Supporting the NHS

Stabilising Waiting Lists

Manx Executive Challenge

Green Team

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Note: The appendices are in a separate document.

1. Executive Summary

The Isle of Man's health service is something which affects every resident on the Isle of Man, so we are fortunate that it is of such high quality. However, it will be affected over the coming years as the population ages and advances in medical science significantly increase the cost of provision.

The issue of increasing health costs has been brought into focus by the impact on the Isle of Man Government's finances of the recent changes to the VAT sharing arrangements with the UK. These changes have resulted in a reduction of Government revenue of about 25%, which has led to a review of all aspects of Government spending. For this year (2010/11), the newly formed Department of Health has been protected from a reduction in budget; but this has led to even harsher reductions in the budgets of other departments; and there is no guarantee that it can be protected from real terms cuts in the future. This is likely to mean the end of initiatives that, over the last few years, have reduced patient waiting lists, leading to a reversal of this trend.

Just over half of the Department of Health's budget for 2010/11 has been allocated to Nobles Hospital, mainly funded through Tax and National Insurance (NI) receipts. However, a small portion of this funding comes from revenue generated through charging for the use of Nobles facilities for private health provision. Most private care is funded through Private Medical Insurance (PMI).

This report shows how extra revenue can be generated for the NHS by encouraging increased uptake of PMI and ensuring more private health care is delivered through Nobles, rather than via referrals to the UK, thus retaining more of the revenue arising on the Island. Furthermore, the report demonstrates that services at Nobles can be expanded on the back of revenue generated through increased private provision, to the benefit of private and NHS patients alike. It also shows how the inevitable increase in waiting lists can be avoided with waiting lists stabilised at their currently low levels in a cost neutral way. Finally, a plan for implementing the changes required is outlined.

The Green Team believes we have an NHS to be proud of. We wish to protect the high quality of service it delivers whilst helping to reduce its burden on the public purse.

2. Introduction

2.1 The MEC brief

For the 2010 Challenge, all the teams were given the same brief: "*In 2008/2009 we have seen major changes in the economic climate, both worldwide and locally, putting severe pressures on public, private, charitable and social organisations alike. In order to succeed and prosper, all of these sectors on the Isle of Man need to become more inventive and imaginative, and develop creative solutions to the challenges they face.*

Within your allocated sector select and define a project that you believe should be implemented for the benefit of the Isle of Man and its residents. Produce a business plan to make the case for your proposals, showing the viability, the cost / benefit, timescale and where the funding will come from. To back this up produce a 15 minute visual presentation."

The Green Team received the Public Sector and decided to define a project that would involve support for the NHS[1] which faces pressures, both financial and social[2].

Note: The project plan and charter are shown in appendices 1 and 4 respectively, whilst the methodology used to select and research the project, analyse the findings and document the results is shown in appendix 4.

2.2 The financial situation facing the Isle of Man

Although it may have skilfully avoided the worst effects of the global financial crisis and recession that followed, the Isle of Man has not been totally unscathed by their impact. Perhaps the most obvious effect is on Government revenue, from reduced VAT receipts arising from the amended revenue sharing arrangement with the UK government. The Chief Minister, Tony Brown, stated that in 2009 the reduction in the rate of VAT to 15% reduced government income by about £40 million and that the revised arrangements will result in a loss of revenue of £90 million in 2010 and £150 million in 2011 and subsequent years (Brown, 2009), this is about a 25% reduction in government revenue for 2009/10 (Isle of Man Treasury, 2009). This in turn will have a significant impact on government spending and it is unlikely that the NHS will remain completely immune even though the DHSS budget for 2010/11 has been maintained in absolute terms (Isle of Man Treasury, 2010). Figures 1 and 2 illustrate the effect of these revenue reductions on Departmental budgets.

1 When referring to the NHS in the report, we mean the Isle of Man Health Service unless specifically referring to UK NHS.

2 It is worth noting at this point that the team restricted scope fairly tightly in order to ensure we could deliver a worthwhile result in the time frame permitted by the challenge; in particular, we felt that it was worth noting that, as we regularly encountered confusion between the Reciprocal Health Agreement with the UK Government and with health/travel insurance, the agreement with the UK is not considered in this proposal.

