

The big picture

Digging down into regional PHIN data

Ring in the changes

WPA CEO Nathan Irwin talks about how the insurer is adapting to a changing market

The long road to treatment

Waiting times analysis by the team at Candesic

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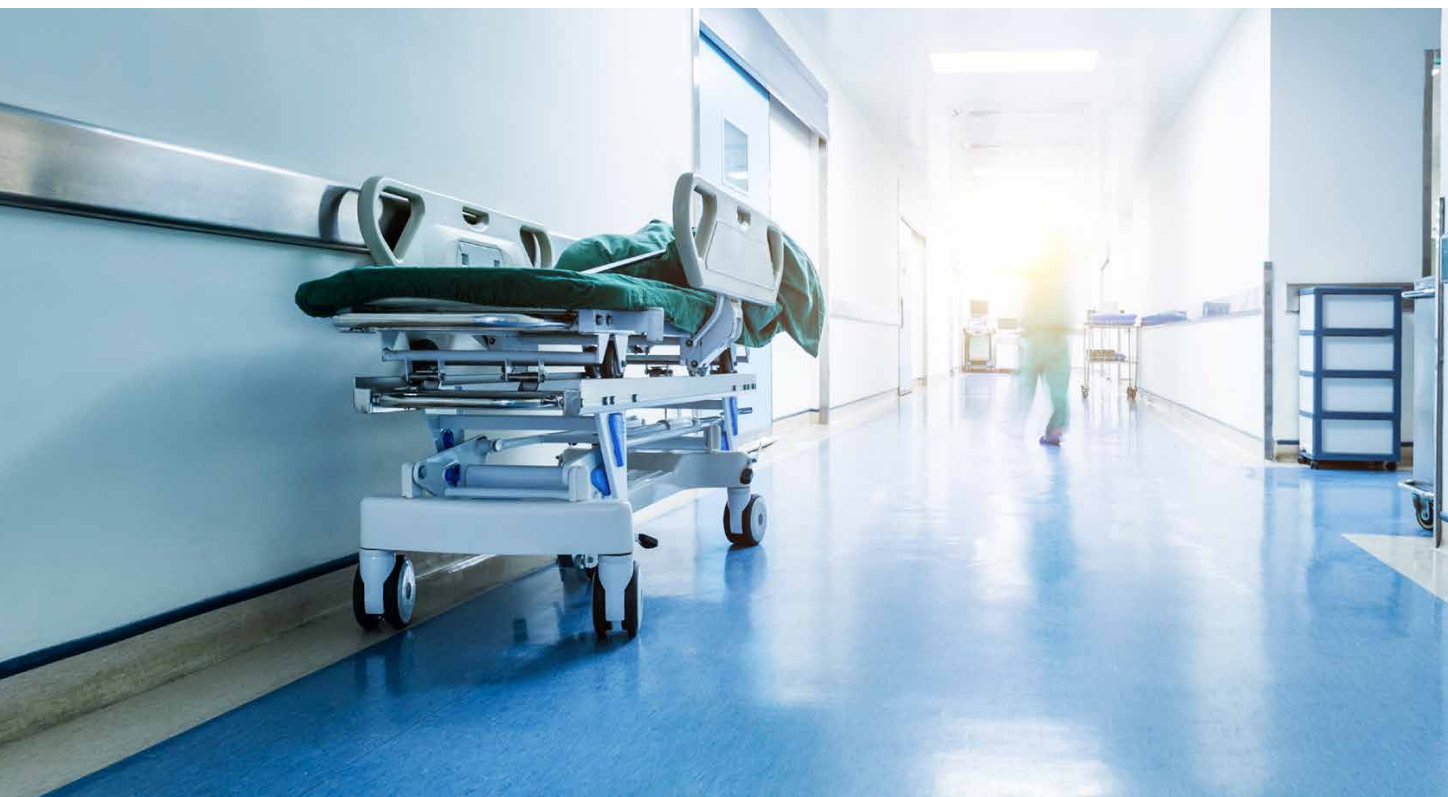
In focus

Movers and shakers

Could the central London private hospital market be poised for a shake-up?

LaingBuisson
INTELLIGENCE + INSIGHT

Candesic's **Dr Leonid Shapiro**, managing partner, and **Fabio Ruffinoni**, engagement manager, discuss the company's latest analysis of NHS waiting lists and private hospital data, detailing a surprising driver of waiting lists, the immense magnitude of the challenge for the NHS, and the extent private operators can come to the rescue



NHS waiting lists

what it will take to return to 2019

The NHS is in a rut. Not only is the waiting list high, but the nature of people on it has changed, becoming more acute and needing higher levels of care due to a lack of treatment over the pandemic. However, this fundamental change will not go away with incremental capacity improvements. Instead, a game-changing shift in capacity is needed, not only to reduce the waiting list to pre-pandemic levels, but to stop it from growing further.

Private acute hospital operators, if the NHS desired, could play a pivotal role. But private providers benefit from this NHS rut in the form of higher self-pay

and PMI demand. The NHS isn't doing itself any favours; it isn't outsourcing as much as it could and not incentivising private providers to come to the rescue. This must change both for the long-term survival of the NHS and for a sustainable long-term symbiotic relationship between the private and public sectors.

Let's face it. The NHS is in a state never before seen in its 75-year history. More than one in eight people in England are waiting for NHS treatment and of those waiting, more than 10% are waiting for two or more treatments. More than 40% of those waiting have been waiting for longer than the NHS target 18 weeks,

and over 5% of those waiting have been waiting for over a year (see Figure One). In the past 12 months, over 100,000 people are being added to the waiting list each month.

How can this be?

