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PRIME MINISTER

A SCHEME FOR CONTRACTING OUT OF THE NHS

I attach the paper on contracting out of the NHS which was commissioned from the Treasury at our last meeting.

The paper concentrates on developing and analysing an option which seems to be the most promising if this line were pursued. Its main features are as follows:

- A significant increase in the NHS element of national insurance contributions with an offsetting increase in the Treasury supplement to the National Insurance Fund and no change in tax or NIC rates.
- A rebate payable to those who "contracted out" by taking private health insurance cover satisfying some minimum requirements.
- Those who contracted out would not formally give up their rights to NHS treatment; rather they would undertake to pay for all treatment within the terms of the insurance policy, even where it is provided in NHS hospitals.
- The rebate would be a flat rate of perhaps £50 a year per head.
- Since the rebate would not be available to the elderly, who do not pay NICs, they would instead be entitled to tax relief on premiums paid to private health insurance schemes.

The main alternative to a scheme on these lines would be one simply based on tax relief for private health insurance premiums. The case here is strongest for the elderly. This has already been

advocated by a substantial group of our supporters in the House, led by Sir Phillip Goodhart. A case could be made for extending it to company health schemes (by exempting employer-paid premiums from tax as a benefit in kind), but there would be strong pressures then for a corresponding concession in respect of all premiums, however paid.

However, there are significant drawbacks about introducing tax relief to promote private health care. Our general policy is to widen the tax base in order to be able to reduce tax rates, so as to leave people with more of their own money and the freedom to choose how to spend or save it. I am therefore most concerned that we should not do anything to reverse the progress we are making in simplifying and streamlining the tax system. Moreover, the introduction of tax relief for private health care would make it more difficult to justify the absence of tax relief for private school fees. And many of the arguments against an NIC rebate (see below) would apply equally to a tax relief.

Returning to the NICs proposal, the financial implications of contracting out are discussed at the end of the paper. The calculations are necessarily a bit speculative, but the message is disturbing. There is a significant initial cost in paying the rebate to those who already have private insurance. This would at once reduce net private funding. A lot more people would need to contract out and top up from their own resources to make good this loss. But the rebate is unlikely to be large enough to attract additional people into taking out private insurance in sufficient numbers. Thus, there would be higher costs to the public purse without any assurance of an increase in the amount of private money going into health care. It must therefore be doubtful if this is the most cost-effective means of devoting additional public funds to the NHS.

There is moreover a major distributional point. The first beneficiaries of such a scheme would inevitably be those who alredy pay for private health care, who tend to be the better off section of the population. This would be particularly difficult to defend after the present controversy over the social security changes and the community charge. Moreover, one of the reasons people would subscribe to private health care with these incentives would be to get what they perceive as better or more timely treatment. We would have to be prepared to deal with accusations that we were providing tax relief to help the better off to jump the queue. Again, if we are going to spend an additional sum of public money on health, is this the best way?

I am forced to the conclusion that contracting out is on balance unattractive and should not be pursued on this occasion. It has too many problems for too few (and uncertain) rewards.

I am copying this minute and attachment to John Moore, Tony Newton, Sir Robin Butler and Sir Roy Griffiths.

Moira Wallace

pp **NL**
22 April 1988

(Approved by the Chancellor and signed in his absence.)

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A SCHEME FOR CONTRACTING OUT OF THE NHS

Note by the Treasury

1. At present, the NHS is overwhelmingly free at the point of use, whereas fees and charges for private health care reflect the full cost of the service. The NHS is financed out of general taxation (including that paid by those who choose not to use it), while the private sector is paid for by its customers. There is therefore a financial disincentive to make use of the private sector, and hence a major obstacle to the development of private health care, which might otherwise provide a means of easing the pressure on the NHS.

2. One obvious way to reduce this "cliff edge" between the public and private sectors would be wider use of charging in the NHS. Those who chose the private sector would then avoid that expense. Otherwise, there are two broad ways in which the problem might be tackled:

a. Some form of tax relief for the cost of private health care.

b. Some form of remission from national insurance contribution for those who chose to contract out, in some sense, of the NHS.

3. These options are by no means mutually exclusive. Indeed, it is possible to combine elements of each within one package: for example, a rebate of national insurance contributions for those in

work, tax relief for the elderly, and more use of charging in the NHS. This paper deals mainly with the option of remission for those who contract out. But the issues raised by the idea of tax relief are also germane, and these are considered first.

