NHS reform: towards consensus?

A report from the
Partnership for Better Health project

By

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ADAM SMITH INSTITUTE
2002

Preface

This paper crystallizes a part of the work of the Adam Smith Institute over the past two years in the Partnership for Better Health project – a programme of work to develop early, practicable reform of the NHS.

The aim of the project is to create a blueprint for maximising health outcomes from the given resource. The vantage point is that of the general public and the goal is to identify and define the key areas in healthcare – funding, management and provision – where practical innovation and implementation will deliver easier access to higher-quality services and substantial improvements in health outcomes.

In a wide-ranging research and discussion program involving key figures in healthcare in the public and private sectors, in the UK and overseas, a range of options have been calibrated for their political and commercial practicability as a preliminary to a wider public debate.

This is the perfect time to be putting forward new ideas to re-think the future of public healthcare in the UK. The NHS is in crisis, public opinion is ready for change and the government has made clear its determination to modernize public services. And yet there has been no consensus on the essential reforms. We must aid the development of consensus by defining the best options for reform as the essential preliminary to opening the way to fundamental and systematic reform of the NHS.

The project team has been led by Dr Eamonn Butler (Director-General) and Matthew Young (Projects Director).

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Bibliographical information

Published in the UK in 2002 by
ASI (Research) Ltd

ISBN 1-902737-31-8

Summary

The NHS is in crisis, leading to tens of thousands of unnecessary deaths each year. Both more money, and fundamental reform is needed. However, increasing funding from general taxation, or introducing a hypothecated tax, will do nothing to address the root cause of the problems of the NHS ¾ that it is a politically controlled state monopoly that is institutionally unresponsive to the needs of patients.

The debate about the future of health care that has erupted in Britain has prompted serious examination of health systems in other countries ¾ including fees for service, social insurance and private insurance ¾ each of which have advantages and disadvantages.

Here we propose a new health system for Britain, which is capable of drawing broad political support, and giving the world's fourth largest economy the level of medical services it deserves. It is not re-inventing the wheel, but draws on the lessons learnt from health systems already seen in the rest of the developed world.

We propose a system of competing social insurance schemes that are independent of government, similar to those in the Netherlands, Germany and Switzerland. Membership would be compulsory for all citizens, and the social insurance schemes would be banned from refusing membership to anyone. Premiums would be proportional to income, making sure the system is as fair as general taxation, with the premiums for the very poorest paid by the state. Hospitals and other health care providers would be separated from the social insurers, with the government acting not as a manager, but as a regulator, making sure the system works fairly and efficiently. All services will remain free at the point of access, unless people choose to pay fees for service in order to reduce the monthly premiums or to buy extra services.

This system will offer patients a full choice of who they are treated by and where, and it will bring more money into the health system making sure that the supply of health services keeps up with people's demand for them. It will be a one-tier service, ensuring those on low incomes get as good treatment as the better off, in contrast to the NHS which is rapidly deteriorating into a two-tier service. This will be a system that gives Britain the health service it deserves, improving medical care for rich and poor alike.

Comments

Initial responses to this paper have been encouraging and a selection of the comments received are set out below:

Professor Alain Enthoven

“It is a worthy contribution. I agree with your analysis of the demerits of political control. Decentralized private local control (private meaning probably non-profit) is necessary. I think it is a good idea that people pay their social insurance themselves so that they have some idea what it costs (which most Americans do not). “

Professor Alain Enthoven, Stanford University
9 April 2002

Sir Graeme Catto

"This discussion paper makes a valuable contribution to the increasingly well-informed debate on the future of the health services within the UK. Both the public and the medical profession are united in putting the interests of the patient first. The issue now is to determine how best and within what timescale that can be achieved."

Professor Sir Graeme Catto, King's College London
President of the General Medical Council
3 April 2002

Indarjit Singh OBE JP

“In recent years there has been increasing concern over long hospital waiting lists, postcode disparities, inadequate consultation time in GP surgeries, a general shortage of nursing and other hospital staffing, and increasing evidence that the NHS, once the envy of other countries, is slowly slipping to 3rd world standards.

It’s difficult to dispute the reports assertion that simple cash injections related to GDP are not enough to give us the standards of health care that we all desire and expect.

The idea of ‘entitlement cards’ funded by competitive compulsory insurance schemes, put forward in the Report, merits serious consideration. Premiums would be based on total income, with payments from general tax for the lower paid, to ensure social equity. The entitlement card will give the patient greater choice in GP and hospital treatment. It is also suggested that there should be a ‘pooling of risk’ with insurers not being allowed to refuse cover to the elderly or those in poor health.

The general tenor of the report is one of realism and rationality, and a concern for social equity and as such, its proposals deserve serious consideration”

Indarjit Singh
Director, Network of Sikh Organisations UK
27 March 2002

Rt Hon Frank Field MP

"The model described here is essentially the one Lloyd George set up which ran from 1911 to 1948. It had drawbacks but so too does the present system. If the Government reforms do not soon show signs of success – crucial here will be a big hit on the waiting list front – a system of competing health suppliers regulated by government and run on insurance lines will begin to be practical politics."

Frank Field, House of Commons
27 March 2002

Lord Desai

"This paper is a constructive contribution, perhaps one of the very few constructive contributions, to the debate about the reform of the NHS. It deals with depoliticisation as well as decentralization of the NHS. But it goes beyond and proposes a viable alternative which will give patients a real sense of ownership. A real stimulus for radical thinking on health therefore can only come from such attempts which look critically at all arrangements but then doesn't fall back on the status quo because all other arrangements are not perfect. This paper comes up with a solid alternative that combines the best from many systems."

Meghnad Desai, Director,
Centre for the study of Global Governance, LSE
27 March 2002

Professor Stephen Smith

"This document provides the framework for the forthcoming health service debate. All those who provide healthcare must be able, without fear, to contribute their knowledge and experience to this debate. We must not be frightened into thinking that the current NHS is the only way that decent healthcare can be provided for all."

S. K. Smith
Professor of Obstetrics and Gynaecology, Cambridge
27 March 2002
These are the views of the author and in no way represent the views of Addenbrooke's NHS Trust or the University of Cambridge.