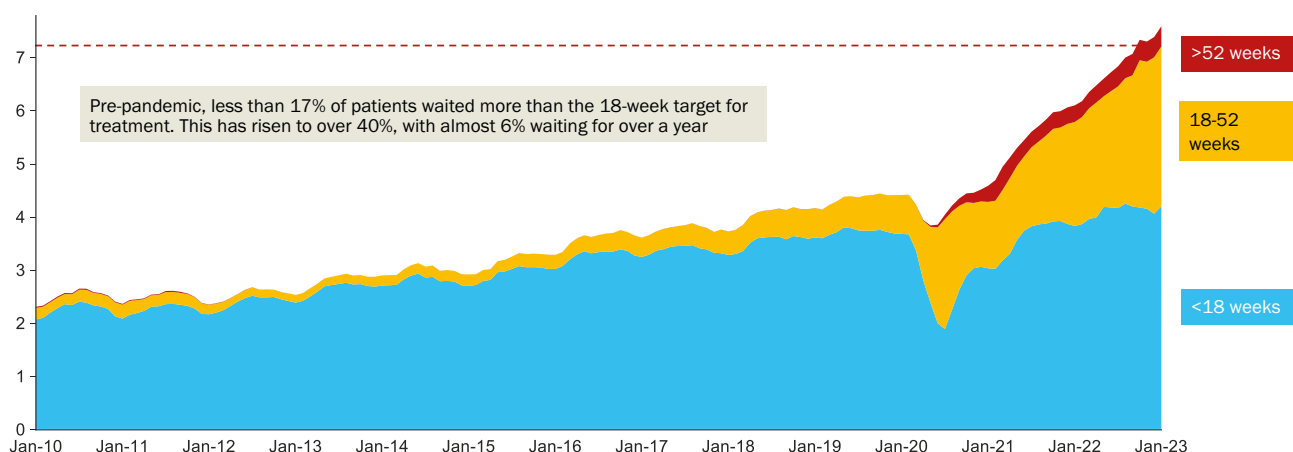
Why is our waiting list growing despite the NHS operating at 97% of its pre-pandemic capacity and supported by record effort levels and record levels of funding. And what will it take for the NHS, either alone or with the help of the private sector, to not only stop the waiting list from growing further, but return it to pre-pan-

FIGURE ONE – CURRENT SITUATION

THE PANDEMIC RESULTED IN UNPRECEDENTED WAITING LISTS, LEADING TO PATIENTS WAITING FOR MORE THAN 52 WEEKS FROM REFERRAL TO TREATMENT

PATIENTS ON RTT¹ WAITING LIST BY WAITING TIMES IN ENGLAND (APR-2007 – JAN-2023)

MILLIONS OF INCOMPLETE PATHWAYS BY WAITING TIME



NOTES 1 REFERRAL TO TREATMENT OCT 2022–DEC 2022 DATA DOES NOT INCLUDE DATA FROM MANCHESTER UNIVERSITY TRUST, WHILE OCT 2022 AND NOV 2022 ALSO DOES NOT INCLUDE FRIMLEY HEALTH DATA AND JAN 2023 DOES NOT INCLUDE DATA FROM GUYS AND ST THOMAS NHS FOUNDATION TRUST

SOURCE NHS DIGITAL; CANDESIC RESEARCH AND ANALYSIS

demic levels?

Candesic conducted a deep dive analysis of waiting times data, which is inherently noisy and complex, and combined it with what we are hearing from hospital managers and GP referrers. We have uncovered the key driver of waiting list increases (it isn't lack of NHS bounce-back) and run various scenarios of NHS productivity and private sector outsourcing to estimate what it will take to bring waiting lists down. The results are not pretty.

Before we jump into our findings, we should discuss how waiting lists are measured and what has been driving their growth.

Figure Two shows when patients enter and exit the waiting list as they follow their pathway of care. It differs in patients needing inpatient treatment, those who can be treated as an outpatient, and those who don't need treatment at all. All patients enter the waiting list when their GP (typically) refers them to a specialist doctor. They may then have several outpatient appointments and diagnostic tests before a diagnosis and treatment plan is made. Patients leave the waiting list when they start getting treatment (typically a procedure in a hospital or a prescription for drugs) or a

POST-PANDEMIC,
ONLY 12% OF
WAITING LIST
PATIENTS ARE
DEEMED TO NOT
NEED TREATMENT.
THIS DIFFERENCE
HAS BEEN THE
PRIMARY DRIVER
OF THE POST-
PANDEMIC WAITING
LIST GROWTH

decision being made that no treatment is necessary or possible. It should be noted that millions of patients who have left the waiting list are still waiting to complete their treatment and attend follow up

