

Investigating what the UK can learn from the French model of healthcare funding

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The UK is reaching a healthcare funding crisis. The population is ageing and there is strong demand for a process of modernisation.¹ But the finances to ameliorate these problems are not available. The UK funding model cannot keep up with the financial demands of quality universal healthcare.² Yet the system remains without serious proposals for reform. This report seeks to understand the ways in which healthcare in the UK is failing and how the method of funding may be responsible.

The weaknesses of the oft-referenced US model should not stand as confirmation of the pre-eminence of the government-controlled system. The shortcomings of the American structure should serve only as a warning against shifting the majority of funding responsibility to the private sector. This comparison obscures the fact that an abundance of European nations have rejected the notion that universal healthcare must be funded through taxation. A significant number of countries with universal healthcare avoid using direct, unhypothecated taxation as their core funding mechanism. This includes Germany, Switzerland, the Netherlands and France. And given its similarities to the UK in foundational principles and domestic appreciation for the respective system, as well as its relative strengths, France shall be the nation under review. After exploring the key mechanisms, analysis will turn to the merits and drawbacks of the model. This will aid in assessing whether elements of the French healthcare funding system are suitable and effective enough to implement in the UK.

A discussion about funding does not require a change of priorities. It means considering that financing problems in the UK may not simply be a matter of the Conservative Party failing to support the NHS. It appears that the model for funding healthcare in the UK is unsustainable, inefficient, and is in part responsible for the failure to address key problems. This does not mean that the system requires radical upheaval. This does not mean that transitioning to an insurance-based French model is the solution or even a possibility. And this certainly does not mean that privatisation is being recommended. It does, however, indicate that the UK should be open to understanding how funding sources could be adjusted and diversified. And this involves learning from a country that is a world leader in the field.³

¹ Charlesworth, A. et al. (2018) *Securing the future: funding health and social care to the 2030s*, The Institute for Fiscal Studies. Retrieved from

https://www.ifs.org.uk/uploads/R143_Chapter4.pdf

² Charlesworth, A. et al. (2018) *Securing the future: funding health and social care to the 2030s*, The Institute for Fiscal Studies. (see earlier)

³ World Health Report 2000 (2000) *Health Systems: Improving Performance*, World Health Organisation. Retrieved from http://www.who.int/whr/2000/en/whr00_en.pdf

Funding problems facing the UK

The UK funding model

The UK operates a tax-funded model that aims to pool risk across a large population base. While private medical insurance is available, just 11% of the UK population is covered in this way.⁴ And within this group, a much smaller proportion has comprehensive private insurance.⁵ Of the £125 billion raised for healthcare in England in 2017/18, just fewer than 80% came through taxation.⁶ Since 2003, National Insurance contributions have represented around 20% of the overall funding.⁷ Charges on dental treatment and prescriptions are also in place. In total, £1.6 billion was raised in patient charges in 2016/17.⁸

Insufficient funds

The NHS is facing severe pressure from a growing and ageing population, expectations of modernisation, and increasing costs. Even without modernising the service, UK healthcare requires a considerable increase in funding. Estimates for a 'status quo' scenario suggest that an additional 1.6% of GDP is required by 2034.⁹ Factoring in desires for modest improvements in provisions, an additional 2.6% of GDP would be needed by 2034.¹⁰

This issue is accompanied by serious hospital deficits. The funding gap between patients' needs and NHS resources in 2014 was estimated to be £2.2 billion.¹¹ NHS bodies ended the 2015/16 financial year with a £1.85 billion deficit.¹² Although it is true that the Audit Office praised the NHS for the care that it offers, declines in performance in key areas were noted in the report.¹³ The funds raised were deemed insufficient to meet financing targets. The ability to meet key health targets depends on funding and the UK is failing to raise the necessary amount.

The UK spends 9.8% of GDP on healthcare according to the latest ONS figures, above the OECD average.¹⁴ However, comparison by expenditure per capita in terms of purchasing power parity highlights the failures of the system. Measured using this method, the UK spent \$4,144.60 in 2015.¹⁵ This compares unfavourably with France (\$4,542.31), Japan

⁴ Commission on the Future of Health and Social Care in England (2014) *The UK private health market*, The King's Fund. Retrieved from

<https://www.kingsfund.org.uk/sites/default/files/media/commission-appendix-uk-private-health-market.pdf>

⁵ Commission on the Future of Health and Social Care in England (2014) *The UK private health market*, The King's Fund. (see earlier)

⁶ Rahman, G. (2018) 'How is the NHS funded?', Full Fact. Retrieved from

<https://fullfact.org/health/how-nhs-funded/>

⁷ Rahman, G. (2018) 'How is the NHS funded?', Full Fact. (see earlier)

⁸ Rahman, G. (2018) 'How is the NHS funded?', Full Fact. (see earlier)

⁹ Charlesworth, A. et al. (2018) *Securing the future: funding health and social care to the 2030s*, The Institute for Fiscal Studies. (see earlier)

¹⁰ Charlesworth, A. et al. (2018) *Securing the future: funding health and social care to the 2030s*, The Institute for Fiscal Studies. (see earlier)

¹¹ Dolton, P. (2017) *Is NHS Funding in Crisis?*, National Institute of Economic and Social Research. Retrieved from

<https://www.niesr.ac.uk/sites/default/files/publications/NIESR%20Briefing%20Paper%20No5%20-%20Is%20NHS%20Funding%20In%20Crisis.pdf>

¹² Dolton, P. (2017) *Is NHS Funding in Crisis?*, National Institute of Economic and Social Research. (see earlier)

¹³ Dolton, P. (2017) *Is NHS Funding in Crisis?*, National Institute of Economic and Social Research. (see earlier)

¹⁴ Office for National Statistics (2018) 'UK Health Accounts: 2016'. Retrieved from

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2016>

¹⁵ World Bank (2015) 'Current health expenditure per capita, PPP (current international \$)'. Retrieved from

<https://data.worldbank.org/indicator/SH.XPD.CHEX.PP.CD>

(\$4,405.13) and the Netherlands (\$5,313.24), as well as a number of other developed countries.¹⁶

Research suggests that the tax-based nature of the model is partly responsible for this low spending capacity. According to World Bank research, across 29 countries (16 insurance-funded; 13 tax-funded), insurance-based systems allowed 3-4% more spending than tax-based models.¹⁷ A further study suggests that this figure is 11%.¹⁸ The evidence suggests that, by virtue of the funding mechanism, fundraising is more effective when utilising insurance as the core source of finances. This may be explained by greater efficiency in collection, greater incentives to contribute, and greater hypothecation in the process of distribution.

Unsustainable methods

The NHS is taking an unsustainably large share of national income. Between 1950 and 2011, spending on the NHS grew by 4.04% per year.¹⁹ GDP, in this time period, grew by just 2.54%.²⁰ If similar rates of change continued, the NHS would consume one-fifth of national income by the 2070s and half by 2135.²¹ This fiscal trend cannot continue.

The income tax burden is also unsustainable, while hypothecation is insufficient. To achieve even the 'status quo' scenario of NHS development, all rates of income tax would have to increase by approximately 5p.²² And increasing tax rates does not guarantee that this extra revenue will be spent on health.

