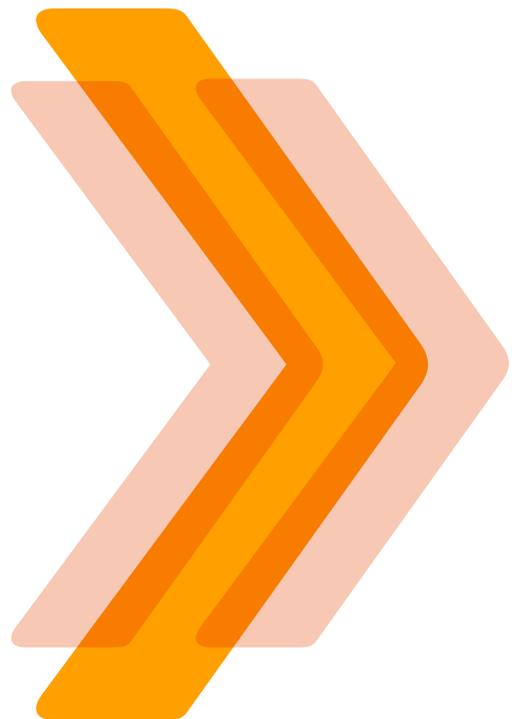


Independent health care and the NHS

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Key messages

- Discussion around the role of the independent sector in providing health care often focuses on the 'privatisation' of the NHS. Private providers have always played a role in the NHS, and while there was a small increase in NHS expenditure on independent sector providers following the implementation of the Health and Social Care Act 2012, it has flatlined at a lower level since.
- Although the role of the independent sector in providing NHS services has not increased substantially in recent years, according to some data sources, private spending by individuals on health care – known as 'out-of-pocket' spending – has.
- Spending on health care services is higher in households with the most disposable income. However, for the top decile, household spending on health care services as a proportion of disposable income is roughly equivalent to that seen in the least well-off households.
- In the five years before the Covid-19 pandemic, compared to households with higher disposable incomes, households with lower disposable incomes have seen a larger increase in the share of their disposable income that is spent on hospital services – from 0.3 per cent in 2015/16 to 0.8 per cent in 2019/20.
- People's motivations for self-funding their health care, rather than using the free-at-the-point-of-use NHS, are mixed. Polling data suggests that more people would now consider self-funding as a direct result of long waiting times and difficulties accessing NHS treatment. However, some market analysts have argued that economic conditions, including the rising cost of living and recession, may slow the rate of increase in private spending on health care.
- The increase in the numbers of people choosing to self-fund health care may have serious implications for inequalities in health and access to services if people with lower disposable incomes are forced to choose between higher costs of health care or longer waits.

Introduction

The role of the independent sector in delivering NHS services has always been a controversial, politically charged topic. The NHS has always relied heavily on the private sector to manufacture and supply everything from beds to bandages, pharmaceuticals, surgical kits, scanners and much else. The controversy and concern are chiefly around the provision of clinical services – particularly the incremental, or wholesale, transfer of services from NHS trusts (acute, mental health and community) to non-NHS bodies, including independent sector health care providers.

These concerns are longstanding but have not always been borne out in the data. The proportion of NHS spending on the private sector has flatlined in recent years. And during the early months of the Covid-19 pandemic, the NHS and independent sector providers worked in partnership to maximise capacity.

Public support for the core principles of the NHS – that it is free at the point of use and funded from general taxation – remains steadfastly high; however, growing waiting lists, long waiting times and a persistent workforce crisis mean that public satisfaction with the NHS has hit historic lows, and people expect that the situation will only get worse ([Wellings et al 2022](#); [YouGov 2022](#)).

Long waiting times and workforce shortages in the NHS were not created by the Covid-19 pandemic but have been greatly exacerbated by it. As waiting lists continue to grow and the public continues to experience difficulties accessing health services, and as the NHS workforce crisis intensifies, more people may choose to opt out of the NHS and pay for treatment privately.

