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Business and healthcare for the 21st century

Absence from work due to sickness costs UK business nearly £11bn a year, but the cost to society is nearer £23bn a year. Improved management of occupational health and delivery of publicly funded healthcare, together with action on the long term funding of healthcare, are needed to reduce this cost.

Executive summary

The cost of sickness absence to business and society is higher than it should be, partly because of capacity constraints in the healthcare system. Business also shares a wider social and macro-economic concern to see improvements to the health system while keeping public spending under control. The solution lies in addressing three underlying issues:

- Some businesses are better than others in managing workplace absence and employee healthcare, and more could be done to address this within companies
- The delivery of publicly-funded healthcare in the UK is inefficient. Key reasons are insufficient priority for treating non-urgent illnesses, bed-blocking due to inefficient arrangements for elderly care, poor use of information technology, failure to maximise the value of key staff, and insufficient diversity and contestability in service delivery
- The levels of both public and private expenditure on healthcare in the UK (totalling 6.8% of GDP) are lower than those in other developed countries.

Action to address these shortcomings will require government, the public, private and voluntary sectors, employees and trade unions to work together to:

- Improve business management of occupational health and rehabilitation issues
- Enhance the efficiency with which the public and private sectors deliver publicly-funded healthcare. Key priorities include streamlining operations, improving management of human resources, promoting diversity and contestability in service delivery, establishing the right incentives to good performance, and informing and empowering patients. Better use of IT should facilitate taking clinical decisions to the local level while allowing the NHS to develop common systems and 'join-up' corporately
- Stimulate a mature debate about identifying and developing sources of additional funding for health-care. This needs to consider options for increasing private spending on healthcare – for example through greater use of private medical insurance, a greater role for charges at point of use, and greater commercialisation of some NHS services.

Introduction

A healthy population and first-rate healthcare system are as vital to business as they are to government and individuals. Absence from work due to sickness costs UK business nearly £11bn a year, but action to reduce it benefits all of society.

As taxpayers, firms want to see effective public spending on health. Business also has an interest as provider of healthcare services and products.

Everyone should have access to good and affordable healthcare, delivered by motivated and professional staff using cost effective treatments, first-class facilities and the best available information. A broad, well-managed programme of reform will be vital to realising this ambition, involving all stakeholders – politicians, the public, private and voluntary sectors, employees and individuals.

This brief sets out a CBI perspective on some of the key issues surrounding healthcare provision in the UK by:

- Highlighting the cost to business of sickness absence
- Identifying the key causes behind the need to improve cost, quality and capacity of health care provision
- Establishing the key business priorities for improving healthcare provision. These would lower the cost of workplace absence to the UK economy and yield wider benefits.

Sickness absence is a significant cost to business

Workplace absence is relatively low in the UK compared with other OECD states, possibly due to a less generous social security and benefit regime. The UK also has a strong track record in reducing the rate of accidents in the workplace, although there are signs that this trend is now being reversed – particularly in certain sectors such as construction.

Nevertheless, the direct cost of workplace absence due to sickness still imposes a major cost on UK businesses. In 2001, it was £10.7bn – a figure that has remained broadly constant for the last four years.

The total cost, including poorer quality services and products, is much higher. If the cost to the government in increased welfare payments were added, the cost of sickness-related absence would rise to some £23bn a year.

The costs of absence vary between businesses

Employers believe that the majority of absence is due to genuine sickness. The impact of sickness-related absence will vary, not only according to sector and types of activity, but also from firm to firm:

- On average, employees took 7.8 days absence per year. Absence was highest in the public sector (10.2 days), compared with the averages in services (7.7 days) and manufacturing (6.9 days)
- Absence is higher for manual workers (9.5 days) than for non-manual workers (6.3 days), largely due to the larger variety of illnesses/complaints that can necessitate absence
- There is a marked difference in absence rates between the best and worst performing companies, in general, and replicated by sector and company size (see Exhibit 1).