A model that funds healthcare through taxation, filtered through the central budget without hypothecation, places distributive power into the hands of government. This links spending on healthcare not only to the decisions of the particular ruling party, but also to the state of the economy. Funding goes through periods of feast and famine, due to economic fluctuations and new governments adjusting their priorities. These combine to limit the reliability of the structure. Indeed, it is not necessarily the use of taxes as a funding source that hinders the system, but the predominance of unhypothecated taxation in the UK model.

Current fiscal trends are linked to the connection of healthcare to the central budget. As new healthcare spending necessarily results in cuts to other departments, serious investment is difficult. The lack of diversity of financing sources in the UK healthcare structure severely restricts funding possibilities. A commitment to utilising just one source for the vast majority of funding increases administrative risks and is restrictive when attempting to raise funding capacity.

¹⁶ World Bank (2015) 'Current health expenditure per capita, PPP (current international \$)'. (see earlier)

¹⁷ Wagstaff, A. (2009) *Social Health Insurance vs. Tax-Financed Health Systems - Evidence from the OECD*, World Bank. Retrieved from

<http://documents.worldbank.org/curated/en/545121468028868365/pdf/WPS4821.pdf>

¹⁸ Wagstaff, A. and Moreno-Serra, R. (2008) *Europe and Central Asia's Great Post-Communist Social Health Insurance Experiment: Impacts on Health Sector and Labor Market Outcomes*, World Bank. Retrieved from <https://openknowledge.worldbank.org/bitstream/handle/10986/7382/wps4371.pdf?sequence=1&isAllowed=y>

¹⁹ Appleby, J. (2013) *Spending on health and social care over the next 50 years*, The King's Fund. Retrieved from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Spending%20on%20health%20...%2050%20years%20low%20res%20for%20web.pdf

²⁰ Appleby, J. (2013) *Spending on health and social care over the next 50 years*, The King's Fund. (see earlier)

²¹ Appleby, J. (2013) *Spending on health and social care over the next 50 years*, The King's Fund. (see earlier)

²² Charlesworth, A. et al. (2018) *Securing the future: funding health and social care to the 2030s*, The Institute for Fiscal Studies. (see earlier)

Furthermore, overtreatment is an unsustainably large problem. In the case of blood glucose evaluation, there are 1000-fold differences in the rate at which GPs order such tests.²³ This can mean that some people are not getting necessary testing, but it is more likely explained by some tests being carried out too much. Overtesting leads to overtreatment, which wastes resources and increases costs. Tonsillectomies in children are a key example of an elective treatment that is overused. These are performed at a rate of 145 to 424 per 100,000 children.²⁴ This is in the face of evidence suggesting that the treatment is 'of low clinical value'.²⁵

Furthermore, free services lead to the abuse of provisions. Services can be used without due attention paid to medical necessity.

Inefficient system

Tax-funded models, and particularly the UK due to its large governmental involvement in administration, are affected by 'an inefficient, centralistic setup' with a bureaucracy that attempts to regulate and manage the system of healthcare.²⁶ Notwithstanding recent efforts to devolve some duties to medical professionals, the structure of healthcare administration in the UK still suffers from the inefficiencies of excessive governmental oversight. This will continue to be the case while the state is in charge of managing funding and spending. The inefficiencies may initially be caused by the bureaucratic burden that results from attempting to manage complex decisions from central government, without the necessary division of responsibilities. But this affects the entirety of the system, as the use of resources in hospitals and surgeries is affected by decisions made at the stage of central government.

Services affected

Insufficient funding is causing patients to have to wait for access to urgent clinical care. The '18-week referral-to-treatment standard on planned care' was last met in February 2016.²⁷ The goal for four-hour A&E waiting times has not been met for three years.²⁸ The '62-day cancer standard' has been continually missed during the same time period.²⁹

OECD data in 2014 placed the UK behind only Montenegro, Romania, Slovenia, Poland and Turkey in terms of doctors per 1,000 people.³⁰ In the UK, this figure is 2.8.³¹ The difficulty for patients to get appointments can be partly explained by this shortage. GP vacancy rates are high and 'record numbers of GP practices are closing'.³²

²³ Alderwick, H. (2015) 'Is the NHS delivering too much of the wrong things?', The King's Fund. Retrieved from <https://www.kingsfund.org.uk/blog/2015/08/nhs-delivering-too-much-wrong-things>

²⁴ Alderwick, H. (2015) 'Is the NHS delivering too much of the wrong things?', The King's Fund. (see earlier)

²⁵ Alderwick, H. (2015) 'Is the NHS delivering too much of the wrong things?', The King's Fund. (see earlier)

²⁶ Doetinchem O., Schramm B., and Schmidt J.O., (2006) 'The benefits and challenges of social health insurance for developing and transitional Countries' in Laaser U., and Radermacher R (Eds.): *Financing health care - A dialogue between South Eastern Europe and Germany*, Series International Public Health; Vol. 18, Jacobs Editing Company. Retrieved from http://www.who.int/health_financing/issues/shi-doetinchemschrammschmidt.pdf

²⁷ Anandaciva, S. and Thompson, J. (2017) *What is happening to waiting times in the NHS?*, The King's Fund. Retrieved from <https://www.kingsfund.org.uk/publications/articles/nhs-waiting-times>

²⁸ Anandaciva, S. and Thompson, J. (2017) *What is happening to waiting times in the NHS?*, The King's Fund. (see earlier)

²⁹ Anandaciva, S. and Thompson, J. (2017) *What is happening to waiting times in the NHS?*, The King's Fund. (see earlier)

³⁰ Dolton, P. (2017) *Is NHS Funding in Crisis?*, National Institute of Economic and Social Research. (see earlier)

³¹ Dolton, P. (2017) *Is NHS Funding in Crisis?*, National Institute of Economic and Social Research. (see earlier)

³² Dolton, P. (2017) *Is NHS Funding in Crisis?*, National Institute of Economic and Social Research. (see earlier)

Moreover, hospital bed provisions are suffering from funding shortages. In the past 30 years, the total number of beds in NHS hospitals has halved.³³ The UK currently has fewer 'acute beds relative to its population' than almost any other developed country.³⁴

And while ill health related to substance abuse is increasing, spending on drug and alcohol support has been significantly reduced. 118 councils that replied to information requests were collectively spending £452 million in 2014/15 to combat substance-based problems.³⁵ This compares to £535 million in 2013/14 - a reduction of 15.5%.³⁶ An ONS release shows 3,756 deaths relating to drug poisoning in England and Wales in 2017 - the highest number since such data was first collected in 1993.³⁷ This highlights the failings in public health spending and the need for greater funding.

Successes

However, healthcare successes in the UK should also be acknowledged. Although experiencing funding-based problems, the service is effective in carrying out its core tasks.

Life expectancy increases are significant. Since 1981, life expectancy for men has increased from 70.9 years to 79.4 years.³⁸ For women, the increase has been from 76.9 to 83.3.³⁹

There are now far fewer infectious diseases. Typhoid and tuberculosis are now extremely rare in the UK.⁴⁰

Since 2000, the gap in expenditure between the UK and the EU 14 has been closed.⁴¹ Low spending patterns were transformed through a re-allocation of funds by the Blair government.⁴²

Indeed, the reality is that the healthcare system in the UK functions excellently. But this is partly why the funding crisis is such an important issue. Firstly, the successes detailed above could be even greater with an increased funding base. But in addition to that, it should be recognised that the continuation of these achievements is not inevitable. Healthcare provisions require funding that is both substantial and sustainable. As neither of these qualities is being sufficiently provided by the current system, it is paramount that alternative models are evaluated.

