

Step by Step Reform

Health Policy Consensus Group

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1. The Underlying Conundrum

The provision of health care is a thorny issue because of the dual character of medical demand. On the one hand, severe pain or dysfunction may prevent people from leading a normal life and in extreme cases life or death may be at stake. On the other hand, some demands for medical services are a matter of personal preference. No less important, some ill health is a matter of sheer misfortune and some a consequence of a self-destructive lifestyle.

When the NHS was founded illness was seen primarily as a misfortune which should be dealt with as a matter of necessity. Today it is more apparent that health care is sometimes an urgent necessity and on other occasions no different from many other personal goods and services we might want.

This dual character explains why it is so difficult for a government to decide on the quantity and standard of care to be provided without charge for the poorest members of society. For decades governments operated on the assumption that objective clinical need would determine priorities. However, the unavoidable reality is that in countries where people can spend their own money as they believe best, the majority have consistently chosen to spend a great deal on medical services, much of it unrelated to clinical need in any technical sense. In such countries, the spending pattern of people on middle incomes and above determines the expectations of everyone in society and sets the benchmark against which the quality and quantity of government-funded medical care are judged. As prosperity has risen, so it has become ethically unacceptable to offer a service to the poor that is recognisably inferior to the standard available to people on middle incomes.

Public policy makers continue to struggle with these conundrums in all countries, but some have devised solutions which have proved more effective than others. It is our conclusion that countries with social insurance systems (Germany, France, the Netherlands and Switzerland) have the most to teach us. But we cannot point to a particular ready-made scheme which can be copied in its entirety. Here is our reasoning.¹

¹ To aid the reader's understanding of what may be unfamiliar health economics and insurance terms, we include a glossary at the end of this paper.

2. **Where We Are Now: UK Health Care in 2002**

The UK government has a near monopoly over the funding and provision of health care. After decades of political control, our healthcare spending is comparatively low, but is set to rise to something approaching the EU average over the next few years. Our healthcare outcomes are comparatively poor.

The 28 English strategic health authorities supervise 304 Primary Care Trusts (PCTs)¹ which are to be the main buyers of services from hospital trusts which, under a system of earned autonomy, are subject to a regime of inspections and monitoring by central government and semi-autonomous agencies. Labour's purchaser-provider split is a development rather than a reversal of the Tories' internal market.

With some minor recent exceptions, patients have no choice among doctors and hospitals.² Patients in the UK cannot choose their third party payer. We have very few compulsory user charges and there are many exemptions for those that do exist. UK politicians through targets, departmental circulars and arms-length rationing under the 'scientific' guise of NICE, interfere with clinical autonomy or the professional duty of clinicians to act in the interests of patients.

There has been much criticism of the Government's plans to increase the role of the private sector, but it already provides much mental health and residential care. The central issue is the degree of competition rather than the public-private split.

3. **The Main Features of an Ideal Healthcare System and Some Options**

In our first publication, *Options for Funding*, we examined the features of eleven different healthcare funding systems. As a result, we have identified six characteristics of an ideal health system and a number of options for policy makers.

1. *The primary role of government should be to create the legal and regulatory framework, to ensure that access to a high standard of care is guaranteed to all, and to ensure the supply of essential public health services.*

Options: Should the government determine the content of a minimum/core package or should the government guarantee be market-tested, i.e. based on a package that middle income earners choose to purchase themselves?

2. Patients should have a choice among a range of competing healthcare providers.

Options: We anticipate a variety of organisational forms, including mutual organisations, public bodies and private companies. However, if the exercise of patient choice is to act as driver for improved treatment, the allocation of resources must be closely linked to those choices; only then will providers bear the direct financial consequences of inadequate service provision.

3. Health insurance should be compulsory.

Options: Should premiums be paid by individuals (Switzerland) or partly by employers and employees (France, Germany, the Netherlands)? Should premiums be income related (Germany) or based on the market value of the product (Switzerland)? Should we separate long term care for the elderly and disabled from other healthcare (the Netherlands, Germany, and the USA)?

4. Patients should be free to choose from among a range of third party payers.

Options: Should choice of third party payer apply to all healthcare insurance or only to top-up voluntary insurance? For an insurance market to function at its best, some regulation will be required, but what form should it take? Should there be state licensing of approved insurers? Should consumers be able to purchase insurance in groups to reduce costs? Should insurers charge the same premium for all adults, that is, should premiums be community rated and not based on medical history? Should competing insurers be subject to a process of risk adjustment to ensure an even spread of health risks?

5. There should be no compulsory user charges.

Options: Should individuals be able to choose to pay user charges in return for a lower annual premium? If so should premium reductions be regulated by the government?

6. Politicians must not override the professional duty of clinicians to act in the interests of patients.

Options: There will always be limits to expenditure and the need to guard against maverick physicians. What should the role of professional associations be?

Note: the above features and options do not rule out the French, German, Dutch or Swiss systems, but would rule out the current US system.

4. How to Get There: Evolution Not Revolution

It will not be easy to move from a public sector monopoly funding system like the NHS to an alternative. The recent major reforms in Central and Eastern Europe teach us that in order for a working insurance system to develop it is necessary to move step by step over a period of years. Similarly, reforms over the past decade in the Netherlands and Germany show us that incremental market orientated change is feasible, though not without difficulties.

We consider funding first. Here are four possible solutions:

- Evolutionary reform of primary care trusts
- A tax-funded core-service with treatment vouchers and top-up insurance
- Social insurance with individual payment
- Social insurance with consumer health purchasing co-operatives

4.1 Evolutionary Reform of Primary Care Trusts

Scheduled to have control over 75% of NHS budget by 2003/4, the 304 primary care trusts (PCTs) may lend themselves to change. Each person receives care from his or her local PCT, which is partially a local monopoly fundholder, partly a direct provider of primary care, and partly a purchaser of hospital and outpatient services managed by separate organisations.

We consider three possible routes for reform of PCTs³:

- Offer choice of PCT
- Convert PCTs to consumer mutuals
- Convert PCTs to producer-led healthcare maintenance organisations

Choice of Primary Care Trust.

The simplest reform of PCTs would be to introduce free consumer choice of PCT. The income of a PCT is based on a weighted capitation formula and it would be administratively simple to transfer funds between PCTs according to the preferences of patients. Such a reform would effectively enable individuals to choose from a wider range of GPs and hospitals. In practice, as PCTs are geographically defined and cover quite large areas, it is unlikely that many people would choose to

change PCT, but experience of systems in other developed countries shows that the existence of choice is perhaps more important than the exercise of it. In any event, such choice would be of limited value without a clear change in patients' access to specialists. Experience of hospital choice in Denmark suggests that real choice requires money to follow patients and for consumers to have easy access to high quality information comparing the quality of care available at different institutions, including waiting times for elective surgery.

Convert Primary Care Trusts to Consumer Mutuals

Another possibility would be to convert PCTs to mutual organisations owned by their members. At the minimum this would require direct representation of patients on the controlling body of the PCT, but it would be better to go a step further to create real ownership by giving members control of their share of the Treasury allocation to the PCT. Members would be allowed to take this amount with them to another PCT to give trusts an incentive to provide a good standard of care.

Such a change would go some way towards empowering patients, but PCTs would still have cash-limited budgets set by central government. To overcome this problem, people need to be free to add to the funding available to their PCT, but how can such freedom be made compatible with social solidarity?

One method would be to let PCTs establish separate mutual funds for service development. Members could pay into the fund just as they pay into any savings account. Interest would be free of tax and payable if the capital were tied up for long enough to allow its use for investment in health facilities – perhaps until retirement age. Once the members reached the age of 65 the capital could be withdrawn or left to gather further interest. Each year huge amounts are invested in pensions and, if the tax regime for mutual health funds were the same as it is for pensions, it is possible that many people would be willing to invest in mutual health funds as a way of combining provision for retirement with support for the NHS. As the years passed and members grew older, money would start to be withdrawn from the mutual funds, but in the short run there will be a major growth in funding for the development of healthcare services. If we are to catch up with other European countries we need just such an immediate boost in funding.

It may be possible for bodies such as friendly societies to work with primary care trusts at the margin, for example by funding chronic care and certain occupation-limiting ailments that the National Health Service cannot really deal with.

An arrangement based on mutually-owned PCTs would be voluntary and potentially create a sense of genuine social solidarity – always promised by the NHS but never achieved. However, doctors may be hostile to such an arrangement if there is little physician input.

