private payment for health: boon or bane?

THE SOCIAL MARKET FOUNDATION
HEALTH COMMISSION – REPORT 2A

The Commission would like to thank Sally Williams, Secretary to the Commission until December 2003, and subsequently Niall Maclean, for their hard work in preparing this report.

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The Social Market Foundation

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Chairman's introduction

I recently attended a Fabian seminar on health. It was a typically British affair, with politicians, medics and academics assembled around the table lauding the wonders of the NHS. My eye caught the German participant, whose blood pressure was clearly rising dangerously. Eventually he could bear it no longer. "You British think you have the best health system in the world," he said – "And you have to wait to see a doctor."

That experience was in my mind when our Commission turned its attention to alternative methods of funding health care. This is a debate which came and at least temporarily went without touching the sides. When the Chancellor set up the Wanless review, he did so with terms of reference which entrenched the continued existence of a publicly funded NHS. Nevertheless, Wanless did skip briefly over the case for alternative funding methods. He concluded carefully that a system where health care is financed through general taxations is both fair and efficient from a macroeconomic point of view. And that was that: Britain rapidly concluded that our funding system was fine.

Given the long debate about funding methods that has gone on practically since the health service began, it is perhaps surprising that that conclusion was not more controversial. The reason for the lack of dissenting voices is simple – in the 2002 Budget, the Chancellor put in place the largest ever sustained increase in NHS funding. Between 2002/3 and 2007/8, there will be an average yearly increase in funding of 7.4% in real terms. In cash terms, total net NHS expenditure is expected to increase from GBP 55.8 billion to GBP 90.2 billion over the same period.

This has greatly weakened the potentially most potent argument in favour of alternative funding methods – that they would provide increased funds for the NHS. Private medical insurance has often been held up as an important way to raise more cash for health. European social insurance systems look to be better funded. The 2002 Budget has made the argument on grounds of increased funding look rather superannuated.

However, there is room for doubt as to whether Mr Brown's funds will prove effective in raising standards. Some argue that the intrinsic flaws in the organisation of the NHS – "command and control" – will mean that they are largely wasted. Others believe they will be absorbed in higher pay and prices, without a corresponding increase in supply.

There is even more room for doubt as to how long tax-funding on this scale can continue. After all, if NHS spending continuously rises faster than GDP it follows logically that it must at some point consume the whole of GDP. Wanless seemed to think that tax funding will remain viable at least for 20 years or so. However this conclusion was based on his hope that the public would become fully engaged in looking after their own health, for example, by stopping smoking and so on. This is debatable.

Day by day, more evidence emerges of new and not wholly foreseen pressures on NHS spending. The currently fashionable one is concern about growing obesity, with 10% of children now officially classed as obese. This trend of growing obesity has serious implications for the incidence rates of conditions such as diabetes and heart disease. The National Audit Office estimates that obesity is costing the NHS £500m a year, with losses to the economy on top. But there are other examples and other costs: for example, the Wanless estimate of a £2 billion cost for appropriate lipid control through statins may be too low as newer more effective statins (so called 'super-statins', such as rosuvastatin) come on to the market.

For the moment, none of this is creating a crisis. The present position is that more money is flowing into health; that few would argue that the system could cope with even greater injections; and therefore that financing more health spending is taking a lower priority in debate.

However, the possible pressures in the long term mean that the funding debate has not lost its relevance even if it has for the moment lost its urgency. Even now certain alternatives to the status quo are floated frequently. Three in particular have attracted the attention of my commission. They are:

1 Private payment for medicine including medical insurance
The notion that private provision supported by medical insurance could supplement the funds raised by the National Health Service remains current. Some see scope for new incentives for people to take out private insurance (for example, the Conservative Party's heath 'passport' proposals). Others are attracted by methods of increasing employer provision of private insurance. The private insurers themselves (e.g. Norwich Union and BUPA) have been developing a variety of ingenious proposals with this end, claiming that the savings to the National Health Service from additional private provision will be sufficient to make them self-financing.

