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Systems for Success:

Models for Healthcare Reform

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POLITEIA

2004

First published in 2004
by
Politeia
22 Charing Cross Road
London WC2H 0QP
Tel: 0207 240 5070 Fax: 0207 240 5095
www.politeia.co.uk
e-mail: info@politeia.co.uk

Policy Series No. 39

Support for this study has been granted by
the Foundation for Social and Economic Thinking

ISBN 1–900525–73–9

Cover design by John Marenbon

Designed and Printed in Great Britain by
Sumfield & Day Ltd
Station Street
Eastbourne
BN21 4RQ
www.sumfieldandday.com

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Introduction

Britain's health service has failed the people of this country. Though theirs is a rich and successful country, the system of healthcare now provided by the NHS is shameful. What many politicians acknowledge in private, and increasingly in public, has always been so. The NHS, set up as a nationalised industry during the most Stalinist period of British political thought, does not work. From the start there have been insurmountable problems. It began life as the third largest nationalised industry of the day with 500,000 employees (second only to transport, with 900,000 and coal, with 800,000). Ever since, it has been owned by the state and run by the *diktat* of the health minister of the day, through a vast bureaucracy of regional boards, health committees, GP and local authority committees and an ever growing army of advisory bodies and officials.

Across the globe, the model of centrally-planned, state-owned command systems and nationalised industries had, by the end of the twentieth century, been seen to fail along with the states which, organised entirely along these lines, had been the objects of emulation by progressives in the 1940s and 1950s. Yet the NHS, one of the last monuments to the collectivist era, the survivor of its share of national plans, restructuring and reorganisation, preserves almost entirely its Stalinist form, and is even larger and more unwieldy than ever. The NHS employs almost one million people, of whom consultants account for only 2.4 per cent. Hospital doctors constitute only 6.6 per cent and GPs 2.9 per cent. There are fewer qualified nurses (28.6 per cent) than managers and support staff (29 per cent).

Despite the huge cash injection of taxpayers' money, this dismal imbalance remains. Higher taxes have not resulted in higher proportions of medical staff. In fact, the proportion of doctors and nurses in the health service remains as small as it was in 2000 (according to the most recent available figures which are for 2002). The proportion of consultants remains unchanged at 2.4 per cent. The proportion of GPs gets even smaller, down from around 3.2 percent to 2.9 per cent. And the proportion of qualified

nurses in the NHS, at 28.6 per cent, is little different from two years ago when it was 28.8 per cent.

NHS Workforce 2002

		Number (wte)	%
Total NHS workforce		976,573	100
Hospital doctors (inc. consultants*)		64,170	6.6
(*Consultants		23,682	2.4)
GPs (excl GP retainers)		28,740	2.9
Qualified nurses		279,287	28.6
Management and support staff		283,224	29.0
Scientific, therapeutic and technical staff (inc. unqualified staff)		122,912	12.6
OTHER	Unqualified nurses	95,051	9.7
	Nursing learners	2,277	0.2
	Healthcare assistants	31,024	3.2
	Other GP practice staff	55,110	5.6
	Practice nurses	11,998	1.2

NHS Workforce 2000 and 2002 (numbers and percentages)

		2000		2002	
		Number (wte)	%	Number (wte)	%
Total NHS workforce		890,660	100	976,573	100
Hospital doctors (inc. consultants*)		57,941	6.5	64,170	6.6
(*Consultants		21,077	2.4	23,682	2.4)
GPs (excl GP retainers)		28,154	3.2	28,740	2.9
Qualified nurses		256,276	28.8	279,287	28.6
Management and support staff		257,703	28.9	283,224	29.0
Scientific, therapeutic and technical staff (inc. unqualified staff)		110,412	12.4	122,912	12.6
OTHER	Unqualified nurses	89,831	10.1	95,051	9.7
	Nursing learners	1,970	0.2	2,277	0.2
	Healthcare assistants	23,137	2.6	31,024	3.2
	Other GP practice staff	51,872	5.8	55,110	5.6
	Practice nurses	10,711	1.2	11,998	1.2

(I am grateful to the Department of Health's Statistics Division for their help in providing and presenting the most recently available figures. *The Chief Executive's Report to the NHS: Statistical Supplement, Department of Health* (December 2003) uses headcount figures (for 2000 and 2002 respectively the figures are: consultants 24,400 and 27,070; GPs, 28,590 and 29,200; qualified nurses, 335,950 and 367,950).

Sources: Department of Health Non-Medical Workforce Census; Department of Health Medical and Dental Workforce Census; Department of Health General and Personal Medical Services Statistics)

No longer is there any pretence about the nature of the NHS: it is run as a gigantic bureaucracy by the Secretary of State and his officials in Whitehall through regional, local authority, district, primary care and NHS trust bodies. By its very nature it is politicised, with politicians and their officials deciding on the levels and basis for funding, the nature of priorities and even who is treated first and for what illness. It is driven by target, directive and the politics of the day, not medical need. The NHS remains both a monopoly provider of healthcare and a monopsonist employer. Talented medical teams have little power to challenge what are, in effect, the life and death sentences passed by managers and bureaucrats on their patients - except by leaving the service entirely. And the people of this country who use and fund the service are equally powerless and exercise no control over how and to whom the funds are distributed.

The Government is as aware of the problem as all previous governments since the start of the nationalised service in 1948 have been. But its attempts to reform the structure, like previous attempts, continue to founder in face of the opposition of the interest groups and its own diehard left. Nonetheless, the Labour Government, like the Conservative Party, has grasped that the NHS itself is dying. Both parties now look to ways to challenge the grip of the nationalised, unitary model, Labour through its 'foundation' hospitals, and the Conservatives through its 'passports' scheme for publicly funded independent treatment.

This pamphlet suggests that a more radical approach is needed to tackle the two fundamental problems of the NHS – those of structure and funding. The NHS should no longer operate as a state monopoly, with the Government

organising and providing healthcare. Nor should Government control the allocation of public funds other than to distribute them in respect of every individual person. Raising taxes will not alone resolve the problems of the NHS. The fact that funding is controlled, raised, and distributed by the state is itself a fundamental problem. Beveridge, one of the moving forces behind a national health service, implied that tax could not, alone, fund the health service[i]. His instinct was to keep the independent panel doctors and the voluntary resources which went with the thriving voluntary hospital sector together with, for the first time, tax-funding[1].

This pamphlet examines other models for healthcare freely available for all in similar, industrialised democracies. In particular, it considers the French and German systems, each of which in its own way is the envy of this country. These systems are based on the principles of a mixture of providers, public and private and individual ownership of funding, together with a mixed base for funds. They have been tried and tested with the same (or larger) populations and demographic and health patterns. They are not alien models: indeed the systems of our Western neighbours have more in common with the model intended for a new national health service in 1945 when a mixture of providers, voluntary, independent and public, was seen as better than a gigantic state system. They are also systems which are mainly publicly funded, but allow for additional top-up or insurance funding, exactly in the way Beveridge wanted. The message from these systems is clear: what is needed is for supply to be freed up, so that private, trust and public bodies, hospitals and doctors (and enough of them), can provide the treatment and care people need, and that funding is tied to the user, not lost in the system.

Before discussing other models, this study will consider the origins of Britain's NHS and the principles on which it was to be founded. The historical analysis will show that the UK's intended model – preferred by the war-time National Government – pioneered the principles on which other systems elsewhere have since flourished. In fact the model planned in the UK in terms of structure (a mixture of public and private providers) and funding (public with top-up voluntary schemes), is clear from the 1944 White Paper; and, though abandoned by the 1945 Labour Government, could now form the basis of successful healthcare reform.

A National Health Service [2]

The 1944 White Paper, which proposed 'a comprehensive health service' freely available to all, was the result of the consensus reached by the war-time Coalition following many decades of preparation, consultation and planning[3]. By the end of the war the ground was prepared and a workable scheme agreed with the main participating bodies, hospitals, doctors and local authorities, ready for introduction once the war was over. Costs would be met from tax, rates and social insurance, and there would be scope for top-up funding in the system.

Though the health service was to be centrally co-ordinated, healthcare would have been provided free of charge using a mixture of private, public and voluntary hospitals and doctors. Hospitals would contract with the service to provide beds and treatment, and GPs would be part of a nation-wide panel system providing GP care for all. Funding would in the main be public, for the first time. It would be provided through tax, rates and social insurance, with scope for extra top-up and private funds. The aim was for a mixture of providers in order to develop the status quo. This option was favoured by the Coalition – Conservative, Labour and National Liberals – and by Sir Arthur Rucker, from the Health Ministry, who proposed a joint hospital board structure to plan the voluntary and local authority hospitals, with financial support on condition they co-operated. Such a system would, he explained, avoid the problems of nationalisation, for which the Ministry did not have the staff or the administrative capacity.