Convert Primary Care Trusts to Producer-Run Health Maintenance Organisations

It might be more realistic to convert PCTs into health maintenance organisations run by doctors. Patients should be free to switch to another PCT if dissatisfied, but ownership and control of the PCT would lie with the doctors who work in it. In most markets for goods and services we do not rely on direct consumer representation on company boards to ensure good service, but rather on competition. Health care is no different. There has been a long and successful history of HMOs in America, although some HMOs have come under heavy criticism from consumers.

4.2 Tax-funded Core-Service with Treatment Vouchers and Top-up Insurance.

This section is largely based on Ruth Lea's IoD Policy Paper, *Health Care in the UK: The Need for Reform*, which sets out the case for a voucher, or 'NHS passport' scheme, which would enable people to spend more of their own cash on health care, in return for much greater choice.⁴

Funding the Voucher

Advocates of the voucher typically reject major changes to the existing funding mechanism, thus ruling out increased user charges, social insurance, extra taxes, hypothecated tax, and private insurance with tax incentives or otherwise. According to one such scheme⁵:

- All individuals would have a health voucher which would entitle them to a universal and free basket of 'core' services which would be funded by general taxation, as today;
- 'Core' services would be strictly defined by the Government, following the recommendations of an independent advisory medical committee, and would concentrate on serious and long term illness and care for certain specified groups (such as the elderly,

disabled, babies, children, pregnant women and so forth). Some procedures will remain outside the scope of the core package.

- If patients wished to use current NHS Trust facilities to receive ‘core’ services, their treatment would be free.⁶ Those patients wishing to use other, private sector, facilities for ‘core’ services, to obtain higher quality treatment or greater comfort, would be given a ‘credit note’ (i.e. a voucher) to the value of their NHS treatment and would pay the marginal cost or ‘top up’ charge between the national Health Resource Group (HRG) price and the actual price charged by the alternative provider. The government would set the price it will pay - the value of the voucher - by defining the cost of each of the core service procedures using existing Health Resource Groups. For example a cataract operation may be priced at £2,000. Thus, the portable cataract operation voucher would be worth £2,000. Some private providers may even be able to provide services at a lower cost than the voucher rate, in which case individuals might receive a rebate. This would give many more people access to affordable private sector treatment by eliminating the disincentive of ‘paying twice’ faced by those choosing to go private today.
- Patients wishing to be treated for ‘non-core’ services would be responsible for the whole cost. Competing insurers would offer individuals and groups (perhaps based on employers, unions, or churches) a range of top-up policies that would include coverage for many such ‘non-core’ services, and cover extra payments required when the voucher fails to meet the full cost of treatment. Certain ‘non-core’ services, such as cosmetic surgery, will not be insurable; patients seeking such services would be required to pay out-of-pocket.⁷ A range of deductibles and no-claims bonus options are likely to emerge.

Determining the ‘Core’ in a Voucher System

Ruth Lea argues that maximizing economic ‘health gain’ should be central to what should or should not be in the core services. Those treatments that are unsatisfactory on economic grounds should be excluded. For example, screening programmes that are proven to have little effect may be excluded. Resources would be concentrated on serious and long-term illness.⁸ Newly developed treatments or services would only be added to the core services list after clear evidence of effectiveness is produced.

Ideally, health care would be taken out of the hands of politicians; however, as a tax-based system Ruth Lea argues that the Government would have to control overall public spending on health care. The rationing process must be clear and transparent, thereby boosting fairness and allowing individuals and families to make necessary insurance arrangements for non-core services. Recommendations on priorities for health care should be made by a politically independent committee of experts (clinicians, epidemiologists, statisticians and economists), on a sound medical and economic basis. Such a committee would prevent the undue influence of certain powerful lobby groups.

Provision of Health Services

Supply-side reform would have to go hand in hand with the introduction of vouchers that allowed money clearly to follow patients. An important element of this scheme would be the break-up of existing monopoly of provision, and the likely outcome would be a mixed-economy provider market. The subsequent encouragement of provider competition would enable the system to become sensitive and responsive to patients' preferences. It is likely that the emerging private sector market, through effectiveness and efficiency pressures, would also lead to improved performance by NHS providers and help cut waste. Healthcare professionals would have greater freedom and, frequently, better pay.

The healthcare voucher itself would stimulate competition between providers, but beyond that a system of managed competition would be advantageous, whereby:

- The NHS would cease being a major provider of care. The NHS would be redefined as the funder of core services (funded by the taxpayer), about which it would decide, and be the regulator;
- NHS Trusts for both acute care and community care would become independent non-profit making public service mutuals. They would not be publicly owned, and they would manage their business affairs independently. They would hire their own staff and pay by negotiation in the local market.
- These NHS Trusts would comprise the NHS's approved list of providers of core services and be obliged to provide core services without charge;

- GPs would remain as strict gatekeepers to the core services. They should have autonomy returned to them. Patients must also have greater choice of GP and be able to change GP more easily.

Regulation

All providers would be obliged to provide a high standard of care. In Ruth Lea's 'passport system' the NHS would be the regulator, ensuring that standards were maintained throughout the whole of the healthcare sector, including all current private providers.⁹ Perhaps the existing 28 Strategic Health Authorities could perform this regulatory role.

Advantages and Disadvantages

Proponents of voucher schemes emphasise two advantages. First, there would be improved choice of provider.¹⁰ And second, there would be an increase in private expenditure. We expect that this system would stimulate provider competition and expand the range of services offered, whilst NHS 'approved providers' would remain the default option.

Critics rightly point out that any such proposed voucher scheme will be to the advantage of the better off members of society who can afford to pay extra. However, its proponents, including the Conservative Party¹¹, counter that we already have a system in the UK, whereby only the rich can afford full private sector costs of treatment or private insurance. In contrast, a voucher scheme would enable the benefits of choice and competition between public and private sectors, and the stimulating effects of increases in private contributions to overall healthcare expenditure, to trickle down the income scale to a greater number of people.

Treatment vouchers, however, are not a universal solution and may not lead to large increases in private top-up expenditure because, as long as the government pays a percentage of the voucher cost, it is bound to impose a cash limit on total public expenditure on vouchers.

Patient Pathways in a Tax-funded Core-Service with Treatment Vouchers and Top-up Insurance

The voucher system outlined above would apply to all UK residents. Single unemployed people, the retired, cohabiting couples and married couples with children, would all be entitled to the same ‘core’ services, funded from taxation, and free of charge. Likely differences in patient pathways become apparent when we consider the use of more expensive treatment facilities, and those seeking ‘non-core’ treatment services. We assume that non-profit and for-profit insurers would offer a range of policies to cover top-up medical expenses – those above the value of the voucher. In its reliance on top-up insurance for extra comfort, speed, and non-core services, the system would somewhat resemble that currently operating in France – where the purchase of supplementary private insurance, either through employers or on an individual basis, is the norm for roughly 90 per cent of the population and where there is complete freedom of choice of healthcare provider. However, unlike the French system we assume that patients would use GP services as they do now; therefore top-up cover would not cover GP services.¹² Let’s see how a typical married couple (Mr. and Mrs. Brown), with dependent children and elderly parents would be affected.

When they married, Mr. and Mrs. Brown decided to purchase top-up insurance, in order to obtain faster treatment. They pay slightly less per person than unmarried individuals, the average being roughly £80 rather than £100 per couple per month. Insurers also offer significant reductions for households with children, so for example the Browns, with two young children, pay around £110 per month (£80 per couple and £15 per child) for a typical non-profit community rated top-up policy. This policy entitles all family members to seek diagnosis and treatment for a wide variety of ‘core’ conditions in private hospitals and clinics, without paying extra fees above the voucher. However, the insurance policy requires the Browns to seek prior permission from the insurer before agreeing to pay top-up fees and that they pay excess fees up front and subsequently seek reimbursement from the insurer. With two children, significant sums of money can be outstanding at times.

Mr. Brown fractured his fifth metatarsal. Because of the pain involved and potential for long-term serious damage, fracture treatment is classified as a 'core' service. Following preliminary diagnosis, Mr. Brown decided where to be treated by consulting the lists of local providers published by the local strategic health authority and his insurer. These lists include details of services available, treatment prices, waiting times, and a number of other performance indicators. If Mr. Brown had chosen to be treated at one of the newly independent former NHS hospitals, neither he nor his insurer would have paid any top-up fees.

