THE WHITEHALL REPORT 2020

MARWOOD GROUP

Contents

Introduction

It is difficult to imagine beginning the Whitehall Report 2020 with anything other than a reflection on Covid-19 and how one virus can so drastically alter our daily lives. Despite the warning signs contained in previous SARS and MERS outbreaks, the world has struggled to find a way of successfully containing the virus' spread. Tragically, as we go to print, global confirmed cases stand at over 25m, with worldwide deaths nearing 900,000.

The all-encompassing nature of the pandemic has made it difficult for governments to focus on other policy initiatives. Although our report covers policy, funding and regulation developments from August 2019 through to August 2020, since March 2020 we have seen almost all political decisions made through the prism of Covid-19.

However, as much as the world has changed, it has not stopped. It is important not to forget the turbulence the UK political system experienced in the six months that preceded the pandemic. This included Boris Johnson winning the leadership of the Conservative Party, being taken to the Supreme Court after controversially shutting down parliament, agreeing a Withdrawal Agreement on Brexit and winning a comfortable majority at the General Election.

Brexit – that event that has dominated the political consciousness for four years – may have been pushed out of the headlines but the clock is still ticking. As we reach September, there are now less than four months left to agree terms with the EU or Britain will actually leave without a deal.

The events of the last year have served to reinforce key messages that Marwood Group has long been telling those we work with:

1. Recognising the importance of Government decision-making is paramount when investing in in health and social care
2. Public funding of healthcare services can make healthcare assets a safe haven in times of economic stress
3. The independent sector will always have a role to play across health, social care and the life sciences – and the NHS is not the closed market that it may first appear

The power of government action has rarely been so clearly on display as in the last six months. It has exerted control to an unprecedented degree, and mainly with the broad acquiescence of the electorate. The Department of Health and Social Care has directed the activities of both the NHS and independent sector partners, whilst using emergency legislative powers to suspend statutory assessment processes for continuing healthcare and older people care assessments.

Over time all of these actions will be reversed, but in a world that has got use to a rather looser hand of government and a sense that the market can dominate decision making, it was a reminder that when it comes to the health and care of citizens, the government can - and will – make decisions that have very real, positive or negative, impact on revenue flows.

Healthcare in the UK has done remarkably well in recent years compared to other public funded services. The five-year funding settlement in 2018 secured its income in the medium-term, and the emergence of Covid-19 has, if anything, strengthened its position. The government will be well aware that it cannot be seen to be not properly resourcing the NHS during this period – particularly with a waiting list that could reach 10m. However, with pressure facing multiple public services, it remains to be seen how many more times the government will be willing to dip its hand into its pocket.

The ballooning waiting list acts as a reminder not to forget the vital role that the independent sector will play in helping the system to recover. The NHS was already expected to consider the role other providers could take to meet waiting list demands – it was written into the NHS Long-Term Plan. The pandemic has only increased that need, and the operational planning guidance set out by NHS England is very clear that local systems should bring in the independent sector wherever possible.

It is not just those providing elective care that stand to benefit. The life science industry has been heavily engaged in developing rapid fire testing kits and exploring vaccine options – making use of the unique structure of the NHS to rapidly advance testing at a far faster pace than many other countries. Diagnostic companies are fully integrated into the new testing networks, whilst those operating remote working solutions are recognising this as the point of no return for clinical acceptance of virtual healthcare options.

Overall, Marwood Group recognises the tough economic conditions will have created much revenue uncertainty during the year – but looking forward, health and care sectors appear to be in a stronger position than many other industries. We remind our readers that the complexity of the system should not be underestimated. As we have seen, it can be subject to direct political intervention and indirectly impacted by wider policy objectives. It is a heavily regulated environment, whilst reimbursement responsibilities are split between multiple organisations.

The landscape has also evolved substantially over the last year – with strategic transformations that have been under discussion for years put in place in a matter of months. It is therefore vital that investors are able to navigate the complexity of the system and understand what the evolving landscape means for an asset when making decisions.

Our annual Whitehall Report acts as an important reference document to decode the complexity of health and care in England. We hope our insights into the key developments affecting the regulatory, reimbursement, and policy levers impacting on the health, social care and pharmaceutical markets in England help support you to make the right decisions for your business.

We hope you enjoy our Whitehall Report, and would be more than happy to discuss further any topics that we have covered.

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Key Policy Developments In Health And Social Care 1

Covid-19: Recognising the Failure, Understanding the Opportunity

As emphasised in the foreword, the Covid-19 pandemic should first and foremost be considered in terms of the human cost. By September 2020 more than 41,000 people had sadly lost their lives to Covid-19 in the UK, and that number will continue to rise in the months ahead.

There will be countless others that suffer negative health outcomes and shortened life opportunities because they were not able to access routine elective care when it was needed or due to long-term economic factors directly impacting on their wider environment.

As the UK emerges out of Wave One, questions are beginning to be asked about the government's response to the crisis. Labour – under new leader, Keir Starmer – has made the political decision to not press the government too firmly during a national crisis, judging that being seen as opportunistic could rebound upon them. However, the fact that the UK has recorded the highest excess death rates in Europe, alongside well documented failures in key planks of policy, and confusion over lockdown protocols, has meant media focus is turning to government decision-making and pressure is building for a public inquiry.

Five key areas that the government is likely to face questions over:

1. Planning and decision-making for when a full national lockdown would be implemented
2. Purchasing and distribution of PPE across care providers
3. Decision to prioritise discharging individuals from hospitals into care homes, and the subsequent impact on the sector and existing care home residents
4. Roll-out of clinical tests for people with suspected Covid-19
5. Development of the 'Track and Trace' contact app

Even if a vaccine emerges that allows the public to move on in their day-to-day lives, Covid-19 will continue to dominate political decision-making for at least the next year. This will be seen in both the government's response to the impending economic crunch, and how key decision-makers are held to account for their actions during the pandemic.

Covid-19 has proved that rapid policymaking and system transformation is possible.

Like many countries across Europe, the government demonstrating the full weight of its authority by creating emergency legislation at pace, and directing how citizens and businesses could act during a national crisis. After several years of inching forward on Brexit issues, it came as a welcome reminder that it is possible to put in place rapid change when necessity demands it.