What was that status quo? The voluntary hospitals, including the great teaching hospitals, were by the outbreak of war, providing around one third of the beds (87,000) including most beds for specialised and difficult cases. In addition there were the local authority hospitals (175,868 beds) – the 1929 Local Government Act having created a framework for a municipal hospital sector under local authorities, supported by Exchequer grant. In the new health service voluntary hospitals would receive some, but not all, their funding from the Exchequer and would continue to raise funds themselves. Indeed, having raised all their own funds before the war (through donations, investments, and fees paid through insurance and self-pay), Beveridge was keen not to lose this source, and in the new scheme they were to remain independent. As for the doctors, the system of insurance cover under the

National Health Insurance Act 1911 had been extended to some 43 per cent of the population in 1938 (compared with 27 per cent in 1911). It was now to be extended to the whole population, by expanding a version of the existing panel scheme rather than introducing a state salary service to which GPs were opposed.

From National to Nationalised[4]

That system of a mixture of independent and public providers did not happen, for after the Labour victory of 1945, the new Health Minister, Aneurin Bevan, rejected the all-party measure. Instead, he introduced legislation more in line with socialist ideology. He set out to nationalise the system, take the hospitals into public ownership and direct the system centrally from the Department of Health as a state-owned and state-run system, with the state controlling the distribution of funds. The model had been favoured by the Socialist Medical Association and the Labour Party Conference which, in 1945, declared for the immediate public take-over of the voluntary hospitals. In general, the Left in the inter-war years favoured a state-run nationalised system, funded publicly with the voluntary hospitals nationalised, and variants of its scheme envisaged a system run by local authorities.

The Left's opposition to the Coalition Government's approach was on grounds of principle – the attack on the voluntary sector and destruction of local ownership, and the transfer of local authority hospitals to the state (many of which had been developed with the support of local people and funding). The undermining of the doctor-patient relationship and its replacement by a doctor-state contract was to have consequences for the independence of doctors on professional matters. Those affected by Bevan's scheme had differing views. The voluntary hospitals were divided, with one group, the British Hospitals Association, holding out against nationalisation, and others keen to co-operate in order to win a favourable settlement, including the King's Fund and the Nuffield Trust. Meanwhile the doctors and consultants insisted on basic freedoms. Bevan refused to move from his essentially socialist model, even though advised by his own officials that he could have all he wanted with the original 1944 mixed scheme. In what was in effect policy by *diktat*, he imposed his settlement and accompanied it with what now appears to be the most shameless campaign of lying propaganda,

the echoes of which return to fuel the campaigns to retain the status quo today. His health service would win 'the envy and admiration of the world', would be at the 'forefront of all countries . . . in medical services'. It would end the morally 'repugnant' voluntary hospitals which stood in the way of 'the intelligent planning of the modern world' and its introduction, he implied, was the only way to provide free health care for all. Opponents he depicted as against a national health system, indifferent to the sick and poor 'crying out for care'; callous and personally greedy, if not venal.

Bevan's bill became law in 1946, to take effect in July 1948[5]. The NHS would consist of a centrally planned and owned hospital service, a local authority health service and a GP service (ultimately to be under local authority control), all run as parts of a bureaucratic structure controlled by the minister, health boards, hospital committees, executive councils and local health authorities. Hospitals were taken into a single system, with their assets being transferred to the state, a fate which was also to follow for the teaching hospitals. The same was to happen to GPs. Their remits were decided centrally and their practices were, in effect, nationalised: the entry of new doctors into the profession was to be controlled by the state and the sale and purchase of practices was to be prohibited. Bevan's express aim was to remove the concept of incentive and reward from general practice and ultimately for GPs to be a full-time salaried officials under local authority health centres.

From the outset the NHS never worked, suffering from the two fundamental problems of structure and funding.

The NHS structure was subject to constant reorganisation. The post-war decades of ever more ambitious central planning found their apotheosis in the National Health Service. With each decade came another grand plan or reorganisation reflecting the grandiose planning concepts which gave the work of government in the post-war decades a collectivist and corporatist flavour. The hospital plan of the 1960s aimed to modernise 'the whole pattern and content of the hospital service', with each aspect fitting 'the principles and priorities of the plan', with a network of gigantic district hospitals serving 100,000-150,000 people. The drive to one gigantic structure was the aim of the next plan, proposed in 1968 for a 'unified administration of the medical and related services' under one authority, leading to a series

of Green and White Papers in the 1960s and 1970s by successive governments proposing different complex schemes for restructuring the NHS[6]. These were to culminate in the new NHS in 1974, to be based on regional health authorities, area health authorities, family practitioner committees and district management teams. The 1974 model in turn gave way to the 1982 abolition of area health authorities and the scaling down of the hospital model from the 1960s version of the district general, to one more locally based. And so the pattern continued, throughout the 1980s and 1990s, leading to the latest proposals for restructuring the hospital system.

The funding of the NHS, by tax, was never sufficient, a fact known to Governments from the outset, when Attlee's Cabinet was divided and weakened in the battles between Bevan and Gaitskell who as Chancellor wanted to curb NHS spending (Labour Chancellors used to do this!). Successive administrations of both parties resorted to different measures to curb spiralling cost by controlling expenditure – on drugs, recruitment of doctors, resisting entitlement, or even treatment by introducing charges – for prescriptions, eyes, teeth, or accommodation (hotel charges) and by cutting capital projects. Salaries and pay claims remained particularly problematic, with health resources disappearing in pay claims, often of ancillary or unskilled staff. Capital expenditure too was cut, in the first decade of the NHS falling drastically under the NHS to a fraction of its pre-war per annum level (from £35 million in 1938-9 to £8.3 million in 1949-50 and £10.6 million in 1955-6). Beveridge's model has been justified over the decades: tax, as the sole source of funding, was never enough.

The Alternative – Mixed – System

Already the British debate has moved dramatically towards challenging the monopoly of the NHS as sole provider and controller of health in this country. But welcome as this development may be, more radical change is now needed to allow for the development of a truly mixed system which the patient is free to use and in which medical staff may practise freely. What sort of system should this be?

The French and German systems both illustrate how the NHS might now develop – indeed could have developed in 1946 had the original plan been followed.

The provision of healthcare is, in both France and Germany, mixed. Doctors (both GPs and consultants) are on the whole independent practitioners and must compete for, and be accountable to, patients. Hospital care is provided through a mixture of public, private and voluntary hospitals. In each of these countries there is a balance between public, voluntary and private sector providers, with under half the hospital beds being in the private or voluntary sector (35 per cent in France and 45 per cent in Germany).

Funding in both France and Germany is from a mixture of – mainly – public sources, including a compulsory insurance contribution, supplemented by other taxes and a top up co-payment. Funding is then allocated in respect of the individual patient, not the system. Spending per capita in Germany is £1,390 and in France £1,344*. The figure for this country is £1,300 (£1,270–£1,300)*. However, the main difference will be in how the funds are distributed. In Germany people have a health premium administered by the sickness funds, which entitles them to a choice of (private) GP and specialist care and private or public hospital care and treatment. In France, the distribution is through reimbursement to patients and a direct grant to hospitals. In both countries there is an additional co-payment where individuals pay a small percentage towards their treatment. In Germany this is some 5 per cent. In France it varies depending on what type of care is involved (e.g. GP care, where 70 per cent is reimbursed) or on the nature of the disease (as in the case of 30 or so diseases) when care can be entirely free. For these, payment is made is at the time, or people can take out a top-up insurance to cover costs (as 87 per cent do in France). Both countries ensure that those on low incomes or unemployed have healthcare costs met from public funds. (*Figures for Germany are for 2003, for the UK, 2003–4 and France, 2000.)

Both systems are in principle nearer to that intended in 1944 for the NHS. They allow for the variety of hospitals and for the additional insurance and voluntary funds, envisaged by Beveridge as important in securing additional voluntary funds. Both include the private and voluntary sector in their universal healthcare with funding linked to, or following, the patient.

How can a change to funding the user now be introduced into this country? Deepak Lal provides an economic model which shows that the present levels of public funding could be translated into a health premium for each man

woman and child in this country, at levels almost as generous as the German model, and more generous than the successful Kaiser Permanente model with which Lal illustrates his proposed National Health Insurance system.

A structure with a variety of healthcare providers – private, voluntary and public – hospitals and doctors – works better for patients (and doctors) than a state-planned and run structure. So too does the principle of funding tied to the patient; it would enable patients in Britain to control the public funding, until now spent on their behalf. Once the patient 'owns' the pot and is responsible for its spending the full amount we now pay per person per annum in this country (£1,300), further ways of funding healthcare can be discussed, if that is what is wanted.

How would such a system work? Here the models from both France and Germany are instructive. In terms of structure, both countries have competing private and state hospitals and competing, mainly independent, GPs and specialists. Patients may be treated by independent doctors or by state or independent hospitals. In Germany the administration of healthcare for the patient is organised by the sickness companies and such a model could be employed in the UK.

Answering the Objections

Although many people in this country would heave a sigh of relief if the existing model of the NHS were replaced by one of the successful healthcare systems found elsewhere, such as that in France or Germany, certain doubts need to be assuaged:

The change to a mixed system would be cumbersome and while it was taking place treatment of the sick would suffer.

Answer: The recent examples of denationalisation illustrate the ease with which successful schemes can be introduced. The most telling example comes from Germany where the East German system, most akin to the NHS in its nationalised structure, was changed almost overnight and sixteen million people were brought fully into the West German system over a period of two years.

