



Public–private sector interactions and the demand for supplementary health insurance in the United Kingdom



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ARTICLE INFO

Article history:

Received 20 August 2015

Received in revised form 11 March 2016

Accepted 1 May 2016

Keywords:

Private health insurance

Demand

Waiting times

Quality

National Health Service

Hospitals

ABSTRACT

We examine the demand for private health insurance (PHI) in the United Kingdom and relate this to changes in the supply of public and private healthcare. Using a novel collection of administrative, private sector and survey data, we re-assess the relationships between the quality and availability of public and private sector inpatient care, and the demand for PHI. We find that PHI coverage in the United Kingdom is positively related to the median of the region- and year-specific public sector waiting times. We find that PHI prevalence *ceteris paribus* increases with being self-employed and employed, while it decreases with having financial difficulties. In addition, we highlight the complexities of inter-sectoral relations and their impact on PHI demand. Within a region, we find that an increase in private healthcare supply is associated with a decrease in public sector waiting times, implying lower PHI demand. This may be explained by the usage of private facilities by NHS commissioners. These results have important implications for policymakers interested in the role of private healthcare supply in enhancing the availability of and equitable access to acute inpatient care.

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1. Introduction

This paper examines the determinants of demand for private health insurance (PHI) in the United Kingdom – a context in which the National Health Service (NHS) provides a comprehensive statutory package of services free-at-the-point-of-use, and in which supplementary coverage is held by approximately 15% of the population aged over 20. This coverage offers insurance against the costs of privately-delivered services that are also provided within the NHS (for which PHI subscribers must continue to pay through their taxes and to which they retain full

access). The key attractions of holding such coverage are therefore the access to faster treatment and wider choice of specialists, facilities and timing of treatment that it may provide [1]. However, premiums for individual purchasers tend to be expensive, and only a minority of employers offer coverage to their staff [2]. Accordingly, baseline models view the perceived quality of public sector provision, together with income, as the main determinants of the demand for PHI (e.g. [3,4]).

To date, conflicting results have been observed with respect to the association between PHI demand and the quality of NHS services, as measured by waiting times.² Besley et al. [3] find that regions of England characterised

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² As clinical outcomes data are rudimentary in the NHS, consumer perceptions of quality are likely to focus on intermediate aspects, especially waiting times.

by longer waiting lists have higher PHI coverage on average. King and Mossialos [5] also find significant associations between waiting times and PHI coverage. In contrast, Propper et al. [6] find that, in England, waiting lists do not play a role in explaining PHI coverage. Instead, the number of private hospitals and senior doctors are important, along with age. The authors suggest that as the stock of medical labour is fixed in the short run higher private sector capacity reduces the supply of senior doctors available to the NHS, giving rise to a perception among patients that the quality and capacity of the private sector has increased relative to those of the NHS. Overall, the evidence suggests that perceived differences in quality and capacity between the public and private sectors have a major influence on PHI demand.

However, the latter study draws attention to the complex nature of public–private sector interaction in terms of the effect on demand for PHI. In this respect, it is significant that the extent of such interaction has increased since these earlier studies were conducted. This is especially the case in England where market-oriented structural reforms aimed at providing patients with more choice have been an important part of the policy framework. Since 2002, many NHS patients (in England and to a lesser extent in Scotland and Wales) have been treated at private hospitals for diagnostic and elective services. From January 2006, General Practitioners were required to offer patients a choice of four or five hospitals [7]. In addition, reforms introduced between 2003 and 2008 formalised and greatly increased the ability of private hospitals to compete with NHS hospitals for patients, for instance through the so-called Independent Sector Treatment Centre programme, which delivered a wide range of routine elective care for NHS-funded patients [8]. In consequence, spending on private facilities by NHS commissioners in England (mostly Primary Care Trusts and, from 2011, some Clinical Commissioning Groups) more than quadrupled in real terms between 2002 and 2012, to £1.2 billion [9]. By the end of that period funding from NHS commissioners constituted 28% of inpatient income for private hospitals [10].

In this context, the relationships between the supply of private healthcare and the demand for PHI have become more complex than was the case when the aforementioned studies were undertaken. For instance, higher private sector capacity might increase the demand for PHI if inpatient care providers are able to “induce” demand for their services and consumers seek financial protection against the associated costs [11]. In this case, the positive effect of higher private sector supply on PHI demand may offset the negative effect of lower NHS waiting times on PHI demand. Conversely, if private hospital capacity is made available to NHS patients, and this leads to a reduction in NHS waiting times, this may contribute to a reduction in PHI demand.

Our aim, therefore, is to examine the PHI demand and the relationships with the quality and availability of public and private sector inpatient care. To address this aim, we use a novel combination of survey data from 2000 to 2011 matched with administrative and private sector data. In addition, we use new waiting time measure. According to Foubister et al. [2], PHI packages typically cover surgery as an inpatient or day case, hospital accommodation

and nursing care, and inpatient tests. We therefore use a measure of NHS waiting time that is likely to be most relevant to the choice between publicly and privately financed healthcare – the median inpatient waiting time.

The remainder of this paper is structured as follows. In Section 2, we outline our data sources and descriptive statistics. In Section 3, we present our empirical results. In Section 4, we relate our findings to previous theoretical and empirical literature and end with an outline of policy implications.

2. Data and preliminary analysis

We make use of data from two surveys covering the period 2000–2011: the British Household Panel Survey (BHPS) and the English Longitudinal Study of Ageing (ELSA). Both the BHPS and ELSA data were accessed through the UK Data Archive (UKDA). The BHPS ran annually between 1990 and 2008 but the questions regarding PHI coverage were only asked from wave 6 (1996). After 2008 the *Understanding Society* survey replaced the BHPS, but does not provide information on PHI coverage. In our analysis of the BHPS we excluded respondents aged below 20 years and those living in Northern Ireland. We focus on the years 2000–2008 as some of the regional level indicators are not available for earlier years. ELSA is a bi-annual survey covering people aged 50 and above, restricted to England only. The first wave of the survey was conducted in 2002/2003, and we use data up to years 2010/2011 (wave 5). Using two different surveys (BHPS and ELSA) allows us to check the robustness of the results with respect to the source of individual data, finding that the results are qualitatively robust. In addition, the ELSA data make it possible to extend the analysis period up to 2011.

We focus on a single indicator of PHI coverage: whether the respondent is covered by any type of PHI, regardless of whether this coverage is provided by an employer or through the purchase of another family member. The prevalence of PHI coverage among the population aged over 20 was 15.4% in 2008, the final year of the BHPS. Of this, around one third paid all or a part of the premium directly; one third received the insurance via their employer; and the final third were insured through the purchase of another family member.

Table 1 shows the time pattern of PHI coverage rates in the UK. The coverage rates fell at the end of the 1990s, when tax relief on PHI premiums was discontinued, and again in 2007, which we assume is due to the financial crisis which began in that year. The degree of stability in the PHI rates is notable, given that this was a period in which NHS funding increased at its fastest ever rate, at an average of 6.6% per year between 2000 and 2008 [18], which might have been expected to exert greater influence on PHI coverage rates. This may imply that the high transaction costs associated with buying and selling PHI, alongside a certain degree of consumer inertia, were features of this market in this period. In addition, as we discuss below, factors such as lower waiting times and the higher supply of private care may have offsetting effects.

According to the BHPS data, PHI coverage is most prevalent among people aged 30–60, and the coverage rate peaks

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