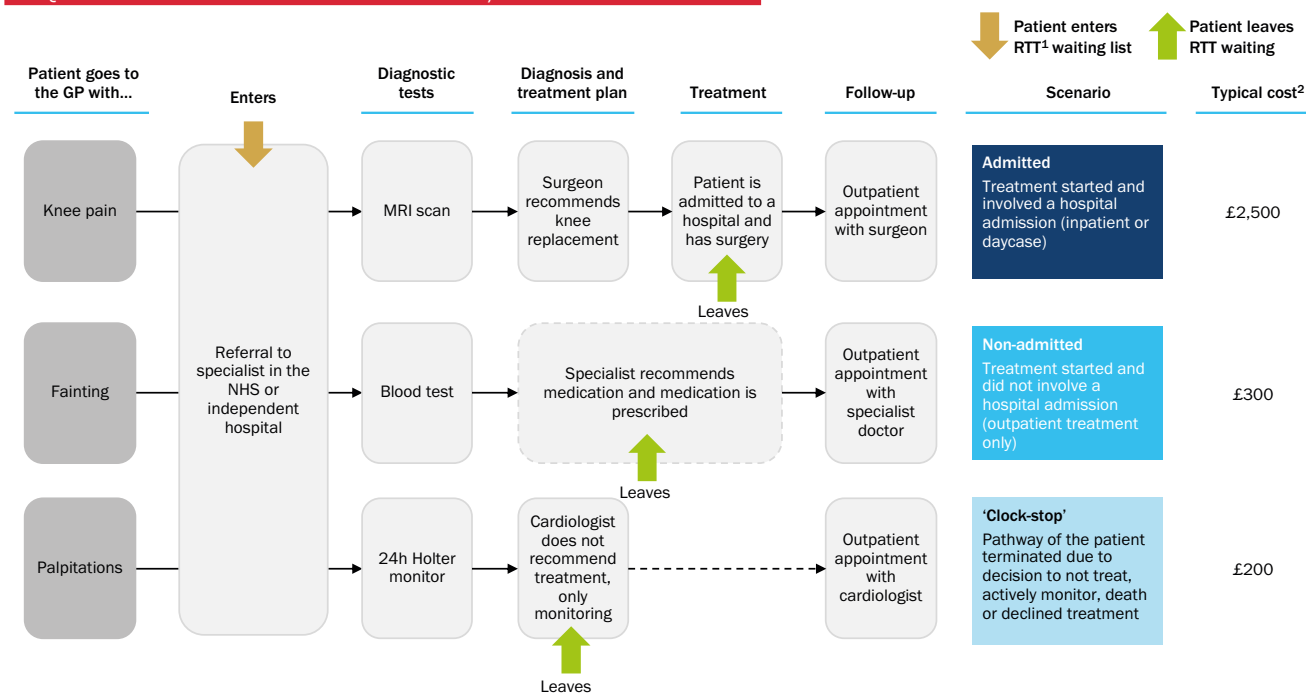
appointments with specialists, which have been delayed post-pandemic; this is often referred to as the hidden waiting list.

Pre-pandemic, things weren't good, but the NHS was coping, providing sufficient capacity (on its own and with private outsourcing) to keep waiting list growth to 23,000 per month. Over lockdown, this capacity significantly reduced, but post-pandemic, it has returned to pretty-much similar levels. Despite this successful rebound in capacity, the waiting list continues to grow massively (see Figure Three).

It's important to note that reducing waiting lists to pre-pandemic levels is not a sufficient target for the government and NHS. Waiting lists were high pre-pandemic, growing at 2% p.a. in the six years previously, and the NHS was only treating 82% of patients within their 18-week limit, rather than the 92% they have been targeting.

FIGURE TWO – ENTERING AND EXITING WAITING LIST

AFTER ENTERING THE WAITING LIST AT GP REFERRAL, PATIENTS LEAVE THE WAITING LIST IN ONE OF THREE WAYS, REQUIRING DIFFERENT LEVELS OF EFFORT/COST FROM THE NHS



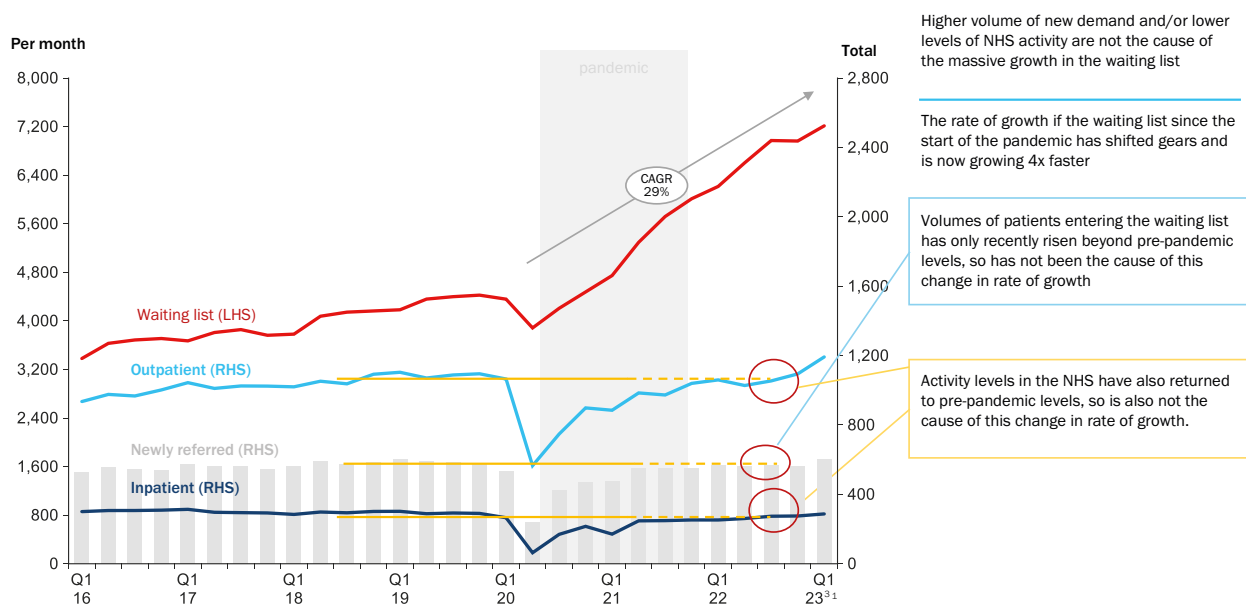
NOTES 1 REFERRAL TO TREATMENT 2 PER NHS TARIFF

SOURCE CANDESIC RESEARCH AND ANALYSIS

FIGURE THREE – NHS TREATMENT VOLUMES REBOUND

DESPITE SIMILAR NUMBER OF PATIENTS ENTERING THE WAITING LIST AND TREATMENT VOLUMES RETURNING TO PRE-PANDEMIC LEVELS, WAITING LISTS CONTINUE TO GROW AT 29% P.A.