The poor will suffer in a mixed system, although the rich will benefit.

Answer: There is no reason why the poor or anyone else should suffer, if the system is run, as is proposed, by independent competing companies who administer the system and ensure that providers maintain the service for which the premium pays. A system, where every basic premium was tax-funded would cover everyone; and if, as in France and Germany, a political decision were taken to introduce co-payments, then poorer people or the unemployed could have their co-payment or contribution paid for from public funds.

Very sick people, or higher risk people, might be refused treatment by independent providers.

Answer: The NHS covers the whole population, old and young, well and ill, acute and chronic, and does not exclude individuals from care on grounds of health. So the health organisations administering the scheme would only be eligible to register for it, if they took the whole pool. This is what happens in Germany and can be made a legal requirement for those operating the scheme. The major private health companies in the UK are confident that they could provide the same, or indeed a better, service than the NHS currently does, provided they had the same random pool of the population. The German cost per person per annum proves that this can be done as does the cost per annum for the Kaiser Permanente in California.

Given that, since 1948, most healthcare has been funded solely from tax (with miniscule national insurance contributions), politicians will not want an insurance system, or appear to raise a fresh tax masquerading as employer/employee health contribution.

Answer: Deepak Lal's proposal avoids a contributory insurance system. Instead it converts tax funding to an insurance premium tied to every man, woman and child in the country. No new money is to be found and no fresh charges made.

The system proposed would be administratively complex for users and expensive to administer.

Answer: People in Germany are not involved in the administration. This is done on their behalf by the health companies who contract with the hospitals and other providers on behalf of the patient. In future all Germans will have a plastic card which will be all that will be needed for administrative purposes. The same is true of the Kaiser Permanente scheme. Such schemes would be as simple for the user as the present one, and at administrative or management level, probably less bureaucratic and cheaper than the complex NHS structure.

For a fuller discussion of these points see my *Second Opinion? Moving the NHS Monopoly to a Mixed System*, Politeia 2001).

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[1] Cmd. 6404, *Social Insurance and Allied Services,* report by Sir William Beveridge, HMSO, London 1942, reprinted 1995. Cmd. 6502, *A National Health Service,* HMSO, London 1944. Beveridge suggested that the health service should be financed by mixed funding: insurance contributions and exchequer support, possibly with charges.

[2] See Sheila Lawlor, *Second Opinion? Moving the NHS Monopoly to a Mixed System,* Politeia, London 2001, for a fuller discussion of the historical background and the sources on which it is based, see

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II
Healthcare in Germany

Introduction: One System throughout Germany

After the unification of Germany in the early 1990s, the change from a state-run healthcare system to one run by independent providers was successfully accomplished in a very short period. The state-directed health system of the former German Democratic Republic (East Germany) had been characterised by centralised decision-making, lack of accountability by doctors, nurses and managers, uneconomical use of limited resources, crumbling buildings, out-of-date technical equipment and many other difficulties in medical care. Within two years, it had been reorganised along the lines of the system in the former Federal Republic (West Germany). This transformation was made possible by the extension of the organisational structure and health insurance laws of West Germany. From 1 January 1991, all health insurance providers were able to become active in the states in the East. Government subvention ensured that the insurance providers received sufficient contributions. Within two years, 90 per cent of primary healthcare, provided in the former Democratic Republic by polyclinics and other state-organised means, was undertaken by independent doctors and dentists. By mid-1992 there were roughly 15,600 doctors and 11,00 dentists in private practice. The old polyclinics either disintegrated or developed into, for instance, health centres or group practices. The story was much the same in hospital medicine. Many clinics were taken over by local government, or by charitable or private providers.

Everywhere there are now independent chemists, rehabilitation clinics and so on. There is today no fundamental distinction between the structure of healthcare in the former East Germany and that in what was West Germany. Just as in the other *Länder*, there are, for instance, no waiting lists. The provision of health practices with the most modern medical technology is at the same level as in the old Federal Republic. This experience makes it clear that the transformation of a state-organised healthcare system into a market-based one is certainly possible. One essential condition for success was that the main organisations involved, especially the insurance providers and the associations of doctors and hospitals, were able to carry out the reform of the

system on the basis of a clearly defined concept – that is to say, the model which had been in use in West Germany.

The Role of the Market

Germany has neither a state-run, nor an entirely free market system. However, a large role is accorded to the market. The German approach has always been based on the firm belief that people's needs are better met in a system where competition exists and where private suppliers work for patients who are also their customers. Indeed competition is at the very heart of the philosophy which underpins the delivery of healthcare in Germany. Why? Because it both it guarantees people's dignity and promotes technical innovation. There is a political consensus in favour of private institutions as suppliers of care with the whole system being financed as far as possible independently of the state budget. Self-financed sickness funds are better guardians of the people's rights and entitlements than state bureaucracies.

The challenge for us has always been to use the advantages of private supply and competition in ways which are compatible with social solidarity and broadly stable contribution rates. That is not very easy. It means finding a successful balance between the market, personal freedom and necessary regulations to ensure fairness and justice. To maintain this balance changes are often necessary. That is why health care reforms are such a regular feature of politics in Germany. Last summer following discussions between the main parties in the federal parliament, a common platform for further reform was achieved.

How the System Works

In order to assess the importance of the latest reforms, it is necessary first to take stock of the existing statutory health insurance system which covers 90 per cent of the population – some 71 million people. All individuals, other than civil servants and top earners, are members of sickness funds – with the remaining 10 per cent having private insurance or, if they are civil servants, their own insurance schemes.

The cost of the statutory health insurance system is around £99 billion (145

billion €) in 2003, equivalent to £1390 (2040 €). Per capita spending in Germany of £1390 compares with the UK figure of c. £1300 (£1270-1300) per head for every insured person (2003-4 figures). The system is funded by contributions (social insurance payments by employers and employees) not – up until now – from taxation.

Uniform Package of Benefits in Statutory Health Insurance

- **Services: Benefits in kind**
  - Ambulatory dental care, dentures
  - Hospital treatment
  - Family planning services
  - Maternity benefits
  - Preventive care
  - Medical services for rehabilitation
  - Physiotherapy
  - Therapeutic appliances
  - Pharmaceuticals
- **Benefits in cash**
  - Sickness benefits
  - Maternity allowances
  - Death benefits

There are different types of sickness funds. All of them must provide a uniform package of services with additional services being allowed in the field of prevention only. Patients pay the same charges (known as co-payments) in all sickness funds. At about 5 per cent of the total the rate of co-payment is extremely modest. No fees are charged for seeing a consultant and children are treated free.

Co-payments

• Hospital care	➪ 9 € per day for max. 14 days
• Dental prosthetics	➪ 50% of costs
• Pharmaceuticals	➪ 4, 4,50 5 € per pharmaceutical product, depending on volume of the package
• Physiotherapy	➪ 15% of costs
• Out-patient physician's care	➪ no co-payment

All sickness funds are non-profit-making organisations. They establish their own contribution rates within a binding legal framework. Rates must cover the expected expenditure of the fund. If deficits should arise, the contribution rates have to go up. Since the start of 2003 the rates have ranged from 10.6 to 15.9 per cent of earnings (shared between employer and employee), with an average of 14.3 per cent. The federal and Länder governments play no part in determining the overall expenditure of the individual funds which depends entirely on the cost of the actual health care services which are delivered.

The main problem is to keep expenditure and income in balance in order to keep the contribution rates stable. Different mechanisms are used from cost-containment measures to very liberal incentives to invest. The contribution stabilisation rule is particularly important. It ensures that spending by the sickness funds for, say, the services of panel doctors or the hospital should not increase by more than the average increase in wages, though there are exceptions and no severe penalties are incurred if expenditure does turn out to be higher.

Budgets laying down the total spending on panel doctors at Länder level are negotiated between the sickness funds and the associations of panel doctors. Budgets for individual hospitals are negotiated between the funds and the hospitals. But they are not immutable. If more patients than expected are treated the budgets are increased.

The whole statutory health insurance system is based on the principle of social solidarity. Contributions are salary-related and independent of individual risk. Family members who are not in work are insured without additional contributions. Contributions are equally divided between employers and employees with each paying half of the premium. As regards pensioners, contributions are shared between the pension insurance system and the individual insured; for the unemployed, contributions are borne by the unemployment insurance system, which is itself funded by contributions from those in work. People who have never worked have a right to become a voluntary member in the statutory system, paid by themselves or the welfare system of the cities. For those without a regular income, the minimum premium is about £75 a month.

There is an income ceiling of £2,346 per month on the premiums. The average maximum premium is £340.

In addition to the individual sickness fund there is also a revenue-redistribution system based on the principle of social solidarity – known as 'risk-structure compensation' – between all funds in the statutory system. It is a highly complicated system responsible for distributing funding of some £8 billion. It came into effect in 1994 as a precondition for the introduction in 1996 of the right to choose between sickness funds, which created competition within the statutory health insurance system.

The dominant competitive factor is the contribution rate, though the comparative reputations of the funds and the additional services they can offer also play their part. The most competitive sickness funds – those with the lowest contribution rates – are the company funds. In the past few years they have won many new members.