³³ Ewbank, L., Thompson, J., and McKenna, H. (2017) *NHS hospital bed numbers: past, present, future*, The King's Fund. Retrieved from

<https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers>

³⁴ Ewbank, L., Thompson, J., and McKenna, H. (2017) *NHS hospital bed numbers: past, present, future*, The King's Fund. (see earlier)

³⁵ Rhodes, D. (2018) 'Drug and alcohol services cut by £162m as deaths increase', BBC News. Retrieved from

<https://www.bbc.co.uk/news/uk-england-44039996>

³⁶ Rhodes, D. (2018) 'Drug and alcohol services cut by £162m as deaths increase', BBC News. (see earlier)

³⁷ Office for National Statistics (2018) 'Deaths related to drug poisoning in England and Wales: 2017 registrations'. Retrieved from

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations>

³⁸ Health Careers (2013) 'Achievements and priorities in public health'. Retrieved from

<https://www.healthcareers.nhs.uk/working-health/working-public-health/achievements-and-priorities-public-health>

³⁹ Health Careers (2013) 'Achievements and priorities in public health'. (see earlier)

⁴⁰ Health Careers (2013) 'Achievements and priorities in public health'. (see earlier)

⁴¹ Dolton, P. (2017) *Is NHS Funding in Crisis?*, National Institute of Economic and Social Research. (see earlier)

⁴² Thorlby, R. and Maybin, J. (2007) *Health and ten years of Labour government*, The King's Fund. Retrieved from

https://www.kingsfund.org.uk/sites/default/files/field/publication_file/health-ten-years-labour-government-achievements-challenges-may2007.pdf

Why France?

Strong outcomes

Perhaps the clearest reason for using France as a point of comparison is the success of the system. As well as the structural merits that will be discussed later, French outcomes are comparatively strong.

The cancer survival rate (1999-2007) was 58.6%.⁴³ This compares to a rate of 50.2% in the UK across the same time frame.⁴⁴

Regarding Cerebrovascular disease, the age-standardised death rate per 100,000 in France (2016) was 331.7.⁴⁵ The UK had a far higher rate of 452.5.⁴⁶

Average life expectancy in France (2016) stood at 82.4 years.⁴⁷ The same study placed life expectancy in the UK at 81.2 years.⁴⁸

The extent of the link between funding and outcomes is ambiguous. It is certainly true, though, that a greater capacity to spend gives a health system the opportunity to improve provisions that will alleviate health problems. Regardless, it is important that the healthcare system used as a point of comparison is shown to be effective on key metrics.

Similar domestic appreciation for the respective system

87% of British citizens are 'very or fairly proud' about the NHS.⁴⁹ And following the infamous quotation from Aneurin Bevan, the idea that the NHS is 'the envy of the world' remains strong.⁵⁰ Using the French example, though, there does not appear to be too much justification for this. In 2008, 70% of the French public described their healthcare system as 'the envy of the world'.⁵¹ Substantial changes to the funding structure are very difficult to achieve. 2017 Presidential candidate François Fillon was forced to retract his proposal of radically reducing the social insurance aspect of healthcare funding.⁵² His proposal to finance provisions through a private model (with exceptions for serious and long-term illness) was widely criticised.⁵³ It is certainly not true that other nations have no appreciation of the UK example. But it is apparent that the French are as forthright about the superiority of their

⁴³ European Journal of Cancer (2015) *Survival of Cancer Patients in Europe, 1999–2007: The EUROCARE-5 Study*, Elsevier. Retrieved from

https://ac.els-cdn.com/S0959804915007054/1-s2.0-S0959804915007054-main.pdf?_tid=2c7bcfee-f41c-498a-945c-7e6522f691c2&acdnat=1536852275_ebc88f8dd3aea5be6375c0f1b63b229b

⁴⁴ European Journal of Cancer (2015) *Survival of Cancer Patients in Europe, 1999–2007: The EUROCARE-5 Study*, Elsevier. (see earlier)

⁴⁵ Institute for Health Metrics and Evaluation (2016) 'France Country Profile', University of Washington. Retrieved from <http://www.healthdata.org/france>

⁴⁶ Institute for Health Metrics and Evaluation (2016) 'United Kingdom Country Profile', University of Washington. Retrieved from <http://www.healthdata.org/united-kingdom>

⁴⁷ Organisation for Economic Co-operation and Development (2017) *Health at a Glance 2017: OECD Indicators*. Retrieved from <https://data.oecd.org/healthstat/life-expectancy-at-birth.htm>

⁴⁸ Organisation for Economic Co-operation and Development (2017) *Health at a Glance 2017: OECD Indicators*. (see earlier)

⁴⁹ Smith, M. (2018) 'The NHS is the British institution that Brits are second-most proud of – after the fire brigade', YouGov. Retrieved from

<https://yougov.co.uk/news/2018/07/04/nhs-british-institution-brits-are-second-most-prou/>

⁵⁰ Trigg, N. (2018) 'NHS 'poor' on treating deadly illnesses', BBC News. Retrieved from <https://www.bbc.co.uk/news/health-44567824>

⁵¹ Bidgood, E. (2013) 'Why the French model may have the answer to the NHS's many challenges', City AM. Retrieved from <http://www.cityam.com/article/why-french-model-may-have-answer-nhs-s-many-challenges>

⁵² Love, B. (2017) 'French presidential candidate Fillon changes tack on healthcare', Reuters. Retrieved from <https://www.reuters.com/article/us-france-election-fillon-idUSKBN1600QT>

⁵³ Love, B. (2017) 'French presidential candidate Fillon changes tack on healthcare', Reuters. (see earlier)

system as the UK public is about theirs. Hence, it should be clear that a consensus on insurance-led healthcare is just as easily formed as the British consensus on tax-funded provisions. National pride for a healthcare system is not exclusive to the UK.

Similar foundational principles

It may appear that the UK and France diametrically opposed on healthcare because the former uses a Beveridgian system, while the latter operates a Bismarckian model. Broadly, in a Beveridgian system, healthcare is 'provided and financed by the government through tax payments'.⁵⁴ Meanwhile, the Bismarckian model uses an insurance system 'financed jointly by employers and employees through payroll deduction'.⁵⁵ The Beveridge-Bismarck comparison is useful for understanding the division between tax-funded and insurance-based structures. But it is not valuable when considering motivation and expectation. Healthcare is viewed in both countries as requiring government oversight. Much like the UK, French healthcare is based on the promotion of 'universalism and equality'.⁵⁶ These are not distinctly British virtues.

A more moderate model than other insurance-based systems

Among a range of alternative models of healthcare funding, France is the most appropriate comparison. Insurance-based models across Europe are usually described as 'Pure Social Health Insurance (SHI)' with funds coming almost exclusively from an earmarked payroll tax.⁵⁷ A Canadian-style system, whereby deductions imposed on wages that fall below a certain threshold are subsidised by tax revenues, could be called 'Government subsidised SHI'.⁵⁸ The French model is most accurately described as a 'Mixed Bag' form of SHI, with funding coming from a number of sources.⁵⁹ This makes it a more apt model from which to learn, as a change to be more like France would not necessarily involve a conversion to SHI. A diversified fund means that alternative taxes and small charges can also be considered. Furthermore, the compulsory nature of this insurance makes it more like a tax-based model than other European insurance-based system. As risk does not influence premiums, French healthcare insurance is unlike more conventional forms of indemnity. The key difference is that proceeds from SHI are hypothecated for spending on healthcare.