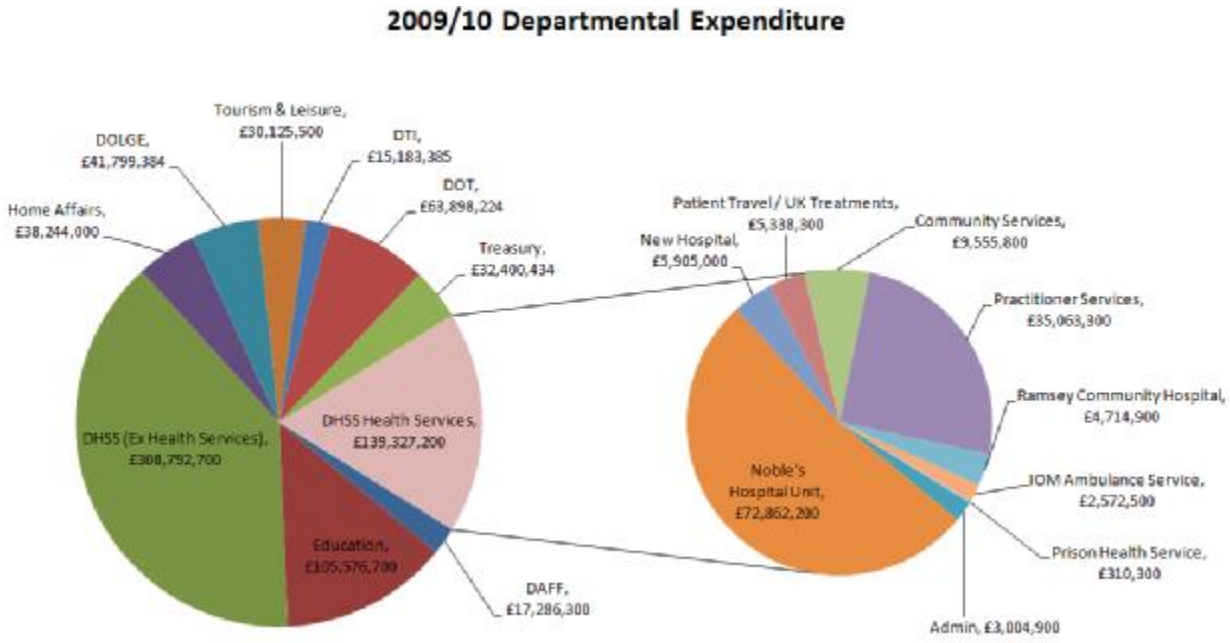

Figure 1: Departmental Expenditure 2009/10

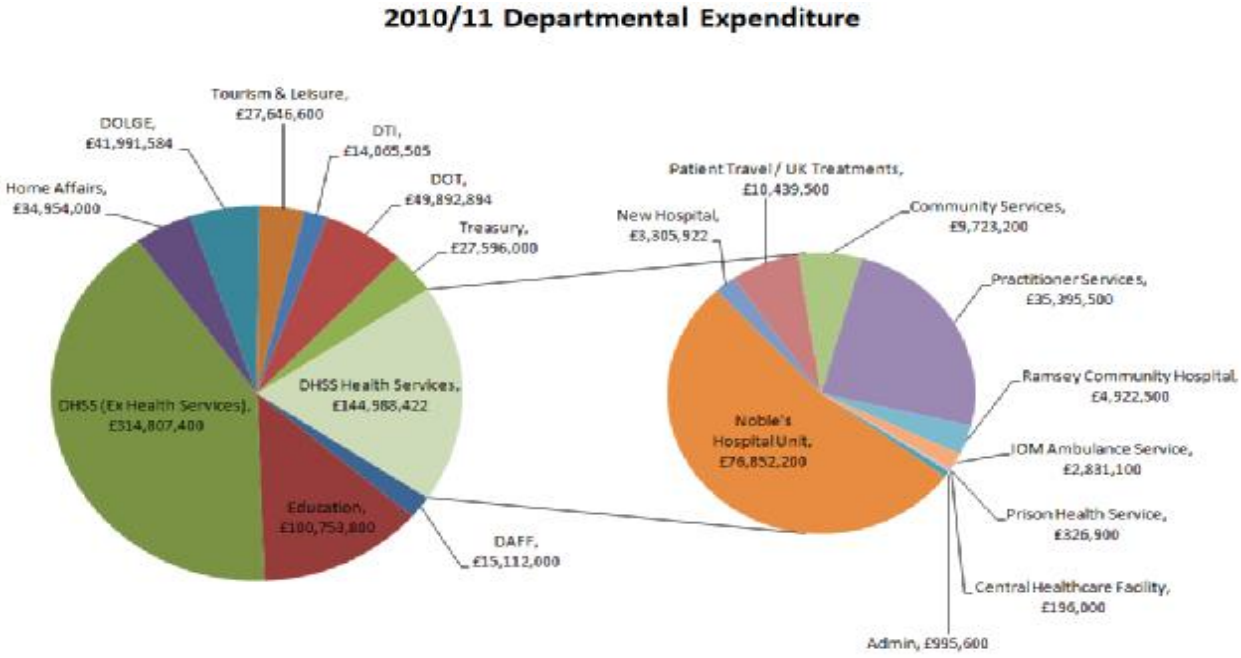

Figure 2: Budgeted Departmental Expenditure 2010/11

2.3 The impact on the health service

Although the NHS hasn't seen a budget cut this year (in absolute terms) this means other departments must take a larger cut (Isle of Man Treasury, 2010b) and there is no guarantee that this can be maintained in the future; also, the NHS has continued to struggle to operate within budget (see their press release (2006) and the 2010/11 budget speech); so it is highly probable that there will be strenuous efforts to manage costs making it likely that non-essential services will be reduced (McGregor Edwards, 2009).

NHS costs and revenue are affected by a number of factors:

- The ageing population will increase pressure on NHS and Government budgets through the increased health costs associated with older people.

- Related to this, the smaller proportion of the population that is economically active will further reduce Government revenue from Income Tax and NI.

  These two factors have led the DHSS (2008a) to state that "...services and budgets were coming under mounting pressure from a range of factors, not least the ageing population – the number of people aged 75 and over is estimated to grow by 60% from 6,700 in 2006 to 11,000 in 2026." A study of UK health costs by the Institute of Fiscal Studies (Emmerson et.al. 2000) illustrated that the NHS cost per head increases by 450% for 45 - 64 year olds to the over 85 years old and by 91% from 45 - 64 years old to 65 - 74 years old. A recent study in the UK stated that, with all other things being equal, the change in demographics would result in an increase in health spending of 1% a year (Appleby et.al., 2009). If applied to the Isle of Man, this would amount to approximately £1.3m for this year and approximately a £42m increase over 30 years.

