[redacted]
<[redacted]@BUPA.com>
21/08/2008 23:13

To <[redacted]@dh.gsi.gov.uk>, <[redacted]@dh.gsi.gov.uk>
cc <mike.richards@gstt.nhs.uk>, <[redacted]@gstt.nhs.uk>, "[redacted]" <[redacted]D@BUPA.COM>, "[redacted]" <[redacted]@BUPA.COM>, "[redacted]" <[redacted]@BUPA.COM>, "[redacted] \(Director CorpCommunications\)" <[redacted]@BUPA.COM>
Subject Bupa submission to the Richards' Review

Mailbox analysis av

[redacted]
Deputy Head - Review of the Consequences of Additional Private Drugs for NHS Care
Department of Health
Richmond House
London SW1
020 7210[redacted]

Dear [redacted]

I am delighted to attach:

1. Bupa's submission to the Review;
2. A covering letter to Professor Richards; and
3. Several articles referred to in the submission that can only be obtained from subscription websites. Thought it might be easier for you if I email them to you. All the other web references should be readily accessible.

As I indicated might be the case in my preliminary letter, Bupa has chosen, on the grounds of transparency and consistency, to prepare a single submission to both your Review and the parallel Conservative Party Consultation.

I will mail you a hard copy of our submission as soon as possible, hopefully tomorrow.

[redacted] and I look forward to meeting Mike and you again at the KPMG breakfast on 9 September. If you wish to speak with us in the meantime please do not hesitate to ring me on 07771[redacted] or [redacted] on 07768[redacted]. If possible, please ring us on or after 1/9 when we will both have returned from annual leave.

With best wishes

[redacted]

[redacted] | Head of Public Policy | Bupa

Bupa House, 15-19 Bloomsbury Way, London, WC1A 2BA
T: +44 (0) 20 7656 [redacted] | F: +44 (0) 20 7656 2705 | M: +44 (0) 7771 [redacted]
[redacted] | [redacted]@bupa.com [redacted]

20080821 MB 6 Richards Review submission FINAL.doc

Shmueli article.pdf Gross article.pdf

[redacted]

[redacted]
<[redacted]@BUPA.co
m>

21/08/2008 23:13

To <[redacted]@dh.gsi.gov.uk>,
<[redacted]@dh.gsi.gov.uk>
cc <mike.richards@gstt.nhs.uk>,
<[redacted]@gstt.nhs.uk>, "[redacted]
[redacted]" <[redacted]LD@BUPA.COM>,
"[redacted]" <[redacted]@BUPA.COM>, "[redacted]
[redacted]" <[redacted]@BUPA.COM>, "[redacted]
\(Director CorpCommunications\)"
<[redacted]@BUPA.COM>

Subject: Bupa submission to the Richards' Review

Mailbox analysis av

[redacted]
Deputy Head - Review of the Consequences of Additional Private Drugs for NHS Care
Department of Health
Richmond House
London SW1
020 7210[redacted]

Dear [redacted]

I am delighted to attach:

1. Bupa's submission to the Review;
2. A covering letter to Professor Richards; and
3. Several articles referred to in the submission that can only be obtained from subscription websites. Thought it might be easier for you if I email them to you. All the other web references should be readily accessible.

As I indicated might be the case in my preliminary letter, Bupa has chosen, on the grounds of transparency and consistency, to prepare a single submission to both your Review and the parallel Conservative Party Consultation.

I will mail you a hard copy of our submission as soon as possible, hopefully tomorrow.

[redacted] and I look forward to meeting Mike and you again at the KPMG breakfast on 9 September. If you wish to speak with us in the meantime please do not hesitate to ring me on 07771[redacted] or [redacted] on 07768[redacted]. If possible, please ring us on or after 1/9 when we will both have returned from annual leave.

With best wishes

[redacted]

[redacted] | Head of Public Policy | Bupa

[redacted]

Professor Mike Richards
NHS National Clinical Director for Cancer
Chairman of Review of Consequences of Additional Private Drugs for NHS Care
Room G06A
79 Richmond House
Whitehall
SW1A 2NS
Email: Additionaldrugsreview@dh.gsi.gov.uk

21 August 2008

Dear Mike

Bupa submission to Review of Consequences of Additional Private Drugs for NHS Care

It was very good to meet you, as part of the ABI delegation, on 29 July.

I am delighted to enclose Bupa's submission to your Review. We have provided a summary at the front to give you and your colleagues an overview of the key points.

For the sake of transparency and consistency Bupa is making a single submission to both your Review and the parallel Conservative Party Review[1] entitled: The relationship of private treatment to NHS care: a consultation. Responses to the specific questions you put to the ABI can be found at Annex A of the submission. Similarly responses to the specific issues and questions raised in the Conservative consultation can be found at Annex B.

Bupa's view is that high cost cancer drugs are but one part of a broader financing challenge. "Top ups" are one policy option amongst a number that may have to be considered in combination.

Bupa's Mind the Gap Report in 2006 projected that the NHS faces an annual "funding gap" of approximately £11bn (about 10% of total health expenditure) by 2015. Bupa thinks that the key issues modelled in the Report have been largely born out by subsequent

[1] http://www.tory.org.uk/getfile.cfm?file=Consultation_document&ref=GENERALFILE/3585&type=pdf

announcements and analysis of NHS performance and proposed allocations.

The Mind the Gap project team concluded that the projected "gap" might be "filled" by a combination of NHS productivity gains, additional co-payments for NHS services and to "top ups" to NHS entitlements.

Bupa thinks that the Australian experience of a "duplicative" role for PMI with substantial positive and negative incentives to encourage PMI uptake may also be relevant to the UK.

Bupa is strongly of the view that these matters are very important for the future of the UK health system – and think that the potential opportunities for combining public and private health financing to better effect, are far broader than the specific issue of "cancer drugs," important though that issue is.

I am mindful that you have been asked to examine, in particular, the clinical effectiveness, efficiency and equity implications of any change in policy and guidance on the relationship between public and private health funding in England. My colleagues and I have therefore tried to be as explicit and exact on these matters as, our conceptual thinking, and the limited and partial evidence allows.

