



Private Spending on Healthcare

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Extracts from the report by the ippr, supported by Aviva

Foreword

The NHS has provided a significant contribution to improving the health and well-being of people in the UK for over 60 years. It is important to reflect on the future of our health services to make sure they are capable of meeting our needs in the coming years. There is an ongoing debate which relates to how the NHS is funded now and in the future. This subject is regularly being discussed in the media.

We are pleased to have been able to contribute to this debate in collaboration with the Institute for Public Policy Research (IPPR). The report 'Private Spending on Healthcare' (available in full at www.ippr.org) considers a broad range of issues relating to private spending on health.

We have produced an abridged report which highlights the key messages and proposes possible solutions. We agree that the government should consider the broader role that private medical industries have played in satisfying customer need and driving better public health for the nation. In addition, there are two focussed summaries on the top-up fee debate and the role of the employer in our nation's health. We believe both areas are very topical and central to any discussion on the future provision of healthcare in this country.

Finally, I would like to thank the IPPR for their help in the production of this report. It has been a privilege to contribute to the research which has identified a positive solution for health services in the UK. We hope that the report is of interest to you and gives you a fresh perspective on an important national issue.



Gil Baldwin
Managing Director UK Health

Executive summary

The debate about healthcare finance in the UK continues after 60 years of the National Health Service (NHS). Both critics and supporters of the NHS question whether the UK can continue to provide tax-funded healthcare free at the point of need, as private incomes increase and as demands and the costs of healthcare continue to place ever greater pressures on the health budget. In particular, shifting the balance of healthcare finance from the public to private purse is put forward by some as a desirable, or an inevitable, development. But with the focus of policy and research invariably fixed on the NHS itself, the role of private spending in the UK health economy is surprisingly under-studied.

This report addresses two key policy problems:

- **The macro level problem is the future financing of healthcare in the UK.** We examine how much and how future healthcare will need to be funded. In particular, we are interested in the role that private health spending is likely to play in meeting future healthcare spending demands.
- **The second problem is how the current contribution of private spending in the health economy could be improved.** Private spending in its many forms has always co-existed with the NHS, but has received less attention from policymakers as an integral part of the health system. We examine recent trends and evidence of the efficiency of different types of private spending, making recommendations on how they could be improved.

Note that this report focuses on private spending rather than private provision (which includes privately and publicly-funded elements). This includes spending on private health insurance, self-paid hospital care, private dentistry, over-the-counter medicines and employer spending on worker health and wellbeing.

Our core arguments can be summarised:

Total healthcare spending is likely to increase

We agree with the overall projections made by health economists that total healthcare spending in developed countries (including the UK) is likely to increase in the future. Demographic change, the inflationary impact of new technology and the rising relative cost of healthcare labour, as well as economic growth, will combine to lead to a likely increase in costs of, and demand for, healthcare. Improvements in productivity are necessary, but will not prevent the need for increased spending. This is not a bad thing in itself, because it leads to progress in life expectancy and wellbeing.

Other types of consumption will fall (relative to total income) as healthcare spending rises. However, this does create significant challenges for policymakers within the constraints of current public finances.

The forecast increases in healthcare spending reflect the fact that societies are likely to value this rather than other types of consumption. Such expansion could well be *affordable*, in the sense that it would not impose a decline in the absolute level of non-healthcare consumption¹. In simple terms, as economies grow, healthcare will continue to consume a growing slice of a larger cake (so the remaining cake can also grow). The central issue in healthcare is, therefore, not whether we can afford to spend more on medicine, or whether it is a *good idea* to do so, but what is *the best way of paying for it*.

1. While medical expenditure is predicted to rise faster than GDP, non-medical consumption will still increase as long as the growth rate of medical expenditure weighed by the share of medical expenditure on GDP is less than the GDP growth rate itself.

Private spending plays a residual role in most international health systems, and cannot efficiently replace public spending

Private spending as a proportion of total healthcare spending has converged internationally and remained relatively stable for 20 years (at between 25 and 30 per cent). There is not a trend towards an increased private share of healthcare finance. Looking at its role in the UK and international health economies, we conclude that private spending will remain relatively marginal (currently 16 per cent of total healthcare spending) compared with collective funding mechanisms. At a system level, theory and evidence suggest that privately-funded healthcare plays a different role to the publicly-funded sector. It is not possible to transfer the burden of funding healthcare from the public to the private sector efficiently; increasing private spending is not an efficient way of raising healthcare finances.

Public spending remains the most efficient and equitable way of funding healthcare and of funding rising costs in the future

We find that the theory and evidence on the economics of healthcare funding show that private spending is generally less efficient than public spending and administration where risks are collectively pooled. This will continue to apply as healthcare costs and demand increase in the future. The most efficient way to finance increasing healthcare costs will be through public spending. Moreover, increasing publicly-funded healthcare spending will still be worthwhile if society values the added benefits brought by new technologies and the care of an ageing population.

Future governments will therefore need to raise increasing sums collectively

The implication of this finding is that future governments will need to raise finances collectively in order to fund increased healthcare spending efficiently. Unless collective funds are raised, we will find a shortfall in funding compared to growing healthcare demand and costs. For example, without increasing NHS resources there is likely to be a shortfall of between £6.5bn and £16.3bn by 2012/13 (ippr calculations based on Wanless et al 2007 and HM Treasury 2008, based on 2012/13 estimated prices). This is often described as a 'health gap.'