In addition to competition within the statutory system, there is also competition between the private insurance funds and the statutory system. Those with earnings above the compulsory insurance income limit and self-employed people can leave the statutory health care system and choose private insurance instead. About 200,000 do so every year. Since in the main young people with good incomes and low risks choose this option, the income threshold was raised at the start of 2003.

The idea of insuring the whole population in the statutory system is now under active discussion. Although the supporters of this idea do not have majority in the Bundestag yet, they are clearly gaining ground.

Having considered the funding arrangements, we can now turn to the supply of services.

Medical services are delivered mainly by private bodies. All non-hospital doctors and dentists, all pharmacies, all physiotherapists and other specialists are private contractors working freelance. Hospitals are in both the private and public sector, run as corporations, established by cities and the Länder. There are 540,000 beds of which 300,000 are public (55 per cent), and 200,000 (37 per cent) are provided by charities like churches; only 8 per

cent are privately run.

Investments in medical technology are mostly individually organised and financed by each supplier. Only hospital investments are financed with tax-funded subsidies from the Länder and can be influenced by them, though hospitals including state ones, if they have donations, can also invest their own money. There are no investment planning authorities for the overall system.

Supply System

- Primarily individually organised per hospital or physician's office
- Demand planning for hospitals and panel doctors
  - 120,000 doctors / 50% specialists
  - 60,000 dentists
  - 2,050 Hospitals with 550,000 beds
  - 16 Million cases
  - 22,000 pharmacies
- Total: 2,2million people

The system is organised as a three-way relationship between the patient, the doctor or hospital and the sickness fund. 'Self-government' is the way we sum up these arrangements.

How does this work in detail? The associations of the sickness funds at both federal and Länder levels, along with the associations of the panel doctors or hospitals or other health care providers, are required by law to fix the detailed rules within an established legal framework. The rules define which treatment methods can be used; set out the fee scale for panel doctors and the reference prices for drugs; and lay down quality assurance measures. The roles of the federal government and the Länder ministries are restricted to supervisory tasks and to providing the necessary legal framework.

These measures have equipped Germany with a system that is decentralised and in the main delivered by private institutions. But free market principles

have not been applied in an entirely unrestricted way. There is a demand-oriented planning system for panel doctors (GPs) and dentists organised by the self-governing partners. New hospitals that propose to treat statutorily insured patients must have a contract with the statutory health insurance funds. For this, they must be recognised in the Länder's hospital plans.

These limitations on the free market do not, however, limit the advantages enjoyed by patients in this system. They have freedom of choice. They can choose their general practitioner and can change him or her freely. They can go direct to a specialist and to a hospital of their choice. They are not involved in the administration of reimbursement, which is dealt with by the funds and the doctors and hospital. The various sickness funds and the medical suppliers advertise their work in order to attract patients. Hospitals invest in comfort and service in order to attract patients.

Problems

The central questions now being asked in Germany are: can we still afford this system and is it as efficient as it should be? Without doubt a lot of money is spent – 10.6 per cent of GDP in Germany as compared with 7.3 per cent in the UK (2000 figures). Per capita, our health expenditure ranks third in the world (Source: World Health Organisation Report, 2000), but in terms of performance, we are in 25th place, far behind the UK (18th).

What people in Germany are now saying is: 'We are paying for luxury care but only receive medium quality care in return'. This is too sweeping but we do have structural problems that need to be addressed and difficulties over funding which arise to some extent from competition and the private organisation of our supply side.

There are a number of specific factors which have exacerbated the situation. We have a very high quota of physicians. We have too many hospital beds and the average length of stay – nearly 10 days – is unusually long. Much new medical technology is unused, despite the strong pressure to introduce it because the fees that arise for technology are often higher than for personal services. Some services are unnecessary – or duplicate others. There is a lack of sensible co-operation between networks of GPs. There is a lack of adequate quality assurance in some specialisms – and of properly

structured programmes in others such as chronic diseases like diabetes. Finally, there is also a major funding problem. The main sources of revenue are wages and pensions which are greatly affected by economic cycles.

So there are more than enough reasons to take the continuing process of health care reform to a new stage. Indeed, the pressure is acute because the sickness funds have been in overall deficit for three years and contribution rates have soared. Recent political decisions have exacerbated the problems.

Contributions by the unemployed have been cut to make savings in the unemployed insurance fund. Co-payments have been reduced while a range of benefits have been extended (for example to assist rehabilitation after treatment).

A Consensus for Improvement

A political consensus has now emerged as to how these acute problems should be tackled. The overall aim is to reduce the average contribution rate to the sickness funds from 14.4 per cent to 13 per cent. In the context of the 145 billion Euro spent on the statutory healthcare system, this is a very significant reduction. This fall in income has to be matched by structural reforms within the system to improve its quality and efficiency – and to make the way it works more transparent.

There is also a political consensus that benefits must be reduced. Death benefits will be cut. Free spectacles will only be available for children and the very disabled. Co-payments will be extended to cover 10 per cent of the cost of drugs and to provide a contribution to the cost of hospital stays (10 Euros for 28 days). The cost of pharmaceuticals will no longer be reimbursed (with some exemptions).

For over a hundred years it has been a basic principle of our statutory health care system that contributions should be paid in equal parts by employer and employee. That is now to change. Under the new consensus it is agreed that the employer's share should be reduced to 46 per cent with employees contributing 54 per cent.

Furthermore, for the first time in history, some of the proceeds of taxation

will flow into the statutory healthcare system. There will be extra taxation on tobacco with the additional money being used to finance benefits which are not really a responsibility of the insurance system, such as family policy benefits.

Another shift in our arrangements to provide 'social solidarity' is planned as regards the respective contributions of the old and young. Retired people contribute only 19 per cent of the revenue, but they are responsible for 45 per cent of the spending. In future to provide more 'intergenerational solidarity' the additional pensions that older people may have will be taken into account in assessing contributions.

Major structural changes are also being planned. General practitioners will become 'gate-keepers' of the system, referring patients where necessary to a specialist (ending the patient's right of direct approach to the specialist); as a result insurance premiums charged by sickness funds will be lowered. In addition, steps are being taken to break the stranglehold of the panel doctors' associations on the system. No longer will they alone rather than the individual doctor be able to make contracts with the sickness funds.

In future in some fields the sickness funds will be able to enter into contracts with individual doctors, and with doctors and hospitals which work together as integrated suppliers. The aim here is to bring more competition, innovation and quality-based procedures into the system.

Hospital services will be extended to provide more outpatient treatments, while for inpatients new systems will soon be in place to cut the time that most of them spend in hospital and so reduce existing overcapacity.

One very controversial issue is the plan to establish a government-run body along the lines of the UK's National Institute of Clinical Excellence (NICE). Without doubt, there is a need for independent cost/benefit analyses of new medical procedures and of new drugs coming on to the market. Such a body would also be responsible for producing guidelines in conjunction with the associations of the sickness funds and the medical suppliers.

More transparency is being introduced. In the past the patients had no idea what services cost; sickness funds have not been allowed to provide figures

for the services delivered to the individual patient by the panel doctors, as a result of our sophisticated data protection system. In future patients will be entitled to a 'patient receipt' from their panel-doctor or hospital with information about the treatments they receive and their price.

All our 500 sickness funds must now enter their data on databases. In a few years databases will help to identify developments that have failed so they can be stopped. Indeed German medicine is going electronic with a chipcard through which patients will be able to collect their entire medical history.

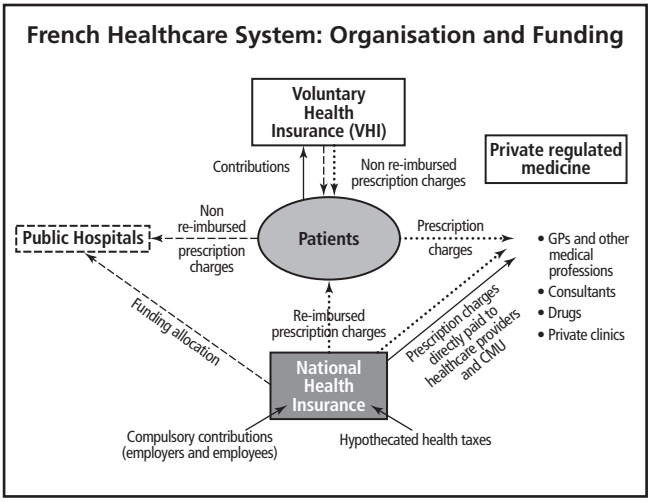
Conclusion

The German healthcare system is therefore facing a new period of reform, designed to ensure that the principles on which it has been built and developed so successfully continue to provide the foundation for success. In Germany the user is funded, not the system, so that he or she can choose from different providers, doctors and hospitals. Those who are without income are funded for this purpose from public funds. In particular, greater competition will be built into the system to promote innovation, quality and indeed efficiency at every level. Unnecessary extravagance and waste will be cut and greater transparency introduced. For Germany, the central principles will provide the dynamic for reform: the twin themes of a healthcare system freely available to all and publicly funded through insurance contributions, where the user is funded and a system which relies for its strength, accountability and efficiency on ensuring a mixture of competing providers at every level, from the private, the charitable and the public sectors.

