

Mutuality: supporting health and wellbeing in the UK

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Contents

Executive Summary 3

Introduction 4

NHS Savings..... 6

Welfare State Savings..... 7

Employer Savings 8

Individuals' Savings..... 8

Conclusion 9

Appendix A..... 10

Appendix B..... 11

Executive Summary

There is pressure on public health services like never before. Frequently stories appear in the media highlighting growing waiting lists in the NHS against a backdrop of rising costs and pressure on staff, services and infrastructure alike. Add to that an aging population lacking access to later-life care and declining health due to an increase in long-term sickness, and it is clear there are major challenges for this and future UK governments. So much so that the Government has recently launched a consultation aimed at increasing employer uptake and widening the reach of occupational health to keep workers healthy. The over-riding objective being to “...*grow the economy and tackle inactivity by improving productivity and preventing health-related job losses.*”

In effect, this could lead to a shift in responsibility for public health away from central health services and onto employers and individuals.

Our report looks at the valuable contribution to public health finances given by the mutual and not-for-profit sector through the provision of health protection policies to employers and individuals. Most of these organisations are long-established with a strong heritage of protecting workers from the impact of ill-health, unemployment or old age.

These (many small) mutual organisations continue to operate effectively in the healthcare and protection sectors today. They do this by complementing, rather than competing, with the NHS and welfare state. They actively support employers in helping their employees to remain healthy and productive and, where they are unwell, to help get them back to work sooner.

The analysis in this report considers the potential benefits to the NHS from these organisations in terms of savings in treatment costs, and rehabilitation and accelerated recuperation.

We have looked at the potential benefits to the welfare state in terms of savings from the replacement of sickness benefits paid by the state and early return to work from rehabilitation.

We have also considered the benefits given to employers through a reduction in sick pay and a reduction in other costs from early return to work, and to individuals through receipt of policy benefits.

We have estimated that cost savings to the NHS, welfare state and employers arising from the provision of health protection policies during 2022 by the group of organisations covered in our analysis to be almost **£1bn**. This demonstrates the very valuable, and sometimes overlooked, contribution to public health services made by this sector.

Introduction

Purpose and scope of this report

1. This report is an update to the previous analysis OAC published in 2017 on the mutual sector's contribution to the NHS and welfare state in the UK. It summarises the findings of our research carried out into the mutual and not-for-profit sector's contribution to savings in the NHS and welfare state, and to employers and individuals, through the provision of Health Cash Plans (HCP), Private Medical Insurance (PMI) and Income Protection (IP) policies.
2. Since the last report, we have added data from a number of additional organisations falling within the slightly wider definition of mutuals and 'not-for-profit' entities, with this enlarged group producing considerably higher estimated savings to the NHS and welfare state. Growth in customers served by these organisations and increasing levels of cover also result in higher savings.
3. In preparing this report we have worked closely with the Association of Financial Mutuals (AFM) and are grateful for the support they have provided in collecting the data and their knowledge and valuable insights into the sector.
4. Except with the written consent of OAC, the report and any written or oral information provided must not be relied upon by any other person.

Underlying data and assumptions

5. The data underpinning our analysis is collected from the following sources:
 - annual report and accounts;
 - solvency and financial condition reports;
 - information collected via AFM surveys; and
 - press releases including claim statistics.
6. In addition, we have drawn information from other available public information sources:
 - tax rates and allowances from the government website www.gov.uk;
 - median weekly earnings from the Office for National Statistics (ONS); and
 - publicly available research and relevant reports.
7. Appendix A contains a complete list of organisations ("the report group") whose data has been considered as part of the analysis.
8. Appendix B summarises the key assumptions we have made.

The growing problem of sickness on the UK economy

9. NHS England publishes statistics for referral to treatment (RTT) waiting times for consultant-led elective care. The number of RTT pathways where a patient was waiting to start treatment at the end of June 2023 was 7.6 million. At the end of 2017 the figure was 4 million. At the time of publication of this report, this is a record high.
10. In July 2023 the ONS reported that the number of people economically inactive because of long-term sickness had risen to over 2.5 million, an increase of over 400,000 since the start of the coronavirus pandemic.
11. The House of Commons research briefing ("NHS Key Statistics: England, July 2023") stated:
"The 62-day waiting time standard for cancer (measured from urgent GP referral to treatment) has not been met in recent years. Performance declined between 2013 and 2018. Since the pandemic it has fallen further, with 54.7% of patients waiting under 62 days for treatment in January 2023 (target: 85%)."

12. In July 2023, the government published two consultations on supporting greater occupational health provision.
13. These statistics evidence a health service under increasing pressure dealing with a large and increasing population of sick people who are not being seen within target timescales for diseases where the outcome can be time critical.
14. Everyone has an interest in healthy working lives and health services that meet the population's needs. There is likely to be a range of measures that can address these issues including the role of products provided by the mutual and not-for-profit sector.