A focus on doing what needs to be done to address the crisis has seen system transformation that had been discussed for over a decade put in place in a matter of weeks. This will have profound and long-term consequences for healthcare delivery in the UK, as new ways of working will prove difficult to roll back once embedded in daily clinical practice.

SERVICE	OUTLOOK IN A POST-PANDEMIC HEALTHCARE LANDSCAPE
Remote Consultations	The most public facing transformation has been the rapid roll-out of remote consultations across healthcare settings. Over 2019, it was clear that change was coming. New healthcare technology providers were pushing for change, and a supportive Secretary of State was seen as a key enabler. The major barrier had been finding a payment mechanism that would support the roll-out and convincing a sceptical clinical landscape of the value of change. However, the complete suspension of routine face-to-face primary care appointments changed the landscape overnight. Primary care has moved to a triage first model reliant on remote consultations. Although video-conferencing using dedicated platforms may remain an ambition rather than reality, there has been a massive expansion of remote consultations. This has been enabled by allowing basic tools such as WhatsApp, Skype and FaceTime to be used as short-term solutions. If GPs can be convinced of the time-benefits of these types of services, much of the existing opposition to the roll-out may disappear as services return to normal. There has also been a rapid roll-out of video conferencing tools to support outpatient appointments. Whilst there has been some criticism over the seemingly preferential treatment of Attend Anywhere, it has subsequently been confirmed that from next year, there will be a framework of providers to offer NHS Trusts maximum choice.
Independent acute healthcare providers	With the complete suspension of routine elective work, independent acute healthcare providers who would normally rely on overflow capacity work from NHS Trusts saw their revenue streams disappear overnight. However, during the crisis a new working relationship with the NHS began to develop. The independent sector functioned as an auxiliary support, with core NHS Trusts housing A&E locations rapidly remodelled to mitigate Covid-19 transmission. Capacity in the independent sector was used to ensure that non-Covid-19 surgical interventions could be undertaken. In the short-term, tension over cost appears to be growing – and the sudden dropping of London private providers from a national framework agreement may be the first in a series of skirmishes as the Government attempts to use its monopsony purchasing power to force prices down. However, in the longer term, it will be local relationships that determine referral protocols. With an elective care backlog likely to reach 10 million, and pressure from the government to begin a staged approach to normal targets, the independent sector has a real opportunity to position itself as a collaborative local partner.

SERVICE	OUTLOOK IN A POST-PANDEMIC HEALTHCARE LANDSCAPE
Diagnostic Testing Networks	There has been considerable criticism of the testing arrangements set up during the pandemic – much of it with good reason, and partly the result of the government failing to match its upbeat messaging with people's experiences of the reality. However, the model employed has effectively put in place policy ambitions around consolidated pathology services that were proving difficult to embed under routine conditions. It has allowed clinical diagnostic companies to gain an important foothold in the NHS market, which – given the requirement for continued testing over the next six months and the wider pressure the NHS is under – may be likely to last.
Discharge into social and community care	One of the most controversial elements of recent health policy was discharging people from acute care settings into residential or community settings before testing was widely available. This may prove to be a major factor for the way that Covid-19 swept through care homes during lockdown. Leaving aside issues related to the pandemic, what the situation proved was that with political will and empowered clinicians, it was possible to clear the bed-blocking crisis that had caused capacity issues in recent years. Care providers may stand to benefit with less void days as pathways smoothen and hospital bed occupancy days begin to drop. Whilst providers may be wary of accepting new admissions without a full assessment, a new approach to undertaking care package assessments may be considered.

Key Challenges Facing the Health and Social Care System

System Transformation

- Attempts to manage demand has led to large scale changes in operating procedures that usually take years to embed
- There has been a massive and rapid shift to digital first primary care services, and a roll-out of digital options in outpatient appointments
- Rapid acute discharge is possible if rules and regulations are eased - but understanding the impact on other parts of the health and social care system is vital
- Private sector capacity has been diverted to support the public sector

Will changes be embedded as the 'new normal' for the NHS, and will lessons that it 'can' be done rapidly mean that future change 'will' be done rapidly?

Social Care Sustainability

- Social care has been hit hard by the pandemic, exposing the fragility of the sector and putting providers under significant economic and operational stress
- The crisis has forced the government to engage with the topic of long-term funding sustainability - after dodging the question for much of the last decade
- Long-term care insurance or a tax ringfenced for those over 40 have been suggested as potential funding options - both options are likely to be politically unpopular, as it will require the public to pay more for their care
- A radical proposal to merge NHS and social care budgets would lead to significant impact on providers

Will governments use the crisis as an opportunity to have an honest conversation with the public about the need to reach an agreement on how future social care needs should be funded?

Public Spending Pressure

- Public finances will come under huge pressure as the impact of propping up the economy during the crisis unwinds
- The NHS has been promised 'a blank cheque' to manage the crisis - with the total likely Covid-19 spend running in the billions
- After emerging from a decade of spending restraint, Boris Johnson was elected on an upbeat message that promised substantial increases in public expenditure
- Tax rises may be required - but the government will be conscious of not wishing to alienate the so-called 'red wall' voters that switched their allegiance to the Conservatives in the last election

If spending cuts are required, will the government feel it would be politically viable to reduce spending to health and social care sectors?

Managing Pent-up Demand

- The NHS was facing serious waiting list pressures before the pandemic - with its reduction being a key area of focus in the NHS Long-Term Plan
- Freezing routine elective surgery, alongside growth in new patients, has meant that pent-up demand has been building up
- Second and third wave Covid-19 spikes, alongside traditional winter pressures, will also contribute to demand pressures
- As systems revert to normal, there will be large pent-up demand to resolve, an exhausted and depleted workforce to deliver them, and a growing pool of patients requiring urgent interventions

Given the lack of capacity in the public sector, what role can the private sector play in providing auxiliary support to support waiting list reduction?

A New Prime Minister: Assessing the Impact of Boris Johnson on Health and Social Care

A turbulent but successful first six months in office

It has been just over a year since Boris Johnson took over as Prime Minister, after replacing the increasingly beleaguered Theresa May as the leader of the Conservative Party. It is difficult to imagine any political leader facing a more turbulent first six months in office.

After the usual machinations of any Conservative leadership contest saw Boris Johnson emerge victorious, he enjoyed a relatively peaceful summer before returning to wield executive power on a scale rarely seen.