Indeed, there is plenty in the French model to investigate. And it need not be based solely around the relative merits of tax-based and insurance-based structures.

French funding model

Social health insurance

⁵⁴ Physicians for a National Health Program (2008) 'Health Care Systems - Four Basic Models'. Retrieved from http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php

⁵⁵ Physicians for a National Health Program (2008) 'Health Care Systems - Four Basic Models'. (see earlier)

⁵⁶ Nay, O. et al. (2016) 'Achieving universal health coverage in France: policy reforms and the challenge of inequalities' in (ed. Horton, R.) *The Lancet*; 'France: Nation and World', Elsevier. Retrieved from <https://hal.archives-ouvertes.fr/hal-01314882/document>

⁵⁷ Thomas, S., Ryan, P., and Normand, C. (2010) *Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland*, The Adelaide Hospital Society. Retrieved from https://www.tcd.ie/medicine/health_policy_management/assets/pdf/Effective-Foundations_Adelaide-Hospital1.pdf

⁵⁸ Thomas, S., Ryan, P., and Normand, C. (2010) *Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland*, The Adelaide Hospital Society. (see earlier)

⁵⁹ Thomas, S., Ryan, P., and Normand, C. (2010) *Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland*, The Adelaide Hospital Society. (see earlier)

This is a compulsory scheme. It is the funding mechanism of the *Protection Universelle Maladie*, a system established in 2016 to unify the structure of universalised healthcare (previously *Couverture Maladie Universelle*).⁶⁰ French residents are required to register for national health insurance coverage and receive the *carte vitale*.⁶¹ Enrolment onto the scheme means that the cost of treatment and services will be mostly reimbursed (rates differ depending on the provision) by the government.⁶² The shortfall can largely be covered by voluntary health insurance, discussed later. The state pays for the healthcare of the very poorest in full, funded by tax revenue. *Couverture Maladie Universelle Complémentaire* insurance finances, in full, the co-payments for all healthcare provisions.⁶³ Patients covered by this are 'exempted from the requirement to pay providers directly'.⁶⁴

Resources for this form of insurance are mainly drawn from employer and employee contributions. Although before 1998 the employee contribution was 6.8% of earnings, it has now been reduced to 0.75%, as a general social contribution has been introduced to largely replace it.⁶⁵ This contribution is based on total income, meaning that in addition to taxing workplace earnings, money is also drawn from supplementary sources of income, such as winnings.⁶⁶ The latter source is taxed at a higher rate.⁶⁷

Voluntary health insurance

The main function of private health insurance in France is to finance the difference between coverage granted by SHI and the overall cost of healthcare. In some cases, it will be used to finance services not covered by SHI at all. Unlike in the UK, private health insurance cannot be used to avoid waiting lists.

The three categories of operator in the voluntary health insurance market are mutual insurance companies, commercial insurance companies, and provident institutions.⁶⁸

Mutual insurance companies (*mutuelles*) aim to 'achieve solidarity and mutual aid'.⁶⁹ These are non-profit organisations and make up the majority of firms offering voluntary insurance.⁷⁰ Regulations prevent, to a large degree, disparities in premium costs. In spite of this, some companies set premiums based on means-testing.

⁶⁰ Expatica (2018) 'Guide to health insurance in France'. Retrieved from

https://www.expatica.com/fr/healthcare/Guide-to-health-insurance-in-France_108848.html

⁶¹ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. Retrieved from

<http://www.civitas.org.uk/content/files/france.pdf>

⁶² Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁶³ The Henry J. Kaiser Foundation (2009) *Cost Sharing for Health Care: France, Germany, and Switzerland*. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7852.pdf>

⁶⁴ The Henry J. Kaiser Foundation (2009) *Cost Sharing for Health Care: France, Germany, and Switzerland*. (see earlier)

⁶⁵ Sandier, S., Paris, V., and Polton, D. (2004) *Health Care Systems in Transition*, European Observatory on Health Systems and Policies. Retrieved from

http://www.euro.who.int/_data/assets/pdf_file/0009/80694/E83126.pdf

⁶⁶ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁶⁷ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁶⁸ Chevreur, K., Brigham, K.B., Durand-Zaleski, I., and Hernández-Quevedo, C. (2015) 'France: Health System Review' in (eds. Busse, R. et al.) *Health Systems in Transition*, Vol. 17 No. 3. Retrieved from

http://www.euro.who.int/_data/assets/pdf_file/0011/297938/France-HiT.pdf?ua=1

⁶⁹ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁷⁰ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

Commercial companies are structurally similar, but are for-profit and have no social obligations.⁷¹

Provident institutions are non-profit, but are designed to provide cover for companies.⁷² Fiscal rebates are offered by government as an incentive for firms to provide insurance for their workers.⁷³ Use of risk rating is limited.⁷⁴

Services and products ineligible for full reimbursement

Co-payments that are not reimbursable through either system of insurance exist, with an annual limit of €50.⁷⁵ For a visit to the doctor, the amount is €1.⁷⁶ It is €0.50 per prescription drug.⁷⁷ And hospital treatment above €120 is €18.⁷⁸

Taxes on the pharmaceutical industry

The Promotion Tax is levied on advertising expenses, including the 'salaries and related expenses of medical representatives'.⁷⁹ It is able to generate between €130 million and €165 million per year.⁸⁰

The Tax on Direct Sales applies on sales made directly to pharmacists, as opposed to the conventional method of selling through intermediaries.⁸¹ The Tax on Direct Sales provides between €250 million and €350 million for the annual budget.⁸²

The Tax on Sales is relevant for all sales of items that are 'refundable under the terms of the French healthcare system'.⁸³ It has annual revenue of between €215 million and €250 million.⁸⁴

The tax on the annual increase of sales is enacted when sales of refundable products increase beyond a threshold that is currently at 5%.⁸⁵

⁷¹ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁷² Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁷³ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁷⁴ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁷⁵ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁷⁶ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁷⁷ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁷⁸ Green, D. and Irvine, B. (2001), Updated by Clarke, E. (2012) and Bidgood, E. (2013) *Healthcare Systems: France*, Civitas. (see earlier)

⁷⁹ Cuadrado, J-L. and Daminao, C. (2011) 'French taxes specific to the pharmaceutical industry: cutting the health expenses or a different way of taxing the profitability of the pharmaceutical industry in France?', Thomson Reuters. Retrieved from [https://uk.practicallaw.thomsonreuters.com/9-505-7303?transitionType=Default&contextData=\(sc.Default\)&firstPage=true&comp=pluk&bhcp=1](https://uk.practicallaw.thomsonreuters.com/9-505-7303?transitionType=Default&contextData=(sc.Default)&firstPage=true&comp=pluk&bhcp=1)

⁸⁰ Cuadrado, J-L. and Daminao, C. (2011) 'French taxes specific to the pharmaceutical industry: cutting the health expenses or a different way of taxing the profitability of the pharmaceutical industry in France?', Thomson Reuters. (see earlier)

⁸¹ Cuadrado, J-L. and Daminao, C. (2011) 'French taxes specific to the pharmaceutical industry: cutting the health expenses or a different way of taxing the profitability of the pharmaceutical industry in France?', Thomson Reuters. (see earlier)