Long-term absence is a particular concern

Most absence cases are short-term (typically five days or less) but a large proportion of lost time (40%) is accounted for by long-term absence (lasting more than 20 days). And a particular concern here is the strong correlation between long-term illness and early exits from the labour market.

Government statistics suggest that 60% of those employees who are off work due to illness for more than five weeks do not return to work and 80% of people moving from

Exhibit 1: Workplace absence rates vary across the business community

	Mean	Best performing quartile	Median	Worst performing quartile
Employees				
Manual	9.5	5.5	9.0	12.1
Non-manual	6.3	3.5	5.3	6.5

Source: CBI absence and labour turnover survey 2001

social security payments to incapacity benefit do not return to the workplace. Yet other countries, such as Sweden and the Netherlands, have much higher return to work rates than the UK. This relatively poor performance on rehabilitation has meant that the UK now has the highest rate of working age incapacity due to sickness in the EU. Seven percent of the working age population in the UK is claiming incapacity benefit, compared to 2.1% in Germany and 0.3% in France.

Apart from the personal challenges posed by early departure from the labour market, there are concerns for business. Early exits can mean a loss of valuable experience, skills and expertise to firms. More generally, and particularly in those instances when the labour market is tight, this phenomenon will also add upward pressure to wages and inflation.

The healthcare system is adding to absence costs

There are wider social and economic reasons for improving the healthcare system. But the £23bn cost to society of sickness-related absence from work must factor large in the opportunity cost of failing to grasp the nettle.

Businesses have reported that the healthcare system is contributing to the absence bill. Key factors which have added to the cost of absence include:

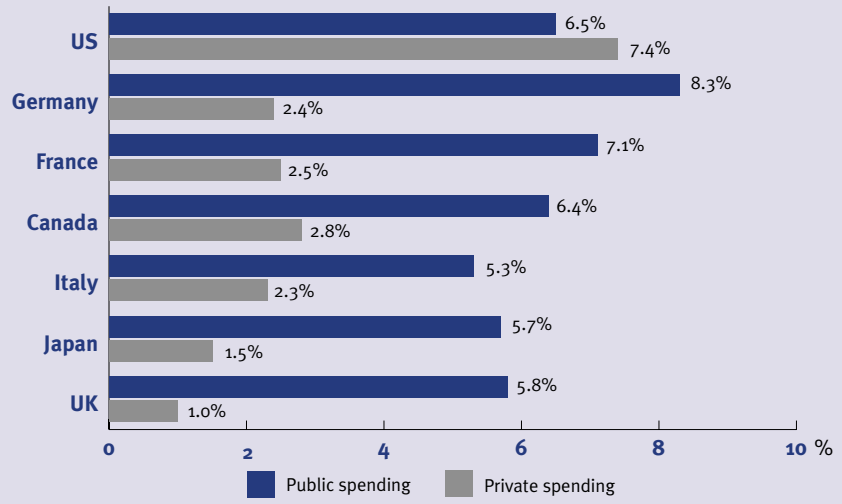
- GPs' lack of expertise in occupational health issues and the pressure from their case loads. Together, these factors mean that GPs are either unable or unwilling to manage minor illnesses with a view to returning employees to work
- Time taken to see a specialist – often leads to prolonged absence, particularly in the case of non-urgent conditions such as back pain and other muscular-skeletal conditions
- Cancellation of routine operations – leading to prolonged periods of absence.

Empirical evidence backing the link between absence levels and poor outputs from social healthcare is difficult to establish. However, some empirical evidence does support a connection between poor performance from the social healthcare sector and employer demand for private sector healthcare, suggesting that employers are responding to increased absence costs by seeking a private sector solution.