- As medical science advances, the cost and demand for possible treatments increases leading to cost inflation for health services. From 2001 to 2006 NHS expenditure increased from £90.5m to £120.6m, this represents an increase of 33%. In the same time period the NHS expenditure per Manx resident increased by 27% (Isle of Man Treasury 2001, 2006a & 2009a).

The impact of these pressures are leading to questions being asked about the continued affordability of the NHS in the UK (see the articles in The Scotsman, 2009; The Times Online, 2006; Appleby et.al, 2009; and James, 2009) and that the way health care is funded needs to change. There is no reason to assume the situation is different on the Isle of Man. In fact, in 2004, these issues listed caused Dr Ian MacLean the, then, Chief Administrative Medical Officer and Director of Public Health on the Isle of Man to state,

"These realities inevitably lead to some form of rationing, usually through queuing for services of limited availability. As a result, some people opt for private treatment as an alternative, either because of rationing pressures as mentioned above, or for reasons of convenience." (MacLean, 2004). In the same document he went on to state: "Demand for innovation and development in health care is probably infinite, as are our customers' aspirations. In contrast, resources are strictly finite. Left to itself, this situation is likely to result in an unaffordable Health Service in the not too distant future."

Furthermore, speaking on the Manx Radio Sunday Opinion show 21st March 2010, in response to the question posed by Roger Watterson "can this (the health system in its current guise) go on?", Hon. W. E. Teare M.H.K. (Teare, 2010) responded "I feel that it can't be sustainable.....the way that it's been structured at the outset, which is over 60 years ago now, is difficult to sustain going onwards and I feel that as time passes we should continue to look at it", "....we will have to take a long, hard, cold look at it again, and whatever form the 'new' National Health Service takes will enable us to move forwards with confidence into the next sixty years".

Adding to this, Mr David Killip (Chief Executive for DHSS) stated "I would agree with the Minister that there is a need to re-appraise the extent to which the 'State' can provide medicine to the community as a whole", "Whilst we all continue to embrace the principles of what Beveridge[3] was describing, I think there is scope to say that the practice will have to change" (Killip, 2010b).

2.4 Rising Waiting Lists

Waiting lists are one of the most obvious indicators of the quality of a health service. Until recently, the NHS has been able to fund special initiatives to reduce the length of waiting lists (Harris, 2010). However, with tighter budgets, these initiatives are likely to end, resulting in waiting list increases (Harris, 2010; McGregor Edwards, 2009). These pressures will only add to this adverse trend.

3 Lord Beveridge first proposed his idea for the 'Welfare State' in the 1942 'Social Insurance and Allied Services Report'. This led to the creation of the NHS in the summer of 1948.

3. Background

3.1 The Isle of Man Health Service

The NHS has a current annual expenditure of about £130m (Isle of Man Treasury, 2009b). This is mainly funded through tax and NI contributions and covers areas such as primary healthcare, the ambulance service, buildings and administration, and hospital care. Delivery of hospital care is through Nobles Hospital (314 beds) which is the focus of major surgical activity on the island. For minor care, Ramsey Cottage hospital (41 beds) can also used.

Whilst much of the treatment provided to island residents is delivered on-island the NHS procures specialist services (which are not economically or clinically feasible for delivery on island) from the UK NHS. These services include specialist surgical procedures which cannot be provided on island, primarily due to the naturally limited range of specialities available from within the team of Consultants on the island, but sometimes due to a lack of specialist facilities. The estimated cost given in the 2010/11 budget for UK treatments (including travel) is approximately £10.5m (Isle of Man Treasury, 2010a) – approximately 8% of the budget.

3.2 Nobles Hospital

3.2.1 Funding

Nobles hospital with a 2010/11 budget of just under £74m has 20 ward areas including the one Private Patients Ward of 14 beds. All major surgical activity on the island is delivered at Nobles.

Whilst the vast majority of activity is publicly funded, the NHS also generates revenue from private procedures. This revenue comes mainly through charging for the use of the facilities at Nobles (such as theatre use and stays in the Private Patients Ward).

3.2.2 Revenue from private provision

Consultants (including Consultant anaesthetists) involved in private provision charge patients directly and the hospital does not receive income in respect of these charges. Total private income to the hospital (from use of facilities, drugs etc.) during the first nine months of 2009 was approximately £1.3m, with a gross margin of approximately 45% (Harris (2010b).

Private health care has not been pro-actively encouraged in the past due to the ill-founded belief that private provision can only be delivered at the expense of publicly funded services - in other words, allowing people to 'queue jump' by paying to take a treatment session that would otherwise be delivered to a publicly funded patient. In fact, this does not occur on the

island because Consultants are contracted to deliver a set amount of NHS work and therefore undertake private work in their own time. In 2004, the Director of Public Health stated "It is clear that there is an insufficient volume of private work to justify the development of separate facilities for private work on the island. Thus, a 'mixed economy' has developed over time, with NHS facilities being used to provide both NHS and private care." (MacLean, 2004).

3.2.3 Factors affecting throughput

The main factors affecting the rate of throughput for private care delivery at Nobles are:

- **The private patients ward**;
  Our research shows that this has a current occupancy of 41% over half of which is overspill from NHS wards. So less than 20% occupancy is caused by private use. Therefore, private patient occupancy of the private ward could more than treble (to 60% occupancy), even with current levels of NHS usage, whilst keeping overall occupancy below the optimum level (of 85%) – see figure 3.