NUMBER OF PATIENTS ON THE WAITING LIST AND THOSE RECEIVING INPATIENT OR OUTPATIENT TREATMENT
THOUSANDS OF PATIENTS



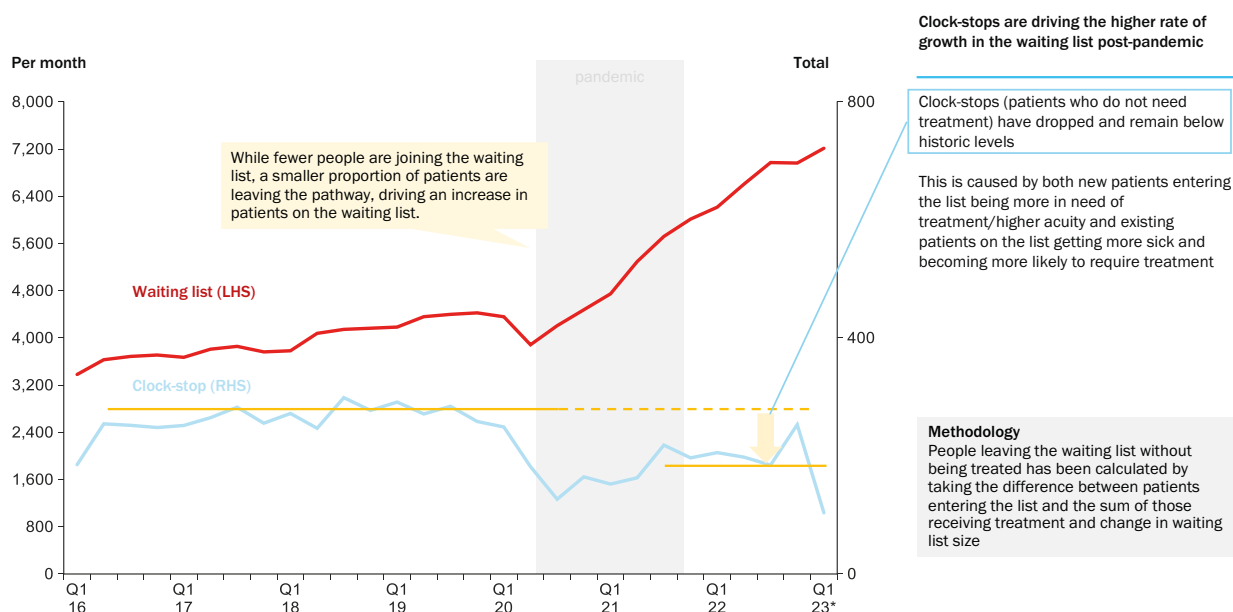
NOTES 1 ADMITTED (INCL. DAYCASE) 2 NON-ADMITTED 3 DATA FOR JAN 2023 AND NOT THE FULL QUARTER, WHILE DEC 2022 DATA DOES NOT INCLUDE DATA FROM MANCHESTER UNIVERSITY TRUST, WHILE OCT 2022 AND NOV 2022 ALSO DOES NOT INCLUDE FRIMLEY HEALTH DATA

SOURCE NHS DIGITAL; CANDESIC RESEARCH AND ANALYSIS

FIGURE FOUR – WAITING LIST EXPLANATION

THE MAIN DRIVER OF WAITING LIST GROWTH HAS THEREFORE BEEN FEWER PATIENTS LEAVING THE WAITING LIST WITH NO TREATMENT ('CLOCK-STOPS')

NUMBER OF PATIENTS 'LEAVING' THE WAITING LIST WITHOUT TREATMENT ('CLOCK-STOPS')
THOUSANDS OF PATIENTS



NOTES 1 DATA FOR JAN 2023 AND NOT THE FULL QUARTER, MULTIPLIED BY 3 OCT 2022–DEC 2022 DATA DOES NOT INCLUDE DATA FROM MANCHESTER UNIVERSITY TRUST, WHILE OCT 2022 AND NOV 2022 ALSO DOES NOT INCLUDE FRIMLEY HEALTH DATA AND JAN 2023 DOES NOT INCLUDE DATA FROM GUYS AND ST THOMAS NHS FOUNDATION TRUST

SOURCE NHS DIGITAL; CANDESCIC RESEARCH AND ANALYSIS

So, what is driving waiting list growth and why can't the NHS control it?

The third way patients leave the waiting list, when no treatment is required, is often ignored by commentators. We have analysed this component and its impact on waiting list growth. Figure Four shows how this third kind of patient cleared from the waiting list has become more rare. Pre-pandemic, 16% of patients cleared from the waiting list did not need treatment. Unlike those receiving treatment, this didn't bounce back. Post-pandemic, only 12% of waiting list patients are deemed to not need treatment. This difference has been the primary driver of the post-pandemic waiting list growth. So, the reason that the NHS is not coping isn't because it has less capacity than pre-pandemic, but because a greater proportion of patients on the post-pandemic waiting list need treatment.

This is unsurprising. Many patients didn't get the treatment they needed over lockdown and have become more sick/acute, so when they now finally get

THE RESULT IS A PERFECT STORM WHERE THE FUNDAMENTAL SHAPE OF THE WAITING LIST HAS CHANGED POST-PANDEMIC, RESULTING IN MUCH GREATER DEMANDS FOR TREATMENT

referred and come onto the waiting list, more of them are likely to need treatment. GPs have also raised the bar for who they refer. Knowing the state of the waiting lists, GPs are waiting and referring

patients when they are sicker and more acute (see Figure Five). The result is that those entering the waiting list are more likely to need treatment (see Figure Six).

Finally, as patients stay on the list longer, their condition often gets worse, necessitating treatment. The result is a perfect storm where the fundamental shape of the waiting list has changed post-pandemic, resulting in much greater demands for treatment.