III
The French Healthcare System

Introduction

The French healthcare system is based on certain fundamental principles. First, the system is mixed. Both the private and the public sector finance healthcare and provide it. Second, the system ensures protection for all citizens with poorer people having healthcare entirely free of charge; and those above a certain income expected to pay a small percentage of the costs. Third, people themselves exercise choice – over the doctors, specialists and hospitals (public and private) which provide healthcare – and citizens are reimbursed directly for a percentage of costs incurred, and a direct grant is made from public funds to most hospitals.



Structure

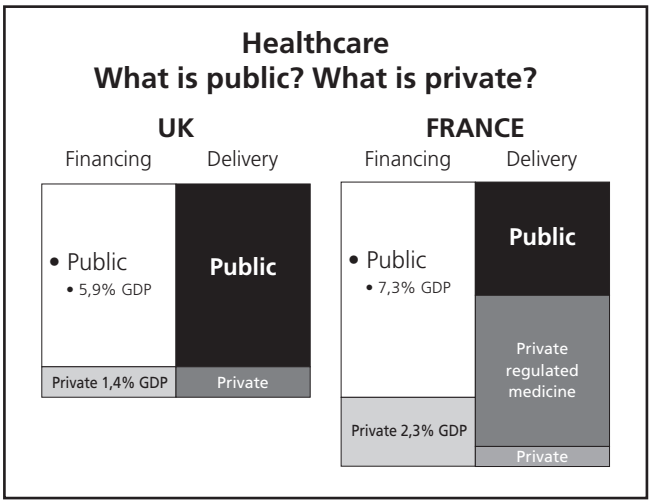
France has a complex mix of private and public sector elements for both the financing of healthcare and provision (as the chart above shows).The system is based on compulsory public health insurance, which is supplemented to a very large extent by voluntary insurance provided mainly by non-profit mutual societies. This is a top-up insurance scheme designed to cover part or all of the costs of co-payment. The healthcare system is closely regulated

by the government which has overall responsibility for the protection of all citizens. Central government undertakes responsibility for the public's health in general; it secures protection, controls relations between institutions financing care, exercises regulatory authority over the public hospital system, and organises the training of health professionals.

Since 1996, the French Parliament has discussed and approved on an annual basis the objectives of the national health policy and related financial framework, including the maximum rate of increase in the health insurance scheme's expenditure.

The following table illustrates how the mixed system with two healthcare systems works:

Regulated private medicine	*Public service hospitals*
• Principles defined by law (1930)	• Doctors, nurses and administrative staff employed by hospitals under statutory rules
• Free location for doctors	• Public establishments administered by a board chaired by town mayor
• Free choice of doctors	• Lump sum financial allocation from funding bodies
• Clinical freedom to prescribe	• 1031 public hospitals and 660 private-not-for-profit hospitals
• Consultation fees paid by patients	• 95,000 doctors and 16,000 junior consultants
• Fees reimbursed up to limits fixed by state and health fund bodies	• 43.6 billion € (£27.25 billion) in 2000
• 118,000 doctors (3/1000); 50 billion € (£31.25 billion)	
• 1300 private clinics; 6 billion € (£3.75 billion) in 2000	



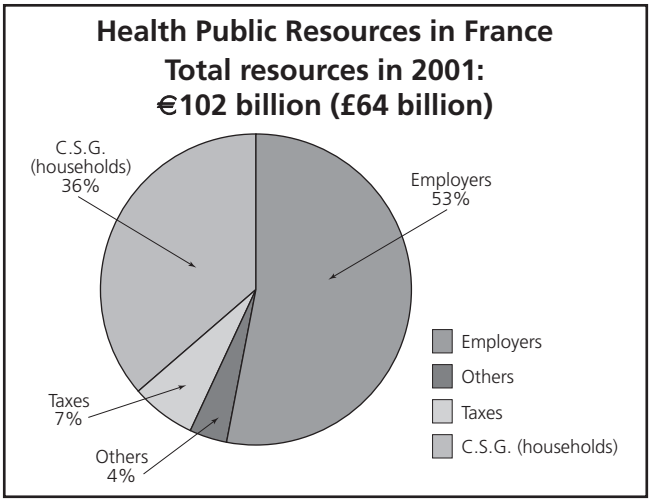
Funding: Spending on healthcare – the overall sum

Healthcare provision is based on a public/private mix with primary healthcare (GP and specialists') care mainly private and hospital care mainly in the public sector.

According to OECD data French expenditure on health as a proportion of GDP was 9.5 per cent in 2000. Total current expenditure on health in France was estimated at EUR 140.6 billion (£88 billion) or nearly 10 per cent of GDP. (The difference of 0.5 per cent is due to the OECD's definition, which includes capital expenditure and excludes sickness benefits and research and training costs.)

The sources of funding

The funding of national health current expenditure comes from different sources – around three-quarters from public sources which include mainly compulsory insurance contributions and taxes, and the remaining quarter from private or voluntary payments.



The public sources amount to 77 per cent of health expenditure (7.7 per cent of GDP). They include:

- the compulsory health insurance contributions based on payrolls and paid by employers and the self-employed (53 per cent of the public element);

- a part of the general social contribution (*contribution sociale généralisée* (CSG), levied on all incomes to contribute to the funding of both the national health system and the national pension system (36 per cent);

- earmarked taxes either paid by pharmaceutical firms or levied on alcohol and tobacco (7 per cent);

- the state and local authority direct payments of health costs (4 per cent);

Voluntary or private sources include voluntary health insurance (12.4 per cent) and out-of-pocket payments by the population (10.8 per cent), accounting for 23 per cent of the total expenditure (2.3 per cent of GDP).

The health insurance contribution rates are set by the French Parliament through the annual Financing of Social Security Act. The CSG, created in

1991, is based on total income (a flat-rate whatever the level of income) and is collected by the Inland Revenue. It has replaced most of the employee component of the compulsory social insurance contributions since 1998.

The compulsory health insurance contributions are collected by a central account agency, which also gets the CSG collected by the Inland Revenue. Both revenues are then transferred to the National Health Fund with one very large fund covering all salaried workers (around 80 per cent of the population) and several smaller funds covering other categories, such as farmers and the self-employed. The Fund has the responsibility of managing the whole national health insurance system (NHI), through a network of regional and local bodies. Its governing board is made up of delegates of employers and employees (unions) with a chief executive appointed by central government through the department of health and social affairs.

Allocation and Distribution of Funding

In 2000, total current expenditure on health in France was estimated at €140.6 billion (£88 billion) or 10 per cent of Gross Domestic Product (GDP) which was valued at €1,416.9 billion. Healthcare consumption accounted for 86.9 per cent of total healthcare expenditure (€2,017 per capita on average). It can be split into four categories: hospital care (accounting for 46 per cent), ambulatory care (26 per cent), drugs (21 per cent) and other medical goods and transport (7 per cent).

The public funds, collected as explained above, are distributed by the health regional and local bodies to cover health expenditure on the following two lines:

i) direct allocation to hospitals based on annual estimates reviewed and approved by regional health authorities (RHA). Each RHA is responsible for defining and implementing the policy for the provision of hospital care at the regional level, as well as analysing and co-ordinating the activities of both public and private healthcare establishments. Each agency also sets the budget of the public and private not-for-profit hospitals through annual allocations and defines which medical equipment and functions they are entitled to. Department officials, as well as administrative and medical representatives of the funding bodies of the national health insurance system (NHI), sit on the executive committee of

the RHAs whose chief executives are appointed by the government);

ii) reimbursement of part of the health costs incurred by users when charged by private medical providers or clinics (medical fees and rates of reimbursement are set by the national health fund and the department of health and social affairs).

As regards co-payment, an individual may take out top-up insurance to cover it or prefer to pay (87 per cent of the population has subscribed to top-up insurance). For those less well-off the co-payment is funded from tax through a scheme known as universal medical coverage (CMU in French).

How it Works: Patients, Doctors and Hospitals

Primary Care

An important feature of the French system is free access to healthcare with no distinction between primary and secondary care. GPs do not have a 'gatekeeper' function. There are no restrictions on provider choice. In order to be covered by the national health insurance (NHI), health services must be provided or prescribed by a doctor, dentist or midwife and delivered by health professionals or by institutions registered with the health insurance system. Most outpatient care is provided by doctors, dentists and medical auxiliaries working in their own practices.

The system operates through direct payments by patients to providers with reimbursement from the national health insurance funds. The reimbursements are never comprehensive as the principle is that there should be a co-payment or user charge which is not eligible for reimbursement by the NHI system. The principle of the co-payment rests on the belief that, in a system of free access by patients and free prescriptions by physicians, there should be a way to regulate healthcare consumption. Most of the time people take out voluntary complementary insurance which covers the whole, or part, of the user charge. The poorer part of the population, through a scheme called *Couverture maladie universelle,* can benefit from healthcare free of charge.

France, therefore, offers a system which centres on patient choice for GP and consultant care. The table below illustrates the differences between French and UK primary care.

