Commission on the
Future of **Health** and
Social Care in England

The UK private health market

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The NHS may dominate the provision of health care in England, but that still leaves the country with a significant private sector.

Private acute market

According to LaingBuisson, the best source of data by far on the private health market, the private acute medical sector – essentially operations and treatments, excluding mental health and primary care – generated some £6.42 billion of income in 2011. That was made up of the private acute hospital sector (£4.141 billion), plus income from NHS private patients (£482 million) and specialists' fees (£1.585 billion), which are generally charged separately on top of accommodation, tests and the use of equipment. The remainder came from £135 million spent on private screening and £73 million on termination of pregnancies (LaingBuisson 2013).

Sources of funding

If that is the shape of the provider market, what are its sources of funding? Overseas patients accounted for about 2.8 per cent of private hospital revenues, though a much higher percentage in London. UK patients who paid out of their own pocket – so-called 'self-pay' patients – accounted for just under 15 per cent of revenue, while a little more than 26 per cent of private hospital revenues (or just under £1.1 billion) came from NHS purchase of operations and procedures, mainly at standard NHS prices. The remaining income – 56 per cent – came from private medical insurance of one sort of another. The balance between these four sources of revenue – insured patients, self-pay, overseas patients and NHS purchase – has fluctuated significantly over the years, affected by a wide range of factors that include the economic cycle and government policy.

NHS purchase of private acute hospital care has risen steeply in recent years from just under 10 per cent of private hospitals' revenue in 2004 to 26 per cent in 2011. In the 1970s self-pay accounted for some 30 per cent of revenue but has since been in long-term decline and now accounts for 15 per cent of private hospital income.

Likewise, individual purchase of private medical insurance has been in long-term decline. Since 1991, the number of company-paid subscribers has grown by an estimated 22.5 per cent, compared to a 22.5 per cent fall in 'other' subscribers (those who meet the whole cost of the policy themselves) (LaingBuisson 2013, p 146). In the mid-1980s, the split was roughly half and half. In 2011, just 18 per cent of the market was made up of individual subscribers, with employer-based insurance accounting for 82 per cent.

Demand for private medical insurance has been relatively flat over the past decade or so. Following spectacular growth between the mid-1970s and 1990, subscriber numbers rose only from 3.5 million in 1992 to 4.3 million in 2009 (subscribers being those who hold policies, which can cover dependents as well, as opposed to individuals who have

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cover). Between 2009 and 2012, the numbers fell back to just under 4 million as a result of the recession following the global financial crisis (LaingBuisson 2013). Even so, around 13 per cent of all elective surgery (non-emergency surgery) on UK residents was privately funded in 2011 (LaingBuisson 2013).

Type of private medical insurance

Roughly 11 per cent of the UK population has some form of private medical insurance. That figure, however, gives a misleading impression as far from all of that cover is comprehensive. Few policies, whether company-paid or provided, or individually paid, offer maternity or mental health cover. None provide cover for accidents and emergency or for general practice.

But even within those limitations, the precise level of cover varies significantly between policies. There are varying levels of co-payment, and varying financial limits to cover, along with differing restrictions on which private hospitals can be used without additional payment. There are policies which only take effect when the NHS wait is longer than a specified period, or which operate as a form of 'stop-loss' insurance – where the individual meets the first £1,000 or £2,000 of the cost of care, for example. In addition, some merely cover particular conditions, for example cancer or cardiac care. Many of these variations exist in the company-paid market, but they are even more pronounced when individuals buy cover for themselves or their families.

There is no good published data that allows the extent of these various levels of cover to be analysed. But it is clear that nothing like 11 per cent of the United Kingdom has what might be described as comprehensive private medical insurance. Indeed, LaingBuisson recently remarked that 'it is believed that the private medical insurance market has been characterised in recent years by downgrading… switching to products with narrower cover or with fewer dependants included' (LaingBuisson 2011, p 154).

The dominance of company-paid schemes is partly explained by the fact that individuals can enjoy appreciably lower premiums in a company scheme than in an individual one.