⁸² Cuadrado, J-L. and Daminao, C. (2011) 'French taxes specific to the pharmaceutical industry: cutting the health expenses or a different way of taxing the profitability of the pharmaceutical industry in France?', Thomson Reuters. (see earlier)

⁸³ Cuadrado, J-L. and Daminao, C. (2011) 'French taxes specific to the pharmaceutical industry: cutting the health expenses or a different way of taxing the profitability of the pharmaceutical industry in France?', Thomson Reuters. (see earlier)

⁸⁴ Cuadrado, J-L. and Daminao, C. (2011) 'French taxes specific to the pharmaceutical industry: cutting the health expenses or a different way of taxing the profitability of the pharmaceutical industry in France?', Thomson Reuters. (see earlier)

The tax on marketing authorisations is imposed on the process of auditing and analysing the report that supports a pharmaceutical product in view of its marketing.⁸⁶

Sin taxes

These taxes are levied on some products deemed to carry serious health risks. These are hypothecated and so the funds are protected from budgetary negotiations.

Taxes on alcohol generated nearly €2.8 billion in 2012.⁸⁷ This does not include VAT - only excise duties and related taxes.

Within three years, the price of a pack of cigarettes is expected to rise to €10.⁸⁸ 80% of that price goes to taxes worth more than €14 billion annually.⁸⁹

Since 2012, the sugary drinks tax saw a 19 cent-per-litre increase in the cost of fruit juices and a 16 cent-per-litre increase for diet sodas.⁹⁰ This was expected to raise around €120 million per year.⁹¹

Merits of the French model

Considerable capacity to spend

When healthcare is tax-funded, spending decisions are made by central government, as money is drawn from a central pot. Commitments largely reflect ideological alignment. In the French model, spending is based on finances raised from a number of hypothecated sources. And evidence suggests that SHI models, in general, will be able to spend more capita on health than tax-financed systems, given the efficacy of their funding mechanism.⁹² As previously mentioned, SHI systems were shown to permit 3-4% more spending.⁹³ Healthcare spending in France in 2017 was \$4902 per capita; in the UK, this figure was \$4264.⁹⁴ This is a percentage difference of 15%.

The higher spend is not evidence of wasteful spending. France has access to more advanced resources as a result of their positive financing. Their strong outcomes may be partly explained by the investment in technology that comes from raising more funds.

⁸⁵ Cuadrado, J-L. and Daminao, C. (2011) 'French taxes specific to the pharmaceutical industry: cutting the health expenses or a different way of taxing the profitability of the pharmaceutical industry in France?', Thomson Reuters. (see earlier)

⁸⁶ Cuadrado, J-L. and Daminao, C. (2011) 'French taxes specific to the pharmaceutical industry: cutting the health expenses or a different way of taxing the profitability of the pharmaceutical industry in France?', Thomson Reuters. (see earlier)

⁸⁷ Petkantchin, V. (2014) *Sin taxes: the examples of alcohol and tobacco*, Institut Économique Molinari. Retrieved from http://www.institutmolinari.org/IMG/pdf/note0214_en.pdf

⁸⁸ Rodriguez, C. (2017) 'The French And Their Cigarettes: The End Of The Affair?', Forbes. Retrieved from <https://www.forbes.com/sites/ceciliarodriguez/2017/09/26/at-47-billion-cigarettes-a-year-france-raising-price-to-e10-a-pack/#37b2f5874ca6>

⁸⁹ Rodriguez, C. (2017) 'The French And Their Cigarettes: The End Of The Affair?', Forbes. (see earlier)

⁹⁰ Mazzochi, M. (2017) *The impact of the French soda tax on prices, purchases and tastes: an ex post evaluation*, Toulouse School of Economics. Retrieved from <https://www.tse-fr.eu/sites/default/files/TSE/documents/sem2017/food/mazzochi.pdf>

⁹¹ Assemblée Nationale (2011) *Compte rendu intégral de la séance ordinaire*. Retrieved from <http://www.assemblee-nationale.fr/13/cril/2011-2012/20120023.asp>

⁹² Wagstaff, A. (2009) *Social Health Insurance vs. Tax-Financed Health Systems - Evidence from the OECD*, World Bank. (see earlier)

⁹³ Wagstaff, A. (2009) *Social Health Insurance vs. Tax-Financed Health Systems - Evidence from the OECD*, World Bank. (see earlier)

⁹⁴ Organisation for Economic Co-operation and Development (2017) 'Health spending'. Retrieved from <https://data.oecd.org/healthres/health-spending.htm>

Advances in gene therapy in France, for example, have enabled significant medical breakthroughs.⁹⁵

Sustainable

Protection from budgetary negotiation is crucial to the sustainability, and in turn success, of a healthcare system. The fact that the French fund, by virtue of its insurance-based funding source, is independent enables the mobilising of 'money that remains flexible'.⁹⁶ As it is shielded from annual budgetary changes, it is protected against political transformation and economic downturn. In France especially, the diversity of funding mechanisms prevents over-reliance on the success of a single source. Fluctuations in the money supply from any one of the sources will still affect capacity, but not in the same way that tax-funded systems suffer if the money raised is insufficient.

The hypothecation element is particularly important because it preserves a link between the money going into the system and the provisions coming out. Beneficiaries may be more disposed to pay the amount required for comprehensive coverage, as insurance contributions go directly towards health spending.⁹⁷ Greater contributions come from individuals who are confident that their money is going to provide them with health coverage. This differs from a scenario in which the allocation of money is left to the whims of the current government. Hypothecated funds aid in overcoming the distrust of policymakers that restricts financing potential. Thus, there is increased certainty about health funding levels in the medium-term.⁹⁸ Furthermore, as insurance companies must be accountable to members, transparency can be achieved in this sector also.⁹⁹

Sin taxes are hypothecated as well. They simultaneously raise finances for health provisions and deter the consumption of unhealthy products. It has been argued that, due to their regressive nature, sin taxes unduly harm the poor.¹⁰⁰ In spite of this continuing line of argument, recent evidence suggests that the conclusion is misguided. As the poorest are most at risk of dying from a non-communicable disease, they benefit most from being discouraged from buying certain products and from the health services that are funded by purchases.¹⁰¹

⁹⁵ Gallagher, J. (2017) 'Teenager's sickle cell reversed with world-first therapy', BBC News. Retrieved from <https://www.bbc.co.uk/news/health-39142971>

⁹⁶ Siddiqi, S., Mataria, A., and Banzon, E. (2014) 'Benefits and pitfalls of social health insurance in pursuit of universal health coverage: lessons for the Eastern Mediterranean' in Fikir, M. (Ed.): *Eastern Mediterranean Health Journal*, Vol. 20 No. 9, World Health Organisation. Retrieved from http://applications.emro.who.int/emhj/v20/09/EMHJ_2014_20_9_527_528.pdf?ua=1

⁹⁷ McKenna, H., Dunn, P., Northern, E., and Buckley, T. (2017) *How health care is funded*, The King's Fund. Retrieved from <https://www.kingsfund.org.uk/publications/how-health-care-is-funded>

⁹⁸ McKenna, H., Dunn, P., Northern, E., and Buckley, T. (2017) *How health care is funded*, The King's Fund. (see earlier)

