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The Private Health Insurance Market in the UK over the Period 1986-1995 : an Analysis of Main Developments*

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-Abstract-

Key Words : private health insurance(사건강보험)

이 논문은 지난 10년간(1986-1995)의 영국의 사건강보험(private health insurance) 시장의 전반적 추이를 관찰, 국민 의료 써비스(National Health Service)와의 관계 및 역할 변화를 고찰한 것이다. 가장 대표적인 PMI (private medical insurance)와 PHI(permanent health insurance), LTCI(long term care insurance)를 집중 연구하였으나 지면관계상 PMI를 중점적으로 다루고 PHI나 LTCI는 간략히 소개하였으며 관련도표는 모두 생략하였다.

영국의 사건강보험 시장은 1990년대 초의 정체기를 거친후 이제 서서히 가시적인 성장을 보이고 있다. 많은 영국 국민들은 정부가 기본적인 복지혜택 외에는 더 이상의 치료와 미래 간호를 보장할 수 없다는 사실을 이해하고 있으나 아직 대부분은 어떤 형태로든 NHS 외의 보호장치를 가지고 있지 못하다. 따라서 영국민의 사건강보험에 대한 관심은 점차 고조되고 있는 것이 현실이다.

사건강보험 시장의 성장은 몇가지 중요한 요소에 좌우된다. 첫째, NHS의 capacity이다. 달리말하면, NHS에 대한 정부의 각종 정책과 태도는 시장에 직접적인 영향을 미친다. 둘째, 경제성장은 상당히 결정적인 요소이다. 1990년대 초의 침체에서 이미 보았듯이 경기후퇴와 그와 동반된 높은 실업은 사적 의료써비스의 구매력을 감소시킨다. 셋째, 시장을 확대하려는 보험회사의 노력 또한 빼놓을 수 없는 중요한 요소이다. 새로운 구매자를 위해서 또 시장에서의 치열한 경쟁에서 살아 남기 위해서 보험회사들은 폭넓은 범위의 상품을 개발하고 노동자들을 위한 값이 저렴한 상품들을 소개시켜 왔다. 비록 이런 종류의 저렴한 상품들은 커버하는 범위가 불충분하지만 총 인구의 보험가입을 증가시킨다.

현 상황에서 PMI는 NHS에 대한 대안이 되지 못하고 단지 부분적 대용책일 뿐이다. 또한 시장을 확대시키려는 정부의 노력에도 불구하고 극소수의 사람들만이 PHI에 커버되고 있다. LTCI는 너무 비싸 지극히 부자들만이 구매할 수 있을 뿐, 평균임금 또는 그 이하의 사람들은 보험료를 감당할 수 없다. 한편, 영국의 사건강보험 시장에 대한 전망 또한 복합적이다. 즉 PMI 부문은 서서히 성장, PHI 부문은 계속적으로 꾸준히 증가, LTCI 부문은 제한적이기는 하나 발전하리라 보는 것이다. 따라서 미래시장을 예견하는 것은 그리 쉽지 아니하다.

결론적으로 영국국민은 질병, 또는 치료가 필요한 경우 전적으로 NHS에 의존하고 있으며 현재의 사건강보험은 다양한 질병위험에 대한 보호를 제공하기 보다는 단순히 부가적인 혜택에 지나지 않을 뿐이다.

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Introduction

This paper will look at the overall market for private health insurance in the UK during the last ten year period 1986−1995, concentrating on private medical insurance (PMI), permanent health insurance (PHI) and long term care insurance (LTCI). These three areas are very different in terms of the risks covered, but similar in so far as the private instruments are all insurance−based and the role of the private sector has grown in recent years.

1. Private Medical Insurance (PMI)

Private medical insurance (PMI) is an insurance designed to pay for the cost of non−emergency medical treatment. There has always been private health care alongside the NHS although its size has varied according to political, social and economic circumstances. PMI has been the main engine of private health care growth in the UK.

