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# WHAT ARE WE AFRAID OF?

Universal healthcare in  
market-oriented health systems

By Kristian Niemietz  
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## Summary

- While in many other policy areas, there is a political appetite for learning from international best practice, healthcare remains the exception: the healthcare debate remains inward-looking and insular. This is exemplified in newspaper headlines such as ‘Can a private business run a hospital?’, which an odd question given that there are thousands of examples from abroad of private businesses doing precisely that.
- The UK is far from being the only country which has achieved universal access to healthcare. With the notable exception of the US, practically all developed countries (and plenty of developing countries) have managed to do so in one way or another. But Britain is probably the only country where universal healthcare coverage is still celebrated as if it was a very special achievement.
- The NHS is often unduly eulogised for minor achievements, because it is being held to unrealistically low standards. The NHS should not be compared with the state of healthcare as it was prior to 1948, or with a hypothetical situation in which all healthcare costs had to be paid out of pocket. Rather, it should be compared with the most realistic alternative: the social health insurance (SHI) systems of Continental Europe, especially the Netherlands, Switzerland and Germany.
- SHI systems are far more market-oriented, competitive and patient/consumer-driven than the NHS. They show a much greater plurality in both provision and financing, usually with a mix of providers (public, private for-profit and private non-profit) and a mix of payers (for-profit insurance, non-profit insurance, out-of-pocket payments, supplementary insurance). For example, in Germany, fewer than half of hospitals are government-owned.



- SHI systems still redistribute from the healthy to the sick, and from the rich to the poor. This happens mostly through risk-structure compensation schemes, which redistribute from insurers with a high proportion of 'good risks' to those with a high proportion of 'bad risks' and thereby make 'cherry-picking' of healthier clients economically unviable. Low-income earners also receive demand-side subsidies to help them pay their health insurance premiums.
- SHI countries consistently outperform the NHS on measures of health outcomes, quality of healthcare provision and efficiency. Cancer and stroke survival rates are higher, fewer patients suffer from complications after a hospital operation, and the number of deaths that could have been prevented through better healthcare ('mortality amenable to healthcare') is lower. On the latter measure, the UK could avoid at least 14 unnecessary deaths per 100,000 inhabitants each year if it rose to the standards of the SHI countries.
- SHI systems do not just outperform the NHS in terms of *average* outcomes, they also achieve more equitable outcomes. The extensive use of market mechanisms does not have to conflict with the aim of reducing health inequalities. According to reasonable indicators of equity, the performance of the NHS is about average amongst developed countries; the performance of SHI systems are amongst the best in the world.
- The only visible advantage of the NHS model over SHI models is that it is better at containing costs. However, part of the difference is explained by the fact that SHI systems make it much easier for patients to top up and/or upgrade statutory healthcare privately if they wish. NHS patients are not allowed to do this.
- In the Netherlands, health insurance companies and healthcare providers operate under private law like any other business. 'Hospital planning' has been largely abolished; the opening and closing, downsizing and expanding of hospitals is no longer a political matter.
- In Switzerland, people have genuine freedom of choice between different health insurance policies. They can, for example, choose a deductible of up to CHF 2,500 in exchange for a premium rebate, in which case they have to pay all healthcare costs up to that level out of pocket. People can also voluntarily limit their degree of provider choice in exchange for rebates, by opting into various forms of managed care models.

- Germany started a wave of hospital privatisations in the early 1990s. The private for-profit sector now has a market share of about one fifth, and the private non-profit sector accounts for over a third of the hospital sector. There is no evidence that quality of care has suffered, and some evidence that it has actually improved.
- This briefing does not claim that abandoning the NHS in favour of a SHI system would solve every problem faced by the health sector. The most important challenges, especially the demographic ones, are actually common to both systems. But the briefing does argue that SHI systems have a number of clear advantages over the NHS model, and that it would be possible for the UK to move a lot closer to a SHI system without giving up on the NHS – or the principles it embodies - in its entirety.

“Many people believe that the very idea of universal healthcare – making sure everyone can access healthcare when they need it regardless of wealth – is an idea invented in Britain and uniquely realised in Britain. None of this is true. But it leads us to hold the institution of the NHS in a peculiar reverence.”

Roger Taylor (2013)

# Introduction

The 2010 general election campaign was characterised by an appetite for learning from international best practice. All major political camps showed a curiosity for reform ideas which had worked elsewhere, whether it was relatively novel policies such as Swedish 'Free Schools' and American 'workfare' programmes, or well-established ones such as the vocational education systems of the German-speaking countries and the childcare systems of the Nordic countries.