It is impossible to eliminate the cost to business of illness-related workplace absence. But there are three critical reasons – aside from individuals' lifestyle choices – why the capacity of the healthcare system is under pressure and the cost to business and society is therefore higher than it should be:

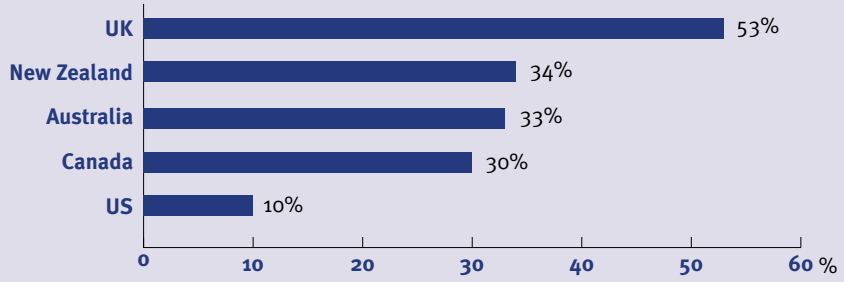
- The UK fails to give as much priority to healthcare spending (both publicly and privately funded) as other developed countries

Exhibit 2: UK spending on health has a long way to catch up with other OECD states



Source: IFS 2000

Exhibit 3: Patients waiting longer than one month for non-emergency treatment



Source: The Commonwealth Fund 1998

- There are major shortcomings in the arrangements by which the public and private sectors currently deliver publicly-funded healthcare

- Some businesses are better than others at managing workplace absence and employee healthcare.

The UK spends relatively little on healthcare

Total UK expenditure on healthcare, as a percentage of GDP, still lags well behind other OECD countries (see Exhibit 2). Not only is the level of public funding at the lower end of that achieved in other developed nations; but private spending on healthcare in the UK is also significantly less than that achieved in other countries.

With the extra spending announced by the government in 2000, the UK is likely to reach the current level of EU healthcare expenditure (now at 8% of GDP) by 2006. But during this time healthcare expenditure in other EU countries is likely to increase further. The gap may not be set to increase, but on current trends it is unlikely to narrow either.

Delivery of publicly-funded healthcare is inefficient

Most medical care – covering primary care and the whole range of clinical and clinical-support services – is still carried out by the NHS, funded largely by taxpayers, but delivered by a mix of public and private sector providers. Most individuals and many businesses depend on the social healthcare system to meet their healthcare needs. The publicly-funded healthcare system is clearly failing to meet those needs. The UK has one of the slowest treatment times for non-urgent surgery among OECD countries (with more than half of UK patients needing non-urgent surgery having to wait over a month), inflating the costs of absence to business (see Exhibit 3).

Exhibit 4: Significant areas of social healthcare are delivered or part-funded by the private sector

- Private sector involvement in elderly care has grown over the last decade, at the expense of direct local authority or NHS provision. Over 80% of elderly care is delivered by the private sector, and nearly 20% is paid for privately
- Twenty-five percent of hip operations and 20% of cardiac operations are delivered (free at the point of use in the NHS) by the private sector
- Forty percent of dental care now operates outside the NHS
- Optical and dental treatment are both subject to charges under the NHS.

There will always be a debate about the level of resource made available to raise performance. But the way in which the publicly-funded healthcare system is run also has a major impact. Operational and structural inefficiencies in the system have exacerbated funding difficulties, including the following.

Insufficient priority on treating non-urgent illness. Pressures on healthcare provision have led the NHS to prioritise acute medical care over less urgent but debilitating illnesses. Money spent on acute care has risen by 19% in real terms over the last ten years, partly at the expense of elective care. As a result, waiting times for non-urgent treatments have grown, worsening health outputs and increasing the level of unnecessary absence.

Bed-blocking. Bed blocking is a major problem in the NHS, contributing further to delays in treatment and often caused by overspill in providing for elderly care. While the NHS Plan recognised that the provision of elderly care could be better and more efficiently managed by pooling resources of local councils and health trusts, it noted that few pooled schemes were currently in operation. Recent government action to address this issue is welcome, but it should be kept under review to check whether the resources allocated are sufficient to solve the problem.