If, at the conclusion of your Review, you make recommendations advocating that patients be allowed to "top up" their NHS funding – we hope you will give careful consideration to our views that:

1. Insuring for "top ups" (supplementary health insurance) is preferable to out of pocket payment for "top ups" in terms of improved financial protection, greater social inclusiveness and great efficiency in purchasing effective high value care;

2. "State owned" health insurance agencies rarely have either the commercial agility or management freedom to provide world class health insurance services on a sustainable basis.

In conclusion, Bupa recognises that the factors influencing the impact of any change in policy in this area are multiple and complex in interaction; the international experience, such as it is, is not entirely aligned with the UK context; and issues of policy implementation, regulation and emerging market structure are all of paramount importance.

Bupa therefore supports the BMA's stated view that detailed consideration of them is passed to a Royal Commission that enjoys a well balanced cross party array of political, economic, medical, financial and legal expertise. Bupa thinks that such a Royal

Commission should be given the authority to conduct real but limited experiments to explore the economics of these matters, in practice, in a specifically English (or UK) context.

I hope you will find Bupa's submission helpful. [redacted] (Managing Director, Bupa Membership, our main UK health insurance business) and I would welcome any further dialogue you, or your colleagues, would find helpful. Please do not hesitate to contact me if you, or your colleagues, would like clarification or amplification of any particular point in our submission.

With very best wishes

[redacted]
Head of Public Policy
Bupa
Email: [redacted]@bupa.com
Tel: +44 (0) 20 7656 [redacted]
Mobile: +44 (0) 7771 [redacted]

Bupa's combined response to The Richards' Review and the parallel Conservative Party consultation

Executive Summary

Bupa recognises that the NHS is a highly valued national institution that commands support across the mainstream political parties. Bupa also recognises both the unprecedented financial investment that has been made in the NHS over the past five years and the considerable political, policy making and managerial efforts that have accompanied that investment in order to modernise the NHS. Bupa has actively supported these reforms and participated in them. Bupa continues to support the NHS modernisation agenda, principally through its involvement in the NHS FESC programme and other support for World Class Commissioning. Bupa is also a major customer of the NHS.

As a customer focused organisation delivering diverse high quality health and care services to 10m people across a number of geographic markets (including UK, Spain, Australia, New Zealand, Saudi Arabia, Hong Kong and USA) Bupa has considerable experience of delivering services that meet the needs of patients and consumers of healthcare which operate within a variety of funding systems alongside a significant state health system. Accordingly, Bupa hopes it can contribute real experience and practical examples to this important Review and the parallel Conservative Consultation.

First, regarding specific issues raised in the Review and consultation:

Bupa thinks it vital that the choice of a private treatment should not affect a patient's subsequent NHS entitlements, at least negatively. Such an approach is only fair from the perspective of that person as both a patient and a taxpayer.

It is probably fair to assert that the great majority, if not all, Bupa members are net contributors to the NHS for they are required to pay their full contribution to the NHS but only make partial use of NHS services. The concern that private patients are receiving subsidised access to NHS services therefore seems inaccurate and misconceived.

Second, Bupa thinks that the present Review and Consultation both take a too narrowly focused approach to a set of challenges that must be considered more broadly, namely:

- **Is the UK investing enough money in personal health services?**
- **Is that money spent effectively and efficiently?**
- **Is the money giving people the services they want and need?**

Third, re choice and health financing reform more generally: Bupa believes that all individuals and employers should be entitled without limitation to pay for their healthcare if they choose to do so. Bupa is committed to providing affordable healthcare solutions to those that want to.

As highlighted in Bupa's Mind the Gap Report in 2006, Bupa thinks that the NHS may face an annual "funding gap" of approximately £11bn (about 10% of total health expenditure) by 2015. The Mind the Gap analysis appears to have been largely born out by subsequent developments.

Bupa identifies at least five options to improve the financing of the NHS in England and the health system of England overall:

1. **Improve NHS productivity;**
2. **Improve the effectiveness and efficiency of NHS Commissioning;**
3. **Increasing the scope of NHS "co-payments";**
4. **Introducing "top-ups" to NHS entitlements;**
5. **Strengthening positive and negative incentives for demand for "duplicative" voluntary/private medical insurance (V/PMI).**

Bupa commends the OECD taxonomy of health insurance[1] as a good means of distinguishing the different roles of health financing and their associated insurances. These roles and insurances have distinct economic dynamics.

There is already a considerable policy focus in DH/NHS policy making on the need to improve NHS productivity and the means to achieve this. In 2006 ONS estimated that annual NHS productivity growth between 1999 and 2004, if adjusted for quality improvement had been between -0.5% and +0.2%. In the Budget 2007 HM Treasury set a target that the NHS will achieve a 2% annual increase in (non QA adjusted) productivity every year between 2008 and 2011.

Similarly over the past few years there has been an increase focus on improving the effectiveness and efficiency of NHS

[1] http://www.oecd.org/dataoecd/24/52/31916207.pdf

Commissioning. In December 2007 DH launched its World Class Commissioning initiative. In March 2008 Secretary of State Alan Johnson confirmed the "Framework for External Commissioning Support" as a nation wide policy initiate to provide private sector support to NHS Commissioners.

This paper therefore focuses on the scope to increase NHS co-payments and the outline economic case for introducing "top-ups" to NHS entitlements. From a theoretical perspective the economic case for "co-payments" is sound but not as strong as that for "top ups."

In theory, a "supplementary" role for "top up" funding should improve macro-economic efficiency and market efficiency. It should also be sustainable and manageable. The establishment of a basket of NHS core services at the same time would be a logical and desirable development which should also improve horizontal equity. If a solid market in "supplementary" health insurance were to develop, "top ups" could also optimise the allocative efficiency of that spending component. The presence of "premium subsidies," for disadvantaged groups, paid by central or local Government, could protect or even improve vertical equity.

Robust evidence in support of this analysis is incomplete. A key limiting factor is that there is no country that has an exactly identical institutional structure to the one that would obtain in England if we were to move additional financing onto a supplementary basis. The closest parallels are probably with The Netherlands and Israel.

If the Review or Consultation concludes with a recommendation advocating the use of "top ups" in the NHS (on a narrow or wider basis) Bupa would wish to:

- Highlight the advantages of "insured top ups" (i.e. supplementary health insurance) over "out of pocket top ups" on the grounds of financial protection, social inclusiveness and clinical effectiveness;

- Highlight the disadvantages of "state owned and managed" voluntary health insurance organisations;

- Highlight the advantages of a clear statement of NHS entitlements, through the establishment of either positive or negative entitlement lists.