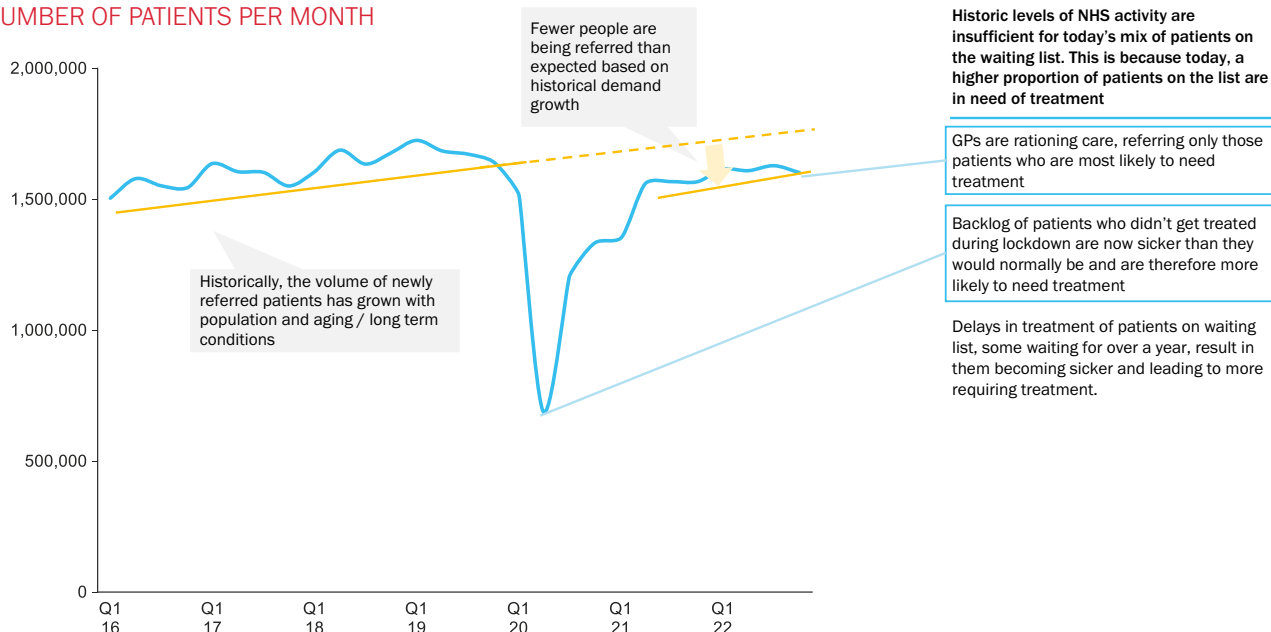
The flat nature of the non-treated proportion post-pandemic in Figure Four suggests that this problem is here to stay, as it has not changed despite the NHS rebounding capacity. What this suggests is that incremental increases in capacity are not going to be sufficient to shift this new world waiting list. We must have a fundamental change in thinking just to halt further waiting list growth, let alone reduce it. Figure Six shows the impact of this pre- and post-pandemic on the net increase in waiting list numbers.

This is therefore a call to NHS and government leaders to act now or be stuck in this rut, with the nation's health deteriorating for decades. We must fundamentally shift our thinking from firefighting

FIGURE FIVE – NEWLY ADDED PATIENTS

PATIENTS ON TODAY'S WAITING LIST ARE MORE SICK AND MORE LIKELY TO NEED TREATMENT THAN THOSE PRE-PANDEMIC, DRIVEN BY RATIONING AND THE IMPACT OF LOCKDOWN AND LONGER WAITS

MONTHLY NEWLY REFERRED PATIENTS
NUMBER OF PATIENTS PER MONTH



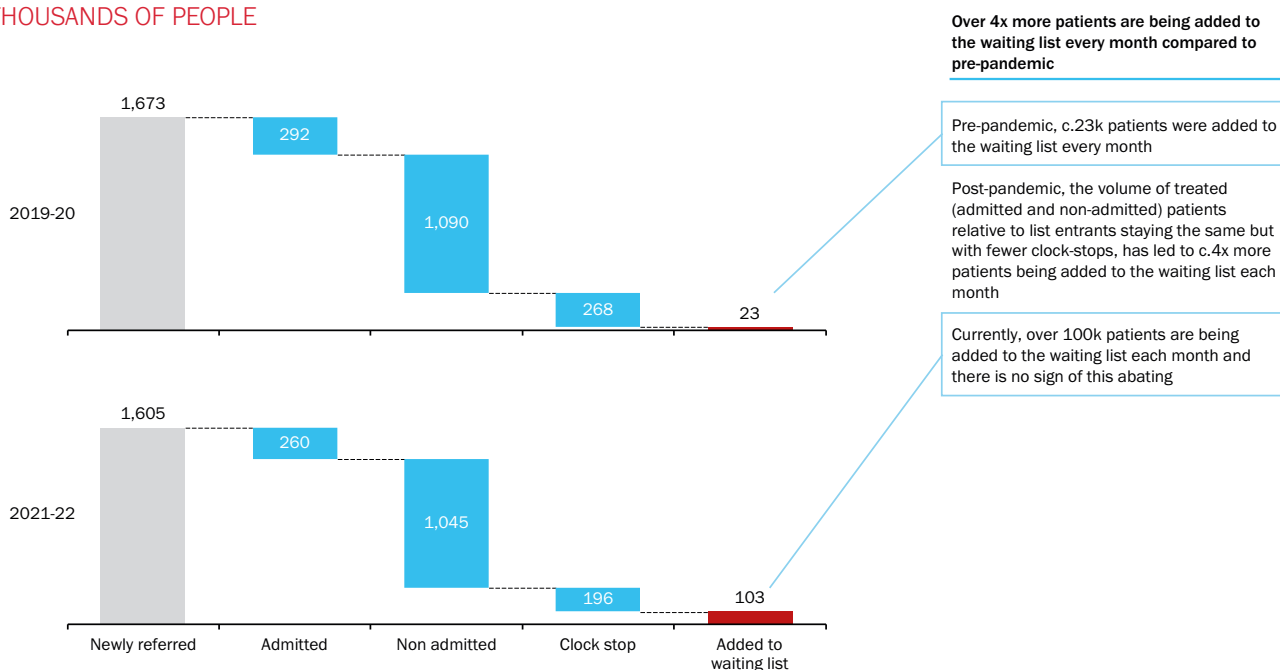
NOTES OCT 2022 – DEC 2022 DATA DOES NOT INCLUDE DATA FROM MANCHESTER UNIVERSITY TRUST, WHILE OCT 2022 AND NOV 2022 ALSO DOES NOT INCLUDE FRIMLEY HEALTH DATA AND JAN 2023 DOES NOT INCLUDE DATA FROM GUYS AND ST THOMAS NHS FOUNDATION TRUST