They gain the benefits from insurance pooling, and companies frequently contribute towards all or part of the cost. Sales and administration costs are higher for individual subscribers, but insurers are understood to make appreciably higher margins from individual business than they do from company schemes. In 2009, the average income per subscriber in company-paid schemes was £790. For individual subscribers it was almost twice as much at £1,526 (LaingBuisson 2011, p 155). Individual subscribers tend to be older, with higher health risks. So while they make up only 18 per cent of those covered, they account for almost 40 per cent of the payments those insurers make to private hospitals and specialists (LaingBuisson 2013, p 37).

In the United Kingdom, contracts are annualised and experience-rated – that is, rated for claims experience both for groups and for individuals. Prior conditions tend to be excluded or attract a much higher premium. Policies are rated for age and gender. So older individuals, who are more likely to claim, pay higher premiums. This is in contrast to community rating.

In its purest form, community rating prohibits insurers from adjusting premiums in any way to make allowance for higher likely claims, adjusted by age, sex or medical history. They have to take all comers. In less pure forms, premiums can be varied in various ways, by geography, or for certain behaviours likely to predispose to disease, such as smoking. Ireland, Australia, the Netherlands and Switzerland are all examples of countries that

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require private medical insurers to use community rating in one form or another. Such arrangements generally require some form of inter-company adjustment, run by the state or a state-sponsored insurance agency, to allow for differing claims experience, so that a particularly random bad year of very expensive claims does not put an insurer unreasonably out of business.

Other elements of the private health market

Private general practice may amount to around 7 million consultations a year, or a mere 3 per cent of all GP consultations, earning the private general practice market some £500 million a year. Those figures are a broad estimate, not a precise calculation (LaingBuisson 2011).

The market for private mental health hospitals in 2011 amounted to £1.1 billion, of which 87 per cent was NHS purchase. Private medical insurance accounted for 6 per cent of revenues and self-pay for 7 per cent (£76 million) (LaingBuisson 2013).

There is also a highly fragmented market of undetermined size for treatments provided by professions supplementary to medicine such as physiotherapy and podiatry, psychotherapy as well as the private provision of alternative therapies such as acupuncture and homeopathy.

Workforce

It is also crucial to understand that the NHS and the private sector share the consultant, or specialist, workforce. For nursing, and other health care workers, the private sector operates in a more diversified market, with staff moving between the public and private sectors and back again.

Accurate figures on the number of consultants undertaking private practice are not available. The British Medical Association (BMA) private practice committee estimates that 28,000 consultants undertake some private practice in the United Kingdom, with the bulk of that concentrated in England (BMA personal communication, 2012). Based on a relatively small sample of 670 respondents to a survey of 3,000 NHS consultants, the BMA estimates that 53 per cent of consultants undertake some private practice, a steady downward trend from 59.5 per cent in 2005. It is a trend that is confirmed by other estimates made by the National Audit Office, the Monopolies and Mergers Commission and the Health Select Committee. In 1992 and again in 1999, the latter two bodies both estimated private practice participation to be 70 per cent of the consultant workforce.

The BMA survey also points to an ageing workforce which is undertaking private practice. In March 2009, the BMA reported that fewer than 10 per cent of new consultants were practising privately, and that just under two-thirds of consultants who were practising privately had done so for 25 years or more. This may, in part, reflect the considerable increases in NHS pay under the new consultant contract agreed in 2004, increases which have now come to an end with public-sector pay freezes. It may also reflect the feminisation of the consultant workforce. In 2009, the BMA found that only 30 per cent of consultants with a private practice were female, despite the fact that women in 2011 made up 47 per cent of the consultant workforce, with the proportion set to rise now that women are the majority intake to medical schools.

Relatively few consultants – perhaps 3,000 – work entirely in the private sector. These are heavily concentrated in London, and the vast majority of them will have held an NHS consultant post. It is existing NHS consultants, working in their own time, who

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undertake the vast majority of private practice – perhaps 85 per cent (LaingBuisson 2011, pp 112–13).

