHSI), working hand in hand with Trust CEOs. And with NHSI only coming into existence on April 1st, it's an enormous task to achieve from a standing start. But it's not Mission: Impossible. Far from it. The jury's still out on whether the NHS needs more money in absolute terms, but the Carter report proves that more can be done with what hospitals have already got. So in that spirit, here's our five-step 'starter for Carter', both for NHSI and for hard-pressed Trust CEOs who want to do the best possible job, but are already running to stand still:

continued overleaf

Start with the quick wins

Some of Carter's recommendations are little more than applied common sense – like using the same set of metrics across the whole NHS. Carter's recommendations are based on internal NHS benchmarking of what the best are already doing, which means they can – by definition – be achieved by everyone. Other recommendations are what every profit-making enterprise is doing already (or risking failure if it isn't). Many of these things are already happening here and there across the NHS, so they should be easy to share, adapt, and put in place. Like sharing back office functions, and rationalising procurement. Get those done fast and don't be afraid to buy in the tools and expertise you need, if you don't have them already. The key is to start moving in the right direction: at this stage, and with this timetable, some action is better than no action at all.

Unlock the power of your own people

The NHS is a uniquely complex animal – Europe's biggest employer, and far larger than any multinational, but with none of the systems and processes businesses can use to mandate change. The only way to do that in the NHS is by using influence, and ensuring people are engaged, empowered, and held to account. And it's much easier to do that if that change is presented in terms of carrot not stick. People will change – and change willingly – if the consequences are positive, immediate, and certain, and accountability is clear. Both personally, for them, and professionally, for patients. In other words, it's about hearts and minds, not fear and fines.

Engage clinicians

Clinicians are the beating heart of the NHS, but at times they can also stand in the way of the sort of culture shift Carter's reforms will need. In many cases they aren't even aware they're doing this, it's just that costs and efficiencies don't feature highly on their list of priorities: there can be an unhelpful disconnect between delivering care and operating efficiently. This is something that needs to change, and they will need support to do that.

Be a role model

This starts with a look in the mirror: what sort of role model are you? The leaders of Trusts need to 'be the change they want to see', whether they're CEOs, senior managers, or clinicians. Whatever the sector, whatever the challenge, lasting and sustainable change can only be achieved if it's led and modelled from the top. In practice, this is a four-stage process: start behaving differently yourself; tell your people why you're doing that and why you need them to do the same; empower everyone to challenge instances of the 'old way'; and give people the right training and support. Doing this is tough, no question, but it's much easier than trying to impose change through command and control.

Build capabilities

This might sound like a long-term project – so long-term, in fact, that there's no point thinking about it for a target that's only four years away. Not true. We've been working with NHS teams through an immersive 12-week programme that builds capabilities from the ground up, team by team, ward by ward. Exactly the sort of approach, in fact, that Carter's recommendations will need. We've helped those teams to address specific circumstances and challenges by taking control, sharing the same goals, and celebrating success. They're motivated to deliver a better outcome for patients – we show them that they can do that and save money at the same time. As one Trust CEO told a colleague, "It's taking cost out and our people like it".

To sum up, the Carter report is a huge challenge for the NHS, but only identifies £5 billion of the £22 billion savings the system needs to find. It's also an enormous opportunity. The politicians' eyes may be on the £22bn prize, but making the NHS more agile, flexible, and innovative could be an even bigger win, long term. That's a transformation of a completely different order of magnitude. But getting Carter done is a great way to start.

Brian Pomering
Partner

T: +44 (0) 20 7213 2101
E: brian.d.pomering@uk.pwc.com

Healthcare commissioning:
The search for a feasible way forward

Andrew Heyes floats the idea of a flexible approach to commissioning that allows for a system where outcomes are at the heart rather than inputs.

In the almost 70 years since it was established, the NHS has come to hold a central place in the UK's national life. It was born out of the energy and idealism of the post-war period, but as the population has grown and aged, and healthcare has become more complex and more expensive, it's become more and more difficult to meet people's continued expectations at a cost the electorate is willing to afford. Budgets have come under strain, despite the fact that governments of all colours have been forced to treat the NHS as a sacred cow, and attempts to bring in more private sector involvement often meet with scepticism, if not outright hostility. Add to that the increasingly devolved nature of healthcare provision across the UK, and the challenge for those who commission that care is little short of daunting.

That's where the NHS Five Year Forward came in. This looked at the different possibilities for service delivery, and commercial and contract management, and concluded that tinkering with the number and functions of the health authorities, primary care trusts and clinical commissioning groups was not the answer. It was neither efficient nor effective. A better approach might be to accept that there didn't need to be a single definitive model that all parts of the NHS had to adopt, but allow a more flexible approach based on local needs. In other words, shifting the emphasis from inputs to outcomes, and how to what.

