فراخوان

ترجمه کتاب

پژوهشکده بیمه، به منظور کمک به گسترش دانش بیمه‌ای، ترجمه کتاب

Healthcare insurance products IF7

را در دستور کار خود قرار داده است. لذا از کلیه اساتید، پژوهشگران، صاحبنظران و کارشناسان دعوت می‌شود که در صورت تمایل به ترجمه کتاب مذکور، کاربرگ درخواست ترجمه پیوست را به همراه سوابق علمی و اجرایی خود و ترجمه صفحات ذکر شده با ذکر عنوان کتاب، حداکثر تا تاریخ ۱۴۰۵/۰۳/۲۰ به آدرس ایمیل nashr@irc.ac.ir ارسال فرمایند.

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ب- سابقه تألیف/ترجمه (حداقل ۳ عنوان از آثار خود را اعلام بفرمائید)

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ج- سابقه اجرایی

ردیف	محل خدمت	مدت زمان خدمت

B3 Private healthcare and the NHS

As the principal supplier of healthcare in the UK, developments in the NHS have had a significant influence on the *private healthcare* system that has grown up alongside it. Given that the NHS offers patients medical treatment or care that is largely free at the point of use, it is clear that the perceived differences between the service offered by the NHS and privately financed treatments are very important.

The principal differences that define the split between the public and private sectors are:

- the time spent waiting to be treated (waiting lists) and choice regarding when to be treated;
- the choice of facilities (often referred to as 'hotel facilities' to differentiate it from the actual medical treatment);
- the private sector allows choice of specialist, who is then likely to personally carry out all treatment (so the patient will not get passed on to a more junior doctor);
- the private sector may offer treatments using techniques or technology that may not be available through the NHS;
- certain private hospitals may not have intensive care back-up technology available; and
- most private hospitals have no accident and emergency (A&E) facilities.

In the exceptional circumstances from spring 2020, many people had to wait an uncertain period for private treatment too, although historically this is rare. Waiting lists remain a key driver for demand for private treatment and medical insurance.

An important benefit in choice of facilities is that patients in private hospitals usually have their own room or share with just one or a few other patients. Such wards tend to have fewer problems with healthcare-associated infections (HCAIs), such as the hospital superbugs MRSA (*methicillin resistant staphylococcus aureus*), MSSA (*methicillin sensitive staphylococcus aureus*) and C.diff (*clostridium difficile*). Older hospitals with large open wards can increase the risk of cross-infection, although numbers of HCAIs have fallen dramatically in recent years.

According to NHS England, before COVID-19 approximately 300,000 patients a year in England were affected by a healthcare-associated infection as a result of their care within the NHS. (Source: *www.england.nhs.uk/wp-content/uploads/2015/04/10-amr-lon-reducing-hcai.pdf.*) Corresponding figures for independent hospitals are not known, but the figure is likely to be substantially lower, albeit partly because of the nature of the treatments given. It is interesting to note that new NHS hospitals are being built with many more individual rooms and fewer (or no) traditional large wards. COVID-19 has influenced this process, although it is likely to be many years before having a single room as an NHS patient becomes the norm. Even then, the quality of the hotel side of hospital accommodation is generally likely to be higher in independent hospitals.

Differences between private health care and the NHS often arise due to the type of treatment that is required. Some treatments may be available in both an NHS and a private hospital, or may only be covered by medical insurance, or even need to be paid for privately. These include the following:

Emergencies	These will be sudden or unexpected illnesses or injuries that need immediate hospital attention at the accident and emergency department. This facility is usually provided under the NHS. Many medical insurance policies specifically exclude this type of treatment, which is not widely available privately.
Complementary or 'alternative' medicine	This includes therapies outside of 'traditional' medicine (for example, acupuncture, osteopathy and homeopathy). Certain treatments are available under the NHS and some may be funded by some private medical insurers.
Cosmetic surgery	This is non-essential surgery that will change a person's appearance (for example, a breast implant or face lift). This will tend to have to be paid for privately and is usually excluded under medical insurance policies unless it is required as a direct consequence of a condition or treatment (such as breast reconstruction after a mastectomy).

Improvement in the service levels and quality delivered by the NHS might be expected to reduce the demand for private medical treatments and, therefore, for insurance going forward. However, because of the difficulties of statistical interpretation and the inevitable party-political biases in discussions, it is hard to know whether improvements in NHS

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services will result in many people switching away from private healthcare. However, in the short-term, the slow decline of individual PMI may continue (although that is often driven more by price and sustainability concerns).