1.1. Scope of the UK market

At 31 December 1995 there were an estimated 3,289,000 PMI policy holders in the UK covering 6,188,000 people − 10.6 per cent of the UK population (Laing and Buisson, 1996). The number of PMI policyholders have increased steadily from 2.4 million in 1986 to 3.3 million in 1995. In the same period, the number of people insured by private medical insurance was increased from nearly 5 million, 8.7% of the UK population, to 6.2 million, 10.6% of the UK population. In 1990, the proportion of the population covered by PMI, 11.5% of the UK population (6.6 million people), was at its highest since the introduction of the NHS. However, the figure had fallen back to less than 6.2 million by 1993. Since 1993 the proportion of the total population remained relatively static despite the growth in the number of people insured during the period 1993−1995. This was partly related to the recession and the fact that employers were less willing to pay for such fringe benefits. According to MSI Databrief (1994), the slowdown in the rate of growth in 1993 and 1994 is believed due to continued PMI inflation which impacted on demand during the recessionary period.(Table 1 : UK market for PMI 1985−1995 생략)

PMI subscription income for all medical insurers combined was £609 million in 1986, the income more than doubled between 1986 and 1991, increasing to £1,271 million, and almost trebled over the last ten years, at £1,701 million in 1995. Increases in subscription costs, combined with the effects of the economic recession in the UK contributed to relatively stable levels of subscription numbers in the UK during the early 1990s (MSI Databrief, 1994). Mark Newson, Head of Marketing at BUPA, notes that although PMI trends are on the increase, growth is relatively small. "The market is seeing a deepening rather than a widening of insurance" (British Journal of Health Care Management, 1996).

1.2. Industry structure and market share

The PMI market is supplied by either provident associations or commercial insurers. In early 1996, there were 27 private medical insurance (PMI) carriers active in the UK market. Eight of them are the non−profit distributing provident associations which developed in the 1930s and early 1940s to provide healthcare insurance prior to the introduction of the NHS, and the remaining 19 are commercial insurers which have entered the healthcare market more recently including mutual societies such as Norwich Union (Laing and Buisson, 1996). With increased competition, provident associations have lost market share over the last ten years. The share of subscription income held by the three largest providents combined. BUPA (British United

Provident Association), PPP (Private Patients Plan) and WPA (Western Provident Association) was more than 90% of the private medical insurance market in 1986. However, their combined market share has fallen significantly to approximately 80% of the total PMI market in 1995. The three main changes in the last decade have been firstly, the relative decline of BUPA, secondly, the relative growth of PPP and the growth of commercial insurers' market share. (Table 2 : PMI market share by subscription %, UK 1986－1995 생략)

MSI Databrief(1994) analysed that the market has become increasingly competitive primarily due to the following: firstly, commercial insurers' experience of adopting aggressive promotional and marketing campaigns, secondly, the substantial capital behind commercial insurance companies, and lastly the low brand loyalty amongst people taking out insurance policies means that many individuals and employers will search for the cheapest policy at the time of renewal and are quite willing to change their insurance company.

Although the provident associations still account for 80% of the total market, commercial insurers have been increasing market share, and with the entry of Legal & General into the individual paid PMI market, it seems likely that the commercial insurers' market share will continue to increase (Laing & Buisson, 1996). Meanwhile, Ferriman (1992) pointed out that greatly reduced profitability between 1990 and 1993 discouraged potential new entrants among insurance companies, and those already operating in this area are imposing 'stringent new rules for medical treatment' under which 'subscribers now approval from their insurers before starting treatment'.

1.3. Market segmentation

PMI consists of two principle submarkets, company paid and individual paid with a third category － voluntary employee paid groups － where companies, professional associations or trade unions act as an umbrella organisation but where employees pay the premiums entirely out of their own pockets (Laing & Buisson, 1996). The majority of PMI policies in the UK are part of company schemes as opposed to either group schemes or policies taken by individuals. In 1986, of all people in full time employment with medical insurances, only 18% had an individual scheme, with 65% having some form of company scheme and 17% belonging to some other group scheme (Munich Re, 1990).(Table 3: Customer profile of the UK PMI market, 1993 생략)

MSI(1994) estimates that 65% of all policies in the UK in 1993 were company schemes. The greatest proportion of these were fully paid by the employer. However, this share is believed to have declined in comparison with that recorded in the 1980s as more employers became reluctant to put forward the whole amount due to rising subscription costs and greater pressure on their own margins during the recession. Company policies which are paid by employees and part paid by employers are believed to account for a growing proportion of the sector. Individual policies accounted for 20% of the total number of policy holders in 1993, but the proportion of individual policies was eroded as this sector was more adversely affected by the recession than that of company policies.