2 Social insurance
The belief here, based primarily on European experience, is that there are ways of funding health care through social insurance that would provide more buoyant revenues, increase consumer choice and reduce inefficiency. Several think tanks (most notably Civitas) urge careful consideration to be given to the merits of social insurance schemes.

3 A core package
It is often suggested that as the things medicine can do grow and grow, it will be necessary to set some limits on which of those things the NHS will pay for. Should it pay for Viagra? For fertility treatment? Or should these be things that people pay for themselves, either through private insurance or self-pay?

We have discussed these three as a Commission. It has not been our aim to come down either in favour or against them as a block. Rather, we have wished to look at the arguments in each case, to try to clarify precisely what is being proposed, and to separate the runners from the non-starters.

These funding options will not go away. In the event of a change of government, indeed, they could push their way rapidly up the agenda. We have therefore thought it helpful to publish a series of individual papers covering each of them and our reflections on them. We hope they will stimulate debate now, and condition future debate when the current tide of taxpayer money flowing into the NHS begins to ebb.

This is the first of these papers. It covers the role played by private provision in supplementing a tax financed system, including individual insurance, corporate insurance and self-pay.

This is of course a subject that still attracts tremendous ideological passion. On the left, private provision is seen as offensive, a detraction from a health service that provides the best (and the same) care to all free at the point of use. On the right, politicians who are generally unwilling to put increased funds into public services are prepared to propose lavish subsidies to those who insure themselves privately, even when such subsidies would largely favour the better off and even when there is little evidence that they would bolster take-up.

Our own view is passionately pragmatic. No-one can seriously argue that people could be stopped, or indeed should be stopped, from spending their own money on their own health care if they wish to. In addition, private financing is already bringing additional resources into health care; such spending accounts for some 16% of the NHS budget. If it ended tomorrow, all Mr Brown's largesse would go into filling the gap and none to improving the NHS. There are legitimate concerns about queue jumping, but the answer to this is to cut NHS queues, not private funding.

Moreover, quite besides the extra resources it provides, the positive virtues of a privately financed sector are enormous. It can provide beacons of excellence. It allows choice. It provides a safety valve for many people whom the NHS has failed. It allows for experimentation, and innovation, including innovation in methods of contracting and control of costs. Some ideas that the private sector has come up with are exciting: for example, the service provided by BUPA and others in helping to inform customers and guide them as to where and how to get the best treatment at a guaranteed and competitive cost. A healthcare system deprived of all this would be the poorer, and the sooner those on the ideological left realise this, the better.

We do not however go so far as to favour subsidy to the private sector, whether in the form of payments from the NHS or in tax-relief. All the evidence is that such subsidy would mostly be deadweight, cutting the cost to individuals without increasing take up by much. Moreover, the subsidy would be paid for by higher taxes, often on poor people, while the beneficiaries would be overwhelmingly the better off.

Papers on the other two areas will follow. It should be said that, as a Commission, we do not take the view that these are currently the most urgent issues at present facing the NHS. Some other issues have overtaken them at the forefront of debate because of government policy: Foundation Hospitals is an example. Others are in urgent need of further discussion: how the Primary Care Trust concept should evolve is one important example. The wider agenda around choice, competition and exit needs further work. And the training and practice of medical professionals is as crucial as it is tricky. These are issues to which we hope to return in our third report.

David Lipsey
Chairman, SMF Health Commission

Private payment for health: boon or bane?

KEY POINTS:

- Analysis of the role private payments could play in UK healthcare has often been hindered by over-simplistic ideological views.
- Private health expenditure is a significant and growing part of overall health spending in the UK. It represents partial exit from a monopolistic state provider, provides additional capacity and choice in the health system, has provided examples of excellence in provision, and has helped pave the way for healthcare that is more responsive to individual patients.
- The economic arguments for encouraging employers to pay more towards healthcare are more compelling than those for individual tax relief.
- Possible pressures on health funding in the long term mean that the debate on financing has not lost its relevance and may need to be revisited if increased public spending becomes unsustainable.
- The Commission does not, at this stage, advocate any policy change. We do however believe that private payment ought to be recognised as an important adjunct to the status quo regarding NHS financing.