Recently, there has tended to be a widening gap between the public's perception of what it wants from its health service, and what the NHS is able to provide. Consequently, this has helped to maintain the demand for many forms of private medical treatments.

Question 1.2
Why is a PMI insurer unlikely to cover cosmetic surgery?

B3A The NHS and the private sector

In most countries the public and private healthcare sectors work alongside or together with one another, and the UK is no exception. This is evidenced by the fact that although the majority of treatments under PMI policies are carried out in private hospitals, the NHS does sell its services to private purchasers, allowing them to make use of some NHS facilities. The NHS also uses the private hospital sector for some general and acute work, especially since the introduction of dedicated independent sector treatment centres that reduce waiting lists in key areas and in spring 2020 effectively took over the UK's independent hospitals on a temporary basis to help it cope with COVID-19.

The Department of Health and Social Care (DHSC) has reported that in 2018/19 around £9.2bn was spent on buying healthcare from independent sector providers by the NHS in England, or around 7.3% of all health spending. By 2022/23, this had increased to around £11.5m, or 6.5% of all NHS expenditure, the House of Commons Library reported in July 2024. (Source: *researchbriefings.files.parliament.uk/documents/SN00724/SN00724.pdf*).

For the future, independent sector treatment centres (also known as surgicentres or specialist hospitals), NHS patients choosing private instead of NHS hospitals and the fallout from current and future coronavirus outbreaks, could see this figure increase further, although the 2024 change of government could see further changes.

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C Healthcare insurance market

C1 Private healthcare sector

The private healthcare sector provides surgery and other medical treatment for patients who are willing and able to pay either directly (out of their own pocket), or indirectly (through insurance). The market is highly specialised, with around 25 types of operations accounting for over 70% of expenditure. Many of the medical conditions that give rise to these procedures are not life-threatening. Nevertheless, they do threaten the quality of life of the people concerned, who would otherwise have to wait on NHS lists for their operations. The main advantages to be gained by people buying private medical treatment are perceived to include:

- less time waiting for operations related to non-urgent conditions (for example, varicose veins, hip replacements, hernia repairs and hysterectomies), where capacity has been rising in the private sector for some years;
- a choice of the consultant who will personally perform the operation and/or supervise the course of treatment (rather than being treated by a doctor who is managed by a consultant);
- a choice of admission dates;
- a choice of hospitals;
- a private room with more comfortable facilities and perhaps an en suite bathroom, broadband, a telephone, a television and better food. In some cases, patients can carry on working too and they may feel more secure in a private room (e.g. less risk of personal items going missing);
- cleaner hospitals — the way in which independent hospitals are managed, including a much greater proportion of individual rooms means there is much less incidence of HCAIs; and
- in some cases, treatments may be available which are not offered through the NHS.

An independent hospital may not deliver all these perceived advantages, but nevertheless most people expect to gain a number of benefits if they use an independent hospital.

Current figures are not available but before the pandemic, in 2018, independent acute medical hospitals and clinics generated a combined revenue of £11bn. NHS private hospitals' private patient income was estimated at £620m in 2016/17 (figures from LaingBuisson's *Healthcare Market Review*, 15th edition, 2018).

Despite the benefits of private medical care, when dealing with emergencies (for example, in the cases of heart attacks, strokes and traumatic accidents) the NHS is still the primary source of assistance, even for people with private health insurance cover. This is because few private hospitals cater for emergency treatment.

In addition to emergency treatment, PMI policies do not routinely include the costs incurred as a result of:

- normal pregnancy and childbirth;
- chronic illnesses such as asthma or diabetes;
- long-term physical disability or psychiatric illness;
- complementary or 'alternative' therapies (although some policies now offer this facility); and
- cosmetic surgery.

Consider this...
Roughly what proportion of the population has a privately funded operation each year?

C2 Provident insurers

Provident associations were introduced during the 1920s and 1930s. They:

- are non-profit-making organisations for the provision of medical insurance;
- have no shareholders and so pay no dividends;
- count all their operating surpluses as part of their reserves and so are not subject to corporation tax; and
- are equally unable to attract tax relief for any losses from their activities.

Originally, these associations were regionally based and closely affiliated with local hospitals. They provided insurance to cover the costs of hospital treatment.

