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SECURING OUR FUTURE HEALTH: TAKING A LONG-TERM VIEW

Thank you for the opportunity to comment on your interim report. No doubt individual insurance companies will make their own responses to you, but this letter is the ABI's response on behalf of all of its members. We represent companies which help people or organisations, though insurance, with the money to pay for healthcare needs. We do not represent any companies in their role as healthcare providers, although some may cover both functions.

Introduction

Your report highlights a number of major issues for the UK. Two major themes stand out with which we wholeheartedly agree: first, the UK has suffered from a cumulative under-investment in the healthcare system over the last 20 years and the results of this are now being felt in terms of performance, manpower, infrastructure and outcomes. Second, the future demands on the UK's healthcare system, as illustrated in the work in Section C of the Report, are going to be significant and place a further burden on the country over the next 20 years. In the light of these two themes, we believe the Government needs to encourage additional voluntary forms of funding where it can and use the experience of the insurance sector to relieve some of the inevitable burden on the public purse. This can be achieved without undermining the fundamental principles of the National Health Service.

That you are consulting us at all is, in our view, a major step forward. Duncan Innes's presentation and discussion with the ABI and leading health insurers on 8 January was constructive and stimulating. In the past there have been limited discussions on possible future models and ways of working between the public and private sectors and sadly those discussions have usually been beset by ideological differences.

The reality of private sector insurance

In your report you rightly point out that in the UK 83% of health spending is publicly funded and that this figure is high by international standards; the EU average being 75%. Nevertheless, the number of people who benefit from healthcare insurance is significant and, in many cases, rising. I would like to draw your attention to the following figures:

- *Private medical insurance*: the main types are individual (where people take out their own policies) and corporate (where companies take out policies to cover their staff and often their families). Published ABI figures for 2000 show that the total number of people with cover has risen to over 6.5 million in the UK. While the number of people taking out their own cover has fallen to just under 2 million this has been more than offset by those covered by corporate policies – 4.6 million. In other cases people opt for cash plans (which pay out an amount on illness) and Laing and Buisson figures show that in 2000 there were 3.1 million subscribers, and 6.9 million people covered.
- In addition there is an increasing tendency for people to opt to self pay for private provision. Industry-wide figures are not available but BUPA hospitals report a growth rate in the self pay market of 30% between 1998 and 2000. Sometimes individuals bear the whole risk and in other cases insure for part of the risk using co-payment or cash-plan policies.
- *Income protection insurance*: besides covering loss of income due to illness individuals may be offered rehabilitation and this is increasingly an area where individuals, companies, and the state have a common interest. As with PMI there are individual and group policies. ABI figures show that the number of individual policies has risen to 1.5 million and that the number of members of group income protection schemes has risen to 1.8 million.
- *Long-term care*: this remains an embryonic market - unpublished ABI data show that in 2000 there were around 15,600 regular premium policies in force and 20,000 single premium policies in force. Given the publication of the rules on funding of nursing and personal care by the various UK countries and the Treasury's decision to regulate this market we believe there is considerable scope here for greater population coverage.
- *Critical illness*: these policies pay out on diagnosis of a life threatening condition. They are sometimes mortgage-linked and linked to life insurance. Individuals may choose to use them to meet cash and/or health needs. Since critical illness cover was introduced to the UK around 15 years ago, the number of people covered has grown to well over 3.5 million and it is estimated that over £359 million has been paid out to people who have become critically ill.

In summary, despite the low proportion of private healthcare expenditure in the UK the number of people with experience of private health cover of one kind or another is already significant (at between 9-10 million people covered) and growing. Private healthcare is increasingly one of the major concerns for employers in the UK as they cope with a growing burden of sickness absence and longer waits for treatment for their employees. Assuming these trends continue,

more and more people will have experienced an element of privately funded health cover in the UK. This will continue to have an impact on individuals' and employers' perceptions of what choice should be available to them in terms of meeting their overall healthcare needs.

