

Stakeholder Health Insurance

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David G. Green

Commentaries

Tim Baker

Nicholas Beazley

Adrian Bull

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Preface

Some overseas systems guarantee a higher standard of care than the NHS for the poorest members of society. Can we adapt these alternatives to improve health care in the UK?

The July 2000 National Plan for the NHS reaffirmed the Government's commitment to public sector monopoly. Health care was to be financed predominantly from taxation and hospitals were to remain firmly in the Government's hands.

In the months preceding the National Plan, there had been much media discussion about the merits of alternative systems, including European social insurance schemes, and the Government's response was to devote a chapter to their rejection. It judged them against two criteria: equity and efficiency. It defined efficiency as: 'testing whether a proposal would achieve its proposed end and whether it provides the greatest possible health improvement and healthcare within the funding available'. And it defined equity as: 'analysing how well the proposal would match financial contributions to ability to pay, and how well it would match healthcare to health needs.'¹

Some overseas systems were found wanting when measured against these criteria, but elsewhere in the document the NHS is compared unfavourably with other European countries. The National Plan admits, for example, that cancer survival is worse in the UK than in many European countries, and it admits that deaths from coronary heart disease have fallen less than elsewhere.² Moreover, it concedes that the NHS has suffered from 'decades of under-investment' and that spending has 'consistently lagged behind other developed countries'. As a result, it has insufficient capacity to provide the services the public expect. There are too few hospital beds compared with most other health systems, and too few doctors: 1.8 practising doctors per 1,000 population compared with

the European Union average of 3.1. And the Government acknowledges that the NHS carries out too few operations in contrast to countries such as the Netherlands, where twice as many heart bypass operations are performed.³

The chapter in the National Plan which dismisses overseas systems reads as if the Government made up its mind first and then set out to gather whatever evidence it could find to bolster its conclusion. It would have been better to ask a very different question: is there an overseas system that guarantees all its people, and especially the poorest, a high standard of care? And if so, is that standard higher than the NHS? An honest observer looking at countries such as Germany, France or the Netherlands would have to answer this question with a resounding 'yes'.

Consequently, the chief purpose of this publication is to ask whether we could adapt successful overseas schemes to the UK. There are several viable alternatives and the first essay describes one such model, stakeholder health insurance, selected because it is based on an overseas scheme which has a long track record of success. The proposal is accompanied by critical commentaries from representatives of three leading private insurers.

The National Plan was a great missed opportunity which left the fundamental flaws in the NHS unresolved. However, there are also elements in the document which suggest that the Government is beginning to recognise that public sector monopoly is not viable in the long run. The tendency of the document to face both ways is most apparent in its discussion of consumer responsiveness. The Secretary of State says in his introduction that the NHS will be reformed 'from top to toe' to 'meet the challenges of rising patient expectations'. Yet, a rational person choosing a structure most likely to be responsive to consumers would not necessarily pick public sector monopoly.

There is also evidence of facing both ways in the discussion of hospital autonomy. The Government concedes the value of managerial autonomy, but cannot bring itself fully to let go. As a result we end up with the compromise of

'earned autonomy', a half-way house which could easily turn out to be the worst of all worlds, not least because central power can still be exerted at any time.

The National Plan leaves a great many questions unanswered and these essays are early contributions to the next stage of the debate.

David G. Green

Stakeholder Health Insurance: A Better Way to Guarantee Access For All

David G. Green

Summary

The underlying problem is that the NHS does not achieve its own objectives. It suffers from three long-standing flaws:

- It is underfunded because its method of funding is unrelated to personal demand and need.
- There is a lack of competition.
- There is a lack of respect for individual choice and responsibility.

Unfortunately, the Blair Government has made matters worse by diminishing competition:

- GPs have been dragooned into primary care groups which have turned them into gatekeepers rather than champions of the patient.
- Hospital mergers affecting about 20 per cent of trusts in the last two financial years have reduced incentives for improvement.

What advantages would stakeholder health insurance offer?

- A universal market-tested guarantee instead of a mere political promise.
- Competition and personal choice.
- The renewal of civil society through the restoration of

hospital independence.

- Because the scheme is not linked to employers (unlike the social insurance schemes of continental Europe) it will not distort job opportunities.
- People will buy insurance collectively with the result that administration costs will be lower, consumer bargaining power will be increased, and individuals will have access to good quality information to aid their choice.
- There will not be a single regulatory regime, but competing regulators to reduce the dangers of over-regulation, particularly the crowding out of innovation and, because individuals can choose whether or not to opt into the new system, change will be evolutionary.

Introduction

Give us back some (but not all) of our tax and let us take personal responsibility for our own health care! And what's more, extend the same power of choice to the poor and elderly!

Could such a plea become a reality? The chief argument used against the introduction of competition and private finance in health care is that the poorest people would be worse off. Is it possible to envisage reforms that would bring about substantial improvements for the poorest section of the community, as well as for the majority? Such a change would not satisfy diehard ration-book collectivists but it would achieve a genuine guarantee of access for everyone, a promise which the NHS has not achieved in practice.

Public opinion has suffered quite a jolt in recent months as people have come to see that, even judged against the yardstick of its own objectives, the NHS falls a long way short. The NHS aims to be universal, comprehensive, equal ('uniform' across the country) and of a high standard.

Universal and Comprehensive: The NHS is formally universal, but not everyone who goes to see a doctor will be treated. Universal access is of limited value unless it is

clear what range of services the individual has access to and, far from being comprehensive, the NHS does not even provide every service that is regarded as necessary in countries of comparable wealth.

Equal: Use of the term equality confuses two ideas. The first is that 'everyone, rich and poor alike, should have access to care'. That is, no one should fall below a certain standard. The second is that 'no one should ever get more than anyone else'. The latter confuses envy with a legitimate concern for the less fortunate. In any event, the NHS does not deliver the same standard to everyone. It seeks uniformity by giving GPs control of access to hospital care in the expectation that clinical need, and not consumer preferences, will prevail.

There are three main points to make. The first has to do with practicalities. A government can deliver universal access by providing a guarantee. But it can not eradicate all differences in provision, either between individuals or localities. The NHS has always varied from area to area.

Second, differences in standards, quality and practice style are useful. Competition creates the ability to make comparisons. Moreover, the advantages that result are not private and exclusive, as egalitarians imply. There are significant common benefits. Competition produces rebound effects which ricochet through the system encouraging the least successful doctors or hospitals to raise their standards. The ostensible uniformity of the NHS is achieved by suppressing competition, which tends to lower standards.

Third, differences in health provision reflect legitimate personal preferences for a variety of styles of coverage and treatment. The egalitarian tends to assume that all differences are the improper fruit of riches and that, therefore, they can be suppressed. But people with the same income might well have different preferences. When you suppress *ability* to pay you also suppress *willingness* to pay.

Standards: Nor does the NHS provide a universally high standard by comparison with other countries. It is often as good as systems elsewhere, but with glaring exceptions.