The start of the NHS forced a major reorganisation and rationalisation of provident associations. The NHS provided State-funded healthcare on a national level, which required provident associations to join forces and forego their regional bias in favour of nationwide coverage. Today's remaining provident associations were created through the merging of smaller, regionally based provident associations during the late 1940s and early 1950s.

The increase in demand for PMI since the 1950s has been met by specialist healthcare provident associations: the main companies being Bupa, AXA Health (originally PPP – Private Patients' Plan), WPA and Simplyhealth (previously BCWA). However, AXA Health (then called PPP Healthcare) ceased to be a provident association in 1996 when it converted into a commercial insurance company. It was subsequently sold to another **commercial insurer**, Guardian Royal Exchange (GRE) at the end of 1997. In its turn, French insurance group, AXA, acquired GRE in 1999. In 2005, BCWA became part of the Simplyhealth group (best known for its HSA/Simplyhealth health cash plans) and in 2012 the group took over the PMI book of Groupama Healthcare too. In 2015, Simplyhealth sold its PMI and related businesses to AXA PPP healthcare (now AXA Health).

The largest provident association, Bupa, not only sells PMI but also acts as a holding company for several other subsidiary companies that operate in the health sector. For example, Bupa runs nursing homes, dental surgeries, offers health screenings, and it also has subsidiaries across the world. It was previously a major independent hospital provider, but sold all of those before later buying one hospital in London. Now, Bupa is a major global organisation. Corporation tax is paid on the profits from these other activities.

As insurance companies, the health insurance operations of the provident associations are governed by the **Financial Services Act 2012** (and subsequent modifying rules and

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legislation including the **Bank of England and Financial Services Act 2016**) as well as the **Companies Acts** and are subject to the insurance company solvency rules including **Solvency II**.

Following the conversion of AXA Health to a commercial insurer, the market share of provident associations dropped to less than half of all PMI policies. The remaining half is held by the commercial insurers. Other forms of mutual organisations, such as friendly societies, health cash funds and mutual insurance societies may also sell medical insurance. Self-funded schemes and trusts may also be run by PMI insurers and provide PMI-style benefits, but not as an insurance contract.

Question 1.3
Which came first, the NHS or private medical insurance?

C3 Commercial insurers

In the late 1980s and early 1990s, there was a significant change in the UK healthcare insurance market. It has attracted an increasing level of interest from mainstream insurance companies, specialist third-party administrators (TPAs) and financial consultants. There are now over 20 commercial insurers operating in the healthcare insurance market. The greatest inroads into the provident associations' domination of the market for private healthcare insurance bought by individuals, were made by Aviva (previously Norwich Union Healthcare) and Standard Life Healthcare. Then, in 2004, Prudential joined the market with PruHealth (now VitalityHealth following Pru's sale of its stake), this was a joint venture with the South African Discovery group. In 2010, Prudential also took over the PMI book of Standard Life and later sold is share of the Vitality group to Discovery.

Unlike the provident associations, insurance companies are profit-making organisations with shareholders to whom they need to pay dividends out of their taxed profits.

C4 Managing general agents

A managing general agent (MGA) or a managing general underwriter (MGU) is an insurance agent or broker that has been granted underwriting authority by an insurer or by a Lloyd's syndicate. MGUs operate under a delegated underwriting authority, enabling them to make underwriting decisions to save time and costs.

MGAs can therefore devise a healthcare insurance plan or scheme and market it in their own name. However, the underwriter will be a licenced insurance company or one or more Lloyd's syndicates. This method gives two main advantages:

- The MGA can market is own products and use its brand to access potential customers. If necessary the underwriter can be changed in future, but this usually only happens if better terms can be obtained elsewhere or if the original underwriter no longer wishes to write this class of business.
- The underwriter can gain access to the healthcare insurance market without risking its reputation if it runs into difficulties or decides to exit the market. If it underwrites more than one scheme, it can gain economies of scale under various product and brand names, which can also spread its risk.

