Resetting the provider/ insurer relationship

By **Kelsey Rees** - 21st July 2020

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In the first of a three-part series exploring the impact of the Covid-19 pandemic on the private healthcare market, Check4Cancer chief medical officer Professor Gordon Wishart and Philip Housden, managing director of healthcare consultancy Housden Group, look at the new relationships emerging between private medical insurers and healthcare providers in the delivery of cancer services

There are now multiple personal case studies in the media that suggest that the partnership between the NHS and independent hospital sector entered into in March to protect the NHS from being overwhelmed by the Covid-19 pandemic has not protected cancer patients in all parts of the country.

While the pandemic has had a major impact on the diagnosis and treatment of many time critical conditions, in this article we use cancer services as an example of how the lockdown restrictions could have a lasting effect on the relationships between UK Private Medical Insurers (PMI) and private healthcare providers.

The NHS has come late to the view that the public-private partnership would be best used to establish a national network of 'Covid-light' independent hospitals that could continue to provide diagnostics and treatment for many different time critical diseases and conditions during the crisis.

Instead, the partnership led to most independent hospitals closing operating theatres and restricting outpatient activity to remote consultations by telephone or video, with frustration about the lack of activity expressed by consultants as well as independent hospital managers.

It could be argued that the lack of utilisation of independent hospitals for NHS patients was partly driven by an observed 70% reduction in GP referrals for early cancer diagnosis as well as a 60% reduction in attendance for chemotherapy, in addition to a

lack of NHS management focus on non-Covid patients. There is no doubt that patients were and are still concerned to attend NHS hospitals for fear of contracting Covid-19.

Since the Blair government, private hospital groups have been an essential part of the strategy to help support the NHS reach its waiting time targets and, given current delays to cancer diagnosis and treatment as well as suspension of cancer screening services, NHS access to private resources is likely to continue long after lockdown has finished. In fact, there are already plans to extend the public-private partnership by two months, or longer in certain parts of the country.

IF PMI BECOMES LESS RELEVANT OR LESS AFFORDABLE, THIS COULD LEAD TO A GREATER BURDEN ON THE NHS

It is now predicted that as many as one in six people in England could be waiting for NHS treatment by the autumn as a result of Covid-19 forcing hospitals to run at 60% capacity and, figures put together by health economists at the Nuffield Trust show that as many as 10 million people will be on waiting lists for NHS treatment before the end of the year.

With extension of the public-private partnership, and with many older NHS hospitals unprepared for the kind of infection prevention and control needed in the coming months, it is anticipated that private healthcare companies could end up providing up to two million NHS procedures a year.

Nigel Edwards, chief executive of the Nuffield Trust think-tank, has reported that only 15 20% of surgery has been performed during lockdown and that, despite being a country with high-income standards and high-income expectations, it is likely the NHS will experience an overall 'relative decline' during the next 18 months.

A balancing act

The historic delivery of surgical waiting list initiatives by the independent sector has suited the business model of the traditional private hospital that is built on high utilisation of operating theatre capacity. The financial cost to the NHS to deliver future waiting time targets is one of the unintended consequences of driving a lockdown approach to the pandemic rather than a test, track and trace strategy. It, therefore, appears that for the next 12-18 months, independent hospital groups will have to balance reintroduction of their core private services for insured and self-funding patients, while also managing NHS patients that are referred as part of these waiting-list initiatives. While this may provide
increased activity and revenues in the shorter term, looking forward it may become increasingly difficult to protect their core insured private business.

It is well known that some independent hospital groups have relied more on NHS activity than others to deliver their business plans, but NHS contracts can be time-intensive to manage and can be stopped at very short notice. Furthermore, the recent wholesale

takeover, albeit temporary, of the private sector by the NHS could lead to significant and lasting changes in the dynamic between UK PMI companies and independent hospital provider groups.

On one hand, PMIs will have to contend with their insured members unhappy not getting what their premium paid for, and the resultant pressure on future renewal premiums and member retention. If PMI becomes less relevant or less affordable, this could lead to a greater burden on the NHS. Furthermore, the economic recession will lead to job losses and less corporate employees with PMI.

On the other hand, private hospitals have had the frustration of CT and MRI scans lying idle through the lockdown period. It is possible that the de-stabilisation of their core insured business by independent hospitals has raised the risk of future repetition such that UK PMI companies could look elsewhere for provision of clinical services for their members, which in turn threatens the future security of some independent hospital groups.

The public-private partnership could, therefore, have a dramatic effect on the traditional partnership between UK insurers and the private healthcare providers.

Waiting list explosion

So why have many insured members not been able to access diagnosis and treatment in private hospitals during the lockdown period? A report in The Times on 4 June 2020 highlights that although a few private hospitals are being used as 'Covid-free' hubs to treat some (largely cancer) patients, the extra capacity is still not being utilised4. In the meantime, waiting lists for the whole of the UK are growing by the minute as normal treatments and surgery have been put on hold.

Richard Packard, chairman of the Federation of Independent Practitioner Organisations, which represents private consultants, told The Times that 'the UK simply cannot afford to allow medical and surgical capacity to sit idle while pathology and waiting lists build and patients suffer'.

There is no doubt that the pandemic has led to a dramatic rise in remote consultations by telephone or video, and it is possible that a number of other innovations could help to manage patients away from NHS hospitals including offsite clinics for walk-in referred patients or diagnostic services.

