BUPA's Interim Response to the Labour Party public consultation document "A future fair for all"

December 2003

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Executive summary

1. **BUPA is a provident association. This means that any profit is reinvested in better schemes and services for the benefit of BUPA's customers.**

2. **This interim response concentrates on questions of genetics and private health insurance; we will respond later on other issues.**

3. **Genetic profiling is only a part predictor of any individual's future health.** There is no evidence that greater availability of genetic profiles would either raise the costs of insurance or threaten the existence of the private health insurance market.

4. **The experience so far is that genetic science improves the quality of cover that is available.**

5. **The industry body's code of practice does not allow insurers to ask people to undergo genetic tests in order to obtain insurance[1].** BUPA doesn't ask people to provide the results of any tests they may already have taken, nor do we take a family history. In fact, we ignore the results of any tests for the purpose of underwriting. The Human Genetics Commission says that no one should be unfairly discriminated against on the basis of his or her genetic characteristics[2]. We agree.

6. **Private health expenditure is an important part of total health expenditure in the UK, and makes a valuable contribution to the healthcare system and the economy.** Since genetics will not have an effect on private health funding in the long term, the contribution of private medical insurance to funding will continue to be important.

[1] Association of British Insurers Code of Practice on Genetic Testing 1999
[2] Inside Information: balancing interests in the use of personal genetic data Human Genetic Commission 2001

About BUPA

BUPA is a provident association. This means that any profit is reinvested in better schemes and services for the benefit of BUPA's customers. BUPA is a broad-based health and care organisation with a growing international presence. It has operations in Ireland, Spain and Malta, Saudi Arabia, Thailand, Hong Kong, Singapore and Australia. It has more than seven million customers in 180 countries and approximately 40,000 employees. Its main interests are health insurance, hospitals, care services, health assessments, workplace health and childcare services and recruitment services for healthcare professionals.

In the UK BUPA runs 34 hospitals and the first privately operated Diagnostic and Treatment Centre at Redwood, which treats 1,000 NHS patients a month.

BUPA Care Services cares for over 17,000 residents in 246 care homes, approximately 70 percent of whom receive some form of state support. It is also providing over 200 intermediate care beds to the NHS. BUPA is a leader in good employment practice; for example in March 2002 BUPA Care Services won the Large Employer Award at the New Deal Awards in recognition of its demonstrated commitment to diversity and equality.

BUPA makes a big investment in the training and education of its staff; particularly in management training and in post-graduate and post-registration courses for clinical and professional staff. For example, BUPA Hospitals delivered over 2,800 days of training to 1,600 staff, with courses ranging from management skills to return to practice programmes.

BUPA Membership, as a commissioner of clinical services, has a strong record of driving quality initiatives in the independent sector. It accredits breast and colon cancer units in both independent and NHS hospitals; it encourages appropriate delivery of care; and has co-funded BUPA's leading edge work on the measurement of clinical outcomes using patient survey tools. This work was also supported by BUPA Hospitals who implemented the survey across their network, having already introduced and implemented evidence-based care pathways with the support of their consultants. In common with other hospitals in the sector, they have also joined a common benchmarking scheme to measure clinical performance indicators across the sector in a consistent manner.

BUPA's award winning Community Connections programme was set up in 2001 to recognise, assist and reward the good work already being done by BUPA people in their local communities. In less than three years since its launch almost 2,000 people have been engaged in a wide range of community-based activities. These activities are mainly to support three key areas - education, care and health/medical research. Employee volunteering is a core part of BUPA Community Connections programme covering city challenges, team fundraising and working with local schools. BUPA also grants £1.5 million to the BUPA Foundation to fund medical and NHS research.

Consultation Questions

What are the implications of genetics for private health insurance?

The consultation document suggests:
"As genetic knowledge brings greater predictability of a person's future healthcare needs it is likely to undermine the market for voluntary private health insurance as it becomes ever harder to pool people's risks with premiums mirroring each individual's predicted healthcare costs".

Analysis

However, none of the published academic research by actuaries suggests that genetic information will lead to significant changes in insurance prices or in access to insurance[3]. In fact:

Genetic profiling cannot - and will not - predict your future health: and will not, therefore, make people uninsurable for private health insurance. For example, knowing you have the BRCA1 gene that has caused breast cancer in other members of your family does not tell you whether you will get it`[4]. For more common diseases like heart disease or osteoarthritis, your genetic make-up is only one element influencing your risk of getting the disease. Environmental factors like lifestyle and diet are equally important[5]. The UK Biobank project will provide more evidence to establish the effects of our genes, combined with lifestyle factors, on the risk of developing common diseases. However, the project is just starting and will take ten years to produce results[6].