C5 Wellbeing providers

Wellbeing providers offer an increasingly wide range of services, both to healthcare insurers and to employers, and demand for their services has increased significantly since the pandemic, both for individuals and for employers for their employees. Such services may be on a standalone basis or included as a benefit within an insurance policy or self-insured scheme. Providers often start as a specialist healthcare provider and some are now owned by insurers. Wellbeing services serve a variety of purposes including:

- reduced sickness absence;
- helping employees stay healthy or to improve their health;
- helping employees better manage long term health conditions;
- encouraging greater fitness levels;

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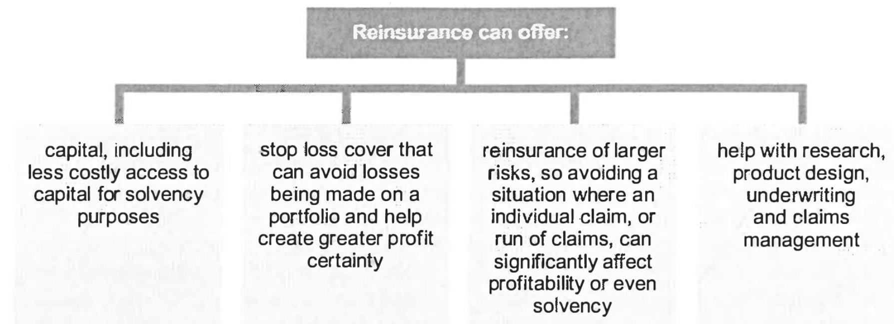
- providing better healthcare management information to employers,
  - this is often done on an anonymised basis so as not to compromise employee data confidentiality. In turn, that can also encourage employees to be more open without the fear of possible repercussions from their employer;
- being seen to be a caring employer, which helps recruitment and retention; and
- minimising the cost long-term of providing healthcare benefits to employees and their families.

C6 Reinsurers

In many forms of insurance, reinsurance is an important or even essential element of the market.



For some non-insurance company providers, reinsurers can provide an insurance vehicle to underwrite the risk. For example, a broker may develop a product idea to meet its customers' needs, then work with a reinsurer to price and manage the risk, and also with regard to handling claims and administration. The broker's key responsibility is marketing, and it will be remunerated by taking a proportion of the premiums and/or emerging surplus. In addition, the reinsurer may help towards funding the upfront costs of setting up the business.

In medical insurance, reinsurance has tended to be less important than for other types of risk. This partly reflects the fact that PMI is short-tail business – claims are incurred during the policy year and rarely run beyond. However, the role of reinsurance could change, and the sheer size of the market may encourage more innovative solutions (involving the greater use of reinsurance) to emerge. The increase in very high value claims (especially for cancer treatment) is opening up the scope for stop loss reinsurance, where the reinsurer may take on all claims above a specific threshold (e.g. £250,000).

C7 Health cash plans

Health cash plans trace their ancestry as a movement back to the nineteenth century. Many were set up as local or regional funds to pay for hospitals and healthcare costs for working people – mainly working men.

With the establishment of the NHS in 1948, many hospital funds changed from paying for health treatment to paying a small cash sum for each night spent in hospital. Later, as hospital in-patient stays shortened, new benefits were added. Today, the most common claims are for dental and optical treatment.

Health funds are mutual organisations run for the benefit of their members. Many make significant donations to medical charities and similar health-related causes out of their surpluses. A number of commercial insurers also operate health cash plans.

In recent years, many smaller funds have suffered from a declining or ageing customer base and rising costs. As a result, several organisations have merged with larger funds. To counter that, many cash plans now market small premium employer-funded schemes with great success. At the start of 2021, over 2.5 million individuals paid for a health cash plan (covering 3.3 million people) and there were over one million employer contributors (source: *LaingBuisson Health Cover UK Market Report*, 17th edition, 2022). In 2023, LaingBuisson reported a slight fall in premium income, although demand for company paid plans increased.

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C8 Self-insured schemes and third-party administrators (TPAs)

A growing proportion of private medical schemes are non-insured schemes run on behalf of employers for their employees, by third party administrators (TPAs). TPAs can be standalone organisations or part of a larger group, including medical insurers. However, they are not risk-bearing insurance companies and instead focus on claims administration and management, scheme design and negotiation. They provide additional competition in the company-paid PMI sector and by the start of 2021 covered over one million people (LaingBuisson data 2022). Non-insured company-paid healthcare schemes paid out an estimated £639m in claims in 2020. TPAs offer a service to the employer by providing a full claims administration service and by holding the client's funds, paying claims on their behalf. The role of the insurer when working with TPAs is to underwrite and provide stop loss insurance. Some insurers also operate a TPA, often through a subsidiary business.

In addition to TPAs there are specialist healthcare consultancies. These exist to provide advice to corporate clients on selecting healthcare solutions (and often other employee benefits) for their employees. They also offer them some cost-containment services.