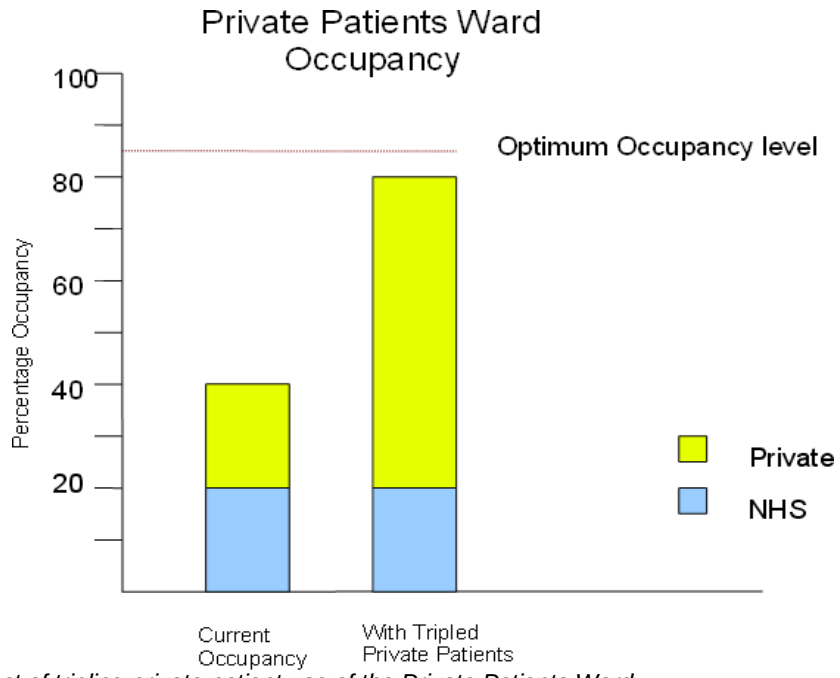

Figure 3: Affect of tripling private patient use of the Private Patients Ward.

- **Surgical theatres**;
  Only five of the six theatres are regularly used at Noble's and these are not open at weekends. There are not enough people to staff six theatres though it would be possible to increase capacity by opening the theatres for longer during the week or at weekends. Also, whilst the theatres are heavily booked, they are not fully utilised with many theatre session bookings only being partially used. It would be possible therefore to increase capacity purely by managing theatre bookings more efficiently.
- **Staffing**
  The main constraints are Consultant surgeons and anaesthetists, and theatre staff.

Note: Much private work is performed without the need for main theatres or for overnight stays reducing the need for use of the Private Patients Ward. There is plenty of capacity to increase this sort of work although a significant increase in throughput might require an increase in Consultants and theatre staff.

3.3 Private Health Care

3.3.1 How is private care paid for?

Whilst hospital figures show that about 30% of private patients are self funding (see appendix 6), it is highly likely that this number is lower, with patients paying the hospital and then recovering these fees from an insurer; therefore it is probable that the vast majority of private care is actually paid for through Private Medical Insurance (PMI).

3.3.2 Private Medical Insurance

Harris (2010) states the main reasons many individuals take PMI are:

- the perception that the insured will receive better care if they are treated privately;
- to avoid waiting lists – this is generally for treatment of non-life threatening conditions and in particular for painful, chronic conditions (e.g. joint replacement).

Employers also provide PMI as a benefit to their staff and therefore benefit from improved return to work times, and increased staff retention.

3.3.3 PMI on the Isle of Man

In order to get a better understanding of the local market for PMI, we conducted some preliminary 'primary' research (see appendix 8) which illustrates that there is an active market for PMI and private health care on the island. The vast majority of those surveyed were in some form of employment (i.e. full or part time).

The results suggest that, within the economically active population (about 44,830):

- **There's a large untapped market** of about 25,687 (the other 19,143 having PMI);
- **Employers generally pay for PMI cover,** but
- a large minority of those with PMI (25% - about 4,690) pay the premiums themselves, suggesting that a sizeable percentage of the working population recognise the benefits from having such cover in place without any special incentive;
- **If people had to pay for cover themselves, two thirds would do so**;
- **87% of those surveyed who were without cover would be more willing to take out cover if there were some form of financial incentive available from the Government.**

We also surveyed employers and those that responded to our survey varied in size from having 1 employee to larger organisations with over 100 employees. There are currently about 4,000 employers on the Island.

The results suggest that:

- **Larger organisations are more likely to provide PMI as a benefit**, and there are around 1,600 employers (40%) who do not provide it for their employees;
- Employers providing PMI generally provide it to <u>all</u> their employees (80% of those offering PMI to their employees did so);
- It appears that a financial incentive from the government will not necessarily be a deciding factor in the decision to introduce PMI benefit for staff members. Comments in the survey returns suggest that this may be due to the fact that they are not convinced of the benefit of providing cover. It appears to be particularly true of smaller employers where the cost of cover weighed more heavily.

Both surveys showed there were some concerns over the facilities that are available on the Isle of Man and therefore whether staff would be able to benefit from the cover.

3.3.4 The impact of waiting lists on PMI uptake

These survey results arise within a context of existing shortened waiting lists. Both Harris and McGregor Edwards state that take up of medical insurance and Private Health Care (PHC) is sensitive to the length of waiting lists; waiting list increases lead to increased demand for PMI. Harris (2010a) goes further to state that in the UK, private providers have been closing hospitals as PHC demand reduces as a result of the UK waiting list initiatives. McGregor Edwards (2009) supports this, stating that there had been a 29% decrease in private procedures performed at Nobles in 2009 over the figure for 2008 as a result of the waiting list initiatives.

As this situation inevitably reverses (due to reduced waiting list initiatives and tighter budgeting restrictions), the demand for PMI and private treatment will increase. A recent article in the Financial Times (Timmins, 2010) reports that the largest private hospital group in the UK supports this view. Therefore we expect that the uptake of PMI will increase in the near future and that this increase would be maximised by some form of incentive.