One of his first acts in the Autumn was to prorogue Parliament – essentially shutting down Parliament to end a session. Usually an uncontroversial piece of parliamentary process, in this case, it meant parliament wouldn't sit for six weeks during a time-critical period for debating the Brexit withdrawal process. This was interpreted as a mechanism for avoiding meaningful parliamentary debate on the Brexit withdrawal process. The Supreme Court subsequently ruled the act illegal, and the government was forced to allow Parliament to sit from early October 2019.

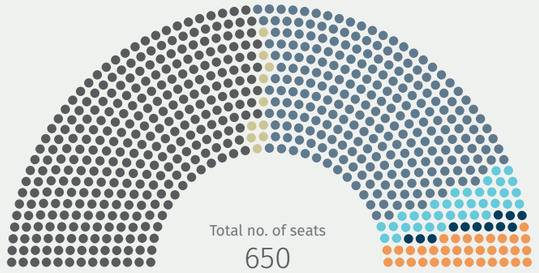
By Christmas, Boris Johnson managed to steer the passage of the EU Withdrawal Agreement through Parliament, lose more parliamentary votes than any prime minister in recent history, withdraw the whip from multiple Conservative MPs in an act that split the party more fundamentally that any time since the 19th century, and win a general election which substantially strengthened his authority both within his own party and Parliament.

It was yet another reminder to those within the Westminster bubble of how little importance the wider electorate places on these parliamentary scuffles. The Labour party may have been able to claim the moral high ground, but the Conservatives were able to point to securing a deal on Brexit – which is ultimately what resonated most strongly with voters.

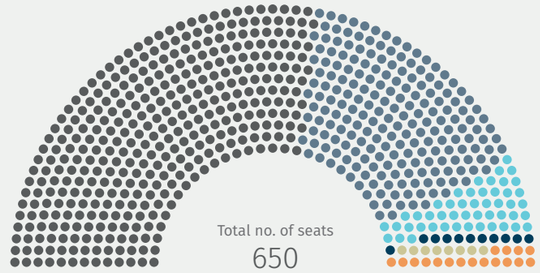
The Labour Party's failure to develop a convincing Brexit narrative or articulate how they pay for their election spending pledges led to a disastrous day at the polls, with support crumbling across the country – particularly in the so-called 'red wall' of Midlands and Northern constituencies.

The year ended with the Conservative Party enjoying a comfortable majority of 85, the Labour Party beginning a new period of soul-searching that would result in the far more electable Keir Starmer taking over the reins of leadership, and Britain and EU entering the next intense phase of deal negotiations.

UK Parliament – July 2019



UK Parliament – July 2020



Regulation and policy create a favourable environment for online primary care providers and digital services

The NHS LTP sets out the objective to make 'digital-first' primary care available to all patients by 2020/21. This means that patients will be able to access online consultations. Patients will be given a choice to use these services as alternatives to a face to face GP consultation and will be able to choose between their practice's service or one of the new digital GP providers that have contracts with the NHS. The strengthening of the quality regulation framework will support the policy objective.

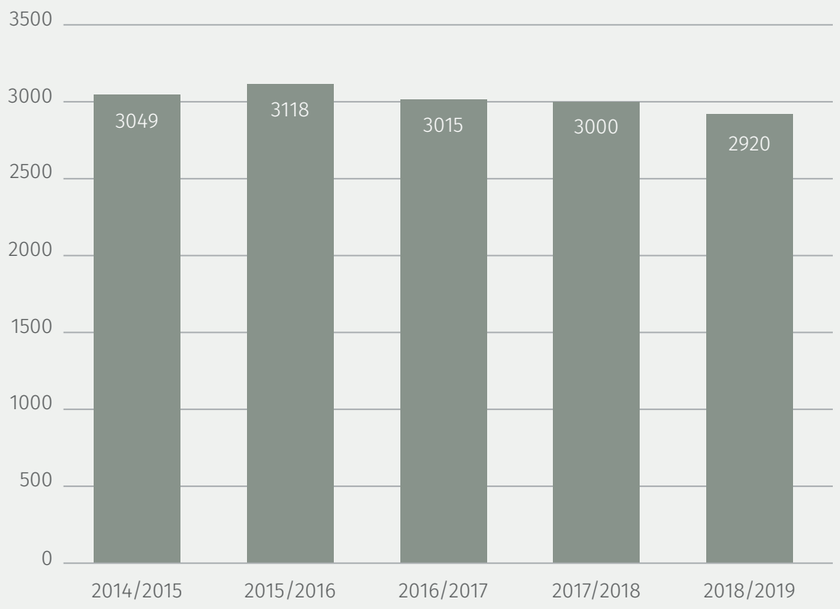
This is likely to create opportunities for telehealth companies to sell their services to GPs or to operate as stand-alone alternative providers under contract with the NHS. These services have already been developed over the past few years. As they will deliver health services, they will need to register with CQC and will be regulated in a similar way as traditional GPs, being subject to CQC inspections and rated against the five key questions. Companies wishing to compete in this space will likely have to demonstrate how their services match CQC's standards as a condition of contract.

It is believed that these services will eventually expand to include other digital services like e-pharmacy, digital mental health, digital physiotherapy etc. This reflects trends in the transformation of primary and community care services increasingly working together. These services could be additional investment opportunities for new investors or potential horizontal integration opportunities for existing investors in primary care.

Key Messages for Primary Care: Dentistry

- Dental services provision in England primarily consists of independent, small or single-handed practices, alongside a few larger corporate groups that operate across multiple locations. Most dental practices offer a mixture of NHS and private-pay services, but some focus on the pure-NHS or pure private-pay sectors
- Between June 2017 and June 2019, 22m adults and 7m children had an appointment with an NHS dentist
- There are over 33,000 dentists registered with the General Dental Council in England. Over 24,000 are performing NHS dental activity. England has fewer dentists per person than Germany, France or Italy
- The cost of NHS dentistry is split between the user – through a patient charge – and by NHS direct payments to dentist. Recent increases to the patient charge have averaged 5% per year, although it was frozen in 2020, reflecting the impact of Covid-19
- All routine dental activity was suspended in March 2020 as a result of Covid-19. NHS payments were maintained which provided some stability for those operating in the public-pay sector. Dental practices are now able to resume practice. However, there are capacity constraints due to requirements to ensure premises reduce avoidable transmission risks
- Private pay dentistry was buoyant ahead of the emergence of Covid-19. The enforced closure of dental practices will have hit revenues hard. However, pent-up demand and continued access pressures in NHS-provided care may enable some defensibility in the wake of a period of economic constraint