Nick Ross

"It is first-class, brave, refreshingly clean of rhetoric and dogma, keeps faith with the egalitarian fairness which was the founding purpose of the NHS, and transfers power from the politicians to the people. I have some questions about the economic consequences, not least wage inflation, and would have preferred some specific emphasis on evidence-based clinical outcomes (for I do not believe market forces always lead to better health), but these are minor criticisms. In the snowstorm of reports, articles and speeches about reforming the NHS this is the most bracing. I'm only sorry I have read it too late to be able to help. "

Nick Ross, broadcaster
9 April 2002

Michael Hall

"I think the publication is excellent. It embodies much of what I have been arguing for the past few months. Congratulations on a really comprehensive and well argued publication.

Michael A Hall, Chief Executive, Standard Life
10 April 2002

David Laws MP

"This report correctly identifies the major funding and organisational problems faced by the NHS.

The report also successfully proposes solutions designed to address the current funding gap facing our health services, combined with the lack of choice for consumers and competition between providers.

I hope that these proposals will help forge a new consensus about the future of the health services in the U.K. which will lead to better health outcomes for all of the population, not least those on lower incomes who currently find that they are sometimes offered a second class service. "

David Laws MP
13 April 2002

Introduction

The NHS is a politically controlled state monopoly, free at the point of use, funded out of tax, and almost identical to the old health services in the former communist countries of Eastern Europe. When those countries eventually dropped communism because it didn't work, they all examined their health systems and looked at what they could learn from elsewhere. Every one of them dropped their NHS-style systems and built up new health services from scratch.

Britain has long suffered the drawbacks of not having regular revolutions, but it is time we too reinvented our health system, learning the lessons of what works in other countries.

There is almost universal consensus — among health professionals, the government, patients and the media — that the NHS is in crisis. Few people pretend that patients in Britain are getting the medical services they should be able to expect in what is the world's fourth largest economy.

There is also widespread consensus on the urgent need for reform. The government set out its agenda for reform — which it claimed to be the most revolutionary for a generation — in ***The NHS Plan: A plan for investment, a plan for reform***[1] published in 2000. Sadly, this passionate declaration of faith in state management, is just another instalment of centrally-driven change and falls woefully short of the fundamental reform that is needed.

There is further widespread consensus that we need to spend more money on health in Britain, and that the reforms must make the services far more patient-centred.

And that is where the consensus ends.

In 2001, a 'debate' on the future of the NHS took off — with its founding principles, so long held almost sacrosanct, being publicly questioned for the first time. Previously, it had been taken for granted that Britain should stick to the NHS model of a free-at-the-point-of-access state monopoly of funding and provision. .The questioning of the NHS model has exploded so fiercely that the Labour government has been forced to repeatedly defend what it had at the last election considered its trump card — its thorough commitment to the NHS, the Labour Party's proudest invention.

Both in the National Plan, and in the Wanless Report[2] commissioned by the Treasury, the government laid out why it believed that the NHS model is the most fair and efficient. In March, 2002 the Chancellor Gordon Brown dedicated an entire

[1] The NHS Plan: A plan for investment, a plan for reform – Stationery Office July 2000
[2] Securing our Future Health: Taking a Long-Term View – Interim Report published by HM Treasury November 2001

speech[3] to defending tax-based funding of the NHS, criticising in turn all the main alternatives, including private insurance, user charges and social insurance.

The argument from the NHS critics can be largely characterised as 'The NHS doesn't work — it's better over the Channel.' Numerous reports have looked at the mixture of social insurance, user charges, state and private hospitals that make up health care in France, Germany, Netherlands and other developed countries. The Conservative Party launched a high-profile tour of several countries to see what can be learnt.

The advantages and disadvantages of the NHS and other systems have been debated. But no one has yet proposed a viable alternative for Britain, learning from other countries, and laying out not just the principles, but very specific policies for change to build a new health service of which Britain can be proud. Any new system must be capable of attracting widespread political and public support, and be delivered quickly, giving real tangible benefits.

This is what this paper sets out to achieve. It is a first proposal, which can be debated, criticised, improved — or, if decided to be unworkable, discarded.

We describe the symptoms of the NHS's malaise, diagnose its root causes, and then offer a treatment that will hopefully lead to a cure. The reality is that there is no perfect system but we believe the proposals here provide a practical foundation capable of attracting widespread support and implementable within 3-5 years.

[3] Chancellor of the Exchequer's speech on Economic Stability and Public Services 20 March 2002.

The symptoms

The NHS has a severe shortage of capacity, directly costing the lives of tens of thousands of patients a year. We have fewer doctors per head of population than any European country apart from Albania. We import nurses and doctors from the world's poorest countries, and export sick people to some of the richest (see the charts below, and the statistical table in the Appendix).

More than one million people — one in sixty of the population — are waiting for treatment.[4] They are waiting far too long, every step of the way — for the first appointment with a GP, for initial consultation with a specialist, for diagnosis and for treatment. Patients needing heart bypasses often have to wait over a year for treatment. One in four cardiac patients die while waiting and one in five lung cancer patients wait so long they go from being treatable to untreatable. The cancer survival rate in Britain is lower for cancers than almost all other developed nations. World Health Organisation figures show that if the UK had the same cancer survival rates as the European average, it would save 10,000 lives a year; if we had the best in Europe, it would save 25,000 lives a year.[5]

People with painful skin conditions, children needing speech therapy, or elderly people needing hip replacements so they can walk, can expect to wait several years for treatment. In Accident and Emergency wards, patients routinely have to wait in pain for six hours or more to see a doctor. Many drugs and treatments widely available elsewhere are denied to NHS patients.