There does need to be a greater emphasis on improving efficiency within both public and private sectors in order to ensure that the benefits of spending are maximised, but this will not obviate the overall need to raise collective funding in the long term. There are debates about the best way to raise collective funding – between central taxation or a form of social insurance. While these issues fall outside the scope of this paper, we suggest that ideas for hypothecation or social insurance need to be debated.

Private spending will continue to play a valid role in the UK health economy

Although we conclude that increasing private spending will not solve the 'health gap', we argue that the role of the privately-funded sector should not be overlooked by public policy.

Private spending provides valid functions to the health economy to correct some of the problems associated with a publicly-funded system. First, the problem of 'moral hazard' (individuals consuming more 'free' healthcare than is efficient) creates an argument for some costs to be borne by the individual in certain circumstances. Second, private spending plays a role where the criteria for publicly-funded healthcare are less well met, for example where the costs are low, as in the case of many minor ailment treatments. Third, individuals can purchase

healthcare privately when the single 'insurance plan' (namely, the NHS) does not meet their individual preferences (therefore improving 'allocative efficiency'). In particular, the privately-funded sector also provides an important comparator for public services, and the competitive dynamic should be maintained.

Private spending may also play an important role alongside public funding to support preventive health interventions, a question that ippr will address in future research.

Policy should work to improve the role of private healthcare spending to the benefit of the NHS, consumers and the wider health economy

The Government has made a commitment to pursue efficient markets in the private sector as well as delivering public services. Where there are market failures in the private healthcare market these should be ameliorated as far as possible. We therefore evaluate options for improving the efficiency of the diverse private healthcare markets. We argue that:

- Private health insurance is taxed at five per cent but self pay (or out-of-pocket spending) for private treatment is tax exempt. This anomaly should be removed so that tax is charged on all private healthcare equally (for example, five per cent VAT on self-pay).
- The rapid expansion of private cosmetic 'healthcare' spending warrants greater attention from policymakers to ensure sufficient safety regulation and consumer protection, in particular at the point of information, marketing and sales.
- The Government should review the NHS policy on patients purchasing additional 'top-up' treatments that are excluded from NHS provision to meet patients' demands without creating a two-tier health system.

- The expansion of privately-funded dentistry with high prices requires a regulatory framework to inform consumers and ensure that there is effective competition. Access to NHS dentistry needs to be improved in areas where dentists have opted out of publicly-funded provision.
- Learning from dentistry, rules restricting NHS GPs' private practice should not be relaxed.
- The use of community pharmacies by patients with minor ailments and chronic conditions should be encouraged where appropriate and safe.
- The private health insurance industry has high margins and little competition on price. The industry should improve competition in order to increase value for consumers and regulators should monitor progress.
- The Government should fulfil its commitment to review NHS charges to ensure they are more consistent and achieve economic efficiency and equity aims; in particular, there are concerns about the rise of hospital charges and some higher dental charges.
- Ways to harness synergies between employer and NHS goals in improving health among those of working age should be developed, including better information and guidance for employers and pilots of joint Primary Care Trust- and employer-funded health improvement programmes.

Private spending has a valid role in the health economy but the interaction with the publicly-funded system needs to be managed to ensure that the benefits are achieved

The privately-funded sector does not inevitably damage public healthcare. However, there are real risks that need to be managed, particularly to ensure that NHS consultants fulfil their contractual commitments. Equally, the potential benefits need to be harnessed, including NHS providers generating income from private patients and benchmarking public healthcare with the best of the private sector. Specific recommendations include:

- More effective monitoring and implementation of the NHS Consultants' Contract to ensure that NHS commitments are fulfilled before Consultants see their private patients.
- Continue efforts to reduce NHS waiting times to reduce opportunities for Consultants to shift patients onto their private list.
- Ensure that the recruitment and training of doctors and other staff continue to expand so that private healthcare does not affect the availability and price of health professionals.
- The Healthcare Commission should regulate safety in private healthcare to reduce adverse incidents that incur costs for the NHS.
- The NHS should reclaim from private providers the costs of reparative treatment in cases of negligence.
- Continue efforts to improve quality in the NHS in order to maintain the political support for collective funding.
- Innovations in private healthcare, including waiting times, choice and new treatments, should be monitored and evaluated by the NHS to determine whether they should be pursued in the public system.

Conclusions

Total healthcare spending is likely to continue to rise in the future; this should not be considered a problem per se. Collective funding will remain the most efficient way of financing healthcare. Private spending plays a valid role in the health economy but will not provide an efficient means of increasing resources for healthcare. Therefore future governments will need to raise increased resources for healthcare collectively.

While private spending is not a magic bullet for the long-term funding challenge, policymakers should consider the contribution and efficiency of the diverse types of private healthcare spending as integral to future health system strategies. Our recommendations would ensure that the benefits of private spending are maximised while the risks to the public sector are managed. Pursuing these would improve the efficiency of the whole health economy and thus the wellbeing of citizens.

Employer spending on health

As well as the role of private spending in funding healthcare as traditionally defined, we are also interested in other types of spending on health and health improvement and in this chapter focus on employer spending on health. ippr has repeatedly argued that health policy should focus beyond narrow definitions of healthcare, often dominated by hospitals, and consider the factors that affect health outcomes and social wellbeing. Therefore, while we argue that private spending will not provide easy solutions to healthcare funding problems, it has the potential to play a significant role in meeting the public health challenges of the 21st century.

