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A Mixed Economy For Health Care :

more spending, same taxes.

David Willetts & Michael Goldsmith

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Introduction

In no advanced Western country do health services depend entirely on tax-financed public expenditure. People also spend their own money privately and directly on health care.

Approximately 0.7% of British GDP now goes on private spending on health care. This is much lower than in most other advanced countries; the comparable figure for Germany is about 1.6% of GDP, and for France about 2.7%. One of the reasons our performance is so bad is that until recently people spent their own money on health care despite government policy, rather than because of it.

The history of private health care in Britain over the past 40 years is largely defensive and reactive. BUPA, Britain's largest health insurer, was set up at the same time as the NHS - the idea was to merge most of the major Provident Associations so as to make it easier to run them down. Private NHS pay-beds were allowed because the doctors fought for them and Bevan feared that the alternative was 'a rash of nursing homes all over the country'. They were not seen as a positive and attractive addition to the range of services available on NHS sites. Private health insurance grew rapidly in the late 1970s, not so much to extend health care but rather as a device to get round Labour's pay policy. At the same time, private hospitals expanded as a defensive measure to preserve private medicine when Barbara Castle was trying to drive it out of the NHS.

Until recently, private health care was regarded by some as roughly equal to Private Walker, the spiv with greased-back hair in 'Dad's Army' who could always fiddle the rationing system and get you extra bacon or silk stockings at a price. Even now, BUPA's television advertisements use the fact that it is a not-for-profit organisation as a positive selling-point. The Left believes it is immoral to profit from health care, without asking whether it is it also immoral for grocers to make profits out of our need to eat.

The NHS has been such a powerful model of how health care should be provided that private expenditure and private provision have been cast out to the margins. So it is worth reminding ourselves of the fundamental reasons why a mixed economy in health care is a good thing.

If there is a publicly-financed service, then some citizens will not enjoy as much health care as they might choose to buy on their own account. The wealthy will always be able to leave the state system entirely and start all over again with their own money. But a genuine mixed economy in health care requires that those who wish to do so should be able to buy extras with their own money.

Dependence on tax finance can also depress total spending. Richard Crossman pointed out in a White Paper published when he was Secretary of State for Social Services: 'People are prepared to subscribe more in a contribution for their own personal and

family security than they ever would be willing to pay in taxation devoted to a wider variety of different purposes.' His argument suggests that tax financed spending is always likely to be lower than spending financed out of social insurance or with scope for direct private payment. It is ironic that whilst the original case for the NHS was supposed to be that it would spread access to health care, now its most sophisticated defenders argue that we have excessive demands for health care which can be most effectively rationed by the NHS.

The arguments for a mixed economy in health care are not just theoretical. It is clearly also a popular policy as a poll conducted by NOP for BUPA last April showed:

* 62% of those interviewed wanted a mixture of State and private provision, as against 32% wanting State health care only, and 3% wanting a private health service only
* 70% disagreed with the statement that all private medicine in this country should be abolished and only 22% agreed with it
* 70% disagreed with the statement that no doctor should be allowed to see private patients, whereas only 20% agreed
* 73% agreed with the proposal that employers should be encouraged to provide preventative medicine -- such as health-screening for their employees

The conventional objection to a mixed economy is that it will lead to two-tier health care. We are told that the NHS will become a service just for the poor and that means a poor service. This underestimates the power of the NHS which, in some form we are all likely to need from time to time. But equally we must be able to exit from the system for specific requirements. This is essential if we are to maintain the quality of the NHS for everyone. It is the existence of that option which puts pressure on the main provider to raise the quality of its service. And anyway the NHS itself can be manipulated by higher income groups so that they get better service - there is good evidence for example that the articulate middle classes get much longer consultations from GPs.

The question addressed by this paper, therefore, is what more can be done to encourage a mixed economy in health care? It could be argued by a cynic that the tendency of the NHS to self-denigration, assisted by Opposition politicians and popular journalists, is a powerful device for encouraging people to buy private health care. But we also need other more satisfactory mechanisms which encourage people to spend more of their own money on health care.