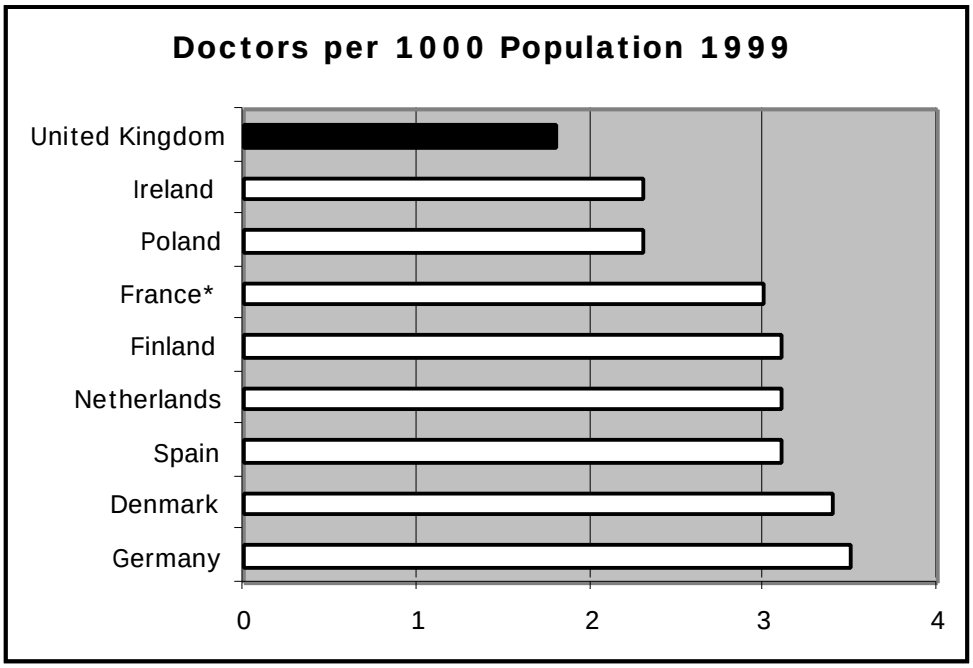
The patient experience of the NHS is often far below what they would tolerate in any other area of their life. They generally have no choice of the time or date of their appointment, and even so still have to wait for many hours before being seen. Hospital food is often unpalatable, and hospitals are often filthy. GP appointments last on average 7 minutes, far too quick for a proper diagnosis.[6]

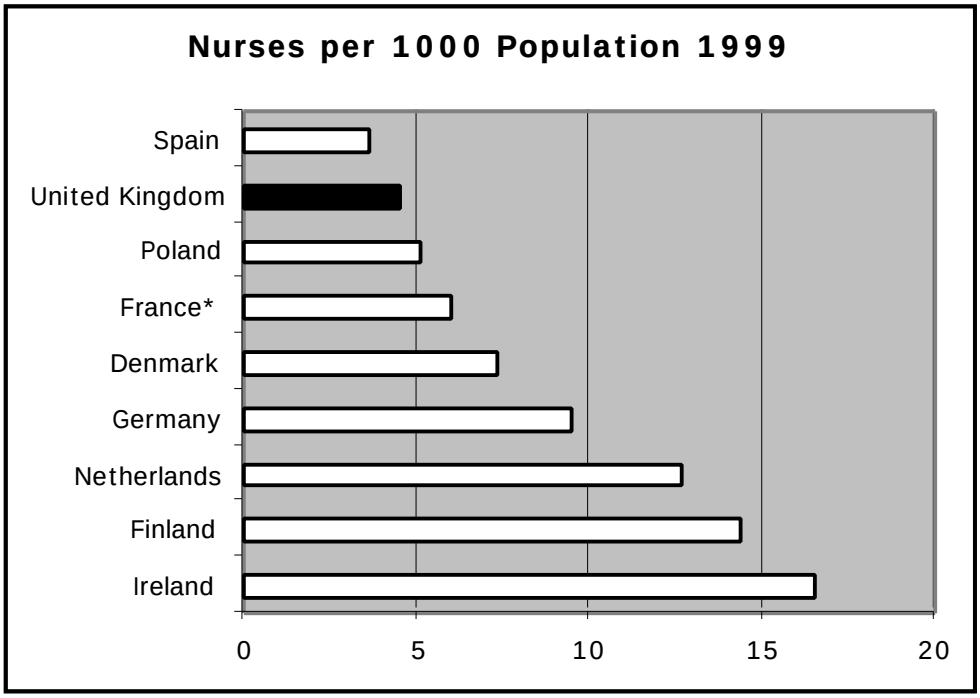
The treatment in the NHS is so bad that it is driving millions of people towards private medicine**.** Seven million people are covered by private medical insurance, while in addition around a third of a million pay out of their pockets for private operations each year.[7] Most NHS hospitals are now so short of money they have abandoned their core founding principle, and now accept money from private patients to give them privileged access to the same beds, nurses, doctors and operating theatres. Specialist NHS hospitals, such as the Royal Marsden, now generate up to a quarter of their income from fee-paying patients.[8]

The health system in Britain is now clearly a two-tier service with the rich getting treatment denied to the poor — precisely the problem that the NHS was meant to

[4] DoH statistics on Waiting Lists at March 2002 [latest publication 5 April 2002]
[5] WHO Eurocare 2 study on cancer survival rates in Europe, 1999
[6] University of Edinburgh Department of General Practice study 1998
[7] Laing's Healthcare Market Review 2001-2002
[8] Laing's Healthcare Market Review 2001-2002

address. Without serious reform, the NHS is sliding further into becoming a "sink service" for the poor.