Having this degree of flexibility is all the more important given the dramatic demographic shifts currently underway. Local populations are changing, and it's getting harder to predict what they will need, even five years out. And in an internet age, people are better informed, and more will expect to be consulted about the decisions being made in their area.

The answer, then, may lie in harnessing the power of multiple providers, with a range of commissioning models from a single provider at one extreme, to a group of different bodies working together, at the other.

The aim would be to provide flexibility and autonomy on the ground, within a rigorous centralised governance framework, to ensure that standards are met and the quality of care properly monitored. That framework would also have to include appropriate payment mechanisms and incentives, covering all the potential ways of providing care.

At the moment, we see the emergence of two potential models: one based on a 'prime provider' reporting to the NHS and sub-contracting other services; and the other on an alliance, each working to an NHS commissioning body. Each has its own advantages – and disadvantages.

To learn more about these advantages and disadvantages, and other key themes related to contract management in the public sector, read our publication, 'the Negotiator': https://www.pwc.co.uk/industries/government-public-sector/central-government/insights/the-negotiator-feb16-edition.html

Andrew Heyes
Associate Director

T: +44 (0)28 9041 5498
E: andrew.heyes@uk.pwc.com

Chain reaction: are hospital chains a sustainable NHS delivery model?

Ian Baxter and Jack Tabner outline insights gained from a review of a hospital chain operating in Germany – are they a potential answer for the NHS and what are they key considerations?

The hospital chain model has been receiving growing attention in the NHS, most recently with the news that Bolton FT is reportedly considering joining the Salford and Wigan Foundation Chain. With the NHS provider model under pressure, are hospital chains the answer?

Both the NHS Five Year Forward View and Dalton Review position hospital 'chains' – among others – as an innovative, credible and collaborative model of healthcare delivery for the NHS and three foundation chains are currently being explored through the NHS England Vanguard programme (Salford and Wigan Foundation Chain, Northumbria Foundation Group and the Royal Free London).

The concept of chains will be relatively familiar or intuitive for most. A chain store model works for retail, so why not then for hospitals? The same principles that underpin chains in other sectors can surely enable secondary care to realise efficiencies, achieve greater economies of scale, avoid future cost and deliver better outcomes for patients.

The German experience of hospital chains is touted as being the most positive, and is directly referenced in both the NHS Five Year Forward View and the Dalton Review, so a team from PwC travelled to Berlin to study several sites of a hospital chain operating throughout Germany. We came away with three key insights for the NHS as it considers how the use of hospital chains may help to drive transformation and sustainability:

1. Strategic leadership is paramount to delivering greater economies of scale and standardising practice effectively

The skillset of the leadership of a chain is what distinguishes it as an organisational model. It requires a separation of strategic management (at HQ level) from the operational management of each chain entity or site. Within a chain, different models of leadership can be employed per site as necessary. For example, a more rigid command and control style leadership can work for one site whereas a more devolved approach may be more effective for another site.

The Dalton Review beckons leaders of successful NHS organisations to use their social entrepreneurial spirit to develop innovative solutions to their challenges and to codify and spread their success. The best standards of care can and should be available, reliably, to every local site in the country. This is precisely what we saw in action at the German hospital chain we visited and should be adopted within the NHS.

2. Cultural autonomy can be retained by hospitals within a chain, but the challenge of achieving a cohesive culture cannot be underestimated

The culture of an NHS provider is derived from a number of factors over many years. Local geography, historical service changes and local demographics all play their part. Some may fear that as hospital chains are established, the community engagement, flexibility to local needs and cultural significance of individual provider sites may lose out to a "one size fits all" corporate franchise.

A key component of a hospital chain is that it operates with an overall set of values and a single strategic framework which permeates at the level of each local provider. However, we also found that, in spite of the standardisation of practice that comes with being a chain, nuanced cultural values of individual sites in the German chains were retained and celebrated.

While joining a chain can have potential positive cultural impacts on participating sites, the scale of the initial challenge to join together multiple staff bodies and ways of working cannot be underestimated. Both clinical and management staff need to feel not just engaged with, but actively involved in the transition to being part of a chain; shifting their collective mind-set to one of proactive cooperation for the good of the patient.

3. Joining a hospital chain is not a panacea for hospitals in enormous financial deficits – form must follow function

While the German hospital chain experience can shed light on executing a successful turnaround of a failing hospital (e.g. the detailed due diligence processes, the robust contractual agreements, the effective post-merger integration), this isn't always the case and due consideration must be given to selecting appropriate hospitals to form a chain.