According to Laing & Buisson(1996), company paid PMI was the fastest growing segment throughout the 1980s, followed by individual paid PMI. Voluntary group purchase expanded rapidly during the boom years of 1979－81 as the provident offered generous discounts to encourage take up among largely middle and lower income groups. But claims experienced proved high, premiums were increases substantially and subscriber numbers have suffered erosion since. In the 1990s, both company paid and 'other' PMI subscriber numbers have plateaued. Claims costs

per subscriber are substantially lower in the company paid sector than in the individual or employee paid sector. This is to be expected since company paid subscribers have a younger age profile. According to the GHS for 1987, only 2% of company paid subscribers are 65 or over, compared with 25% of individual subscribers. Meanwhile, the group market has been fairly flat in terms of numbers covered (Mintel, 1996).

1.4. Coverage

PMI typically funds the cure or relief of acute illness or injury. PMI does not cover the treatment of chronic illness and pre-existing conditions. The coverage available under a policy will vary greatly according to the insurer, the premium level chosen and the hospital band selected.

The main element of private medical costs is hospital accommodation. Most insurers offer a number of different premium levels based on different bands or grades of hospital.

A standard policy usually covers :

a) In-patient treatment
b) Home nursing and out-patient treatment where follows in-patient treatment.
c) Specialist treatments such as psychotherapy.
d) Cost of a hospital room, nursing care and theatre fees.
e) Professional fees, such as surgeon, anaesthetist and consultant.
f) Drugs, dressings
g) X-rays and other peripherals.
h) Treatment abroad for limited periods, to cover e.g. holidays.

The most common exclusions are :

a) Chronic conditions : Illnesses requiring permanent or prolonged treatment e.g. terminal cancers, diabetes, multiple sclerosis.
b) Pre-existing on-going conditions.
c) Self-inflicted injuries or disorders
d) Alcohol or drug abuse.
e) Cosmetic surgery, unless resulting from an accident.
f) HIV and AIDS with some exceptions
g) Routine dental treatment
h) Private GP consultation
i) Routine health checks
j) Transplants (except skin grafts and corneal)
k) Many alternative therapies, preventative treatments
l) Routine pregnancy and childbirth
m) Fertility treatment, with some exceptions
n) Services sought without a referral from a family doctor
o) Appliances (wheelchairs, spectacles etc)

In addition, some insurers are adopting a moratorium clause in their policies. This clause usually excludes in the first 24 months of insurance any medical condition or related condition for which the insured has received treatment, sought medical advice, or was aware existed during the five years immediately preceding the application for the policy.

As the market has grown, PMI has become fragmented, exhibiting extreme variations in premiums and cover. Laing and Buisson (1996) opined that an increasing level of competition over recent years in the medical insurance market has led companies to develop a wider range of policies in order to attract new market entrants. This has included low-cost policies which typically provide less cover but serve to penetrate the total population further.

1.5. Who buys PMI

Age

According to Munich Re's analysis (1990), in 1986, 9% of all people between 45 and 64 and 8% of all those aged 65 and over are covered by medical insurance in the UK. It is not surprising that a tiny proportion of those with employer-

provided insurance are over 65 years of age, but it is also clear that the elderly are less likely to purchase private insurance for themselves, possibly because of higher premiums. It is also true, however, that old age is correlated with low incomes, which could be driving this result (Besley et al, 1996). Meanwhile, marriage significantly appears to be an important buying trigger for individually held policies while having children does not. The reasons for the difference between the married and unmarried can be explained by age and the fact that many group schemes either cover spouses and children at no cost to the employee or provide a low cost family option (Mintel, 1996).

