

## Don't do nothing - that's been tried

23 September 2004

Good morning and thank you for the invitation to address this conference at, what I think we all agree, is a significant time for our sector.

Today in my speech I would like to make a number of points that I hope, get to the heart of my brief for this speech and illuminate potential future relationships between insurers and health care providers that are likely to lead to successful businesses for all of us and our customers.

My first point - the literature for this conference refers to: "the dramatic changes taking place this year in the structure of the independent sector". Laing and Buisson are right, of course: the past 12/18 months have been hugely significant: a sector, which has had stability and continuity more or less for 20 years, is facing a time of major change, unprecedented in its history.

The literature also asks whether we are entering a period of: "Boom or Doom". That's a question that many people have been asking of late: what is the future for the independent sector given the prospect or perception of an improving NHS? I am going to tell you why I believe there are prospects for significant growth in the private sector in the future. To realise that future requires taking some big decisions and big decisions imply significant business risk. The decisions therefore need to be carefully calculated to turn *my* stated confidence into commercial reality. What is all too real already however, is, that whether you are a provider or an insurer, to do nothing is not an option. This is a watershed moment in our history and simply continuing with the status quo, I don't think is the right answer. It isn't doing more of the same, harder or better, it's doing different things. And I know I'm not alone in this room in thinking this.

Something else struck me about the conference literature. The first was that despite its references to change, it ironically embodies possibly the major obstacle to change in our sector, namely: today is about providers and tomorrow is about insurers: the traditional "divide" is alive and well and working against us.

When I spoke at this conference two years ago I gave a number of examples where the traditional adversarial relationship and posturing between insurers and providers were at work to damage the sector. Whether it was our failure to have any planned approach to capital development (for example MRI), the inability to work jointly to address the systematic and unjustifiable variations in clinical practice taking place in every private hospital that add unnecessary costs to care, or the reliance on Clinical Governance to magically ensure the delivery of cost-effective and appropriate care by consultants – all these signs indicated that trouble lay ahead. We had done nothing to address this which was not surprising when the UK private acute care market was growing at between 6% and 15% in real terms each year, as it had since the early 1980s.

It is only now, with the Government's drive to transform the performance and perception of the NHS and the flattening of PMI volumes that people have understood that this approach is unsustainable. My second point is that there have been diverse but extreme strategic

reactions among providers and most are probably feeling that they are betting the farm on the rightness of these strategies.

Providing services to the NHS is playing in quite a different market. It requires different skills, competencies and attitudes. The HRG tariff for a hip replacement is \$5,563 including doctors' fees – can you really deliver it? My third point relates to the NHS phenomenon and the feeling among some in this room that NHS plurality is *the* solution to sustaining future business performance. The NHS changes should unite providers and insurers who are interested in serving the private paying customer, to ensure that they are buying and receiving high quality, cost-effective care that is different from the free alternative, in ways that matter to patients.

Consumers will want to buy more when their expectations have been raised by a better NHS. Whether you are an insurer or a provider – hospital or doctor – we should be rewarding performance, quality and cost-effectiveness. We should be able to demonstrate this to customers simply and transparently. The customer should be in charge and in control, not placed in the position of a semi-blind foil for producers' interests. Customers need better information, good guidance, benchmarks and comparators of services and more variety of choice in provision.

While we must *always* acknowledge the need for proper commercial separation – and I say this mindful of my own company's position of having both provision and funding in the same Group – there has never been a time when independent hospital providers, doctors and insurers are more aligned. There is sufficient common ground, mutual dependence and common objectives – the customer prime among them – to make meaningful cooperation on creating new and better health care models for customers the right and sensible thing to do. In an environment of change and turbulence we would expect the innovative and entrepreneurial to spring up, for there to be radical rethinks of traditional ways of doing things; the opportunity for new players and approaches to emerge and challenge the status quo. We need more of this to grow the private market.

As the old antipathies between public and private in the area of provision are increasingly being eroded, so I hope, will the antipathy towards the funding side. Many of the private hospital providers from whom the Government wants support, rely in the main on their PMI patients: if the PMI patient disappears, so does a lot of the capacity that is supporting the NHS.

This leads on to my fourth point which is that PMI and wider private funding options are not dead and growth is a real prospect, not a vain hope. Why do I say this? I have made the point that as the NHS improves, as choice in health care becomes more meaningful to more people, then expectations will rise and people will start to want to exercise real choice.

And there will remain differences between what we offer and what the NHS offers and will offer. In a recent poll, 80 per cent of people said they wouldn't give up their PMI even if the NHS achieved its 2008 waiting list targets. Sixty per cent said they would hold on to their PMI if, like the independent sector, the NHS had no waiting lists. In another piece of research, almost 90 per cent of people said that recent improvements in the NHS had not made their PMI less valuable.

What this tells us is that people value what we offer. What it also tells us – because so few people would, apparently, give up their PMI even if the NHS met private sector waiting times – is that fast access is not the only reason people buy PMI.