Bupa supports the British Medical Association's call for a Royal Commission to examine these matters. They are of vital importance to the future of the NHS and overall health system in

England. The issues are complex and contested, both in themselves and in their interactions and impact on system goals. The international evidence on these matters is of partial but not complete relevance to the particular circumstances of England.

Bupa's approach to the evaluation of new clinical technologies is set out and evaluated in a peer reviewed paper by Dr Virginia Warren (Assistant Medical Director, Bupa Group Medical Team) in the Journal of Health Services Research and Policy (Volume 12, No 3, July 2007)[2]. There was a 90% concordance between Bupa evaluation decisions and subsequent NICE decisions (35 out of 39 cases). The remaining four cases are examined in the article which concludes that the Bupa fast appraisal methodology is fit for purpose.

Bupa currently funds, for its UK insured members all oncological drugs and biologicals that have European licences for use within the terms of their licence and any amendments to it. This includes those that are currently being evaluated by NICE Technology Appraisals and by the Scottish Medicines Consortium, and those for which those organisations have issued guidance to the NHS which is more restrictive than the terms of the licence. Bupa take this approach because it has a rule that it routinely fund consensus treatments. Bupa's view is that the in-licence use of a drug or biological is a consensus treatment.

[2] http://jhsrp.rsmjournals.com/cgi/content/abstract/12/3/142

Contents

Background

On 17 June The Rt Hon. Alan Johnson MP, Secretary of State for Health, announced to Parliament that he has asked Professor Mike Richards[3], NHS National Clinical Director for Cancer to undertake a Review and report to him by October. The main stated purposes of the Review are: To examine current policy relating to patients who choose to pay privately for drugs that are not funded on the NHS and who, as a result, are required to pay for the care that they would otherwise have received free on the NHS; and To make recommendations on whether and how policy or guidance could be clarified or improved.

The Conservative Party has issued a parallel Consultation[4] entitled: "The relationship of private treatment to NHS care: a consultation". The purpose of this consultation is stated as: ...in light of the Government's recent announcement, [the Conservative Party] are seeking the views of the public and interested bodies on the best approach to the circumstances where an NHS patient wishes to 'top-up' their NHS care by purchasing, privately, additional drugs or services..

The Review and parallel consultation have been prompted in part by the case of Mrs Linda O'Boyle[5] and also, possibly, by the publication of a draft EU Directive on Cross Border Healthcare[6]; which if passed as presently drafted, creates the possibility of patients being able to "top up" some NHS entitlements when travelling overseas.

Bupa recognises that the NHS is a highly valued national institution that commands support across the mainstream political parties. Bupa also recognises both the considerable financial investment that has been made in the NHS over the past five years and the considerable political, policy making and managerial efforts that have accompanied that investment in order to modernise the NHS. Bupa has actively supported these reforms and participated in them.. Bupa continues to support the NHS modernisation agenda, principally through its involvement in the NHS FESC programme. Bupa is also a major customer of the NHS.

As a customer focused organisation delivering high quality health and care services to 10m people across a number of geographic markets, Bupa has considerable experience of delivering services

---

[3] http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/Nationalclinicaldirectors/DH_086040

[4] http://www.tory.org.uk/getfile.cfm?file=Consultation_document&ref=GENERALFILE/3585&type=pdf

[5] http://www.parliament.the-stationery-office.co.uk/pa/cm200708/cmhansrd/cm080617/debtext/80617-0001.htm

[6] http://ec.europa.eu/health/ph_overview/co_operation/healthcare/cross-border_healthcare_en.htm

that meet the needs of patients and consumers of healthcare which operate within a variety of funding systems alongside a significant state health system. Accordingly, Bupa hopes it can contribute real experience and practical examples to this important Review and the parallel Conservative Consultation.

Legal and policy context: the interface of NHS and private care

At present the role of "additional health financing" (i.e. non NHS health financing) in the UK is essentially "duplicative"[7]. The NHS Act 2006 1.(3)[8] requires that NHS services "must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed. "

Powers to charge for NHS services are set out in Part 9 (Sections 172 to 191) of the NHS Act 2006[9]. Amongst other things charges may be levied for non-UK residents (Section 175) and "Amenity" beds (Section 189).

Policy guidance on the interface of NHS and private care is set out in DH (2003) "A code of conduct for private practice; guidance for NHS Medical Staff" which in turn refers back to DHSS (1986) "Management of private practice in Health Service Hospitals in England and Wales (the Green Book)". DH subsequently published DH (2004) "A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants." All three documents were laid in the Library of the House of Commons following a Parliamentary Question from Christopher Chope MP (Hansard, 22 January 2008: Column 1939W)[10].

Paragraph 3.22 of the 2003 guidance states, *inter alia*, that:

- A patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- Any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- Any patient changing their status after having been provided with private services should not receive unfair advantage over another patient.

For fuller discussion of this matter see the response to a Parliamentary Question from Ann Milton MP (Hansard, 16 June 2008: Column 763W)[11].

---

[7] See http://www.oecd.org/dataoecd/24/52/31916207.pdf for the OECD taxonomy of the roles of health insurance and http://www.oecd.org/dataoecd/42/6/33820355.pdf (Table 1) for OECD's assessment of the role private health insurance plays in different OECD countries.
[8] http://www.opsi.gov.uk/Acts/acts2006/ukpga_20060041_en_2#pt1-pb1-l1g1
[9] http://www.opsi.gov.uk/Acts/acts2006/ukpga_20060041_en_13#pt9-pb1-l1g172
[10] http://www.parliament.the-stationery-office.co.uk/pa/cm200708/cmhansrd/cm080122/text/80122w0039.htm#0801245000047
[11] http://www.parliament.the-stationery-office.co.uk/pa/cm200708/cmhansrd/cm080616/text/80616w0032.htm

Lack of clarity around the current legal (or policy) definition of an NHS "visit" or "episode of care" is a key problem. NHS Trusts and Primary Care Trusts are interpreting these terms in significantly different ways ranging from:

- Separate "episodes of care" (NHS and private) (by different consultants or clinical principals) within a single "visit" (to a facility); to

- An "episode of care" compassing lifelong personal and private responsibility for a medical condition following any privately funded intervention in relation to that diagnosis; or

- Responsibility for any complications or necessary treatment arising from any privately funded intervention.