And yet there is one policy area which remained completely untouched by this trend: healthcare. The healthcare debate remains insular and inward-looking, seemingly oblivious to any developments from beyond the shores. A case in point is the recent media coverage of Hinchingsbrooke, an NHS hospital which was managed by a private company, Circle, for about three years, until the company announced its intention to pull out. This was widely interpreted as 'proof' that the world of business and the world of healthcare do not mix, and are best kept apart. The BBC's business editor, for example, covered the story in an article entitled 'Can a private business run a hospital?'<sup>1</sup>; a rhetorical question which the article resoundingly answered in the negative.

From the way the story was covered in the media, a reader could easily have taken away the impression that Hinchingsbrooke was the first and only example of its kind. If one restricts the inquiry to the UK, that impression

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1 Ahmed, K.: 'Can a private business run a hospital?', *BBC Business News*, 9 January 2015. Available at <http://www.bbc.co.uk/news/business-30742845>. For a riposte, see Haldenby, A.: 'Private companies can deliver exactly what the NHS needs', *The Spectator Coffee House*, 9 January 2015. Available at <http://blogs.spectator.co.uk/spectator-surgery/2015/01/private-companies-can-deliver-exactly-what-the-nhs-needs-in-future/>

would not be so far from the truth. And yet in other developed countries, there are literally thousands of examples of private companies running, or owning, publicly funded hospitals. In Western Europe as a whole, mixed private-public hospital provision is the norm, and a hermetically sealed public sector monopoly is the exception.

Needless to say, this says nothing about whether private sector involvement is sensible or desirable. A defender of the status quo could, with some justification, argue that the empirical evidence on private-public arrangements is mixed (see e.g. Shen et al 2005), and that in the absence of definitive evidence, hostility to the private sector was a form of erring on the side of caution. But 'Can a private business run a hospital?' is an odd question when private businesses are doing precisely that in dozens of comparable countries.

There is a general tendency in the British healthcare debate to look inwards and ignore international experience, but there is an exception to this rule. The one healthcare system which does feature frequently in the British debate is the American one, which is an odd choice, because it has to be the least relevant comparison. There is, to the best of the author's knowledge, nobody in the UK who advocates an emulation of the US healthcare system, and even if the UK were ever to adopt a different model of healthcare, it would surely not be the US model. It is difficult to avoid the impression that the US system is being singled out because its well-known flaws make it a relatively easy target to attack.

Continental European social health insurance (SHI) models are a much more relevant comparison, because they share a number of important features with tax-funded single-payer models such as the NHS, and these happen to be precisely the features that the British public values most about the NHS. Like single-payer models, SHI models also offer universal access to healthcare, and they also seek to decouple the consumption of healthcare services from an individual's income. The main conventional arguments in defence of the NHS model – that it covers the whole population and that it does not differentiate by income and health status – are fair arguments when comparing the NHS with the American system. But they are a nonsensical argument when comparing the NHS with an SHI model, because these are features which both models have in common.