In this briefing, we set out some of the trends in public and private spending on independent sector health care providers. We consider what factors may be driving these trends, look at the impact this has on household spending among different groups, and consider some of the implications for the public and the NHS.

The independent sector and the NHS: is the NHS being privatised?

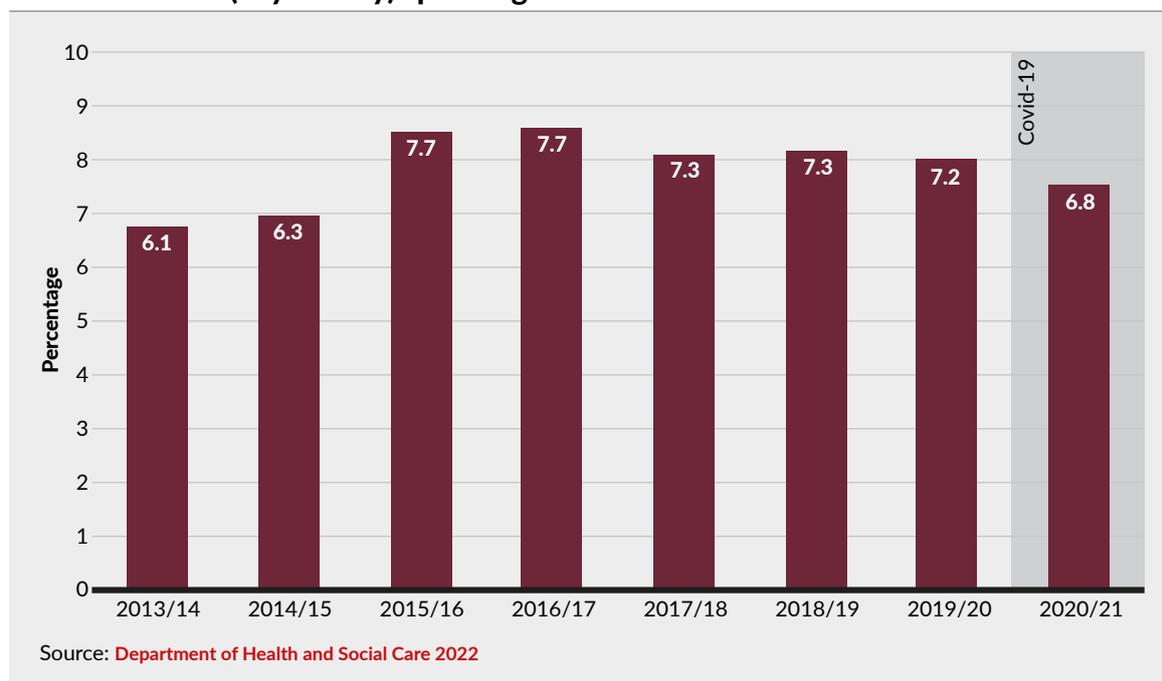
Private providers have always played a role in the NHS. They have provided services such as dentistry, optical care and community pharmacy for decades. Also, most GP practices are private partnerships and have been since the founding of the NHS.

Independent providers have also been used in a variety of ways by successive governments to provide additional capacity in response to pressures on NHS services, and the NHS allows some private purchase of NHS-operated services. Indeed, recent guidance from NHS England encouraged trusts to explore options for maximising income from outside the NHS, which includes people willing to self-fund their own care as part of the Covid-19 recovery ([NHS England 2022b](#)).

The Health and Social Care Act 2012 introduced a range of market-based reforms to the NHS in England, which led to a greater focus on competition and more frequent re-commissioning of services. This caused some concerns that the Act would lead to the wholesale privatisation of the NHS and that independent sector involvement would grow rapidly.

There was a small increase in spending on independent sector providers in the years following the Act, from 2013/14 to 2016/17 – a period when the NHS was beginning to struggle with rising demand for services ([Department of Health and Social Care 2022](#)). But the share of NHS spending on the independent sector has broadly flatlined in recent years (see Figure 1).