It would be short-sighted to simply buddy up more sustainable hospitals and financially failing ones and then write off the concept if the collaboration doesn't produce immediate benefits. Given the history of mergers in the NHS, the fear may also be that smaller trusts will be gobbled up by larger ones in the name of efficiency, leaving services much less accessible for local people; or that chains will end up squeezing out competition and actually compromising care in the quest to maximise profit. Ultimately, as emphasised by Dalton, form must follow function and organisational models should not become an end in themselves.

International best practice suggests that the hospital chain model can potentially spread clinical excellence and deliver efficiencies. However, there are also a number of obstacles that need to be addressed if the hospital chain model is to take off in the UK, particularly around the role of commissioners and the implications for regulation. The history of mergers in the NHS, and in the wider world of industry, is by no means one of predictable success. Equally, there isn't the resource for even high-performing Trusts to complete acquisitions in the current financial context. If NHS England is serious about getting behind hospital chains, addressing these obstacles will be critical.

Read the full report at *www.pwc.co.uk/hospitalchains*

Ian Baxter
Partner

T: +44 (0) 7710 397745
E: ian.baxter@uk.pwc.com

Jack Tabner
Associate

T: +44 (0) 7860 885138
E: jack.a.tabner@uk.pwc.com

Health and care:

The inevitability of workforce demand and the difficulty of affordable supply...

Mike Farrar, Chair of the Public Sector Health Board, discusses the challenges the NHS face to supply the demand of increasing growth in demand for the health and care workforce.

In PwC's recently published UK Economic Outlook, March 2016, we projected that, as we look forward to 2025, there is likely to be a continuation of relatively strong growth of jobs in the health and education sectors. This refers to the total number of jobs in both the public and private sectors, but I will focus this blog on the public health sector and explain why I think this is not surprising but that there are some very real challenges and issues we need to consider.

The 'health and care order book' is clearly full, as the consequences of an ageing population suffering from multiple morbidity of various chronic diseases such as diabetes, hypertension, and liver disease feeds through to become a major driver for additional service capacity. This creates the demand that underpins the jobs growth projection.

Analysing and predicting a growth in demand for the health and care workforce is not difficult, but identifying how the country and the NHS will supply it, certainly is...