⁹⁹ Doetinchem O., Schramm B., and Schmidt J.O., (2006) 'The benefits and challenges of social health insurance for developing and transitional Countries' in Laaser U., and Radermacher R (Eds.): *Financing health care - A dialogue between South Eastern Europe and Germany*, Series International Public Health; Vol. 18, Jacobs Editing Company. (see earlier)

¹⁰⁰ Callahan, D. (2012) 'Sin Taxes Are Bad Public Policy', Huffington Post. Retrieved from https://www.huffingtonpost.com/david-callahan/sin-taxes-are-bad-public_b_2285162.html

¹⁰¹ Boseley, S. (2018) 'Tax sugar, alcohol and tobacco to help the poor, say experts', The Guardian. Retrieved from <https://www.theguardian.com/society/2018/apr/04/sin-tax-sugar-alcohol-tobacco-to-help-the-poor>

Highly efficient

The French healthcare funding system, due to its basis in insurance, is able to combine 'public interest with market mechanisms'.¹⁰² Creating a clear division between state regulatory activity and financing and provision allows for the more efficient running of the administration at the lower ends of the system. Social health insurance models allow a 'high degree of fine-tuning' through their separation from government at the level of bureaucracy.¹⁰³ When operated at this level, the administration can 'define service packages', 'control service delivery', and 'negotiate remuneration mechanisms'.¹⁰⁴ Further to this, they are able to negotiate contracts with providers in public, private, and non-profit sectors.¹⁰⁵ Hence, the organisation of the healthcare system is efficient and productive.

Discourages the overuse of services

The small charges on treatments, consultations, and hospital stays, levied in France through restricting reimbursements, help to discourage the excessive use of services. To improve waiting times and use finances more responsibly, people must be encouraged to use health services only when medically necessary and to engage in less risky behaviour.¹⁰⁶ There is a danger that such charges deter individuals from seeking help when unsure about medical necessity. But the fact that the charges are so small should prevent this from happening.

Performs well on several quality indicators

The productivity of a system can be improved by adding resources. France's funding capacity and efficiency allows it to operate with far more beds. The most recent statistics suggest that France has 6.05 hospital beds per 1000 people (2016), while the UK has just 2.58.¹⁰⁷

France is able to limit out-of-pocket payments, thus ensuring a strong level of equity in the system. There is no evidence to suggest that inequality in healthcare provision is greater in countries using SHI than countries using a tax-funded model.¹⁰⁸ Out-of-pocket payments per capita (2016) in France stood at \$456.70.¹⁰⁹ The \$629.50 spent per capita in the UK is far higher.¹¹⁰

Furthermore, greater funding capacity, sustainability, and efficiency allow mental health services to be more adequately funded in France. Spending on mental health services in

¹⁰² Doetinchem O., Schramm B., and Schmidt J.O., (2006) 'The benefits and challenges of social health insurance for developing and transitional Countries' in Laaser U., and Radermacher R (Eds.): *Financing health care - A dialogue between South Eastern Europe and Germany*, Series International Public Health; Vol. 18, Jacobs Editing Company. (see earlier)

¹⁰³ Doetinchem O., Schramm B., and Schmidt J.O., (2006) 'The benefits and challenges of social health insurance for developing and transitional Countries' in Laaser U., and Radermacher R (Eds.): *Financing health care - A dialogue between South Eastern Europe and Germany*, Series International Public Health; Vol. 18, Jacobs Editing Company. (see earlier)

¹⁰⁴ Doetinchem O., Schramm B., and Schmidt J.O., (2006) 'The benefits and challenges of social health insurance for developing and transitional Countries' in Laaser U., and Radermacher R (Eds.): *Financing health care - A dialogue between South Eastern Europe and Germany*, Series International Public Health; Vol. 18, Jacobs Editing Company. (see earlier)

¹⁰⁵ Doetinchem O., Schramm B., and Schmidt J.O., (2006) 'The benefits and challenges of social health insurance for developing and transitional Countries' in Laaser U., and Radermacher R (Eds.): *Financing health care - A dialogue between South Eastern Europe and Germany*, Series International Public Health; Vol. 18, Jacobs Editing Company. (see earlier)

¹⁰⁶ McKenna, H., Dunn, P., Northern, E., and Buckley, T. (2017) *How health care is funded*, The King's Fund. (see earlier)

¹⁰⁷ Organisation for Economic Co-operation and Development (2018) 'Health Care Resources'. Retrieved from https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_REAC

¹⁰⁸ Wagstaff, A. (2009) *Social Health Insurance vs. Tax-Financed Health Systems - Evidence from the OECD*, World Bank. (see earlier)

¹⁰⁹ Organisation for Economic Co-operation and Development (2017) 'Health spending'. (see earlier)

¹¹⁰ Organisation for Economic Co-operation and Development (2017) 'Health spending'. (see earlier)

France (2011) was 12.91% of health expenditure.¹¹¹ Three years later, mental health spending in the UK still only represented 11% of health expenditure.¹¹²

Efficiency and flexibility, when combined with a wealth of resources, result in low waiting times. Only 7% of patients experienced a 4-months+ wait for elective surgery (2010) in France.¹¹³ In the UK, this figure was 21%.¹¹⁴

It should be acknowledged, however, that when examining waiting times from the perspective of access to a doctor or nurse, France is not as effective. In the same study as cited above, 17% of patients waited six days or more for an appointment when in need of care.¹¹⁵ Just 8% faced the same problem in the UK.¹¹⁶ This should highlight the fact that, although French performance is strong, it should not be viewed as a perfect system.

Drawbacks of the French model

Negatively impacts the labour market

As the French system contains a payroll tax, some economic inefficiency is inevitable. Growth in formal sector employment is negatively affected by the funding model. 'Labour market formality' and wages are also reduced by the very existence of a payroll tax.¹¹⁷ SHI works as a disincentive for joining and remaining in the formal sector, though this has become less significant since the introduction of the mandatory general social contribution. With regard to employment levels overall, research indicates that total employment in SHI-based countries 'as a share of the working-age population' is, on average, 5-6% less than in tax-funded nations.¹¹⁸ A further study places this figure at 10%.¹¹⁹

Vulnerable to macroeconomic fluctuations

Although SHI-based systems are resistant to fluctuations in governmental budgetary priorities, the risk of financing oscillations can be found in the labour market. A weak labour market will result in reduced revenue from payroll contributions, which may lead to deficits. The healthcare system in France runs a deficit, which stood at €3.4 billion in 2016.¹²⁰ This

¹¹¹ Department of Mental Health and Substance Abuse (2011) 'Mental Health Atlas 2011: France', World Health Organisation. Retrieved from

http://www.who.int/mental_health/evidence/atlas/profiles/fra_mh_profile.pdf

¹¹² The King's Fund Verdict (2015) 'Has the government put mental health on an equal footing with physical health?', The King's Fund. Retrieved from

<https://www.kingsfund.org.uk/projects/verdict/has-government-put-mental-health-equal-footing-physical-health>

¹¹³ The Commonwealth Fund (2010) *The Commonwealth Fund 2010 International Health Policy Survey in Eleven Countries*. Retrieved from

https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_chartbook_2010_pdf_2010_ihp_survey_chartpack_full_12022010.pdf

¹¹⁴ The Commonwealth Fund (2010) *The Commonwealth Fund 2010 International Health Policy Survey in Eleven Countries*. (see earlier)