Figure 1 NHS spending on independent sector providers as a share of total health resource (day-to-day) spending



The Health and Care Act 2022 undoes many of the market-based reforms of the 2012 Act. It focuses more on collaboration than competition, and removes the need for frequent re-tendering of NHS services ([The King's Fund 2022](#)). As such, the likelihood of any significant and permanent expansion of independent sector delivery of core NHS services is low.

However, in the near term, the independent sector is likely to have an important role in supporting the NHS's recovery from the pandemic, particularly in working through the elective backlog. The elective recovery plan ([NHS England 2022a](#)) states that patients who are waiting a long time should be given greater choice in who provides that care. It includes proactively offering patients information about independent sector providers who can provide NHS services.

The size and structure of the private purchase health care market

Definitions

- **Out-of-pocket payment:** refers to a purchase made by an individual out of their own money.
- **Voluntary health insurance:** cover purchased by an individual from an insurance provider, which can be used in place of or as complementary to NHS treatment.
- **Employer-provided insurance:** where an employer provides health cover as a benefit of employment.

While the role of the independent sector in delivering NHS services may have remained steady, trends in private purchase of health care by individuals – either as out-of-pocket spending or via private insurance – are more complex.

Although the vast majority of spending on health care is financed through government, in 2020, out-of-pocket spending accounted for 12.5 per cent (£32.3 billion) of overall health care spending in the UK, and voluntary health insurance accounted for 2.2 per cent (£5.8 billion) ([Office for National Statistics 2022](#)).

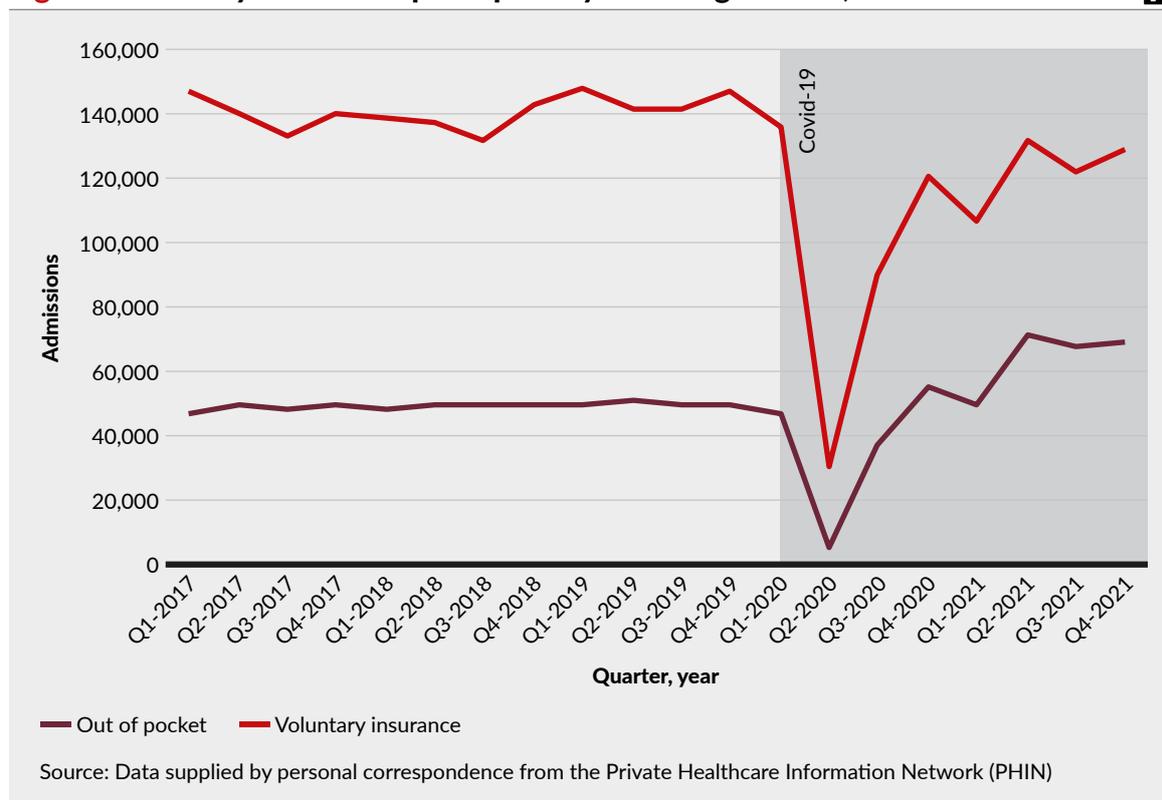
This definition of ‘health care’ incorporates spending on a wide range of services, including hospital care, and some elements of social care such as some long-term residential care, home care services, primary care and discrete administration costs. When we look exclusively at spending on hospital services and ambulatory care, for example, just over £10 billion was financed through voluntary health insurance and out-of-pocket spending. This is a substantial share of total health expenditure, but far smaller than total state expenditure on health ([Office for National Statistics 2022](#)).