Poor use of information technology, weak collaboration and a lack of common systems. There are major deficiencies in data storage and management within the NHS. Poor and inadequate use of IT, for example, hampers efforts to ensure that patients' medical records are accurate, up-to-date and easily available. These problems can lead to delays, or at worst, incorrect treatment.

More generally, service delivery is unduly fragmented and costly through a failure to 'join up' the NHS through common systems and collaborative procurement. Service delivery should be devolved to the local level, but without feeling fragmented to the service user.

Variations in management expertise. There has arguably been a tendency to manage the NHS as a monolith, even though it is recognised that management performance varies from organisation to organisation. The recent data on hospital performance has highlighted key variations and should provide a basis for providing more targeted support, including by building on well-established NHS management training programmes.

Insufficient diversity and contestability in delivery. The existence within the social healthcare system of a diverse range of public and private sector providers can provide an important spur to innovation and improvement. But the scope for building on this is being hampered by a debate that is often poorly informed in three ways:

- Confusion over issues of funding and delivery. The question of who should fund health services is very different to that of who should deliver them. Yet all too often discussion about the real and potential benefits of private sector service delivery within the NHS is confused with allegations of privatisation and the demise of a healthcare system that is free at the point of use. This confusion prevents objective debate about the real issues
- Lack of awareness about the current extent and benefits of private sector delivery. The NHS already contracts out some £1.5bn of care, chiefly for mental illness, learning disabilities and some acute care such as waiting list operations. Last year, about 150,000 procedures were bought from private hospitals – a fraction (though it is growing) of the 5.5 million delivered by the NHS annually. The private sector also delivers a range of construction and support services. On current plans, the PFI will refurbish or rebuild 64 hospitals, and several hundred GP surgeries and health centres through the NHS Local Improvement Finance Trust, in England alone (see Exhibits 4 & 5)

Exhibit 5: PFI/PPP case study — Queen Elizabeth Hospital, Greenwich

Greenwich Healthcare NHS Trust was awarded a contract with the Meridian Hospital Company in July 1998 for the design, construction and financing of a new hospital building and the maintenance and operation of the entire hospital covering 3,300 beds. The capital value of this project has been estimated at £93m and the private sector spend (including management of the facilities) is likely to reach £150m.

The hospital was completed on time on 1 November 2000 and it was fully operational a month ahead of schedule on 31 March 2001. The new hospital replaced a 1960s hospital in need of repair and provides a pleasant environment for the care of patients.

Cost savings of over £17m were identified before the decision was made to select a private sector partner.

- Lack of balance in presenting the merits of private sector delivery. Too often, debate about the merits of private sector delivery deteriorates into one of 'private bad, public good' and vice versa, generating opposition to diversity of supply. In fact, the private sector has a long history of delivering publicly-funded health and social services. Inevitably, the track record is mixed, as it is for in-house provision. There is a combination of outstanding successes, satisfactory performance and important lessons from what has not worked well. Private sector involvement may indeed often make sense, but it will not always represent the best option. And indeed the most appropriate form of public private partnership will vary from project to project.

Some businesses are better than others in managing absence

As suggested above, there is significant variation in employers' performance in managing workplace absence. And this difference also exists between organisations within the same sectors and between companies of a similar size.