A particular consequence of the NHS has been a deterioration in the doctor/patient relationship. It has become one of gatekeeper and supplicant rather than expert adviser and client. Under any system, scarcity of resources creates the potential for the doctor to be a gatekeeper. Moreover, purely on clinical grounds a doctor may refuse treatment because he thinks it dangerous or ill-advised. But in a command-and-control system financial gatekeeping is heightened.

Framing Achievable Objectives

The real problem is that the objectives of the NHS are not achievable. Moreover, they are not mutually consistent.¹ In particular, the eradication of differences in the name of equality suppresses competition. And the suppression of competition in the name of *uniform* standards has meant *lower* standards. The only people to benefit from suppressing competition are providers who want to cover up their deficiencies. A genuine concern for the poorest people would seek to discover how to preserve competition, which is in the interests of all, whilst maintaining access for the poor.

The challenge is to frame some different objectives for health policy which are mutually consistent and, in addition, to accept the discipline of devising a new health-care system which would make the poorest people better off than they are under the NHS.

There are two main requirements. First, competition should be introduced. Second, health care should be financed by insurance, not from taxes. And both competition and private finance should be introduced in a manner which improves the standard of service being received by the poorest section of the community.

Competition

Competition should be encouraged in order to raise standards. It is neither necessary nor advisable for the government to own all the hospitals and employ all the medical professionals in order to guarantee access. For there to be genuine competition, hospitals should be independent of government, but it does not follow that they should function as for-profit organisations.

In order to re-create the experimentation and creativity that flows from competition, NHS hospitals should be privatised as non-profit hospitals, rather like modernised versions of the old voluntary hospitals. It would allow medical staff to evolve, enhance and develop their special local tradition, and would help to rebuild the social fabric.

Before the NHS nationalised all the hospitals in 1948, some were government owned (usually municipal hospitals) but the majority of ordinary hospitals were voluntary. That is they were owned by local charities, supported by a mixture of donations, charges and regular contributions from local people in the form of pay-packet deductions. Voluntary hospitals united the local community: the wealthy were expected to contribute out of their abundance, and did so; and the rank and file made their regular small weekly payments through the hospital contributory funds. All sections of society felt a loyalty to the local voluntary hospital.

Moreover, in the rest of Europe, private hospitals have been allowed to co-exist with the public sector. Slightly over half the hospitals in Germany are independent of the government, along with one-third of the hospitals in France, over 80 per cent in the Netherlands and 60 per cent in Belgium.

Insurance

First, we cannot rationally discuss universal access without describing the services to which access is being given. When we buy other types of insurance we expect a contract stipulating our entitlements, and so when the taxpayer buys health insurance on behalf of the poor then

a contract should similarly lay down the legally enforceable entitlements. But what should that standard be? And how should it be fixed?

There is no escape from affordability. Wealthy countries can afford to spend more on health care. In the third world, for instance, affordability affects fundamentals like vaccination; whereas in the wealthy United States, it affects the availability of experimental procedures such as the transplantation of artificial organs or heart and lung transplants. In the UK, however, the standard and scope of care does not predominantly reflect income per head but the tendency of the 'command-and-control' NHS to ration life-saving treatments, including renal dialysis and cancer care.

What counts as 'comprehensive' at any moment is in the process of being discovered and rediscovered. The advantage of a system based on insurance is that it allows gradual evolution towards a reasonable standard which reflects consumers' judgements about the type and cost of cover they want.

The allocation of funds by the UK Treasury is crude by comparison. It bears no relationship to medical demand. It is what the government can afford or chooses to spend—this year influenced by efforts to control inflation, next year by an impending general election. In any event it is a global amount with no room for individuals to pay for more or less. Typically, the government conducts a public expenditure survey each year, and targets are agreed for three years. The NHS asks for a particular budget and the Treasury decides how much it can have. In England, after deducting an amount for national services, such as blood transfusion, budgets are distributed to health authorities and primary care groups and trusts.

This process of allocation can be compared with a private insurance market. An insurance company knows the demand and expectations of its customers from previous years and can adjust premiums from year to year to match their preferences. It will present itself to the public in a particular way, offering specific contracts. For example,

American consumers can compare and choose between different practice styles. Some health maintenance organisations (HMOs) might offer hospital care in the form of shared rooms, with the possibility of paying extra for a private room. The premium tends to be cheaper than for a 'managed fee-for-service' insurance plan that offers unfettered choice of hospital or specialist. And it would probably be cheaper than a 'point of service' plan which, like an HMO, offers care through a fixed panel of doctors without further charge, but with the option of choosing an alternative doctor or hospital (at the point-of-service) in return for meeting part of the cost out of pocket.

The availability of such comparisons allows doctors and hospitals to get a better feel for what people want. As people change insurers or providers from year to year, a far more accurate assignment of funds takes place.

Typically, a contract of insurance in the US will entitle individuals to all needed health care. In practice this means that, if a qualified doctor says something is necessary, then the insurer must pay, or be sued for breach of contract. More recently insurers have tried to exclude 'experimental' procedures. This criterion allows more scope for disagreement, but ultimately the test is 'normal practice' or the consensus among medical practitioners. In extreme cases the line can be fuzzy, but the ultimate arbiter is the court of law. Under the NHS, the courts have typically refrained from requiring the NHS to provide specific services precisely because availability depends on political decisions about how much care can be afforded.

Opponents of insurance typically highlight two main problems: the exclusion of people with pre-existing conditions and the related tendency of some insurers to 'select' customers in order to avoid those most likely to make large claims ('adverse' selection from the insurer's vantage point). Over the years many different solutions to these problems have been attempted, but perhaps the most promising have been schemes based on group insurance with a 'sponsor' acting as a consumer champion, also called

'managed competition'. Sponsoring agencies, which could be private organisations, including large employers, or statutory bodies insulated from the political process, facilitate consumer choice by offering comparative information about quality and price and by filtering out bad insurers. Such schemes have been championed for more than 20 years by Professor Alain Enthoven. Originally called consumer choice health plans, the latest name is the health insurance purchasing co-operative (HIPC). Before discussing how to apply the idea in the UK, I will describe the essential elements of Professor Enthoven's scheme.

Health Insurance Purchasing Co-operatives

Enthoven's scheme comprises four main elements. First, each year consumers choose a comprehensive care package for one year. Second, they do so through agencies whose task is to facilitate choice by providing comparative information about quality and price and by weeding out unsatisfactory insurers. Third, the consumer's choice should be cost-conscious, that is, part or all of the cost of the premium should be met by all individuals except the absolutely poor. And fourth, providers should compete in structures which integrate provision and insurance, either by establishing a single system, such as a health maintenance organisation or by creating schemes based on contracts between insurers and independent providers.²

The relevant 'price', insists Enthoven, is not the cost of any given medical procedure, but the annual insurance premium, because it gives the consumer a reason to think about the total cost and to try to minimise it. Consumers must be price-conscious at the time of taking out the insurance package and in a position to compare packages. To facilitate comparisons insurers should be required to price equal packages, so that during the 'open-enrolment season' of about four weeks every year, systematic comparisons can be made, comparing like with like.

