The National Health Service (NHS)
Updated October 2012
Brief history

Founded on 5 July 1948
Spearheaded by Aneurin "Nye" Bevan, Minister of Health

Concept of the NHS is shared across the UK
However, accountability, commissioning and delivery of NHS services is devolved and varies across:
- National Health Service (NHS) (England)
- NHS Wales
- NHS Scotland
- Health and Social Care (HSC) in Northern Ireland

3 Core principles
Healthcare for all (even for temporary residents or visitors)  Free at the point of use  A tax funded system

Bringing medicines to life
Key statistics

- The world’s largest publicly funded health service
- Staff across the NHS are in contact with over 1.5 million patients and their families every day

The NHS employs more than 1.7m people

Of those, just under half are clinically qualified, including 39,409 general practitioners (GPs), 410,615 nurses, 18,450 ambulance staff and 103,912 hospital and community health service (HCHS) medical and dental staff

1948 budget: £437m
(roughly £9 billion at today’s value)

2011/12 budget: £106bn

- Just under 10% of the total NHS budget is spent on medicines

Bringing medicines to life
The rate of secondary care growth is slowing.

Forecasts suggest projected growth for medicines spending of 1-2% each year in primary care and 7.3-8.7% each year in secondary care between now and 2015.

NHS spend is tightly controlled by Government cash limits.

Funds are allocated geographically according to a complex formula, which amounts to giving commissioners a capitation payment per person for whom they are responsible.
NHS Wales

- Strategic decisions about health made by the Welsh Government
- **National Delivery Group** responsible for delivery and development of healthcare
- **Seven Health Boards** provide primary and secondary care services
- In addition to the Local Health Boards, there are **three NHS Trusts**:
  - Welsh Ambulances Services Trust
  - Public Health Wales
  - Velindre NHS Trust providing specialist services (such as cancer care)
- There are **eight Community Health Councils** containing lay representatives
- **Governance structure and quality standards**:
  - Healthcare Inspectorate Wales (HIW)
    - *‘Doing well, doing better: standards for health services in Wales’ (2010)*
  - HIW also regulates Independent Healthcare
  - National Advisory Board – provides independent advice to Minister of Health & Social Services
- **National Leadership and Innovation Agency for Healthcare (NLIAH)**: best practice and innovation
- Other than pricing of medicines, English DH has little involvement in development of health policy and delivery of services in Wales
- Ministerial funding direction for NICE and AWMSG guidance
- Prescription charges abolished
With devolution in 1999, healthcare landscape changed as health became responsibility of Scottish Parliament.

Budget allocation from Scottish Government Health Directorate to 14 area NHS Boards responsible for primary and secondary care.

Eight Special Health Boards.

Scottish Medicines Consortium (SMC) (instead of NICE in England) reviews all new medicines and indications within 18 weeks of launch - SMC advice is not mandatory.

Free personal care for elderly, free eye and dental checks for all.

No prescription charges.

Resistant to greater use of the private sector.

Plans to amalgamate health and social care sector.
Health and Social Care in Northern Ireland

- Five Health and Social Care (HSC) Trusts – integrated services are provided locally and on a regional basis
- 350 GP Practices throughout Northern Ireland, 10 acute hospitals
- The Health and Social Care Board (HSCB) is responsible for commissioning integrated health and social care services, resource management, performance management and service improvement
- The HSCB works to identify and meet the needs of the Northern Ireland population through five Local Commissioning Groups which cover the same geographical areas as the HSC Trusts
- Prescription charges abolished
- NICE guidance implementation policy published in September 2011

Bringing medicines to life
The NHS in England

Current structure

**National**
- Secretary of State for Health
- Team of Health Ministers
- Department of Health (DH)
- NHS Commissioning Board (NHSCB)

**Regional**
- x10 Strategic Health Authorities (SHAs)
  - (in the process of merging into 4 super hubs)
- Non departmental bodies
  - For example: Care Quality Commission
  - NICE
  - Monitor

**Local**
- Acute trusts (170)
- Ambulance Trusts (11)
- Care Trusts (11)
- Mental Health Trusts (58)
- Clinical Commissioning Groups (212)
- Primary Care Trust clusters (50)
- Primary Care Trusts (151)
The NHS Constitution (2010)  
England only

“The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science - bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic need, when care and compassion are what matters most.”