Analysis of the role private healthcare payments could play in the UK has often been hindered by over-simplistic ideological views – many of those on the political left straightforwardly decry such payments as an offence to equity, while many of their counterparts on the right often reify private payment as a magic bullet solution to all healthcare financing problems. Even those of more moderate ideological persuasions are wary of even exploring the possible benefits that could come from encouraging forms of private payment, for fear of being viewed as 'unfaithful' to the 'ideals of the NHS.' This wariness remains widespread, despite the fact that Government is increasingly making use of the private sector as a provider of certain NHS services.

Amidst the ideology and wariness, we ought not to lose sight of some salient facts. Firstly, there is evidence to suggest that private payment and good health outcomes exist in a relationship of direct proportionality – the World Health Organisation (WHO) has noted that those countries where the proportion of private payment is higher have better health outcomes (WHO 2000). Secondly, private health expenditure is a significant and growing part of overall health spending in the UK, and makes a valuable contribution to the healthcare system. By taking some patients out of the NHS for periods of time, private payment can increase capacity within the NHS. Increased capacity makes it easier for clinical outcomes to be met in full and on time. Thirdly, patient exposure to the type and quality of healthcare offered in the private sector raises their expectations when they next come into contact with the NHS. This, if harnessed correctly, could act as a spur to improve the quality of NHS services.

Before proceeding any further, it will be useful to outline the various forms private payment can take. Too often, private payment is simply equated with private medical insurance. In fact, this is just one form of private payment. Other forms include health cash plans, dental benefit plans, critical illness insurance, income protection and long term care insurance, direct payments ('self-pay'), and co-payments ('charges').

The Government could encourage more private funding of healthcare in the UK by stimulating the take-up of any one of these products or payment mechanisms. The Commission has already published its

analysis of existing NHS charges (Social Market Foundation 2003). Our conclusions on extending charges to other areas of healthcare will be published as part of this series of four papers examining healthcare finance mechanisms.

As part of our work on charges, we recommended Government endorsement of dental capitation schemes and better consumer information to encourage membership of this market. We do not revisit the options for Government intervention to encourage the long term care insurance market considered by the Royal Commission on Long Term Care in 1999. Nor do we examine critical illness insurance or income protection, as these are essentially personal benefits and do not contribute funds directly to the health system. The market for health cash plans remains small-scale and is not considered here. Instead this paper focuses on the case for encouraging more private payment for healthcare via two main routes: PMI and self-pay. Before considering these two options in detail, it will be useful to examine what scope exists for increasing private payment, and to outline the benefits of so doing.

INCREASING LEVELS OF PRIVATE PAYMENT: SCOPE AND BENEFITS

There are two main ways of measuring the extent of private payment:
- as a proportion of consumer spending;
- as a proportion of total healthcare spending.

When consumers become wealthier, they have more to spend on health – and the evidence is that they do so. As a result, private health expenditure has risen continuously since 1987 and now stands at 1.7 per cent of total consumer spending (Office for Health Economics, OHE, 2002). Yet this proportion is still one of the lowest among the major industrialised countries. In 2000, private health spending accounted for 1.2 per cent of GDP in the UK, compared with 2.3 per cent in France and 2.6 per cent in Germany (OHE 2002). This suggests there is at least scope for private payments to contribute more towards the demands for increased healthcare spending highlighted by the Wanless Report (2002).