Enthoven is anxious that consumers should not have to choose between lists of covered and non-covered items,

because it is an almost impossible choice for individuals to make. An insurance policy should cover 'all needed care' and cost control should not be primarily achieved by excluding treatments or excluding people but by controlling costs. To give but one example, costs can be controlled without reducing quality by ensuring that operating theatres are fully used, skilled staff are effectively deployed and by ensuring the right balance between highly skilled and semi-skilled employees.

Schemes based on 'managed competition' have been found to work. There are examples of such systems in operation in California and Minnesota, but I will mention only one: the Federal Employees Health Benefits Program.

The latter began operation in 1960 and now offers nearly 400 insurance plans to some four million policy-holders covering about nine million people. Every year in November/December there is a month-long 'open season' when people choose their insurer for the next year. They receive an official guide and a consumer group also publishes a private guide. Each year only about five per cent of policies change hands, but the impact on individual insurers can be substantial, with some losing half or more of their subscribers. All insurers must community rate. Literally, this means that a retired person pays the same as an 18-year-old trainee. Insurers must also accept all applicants regardless of pre-existing conditions.

Since 1999 the federal government contribution has been based on a 'fair share' formula. It pays the lesser of two amounts: 72 per cent of the programme-wide weighted average premium or 75 per cent of the actual premium of each person's chosen plan. Employees pay the difference.³ Two types of cover are offered: 'self only' and 'self and family'. In 1995 the maximum was \$1,600 per year for a 'self only' policy and \$3,490 for 'self and family'.

In *How to Pay for Health Care* I proposed that a similar scheme in Britain could be based initially on health authorities, with each authority becoming the purchasing co-operative for its locality. If implemented, the end result would not be a pure market system, nor a pure collecti-

vised one but it would bring about a different balance between the public and private sectors. The government would confine itself to creating the framework within which collective private initiative can work for the common good. And it would provide universal access — something the NHS has never achieved in practice—by providing a clear entitlement for the poor.

Since publication of the original proposal in 1997, there have been further NHS reforms, not least the introduction of primary care groups, and so what follows adapts the original idea to the new circumstances.

Stakeholder Health Insurance: How It Could Work

Alain Enthoven advocates health insurance purchasing co-operatives. Perhaps a better name would be ‘stakeholder health insurers’. For the sake of administrative simplicity, existing health authorities could establish stakeholder health insurers (SHIs) in their areas. We would all continue to pay taxes as at present and health care would continue to be provided through primary care groups, without further charge. However, individuals would be free to receive their care through the local stakeholder. In return for assuming responsibility for part of the cost, they would receive a tax credit representing part of the tax they had paid towards the NHS. Before turning to the details of this tax credit, further aspects of the scheme should be explained.

The SHIs should be independent of government, and preferably mutual organisations run by boards representing members. Each year, SHIs should invite private insurers to submit tenders for a comprehensive package of cover for anyone within the SHI boundary. All insurers should be required to price a standard contract: to facilitate value-for-money comparisons; to reduce market segmentation based on the range of services covered rather than on price or quality; to guarantee no hidden gaps in coverage; and to prevent risk selection from reducing incentives to produce value for money. This standard

package should be defined by each SHI to reflect members' preferences and to facilitate comparisons between SHIs. Only insurance plans which complied with the standard package should be included in the scheme. However, they should be free to offer other insurance schemes in addition to the standard package.

One of the dangers of a system of regulation or 'managed competition', as Professor Enthoven calls it, is that in its anxiety to protect consumers it becomes too intrusive, suppressing valuable initiatives which might benefit consumers. A system of SHIs could have this effect, but the danger is mitigated in two ways. First, SHIs should be allowed to compete for members. Individuals should not be compelled to join the local SHI, but should be free to join another area-based SHI or one not based on locality at all (see below p. 13). Second, insurers should be free to offer insurance policies which differ from the standard package.

In essence the scheme accepts that unfettered market competition has beneficial effects for some and harmful effects for others. The challenge is to preserve the huge advantages of innovation whilst eliminating known harms. The balance between appropriate regulation and over-regulation is always difficult to strike. A system of stakeholder health insurers is one of competing regulatory regimes, which accepts that we can learn from innovation in regulatory methods and strategies, just as we learn from diversity of provision.

Consumers would make their choice once a year, based on the quoted prices and any comparative information supplied by the stakeholder. They could have, say, four weeks to consider the options and notify their decision to the SHI. There should be continuous coverage, to prevent insurers from dumping costly subscribers. There should also be community rating, that is the premium ought to be the same regardless of the health status of the individual, though age rating would be acceptable. No one should face exclusions or limitations of coverage because of pre-existing conditions.

There are some dangers to be avoided. Although I have recommended that health authorities should initially establish stakeholders, it is very important that health authorities should not also be planning agencies, controlling investment in medical facilities. Such planning is best accomplished by competing providers. Enthoven's proposal enjoys bipartisan support in America and Paul Starr, who is among the left-leaning supporters, has strongly argued that purchasing agencies should not be planning agencies. Their task is to be the consumer's champion and to foster and facilitate informed choice. To give them a planning role, he says, would be to create a potential conflict of interest between their advocacy and planning duties.⁴

Thus, the resulting system would work something like this. We would all continue to pay taxes as now, and people wishing to continue receiving care from the NHS need take no action at all. People who prefer to be covered by insurance would opt to receive care through their local SHI. Each existing health authority would establish a stakeholder health insurance agency whose task would be to ask private insurers to price the same comprehensive package of care. Anyone choosing to pay more would do so with his or her own money.

Hospitals, NHS or private, would charge insurers for their services. Private hospitals, whether for-profit or not, would compete on equal terms. All hospitals would be free to enter into contracts or arrangements with insurers as they believe best. Similarly, GPs functioning through primary care groups would charge insurers or offer pre-paid services.

Initially the scheme would be based on existing health authorities, but as under Enthoven's scheme, it should be possible to establish mutual purchasing agencies other than area-based stakeholders. This would create competition between SHIs and permit consumers to escape from their local SHI if it proved to be ineffective. A common objection to small-scale purchase of health insurance is that the administrative costs tend to be very high. How-

ever, the RAND Health Insurance Experiment found that groups of 10,000 or more have administrative costs of 5.5 per cent, whereas for smaller groups it can be 40 per cent.⁵ Thus, groups of 10,000 are large enough to secure the relevant economies of scale.

The Tax Credit and How to Ensure Universality

How might a system of tax credits work? For each person opting to receive insurance cover through the stakeholder rather than the NHS, a sum of money would be paid by the government to their stakeholder. How would this tax credit be calculated? There would need to be an interim arrangement until enough experience had been gained of the evolving insurance market. Two years would probably be sufficient, and during these two years the Treasury should apportion an age-weighted amount per person based on the previous year's NHS expenditure (approximately £800 per head). In subsequent years, the Treasury allocation should be based on the market price for the standard package defined by each stakeholder. The Exchequer subsidy should be a percentage of this market price.

The challenge I set at the beginning was to devise a system that would, above all, assist the least well off and, to that end, the tax credit should also vary according to financial circumstances. The major problem for any system which has to be adjusted according to income is how to deal fairly with people at the margin between total dependency and self-sufficiency. Needless to say, people on benefit who cannot be expected to work should receive the full cost of the standard insurance plan. The majority of earners are capable of paying their share out of pocket, but what about those 'in between'?

