

*Adam Smith Institute*

# **PARTNERSHIPS FOR BETTER HEALTH**



## **FUNDING UK HEALTH CARE Innovation to avert a crisis**

### **Key Points**

- **The UK system of financing health care through taxation is now unique in the world.** Virtually all other countries have moved towards mixed systems, which combine equity with commercial incentives.
- **Tax funding alone will not give us world class health services.** Despite big budget increases in the past, NHS facilities and services remain shocking by European standards. Taxes equivalent to a VAT rate of 27% would be needed to match the spending levels of our Northern European neighbours.
- **Tax funding cannot keep pace with the upward pressures on the cost of health care.** People resist tax rises because they fear the extra money will be lost in the general pot, or wasted within a politicized system that is unresponsive to their individual needs. But without structural change, private spending will not fill the gap.
- **The European social insurance models channel much larger sums into health care, and deliver a better service with significantly higher levels of patient satisfaction.** Europe's sensitively structured copayments systems encourage patients to be more responsible users of health care and generate additional revenues that can be ploughed back into essential services.
- **The UK too should take note of the world's experience and move towards the mixed funding model.** It should adopt compulsory social insurance in which people can choose between different funds that can vary the service they provide around guaranteed access to a comprehensive healthcare package
- **This arrangement will preserve equity, the greatest strength of the NHS.** It will also increase transparency, provide choice, empower users, spur innovation and attract new spending into health care. It is compatible with private insurance, through which choice could be extended even further.

## Summary

The NHS budget faces increasing pressures. Ageing populations, rising patient expectations and new technologies will all continue to add to the demands placed on health care expenditure.

Yet despite a number of attempts to “reform” the NHS over 50 years, *no serious attempt has ever been made to examine the sustainability of NHS funding. Governments have never publicly questioned whether the funding of health care in the UK will be able to keep pace with our rising demands. The experiences of other countries on this question have been dismissed as irrelevant.*

But we can only keep our heads in the sand for so long. The traditional response to funding crises has been to give the NHS “unprecedented increases” in resources—something which has happened many times in the NHS’s history. What politicians have failed to admit is that three, four or five per cent increases in real NHS expenditures have not broken the cycle of winter crises and waiting lists. *Patients still get a raw deal, facing geographic differences in the services they are entitled to and often being treated in run-down facilities by an organisation that is unresponsive and indifferent to the views of its users. No wonder that satisfaction levels with health services are far lower than in many European countries. Surely it is time to take a more imaginative look at how the financing of UK health care could evolve.*

This paper shows that *the UK cannot rely on tax funding alone to provide it with a world-class health care system. Public expenditures simply cannot keep pace with rising demands, and within the current system we cannot rely on private expenditures to make up the shortfall. More fundamentally, it is clear that a tax-financed health system will never be able to give the UK public the health system it deserves. A system where central management sends out 700 circulars of instructions and guidance a year to health professionals and managers will never focus on the patient. NHS management and providers are looking inwards and upwards to the NHS Executive and not outwards and downwards towards patients. Such a large, centrally managed and bureaucratic system simply will not be responsive to the views and demands of patients and the public.*

The UK health care funding system is now almost unique in the world: other countries are moving to a much more mixed system, and we should too. Specifically we need a system that will maintain equity, introduce choice, increase

transparency, promote individual responsibility for health and bring in private expenditures to supplement public money. This means that *the UK must move to a pluralistic insurance-based system, along the lines of that used by many of our European partners. These systems retain the NHS’s key strength of equity but introduce flexibility for achieving many other benefits—as evidenced by the high levels of satisfaction reported by their users. Most importantly, their transparency and choice encourages additional resources into the health system, which simply will not happen within the existing NHS.*

This is not to suggest that a move to pluralistic funding should happen in one go. But there are a number of steps that could be taken to move us in the right direction. For example, *better use be made of copayments: sensitively structured, these need not harm equity and will encourage the more responsible use of health services. By deterring the unnecessary use (and abuse) of healthcare services, and by raising revenues, they will release monies that can be targeted on funding a comprehensive set of health services.*