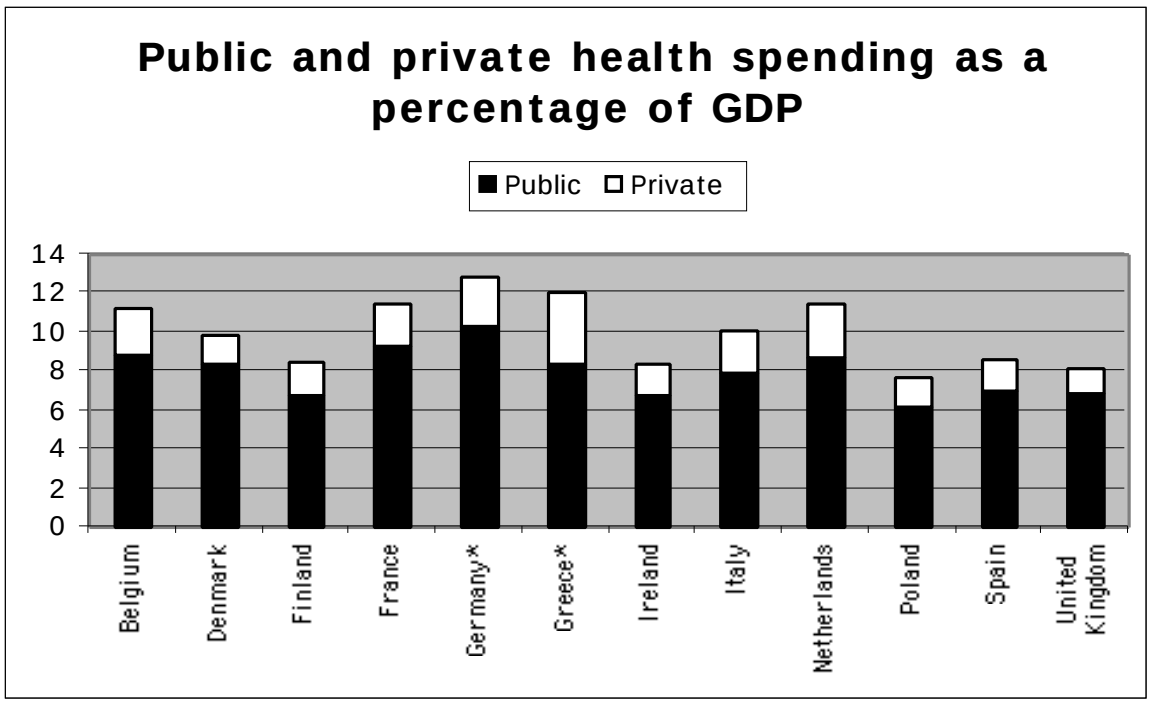
Source: OECD Health Data 2001
* France: 1997-98 figures

The diagnosis

The poor performance of the NHS is the result of a range of fundamental problems. Most are closely tied to the issue of funding, which is why changing the funding system of the NHS essential to any serious reform.

Underfunding

We spend far less on health services in Britain than most other European countries, both in absolute terms and as a proportion of GDP. We spend roughly a third less than France and Germany, and half the amount of the US. The volume of health spending that is funded through taxation is in fact roughly the same in both the UK and our European neighbours (and indeed, even in the US), at around 6 per cent of GDP. The difference is that much of Europe supplements the tax payment with a further 3-4% of GDP in 'private' spending by the individual through charges for services and health insurance.[9]



Source: OECD Health Data 2001

The NHS was long hailed as the best way to provide a cost-effective health service, but its defenders and critics alike agree that we are now 'rationing ourselves to death'.

[9] OECD statistics on public/private healthcare funding 2001

Inability to match supply with demand

There is no mechanism within the NHS monopoly to ensure that supply of health care — spending on doctors, hospitals, drugs etc — keeps up with the public demand for it. This is the fundamental root cause of underfunding in the NHS.

NHS defenders say that under-spending on health is the cause of the problems in the NHS; but in reality it is the tax-funding monopoly that is the cause of the under-spending. Figures from the OECD show that spending on health is far lower and more erratic in countries whose health services are funded mostly out of general taxation, and health spending is higher and more responsive to societies' demands in those countries where health services are funded out of social insurance.

Apart from going private, the only way for members of the public to increase health spending is to vote once every five years for a new government that promises to spend more on health. Imagine if we had to decide how much money we were going to spend on our food for the next five years by voting for a political party!

People vote on a range of issues — crime, education, immigration — of which health spending is just one. Often, in Britain electors have not had any choice — in the 1997 election, for example, Labour promised to match the Conservative's budget plans, which amounted to a spending freeze on health for the next two years.

Chancellors have to decide spending on a range of other issues — social security, education, defence etc — and will always be under pressure to strictly control spending on health. The NHS has long-run excessive rationing built into it, because there are constant direct pressures to contain spending, and only once every five years, indirect pressure to increase it.

After a delayed start, the government has now promised to sharply increase spending on health, with Tony Blair committed to meet the European average. But no one should expect this growth to be sustainable. Things may look rosy when there is a Labour government, elected to increase spending on health, and thanks to record budget surpluses, actually able to do so. But what happens when there aren't budget surpluses, or it loses power because of other policies? After a brief spurt, we will just be back to the long run situation of excessive rationing.

Perverse incentives

Simply increasing spending from general taxation also does nothing to address the perverse incentives that riddle the NHS, making it possible to throw increasing amounts of money at it with no noticeable effect.

The money flows in the opposite direction in the NHS than it does in almost all other organisations that provide goods or services, flowing from the top to the bottom rather than the bottom to the top. The Chancellor pays a big cheque to the health secretary, who then divides it up between regions, and eventually the money filters down to the patient. In most organisations, the money comes from those actually receiving the service, and flows up the tree to pay for the service, overheads and central administration.

This financial inversion in the funding of the service leads to perverse incentives throughout the NHS, so that good practice tends to be punished and bad practice rewarded. Treating a patient imposes a cost burden on a hospital, rather than bringing it a financial reward. Treating a patient well — taking time, labour and resources — simply increases the costs of the hospital without any hope of financial reward for the extra expenses occurred. Throughout the history of the NHS, managers have been encouraged to go over budget and have long waiting lists — even if that means treating as few patients as possible — because they would then be given extra money to help them cope. Managers with no waiting list would be punished by having their budget cut.

The Conservatives made some attempt to redress these perverse incentives by introducing the internal market, which only came into partial effect and had little impact before being abolished. Labour has now partially reinvented the internal market by devolving most health care spending to primary care trusts, and has also invented bonuses for well-performing hospitals and sacked managers of poorly performing hospitals.

However, the NHS will remain a centralised state monopoly, and all these reforms will do little to reverse the perverse incentives that undermine most attempts at reform. Sweden, which also largely funds health care out of taxation (in combination with extensive user charges), has undergone a far more radical programme of introducing an internal market with massive decentralisation, splitting up purchasers and providers, and establishing each hospital and department as a 'profit centre'.