Turning to the public and private proportions of health spending, public health spending in the UK was 83 per cent of all health expenditure in 2000 (OHE 2002). This was the highest proportion in the OECD or the EU. It means that the burden of healthcare costs in the UK is largely carried by taxpayers, rather than individuals or businesses. Private health spending was 17 per cent in the UK, compared with an average of 25 per cent across the EU and 41 per cent across the OECD. This also suggests that there is at least scope to shift some of the burden of health spending away from taxation towards private payment.

Often forgotten are certain treatments (complementary therapies, vitamins and food supplements), which are almost always paid for privately, and represent an increasing proportion of overall health spend.

Were we to encourage an increase in private payment, we could expect concomitant benefits to flow to the NHS:

- NERA (2003) estimates that 6.7 million people with PMI are treated as inpatients by the private sector and that, in 2001, 25 per cent of independent hospital revenue was derived from patients who chose to pay for private acute care directly themselves (estimated at 250,000 patients). It argues that these two groups are transferring their demand for acute care out of the NHS and into the private sector, thus easing pressures on the NHS. It claims that in 2001, 7.5 per cent of independent hospital revenue was due to NHS patients receiving treatment in the private sector (estimated at 75,000 patients).

- NERA (2003) also estimate that, in 2001/02, £520m in exchequer revenue was linked to corporate PMI alone.

- The private hospital sector was treating around 750,000 patients a year in 1999 and was estimated to be taking 300,000 patients off the NHS waiting list (NERA 2000). Today's figures are likely to be much higher. Given that the overall waiting list is getting on for a million people in England (Department of Health 2003), this is a substantial contribution.

- NHS 'pay beds' comprise a significant proportion of total private capacity. The profit they make is returned to the NHS to the benefit of NHS patients. Industry sources claim that PMI schemes specifically designed to utilise NHS pay beds are usually between 25 per cent and 40 per cent cheaper than other PMI policies.

WHAT FORM OF PRIVATE PAYMENT?

Private Medical Insurance

Helping to cover the costs of treatment through insurance is the most common form of private payment both in the UK and abroad. It is important to reiterate, however, that the market is a relatively small part of the health system in this country compared to the likes of Germany, France and the United States.

While the current Labour Government has tendered for some private sector provision of hospital management and for treatment centres to treat NHS patients, it has shown no interest in relieving pressures on the NHS by encouraging patients to 'go private', and has withdrawn incentives introduced under the Conservatives to stimulate take up of PMI. Prior to the July 1997 Budget, people over 60 years old (including couples with one person aged 60 or over) received basic rate tax relief on the purchase of PMI. Before April 2000, employers did not have to pay any employers' National Insurance contributions on PMI. This mirrors a wider trend across the EU to reduce or abolish tax relief for voluntary health insurance. There is no tax relief in six EU countries and only very limited tax relief in a further two (Mossialos & Thomson 2001).

The loss of these subsidies has had negative consequences for the UK PMI market, particularly in relation to individual subscribers. Yet insurers have seen their revenues grow over the last few years, despite a rise in the claims incurred, mainly because of premium increases (Laing & Buisson 2003). According to the Association of British Insurers (ABI) the PMI market is worth around £2.2 billion a year (Stears 2001). It estimates that 70 per cent of patients using the private sector have their treatment paid for by PMI.

Over seven and a half million people – 12.8 per cent of the population – are covered by PMI (Laing & Buisson 2003; Association of British Insurers 2003). Two-thirds of policies are provided through employer schemes; the remaining third are provided to individual subscribers.

PMI schemes are the second most popular benefit for employees after pensions, although just 20 per cent of employers provide health insurance (Virgin Money 2003). Traditionally, people in better paid jobs have been more likely to be offered PMI as a benefit (Emmerson et al 2001). However, according to industry sources, it is increasingly the norm in some sectors (e.g. pharmaceuticals, brewing and financial services) for all their employees to be covered by PMI schemes.