Based on expenditure in France and Germany, let's assume that the cost of a standard insurance package for a husband, wife and two children is £2,600 per year. For people on benefit the government would pay the full amount to the SHI. For others, the government would need to decide what percentage of the standard-package pre-

mium should be paid from taxes, and at what income level people could be expected to make a contribution. The tax credit should be in the range 50-75 per cent of the standard plan. If it were 50 per cent, the tax credit would be £1,300 per year and the maximum out-of-pocket payment would be £1,300 per year, plus any extra a consumer chose to spend.

However, if everyone whose income exceeded a certain point had to pay £1,300, it would be likely to have a behavioural effect on some people whose incomes were just below that point. They might be deterred from earning more. The difficulty could be avoided by tapering the tax credit to bring about a more gentle transition from subsidy to self-sufficiency. If the tax credit were £1,300, then a taper of 25p for every pound of tax liability above each family's tax threshold would have a smaller behavioural impact. At this point, however, a digression from the argument is necessary.

Work Incentives at the Margin: A Digression

Some critics regard the presence of a high 'marginal deduction rate' at a certain point in the income range as a decisive objection. However, to abandon any scheme for that reason alone would be to consider it acceptable to refrain from work altogether or reduce work effort because of the generosity of the benefit system. Such a view is surely paradoxical, particularly if the upshot is the continuation of public sector monopoly which fails, in reality, to provide universal cover for the poorest people. The issue can be understood more clearly if we personalise it. Imagine you lose your job and that you have a brother who offers to pay you £200 a week until you get another job. After four weeks you are still out of work and he asks when you are expecting to get a job.

You reply, 'Why should I get a job when I can get £200 a week from you without working?' Most people can see that it would be reasonable for the brother to reply that he will go on paying you for one more week, and then the money

will stop. The wider community is in exactly the same position, and someone who is able to work but refuses to do so because he is better off on benefit is simply taking advantage of the generosity of other people, no more and no less. Consequently a benefit system can legitimately be based on reciprocal obligations, including an obligation to perform public work in return for benefit.

Moreover, financial incentives are not the only influences on decisions to work or not work. Individuals take into account many factors, including self-respect, loyalty to children, a spouse or an employer. Consequently, many people do not take advantage of the generosity of the system, but strive that bit harder to get clear of the income zone in which they face a high marginal deduction rate.⁶ In any event, the impact on behaviour at the margin, while of some significance, is of minor importance compared with the gains to be made by empowering consumers across the income range. It is fundamental to the scheme that the poorest people should have the power to choose an alternative insurer.

The Impact of the Tax Credit

There would be an individual policy and a family policy. The cost might be £1,300 for an individual and £2,600 for a family. Let's assume that the cost of a standard insurance package for a husband, wife and two children is £2,600 per year. For people on benefit the government would pay the full amount to the SHI. The tax credit for people with earnings would taper away at 25p for every pound of tax liability above each family's tax threshold. The taper could stop when the amount of credit was equal to 50 per cent of the cost of the standard plan. No one would receive more than a 50 per cent subsidy.

How might such a scheme affect a family of a husband wife and two children at different income levels? For families with no tax liability the stakeholder would receive £2,600 from the government and there would be no out-of-pocket payment. For a family with a tax liability of £1,000

the stakeholder would receive £2,350 from the government and £250 from the family. For a family with a tax liability of £2,600 the stakeholder would receive £1,950 from the government and £650 from the family. A family with a tax liability of £5,200 would pay £1,300 to the stakeholder which would receive £1,300 from the government. At this point the tax credit would be 50 per cent of the standard plan, the maximum subsidy.

Conclusion

The end result would be universal access to a guaranteed standard, rather than universal access to a politically-determined standard which bears little relationship to either national wealth, medical need or personal demand. There would be competition to create room for experimentation and the discovery of new and better ways of meeting human needs. The dispersal of hospital ownership to localities would help to rebuild the social fabric. And above all, the poorest people in the society would have been empowered. They would be free to receive care from the NHS as at present. If they prefer to switch to an alternative insurer, they will enjoy the same power to do so as anyone else.

Thus, we would all pay taxes as at present. People happy with the NHS need take no action. People who would prefer to take personal responsibility would contract out and receive a tax credit representing 50 per cent of the cost of a standard health insurance scheme.

Moreover, stakeholders would give advice to help individuals choose, and because insurance is being bought by a group they would enjoy lower administrative costs and more bargaining power. Each stakeholder would be a mutual organisation charged with representing members, not an arm of the Treasury, charged with parsimony.

Commentaries

Time to Split the NHS

Adrian Bull

In the introduction to the paper the author states that the NHS falls a long way short of achieving its own objectives. This is a widely held, but ill-defined view, largely because those objectives are over generalised and poorly defined. The NHS embodies two quite distinct functions. The first is to be the funding vehicle by which the Government ensures that a health service is available to which the population has universal access, largely free at the point of use. This, in reality, is the Department of Health's function, but it has become synonymous with the NHS. The second role of the NHS is to be the organisation which manages and provides those same healthcare services to the public. In this regard, the NHS is the dominant provider of services in what is, in effect, a nationalised industry. Despite the Thatcher experiment of divorcing the purchasing from the provider function within the NHS, the two functions have never been separated out into two different organisational structures. Many of the principles of the purchaser/provider split under those reforms have been retained in the primary care group structures of the current government. This continues, however, to be within the framework of the single, national NHS.

The NHS' aims should be considered in these terms—and the two functions have quite different sets of objectives. As the funding mechanism to ensure that the nation has health care free at the point of use, the NHS continues to be broadly successful. Costs are well controlled, the nation's expenditure on health is held within reasonable limits, and health care continues to be largely free at the point of use; there are no financial deterrents in the system

which hinder a person seeking access to address their health concerns. With some exceptions at the margins, the funding of health care is broadly comprehensive and equal across the country. Furthermore, the NHS as a funding mechanism has ensured a remarkably successful series of preventive and surveillance services—specific examples being immunisation programmes, health visiting services and testing for neonatal disease. From this point of view, the NHS is a moderate success. The paper does correctly identify a flaw, however, in that there is no clear statement or description of the range of services which should be funded by this system. At its inception, the NHS aimed to fund all health services—including long-term nursing care of the elderly, and all dentistry. These two services have now mostly fallen outside the remit of the NHS funding, while other lifestyle-type conditions and services remain within its remit. This issue must be debated and resolved, and piecemeal statements about individual drugs or operations from the National Institute for Clinical Excellence (NICE) will not achieve the clarity of purpose that the nation requires.

The objectives of the NHS as the means of *delivering* healthcare services form a separate yardstick—and in this regard the NHS is indeed a failing organisation. The paper points out that, in general, uniform standards of care provision have led to lower rather than higher standards. Patients' comments about the care they receive from the NHS are heavily coloured by their relief that it is free at the point of use. Despite this, there is widespread dissatisfaction with standards of care provided. The NHS also suffers from significant deterioration in capital stock, poorly developed and fragmented IT support systems, disillusioned staff with widespread vacancies in technical and clinical disciplines, and poor and unreliable access to the service (long waiting times for out-patient appointments at hospitals, unacceptable delays in GP appointments, long waits for treatment and regular last minute cancellations of operations).

