Ubezpieczenia zdrowotne w Wielkiej Brytaniii – wybrane zagadnienia prawne
(Health insurance in Great Britain – selected legal issues)

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I. INTRODUCTION

Growing interest in private health insurance with its potential to relieve pressure on public budgets and enhance choice, raises questions about the best way to create or expand and shape markets to achieve specific aims. There are no easy answers to those questions, but one thing seems to be clear: if policy makers intend to use private health insurance to achieve a particular objective, they must be able to direct market behavior appropriately. Otherwise, the type of market most likely to emerge is the one that simply provides access to acute care in the private sector for wealthier people. However, on new markets like in Poland, lack of regulatory capacity often presents a barrier to effective policy direction [1]. In the established markets of the EU, many of the constraints facing policy makers come from single market legislation [2]. Here we are going to use the case of the Third Non-Life Assurance Directive to illustrate some of these constraints and to show how they can undermine the achievement of health policy goals such as financial protections, equality of access to health care and quality of efficiency in the organization, and the way health care is provided. Another important issue is how to define Voluntary Health Insurance; and what should be included in it? Should it be dependent on, or independent from the current system? What level of health care provision should it offer, should it be accessible to all citizens or exclusively only to those with high income? There is a lot of problems which need to be solved. Professional such as doctors and nurses are governed by their licensing bodies whether they practice in the NHS or in the private sector [3]. For example, the Commission for Health Improvement’s jurisdiction is limited to the NHS. So is the health Service commissioner unless the private provider is treating an NHS patient. First the authors briefly examine the state of private health care in UK and secondly, as well as examine existing regulation and suggest what might be established instead [4]. Another problem is defining the boundaries of independent and private healthcare. Issues that require regulations arise from situation regarding private beds in the NHS. There are a number of different arrangements for private in-patient health care within the hospital Trust of the NHS [5]. The paper is also going to present a

Streszczenie – W pracy przedstawiono zmiany zachodzące na rynku ubezpieczeń zdrowotnych w Wielkiej Brytании powstające pod wpływem wybranych europejskich uregulowań prawnych.


Abstract – The paper presents changes which United Kingdom health care market undergo under the influence of selected European Union legal regulation. The analysis covers The Third Non-Life Assurance Directive 92/96 (OJ L 92.360.1), regulations of British National Health Service (NHS) functioning, as well as regulations of voluntary health insurances. The cooperation between NHS and private insures is particularly scrutinized.

Key words - voluntary health insurance, British health care market, The Third Non-Life Assurance Directive.

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brief over-view of the institutional structure and main characteristics of the UK health care sector. Some data on the impact of public sector health service quality on private insurance decision will also be presented. Section third is going to present a model of public and private cooperation regarding health care, based on British experience. The UK government wishes to see the NHS make the use of the private sector in two main areas [6]. First, it wishes to see an extension of the Private Finance Initiative (PFI) whereby private sector finance and management expertise are drawn upon in order to finance, build, operate and manage NHS capital projects, particularly new hospitals. The government intends that the share will grow and, increasingly, be extended to investment in primary care premises. The government claims that the PFI enables capital projects to be undertaken that would not be possible if there was total reliance on public funding, and that the involvement of the private sector increases efficiency in terms of work being completed on time and to cost. Second, the government wishes to see a growth in public-private partnerships whereby the private sector provides services funded through the NHS. It was claimed that no organizational or institutional barriers should stand in the way of providing better services for patients, and that the private sector has a role to play in achieving this aim. In the search for improvement of health systems, many areas have been explored extensively from a comparative perspective, particularly as improved data on health outcomes within different European countries has opened up opportunities for comparative analysis. However, other areas are still conceptualized primarily within national boundaries, and significant areas remain relatively unexplored from the comparative European perspective. Supplementary private insurance covers the same service as offered by statutory insurance. However, it does give rise to concern if provides faster access and if it distorts public resource allocation. The availability of supplementary private coverage can create perverse incentives for insurers and providers, leading to inequalities of access to health care for people covered by statutory insurance, boundaries between public and private provision need to be clearly defined. One of economically successful ways to do that is public–private partnership (PPP). Public–private partnerships (PPPs) are fast becoming the dominant method of tackling large, complicated and expensive public health problems on the British market. In British experience, there is no reason why a PPP should not be effective, provided it is established on the premise of a ‘partnership’ between public and private sector, which means–NHS, private capital and private insurers. PPPs are seen as a panacea for resource-constrained governments that can no longer provide public services solely from their national budget. This kind of relationship, based on mutual economic advantage and greatly improving the quality and accessibility of public health care system, can be easily implemented anywhere.

II. METHOD

The research is based on scientific literature analysis. In addition to academic literature identified through search of main electronic databases, systematic Internet searches have also been carried out and extensive use of grey literature, including industry and government reports have been made. The research has been done at individual level, using attitudinal data from a series of large scale British surveys. It should also be pointed out that that study is constrained by lack of data availability in some areas.