Employer schemes tend to be cheaper and annual price increases smaller, as employers can spread the risks across the full range of their employees, the age mix is younger and there is less predisposition to

claim. However, increasing demand from companies to self-insure private medical expenses by means of trusts is thought to have displaced some demand for traditional company paid PMI (Laing & Buisson 2003). As many companies move away from traditional final salary pension schemes, there's a fear that health insurance will be the next employee benefit to be watered down (MacErlean 2002).

The PMI market for individual subscribers has come under pressure from increased costs in recent years. As a result, premiums have increased considerably – often well above the rate of general inflation – to the extent that they are often about 50 per cent more than the premium a small company would pay (personal communication, T Baker, Norwich Union Healthcare 2002). This partly reflects expensive new developments in healthcare technologies, new drugs and treatments. Individual policyholders today tend to be older and their premiums on average higher than younger policyholders, because of the greater likelihood that they will need expensive medical care. Those who enjoy free health cover during employment can be hard hit when they retire and have to meet the cost of premiums themselves.

The overall picture is one where the employer market is becoming more important than individual PMI. King & Mossialos (2002) argue that, over time, individually purchased insurance could be partially displaced by company-based plans. Laing & Buisson (2003) suggest that maximum penetration has already occurred in the individual sector. It is likely that individuals reflect on information about waiting times in deciding whether or not to purchase PMI (King & Mossialos 2002) and research suggests that those with PMI are less confident of receiving high-quality NHS care (Mulligan 2001). So reductions in NHS waiting times and other improvements in NHS care could reduce the desire for individuals to opt for insurance. As Laing and Buisson (2003) remark: 'the government's ambitious targets for inpatient and outpatient waiting times to be met by 2006 and beyond, and strategy for choice to become an option for NHS patients in the future, threaten to bridge the gap between the NHS and private healthcare.'

The market has witnessed a number of product trends aimed at attracting customers in both the individual and employer sectors, particularly for groups where PMI penetration has been low. Many insurers have developed budget policies to make PMI more affordable and attract subscribers among the lower socio-economic groups (Laing & Buisson 2003). No claims and loyalty bonuses, discounts for a healthy lifestyle, higher excesses and reductions in cover or partial cover are some of the features. Enhanced benefit plans, offering wider cover than standard policies, have also been introduced. Add-on benefits include: travel insurance, cash benefits, GP minor surgery, free sight tests, dental cover and health screening. Many insurers offer PMI policies with other health insurance products, particularly critical illness. Other trends include plans targeted at specific groups of people (e.g. the self-employed, or people wanting to insure against heart disease and cancer), as well as back to work policies, fixed price products, and individual underwriting.

Insurers have introduced a number of cost containment initiatives, the most significant of which are Preferred Provider Networks, where insurers enter into an explicit relationship with a number of 'preferred hospital providers'. In return for agreeing aspects of care such as access, cost and quality standards, preferred providers are guaranteed certain levels of business. Policyholders usually receive a discount or additional benefits. Some insurers have taken this a step further and developed Treatment Networks for things like breast or bowel cancer. By directing patients to hospitals that offer the most efficient supply and highest quality for their particular treatment, insurers can reduce their costs. Most of the large insurers now apply measures like audit of treatment outcomes, medical helplines and clinical pre-authorisation, designed to ensure that policyholders receive appropriate care and that claims are not paid for unnecessary treatment (Laing & Buisson 2003).

Finally, policies designed to dovetail PMI with NHS cover ought to be mentioned. These encourage PMI customers to use the NHS if waits are low but use their PMI when they are not. Policyholders receive both lower premiums and cash back if they use the NHS. This helps flex PMI usage around where the NHS is struggling but reinforce the value of the NHS where it is the best option (personal communication, I Candy, Norwich Union Healthcare 2003).