There are potential benefits to the economy, NHS and public health from employer spending on health but currently this is constrained by a lack of guidance and good evidence of cost effectiveness. Spending by employers on occupational health has been rising fast (to £400 million in 2007) driven by awareness of the costs of sickness. Some employers also invest in preventive health in the workplace. However, still only a minority of workplaces have access to occupational health services.

The Government needs to remove barriers to expanding employer spending by improving evidence and guidance. There is potential for better collaboration between the NHS and employers to improve health in the workplace, including co-funding of preventive interventions.

While our discussion of private health insurance (PHI) touched on the role of corporate insurance, noting that employer spending on PHI is over £2 billion per year, there are wider activities undertaken by employers that can affect health outcomes. Employer spending on improving employee health has been a less-developed market. But it is not an insignificant market and has the potential to play an important role in public health improvement. This has recently attracted the attention of policymakers, although the exact direction of policy is not yet clear.

Trends in employer health spending

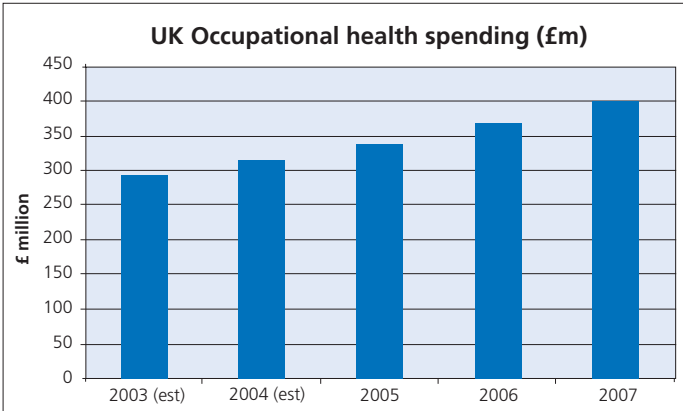
There are different ways in which employers can spend on employee health. In general, these are divided into three types, as illustrated in the diagram below, commissioned from PricewaterhouseCoopers as part of a Government-sponsored inquiry into working age population health (Black 2008).



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In terms of employer spending, the best data relates to occupational health (OH) which focuses in particular on managing ill health, including advice and early intervention to reduce sickness absence. Analysis by research company MBD values spending on OH at just under £400 million in 2007, a rise of 8 per cent on 2006, which was preceded by a rise of 9 percentage points from 2005. The market has been growing faster than the economy, with has risen between 6 and 9 per cent since 2003 (MBD 2007).

Figure 11.1. Spending on occupational health in the UK (£m)



Source: MBD 2007, and ippr estimates

However, the extent to which this spending meets the needs of the workforce (or employers) is limited. Health and Safety Executive-commissioned research showed that only 15 per cent of all British firms provided basic occupational health support, and only 3 per cent provided comprehensive support (HM Government 2005). NHS Plus, the publicly-owned occupational health service for NHS Trusts and small and medium enterprises (SMEs) notes that despite growth, significant inroads have not been made into the problem of access to OH for SMEs (NHS Plus 2008).

MBD notes that much of this growth has been driven by *public sector* employers spending more on OH. According to our definition this would be counted as private spending, since it is not healthcare spending from the collective risk pool but is private to those employees who are covered.

The factors affecting the growth of the market include a growing cost – or rather a growing awareness of the cost – borne by employers due to poor health of employees. For private companies, and for public organisations with quasi-commercial incentives, the decision to spend income on employees’ occupational health – rather than higher wages – should theoretically be a rational one. Spending an extra pound on employee

health should generate improved productivity at a faster rate than spending it on higher wages or more staff in order for there to be sufficient incentive for an employer to make that occupational health investment.

The business case for spending on occupational health has been highlighted by the Confederation of British Industry, which estimated the direct cost of workplace *absence* in 2006 at £13.4 billion, with indirect costs such as impacts on quality and customer satisfaction bringing the total cost to over £20 billion (CBI 2007, with health warnings about the reliability of the data). There are also wider productivity costs of employee ill-health from employees who are not absent but are still unwell: Bramley-Harker et al (2006) conclude that the latter productivity cost is likely to be greater than that of absence, but harder to measure. It should be remembered that not all of these costs can realistically be eliminated by spending on occupational health.

In practice the decision to invest in occupational health rather than wages (or other employment costs) is often constrained by limited information. The growth of the market is enabled by the level of knowledge of employers of the potential cost-benefit of occupational health spending. MBD's prediction of continued growth (by 34 per cent between 2007 and 2012) is based on 'the increasing awareness of occupational health issues' (MBD 2007). The reverse is also true – a survey of employers by Aviva found that a lack of guidance and information was a significant barrier for 43 per cent of small businesses against spending on employer health. This finding is confirmed by Black who states that 'the reason health and wellbeing initiatives are not more numerous in the workplace today is the lack of a well-developed business case as to why businesses should invest in them' (2008: 53).

Workplace regulation – both domestic and European – as well as increased litigation through 'no-win, no-fee' cases, have also encouraged the growth of the OH market. Union pressure and awareness-raising have added to growth in the public sector; the expansion of less-unionised private sector spending (and outsourcing) of OH is due to a growing

corporate awareness of its benefits (Laing & Buisson 2006).

The OH market is also constrained by the capacity of the market to expand the provision of services, with MBD highlighting the 'lack of trained occupational health professionals' (MBD 2007). As mentioned, smaller companies in particular are less likely to spend resources on occupational health and report a greater unmet need for information and support to improve occupational health. There are obvious economies of scale barriers in organisations that are not big enough for a dedicated human resources function, let alone an occupational health department.