## How social health insurance systems achieve universal coverage

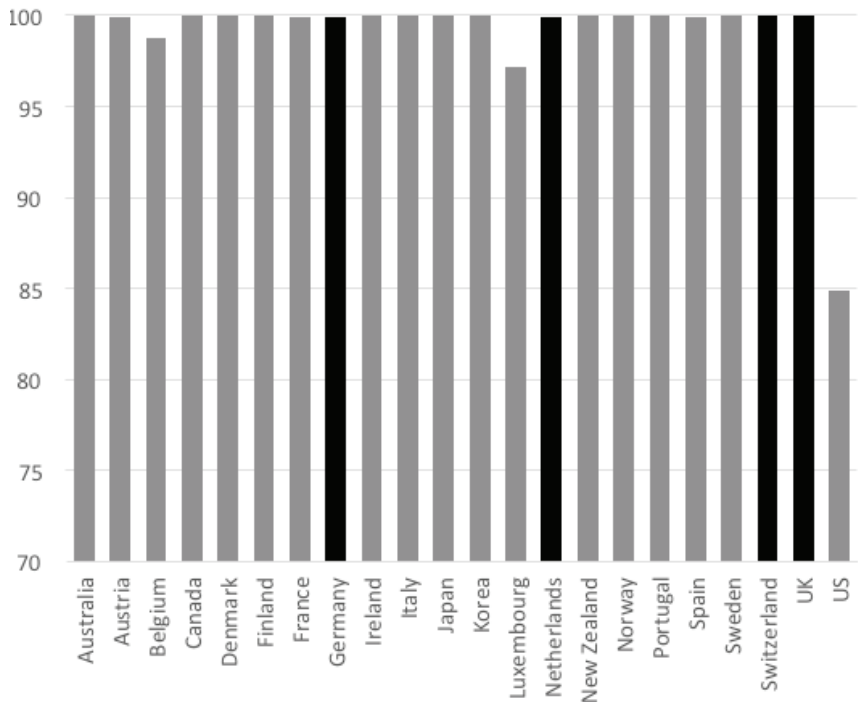
At first sight, SHI systems look a lot like private insurance systems. Individuals pay regular contributions to a health insurer and, when they need treatment, their insurer reimburses the providers of that treatment for the expenses incurred. The main difference between social insurance and conventional insurance is that while social insurers can be private for-profit companies, they cannot vary premiums in accordance with individual health risks, they cannot reject applicants, and they cannot rule out coverage for pre-existing conditions. ‘Cherry-picking’ of healthy clients is prevented through risk-structure compensation schemes, which redistribute revenue between insurers on the basis of their customers’ risk profile. Risk-structure compensation attempts to create a situation in which insuring a person with complex chronic conditions is (ex ante) just as economically viable as insuring a person in robust health. Insurers are to out-compete each other by offering better services, not by attracting healthier clients.

Just as insurers are obliged to accept all applicants, all residents are obliged to take out health insurance for themselves and their dependants. This ‘individual mandate’ is coupled with premium subsidies for low-income households, to ensure that health insurance is universally affordable.

Tax-funded systems automatically achieve universal coverage, simply because healthcare facilities are open to all residents and free (or nearly free) at the point of use, not unlike a public park or a public library. In SHI systems, universal coverage is achieved through a combination of mandates and subsidies. But the results in terms of coverage are ultimately

indistinguishable (see Figure 1), and neither are there recognisable differences in the *scope* of coverage between the systems (Joumard et al, 2010, p. 38). Simply put, Britain is not the only country that has achieved universal access to healthcare, but Britain is probably the only country where this is celebrated as if it were a unique achievement.

**Figure 1: % of the population with health insurance coverage for a core set of services, 2011**



OECD (2013, pp. 138-139)

The healthcare debate in the UK suffers from the lack of a realistic benchmark. In other areas, we sometimes judge policy outcomes (or market outcomes) against impossible standards, and then interpret inevitable shortfalls as ‘failures’ (the so-called ‘Nirvana fallacy’). Healthcare is the one area where we observe the opposite phenomenon: the NHS’s achievements are frequently judged against implausibly low, unambitious standards, and the NHS is then eulogised for minor achievements. This is exemplified in often-heard statements like ‘The NHS once saved my

life' or 'I am grateful to the NHS for...', where the implicit benchmark seems to be either the state of healthcare as it was prior to 1948 (when the country was much poorer and medical technology much more primitive), or simply the absence of *any* healthcare. If nothing else, this briefing will propose a more realistic benchmark.

We cannot know what healthcare in the UK would look like today if the NHS had never been founded. But, given that the 1911 National Insurance Act had already established the basis of a social insurance system, and given that the objective of universality which motivated the founding of the NHS could also have been achieved within the latter, it is not such an outlandish claim to argue that, if the NHS had not been set up, the UK would eventually have found its way towards a SHI system of one kind or another. This makes the standards achieved in developed SHI countries a realistic benchmark against which to compare the NHS. These outcomes are, in a sense, the 'opportunity cost' of the NHS.

Below the core features of the three 'purest' examples of SHI systems will be discussed: the Dutch, Swiss and German systems. Aspects which are most relevant to NHS reform debates will be highlighted.