Principles and evaluation criteria

The Secretary of State's terms of reference to Professor Richards state that:
"In making recommendations,[he is required] to take into account: the importance of enabling patients to have choice and personal control over their healthcare; and the need to uphold the founding principle of the NHS that treatment is based on clinical need not ability to pay: and, to ensure that NHS services are fair to both patients and taxpayers."

Similarly the Conservative Consultation states (1.3):

"Our approach to this issue will be determined in accordance with our continuing commitment to NHS principles, including that: NHS resources should be devoted to NHS patients; NHS patients should have equitable access to NHS care, regardless of their ability to pay; NHS services should be "free of charge except in so far as the making and recovery of charges is expressly provided for by or under enactment whensoever passed" (NHS Act 2006); and If patients access private treatment this should not affect their NHS entitlements, either positively or negatively.

Bupa agrees with both sets of stated principles but has the following comments:

Bupa thinks it vital that the choice of a private treatment should not affect a patient's subsequent NHS entitlements negatively. Such an approach is only fair from the perspective of that person as both a patient and a taxpayer.

Bupa knows that many insured members make use of both NHS funded and insurance funded services. The great majority use NHS primary care services (including NHS GP services) and in an emergency may use NHS "blue light" services (i.e. Ambulance, A&E, ICU and emergency NHS hospital admissions).
The issue of "fair" access is therefore largely focused on diagnostic and urgent and elective out-patient, day-patient and inpatient services.

As the DH 1986 guidance recognises[12] there are reasons why a private patient may wish to change status to an NHS patient including "a significant and unforeseen change of circumstances" whether financial or medical.

It is probably fair to assert that the great majority, if not all, Bupa members are net contributors to the NHS for they are required to pay their full contribution to the NHS but only make partial use of NHS services. The concern that private patients are receiving subsidised access to NHS services therefore seems inaccurate and misconceived.

It is however fair to note that the principal concern of all the above mentioned DH guidance is that former private patients should not get "quicker" access to NHS services than any other NHS patient if and when they "switch" status. However the DH guidance is vague and does not address the dilemma doctors face regarding the different levels of knowledge they have about patients with different histories.

Bupa thinks that all of the above takes a too narrowly focused approach to a set of challenges that must be considered more broadly, namely:

- **Is the UK investing enough money in personal health services?**
- **Is that money spent effectively and efficiently?**
- **Is the money giving people the services they want and need?**

Bupa therefore thinks that the following wider evaluation criteria should be applied to the matters under consideration and the wider questions raised above:

Macro-economic efficiency – Would a change (in policy) help optimise the level of total healthcare expenditure – not too much, not too little?

Technical efficiency – Would a change help people buy the right (highest value for money) things? (linked to *Effectiveness*)

[12] Ibid. Para. 23

Allocative efficiency – Would a change help ensure the right people get things?

Market efficiency – Would a change help people get what they want and are able/prepared to pay for?

Effectiveness – Would change improve health outcomes?

Equity – Would the change protect or enhance the equal treatment of equals (horizontal equity) and/or (where "human rights" or "fairness" on other grounds requires/commends) the equal treatment of un-equals (vertical equity)?

Sustainability – Is a proposed change readily achievable (politically and technically), sustainable and flexible?

In short Bupa believes that whilst equity of access is indeed a very important policy evaluation criterion it should not be the sole criterion, or even necessarily the principal criterion, by which these matters are judged. Indeed equity is not the sole or principal criterion by which other formal decisions about scarce resources are made by DH and/or NHS – NICE and capital investment decisions, for example, are made on the grounds of technical efficiency.

New clinical technologies: present and future

Bupa's approach to the evaluation of new clinical technologies is set out and evaluated in a peer reviewed paper by Dr Virginia Warren (Assistant Medical Director, Bupa Group Medical Team) in the Journal of Health Services Research and Policy (Volume 12, No 3, July 2007)[13]. There was a 90% concordance between Bupa evaluation decisions and subsequent NICE decisions (35 out of 39 cases). The remaining four cases are examined in the article which concludes that the Bupa fast appraisal methodology is fit for purpose.

Bupa currently funds all oncological drugs and biologicals that have European licences for use within the terms of their licence and any amendments to it. This includes those that are currently being evaluated by NICE Technology Appraisals and by the Scottish Medicines Consortium, and those for which those organisations have issued guidance to the NHS which is more restrictive than the terms of the licence. Bupa take this approach because it has a rule that it routinely fund consensus treatments.

[13] http://jhsrp.rsmjournals.com/cgi/content/abstract/12/3/142

Bupa's view is that the in-licence use of a drug or biological is a consensus treatment.

There are occasions when there is a good amount of high quality evidence concerning the effectiveness of a drug or biological for a specific pathology at a given stage in its natural history, but the licence, if any, does not cover this context. Bupa would then fund the treatment routinely. An historical example is lenalidomide for relapsed multiple myeloma in the months before it had any licence. At the moment Bupa are funding erlotinib for first line use in NSCLC for people who are performance status II or III only if they are participating in the TOPICAL trial. We are funding it first line for never smokers who are performance status I (and therefore too well for TOPICAL) on a case by case basis, and are likely to move to funding it routinely first line for such never smokers.

In summary, Bupa funds clinical technologies: after licence, but before NICE appraisal, within the terms of their licence; after NICE appraisal, when they are deemed to be effective (and adequately cost effective to be affordable equally to Bupa members on an actuarial basis) but not adequately cost-effective to fall within the basket of services approved by NICE for use in the NHS; and, occasionally, outside the terms of their license when there is compelling evidence and a case to do so.

Envisaged future demand for new clinical technologies

Demography, epidemiology and successful innovation are important drivers of demand for new clinical technologies. The Baby Boomers have arrived in the age group with high cancer incidence rates. Three cancers have noteworthy changes in exposure to risk factors: breast cancer is unusual in being more common in those who are better off, so the improvements in standard of living over recent decades will lead to increased incidence rates over and above the 'Baby Boomer' effect of increase in number of people at risk; women's smoking related cancer incidence rates are level while men's are falling; the UK is at the beginning of a mesothelioma epidemic.