¹¹⁵ The Commonwealth Fund (2010) *The Commonwealth Fund 2010 International Health Policy Survey in Eleven Countries*. (see earlier)

¹¹⁶ The Commonwealth Fund (2010) *The Commonwealth Fund 2010 International Health Policy Survey in Eleven Countries*. (see earlier)

¹¹⁷ Rannan-Eliya, R.P., Irava, W., and Saleem, S. (2013) *Assessment of Social Health Insurance Feasibility and Desirability in Fiji*. World Health Organisation and Fiji Ministry of Health. Retrieved from

<https://srhr.org/abortion-policies/documents/countries/04-Fiji-Assessment-of-Social-Health-Insurance-2013.pdf>

¹¹⁸ Wagstaff, A. (2009) *Social Health Insurance vs. Tax-Financed Health Systems - Evidence from the OECD*, World Bank. (see earlier)

¹¹⁹ Wagstaff, A. and Moreno-Serra, R. (2008) *Europe and Central Asia's Great Post-Communist Social Health Insurance Experiment: Impacts on Health Sector and Labor Market Outcomes*, World Bank. (see earlier)

¹²⁰ Reuters (2015) 'France aims to slash welfare budget deficit in 2017' Retrieved from

means taking on debt and using funds from years of surplus. In cases of extreme downturn, funds may have to be drawn from general taxation, hence taking on the limitations that accompany this source of funds.¹²¹ Without careful administration, the revenue from an insurance-based system can change with swings in the state of the economy.¹²² France is, thus, not impervious to external forces.

Harms the international competitiveness of organisations

In a market within which labour can move freely across borders, competitiveness in global commerce is essential. The high taxes on wages that are found in the French system may reduce the ability for French firms to deter employees from taking their labour abroad. When compared to countries that fund healthcare through taxation, it is difficult for French companies to be competitive on wages.¹²³ Furthermore, as employees must contribute to payroll taxes, their costs rise and they are placed at a further 'competitive disadvantage' globally.¹²⁴ It may also be argued that the narrower tax base that forms from focusing on payroll taxes restricts collection capacities.¹²⁵ Again, the mandatory contribution, and the consequent cut to the payroll tax, reduces the significance of this factor.

Contains unexpected costs

As a result of the large administrative elements in the French system, bureaucratic costs can be high. In the private sector, the existence of such a large number of insurers competing for consumers means that switching providers based on economic incentives and considerations is common.¹²⁶ Transitional expenses can be large, as can those involved in the regulation of these markets. 'Marketing insurance and handling claims' also involve high costs.¹²⁷ Although the for-profit sector is not as vast as the non-profit branch of voluntary health insurance, it still covers a great enough number of people to produce a notable administrative burden.

Another form of cost that may arise, possibly unexpectedly, is additional charges levied on patients. In areas of France where regulation is not as strict, doctors and consultants can charge 'an extra fee on top of the official rate'.¹²⁸ Patients may not be fully covered for such an occurrence through either form of insurance. Some may find that they are not covered at all for the additional charge. In this circumstance, out-of-pocket costs can build up more easily. The cap of €50 per year does prevent these extra charges from becoming unmanageable, but these fees are inconvenient, harming the lower-middle class most severely. This undermines the principle of equity that is otherwise enshrined in the system.

<https://www.reuters.com/article/france-health-idUSL8N1BY54G>

¹²¹ Cylus, J. et al. (2018) *Identifying options for funding the NHS and social care in the UK: international evidence*, The Health Foundation. Retrieved from

https://health.org.uk/sites/health/files/Social%20care%20funding%20-%20international%20evidence_web.pdf

¹²² Cylus, J. et al. (2018) *Identifying options for funding the NHS and social care in the UK: international evidence*, The Health Foundation. (see earlier)

¹²³ McKenna, H., Dunn, P., Northern, E., and Buckley, T. (2017) *How health care is funded*, The King's Fund. (see earlier)

¹²⁴ Ham, C. (2017) 'Health care funding: is the grass greener on the other side?', The King's Fund. Retrieved from

<https://www.kingsfund.org.uk/blog/2017/03/health-care-funding-grass-greener-other-side>

¹²⁵ Ham, C. (2017) 'Health care funding: is the grass greener on the other side?', The King's Fund. (see earlier)

¹²⁶ Wanless, D. (2002) *Securing our Future Health: Taking a Long-Term View*, Her Majesty's Treasury. Retrieved from

<https://www.yearofcare.co.uk/sites/default/files/images/Wanless.pdf>

¹²⁷ Ham, C. (2017) 'Health care funding: is the grass greener on the other side?', The King's Fund. (see earlier)

¹²⁸ National Health Service (2016) 'Healthcare in France, including Martinique and Guadeloupe'. Retrieved from

<https://www.nhs.uk/using-the-nhs/healthcare-abroad/healthcare-when-travelling-abroad/healthcare-in-france/>

Implementation in the UK

What transitioning to an SHI-based model would look like

The introduction of an additional payroll tax for social health insurance is the most feasible method of collection. This would be implemented alongside the existing PAYE income tax system and the National Insurance scheme. Employers would pay into this through a fund similar to the Employers' National Insurance contributions fund. This would function in the formal sector, coexisting with a mandated social contribution for the informal sector. All contributors receive a health insurance card similar to the *carte vitale*, while those earning under a certain threshold continue to have their healthcare funded by central government.

The Department of Health and Social Care would remain responsible for establishing targets on health policy. Its main role in the transitional process would be to construct the legal framework by which health insurance agencies must abide.¹²⁹ Government must enshrine in law the design for the arrangement and the income threshold for charges.

To collect and use funds, the bureaucracy that currently deals with income tax collection and organisation would be expanded. Their competences would include procedures for handling insurance funds, overseeing operations and investigating fraud.¹³⁰ The *carte vitale* or a similar system would also be controlled from here. The cards would be produced by this body and reimbursements would be administered from here for treatments and services.

Health services must be purchased from existing providers.¹³¹ Providers would have to be independent of funds, permitting the established legal structure to control standards.¹³² Autonomy in implementation is essential to ensure efficiency.¹³³

Voluntary health insurance would be implemented organically, with existing health insurance companies maintaining their role. How they structure this is a privately controlled issue, but laws would have to be in place to prevent insurance from being used as a way of purchasing better service. It must simply be a top-up mechanism.

Why a full transition is not feasible

The tax-funded and insurance-based distinction may not seem significant, but adopting this element of French healthcare funding means transforming one of the key elements of UK system. Whether this would enhance capacity, sustainability and efficiency does not matter when considering the practical implications of change. Wholesale alterations to healthcare would be deeply unpopular and recommending that a government initiate them is both misguided and unproductive. In a 2014 poll, 52% of the UK public said that the NHS is what

¹²⁹ Doetinchem, O., Carrin, G., and Evans, D. (2010) *Thinking of introducing social health insurance? Ten questions*, World Health Organisation. Retrieved from http://www.who.int/healthsystems/topics/financing/healthreport/26_10Q.pdf

¹³⁰ Doetinchem, O., Carrin, G., and Evans, D. (2010) *Thinking of introducing social health insurance? Ten questions*, World Health Organisation. (see earlier)

¹³¹ Doetinchem, O., Carrin, G., and Evans, D. (2010) *Thinking of introducing social health insurance? Ten questions*, World Health Organisation. (see earlier)

¹³² Thomas, S., Ryan, P., and Normand, C. (2010) *Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland*, The Adelaide Hospital Society. (see earlier)

¹³³ Siddiqi, S., Mataria, A., and Banzon, E. (2014) 'Benefits and pitfalls of social health insurance in pursuit of universal health coverage: lessons for the Eastern Mediterranean' in Fikir, M. (Ed.): *Eastern Mediterranean Health Journal*, Vol. 20 No. 9, World Health Organisation. (see earlier)

'makes them most proud to be British'.¹³⁴ No government would be willing to fund such a radical change and the public would not appreciate pressure to make it.