Lack of choice

The state monopoly means that patients have very limited choice, and basically have to accept what they are given. They have some choice of GP within their area (but it is difficult and time consuming to switch between them, in contrast to the ease of going to another doctor in France), and almost no choice of hospital or specialist. Obviously, choice doesn't apply in some areas — if you are in an accident, you just want to be treated as quickly as possible. But true accidents and emergencies are a tiny fraction of the entire NHS workload.

This can be intensely frustrating for patients who have learnt to enjoy choice in every other area of their life, and seriously undermines complaints systems for redressing wrongs. Patients with ongoing treatment are too frightened to complain about a doctor who quite literally holds the power of life and death over them. Medical authorities can adopt an incredibly defensive, dismissive and arrogant position because they know that the patient has to either 'like it or lump it'.

It is also inefficient, because it removes a strong incentive for improvement in the services. Since patients by and large can't choose to go to a clean hospital or a good doctor, there is limited pressure on dirty hospitals and bad doctors to raise their standards.

If the government still controls where the money goes, then patients have only whatever choice the Health Secretary decides to grant them — which is ultimately very little choice indeed.

Monopolistic lack of competition

The lack of patient choice is reflected in the almost complete state monopoly of both the funding of health care (through the tax system) and the provision of services (through the NHS). This constrains the amount of health care we can access and offers no mechanism for responding to patients' preferences. It stifles innovation because different practices are not tried out in different areas and shown to be effective or otherwise. Because different hospitals are not competing for patients but are part of the state monopoly, they have limited incentive to improve by adopting best practice.

The NHS is the largest employer in the free world with over one million employees, so centralised that the health secretary has to tell hospitals how to improve their cleaning, and spice up their menus. But an organisation of this size cannot be efficiently centrally managed. The top-down, almost Soviet-style, micro-management of the service simply isn't working. Layers of bureaucracy and short-term political priorities create major inefficiencies, emasculate local management, thwart local responsiveness and encourage creative accounting in responding to Whitehall target-setting. There are now more bureaucrats in the NHS than beds.[10]

Political control

The problem for the NHS is not just that it is centralised, but that it is centralised in the hands of politicians. The Prime Minister and health secretary have total managerial control over the NHS, even though they may previously have had no relevant experience. The power is concentrated in their hands because they control the funding of the service. Secretaries of state and their junior ministers come and go with sometimes stunning frequency, and they all have one thing in common: they want to make headline-grabbing changes in order to advance their careers. The NHS suffers from a bewildering array of initiatives dictated by ministers, who are then replaced by other ministers who issue totally conflicting sets of dictats. The most obvious recent example was the target to cut waiting lists by 100,000, which was dropped as soon as it was reached because it had such a disastrous effect on clinical priorities.

The NHS, then, is a large complex organisation being steadily devastated by management by political whim. This is not a controversial point — it has almost universal agreement among health analysts, doctors, hospitals managers and patient groups, and is the conclusion of endless reports from NHS-supporting organisations such as the King's Fund and the Association of Community Health Councils of England and Wales. The only people who dispute it are the politicians.

[10] DoH Health & Personal Social Services Statistics 2001

Successes of the NHS

The NHS has strengths as well as weaknesses, and any alternative system must also be able to replicate these.

Ensuring access for the poor

Despite the growing two-tier health service in Britain, the NHS does in principle offer equal treatment to rich and poor alike. It is taken as axiomatic that those on low incomes should have access to high quality medical services, and that no one should be denied access to essential treatment because they can't afford it. Although this is meant to be one of the strengths of the NHS, social insurance systems such as those in France, Germany and Netherlands achieve this far better, ensuring their poor get better treatment than they do in the UK.

Pooling risk

Risk must be pooled between those who enjoy a long healthy life and those suffering chronic illness; between the young and the old. This is absolutely essential to ensure that the burden of health care doesn't fall on those least able to bear it.

Cost control

The greatest success of the NHS is its ability to keep down costs. It suppresses wages for medical staff such as nurses, restricts the number of doctors, hospitals and beds, rations drugs and other modern treatments, and so delivers a very cheap health care service. By some measures, this is cost-effective, although it also imposes a lot of external costs — for example, keeping sick people away from work for too long. But in contrast, some health insurance systems have a very poor ability to contain costs, which consequently spiral out of control. In the US, France and Germany, controlling spending is one of the biggest challenges their health systems face.

Economic impact

Paying for the health service must not cause damage to the wealth of the nation by distorting the economy. In France and Germany, businesses frequently claim that social insurance, paid by employees and employers, is a tax on jobs, leading to high unemployment.

The treatment

Increasing spending from general taxation, combined with modest structural reform — such as giving patients choice of hospital — simply fails to address many of the more fundamental failings of the NHS, and so will have limited immediate or long-term impact.

Those who suggest that health spending should be increased and then fixed at a certain percentage of GDP are also showing a fundamental misunderstanding of the nature of the pressures on health spending.

Health is what economists call a 'superior good' — the richer we are as individuals or as a nation, the greater the percentage of our income we want to spend on it. We are also ageing as a population, meaning that just to stand still, we need to increase health spending as a proportion of GDP. Thirdly, technological advances generally mean that health service inflation is higher than consumer price inflation. The combination of these factors means that the ideal level of health spending may rise, for example, from 9% of GDP now to 15% or 20% in 50 years time.

Any effective health system must have the automatic ability to match supply of health services with the population's demand for them and preparedness to pay for them. Simply increasing spending on health from general taxation does nothing to address this issue.

Introducing a hypothecated health tax, although politically appealing, will fail to address the fundamental problems of the NHS. Hypothecation — or ear-marking — makes it easier for the Chancellor to overcome voter resistance to increasing taxes to pay for health. But, crucially, it will still leave the chancellor with total control over the level of funding, and the government with total managerial control over the NHS, and it will do nothing to promote patient choice. If the government still controls where the money goes, then the patient only has whatever limited choice the Health Secretary decides to grant him — which is ultimately very little choice indeed.

Real patient choice will only come with 'patient fund-holding' — ie when patients choose to go to a particular doctor or hospital, they bring the money with them to pay for that service, as happens in social insurance systems such as France.

The reality is that many other systems fail in one or more of these criteria, as NHS defenders are quick to point out. For example, the US system is often accused of providing an inferior service for people on low incomes or imposing insupportable burdens on the chronically sick. However, by learning from the experience of other countries, it is possible to design a system that tackles all the drawbacks and adopts all the strengths.