Socio-economic characteristics

There is also a variation according to socio-economic groups. According to Besley et al's study(1996), the privately insured tend to be better off, better educated, middle-aged and more inclined to support the Conservative Party. It is found that by Mintel that in 1996 working managers have the highest ownership levels of any group at 44% with around 30% covered by their employers' scheme. Those covered by group schemes underline the fact that the perk is considerably biased towards the professional and managerial classes.

Regional analysis

The level of market penetration of PMI tends to vary significantly between the regions. The greatest proportion of the population covered by PMI live in the Outer Metropolitan Area, indeed, in this region 20% of the population can utilise private healthcare facilities. This is closely followed by the Outer South East region, where 19% of the population is protected by medical insurance. The proportions of the population in London and East Anglian are also above national average. In contrast, the remaining areas fall below the national average, with Wales, Scotland and the North recording the lowest coverage. In the North, only 4% of the population is protected by medical insurance (MSI Databrief, 1994).

Attitude

The great majority of individualism, whether insured or not, would like to see public health spending increased. None the less, the privately insured do show a greater tendency than do others to want no increase in health spending, with 15% rather than 9% falling in this category. Calnan, Cant and Gabe (1993) also found that those with private insurance are less likely than others to rank health spending as their top priority for additional public expenditure.

Adverse selection

When it comes to adverse selection, there appears to be little urgent problem actually happening in the UK. Adverse selection occurs when potential subscribers know more about their risks than the insurer does. Unhealthy people are likely to subscribe, thus insurers increase its premium to anticipate adverse selection, forcing lower-risk subscribers to opt out (Hall, 1994). However, the privately insured in the UK tend to be better off, better educated, middle-aged and the main reason for buying such insurance is to avoid the NHS waiting lists for the elective surgery and to get 'hotel' benefits in the private sector. It does mean that the purpose of buying PMI is not to gain an access to health service itself but to gain additional benefit. Another thing to be considered is that generally the health of the poor is worse than the rich and they are in high-risk, however their main needs for health service are covered by NHS, thus, they need not buy PMI separately and also cannot buy it due to the high cost. UK people heavily rely on the NHS and only are relatively healthy minority of people (around 11% of the UK population) are covered by private insurance.

1.6. Why buy PMI?

Whether an individual chooses to private health insurance is a multifaceted decision. According to Besley et al's study (1996), the main reason for buying such insurance is to gain access to private medical care in the event of that being necessary. It is the enhanced flexibility of private sector treatment which attracts individuals. There are also valued 'hotel' benefits in the private sector (private rooms and telephones being examples). It allows discrimination between hospitals and consultants, consequently more individualised treatment. Amongst many reasons, avoiding long waiting lists for non-urgent operations is the most popular one. Calnan et al (1993) also noted that people take out private health insurance to minimise the risk of not being treated immediately and the consequent loss of time and money being on the waiting list causes. It is widely accepted that crises in the NHS have produced more rapid growth in private medical insurance and private insurance provides a means by which individuals can reduce their reliance on the NHS as a source of health care. However, the most important point to note about the current state of medical insurance is that it does not offer an alternative service to the NHS. PMI is essentially an indemnity cover which is complementary to the excellent care available in the NHS.

1.7. Claims

The incidence of claims and their costs have been rising steadily in the 1990s. The value of claims incurred is estimated at £1450 million in 1995, an increase of 8% on 1994 (Laing & Buisson, 1996). According to Illman (1995), there has been 'a tidal wave in claims'. In 1989, 23 out of every 100 BUPA subscribers made a claim ; by 1992, the figure had risen to 31 in every 100 ; and by 1993, to 33 in every 100. It is estimated that by 1999, 57 in every 100 members will make a claim.

It is suggested that by Mintel (1996) in effect, the PMI sector is facing the same problems as the NHS. Firstly, medical advances have raised the public's expectations of healthcare but the cost of new treatments is usually high and requires substantial investment in new technology. Secondly, the incidence of claims continues to rise and, ironically, a major factor for this is higher premiums encouraging subscribers to 'get their money's worth' by seeking treatment for conditions they ordinarily would not, or would delay until it worsened. It is likely that claims will continue to increase in the future causing an inevitable rise in premiums.