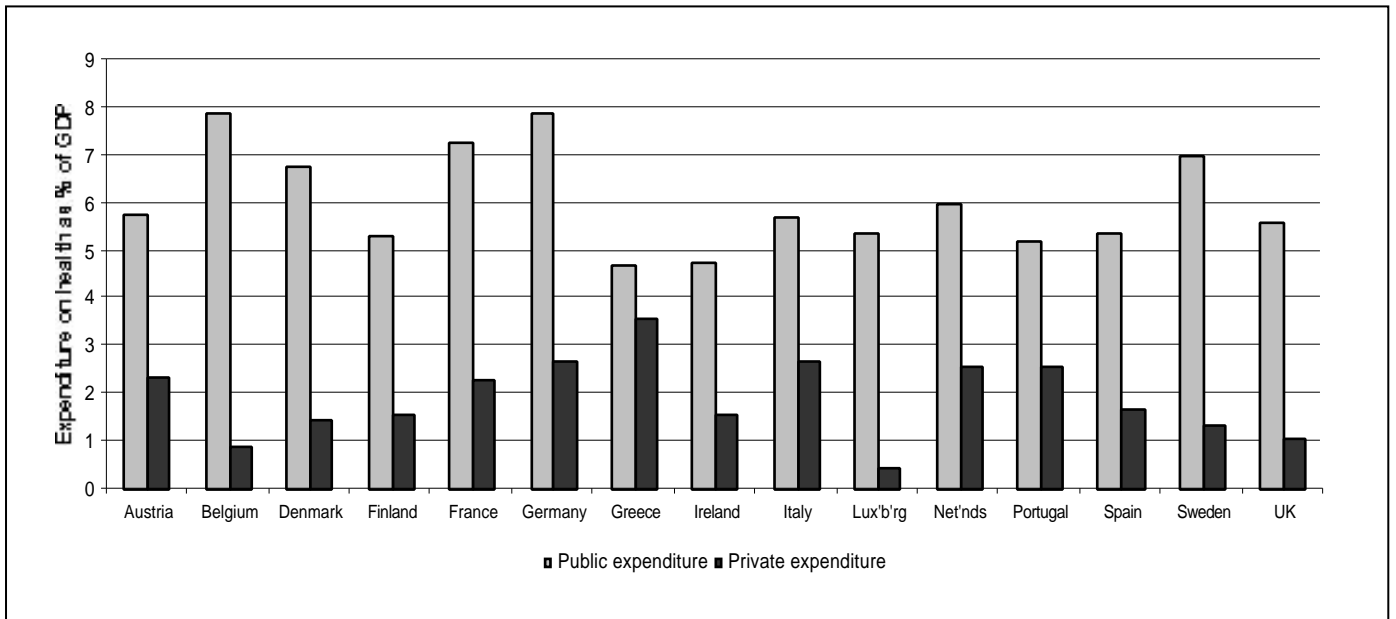
Moreover, immediate steps could be taken to improve transparency and increase choice. More could be done to encourage the use of private insurance and out-of-pocket expenditures within the current system, which would ease the pressure on NHS resources and would be a useful test of the public’s response to greater choice. This should be accompanied by greater transparency in determining what will and what will not be provided by the NHS. Transparency of this type is central to our proposals. An immediate benefit is that it will allow individuals to make informed choices about the sorts of private insurance or savings plans that they might purchase.

Of course, further work is required to develop these proposals. Over the coming months, the ASI will embark on a work programme to build on the ideas, including detailed analyses of the structure and relationships of an insurance-based system and a plan for moving towards it.

## Why is the rest of the world out of step with us?

Before looking at ways of improving the financing of UK health care, it is first sensible to set out a few simple facts that demonstrate why the current system of funding is unsustainable.

**Figure 1**  
**Comparison of Expenditure on Health as % of GDP, EU Countries 1998**

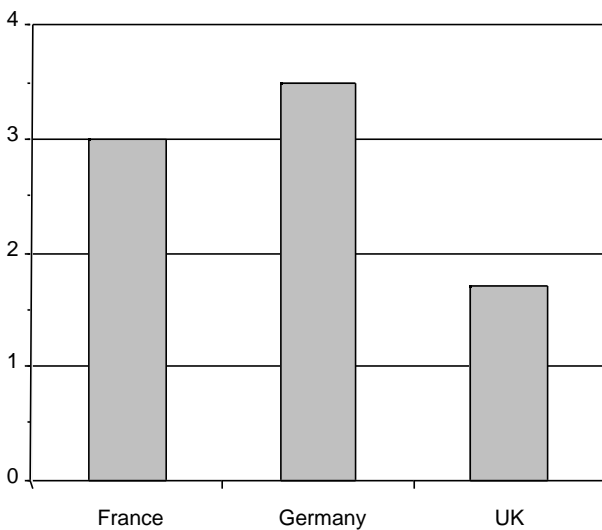


Source: OECD Health Database 2000

Figure 1 is a common way of illustrating levels of health expenditure in the UK and comparing them to those of our European partners. It compares expenditure on health as a per cent of GDP in 1998, shown separately for public expenditures (shown in grey) and private expenditures (shown in black).

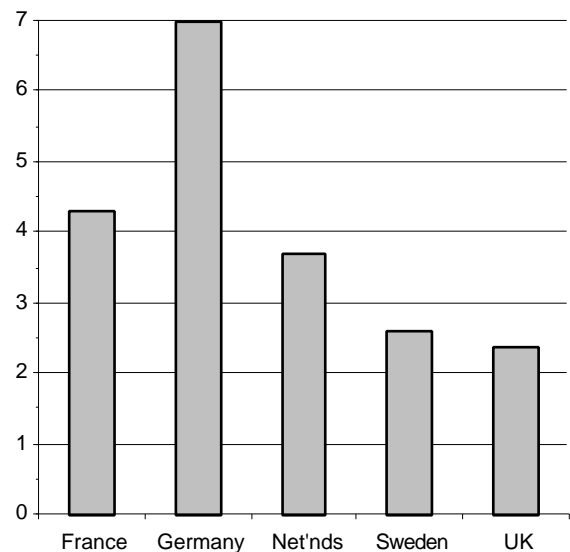
Note particularly the expenditure levels of the UK, which are shown on the far right of the chart. The message is really quite straightforward. As a per cent of GDP, the UK's public expenditure on health care is low, particularly if the Southern European countries are excluded from the comparison. Compared to the Nordic countries, France, Netherlands and Germany, the UK has the lowest public expenditure on health relative to its GDP.