4. The proposal

4.1 The key aims of the proposal

In order to support our NHS into the future, we elected to look at ways to:

1. **Create additional revenue** through increased private health care provision delivered via the NHS (mainly Nobles hospital);
2. **Mitigate the impact** of real terms budget reductions, such as increased waiting lists, in a cost neutral way;
3. **Extend the range of services** available by attracting Consultants with specialist skills we currently lack.

4.2 The main elements of the proposal

4.2.1 Generating revenue via private health care provision

Our investigation has shown that by doubling the number of private patients, annual NHS income can be increased by a minimum of £1.7m giving an estimated increase in revenue (after costs) of about £800k. Harris (2010b) stated this should be achievable within current capacity (though another anaesthetist might be needed). As private care is mostly funded via PMI, we believe we need to encourage island residents to take out PMI. This will be achieved by:

1. Actively promoting increased PMI take up by residents on the island, through incentives. This can be done through gaining agreement from the Income Tax Division (ITD) and the Department of Health and Social Security (DHSS) to:

    a) provide tax relief (currently only available to those paying contributions who are over 65);
    b) allow tax exempt benefit status (currently only available if benefit value is lower than £400 and does not extend to family cover);
    c) provide a reduced NI Contribution rate for those who are able to prove they have taken out a qualifying PMI policy (see appendix 6).

2. Passively – as noted in the introduction, with cuts to less essential services and rising waiting lists, there will be increased incentives for those who have PMI cover to use it and for those who haven't got PMI cover to get it.

3. Encourage organisations to provide PMI as a benefit for their staff through an NI rebate and by publicising the benefits to the organisation.

4.2.2 Retaining more of this revenue on the island

This can be achieved in two ways:

- By encouraging PMI providers to incentivise island policy holders to take treatment on-island when possible; It could reduce their costs if they wrote clauses into their policies that treatment should be received on-island if available. This would require competitive pricing by Nobles and also it would require providers who currently provide 'Island Benefit' (which covers or subsidises travel off-island) to policy holders to remove this from their policies. The result will see Islanders with PMI policies being financially encouraged to take private treatment on island. McGregor Edwards (2009) states that there are indications that the providers may be looking to do this, so the encouragement needed may be minimal.
- Encouraging GPs to refer to on-island consultants where this is possible; A factor limiting the demand for locally provided private treatment is a perception amongst some GPs that the specialist skills are not available on the island (Hardinge, 2009), leading them to refer patients, going private, to consultants elsewhere.

4.2.3 Extending the services available

The extra demand generated would give the NHS the option to extend private services and allow the NHS to plan for increased levels of private delivery, through means such as:

- Employing more consultants – each consultant will be contracted to provide a set amount of NHS care, with private work being undertaken outside contractual obligations. In particular consultants should be sought who have specialist skills not currently available on-island where there is sufficient demand to make this economically viable (and to ensure the Consultant has sufficient work in their specialism to remain up to date) thus extending the range of treatments available;
- Increasing available capacity by improving management of theatre bookings and by extending the period during which the main theatres are available (including weekends);
- Consider increasing the number of anaesthetists and theatre staff which may be needed once significant increases in throughput were being achieved.

McGregor Edwards (2009) stated that the NHS found it relatively easy to attract top flight consultants onto the island due to a combination of the lower tax regime, reduced pressure compared to the UK NHS and the lifestyle on offer. Many are encouraged to come or stay by the prospect of income from private work (this is supported by the results of our survey of

consultants – appendix 9). More may be encouraged by even greater rewards of private work made possible by maximising the usage of the facilities required. Weekend theatre openings would also have the benefit that it would make it easier to use visiting consultants who would work over an extended weekend (Fridays to Monday mornings). Whilst this might give rise to clinical governance issues (such as dealing with follow on care for patients who have been thus treated), it may be possible to deal with this, and is certainly worth further investigation.

These actions provide a range of 'lever actions' which can be adjusted to optimise the result.

4.2.4 The end result

In summary these actions would result in:

- **Increased PMI uptake**;
- Increased **economies of scale** which would permit more competitive pricing, increased margins, or both;
- **Increased private referrals** to Nobles;

Leading to:

- **Increased retention of private health expenditure** within the island economy;
- **Increased private health business** delivered by Nobles Hospital, resulting in greater revenue;
- A **more extensive range of local services** available to NHS and private patients.

4.3 How the proposal meets the aims of the brief

The NHS is a service which affects every resident of the island. It is therefore important that this service is protected against the revenue challenge faced by the government, in a way that minimises its impact on government spending.

4.3.1 Key benefits

The actions stated generate the following key benefits:

1. **Reduced or stable waiting lists** - If the private patients had been doubled in 07/08 and 08/09 the waiting list would have decreased by 3.8% instead of increasing 4.8% and at the end of 08/09 the waiting list would have been 16.5% lower. Given that we expect waiting lists to rise, these actions will help to hold these rises down in (at least) a cost neutral manner (see outline financial information on page 24) leading to an estimated extra 880 patients receiving treatment in 2011. Detailed calculations are shown in appendix 6;
2. **Increased Consultant services available** on-island which would be available to both private and NHS patients.