Health outcomes and levels of public expenditure

In his presentation to us, Duncan Innes drew attention to table 5.2 (page 74) of your report and in particular the entry that seems to show a correlation between mortality rates and the share of public spending in total health spending across OECD countries. We have the following comments:

- In the UK there is already a high proportion of total health spending coming from taxation. In our view expenditure on healthcare needs to increase in both the private and the public sector.
- Whatever the academic arguments in favour of public finance for healthcare (and we note that recently the BMJ published research on Kaiser Permanente in the USA which favoured not-for-profit healthcare), the reality is that the UK 's publicly financed healthcare system has been associated with a significant cumulative under-investment in resources, infrastructure and poor service provision.
- The figures are derived from all OECD countries ie they are more evidenced by figures from countries other than the UK where private sector funding is higher. As a result, we would argue that a comparative analysis of OECD countries actually suggests that use of the private sector has in fact contributed in part to better comparative outcomes in other OECD countries and the UK would do well to learn from their experience.
- Public and private expenditure funding and services both have different characteristics. The public sector has a clear and important role in most healthcare systems. The private sector also has a significant contribution to make in terms of providing relevant products; a welcome choice of different options tailored to individual need; excellent customer service standards, enabling an appropriate investment in the latest technology; and, of course, freedom from Government funding limitations. There are many models of insurance to deliver the objectives of access and equity which Governments may require.

Morbidity and rehabilitation

Despite the dearth of suitable data, the lack of focus on morbidity in current health planning is a real issue. Morbidity is a much greater generator of NHS expenditure than mortality. The NSFs are largely directed at the major causes of mortality (the 5 disease areas are said to account for only 10% of NHS expenditure and 12% of morbidity costs). The NHS Plan/Our Healthier Nation targets are also expressed in mortality terms. To measure success in managing mental health, for example, on the basis of a fall in suicide rates (welcome as this would be) is hardly representative of the problem.

Whilst it is encouraging to see an assessment of the role of prevention we believe that more attention could be paid to how we can reduce the level of risk in the community via earlier intervention and rehabilitation. Paragraph 2.3 states that almost half of all NHS spending is for people of working age. Consumer expectations for this group will largely centre upon how well they can resume their working activities and social lifestyle after a period of sickness. In summary we believe the area of morbidity and rehabilitation deserves more attention.

Patient choice

In your questions for consultation 7.3 and 8.1 you mention “a more patient-centred service” and “improving patient information”. We agree with your assessment that these will be major drivers on expectations and cost. In our view though, they are part of the bigger picture of “choice” which you mention in question 8.2. In practice what is happening is a move from paternalism, to consumers demanding, and having, choice in every other consumer arena. Key challenges for the future are to find ways to give genuine choice to individuals and to provide mechanisms to make the healthcare system in this country more responsive to local needs. There is evidence in Europe to suggest that health systems which are more responsive to local needs generally have higher customer satisfaction levels.

Some future policy options

The ABI will continue to work with the insurance industry and other key stakeholders to develop future policy options. In the meantime we have attached in **Annex A** some thoughts on possible areas of potential future public/private partnerships.

Conclusion

We welcome your report and the opportunity to comment on it. We believe the UK insurance industry does have a lot to offer on the way forward and to contribute to a modern and dynamic healthcare system capable of meeting the future needs of this country and its citizens. We have a number of detailed comments on your report and these are attached at **Annex B**.

I am copying this letter to Simon Stevens at the Number 10 Policy Unit, and Paul Corrigan and Sheila Adam at the Department of Health

Yours

ANNEX A: FUTURE POLICY OPTIONS

Provision of Commissioning Services to PCTs

In the UK voluntary contributions to health insurance can be used to fund the whole array of clinical services and the private sector has considerable expertise in commissioning healthcare. This expertise is potentially of real value to PCTs and there is scope for capitalising on the systems and infrastructures developed by the sector in the purchasing of healthcare and the provision of patient focused care, in a timely and efficient manner.

Long-term care

The extent to which elderly people make provision for long-term care in their old age is a major problem in the UK. Unless action is taken it will get much worse. We agree that the evidence suggests that the need for social care services rises sharply with age and, in answer to question 9.2, in our view the current position will not be sustainable as the baby boomers become elderly. That generation will expect the state and the private sectors to have developed appropriate solutions so that they can make an informed and simple choice about how to meet their long-term care needs (at home or in residential/nursing home accommodation). So far the Government have concentrated on deciding at macro-level what elements of care they will fund and the insurance industry in providing products to individuals that could meet the gap. What have not been addressed are:

- How government and the private sector can raise elderly people's awareness of the need to make provision and the options open to them;
- How could access to funding be improved and simplified;
- Different options for care and financial support (including use of pensions);
- How the level of risk could be lowered eg through early intervention.

