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CONTRACTING OUT

Note by the Secretary of State for Social Services

We are agreed that an important element in our overall strategy is to develop a thriving mixed economy of public and private health care, which will give more competition and more choice.

2. With this in mind, we have agreed that we should give tax relief for private medical insurance premiums paid by or on behalf of the elderly. We have not however reached agreement on any stimulus for private health insurance for those of working age. And the Chancellor has now advised against any change in the present arrangements for exempting from tax employees who are members of company health insurance schemes, except for the over 60s.

3. I believe we should do more to encourage people in work to take out health insurance. While the annual growth in company schemes has been around 5% in recent years, the annual growth for privately arranged and paid schemes has been about 1½%. If the Chancellor does not favour encouragement through the tax system, I recommend we do so through the national insurance system.

4. My officials have prepared the attached note which sets out how such a scheme might work.

5. The essence of the scheme is:

first, it is a limited scheme, carefully targetted at an area which is giving us considerable difficulty - cold elective surgery.

second, it draws very substantially on the model of contracting-out of the state earnings related pension scheme and would use the machinery already developed in the DHSS Newcastle Office for personal pensions. So it would be readily understood by the public.

third, under the scheme, those paying national insurance contributions would be able to contract out of NHS funded provision of cold elective surgery in return for a contribution rebate. For the sake of simplicity, such a rebate should be flat rate and not age related. It would be a condition of contracting-out that, like personal pensions, the employee concerned was covered by an appropriate health insurance policy with an approved insurer.

fourth, there would be no need for anybody to carry any health identification card. No one would be denied emergency treatment by an NHS hospital.

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6. I emphasize that this is a scheme for limited contracting-out. There is likely to be an initial deadweight cost, as there was with pensions. But I believe that, as with pensions, the development of health care contracting-out would generate a positive response whereby the overall extra resources attracted into private health care more than outweighed any deadweight costs. On top of that, it would encourage competition, provide more choice and have a major impact on one of our weak spots - waiting times for cold elective surgery.

June 1988

CONTRACTING OUT

1. This note describes a limited scheme for contracting out incorporating two key features:

- adoption of the idea contained in the Chancellor's paper. "A scheme for contracting out of the NHS" to increase the NHS element of National Insurance Contributions (NICs), with an increased Treasury Supplement.

- the facility for NIC payers to "contract out" of NHS funded provision of elective surgery in return for a contribution rebate. This rebate would contribute to the cost of an appropriate health insurance policy with an approved insurer.

2. The way in which a scheme of this sort might operate is discussed below. A number of more technical questions are covered in the Annexes. However, the major operational consequences of the scheme would be:

- Tax and NI rates could remain unchanged. This would avoid the disadvantagous distributional effects of a wholesale transfer to NI funding, although without gaining the important advantage of transparency of expenditure explicit in complete hypothecation.

- There would be no question of NI contributions establishing entitlements to treatment. All who wished to do so would remain entitled to the full range of state funded NHS treatment. Only those who voluntarily chose to contract out would lose entitlements to state funded elective surgery.

- Although people would remain at liberty to insure privately against as wide a range of medical contingencies as they wished, the major stimulus of the rebate scheme would be to the new low cost policies covering elective surgery increasingly offered by the major private insurers.

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Operation of the scheme

3. Finance

- The value of tax and NI revenues for the NHS and social security implied by the Treasury's contributions scheme are shown in the table in Annex 1.

4. Collection of contributions

- Employers would continue to collect health and appropriate NI contributions from employees.

- As the NHS would be only partially financed from NICs employers are not required to identify their employee's monthly health contributions separately on pay slips.

5. Contracting out

- Contributors may contract out of state funding for elective surgery on behalf of themselves and their immediate dependants.

- As a condition of the rebate individuals must arrange, at least, a minimum approved insurance cover, either through their employers or on a personal basis. The required minimum insurance would cover a defined list of the main elective surgical procedures. A number of policies covering precisely these procedures are already on the market, for example the "Budget BUPA" plan (see Annex 2).

The contracted out patient's route to treatment

6. Non-emergency admissions:

- Following consultation with a GP, a contracted out patient would be referred to either a private health care provider or for admission to an NHS pay bed.

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- Both public and private health care providers would ascertain the willingness of insurers to pay for private treatment before admitting a patient.

7. Emergency admissions:

- In the case of emergency admission to an NHS hospital, the health authority concerned would be empowered to seek any payment due from private insurers. As all patients must be either privately insured or fully "contracted in" to the NHS, there could be no question of patients being denied treatment which they urgently required.

8. Pre-existing conditions:

- These will not generally be covered by private insurers.

- Patients' GPs, being aware of the existence of these conditions and any exclusions from private health cover that they involve, could make references for state funded treatment as appropriate.

- Patients in these circumstances will have a guaranteed entitlement to state funded treatment for those conditions not covered by their private policies.

9. Exclusion from state funded treatment of those contracting out

In practice, exclusion would be self policed, as non urgent treatments are those for which waiting times apply in the NHS but immediate access and treatment is available in the private sector.