A tax relief

4. The most frequently canvassed option is to give tax relief for private health insurance premiums. A parallel option would be to exempt premiums paid by employers under a company scheme from taxation as a benefit in kind in the hands of the employee. An alternative approach might be to allow tax relief for money spent in paying directly for treatment. Total private health insurance premiums were just over £600m in 1986. Direct expenditure on uninsured private health treatment was a further £500 million.

5. Bills for medical treatment tend to be unpredictable and large. If private health provision is to be encouraged, people will need to be encouraged to take out insurance. It would seem preferable therefore, if there is to be any form of tax relief, to concentrate that relief on insurance rather than direct payments for private treatment. This would also avoid the need for the Inland Revenue to vet claims for individual payments according to whether or not they were medically necessary, with Ministers having to defend the resulting decisions. As well as being contentious, this would need substantial extra staff.

6. Any relief on premiums could be targetted on those who find it most difficult or expensive to obtain private health insurance. At present, the most heavily discouraged group is the elderly.

About 170,000 policyholders (15% of those not in company schemes) are over 65. But most schemes will only take on new customers over 65 with limited cover, and those who are already in the scheme face steep increases in their premiums. This effect would be even more pronounced for those previously in company schemes whose premiums had been paid wholly by their employers. Tax relief would mitigate the increase experienced on reaching the age of 65. It might also encourage insurance companies to begin offering more comprehensive schemes for the elderly. On the other hand, around two thirds of pensioner households pay no income tax, and so could not benefit from a new relief.

7. The other possibility would be to encourage the growth of company schemes by exempting premiums from the benefits in kind legislation. Such a step might trigger a further significant spread of company schemes, and encourage firms to extend to all the workforce those schemes presently confined to managers.

8. It might however be difficult to justify a relief for company schemes but not for premiums paid by small businesses, the self-employed, and individuals. There would be pressure to extend tax relief to all private health insurance premiums. This would in turn lead to pressure for concessions in other areas - for example, those who opt out of state education by educating their children privately, or those who pay for child care when at work, which would substantially undermine the Government's policy of simplifying the tax system and reducing special reliefs. A special relief from the benefits-in-kind charge would also be counter to the changes made in the last Budget. A relief confined to the elderly would be less liable to give rise to problems of this sort.

9. There would be an initial "deadweight" cost because those who already insure themselves would get the new relief. Tax relief for private health insurance premiums would cost £230m a year initially, made up of £80m for exempting employer-paid premiums from the benefits in kind charge, £130m for relief for premiums paid by individuals of working age, and £20m for the cost of tax relief for pensioners. The cost of any relief could be expected to increase subsequently as more people took it up.

A rebate for contracting out

10. The most obvious option here is to use the existing national insurance system. Part of the revenue from national insurance contributions is already allocated by statute to the NHS, as the attached table shows.

11. In 1988-89 total NHS contributions will be some £3.3bn, or about 16% of net NHS expenditure. This would be insufficient to underpin a viable contracting out scheme, since acute services (which are what private insurance would presumably cover) account for around a third of NHS expenditure. If the NHS element of NICs were increased, the income of the National Insurance Fund would fall. The shortfall could be made good by increasing the Treasury Supplement from general taxation to the Fund, thus leaving overall tax and NIC rates unchanged. The supplement is currently 5% of gross contribution to the NI Fund, but was 18% as recently as 1979. The Annex illustrates how this might be done: the Treasury supplement is increased to 17½%, still just below the 1979 level.

12. Contracting out of the NHS might be seen as analogous to contracting out of SERPS. In return for giving up a right to certain categories of treatment under the NHS, individuals could make their own arrangements and receive a rebate as a contribution towards the cost.

13. The analogy could not however be pressed too far. In its most rigorous sense, contracting out would imply that the individual formally relinquished rights to certain precisely defined categories of treatment which the state would no longer be obliged to provide for him. He would however continue to receive other types of treatment under the NHS, which were not available in the privately insured sector - probably primary, geriatric, chronic disease, other long stay care, maternity care where complications do not arise, and so on. This would bring the state directly into decisions about whether particular individuals at particular times fell on the NHS or contracted-out side of the line. There would be highly contentious individual cases, with the prospect of political controversy and litigation. Private health schemes would have to be heavily regulated to ensure that they continued to offer adequate cover so that the NHS did not have to step into the breach. Individuals might feel obliged to carry some form of identification indicating whether their health cover was public or private sector. These are not very attractive features.