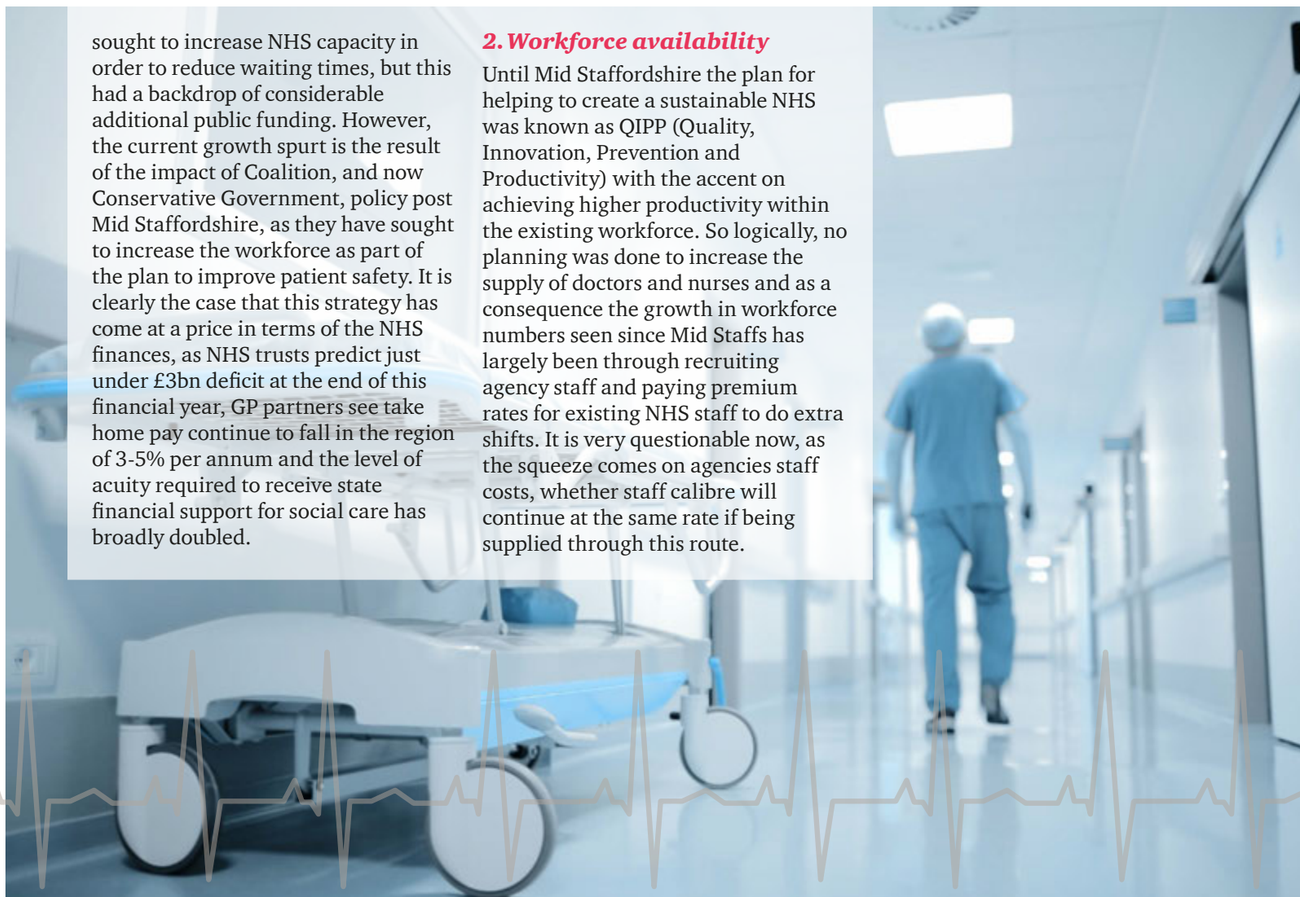
This is for a number of reasons -

1. Affordability

The NHS is facing one of its biggest financial challenges ever, and when you ask the reason why, you can see that it is almost entirely attributable to the NHS increasing its workforce at a pace that outstrips its budget. It is true that the early years of the 2000s saw a major growth in the workforce as the Labour Government of the time sought to increase NHS capacity in order to reduce waiting times, but this had a backdrop of considerable additional public funding. However, the current growth spurt is the result of the impact of Coalition, and now Conservative Government, policy post Mid Staffordshire, as they have sought to increase the workforce as part of the plan to improve patient safety. It is clearly the case that this strategy has come at a price in terms of the NHS finances, as NHS trusts predict just under £3bn deficit at the end of this financial year, GP partners see take home pay continue to fall in the region of 3-5% per annum and the level of acuity required to receive state financial support for social care has broadly doubled.

2. Workforce availability

Until Mid Staffordshire the plan for helping to create a sustainable NHS was known as QIPP (Quality, Innovation, Prevention and Productivity) with the accent on achieving higher productivity within the existing workforce. So logically, no planning was done to increase the supply of doctors and nurses and as a consequence the growth in workforce numbers seen since Mid Staffs has largely been through recruiting agency staff and paying premium rates for existing NHS staff to do extra shifts. It is very questionable now, as the squeeze comes on agencies staff costs, whether staff calibre will continue at the same rate if being supplied through this route.



3. Workforce planning, creation of new places and time lags

The problem is of course that, as in most sectors, the NHS has to play catch up. So if the demand for care grows it can easily outstrip the pace at which the NHS can commission new training places and the pace at which these deliver qualified staff to the coal face. Even with the best of intent the resources available to pay for new training places is limited and the time taken for them to qualify will all have an impact on the growth in supply of key clinical staff.

4. Morale and industrial relations

It may appear very inconvenient and esoteric to the outsider but the junior doctors current dispute could have a longer lasting impact on the NHS than is currently being acknowledged. It is undoubtedly the case that the number of applications from newly qualified doctors, trained in the UK, to practise overseas is rising considerably. In light of this it becomes harder to see the supply side of doctors flowing through in a simple 'one trained, one employed' fashion.

5. Immigration policy

As the CEO in the North West SHA, I had the privilege to sit on the National Migration Impact Forum established by the Home Office during the latter stages of the Labour Government. I think it's true to say I was an outlier! My views were that, without immigrant labour, the health and care service would struggle to meet demand. Indeed, medicine in the NHS has been excellently underpinned for many years by doctors trained in the Indian sub-continent and other countries across the globe but also in recent years something in the order of 45% of the residential care workforce in the North West was of recently arrived Eastern European origin. Our changing views on immigration as a nation and the political landscape are seriously threatening the ability of the NHS to source labour from outside of our own shores and as I look forward into 2016 and beyond it is hard to see how this trend is going to be managed. Our UK Economic Outlook report does identify a significant tightening of migration controls as a major risk.

So what is the upshot?

The health sector needs more staff to meet demand but is very unlikely to be able to afford them or to supply them through the traditional routes.

In terms of possible solutions to the conundrum we are forced to focus on methods to improve productivity and, in essence, it brings us back to the concepts that underpinned QIPP:

Quality – by reducing the variation in clinical standards and improving everyone's overall compliance with best clinical practice it is possible to see a major productivity benefit from the existing workforce - especially if we tackle the variation in primary care practice.