Preliminary research results

Changes in UE regulation, culminating in the 1994 third non-life insurance directive, have led to creation of a single market for Voluntary Health Insurance Board (VHI) in the EU. In attempt to increase competition and consumer choice, this directive abolished national control on VHI premium prices and policy conditions. Although EU member states may invoke the “general good” to justify national regulation under certain conditions, guidelines regarding the general good are vague and open to interpretation. What that means in practice is that the market for VHI has been liberalized and deregulated to the extent that governments can intervene only where VHI acts as a substitute for statutory health care, which is not the case of UK.

VHI may increase access to health care for those who are able to purchase an adequate and affordable level of private cover. At the same time it is likely to present barriers to access, particularly for older people, people of poor health and people with low incomes. Access to health care within VHI markets is very much dependent on the regulatory framework, in place and the way in which insurers operate. It may be affected by how premiums are rated, whether they are combined with cost sharing, the nature of policy conditions, the existence of tax subsidies to encourage taking up or cross-subsidies to the statutory health care system and the characteristics of those who purchase it. It may also be affected by whether or not benefits are provided in cash rather than in kind, the way in which providers are paid and the extent to which policies is purchased by groups – usually employers – rather than individuals. Due to information failures in VHI markets, insurers need to find ways of assessing an individual’s risk of ill health in order to price premiums on an actuarily fair basis.

Insurers in European VHI markets are generally subject to a low level of regulation. In most non-substitutive VHI markets regulation is exclusively concerned with providing that insurers remain solvent rather than concentrating on issues of consumer protection. Ireland is the only country in which insurers are required to offer open enrolment, community-rated premiums and lifetime cover and are subject to a risk equalization scheme. Elsewhere insurers are permitted to eject applications for cover, exclude or charge higher premiums for pre-existing conditions, rate premiums according to risk, provide non
standardized benefit packages and offer annual contracts. Benefits are usually provided in cash – that is, insurers reimburse individuals for their health care costs. In loosely regulated VHI markets, older people, people in poor health and people with low incomes are likely to find it difficult to obtain affordable coverage. People in poor health may not be able to purchase any cover. Health care in the United Kingdom (including England, Scotland, Northern Ireland, and Wales) is coordinated by the National Health Service, which was set up in 1948 “to provide health care for all citizens, based on need, not the ability to pay” [7]. The NHS is run with taxpayer funds and is managed by the Department of Health. The Department of Health “sets overall health policy in England, is the headquarters for the NHS, and is responsible for putting policy into practice [8]. The NHS recently delegated most patient care to organizations called Primary Care Trusts, or PCTs. PCTs receive 75% of the NHS budget and are locally based; “they control their own budgets and own their own assets” [9].” They coordinate care between providers and local agencies, and ensure that “all other health services are provided, including hospitals, dentists, mental health service, NHS Walk-In Centres, NHS Direct, patient transport, population screening, pharmacies and opticians [10].” Some UK residents opt for private insurance rather than coverage under the NHS. According to Dr. Trisha McNair in the BBC, more than 10% of the population in the UK is now covered by some form of private health insurance; she believes that most have private medical insurance as a work-related benefit, while the number of people paying for it themselves has recently dropped, probably due to higher prices [11]. According to the Independent Health care Association, which represents private health care providers and insurers in Great Britain, the independent health sector accounts for 25% of all UK health and social care spending. In 2001 an agreement was reached between the Institute for Healthcare Advancement (IHA) and the NHS, under which NHS patients were eligible to receive treatment at independent medical facilities. Individuals can also take out additional, private health insurance to cover expenses not covered by NHS, while still utilizing some NHS services. Researchers at the Organization for Economic Cooperation and Development have suggested that private insurance in the United Kingdom largely replicates the care offered by the state, and that consumers primarily choose private coverage to gain access to more providers and more timely delivery of care [12]. According to the NHS, “Every UK citizen has a right to be registered with a local GP (general practitioner) [13].” People seeking asylum and refugees are subject to a slightly different process; according to the Department of Health, “Like other UK residents, persons with an outstanding application for refuge in the UK, are entitled to use NHS services without charge.” [14]. Basic services – such as a visit to a primary care physician, a specialist, in-patient care or x-ray and pathology services – are free for persons eligible for health care under the National Health Service [15]. Other costs of health care – such as prescriptions, dental treatment, optical services, travel for treatment, wigs or fabric supports – may be paid by the patient, or they may be subsidized by the NHS depending on a number of factors. According to the NHS booklet HC11, “Help with Health Costs,” the several categories of people (children under 18, pregnant women, pensioners, etc) are eligible for some forms of assistance with specific expenses, including prescription drugs and vision and dental care. The British health care system is experiencing serious problems with its funding, service, and staff that vary in severity across the region. A long-standing problem has been long times of waiting for care, particularly for elective services and procedures. In the United Kingdom in 1990, 41.2 percent of Britons reported waiting more than 12 weeks between seeing a specialist and receiving surgical care [16]. A NHS watchdog group reported that some PCTs lack essential senior staff, forcing “some practices to close their lists, while other areas suffer from a severe lack of district nurses. There are also long waiting lists for therapists, particularly physiotherapists” [17]. Another study found that for the past several years, waiting ranked as the first and second most critical failures of the NHS [18]. There are also allegations of declining quality of equipment and staff; another group, Audit Scotland, found that a quarter of all NHS equipment in Scotland has become dangerously outdated, while “only half of Scotland’s health trusts could demonstrate that staff had a proper understanding of the equipment[19].” Together these factors have contributed to serious dissatisfaction with the health care system. In the London Telegraph, Sheila Lawlor declared that the question was “who provides the healthcare and whether we get value for money. The answer, patently, is that we do not [20].” Those who can afford it may opt for private care: conservative shadow health secretary Liam Fox suggested that the number of people opting for private care rose by 29% in 2001 because of dissatisfaction with the NHS[21]. A recent poll stated that 35% of British citizens ranked health care the most important [22] national issue. A 1999 poll found that a slim majority of 55.7 percent were very or fairly satisfied with their health care system, while 42.3 percent were fairly or very dissatisfied with it [20].