Private health insurance is often seen as the obvious mechanism for enabling people to buy extra health care for themselves. Private health insurance as it now stands is not a full alternative to the NHS -- it is, in practice, a mechanism for topping up on NHS care if it is either inadequate or lacking in choice. Private health insurance attracts customers because it covers approximately 20-30 classic items of cold surgery -- such as varicose veins, hernias and tonsillectomies -- for which there are often long NHS waiting-lists.

We describe it in more detail in chapter 2 and argue that, whilst it clearly is desirable that private health cover continue to grow, it would be wrong to give it tax relief. Private health insurance can never be adequate on its own as a means of

increasing private spending on health for four reasons. First, as the co-authors argued in 'Managed Health Care: a new system for a better health service' (Health Review No 1, CPS, February 1988) the American system of private health insurance came close to collapse because nobody had responsibility for managing health costs. This mistake should not be repeated here.

Secondly, old people are by far the largest users of the NHS and it has not yet proved possible to devise a form of private health insurance which can be successfully marketed to them. The co-authors hope to consider proposals for care of the elderly in a subsequent paper.

Thirdly, private health insurance tends to concentrate on cold surgery such as hernias and varicose veins. If the range of treatments covered by health insurance is to increase a substantial increase in the number of NHS pay beds would be necessary. Advanced medical treatment in all its variety is best provided on NHS sites. Chapter 3 of this paper argues for the revival of private medicine within the NHS.

Finally, companies with a clear interest in the health of their employees may well want to buy health care for them directly. At the moment, the premiums on a company health insurance scheme are usually fixed by taking the cost of last year's claims and adding an administration charge. This system could be short circuited by companies running their own schemes. They may also want to provide occupational health care for their employees. This is discussed in Chapter 4 of the paper.

2.

Private Health Insurance

The boom in private health insurance over the past few years has done more than anything else to spread private health care more widely round the population. Insurance contracts pick up the costs of both hotel accommodation in private hospitals (or NHS pay-beds) and, separately, consultants' and other professional fees. These two elements cost roughly the same amount.

The figures below show that there was a rapid increase in membership in the early 1980s.

Private medical insurance in the UK: 1955-86

Year	Subsc-ribers 000s	Persons insured 000s	Subscri-ptions paid £m	Benefits paid £m	Insured % UK pop	Subscrip-tions per insuree £
1955	274	585	1.8	1.5	1.2	3
1960	467	995	4.5	3.8	1.9	5
1965	680	1445	9.1	8.0	2.7	6
1970	930	1982	20.4	16.9	3.6	10
1975	1087	2315	54.9	45.6	4.1	24
1980	1647	3577	154.3	127.6	6.4	43
1985	2409	5142	520.0	455.4	9.1	101
1986	2485	5309	612.5	513.3	9.4	115

Source: Laing's Review of Private Health Care, 1987
Note: Figures up to 1980 for BUPA, PPP and WPA
Figures for 1985 and 1986 are estimates for all insurers

The rapid growth in the early 80s was not without its problems for the health insurers. It brought in people who were much worse risks than those who had traditionally taken out private health insurance so the volume of claims per person went up. The insurers responded to this increase in claims by putting up their premiums by 25% a year compound during the early 1980s. As a result, some of the good risks abandoned their private health insurance because the cost appeared to exceed the likely benefits, whilst the bad risks stayed in. It looked for a time as if private health insurance might get into the classic vicious spiral in which claims per person rise, premiums rise, total membership starts falling and thus total income for the insurer also falls. The insurers got the position back under control by about 1984. They achieved this more by shifting costs on to others than by containing them in total. Contracts were restricted with new clauses excluding items such as renal dialysis, psychiatric cases, alcohol-related diseases, and longer term conditions. This reveals a weakness in private health insurance as currently operated in the UK: it does not manage health care costs, but is largely a passive system for meeting bills which are presented by insured people. This inadequate control system has led to the extraordinary explosion of medical claims and health insurance costs in America. The solution, described by the co-authors in Health Review No. 1 ('Managed Health Care: A new system for a better health service', CPS, February 1988), was for the financiers to take direct management control of the use of health facilities.