The strengths of both TPAs and consultancies are claimed to be:

- **Independence**: the traditional position of a broker, although not all TPAs are independent.
- **Motivation**: if they are rewarded for controlling their clients' costs, their aims are identical.
- **Flexibility**: TPAs specialise in solutions tailored to a client's needs rather than offering standard packages.
- **Information**: they retain and administer all data relating to their client's healthcare insurance arrangements, including claims details.

Commercial insurers, TPAs and financial consultants are typically drawn into entering the healthcare insurance market by the perceived opportunities for profitable growth. The entry of these companies into the sector has had the inevitable effect of creating a more competitive environment. Consequently, the provident associations have had to take a more commercial approach to underwriting, overhead costs, product design, pricing, sales and marketing.

C9 Market size and structure

In its annual survey of the healthcare insurance market, LaingBuisson estimated that at the start of 2021, just over 4m subscribers had healthcare insurance cover (insured and self-insured) and in total some 7.13m people were covered (adults and children), which accounted for around 10.6% of the UK population. In the 1970s the market doubled from the level of 1m subscribers; in the 1980s, it grew by more than 50% to 3.5m. However, the 1990s were a disappointment with much of the growth coming from the company-paid sector and mainly due to a buoyant economy.

LaingBuisson estimates the underwriting loss ratio on insured business at 63% of the premium income in 2020, but this figure does change from year to year and excludes all other costs associated with managing the insurance. In that year, the ratio was also artificially low (it was an estimated 72% in 2019) as fewer procedures were being carried out due to COVID-19. The ABI no longer publishes annual PMI sales data and most market data is now published by independent consultants, of which LaingBuisson is the best known.

However, the Association of British Insurers (ABI) did report in February 2020 that the number of individuals with medical insurance had dropped to 1.2 million - a fall of nearly 10% - in the four years between 2015 and 2019. In addition, the number of people covered by corporate health insurance also fell, to 3.5 million, a fall of over 5%. This was during the period that IPT (insurance premium tax) doubled to 12%. The ABI added that during 2015-2019 health insurers paid out over £10bn in claims for important medical treatments, including cancer, mental illness and cardiovascular treatment, providing much needed relief to the NHS. (Source: *www.abi.org.uk/news/news-articles/2020/02/health-insurance-cover-drops-by-nearly-10-in-four-years-following-stealth-tax-raid/.*) In 2021, the ABI reported that in 2019 PMI insurers paid out £8.7m in claims every day and ABI members wrote £4.73bn of medical expenses insurance premiums.

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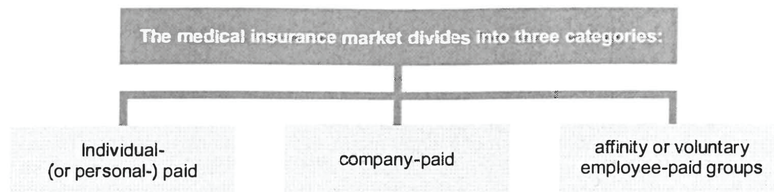

This last category is where employees pay their premiums entirely out of their own pockets. Nevertheless, their employer (or some other group or organisation to which they belong) promotes healthcare insurance policies for them, usually offering premium discounts compared to what they would pay if they bought as an individual customer.

Employers are involved, to some degree, in the choice of over 75% of all the healthcare insurance taken out by members, even though they are responsible for paying the full amount of the premiums for only around 40% of the members covered.

Inevitably, there is a significant difference in the age profile of members in company-paid schemes and members paying their own premiums for healthcare insurance. Whereas virtually all employees are under 65 years of age, around 25% of individual-paid members are retired. This age difference is an important factor, accounting for different average monthly premium rates between company-paid and individual-paid members. Other factors include lower administrative costs and fewer non-core benefits for many top-of-the-range individual plans. Whereas company-paid members cost their employers approximately £1,010 a year in premiums in 2020 (around £84 a month), individual and employee-paid healthcare insurance members paid, on average, double that at £2,036 a year (£170 a month, excluding insurance premium tax (IPT)), partly reflecting the fact that it tends to be older people who have individual cover.

The highest level of healthcare insurance cover is held by households headed by middle-aged (45–64 age group), professionally employed people. In this category more than one in four people have healthcare insurance, compared with around only 2% for all manual workers in the same age group (source: *General Household Survey* 1995). Healthcare insurance coverage also shows significant variation by region. For example, coverage in 2006 (the latest available figures) was estimated to be highest in the South-East area with 18.5% penetration, compared to only 5.5% in the North East (source: *Family Resources Survey 2004/05*, Department for Work and Pensions and LaingBuisson).