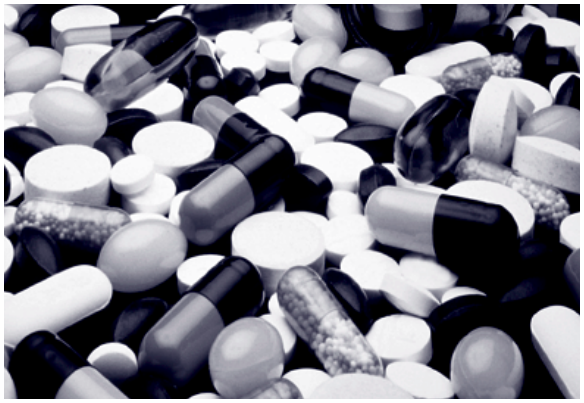
Health-related causes are not the only reason for work-place absence, of course, but employers have consistently reported their view that general sickness is the most significant cause of absence and that the vast majority of sickness absence is genuine. But – in addition to action to address shortcomings in general healthcare provision identified above – there appears to be plenty of scope for employers themselves to manage better the impact of sickness-related absence:

- CBI absence surveys reveal that one quarter of firms (predominantly from the manufacturing and public sectors) do not keep records of causes of absence and specific illness
- CBI research indicates that absence rates are significantly lower where employers give primary responsibility for managing absence to senior managers or HR managers, rather than line managers – yet line managers continue to have primary responsibility for absence in 75% of organisations
- Organisations have a range of policies to deal with short term absence. But many organisations appear not to have adopted policies to address long-term, sickness-related absence. For example, 30% of employers report that they do not operate occupational health provision. The lack of effective policies to manage long-term absence is worrying because 40% of all absence is long term
- In the case of occupational health provision, some sectors (such as general manufacturing, services and construction) have less complete provision than others (such as those engaged in higher-hazard activities). And the quality of provision from the different sources used by employers can vary significantly between, for example, contractors and in-house professionals on the one hand and GPs and the NHS on the other.

Action is needed to improve healthcare provision

Action to reduce the cost of workplace absence due to illness should be an integral part of the general approach to improve the competitiveness of British business. Also these costs – along with the wider social and economic arguments – make a powerful and urgent case for improving the capacity, quality and costs of health care provision.

The previous section identified much that needs addressing. In this section, we identify three particular



areas for action that will require business, government, the public sector and trade unions to work together to:

- Improve business management of occupational health and rehabilitation
- Enhance the efficiency with which the public and private sectors deliver publicly-funded healthcare
- Stimulate a mature debate about identifying and developing sources of additional funding for healthcare.

Promoting better business management of sickness absence

Action is needed, both to raise awareness of the benefits of better management of sickness-related workplace absence and to promote adoption of effective measures. Such action needs to be targeted according to the size and activities of firms but should include:

- Spread of best practice. For example, the CBI's Absence and Labour Turnover Survey is a benchmarking tool which can help foster a better understanding of the effectiveness of corporate policies on absence management
- More emphasis by government and business to promote higher return-to-work rates. Further research on effective rehabilitation policies and arrangements could be undertaken to identify and promote best practice solutions suitable for different types of workplaces. The insurance industry, working with others, has sponsored and supported the promotion of rehabilitation programmes. Government could enhance this effort through carefully targeted economic incentives
- Specific campaigns to promote the benefits of active policies in occupational health in those sectors where there is scope to improve performance (such as some parts of manufacturing, construction and services)
- Promoting diversity and increased take-up of occupation health provision. This might include careful use of economic incentives (such as grants and tax-breaks) to encourage, for example, SMEs' use of occupational health contractors
- Improving the quality of occupational health provision, not only among GPs and the NHS but also in the private sector. A recent CBI survey on occupational health revealed that while 59% of doctors working for respondent companies had OH qualifications, these were concentrated in only 42% of businesses.

Improving delivery of publicly-funded healthcare

A wide range of measures is needed to promote more effective delivery of social healthcare by the public and private sectors.

Streamline operations. Bed-blocking has been a major problem in the NHS. The recent government initiative to solve this problem is welcome, not least because the £300m of extra funding is underpinned by an agreement on partnership working between the NHS, local government and the independent sector. This initiative should be kept under close review to check if further resources are required or there is a need to spread good practice. Local authorities, who have too often forced down fees to the independent sector to unsustainable levels, must now be willing and able to pay what it costs to deliver a quality service.