There are at least four areas of innovation which can be expected to contribute to demand. There are more monoclonal antibodies and tyrosine kinase inhibitors coming on stream, and the licence amendments for bevacizumab, for instance, suggest that some will have much wider use than was initially obvious. Robotics will increase the proportion of surgeons who can achieve the outcomes (tumour control & minimisation of complications) of the most skilled i.e. maintenance of continence and potency following radical prostatectomy; immunisation based on gene therapy of micro-organisms is anticipated to cure some cancers and control others; and increasing understanding of the contribution of weak genes to the

development of 'ordinary' cancers may allow population screening programmes to be somewhat tailored to individual risk.

NICE Technology Appraisals consultation document of 7 August 2008

Bupa note that earlier this month NICE Technology Appraisals team issued a consultation document on bevacizumab, sorafenib, sunitinib and temsirolimus for the treatment of advanced and/or metastatic renal carcinoma in which they were not recommended as treatment options. Two of these - sorafenib and sunitinib - have been evaluated by the Scottish Medicines Consortium and not recommended for use by the NHS in Scotland (guidance Oct 06 and June 07 respectively). The other two have not been evaluated by the SMC. Bupa funds all four 'in licence' for renal carcinoma; as mentioned above, we regard use of drugs and biologicals in licence as consensus treatments. We are aware of the phase III MRC SORCE trial randomising patients with localised disease who have had a nephrectomy to sorafenib or placebo, and have given discretionary support to at least one member participating in this.

Financing reform in the NHS

The need for financing reform

As highlighted in Bupa's Mind the Gap Report[14] in 2006, Bupa thinks that the NHS may face an annual "funding gap" of approximately £11bn (about 10% of total health expenditure) by 2015.

The Mind the Gap Project Team, which included economists from Frontier Economics and NERA, concluded that, based on likely progress made through the period 2002 to 2008, the NHS would need annual real terms increases in expenditure of between 4.5% and 4.9% per annum through the period 2008 to 2015.

The Project Team similarly concluded that, based on likely economic and fiscal growth, public expenditure constraints and competing demands from other public services, the NHS was more likely to receive real terms income growth of between 3% and 3.5% through the period 2008 to 2015.

The Mind the Gap analysis appears to have been largely born out by subsequent developments.

Sir Derek Wanless undertook a Review[15] entitled "*Our future secured?*" for The King's Fund, evaluating what the NHS had achieved since his 2002 Review[16] for HM Treasury entitled "*Securing our Future?*". Sir Derek's conclusion was that the NHS had achieved an overall level of progress somewhere between his original "slow uptake" and "steady progress"[17].

In his original Review Sir Derek stated that the NHS would need real terms expenditure growth of 4.9% per annum from 2008 if the NHS was on the "steady progress" trajectory by that date.

However, in the Budget 2007[18] the Chancellor capped overall real terms public expenditure growth at 2% and awarded the NHS (in England) an annual real terms budget increase of 4%. Several commentators including John Appleby, Chief Economist of the King's Fund, analysed the underlying growth rate in the NHS budget (net of virement of capital expenditure) as closer to 3.2%[19].

---

[14] http://www.bupa.co.uk/about/html/pr/health_finance_project.html
[15] http://www.kingsfund.org.uk/publications/kings_fund_publications/our_future.html
[16] http://www.hm-treasury.gov.uk/Consultations_and_legislation/wanless/consult_wanless_final.cfm
[17] Re input costs "between slow uptake and steady progress", Re resources (staff, premises and equipment "closer to the steady progress scenario", Re outputs "between slow uptake and steady progress", Re outcomes " A long way short of the fully engaged scenario and on a path between slow uptake and steady progress", Re productivity "closer to the slow uptake scenario."
[18] http://www.hm-treasury.gov.uk/budget/budget_07/bud_bud07_index.cfm
[19] http://www.guardian.co.uk/commentisfree/2007/oct/09/reflectingopinionsurveyswhi

Options for financing reform

Bupa identifies at least five options to improve the financing of the NHS in England and the health system of England overall.

These are:

1. **Improve NHS productivity;**
2. **Improve the effectiveness and efficiency of NHS Commissioning;**
3. **Increasing the scope of NHS "co-payments;**
4. **Introducing "top-ups" to NHS entitlements;**
5. **Strengthening positive and negative incentives for demand for "duplicative" V/PMI.**

There is already a considerable policy focus in DH/NHS policy making on the need to improve NHS productivity and the means to achieve this[20]. In 2006 ONS estimated that annual NHS productivity growth between 1999 and 2004, if adjusted for quality improvement had been between -0.5% and +0.2%. In the Budget 2007 HM Treasury set target that the NHS will achieve a 2% annual increase in (non QA adjusted) productivity every year between 2008 and 2011.

Similarly over the past few years there has been an increase focus on improving the effectiveness and efficiency of NHS Commissioning. In December 2007 DH launched its World Class Commissioning initiative[21]. In March 2008 Secretary of State Alan Johnson confirmed the "Framework for External Commissioning Support" as a nation wide policy initiate to provide private sector support to NHS Commissioners[22].

The next section of this paper focuses on the scope to increase NHS co-payments and the outline economic case for introducing "top-ups" to NHS entitlements.

"NHS co-payments"

The Bupa Mind the Gap project examined a number of options for increasing the scope of NHS co-payments. The Project Team concluded that the only co-payment options that might feasibly raise a significant sum of additional money for the NHS are: a reduction in the present exemptions from GP prescription charges. In 2005 87% of

---

[20] http://www.health.org.uk/publications/research_reports/value_for_money_1.html

[21] http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm

[22] http://www.dh.gov.uk/en/News/Speeches/Speecheslist/DH_083369

prescriptions written were exempt from charges. The Project Team calculated that removing all exemptions might raise up to £6bn per annum. Setting GP prescription charges at the same level as Germany (the highest in the EU at present) might raise £3.8bn per annum. Similarly the Project Team calculated that by 2015 a new £10 charge per GP attendance might also raise an additional £2.5bn per annum[23].

From a theoretical perspective the economic case for "co-payments" is sound but not as strong as that for "top ups." The principal arguments for co-payments (at the point of use) are: that they can reduce "Moral Hazard" – i.e. "a change of behaviour in the presence of insurance" by respectively patients (Type 1) or suppliers/providers (Type 2) (largely doctors) and that they can raise significant sums towards the overall cost of services.

The potential disadvantages of co-payments are: That they may discourage poor people from accessing NHS services they need on a timely basis and that the charge is levied at a moment of economic vulnerability; i.e. when the patient is sick.