SOURCE NHS DIGITAL; CANDESIC RESEARCH AND ANALYSIS

FIGURE SIX – WAITING LIST

AS FEWER PEOPLE HAVE BEEN ADMITTED AND EXITED THE WAITING LIST, AN EXCESS BACKLOG HAS BEEN GENERATED

PATIENTS BEING ADDED TO THE WAITING LIST EVERY MONTH
THOUSANDS OF PEOPLE



SOURCE NHS DIGITAL; CANDESIC RESEARCH AND ANALYSIS

to fireproofing. Yes, it will cost more in the short term but will save costs and improve the nation's health in the long term. It's not enough for the government to merely fund the NHS more. The NHS will need the help of the private sector and its capacity to get out of this rut.

We have analysed and modelled a number of scenarios of how capacity would have to change. Our findings show that the NHS would have to one-time increase inpatient/day-case ongoing capacity by 7.2% to halt waiting list growth and 11% to return it to pre-pandemic levels in the next five years.

Our finding for outpatient treatment requires increases of 6.8% and 10%, respectively. For perspective, bringing the waiting list down to pre-pandemic levels would require the NHS to build 280 theatres and 4,200 beds. That is equivalent to 5.5 Newcastle upon Tyne Hospitals trusts, which is the seventh largest acute NHS trust in England. This analysis is shown in Figure Seven.

How could the NHS achieve this without having to build this 4,200-bed super hospital?

It could utilise private sector capacity to help clear this backlog. We have modelled how much more outsourcing the NHS would have to do to achieve this. We estimate that private providers would have to increase inpatient NHS-paid activity by 40% to halt the waiting list and 67% to reduce it to pre-pandemic levels over the next five years.

However, even if the NHS offered more waiting list work to private providers, private providers may not take it. They are currently benefiting from long waiting lists in the form of increased demand for self-pay and PMI. And they prioritise this rather than chase NHS work as they achieve a greater return on treating privately paid patients due to the higher fees attached.

But even if the NHS a) had the money to outsource more, and b) was able to convince private providers to take on more NHS patients, could the private sector

rescue the NHS? It could.

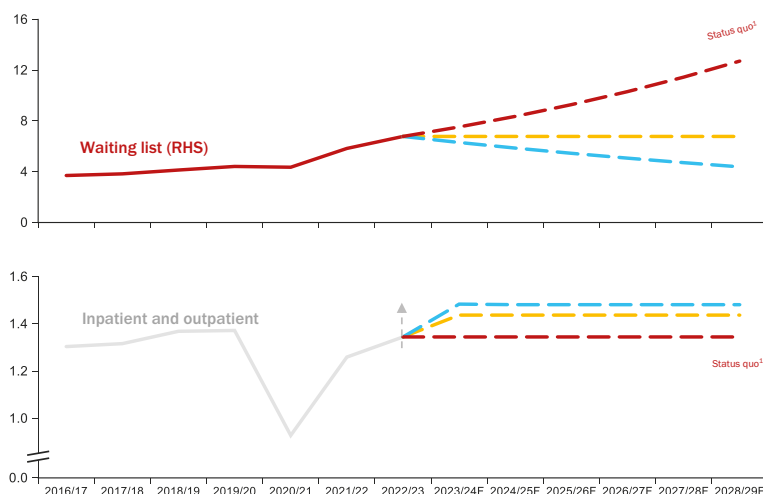
Our analysis suggests there is sufficient capacity in private sector hospitals to increase NHS outsourced work by 67% with minimal impact on privately paid work. This is because theatres in private hospitals typically operate at 60% utilisation but can operate at 90% utilisation if dedicated to a single procedure and operated in a more 'industrial' way. This is of course dependent on the private sector being able to source enough staff without detracting them from clearing volumes in NHS hospitals, but the private sector is more flexible in offering incentives and more pay to staff to work overtime and better able to increase the effective capacity of staff with the same number of people.

Figure Eight shows that private hospitals currently conduct 13% of the nation's elective admitted work, composing of 520,000 NHS-paid and 850,000 privately-paid procedures. If NHS volumes in private hospitals were to increase by 67% (enough to reduce the waiting list to

FIGURE SEVEN – WAITING LIST RESOLUTION MODELLING

THE NHS MUST INCREASE CAPACITY BY c.7% AT A COST OF £3.2BN TO HALT THE GROWTH OF THE WAITING LIST, OR c.11% AT A COST OF £4.8BN TO RETURN IT TO PRE-PANDEMIC LEVELS IN FIVE YEARS

VOLUME OF PATIENTS BY SETTING MILLIONS OF PATIENTS



Scenario 1

Halt growth of waiting list

Inpatient capacity growth required	Outpatient capacity growth required	Cost ²
7.2%	6.8%	£3.2bn
(19,553 procedures per month)	(72,895 procedures per month)	

Scenario 2

Return waiting list to pre-pandemic levels in five years

Inpatient capacity growth required	Outpatient capacity growth required	Cost ²
11%	10%	£4.8bn
(29,389 procedures per month)	(109,561 procedures per month)	