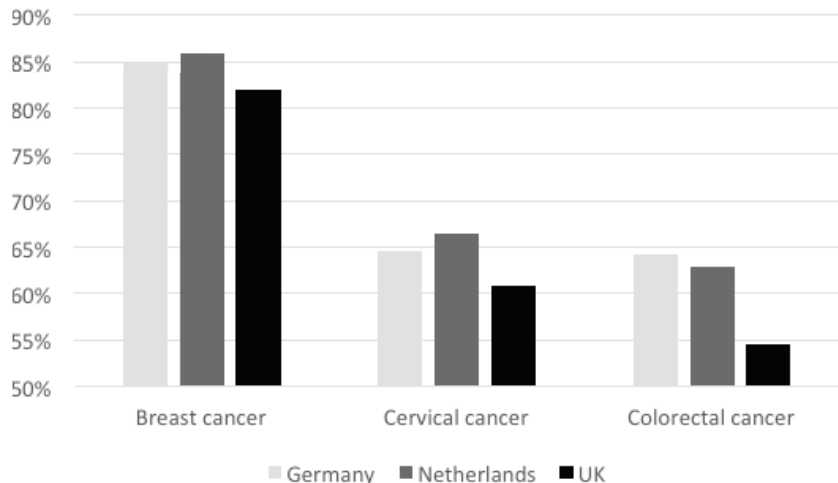
While it will be argued that SHI systems are generally superior to single-payer systems in terms of outcomes, efficiency, accountability and responsiveness to patient demand, this paper should nonetheless not necessarily be read as a plea for the introduction of a SHI system. SHI systems and single payer systems may share the common advantage of universality, but they also face common challenges and suffer from common weaknesses. SHI systems are just as vulnerable to demographic changes as the NHS and, like virtually any healthcare system, they struggle to balance limited supply with potentially unlimited demand. In this paper we do not offer solutions to those big-picture problems which are the subject of ongoing work.



## The NHS versus social insurance systems: health outcomes

Cancer survival rates are a useful, if partial, proxy for health system performance. Since they are independent of cancer incidence, they partly control for some of the factors that affect the latter, such as lifestyle habits, environmental and socio-economic influences. Survival rates in the UK are several percentage points below those recorded in the Netherlands and Germany (comparable data for Switzerland are not available).

**Figure 2: Relative<sup>2</sup> five-year cancer survival rate, 2007-2012 or latest**

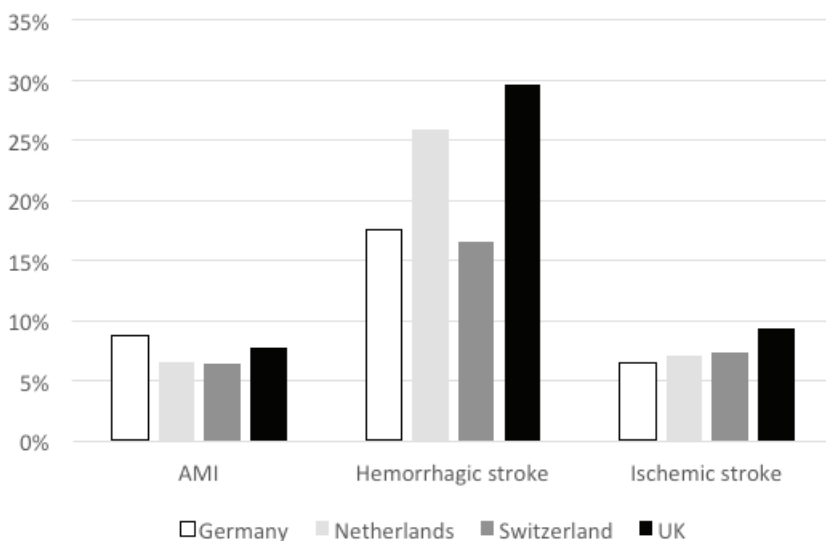


OECD StatExtracts (2015)

2 'Relative' means compared with the mortality rate of a randomly selected group in the same country with the same age composition.

For similar reasons, stroke mortality rates can also be used as representative partial outcomes. British patients are generally less likely to survive a stroke than patients in the three comparator countries, although for Acute Myocardial Infarction (AMI), the UK records a slightly higher rate than Germany.