"Complementary health insurance" (i.e. insurance against co-payments) can address access concerns and reduce the risk of impoverishment, though if incorrectly designed it can re-introduce the "moral hazard" that co-payments are partly designed to ameliorate.

"Topping up" NHS entitlements

It is important to distinguish arguments from economic theory and arguments supported by evidence.

In theory, a "supplementary" role for "top up" funding should improve macro-economic efficiency and market efficiency. It should also be sustainable and manageable. The establishment of a basket of NHS core services at the same time would be a logical and desirable development which should also improve horizontal equity.

If a solid market in "supplementary" health insurance were to develop, "top ups" could also optimise the allocative efficiency of that spending component. The presence of "premium subsidies," for disadvantaged groups, paid by central or local Government, could protect or even improve vertical equity.

From a commercial perspective, one would expect, <u>in theory</u>, a resulting market in "supplementary" health insurance to be large and of high "value" to customers.

[23] Bupa Mind the Gap Project, unpublished materials

It is impossible to generalise whether a resulting "supplementary" health insurance market would be profitable. The factors/risks that would, cumulatively, influence that include: degree and nature of regulation, market structure, degree of risk sharing and external subsidies and liabilities[24] [25]

Robust evidence in support of most of this analysis is incomplete. The best summaries of the existing evidence base are perhaps to be found in:

OECD (2004) Private Health Insurance in OECD Countries: Policy Brief[26]
OECD (2004) Private Health Insurance in OECD Countries[27]
Health Financing Revisited (2006) The World Bank[28]
Private Voluntary Private Health in Development: Friend or Foe (2006) The World Bank[29]

A key limiting factor is that there is no country that has an exactly identical institutional structure to the one that would obtain in England if we were to move additional financing onto a supplementary basis. The closest parallels are probably with The Netherlands and Israel – but in these countries health insurers provide both state-mandated and controlled (NHS equivalent) primary health insurances and voluntary supplementary health insurances and their published P&L accounts cover both lines of business; and we do not have an England/UK specific economic study of "willingness to pay" for out of pocket "top ups" and/or "supplementary" health insurance.

"Top ups"; associated policy issues

If the Review or Consultation concludes with a recommendation advocating the use "top ups" in the NHS (on a narrow or wider basis) Bupa would wish to:

- **Highlight the advantages of "insured top ups" (i.e. supplementary health insurance) over "out of pocket top ups" on the grounds of financial protection, social inclusiveness and clinical effectiveness;**

- **Highlight the disadvantages of "state owned and managed" voluntary health insurance organisations;**

[24] http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf (see Table A.3.1 page 115)
[25] Bassett M. (2007) Presentation to Harvard International Development Conference 2007, Kennedy School of Government, Cambridge MA (.ppt available from author)
[26] http://www.oecd.org/dataoecd/42/6/33820355.pdf
[27] http://www.oecd.org/document/10/0,3343,en_2649_37407_33913226_1_1_1_1,00.html
[28] http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf See page 103ff and Chapters 7, 8 and 9.
[29] http://www.ifc.org/ifcext/che.nsf/AttachmentsByTitle/VHIBook/$FILE/VHI+Book.pdf See Appendix page 335ff, particularly page 366ff

- **Highlight the advantages of a clear statement of NHS entitlements, through the establishment of either positive or negative entitlement lists.**

Bupa thinks that the use of "supplementary health insurance" to enable people to insure against the need for NHS "top ups" would: substantially reduce the risk of financial impoverishment (through the mechanism of risk pooling); substantially increase the social inclusiveness of "top ups" through the combined effects of pre-payment and risk pooling; and improve the clinical effectiveness of "top up" expenditure because of the presence of an effective "commissioning" capability (both "purchasing" and "performance management") in specialist health insurance organisations like Bupa.

Bupa thinks that the performance of "state owned and managed" health insurance organisations (in an "additional" financing role) has been disappointing. Bupa thinks that such organisations have not demonstrated the commercial agility or customer focus of other health insurance organisations. This may have been caused in part by the failure of at least one Government to establish their "state owned" health insurance organisation on a sound financial basis with standard solvency margins. Such solvency margins protect customers from year by year variations in the burden of disease and also help "smooth" the costs of the introduction of new technologies.

Bupa thinks that, building on the Secretary of State's recent announcement re the status of NHS decisions, a clear and comprehensive statement of NHS entitlements (through the development of either a "positive" or a "negative" list) at both national and local levels would: not only help insurers develop "supplementary health insurance" products, but, also as importantly, improve horizontal equity within the NHS.

Financing Reform; relevant International experience

The Netherlands – "Top ups" through "supplementary health insurance"

From a policy perspective it might be valuable to examine evidence on the performance and impact of the "supplementary" health insurance market in The Netherlands following their major reforms[30] (The Health Insurance Act – Zorgverzekeringswet – ZVW) implemented in January 2006 which, amongst other things, made it compulsory for all Dutch citizens and residents to have a state-mandated (NHS equivalent) primary/basic health insurance scheme for the first time – all

[30] http://www.minvws.nl/en/folders/z/2006/the-new-health-insurance-system-in-three-languages.asp

mediated through a mixed market of for profit and not for profit private health insurers. These insurers are also permitted to market supplementary health insurance products.

At present the main data available post 2006 is from the website of the Dutch health insurance regulator (DNB)[31]. This gives information about balance sheets, P&L (primary/basic insurance only), solvency and lives covered (basic and supplementary).

The Netherlands is also a pilot country for the system of National Health Accounts set up by OECD but now jointly administered by WHO. See http://www.who.int/nha/country/nld/en/. At present only data for 2006 is available but this should be a source of valuable information in future years.

Headlines from the available evidence are:

Very high proportion of Dutch lives covered by supplementary insurance (over 15 million lives, 90%+ of population by Q1 2008)

As of 2006 premium income from supplementary insurance was Euros 3.4 bn, average premium income approximately Euros 227, representing about 11% of combined primary/basic and supplementary insurance premium income.

The Dutch health insurance market has consolidated very rapidly since 2006. As of June 2007 94% of the market was controlled by five insurers: Achmea 29%; UVIT 26%; CZ 20%; Menzis 13%; Multizorg 6%.