In the light of this analysis, I take issue with the paper's

statement that 'health care should be funded by insurance, not from taxes', although I agree with the statement that 'competition should be introduced [for the delivery of care]'. Competition is a necessary but not sufficient response to the failure of the NHS as a provider organisation. There is no overriding strategic statement about what the NHS is trying to achieve as a deliverer of services. There are tactical objectives in some areas, but these are set in such a way as to conflict with what some in the organisation see as its core overriding priorities. For example, the current leading political objective is to reduce waiting lists, but this rides roughshod over the clinical priorities and needs of those either in an acute situation, or with varying life-threatening conditions waiting for elective surgery. Nor will there ever be a clear set of objectives around the delivery of excellent care and service (as there should be), while the same organisation is also charged with delivering the maximum volume of care from a fixed (and inadequate) budget. At the same time, this confusion of roles and functions prevents the NHS as a purchaser of services from energetically driving the providers to increase their standards of provision, because it does not have the sanction that must be available to any purchaser to enforce this—the sanction of withdrawing business to an extent which would threaten the provider's continued viability.

Because of this, the paper is right to call for hospitals (and I would extend this to all service providers) to be run independently. The concept of the NHS should be split into two: the method and means by which taxpayers' money is used to fund access to health care free at the point of delivery on the one hand, and an organisation which is charged with delivering excellent care on the other. The paper calls for all hospitals to be independent of government. This is not entirely necessary: it is simply necessary that service providers which are independent, whether or not they are also profit-making, should be equally able to tender for and deliver the services commissioned by the Department of Health as the country's payer. It is necessary in such a context for a full mix of providers to be able

to compete fairly with each other in order to stimulate continuous improvement in standards. The mix would include government-owned, independent not-for-profit, and independent commercial organisations.

The paper, when addressing the insurance proposition, calls for a description of the services to which the Government should provide access under its health scheme. There is some contradiction in this section, in that a contract of insurance in the United States is then described as entitling individuals to 'all needed health care', explained as being whatever a qualified doctor says is necessary. Several healthcare systems have attempted to define, by means of a list, those treatments which should be part of the scheme. Such attempts include the Oregon experiment of prioritising treatment/condition pairs (now a largely discredited exercise), and the Netherlands' exercise to define the core services provided by its state system. In all cases to date, the complexity of the task has prevented a comprehensive solution. Other countries, such as New Zealand, have taken a different approach of defining mechanisms by which doctors should allocate priority to patients within the system, allowing the low-priority cases to have a lower speed of access to care than the higher priority cases. In the UK too, private medical insurance does not list the range of treatments which are available. Rather it defines in broad terms the principles which will govern assessments of eligibility, and amplifies these by explaining, and in some cases explicitly defining, what types of condition or treatment will not be eligible. This is the approach that should be adopted by the Government in setting up a new purchasing NHS to commission services for the country. But the first requirement would be to establish the broad principles which should govern the function. For example, prevention services should be limited to prophylactic treatment and diagnostic screening (immunisation, neonatal screening, hypertension treatment) and should not include lifestyle promotion or education; interventions will not be provided which are a

matter of lifestyle improvement rather than clinical necessity, e.g. hysterectomies without specific indication, post-menopausal fertility treatments, support of dysfunctional personality or emotional (as opposed to psychiatric) problems, cosmetic treatments other than restorative or reconstructive surgery.

Within a national framework for the commissioning of services such as this, different priorities could be allocated to different treatments or conditions, according to set criteria, on an individual basis. The paper also describes the different models of providing care in an insurance-based market such as the US, citing HMOs and open access fee-for-service, arguing that individuals will make their own decisions about what type of service will satisfy their needs and expectations. This is a philosophy which must be accepted in the UK. It should be entirely acceptable that, if people are not content with the nature of the service commissioned on their behalf by the state, or if, for reasons of preference or convenience, they wish to obtain greater priority outside the public system than has been made available within it, or if they wish to avail themselves of those lifestyle treatments which do not come within the range of state-funded care, they are able to do so through private means. Nor should this be seen as somehow undermining or threatening the state's continued role in guaranteeing access to those services which are within its remit.

I disagree with the paper's conclusions that a stakeholder health insurance proposition is the answer to the shortcomings of the UK's health system. 'Managed competition' is an interesting system, which is described well here, and it is one which offers answers to some of the problems inherent in a system such as that of the United States which is founded entirely on the principles of insurance. It is right to question and challenge whether the UK's system of funding healthcare services is viable, and to compare that system with others such as that of the United States. It is right to see what lessons the systems in other coun-

tries have that might be adapted for or incorporated into the system in this country. A change such as the one that is proposed would, however, be enormously complex, would be a radical departure from the history and culture of health care in this country, and would, moreover, be an experiment of high political risk, with a system which has not been tried or proven in any country other than the United States, which has a historical level of health expenditure and a culture of access to health care which is entirely different from that of the United Kingdom. One example of the differences that would have to be addressed is the relative expertise that the populations of each country have in using and obtaining maximum personal advantage from such arrangements. Americans have grown up with similar arrangements and are well versed in the problems and pitfalls to be considered. The British would be at a serious disadvantage, with an inadequate knowledge and understanding of the system which would take a considerable period of time to rectify. A second example of the differences is the extent to which primary care is a key part of all health transactions in the United Kingdom, but is a requisite only of HMO-type provision in the United States. The stakeholder scheme does not address fully the issues of direct access to secondary care, or the requirement to access the system through a primary care physician. A third example of the differences between the two countries is the extent of oversupply of doctors, specialists and hospitals in the United States, compared with their under-provision in the United Kingdom. In any system of pluralist purchasers, the constraints of available providers in the UK would severely constrain the ability of those purchasers to achieve the degree of change and control that has been obtained by the US insurance companies. Indeed, the current levels of provision would significantly reduce the benefits to be gained from any system of greater flexibility and competition.

Other sweeping statements are made about the fundamental changes which would need to be introduced to

facilitate this proposition—such as, for example, the statement that there ‘should also be community rating’ and that ‘no-one should face exclusions or limitations of coverage because of pre-existing conditions’. These conditions are, of course, prerequisites for any healthcare funding system that depends principally on the insurance proposition. But a third key requirement that must go along with these two for the system to be sustainable is widespread and continued uptake of insurance at all age levels, since only by this means would adverse selection be avoided and the risk spread sufficiently to make the absence of exclusions sustainable. Similarly there would have to be some compulsion or very strong incentive for people to continue with the insurance proposition on an annually renewed basis, again to ensure widespread uptake, if the insurance funds were required to support long-term or chronic care. This is because of the risk of adverse selection if those without ongoing needs were able to opt out of the system, while those with such needs were able to renew their insurance without question. It is not clear from the paper whether the option of continuing to have health care funded from general taxation, through primary care groups, as opposed to the option of taking out the stakeholder insurance, would satisfy these conditions. Indeed the unfamiliarity of the British people with the insurance option would make a low initial uptake seem likely, with all the attendant risks of anti-selection which would undermine the proposition in the early years.