More fundamentally, another study (Bramley-Harker et al 2006) highlighted the market failure in occupational health which prevented the optimal level of spending from being reached. This market failure relates to the costs of occupational health falling entirely on the employer, with benefits diffused between the employer, future employers and the wider economy and society. This constrains the incentive for occupational health spending to increase, even if such spending might be of high marginal cost-benefit to the economy.

Impacts on the health system of employer spending

As discussed, a factor in the rise of spending on occupational health has been the increased awareness of the costs of employee ill-health, and improved understanding of the potential productivity benefits of improving employee health. Workplace health initiatives can also address prevention of ill health, rather than just early interventions to reduce absence. Health and safety policies can reduce risks of accident or injury in the workplace. Employers can promote healthy behaviour through the provision of healthy diet options and exercise facilities, for example.

There are also wider benefits to the economy and society from employer spending on health. Bramley-Harker et al (2006) highlight the wider costs of employee ill-health – and consequently wider benefits from occupational health spending. Employers bear the costs of short-term absence; after three days employers can claim a rebate from National Insurance Contributions for statutory sick pay, creating a cost to the Exchequer. After 28 weeks, employees may become eligible for incapacity benefit, with full funding

responsibility shifting to the state – at a cost of £6.6 billion in 2005-06 (ibid).

Other costs to the state include NHS treatment costs (some of which could be avoided through early occupational health intervention) and other benefits for which sick workers may be eligible. Then there are the wider social costs to the families and communities of sick workers, of worklessness and poverty. In theory, therefore, there are likely to be benefits to the NHS, social security, families, communities and wider society from spending on occupational health.

So there is some good evidence for employer spending on health being efficient. Compared with spending on supplementary Private Health Insurance, which duplicates NHS entitlements and has inefficiencies in the market, we would expect that private spending on occupational health is more efficient and can contribute to improved population health and wider economic and societal benefits. However, there are no systematic reviews or comprehensive surveys of occupational health spending across the economy. There is no study that we have identified that estimates the overall cost-effectiveness of occupational health spending at a national level.

Policy discussion

There are evident economic and social benefits achieved from occupational health spending, although there is a lack of systematic evidence of the efficiency of existing spending. The market is expanding rapidly already, with future expansion expected to take place in the medium term. From a health system and public policy perspective, the policy aim should not just be to incentivise spending on OH. This may be a route to the main aim, which is to improve the health and productivity of the working age population. This is a much bigger agenda than this project can cover, but we will explore how policy can enable private spending on occupational health to contribute to this aim.

First there is the question of how well the existing £400 million of ‘private’ (including public employer) spending on occupational health is being channelled. Then there is a secondary question about the extent to which barriers to the development of this market might be reduced, so that increases in productive spending might be encouraged. However this

should be in the context of a more holistic approach to improving working age health through a range of routes other than employer spending.

Efficiency of current occupational health spending

Although there are good examples of efficient occupational health spending, this does not mean that all spending in this sector is necessarily efficient. NERA (Bramley-Harker et al 2006) and PricewaterhouseCoopers (Black 2008) have both reviewed the evidence and put forward optimistic conclusions about the business case for employer spending. However, not every evaluated occupational health intervention has a positive finding. As with spending on healthcare, there is a need to better measure the outcomes – and therefore the productivity – of occupational health spending. Market analysts conclude that evidence of cost-benefits of spending, rather than lack of fiscal incentive, is the main barrier:

'The 'holy grail', which could allow massive latent demand to be released, is the development of sickness absence management systems of proven efficacy.... No occupational health provider has yet developed an approach which can offer dividends regardless of context.' (Laing & Buisson 2006: 226)

Occupational health providers should lead the development of this evidence base, in order to improve the services that they offer and to make a better business case for public policy to support this area of private spending.

To advance this aim, NHS Plus, the NHS-owned occupational health provider, has set up a research programme into clinical effectiveness of occupational health interventions, and has recommended that government fund this programme of research in the medium term (NHS Plus 2007). There may also be a case for business investment in this research effort since the benefits will accrue to businesses in the longer term.

Removing barriers to efficient employer spending on occupational health

Aviva's survey found that lack of guidance and information is an important barrier for many employers, particularly smaller employers. These information and guidance gaps are already being addressed by government policy, for example the provision of a website and helpline for small businesses. Carol Black's report recommends the improvement of guidance and information through a business-led health and well-being consultancy service (2008: 11). How this would work in practice is less clear, and it was a missed opportunity that the Department for Business, Enterprise and Regulatory Reform has not been included in this policy agenda (led by Departments for Work and Pensions and Health).

Should the Government seek to encourage companies to spend more money on healthcare in the workplace, for instance by using the tax system or providing direct incentives? At present the case for such interventions remain unproven:

- First, there is insufficient evidence of the cost-effectiveness of all occupational health spending to be able to assume a satisfactory return from public subsidy.
- Second, lower taxes or additional subsidies would have undesirable crowding-out effects on employers who are already investing in occupational health. There is a relatively good business case for many employers to invest in employee health without the need for subsidy.
- Third, tax subsidies would also create differences in the way cash benefits and in-kind benefits (such as occupational health) are treated, leading to undesirable distortions in the specific form through which employees take their compensation from work.
- Finally, MBD's market analysis suggests the occupational health market is growing rapidly without fiscal incentives (and is forecast to grow by a third in the next five years); and that the main reason for growth is improved understanding of the cost-benefits for productivity (2007).