There is very little routinely published data on the number and type of procedures people are privately purchasing. The only area where data is routinely published

is on hospital stays. In 2021/22, there were a total of 725,820 privately funded hospital stays in England (**Private Healthcare Information Network (PHIN) 2022**).

PHIN data shows that in the early phases of the pandemic, there was a sharp reduction in the private purchase of hospital care. This has now rebounded; purchase via private insurance schemes is just below pre-pandemic levels, while out-of-pocket purchases have exceeded pre-pandemic levels (see Figure 2).

Figure 2 Privately funded hospital spells by financing scheme, UK



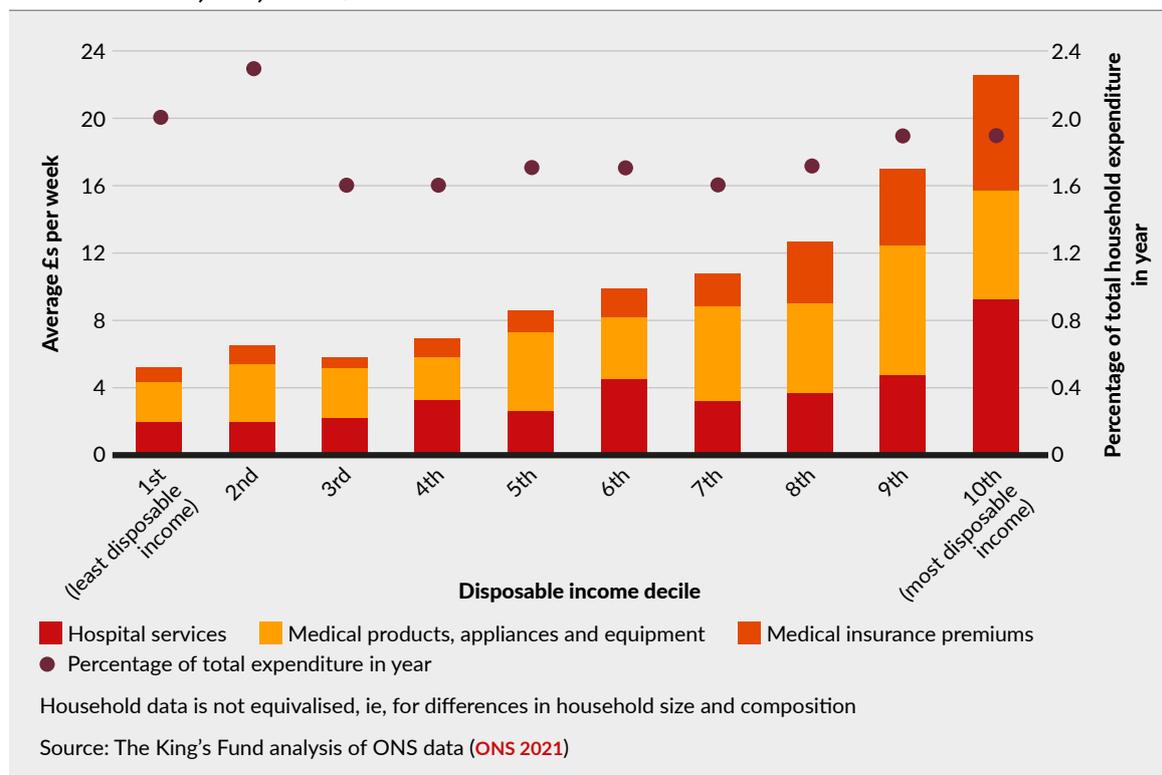
It is unclear why out-of-pocket purchases have increased beyond pre-pandemic levels. In part, it is likely to be because the independent sector is catching up with demand, given that activity decreased so dramatically in the early months of the Covid-19 pandemic. However, problems in accessing NHS care, including long waiting times for diagnostic care and consultant-led treatment, could be contributing to rising demand (**Triggle 2022**).