Private health insurance can be targeted either at individuals, or at companies. Individuals' subscriptions tend to be much higher because there is no pooling of risk and the insurer fears adverse selection. Individuals pay out of post-tax and post-national insurance income and this is therefore not at all tax-effective. Affluent individuals may decide that they will simply pay private health bills direct out of their own savings -- and this is indeed how approximately 25% of private bills are met. Private health insurance looks a much more attractive proposition when provided by a company which enjoys the benefits of group pooling. There is a distinction between company-paid schemes in which the individual is taxed on the company's contribution as a perk and employee voluntary schemes in which individuals pay for themselves on terms negotiated as a bulk group by the company. Laing's Review of Private Health Care estimates that these are about 590,000 individual subscribers, 1,600,000 company paid subscribers and 390,000 employee voluntary subscribers.

Health insurance would become a more attractive proposition if it got tax relief. Some burden on the NHS would be relieved as a result. But there are several powerful objections to such a measure.

First, there are already significant financial incentives for companies to offer private health insurance as part of their remuneration package. Although the premium paid by the company is taxed as a benefit in kind for employees earning over £8,500 a year, it nevertheless does not bear national insurance -- thus saving employers and employees 20% of their gross pay bill. A further incentive is that company health insurance schemes cost less than individual subscriptions.

The second objection is that those who live by political favours can die by political favours. It is not sensible to base the future development of health care on a tax anomaly which could easily be reversed.

Thirdly, the cost of giving tax relief on private health insurance might well exceed the savings to the NHS. On average, the NHS spends £190 a year on every person aged between 20 and 64. A £250 insurance premium that would have previously borne tax at 40% costs the Exchequer £100 in lost tax revenue. But it is not clear that the NHS would spend £100 less on every adult with private health insurance.

It is desirable to help people opt out and take a public financial contribution with them but that points to vouchers whose value can be controlled and which are not of greater value to people with higher rates of tax. There is however one area where there is a case for tax relief on private health insurance contributions. Self-employed people cannot get group cover and should be able to set the cost of their higher individual insurance premiums off against tax.

This paper focuses on two other approaches for bringing more private spending into health care. The first is for the NHS itself to sell more services. The second is for companies to spend more directly on the health of their work force, possibly with the assistance of third party administrators like Medisure (of which one of the authors is a Director) and Remedi.

What extras can the NHS sell?

The traditional NHS principle has been that if something is worth having, it ought to be free and, if you can't get it for free you ought not to have it all. Pay-beds are, of course, a notable exception to this principle but they have been a source of embarrassment, defensiveness and conflict in the NHS for decades. The Health & Medicines Bill, currently going through Parliament, should change all this by making it easier for the NHS to generate income for itself. The obvious, trivial examples of income-generation are the florist in the hospital corridors, the snackbar in the out-patients department, or the sale of laundry services to a nearby hotel. All these are useful initiatives but income generation only really starts making a difference when private medicine makes a comeback on NHS sites. Private medicine has always existed in the NHS and takes three forms: pay-beds, amenity beds and private out-patient appointments. These are considered in turn below.

Pay-beds deliver private medical treatment on an NHS site. A patient pays to see the specialist of his choice at a time that is convenient to the patient. Often pay-beds are separate private rooms but this is not always the case; indeed, strictly speaking, since Barbara Castle's legislation, a pay-bed is simply a bed in an NHS hospital in which a specialist has a private patient. It is the way in which a bed is used that makes it a pay-bed, rather than where it is located. Barbara Castle fought a long, totally misconceived campaign to drive private pay-beds out of the NHS. But as the table below shows, regrettably, she had some success -- it is disappointing that after eight years of Conservative government, there are still only about 3000 pay-beds in the NHS as against 4,500 in 1975.

	Authorised beds	Occupied beds	Nos of patients treated
1955	5577	2801	70960
1960	5450	2728	82160
1965	5472	2890	98580
1970	4421	2567	112330
1975	4196	1862	97640
1980	2441	1531	99800
1985	3018	1077	72300

Source: Laings Review of Private Health Care 1987
Note: authorised beds are the total number which the Secretary of State has permitted. Occupied beds are the average number of beds occupied on any day during the year in question. It can be seen how low occupancy rates are.