1. A comprehensive service, available to all
2. Based on clinical need, not ability to pay
3. Aspiring to highest standards of excellence and professionalism in providing high quality care that is safe, effective and focused on patient experience
4. Services reflect needs and preferences of patients
5. Works in partnership with other organisations in the interests of patients and local population
6. Committed to providing best value for taxpayers’ money
7. Accountable to patients and public communities it serves
The National Institute for Health and Clinical Excellence (NICE)

- An Arms Length Body funded by the Department of Health
- Set up in 1999 to reduce variation in the availability and quality of NHS treatments and care
- Provides guidance to the NHS to help resolve uncertainty about which medicines, treatments, procedures and devices represent the best quality care and which offer the best value for money

Up to 150 quality standards

- Responsible for:
  - Evidence-based guidelines (diagnosis, treatment and prevention of diseases)
  - Up to 150 quality standards over the next 5 years (currently under review)
  - Technology appraisals for medicines
  - Producing public health guidance
  - Diagnostic and medical technologies programmes
  - Overseeing the development of the Quality Outcomes Framework (QOF) which incentivises GPs based on performance indicators

NHS
National Institute for Health and Clinical Excellence
The National Institute for Health and Clinical Excellence (NICE)

Ongoing developments include:

- The Health and Social Care Act 2012 sets out plans for NICE to become a non-departmental public body
- Remit to expand to produce quality standards for the social care sector
  - Eg. pilot programmes and consultations have been launched for dementia care and health and well-being of looked after children, with a publication date for the final quality standards due in April 2013
- Work alongside the NHS Commissioning Board, and professional and patient groups, to develop a Commissioning Outcomes Framework (COF)
  - First set of 44 indicators released at the start of August 2012, for implementation from April 2013 onwards
Drivers for change in England

- The NHS in England needs to achieve up to £20 billion of efficiency savings by 2015 (Nicholson challenge, 2009)
- The Health and Social Care Act 2012 passed into law in March 2012 and drives the biggest changes to the NHS since its inception

Four core objectives of reforms:
- Putting patients and public first
- Improving healthcare outcomes
- Autonomy, accountability and democratic legitimacy
- Cutting bureaucracy and improving efficiency
Developments to date

Putting patients and the public first

- Patient choice
- “No decision about me, without me”
- Healthwatch England – due to launch in October 2012
- Health and Wellbeing Boards – of 152 local authorities, 138 already have emerging Health and Wellbeing Boards
- Lay members on Clinical Commissioning Groups (CCGs)
- GP contract incentives for patient participation
Improving healthcare outcomes

- Strengthened role of NICE (up to 150 quality standards to inform commissioning by 2015)
- Evidence-based outcome measures (not process targets)
- Prescribing targets set locally
- Proposed value-based pricing of new medicines – to encourage innovation and access
- Provider payment mechanisms (tariff, standard contract, CQUIN, QOF, COF and PHOF)
Developments to date

**Autonomy, accountability and democratic legitimacy**

- Devolved power to Clinical Commissioning Groups (CCGs) – staff appointments currently taking place
- Establishment of NHS Commissioning Board in October 2012 – will provide leadership for the new commissioning system
- SHAs and PCTs officially abolished in April 2013 – 4 regional clusters, 50 local clusters
- All Trusts to become Foundation Trusts – currently 144 in place
- Any willing qualified provider (including from the private sector)
Cutting bureaucracy and improving efficiency

QIPP

- £20 billion in efficiency savings to be made by 2015
- 1.5% cut in tariff and non-tariff costs
- DH estimates approximately £3.9 billion savings achieved to date

- Shift of power towards patients and clinicians (e.g., GP commissioning consortia)
- Competition on quality, not cost
- Potential for QIPP to be incorporated under ‘transformation’ workstream led by Jim Easton
“While the NHS is recognised as a world leader in invention, the spread of those inventions has often been too slow, and sometimes even the best of them fail to achieve widespread use.”