Total inflation-adjusted NHS income for dental practices in England has slightly declined since 2015-16



Data: Total RPI-adjusted NHS income for dental practices in England (2014/15 to 2018/19) (£, m; 2018-19 prices). Income derived from NHS England allocated funding to dental services, and patient charges

Source: National Audit Office

Payers

The majority of dentists in England provide both NHS-funded and private-pay services. They are exposed to two major payers; the NHS and individual private payments. There is a wide variety of out-of-pocket private payment options. Some dentists focus on high-end luxury dental services, but in recent years, chain providers have begun to offer low-cost private pay. The Bupa 'essentials' range, priced only slightly above the level patients' pay for NHS services is an example of this model. Smaller revenue streams come via dental insurance and capitation plans like Denplan.

NHS funding trends

Unlike the majority of NHS services, dental services are not free at the point of need. Patients are required to contribute to the cost of services through a co-payment, known as the 'patient charge', unless they qualify for an exemption. This creates two separate revenue streams for NHS dental practices.

Direct NHS payments

In 2018/19, direct NHS payments to dentistry amounted to about £2.06 bn - representing 71% of the total NHS income for dentists. The amount paid directly by the NHS varies year-on-year but has gradually been declining in real-terms in recent years. According to the British Dental Association, government spend on dentistry per head has fallen by £4.95 in the last five years - to £36 from £40.95.

Patient charge (co-payment)

Dentistry is one of the few areas of the health service where individuals have to make a contribution to receive services. In recent years, this patient charge has increased much faster than direct NHS payments. This has meant the burden of funding NHS dental services has increasingly shifted towards patients.

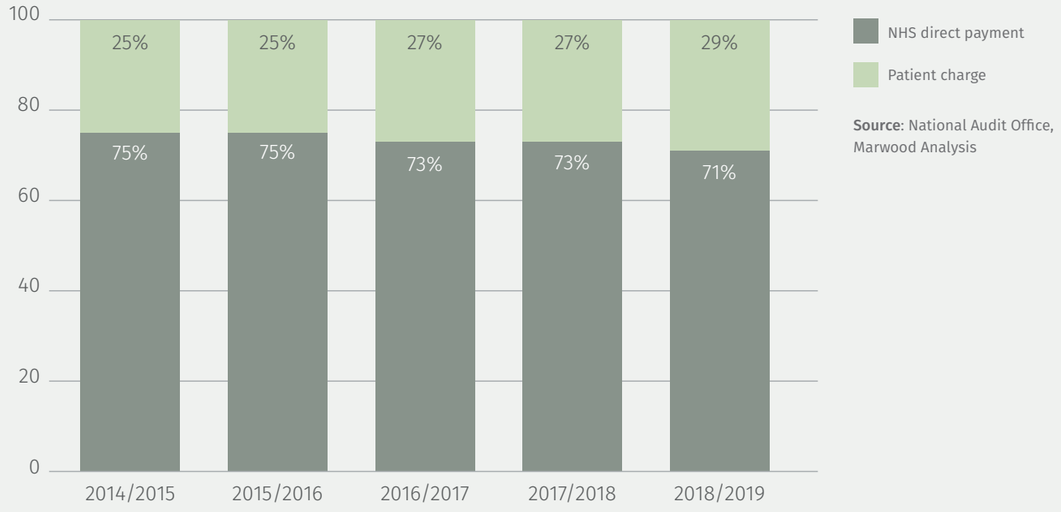
In 2011/12, patient charge revenue contributed to just 23% of the total dental revenue. By 2018/2019, it had increased to 29%. This growth in the patient contribution to overall dental practice income is expected to continue in the next few years. Annual increases have offset dental income decline as a result of minimal increases to direct NHS payments.

There are three different levels of charge (known as 'bands'), depending on the type of treatment. In the past four years, patient charges have increased by about 5% per annum across all bands. As a consequence of the Covid-19 pandemic, NHS dental charges have been frozen at the 2019-2020 rate until 01 October 2020.

TREATMENT BAND	TYPE OF TREATMENT	PATIENT CHARGE (2019/20)
Band 1	Check-up, diagnosis, treatment planning and maintenance	£22.70
Band 2	Fillings, root canal, tooth extraction	£62.10
Band 3	Complex treatment that includes laboratory element	£269.30

Individuals can be exempt from the patient charge, with NHS England direct payments covering the full amount for their patient care. However, over half of all dental activity is performed on people eligible for the patient charge. Non-paying adults are also far more likely to be receiving Band 3 treatment - with about 50% of dental activity in this intensive bracket. This compares to just over 25% of paying adult's dental activity falling into Band 3 treatments.

Change in NHS Direct Payments v Patient Charge Revenue (2014/15 – 2018/2019)



Source: National Audit Office, Marwood Analysis

NHS dentists have seen their income protected during the pandemic. As services resume, there may be opportunities for consolidation as some dental operators seek to exit the market

As dentistry was suspended during the lockdown, dental practices across the spectrum faced a collapse in incomes. Practices operating as independent businesses had some short-term defensibility as they would likely be eligible to access broader Government-backed business protection schemes and could furlough members of staff.

However, the concern over the spread of Covid-19 through the use of aerosol generating procedures (AGP) has meant that even as dental practices return to operation, operational capacity may remain severely limited.

For those operating in the public pay space, NHS England has guaranteed monthly payments equivalent to 1/12 of their annual activity targets. However, there has been criticism over the lack of forward planning about what will happen when routine work re-commences, and there is a likely surge in demand from people who had required but not accessed dental treatment over the previous three months.

Private dental practices face the challenge of regulating the inflow of patients, where capacity has been cut by up to 75%. With fewer booking slots, practices will have to re-evaluate their patient selection criteria, as they balance meeting the clinical needs of their patients against the financial security of their practice.

With the potential for dental practice closure, accessibility may return as a live issue. This may be reinforced unless the NHS reverses the long-term decline in UDA commissioning. A growing population has meant that dental activity equates to 1.56 per person in 2019; a decline from 1.67 in 2012.

This may provide opportunities for other larger dental practice groups who are able to mitigate the exposure risk to acquire new sites.