1.8. Price of PMI

The price of PMI is believed to be the major factor which determines the size of the private medical insurance market. Premiums generally appear to rise in line with increases in medical care costs. An increase in the demand for private insurance is likely to be one determinant of the overall level medical care costs. Other factors include the capital costs of building hospitals, the ratio of capital to staff, the target income of doctors and the quality of uninsured patients. Thus, the price of PMI ultimately depends, first, on prices charged by hospitals and specialists and, second, on the level and nature of utilisation for which claims are made. (Table 5 : PMI Price inflation 1986-1995 생략)

The insurers have sought to control costs, arguing that market growth is dependent on premia stability and that increases in contributions will reduce coverage(Propper and Maynard, 1989). However, it is widely accepted that insurers' attempt to reduce costs by launching various budget policies has been only partially successful. It has not led to a significant increase in new subscribers but has helped reduce the number of

non-renewals through policyholders trading down to lower levels of cover.

The problem of the steadily rising cost of medical insurance is a fundamental problem for the industry and is the main reason why the market has stagnated in the 1990s. Steadily rising cost have taken the standard PMI policy further out of range for the majority of adults and with medical inflation expected to continue to rise in the future, the scenario is that without some form of government compulsion there is little chance of consumer penetration increasing (Mintel, 1996).

Here the problem of moral hazard should be born in mind. There are a number of ways of adjusting insurance systems so as to cope with moral hazard problems. One is the provision of a 'deductible' or of co-payment. Deductible provisions would require the agent to meet the full costs of expensive users up to a certain limit, after which any excess is met by the insurer. A co-payment system would require the agent to meet a percentage of the costs of any excess, while the insurer met the rest ; this would preserve some incentive for economy (Le Grand and Bartlett, 1993). Another one suggested by Culyer (1993), which is increasingly practised in the USA, is for them to adopt a quasi-regulatory role, in which they specify levels of reimbursement prospectively, or set limits on, especially used by large US employers who offer health-care insurance as a fringe benefit, is to make special arrangements with Health Maintenance Organisations (HMOs) or Preferred Provider Organisations (PPOs).

1.9. Taxation of PMI

The Government provides substantial subsidies through tax relief for private medical insurance.

Corporate tax relief is available on private medical insurance premiums paid by employers on behalf of employees whose earned income, including the value of benefits, is less than £8,500 a year. Employers are also able to obtain business tax relief for the expenses incurred in providing any benefits in kind in the same way as for salaries and wages (Blunkett,1994).

Personal tax relief : Tax relief was introduced in April 1990 for PMI policies for people over 60 years of age. Relief is obtainable whether the policy is bought by the older person himself/herself or whether bought by a young person for the benefit of someone over 60. The Government has offered this tax relief, both as an encouragement to insurers to provide cover for over 60's and to encourage the take up of the insurance amongst this age group. Many insurance companies were attracted into this market. However, Industry sources universally indicate that this new tax concession did little to expand volume of demand in that sector of the market for PMI because administrative costs ware too high and the over 60s are not a profitable section of the market.

Laing & Buisson (1994) argued that the impact on demand would be larger if tax concessions were offered to persons below the age of 60, or if tax concessions were given to companies or individuals taking out long term, pre-funded policies designed to pay for PMI after retirement. However, such concessions are unlikely to be made available in the foreseeable future because of the political sensitivity of healthcare.

1.10. The future of PMI Market

The private medical insurance market has endured a period of stagnation following the growth of the market in the 1980s, and shown a slight recovery in 1996 mainly due to the improvement in the economy. Despite a reduced rate of growth in market size in 1993 and 1994, MSI strongly believes that the PMI market will enjoy moderate growth in the late 1990s as the domestic economy recovers, and corporate margins and private disposable income increases. In

fact, factors such as the continual problems of the NHS, an improving economic growth and the rising expectation for higher standard of health care suggest that PMI market should be expanding. In the medium to long term trends in the PMI market, MSI believes that greater emphasis will be placed on PMI in the future as it becomes one of the mainstream funding sources for healthcare in the UK, forecasting that the UK PMI market will continue to grow at 5% per annum, covering 16.5 per cent of the population by the year 2000.