In our view there is real scope for public private partnerships between the private insurance sector that could make headway on these points. We think this could be piloted at Local Authority and possibly Care Trust level. The practicalities of arranging this will be made easier with the introduction of Section 54 of Part Four of the Health and Social Care Act 2001, which allows private top-ups to means tested allowances.

Enhanced hospital accommodation etc

Paragraphs 2.23, 2.38, and 4.22 of your report highlights the demand for better non-clinical services, for example enhanced accommodation and amenity charges. In our view this is an area of considerable unmet demand and is one of the reasons people opt to take out PMI insurance – at present to cover this and clinical costs, there being no “in-between” option which could be covered by insurance.

It is difficult to envisage public/private partnerships between NHS Trusts and insurers to market such a product because of the range of hospitals that any patient might be referred to. The move to Primary Care Trusts does however open a window to such partnerships. It is quite credible to imagine a set up whereby an insurance company would contract with a PCT to meet such needs. .

Complementary medicine

Complementary medicine, although increasingly available through GPs, remains largely individually funded (para 7.25), sometimes through insurance and sometimes through self pay. It may be, however, that in some PCTs there would be sufficient number of people to make it worthwhile to set up a partnership with an insurance company to provide a specified range of alternative or additional services for those who were prepared to pay towards them.

Rehabilitation/work related illness

The Road Traffic Act allows the NHS to recover the cost of NHS treatment following road traffic accidents to be recovered from the driver's insurance or, if not insured, from a pooled insurance fund. We have already mentioned the growth in the corporate PMI and IP market. It could be argued that a compulsory basic PMI/IP package to cover the cost of **work related** treatment would be a natural provision from the road traffic accident approach and the move towards corporate private health coverage. It might be an extension of existing employer's liability arrangements and could have the following advantages:

- The individual concerned and society would benefit because early treatment and rehabilitation would reduce dependency and encourage rejoining to work and employment;
- The State would benefit due to decreased sickness and incapacity claims ;
- The NHS would gain through additional funding;
- The employer would benefit because of early return to work but it would be important to ensure the burdens on small employers were not too great;
- Insurers and policyholders would benefit because of reduced payouts and premiums respectively.

That said, it would represent an increasing burden on business and we expect there would be objections from, for example, the CBI.

An alternative (or addition) to a compulsory basic system could be to reward best practice employers for introducing quality controls to manage work absence (which, of course, goes beyond work related treatment).

These are just some thoughts on future policy options and they clearly need a lot more work. We would welcome the opportunity to debate them further with yourself, government Ministers or officials, and key stakeholders in the NHS and local government.

ANNEX B: DETAILED COMMENTS ON THE REPORT

Para 2.22 – the final sentence is aspirational. People can and do access the NHS in this way and increasingly so. Indeed, recent announcements suggest that in future NHS

Patients using NHS funding will be able to access **private** healthcare provision too. Unless there are proposals to ban it the best way forward (from the Government's perspective) is surely to recognise what is happening; reduce the need to access it (for things the NHS should be meeting), and increase patient choice to access areas that the NHS was not intended to meet?

Para 2.39

Q7.1 – experiences of private sector provision and other EU state provision will become more common

Q7.3 – “patient choice” rather than “patient centred” would move from paternalism to consumer focused. Again on “patient information “ in Q8.2

Para 2.55 – To the list of factors affecting morbidity we would add “work fitness” and “social fitness” ie how fit does a person need to be to earn a living and enjoy their lifestyle and are these standards becoming more demanding?

Para 2.73 – there could be greater emphasis on the potential of patient access to the internet/digital TV and to pharmacists.

Para 2.75

Q12.1 – the trends in social care uptake could have different effects on different UK countries given their different funding commitments and this in turn could impact on health trends.

Para 3.43/44 – there will be different funding implications when NSFs go beyond clinical services and move into areas not NHS funded.

Para 4.2 – corporate PMI and IP may become more significant in future years.

Para 4.37 – suggests that charges may lead to less use of preventative care but it should also consider if charges lead to less “frivolous” use of the system.

Para 4.4 – social insurance should distinguish between the range of totally solidarity based insurance to largely risk or geographical pool based.