The private pay dental sector

The dental sector is one of the few elements of the healthcare system that has a clear and distinct private sector operating in parallel with the public sector. Whilst private pay exists throughout, the size of the market tends to be minimal compared to NHS delivery – or it provides services that are just not offered through the public health system.

Whilst the private pay market was hit following the 2008 financial crisis, it has rebuilt itself over the past decade. The sector has evolved significantly, with the emergence of medium- and large dental chains. The offer has evolved to cover offerings to consumers at varying price points, including increasingly offering a direct low-cost model to compete with the NHS.

This model has evolved during to the continuing increase in the patient charge. This charge has meant that unlike most elements of the healthcare system, people may view themselves as consumers as much as patient.

This is reflected in Marwood's interviews with dental users. We found that there is a perception of quality associated with private-pay dentistry. This is driven by the belief that private dentists have more time with patients and can therefore be more thorough in their check-up and treatment delivery. They are also seen to have access to better equipment; provide a wider range of services; are more accessible in terms of appointment times and availability; and are more likely to have a personal relationship with their patients.

Alongside this there is continuing demand for cosmetic services not accessible on the NHS. Marwood conducted a survey of dental practices, and demand for cosmetic services was the leading reason identified by dental professionals for why people were choosing private pay options. This type of add-on services may suffer in the wake of the pandemic, but the underlying demand may remain in the longer-term.

Demographic change is also expected to drive increased demand for private dental care. Older age is correlated with increasing dental need and this represents an increasing population within the UK.

Coronavirus and the potential impact on private-pay

Ahead of the emergence of Covid-19, the private-pay dentistry segment was buoyant – as consumer demand continued to increase from its slump following the fall-out of the 2008 financial crisis.

With the economic impact still to feed through into consumer spending decisions, and all dental activity limited, it is not possible to be certain how this will play out in the private pay segment. We do know that in 2008, the decline in private pay was augmented by increases in funding that improved access to NHS dentistry.

Though it is likely that the private-pay segment will be hit by the short-term impact of Covid-19 forcing dental practices to close, and reduced operating capacity in the longer-term, these factors will also impact on NHS dentistry. There is likely to be a significant pent-up demand that will not be able to be met by the public-pay segment without additional funding.

The sector is in a very different place in 2020. The re-emergence of private-pay in the last few years has been linked to limited NHS funding, increased patient charges, and an increasing tightening of the availability of the range of services available on the NHS.

The emergence of low-cost dental alternatives and the importance placed on accessing services at a convenient time may well sustain private demand. However, this demand may well be focussed among particular customer segments and geographic regions. The level of localised NHS availability is likely to be a key driver in decision making.

The longer-term risk will be consumers choosing to forego private-pay options in the face of a sustained economic decline. However, given the demand pressures on the NHS, this could lead to increased interest in the low-cost private-pay model, with traditional NHS users paying slightly more to access a low-cost private option, and higher-end private-pay users switching down to save money whilst remaining within the private segment.

Policy And Legislation

General Dental Contract Reform

Issues with the 2006 General Dental Contract

Dental policy rarely garners much political attention, and sector conversations are dominated by attempts to reform the 2006 NHS General Dental Service contract, which remains highly unpopular with the dental profession, and viewed as not fit for purpose by the British Dental Association. The activity-based payments system is blamed for dentists spending too much time chasing agreed activity targets and being incentivised to focus on treatment rather than preventive activity.

Understanding NHS dental payments: Units of Dental Activity

Dentists providing NHS services are currently reimbursed on the basis of the Units of Dental Activity (UDA) system. Each dental practice that provides NHS activity will have a contract specifying the volume of UDAs they should deliver annually. Treatments will be valued at between 1 and 12 UDAs. This is supposed to reflect the complexity and length of time different treatments will take. It aims to ensure dentists are not disincentivised to provide complex, lengthy treatments. Dentists earn between 1 and 12 UDAs depending on the type of treatment provided. The unit price of UDAs is agreed on a practice by practice basis, leading to variation between practices.

Under the current contract, dentists carry most of the financial risks. If a practice fails to achieve the volume of UDAs they committed to deliver, their NHS payments are adjusted to reflect lower volumes. However, there are no requirements on commissioners to fund over-delivery of UDAs. This balance is meant to ensure that dentists do not under-deliver to NHS patients by over-committing to private provision, but also allows NHS England to help manage the cost to the NHS by not rewarding over-delivery. When practices miss their UDA volumes for three consecutive years, NHS England may also reduce the contractual volume of UDAs a dental practice can deliver.

Social Care in England

Social care provision in England is primarily the responsibility of local authorities. However, national government exerts a high degree of control over both direct and indirect levers that affect local authority decision-making.

Health and social care are split between two different funders.

- A health need will be funded through the NHS, and ultimately by the Department of Health & Social Care
- A social care need – if a person meets both the needs and eligibility thresholds – will be paid for by a local authority. For children who require a high level of support (a EHC plan), their support costs should be split between two different internal local authority budgets – and local health service may also be required to contribute

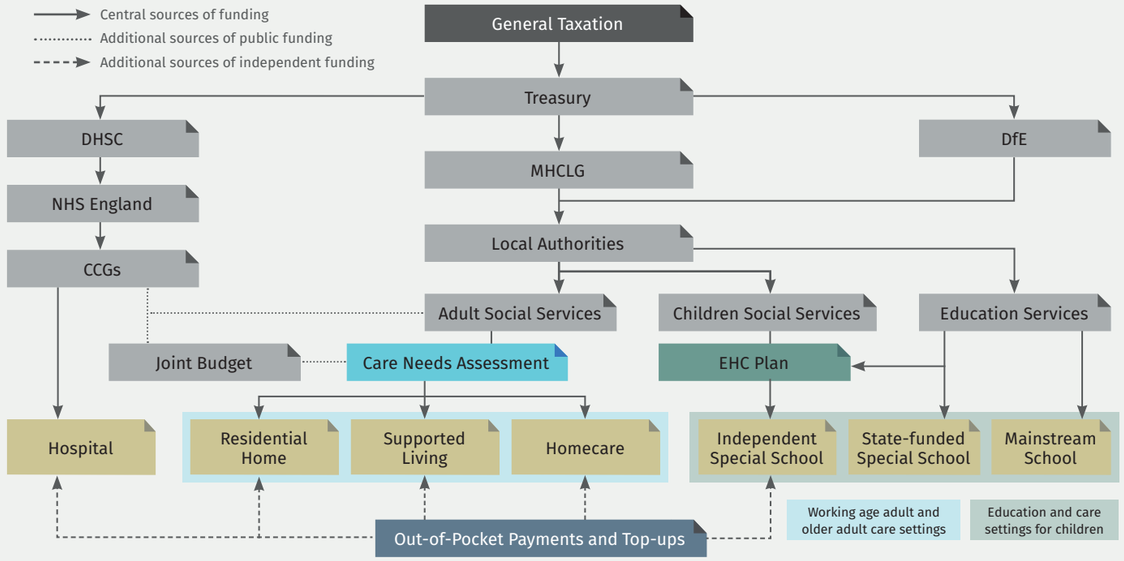
Central government is responsible for setting a local authority's budget, but social care is not directly ring-fenced so local authorities can choose to spend money how they wish. However, they are required to meet their statutory responsibilities. Growing demand has meant that increasingly local authorities are reducing non-statutory services to ensure funding is available for statutory needs