The data on hospital activity also allows us to look at the types of procedures that were carried out privately. Many of the treatments delivered were diagnostic tests and orthopaedic care; however, the two most common treatments were chemotherapy and cataract surgery (**PHIN 2022**).

Who is purchasing private hospital services and other medical care?

The available data allows us to look at weekly household spending on hospital services, medical goods and medical insurance premiums by disposable income decile (Office for National Statistics 2021).¹ Household spending on health care services is higher in households with the most disposable income. However, household spending on health care services as a proportion of disposable income in more well-off households is roughly equivalent to that seen in the least well-off households (see Figure 3).

Figure 3 Household spending on medical expenses, split by disposable income decile, UK, 2019/20



1 We have used data up to March 2020 and excluded the period 2020/21. This is because the impact of the Covid-19 pandemic, the furlough scheme and associated changes to household spending mean that the data is not directly comparable to recent years.

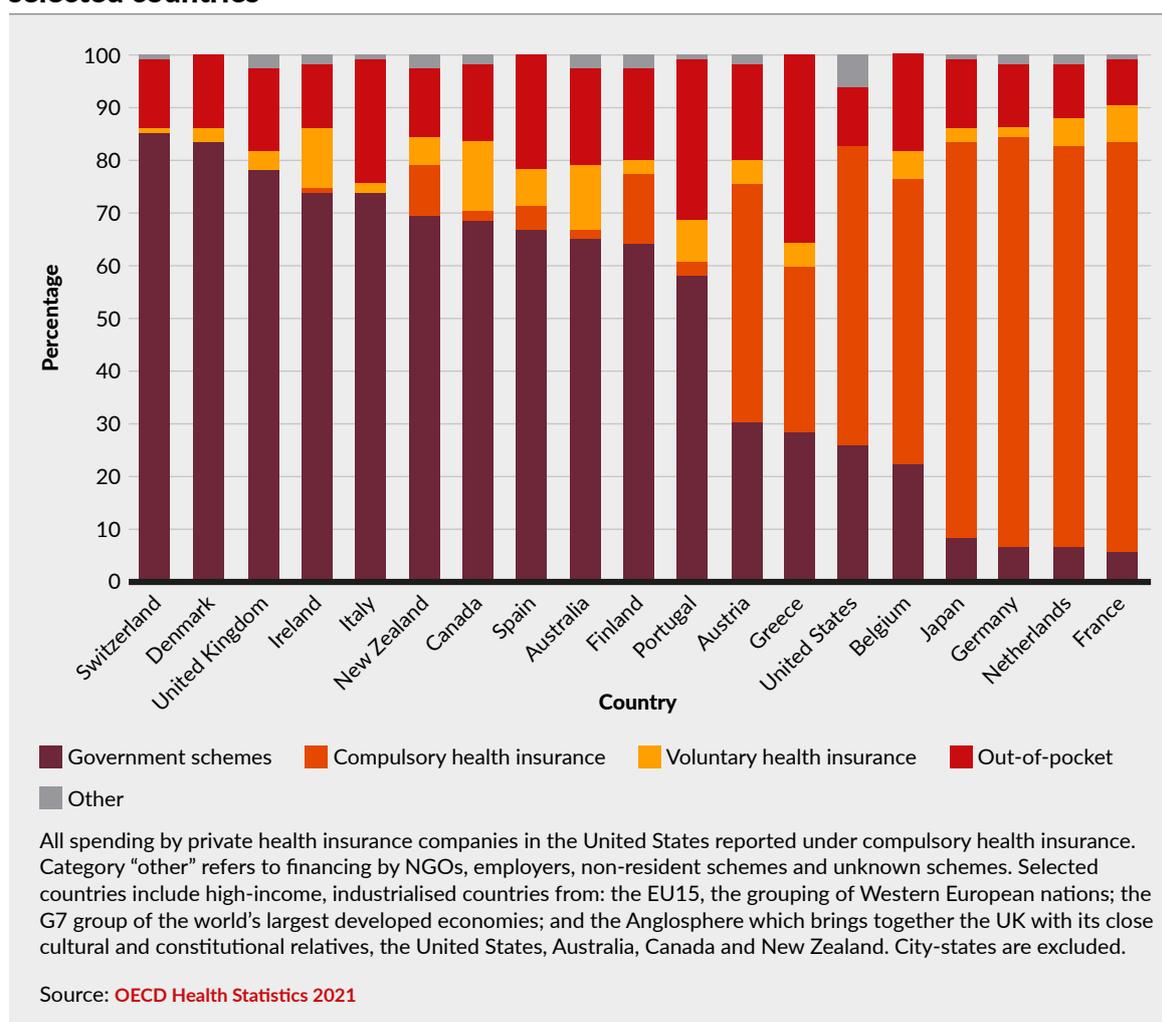
In the five years before the Covid-19 pandemic, households with lower disposable incomes have seen larger increases in household spending on hospital services (ie, excluding medical products and insurance premiums) as a proportion of their disposable income – from 0.3 per cent in 2015/16 to 0.8 per cent in 2019/20.²