Innovation – most sectors have faced similar challenges to that faced by the NHS but have responded by 'pulling through' innovation. The NHS has to catch up very quickly and I would cite two key areas - rapid adoption of new technology/digitalisation of business and care processes; and critically, changing the nature of the relationship between the service user and the service supplier. The NHS can get great value by investing in patient education, carer support and transparency as means to empower us to be more health conscious but also more productive contributors to our own healthcare.

Prevention – of course this is a straight forward option for us as a nation, but can we be bold enough to change the economic incentives around our own lifestyle choices? For example, will the recently introduced sugar levy help us to avoid some of the demand that we might otherwise experience in 2025, and could a reduction in our overall alcohol consumption prevent many of the immediate pressures on our urgent care services?

Productivity – in commissioning and delivery systems' redesign - in some ways the holy grail, but with a fighting chance that if the NHS and care system can implement the Five Year Forward View, then by removing silos and the tyranny of annualised accounting, coupled with devolution of decision making to particular 'places' we will see a structural productivity gain. Integrated commissioning budgets and an intelligent provider response should follow from this policy. Providing there is an ability to keep some competitive grit in the oyster, it is possible to see how the NHS can begin to move the productivity dial forward at pace and scale.

So let's return to the predicted increase in jobs in the health sector. The analysis of demand for jobs if we continue to work in the way we have always done is probably a very accurate one, but the real question might be what can be done to avoid this increase being necessary? Assuming, of course, that we could concurrently maintain the quality of care, get better health outcomes and continue to live longer.

It might well be better to ask the public of the UK - are you prepared to pay more on tax for these extra jobs and especially ones that we can only fill at premium rates?

"Analysing and predicting a growth in demand for the health and care workforce is not difficult, but identifying how the country and the NHS will supply it, certainly is..."

Mike Farrar
Chair, Public Sector Health Board

T: +44 (0)7771 783495
E: mike.farrar@uk.pwc.com

Capture the growth: Understanding consumers is vital for new healthcare entrants

Andrew McKechnie, Private Health Lead, details research which shows a very real opportunity for non-traditional players to enter the health and well-being market.

Consumers are becoming more interested in and engaged with their health and wellbeing. Our research from Capture the Growth report suggests they are more discerning and demanding and their purchasing behaviour is evolving. But, the story is nuanced. We shouldn't think of consumers as a single entity; one size doesn't fit all. Different groups think and behave in different ways and have different demands from the products and services they buy and use.

Why is this important for healthcare businesses and new entrants?

Well, businesses will only be able to succeed if they identify, understand and respond to consumers' wants and needs. And flexibility will be crucial – this is an ever-changing ecosystem. Getting under the skin of how different groups of consumers think and behave is critical. Understanding consumers' underlying attitudes is the only way to develop a compelling proposition.

Who are these consumers?

We've spoken to over 2,000 consumers across the UK, of different ages, from different backgrounds, with different lifestyles and different family structures, to understand what consumers want from new entrants. We've found out how they engage with healthcare and wellbeing and what the opportunities for new entrants could be.

For *Betty*, her healthcare is a priority. She wants to see a trusted professional face to face but is happy to do that in a range of settings, whether that be at the GP surgery, clinic or hospital, but also at home, in a retail store or in a pharmacy. Advice, trust and credibility are key. She wants to get more involved with wellness and fitness but is a bit apprehensive – she needs advice and guidance to help her navigate such a broad range of options.

Betty, 73:
a woman who wants old-fashioned care, close to home

"With a large and growing market, positive demand drivers and consumers' expectations and willingness to pay increasing, now is the time for new entrants to examine their UK healthcare and wellbeing strategy."

Donna puts her family's healthcare first. She sees wellness as a way to improve her own health – e.g. taking vitamins and supplements. She's also started to think about her own fitness a bit more, but fitting it in around her busy schedule is difficult. Donna's always on the go, so she wants something easy to use, easy and convenient to access and good value for money. Therefore, she's happy to use many different channels for both shopping and healthcare.

Donna, 43:
a busy mum who puts her children's health first

For Jack, fitness, wellness and technology are his priorities and he's willing to spend in order to get the top of the range products from the best brands. Healthcare isn't really front of mind for him at the moment but when he needs it, he wants quick and convenient access and is happy to do this remotely or in non-traditional channels like a retail store.

Jack, 24:
a fitness fan with an app for everything

Despite their differences, there's a consistent theme emerging across these groups: they are all willing to try, use and pay for products and services offered by new entrants. Of course these products and services will look different for each group and we've gathered detailed insights on what ideas would resonate.

What are the implications for providers?