For these same reasons, it does not seem sensible for the NHS to sole-fund a 'Fit For Work' service, as proposed by the Black report (op cit). Current private spending on early intervention and rehabilitation would be crowded out. Black makes a general claim that there will be returns in the form of reduced benefit dependency and increased income tax receipts. But a quantitative economic case for the Government to fund this service has not yet been made.

We do not rule out the use of such measures in the future, but any such intervention from Government would have to be based on a careful analysis of cost and clinical effectiveness. While there may not at present be a strong argument for a general tax subsidy for all employer spending, there may be a case in the future for incentivising employers to invest in preventive interventions where there are fewer short-term business benefits but greater long-term gains for the wider economy and society. This would be the area where employers might need encouragement to invest, and where there would be long-term health improvement benefits.

In the first instance, for example, there are current anomalies whereby large employers building exercise facilities are not taxed (as a benefit in kind), whereas subsidies for gym membership would be. From an economic perspective, however, there are problems with removing taxes from preventive health in-kind benefits as this then distorts incentives in the way described above. Nevertheless, it seems anomalous to disadvantage small companies in this way.

From a health policy perspective, the NHS reform programme presents a new opportunity to address the relatively poor focus of the NHS on improving health – including employee health – rather than just responding to sickness. If commissioners are sufficiently incentivised to improve population health then the drive to develop commissioning to improve population health should push the development of occupational health up the NHS's agenda. This was emphasised in the 2007 Commissioning Framework which guided commissioners to work with SMEs to improve occupational health, including providing advice and support. The Framework also guides commissioners to 'encourage all local employers to use

workplaces as settings for health improvement’, including both occupational health and health promotion programmes (DH 2007b: 48). However, it did not made clear how commissioners should do this.

One approach would be a facilitative one, whereby Primary Care Trusts help local SMEs to overcome the lack of economies of scale by pooling their resources for a shared occupational health service. While they may not be able to afford an occupational health service on their own, small employers might be able to pay in a smaller subscription to a pooled occupational health service and health improvement interventions.

A more interventionist approach might be for PCTs and employers to co-fund employer health services. At the moment, employer and NHS funding streams tend to be separate: NHS commissioners fund health services and health improvement initiatives indirectly to improve employee health and reduce absence; separately, some employers invest in employee health, either using private provision or NHS Plus. We have not found any examples of PCTs and employers co-funding health interventions – perhaps because this would be considered charging for NHS services. However, the division of private and public funding streams for workplace health improvement initiatives may be creating a barrier to more innovative approaches.

Public-health-focused commissioners should look for synergies in these funding streams. Where there is a potential for health improvement gains, NHS commissioners could develop partnerships with local employers – particularly those smaller companies that do not have the economies of scale to develop their own occupational health capacity – to co-commission shared occupational health and health improvement services.

These services could be provided by the NHS or by independent occupational health providers, with possible sharing of risks between public and private partners. We believe these more imaginative approaches to pool interests, expertise, risks and resources should be piloted by innovative commissioners to explore the cost-benefits. There may be a risk that NHS involvement would crowd out employer investment. But we argue that this would be a more efficient approach

than just subsidising or incentivising employer spending through fiscal tools, or continuing with the separation of funding streams and the missed opportunity to improve the health of the working-age population, particularly in small companies.

Summing up

Employer spending on health improvement has the potential to play a greater role in the future. In the long term, the establishment of a baseline of working-age population health – the goal of the Government's health and work programme – will provide an evidence base from which to assess the effectiveness of particular interventions, including employer spending on health and wellbeing. From a policy point of view, occupational health is only one way of improving working-age health, including return-to-work services for the long-term sick who are not currently employed. But private spending should be harnessed as a key tool to improve working-age population health, and policies should aim to address the barriers to investment in occupational health and realise the potential benefits.

'Top-up' private purchases for NHS patients

Should NHS patients be able to self-pay for additional treatments – to 'top-up' their NHS care with additional private treatment? High profile cases have attracted significant media attention and stimulated much debate in the policy world (see for example Mitchell 2008, Moore 2008). These cases normally feature patients who want access to drugs not provided by the NHS, and in turn want the ability to pay for such extra treatment out of their own pocket.

Under current NHS rules patients are not allowed to supplement their treatment and combine private and public healthcare. Department of Health (DH) guidance states that: 'A patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation'² (DH 2003: 10). The application of this rule has led to cases in which patients who self-fund for treatments that are excluded by the NHS are then denied access to any NHS treatment for that condition (see Mitchell 2008, Moore 2008).

These rules are currently being challenged by cancer patients who wish to purchase drugs that have not been approved by NICE but who are under threat of being denied the rest of their NHS treatment package as a result. Campaigning organisations like Doctors for Reform (Charlson et al 2007) and the public law barrister, Nigel Griffin QC (2006) have argued that it is unlawful to deny NHS treatment to patients who complement their care by purchasing additional treatments. However, both the Government and local NHS Trusts (for example, Richards et al 2001) have argued that allowing patients to top up their treatment would undermine the NHS principles of equity.

2. Note that this guidance is for consultants rather than for hospitals to prevent them from 'pushing' NHS patients onto their private lists (see Chapter 12), but has been interpreted as applying to the NHS in general.