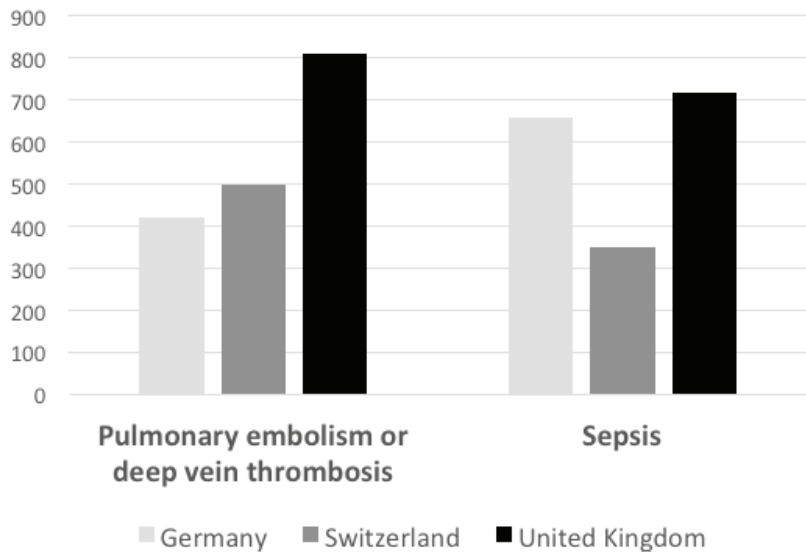
**Figure 3: Age-/sex-standardised 30-day in-hospital stroke mortality rate, 2012 or latest available year**



OECD StatExtracts (2015)

One limitation of mortality/survival rates is that they fail to capture aspects of quality that stop just short of affecting survival chances. The prevalence of post-operative complications can therefore be used as a complementary measure. On this proxy of clinical quality and safety, the UK trails notably behind Switzerland and Germany (comparable data for the Netherlands are not available).

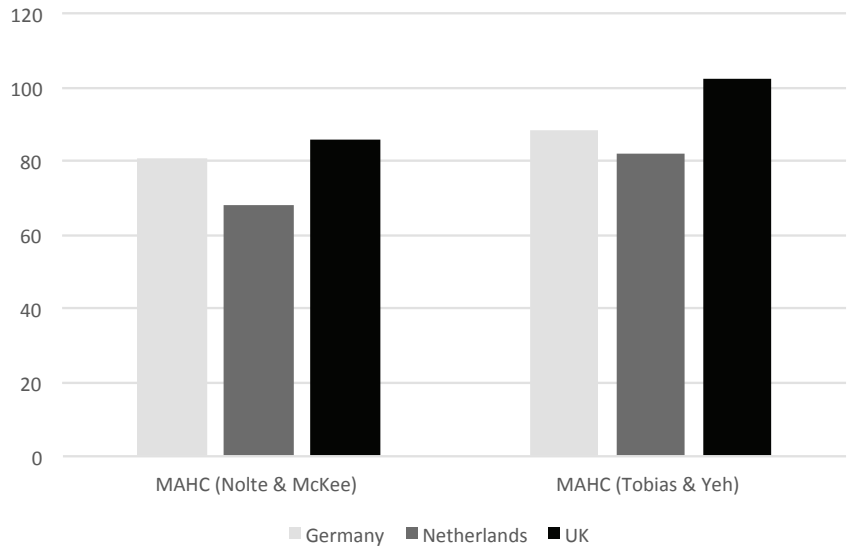
**Figure 4: Postoperative complications: cases per 100,000 hospital discharges (corrected for secondary diagnoses), 2012 or latest available year**



OECD StatExtracts (2015)

The above are partial measures. More holistic measures that attempt to reflect the quality of the healthcare system as a whole are more problematic: the more encompassing an outcome measure is, the less clear is the extent to which the outcome is really attributable to the healthcare system rather than other things. Yet measures of mortality amenable to healthcare (MAHC) are a step in the right direction, as they at least strip out factors that are completely out of the reach of the healthcare system. MAHC figures are derived by contrasting a country's actual mortality profile with the profile that would be observed in an 'ideal' health system, in which all diseases that could theoretically be cured really are successfully cured. Figure 5 shows the number of annual deaths per 100,000 inhabitants that could, according to two different versions of MAHC, have been avoided through better (or more timely) healthcare.

**Figure 5: Mortality amenable to healthcare (avoidable deaths per 100,000 people), 2007 or latest available year**



Gay et al (2011)

In summary, on almost any measure of healthcare quality, the UK lags behind the main social insurance systems.

## The NHS versus social insurance systems: efficiency

A conventional argument in favour of single-payer systems is that they are better at containing costs. There is some truth to this. Insurance-based systems are built on principles of self-governance, patient choice and therapeutic autonomy. This means that governments have little control over variables such as referral patterns or the provision of prescriptions and the flipside of this is that they have no direct control over costs either (see e.g. Oberender et al, 2002). It is partly for this reason that healthcare spending in the UK is more than two percentage points of GDP below the levels observed in the SHI countries.