14. There are however other ways of approaching this. The rebate could be conditional on two slightly looser requirements: that the insurance scheme met a certain minimum level of cover, and that those who took private insurance undertook to pay the full cost of

any treatment within the terms of their policy which they received from NHS hospitals. Systems would need to be set up to ensure that insurers were billed for any treatment provided in NHS hospitals. Responsibility for assessing individual cases would rest with the insurer, and not with the state. Where a case was not covered, for example on grounds of cost or length of stay in hospital, the excess would be provided under the NHS. Where cover was refused on grounds that the particular procedure was not medically necessary, it would, as now, be for the individual to meet the cost himself.

15. Individuals who contracted out would receive a rebate of some or all their NHS contributions. This would further complicate the national insurance system. (A further question would be whether rebates in respect of those in employer-paid company schemes should be paid to the employer, to the employee or split between the two.)

16. Those who did not pay NICs, notably the elderly, could not benefit from contracting out. Yet the elderly are proportionately the biggest users of the NHS. To encourage them also to take out or continue private insurance, therefore, NIC rebates might have to be supplemented by a tax relief for the elderly along the lines discussed in paragraph 6. There would be pressure to extend this to others who do not pay NICs, including for example non-working widows and those who have taken early retirement (although those who had done so on health grounds might be unable to obtain private insurance in practice).

Structure of the rebate

17. The first main alternative would follow SERPS by providing a percentage contribution rebate for those contracted out. This would have the merit of relative simplicity for both the DHSS and employers. But it also has problems:

a. In both state and contracted-out pension schemes the benefits are earnings-related, so an earnings-related rebate is appropriate. This is not the case for health care.

b. Higher earners would get bigger rebates. The rebates might even exceed the cost of private health insurance, so that they made a profit by contracting out. On the figures suggested in the Annex, the annual NHS contribution by those at or above the earnings limit (£15,860 a year) would be £380. Somebody on £50 a week by contrast would pay an NHS contribution of £62 a year, and would hence get a rebate of only one-sixth that of the higher earner.

18. The other alternative would be a flat rate rebate payable weekly or monthly. This would be in some ways analogous to a voucher scheme.

19. Under a flat rate rebate scheme, rebates could in principle be payable in respect of both individuals and their non-working dependants. This would, of course, increase the number of cases in which the rebates would exceed what individuals paid in NHS contributions or even total NICs. In such cases, the excess of rebates over NHS contributions would score as public expenditure, in the same way as payments to non-taxpayers under the mortgage interest relief scheme.

20. How big should the rebates be? The average cost per head of the NHS is at present around £375 a year, of which some £120 is for acute hospital services. But there is wide variation with age, as illustrated by the following table of very approximate projections for 1988-89:

	All NHS services	Acute hospital services
age 0-4	£350	£150
age 5-15	£220	£55
age 16-64	£230	£65
age 65-75	£650	£250
age 75+	£1500	£550

The average private health insurance premium was some £120 per head in 1986; extrapolating from past trends (under which the average premium has been growing in recent years at about 10-12% a year, reflecting both increasing medical costs and a changing age structure of the insured population) the figure is likely to be nearer £150 per head in 1988.

21. In considering the appropriate rebate, the following factors are relevant.

a. Insurance cover for primary care and geriatric, chronic and other long stay treatment is unlikely to become available in the short term. The second column of the above table is the more relevant comparison with the cost of private insurance.

b. There would inevitably be "adverse selection" - the tendency for any choice to be taken up wholly or mainly by those with most to gain from it. Thus, those who contracted out would tend to be the younger, fitter and better off who already have private insurance or who would be charged the lowest premiums by private insurers. Those who contracted out would tend to cost the NHS less than the average, while those who stayed behind would be more expensive.

c. The option of contracting out would be available only to those in work who, as the above table shows, cost less than the national average.

22. Taking all these factors into account, and including a loading for adverse selection, a contracted out rebate of around £50 a year per head would probably be appropriate. (This is probably around one-third the average insurance premium per head.)

Financial implications

23. It is difficult to quantify with any certainty the financial consequences of a scheme on these lines. This would depend on the amount of the rebate, on the extent to which it is passed on in the form of lower premiums and on the numbers taking advantage of it who would not otherwise have taken out private health insurance. Take-up is obviously related to the size of the rebate; but it is very difficult at this stage to assess the likely size of the effect. Such research as has been done (mainly in the USA)

suggests that demand for private health care rises by about ½% for every 1% fall in the cost of premiums. But this may not be a good guide to the consequences of introducing a major new scheme of the sort discussed in this paper.