A number of factors have combined to push the salience of top-ups as an issue for the NHS:

- **New drugs and treatments exist.** A new generation of cutting-edge drugs, particularly for the treatment of cancer, have become or will soon be available. These drugs are more likely to be personalised to the individual patient – meaning they are likely to work in more specific cases, but not be effective for a majority of patients. They are also more expensive than current treatments. It is likely in some cases that they have the potential to be effective for individuals, extending life by months. These drugs may fail the kind of cost-effectiveness tests that NICE and commissioners apply. However, individual patients may consider them valuable.
- **Patients are more informed than they once were.** The creation of a more explicit rationing process and the emergence of new, high-cost drugs have coincided with the increasing availability of information about new treatments and more willingness of patients to challenge medical decisions. Information about new treatments is available in the media and the internet before it is even licensed. This is not always high quality information. Concerns have been raised about drug companies marketing new treatments to doctors and patients when their effectiveness is questionable. However, policymakers should embrace the new world of more informed and demanding patients, particularly since patient empowerment can lead to improved outcomes and engagement in health (Farrington-Douglas and Allen 2005).
- **Patients have more access to assets.** The capacity of patients to self-pay for elements of their healthcare has increased as asset-holding has spread (in particular home-ownership), and access to lump sums of wealth has increased. Some patients have always had access to such financing, of course, and have been able to make the decision to opt out of the NHS and finance private treatment.

- **More explicit rationing by the NHS.** Since the introduction (since 1999) of NICE assessments of new and existing treatments, the NHS has become more explicit about the need to prioritise which treatments should (and should not) be funded according to explicit cost-efficiency criteria. There is now a more defined group of services that the NHS does not provide.³ These include drugs and devices that have either not yet been assessed by NICE, or have been assessed and recommended for exclusion from the NHS package (the final funding decision being taken by local PCTs). This already existed with treatments like some IVF therapy, osteopathy and scans where the NHS does not fund all desired treatments (as well as non-health-related cosmetic treatment) (Moore 2008).

The combination of these trends – new treatments, more informed patients, access to assets and explicit rationing – creates a real pressure for the top-up issue to be addressed.

Problems with the current system

While policymakers should be cautious about arguments based on ideology or self-interest, there are compelling arguments about new drugs and the need for a more sustainable solution for non-NICE approved treatments. While the numbers of patients affected may be relatively low at present, these trends indicate that the issue will increase in the future. There are a number of problems thrown up by the current position of the NHS, about which policymakers should be concerned:

- **Patients who decide to top-up their treatment can be denied access to the rest of their NHS care package.** Interpreted strictly, the guidance allows NHS providers to deny patients the NHS package of care because they have purchased an additional treatment (this has been threatened, for example, by South Tees Hospitals NHS Trust [BBC 2007]). This can be seen as undermining the universalist principle that everyone should have equal access to NHS services according to need.

3. There is no nationally defined package of entitlements, allowing flexibility for the NHS locally to take its own decisions on priority-setting. The NICE process provides a list of what is excluded.

■ **The current policy is applied inconsistently in different areas.**

There is evidence of geographical inconsistency, as some patients have won (out of court) their battle to mix private and public treatment (Lilley 2008). There is also inconsistency between topping up hospital treatment and other types of care. The credibility of the current strict ruling is further damaged by the fact that local PCTs often reverse their decisions to refuse to fund a particular treatment following individual campaigns, by citing particular special circumstances.

■ **Other types of top-up exist in the health system.** There are examples of mixing private and public funding streams to access superior drugs and treatments within the NHS, including patients paying for private tests to reduce waiting times for NHS surgery, purchasing private prescriptions from NHS GPs for Viagra, purchasing infusion pumps or interferon beta for use in NHS treatment (Richards et al 2001). In some areas, for example maternity, mothers can 'top up' for a private bed within their NHS care package.

■ **Inconsistencies could undermine the credibility of NICE and NHS processes.** Faced with a high profile local campaign and the alternative of denying NHS care to a patient who purchases a non-NICE approved treatment, or providing the additional non-NICE approved treatment for free, PCTs may be opting for the latter when decisions are appealed. This has opportunity costs for other patients, and undermines the whole purpose of cost-effectiveness assessments. It also opens up the system to patients with the sharpest elbows. This situation reflects the fact that the NHS's approach to topping up has not changed to reflect the new system of NICE approval and more transparent PCT decision-making.

We argue that some form of priority-setting or rationing of NHS resources is necessary – and desirable for efficiency and equity reasons. The rules of the NHS should reflect the fact that it offers equitable access to effective promotion of health and provision of healthcare that the public value, within constrained resources and competing priorities.

- **Not allowing top-ups can reduce efficiency of allocation processes.** There is a basis in economic theory for allowing patients to top up publicly-funded healthcare. As has been discussed in this report, publicly-funded healthcare inevitably sets a limit on the package based on the average value placed on healthcare spending. If individuals value a particular treatment more highly than the median value reflected by the NHS, then allowing them to purchase that treatment would improve efficiency.

Founding principles?

It should be noted that there is some debate about what the 'founding principles' of the NHS have to say about private payments for additional treatments. Richards et al (2001), reporting on the proceedings of an NHS ethics committee that rejected a request to top up treatment, quote the founding principle as being to ensure 'the best that science can do is available for the treatment of every citizen at home and in institutions, irrespective of his personal means' (Beveridge 1942, quoted in Richards et al 2001: 563).

That quote, however, implies an NHS that did not have to ration treatment. On the other hand, Musgrove (2000: 845) argues that the Beveridge's vision was that 'the duty of the state includes leaving the individual free to provide more protection and more care than that guaranteed by public insurance... not preventing people from rising above [the] minimum'.