It is also interesting to note, while considering managed competition as the answer to the UK’s problems, that the US is exploring ways of moving beyond group or individual insurance as the answer to the problem they face of very high levels of national expenditure on health. One option that is being actively explored is to introduce highly tax-incentivised Medical Savings Accounts, under which employers, instead of providing health insurance schemes, give their employees a sum of money (approximately \$5,000) per annum, part of which is used to fund ‘cata-

strophic' health insurance (effectively against charges in excess of \$3,000), part of which goes into a tax-efficient savings account which the individuals draw on to meet charges for smaller healthcare needs. This type of approach could well represent a significant evolution in the way health care is funded in the United States, and has some similarities with schemes in other countries such as, for example, Singapore.

On this point it is interesting to note that the paper does not address the key issue of co-payment, whereby the individual is required to pay part of the costs associated with any use of the healthcare service. This is an essential part of many insurance systems, and serves to counteract the problem of 'moral hazard'—the incentive for those who have paid their premiums to seek to maximise their use of the service which is free at the point of delivery. The NHS also suffers considerably from moral hazard, with numerous anecdotes circulating widely of inappropriate demands on various access points of the system—whether out-of-hours calls to GPs, unnecessary attendance at A&E departments, or spurious calls to the emergency services for attendance to resolve minor and non-urgent problems. In proposing a system whereby individuals could either stay within the general taxation-funded system, through primary care groups (PCGs), or opt out, with tax credits, into a stakeholder insurance scheme, the author should explore how co-payments would be introduced equitably into both systems to avoid disadvantaging those who chose one rather than the other.

As part of the proposals, the paper puts considerable emphasis on the need to separate the *purchasing* of healthcare services from the *planning* of those services. This is a sound requirement, but is part of the need to separate the purchasing (or commissioning) function of the NHS from the actual provision of services. Planning is an essential part of the delivery of the services, and this division has been considered above.

The detailed mechanisms of the tax credit proposals,

which the paper fully describes, are not at issue. It is unfortunate that the paper, having broadly identified the key issues of confused objectives and lack of diversity of provision in the earlier sections, explores only one option as a solution—and takes as that option a system which would require such fundamental and radical change to the current arrangements as to be politically and pragmatically unfeasible.

There are several matters which should be considered more carefully as ways in which the current system could be developed and adapted, using some of the better principles of the alternative system that the author advocates. There is an imperative requirement to clarify the objectives of the NHS—and in doing so to divorce the NHS as a means of funding the healthcare needs of the country from the NHS (and diverse alternatives) as the means of providing healthcare services. This would also require a clear statement describing the central remit of the nation's public health services—the criteria or principles that determine the range of conditions and treatments that it offers—as well as a clear and transparent mechanism to allocate acceptable priorities within that system. Such initiatives would need to be allied to a change in the cultural and political attitudes towards health services which would allow (and even encourage) individuals or their employers to obtain access to clinical services that were not seen as part of the public sector's remit, or to obtain greater priority and speed of access than would be allocated in the public system. This would allow a significant expansion of self-payment for services outside the public sector—whether on a pay-as-used basis, or through medical insurance—which together already contribute some £3 billion of healthcare expenditure. In determining these more explicit arrangements for a mixed-economy health sector, in which health care funded from general taxation would continue to be at the core, the role of co-payment for services, whether funded by the public system or from private insurance, should be carefully re-examined,

with the twin aims of removing the adverse incentives of moral hazard from both systems, and ensuring that patients in either system act more powerfully as consumers of the services by linking more closely and directly the payment for services with the use of those services.

In conclusion, the author has identified a number of key weaknesses in the current arrangements for health care in this country. The merits of one alternative system, currently operative in the United States and a successful means of addressing some of the healthcare problems in that country, are fully described. A radical change in the UK from the existing system to the proposed alternative would, however, be to embark on an experiment of politically unacceptable scale and risk. Instead, the lessons that are available to us from the United States and elsewhere should be used to identify ways in which the current UK system might be modified, to preserve what it is achieving and to develop what it currently does not offer. At a fundamental level, this requires the complete disaggregation of the payer or commissioning function of the NHS from all provision, the introduction of a fully diverse provider sector which provides real competition between providers to deliver the commissioned services, the clear description of what healthcare services the government intends to fund for the population, the significant expansion of the level of provider resource to enable genuine competition between providers, instead of the current situation of significant under-provision, and the development of a culture which recognises the right of each individual to obtain additional care or higher priority of access by private means outside the state-funded system.

The Need For Competition

Nicholas Beazley

Dr Green's analysis identifies three issues as being long-standing problems of the NHS and which need to be resolved:

- Underfunding
- Lack of competition
- Lack of individual choice

This paper comments on these issues and Dr Green's proposals to remedy them through stakeholder insurance.

Underfunding

The Prime Minister seems to agree with the first of these, and his recent plans for the NHS concentrate on it, at least at this stage. He, and many others, expect improvements in the services to flow inevitably from greater funding. But underfunding is a complex issue and impossible to answer with our current information on the NHS. Clearly there has been insufficient money spent to keep the capital assets in good repair, to meet the demands placed on it by the expectations of patients and professionals, and to ensure enough flexibility to cope with variations in demand as well as new developments. Waiting lists and times and the shortages of beds are testaments to this. The NHS also looks underfunded when compared with health services in other developed countries.

But there are uncertainties. How do we know that what is being sought or provided is sensible and appropriate? What is the real extent of need or demand that can properly be met and improved by healthcare interventions? What are the issues in the system which lead to inefficient

use of both time and money? These are important questions in any arena, and particularly so in a system that is very largely funded out of taxation.

Lack Of Competition

The fact that some of these questions cannot be answered is in part a reflection of the second issue: the lack of competition. Supporters of the NHS frequently assume that the low levels of management activity, and in particular the virtual absence of any need for billing systems, are significant advantages in themselves. They believe that this absence of transaction costs makes the system highly desirable and preferable to, for example, the system in the USA. Indeed this monopolistic position and power is, so supporters argue, at the centre of what makes the NHS good. It is surprising that this begging of the question of whether competition is more or less productive of an efficient system than centralised organisation and funding, is rarely challenged.

Those responsible for regulating monopolistic industries make the opposite assumption, namely that a large monopoly, far from being an efficient way of providing services, is likely to be unable or unwilling to change and develop in ways that benefit the customer. Incentives for improvement are difficult to generate. Different approaches to care arise only coincidentally instead of as a means of differentiation and maintenance of high quality services.

Lack Of Individual Choice

The lack of individual choice inherent in the current system is no longer sustainable. The absence of significant choice remains a major deficit in the Government's National Plan, despite some of the rhetoric. We have seen service levels increase dramatically in previously poorly performing sectors such as utilities, telecoms and postal services. The consumer will now insist that the NHS follows. Asymmetry of information, the fact that the

providers are vastly better informed than the consumer about the services and treatments available, and their outcomes, has long been a barrier. But this was being eroded even before the availability of information on the internet dramatically transformed the way consumers were able to look at what was available and its applicability to them. There is no reversing this.