However, some analysts do not expect PMI market to increase substantially in the long term. There are many reasons for this. It can be said that in essence, the problems of facing the PMI sector are the same as the NHS : Rising the real cost of treatment, a more health-conscious consumer base requiring the latest medical treatments, rising expectations, an ageing population. Another fact to be considered is that claims will continue to increase in the future causing an inevitable rise in premiums and also downtrading to less comprehensive cover can be expected to continue.

What is more, it is reported in British Journal of Health Care Management (1996) that the possibility has also been raised of NHS Trusts becoming distributors of PMI products. NHS trusts who have been steadily increasing their share of private patients are taking tentative steps towards launching their own insurance policies to meet the growing need to raise revenue for NHS services. Although it seems unlikely that any NHS branded health insurance packages in fact will be introduced, having own brand insurance could influence on the future of PMI market.

In addition, a crucial key factor to the market's development has been government policy and attitudes towards the NHS. The tighter public expenditure controls are, the greater is the scope for private insurance. Although Conservative policy towards private healthcare is avowedly to let it find its own level, in the near future the private market is unlikely to expand rapidly under Labour government because of their assurance of the NHS and their hostility to private medical insurance. Consequently, it is not straightforward to forecast the future of the private medical insurance market in the UK.

1.11. The relationship between PMI and the NHS

The relationship between private medical insurance and the NHS is complex and controversial. When looking at the relationship, there are many aspects to be considered. Firstly, many researchers have found that British people greatly support for the National Health Service (NHS), but have become dissatisfied with the standards of service. So far this has not resulted in an exodus from the NHS, however it is suggested that continued underfunding could have this effect, and crisis in the NHS will produce more rapid growth in private health insurance. Many product innovations in the late 1980s increased product affordability by restricting the conditions covered. As a result, it is clear that the current state of PMI does not offer an alternative service to the NHS but only a partial substitute for the NHS. Thus, even individuals with private insurance depend on the NHS for some forms of medical treatment, especially for emergency and catastrophic treatment. However, PMI allows people to have services when they need without long waiting for non-urgent operations. Secondly, private medical insurance has been the main engine of private health care growth in the UK. According to Johnson (1995), the reforms implemented under the NHS and Community Care Act of 1990 are likely to have the effect of encouraging private health care. Individual hospitals have been given the opportunity to become independent of the DHAs by forming self-governing Hospital Trusts, controlling their own funds and appoint-

ing their own staff. The trusts are expected to compete for contracts with private and conventional NHS hospitals, and they have been encouraged to enter into joint arrangements with private companies. At the same time, the slimmed-down DHAs were encouraged to shop around for the best deal and to make use of private facilities wherever this seemed appropriate. Meanwhile, it is also reported by Blunkett(1994) that with the expansion of Trust hospitals' private facilities, many insurers are now offering "preferred hospital" schemes which give access to NHS pay-bed facilities, but exclude treatment in private hospitals. For example, Norwich Union's Trustcare policy gives access to 663 NHS hospital pay bed facilities. In addition to that, another development should be considered in this area. The initial surge in private health care in the early 1980s was concentrated in the hospital sector, but more recently a small number of companies have begun to operate in the primary health care sector. There has also been a modest growth in private psychiatric care. Some of private insurance companies have shown a greater willingness to provide cover for this type of care (Johnson, 1995). Lastly, there is a large political element to bear in mind. Some analysts argue that the principal means for the NHS underfunding problem should be to stimulate PMI because simply cutting in real services and lower spending on NHS will precipitate an increase in private insurance. However, traditionally, the Labour party has been hostile towards the private medical sector and came into power in 1 May 1997. Therefore, it seems likely that PMI market in the UK significantly depends on the capacity of the NHS to care for patients, and the relationship between PMI and the NHS depends on the government policy and attitudes towards the NHS.