24. Exchequer costs would increase by the cost of the rebate, less any reductions in expenditure on the NHS. The deadweight cost of a £50 rebate to the 5½ million people already covered by private health insurance would be just under £300m. As more people took advantage of the rebate and contracted out, the cost would rise. The suggested rebate of £50 a year would reduce the cost of insurance premiums by about one-third. If the elasticity suggested above is correct, there would be a further 1 million people contracting out, at an additional cost of £50m. If the effect was in fact greater, with, say, 3 million more contracting out, the cost would rise to £450m.

25. In the short term, it is unlikely that NHS costs would fall significantly from what they would otherwise have been. While the higher numbers contracting out would reduce the pressure of demand on the NHS, this would be likely to be reflected in shorter waiting lists or other improvements in service.

26. In net terms private resources going into health care would in the first instance decline, because £300m would be met from public funds rather than private hands. Again, however, the picture would change as more contracted out. Assuming a £50 rebate and an average premium of £150, net private sector payments for health care would rise by £100m for every further million people who contracted out. It would however need 3 million more to contract out (a relatively high elasticity of demand) before net private sector resources even got back to their present level.

27. There would be other cost pressures over time. Some of the rebate might feed through to higher costs rather than increased private sector activity. And there would be strong pressure for annual uprating of the rebate.

28. The result would be an overall increase in the resources, both public and private sector, devoted to health care as more people contracted out. But, unless the response to the new rebate was very big indeed, the increase in total health expenditure might be less than the increased cost to the public purse. Even on optimistic assumptions about people's response, the proportion of health care financed privately would probably be less than it is now.

HM Treasury
April 1988

Rates of Class 1 contributions for 1988-89

	Primary contribution (employee)			Secondary contribution (employer)	
	Standard rate		Reduced rate for married women and widow optants	Not Contracted out rate	Contracted out rate††
	Not Contracted out rate	Contracted out rate††			
	%	%	%	%	%
National Insurance Fund	–				
Weekly Earnings					
£41.00 - £69.99	4.05	2.05	2.90	4.20	0.40
£70.00 - £104.99	6.05	4.05	2.90	6.20	2.40
£105.00 - £154.99	8.05	6.05	2.90	8.20	4.40
£155.00 and over†	8.05	6.05	2.90	9.65	5.85
National Health Service†	0.95	0.95	0.95	0.80	0.80
Total					
Weekly Earnings					
£39.00 - £64.99	5.00	3.00	3.85	5.00	1.20
£70.00 - £104.99	7.00	5.00	3.85	7.00	3.20
£105.00 - £154.99	9.00	7.00	3.85	9.00	5.20
£155.00 and over†	9.00	7.00	3.85	10.45	6.65

Notes: † The contribution rates apply to earnings up to the upper earnings limit for employees and to all earnings for employers.

†† Applies only to earnings between the lower and upper earnings limits. The corresponding not contracted-out rate applies to earnings below the lower earnings limit and, for employers, to earnings above the upper earnings limit.

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ANNEX

NATIONAL INSURANCE FUND AND NHS FINANCING 1988-89

The table below sets out the present flows of NIC and general taxation revenue into the NIF and NHS this year, based on GAD figures for national insurance and PEWP figures for the NHS. All figures are GB. The NHS figures are net of charges. It shows for comparison an alternative model under which the NIC element of NHS funding is increased from £3.3bn to £6.7bn to cover the cost of acute hospital services, with the resulting shortfall in the NIF met by an increased Treasury supplement. It is assumed that the increased NHS allocation is provided by doubling the contribution by the self-employed, and raising the balance largely from employees. The scope for increasing employer contributions is limited by the very low NIC rates payable for some employees. There are of course other possible combinations. This one is set out simply to exemplify the principle.

	Present position		Alternative	
	£ bn	rate	£ bn	rate
NIF income				
Employees	11.9	2.05-8.05%	9.3	0.6-6.6%
Employers	14.3	0.4-9.65%	13.6	0-9.25%
Self employed	0.7	£3.42+5.15%	0.6	£2.80+4%
Treasury Supplement	1.6	5%	5.0	17.5%
Total	28.5		28.5	
NHS income				
Employees	1.7	0.95%	4.3	2.4%
employers	1.5	0.8%	2.2	1.2%
self employed	0.1	£0.63+1.15%	0.2	£1.25+2.3%
general taxation	17.8	-	14.4	-
Total	21.1		21.1	
NICs				
Employees	13.6	3-9%	13.6	3-9%
Employers	15.8	1.2-10.45%	15.8	1.2-10.45%
Self employed	0.8	£4.05+6.3%	0.8	£4.05+6.3%
Tax contribution to:				
NHS	17.8		14.4	
NIF	1.6		5.0	
Total	19.4		19.4	

NAT HEALTH: Expenditure
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