- Statutory responsibilities for adult social care are set out in the Care Act 2014
- Statutory responsibilities towards children and young people care needs are set out in the Children and Families Act 2014

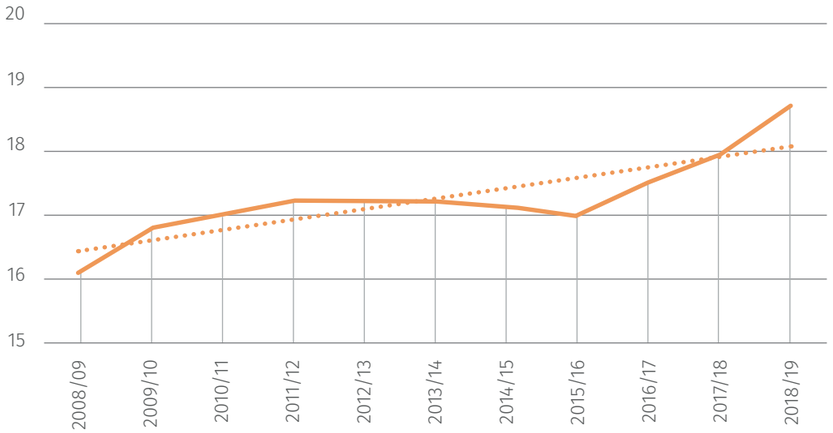
Increasingly government has been exerting indirect centralised control by establishing ring-fenced conditions for funding. The Improved Better Care Fund, which compels money to be spent on clearly defined priorities, and the establishment of the Social Care precept, both force local authority revenue to be directed towards social care objectives.

So long as they meet their statutory obligations, local authorities are free to set their own policy goals in relation to adult and children services. This can involve setting the overall strategic direction, balancing in-house versus outsourced care delivery, setting rates that providers are paid for services, and the level of need a person must experience before qualifying for care.

Funding flow into social care providers



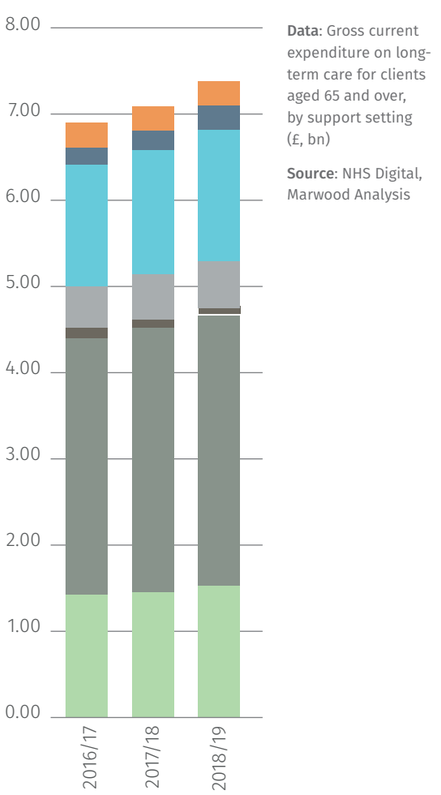
Overall Public Expenditure on Adult Social Care has Begun to Grow Since 2015/16, after Several Years of Funding Restraint



Data: Gross current expenditure on adult social care (£, bn)

Source: NHS Digital, Marwood Analysis

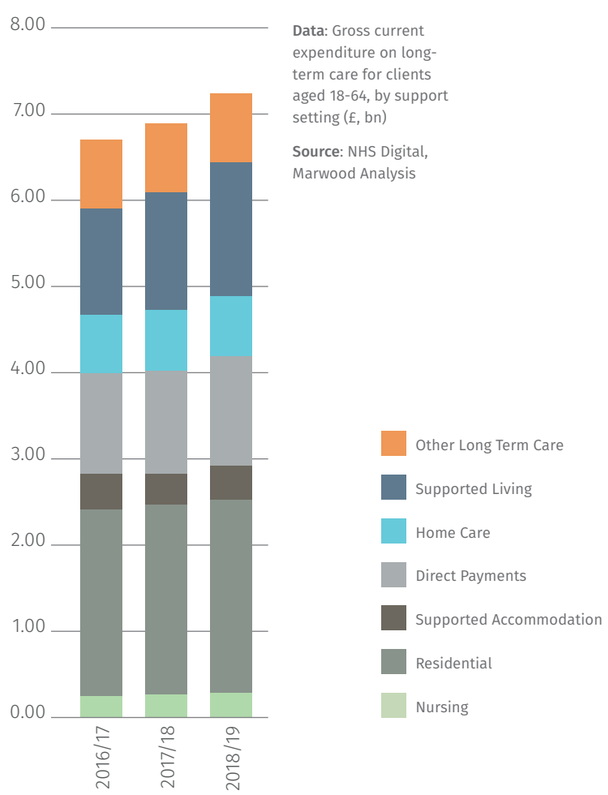
Spending on older people social care by support setting (2016-2019)



Data: Gross current expenditure on long-term care for clients aged 65 and over, by support setting (£, bn)

Source: NHS Digital, Marwood Analysis

Spending on working age adult social care by support setting (2016-2019)