Furthermore, this sort of drastic transformation would involve significant transitional costs. The 'enormous costs and complexity' of transitioning from a tax-based system to SHI explains why this has never been done in Western Europe.¹³⁵ The short-term costs would be extortionate and, in a period of uncertainty surrounding Brexit, it would be unwise to take on such a burden. Although the infrastructure may exist in some capacity, the adaptations that such institutions would have to make carry serious financial risk.

There is also a danger that implementing an insurance-based system would not significantly increase overall health funding. The short-term costs would have to be paid off through long-term benefits. But this would rely on a successful transitional process, continuous support from medical professionals, and sustained financial support from future governments. In practice, these are not guaranteed. A reversal of the process may be the expedient option for an incoming government and the process would have been entirely unavailing.

What can be done

Learning from French healthcare funding does not necessarily mean adopting the core funding mechanism. Perhaps the most important aspect of the French financing model is not SHI, but the diversity of funding sources that are utilised. Outside of the parameters of SHI, the other funding mechanisms used in France increase the money supply and improve sustainability. Crucially, making use of hypothecation prevents central government from altering spending patterns on healthcare.

The sugar tax provides the basis for the introduction of greater sin taxes. Alcohol and tobacco are already taxed in the UK, but these levies should be increased and revenue hypothecated for use only in the healthcare system. This would discourage use of the products, thus helping to relieve a serious health burden, while collecting funds to direct back into healthcare provisions and public health services.

Corporation tax should be reformed to ensure that taxes levied on pharmaceutical companies are hypothecated. Promotional activities can be taxed in addition to sales. This ring-fenced contribution should go towards the improvement of NHS services. Carbon taxes could be utilised in a similar way, especially given the negative health effects associated with air pollution.¹³⁶ This would deter environmentally damaging behaviour, while further diversifying funding options.

Small charges on services should be considered, but only for the wealthiest patients. The ability for those over a certain income threshold to pay a very small amount for GP visits and hospital stays should be utilised to secure extra funding and prevent the overuse of services.

The inefficiencies that are inherent in the funding process of a tax-based model can be counteracted by improving efficiency at the level of services. A more considered management of people and resources within the NHS would help to cut the £5 billion of

¹³⁴ Quigley, A. (2014) 'Maintaining pride in the NHS: The challenge for the new NHS Chief Exec', Ipsos MORI. Retrieved from <https://www.ipsos.com/ipsos-mori/en-uk/maintaining-pride-nhs-challenge-new-nhs-chief-exec>

¹³⁵ Ham, C. (2017) 'Health care funding: is the grass greener on the other side?', The King's Fund. (see earlier)

¹³⁶ World Health Organisation (2018) 'Climate change and health'. Retrieved from <http://www.who.int/news-room/fact-sheets/detail/climate-change-and-health>

waste identified in the system.¹³⁷ Improving the leadership capacities of NHS staff at all levels through concentrated training would aid in creating administrative efficiency.¹³⁸ Aiming for efficiencies in procurement and logistics is the most direct way of ameliorating the problem.¹³⁹ Creating a 'culture of relentless cost containment', as recommended by Lord Carter Coles, may be the necessary step to influence improvements in efficiency at all levels of the system.¹⁴⁰

In pursuit of further funding, the key improvement that can be made is the initiation of conversation among senior political figures regarding different approaches to funding healthcare. To achieve progress and facilitate modernisation projects, the NHS must receive more money in a sustainable way. Thus, a change must be made. The most effective way to enable more open dialogue on the issue is for a cross-party group to create an ad hoc House of Commons select committee. A Healthcare Funding Select Committee would expand discussion and aid in proposing legislative changes that would help to ease the crisis in funding. This would also help to create a change in attitude towards the subject of healthcare financing. Crucially, through discussing a range of funding options, the committee could disrupt the consensus that the current model of healthcare funding is the only viable system.

Conclusion

Pride in UK healthcare, and a reluctance to change, is understandable. The UK is a pioneering force in the field, leading the global revolution that transformed how governments approach citizen welfare. But it is only by challenging assumptions, such as the idea that the current healthcare funding structure is the only way to finance provisions, that progress can be made. And progress is certainly necessary, given the failures demonstrated and the legitimacy of the connection between these shortcomings and the funding structure.

Notwithstanding its many successes, the system of funding healthcare in the UK has plenty of room for improvement. Its inability to raise sufficient funds, its unsustainable nature, and the inefficiencies within the apparatus are issues that are not being appropriately addressed. Action to improve the financing situation in the UK is difficult to find. This is in spite of the fact that an effectively managed funding model exists in a nearby, democratic ally. The French system, though weaker in its approach to the labour market, is more successful than the UK on key criteria and performance metrics, while its funding structure is not radically different. Indeed, learning from the French means understanding that non-taxed-based healthcare funding models are not attempts at privatisation. They can be universal and effective, while drawing funds from alternative sources. In turn, learning from the French does not mean that converting to an insurance-based system is a practical or sensible suggestion. Given the

¹³⁷ Carter, P. (2016) *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Department of Health. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

¹³⁸ Carter, P. (2016) *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Department of Health. (see earlier)

¹³⁹ Carter, P. (2016) *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Department of Health. (see earlier)

¹⁴⁰ Carter, P. (2016) *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Department of Health. (see earlier)

political unpopularity and administrative costs, it would be imprudent to recommend radical change in the UK.

There is a case, however, for attempting to facilitate a change in attitude through cross-party discussion. Establishing a Healthcare Funding Select Committee would help to broaden the conversation and open up a dialogue between key political figures. It is crucial that the consensus on healthcare funding in the UK is challenged. And this starts at the top of the political hierarchy. The supposition that only taxation, filtered through a central budget, can finance healthcare is restricting funding capabilities and sustainability in the UK. In turn, this is limiting the ability for the NHS to fund modernisation projects and address the problems that accompany an ageing population.

More specifically, the diversification of funding options should be closely examined. That which can be learned from France on healthcare funding does not lie in the headline, but rather the detail. The French model is not funded exclusively through mandatory contributions, but from a combination of sources. These other mechanisms can be utilised in the UK without significant bureaucratic and transitional costs. Sin taxes, pharmaceutical taxes, and service charges are proven methods of increasing funding capacity for healthcare provisions, while also enhancing sustainability. Alongside improvements in efficiency in the use of staff and resources, these methods can contribute significantly to easing the funding crisis. The foundational principles of the NHS can still be largely preserved, but the core tax revenue could be subsidised through reliable, hypothecated sources. This should result in greater spending capacity and more secure and sustainable financing. These are crucial steps towards delivering the standard of healthcare for which the UK should aim.

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