Defenders of the NHS too often point to the difficulties of any radical reform, saying it will cause years of confusion, that it’s a practical impossibility and no one will ever be satisfied. This is the counsel of despair and patently nonsensical. When setting up the NHS, Aneurin Bevan radically reformed the health system in the country. Fifty

years later, any similarly radical reform must also be a practical reality, capable of achieving widespread support.

Britain's new Health Service

We suggest a system of competing social insurance schemes, with premiums based on a proportion of total income and paid by individuals rather than companies. Those on the lowest incomes would have their premiums paid out of general taxation. No one will have to pay user charges unless they choose to do so (as a way of reducing their premiums), or to exercise their right to buy additional services. There should be a separation between government, purchasers and providers.

Government — should have no direct managerial role, concentrating instead on setting policies to ensure a fair and efficient health system, regulating health purchasers and providers, setting and enforcing minimum standards for patients. There will also be a major role for government in ensuring that the poor get full access to services, by subsidising their treatment out of general taxation. The NHS must be relieved of direct political management.

Purchasers — these will be social insurance providers, who collect premiums from their members (or from the government on behalf of members who cannot afford to pay their own premiums), and buy health services on their behalf.

There should be a variety of insurers in competition with each other, as there is in Germany, Netherlands and Switzerland. All should be obliged by law to offer a comprehensive minimum set of services. And it must also be illegal to turn down any patient at any age and state of health, so that the insurers cannot cherry-pick the young and healthy, nor people from certain occupations, nor people from certain regions. The Netherlands, Switzerland and Germany have all found such constraints work against the public interest and have dismantled them.

The social insurers should be independent from government, but can be run by unions, employer groups, or mutual organisations. Making them by law non-profit, as is the case in Switzerland, would probably make the new system more politically acceptable.

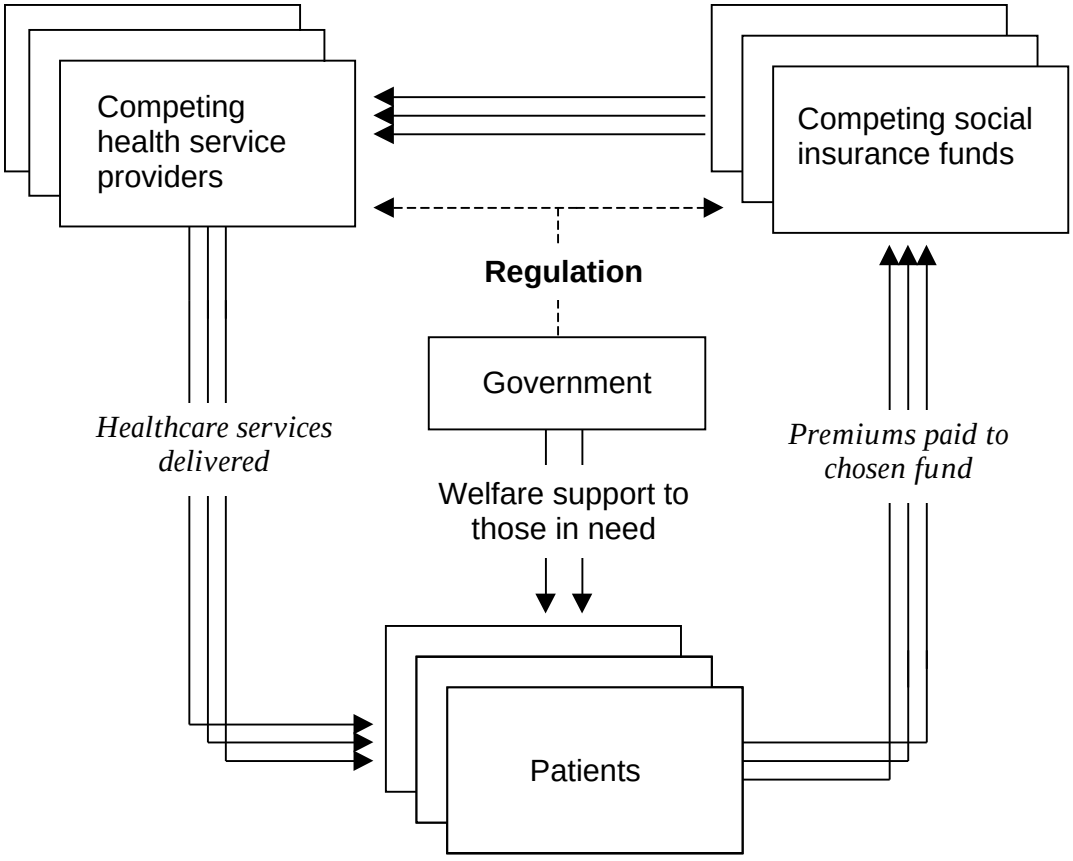
Competition between social insurers in Europe is clearly effective in providing an incentive to keep health care costs down, while keeping service standards and health outcomes up.

In order to guarantee maximum choice for patients, vertical integration should at least initially be banned, so that social insurers should not be allowed to own any hospitals.

Providers — all NHS hospitals and other provider units should be set free from direct Department of Health control. It may be decided that some should be left in the state sector, but they must be run at arms length, like executive agencies. Some may be run by not-for-profit groups like trusts, charities and religious organisations, and some can be privately run. All must offer services to patients on an equal basis, irrespective of insurer. Some may decide to specialise, or, for example, provide

advanced primary care services offering minor operations, diagnostic equipment and therapies. They must have published tariffs, which are equal for all patients.

Diagram: Operation of the proposed social-insurance system



Social insurance must be compulsory

It must be compulsory to buy social insurance. Were it voluntary, only the sick and old would buy it, pushing up the cost and making it unaffordable to those who need it most (the problem that private medical insurance has in the UK). This compulsion, practised by existing social insurance schemes, will provide the necessary cross-subsidy between the young and healthy, and the sick and old.