Ultimately their thinking will have to evolve – they will have to think differently about their customers, proposition and operating model. They will need to better understand the landscape for new entrants, identify the pockets of opportunity, evaluate what it means for their business and drive detailed insights on what it means for their current and future customers.

Read the full report at *https://www.pwc.co.uk/capturethegrowth*

Andrew McKechnie
Partner, Private Health Sector Leader & Deals Lead

T: +44 (0)20 7212 6327
E: andrew.mckechnie@uk.pwc.com

A vision for the future of the UK's Early Access to Medicines Scheme

Strategy&, part of the PwC network, supported the Office for Life Sciences to carry out an independent review of the Early Access to Medicines Scheme (EAMS). Via interviews, survey and cross-stakeholder workshops, the review assessed EAMS' achievements to date and future opportunities for change.

The UK's Early Access to Medicines Scheme

The Early Access to Medicines Scheme (EAMS), launched in 2014, aims to provide patients with earlier access to innovative medicines pre-marketing authorisation in instances of clear unmet medical need.

The scheme provides a valuable opportunity for early dialogue between industry, government and arm's length bodies including the MHRA, NICE and the NHS, and, looking ahead, there is collective appetite from all parties to build on what the EAMS has achieved to date.

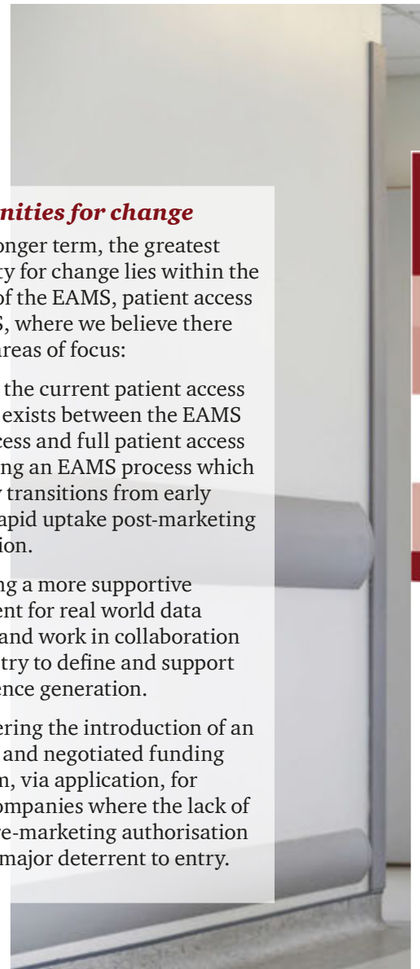
Opportunities for change

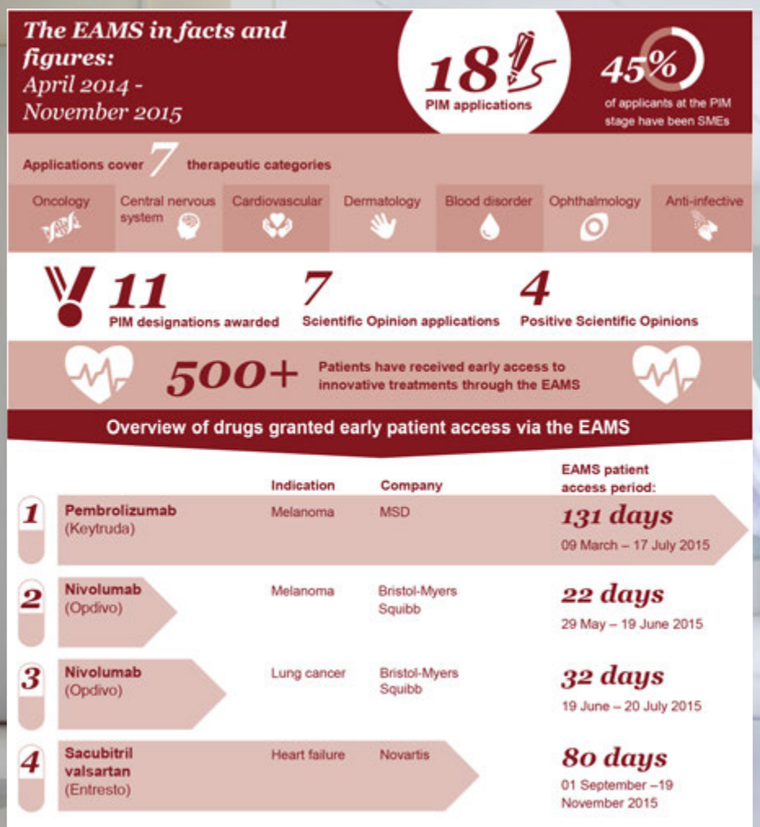
Over the longer term, the greatest opportunity for change lies within the last stage of the EAMS, patient access in the NHS, where we believe there are three areas of focus:

1. Closing the current patient access gap which exists between the EAMS patient access and full patient access by delivering an EAMS process which seamlessly transitions from early access to rapid uptake post-marketing authorisation.