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LaingBuisson estimated that PMI penetration (PMI as a percentage of the total population) by age group in 2004/05 (again the latest available figures) was:

Under age 44	13%
45–64	16%
65+	7%
All ages	13%

Since then, penetration dropped below 11% in recent years, before rising again to 11.1% in 2022. The age breakdown is likely to be broadly the same.

Back in 2004, the individual PMI market grew in terms of people covered for the first time since 1997 but has since fallen again. Demand for PMI has remained relatively buoyant despite significantly more spending on the NHS, continuing inflation and price rises for PMI plus wider economic difficulties since 2007. More recently, pre-COVID, there had been a slowdown in NHS spending but a small rise in NHS dissatisfaction and concern about its future. In 2023, with the NHS having problems on a number of levels, many specialist brokers are reporting increased demand for PMI.

In December 2023, AXA UK found that one in five adults were seriously considering buying health insurance in the next three months, and in August 2024 market leader Bupa reported it had added more than 433,000 new customers across its UK operations in the first half of 2024. However, part of that would be across its non-PMI businesses.

In May 2024, the ABI reported that in 2022, some 160,000 people received inpatient care and 1.3 million outpatient care through health insurance.

(Source: *www.abi.org.uk/globalassets/files/publications/public/health/2024/increased-use-of-health-and-protection-services-in-2022.pdf*).

The use of insurance also has important economic benefits. Analysis by WPI Economics found that the use of health services through insurance in 2021 increased the labour supply by 12,500 full time equivalent workers and prevented around 14 million days of long term sickness absence. This generated £6.1bn in financial benefits across businesses, the wider economy and the Exchequer.

D Health trusts and self-funded schemes

D1 Health trusts

Health trusts (also known as healthcare or medical trusts) are an alternative way to insurance for employers to deliver private healthcare for employees. They were originally only available to very large organisations because of the cost of setting up and administering such a trust, although the availability of standardised trust wordings now makes them viable for smaller organisations too. A health trust has the following features:

- It is not an insurance policy, therefore payments into the fund are not premiums (and should never be referred to as such) so do not attract insurance premium tax (IPT). This in itself is a significant saving.
- The employer pays money into a health trust which is administered by trustees or by a trust company. The trust is subject to trust law and the funds have to be managed accordingly. For example, funds cannot be withdrawn for other purposes and if there is a surplus, the trustees could consider reducing contributions for a time.
- Fees charged by the scheme provider are subject to value added tax (VAT) (currently 20%) but may effectively be reclaimed by the employer if it pays VAT.

Refer to

Refer to *Taxation* on page 1/16 for details on taxation

- The trustees determine what benefits employees are entitled to, arrange any stop loss insurance, and pay out benefits. Benefits can include any that might be included on a typical corporate group PMI scheme and trustees may choose to add other benefits too.
- Different groups of employees can get different levels of benefit, so more highly paid staff may receive higher benefits than shop floor workers, for example.
- The use of trusts was often limited to schemes with 3,000 or more members. Smaller schemes can, however, be viable, depending on how much it costs to set up and run the trust. The use of a standardised or generic trust can reduce costs and make a trust viable for a smaller employer. Care needs to be taken as very small schemes risk considerable cost fluctuation (even a few large value claims could significantly increase costs), which may make trusts unsuitable for small schemes, regardless of any financial benefits.
- A trust does not have to be approved by anyone but trust law is complex and firms will usually take specialist legal advice before setting up a trust (for example, if a mistake is made in drafting the trust, payments could be subject to tax or the trust may be illegal).
- Employees receive benefits in line with the trust's rules but these benefits are not absolutely guaranteed. For them to be so would mean that the arrangement is deemed to be insurance and so subject to IPT. In practice it would be rare for an employee not to get the treatment they expected to get under a health trust.
- Benefits are not taxable in the hands of the employee, as with healthcare insurance contracts.
- Employees are taxed on a national share of the total amount contributed by the employer as a benefit in kind. For example, if a scheme costs the employer £500,000 a year, and there are 1,000 employees, the taxable (P11D) benefit for each employee would be £500 a year, assuming all qualify for the same benefits.
- Stop loss insurance may be arranged to limit the employer's liability. Stop loss insurance may either cover all claims costs in any year, or individual claims, or both. The premium for that is payable to an insurance company and will attract IPT.

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