Pay-beds still account for about 70,000 operations a year -- nearly 20% of the 400,000 or so operations carried out privately every year. But they account for a much lower proportion of the total income generated by private medicine (£70 million out of total spending on private health care of £680 million). The charges for pay-beds have not hitherto been related to the cost of providing the service; nor have pay-beds been allowed to generate a profit. The Health & Medicines Bill will make it possible for hospitals to set their own pay-bed rates if they wish, provided they cover their costs.

Pay-beds have overshadowed potentially very attractive amenity beds. In amenity beds you get ordinary NHS treatment with no choice of consultant; you simply buy extra privacy and comfort. All amenity beds are in single or twin-bedded rooms. They cost, on average, £12 a night. They are poorly advertised and hence have an occupancy rate that is supposed to be as low as 10%. There are now about 2,500 of them. By contrast, in 1970 there were about 3,700 amenity beds with a 27% occupancy rate. They are declining as patients become more demanding, yet money is not invested in refurbishing them. They have enormous potential and should be expanded and exploited. They are a much more attractive way of raising extra hotel income for the NHS than the imposition of hotel charges on all NHS admissions.

Out-patients departments are the third source of private medical income for the NHS. A patient pays privately to be seen by the doctor of his own choice in the out-patient department. There appears to be a large number of private out-patient appointments in NHS hospitals although, until recently, they were not properly accounted for. NHS income from these appointments is now rising.

Thus pay-beds, amenity beds and private out-patient appointments are potentially significant sources of private income for the NHS, as well as being attractive devices for people to top up and buy extra services. It resembles the Government's reform of other areas of social policy like education and housing, where the approach has also been to make extra options available to people who want them. Surely this is far better than forcing everyone either to pay charges or to opt out. Normal NHS treatment for normal NHS patients would be unaffected but those who wanted to choose their own doctor or a private room would have much more scope.

Hitherto these opportunities have been ignored. They have not been a priority for management attention and have largely been left to doctors to use as they see fit. One senior BMA negotiator engagingly confessed that he had been told the right fee to charge for a private consultation was the price of a good ladies' handbag. The private sector is now ripe for proper commercial management within the NHS.

There are strong and diverse arguments for developing private medicine within the NHS:

[i] A competitive internal market within the NHS requires choice. Choice becomes feasible only when there is some spare capacity. Opening a private facility on an NHS site could be a self-financing method of expanding capacity.

[ii] Medicine in private hospitals is restricted largely to cold surgery. Only 1% of advanced medicine is carried out in private hospitals. To enable people to buy riskier, more sophisticated medicine privately, then the most cost-effective method is to provide it on NHS sites, with extensive medical back-up -- both of equipment and people.

[iii] Private medicine on NHS sites would not only bring in more money but could also bring proper commercial management skills.

[iv] If the option of private medicine is to be spread around the country, then the NHS -- which already has a presence in every town -- is a much better delivery system than constructing private hospitals which require a large catchment area. How else can we spread private hospital care

to Pembroke, Wigan and rural Herefordshire?

[v] Half of private spending goes on hotel services because that is where the NHS is weakest. Amenity beds and pay-beds enables the NHS to provide those extra comforts which will, quite rightly, never be a priority use of public funds -- given the pace of medical advance. Exposition of these arguments came from none other than Nye Bevan, speaking on the debate on the second reading of the National Health Service Bill in April 1946:

> If people wish to pay for additional amenities, or something to which they attach value, like privacy in a single ward, we ought to aim at providing such facilities for everyone who wants them. But while we have inadequate hospital facilities, and while rebuilding is postponed it inevitably happens that some people will want to buy something more than the general health service is providing. If we do not permit fees in hospitals, we will lose many specialists from the public hospitals for they will go to nursing homes. I believe that nursing homes ought to be discouraged. They cannot provide general hospital facilities, and we want to keep our specialists attached to our hospitals and not send them into nursing homes. Behind this there is a principle of some importance. If the State owned a theatre it would not charge the same price for the different seats.

[vi] Barbara Castle's drive to expel private medicine from the NHS led to the rapid boom in separate private hospitals. Doctors who spend most of their time in NHS hospitals, may drive off to a small separate private hospital which is simply a base for them to do their private practice. It might be much more convenient for them if all their patients were together on one site.