2. Permanent health insurance (PHI)

Permanent health insurance(PHI), sometimes referred to as earnings replacement, insures against loss of income due to sickness or disability. It provides up to 75% of an individual's income in the event of illness or accident which prevents the policyholders from gaining employment.

2.1. Relationship between PHI and State Benefits

Permanent Health Insurance provides financial compensation for illness and disability, but many of the natures between PHI and state benefits are the same. The government has made efforts to reduce the number of claimants in state benefits. Changes in state disability benefits that came into force in April 1995 were expected to provide a boost to sales of PHI but this has failed to occur. There has been a steady increase in the amount paid out in state benefits. There has also been a steady increase in the number of claimants incapacitated by sickness and invalidity. In addition to that, the new incapacity benefits is both harder for individuals to get awarded due to a toughening up of increase in the criteria and the level of the benefits are also lower (Mintel, 1996). Burchardt and Hills (1997) argue that PHI might provide income replacement for better paid, but it is unlikely to be suitable for the low paid or those with long-term OSP.

2.2. The future market for PHI

According to Mintel (1996), there is a widely belief that PHI sales should be much higher than they are on the basis of the rising incidence of long term illness and disability affecting individuals during their employment and the fact that employers on average only pay six months earnings to an incapacitated employee. However, despite of the government's efforts, the recent record shows that PHI sales have been in decline

whilst critical illness sales have increased steadily, and it is likely to continue. The Office of Fair trading (OFT) analyzed that the reasons for the 'under-selling' of PHI include : ignorance of the product within the population ; a widely held belief that employers will continue to pay throughout for the duration of any illness ; the "it won't happen to me" syndrome ; poor product design ; and a misleading product title (for non-experts can be confused with private medical insurance for example). It is also suggested that to promote sales of PHI policies, PHI providers should draw up a standard definition of disability and be concentrating on simplifying their products.

3. Long-term care insurance (LTCI)

Long-term care insurance (LTCI) is designed to insure against potential future care expenses, to fund the cost of full time care either in a nursing/residential home or in a person's own home.

People have long received long-term nursing care free through NHS long-stay geriatric beds. During the 1980s there was a clear policy of reducing hospital care for non-acute cases and increasing use of local authority, voluntary or private nursing and residential homes (Burchardt and Hills, 1997). However, due to the high cost of long-term care, very few older people are able to purchase services out of their income. In May 1995, an estimated 103,000 or 28% of independent sector care home residents were self payers, for nursing homes with 47,000 or 27%, and for residential homes with 56,000 or 29% respectively (Laing and Buisson, 1996)). In line with that, there has been a clear assertion that the state can not afford to meet the full cost of care for older people and an implicit view that individuals must provide for their own old age (Health Service Journal, 1995). Consequently, the issue of long term care becomes a major social problem and people's concern about LTC insurance has been increasing. Although the market is currently a small one, the private insurance companies have shown a growing interest in this market and see its prospects as being bright due to a greying population.

3.1. Relationship between LTCI and government policy

It is clear that the private long term care insurance market remains very small compared with the global market for long term care services for elderly and physically handicapped people. The prevailing view is that affordability is the principle barrier to sales. Whynes (1995) argued that the expansion of the private LTC insurance market is presently hampered by two factors, myopia and affordability. However, as concerns grow about whether the state will be able to cover long-term care needs in the next century, and as more people realise that they might be affected by the means test applied to state support, expansion of the role of the private sector is under active debate (Burchardt and Hills, 1997).

In May 1996 the government published A New Partnership for Care in Old Age, containing proposals to encourage people to provide for their own long term care needs and protect their assets. It is said that this proposals could stimulate a burgeoning marketing in private long term care financing products. Especially long term care indemnity insurance in partnership aims to offer an incentive to people of all ages to insure specifically for the possibility they may need residential or nursing home care in later life, and to reduce state spending by offering an alternative to divestment for protecting assets.