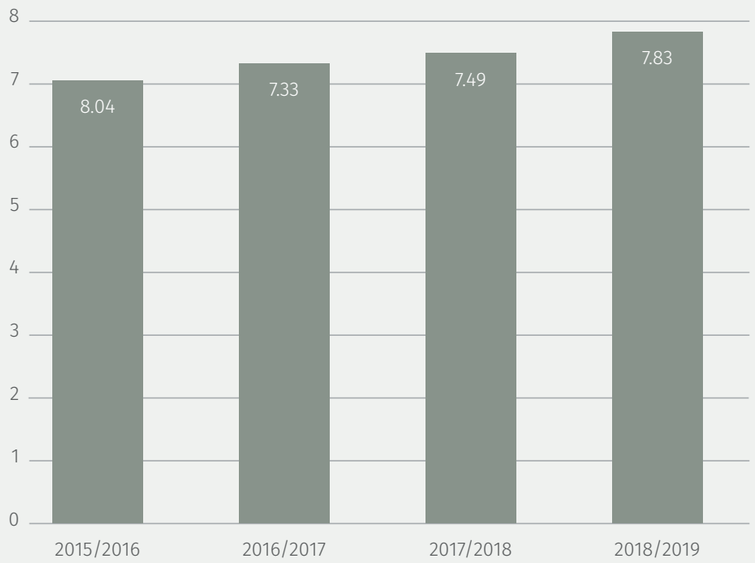
Data: Gross current expenditure on long-term care for clients aged 18-64, by support setting (£, bn)

Source: NHS Digital, Marwood Analysis

Key Messages for Older People's Care

- Older people care services in England refer to services supporting individuals over-65 years old in their activities of daily living. Care provision is delivered mostly by private providers; either within an individual's home (domiciliary care) or in residential or nursing care homes
- The UK's population aged 65 and above is increasing – projected to reach 18.7m in 2045, with nearly 25% of the population being over 65
- Local authorities spend more than £7bn on older people's social care services. Increasingly top-up funding comes from other sources; with approximately £1.5bn annually coming from the Improved Better Care Fund, up to £2.4bn from a locally raised 'social care' precept, and the government promising an additional £1bn each year ringfenced for social care
- Public pay users who most contribute towards their care account for a further £2.9bn in funding. Pure private pay is estimated to make up more than 40% of the older people care market, drawing in over £11bn in revenue annually
- The Covid-19 pandemic had a major impact on the social care sector. Occupancy rates in care homes plummeted, although the impact was not evenly distributed through the system. This will be a short-term impact, with occupancy likely to recover to their pre-pandemic levels within a year. However, there may also be a longer-term shift from care homes to homecare, as a result of residual concern from users and relatives about the safety of residential placements in the near-term
- The pandemic has also forced the government to face the funding sustainability issue of social care. Proposals will be clarified in the Autumn, but politicians are beginning to address issues around long-term care insurance or hypothecated taxes for social care, which may bring long-term funding stability into the sector

Direct local authority expenditure on older people's care has risen slowly in recent years – and has required further support from central Government budgets to sustain care levels



Data: Gross Current Expenditure on long and short term care combined for over 65s, 2015/16 – 2018/19 (£, bn)

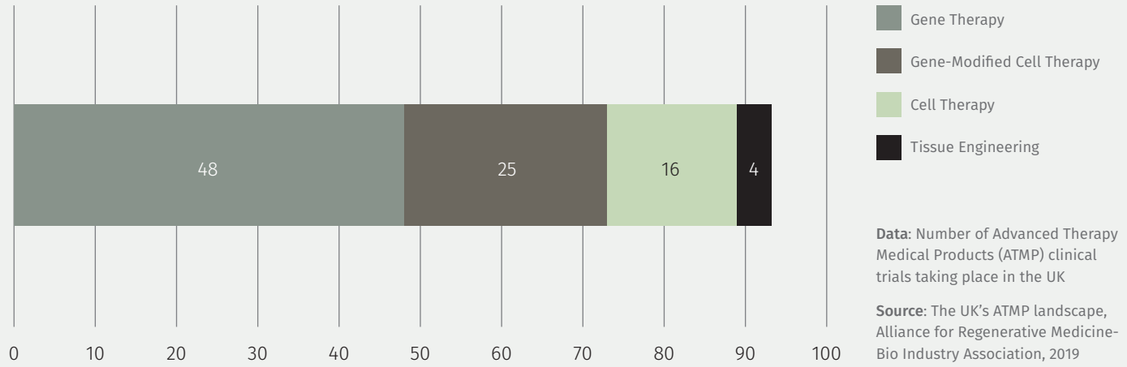
Source: NHS Digital

Note: Funding does not include additional money spent on public pay older people care through the Integrated Better Care Fund, or via locally raised revenue, such as the adult social care precept

Key Messages for Branded and Innovative Drugs

- The UK continues to be an attractive location for pharmaceutical developers and manufacturers, supported by a positive policy and regulatory environment
- In 2019, the biotech sector was worth £1.3 billion, the third-highest year of investment in the industry since 2012. Despite expectations that the Covid-19 pandemic would severely affect investments, a total of £894m has been raised in the first half of 2020, surpassing the £831m raised in the same period in 2018 - a record-breaking year
- The policy focus on innovation and the ambition to strengthen the UK's position as a global leader in life sciences is creating a favourable environment for clinical research. This is supported by increasing join-up between the NHS and industry – including making highly effective use of the NHS's unique patient dataset
- Funding on pharmaceuticals in the NHS remains constrained creating pricing pressures, but the new multi-year spending control agreement allows for annual spending growth of 2% on branded and innovative drugs
- NHS spend on specialised medicines has risen sharply because of a wave of new treatment options, and NHS England's pricing agreements on CAR-T therapies reflect a more flexible approach to funding access to advanced therapies. However, the near four-year battle over Orkambi, Vertex's cystic fibrosis drug, shows that NHS England continue to take a firm line on value for money pricing
- New cancer treatments are expected to continue to be of interest to the NHS, in line with objectives of the NHS Long Term Plan to improve cancer survival rates and enable access to innovative medicines

The UK continues to be a major global centre for clinical trials, research and innovation



Data: Number of Advanced Therapy Medical Products (ATMP) clinical trials taking place in the UK

Source: The UK's ATMP landscape, Alliance for Regenerative Medicine-Bio Industry Association, 2019