Overall the Dutch insurers made losses on the primary/basic insurance in 2006 and 2007 (Euros 563mn and 401 mn respectively on basic technical accounts, Euros 186mn and 140mn pre-tax results after adjustment) But, solvency levels of Dutch health insurers remain strong (Q1 2008) Euros 5.5Bn compared to required margin of Euros 2.7Bn.

Overall the value of the voluntary PMI market declined from Euros 16.4bn to Euros 8.9bn between 2005 and 2006 but this reflects about 40% of the Dutch population being required to purchase a state mandated basic health insurance for the first time in 2006 (and therefore a total change in role of PMI from primary (40% of population) and supplementary (60% of population max) to supplementary (100% of population max) and duplicative..

[31] http://www.statistics.dnb.nl/index.cgi?lang=uk&todo=Verzekeraars

Israel - – "Top ups" through "supplementary health insurance"

In 1995 a National Health Insurance Law (NHIL) was enacted in Israel that, similar to The Netherlands, mandated a primary/basic health insurance provided by four competing private health insurers. These insurers are also licensed to provide supplementary health insurance. An article has recently been published by Shmueli et al[32] summarising trends and issues in the Israeli health system between 1995 and 2005. Headlines of the article (and other sources) are:

Increases in the NHIL basic insurance budget have not kept pace with demographic, input price and technology pressures , leading to an estimated 34.7% fall in "real" value i.e. budget has increased from 12.2 Bn NIS to 22.7 Bn NIS compared with "fully indexed" expenditure of 34.8 Bn NIS between 1995 and 2005 (Note: This analysis assumes/implies no productivity gains in the Israeli health systems through the period analysed)

Private expenditure rose from 25% to 30.7% of total health expenditure between 1997 and 2003, of which the share of supplementary health insurance rose from 11% to 22%.

The proportion of population/sick fund members with supplementary health insurance rose from 37% in 1995 to 51% in 1999[33] to 72% in 2006[34]

Profitability of supplementary health insurances under reported to secure basic package efficiency bonuses

Progressivity of Israeli national health expenditure improved between 1997 and 2003 (Kakwani Index -0.055 to -0.049; Suits Index -0.051 to -0.043)

Gross reports increasing satisfaction with sick funds between 1995 and 1997 but Shmueli reports decreasing satisfaction between 1998 and 2005 albeit from a high base (91% to 81% satisfied).

"Top ups" – other evidence

Another potentially valuable source of summary evidence about the characteristics of supplementary health insurance is the 2007 PhD thesis of Dr Francesco Paolucci entitled "The design of basic and supplementary health care financing schemes: Implications for

[32] Shmueli A, et al., Financing the package of services during the first decade of the national health insurance law in Israel: Trends and issues, Health Policy (2008), doi:10.1016/j.healthpol.2008.02.008

[33] Gross R., Implementing Health Care Reform in Israel: Organisation Response to Perceived Incentives, Journal of Health Politics, Policy and Law 2003 28(4)

[34] Schwartz-Ilan D et al., The History Of The National Health Insurance Law In Israel; summary of PhD submission (2008?)

efficiency and affordability"[35]. A table from the thesis summarising the characteristics of social health insurance in five countries is presented in Annex 2.

Australia – A larger role for "duplicative" voluntary health insurance with strong positive and negative incentives to participate

Private health insurance plays a prominent role in the Australian healthcare system and health policy debates. In 2003 "duplicative" "private hospital insurance" (sic) covered 44% of the population and represented 7.1% of total health expenditure. This level of coverage was achieved by a mix of strong public policy positive and negative incentives; namely a Government rebate of 30% on PMI premiums, a tax penalty for high income individuals without PMI cover and further incentives (re permitted premium setting) to encourage individuals to take out PMI by the age of 30.

The impact, equity effects and sustainability of these incentives was analysed by the OECD in a case study in 2003[36]. Trends in subsequent income, expenditure and solvency levels of PMI in Australia can be found in Healthcare Expenditure Australia 2005-06[37]. See Private Health Insurance Administration Council (of Australia) Statistics for trends in coverage 1998 to 2008[38]. Over the decade hospital insurance coverage has risen from 31% to 45%.

Conclusion

New technology is an important driver of the need to bring more money into the health system in England.

Various options exist to increase total health expenditure in England. They many need to be used in combination.

The solution to the emerging NHS "funding gap" may be found in a mix of NHS productivity gains and co-payments, "top-ups" (insured and out of pocket) and possibly through stronger incentives for "duplicative" PMI (as in Australia). None of these measures rules out a continuing, and indeed increasing role, for taxation as the principal sources of NHS funding.

If Government decides to allow a limited or wider role for "top ups" there are clear public policy advantages in allowing, and indeed

---

35 http://publishing.eur.nl/ir/repub/asset/10758/071206_Paolucci,%20Francesco%20PhD%20thesis.pdf
36 http://www.oecd.org/dataoecd/5/54/22364106.pdf
37 http://www.aihw.gov.au/publications/hwe/hea05-06/hea05-06.pdf
38 http://www.phiac.gov.au/statistics/membershipcoverage/graphs/aust.htm

encouraging, a competitive "supplementary health insurance" market to provide financial protection and decision support to the public.

Recommendation

Bupa supports the British Medical Association's call for a Royal Commission to examine these matters. They are of vital importance to the future of the NHS and overall health system in England. The issues are complex and contested, both in themselves and in their interactions and impact on system goals. The international evidence on these matters is of partial but not complete relevance to the particular circumstances of England.

[redacted]
Head of Public Policy
Bupa

21 August 2008

Contact details

[redacted]
Head of Public Policy
Bupa

Email: [redacted]@bupa.com
Tel: +44 (0) 20 7656 [redacted]

[redacted]
Managing Director
UK Membership
Bupa

Email: [redacted]@bupa.com
Tel: +44 (0) 1784 [redacted]

Mailing address:

Bupa House
15-19 Bloomsbury Way
London
WC1A 2BA

Annex A

Questions from Professor Richards to the ABI [redacted]

1. What are the attendees' views on allowing top-up payments in the NHS?

Bupa thinks that "top-up" payments could be an important [redacted] mechanism for bringing additional money into the English health system in the coming decade. As highlighted in the Mind the Gap Report in 2006 Bupa thinks that the NHS faces a significant and avoidable funding "gap" over the coming decade.