2. Fostering a more supportive environment for real world data collection and work in collaboration with industry to define and support their evidence generation.

3. Considering the introduction of an affordable and negotiated funding mechanism, via application, for selected companies where the lack of funding pre-marketing authorisation remains a major deterrent to entry.



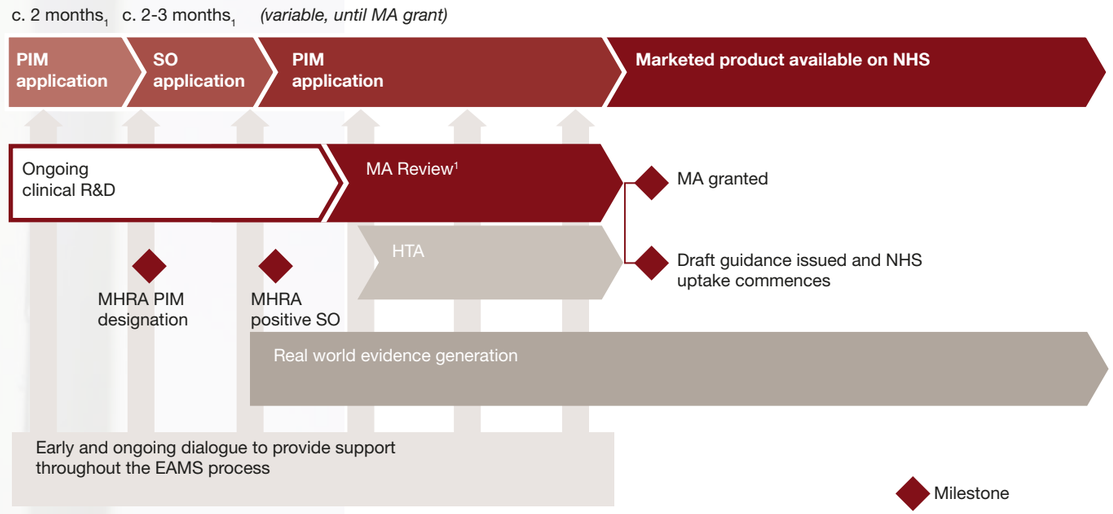


In addition, we also see some potentially quick wins for the EAMS at the earlier stages of the process. They include a clearer articulation of the benefits of participation as well as clarification of the evidence requirements for entry.

A vision for the future EAMS

Our vision is for the EAMS to offer a flexible, transparent, and smooth process that delivers rapid patient access to cost effective products pre- and post-marketing authorisation.

We also recommend that the EAMS aligns with the proposed accelerated access pathways being developed as part of the UK's Accelerated Access Review as well as European-level developments such as the European Medicines Agency's Priority Medicines scheme.



Read the full report at
https://www. gov.uk/government/uploads/system/uploads/attachment_data/file/509612/eams-review.pdf

Jo Pisani
Pharmaceutical and Life Science Consulting Leader

T: +44 (0)20 7804 3744
E: jo.pisani@uk.pwc.com

Getting ahead of the curve

Deming Qin explains the impact the Accelerated Access Review could have on getting innovative medical advances more quickly to the patient.

Our report "Accelerated Access Review Proposition 2: Getting ahead of the curve" outlines Strategy&'s independent recommendations to the Department of Health in support of the Accelerated Access Review (AAR). The AAR team have been tasked with examining how to improve access to innovative medical technologies (including medicines, medical devices, companion diagnostics and digital products) in the UK.

The government will consider our recommendations, gathered from over 150 stakeholders across industry, industry associations, patient groups, government and arms-length bodies, before publishing their final report in April 2016.

An opportune time for change

The AAR couldn't have come at a better time. As many countries around the globe seek to improve uptake of innovation while balancing budgets, the AAR gives the UK an opportunity to distinguish itself, not only as a powerhouse of innovation across Europe and beyond, but also as a healthcare system that places innovative technologies in the hands of its people.

The UK needs to level the playing field with other EU countries like France and Germany, who are leading the way with early access and uptake. Should the UK be successful the benefits to the whole healthcare system will more than outweigh the effort required to make them happen.

Our input to the review

We developed a series of accelerated access pathways – for medicines, companion diagnostics, medical devices and digital products – that outline how patients could receive faster access to safe and effective innovative medical technologies in the UK. The recommended pathways are supported by a flexible pricing and reimbursement framework, potentially available to all innovators, that will facilitate the selection of pricing and reimbursement schemes that reward innovation while balancing affordability.