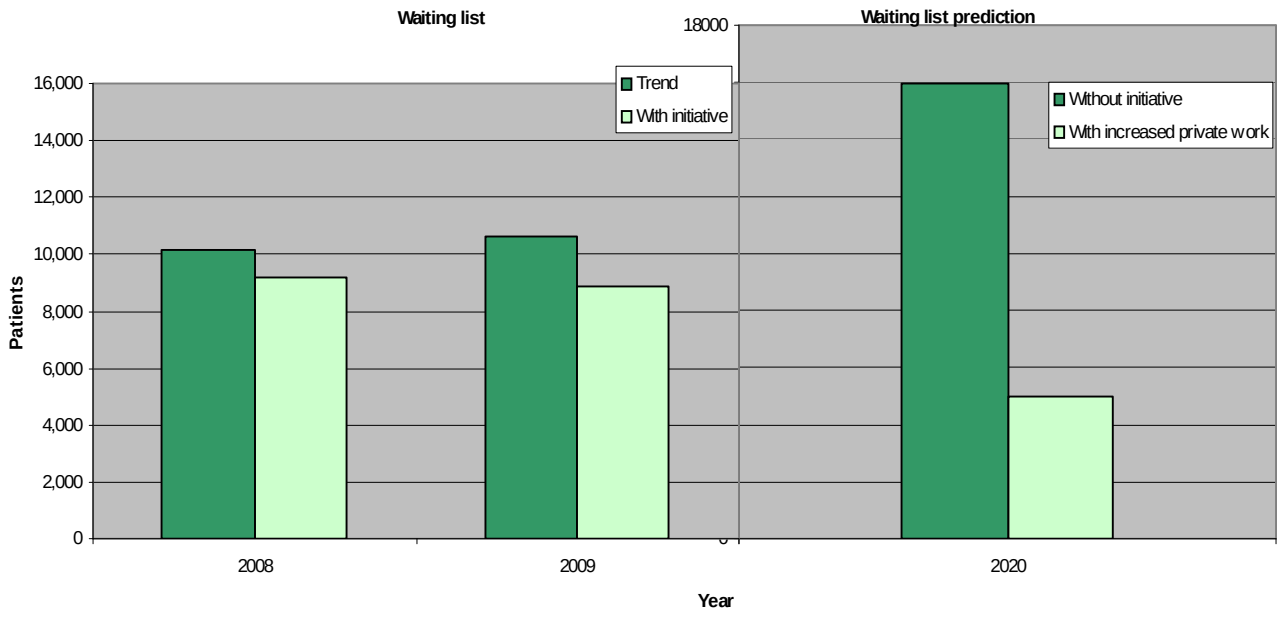

Figure 4: Potential impact of this initiative on waiting lists

4.3.2 Other benefits expected

In addition to the benefits stated above, the following benefits are felt likely to arise, but have not been quantified:

1. **Reduced referrals to the UK** arising from these changes would result in reductions in the need, inconvenience and cost to private patients of travel due to referrals; furthermore, with extended services, there would probably be a reduction in costs incurred by the NHS (and inconvenience to patients and their families) due to fewer referrals to the UK.
2. **Creation of new employment opportunities** through increased on-island business in PMI distribution. Although we anticipate that the actual PMI providers will be located off-island, we expect that local Independent Financial Advisers (IFAs) would benefit from extra revenue generated as a result of increased sales of PMI policies. In addition to commissions in respect of PMI policies successfully sold, the Independent Financial Advisor firms will also be gaining new clients (corporate and personal), which could create additional income earning opportunities by cross selling other products and services;
3. **Provides enhanced benefits packages to employees** at a relatively low cost to employers (as it is an allowable expense), benefiting the employers through improved return to work rates and improved work force productivity (see Dame Carol Black's report (Health Work Well-being Programme (2008) pp49 - 60));
4. **Demonstration of Government inter-departmental cooperation**. The use of an incentive mechanism to increase PMI uptake shows close cooperation between the Income Tax Division and the NHS. Government has been criticised (Brown, 2009) for its inability to cooperate between departments. Agreement in principle for this has already been received, demonstrating that it can be achieved (see Couch, 2010; and Killip 2010).

5. Implementation Plan

The previous section identified the main areas of action, which the implementation plan needs to address:

- Encouraging increased uptake of PMI by individuals and organisations'
- Increasing uptake of private care on island where available by encouraging PMI providers to favour local treatment where available and by
- Extending the range of services.

This section gives further detail on how this could be achieved. The implementation plan needs to take into account the Government budgetary cycle. Therefore, the Tax and NI changes would need to be developed in time for the 2011/12 budget.

The main activities in the plan are:

- Further consultation, analysis of the results and agreement of the final shape of the initiative;
- Submission of changes for the 2011 budget (including preparation of new forms and advice notes);
- Marketing of the agreed initiative;
- Implementation alongside the 2011/12 budget; this would include the agreed actions such as recruitment of consultants, and extension of theatre hours as demand rises.

5.1 Further consultation

We recommend that a consultation phase is conducted because the team's preliminary research was limited to what it could achieve within the given time and budget constraints.

Furthermore, this phase will help to identify the best mix of the 'lever actions' to be taken to ensure the desired overall result (in terms of revenue generated, costs, waiting list impact etc.).

In order to validate the findings, we suggest using a specialist agency to:

- **Survey public opinion**: which can be obtained via a leaflet drop within local papers or via IOM Post, and using online surveys such as the one we conducted;
- **Consult with enterprises:** via leaflets/website/forum – if we are to increase cover provided by employers we will need to make sure that all are on board and that the benefits of PMI to these organisations are well understood. These benefits are:
    - Quicker treatment could potentially mean a quicker return to work for staff ;
    - Enhanced benefits could make for a higher staff retention rate ;

- Improved ability to attract staff to the employer;

(again, refer to Dame Carol Black's report (Health Work Well-being Programme (2008) pp49 – 60)).