Bupa thinks that the issue and potential benefits of "top ups" are wider and more extensive than just "high cost cancer drugs" but that these might be a pragmatic and material set of interventions with which to explore the dynamics of a supplementary role of additional financing.

Bupa thinks that NHS "co-payments" and NHS productivity gains are other potentially important sources of "additional" funding to the English health system/NHS in the coming decade but that these alone will not be sufficient to close the potential funding gap.

Bupa thinks that there is a significant and positive economic rationale for "top ups" which it regards as a potentially large source of additional financing. In theory, a "supplementary" role for "additional" financing should improve macro-economic efficiency and market efficiency. The concomitant establishment of a basket of NHS core services might also improve horizontal equity.

In Israel the presence of supplementary insurance improved also improved overall vertical equity in that system between 1997 and 2003[39] (Kakwani index -0.055 to -0.049).

The presence of Government paid "premium subsidies" for supplementary health insurance for targeted disadvantaged groups could protect or even further improve vertical equity, without exposing the Government to unlimited liabilities.

If a strong market in "supplementary" health insurance were to develop, "top ups" could also improve allocative efficiency - through the strengthening of "active commissioning"; making sure that additional money is spent effectively and efficiently.

[39] Shmueli A, et al., Financing the package of services during the first decade of the national health insurance law in Israel: Trends and issues, Health Policy (2008), doi:10.1016/j.healthpol.2008.02.008

2. How do attendees think the industry would behave in an NHS that allowed top-ups for very expensive drugs?

The industry would wish to develop "supplementary" health insurance products.

These have three notable public policy advantages:

1. They would improve financial protection for citizens wishing to "top up" their NHS entitlements (and reduce the risk of impoverishment, especially for the less well off);

2. They should make supplementary financing more socially inclusive – making it affordable to a wider range of people than otherwise possible and therefore inherently more popular; and

3. They should improve technical quality and efficiency of additional services by the use of expert "commissioning"

To secure these advantages it is vital that the Government take an appropriate regulatory stance. In particular Government should:

1. Avoid establishing any "pseudo" public agency health insurers who are established without full solvency requirements being imposed on them;

2. Focus on "fiduciary" rather than "material" regulation of insurers; and

3. Take care not to destroy the solvency base of existing health insurers through the period of transition from a largely duplicative to a largely supplementary role.

Without these actions the Government risks undermining the existing "duplicative" health insurance market, without creating a robust alternative, which could have significant negative unintended medium term consequences for the NHS.

3. If you were setting up an insurance policy scheme for people who might want to top-up their treatment when they got ill, what sort of restrictions would you place on the insurance policies? How would that differ from a standard cancer insurance policy scheme, if at all?

Bupa would want no restrictions re pricing or product scope placed on supplementary insurance policies themselves.

Any restrictions placed on the role of supplementary funding should be placed on all forms of supplementary funding including "out of pocket" supplementary payments. Bupa would want any such restrictions kept to a minimum – such restrictions are principally justifiable when they protect access to inherently in-elastic goods (where supply cannot reasonably and readily respond to increasing demand – e.g. organ transplants).

Bupa would argue strongly for a largely or completely "risk rated" approach to the pricing of out of pocket "top ups" and also to the pricing of related supplementary health insurance products. Bupa supports a strongly redistributive role for NHS financing (which is mandatory). Seeking to impose even modest re-distribution goals on voluntary supplementary financing/insurance depresses and skews demand (increasing the risk of adverse selection).

4. How would any top ups system impact on existing insurance policies?

From a commercial perspective, one would expect a resulting market in "supplementary" health financing (insured and out of pocket) to be material, manageable, sustainable and broad.

Experience from the Netherlands and Israel suggests that large numbers of citizens (90%+[40] and 70%+[41]) respectively take up "supplementary" health insurance schemes quite rapidly when permitted to do so, and when regulations and incentives are neutral or positive. Experience from these countries also suggests that demand for "duplicative" health insurances decreases proportionately to development of effective "supplementary" products.

[40] http://www.statistics.dnb.nl/index.cgi?lang=uk&todo=Verzekeraar
[41] Schwartz-Ilan D et al., The History Of The National Health Insurance Law In Israel; summary of PhD submission (2008?)

Annex B

Specific issues and questions from the Conservative consultation

1. **Do you agree that whilst receiving NHS care, no-one should be charged for the treatment they receive?**

The most recent figures available to Bupa suggest that the NHS in England receives over £1 billion a year from charges to NHS patients, principally form GP prescription charges and NHS dental charges. This figure excludes over £150 million received from NHS charged patients who do not qualify for "largely free" NHS services and over £400 million from private patients in NHS Trusts and Foundation Trusts.

2. **Do you agree that NHS resources should be used solely for NHS patients and that there should be no cross-subsidy from NHS resources to private patients treated in the NHS?**

Bupa agrees with the proposition in the Consultation that "patients access private treatment this should not affect their NHS entitlements, either positively or negatively".

3. **Do you believe that it should continue to be required, under NHS guidance, that no-one can simultaneously be an NHS patient and a privately-funded patient in relation to the same treatment?**

Yes, but this should not preclude the possibility of a policy of allowing patients to "top up" their NHS entitlements, whilst remaining NHS funded patients.

4. **If you support 4. above, do you believe it should apply "within the same episode of care" or "in relation to the same course of treatment" or "a spell of care"? And what are your views on how these should be defined?**

Bupa believes that patients should be allowed to "top up" or supplement episodes of NHS treatment. The NHS should also guarantee to provide a sound quality of service to entitled patients unwilling or unable to supplement their NHS entitlement.

5. **If you support 4. above do you support proposals, through value-based pricing of new medicines, to ensure that the NHS should not exclude from possible use, medicines which are clinically effective as a part of that treatment, subject to**

continuing comparisons between treatments for relative clinical effectiveness?

Bupa thinks that value based pricing is one possible mechanism for purchasing drugs on behalf of patients to rely solely on NHS funds and for patients who are able to supplement their NHS funding.

6. **Do you agree that if patients access private care in relation to treatments not provided by the NHS, this should not affect their entitlement to NHS services; and their access to NHS treatment should be based on clinical priority?**

Yes; and yes.

7. **Should GPs be able to offer private treatment to their NHS patients, where the treatment or service is outside the scope of NHS coverage?**

Yes, so long as there are safeguards to avoid perverse incentives to GP remuneration.