**Figure 2**  
**Practising Physicians per 1000 population, 1998**



Source: OECD Health Data 2000

**Figure 3**  
**Acute Care Beds per 1,000 Population**



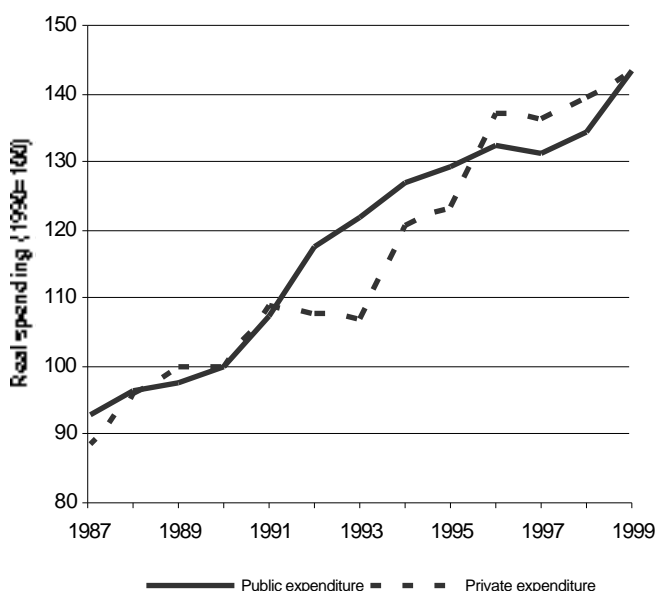
Source: OECD Health Data 2000

This is reflected in the level of inputs to the health system, as Figures 2 and 3 illustrate. They show the number practising physicians and the number of acute care beds per 1,000 population for selected EU countries in 1998. (The countries have been selected on the basis of data availability and of having health systems that the UK might aspire towards.) On both these measures, and many others, inputs into the UK's health system are low.

Of course our public expenditure levels might be less important were the shortfall being made up by private expenditures. However, this is clearly not the case, as Figure 1 demonstrates.

Out of the 15 EU countries, the UK has the 13<sup>th</sup> lowest level of private expenditure, measured as a share of total health expenditures. According to the OECD, in 1998 only 16 per cent of the UK's total health expenditure (equivalent to 1.1 per cent of the UK's GDP) was drawn from private expenditures—a strikingly low figure, especially given that our total health expenditure is already very low (i.e. private expenditure is a low share of an already small pot).

**Figure 4**  
**Trends in Real Public and Private Health Expenditures in the UK, 1987-1999**  
(1990=100)



Source: OECD Health Data 2000

Looking at expenditures in any one year might of course paint a misleading picture. If private expenditures were increasing over time, and their share of total health expenditure were rising in the UK, then we might be less concerned about our low levels of spending: private spending would gradually increase to

make up the shortfall. Unfortunately this is not so. Figure 4 graphs public and private spending on health in the UK measured in real terms from 1987 to 1999. The data are presented as an index, with 1990 set equal to 100.

Again, the message is a simple one. Increases in private expenditure on health have kept pace with public expenditures but have not exceeded them. If one looked further back, for example to the mid-1970s, then the picture would be somewhat different, showing that private spending's share of total health spending has grown over the last 25 years or so. But over the last decade the private share of total spending has stayed remarkably constant, fluctuating between 14 and 16 per cent. On current trends we cannot count on a large increase in private expenditure.

### Public spending won't save us

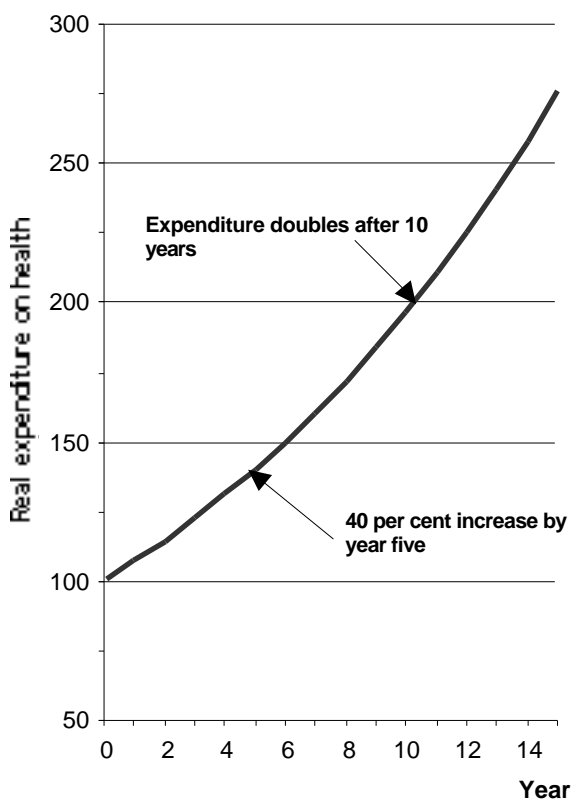
So why does this public/private spending balance matter? If demands on health resources continue to grow, why don't we just increase public expenditures to ease this pressure?