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[3] Prof Angus Macdonald, Director, Genetics and Insurance Research Centre, Heriot-Watt University, Scotland
[4] *The risk of cancer associated with specific mutations of BRCA1 and BRCA2 among Ashkenazi Jews*. NEJM 1997:336:1401-1408
[5] *Genetic Tests and Future Need for Long-term Care in the UK* Continuing Care Conference Dr V Warren BUPA
[6] *Our Inheritance, Our Future* Department of Health White Paper 2003

BUPA is not arguing for genetic test results to be used for underwriting.

We do not ask people to give us the results of any tests they may have taken. The Human Genetics Commission says that no one should be unfairly discriminated against on the basis of his or her genetic characteristics[7]. We agree.

The first wave of the genetic revolution- pharmacogenetics- is helping insured people get the right treatment, not reducing access.

Pharmacogenetics tailors drug treatment to the precise needs of the patient, based on a genetic test. When an insured person makes a claim, the Department of Health has agreed that BUPA can use genetic test results to facilitate finding the best care for that individual. This means, for example, giving breast cancer patients a drug that is going to be effective against their sub-type of tumour. Genetic testing will also help avoid inappropriate or over-treatment - because it will enable doctors to know more about which treatments will work for an individual patient.

Conclusion

BUPA's view – informed by experts in medical, actuarial and genetic disciplines – is that foreseeable developments in genetics will not see the end of private health insurance. Genetic science is not even close to predicting disease with sufficient accuracy to make insurance either unaffordable or unobtainable.

As Sir John Sulston, who led the Human Genome Project and won the Nobel Prize in 2002, has put it, the discovery of the human genome, is " a milestone certainly, and it's fundamental…for medical science for the future. All it is actually is reading out the code of instructions that makes a human being…. But we have not got there yet. This DNA business is just the beginning…"

[7] *Inside Information: balancing interests in the use of personal genetic data* Human Genetic Commission 2001

Ensuring that the NHS remains free at the point of need is a priority for everyone in the healthcare sector. However, demand for healthcare continues to grow, technology is driving up costs and patient expectations continue to increase. This means that keeping the UK population healthy will require solutions that facilitate choice and diversity in the funding and provision of healthcare. In the future people will have to be encouraged and enabled to choose to have private health care, rather than relying on the state to fund and provide for all their needs.

Private health expenditure, at over £5 billion in 2001[8], is an important part of total health spending in the UK. It makes a valuable contribution to the healthcare system, and to the economy. Since genetics will not have an effect on private health funding in the long term, the contribution of private medical insurance to funding will continue to be important.

[8] *Compendium of Health Statistics* Office of Health Economics 15th Edition 2003-2004

Policy Recommendations

1. BUPA recommends the Government reintroduce tax incentives for individuals and companies who take out private medical insurance.

The private sector plays an important role in the delivery of acute health care, relieving pressures in the NHS in a variety of ways. To believe that encouraging people to take out health insurance will hurt the NHS ignores the important contribution the private sector plays in the UK economy. BUPA treats approximately one million people a year who would otherwise have to be treated on the NHS. The independent health care sector contributes approximately £2 billion to UK PLC in tax revenues, savings to the NHS and employment. Also, companies that provide PMI find sickness absence is reduced and productivity is increased. This is significant because CBI estimates sickness absence costs UK business £23 billion a year[9]. National Economic Research Associates (NERA) estimated that companies that provide PMI for their employees gain a day in productivity and reduced sickness absence for every employee covered. This means that in 2002 the corporate PMI industry gained 2.5 million days of work.

NERA research suggests that if a company received tax relief on its National Insurance contributions for providing PMI, reinvesting just 60 pence of every pound received in tax relief would create a net positive effect to the Exchequer, allowing more funds to be put into the NHS.

Experience in other countries confirms that encouraging people to take out private medical insurance relieves pressure on state systems. Australia is a good example of this. When the Australian government brought in incentives for individuals to take out private medical insurance, the steep rise in public hospital expenditure - $3 billion in five years - halted and has remained stable at $14 billion for the last four years.[10]

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[9] CBI; *Business and Healthcare for the 21st Century*; November 2001 www.cbi.org.uk
[10] Harper Associates; *Preserving Choice: A Defence of Public Support for Private Health Care Funding in Australia*; April 2003

2. There needs to be a level playing field in the regulatory environment.

NHS and independent hospitals are regulated differently, despite the fact that private patients are sometimes treated in NHS hospitals and NHS patients are sometimes treated in private hospitals. This is confusing for both patients and staff alike and also costly for hospitals to administer. NHS and independent hospitals should operate under a single set of regulations common to both sectors. This would ensure a high degree of transparency for the patient.

Regulation should comprise both minimum standards, as is the case in the independent sector and guidelines, as is generally the case in the NHS. This would eliminate the need for most, if not all central targets. A core set of minimum standards for both sectors would do more for patients' safety than a raft of targets, as standards are basic requirements whilst targets are aspirational. No one should have to go to a hospital that nearly meets its targets.

NHS hospitals should be registered in the same way as independent sector hospitals. If a hospital fails to meet the minimum required standards for patient care and quality, it should not be allowed to treat any more patients until it is turned around.