Should the government encourage private funding mechanism? There are equity objections to stimulating private financial products designed to complement state funding. However, for pensioners with moderate incomes long term care insurance could free them from reliance on public

support, perhaps allowing them further scope for choice and peace of mind (Wittenberg, 1989). This is the main justification for encouraging private sector initiatives (Laing, 1993). Such a statement as this however appears to be based on the view that in a mixed economy of care, the public sector is least desirable : a party of government which wishes to encourage private finance may actually wish to make the public system less attractive in order to encourage private finance and provision (Parker and Clarke, 1995).

Johnson (1995) opined that the rapid development of private residential and nursing homes could not have occurred in the absence of two sets of favourable circumstances. The first was the willingness on the part of banks and financial institutions to finance the operation, and the second was the massive state subsidy in the form of income support payments. On the other hand, many commentators have warned that the continued development of private insurance brings the danger of a new gulf opening up between the better off and the poor. Johnson and Falkingham (1992) also noted that "The expansion of such schemes, while providing a means for people to plan for their health care needs in later life, may serve to increase inequality within the elderly population."

3.2. The Future market for LTCI

Opinions about the future market are divided between those who enthusiastically predict that it will become a mass market product and those who are sceptical. The proponents are convincing with the demographic timebomb and the people's strong desire for protecting their assets. Demographic trends, with increasing proportions in the population of people aged 75 and over and aged 85 and over, will mean an increase in the proportion of older people requiring some form of support, and an expanding market for commercial suppliers. Thus, some private insurance companies have shown a growing interest in this market. On the other hand, the opponents note the high cost of policies plus the population's inbred reluctance to take out insurance. It is a wellknown fact that people have a tendency not to think about long term care when still young.

Up until now, all long-term care products are expensive. The very rich can afford to pay for residential nursing care at the time of delivery, while those on average and below average incomes cannot afford the insurance premiums. Without some government stimulus, the market for long term care insurance will remain small. However, if the government takes action to encourage take-up of policies, there may be significant changes in the long-term care insurance market. And again, as the new government's policy on the long-term care has yet been unknown, it is difficult to forecast the future of LTCI market.

Conclusion

Changes in the take-up of private health insurance are strongly influenced by government subsidy and the state of the economy as well as by the activities of the sector itself.

This paper has shown that the private health insurance market endured a period of stagnation in the early 1990s, but now there is slow but visible growth. MSI forecasts that the market is likely to grow in the short term mainly due to the expected further penetration of PMI in the population. In addition, according to industry resources, most consumers now understand that the state cannot guarantee their treatment and the future care except for basic welfare benefits, while the problems of the NHS are also widely recognised. The vast majority of adults still have no form of private protection and the cost of taking out private health insurance is too high.

The growth of the private health insurance market depends on some important factors. First

of all, it seems likely that the private health insurance market in the UK significantly depends on the capacity of the NHS to care for patients, especially in the PMI market. In other words, government policy and attitudes towards the NHS have a direct impacts on the market. Secondly, economic growth is a highly crucial factor. As already seen in the early 1990s' stagnation, the recession and its accompanying high level of unemployment will reduce employers' and employees' capacity to purchase private services. Last but not least, the growth of the private health insurance market can be highly affected by insurance companies' efforts to expand their market. In order to attract new market entrants and to survive increasing competition in the market, insurance companies have developed a wider range of products and introduced cheaper policies (with lower benefits) for the majority of the working population. Although this kind of low-cost policy typically provides less cover, it serves to increase insurance of the total population. In addition, some insurance companies have expanded into new markets.

In the current context, private medical insurance (PMI) does not offer an alternative service to the NHS, but only a partial substitute. As for permanent health insurance (PHI), despite the government's efforts to increase the market, very few people are covered by PHI. Long-term care insurance (LTCI) products are very expensive. Thus, the very rich can afford to pay for the future care, while those on average and below average incomes cannot afford the insurance premiums. Consequently, it can be concluded that in the UK, people rely heavily on the NHS for cover against the risk of becoming ill and needing medical treatment. The current private health insurance is simply an additional benefit rather than a sharing of the responsibility for provision of protection against a variety of health risks.

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