Unfortunately, to rely solely on public spending increases is not really a credible solution, particularly over the longer term. In early 2000, the Prime Minister indicated an ambition to increase levels of total UK health expenditure to match the European average by 2006. This received a lot of attention at the time about precisely what the commitment meant. The government has interpreted it as around 8 per cent of GDP, taking a simple average of spending levels in the EU. But if these spending levels are weighted to reflect the size of different countries the figure comes out higher, at around 9 per cent of GDP. Furthermore, if we include only those countries with health systems that the UK might aspire towards (and exclude the systems in, for example, Southern Europe, because they are not the quality health systems that the UK should be aiming for), the target figure is even higher, at around 9.7 per cent of GDP. But rather than getting bogged-down in definitions, a simple look at some key facts highlights the problems.

It has been estimated that reaching EU levels of spending by 2006 (of about 9 per cent of GDP) will require real increases in NHS spending equal to 9.7 per cent a year from 2000-1 to 2004-5.<sup>1</sup> In March 2000, the first steps towards this target were announced when the government committed itself to increasing the NHS budget by 6.1 per cent per annum in real terms over the next four years.<sup>2</sup> This is a significant increase.<sup>3</sup>

But are these sort of increases sustainable in the longer term? Figure 5 illustrates how much the health budget would increase over the longer term if expenditure were increased by only 7 per cent in real terms per annum (well below what we would need to match the European spend). Figure 5 shows how much a budget of £100 would increase over the next 15 years. Within 5 years the budget will have increased by 40 per cent (in real terms) and within 10 years the budget has doubled. That's a bill of well over £100b (in real terms) in 10 years' time—more than a quarter of all public spending as it stands today.

**Figure 5**  
**Expenditure on Health: The Effect of a 7 Per Cent Real Increase Per Annum**



So how can expenditure increases of this sort be financed in the UK in the long term? We have already demonstrated that, within the current financing arrangements, private expenditure does not look to be a viable option. *Certainly, private expenditure may well have the potential to increase significantly—but within the current financing framework, there is little reason to believe that it will.*

*The alternative then is for public expenditure to increase, as has already begun. But it is not really sensible to think these increases can continue*

*indefinitely, as the simple projection illustrated in Figure 5 shows. There are two broad ways that public expenditure on health could be increased. Increases could be financed through higher taxation and hence higher levels of government expenditure, or health's share of current levels of government expenditure could be increased (or a combination of the two).*

**Higher taxes?** The difficulty with the former is the age-old criticism of tax-funded health systems, namely that raising government expenditures is problematic because it depends on higher tax revenues (or increased government borrowing, which is only a short-term fix). Assuming a 1p increase in the basic rate of income tax raises £2.65bn in tax revenue, then meeting the government's commitment of raising health expenditures to EU levels is equivalent to increasing the basic rate of income tax by 2p per year, or an immediate increase in VAT from 17.5 per cent to 27 per cent.<sup>4</sup> These increases are far higher if we aim for levels of spending in EU countries that have the sort of quality health systems the UK should be aiming for. Clearly, this is not going to be popular with voters and so may be unlikely to happen. It also goes against government commitments to keep tight controls on the total levels of public expenditure. It could also exceed the Maastricht conditions for European Monetary Union, which set limits on government spending, that seem increasingly relevant to the UK.

**Changed priorities?** So if a significant increase in overall government expenditure is not a likely option, the alternative is for health's share of the current government expenditure to increase. This would mean tough decisions have to be taken, deciding which other areas of government expenditure should be cut (or restrained) to fund large increases in health expenditure. Again, this option is unlikely to be popular with the electorate: *it could hardly be argued that the quality and standards of many of our other public services are sufficiently high to be able to withstand cuts, or zero real growth in their budgets, in order to release funds, even for health care.*

All in all, the scope for increased spending looks bleak. It is hard to see where significant increases in government expenditure are going to come from, and it is unlikely that significant cuts in other areas of public expenditure to fund health would be supported. So this brings us to other ways of encouraging health expenditure—including ways of encouraging private expenditure. Many other European countries manage to do this without being driven into

despair over questions of equity, and the UK could do the same.

## How do other countries finance their health care?

There are three general ways that health care can be financed though in practice, countries adapt these generic systems to fit their own circumstances. Two of these broad approaches are found in Europe: *tax financing* and *social insurance*. The US is an example of the third type of system, centred on *voluntary private insurance*.

### Tax-funded health systems

The UK is an example of a tax-financed health system. Funding for health care is drawn predominantly from general tax revenues. A budget is set that is determined centrally by the Treasury/Finance Ministry, and that determines what share of government receipts will be spent on health. Once decided, the budget is then distributed to those responsible for purchasing or commissioning health services. Copayments for prescriptions are routine, though payments for other services are less common. Generally, services are free to patients at the point of use.

**Equity.** *Supporters of tax-funded systems argue that they are equitable. Revenues are drawn from general tax receipts so individual contributions to the costs of health care are dependent on their tax payments. The rich subsidise the poor. The sick do not pay more than the healthy. This is an equitable way of funding health care. It is also an efficient way of raising revenues—they are the by-product of a taxation system that already exists. There is also no problem of determining whether an individual is entitled to health care services, as the whole population is automatically covered.*

**Cost.** *Another presumed strength of tax funding is that it provides a strong framework for cost control. Budgets are set centrally and they form a ceiling above which expenditures cannot rise. However, as we can see from the discussion above, this is also a weakness. Tax financing makes it harder to increase the health budget because increases necessitate either an increase in taxation or cuts in other areas of government expenditure. Both are unpopular with the electorate. It is sometimes argued that individuals would be willing to see an increase in taxes if they knew the new money would be spent on health. The trouble with general taxation is that any increase gets lost in general public expenditure and there is no*

obvious link between individual tax payments and increases in health expenditure.