At the moment the system provides, for many, as good a service as they might get anywhere. We should be proud of this and ensure it is preserved. Perversely it also favours the very affluent, who are financially insensitive to the considerable taxes they have already provided for the NHS—about one sixth of their total tax—and have no difficulty providing themselves with an alternative service entirely separately. The people disadvantaged include those on middle incomes, who do have a desire to spend some of their income on their health. But in our system, where there is no compensation for not consuming in the NHS, these people cannot afford a duplicate expenditure.

Accurate Diagnosis And A Possible Solution

Dr Green's diagnosis of the issues facing the current health services in the UK seems accurate and he has thought through a system that addresses many of the problems. He has significantly advanced the debate and comprehensively established how people can be helped to exercise choice and receive a better type of health services whilst also preserving the services available to those who either are unable or unwilling to 'top-up' their package of care. His suggestion as to how to set the balance between the different sources of funding will be essential to ensure that those least able to exercise choice are not disadvantaged. We might wish to debate further whether a tax credit is the best vehicle for basing the financial allocation, or whether some other type of transfer payment would be more efficient. But these are details that can be resolved. More difficult is the political and professional resistance to change on this scale. How the ideas are presented is highly

sensitive.

Dr Green is realistic in recognising that there are uncertainties in setting up a new financial and organisational system and that a number of years will be needed for it to settle down. But he has described a new NHS which preserves and improves on the values of the old. Given the current political climate his ideas need urgently to be included in the debate. With the promised large amount of extra finance being available to health services over the next few years, now is also a good time to start exploring the viability of some of the ideas included in the proposals for stakeholder insurance.

Opening the Door to Consumer Choice

Tim Baker

Background

The public and private healthcare sectors in the UK are inextricably linked. The relationship is symbiotic. The private sector will only provide services where there is strong consumer demand, which is not met by the National Health Service (NHS). Links between the two sectors are numerous. For example, some NHS services are privately provided (such as nursing homes and some mental health services) while key NHS personnel, such as consultants, work in both sectors. The nature of this relationship is based on 50 years of NHS practice, but does it achieve the government's stated ambitions for health care, and is it in the best interest of UK plc?

Currently, healthcare insurance covers some seven million people through private medical insurance (PMI). There are other forms of health insurance such as cash plans, critical illness, income protection, dental and long-term care, but they are less relevant to this particular essay. Those insured with PMI receive benefit for treatment by a hospital consultant for short-term curable conditions. Treatments covered range from removal of skin lesions and varicose veins, through to cardiac artery bypass grafts and oncology. It is in these areas that NHS rationing, especially through waiting lists, has created significant consumer demand for private care. In addition to the 12 per cent of the population with insurance, some 165,000 operations were purchased on a self-pay basis in 1998.

Future growth rates for the PMI market will be determined by two key factors. Firstly, the expectations gap—that is the gap between what the consumer expects to receive in terms of healthcare services and what the NHS actually delivers. Secondly, the underlying performance of the UK economy, most notably growth in average earnings (for the 40 per cent of the market who pay for themselves), and growth in company profitability (the remaining 60 per cent of the market is company-sponsored). Over the last couple of years the PMI market has grown and indications are that this growth will continue and, indeed, somewhat accelerate over the next few years.

There can be little doubt that those accessing private healthcare are receiving faster access to a broader range of treatments than those relying solely on the NHS. The speed of treatment issue is well known and does not need rehearsing here. However, the range of treatments is a more recent phenomenon. The NHS is increasing the rationing of certain care, notably in the area of oncology where expensive drugs such as Taxol (used in treatment of ovarian cancer) are not universally available. PMI consumers, on the other hand, will often receive access to these NHS-rationed treatments.

Thus, it is the case that we have a two-tier health system in the UK. Many of those who can afford to are opting out of elements of NHS care to ensure access to a wide range of high quality healthcare: for the remainder there is no choice. If the NHS cannot, or will not, provide a treatment they require they simply have to make do with what is available. For many this involves long waits in discomfort or even pain and, in extreme cases, an untimely death.

Those of us involved in private insurance should be happy with such a scenario. In the medium- to long-run this background is highly likely to be good for business. And yet we should all be deeply uneasy about the social implications of an increasing divide between rich and poor in terms of health care. And, if we look around us, there are models of funding, particularly in Europe, which

achieve a better balanced system in terms of social cohesion than that of the NHS. A solution which delivers more funding from the private sector does not have only to help the better off.

Stakeholder Health Care

Against this background, does Dr Green's paper present a viable cost-effective model for the delivery of a greater volume of health care without undermining social policy objectives?

I have looked at Dr Green's paper from four perspectives: consumer, insurer, provider and public policy.

Consumer View

Consumers in this stakeholder world have a choice: to stay in the NHS or opt out. How are they going to make a decision? Dr Green makes it clear that insurers competing in this market would need to publish prices for a standard package of care, thus easing the burden for the consumer of comparing competing packages. However, it would also be imperative that information about the NHS package is available so that consumers can compare information to make the 'opt in' or 'opt out' decision. Clearly this would force the NHS to come clean and specify more precisely an individual's entitlement to treatment.

If the NHS were to adopt the same definition as Dr Green advocates for stakeholder health insurers (SHIs) (the 'all-needed-care' model) this would have two implications. Firstly, there would be the potential for a significant increase in NHS funding; it seems unlikely that any government would make such a commitment. Secondly, a key reason for consumers to move towards the insurance sector (wider choice of treatment) is removed. Under this scenario the private sector could compete in two potential areas: quality of clinical care and quality of service. The former would be very difficult to establish, while the latter may be insufficient to encourage consumers to switch from the safety of the NHS. If, on the other hand, the NHS were

to remain, as now, with a lack of clarity of what it did and did not cover, this lack of information may lead to consumer inertia.

Of course, the range of treatments available is only one way of differentiating service. Clearly, consumers who are being asked to pay extra for the SHI model will expect something additional for their money. It may be that a range of factors—faster access, longer appointment times, choice of doctor, single rooms etc.—would be sufficient.

The other factor that will come into play will be quality. Clinical quality can be difficult for professionals to judge, let alone an individual consumer. Consumers are also bombarded with media stories about poor standards of care in both NHS and private sectors. They are confused and concerned. Dr Green's proposal for each SHI to act as regulator may only serve in the short term to increase this confusion. Initially, at least, a single national and unitary system of regulation covering funding, NHS providers and private providers may well be required to ensure sufficient consumer confidence in the system.

As many consumers in today's private market are corporate organisations, it is important that their needs are recognised in any new model. They provide health cover to their staff partly as a perk, but also to ensure employees are fit and healthy for work. Clearly the option of all or part funding SHIs as a perk would remain. Companies will, however, be more interested in purchasing health care for their staff which is focused on the needs of both the employer and employee. Here the concept of a partial 'opt out' for employees of corporate organisations may well be an attractive option.