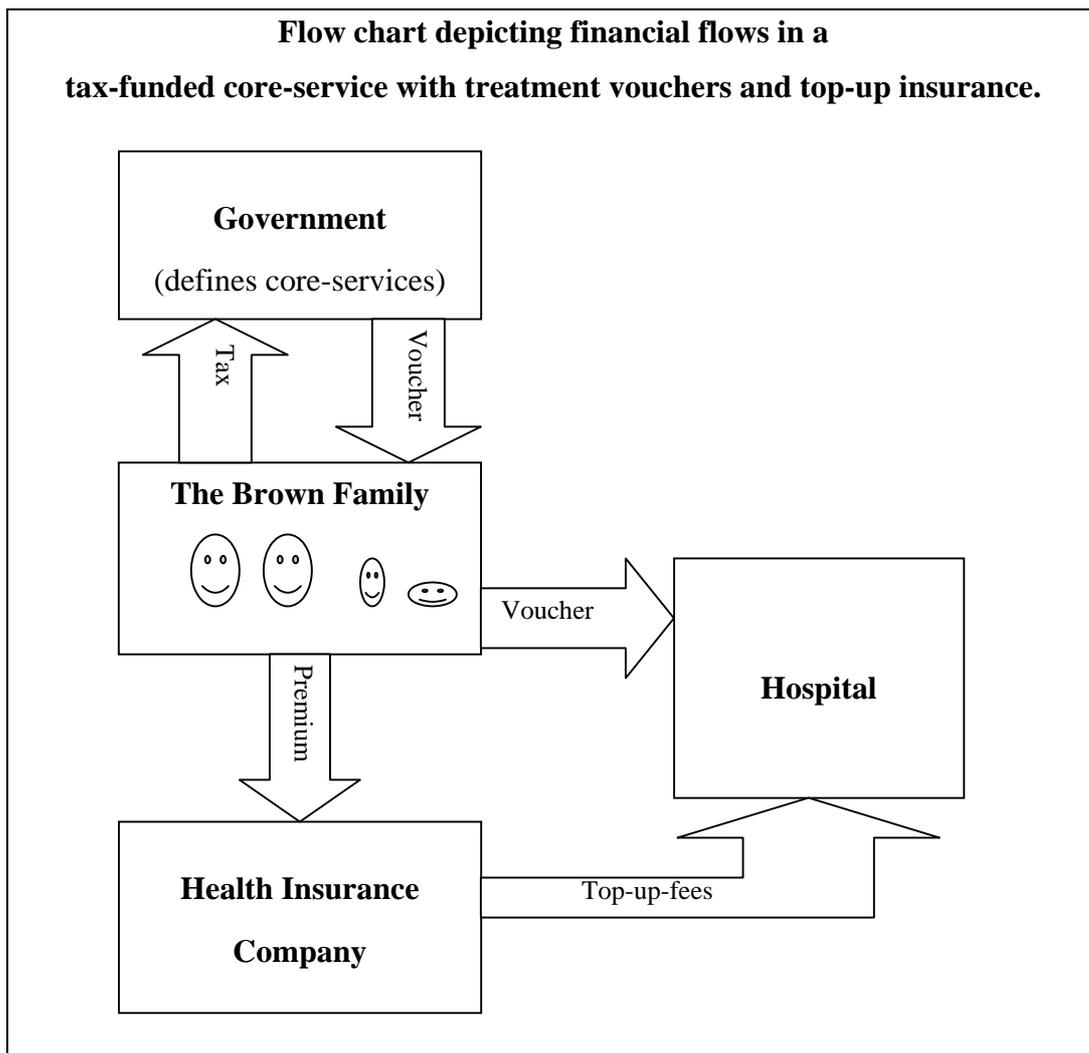
As the price of NHS treatment was £1,000, he was entitled to a treatment voucher worth £1,000. Treatment at one of the local non-profit private hospitals cost £1,500. However, this extra £500 entitled him to guaranteed appointment times of his choice, greater privacy, the use of more advanced technology (a removable aircast rather than a fiberglass cast), and intensive physiotherapy, all leading to a faster cure. The insurance company covered the whole of the £500 extra as Mr. Brown had chosen a policy with no excess for expensive hospital treatment – he simply asked the provider to send the bill for treatment directly to the insurer.

Mrs. Brown's widowed mother Mrs. Bishop, aged 65, relies on the state pension and has no other income. She expects to require medical care regularly but cannot afford top-up cover. However, her daughter buys her a comprehensive top-up insurance policy, costing £70 per month. After suffering from arthritis for years, Mrs. Bishop has been told by her specialist that she requires a hip replacement (a 'core' service).

Let us imagine that the price of an NHS hip replacement with rehabilitation costs is £3,000. If Mrs. Bishop chose to be treated at one of the newly independent former NHS hospitals, neither she nor her insurer would have to pay any top-up fees. However, having compared the performance of local providers through her insurer, it is likely that the much shorter waiting list, greater privacy, and the use of slightly more advanced technology at one local non-profit hospital would attract Mrs.

Bishop, despite the fact that the operation would cost £4,000, and the voucher available would only be worth £3,000.

The insurance company would not cover the whole of the £1,000 extra, as, in order to obtain lower premiums, Mrs. Bishop chose a policy with an excess of £300 for all hospital treatment. She cannot afford the £300, but her daughter and son-in-law offer to pay. She decides to go ahead with the operation, because paying £300 out of pocket and receiving treatment almost immediately is preferable to waiting 6 months for treatment and paying nothing, or to paying taxes and spending £4,000 of her savings out of pocket and being treated almost immediately (as was the case before the voucher system was introduced).



4.3 Social Insurance with Individual Payment

We rule out employer payment. We already have a NI scheme with employers and employees making payroll deductions and so it would be administratively simple to introduce a strictly earmarked employment-based health insurance premium. However, there is no serious constituency in the UK for employment-based social insurance. The burden on employers, likely effects on employment levels, and the potential for coverage problems when people move between jobs, all conspire to make this option difficult in the UK.

Swiss social health insurance is not reliant on employer contributions and the scheme is considered to be successful and equitable. Moreover, two countries with employer-based systems are discussing alternatives based on individual payment. In the Netherlands a commission representing employers and trade unions recommended moving towards individual payment¹³, and the newly elected 2002 coalition government decided to go ahead with the majority of suggested reforms.¹⁴ And in Germany some commentators have suggested switching to individually contracted social insurance.

How does the Swiss system work? First, the Federal Government agrees the standard of care that everyone should receive, flowing advice from a number of committees. This 'basic' package has been likened to a luxury policy in the US or Germany. It covers the cost of medical treatment in the canton of residency and includes inpatient and outpatient services, care for the elderly and physically and mentally handicapped, and unlimited stays in nursing homes and hospitals. Non-profit insurers price the same basic package and offer their products to the public. Prices vary and individuals can opt for different levels of cost-sharing, within statutory limits. Insurers must register with and are monitored by the Federal Social Insurance Office. They are obliged to accept all applicants, regardless of medical history. Customers may change insurer twice per year. There were 93 registered insurance funds offering compulsory basic insurance in 2002, some federal, others regional, religious, or occupationally based.

Switzerland experiences the same problems as other developed countries; the most serious being spiralling healthcare expenditure. Although satisfaction is very high across all income groups, care is very expensive and critics of the system say that it does not produce good value for money. As a result, policy makers and commentators are starting to call for a new generation of health care reforms.

Some critics say that the Revised Health Insurance Law of 1996 has great weaknesses and is part of the problem. The law was intended to encourage greater competition amongst both insurers and service providers, not least by promoting alternative health insurance models, but in practice little progress has been made. These critics contend that there are insufficient incentives for efficiency on the part of patients and providers. The more that doctors prescribe and examine, the more they earn. Nor is there an effective incentive for insurance companies to develop much vaunted innovative, lower-cost insurance policies. A major weakness of the Swiss system is that the sickness funds have to contract with all hospitals. Having to pay ‘all willing providers’ prevents them from selecting approved lists of cost-effective or safe, or consumer-friendly doctors or hospitals. This is likely to change, with a shift in the near future towards greater freedom of contract.

An individually contracted social insurance system could be introduced in the UK. Of course, switching everyone over on an appointed day would be complex. The burden on individuals could not be increased abruptly and so income tax (or other taxes) would need to be cut to adjust for the additional costs falling on individuals.

If a social insurance system were introduced, people may wonder what would happen to their existing national insurance contributions (NICs) – payments, which a significant portion of the population incorrectly thinks are largely spent on healthcare.¹⁵ In fact only about 10 percent of NHS funding¹⁶ comes from national insurance – the remainder is from general taxation.¹⁷ In 2000-2001, the mean average NIC per employee was £1,629. In the financial year 2001-2002 total income from NICs was £65,169 billion. Of this amount, roughly 80% of goes towards pension benefits.¹⁸ By contrast, some 11.2% (£7,304 billion) was ‘allocated to’ the NHS.¹⁹

Despite the fact that national insurance plays only a small part in funding the NHS, the introduction of social insurance would require a rethinking of the existing national insurance allocation to the NHS. Some argue that national insurance should be abolished altogether, or at least that there should be no NHS element. Others would like to see the employer’s contribution increased. However, it is unlikely that employers will want to take on an additional burden. These issues are important, but are not likely to be a serious obstacle to the introduction of social insurance.