**Low esteem.** *It is also generally accepted that satisfaction levels expressed by citizens are lower in tax-financed systems than they are in other systems. The UK, along with some Southern European health systems, illustrates this point. But there are some exceptions. Sweden, for example, has a tax-funded health system but with satisfaction and expenditure levels that are comparable to social insurance systems. A key difference between the UK and Sweden is that its health system operates at a more devolved level than the UK and many other tax-financed systems. Sweden also has a sensibly structured copayment system that focuses demand and resources. Local councils have far more responsibility for determining local tax levels and for managing health service than we see in the UK, and is entirely plausible that this devolved responsibility leads to a health system that is more accountable and more oriented towards the patient and the views of citizens. The NHS's track record in this respect is poor. Large, centrally managed and bureaucratic organisations such as the NHS simply do not focus on the demands and wishes of patients and the public. They are rigid and unresponsive to what their customers want.*

### Social insurance-based health systems

Under a system of social insurance, the bulk of resources for health care are still drawn from payroll taxes levied on employees and employers. These taxes (or premiums) are set as proportion of income and are independent of an individual's health risks—what is often called *community rating*. On the face of it, the premiums are similar to income tax, but the key difference is that the amount is explicitly earmarked for health and flows directly to an insurance fund (with people often being able to choose from a number of competing funds). The funds are non-profit bodies, separate from government, with responsibility for financing the health needs of their enrolees. Such social insurance has a number of interesting features that sets it apart from tax financing, including:

- **Transparency:** under social insurance there is a clear link between individual contributions and the total level of health expenditure. Contributions do not get lost in general tax revenues. This may be an important distinction when considering the willingness of individuals

to pay for increased expenditures on health.

- **Choice of insurer:** often in social insurance systems, individuals are able to choose which social insurer they wish to enrol with. The choice is usually simplified by mandating that insurers must provide a standard package of health care as a minimum, but its aim is to encourage insurers to respond to the demands of patients—a big weakness of the NHS. *Choice is a mechanism for encouraging the provision of high quality, patient-focused, health services. And to judge by the satisfaction levels achieved by insurance-based systems, it works.*
- **Choice of premium:** in some countries, social insurance funds must take all-comers and cannot charge some people more just because their health risks are higher. However, the standard amount charged may differ between different funds to reflect the different service packages that they offer to members. *This opportunity for differentiation gives real choice to patients, allowing them to pay more for non-essential services such as greater privacy, while upholding the equity requirement of equal access to a comprehensive package of health care.*

**Responsive.** These three features all help to make the health system more responsive to patients, which in turn may make it more feasible to encourage increases in health expenditures. In a sense, the devolved nature of the Swedish tax-financed health system has more similarities to social insurance financing than it does to enormous tax-financed institutions such as the NHS. A simple look in other sectors, such as telecoms and energy, illustrate how increased choice, the threat of competition, and less centralization can vastly improve the levels of service received by customers.

**Fair.** As with tax financing, social insurance is generally seen as a fair way of financing health care. Individual contributions are independent of health risks so the poor do not pay more than the rich (although upper limits on individual contributions do mean that social insurance funding is less progressive than tax funding). Tax revenues also flow into social insurance systems, usually to cover premiums for the elderly and those on social security benefits.

An interesting feature of the social insurance system in the *Netherlands* is that it creates a

significant role for private insurance. Individuals earning above a certain income threshold (about a third of the population) are not eligible to join the social insurance system. If they want health insurance, they must purchase it privately.

*Interestingly, this has not led to perceived inequities in the health system. Almost all of those higher earners who are excluded from the social insurance system choose to take out private insurance (rather than self insure), and so are properly protected: but their private insurance does not buy them clinically superior care.*

In *Germany*, there is also some flexibility for opting out of the social insurance-funded health system. As with the *Netherlands*, it is a popular health system. Both encourage high levels of public and private spending and both enjoy high levels of patient satisfaction. *Perhaps the NHS could learn something from these examples.*

## **Voluntary private insurance**

The US is the most commonly cited example of a voluntary private insurance system, for which it generally receives a bad press. For the poor and the elderly, the state provides health care through the Medicare and Medicaid programmes. The remainder of the population must make their own arrangements for obtaining health insurance through private insurers. For many this insurance is provided through their employer, but a large portion of the population is left with the option of obtaining private insurance with premiums based on their individual risk characteristics. Many either cannot afford it or do not bother to purchase it.

What really separates the US from the other insurance-based systems is the level of *compulsion*. Obtaining insurance is not mandatory and many chose not to buy cover. Although inequitable by UK/EU standards, it is the lack of a mandatory requirement to obtain insurance cover rather than the private/social insurer distinction that really distinguishes the US from European health systems. By contrast, the Swiss health system demonstrates that a system of private insurance (with compulsion to purchase) is feasible and popular.