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10. Rejoining the state scheme

Contracted out patients could rejoin the state scheme at the end of their private insurance contract periods. Private insurers would be responsible for informing DHSS that a policy with a particular subscriber has lapsed. However insurers should be prevented from encouraging patients to return to the state scheme in the case of mid contract episodes of ill health. For this reason it may be necessary to make insurance policies offering excesses, co-insurance and no claims bonuses ineligible for the rebate.

11. The value of the contracted out rebate

- could be based on the average costs incurred by the NHS in providing elective surgery to those contracting out.

- In order to limit the tendency for low risk individuals to contract out while high risk ones remain in the state scheme, rebates could be related to both age and family size (a possible method for this is given in Annex 2).

- Alternatively, in order to simplify the scheme, a flat rate rebate could be offered for each individual contracted out of state funded treatment.

12. Payment of rebates

- Rebates would be paid annually, in arrears, direct to the insurer by DHSS. This follows the procedure for the payment of contracted out rebates in the personal pensions scheme and avoids additional burdens on employers.

- Private insurers would claim rebates by submitting a list of policy holders (with their NI numbers) and dependants covered by medical insurance direct to DHSS, guaranteeing that all those contracting out were covered by an appropriate policy.

13. Growth of the private sector

The growth in private insurance cover following the introduction of a contracting out scheme would depend on:

- the proportion of annual premiums represented by the rebate

- the responsiveness (or elasticity) of the demand for health insurance to reductions in its price.

Annex 2 examines the first of these points for a representative set of household groups and makes an estimate of the resulting increased coverage of private health insurance. The available elasticity estimates are, however, tentative and subject to wide margins. The overall effect would largely depend on the response of the private insurance industry.

Annex 1

THE NATIONAL INSURANCE FUND AND NI FINANCING 1988-89

The Chancellor's scheme to increase the NHS allocation from the NI fund proposed raising employee's NHS contributions from 0.95% to 2.4%, with additional increases in contribution rates for both the self employed and employers. The sources of NHS income which would result from this arrangement are shown in the table.

	£bn
Employees contributions	4.3
Employers contributions	2.2
Self employed contributions	0.2
General taxation	14.4
	21.1

The value of employees' contributions in this scheme would be more than sufficient to underpin a contracting out arrangement of the sort described in this paper. Total expenditure on NHS surgical acute specialties, that is, those for which contracting out is envisaged, is in the region of £2bn for 1988/89.

It should be noted that a possible feature of the scheme is that some low earners may be entitled to rebates which are in excess of their annual NHS contributions. Excess rebates of this sort would score as public expenditure. In practice, however, this is unlikely to be a serious problem. A married couple in their mid 50s with two children would have to have earnings of less than £100 per week before being eligible for rebates in excess of their health contributions.

Annex 2

THE VALUE OF REBATES AND THE EXPANSION OF PRIVATE SECTOR

Unless rebates reflect, in some way, the risks represented by groups in the population, the consequence of a contracting out scheme may be that low risk cases tend to leave the state scheme while high risk ones remain.

Age is an important determinant of the risk of requiring elective surgery. The table below shows the value of NHS expenditure per head on surgical acute specialties.

Age Band	Expenditure per head (1988/89 prices)
All ages	41
0-4	13
5-14	16
15-24	21
25-34	24
35-44	29
45-54	37
55-64	54
65-74	88
75+	154

Eight of these specialties account for in excess of 90% of cases from the waiting list, and cover procedures typically offered by most private health insurance policies. These average cost figures would therefore form the best basis of a contributions rebate for contracting out of elective surgery.

Insurance premiums

An indication of the contribution of these rebates to the cost of private health insurance is given below. The table expresses the value of rebates as a percentage of premium costs for a variety of family types. The family rebate consists of the sum of the age specific rebates (calculated on the

basis of expenditure on people in five year age bands applicable to each family member. The costs of premiums are those applicable to BUPA's recently launched "Budget BUPA" plan. This covers 85 in-patient and 30 day care elective surgical procedures which represent the majority of operations on NHS waiting lists.

Family type	Rebate as % of undiscounted Budget BUPA premium
Single person age 20	23.5
Couple mid 20s	23.7
with 2 children	27.5
Couple mid 30s	23.2
with 2 children	26.7
Couple mid 50s	26.9
with 2 children	28.3
Couple mid 60s	29.9

Expansion of private health insurance

US experience, which has to be applied cautiously to the UK, suggests that the demand for private health care insurance rises by about ½% for every 1% fall in the cost of premiums. On this basis the number of private insurance subscribers might be expected to increase by between 12 and 15% as a result of a rebate scheme of this sort. Using estimates produced by the Institute of Health Services Management of the number of people with private health insurance in 1987 as a base, the contracting out scheme could:

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- increase the coverage of private health insurance from 6 million -to around 7 million people

- boost the annual value of premiums paid to between £850 and £875 million, an increase of in excess of £100 million.

However on the basis of a rather more optimistic elasticity estimate where the demand for private health insurance increased by 2% for every 1% fall in the cost of premiums, an additional £350 to £375 million of expenditure could be generated. This would bring about a significant increase in net private sector resources going into health care.

To the extent that, over time, those newly attracted into the private insurance market 'trade up' to more comprehensive policies, the value of private expenditure is likely to rise still further.