In order to ensure that the economic burden does not fall disproportionately on the sick, old and poor, premiums must be community rated. In any event, there should be open enrolment and an obligation to accept any customer. A system of risk adjustment (see below) among insurers would also be essential. In time, premiums may vary considerably and we would expect insurers to offer a variety of deductibles, co-payment options, and no-claims bonuses, all serving to increase price consciousness.

Two practical arguments are advanced against moving to Swiss-style insurance. First, it is said that in its use of flat rate premiums Swiss health insurance would weigh more heavily on the poor. At face value this argument seems plausible; however, it ignores the range of exemptions and transfer payments that may be made to spread the burden of contributions. The Swiss system aims to guarantee that the economic burden does not fall disproportionately on the sick, old and poor. One-third of the Swiss receive premium subsidies. Each of the Swiss Cantons decides how to distribute subsidies among their residents.²⁰ One approach is to cap the premium if it exceeds 10% of taxable income; another is to pay on a sliding scale based on income. The very poor effectively have the full premium paid for them so that everyone is an insured customer. Those receiving premium subsidies effectively have a restricted choice of insurer, because the government typically calculates the maximum subsidy as a proportion of the average insurance premium. For example, if an unemployed man receives 90 per cent of the average premium in subsidy, he could choose an insurance package that was twice as expensive, but would still only receive 90 per cent of the average premium. This system encourages those receiving subsidies to be cost conscious. A proposed revision of the 1996 law aims to ensure that insurance premiums paid by households do not exceed 8 per cent of income.

Secondly, as in France, flat fees or a percentage contribution (co-payments) are required for visits to the doctor, up to an annual maximum. A minimum amount is paid by all patients.²¹ Critics feel that these charges weigh too heavily on the poor and sick. For this reason a sub-committee of the national parliament is consulting on how to introduce a means-tested system of out-of-pocket payment, similar to that used for premium subsidisation.

Risk Adjustment Mechanisms

The regulatory framework for health insurance competition is concerned with equity, as healthcare costs are unevenly distributed among men and women, the rich and poor, young and old, the sick and the healthy. Hence, regulators in most European competitive social insurance systems do not allow insurers to charge high premiums to those high-cost individuals. In Switzerland community rating is prescribed, in Germany premiums are income-related, and a mixture of the two operates in the Netherlands.

The result of this regulation is that certain individuals become ‘bad risks’ for insurers. Insurers may then engage in ‘risk selection’, commonly known as ‘cream skimming’, for example, by carefully targeting marketing at young professional couples in an attempt to avoid bad risks and gain a competitive advantage over other insurers. In Germany, the Netherlands and Switzerland, further regulation aims to prevent such risk selection.

Age, sex, and geographical location are generally used in the adjustment formula, and the resulting equalization payments are significant –amounting to roughly a quarter of total premium receipts in Switzerland in 2001.²² Despite these large financial transfers, many experts question the effectiveness of existing RAMs. The risk adjustment mechanism introduced in 1994 in Germany (based on age, gender, and income) was widely perceived as not adequately reflecting the real costs/risks for insurers. Consequently, there has been a continuing debate about how to improve the performance of RAM formulae by improving the predictors of individual utilisation, especially medical history.²³

These concerns led to amendments to the German social insurance system in 2002; including the introduction of a disease management programmes, and the adoption of morbidity-related risk adjustment. It is hoped, the inclusion of morbidity rates will render the present transfer system fairer, thus enabling the currently disadvantaged insurers to compete with the ‘good risk’ insurers on an even footing. The reform is considered even more pressing because, from 2002, all

statutorily insured people (like the privately insured) are free to change insurer at any time.²⁴ If mostly young and healthy people take advantage of this new law, some insurers could be left with ‘bad risks’ only.

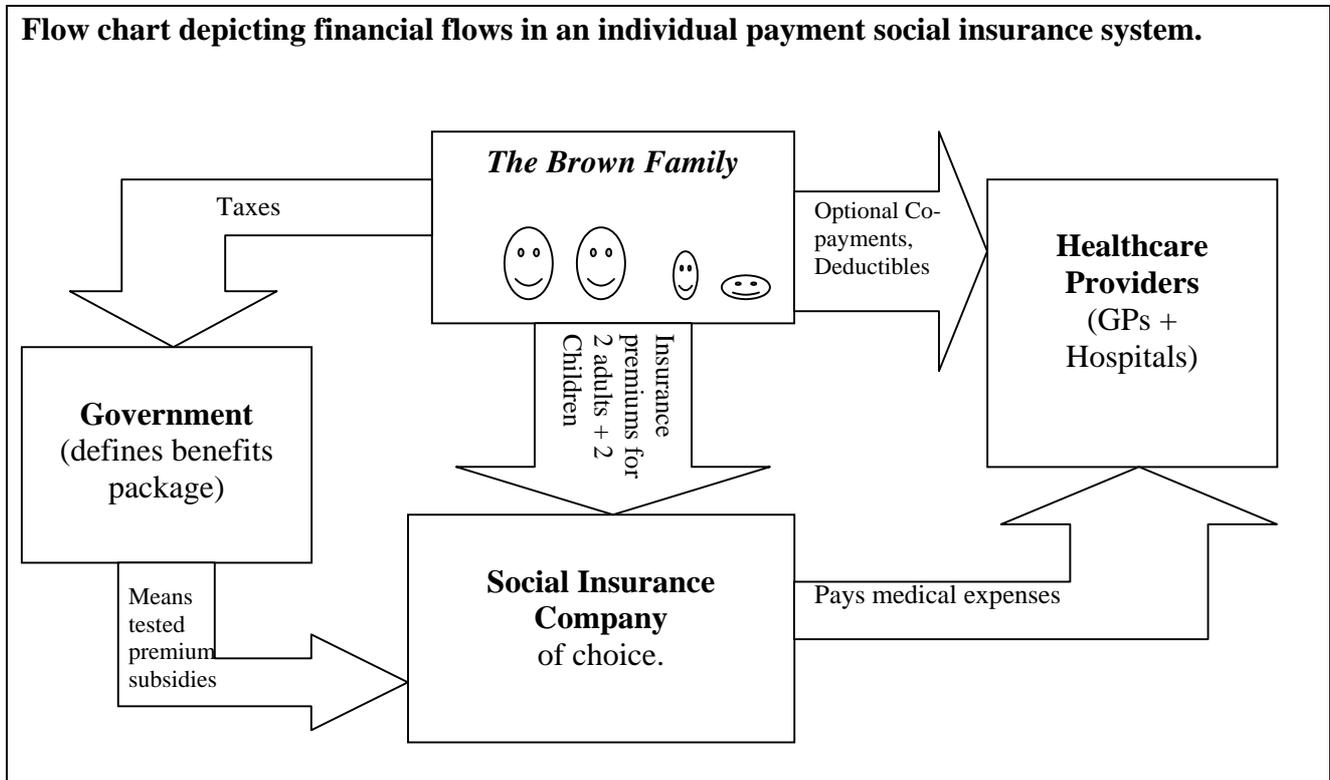
The new risk adjustment mechanism is supposed to not only resolve the financial problems this movement of insurees presently constitutes for the some insurers, but also to render ‘bad risks’ just as attractive as ‘good risks’ so that insurers have an incentive to provide good services for both.

Patient Pathways in an Individual Payment Social Insurance System

Let us look briefly at how such a scheme might affect our hypothetical married couple with dependent children and elderly parents. Using current expenditure on the NHS as a guide (£1,000 per individual per year), we assume the cost of an average insurance policy will be £100 per adult per month – that is £1,200 per year – allowing for extra administration costs and some consumer preference for increased expenditure. (Note that in reality, depending on the number of insurers, we expect premiums to vary significantly, ranging perhaps from £80 to £150+ per month.) We also assume that the premium subsidy threshold is set at 8% of monthly household income. This may seem like a significant portion of monthly income, but the unemployed would also receive higher benefits to take account of their increased healthcare payments.

The Brown family’s annual household income is £35,000. Mr. and Mrs. Brown have separate insurance policies and also must purchase insurance policies for their two children. They are a risk-averse family, who regularly attend a family doctor, and therefore opt for policies with the lowest possible deductible. Their policies cost £100 per month each, while their children’s, through the same insurer, cost £30 per month. Thus the monthly total household premium is £260. With a pre-tax monthly income of £2,917, they are entitled to a small premium subsidy of £27 per month – a fraction over 10 per cent of the total premium ($£2,917 \times 8\% = £233$ (their maximum household

premium); $£260 - £233 = £27$ (the household subsidy)). If the Browns chose a more expensive insurer they would still only receive a subsidy of £27 per month.