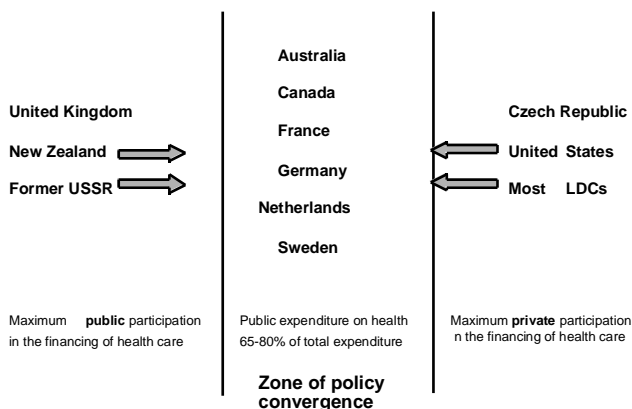
## **Finding the right balance for the UK**

So far we have argued that current mechanisms for financing health care in the UK are not sustainable in the long term. The UK cannot rely

on increased government financing to meet its health care demands sufficiently. Within the current financing system we cannot expect private insurance to fill the gap. This has to raise questions about how the UK should secure its health care funding for the far future.

The work of Professor Richard Feachem suggests that the UK is an outlier in terms of health care financing. This in itself should raise questions. Figure 6 illustrates his notion of “policy convergence”. The basic concept is a simple one. All health systems have a mix of public and private expenditures, but they differ in the balance. The UK is at one extreme, with very high public participation in health care. The US and many less developed countries (LDCs) are at the other extreme, with high levels of private participation. Most countries are moving towards the middle. Not only is the UK an outlier but, as Figure 4 illustrated, we do not appear to be moving.

**Figure 6**  
**Health Policy Convergence**



So what should we do? Do we need wholesale reform of the way the NHS is funded, or can we tinker with the edges with *ad hoc* announcements of increased funding? The trouble with tinkering is we have been doing it for years. *The NHS has had impressive increases in funding in the past, but still our standards lag well behind those of our partners. A more significant reform of financing is needed.*

To be acceptable to both the public and to politicians, any reform of health system financing will need to meet two criteria:

- *The health system should retain the broad principle of equity, the greatest strength of the NHS. However, equitable and universal access to health care is a feature of many different health systems,*

whether tax-funded or insurance-funded. The concept of community rating is common to both tax and insurance settings and is widely used as an equitable way of financing health care.<sup>5</sup> In insurance-based systems, government funding can be used to finance care on behalf of the elderly, the unemployed, or other disadvantaged groups to ensure universal access.

- *A comprehensive package of health services should be covered. Citizens will want to know that their payments towards health care entitle them to a comprehensive set of health services. Defining this package is a controversial topic and few countries have made serious and sustained attempts to do so. Certainly, even expensive items should be included if they provide good value for money; but whether patients should pay extra for lower-cost items (e.g. a copayment for GP visits) is more open to debate.*

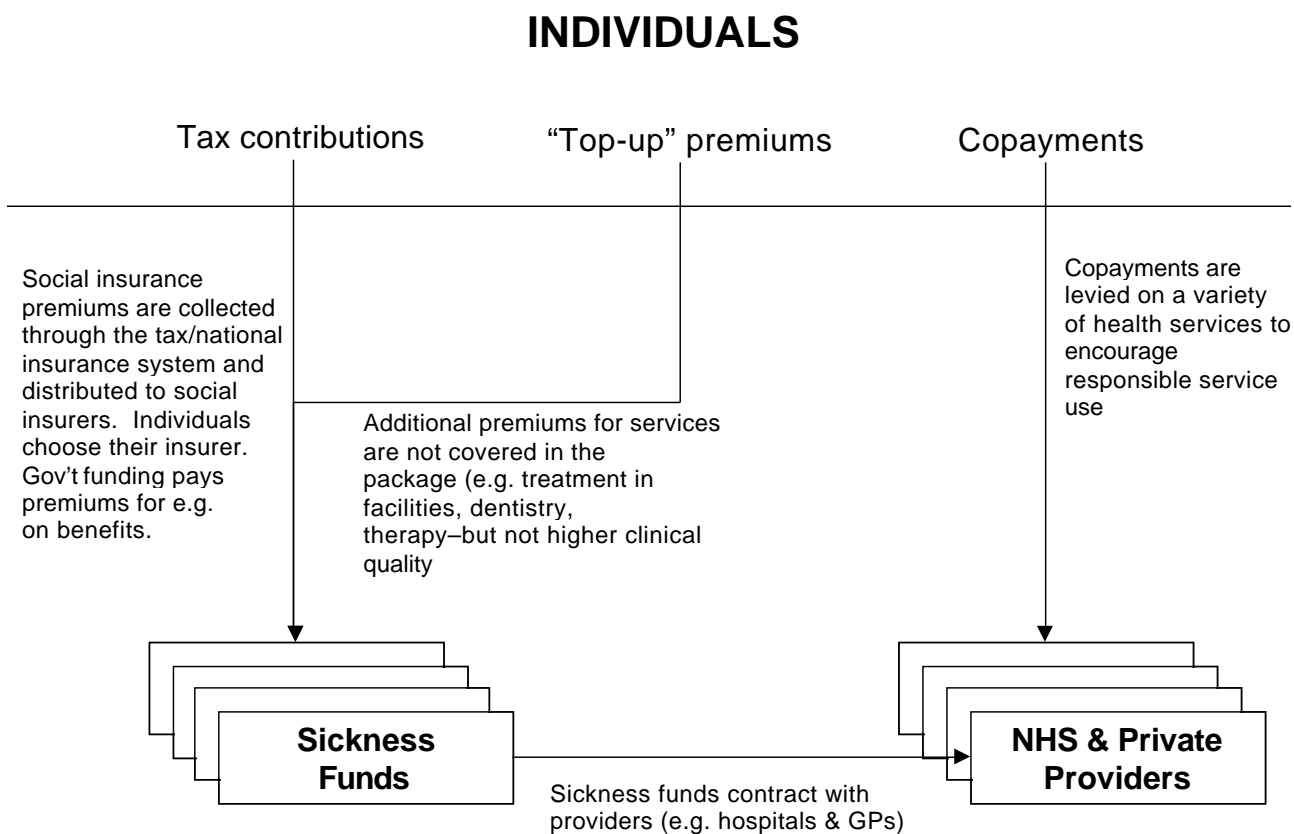
To these two criteria, we add two more; namely that the health system should introduce *choice* (giving power to patients), and we support a greater role for *copayments* (encouraging individuals to take more responsibility for their health care). In essence, we believe that the most promising way forward is close to the “prototype health system” outlined in a study by National Economic Research Associates in 1994.<sup>6</sup> The study envisaged a system where citizens could obtain insurance coverage from one of a number of competing sickness funds/social insurers (*choice*) who would charge a community-rated premium (*equity*) to provide access to a Guaranteed Health Care Package (*comprehensive care*) as a minimum. This package would need to be explicitly defined, but in our view should cover essential health care that individuals cannot reasonably be expected to wholly fund for themselves. Hence there would be a greater role for payments for additional services (*copayments*) to encourage responsible use of health services and to raise additional revenues. Copayments could be paid, for example, for physician visits and there could be a daily charge for inpatient stays (designed to ensure that necessary use of health services was not deterred). But insurers would meet the bulk of the costs of essential services. Citizens would be free to purchase services that fall outside the guaranteed package. (e.g. to cover dentistry, ophthalmology, complementary therapies, private rooms and even copayments) but additional payments could not buy access to