² Figures for the lowest disposable income decile in 2015/16 should be used with caution because they are based on fewer than 20 households.

How does the UK compare to other nations?

While out-of-pocket spending on health care may be rising in the United Kingdom (UK),³ as a proportion of total health spending it remains below the average recorded across all Organisation for Economic Co-operation and Development (OECD) nations. However, it is above the level seen in comparable European nations like Germany, France and the Netherlands (OECD 2021). Voluntary health insurance in the UK is at a much lower level than in most comparable nations (see Figure 4).

Figure 4 Health expenditure by type of financing, 2019 (or nearest year), selected countries



³ Data available is on a UK, rather than England-only basis.

What is driving these patterns and what are the implications for patient care?

Push and pull factors – are people opting out of the NHS or opting in to the private sector?

In the years before the pandemic, NHS waiting lists and waiting times were growing as the health service routinely missed key performance targets. At the same time, overall public satisfaction with the NHS trended downwards from its historic high point in 2010 ([Wellings et al 2022](#)). This raises the question, is there a relationship between access, experience and satisfaction with the NHS and likelihood to self-fund health care?

Some qualitative deliberative research has highlighted how dissatisfaction with the NHS is expressed in 'opting out' ([Costa-Font and Zigante 2016](#); Dowding and John 2011). However, others have argued that the growth of the private health care market is a result of positive innovations within the private sector, including the development of new digital platforms to access health care (such as apps), as well as its capacity to provide more personalised care and the provision of 'non-essential' care like some cosmetic surgeries ([Exley et al 2012](#); Royce 2011).

This is more likely to be the case among households with the most disposable income ([Costa-Font and Zigante 2016](#)). However, the data also shows that the self-funded procedures that account for this growth in private health care are essential treatments like chemotherapy and vital diagnostics.

These push factors – ie, those pushing people away from the NHS – and the pull factors that draw people toward self-funding their health care may operate differently across some socio-economic groups.

Access, quality and public satisfaction – what does it mean for future demand?

If difficulties accessing services and declining satisfaction rates with the NHS have been contributing to increases in the number of people self-funding health care, what impact will the current state of the NHS have on future demand for independent sector health care services?