The compulsion should probably apply to people of all incomes. The Netherlands expels people above a certain income from social insurance schemes, forcing them to go private, whereas the rich in Germany are allowed voluntarily to leave (although only a minority do). However, letting the rich opt out will reduce the element of cross-subsidy essential in any health system, and make it less progressive. It could also lead to a two-tier system, and reduce the political acceptability of reform.

The poor will have their premiums paid out of general taxation

To ensure full access to the poor, all those below a certain income — in particular the unemployed — will have their insurance premiums paid for out of general taxation, as for example happens in Netherlands, and has recently been introduced in France. This ensures that the poor have access to the same hospitals and doctors as the rich, rather than being relegated to a 'sink service', as can happen in the US, and is rapidly happening in the UK. Health care would indeed be a genuine single-tier service.

Premiums must be related to total income

To make sure that the cost of insurance doesn't fall unduly heavily on people with lower incomes who don't qualify for free insurance, the insurance premiums should be income-related. This redistribution from rich to poor is standard practice in almost all social insurance schemes (but not in countries like the US that depend on private insurance). Depending on the scale used, it is quite possible to create a system of paying for health that is as progressive as general taxation. The sliding scale of contributions will also make it far more politically acceptable.

To make it as fair as possible, the premiums should be based on all income (including investment and interest), not just wages. This relieves the burden on workers, and is again a reform recently made in France. For administrative simplicity, it may be best to have a dedicated agency within the Inland Revenue collecting the premiums.

The mixture of compulsion for those who can pay and tax funding for those who can't, will guarantee universal coverage. In Germany, for example, only 0.03% of the population is not covered.

Individuals rather than companies should pay

The cost of insurance should be paid by individuals themselves, as happens in Switzerland. France and Germany have shown that relying too heavily on employers to pay social insurance can create a "tax on jobs" that can damage employment, and have been taking measures to redress this. It will also prevent the problems of the US, where health cover attaches to a particular job, leading to 'job lock' and damaging labour market inflexibility. Making people pay personally makes it easier for them to stay with the same insurance scheme when they move from job to job, or as they move in and out of the labour market.

To ease the burden of paying the insurance, its introduction should be combined with an income tax credit paid for out of the money that the Chancellor would save from the introduction of the scheme. This will ensure there is no sudden jump in deductions from people's wages. It could also, if politically necessary, be partially subsidised out of general taxation, with the government making a direct subvention to the social insurance schemes (a common practice in continental schemes, in order to smooth out cost and risk differences between their different membership populations).

All social insurance schemes must offer a minimum set of benefits set by the government, which must include all essential health care. A quick and independent ombudsman service will rule when patients feel insurers are unfairly withholding treatment (NHS patients have no such independent appeal when the NHS withholds treatment).

People can choose to pay for services to reduce premiums

Different schemes can define if patients need to make any additional direct payments when they access services — such as happens in Denmark, where residents have to choose between the Group 1 and Group 2 state schemes. Some schemes, charging a higher proportion of income, may offer all services for free at the point of access. Other schemes, charging a low percentage of income, may insist on some payments to see a GP or a percentage of the cost of treatment or drugs. This is in effect similar to France, where in fact most people take out a second insurance to cover all co-payments for using services.

Doctors should be able set their own rates for different procedures, but they must set out their charges and charge the same independently of how the patient is paying, either by partial co-payment or fully covered by insurance. This ensures there is some competition between doctors to keep their rates down. Some systems, such as Switzerland, have decided it is better to set rates nationally as a result of negotiations between professional groups and insurers.

There must be a maximum ceiling to additional charges

To protect the chronically or catastrophically ill, the government must set a maximum ceiling on the payments that any individual should make in any twelve-month period — such as the 2% of income maximum introduced in Germany. If any patient incurs more than that level of charges, their social insurer will pay the cost. As well as protecting low-income families from not being able to afford long-term treatment, this maximum will ensure that there is no systemic risk of healthy young people concentrating in low-premium, high-user-charge schemes, leaving the long term sick and elderly ghettoed into high-premium schemes.

Patients should be able to choose their social insurer and doctor

As generally happens in other countries that have competing social insurance schemes, such as Netherlands and Germany, patients should have a free choice of which scheme to belong to. There should be a maximum contract length of one year, ensuring that patients cannot be unfairly tied-in to insurers if they wish to leave.

Patients should also have a choice of being treated by any hospital or doctor anywhere in the country — although some social insurance schemes may offer a discount if patients agree to go to a ‘preferred-provider’ hospital and doctor (since this will allow insurers to negotiate discounts with health service providers).

Other insurers may offer a discount for having to go to a GP as a gatekeeper, with higher premiums for self-referral to a specialist (as happens in the Danish system).

This choice, totally denied to NHS patients, is fairly standard practice across Europe. Obviously, popular doctors or surgeons may end up with waiting lists, in which case patients have to make a choice between waiting or being treated by their second preference. But at least they do have a choice.

The social insurance scheme must pay the fees charged by the doctor or hospital, up to an agreed maximum (as happens in France). If patients want to go to top consultants who charge above this maximum, they can do so out of their own funds.

If patients want to go abroad for treatment, the social insurance scheme must pay for treatment there up to the agreed maximum, again with the patient having to pay any excess (as happens in the Canadian government health insurance scheme, which in effect fully covers health treatment anywhere in the world, apart from the US where it is only partially covered because it is so expensive).

Because patients will bring money with them through their social insurance scheme, there will be a powerful incentive for the health care providers to develop and offer services that patients actually want and need. This could stimulate, and reward, interesting innovations.

People should have smart entitlement cards

In France and Germany, everyone has a card entitling them to services. To keep bureaucracy and administration to a minimum, all people should have a smart card, which identifies them and the scheme they are on, and grant appropriate access to their medical records. When they go to a doctor or hospital, they would show their card, and the charges will be sent automatically to their insurance scheme. A similar system works well in Germany, where it is now illegal to refuse treatment to anyone who presents their smart card. It is envisaged that these cards will provide the essential infrastructure for a standardized electronic patient record.

So will this scheme meet the criteria?

How, then, does this proposal match up against the criteria for a successful health care system that we have already outlined. Let us look at the key measures of success.