There are already practical examples of the revival of pay-beds. A new 12-bed private wing has just been opened at Hemel Hempstead General Hospital. The District Health Authority bore the £235,000 cost of re-furbishing an existing private wing out of their own expenditure allocation and expect to net extra revenue of well over £100,000 a year from it. That is a good rate of return on the investment. In a unique joint venture, the beds have been vigorously marketed to local companies by Medisure. The beds were successfully promoted to the companies by demonstrating the force of the arguments listed above.

Guy's has a much more ambitious scheme to re-furbish its private Nuffield Wing to provide 47 pay-beds, plus five intensive care beds. This was to be done as a joint venture with the Hospital Capital Corporation (a large private group which builds and operates hospitals), but that deal has is now in jeopardy and Guy's may go it alone, using receipts from a local land sale. They expect the wing to yield a net income of £1-million a year.

We believe that every teaching hospital and district general hospital ought to have its own private wing, provided that it is a good commercial proposition and is properly marketed. That involves solving several major practical problems.

First, there have always been labour relations problems in operating private beds. Serving private patients is unpopular with some nurses and ancillary workers. It is not surprising that NUPE and COHSE succeed in keeping this hostility alive because

nurses and ancillary workers get no extra pay for working on private wards -- although the consultants and the hospital each receive a fee. At the moment the Whitley agreements do not permit the payment of bonuses to staff who work on private wards. That needs to be changed so that all NHS staff working with private patients can share in the rewards which private medicine brings. Staff should not be obliged to work with private patients if they do not want to do so -- patients should not be made to feel uncomfortable by getting indifferent service from sullen staff. The spirit of serving the customer might also spread to out-patient receptionists, so that ordinary NHS patients should also benefit from this new emphasis on consumerism.

Secondly, NHS managers do not all have enough management expertise or time to operate large numbers of private wards successfully. So the best approach might well be to bring in separate private management of new private wings. This would also provide an extra role for the management of private hospitals who may feel threatened by a resurgent NHS.

Thirdly, the development or refurbishment of private wings will have a significant capital cost which may not easily be found within a district's budget. It should be possible to raise capital commercially for private wings. There are, quite rightly, strict Treasury rules to stop private finance arrangements becoming fiddles to avoid public expenditure restraints. But if the money raised is genuine risk capital for a distinctive and separate commercial project, it ought to qualify under the Treasury's rules.

Fourthly, the operators of the independent hospitals need to be assured that the competition from the NHS is fair. That requires proper accounting for the cost of capital and separate published management accounts for the private wings.

All these four requirements point to the case for private wings as distinct commercial entities, separately managed on NHS sites. Their advantages lie in the pooling of medical resources between the main NHS operation and the private wing -- this does not also require the pooling of management or confusion about financial responsibilities.

The experience of running successful private wings and private capital-raising could be the ideal basis for encouraging NHS hospitals, if they so wished, to free themselves from direct control by their District Health Authority. Their income would consist of direct revenues from their private pay-beds and also long-term contracts with publicly-financed and managed health care organisations, described in the co-authors' earlier Health Review No.1. These MHCOs would be responsible for ensuring that the residents of a district got free health care by purchasing services from the providers. The hospital itself could revert to the independent status of the sort which many teaching hospitals enjoyed before 1974.

But whilst the regeneration of private health care inside the NHS through the new development of private pay and amenity beds is perhaps the most important way of bringing new extra private money into the NHS, there are other devices which should not be overlooked. Two particular examples are given below.

First, parts of the NHS close down at weekends if they have no special responsibilities for treating emergencies, long-stay or intensive care patients. NHS managers might wish to consider whether there were medical services currently available free

during the week which could be sold at weekends. Many people would be prepared to pay for the convenience of an out-patient consultation or day surgery at the weekend if it did not interfere with their work. Employers might well be willing to pay the NHS for this service. No current entitlement would be lost but an extra option would be created.