- **Consult with PMI providers:** to ensure they understand what is being proposed and gain assurance that they will encourage IOM based treatment where possible. We suspect this will need formal contact possibly lead by the Chief Minister or Minister for Health as our own efforts to engage with the providers have proved fruitless (see emails and letters in appendix 11);
- **Consult within Nobles, Consultants and the Department of Health executive:** to ensure usage of facilities are maximised and made available for increased private treatments to be undertaken within Nobles (for example weekend theatre openings). We need to confirm what additional work they would be likely to take on. We would also need to agree the optimum 'mix' of target procedures (e.g. eyes, Ear Nose and Throat) that will target waiting lists and be cost effective. Moreover, the mechanism by which services for private treatment are charged for (including the range and price) should be reviewed to ensure maximum cost recovery. The mix of private procedures and planned increases in activity levels will need to be agreed. This will drive any subsequent staff redeployment or recruitment (of anaesthetists and theatre staff in particular). The latter could either be of agency staff (initially) or in the longer term, permanent staff;
- **Communicate with GPs on island:** Generating improved awareness of the services available on-island will lead to an increase in on-island referrals for private treatments.
- **Consult with sales providers/outlet:** to ensure that all are aware and able to offer advice to the Isle of Man public and enterprises. The implementation team should also work with them to ensure they support this in other ways (for example by providing a 'help line' facility (i.e. not at Government expense)) as this sector will benefit from commissions in respect of policies sold.

The results will need to be analysed to provide input to the final mix of 'lever actions'. As part of this consultation phase, a working group representing those parties who would be involved in implementation and delivery should be formed. This group would consist of representatives from:

- Health Services
- Income Tax
- Consultants
- Private Medical Insurers
- Employers Groups – these will be important as we expect a large part of increased PMI uptake to be driven through greater numbers of employers providing it as a benefit to

their employees. The benefits to *employers* are set out in Dame Carol Black's report referred to earlier and also in a document produced by Axa PPP Healthcare (2009).

The group (and sub-groups) should work on:

1. The detailed implementation plans outlined in this report; Also it could be used for further investigation into likely markets able to be exposed for Private work;
2. Financial impact on all departments involved;
3. Agree realistic incentive levels (based on likely increased revenue yield for Health Services versus the cost to incentivise) for Tax and NI.

Within 5 months this group should achieve agreement, so that:

- The Public can be informed of plans;
- The budget for 2011/12 can include NI changes and Tax relief details;
- The process for the management of NI and Tax relief can be set up.

5.2 Marketing

Once the consultation phase has determined the likely mix of lever actions the next phase would communicate the initiative more widely in a series of stages:

- **Stage 1 Marketing –** Initial press release to public/enterprise over concept, promotion of benefits, and where PMI can be obtained. This will help to ensure a positive reception from the general public, health professionals and the organisations who are likely to be the main mechanism for increasing PMI coverage. Also, this should deal with any possible misconceptions, such as that of the facilities and skills at Nobles not being as good as those in the UK (see DHSS (2008b) notice about the report on the *Nursing TimesTop100 Judges Statement*);
- **Stage 2 Marketing –** Confirmation of implementation for 2011, direction to providers and GP's over the resource and procedures available at Nobles to ensure the providers and health professionals are ready for when the changes are implemented;
- **Stage 3 Marketing –** Leaflet to be distributed with Tax form, therefore ensuring full island coverage, to further embed knowledge amongst the general public and ensure they are ready to take advantage of the changes. Costs have also been included within the appendices for a leaflet drop via the Isle of Man Courier.

5.3 SWOT Analysis

Strengths	Weaknesses
• Assists NHS funding • Will stabilise or potentially improve current NHS waiting lists • Ensure those who need NHS assistance actually get access to it (i.e. those who can afford PMI cover are incentivised to pay for it, taking pressure off NHS waiting lists) • Potentially improves the overall healthcare offering • Potential to improve/further extend the IOM's bank of specialist skill sets within the Health Sector • Improved employee retention for employers who offer PMI in benefit packages • Less employee time off sick for employers who offer PMI in staff benefits package • Increased tax receipts from consultants increased income (in respect of additional private treatments carried out) • Increased spending on IOM by consultants due to increased income • Potential new enterprises (e.g. new start companies whose aim is to assist with processing claims on behalf of policyholders)	• Can't be accessed by everyone • Relies upon resident consultants willingness to take on additional private treatments • General public perception/attitude to Private Health Care • Investment requirement by Nobles • Cost of PMI cover could be prohibitive in some cases • Not everyone will be able to obtain PMI cover (i.e. underwriting difficulties) • There is a limited population to attract some specialist skilled Consultants to the IOM • We will need to change the mindset of some who wrongly believe NHS lists will be affected if use of PMI policies in increased
Opportunities	**Threats**
• Could attract new consultants to the IOM • Keeps money on the island • Trigger for further investment for Nobles • Potentially create new job opportunities (i.e. support roles within Nobles) • Opportunity to fully utilise all of the facilities at Nobles Hospital • Maximise efficiency within Nobles • Decrease claims cost to PMI insurers - if we can encourage treatment on island, as opposed to off-island • Increased income to IOM based IFA's and insurers who would be involved in selling the actual PMI policies • Potential new enterprise businesses	• No "buy in" from the general public • Insufficient specialist skills available to meet the treatment requirements of PMI claims on the IOM • Investment requirement by Nobles • Could be perceived as encouraging a 2 tiered system • Opposition from 'socialist' politicians (esp. around election time) • Need buy in from employers who will provide group schemes • Potential backlash from certain opposing sections of the IOM public • Potential of IOM ITD not providing a tax incentive • Rising cost of PMI cover • Income received is less than revenue lost through incentives

5.4 Implementation

Implementation would consist of:

- Preparing for the operational changes required within Nobles to operate with the gradually increasing levels of business expected;
- DHSS and ITD to accommodate required process, system, literature and stationary changes
- Tynwald approval of the budget;
- Preparation of the new forms and literature required to inform the public of the detail of the initiative;
- Launching the initiative (putting the processes live).