But, while cost differences are real, the figures require some contextualisation. At least part of the difference must be explained by the fact that SHI systems make it much easier to top up and/or upgrade publicly funded healthcare privately. In the NHS, in contrast, a mixing-and-matching of statutory and voluntarily funded elements is actively discouraged (see NHS Choices, n.d.).

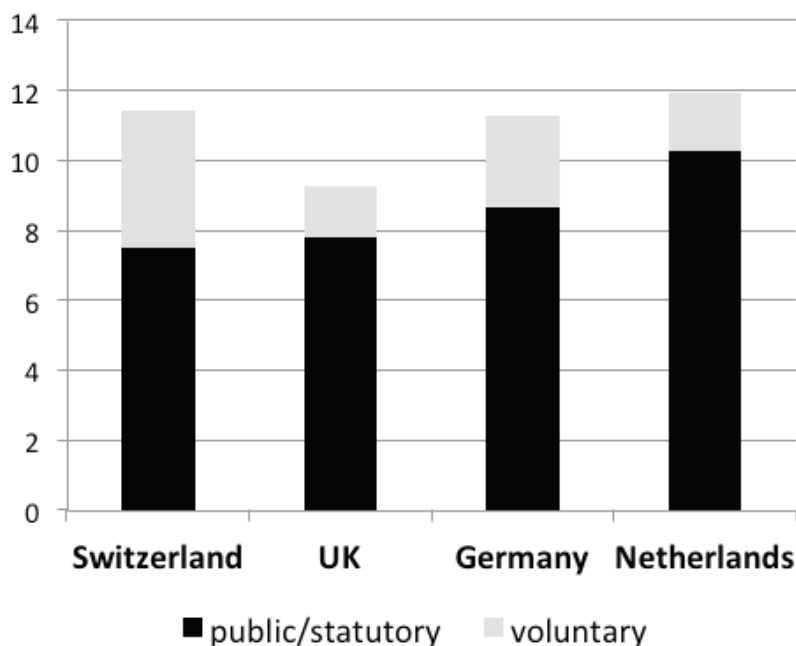
For example, in SHI systems, statutory insurance usually covers the cost of hospitalisation in a shared room. Patients can, however, request an upgrade to a twin or single bedroom, and pay the extra cost themselves (see Stadtspital Triemli (n.d.) for a Swiss example, and Charité Virchow Klinikum (n.d.) for a German example). People can also buy supplementary private insurance to cover such expenses. In Switzerland, 30 per cent of the population have supplementary health insurance, while in the Netherlands, as many as 89 per cent have such insurance (OECD, 2013, p. 139). Other things equal, a country that allows privately funded upgrades and top-ups will record higher spending levels than a country that does not, and this extra spending will not lead to better outcomes: accommodation

in a single room is about privacy and comfort, not about clinical quality. And yet, it would be wrong to classify the system which allows spending on optional extras as 'less efficient'. After all, the patients who pay for those upgrades do so voluntarily.

In the three SHI systems, top-ups and upgrades also exist in the pharmaceutical sector. All three operate 'reference pricing' systems, where medicines that are deemed substitutable are grouped together, and a common reimbursement value is assigned to the whole group. The cost of the more expensive medicines in the group will not be fully reimbursed by statutory insurance, but patients can still opt for those drugs and pay the extra cost – the difference between the market price and the reimbursement limit – themselves. This option does not exist in the UK. Again, other things equal, countries with reference pricing systems will record higher spending levels without necessarily recording better clinical outcomes. But, again, it would be wrong to classify such systems as 'less efficient'. People who pay the extra cost of expensive medicines do so voluntarily, presumably because they derive some benefit from them, even if clinical outcomes are not measurably better. Again, in SHI countries, the cost of top-up payments for medicines can be covered through voluntary insurance.

As a result, the role of private health insurance differs markedly between the systems. In the SHI countries, voluntary insurance is usually *supplementary*, in the UK, it is usually *duplicative* (see CEA, 2011, pp. 10-11): in the UK, insurance covers the cost of substituting private treatment for NHS treatment. In other words, in the SHI countries, private insurance builds *on top* of statutory healthcare while, in the UK, private insurance *replaces* statutory healthcare (with a more luxurious version). With this in mind, it makes more sense to compare government/statutory spending on healthcare across countries and not total spending. On that count, the UK is much less exceptional.