A spokesman for NHS England explained that, 'Private hospital beds were first and foremost intended to provide reserve 'buffer' capacity for coronavirus patients should it have been needed, so it is a mark of success that that has largely not been the case. Now as the overall number of coronavirus inpatients stabilises and hopefully begins to fall, it will over the coming weeks and months be possible to begin to release anaesthetists and other key staff from looking after coronavirus patients so that more routine operations can resume in both NHS and private hospitals.'

This confirms that the private sector was requisitioned as additional capacity for coronavirus patients and, that there was no plan to create 'Covid-light' facilities to allow the diagnosis and treatment of urgent non-Covid conditions.

So, at a time when UK PMI providers are under pressure from brokers and members to reimburse fees for lack of access to clinical services during lockdown, how could UK PMI providers prevent this happening in future pandemics?

Emerging relationships

During the last five to ten years, UK PMI companies have increasingly worked with consultant partnerships and healthcare providers which can deliver diagnostic or treatment pathways against an agreed level of service.

In London, some of these partnerships or providers are already based in purpose-built diagnostic centres that have no in-patient beds, and this model may be attractive to insurance companies trying to prevent future takeover of independent hospitals when the next significant pandemic arises.

This approach is more likely to work well in London due to population size but, a number of new companies are now delivering private chemotherapy and radiotherapy in regional private cancer treatment facilities that are outside the private hospital network.

Therefore, the traditional private referral by your own GP may start to become a thing of the past with the rise in online private GP services and, the evolution of rapid access pathways that do not require a GP referral at all.

In short, we may see fewer patients referred by their NHS GP to the private speciality consultant in the local independent hospital, and the evolution of many new patient pathways supported by these new models that will challenge the status quo that has existed for so long in private practice. In this way, while insurers may be more able to control the pathways that their members access for diagnosis and/or treatment, it may also see a rise in selfpay patients who recognise that low-cost, self-referral access to a rapid diagnosis may be preferable to paying for PMI.

So how do private insurers differentiate and develop their PMI product to stay relevant in the current market? One solution is for insurers to secure preferential access to high quality and cost-effective clinical pathways that provide their members with efficient and cost-effective treatment.

In tandem with this move by insurance companies to work more closely with clinicians and clinician partnerships, insurers are now beginning to focus on the start of the cancer pathway, through cancer prevention and cancer screening, rather than cancer treatment.

Early adopters of this approach have recognised the flexibility of working with a number of smaller providers that can provide adaptable evidence-based services at lower cost, when compared to the relative inflexibility and higher unit costs of delivering hospital-based treatment. Cigna and Vitality Health have already introduced cancer screening to their UK members and other insurers are likely to follow suit in the near future.

Accuracy is king

In summary, insurers will now be looking for partners that can deliver accurate cancer risk assessment and risk reduction through behavioural change and cancer screening, as well as the traditional cancer treatments of surgery, chemotherapy and radiotherapy.

The reduction of cancer risk through behavioural change and screening is more likely to be delivered online rather than in the private hospital networks.

Check4Cancer (www.check4cancer.com), has worked closely with several UK PMI companies to introduce bespoke cancer screening and diagnostics that allow insured members quick access to best practice diagnostic pathways. In this way, insurers can significantly shorten the diagnostic pathway for their members compared to NHS providers.

THE REDUCTION OF CANCER RISK THROUGH BEHAVIOURAL CHANGE IS MORE LIKELY TO BE DELIVERED ONLINE THAN IN PRIVATE HOSPITALS

Check4Cancer's ability to manage and audit rapid access, streamlined diagnostic pathways for breast, skin and prostate cancer and its close collaboration with their consultant networks allowed it to continue to deliver those services, albeit with some reduction in capacity, throughout the lockdown period.

As a result, Check4Cancer was able to provide regular updates to the insurance companies on what services were available in certain locations to provide them with information that they were unable to obtain from other sources.

Elsewhere, we are aware that some health insurers have worked closely with key consultants or consultant partnerships to provide telephone triage of symptomatic cancer patients, with onward referral for investigation when possible. There has also been increased utilisation by health insurers of online GP platforms to manage and triage their members with cancer symptoms.

The requirement to adapt the delivery of private healthcare during lockdown has caused a paradigm shift in the relationship between patients, insurers and private healthcare providers and the focus on the front end of the pathway is likely to be a harbinger of change further down the pathway for independent hospitals.

This closer collaboration between UK PMI and partnerships or pathway providers, and increasing use of online technology, could therefore be sustained and strengthened by the lockdown experience, and perhaps will alter the way that insured members are referred to independent practitioners in the future. Although emergent and not available nationally at present, it could accelerate and become sector wide in the foreseeable future.

These collaborations will be strengthened by the ability of the partnerships and pathway providers to audit their clinical services and, provide increased feedback on the delivered level of service. Inevitably, this will lead to insurers working with a smaller number of consultants in each speciality, with increased focus on the management and audit of

end-to-end patient pathways, to ensure that their members receive best practice at an affordable price.

This will inevitably alter the dynamic between clinical partnerships and the private hospitals, and all of these developments are likely to further reduce the influence of independent hospitals on the referral of insured patients for cancer diagnosis and treatment.

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Kelsey is a recent graduate from Cardiff University where she gained a Masters degree in Magazine Journalism and an undergraduate degree in English Literature. Her role as Editorial Assistant is her first position in the journalism industry where she hopes to progress further in the future.