All this may imply that there is potential for the consultant workforce to undertake more private practice. But women consultants may on average be less interested, preferring a different work–life balance. Any significant expansion of private medical activity would still depend heavily on an NHS employed workforce.

Cost

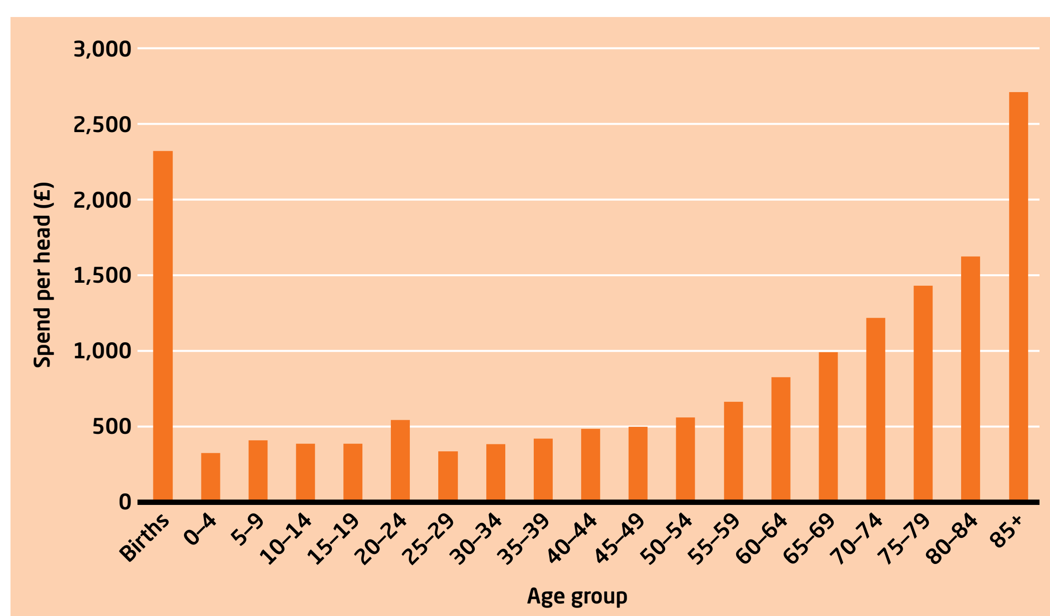
There is also good evidence, for a range of reasons, that private medical care in the United Kingdom is expensive by international standards. Because consultants undertake their private work in their own time, there is an expectation of 'premium' rates being paid. In recent years those fees have been subjected to continued downward pressure by Bupa and AXA, the two largest insurers. Natalie-Jane Macdonald, when managing director for UK membership at Bupa, estimated in 2009 that private medical insurance is twice as expensive as in Spain and costs 80 per cent more than in Australia. This was for a range of reasons including the market being far smaller, the absence of community rating, the fact that UK consultant fees when operating in the private sector are high by international standards, and the lack of significant tax relief (LaingBuisson 2010). Holders of individual policies receive no tax relief. Company-provided insurance is treated as a benefit in kind and subject to income tax, National Insurance and insurance premium tax.

Distribution of cover

Partly because the private medical insurance market is so dominated by company-supported provision, and partly because premiums rise steeply with age, the range of those covered by private health care in the United Kingdom is very different to that of the NHS.

NHS expenditure is concentrated heavily on childbirth and children, and on older people.

Figure 1 NHS expenditure per head in England, by age group, 2012



Source: Department of Health (2011)

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By contrast, aside from a small element of privately paid-for maternity care, there is relatively little private health care expenditure on children and young people. Relatively few companies offer continued support for private medical insurance beyond retirement age, and individual premiums rise sharply with age and medical history. The numbers who benefit from private medical insurance are thus concentrated in the 30- to 64-year age group – an area where NHS spending is relatively low, with relatively few people covered past retirement age where the volume of need is greatest.

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