



## **RESPONSE BY THE ASSOCIATION OF BRITISH INSURERS TO PROFESSOR MIKE RICHARD'S REVIEW OF THE CONSEQUENCES OF ADDITIONAL PRIVATE DRUGS FOR NHS CARE AND THE GOVERNMENT'S POLICY RELATING TO NHS PATIENTS WHO CHOOSE TO PAY PRIVATELY FOR DRUGS NOT FUNDED ON THE NHS**

The Association of British Insurers (ABI) welcomes the opportunity to submit its response to Professor Mike Richards' review of the consequences of additional private drugs for NHS care and government's policy relating to NHS patients who choose to pay privately for drugs not funded on the NHS.

The ABI is the voice of the insurance and investment industry. Its members constitute over 90 per cent of the insurance market in the UK and 20 per cent across the EU. They control assets equivalent to a quarter of the UK's capital. They are the risk managers of the UK's economy and society. Through the ABI their voice is heard in Government and in public debate on insurance, savings, and investment matters.

### **Context**

Current Department of Health policy is that NHS patients who, as a result of choosing to pay privately for drugs not funded on the NHS, are required to pay for the NHS episode of care that they would otherwise have received for free.

The public and medical profession views on the use of private funding, also known as top-up funding, are polarized:

- On one side is the view that the NHS must be free at the point of clinical need and allowing top-up funding would promote a two-tier health system.
- On the other side, the view is that the NHS is free to all at point of clinical need, however there is a limit to what the NHS can provide and people should be free to choose to pay for additional treatment above their NHS entitlement.

### **Managing the funding gap**

1. The NHS entitlement is constrained by resource and budget. The reduction in the past years' increases in NHS funding, demand for new, expensive drugs and interventions, the changing demographic of fewer people working per person of state pensionable age<sup>1</sup>, and patients embracing the concept of choice and being more involved in their clinical healthcare decisions will continue to challenge NHS funding and widen the

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<sup>1</sup> In 2004, there were 3.33 people of working age for every person of state pensionable age. This ratio is projected to fall to 2.62 by 2031 (source: p20, Key Findings, '2004 based National Population Projections for the UK and Constituent Countries', Government Actuary's Department, [www.gad.gov.uk/Documents/Population\\_trends\\_123.pdf](http://www.gad.gov.uk/Documents/Population_trends_123.pdf))

funding gap. Whilst patient choice will drive solutions that could include a range of options, not just top-up funding, the funding gap means that the issue of private funding within the NHS will not go away.

2. The key to reconciling the opposing views on the use of private funding is to introduce patient choice in a way that does not promote a two-tier health system. We believe that this can be achieved by ensuring that:
  - People have consistent access to the NHS through an explicit national entitlement; and
  - Any choices to supplement this national entitlement are real choices that are genuinely affordable for most people. In the case of treatments that are very expensive, for example, drugs that are not approved by NICE which the person wants to pay for, this can work through making these choices available to a large number of people and pooling the insurance risk.
3. Currently the national entitlement varies across the country. There is a tension between national guidelines developed by NICE and their implementation by Primary Care Trusts (PCT) that are charged with managing budgets and rationing healthcare at a local level. The variation is widely perceived to be unfair and inconsistent. However, if all PCTs provided NICE approved drugs and other treatments then all patients would receive their NHS entitlement. Consistent access to the national entitlement, including the transparent assessment by NICE of all drugs and treatments against a quality, efficacious and cost perspective, would ensure the principles of the NHS were upheld.
4. The PMI industry works in an environment of explicit entitlement. We would welcome a nationally consistent NHS entitlement that is clear about what patients are entitled to.
5. People should have a real choice of affordable insurance to supplement their national entitlement. The argument that the use of private funding allows patients to receive cross subsidies from the NHS is inherently wrong because the patient has already paid for NHS care through taxation.

### **The role of insurance**

6. Through risk pooling and insurance products that offer broad cover that meet the needs of a wide population base, premiums can be low cost and therefore offer an affordable, real choice that is available to the general public, not just the well-off.
7. The government will determine the health funding system that best meets the needs of the people. In reaching that decision we would ask the government to recognise that if private funding, or alternative options, are enabled then insurance would have a significant role to play in providing people with a real choice and in avoiding a two-tier health system.

Insurance provides a solution for people to be able to have drugs that are not funded through the NHS. Without insurance, only people who are extremely wealthy or who are prepared to go to extremes, for example re-mortgaging their home, would be able to afford to pay for high cost drugs.

## **The characteristics that could make the insurance market work**

### Broadly defined cover

8. PMI is a choice some patients make to help them manage their healthcare and its cost. PMI insurers respond to the NHS and, alongside a clear national entitlement, can develop products that enable people to have a genuine choice in their healthcare by funding drugs outside the NHS entitlement.
9. The fact that a drug was not cost-effective when applied to the population, as a whole, does not invalidate its effectiveness where it is having a beneficial effect for a specific patient.
10. Therefore, while the focus of the Department of Health's review is on high cost drugs with a low take-up, we need to emphasise that insurance works best through broadly defined products that appeal to a wide range of people and provide certainty by, for example, covering a range of drugs rather than one specific drug.

### High take-up before there is a clinical need to be insured

11. A high take-up of insurance is needed to reduce the risk of adverse selection and to ensure a large risk pool across which to spread the risk. The more people that are insured, the larger the risk pool, and the lower the ratio of claims to insured people, leading to lower premiums. Affordable premiums in turn mean insurance is accessible to more people - promoting financial inclusion.
12. People need to take out PMI when it is relevant for them to do so and should not wait until there is clinical need. PMI is not designed to cover the costs of pre-existing conditions where there is a patient history. PMI is designed to cover the costs of acute conditions, that is, conditions likely to respond quickly to interventions that aim to return people to the health status they had before the acute condition, or a full recovery. This means that traditional PMI does not cover pre-existing conditions or chronic (long-term) conditions and cannot be taken out once a person has a clinical need. However, a framework could be developed for new insurance products that meet the needs of patients and are accessible and affordable within a competitive market.

## **Recommendations**

13. We welcome the review and any additional clarity that can be brought to this area of significant public interest.

14. We suggest that recommendations take account of the fact that this review could set a precedent for other areas beyond drugs, such as, cataract surgery, prostheses, and other non-core episodes of care within NHS care pathways and that the principles may have wider implications.
15. We believe that choice can be introduced in a way that does not create a two tier NHS, by ensuring there is a national entitlement and that top-up choices are real choices that are affordable to most people. We believe that through pooling the risk by making these choices available to a large number of people that insurance has a clear role to play in delivering this.
16. Accordingly, we propose setting up a joint working party between the Department of Health and the insurance industry to explore how financial products might be developed to provide affordable top-up funding, and to consider how the public and private systems could work more effectively together in the future.