The sector's role

15. Today the sector provides customers with a range of products including HCP, PMI and IP policies, insurance contracts that provide cover for, or reimbursement towards, the cost of primary and routine healthcare, specialist consultations, diagnostic tests, and (in the case of PMI) hospital treatment and cancer treatment.
16. HCP policies provide reimbursement towards the cost of an extensive range of treatments including dental check-ups and treatments, eye tests and prescription glasses or contact lenses, physiotherapy, diagnostic tests, and health screenings. PMI policies provide cover for (for example) specialist consultations, diagnostic tests, outpatient treatment including therapies, day patient and inpatient procedures, radiotherapy and chemotherapy. The amount and extent of cover available for both policies will depend on the benefits selected.
17. IP policies are insurance contracts that allow policyholders to protect their income in the event of being unable to work due to accident or sickness. They may be sold on a group basis, where the employer initiates the scheme and provides cover for a group of employees, or on an individual basis. They can be short term, where typically the benefits are payable until a return to work or for a maximum of 12 or 24 months (for example), or long term, where the benefits are payable until either a return to work or retirement.
18. Whilst all three products offer direct benefits to policyholders, they are also beneficial to taxpayers, to employers and to the wider community through enabling a productive workforce.
19. The payments under HCP and PMI can represent direct savings to the NHS, both in terms of the cost of treatment where undertaken privately, and through savings attributable to rehabilitation and advanced recuperation.
20. The payments under IP policies represent a direct benefit payable to policyholders alongside support services. They also serve to reduce welfare state outgo and increase welfare state income through, respectively, lower benefit payments and higher tax receipts (on group income protection policies) than would otherwise be received.

The analysis

21. We have considered the potential benefits to:
 - the NHS in terms of savings in treatment costs, and rehabilitation and accelerated recuperation,
 - the welfare state in terms of savings from the replacement of sickness benefits paid by the state and early return to work from rehabilitation,
 - employers through a reduction in sick pay and a reduction in other costs from early return to work,
 - individuals through receipt of policy benefits, retaining their income and additional benefits gained from being a member of a mutual or not-for-profit organisation.
22. The following sections consider each of these stakeholders in turn.

NHS Savings

Treatment costs

23. In 2022, the report group paid claims of **£629m** in respect of healthcare treatments. A significant proportion of these claims, where the treatment is provided privately, represent direct savings to the NHS.

Rehabilitation and accelerated recuperation

24. HCP and PMI policies allow healthcare needs to be addressed sooner than they might otherwise be under the NHS. It is generally accepted (and various studies and reports back the theory) that early intervention allows individuals to recover more quickly and so reduces sickness levels in the workplace.
25. The Centre for Economics and Business Research (CEBR) published a report in 2015 “The benefits of early intervention and rehabilitation” which showed that where intervention services are in place the length of a typical absence falls by 17% (18% for mental health conditions).
26. A study by Medicash Health Benefits into the UK government’s Children and Family Court Advisory and Support Service (Cafcass) after they introduced a Medicash Health Benefits health cash plan for their employees showed a 15% decrease in the number of sick days taken.
27. Historic analysis by Shepherds Friendly Society indicated that their ‘back to work’ scheme for people that claim on their IP policy reduces the amount of time a claimant is off sick by 90 days, on average.
28. These statistics, although related to reductions in absence rather than in specific cost savings relating to treatment, are relevant when assessing the potential reduction in cost to the NHS from rehabilitation and accelerated recuperation since there will be less need for ongoing or prolonged follow-up treatment and investigations.
29. The likelihood is that, where rehabilitation activities occur, there is a potentially significant cost saving to the NHS in the form of reduced referrals to specialist teams, fewer scans and even cases where surgery might be prevented. Using the published information available we have conservatively estimated these savings as 50% of the cost of the initial treatment provided.
30. A report by Zurich in December 2015 “Income Protection and rehabilitation – working together” concluded that rehabilitation activities were undertaken in just over 25% of their income protection claims.
31. Assuming that, in 25% of claims paid under HCP and PMI policies, a saving of 50% of the cost of treatments provided is made from rehabilitation activities results in an additional saving to the NHS of **£90m** each year.