higher levels of clinical quality or faster treatment.

Perhaps the key to drawing additional funds into the UK health system is *transparency*. General tax increases are unpopular even though the electorate support higher levels of public spending, probably because higher taxes are not seen to feed directly through to health expenditure. This leads us inevitably towards an insurance-based system, where the link between individual contributions and levels of spending is clear. Whether this insurance is achieved through social insurers or through a system of private insurers (regulated to ensure equity) is open for debate. Figure 7 provides a simple diagrammatic overview of our recommendations.

funding can deliver a variety of benefits. It allows *choice* to be introduced (e.g. choice of insurer); and to attract enrolees. Insurers need to offer *high quality health services*. It introduces *flexibility*. Insurance premiums could differ from insurer to insurer (although community rating would ensure that premiums were the same for all enrolees within particular funds). We are not advocating that higher premiums could buy access to better clinical quality care, but if individuals wanted to pay extra for additional comfort or privacy, or for non-essential services, then they should be free to do so. This, and *increased service accountability* are important features of our proposals. If such choice and flexibility brings an administrative cost, then perhaps the additional benefits are worth it.

**Figure 7**  
**Overview of Our Proposals**



Critics will argue that the introduction of choice and moves towards an insurance-based system cannot be demonstrated to deliver additional benefits. They will say that social insurance financing tends to be administratively costly. And it is certainly true that demonstrating the benefits of one health system compared to another is controversial. But insurance-based

The suggestion that the UK should make better use of copayments will also be controversial. Copayments for pharmaceuticals are accepted in almost all industrialised countries, yet in the UK we make particularly poor use of them. There are two rationales for copayments; raising expenditures, and controlling demand. Few would argue that a flat rate charge does the

latter, and the generous exemptions the UK currently has ensures we don't achieve the former either. Something better could be done.

A recent ASI paper<sup>7</sup> argued that prescription charges in the UK should be reformed, moving to a system close to the Swedish model. This type of system strengthens the demand side of the market for prescription medicines, making patients more sensitive to the prices of the medicines they consume. Up to a certain threshold (about £60), patients pay the full cost of their medicines; beyond this threshold they pay only a portion of the costs up to another threshold; beyond that, all prescribed medicines are supplied free of charge. The system of thresholds ensures that the poor and the sick are not denied access to medicines, and in principle exemptions or different thresholds could apply for particularly vulnerable groups. Applied in the UK, such a system could encourage more responsible consumption of medicines and raise significant revenues for other essential services.

But why limit copayments to prescribed medicines? In other countries, particularly those with insurance-based funding, payments for other health services, including physician visits and inpatient stays, are more common. Table 1 provides some examples.

Of course, any moves either to reform the existing prescription charge or extend charges to other health services will meet with resistance. But if the systems are designed to be equitable and do not discourage the appropriate use of medicines or services, they should be supported. Not only could they raise much needed (private) revenues, but by discouraging inappropriate use they can free public resources for use by others.