Scenario 1 7% is the equivalent of c.186 theatres and 2,793 additional beds, corresponding to immediately building 3.7 new hospitals, the size of Newcastle NHS Trust

Scenario 2 11% is the equivalent of c.280 theatres and 4,198 additional beds, corresponding to immediately building 5.5 new hospitals, the size of Newcastle NHS Trust

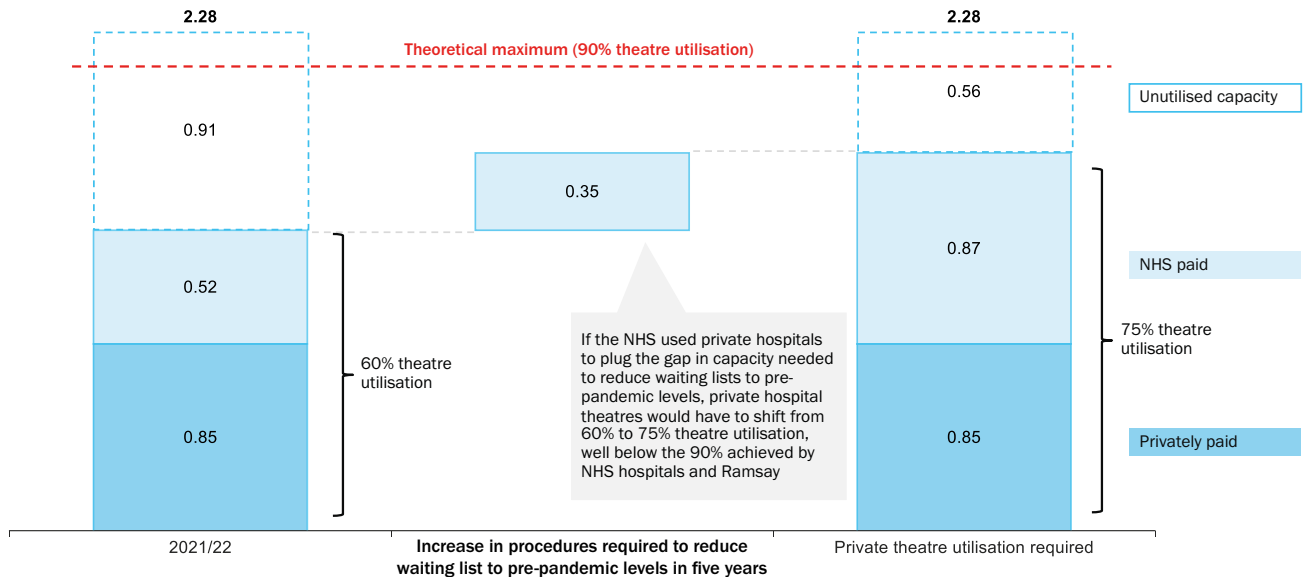
NOTES 1 ASSUMES INPATIENT AND OUTPATIENT TREATMENT LEVELS REMAIN AT TODAY'S LEVELS AND WAITING LIST CONTINUE TO GROW (STATUS QUO) 2 BASED ON NHS TARIFF AND USING A WEIGHTED AVERAGE OF THE MOST COMMON TREATMENTS BY SPECIALTY NEWCASTLE UNIVERSITY NHS FOUNDATION TRUST HAS 51 THEATRES AND 1,400 BEDS

SOURCE NHS DIGITAL; CANDESCIC RESEARCH AND ANALYSIS

FIGURE EIGHT – IMPORTANCE OF PRIVATE HOSPITALS

THERE IS SUFFICIENT CAPACITY IN PRIVATE HOSPITALS TO RETURN WAITING LISTS TO PRE-PANDEMIC LEVELS IF THE NHS CHOSE TO USE THEM

ELECTIVE ADMITTED PROCEDURES CONDUCTED IN ENGLAND IN PRIVATE HOSPITALS BY PAYER (21/22¹)
MILLIONS PER YEAR



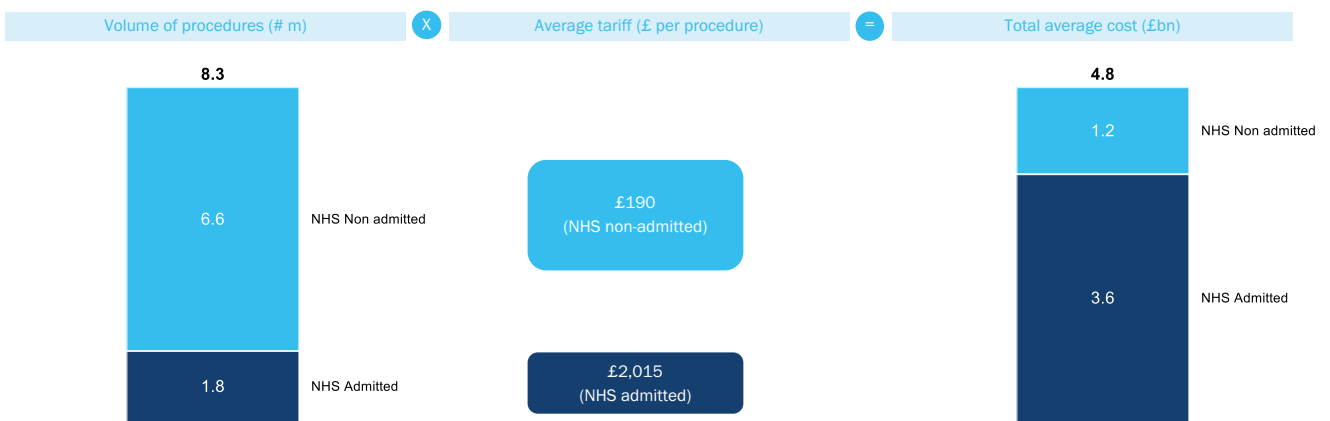
NOTES 1 OCT 21–SEP 22

SOURCE NHS DIGITAL; PHIN; CANDESIC RESEARCH AND ANALYSIS

FIGURE NINE – TOTAL ESTIMATED COST PER YEAR

CANDESIC ESTIMATES 8.3M ADDITIONAL PROCEDURES/INTERVENTIONS WILL NEED TO BE FUNDED AT c.£5BN OVER THE NEXT FIVE YEARS TO RETURN WAITING LIST TO PRE-PANDEMIC LEVELS