Increased spending — a social insurance scheme responds, automatically, to an increase in the public's overall demand for health care, bringing more money into the system. But unlike tax-funded systems, competition, and the need to attract and retain satisfied members, provides a cost and quality control mechanism and spurs innovation and customer-focus.

Ability to match supply and demand — as the public demands more health spending from their social insurance schemes, so the annual premiums will gradually rise, automatically bringing more money into health care.

Choice — patients will be able to choose the type of social insurance scheme they join, and what doctor and what hospital they are treated by. If they don't like what they are getting, they can go elsewhere.

Competition and diversity — There will be a diverse range of health care providers: state, non-profit and private hospitals that will have incentives to attract patients to them.

Care of the poor — Because they are part of the same social insurance schemes as the rich — just paid for out of taxation — the poor will have access to the same medical services, treated by the same doctors with the same drugs and the same waiting times. The fact that social insurance payments would be graded according to income above a certain level means that that the scheme would be as progressive as paying it out of general taxation.

Pooling risk — because it is compulsory to be a member of a social insurance scheme, and insurers are not allowed to refuse access on the grounds of age or health, then there will be a complete pooling of risk.

Constructive incentives — competition between insurance companies will provide pressure for them to improve their range and quality of services; competition between hospitals and doctors will ensure they meet the needs and expectations of patients.

Cost control — competition between social insurance companies and between providers will create pressure to keep costs down — any insurance company that increases costs too much is likely to lose customers. There will be a strong incentive for them to keep down the cost of hospital bills and the drugs budget.

Economic neutrality — because it is not based on employer contributions, it will not be a tax on jobs. Because it is based on total income, not earned income, the cost is not unfairly borne by employees.

Political independence — the government will have no managerial control, but will just set the policy framework to ensure the system works effectively and fairly, and will monitor and regulate it to uphold minimum standards.

How to get there

This is a radical reform of Britain's health service, but no more radical than the creation of the NHS in 1948, or the abolition of NHS-style services and the creation of new health care services in Eastern Europe after the fall of the Berlin Wall.

It will not be easy, but it is not an option to stick with a dysfunctional system. The difficulties of transition can be made easier by dividing it into steps.

· **Freedom to manage** – hospitals and primary care bodies should be set up as free-standing trusts with full managerial freedom, able to innovate and to break down current boundaries. The Department of Health would then pay a fee for each service, forcing the introduction of standardized internal accounting and information systems so they are aware of actual costs and performance. The government must not discriminate between trusts and private hospitals, but will pay directly for all services received by NHS patients.

2. **Licensed insurers** – the government should publish a specification for insurers and invite companies, trade unions or mutual societies to put forward plans to make turn themselves into social insurers, which must meet strictly defined criteria (including solvency, ability to accept all people as members etc). Companies are then chosen — perhaps anywhere between 20 and 100 in number — and awarded licences to operate as social insurers.

3. **Choosing the insurer** – every resident must sign up with a social insurer. Those who do not choose one would be allocated at random between the social insurers (or perhaps allocated to one state-run one). Residents should be issued with electronic smart cards that will contain basic medical information, provide access to detailed records, and act as entitlement cards, which they present each time they access non-emergency services.

4. **Tax credits** – on a pre-determined day, payments for services are switched over from government to the individual as a tax credit for payment to the to social insurers, which also start collecting premiums from their members. The changeover is complete.

With cross-party political will, this can take place on a phased basis within 5 years.

Appendix

Practising physicians and nurses
Total and Per 1000 population (1999)

Country	Physicians		Nurses	
	Total	Per 1000	Total	Per 1000
Australia**	46.078	2.5	149202	9.1
Austria	24,223	3	73,084	9
Belgium*	38,769	3.8	18,180	1.8
Canada	63,727	2.1	228,450	7.5
Czech Republic	30,559	3	83,919	8.2
Denmark	18,043	3.4	38,601	7.3
Finland	15,794	3.1	74,443	14.4
France**	175,431	3	347,981	6
Germany	291,171	3.5	781,000	9.5
Greece**	43,030	4.1	38,112	3.6
Hungary	31,768	3.2	50,415	5
Iceland**	884	3.3	3743	13.8
Ireland	8,469	2.3	61,629	16.5
Italy*	339,264	5.9	265,340	4.6
Japan*	238,771	1.9	985,821	7.8
Korea	61,182	1.3	65,592	1.4
Luxembourg	1,342	3.1	3,054	7.1
Mexico	164,717	1.7	114,394	1.2
Netherlands	48,987	3.1	200,500	12.7
New Zealand	8,616	2.3	36,770	9.6
Norway	12,464	2.8	45,133	10.1
Poland	87,524	2.3	197,153	5.1
Portugal	31,758	3.2	37,747	3.8
Spain	121,400	3.1	140,200	3.6
Sweden**	27,500	3.1	N/a	N/a
Switzerland**	24,026	3.4	N/a	N/a
Turkey	81,988	1.2	70,270	1.1
United Kingdom	**104,417**	**1.8**	**267,575**	**4.5**
United States*	725357	2.7	2,238,800	8.3

Source: OECD Health Data 2001

* = 1998 data

** = 1997/98 data

Total and private expenditure on health, % GDP, 1999

1999	% GDP	
	Total	Private
Australia*	8.6	2.6
Austria	8.2	2.3
Belgium	8.8	2.5
Canada	9.3	2.7
Czech Republic	7.4	0.6
Denmark	8.4	1.5
Finland	6.8	1.7
France	9.3	2.2
Germany*	10.3	2.5
Greece*	8.4	3.6
Hungary	6.8	1.3
Iceland	8.7	1.3
Ireland	6.8	1.6
Italy	7.9	2.2
Japan*	7.5	1.6
Korea	5.4	3
Luxembourg	6.1	0.4
Mexico*	5.3	2.8
Netherlands	8.7	2.8
New Zealand	8.1	1.8
Norway	8.5	1.5
Poland	6.2	1.5
Portugal*	7.7	2.5
Slovakia*	6.3	0.6
Spain*	7	1.6
Sweden*	7.9	1.3
Switzerland	10.4	2.8
Turkey	4.8	1.4
United Kingdom	6.9	1.2
United States	12.9	7.1

Source: OECD Health Data 2001

* = data from 1998