A proliferation of new bodies is being created at the local level without replacing old ones or ensuring that transitional arrangements are widely understood: for example, Primary Care Groups and Primary Care Trusts will run alongside Strategic Health Authorities, Health Authorities and NHS trusts/GP practices. There could be a strong case for streamlining the number of different bodies to reduce the level of bureaucracy and duplication of effort.

Improve management of human resources. Employees are a key resource for the NHS, yet rigid shift patterns mean that many staff retire early rather than continue working on call and anti-social shift patterns. Many

people also retire early on ill-health grounds, while the lack of a formal process to manage career development can mean that talent is wasted. More flexible working arrangements (such as more bank workers to cover on call), better attention to occupational health and rehabilitation and enhanced career development should all feature as part of a coherent strategy to retain and develop quality staff.

Promote diversity and contestability. Diversity and contestability of service provision, properly managed, can help spur improvement in the social healthcare system. Having a diverse range of players provides different sources of innovation and approaches to management. The competitive pressure also acts as a spur to improve performance. No doubt the NHS will feel further competitive pressure to improve its performance through recent developments, giving UK patients access to health services in other parts of Europe.

There is a need to secure the benefits of diversity and contestability within the UK, through a vibrant mix of service provision. This includes roles for the private and voluntary sectors in providing services to the NHS and other public sector clients. Success will very much depend on generating an environment that encourages the active development and consideration of options for private and voluntary sector delivery. Six things need to occur to generate this environment:

- Strengthen the analysis of value for money: there needs to be a constant focus on securing whole life value for money. Too often, there is an undue emphasis on price in comparison to quality issues. And, particularly in PFI, recent debates have focused unduly on technicalities such as how to construct an artificial public sector comparator against which to assess PFI bids. The debate needs to widen, for example, to recognise the benefits of innovation in service delivery, facilities being delivered on time and on budget, assets being properly maintained and the value for money gains over time that come from a diverse and contestable market

- Improve public sector procurement and contract management: priorities range from reducing bidding costs and time scales to embedding a more strategic approach to managing contractual relations

- Develop a wider range of public private partnership models: the optimum model of public private partnership will vary from case to case, depending on issues like how best to package the work and to share the risks. There is a growing range of models – including the PFI – and more will be needed as the public and private sectors explore new areas of partnership. In particular, there needs to be an open mind about the most appropriate models for wider private sector involvement in service delivery. And more thought is needed on how best to integrate the provision of IT services into hospital building programmes

- Embed the recent Concordat between government and private sector healthcare providers (see Exhibit 6): this could be done by bringing together information

Exhibit 6: The Concordat embodies the current relationship between public client and private providers

The Concordat developed between the Independent Healthcare Association and the Department of Health sets out examples of the type of co-operative action that the NHS and the private sector can undertake. The Concordat envisages co-operation with the private sector in three main areas:

- **Elective care** eg PCT/PCGs commissioning or renting accommodation from the private sector, with the service delivered by NHS staff under NHS contracts – or an NHS trust 'subcontracting' a service to the private sector, but having the accountability and responsibility for the results itself

- **Critical care** eg use of private critical care services when this is of benefit to patients and better co-operation between the NHS and the private sector when planning for meeting local needs

- **Intermediate care** eg a focus on goals, such as reducing avoidable hospital admission, facilitating timely discharge from hospital, promoting effective rehabilitation, planning innovative new services in non-hospital environments and minimising premature dependence on long-term care.

The Concordat also proposes a number of areas where the NHS and the private sector could co-operate on generic staff issues, such as:

- Identifying future and existing staffing requirements

- Exchanging information on workforce supply and demand to support training

- Exchanging information on adverse clinical effects, etc.

available at the local level. Statistics (for example, on the number of operations being transferred to the private sector) should be published to indicate the extent to which the private sector is helping to deliver healthcare needs, and to what effect

- Improve the handling of staff issues within PPPs. The CBI has worked with the public sector and trade unions to drive progress in this area, for example to produce Cabinet Office guidance giving more certainty on TUPE (staff transfer arrangements) across the public sector. More work is needed, though, to address what is often referred to as the 'two-tier' workforce problem (of new starters and transferred staff being employed on different terms).