An Insurer's View

The model Dr Green proposes would have profound implications for insurers. The range of cover, marketing, selling, risk management and drivers of profitability would all be dramatically altered. Investment would undoubtedly be required and there is no guarantee that successful

companies in today's market will be successful in the new market. To make such investment worthwhile insurers would need to feel that there was good opportunity for making a market rate of return on capital and that the overall market would be sizeably bigger than exists today.

The SHI model is based on a system of community rating. Unlike in today's individual PMI market, where cover for pre-existing conditions is either excluded or loaded, community rating would enable everyone to access cover regardless of their health status. In addition, consumers would be free to move between insurers, in a specific time period each year, without being penalised. A potential issue of anti-selection arises with the decision to opt in or out of the NHS. Assuming that the SHI option provides more or better care than the NHS, consumers will be more likely to take the SHI option if they believe they will use it. This could be guarded against, to some extent, by making this decision a 'one off' that could only be reversed in exceptional or well-defined circumstances. However, even with such a proviso, anti-selection will still occur. From an insurer's perspective such anti-selection can be priced for as it is in today's market. It will, however, reduce the size of the SHI market since premiums will have to account for it. If tax credits are linked to premiums it will also increase the requirement for Treasury subsidy.

These problems of anti-selection will perhaps be most acute during the transitional phase. Without experience, insurers will not know the extent to which the market will be subject to anti-selection. Thus pricing in the early years could prove very difficult. In such a market insurers could make big losses or big profits, neither of which are desirable in ensuring long-run market stability.

A further concern from insurers is the likely size of the SHI. SHIs which are too small will not justify investment and may suffer from significant fluctuations in risk. Clearly these are key issues for insurers but will also be of concern to customers since they will have an impact on underlying premiums. Rather than working on a locality basis, a more regional approach may be preferable. This

would have the advantage of providing the scale necessary for insurers whilst ensuring that products and services are designed around the needs of local populations.

Providers

The SHI model would change the current provider market from polarised to pluralistic. Public and private providers would compete in both public and private markets. Market mechanisms would ensure that only providers who provided high quality and efficient services would survive.

Within today's provider market there is little evidence of service competition. Within the NHS, patients rarely change their GP and referrals tend to follow long established paths. Even the advent of GP fundholding did little to change this. Within the private sector many private hospitals are effective local monopolies with only minimal competition.

On top of this there are other significant structural issues which impact the private market in particular. While hospital consultants are eligible to mix and match between public and private sectors, NHS GPs do not have the same freedom. They cannot provide private GP services to patients on their or their partners' lists. This acts as a significant break on the development of private GP services and has stimulated the development of free-standing private primary care services in metropolitan areas, especially London. Increasingly consumers are demanding services that are organised for their convenience rather than the convenience of the doctor. Undoubtedly many NHS GPs would like to develop private services and would take advantage of any change in regulation. Without widespread provision of private GP services insurers have found it difficult to develop primary-care-led managed care models of healthcare funding. There is little doubt that such models would be more efficient than the current private sector model of fee-for-service and indemnity insurance. In addition, there is no evidence that such a model would not be supported by consumers. Unlike in the

US, where consumers see such models as restricting choice, perhaps the greatest achievement of the NHS is creating a strong primary care network which, if provided well, consumers see as a benefit rather than a restriction.

In the SHI model, GPs would be free to work in both sectors. This would undoubtedly lead to the development of customer-focused primary care services by entrepreneurial GPs. Opening hours would be extended, home visits would be re-introduced, preventative services would be extended, the physical environment would be improved and greater integration of services would be delivered, to name but a few. The degree to which such services are different from the NHS will be a key determinant of consumer demand for private services under the SHI model. Unlike the hospital environment, many consumers touch primary care on a regular basis. Thus their perception of value for money will largely be based on the service they receive in this primary care environment.

Public Policy Issues

There are undoubtedly many benefits of the SHI model. A consumer-driven approach to health care will radically alter the UK health market. New services, consumer choice, investment, new staff, more training etc. will all be key components of the new market. Will all of this improve health outcomes? Evidence from Europe would certainly support the view that it will.

What would it do to the aims of the NHS—universal, comprehensive, equal and high quality? Clearly the SHI model preserves universality and, with the right regulatory environment, will sustain high quality. The other two are less clear. It is evident that the NHS does not provide a comprehensive service today. Long waits and rationing of certain treatments mean that a truly comprehensive service is only available to those that can afford it. In all likelihood the SHI model would be no more comprehensive. As I have already argued, a clear definition of core NHS provision could be established. Exactly what was included

could be defined through public debate and financial and clinical considerations. Thus the public sector would be admitting that comprehensive health care was no longer achievable but that instead it would provide a core level of high quality services to everyone.

Clearly, in such a model, where the line is drawn will have profound implications, not least of which is on the demand for private care. The more the state provides the less reason for consumers to opt out of public provision into private care. Thus, the ambition of providing as comprehensive a public sector as possible, and stimulating growth in private care, will to some extent be mutually exclusive.

An alternative model is that of compulsion. Under such a system certain consumers are forced to opt out. This is usually based on income as, for example, in Ireland and the Netherlands. The advantage of this approach is that it breaks the link between the quality and scope of public services and the size of the private sector. Hence, it is perfectly feasible for the quality and scope of public and private provision to be similar. The disadvantage is that politicians see compulsion as politically unacceptable, a sort of poll tax with the potential for a similar consumer reaction.

Conclusion

The future of healthcare funding is set to remain a key issue on our national agenda. It will play a major part in shaping the outcome of the next general election. We need more well-informed debate, rather than the 'public is good' 'private is bad' slanging match that tends to dominate the political agenda.

Dr Green's paper is a significant contribution to that debate. It shows how a private sector model can work alongside the NHS. Of course it raises issues, and some very key issues, as I have indicated. However, the concept is worth further consideration and detailed development.

Notes

David G. Green: Preface

- 1 *The NHS Plan*, Cm 4818-I, July 2000, p. 34.
- 2 *The NHS Plan*, pp. 113,116.
- 3 *The NHS Plan*, p. 31.

David G. Green: Stakeholder Health Insurance

- 1 See, for example, Weale, A., 'Ethical issues in social insurance for health', in Sorell, T., *Health Care, Ethics and Insurance*, London: Routledge, 1998.
- 2 Enthoven, A.C., *Theory and Practice of Managed Competition in Health Care Finance*, Amsterdam: North Holland, 1988; Enthoven, A.C. and Singer, S.J., 'A single-payer system in Jackson Hole clothing', *Health Affairs*, Spring 1994, pp. 81-95.
- 3 Office of Personnel Management, Federal Employees Health Benefits Program, A Handbook for Enrollees and Employing Offices, 1999: Web: www.opm.gov/hr/insure/handbook/fehb01.htm.
- 4 Starr, P., 'Design of health insurance purchasing cooperative', *Health Affairs*, Supplement 1993, p. 60.
- 5 Enthoven, *Health Affairs*, Supplement 1993, p. 35.
- 6 See Green, D.G., *An End to Welfare Rights: The Rediscovery of Independence*, London: IEA, Health and Welfare Unit, 1999.