Direct payments

Some individuals have always paid out of pocket for private treatment. The so-called 'self-pay' sector of the market has expanded over the past few years, stimulated by fixed-price offers from insurers and providers under which people pay the one-off costs of treatment, as well as interest free loans and new services (e.g. BUPA's 'On Call' service and Axa-PPP's 'Pay As You Go Healthcare') to help consumers select the best deal. In 2001, about 250,000 people chose to pay directly for private acute care, nearly double the figure who opted for this route in 1997 (personal communication, S Taber, Independent Healthcare Association 2002).

This sector has become a significant part of the business of private hospitals – reaching 25 per cent of independent hospital revenue, according to industry insiders. The phenomenon shows the capability of people to recognise the benefits of buying healthcare, so making more private payments that contribute towards the overall cost of healthcare in the UK. It also demonstrates a growing public interest in private treatment options. Industry sources suggest that a high proportion of self-pay patients (as high as 30 per cent) are in the CDE socio-economic groups, making this funding route not just the preserve of the wealthy.

Many of those who opt to self-pay believe it works out cheaper than paying for PMI (Which? 2002). It enables them to take advantage of the NHS where waits are short and opt for private care when waits are long, without the worry of crippling premium increases for older people. The existence of pre-existing conditions is also a major factor in people choosing self-pay over PMI and the real growth in this market is thought to reflect NHS waiting lists (personal communication, I Candy, Norwich Union Healthcare 2003).

The most expensive procedures, like heart surgery, can cost in the region of £10,000 to £15,000 (personal communication, C Friend, General Healthcare Group 2002). But for someone in good health, this risk may be worth taking – especially given that NHS care is available as a back-up. The biggest risk is that care needs – and costs – will escalate beyond the original price quoted. However, most providers now offer fixed-price packages that take away the worry of hidden extras and unforeseen eventualities. Even so, consumers need to be canny to get the best deals, as prices have been found to vary not only across region, but also within regions and within the same hospital operator (Health Which? 2001).

OPTIONS FOR THE UK

There is unlikely to be much support for a wholesale move to a healthcare system where private insurance becomes the primary funding source. The Government has clearly come down on the side of a tax-funded NHS. The disadvantages of across-the-board private insurance systems such as in the United States are well known and include cream skimming, large gaps in coverage, and inequities in service provision. Insurance-based systems are also vulnerable to the problems of unnecessary consumption (although this is also a feature of the NHS as most services are free at the point of use).

However, this does not mean that we ought not to take seriously the question of whether there is merit in encouraging the expansion of private payment in the UK. One advantage of doing so would be to

expand the overall funding available for healthcare, thereby providing greater capacity. The disadvantages would include the cost to the taxpayer if the encouragement of private payment involved tax relief, and the opportunity cost this represents to NHS expenditure.

Private payment in relation to PMI or self-pay could be stimulated though a number of avenues, including:

- Encouraging employers to take more responsibility for the health of their employees by providing some tax relief on occupational health spending. For example, Royal & Sun Alliance (now FirstAssist) developed proposals for tax breaks for good sickness/absence rates. These are based on the premise that rewards for low absence rates will give companies strong incentives to look after the health of their employees, which in turn may mean investing in PMI and screening services. The idea is that each year auditors would claim tax relief on corporate tax if the absence rate was below a set benchmark (personal communication, R Fielding 2002). Such a model could potentially lead to reductions in the £23 billion cost of sickness absence to the economy (CBI 2001).

- Introducing tax relief on PMI premiums for all, or certain, individual subscribers (e.g. the over-60s). The Conservative Party wants to make PMI more accessible to self-employed people, for example, by creating a 'large umbrella scheme to which they can affiliate, run by the private sector and offering the same costs and benefits as large company schemes' (Fox 2001).

- Giving patients who self-pay a tax credit or other refund reflecting the saving made to the NHS. For example, proposals by the Conservative Party (2003) for a 'patient's passport' could stimulate the self-pay market by enabling patients to take a proportion – 60 per cent (Fox 2003) – of the NHS costs for treatment or investigation to go towards the costs of private treatment.