  But more employment legislation is not the answer. And the idea of seconding staff from the NHS to private sector partners is deeply problematic. Workers would lose out on promotion and development opportunities with the contractor. Meanwhile the contractor and the NHS could too easily blame each other where problems did arise. Rather, the solution lies in ensuring that the government behaves as a 'quality driven' client. This means requiring and being prepared to pay for a quality service. This, in turn, would require service providers to maintain high standards of HR, terms and conditions and pensions.

  Too often in the past the public sector client has used competition to drive down prices to the level where service quality and employment conditions are both compromised. Better procurement is the key to achieving the 'win-win' of better quality services and a better deal for staff

- Give the private sector confidence about future deal flow. There is at least a perception that a moratorium exists on 'conventional' health PFI projects, where staff would transfer to the private sector, while the government explores the alternative of seconding staff from the NHS to the PPP service provider.

  Whatever the merits of the pilot schemes (and the CBI thinks that the secondment route generally causes more problems than it solves), the 'conventional' PFI programme should continue in parallel. Not only would this give a better basis for comparing the secondment and transfer options, it would encourage the private sector to build up the financial and resource capability to handle future deal flow in the health sector. But more generally confidence in the deal flow is essential in all areas where the government wants to have a strategic relationship with the private sector, whereby firms would innovate and build capacity specifically to meet NHS customer needs. A 'stop-go' approach from government clients is extremely damaging.

Establish the right incentives. A vibrant culture of innovation and continuous improvement needs to be underpinned by a supportive incentive structure. Providers should be given the right objectives (so that targets focus on genuine improvement in health outcomes and avoid perverse results, such as increased waiting times for non-urgent treatment). With the NHS under pressure, bold thinking is needed to encourage the best performing trusts to do better (eg by being given greater autonomy) while challenging and supporting those that need to improve.

Inform and empower patients. A stronger culture of continuous improvement also calls for measures to strengthen the focus on patients as 'customers' within the social healthcare system. Central to this is the need for action to empower patients with better quality information on the performance of NHS units. Much of the groundwork for this has already been proposed, with the government announcement of improved performance measures for hospital trusts. But patients are rarely concerned about the overall performance of hospital. They are concerned about the performance of the unit at which they are receiving treatment. Most of the recent examples of poor standards in the NHS relate to individual units or practitioners and would not be reflected in a trust-wide performance measure. Information on the performance of these units could be provided through mechanisms already available, such as NHS direct and NHS direct online.

Develop use of information technology and common systems. Better use of IT, collaborative action and common systems will need to underpin most of the above improvements. A key priority is the development of a robust system for the electronic management of patients records (covering all aspects of a patient's medical history), enabling records to 'follow' patients accurately and with minimum delay. Another is the development of a national electronic booking system. More generally, there is substantial scope for securing scale economies, reducing the need to 'reinvent the wheel' and moving towards more seamless service delivery through more collaboration on procurement and other issues. Handled

well, this should support (rather than detract from) devolving clinical decisions to the local level.

Developing sources of additional funding

There is enormous potential to improve healthcare provision by focusing on what business itself can do (through occupational health initiatives) and what can be done to improve the operation of the publicly-funded healthcare sector.

Ultimately, however, finding ways of increasing the overall level of funding devoted to healthcare remains a key challenge. Many of the operational improvements recommended above would themselves require significant resource (even if they do repay the initial outlay over time through the efficiency gains that they bring).

Despite recent announcements on increased government spending on health, the UK will continue to lag behind the levels of expenditure achieved in other developed countries. The greater range of treatments and drugs on offer, coupled with an ageing population and increased public expectations about service quality, will also drive the need for increased resources to be devoted to healthcare.