This uncertainty about the 'founding principles' reflects the fact that there has never been a theoretically precise definition of 'equity' in the NHS. The system has always 'got by' with a vague understanding of the values that are shared at the time. As new challenges arrive – such as highly expensive drugs and technologies, or more informed consumers – there may be a need for the interpretation of equity to continue to evolve.

Risks associated with allowing top-ups

Although the status quo raises problems, there is no simple solution on access to non-NICE-approved drugs. Allowing patients to top up the NHS package raises tough questions, particularly for those who are concerned with equity and solidarity.

- **Top-ups could threaten equity principles of the NHS.** From a social justice point of view, having two patients with similar needs receiving different levels of treatment could be seen as contravening the principles of equity of access embodied in the NHS.

However, if you are going to have explicit rationing – which, from an efficiency and equity point of view we argue is necessary – then some patients will inevitably purchase the ‘excluded’ treatments privately. It could be argued that the definition of equity relates to access to cost-effective treatments, rather than to an unlimited package. (Allowing topping up would also mean that more people could access additional treatments than if they had to pay for all their care, but this would not be the policy objective.) Rather than encouraging people to go private, this solution would enable all patients to access the NHS package of care equitably. Patients who topped up their treatment would not be choosing to exit the NHS risk pool into a supplementary system. Disqualifying them NHS care could be seen as harming the NHS principles of universalism and equity of access.

Nevertheless, even if private care cannot be prevented, there would still be ideological equity concerns about the NHS actively facilitating different levels of care. This could damage the solidaristic principle of all citizens having absolutely equal entitlements, even if in reality this is not realistic.

■ **Allowing people to purchase top-ups could lead to a ‘two-tier NHS’.**

A longer-term concern about this proposed change is that it would be perceived as creating a ‘basic core’ NHS package with a system of co-payments or means-testing for high-quality care. Some people who argue for top-ups do have such a system in mind.

For the reasons outlined above relating to collective funding through a single insurance plan, we would not wish to see such a system develop. This report argues for a high-quality universal and equitable healthcare system funded collectively. The aim of NICE is to ensure NHS funding is spent most effectively and efficiently, rather than to cut back on healthcare entitlements. The NICE-approved NHS package should expand and improve the quality of care for patients, rather than retreat to a ‘basic core’ service. At present, NICE approves more treatments than it rejects, a trend we expect to continue as NHS funding carries on rising. However, creating the framework for a ‘free’ and a ‘charged’ level of care could make it easier to go down the route of a two-tier NHS in the future.

Of course, a two-tiered system already exists in the UK, with patients who ‘go private’ often receiving higher quality (clinical or non-clinical) services (although the actual comparative quality of private treatment is not measured). There are even two tiers within NHS providers, where private ‘pay beds’ and private patient units are available for privately insured or self-paying patients who may enjoy shorter waits, more intensive staffing and treatments unavailable on the NHS. Indeed it could be argued that preventing top-ups makes enhanced private care more expensive so that the cost of accessing the higher tier is much higher.

- **Allowing top-ups may create false hope and encourage people to purchase ineffective treatments.** One significant risk of relaxing the rules on purchasing additional, non-NICE-approved treatments is that it could facilitate or encourage patients to spend their life savings on very expensive treatments that may not be effective. This could even harm patients if it offered them false hope that the additional treatment would 'save' their life, when in fact it could only extend it by a matter of weeks with a range of side-effects. Allowing top-ups could feed a worrying trend of medicalising the end-of-life experience for patients with terminal diseases, who could suffer and die slowly in hospital rather than spend their last weeks with loved ones at home. This argument has been made by, for example, Dr Gill Morgan, then Chief Executive of NHS Confederation (Moore 2008).
- **Encouraging drug-related campaigns.** Top-ups could provide a greater opportunity for consultants and drug manufacturers to promote new treatments that might not necessarily be in patients' best interests.

A way forward?

The problems that are driving top-ups up the public agenda are likely to grow in the future unless they are addressed by policymakers. If policymakers fail to engage in this debate, they will not be able to solve these issues.

The debate is currently polarised between two opposing paradigms. One side, from an individual, rights-based standpoint, argues that people have a right to spend their money as they wish as long as it does not hurt anyone, and that threatening to deny them the rest of their NHS care is unfair. On the other hand, a consequentialist stance views any blurring of the no top-up rule as leading to a nightmare scenario of charging for high-quality services and the retrenchment of the public system to a poor-quality core, reversing the equity principles of the NHS.

In focusing in particular on a specific range of treatments under explicit circumstances we believe that there is room for a middle way between the extreme perspectives. There is a case in principle to allow those who want to pay for drugs that are marginally effective but fall outside the cost-effectiveness threshold for the NHS to do so. Maintaining would-be private patients within the NHS, this system could enhance the political sustainability of the publicly-funded universal health system. (Although the NHS funding model is not currently under threat this situation may change.) However, even a limited relaxation of the rules on mixing private and public funding would need to be managed carefully.

We argue that private spending is generally an undesirable way of providing access to the majority of healthcare (for economic and social justice reasons). Therefore it should only be the policy solution of last resort rather than a preferred way of funding healthcare more generally. Any move towards a free 'basic core' and charged-for 'high-quality extended' system or multi-tiered NHS should be avoided.

Finally, it is important to note that any changes in this area will not solve the healthcare funding challenge. In terms of the primary question of this report – whether private spending can substitute public spending as healthcare costs increase – we again emphasise that the level of spending from top-ups would be anticipated to be marginal in the context of total healthcare spending. For efficiency and equity reasons, top-up payments are not a desirable method of funding the core healthcare package.