### The transition: moving towards funded healthcare

So, we have identified a number of features that should form part of a better-funded health care system. The purpose of this paper is not to set out a detailed model and a blueprint for moving

**Table 1**  
**Examples of Copayments for Health Services in European Health Systems**

<b>Country</b>	<b>Type of Copayment</b>
<b>Austria</b>	Ambulatory patients pay a quarterly fee to get reimbursement for treatment by a doctor. Inpatients must also pay a fixed fee for all medication, up to a maximum of 28 days per person per year.
<b>Belgium</b>	Inpatients pay a fixed daily fee for all reimbursed medication received.
<b>France</b>	A charge of FFr55 per day is levied on inpatient stays
<b>Germany</b>	Inpatients are required to pay a fixed "hotel" fee, but are not liable for any specific medicine copayments whilst in hospital
<b>Ireland</b>	"Category II GMS" patients pay a fixed charge for outpatient visits and for inpatient stays (with a ceiling set for maximum payments within a 12 month period).
<b>Netherlands</b>	Some patients with private insurance may be required to make payments for physician visits and inpatient stays.
<b>Sweden</b>	Copayments vary by County Council but are levied on first contacts and on inpatient stays (daily rates).
<b>Switzerland</b>	Annual deductible for ambulatory care and a fixed daily rate for inpatient stays

*Source: Saltman & Figueras (1997) European health care reform: analysis of current strategies, Geneva: WHO; and Macarthur (2000) Handbook of pharmaceutical pricing and reimbursement, Informa Publishing Group Ltd*

towards it. However, there are a number of immediate steps that could be taken to move us in the right direction. For example:

- *An improved system of copayments must be implemented. This would better the current fixed prescription charge for medicines and over time could be extended to cover other services. As discussed above, this need not be a challenge to equity. It is a sensible way to raise private expenditures and encourage individual responsibility for health care and prevent the abuse of “free” services.*
- *There must be more explicitness in defining what will and what will not be publicly funded. This is key if the public are to make informed choices about whether to insure for additional services or not. Even if the funding of the health system were significantly increased, the need to ration is not going to go away: new technologies and rising expectations will ensure that difficult choices will always have to be made. This suggests an important role for organisations such as NICE (perhaps in partnership with similar agencies in other countries) and the same value-for-money calculations should apply equally to pharmaceuticals and non-pharmaceuticals.*
- *More must be done to encourage the use of private medical insurance and savings for health care costs— so easing pressures placed on the public system. For example, tax relief could be applied on insurance premiums,<sup>8</sup> easing pressure on the public system. Affordable access to private insurance could gauge the public’s response to additional choice. Any public subsidy (i.e. tax relief) need not necessarily fully offset individual contributions towards the NHS (i.e. what people contribute towards the NHS through their taxes), so it would not mean a mass reduction in funds available for the NHS. But it would reduce the high marginal tax rate that private insurance enrolees currently face. It would attract much needed private expenditure into the health system and would test the public’s willingness to pay extra for their health care (in return for real improvements in standards). In a sense it would have some parallels with the opt-outs that currently operate in the German and Dutch health systems.*

Of course, moves to encourage private insurance will immediately lead critics to claim that this is the privatisation of the NHS and we are moving towards a US-style voluntary private insurance system. *This is not our recommendation. For the longer term, we support an insurance-style system, but within a regulated framework to ensure equity, universal coverage and transparency. Whether the vehicle for this is social insurance or some form of private insurance, and whether it is profit-based or non-profit, are less important questions.*

*The emphasis of our suggestions is to introduce more transparency and choice into the health system, whilst encouraging individual responsibility for health care (e.g. through better copayments). This is the only rational way forward. In its current form, the UK health system cannot rely indefinitely on piecemeal increases in public funding to sustain it in the long term. The current relationship between public and private expenditures does not give much hope of relying on increases in private funding either. It is time for a sensible look at what other countries do. It is time to break out of the cycle of indifference and introspection that has held back the funding debate for far too long. Reform is long overdue.*

## Notes

<sup>1</sup> Appelby & Boyle (2000) Blair’s billions: where will he find the money for the NHS?, *BMJ*, 2000, 320, pp. 865-867

<sup>2</sup> Reported in: Klein & Dixon (2000) Cash bonanza for the NHS, *BMJ* (2000), 320, pg. 883

<sup>3</sup> Although it is not particularly out of line when compared to past increases in NHS spending, which have typically averaged around 4 per cent in real terms per annum.

<sup>4</sup> Appelby & Boyle (2000) Blair’s billions: where will he find the money for the NHS? *BMJ*, 2000, 320, pp. 865-867

<sup>5</sup> Community rating means that an individual’s contributions to the financing of health care are independent of their health risks. This is usually ensured by setting social insurance premiums as a proportion of income, which is the same for all (or for all members of a particular social insurance fund), but is also the same as how funds are raised through, for example, income tax under tax financing.

<sup>6</sup> See Hoffmeyer and McCarthy (1994) *Financing health care*, Kluwer Academic Publishers

<sup>7</sup> Ian Senior, *Paying for medicines*, ASI, February 2001

<sup>8</sup> Critics will argue that this has been tried in the past for the over-60s without little impact on demand. However, this is a fairly narrow focus that was not targeted on those most likely to purchase private medical insurance and so is not really a fair assessment of the impact of tax breaks.



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