As a retired widower on a pension with no earned income and little in savings, Mr. Brown's father benefits from the minimum income guarantee, which gives him a monthly income of about £425. The premium-subsidy rule is that the government will pay the portion of the health insurance premium above 8% of his monthly pension income. With a pension income of £425 per month, he pays £34 per month (8% of x £425) to the insurer of his choice while the government pays a maximum of £66 per month to the same insurer. As a pensioner, Mr. Brown also feels that he benefits from the fact that health insurance premiums are community-rated and therefore do not rise with age.

Although he has free choice of insurer and could change to many with lower premiums, he chooses to remain with the same company as the family has had a policy with them for many years

and considers them reliable and also likes the fact that reimbursement claims are processed quickly. Of course he has no incentive to change insurer on grounds of price, because he will still pay £34 per month. Because he has a low pension income, Mr. Brown's policy has the lowest possible deductible and co-payments. Since the deductible and co-payments are means-tested, like premiums, he does not delay going to the doctor for financial reasons.

4.4 Social Insurance with Consumer Healthcare Purchasing Co-operatives

The chief reason for widespread public support of the NHS is its promise to care for everyone, regardless of income. A system based on purchasing co-ops shares the same ideal but offers, not the equality of the public-sector claimant, but rather the chance for everyone to be a private patient.

First, how would it work for the majority of people in full-time work? And second, how would the poorest members of society be accommodated on equal terms?

At its most basic the system would let people choose to take personal responsibility for their health care costs in return for a tax credit representing part of the tax they have paid for the NHS. They would then be free to purchase insurance to cover the cost of their own care. This would relieve pressure on the NHS and, by creating a more predictable flow of income, give providers a better basis for increasing capacity.

One possibility would be to allow individuals to choose their own insurer one at a time, as in Switzerland. However, there are considerable savings when customers buy insurance as a group. Moreover, insurers will tend to seek customers who are well paid and at low risk of needing health care. Another approach has been suggested by Professor Alain Enthoven, namely for people to buy insurance through health care purchasing co-operatives.

40 Years Experience: The idea is based on a scheme which has been in operation for about 40 years, the Federal Employees Health Benefits Plan, the scheme provided by the US Government for its own employees.²⁵ Every autumn all employees choose their insurance for the next 12 months. They can choose any insurer on an approved list, which has the advantage of weeding out the worst insurers and ensuring that good quality information is made available to allow individuals to make the best choice. Buying as a group also allows members to drive a harder bargain and, in particular,

means that rules can be enforced requiring insurers not to exclude people because of their medical history. The US federal government pays about 70% of the cost of an agreed insurance plan, based on the market price of the choices made in the previous year. Individuals pay the difference between the government contribution and the cost of their chosen plan. This method ensures that everyone has access to reasonable cover without subsidising luxury spending. The full cost of additional cover must be met out of pocket.

Would it work in England?: A transition period will be necessary. The US government pays its employees a subsidy based on the market price of the popular choice insurance plan, but if introduced in the UK, there would initially be no obvious popular choice. Consequently, there needs to be a transition period during which the government contribution is based on the cost of the NHS.

Here is one way it could be done. In each of the 28 strategic health authorities a separate health purchasing co-operative could be established. Initially it could be run by the government on the proviso that responsibility will be transferred to a board representing members, perhaps in the form of a mutual, within two or three years.

To begin with, not everyone will want to change their current arrangements, and so there would be much to gain from allowing individuals to contract-in to the new system one at a time. In addition to accommodating individual wishes, gradual contracting-in would also allow the insurance industry to expand steadily and avoid bottlenecks.²⁶

The purchasing co-op would make available to its members a range of insurance policies offered by competing private insurers. It would aid consumer choice by checking the insurers out and giving independent advice about them – for instance, pointing out which ones have a lot of small-print exclusions. Most important, it would ask all insurers to price the same package of services, so that consumers can easily compare like with like.

As we have seen, the federal employees' scheme is based on the market price of a 'popular choice' plan, but without direct experience of a stable health insurance market it will initially be difficult to determine the basis for the government contribution. The Swiss solution is for the government to define the cover to be provided by the standard insurance plan, but a better alternative would be to allow the price of a standard plan to emerge as a result of consumer choice

and to pay a percentage of it. The government could vary the percentage at Budget time, if the fiscal situation demanded it.

The decision to contract-in to the co-op would be a decision to take personal responsibility for purchasing insurance for all healthcare needs. Taxes will be paid as at present and, to avoid penalising people, the government will need to make a payment to the co-op representing part of the tax paid. Individuals would then be able to choose their insurer and pay any additional cost out of pocket, not direct to the insurer but to the co-op which would make a collective payment to each insurer. This would both reduce administrative costs and increase the bargaining power of individuals.

People in Work: Let us assume that the market price of an insurance policy will be higher than the cost of the NHS (although the impact of competition might constrain any increase). At present the average cost per annum is about £1,000 per individual, or £2,400 for an average household (2.4 people). Under the federal employees scheme there is a family policy and an individual policy (costing about 43% of the family policy). The Swiss method is based on the price per individual, with a price for children under 19 (of about 26% of the adult price) and a price for young people aged 19-25 (of about 67% of the adult price). In our scheme there is a price per adult, with a separate price per child up to 18 (or up to 25, if in full-time education). As in Switzerland, the price of insuring a child is 26% of the adult price.²⁷

We assume that the insurance policy for an individual will cost about 25% above the average cost of the NHS, producing a figure of £1,250 and a cost per child of £325. Here are some simplified examples for people in full-time work.

An individual living alone who decided to contract-in to the purchasing co-op, would receive a tax credit of £1,000 from the Treasury. In this case it is assumed that the aim is to refund 100% of the average cost of the NHS (£1,000), which means that the tax credit will be roughly 80% of the cost of the insurance policy (£1,250). The co-op member would pay the additional £250 out of pocket.

If there were two adults living together, the insurance policy would cost £2,500 and the tax credit would be £2,000.

If there were two adults and one child, insurance would cost £2,825 and the tax credit would be £2,260 (80%). And if there were two children, insurance would cost £3,150 and the tax credit would be £2,520. It would probably be advisable to cap the premium at this point, so that the price is the same for two or more children.

People on Benefits: The main danger is that such a system could operate disproportionately to the advantage of the most well off in society. However, this risk could be avoided by guaranteeing a right to contract out to everyone on equal terms, regardless of income. What would happen to people receiving welfare benefits who would be unable to pay the additional premium? The simplest solution would be for taxpayers to make up the difference. This would mean that everyone would be covered, whether they had just lost their job or were in well-paid work, and whether they were fully fit or frail and elderly.

However, the Treasury would not want any additional costs to fall on the public sector. How could budget limits be met? One approach would be to reduce the percentage rebate paid to self-supporting members of the co-op so that the total cost to the Treasury did not increase. How many people are likely to contract-in to the co-op without being able to pay the additional premium? Currently about 5 million people claim what the Department of Work and Pensions calls 'key benefits' and there are another 4.5 million pensioner couples or individuals who receive half or more of their income from other taxpayers. Let's assume a high take-up rate and that about 10 million people on benefits contract-in to the co-op. If they do not join the co-op they will cost the Treasury on average £1,000 each. If an individual policy costs £1,250 then there is an extra £250 to be found. This sum could be deducted from the Treasury budget allocation for other co-op members who contract-in and pay the personal contribution out of pocket.

For example, if ten million self-sufficient individuals in paid employment contracted-in and bought insurance for £1,250 each, the Treasury would refund £1,000 per person, a total cost of £10 billion. If ten million others on benefits contracted-in, the Treasury would have to find the difference of £250 each, a total of £2.5 billion. This amount could be deducted from the budget allocation (£10 billion) for the self-paying group, leaving a balance of £7.5 billion. This would produce a percentage tax credit of about 60% of the insurance premium (£1,250) or 75% of the average cost of the NHS per person. Thus, an individual in paid work and living alone would

receive a tax credit of £750 and a couple with two children would receive a tax credit of £1,890 (60% of £3,150).

Low income: So far we have been working with two categories: people who are self-sufficient and people who are in receipt of benefits. In practice there are varying degrees of self sufficiency and any cash transfer from the Treasury to the co-op would need to be paid on a sliding scale, according to income, with an upper limit – perhaps based on a formula applied in parts of Switzerland, namely that no one should have to spend more than 8% of taxable income on health insurance.