Secondly, the NHS is particularly weak in providing hotel care. If people would be prepared to pay extra for better hotel facilities, the obvious way forward might be to invite hotel chains to set up on or close to NHS hospital sites. A significant number of NHS patients are in hospital for observation or whilst tests are carried out. Doctors need to know that they will be available at specified times over a period of days and the only way to achieve this, at present, is to keep them in hospital. This is particularly true of some sorts of psychiatric care. But having a hotel nearby with a covered link to the hospital would be a perfectly adequate base for some patients. Similarly, convalescent patients who were not quite ready to go home could be released into the local hotel for a day or two and, of course, relatives and friends, visiting hospital patients from some well way away might be happy to stay in a hotel for a day or two.

The Government's policy towards all such ideas should be to give active encouragement and support. Managers should be urged to experiment and try out schemes like the ones outlined above. If they then encounter political or legal obstacles, the Government should remove them.

4.

How companies can help

During the past year employers have considerably increased their spending on private health care for their employees. Companies have for a long time provided private health care plans as a perquisite for their top managers: they are a cost-effective way of paying them more. Poor publicity for the NHS has increased the pressure for corporate health care to be extended throughout the workforce. Companies are therefore becoming much more interested in providing a greater variety of health care benefits for a wider range of employees.

There is now an enormous variety of employee health care schemes. Private medical insurance can take the form of either full cover for the employee and his family or, at the other end of the scale, prompt treatment plans where employees only get private treatment if there is an NHS waiting-list of greater than six weeks - a true top-up plan. Other types of benefit include preventative medicine health education, wellness programmes and rehabilitative medicine.

Some firms are now employing their own General Practitioners, who look after all the primary care requirements not only of their employees but also their families. Where these experimental schemes have been set up, there has been an extremely successful response from the employees, who appear to have found that this form of company-paid primary care has been more to their liking than that which was provided locally for them by NHS GPs.

The crucial feature shared by many of these new developments is that company health schemes are no longer seen as a perk for rewarding key employees but as a means of getting a healthier, and therefore more productive, workforce. This legitimate corporate interest in the health of their employees can be harnessed as a useful source of extra finance for health care.

The new interest in employee health care is apparent in the rise of third party management of company health insurance costs. Such management of claims not only holds down costs, but also provides useful information about the morbidity of the workforce which can then be used to plan occupational health programmes. Thus for example if a significant number of employees standing at work benches are getting varicose veins, and the company is bearing the cost of treating them then it has a direct incentive to rearrange work practices.

Occupational health schemes are now seen as crucial to reducing rates of sickness and absenteeism and thus improving efficiency. It is in many ways a return to the enlightened paternalism of Victorian employers like the Cadburys who saw alcoholism not just as sinful but also as wasteful. These company schemes may be a much better way of encouraging effective preventative medicine than relying on the NHS which has, quite rightly, other priorities.

People are also wary of intrusion into their lives by government agencies. However, it is striking that one out of every four men in this country suffers a heart attack or a stroke before he reaches retirement age. If enlightened employers take responsibility for their employees' health it may help raise British standards closer to those in most advanced Western

countries, in particular the USA where rates of heart attacks have fallen dramatically. In Britain we need to foster the alternative tradition of enlightened employers taking responsibility for their employees' health care.

One way to sharpen the incentives for employers to promote the good health of their employees would be to reform the Statutory Sick Pay Scheme (and possibly also the Industrial Injuries Scheme). The obligation on companies to provide sick pay would of course remain. But the system of financing it should be changed. At present companies do not bear the cost of sickness pay because they claim back all their expenditure by offsetting reductions in their national insurance contributions. This means that in effect the enlightened employers with low rates of sickness are cross-subsidising the ones with high rates of sickness. Instead, each company should have to fund its own sickness costs. If the overall increase in the burden on companies were thought unacceptable, there could be a general offsetting reduction in employers' national insurance rates. This new system would mean that companies had a direct financial interest in lower rates of sickness amongst their employees. It might be a better fillip to employee health care than tax reliefs. It would not cost the Exchequer anything -- indeed it could be used to increase the net income from national insurance.

Having encouraged employers to finance health care, particularly preventative medicine, the NHS could then be used to help deliver this care. Employers could negotiate long term contracts for the use of pay beds by their employees. They could even help finance the development of new facilities on NHS sites which were dedicated to their employees. A local hospital or GP practice could sell health screening services to companies. Many companies already take responsibility for health screening and spend millions of pounds a year buying it from the private sector -- the NHS ought to be able to compete in that market.