5.5 Post-implementation assessment

Once in place, assessment of the success of the initiative should be undertaken to determine its ongoing value and to determine if further actions are required or if changes to the action levers are needed. This should be ongoing and will involve input from across a number of areas, including:

- Post evaluation of incentive take up, private ward activity, waiting list activity;
- Post evaluation of our highlighted potential 'knock on effects' (i.e. increase business levels for IOM IFA's, new specialists brought to the Isle of Man, establishment of new enterprises);
- Towards the fourth quarter of 2012, the results of the initiative should be reviewed for benefit realisation. This should assess how well the initiative is working and seek to build on successes and expose opportunities for expansion (e.g. increase staff skill base, new procedures) in time for any adjustments to be implemented at financial year end.

5.6 Implementation Timeline

	Q2 2010		Q3 2010			Q4 2010			Q1 2011						Q4 2012
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
Consultation & Review															
Consultation with public															
Consultation with enterprise															
Consultation PMI providers															
Consultation with Nobles															
Analysis of Q1 consultation results															
Consultation with GP's															
Consultation with sales/provider outlets															
Prepare budget, marketing and processes															
Marketing															
Stage 1 — Marketing / Public information															
Stage 2 — Marketing / Public information															
Stage 3 — Marketing / Public information															
Implementation															
Prepare for operational changes															
Present changes for 2011 budgets															
Budget approval by Tynwald															
Updating forms and literature															
Launch – 06/04/2011															
Initial post implementation assessment															
Benefits review and resulting enhancements															

5.7 Financial Assessment

This section provides the financial business case and then some examples to demonstrate the effect of the measures (see appendix 6 for the calculations).

The financial business case

This is the income and cost using current figures:

Net income from doubling the private patients	£780k
NI and Tax income from additional work by consultants	£201k
Total income	**£981k**
Cost of NI reduction (0.5% of total contributions	£430k
Cost of tax allowance (100% of premiums)[4]	£506k
Total cost	**£936k**
Net income	**£45k**

Impact on an individual:

This is the financial impact on an individual earning £32,314 and paying £771.35 annually for PMI.

Cost of policy	£771.35
NI saving	(£13.25)
Tax saving	(£77.14)
Total saving	(£90.39)
Net cost	**£680.96**

Impact on an organisation:

This is the financial impact on an organisation with 20 employees paying £490.56 per employee annually for PMI.

	Total	**Per employee**
Cost of policy	£9,811.12	£490.56
NI savings	(£339.30)	(£16.96)
Net cost	**£9,471.83**	**£473.59**

4 100% of PMI premiums @ 50% relief

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Assumptions

As we do not have access to all financial information needed to calculate these figures we have made some assumptions and generalisations as explained below:

Income from private ward:

We have assumed that the mix of procedures and patients remain the same.

NI and tax income from consultants:

We have used an average salary for a NHS consultant and assumed that 25% of the consultant time is spent on private work (in line with our survey).

NI and tax cost:

We have used an average salary to calculate the NI and tax paid. We have assumed a 40% increase in the number of people on the island with PMI and that the mix of who pays for the PMI stays the same. We have also used an average rate for a corporate and individual policy based on quotes given for different age groups, family sizes and company sizes.

The proposal cost is calculated on a 0.5% reduction on NI payable, in reality a separate table will probably be created for PMI holders taking into account the different limits and rates.

Tax Exemptions

We have not included any cost of the tax exempt benefit status as it is only applicable when the value of the cover exceeds £400 and the employer provides cover to the employee's partner, which is rare, so we estimate this value to not be material.

5 Options Ruled Out

We ruled out a number of options for investigation early on.

The options ruled out as not meeting the 'spirit' of the brief to 'benefit the island and it's residents' were:

1. **Raise NI Contribution rates** for all contributors in order to increase revenue which could be targeted at the NHS. We ruled this out as we were aware that the DHSS was about to raise the Contribution rates and we felt that 'hitting contributors in the wallet' with an additional raise was not the best option;
2. **Reducing services** offered by NHS - this runs counter to the spirit of the statements made by Minister Teare (2009);
3. **Raise prescription charges**. Again, we ruled this out as we felt this would have an adverse affect on residents' available income.

The options ruled out for other reasons:

1. **An efficiency initiative** within the NHS, which would aim to reduce costs through staff reductions and 'Lean' processes. Whilst this is worth considering, we felt that the scope of this was so broad that it would not be feasible for our team to do a professional job in the time frame allowed by the challenge;
2. **'Health tourism'** - Attracting private health business from residents outside of the island; although this might generate revenue, which would benefit the island, it would only have been indirectly of benefit to residents and care would need to be taken not to treat patients from off-island in preference to Isle of Man residents;
3. **Private cosmetic surgery** provision via the NHS. There are other providers for this on-island and would only benefit a minority of residents.

The latter two options were also ruled out in order to ensure the scope of the report remained manageable given the team's time and resource constraints. However, if further throughput of private patients is deemed desirable, these might be worth investigation.

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From Left to Right,

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