An additional hot-button issue is the idea of “health tourism.” The Daily Mail in London alleged that “Migrant health tourists jump NHS queue (and we foot the bill)”. In June of 2003 the shadow health secretary Liam Fox claimed that the NHS was becoming “the health equivalent of Disneyland” as many people came from abroad to get free treatment”. One study suggested that such abuse costs up to 200 million pounds per year, although there is a shortage of the exact figures on the scope of the problem[15]. To get rid of this problem, the NHS released
new rules governing care; most controversial is the new requirement that “those seeking routine care will have to pay in advance if they cannot prove their NHS entitlement [17].” The government has introduced various efforts to improve the health care system, including performance targets that emphasize “safety, clinical cost effectiveness, governance, patient focus, accessible and responsive care, health care environment and amenities, and public health”[18]. Additionally, in 2001 the NHS began ranking Public Care Trusts with a star system, similar to that used with hotels. Those trusts that score highest in categories ranging from staff absence rates to the length of time a patient wait to see a GP are awarded three stars, while the worst receive none. The British Medical Association has pointed out that the system fails to consider the quality of patient care or survival rates[28]. In terms of cost containment, the NHS recently announced that hospitals would, for the first time, receive a standardized fee for 48 different types of treatments for NHS patients as part of an effort to standardize the cost of care and reduce costs. The British Medical Association, however, has protested that “some tariffs will be far lower than the real costs of providing care, putting undue pressure on hospitals to make cuts. The NHS is also experimenting with a system in which patients can receive treatment in other countries, provided that demand for that treatment far exceeds supply in Great Britain. The need for public-private partnerships arose against the backdrop of inadequacies on the part of the public sector to provide public good on their own, in an efficient and effective manner, owing to lack of resources and management issues. These considerations led to the evolution of a range of interface arrangements that brought together organizations with the mandate to offer public good on one hand, and those that could facilitate this goal though the provision of resources, technical expertise or outreach, on the other. It enlists the skills and expertise of the private sector in providing public services and facilities. It is not simply about the financing of capital investments, but about exploiting the full range of private sector management, commercial and creative skills. Private finance initiative (PFI) schemes involve creating partnerships between the public and private sectors. In the health sector, the NHS will continue to be responsible for providing high quality clinical care to patients. But, where capital investment is required, there a role for a private sector partner in the provision of facilities will be increasing. PFI is about building long term and mutually beneficial partnerships between public and private sector partners. Moreover, because the PFI partner's capital is at risk, they will have strong incentives to continue to perform well throughout the life of the contract. This is one of many possible ways, and so far profitable one, of solving the problem of using private insurers money to improve the service of NHS.

III. PIŚMIENNICTWO

[5] Concordat between government and Independent Health Association (IHA), was signed in October 2000. In it the government made a commitment towards planning the use of private and voluntary care providers, not only at a time of pressure but also on a more pro active longer term basis which could be reflected in Long Term Service Agreement.
[6] In 2000, the British Secretary of Health Alan Milburn claimed that no organizational or institutional barriers should stand in the way of providing better services for patients, and that the private sector has a role to play in achieving this aim. He wishes to see the NHS make greater use of the private sector. Source: Speech on the first session of Parliament; 16 October 2000.

[16] Lawlor S. Only competition will make the NHS treat patients better. Telegraph, 10 February 2004, http://www.opinion.telegraph.co.uk/