For example, in a Populus survey conducted for the BUPA Health Debate next month, 98 per cent said they wanted clean and comfortable surroundings and two thirds believed that this was an area where the independent sector had an advantage. Ninety-nine per cent said they wanted good, alternative nursing care and just over half considered this was something they were more likely to get in a private hospital. Ninety-seven per cent wanted to be kept informed about and involved with their treatment; here again, more people thought they would get that privately rather than from the NHS.

Add all this up and what have we got: people want what we have to offer. Our challenge has to be to make it more available to more people and that means make it more affordable, as well as being innovative in the shape it takes. There will always be a market for the comprehensive PMI, but tomorrow's consumers also want straightforward and simple funding products and services tailored to their specific needs. Businesses increasingly want the same for their employees.

One of the interesting dimensions of the annual Health of the Nation survey is that while on the one hand it is notoriously difficult to interest the younger consumer in health because of their unshakeable conviction that they will live forever – their attitude to spending on health are different from those of their parents. They are less resistant to the principal of spending their own money on health.

For that and other reasons to do with changing consumer demand, we can be fairly confident that tomorrow's independent sector will look significantly different to today's. And, of course, it is not just new consumers but the new entrants too, that will drive change. New providers in both primary and secondary care, when coupled with innovation by funders in finding new and attractive propositions for customers, will mean a very different landscape in the future. Current concepts of benefit limits, hospital lists, networks and other familiar features are unlikely to be the language of tomorrow.

So, we should feel confident about future prospects, but not complacent, because to realise those prospects we need to make material changes.

Before moving on to my fifth point there is one caution I should make, something that insurers should be wary of, that might damage prospects for future growth. There is an obvious temptation for insurers to make their products appear better value for money simply by stripping out various the health care benefits within them. Good health care, whether in the NHS or private sector is not cheap and people should be suspicious of products that promise comprehensive health cover "at half the price". It isn't comprehensive and serves only to disappoint when used. This damages the reputation of private health care and PMI and causes problems for patients, hospitals and doctors. The affordability of PMI *is* a real issue - but the solution is not to sell products with materially insufficient cover to customers whose knowledge of health care at point of purchase can only ever be superficial. At BUPA we believe that is fundamental to a PMI sector that is to have growth prospects and we believe

we demonstrate this in areas like our approach to cancer. In designing more affordable health care funding products we need to be more imaginative and customer focused.

Which brings me on to my fifth point and again to something that we should avoid for a successful future. And that is to blame our issues on consultants and imagine that by neutering their power and influence over the patient or referral path, we will solve the situation. We must not forget that our customers, your patients, trust doctors to cut them open (when they are asleep) – this is trust of an order of magnitude quite different from that in an insurer or hospital operator. So, in trying to make the process of care more cost effective, more evidence based and more consistent we must not damage those aspects of our proposition where real value lies. That is not to say that relationships with doctors don't need to change. They surely do, but this must be done with them and not to them.

Doctors as I have indicated are central to our whole proposition; we know that without them we *have* no proposition and there will be few in this room who question the contribution they make. It is precisely because they have such a huge role in the present that they have a responsibility to the future. I am encouraged by the evidence I see that many consultants recognise that the world is changing. In the main, consultants know that their future and the future of the sector are inextricably linked.

The plain truth is that if we want growth in the sector, we need more cost-effective care of consistently high quality that we can measure, and this can only be achieved with the contribution of the medical profession.

A recent article by Jim Johnson, Chairman of the BMA, in "*Hospital Doctor*" makes me believe that we are moving towards a meeting of minds. In his piece he concluded: "The moral of this tale is that times are changing. I am not saying this is good or bad but simply stating fact – the status quo is not here to stay and consultants may have to adapt to a changed market."

And they will. Many doctors no longer wish to work endless hours spread between the NHS and private practice. The old model of the consultant in private practice as a sole trader no longer reflects either the multidisciplinary nature of health care and consultants who are used to working in teams, or the fact that there is no equity in such a practice – no value to be realised at the end of a working life. Consultants may not be primarily business oriented, but they will seek good commercial advice to help them build their health care business. This affords significant opportunities for providers and funders to work in partnership with consultants and for the latter to generate sustainable earnings, possibly higher than today, delivering care that is more cost-effective. This needs to happen more quickly and should be actively encouraged and supported.

My sixth and final point is an obvious one. We need to grasp the opportunities that the current changes offer, be fleet of foot and willing to challenge some of the myths and sacred cows. If we are not then many of us in this room, the incumbents in the private sector, will suffer. For it is not that private health care in both provision and funding is dying, merely that it is changing and evolving to complement a different NHS and a changing consumer. This is in our own hands.

So, in closing, let me try and summarise. We are in a period of change unlike anything we've seen before. While that may be unsettling, we should avoid talking ourselves into decline unless we want a self-fulfilling prophecy. And we should resist others' attempts to do so.

We need to be creative in finding innovative solutions to the problems of today's market – I need more entrepreneurial spirits knocking at BUPA's door.

The funding and provision sides need to talk more to each other and the customer needs to be at the centre of that conversation. There is, as I said at the outset, more that unites us than divides us. This is a critical time to demonstrate this.

Thank you for your attention.