- Removing the Insurance Premium Tax (IPT) that both employers and employees pay on PMI. The argument for this is that IPT is effectively a tax on income that has already been taxed at least once – as corporation tax for companies, or as income tax for individuals.

- Removing the taxable benefit that employees pay if they receive PMI cover from their employer. The Conservatives favour incentivising the corporate PMI sector over the individual market, on the grounds that company schemes offer the price advantages conferred by community rating (Fox 2001). NERA (2003) has demonstrated that the initial cost to the Treasury of providing tax relief on employers' National Insurance contributions on PMI is relatively small at £118 million. Provided employers funnel a portion of the value of this relief back into PMI purchases (i.e by expanding coverage amongst employees) the scheme can finance itself.

WEIGHING UP THE ARGUMENTS

The advantages of stimulating private payment include:

- Increasing health expenditure. Reducing the strain on the public purse by boosting the overall total available for health spending in the UK, which would increase the total capacity of the system to cope with rising demands. It is clear that improving health outcomes will require as much investment as possible; the Government has already doubled the historic rate of growth in its expenditure.

- Sharing responsibility for health financing. There is concern about the ability of the country to continue to afford the increasing burden of high increases in public funding of healthcare. Sharing the burden of health expenditure more evenly between taxpayers, employers and individuals may help because, as shown above, the public purse carries a higher proportion of overall costs than in comparable countries.

- Enhancing choice. Additional capacity will help the NHS to deliver the improvements in care envisaged in the NHS Plan, and to provide additional choice for patients. However, encouraging individuals or employers to take up PMI or make direct private payments is not the only way to generate this extra capacity – much could be achieved simply by using the private sector as a provider for NHS patients, in the way that private treatment centres are being used.

- Driving up quality. More private payments could allow quality across the healthcare system to exceed basic minimum standards and to approach excellence on international comparisons. Increasing the total pot of money available for healthcare also makes cutting edge technologies, such as PET scanning, easier to fund.

- Fairness. Some argue that it is only fair that people should not to have to pay for their healthcare twice – those with PMI or who self-pay incur the costs of private healthcare as well as for the NHS through taxes. Refunding part of their contribution to the NHS would address this unfairness and encourage more people to make private payments.

- Easing NHS pressures. Encouraging private payments would help to ease pressures on the NHS, by reducing the strain as some choose to 'leave the queue', and by providing an element of remuneration cross-subsidy to many consultants. BUPA estimates that if the private sector did not exist, there would be an extra 300,000 people on the NHS waiting list (personal communication, BUPA 2003). Any resources released by not treating someone who goes private are available to be taken up by the next person on the waiting list. Thus tax relief could reflect the saving gained by the NHS from not having to treat an individual with PMI or opting to self-pay.

The disadvantages of stimulating private payment include:

- High deadweight costs. Tax relief on PMI, particularly individual PMI, ends up subsidising those people who already have private insurance. The same is probably true of self-pay, although this can be a one off decision, as opposed to insurance which requires a longer commitment. One King's Fund study revealed that support for the Government to encourage the take up of PMI was highest among the young, social class AB, Conservative voters and those who already have PMI (Mulligan 2001). These findings also reflect the fact that tax relief for PMI is regressive, with gainers tending to have higher levels of savings and more likely to be owner-occupiers.

- Only acute care benefits. Private payments do not allow people to opt-out of the state system fully. The private healthcare sector is essentially a complementary service that allows individuals with PMI or who self-pay to augment the services they receive from the NHS. The NHS must still provide emergency care for people with private insurance. It also provides the bulk of the care for the estimated 17.5 million people in the UK suffering from chronic illnesses. Subsidising PMI or self-pay would lead only to a decrease in acute demands on the public system, and would make little impact on the demand levied by the far greater numbers of patients with chronic conditions.

- Inflate health costs. Implementing tax breaks for private payments would be administratively complex and generate additional transaction costs. There is also some evidence that equivalent treatment may be more costly when undertaken by the private sector (Emmerson et al 2001). These, together with the deadweight costs of the subsidy, would inflate health care costs overall.