A scheme along these lines would be a more genuine exercise in social solidarity. Everyone would be empowered and the self-sufficient majority would bear the direct cost of providing universal choice. At present the claims that the NHS is financed equitably are an ethical fig leaf for public sector monopoly, not genuine support for universal access.

After three years: In the first three years of the scheme individuals could opt to join the co-op and receive a credit based on the cost of the NHS. In subsequent years it would be better to base the payment on the cost of a standard insurance plan that emerged from competition. At first, the tax credit could be 70%, as under the federal employees' scheme, subject to variation at Budget time to allow the Treasury to maintain fiscal control.

Treatment: Where would people go for treatment? Often it would be necessary to use NHS hospitals until more capacity had emerged. In such cases, hospitals would charge insurers, as many already do for private patients. There would no necessity to see a GP before going to see specialist, and people who chose to see a GP would pay a fee agreed with insurers.

Conclusions: It is of fundamental importance that the majority of people should pay the market price for health insurance, to provide a measure of what can be afforded for the poor and to permit demand and supply to come into balance. A price mechanism allows consumer expectations to be realistic. It has been traditional to speak of medical need as if it were technically defined by experts. But personal medical care resembles many other consumer goods. Many economists regard it as a 'luxury good' because as we grow wealthier we tend to want more of it, unlike basic goods such as

water or sliced bread. Because it is partly a matter of personal preference, it is appropriate for people to be price conscious.

At the end of the year there would be a risk adjustment process within each purchasing co-op to ensure that some insurers were not gaining advantage by avoiding high-risk subscribers. The aim of the formula would be to ensure that the income received by each insurer matched the average risk of all members of the co-op. It would mean that insurers whose subscribers had a below-average risk of ill-health would lose income and those with an above-average risk would gain.

Once established we will effectively have two types of NHS membership: ‘mutual members’ (who have chosen to join the co-op) and ‘ordinary members’ who have taken no action. In the long term we expect mutual members to outnumber ordinary members, not only because they will have more control over their own affairs but also because the mutual principle provides a more open and transparent form of social solidarity. All who choose the co-op will do so, knowing that they are simultaneously assuming personal responsibility for their own insurance but also taking personal responsibility for ensuring that cover is extended to all.

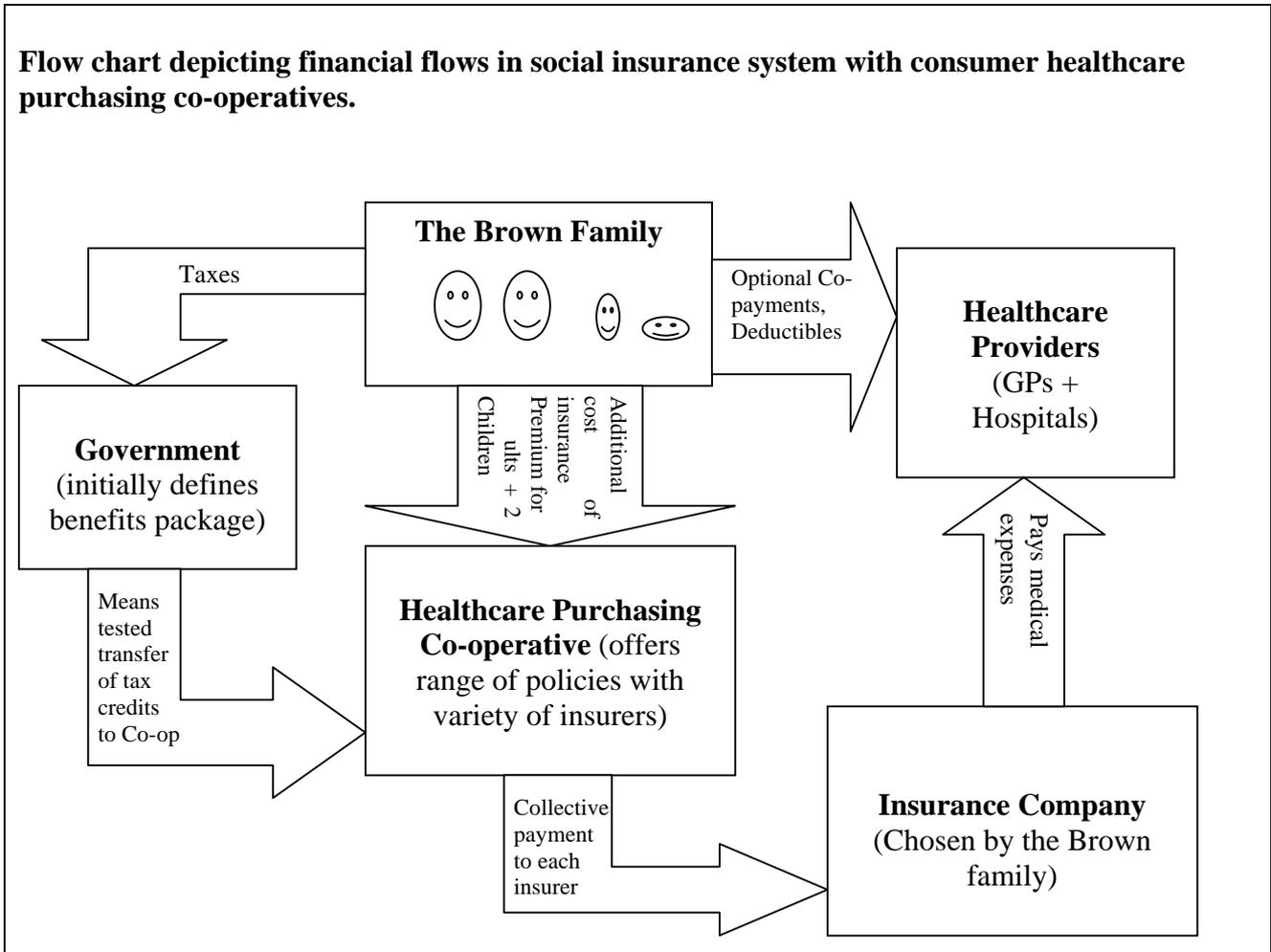
The overall advantages of the scheme are:

- People content with the current system need to take no action at all.
- Equity would be satisfied, not by reducing everyone to the status of a claimant, but by empowering every person to be a private patient.
- Individuals would buy insurance in groups to increase their bargaining power.
- The purchasing co-op would be able to supply useful information to enable members to choose the best providers and thus encourage standards to be raised.
- Heightened competition between insurers would encourage them to seek good value for money from providers (perhaps by integrating provision and finance).

Patient Pathways in a Healthcare Purchasing Cooperative Social Insurance System

Although we have already seen some simplified examples of how a healthcare purchasing co-operative insurance system might work, we now look at how it might affect our hypothetical

married couple with dependent children and elderly parents? We assume that the average premium for the standard package is £1,250 per adult and £325 per child per year.



Seeing the benefits of improved choice, speedier access to care and impartial advice on purchasing insurance, Mr. and Mrs. Brown decided to contract into the co-op system and take personal responsibility for purchasing insurance for all their family's health care needs. Every autumn they must choose their health insurance policy for the following year. The local healthcare purchasing co-op sends a document to every household in September. This document details the range of insurance policies offered by competing private insurers that meet the criteria of the co-op.

The Brown family's annual household income is £35,000 (£2,916 per month). They pay taxes on this amount just as they did before the new health insurance system was introduced. With two children, the household health insurance costs £3,150. They receive a tax credit of about 60%

of the insurance premium (£1,250) or 75% of the average cost of the NHS per person; their tax credit would amount to £1,890, which the government transfers to the co-op. That leaves an extra £1,260 per year (£105 per month) to pay out of pocket, not direct to the insurer but to the co-op, which in turn makes a payment to the insurer. The Browns know that by paying this £1,260 they will both empower themselves and subsidise those on low incomes. If their income fell below £15,750 and a rule limiting their contribution to 8% of their income applied, they would receive a subsidy; if it fell to £12,000 a year, they would have to pay only £960 and if it fell to £10,000, only £800.

Mrs. Brown's mother, Mrs. Bishop, a retired widow on a pension and with no earned income, chooses her health insurance policy for the following year every autumn. Just like her daughter, Mrs. Bishop often uses the co-op's telephone helpline to gain independent advice. As a single person on benefits, the government pays the co-op the full cost of £1,250. Mrs. Bishop has the same opportunity to choose an insurer or a provider as her daughter's wealthier and totally self-sufficient family.