An overview of the core components of all pathways is detailed below; for the individual pathways and details of the flexible pricing and reimbursement framework, see the report.

Impact of the recommendations

Our proposals support the Accelerated Access Review's aim of providing earlier patient access to innovative medical technologies. In addition, they also seek to make the UK a more attractive location for innovation so that companies consider it an early and critical market for product development, clinical and economic validation, and market access in a global context.

Beyond the qualitative benefits, we have also been able to estimate that for medicines:

- Implementation of the recommendations could result in up to 1-6 years of earlier access post-Marketing Authorisation (MA), with potential for additional access pre-MA via the Early Access to Medicines Scheme.
- In revenue terms, this could deliver additional sales of around £11m for an orphan indications and around £525m for a product targeted at a larger population.
- Once the real world data infrastructure and standards of care improve in the UK, we estimate that companies could additionally save around £80m in the cost of conducting these studies across the EU.

Although the focus of the report is improving these pathways for the most transformative products, we expect that streamlining the current processes will potentially benefit all products launching in the UK market.

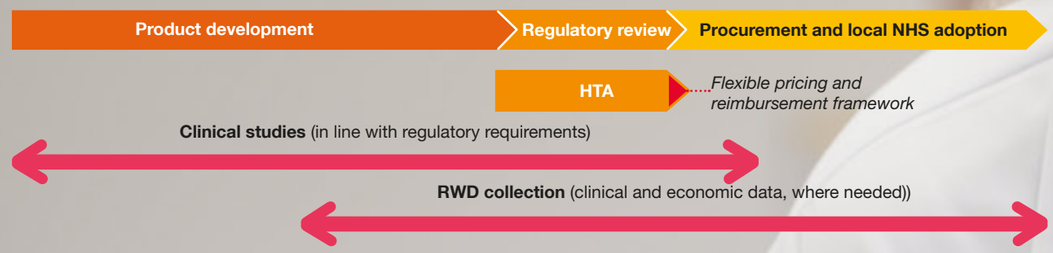
Moreover these benefits could place the UK at the centre of global innovation and impact patients by giving them faster access to the cutting-edge technologies that can improve their quality of life.

Read the full report at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/514445/AAR_Proposition.pdf

Deming Qin
Senior Associate

T: +44 (0) 7753 459176
E: deming.qin@strategyand.uk.pwc.com

Proposed core components of the UK accelerated access pathways across medical technologies



"These benefits could place the UK at the centre of global innovation and impact patients by giving them faster access to the cutting-edge technologies that can improve their quality of life."

Health Industries: Our people

Healthcare matters to us and it matters to our clients.

We all want better healthcare, sooner and the potential is there to make it happen. New technology, new breakthroughs, new ideas. But while there are opportunities, there are challenges too: constrained budgets, an ageing population and an increase in chronic conditions. At PwC we're working with clients to steer a course to success in this new health economy so we help improve healthcare for all.

We're working with the NHS, nationally and locally, as well as the private sector and the pharmaceutical and life sciences sector to deliver real, workable solutions to today's challenges. We're delivering transformation and integration projects with patient outcomes at their heart. And we're supporting organisations through testing financial times, often developing bespoke operational and digital systems. We give strategic support to organisations across healthcare and pride ourselves on convening different parts of the system to solve problems.

We also bring insight and expertise to healthcare as well as engaging in the public policy debate.

Quentin Cole

Partner, UK Health Industries Leader

E: quentin.r.cole@uk.pwc.com
T: +44 (0)20 7212 6784

Sunil Patel

Partner, Government & Health Industries and Health Technology Lead

E: sunil.k.patel@uk.pwc.com
T: +44 (0)20 7212 3484

Rt Hon Alan Milburn

Health Industries Oversight Board Chair

E: alan.milburn@uk.pwc.com
T: +44 (0)20 7212 6784

Jo Pisani

Partner, Pharmaceutical and Life Science Consulting Leader

E: jo.pisani@strategyand.uk.pwc.com
T: +44 (0)20 7804 3744

Andrew Packman

Partner, Pharmaceutical and Life Science Sector Leader

E: andrew.packman@uk.pwc.com
T: +44 (0)18 9552 2104

Ian Baxter

Partner, Corporate Finance

E: ian.baxter@uk.pwc.com
T: +44 (0)20 7213 3914

Andrew McKechnie

Partner, Private Health Sector Leader & Deals Lead

E: andrew.mckechnie@uk.pwc.com
T: +44 (0)20 7212 6327

For more information, subscribe to our Health Matters blog to receive regular insights at:

www.pwc.blogs.com/health_matters

160413-135930-EA-UK