Welfare State Savings

Replacing sickness benefits paid by the state

32. The UK benefit system is complex and there are various types of benefits payable where individuals are unable to work due to sickness. Entitlement to, and the level of any payments can vary significantly. We do not have in-house expertise on the benefits payable under the welfare state and complex interactions with the state benefit system make it very difficult to assess the potential benefits of IP policies. For the purposes of this analysis we have necessarily made some simplified (cautious) assumptions.
33. We estimate that the total cash payments made to holders of IP policies during 2022 by the organisations analysed in this report was £112m.
34. If employees are too ill to work, Statutory Sick Pay (SSP) is paid by the employers for up to 28 weeks. If an employee's sickness lasts beyond 28 weeks they may be entitled to Employment Support Allowance (ESA) or Universal Credit. (Universal Credit is replacing various benefits including income-related ESA.)
35. Self-employed individuals are not eligible for SSP and may apply for ESA or Universal Credit as soon as unable to work.
36. Universal Credit is reduced to allow for any other income receivable by claimants with the reduction depending on whether the income is "earned" or "unearned". The provision of benefits under an IP policy replaces any benefit from Universal Credit pound for pound (under the current formula).
37. Hence savings to the welfare state result from longer term income replacement (beyond 28 weeks) for the employed, and immediately for the self-employed.
38. We need to make high level estimates of the proportion of IP claims that are paid to the employed and self-employed, and also the proportion of claims that are longer than 28 weeks.
39. Data published by LV= suggests that only around 5% of individuals with IP are self-employed¹. The ONS published statistics on the UK labour market which showed that around 15% of all people in work were self-employed prior to the pandemic. These stack up since group IP has by far the largest share of the IP market and the self-employed do not have access to this. The self-employed also, despite having greater need for IP, have less ability to pay, according to the research.
40. We have assumed that the proportion of claims that are greater than 28 weeks is 25%. The rationale for this assumption is contained in Appendix B.
41. Using these assumptions we have estimated the savings to the welfare state from the provision of IP policies by the report group to be **£28m** each year.
42. Note that we have not allowed for any increase to tax or National Insurance (NI) receipts as a result of the provision of IP benefits by the report group as these are only relevant for group IP policies, of which we have assumed the proportion sold by the report group is negligible.

Early return to work from rehabilitation

43. An early return to work will mean that any welfare state benefits due to absence are paid for a shorter period than would otherwise be the case. Additionally, tax and NI receipts will return to pre-sickness levels more quickly.

¹ Liverpool Victoria article "Heightened risk of financial crisis for self-employed"

44. Assuming that the period of sickness and disability is shortened by 25% the estimated benefit savings to the welfare state are **£3m** per year. The extra income from tax and NI receipts we have estimated as **£4m** per year.

Employer Savings

Statutory sick pay

45. Employers pay SSP for the first 28 weeks. They may also pay more than SSP and payments may be made for a longer period than the statutory minimum of (up to) 28 weeks.
46. These payments are independent of any additional income protection payments an employee may have so there is no direct cost saving to the employer in respect of such employees. However, the provision of rehabilitation services by the income protection provider has been shown to reduce the duration of an employee's period of sickness absence by approximately 25% on average.
47. Using the assumptions set out in Appendix B we have estimated that direct savings to employers from the reduction in SSP is **£26m**.
48. There will also be indirect savings to employers when employees return to work more quickly, for example, the cost of paying for overtime or temporary staff, the reduction in productivity and the cost of managing an employee's absence. This estimate is clearly a difficult one to make but conceptually it is likely to be at least the same as the direct cost the employer incurs from making SSP payments since the temporary staff will need to be reimbursed at least at a similar level, but likely to be more.
49. When the additional costs of managing the absence, recruitment and reduction in productivity are allowed for, we conservatively estimate that this indirect saving will be approximately 1.5 times the direct cost saving i.e. an additional **£39m** per year.

Individuals' Savings

Receipt of IP benefits

50. As a result of having their IP policy, individuals receive additional IP payments over and above what they receive from their employer or the welfare state.
51. We estimate that the direct benefit to individuals is **£100m** per year based on the benefits paid in 2022 by the organisations selected for inclusion in this report. This does not allow for the premiums paid by the policyholder into their IP policy.

Savings in price compared to alternative products

52. Cost savings arise for the insurer when sickness absence is shortened through intervention from rehabilitation activities that are provided outside the direct costs already passed onto the customer through their premium. Mutual insurers are able to provide additional services from the surpluses generated by their funds which are passed back to their customers (rather than paying shareholders).
53. Assuming a 25% reduction in sickness absence resulting from rehabilitation activities, and assuming the insurer passes this cost saving directly on to its customers, we estimate that individuals benefit by around **£37m** per year.

Conclusion

Summary of estimated cost savings

54. The table below shows the estimated cost savings to the NHS, welfare state and employers arising from the provision of HCP, PMI and IP policies by the report group. Figures are based on the level of IP claims paid by the sector during 2022 (£112m) and future inflation has not been allowed for.