France (ambulatory care or healthcare provided outside hospitals)	***UK***
• No registration (free choice of physicians)	• Registration with a GP
• Consultation with a GP or directly with a specialist in private practice, or out-patient visit to public or private hospital	• Consultation with GP
• Payment of consultation on a fee-for-service basis partly reimbursed by national health insurance (NHI) with user charge partly or totally covered by voluntary health insurance (VHI)	• Free of charge at point of delivery
• Prescriptions: drugs bought in pharmacy with reimbursement (or direct payment) by NHI and VHI and user charge depending on drug	• Prescriptions for which charge may be levied

Secondary Care (Hospital Inpatients)

Hospital care is available in both public and private hospitals, but public facilities tend to be dominant and provide the majority of hospital beds. Private hospitals can be divided into two main categories. The first group consists of not-for-profit institutions often referred to as private hospitals participating in the public service(PSPH). These hospitals, like the public hospitals, receive a prospective global budget defined on the basis of regional strategic plan objectives. The second group, the private for profit

hospitals, includes regulated clinics and hospitals funded through a day-price system.

Public and PSPH hospitals provide 75 per cent of the beds. Public hospitals (65 per cent of the beds) must accept all patients and provide emergency care. The private sector with 35 per cent of all beds (25 per cent private for profit and 10 per cent PSPH) provides different type of care (e.g. acute, long-term psychiatric and cancer care). The larger clinics may have more than 250 beds and have developed elective surgery and obstetrics thanks to sophisticated equipment. They are doctor-, especially consultant-, owned or investor-owned – and over the last few years there have been a number of mergers, stimulating real competition with public hospitals. Private hospitals include 20 cancer centres with not-for-profit status.

France	*UK*
• Inpatient treatment or operation in public or private hospitals	• Inpatient treatment or operation in public hospitals
• Free of charge in most cases in public and private-not-for profit hospitals with daily charge often paid directly by VHI	• Free of charge
• Fee-for-service and daily charge in private-for-profit hospitals reimbursed (or paid directly) by NHI + VHI.	• Treatment and operation in private hospitals paid by patient and/or medical insurance, if any

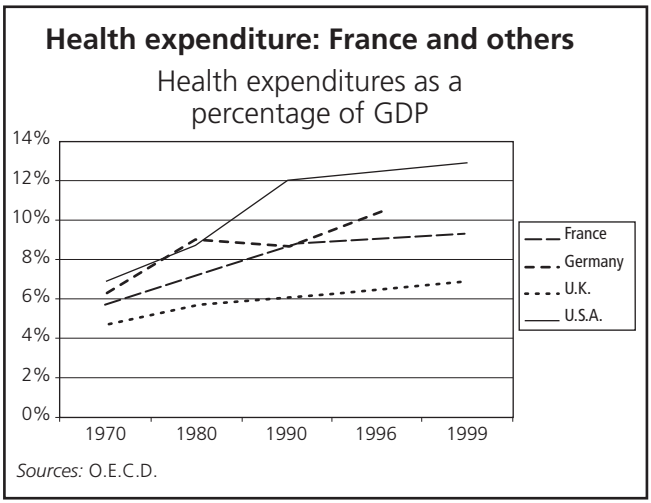
Secondary Care (Outpatient)

Outpatient care is given by consultants in hospitals, and, less frequently, in health centres run by local authorities or mutual associations. There are 1,000 of these municipal health centres where salaried doctors provide primary and preventive care, usually in urban areas. The public hospitals and health centres are exceptions to the normal procedure of direct payment by patient to provider as the NHI system will support directly the eligible costs through a global budget allocation procedure.

France	*UK*
• Outpatient visit to consultant in public or private hospital (direct or upon referral)	• Outpatient visit to consultant in public hospital upon GP's referral
• Public hospitals: free of charge with costs directly supported by NHI and VHI	• Free of charge
• Private hospitals: payment by patient with reimbursement by NHI & VHI	• Visit to private consultant: payment by patient with reimbursement by medical insurance, if any

Advantages and Disadvantages

The French system is based on the principle of individual choice with a mixture of different providers, public and private. A large proportion of the publicly funded national health budget is spent in the form of reimbursements to cover healthcare delivered to individuals through private institutions and a separate proportion allocated directly to the hospitals.



The system is designed to allow for additional funds such as co-payments and individual top-up insurance which currently provide approximately 23 per cent of the total budget. The co-payments of those below a certain income are paid for from public funds. France spends more of its GDP on healthcare (9.5 per cent of GDP in 2000) than the UK (7.3 per cent of GDP) though less than Germany.

France has 3.3 doctors and 6 nurses per 1,000 of the population; the UK has 1.8 and 5.3 respectively. However, if the overall number of doctors is high, there are variations across the country (ranging from 3.6 to 4.2 doctors per 1,000 people (1.7-1.9 GPs) in the Paris area to 2.6 to 3.2 doctors (1.5-1.6 GPs) in the Loire and Brittany).

In France the funding system involves the individual directly as a beneficiary who can choose between different private and public providers, and because the link between benefit and cost is maintained at a global level, the system can allow for increased expenditure without increased levels of tax if the people are ready to accept a reduction in the rates of reimbursement and an increase in the cost of top-up insurance.

Looking Ahead

As in many other Western industrialised democracies, there are pressures in France for more spending on health and costs are already high. Higher taxes to cover such costs would be unpopular in the present climate of opinion. Higher health spending may have to include higher compulsory contributions (and an element of tax) and higher voluntary insurance. Even so certain existing costs and fees may have to be curbed.

However, the growing increase of the deficit on the National Health Insurance Fund in the last two years may lead to more drastic reforms, including stronger controls on drug costs, more rationalisation in the hospital sector and perhaps, as is sometimes suggested, the introduction of arrangements under which serious health risks could be covered by the compulsory national health insurance while for minor risks individuals would have to rely more on private insurance and their own financial choices.

Whatever changes are carried out in the future, it is likely that the French health system will still rest on two principles:

- that contributions and benefits should be firmly linked at individual and global levels through the insurance mechanism (with large and comprehensive compulsory national system and top-up private insurance);

- that should be an important element of redistribution and national solidarity through the compulsory national health insurance system.

IV
A National Health Insurance Scheme

Introduction: The NHS in Collapse

The National Health Service (NHS) is one of the world's last and largest nationalised industries. The difficulties faced by Mr Blair and his Government in trying to reform this industry were evident at his Party's autumn conference this year. The producer interests were out in force there, as they have since been in Parliament, opposing the very modest proposal for foundation hospitals. They, and the old, unreconstructed elements in the Labour Party, resist even the slightest tinkering with this huge nationalised industry. Meanwhile the country itself grows impatient as the Government spends more and more public money on the NHS without evident improvement. The opinion polls continue to suggest that the electorate does not believe more spending is bringing better healthcare. Nor does the evidence suggest it is.

A recent Panorama documentary (29 June 2003) showed that things have got even worse with New Labour's attempt to reform the NHS through multiple targets. One paramedic described how some patients arriving by ambulance at the John Radcliffe Hospital in Oxford last year were not officially admitted, sometimes for hours, to avoid setting back accident and emergency waiting time targets. 'The patient would not be booked into the hospital and so officially had not started waiting', he said. And yet the great British public continues to consider the NHS to be a 'national treasure', which any reformers touch it their peril.

Labour's plans for foundation hospitals may prove problematic if local control becomes politicised. Tax rises, too, may be unsustainable in the long run or the sums awarded may be swallowed up – again – by across-the-board pay claims. The evidence so far is that New Labour's attempt to reform the NHS by pumping in more money, and by increased monitoring through a plethora of targets, has not worked. Most of the cash has been spent on more bureaucrats rather than on doctors and nurses, as well as salary increases. The public seems to have given up hope that New Labour will succeed in improving the NHS. According to a recent YouGov poll, 69

per cent believe the Government is not delivering improvements to the NHS, and 67 per cent believe that the flood of cash Gordon Brown has taken from their pay packets and poured into the NHS will mostly be wasted (Source: *The Daily Telegraph*, 22 September 2003).

These outcomes were perfectly predictable. For New Labour is attempting to refurbish this Old Labour inheritance in Old Labour style by announcing more cash coupled with monitored targets and a national plan for the NHS. It is a policy to deal with non-performing nationalised industries that I have seen offered again and again in country after country during my thirty-year professional career as a development economist. More cash is tied to moral crusades, managerial rearrangements and 'crash' programmes. It invariably fails for well-known reasons: lack of sufficient incentives and of the kind of information required for maintaining productive efficiency.

This is sometimes referred to as the 'soft budget constraint' faced by public enterprises. With no bankruptcy or danger of takeover facing the managers of public monopolies, and with their finances being determined by the political process, there is no incentive for public enterprise managers to achieve any given objective in a cost-minimising manner. Target-setting leads to perverse incentives, as the Panorama documentary confirmed. Thus, as the National Audit Office noted, patients may have suffered. Setting targets for waiting lists has meant that hospitals have altered patient records, failed to add patients to waiting lists, inappropriately suspended patients from the lists or adjusted the lists. In some cases patients' conditions may have deteriorated. This is reminiscent of those Soviet factories which produced either left or right shoes to meet their total shoe targets!