In 2021, public satisfaction levels with the NHS saw an exceptional fall, with just 36 per cent reporting they were satisfied – a 17 percentage point decline on the previous year ([Wellings et al 2022](#)). This is the single largest one-year fall in satisfaction, and it brought overall satisfaction levels to their lowest level in 24 years.

The primary reasons cited for this dissatisfaction with the NHS were that it takes too long to get an appointment and there are too few staff ([Wellings et al 2022](#)). Both these issues are unlikely to be resolved in the short term. The NHS workforce crisis is an endemic one that will take years to resolve. And while the NHS's elective recovery plan sets realistic targets to tackle the backlog and reduce waiting times, it is likely that waiting lists will continue to grow for some time ([NHS England 2022a](#); [Beech et al 2019](#)).

Given this, some market analysts and other commentators have forecast that the private health care market will grow significantly over the next few years ([LaingBuisson 2021](#)). Some independent sector providers have already made significant investments to expand their capacity in England.

However, given the turbulent prevailing economic conditions and mounting concerns about the cost of living, consumer confidence is likely to be impacted, which could limit demand ([LaingBuisson 2021](#)). While 2021 saw a rapid growth in the number of people self-funding a wide range of treatments and procedures, it is unclear whether that trend will continue, and whether the relationship between long waiting times and people 'opting out' will also continue.

Health inequalities, cost of living and a 'two-tier system'

The Covid-19 pandemic starkly exposed, highlighted and exacerbated health inequalities in England ([Williams et al 2022](#)). If limited access to NHS care, long waits and dissatisfaction persist and drive increased out-of-pocket purchase, then there may be a direct impact on health inequalities. People with greater levels of disposable income will be more able to opt out of the NHS and receive more timely treatment, while people on lower disposable incomes may need to spend an increasing proportion of that income on hospital services ([Office for National Statistics 2021](#)). So, problems in accessing NHS care may impact on people's physical and mental health, and their financial situation.

Choice and control

Successive governments have used the independent sector to increase overall health service capacity and to offer patients greater choice and control over their care ([The Health Foundation 2020](#)).

The NHS elective recovery plan published in February 2022 commits to giving patients waiting for planned NHS treatment the right to choose provider, which may be an NHS provider or an independent sector provider. The rationale for this is that giving people choice will improve access, as those who are able and willing to travel will be treated more quickly, which will bring down the total waiting list, and by including the independent sector, this increases overall capacity.

There is evidence to show that greater independent sector capacity in a local health system can improve overall capacity and activity levels ([Kelly and Stoye 2020](#)). This means that more patients get treatment without creating direct negative consequences for the NHS; in fact, it could support NHS performance.

It could therefore be argued that growth in independent sector capacity and activity will provide a net benefit to people using the public system as it moves demand, and therefore pressure, away from the NHS, thereby improving access for those still waiting for NHS treatment ([Colombo and Tapay 2004](#)). However, these benefits would be confined to the least deprived areas of the country, where independent sector capacity is greatest, and this may serve to compound existing inequalities ([Wyatt and Parsons 2021](#)).

Conclusion

Although discussions of the role of the independent sector in delivering health care tend to get drawn toward the idea of the 'privatisation' of the NHS, the reality is far more complex.

Over the past decade, the proportion of NHS spending on the independent sector has flatlined, and the new Health and Care Act 2022 undoes many of the market-based reforms that some argued had opened the door to greater independent sector involvement in the NHS.

To understand the role of the independent sector more fully, we need to look at private purchase of health care, where people use their own money either out of pocket or via an insurance scheme. As NHS waiting lists have grown and public satisfaction rates have plummeted, evidence is emerging that more people – including groups with lower disposable incomes – are choosing to self-fund their health care.

The prevailing economic conditions, including inflationary pressures and the rising cost of living, may stifle this growth. But as long waiting times for NHS care persist, this may widen inequalities in access, as households with more disposable income will be better able to self-fund health care and avoid NHS waiting lists. Those with lower disposable incomes may well still choose to self-fund in order to ensure more timely access to health care, but will run the risk of greater financial hardship if they do so.

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