5. GLOSSARY²⁸

- Community Rating:** The opposite of risk rating, community rating means that all members of an insurance pool pay the same premium regardless of individual risk. Thus, risk is pooled across the whole community. In Switzerland, everyone insured with a given insurer in a given geographical area, pays the same amount – a ‘flat-rate’.
- Co-payment:** See ‘User Charges’.
- Core package:** The phrase core package is used to denote a bundle of medical benefits that are usually deemed medically necessary and that would be guaranteed by the government.
- Deductible:** Phrase in common use in the USA. See ‘Excess’.
- Excess:** Amounts required to be paid by the insured under a health insurance contract, before benefits become payable.
- Gatekeeping:** A system whereby access to specialist and or hospital care is controlled by GPs or ‘family’ doctors. Such a system has two main aims: cost control and guidance to appropriate care providers.
- Group Rating:** Common in the US, group rating is related to community rating and means risk is pooled across, for example, the whole staff of a company or membership of a trade union.
- Income Related Premiums:** Common in social insurance systems, and usually referring to earned income, premiums are expressed as a percentage of income rather than as a fixed monetary amount. For example in Germany premiums average c. 13.5, paid 50/50 by employer and employee. See ‘proportional’.
- Open Enrolment** Under open enrolment, the insured are able to leave one insurer and to join another. Certain time restrictions usually apply.
- Obligation to Contract:** Insurers must accept all applicants.
- Out-of-Pocket Payments:** See User ‘Charges’
- Progressive:** In a progressive system, the rich pay a larger fraction of their income than the poor. Opposite of regressive.
- Proportional:** System such as that in France where premiums are expressed as a proportion of income and are not subject to a contribution ceiling.
- Regressive:** Term used in relation to funding mechanisms to describe a system that weighs more heavily on the poor than the rich. That is, the poor pay proportionately more of their income on health care than do the rich. (See ‘Proportional’, ‘Progressive’, and ‘User Charges’).

- Risk Adjustment Mechanism (RAM):** In a competitive and regulated insurance market, RAMs are used to prevent insurers engaging in cream-skimming/risk selection. Age, sex, and geographical location are generally used in the adjustment formula. There is a continuing debate about how to improve the performance of the RAM formula. Previous medical expenditure or death, are often suggested.
- Risk Rating:** The calculation of insurance premiums according to the risk profile of an individual – taking into account, age, gender, medical conditions and so forth.
- Social Insurance:** First introduced by Bismarck in the 1880s, social insurance is a social security system model under which insurance funds may be independent from government.²⁹ Normand and Busse note that social health insurance has two crucial characteristics. Firstly, the insured pay regular, usually wage-based (i.e not related to risk) contributions. Secondly, independent quasi-public bodies act as the main managers of the system and as third party payer. Beyond those two characteristics, several other features are commonly found in social health insurance systems.³⁰
- Third Party Payer:** A public or private body that receives taxes or social insurance contributions and transfers them to healthcare providers. The patient is the first party payer while providers are the second party payers.
- User Charges** Otherwise known as cost sharing or out-of-pocket payments. These payments are highly regressive³¹, and are usually designed to regulate the behaviour of patients. Rubin and Mendelson,³² distinguish between *direct* cost-sharing and *indirect* cost-sharing). Direct cost-sharing includes co-payment (a flat fee or charge per services e.g.£10), co-insurance (a percentage of the total charge), deductible (a payment covering the first X currency units before insurance coverage applies) and balance billing (an additional fee the provider levies in addition to the payment received from the third party payer). Indirect cost-sharing refers to policies that can result in out-of-pocket payment by patients even though charges are not directly imposed. Rubin and Mendelson³³ include excluded treatments, generic substitution and positive/negative lists in this category.
- Voluntary Health Insurance: (VHI)** Private health insurance terminology is not standardised. This can cause much confusion when discussing the various forms of VHI. Mossialos and Thomson use the following definitions. **Substitutive VHI** substitutes for cover that would otherwise be available from the state (eg Germany, Belgium and the Netherlands). **Complementary VHI** provides cover for services excluded or not fully covered by the state, including cover for co-payments imposed by the statutory health system (eg. France). **Supplementary VHI** cover provides faster access and increased consumer choice.³⁴ Though convenient distinctions, there are often grey areas and overlaps between forms of VHI. For this reason, we use only two terms: **substitutive VHI**, and **supplementary VHI**.

6. HEALTH POLICY CONSENSUS GROUP CONSENSUS STATEMENT

As the NHS Plan begins: “The NHS is the public service most valued by the British people”. But as it goes on: “Despite its many achievements, the NHS has failed to keep pace with changes in our society”. The public now clearly feels that the NHS does not live up to its expectations — a truth that politicians recognise across the political spectrum, but which they refuse to acknowledge publicly.

Rationing, waiting times, delays in introducing innovative technologies, the poor state of many facilities, shortages of doctors, nurses and equipment and a lack of choice all combine to mean that the NHS fails to provide its most basic requirement – universal access to a standard of care that is taken for granted in other comparable countries.

But although there is now widespread agreement about the NHS’s deficiencies, there is no corresponding consensus about the changes necessary to improve health care in Britain. Thoughtful debate on health policy in the UK is paralysed by party politics. The purpose of the Health Policy Consensus Group is to encourage a new cross-party consensus by suggesting a series of guiding principles that will assist policy makers and members of the public in considering how to move towards a responsive, consumer-driven and high quality healthcare service.

GUIDING PRINCIPLES

The key to reform is to put the patient first. All else stems from this concern.

ACCESS FOR ALL

The basic building block of any reform must be ready access for all patients to a government guaranteed high standard of care. Every country is wrestling with how to achieve this end, and many have discovered alternative methods which have secured a more responsive and demonstrably

higher quality service than that provided through the NHS. None provide a ready-made blueprint but we should be willing to learn from their experiences.

The success of any alternative model will depend on its ability to deliver a standard of care to everyone that is markedly superior to that available today through the NHS.

CHOICE & DIVERSITY

Public sector monopolies make it hard even for well-motivated staff to put patients first. As the NHS Plan puts it: “The relationship between service and patient is too hierarchical and paternalistic. It reflects the values of 1940s public services.....The patient’s voice does not sufficiently influence the provision of services”. Staff frequently find that they cannot provide the service they would like. As in almost every walk of life, consumer choice is an essential tool for improving standards of healthcare, the relationship between clinician and patient, and professional autonomy.

A system based upon genuine consumer choice would generate a more attractive range of options for health coverage, available to a wider range of people. Diversity is, of itself, a spur to innovation and improvements in standards. If the existing public sector near-monopoly of healthcare provision were to be ended, a diverse mix of government, private not-for-profit and for-profit healthcare services would be generated, reinvigorating the under-developed health sector of civil society. Health policy should leave communities free to experiment with different funding solutions and public-private partnerships for providing health care, utilising local resources to solve unique community problems.

In order to develop a more responsive service, government policy should be to expand, without dictation or distortion, the opportunities for everyone to make responsible choices in both the financing and provision of their medical care.

FUNDING

The NHS is funded predominantly from general taxes. Typical overseas systems rely on a mix of social or private insurance, out-of-pocket payment and general, local or hypothecated taxes. We should be open-minded and willing to examine other systems to see what we can learn from them.

We take it as axiomatic that all members of society should enjoy access to a higher standard of care than is generally provided by the NHS and that, consequently, a guaranteed package must be defined and made available to everyone from taxes. But health care should not be funded by taxation alone. For care over and above the state-guaranteed package, individuals should be free to spend their own earnings as they believe best.

7. ENDNOTES

¹ In addition, there are five 'Care Trusts', two of which are based on Mental Health Trusts, and three of which are based on PCTs (source – NatPaCT – the National Primary and Care Trust Development Programme, November 2002).

² On July 1 2002, almost 2000 heart patients who had been waiting six months for an operation became eligible to choose to be treated elsewhere in the NHS or in the private sector. As part of a pilot, the same choice has been extended to Londoners waiting more than six months for cataract surgery. By early 2003 Londoners waiting for orthopaedic operations, ear, nose and throat treatment, general surgery and other specialities will be able to exercise similar choice. On 3 October 2002, Alan Milburn said that if these pilots are successful, choice will be extended to other parts of the country." In a speech on 23 January 2003, the Prime Minister confirmed Alan Milburn's statement saying 'I can announce today that from this summer, we will extend this scheme to cover almost all elective surgery in London. And from summer next year these choices will be offered to all elective surgery patients nationwide.'" Note, patients will continue to have very limited choice of GP.

³ They are not mutually exclusive.

⁴ Lea, R., *Health Care in the UK: The Need for Reform*. Institute of Directors, Policy Paper, 2000.

⁵ The voucher scheme outlined here is but one of many options.

⁶ See 'Provision of Health Services' on page 8.

⁷ It is very likely that some cosmetic procedures would be core services – such as those for burns.