Para 4.18 last sentence – we may see the day when the NHS decides what is and is not provided on a universal basis and NICE is beginning to do so. In practice though this has proved extraordinarily difficult for all administrations. In the medium term the most that can be expected is that it will be fairly clear what is **not** available on the NHS.

Para 4.27 – it is important to note that while the funding may be equitable at a macro level it often isn't at a local level – hence the debate on “post-code lottery” and the inverse care law (para 9.58).

Para 4.29 – the ability to raise contribution rates is not open ended – people/employers still have to pay. PCTs represent a form of “fragmentation” of funding arrangements too – the issue is what is obtained for the additional transaction costs.

Para 4.31 – unclear how this relates to the aspiration of meeting EU levels of funding.

Para 4.37 – out of pocket expenses are not all potential efficiency gains – in many cases they may simply be things the government doesn't want to pay for but the patient does and there can be a substantial impact on access, as the French experience has shown.

Para 4.44 – The one-liner on pharmaceutical spending is rather simplistic. Otherwise it is true that cost control requires different levers in private systems – and that forms part of the debate about the future in the EU and beyond. The NHS has its own problems too. There is no panacea and para 5.10 makes this point. It is unclear whether the report considers that the UK private health industry also exhibits poor cost control.

Para 4.45 – In discussing PMI, the report refers to what an individual can afford to purchase; contributions based on an individual's health risk rating; and shifting the burden from the relatively rich to the relatively poor. In practice, as pointed out earlier, most UK PMI is group rated employer business with no individual underwriting.

Para 4.49/50 and 6.19 – if a review is also going on in this area we would be keen to participate in it too.

Para 6.19 – a review of the use of current resources is clearly key and should be undertaken within the context of a broader model.

Chapter 7 – while this covers the health service it does not deal with social and long-term care. Given the earlier paras on the importance of this area and its possible cross impact on the NHS, this chapter could be usefully expanded. The issue comes up again in chapter 9 (paras 9.19, 9.24, and 9.31) and in chapter 11 (front page). Our comments about rehabilitation and fitness to work issues are also relevant here.

Para 7.25 – the rise of stress related conditions is a key medical trend.

Q7.4 – The public may also demand value for money if an increasing amount of their tax is used to fund the NHS.

Para 8.41 – As a site for delivering preventative interventions, the workplace environment should be added.

Q8.1 – a couple of other issues worth examining would be how important health really is to people against other factors like income, career, house, car and leisure etc; and, the cost dynamics of more people being kept alive (but not necessarily cured) and the ability to treat more serious conditions.

Chapter 9 – opening page – muscular-skeletal conditions deserve a mention. They are the second largest cause of income protection claims.

Para 9.63 – “People will seek healthcare when they expect to gain some benefit from doing so”. There are a lot of implications here for the way in which preventative strategies are presented. On the one hand, they could be very successful if positioned attractively, eg

“how to avoid a heart attack/stroke, how to live longer etc” but success could produce its own cost dynamic.

Para 9.64 – draws a comparison between intolerance of minor health problems/rising expectations of quality of life with decreasing likelihood of consulting a GP/increasing likelihood of attending hospital as an outpatient. Surely the latter is related to difficulty in accessing GPs or similar?

Q9.5 – rehabilitation and workplace absence management will also be critical interventions.

Q9.6 – demand for home care and maintenance of independence will grow but this will be influenced by what is available.

Para 10.57 – should mention the govt/ABI moratorium on the use of genetic tests.

Q10.6 – deciding which can be best value on economies of scale grounds and which require innovation pilots and evaluation.

Para 11.22 – Do fee for service reimbursement systems experience over-utilisation of healthcare or the proper use of healthcare ie does the system itself consider it overused or are we only comparing it with our own? Equally, is all that is needed to correct this an adjustment of the amount reimbursed?

Para 11.48 – Would be interesting to see the actual figure and include it in table 5.2. Is it strong primary care or the GP gatekeeper system which is the issue. Also many EU countries have strong primary care systems which have different skill mixes – eg increased involvement of pharmacists. There is some scope for unpacking here.

Q11.1 – two other aspects are worth a mention: the potential for workplace services (prevention, early intervention/absence management) and partnerships with social care services being more joined up.

Para 12.1 – culture/lifestyle are also important issues

Para 12.17 – will this change in the future given devolution and changes to the allocation formula?