Moreover, as Hayek has emphasised, given the unavoidable division of knowledge in any real world economy, the planners will never have the requisite information available to either devise an 'optimal' plan or to monitor managerial performance. Inevitably, therefore, public monopolies are run in the interests of the producers who, with little danger of any competitive supply, and in democratic societies without any fear of the Gulag, can extract what they will to do what they think is best. Mr Blair is learning this universal lesson about nationalised monopolies personally and painfully – unfortunately at the expense of the hapless British taxpayer.

Replacing the NHS by an NHIS: Principles

Given the British electorate's reluctance to give up this collectivist jewel of 'a universal service for all based on clinical need not ability to pay' as the first core principle of the NHS plan stated, what can be done? As it turns out, Gordon Brown's latest munificence with taxpayers' money might provide an alternative, which accepts political reality while creating a system that provides incentives for the efficient production of healthcare.

The starting-point in thinking about public policy for the so-called 'merit goods' of health and education, is J. S. Mill's distinction in his essay, *On Liberty*, between the public provision and public financing of these 'merit goods'. As he and later Hayek (in his *The Constitution of Liberty*) rightly maintained, while there may be a case for the public financing of these 'merit goods' there is none for their public provision. As Mill expressed it in relation to education:

> 'If the country contains a sufficient number of persons qualified to provide education under government auspices, the same persons would be able and willing to give an equally good education on the voluntary principle, under the assurance of remuneration offered by a law rendering education compulsory, combined with state aid to those unable to defray the expense.'

Nor was this standard view of nineteenth-century economists confined to classical liberals. Here is another well-known nineteenth-century economist's view on state education:

> 'elementary education by the state is altogether objectionable. Defining by a general law the financial means of the elementary schools, the qualifications of the teachers, the branches of instruction etc, and . . . supervising the fulfilment of these specifications by state inspectors, is a very different thing from appointing the state as the educator of the people! Government and church should rather be equally excluded from any influence on the school.[1]

The same principles apply to the 'merit good' of health with, moreover, no need for a law to make its consumption compulsory! But this classical nineteenth-century view conjures up the 'means testing' and 'two tier' demons of contemporary political discourse. I have a proposal to convert the NHS into a National Health Insurance Scheme (NHIS), which can exorcise them while adhering to these nineteenth-century classical principles.

The Proposal

The proposal is very simple. It was prompted by considering the amount Gordon Brown promised in last year's budget on health spending till 2004. Conservative policy, which initially was to match the spending plans, is now to reform the system of healthcare. The most recent proposal – passorts for patients – offer patients the opportunity to use hospitals of their choice for operations, with funding to follow at the level paid by the NHS. The sum promised by Gordon Brown was £75 billion by 2005-6. With a population of 60 million, this implies that £1,250 per man, woman and child will be spent on the NHS. The University of California (UC) – a large public university – munificently buys employees and their families excellent private health insurance as a benefit. This can be topped up if the employee wants. I teach at UC at Los Angeles: looking at my June 2003 pay stub I find that it costs the university $673 per month or $8076 per year to insure the four members of my family. Converting this at an exchange rate of $1.6 = £1 yields a premium of £1,260 per family member, which is about the same as the £1,250 per capita proposed for 2005-6 and slightly more than the £1,050 per capita proposed in the current financial year (2003-4) for the NHS. Moreover, the same insurance continues even after retirement, so that UC retirees do not have to rely entirely on the flawed public Medicaid scheme. UC employees thus have completely free medical care of high quality from their entry to their grave, covering all illnesses including long term ones and those of old age.

This presents a magnificent opportunity for the UK Government to purchase for every single man, woman and child a private health insurance policy at least as good as the one UC provides its employees – and judging from personal experience there can be no question of the incomparable superiority of the health care we get in the US to that in the UK. This UC system provides complete and unlimited free lifetime coverage (with no

account of medical preconditions on entering the scheme) through an health maintenance organisation (HMO) much like the GP-based system in the NHS. For those wanting even more choice, the basic insurance can be topped up, as we do ourselves since we live part of the year in London. For a top-up policy which allows us to see any doctor of our choice anywhere in the world, we pay $47 = £29 for each family member per month – with some deductions.

What is more, there are a number of different insurance companies we can choose from each year – an essential feature of the scheme as it provides the necessary incentives for these companies not to attempt to cheat on their promises, and to monitor the doctors and hospitals providing their insured benefits. This power to exit gives the consumers of healthcare in the system the necessary means to ensure that the insurance companies and their agents – the medical practitioners – in fact meet patient needs in a timely, cost-efficient and consumer friendly manner.

The UK Government could now do what UC does on a much larger scale. It could pay from general taxation for a basic health insurance policy – the NHI – negotiated on behalf of the 60 million inhabitants of these islands, providing complete and free health care, with a number of private insurance companies from which individuals and households could choose (and switch between them). Given the larger pool of people it will be insuring, the UK government would have even greater monopsonistic power than UC in negotiating good terms for this basic universal policy. Each citizen would get a private insurance policy from the company of their choice paid for by the state. Each year they would receive a piece of plastic for all members of their family, which would be used to purchase healthcare with the bill being paid by the insurance company financed by the premiums the Government pays them on behalf of every citizen. Every UK citizen would have the same health benefits, as do the 'toffs' today, with their private health insurance.

It may also be advisable to earmark revenues from general taxation for the NHIS. This will probably make it politically easier to raise further revenues for the NHIS, if the costs of healthcare rise in the future. For people can readily see this as a rise in the premium the Government is paying on their behalf. Though, as the sad experience of the Dome suggests, even earmarking revenues cannot tie the hands of a predatory Government, the

electoral consequences of raiding the earmarked revenues for an NHIS are likely to be more drastic, as it could be directly linked to the resulting diminution in the level and quality of healthcare provision.

Most important of all, with this proposal, the government would be able to relinquish completely its responsibility for providing hospitals, doctors and nurses – and the continual angst that this has caused politicians of all parties. They would all become private agents competing with each other, and monitored by the private insurance companies to whom they sell their services. Like most other private industries there would be no need for any Government involvement in providing health care. Moreover, just as with privatised industries, the ensuing competition between health providers would be a sufficient spur for efficiency. There would be no need for 'health authorities', myriad quangos or Cabinet committees to oversee healthcare. The necessary efficiency would be provided by the market, whose abiding superiority over any system of centralised command and control is that it provides the necessary incentives and information (at virtually no cost) to maintain productive efficiency. The government's role would be to negotiate the terms, and pay the premiums for a NHI policy, which would provide the free universal healthcare promised but not delivered or deliverable by a nationalised industry – the NHS.

How would the scheme affect the current providers of healthcare? Currently, GPs and consultants are at least notionally private agents contracting with the NHS; they would therefore merely switch their employer - from the government to the private insurance companies. They could either choose to practise independently as private providers or, as is more likely, many of them could – as they do now – join a joint practice which could become the equivalent of a US-style HMO. But this would be a private entity and not, as at present, part of some government health authority, so the assets including the goodwill of the practice, would belong to them and could be sold to those wanting to join the practice. This would give doctors a market-driven incentive not only to invest in their practice, but also to provide customer satisfaction on which goodwill depends. This would be a much more effective and efficient way of providing incentives for good GP care than all the targets laid down for GPs in New Labour's NHS Plan.

The various NHS hospitals could be privatised in a number of different ways from non-profit trusts to commercially owned entities with stockholders. Depending upon local preferences, new hospitals, which could include the resurrection of cottage hospitals, would also emerge. Unlike a Planning Commission legislating its views, however technocratically and altruistically derived, the market is in Hayek's felicitous phrase 'a discovery process'. The final market-driven outcome would be truly determined by consumer preferences and no, as in the current centrally planned system, by a planner's preferences – the 'gentleman in Whitehall who knows best', in Douglas Jay's immortal phrase.

Moreover, as with the privatisation of other nationalised industries, immediate efficiency gains will arise through eliminating the various layers of bureaucracy, which are necessary to monitor performance in any command and control system lacking the usual market indices of profit and loss. With diversity among hospitals there would also be diversity in the types of management. No planner can know all the alternatives. Hence the constant pressure in every nationalised industry for continual rearrangements and reorganisations to find the holy grail of the ideal management structure – which of course turns out to be a mirage. The only thing we know with certainty is that these extra-market arrangements will never be as efficient as those driven by the market. The main beneficiaries of Gordon Brown's munificence – following Parkinson's law – are not likely to be the patients but the burgeoning number of bureaucrats in a nationalised hospital system.

Possible Objections to the NHIS

What are the possible objections to such a scheme? Four were outlined by John Appelby of the King's Fund in a letter to the *Financial Times*[2] following an article in which I proposed this scheme[3]. The first two concered coverage; the essential points here were that, as the University of California employees are likely to be healthier than the UK population, there would be differences in the 'risk pool', and that the premium UC pays on my behalf does not provide coverage for poorer and older people's healthcare, as is the case with the tax-financed NHS. My answer[4] was that the UC health benefits system covers all employees, including dustmen, cleaners and everyone else (such as university dons), as well as their dependants – including aged

parents and gay partners and their dependants! The students being younger might improve the 'risk pool', but they have their own separate healthcare system. There is no reason to believe the UC employee health system has a pool of healthier people than the UK population. Many of those covered – for example our domestic cleaner from El Salvador, who got a job as a cleaner at the university – are poor and, as the scheme includes retired people and aged dependants, it also protects the old.