The current political impasse is not helpful and ignores the long-term trends outlined above. A review should be established that examines the system in the round. It would look at the possibility of relaxing NHS rules for patients who wish to top up their NHS care with specific treatments that are not available from the state. Such a review could consider the following options:

■ **Examine which categories of drugs might be suitable for top-ups.**

One option would be for NICE to provide advice, as part of its recommendations on a new treatment or guidance on best practice,

over which treatments should be eligible for top-up provision.

For example, treatments that were of high risk to patients and of little proven clinical effectiveness could be rejected as unsuitable for top-up provision. Effective but expensive treatments that failed NICE approval or PCT commissioning mainly on cost grounds (for example, for being less cost-effective than alternatives) could be deemed suitable for top-ups.

- **Examine the information requirements for patients to make decisions on top-ups.** One option would be to require patients to obtain a second opinion before allowing them to purchase the additional treatment. Where appropriate, independent information and support in decision-making – including patient decision aids – could be made available.
- **Examine whether top-up charges could be introduced for older, less cost-effective treatments.** As ippr has argued before (Rankin et al 2007), NICE's role should also be expanded to assess the relative cost-effectiveness of existing treatments (this is part of its remit but, due to limited capacity, NICE has tended to focus on assessing new treatments). This would enable the NHS to decide whether to 'disinvest' in old, cost-ineffective treatments – an important condition for achieving better value from NHS resources (see, for example, Wanless 2002). Top-ups could help to advance this agenda, with NICE setting out what the cost-effective treatment is that the NHS should provide, but with patients remaining free to pay a top-up for additional, non-approved treatments. An alternative approach would be for co-payments to be higher for services that have lower value – drawing on the concept of 'value-based insurance design' (discussed at more length in Chapter 10 of the full report).
- **Examine how equity concerns could be mitigated.** In order to make sure that the provision of top-up care did not harm general NHS provision, all additional costs of treatment would have to be met by the private funder, including (where feasible) funding for treatment of side-effects and complications, as well as NHS

overheads. Equity concerns could also be mitigated by requiring patients who top up their NHS care to pay an additional 'equity premium' that could be redistributed back into the NHS.

■ **Improve trust in NICE processes and PCT decision-making.**

In particular, the NICE assessment process needs to carry the trust of the public so that it does not exclude from the free NHS package (and add to a top-up package) treatments that are valued and that taxpayers would be willing to fund.

PCTs also need to make local commissioning decisions more transparent and accountable (see Rankin et al 2007). As highlighted above, there are geographical inconsistencies between exception committee decisions about whether patients can receive a non-NICE approved treatment. This could become more visible when some patients are receiving treatment as a top-up while others are receiving it fully-funded, raising questions about the consistency in criteria for decisions.

Moving forward on these issues will be difficult for national politicians, considering the polarised positions. In the current political climate, no party would want to be perceived as threatening the values of the NHS. However in a more devolved NHS, it may be possible for local NHS Trusts and PCTs to engage local populations in debate about the question of topping up and to develop their own solutions to the difficult but important questions that are raised by this emerging issue.

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Further information

Aviva continues to invest in understanding the role of the private sector in the provision of healthcare in the UK. A selection of previously published reports is provided below. For copies of the reports in full, please contact Aviva at hcpr@aviva.co.uk

Towards Stakeholder Healthcare

August 2001

The NHS has served Britain well but it is difficult for increases in the tax funded revenues of the NHS to keep pace with increasing demand. This report introduces a 'Stakeholder' Healthcare funding model which would deliver choice, equitable access to healthcare, and increased/sustainable resources, whilst maintaining the NHS as the main provider of healthcare services.

Stakeholder Healthcare: moving from concept to reality

January 2003

Building on the above report, this report develops mechanisms for delivering genuinely stakeholder led healthcare which puts choice, transparency and competition at the heart of the system. Projections within the report suggested spending needed to almost double over the coming decade. Stakeholder healthcare aims to introduce drivers for service improvement alongside transparency in how revenues are raised.

Commissioning in the NHS: challenges and opportunities

May 2005

The commissioning of healthcare – the planning, purchasing and monitoring of the delivery of healthcare – is the widely acknowledged to be the lynchpin of the NHS. This report demonstrated that involvement of the private and voluntary sectors – including insurers - in certain strategic commissioning functions could give the NHS rapid access to much needed commissioning skills.

Health of the Workplace

June 2006

Surveying GPs and employers, this report was the first of its kind to pull together a “cross party” view of the state of workplace health. Despite a third of GPs seeing a dramatic increase in the number of people needing to be signed off work and nine out of 10 GPs blamed employers for failing to take responsibility for their employees’ health and wellbeing, only 38% of UK companies saw employee wellbeing as an HR priority with 40% of companies ignoring it completely, having no system in place for health management.

Sharing the costs – Reaping the benefits: incentivising return to work initiatives

October 2006

Aviva commissioned NERA (National Economic Research Associates) to investigate the causes of low employer take up of workplace health and rehabilitation services and to suggest ways to incentivise take up through fiscal or other means. NERA’s preferred solution is a tax credit through the national insurance system.

Health of the Workplace 2

January 2008

Widening the survey from the previous report to include employees as well as GPs and employers, the major theme arising from this research was that ‘UK plc’ is broadly supportive but still confused and unsure of the value of workplace health and where to access appropriate information. This is despite the clear impact of sickness and absence and potential links with productivity. The conclusion points to government and industry playing a larger part in driving these issues forward.

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