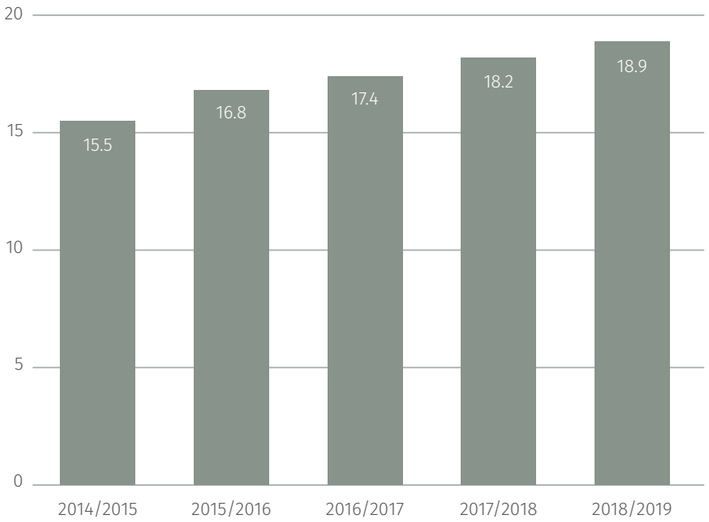
Payers

Overall spend on pharmaceutical products across the NHS has been increasing in recent years – and reached £18.9bn in 2018/19. This total spend covers both hospital and community settings, and all types of pharmaceutical expenditure (branded and innovative, and generics and biosimilars).

Hospital expenditure accounts for an increasing proportion of the spend; reaching 53.7% in 2018/19, and seeing an 11.1% rise on the previous year. In comparison, the total spent on primary care has decreased in each of the last three years, with a 2.1% decline in 2018/19.

The total amount reported on pharmaceutical expenditure is the list price for the products and so does not include any agreed commercial discounting arrangements.

NHS Overall Expenditure on Pharmaceuticals has Risen 22% Between 2014/15 and 2018/19



Note: This represents the reported public pay spend in hospital and community settings for all types of pharmaceutical products. It does not take into account discount agreements or rebates

Data: Prescribing Costs in Hospitals and the Community 2014/15 to 2018/19 (£, bn)

Source: NHS Digital

Spending controls

The NHS spent approximately £8.3bn on branded drugs between Q1 2019 and Q3 2019 – suggesting an annual spend in the region of £11.1bn. This covers products sold via the VPAS or statutory pricing schemes, or via parallel imports. In reality, this spend is mitigated by discounting against the list price, and other price agreements that may lead to rebates.

Voluntary Scheme for Branded Medicines Pricing and Access (VPAS)

In January 2019, the Voluntary Scheme for Branded Medicines Pricing and Access (VPAS) replaced the Pharmaceutical Pricing Regulation Scheme (PPRS). VPAS outlines an agreement on branded medicines spending from 2019 to 2023. It was agreed between the Association of British Pharmaceutical Industries (ABPI), the Department for Health and Social Care and, for the first time, NHS England.

Containing pharmaceutical spend remains a key policy objective for the NHS, and the VPAS attempts to do this whilst ensuring access to medicines for patients. A key element is a cap on the NHS's annual spending growth for branded drugs. The VPAS annual spending under the cap is fixed at 2% per year –this is more generous growth than the averaged 1.1% per year allowed under the predecessor PPRS between 2014 and 2018.

	2015	2016	2017	2018	2019	2020
NHS allocated growth within the branded drugs budget	0%	1.8%	1.8%	1.9%	2%	2%

Source: Department of Health and Social Care

When the cap is exceeded, pharmaceutical companies signed up to VPAS are required to pay back a percentage of their NHS sales to the Department of Health and Social Care. The pay back mechanism is derived from the difference between the 'allowed growth rate' and the 'forecast growth rate'. This is a key mechanism in ensuring the NHS doesn't heavily overspend on pharmaceuticals.

In 2020, this equated to 5.9%. This is a reduction on the 9.6% that was due to be repaid in 2019. The amount a specific company would have to pay back in 2020 would be worked out as follows:

Scheme Payment = Eligible Sales x Payment Percentage for that calendar year

VPAS does differ from the 2014 PPRS in one significant way, the requirement for companies to offer the same deal – whether agreed in England, Scotland, Wales or Northern Ireland – across all. This could present opportunities for the industry, as companies could focus on striking one deal in England and then leverage that across all nations to support faster uptake. At the same time, this creates risks as companies may have to give bigger discounts to all, instead of just to some.

As under PPRS, there are a number of exemptions. For example, spending on vaccines, low-value sales, or sales by small pharmaceutical companies are some of the areas that are not taken into account.

Companies that decide not to join VPAS are, by default, subject to the Statutory Scheme that controls pricing decisions. Functionally it is similar to the VPAS, but since there is less negotiation between the ABPI and the Department of Health and Social Care / NHS England under this arrangement, it means that caps and pay back decisions are imposed on pharmaceutical companies.

NICE's cost-efficiency assessment

The National Institute for Health and Care Excellence (NICE) is responsible for assessing the cost-efficiency of medicines in the UK and provides recommendations for whether they should be reimbursed by the NHS. A key element of this appraisal is the measurement of a medicine's cost per Quality-Adjusted Life Years (QALY) resulting from using the treatment. The QALY takes into account both the length and quality of life. Generally, a cost of £20,000 - £30,000 per QALY is deemed to be cost-effective and should lead to a product being reimbursement on the NHS.

In 2009, NICE increased the QALY to £50,000 for end-of-life treatments and in April 2017, it introduced another threshold for very rare disease treatments, which may have a base QALY of £100,000 per QALY. However, the threshold for ultra-rare disease treatments is weighted by the number of years a drug or treatment can extend quality life and can go up to £300,000 per QALY.

Following this change, NICE recommended that the high-cost gene therapy product, Strimvelis, be made available for NHS reimbursement. Strimvelis reimbursement is particularly unusual as patients access the treatment in Italy, rather than on-site in an NHS facility.

For cost containment purposes, in view of the escalating costs of innovative treatments, NICE introduced a new threshold for expensive drugs. If a drug costs more that £20m per year in the first three years, a commercial discussion is automatically triggered between the company and NHS England, with the aim of mitigating the adverse financial impact on the wider NHS budget. Whilst NICE

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