- Expensive. The abolition of tax relief to the over 60s raised an estimated £135 million for the Treasury in 1999-2000. Although the loss of this tax break led to a decline in the number of individual consumers taking out PMI, the cost of treating additional people on the NHS would be less than the money saved (Emmerson et al 2001). In fact tax incentives are thought to have a minimal effect on encouraging private payment. When tax relief for the over 60s was first introduced in 1990, the numbers of policyholders rose only by about 50,000 in seven years. This had only a 'marginal' effect on the NHS (Department of Health 2000). If tax relief were available on PMI to all adults in the UK, it is estimated that at least an additional 1.8 million people would have to take up private insurance (equivalent to 28 per cent growth in coverage) for the tax to be self-financing (Mossialos and Thomson 2001). Work by NERA (2003) suggests that the costs are smaller for the corporate PMI sector and, depending on the response from employers, could even be self-financing.

- Compounds inequities. Encouraging private payments through subsidies means using taxpayers' funds to expand private healthcare principally for the benefit of those able to afford private care. Therefore, such incentives reduce equity of access to services.

- Creates perverse incentives. Throughout the 1990s there was much debate about the impact private practice by consultants has on NHS waiting lists. For example, Professor John Yates (1995) drew attention to findings showing that long NHS waiting lists often occurred in regions where there were lots of private beds, and that the specialities with the longest waiting lists were also the main, and most lucrative, areas of private practice. In 2000, the Health Select Committee concluded that it was indisputable that consultants' private earnings are highest in those specialties where NHS waiting times are longest. It recommended that the Department of Health examine ways in which the suspicion of perverse incentives can be removed from the system.

- PMI is vulnerable to adverse selection. Private medical insurance providers are vulnerable to the fact that individual purchasers possess privileged information about their health status. The more likely they are to get ill, they more likely they will be to take out cover, and to make subsequent claims. This is not a problem that confronts the NHS, since all individuals are covered.

THE COMMISSION'S VIEW

We are convinced by the economic arguments against introducing tax incentives for the individual PMI market. Some of these arguments are less pertinent when applied to the corporate PMI market. For instance, incentives to encourage PMI take up for this sector may even be self-financing.

However, the Commission takes the view that employers ought to be taking more responsibility for the health and wellbeing of their employees. It is in their interests to recognise the benefits of maintaining a healthy workforce and returning ailing employees to full health as quickly as possible. This might mean employers funding some PMI for their workers; the state should not have an obligation to incentivise employers to do this.

Indeed, it is the majority view of the Commission that it should not be for the state (or taxpayers) to stimulate the take up of PMI, whether for the corporate or individual sector, or self-pay.[1] Our rejection of incentives to stimulate private payments is made on grounds of equity and efficiency grounds. For example, the Conservative's plans for a patient's passport might encourage more patients who could afford it to seek treatment outside the NHS. However, the cost of any subsidy would form a deadweight on NHS funding. Moreover, we are concerned that the policy could compound health inequities and leave the NHS with 'bad risk' patients, reducing it to a safety net for the worst off. We are also concerned that incentives to encourage private payments could lead to calls for similar incentives to encourage private schooling, for instance.

This aside, the possible pressures on the public purse caused by increased NHS expenditure mean that in the long term the funding debate has not lost its relevance. The Government will need to ensure both that the increased public spending is sustainable and that the NHS uses the additional resources efficiently. While the Commission does not advocate any policy change at this stage, we believe that the Government should – while maintaining its commitment to an increasingly well-funded NHS – recognise the importance of private payments to the healthcare economy, and cultivate a more pragmatic approach to the way such payments are regarded. Its aim should be to see where best private payments can make a contribution, while guarding against the potential downsides, such as incentives to inflate waiting lists.

[1] The Commissioner who dissented from this view was Fergus Kee.

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