Strategic approach to innovation in the reformed NHS

Eight key themes:

1. Reduce variation in the NHS and drive greater compliance with NICE guidance
2. In collaboration with industry, develop and publish better innovation uptake metrics, accessible evidence and information about new ideas
3. Establish a more systematic delivery mechanism for diffusion and collaboration within the NHS by building strong cross-boundary networks
4. Align organisational, financial and personal incentives and investment to reward and encourage innovation
5. Improve arrangements for procurement in the NHS to drive up quality and value (make the NHS a better place to do business)
6. Develop staff by ‘hard wiring’ innovation into training and education (managers and clinicians)
7. Strengthen leadership in innovation, set clearer priorities for innovation and sharpen local accountability
8. Identify and mandate the adoption of high impact innovations in the NHS
Value and access

- The National Institute for Health and Clinical Excellence (NICE) will be strengthened
- Commissioning based on the value of medicines
- NICE value appraisals (weightings given to medicines’ benefits with a maximum amount the NHS will pay)
- Proposed value-based pricing system to be introduced when the pharmaceutical price regulation scheme (PPRS) expires at the end of 2013 (new PPRS will be established for existing medicines)
- NICE guidelines to establish the position of a medicine in treatment programmes
- Local formularies based on NICE guidelines
- Community pharmacy services will be commissioned by the new NHS Commissioning Board, not GP consortia
- New NHS organisations and entrants to the healthcare market will provide a different set of customers
- As the NHS seeks greater efficiency savings, there is greater importance of demonstrating value both throughout the product life-cycle as well as where product will add most value in the treatment pathway

Bringing medicines to life
Considerations for industry

New ways of working

- Need to build relationships with new commissioners
- Shift to working with CCGs and clusters
- More clinically-focussed payers may lead to re-examination of traditional sales teams structures and capabilities and a focus on improving market access capabilities

- Increase industry:GP communication (eg where medicines fit into new pathways, when to manage, when to refer)
Considerations for industry

Partnerships

- Continue to work on trust & reputation activities with multiple stakeholders to build a positive environment for partnership working
- Patient focused outcomes should be a key goal of Joint Working initiatives
- Industry involvement in clinical pathway re-design to improve access to innovative medicines
- Provide more add-on services alongside medicines to add a higher value package for customers and patients

Industry to be accepted as a partner to the NHS and an integral part of the solution to delivering better patient outcomes

Bringing medicines to life
Government and industry wish to improve patient access to medicines in a scheme that delivers value to the NHS and fair reward for innovative medicines

- Government proposes a broader definition of value
- Industry agrees with a broader definition of value in a pricing environment that evolves from the PPRS and which supports the greater uptake of medicines

ABPI and industry view
Important principles need to be upheld such as:

- A stable and predictable pricing environment
- Minimal bureaucracy (especially for SMEs)
- Four nations agreement
- Maintenance of free pricing (which currently puts the UK in a favourable position)
- Appropriate reward for industry and innovative medicines

Details of such a scheme require ongoing negotiation
Proposed changes to UK pricing environment

- **2013**: Current Pharmaceutical Price Regulation Scheme (PPRS) runs to the end of 2013
- **2014**: Next pricing scheme will cover branded medicines on the market in Dec 2013 (95% of the branded market in 2018) and a new value assessment process for new medicines launched post 2014:

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- Industry supports a wider definition of value and broadly the above elements however how these will be applied in practice are a key part of negotiations
- NICE is likely to play a key role especially in terms of the QALY threshold (any movement could have a significant impact)
- The definition of innovation is fundamental for industry
- Devolved administrations and NCB in England are responsible for decisions about the use of medicines (uptake) in their systems and aspects of value assessment

ABPI continues to engage with industry and represents industry in negotiations

Bringing medicines to life
Key facts on the costs of medicines

The UK has amongst the lowest priced medicines in Europe

- The UK spends only 0.9% of GDP on medicines - less than the European average of 1.2%
- In the UK, uptake of new medicines is significantly lower than the European average (e.g. the use of new cancer medicines is 33% lower than the European average)

- The proportion of the NHS budget spent on medicines has fallen since 1999 - down from 13% to under 10%
- 65% of prescriptions are written for the over 65s. With 172,000 additional over 65s added to the population each year, the medicines bill is only going to increase
- The UK is very cost-efficient when it comes to paying for medicines - around two thirds of all prescriptions dispensed in the UK are for cheaper generic medicines
- New medicines only account for 10% of the NHS’s total spend on medicines
- Due to the number of products coming off patent between 2009 and 2015, the NHS is set to save well over £3bn

Bringing medicines to life