⁸ Further detail on defining the 'core' service can be found in Lea, 2000.

⁹ Lea, R., *Health Care in the UK: The Need for Reform*. Institute of Directors, Policy Paper, 2000.

¹⁰ In the short term, choice is dependent on level of supply.

¹¹ Shadow Health Secretary, Liam Fox MP, announced a voucher scheme in all but name during their September 2002 party conference. The Conservatives appear to be impressed with the Australian and Finnish systems of incentivising private health care and private insurance, as a means of getting more money into the healthcare system.

¹² In time, top-up insurance for private GP services provided alongside existing GP services may develop. If such policies did emerge, they are more likely to be along the lines of flat-rate capitation based cover, like that for dental services in the UK, rather than cover for individual fees.

¹³ Sociaal Economische Raad. Naar een Gezond Stelsel van Ziektekostenverzekeringen [Towards a sound system of health insurance]. Den Haag: SER; 2000.

¹⁴ Maarse, H., 'Health Insurance Reform (again) in the Netherlands: will it succeed?' *Euro Observer*, Newsletter of the European Observatory on Health Care Systems, Volume 4 Number 3.

2002.<http://www.euro.who.int/Document/Obs/EuroObserverAutumn2002.pdf>

However, following the collapse in mid-October of the coalition government, it remains to be seen whether radical reforms will be implemented.

¹⁵ National Insurance Contributions paid by employees and employers are related to employee income and so are like a direct tax. The contributions are largely paid to the National Insurance Fund (NIF) and build entitlement to benefits. Contributory benefits include retirement pension, widow's pension, maternity benefit, job seeker's allowance and incapacity benefit. These benefits and their administration are paid for out of the NIF. Many other benefits such as those for disability and support for dependent children are funded from general taxation and are not dependent on contributions.

¹⁶ Expenditure on health amounted to 17% of total government tax receipts in 1998 (www.inlandrevenue.gov.uk/education/education4.htm - accessed on 10 October 2002). According to the OECD Health Data 2002, public expenditure on health accounted for 14.8% of general government total outlays in 1999. The average expenditure per individual on the NHS was £1000 in 2002.

¹⁷ National Insurance is charged at 10% for employees (with a non-contributory allowance and maximum payment threshold) and 11.8% for employers – soon to be raised to 11% and 12.8% respectively following Gordon Brown's latest budget, with the extra 1% being strictly allocated to the NHS. In 2000-01, employers contributed 58% while employees paid the balance. The Social Security Administration Act 1992, says (s.162 (1)) 'Contributions received by the Inland Revenue shall be paid by them into the National Insurance Fund after deducting from contributions of any class, the appropriate national health service allocation in the case of the contributions of that class.' S162 (5) defines the appropriate NHS allocation: Primary Class 1 contributions – 1.05% of contributions; Secondary Class 1 – 0.9%; Class 1A – 0.9%; Class 1B – 0.9%; Class 2, 15.5%; Class 3, 15.5%; Class 4, 1.15%. In 1999 combined employee and employer NIC contributions amounted to 22.2% of income. Of that, 1.95% of income was 'allocated' to the NHS. The Treasury insists that the NHS allocation does not simply go into the general tax pool.

¹⁸ According to the most recent Government Actuary's Quinquennial Review of the National Insurance Fund. Daykin, C., *National Insurance Fund Long Term Financial Estimates*, Report by the Government Actuary's Quinquennial Review of the National Insurance Fund, Government Actuary's Department, 1999. (Page 11.)

¹⁹ Daykin, C., Report by the Government Actuary on the Drafts of the Social Security Benefits Up-Rating Order 2002 and the Social Security (Contributions) (Re-Rating and National Insurance Funds payments) Order 2002.

²⁰ Decentralization of political power is marked in Swiss Confederation. Since they grouped together to form a Confederation in 1848, each of the 23 cantons (three of which are divided into two half-cantons) has had its own unicameral parliament, own executive (government), own constitution and own courts. Parliaments vary in size between 58 and 200 members, while cantonal governments have 5, 7, or 9 members. Cantons act autonomously in the organisation of healthcare in their area, administration is organised as each canton wishes (Minder, Amiet, *Health Care Systems in Transition, Switzerland*, European Observatory on Healthcare, 2000; and Federal Chancelry, *The Swiss Confederation a brief guide 2001*) Local supervision of healthcare is the responsibility of cantonal health ministers. The result is 26 slightly different systems (WHO, 'Highlights on Health in Switzerland', World Health Organisation, 2001).

²¹ For details of user charges (otherwise known as cost sharing or out-of-pocket payments), usually designed to regulate the behaviour of patients, see: Rubin, R. and Mendelson, D. (1995) A framework for cost sharing policy analysis, in N. Mattison (ed.) *Sharing the Costs of health: A Multi-county Perspective*. Basle: Pharmaceutical Partners for Better Health.

²² Many argue that the RAMs are anti-competitive and stifle innovation. For example, the Swiss RAM mechanism has been blamed for hampering the development of lower cost managed care (HMO)s., by effectively penalising insurers who offer such innovative less costly products, as they tend to attract a cost conscious younger clientele. Felder finds that for both sexes the age classes between 26 and 40 are highly over-represented within HMOs. The number of HMO patients, decreases with age for both men and women.²² Felder (Felder, S., *Risk Equalisation Schemes, Competition, and Welfare*, ISMHE, Magdeburg, 1999), supported by Beck and Zweifel (Beck, K., Zweifel, P., 'Cream-skimming in deregulated social health insurance: evidence from Switzerland.', in Zweifel, P., *Health, the Medical Profession and Regulation*. 1998) notes that as HMO patients are generally younger (mean) than the population in the corresponding area, HMOs are as a whole net-payers to the Risk Adjustment Mechanism. Thus RAM increases the premiums of HMOs. Since the cost of medical treatment of the patients is lower (one third lower than average), RAM distorts premiums. The cost share of RAM for men is much higher than that for women. In three HMOs RAM payments exceeded 50 per cent of total costs.

²³ Breyer, F., *Identifying Determinants of Health Care Utilization in a Large Panel Data Set of German Sickness Fund Members - with Application to Risk Adjustment*, Paper presented at the 3rd International Conference in Health Economics, July 22-25, York.

²⁴ On condition of notification two months prior to change, and subject to an obligation to stay with new insurer for at least 18 months.

²⁵ For further details, see: *The 2001 Guide to Federal Employees Health Benefits Plans*, United States Office of Personnel Management, 2000.

²⁶ It is assumed that enough fit and healthy people will opt for the cooperative scheme. The system proposed would not be sustainable if people with illnesses or of high risk and low income disproportionately took out the insurance leading to anti-selection, owing to unacceptably high costs.

²⁷ This figure is based on Civitas calculations using premium data published by the Swiss Federal Social Insurance Office (see, BSV, *Primes 2002, CH*. 2001).

²⁸ For a comprehensive overview of healthcare funding mechanisms, see: Mossialos, E., Dixon A., Figueras, J. and Kutzin, J.,(eds.), *Funding health care: options for Europe*, European Observatory on Health Care Systems, 2002.

²⁹ Bodenheimer, T. and Grumbach, K. 'Financing universal health insurance: taxes, premiums and the lessons of social insurance', *Journal of Health Politics, Policy and Law*, Vol. 17, No.3, 1992, pp. 439-462.

³⁰ Normand, C. and Busse, R., 'Social health insurance financing', in Mossialos, E. Dixon A., Figueras, J. and Kutzin, J. (eds.), *Funding Health Care: Options for Europe*, European Observatory on Health Care Systems, OUP, 2002.

³¹ Wagstaff, A. van Doorslaer, E. *et al.*, 'Equity in the finance of health care: Some further international comparisons', *Journal of Health Economics*, Vol. 18, 1999, pp. 263-290. Also see Wagstaff, A, Van Doorslaer, E., 'Equity in the delivery of health care: methods and findings', in Wagstaff, A. and Van Doorslaer, E., and Rutten, F., *Equity in the Finance and Delivery of Health Care: An International Perspective*, Oxford: Oxford University Press, 1993.

³² Rubin, R. and Mendelson, D. (1995) A framework for cost sharing policy analysis, in N. Mattison (ed.) *Sharing the Costs of health: A Multi-county Perspective*. Basle: Pharmaceutical Partners for Better Health.

³³ Rubin, R. and Mendelson, D. (1995) A framework for cost sharing policy analysis, in N. Mattison (ed.) *Sharing the Costs of health: A Multi-county Perspective*. Basle: Pharmaceutical Partners for Better Health.

³⁴ Mossialos, E., and Thomson, S., *Voluntary Health Insurance in the European Union*, European Observatory on Health Care Systems, 2002.