It is in short a universal system for employees, who are a cross-section of the California population. Given the larger numbers to be covered in the whole UK population, the 'risk pool' should even be better under my proposed scheme, and the negotiated premiums even lower. (The next section of this study includes an explicit comparison of costs between the NHS and costs to match the UK's age and socio- economic profile for Kaiser Permanante, a Californian HMO insurance company ,whose HMO plan is offered as one of those fully paid by the University of California, and whose per capita costs, therefore, form the basis of the employer contribution to the UC health insurance plans.)

The third objection made by Appelby is that 'US experience of contract setting and monitoring by private insurers is littered with failed attempts to control costs and ensure efficient use of healthcare. The losers in this system have been the millions of uninsured and under insured people'. Two points need to be made on this. First, I am not sure what is meant by the 'efficient use of healthcare'. There is the *dirigiste,* health economist's view, which seeks to lay down efficient outcomes in terms of some theoretical norm. But just as this is irrelevant in judging the relative efficiency of a market economy, so is any such technocratic norm for healthcare.[5] Ultimately, there is no reason to treat health any differently from any other consumer good, where consumer satisfaction provided at low cost is as good a test of actual efficiency as any other. Given that the costs of providing UC healthcare are about the same on a per capita basis as those planned for the NHS, the only real test is relative consumer satisfaction. In a recent survey, the satisfaction of consumers with their UC health care plans varied from 85 to 93 per cent. Even ignoring the currently dismal level of consumer satisfaction with the NHS as revealed in the YouGov poll, it is difficult to believe that Gordon Brown's billions will change the picture markedly, because of the tendency of public monopolies to absorb the money made available to serve producer, rather than

consumer, interests.

The second point about the alleged inefficiency of the US health system conflates two separate issues: the fact that many people in the US are under- or uninsured, and the efficiency of health care for the insured in good health care systems like that in the University of California. There are historical reasons for the large number of uninsured persons in the US but that is not germane to this argument as my proposed scheme would cover the whole population.[6] For those who are insured in the US, there is no question, from my own personal experience with the US and UK health care systems, about which is more efficient in delivering quality health care (as the comparison of the NHS with Kaiser Permanante in the next section also shows). I should make clear that I am not suggesting that the UK adopt the two-tier US health system. What I am proposing is that the UK emulate the practice of a one top-tier employer-provided insurance scheme for *everyone* in the UK.

The final objection Appleby makes is that 'the proposal relies on government negotiating and monitoring a contract with the insurers that guarantees the outcomes we all want. But if the government is failing to do this through its own 'in house' health authorities, why should it be able to do it with private purchasers?' The answer is simple. Just as with other nationalised industries, for example the natural monopolies such as water and electricity, replacing them with competing providers enables the Government to monitor and ensure desired outcomes through regulatory regimes that rely on the only incentives that work: profit and loss.

There is no reason why my alternative should be any more expensive for health than for water and electricity. Continuing to rely on political command and control mechanisms – like the 'health authorities' – will always end in tears.

The Feasibility of an NHIS: The Kaiser Permanente Study

More can now be said about the feasibility and desirability of my proposed NHIS, as a result of a recent comparative study of the costs and benefits of one of the major insurers of health in California, Kaiser Permanente (whose HMO is one of those offered as part of the UC health plan) with the NHS carried out by Profesor Richard Feacham, Director of the Institute of Global

Health at the University of California San Francisco and Berkeley (and a former Dean of the London School of Hygiene and Tropical Medicine) and his associates.[7]

Kaiser Permanente is a non-profit-making fully integrated health maintenance organisation (HMO) which was set up in 1945 – about the same time as the NHS – by various trade unions. Its total enrolment is now 8 million (about the size of the population of Austria) and of these 6 million are in California. It employs its own doctors (who are salaried employees) and owns and operates its own ambulatory and inpatient facilities. So it is rather like the NHS – except it has to compete for customers!

There are differences in the 'risk pool' of the people covered by Kaiser Permanente and the NHS. 10 per cent of Kaiser's population is over sixty-five as compared with 16 per cent in the NHS. As the Kaiser operation was set up as a 'working class system', it includes all socio-economic tiers including the indigent who are covered by the public insurance scheme, Medicaid (representing 3.5 per cent of those served by Kaiser), but it obviously does not include the unemployed.

Given these differences, particularly in the age profile, Feacham and his associates made adjustments for the differences in age and socio-economic status of the Kaiser and the NHS population. They find that the same age profile as the NHS would increase Kaiser's costs by 13 per cent, and the socio-economic profile by 5 per cent. After adjustments for these elements and for purchasing power parity (PPP), they find that the adjusted per capita costs for Kaiser would be $2,392 as compared with the NHS of $2,186 (in PPP dollars) – i.e. the Kaiser per capita costs would be 9 per cent more than the NHS. Given the necessarily uncertain nature of the calculations, this suggests that there is not likely to be much difference in the costs of the NHS and those of a Kaiser system with the same coverage as the UK population.

But there would be a marked difference in the relative benefits. The average time spent with a primary care doctor would rise from 8.8 minutes in the NHS to 16 minutes in Kaiser. The waiting time to see a specialist, which is seven weeks on average in the NHS (and over six months for 7 per cent of the patients), would fall to twelve days under Kaiser. Nor would they have to go to some other facility for their laboratory, imaging or pharmacy needs.

For unlike the UK, where only about 25 per cent of primary care providers have these on site, 100 per cent of those in the Kaiser system have them. The clinical outcomes under Kaiser are similar to those for the insured US population, which are much better than under the NHS. Take cancer survival rates. In the UK only 5 per cent of patients with stomach cancer can hope to survive for more than five years; in the US the comparable survival rate is over 40 per cent.

Clearly the Kaiser insurance system provides a more responsive and efficient healthcare system at roughly the same per capita cost as the NHS. The essential difference is that, unlike the NHS, Kaiser and its doctors and hospital employees have to compete for business with other insurers in the US system. Even as a non-profit organisation they have to manage their costs and generate sufficient revenues to cover not only the running but also the capital costs (like those of hospitals and equipment) to stay solvent. Here we have an insurance-based system which meets the NHS objectives – universal coverage (given the age and socio-economic adjustments to the actual Kaiser figures), free at the point of use and based on need not income (as the insurance premiums as in the UC system are provided by employers). Moreover, it delivers a quality of health care, at about the same per capita cost as the NHS, which is still far beyond the reach of most people in the UK.

Conclusion

The Government's attempt to set up foundation hospitals is an acknowledgement that, though the state should finance health care, it need not provide it. This has also emerged in the plans to use private hospitals for NHS patients and invite outside bids to clear operating waiting lists.

The trend needs to go further. All hospitals should be allowed freedom from central direction. Instead of hospitals and healthcare programmes being run by Whitehall and the health quangos, there should be a market where individuals are funded by a premium, with the right to have healthcare free at the point of delivery. The Government would be accountable for this money and would invite outside trusts to run the healthcare for individuals with the premiums being paid by the Treasury.

This is the kind of scheme used by the University of California which covers

the healthcare of its employees through the Kaiser Permanente scheme. As the Kaiser Permanente's figures show, the sums involved in extending such a scheme to every person in Britain would cost no more than the sums Gordon Brown has allocated for the years 2005-6.

As for the Conservative proposals for passports for patients, they do not go far enough. The essential point is that the provision of health care should be in private hands, but financed by the state.

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[5] I have dealt with these theoretical economic issues in my 'The role of the public sectors in health financing in developing countries', HRO Working Paper no. 33, The World Bank, June 1994, reprinted in D.Lal, *Unfinished Business,* Oxford University Press, 1999.

[6] There are uninsured people in the US health system because the tax subsidy to employers' health plans which was granted during the period of wartime wage and price controls. Employers sought to get round the age freeze by offering health insurance benefits to employees. The Internal Revenue Service went along with this, granting business a tax deduction and excluding the fringe benefits from employee incomes. As a result, given these tax advantages, most health insurance in the US is provided by employers, which leaves those without large and generous employers having to depend on self-insurance, or much more costly private insurance. See D. Green, *Challenge to the NHS – A Study of Competition in American Health Care and the Lessons for Britain, Hobart Paperback 23, London, Institute of Economic Affairs, 1986;* J.C.Goodman and G.L.Musgrave, *Patient Power: Solving America's Health Care Crisis,* Washington DC, Cato Institute, 1992.

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The NHS is not serving this country well. Huge tax increases under this Government have not brought the consistently high standards of healthcare which the UK, one of the world's most prosperous nations, should expect. A reluctance by successive Governments to undertake essential reforms has left the vast nationalised structure of the NHS intact, one of the few institutions to survive from Britain's most Stalinist period of political thought

Systems for Success considers the – very different – principles on which successful healthcare is based elsewhere. First, that experience shows that there must be a mixture of providers – from all sectors, public, private and voluntary. Second, mixed funding provides the essential top-up needed to supplement resources from taxation. Third, healthcare must be freely available to all, whatever their means.

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