Savings Item	Annual Amount (£m)
NHS Savings: treatment costs	629
NHS Savings: rehabilitation and accelerated recuperation	90
Welfare state savings: replacing sickness benefits paid by the state	28
Welfare state savings: early return to work from rehabilitation	7
Employer savings: reduction in sick pay	26
Employer savings: reduction in other costs from early return to work	39
Individuals' savings: receipt of policy benefits and retaining income	100
Individuals' savings: saving in price compared to other products	37
Total	956

Commentary

55. There is scope for a range of assumptions to be made, and potentially a wide range of possible cost savings as a result. Where possible, we have supported the assumptions we have made from the sources available.
56. We have attempted to correlate this analysis with other published research, in particular the Zurich papers. Most of the previous results for IP correlated reasonably well except for the welfare state savings for replacing sickness benefits where our figure was much lower than Zurich's would suggest.
57. There are further benefits, not covered by this research, that these products undoubtedly provide to the community at large by better enabling a healthy and productive workforce. Such benefits are impossible to cost but are likely to be significant.
58. A further consideration is the impact of Insurance Premium Tax (IPT) in the figures above. We estimate that holders of the HCP and PMI policies covered by this analysis paid an extra **£98m** during 2022 due to IPT.
59. If IPT were to be abolished, then these policies would become more affordable and more attractive to individuals and employers alike. A 20% increase in take-up of these policies could potentially add a further **£65m** per year to the benefits shown above, even after allowing for the loss of IPT revenues to the welfare state.
60. The aim of this research is to provide evidence of how mutual and not-for-profit organisations continue to complement the NHS and welfare state and do provide quantifiable financial benefits. Of particular note is the active support these products provide to employers and individuals in ensuring employees remain healthy and productive.
61. Commentators have illustrated the considerable gap in protection benefits for the wider community. This paper sets out how mutuals and not-for-profit organisations support existing policyholders – the benefits will clearly be even greater with greater participation however that can manifest itself.

Appendix A

List of organisations whose data has been considered as part of the analysis.

Benenden Healthcare

BHSF

British Friendly Society Ltd

Cirencester Friendly Society Ltd

DG Mutual

Dentists' Provident Society

The Exeter

Health Shield Friendly Society

HSF Health Plan

Liverpool Victoria

MDDUS

MDU

Medicash

Metfriendly

National Friendly

NFU Mutual

Holloway Friendly

Paycare

PG Mutual

Royal London

The Shepherds Friendly Society Ltd

Simplyhealth

Sovereign Health Care

Transport Friendly Society Ltd

Wesleyan Assurance Society

Westfield Health

WHA Healthcare

Wiltshire Friendly

WPA

Appendix B

Key assumptions underlying the analysis

Total claims paid for HCP and PMI policies are assumed to be in respect of treatments and procedures that the NHS would have met in full otherwise. The estimated savings reflect an upper amount.

For 25% of claims for private treatment, every £ spent on treatments and procedures results in a 50% cost saving to the NHS arising from rehabilitation and accelerated recuperation benefits.

We have assumed that the employed receive SSP for the first 28 weeks of incapacity and then receive ESA or Universal Credit as appropriate. The self-employed are assumed to fall directly into ESA or Universal Credit. We have assumed that the provision of income replacement benefit replaces any benefit from Universal Credit pound for pound. For simplicity we have not allowed for tapering of benefit.

We have assumed that IP claims paid are split roughly 95% to the employed and 5% to the self-employed.

From the results of the CMI's "all offices" analysis of individual IP sickness experience for 2007-2010, issued alongside CMI Working Paper 96, we have estimated that, across all deferred periods, approximately 50% of recoveries are within 26 weeks. For pragmatism, we have used this as a proxy for the proportion at 28 weeks. We have assumed that the society with the largest claim payments in 2016 (25% of total) has the same experience as the CMI data across all deferred periods. We have assumed that claims for all other mutual/non-profit providers are in respect of very short deferred periods (majority ≤ 4 weeks) and, from specimen calculations, our analysis suggests that approximately 85% of recoveries are within 26 weeks, again adopting this as a proxy for the proportion at 28 weeks. The average is then calculated as $25\% \times 50\% + 75\% \times 85\% = 76.25\%$ which has been rounded to 75%.

Salary coverage under IP policies is 35% on average, based on data published by Swiss Re for the UK in their report "European Insurance Report 2015".

The weekly amount of ESA is taken to be £84.80 based on age over 25, work related activity group (source: <https://www.gov.uk/employment-support-allowance/what-youll-get>).

Median weekly earnings are taken to be £640 for the base year of 2022 (source: ONS gross median full time weekly earnings April 2022).

We have assumed that the provision of rehabilitation support services under IP results in a 25% reduction in the time spent sick by an individual.