COST REQUIRED TO RETURN WAITING TO PRE-PANDEMIC LEVELS
000s AND £



The NHS will need to perform (or pay private hospitals to perform) an additional 8.3m procedures/interventions in the next five years to enable waiting list to return to pre-pandemic levels

Based on weighted average of the most common procedures on waiting list over 20 specialities and covering 65% of total volumes

c.£5bn over the next five years will be required to return the waiting list to pre-pandemic levels (based on NHS tariff prices)

SOURCE NHS DIGITAL; PHIN; CANDESIC RESEARCH AND ANALYSIS

pre-pandemic levels in five years), it would require private hospitals to increase their theatre utilisation from c.60% to 75%, well below the 90% theoretical maximum discussed above.

If the NHS was to outsource more to private providers to enable them to adopt this assembly-line industrial model or if the NHS were to (partly) take over private sector capacity like it did during the pandemic and operate their theatres as such, the additional 15% capacity generated in private hospitals due to this way of working would be enough to both deal with the waiting list and minimally impact capacity available to conduct self-pay and PMI paid procedures.

How much would this cost the NHS?

Our analysis estimates that for the scenario of returning to pre-pandemic waiting list levels in five years, the NHS would need to fund 1.8m admitted procedures and 6.6m non-admitted interventions at a cost of c.£5bn based on current NHS tariffs (see Figure Nine).

Figure Ten shows how we have taken the tariffs of the most common procedures in each specialty, added pre-treatment diagnostic tests and outpatient appointment costs, and multiplied this by the number of procedures required to determine the total estimated cost of £5bn per year, or about £1bn per year for the next five years.

While use of the private sector is an obvious solution, NHS organisations have been reluctant to outsource more. They have barely enough money to cover NHS delivery costs let alone pay extra to private providers to take on more volume. This is about to change.

The Chancellor, Jeremy Hunt, has allocated additional funding of £6.6bn over the next two years to help clear the waiting list. While some of these additional funds will be used to clear waiting lists, the majority will be sucked up into covering NHS inflation. It's very possible the government will continue with this additional 'emergency' funding beyond the initial two years, which will help cover waiting list reduction expenses.

While additional NHS funding will re-

move the funding obstacle, the NHS must still convince private providers to take on more NHS work without cannibalising more profitable privately paid work.

They can do this in two ways: a) by paying more, or b) by buying smartly. Paying more might work from a microeconomic perspective but it is not politically palatable. Offering private providers more money than NHS providers for the same procedure is unlikely to be accepted.

However, buying more smartly, where perhaps the NHS bulk-buys capacity much like it did during the pandemic and/or finding ways to enable/encourage private providers to operate dedicated NHS theatres in a more efficient/industrial way (perhaps through guaranteed high volumes of work like ISTCs were given in the past) is a viable way forward. This will allow greater use of private capacity (that is available now) without forcing private operators to cap privately paid work.

The alternative of building more NHS hospitals won't work as by the time they are built, the waiting list will have doubled again.

FIGURE TEN – METHODOLOGY: TOTAL ESTIMATED COST PER YEAR
OUR ANALYSIS IS BASED ON THE WEIGHTED AVERAGE TARIFF OF THE MOST COMMON PROCEDURES IN EACH SPECIALTY MULTIPLIED BY THE NUMBER OF PROCEDURES REQUIRED

Speciality name	Data collection		NHS admitted		NHS Non-admitted	
	Number of procedures included	Coverage	Proportion of total waiting list	# Average patient cost, £	Proportion of total waiting list	# Average consultation tariff, £
General Surgery	4	35%	10%	2,573	6%	184
Urology	15	77%	8%	1,718	5%	148
Trauma and Orthopaedic	8	49%	17%	3,961	10%	172
Ear Nose and Throat	5	51%	5%	1,677	8%	136
Ophthalmology	1	68%	14%	1,043	8%	145
Oral Surgery	2	64%	6%	294	4%	145
Neurosurgical	2	70%	1%	3,465	1%	291
Plastic Surgery	4	49%	3%	3,594	1%	155
Cardiothoracic Surgery	3	51%	0%	2,207	0%	291
General Internal Medicine	5	66%	0%	1,822	1%	201
Gastroenterology	3	82%	7%	658	5%	219
Cardiology	4	69%	4%	2,888	5%	182
Dermatology	2	87%	3%	397	6%	136
Respiratory Medicine	1	91%	1%	993	3%	229
Neurology	2	76%	0%	226	4%	201
Rheumatology	5	66%	1%	1,822	2%	290
Elderly Medicine	5	66%	0%	1,822	0%	315
Gynaecology	14	83%	7%	1,873	8%	170
Other surgery	5	57%	4%	1,757	7%	169
Other not surgery	5	66%	10%	1,822	17%	275
Total weighted average tariff				£2,015		£190
Total volume of procedures				1.77m	!	6.57m " 8.3m
Total cost				£3.55bn	!	£1.25bn " £4.8bn

Candesc estimates it will cost c.£5bn for the NHS to return waiting list to pre-pandemic levels in the next five years

Including 20 specialities, with an average coverage of c.65% of total volumes, including five procedure types

Candesc estimates an additional c.8.3m procedures/interventions will need to be conducted to return waiting list to pre-pandemic levels