It is not immediately obvious how the need for additional expenditure over time can be met. But it is essential for government to facilitate a mature, constructive debate about how a healthcare system, which meets the needs of business and society as a whole, can be financed in the future.

Limited scope for increased public spending on healthcare

Such a debate should, of course, properly consider the scope for increasing public spending on health. However, this option is likely to have significant limitations:

- The present government has limited its room for manoeuvre to finance additional spending through tax increases
- It is not clear which other areas of public spending might be cut to finance more public spending on health within the current tax and borrowing envelope
- It is not even clear that increasing public spending on health is the most desirable or efficient way forward, as lifestyle treatments become a more important factor in health expenditure.

Options for increasing private expenditure on healthcare

Other options therefore merit careful scrutiny, including the potential to increase the level of privately-funded healthcare. Private expenditure (definitional issues aside) already accounts for some 14-17% of total UK healthcare spending. Most EU countries have developed mixed funding models, relying much more on the privately funded sector. France, Germany and Italy all have much larger privately-funded healthcare sectors than the UK, which makes up the majority of the difference in spending between these countries and the UK (see Exhibit 2).

The variety of experience of private healthcare spending in other countries suggests that there is no single model to pursue, but a number of obvious mechanisms to consider would include the following:

- Greater use of private medical insurance. Eleven percent of people in the UK now make provision for their healthcare, of which 80% is covered by company-provided plans. An obstacle to greater take-up is the perceived high cost of premiums – which is exacerbated by the relatively small numbers of patients opting for private care. Encouraging more patients to go private would help to lower premiums. The tax system could 'prime the pump' for increased privately funded healthcare, by allowing relief on corporation tax for companies providing occupational medical insurance. Other options might be relief on National Insurance Contributions for those who wish to receive private health treatment, or removal of NIC incurred on the benefit of private medical insurance. Over the long term, these tax incentives could be reviewed as premiums fell
- A greater role for charges at point of use. Most countries in the EU make much more use than the UK of user charges and 'out of pocket' household expenses. Some of this cost is borne by individuals; others are paid for through insurance. In the UK, user charges already operate in many of the peripheral services of the NHS (including dentistry, optometry and prescriptions), but are a highly sensitive issue: many studies have pointed to lower consumption among poorer individuals where user charges are in force. Nevertheless, some states have higher user charges than the UK and are considered equitable. France, for example, has a system of insurance reimbursement that allows the majority

of people on moderate incomes to claim for the cost of user charges. This allows patients to pay doctors directly for their services, without having a moderating impact on demand. Lessons might be learned from this, and other models, if user charges were to be expanded further

- Greater commercialisation of some NHS services. One of the largest providers in the privately-funded sector is the NHS, which provides a range of services for fee-paying patients. Other services, such as NHS Plus, appear to be planned on a cost recovery basis. One way to raise additional revenue is to make the NHS more commercially aware and encourage it to exploit its assets. In this context the recent government initiative, allowing successful NHS units to sell services to new markets, could be useful. However, hard-pressed hospital managers should use the new freedoms to build on increasingly successful partnerships between public and private sectors, rather than diverting scarce management resources into new business.

Conclusion

Government and business clearly share responsibilities for raising the capacity of the healthcare system. But they also share the rationale for grasping the nettle, not least through the £23bn cost to business and society of sickness absence from work. Firms must improve their management of workplace absence and employee healthcare. The public and private sectors must work together to improve value for money in the delivery of publicly-funded health care. And we must all engage in a mature and rational debate about additional sources of funding for healthcare.

FURTHER INFORMATION

For further copies of this brief, please contact:
Enquiry Desk, tel 020 7395 8247
Email enquiry.desk@cbi.org.uk

For further information about its contents, please contact:
Jamie Bell, tel 020 7395 8242
Email jamie.bell@cbi.org.uk
Website: www.cbi.org.uk

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