**Figure 6: Healthcare spending in % of GDP**



OECD (2014)

More sophisticated measures of efficiency shed a much less favourable light on the NHS. Joumard et al (2010) model health systems as production functions, which turn inputs (spending levels, staffing levels) into outcomes (life expectancy, conditional life expectancy at age 65, minimised MAHC). The study attempts to control, at least crudely, for determinants of health that lie outside of the health system's control, such as alcohol and tobacco consumption, fruit and vegetable consumption, the concentration of toxins in the air, GDP per capita and educational attainment. Residual variation in health outcomes are attributed to differences in efficiency.

The study finds that the UK loses almost three and a half years of average life expectancy to inefficiencies in the healthcare system. The corresponding figure for the Netherlands and Germany is just over two and a half years, while Switzerland loses less than one year. A similar picture, though with less pronounced differences, emerges for life expectancy at 65, and the UK also shows greater scope for decreasing MAHC through efficiency improvements than the three SHI countries.

## The NHS versus social insurance systems: equity of outcomes

Measures of health status vary a lot across the country. For example, the spread in average life expectancy between the top performing localities (in the South of England) and the bottom performing one (Glasgow) is about ten years, and the spread in average remaining life expectancy at age 65 is about five years (ONS, 2014). In an international comparison, Jourard et al (2010, pp. 53-54) use the standard deviation in mortality as a summary measure of inequality in health status. It turns out that, when it comes to minimising health inequality, the UK's performance is about equal to the OECD average, while the three SHI countries are among the most equitable.

The authors caution that cross-country differences in health inequalities cannot automatically be ascribed to differences in healthcare systems. It is an open question which type of health system is, *ceteris paribus*, better at dealing with health inequalities. But it is still worth noting that market-oriented healthcare systems do not *have to* lead to inequitable health outcomes, and that single-payer systems do not guarantee equitable ones. Given how much emphasis supporters of the NHS model place on the equality aspect, it is also worth noting that the UK is only an average performer in this category.



## The NHS versus social insurance systems: the Commonwealth Fund study

In 2014, parts of the British media quickly promoted the Commonwealth Fund's ranking of health systems (Davis et al, 2014) to the gold standard of international evidence<sup>3</sup>. There was little discussion of the study's methodology, but much comment on the headline result which rated the NHS as the world's best healthcare system.

There is nothing wrong with referencing the Commonwealth Fund study which is a useful addition to the international evidence. But when using this study, one needs to keep some of its peculiarities in mind. The Commonwealth Fund ranks health systems according to five categories (quality, access, efficiency, equity, outcomes). Each of these is subdivided into various sub-categories. Various sub-categories are designed in such a way that they automatically favour single-payer, free-at-the-point-of-use systems over other systems, especially in the 'access' and the 'equity' categories. For example, one sub-category counts the percentage of people who have spent more than \$1,000 on medical co-payments over the past year. In the UK, where the use of co-payments is negligible, it would be virtually impossible to accumulate payments of this magnitude, but it is fairly common in Switzerland (24 per cent), and not exceptional in Germany (11 per cent). Another sub-category relates to cases in which insurers denied full cost reimbursement for a treatment: again, since the UK is not an insurance system, this possibility is practically ruled out by definition, whereas it can occur in the SHI systems.

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3 See e.g. The Guardian: 'NHS comes top in healthcare survey', 17 June 2014; International Business Times: 'NHS Provides the 'Best Healthcare in World', says Commonwealth Fund Report', 17 June 2014; Owen Jones: 'A £10 charge to visit a GP would be just the start of a slippery slope for the NHS', The Guardian, 18 June 2014.

Yet the fact that NHS patients are not faced with co-payments, or coverage limits set by insurers, does not mean that they have unlimited access to any treatment that exists. *All* health systems limit healthcare consumption in one way or another. Systems that do not use overt methods such as co-payments and coverage limits must rely on more subtle ways of rationing instead. Yet while the Commonwealth Fund study registers the former, it does not register the latter.

To see how this can affect outcomes, suppose NHS organisations decide against the funding of an expensive cancer drug. In practice, this would mean that the drug would simply not be made available on the NHS, which is why the Commonwealth Fund study would not register any access barrier. Rather, this would count as if the drug had never been invented. In an SHI country, a similar decision would work out very differently in practice: the drug would still be available in principle, but its cost would not be reimbursed, or not fully reimbursed, by statutory insurance. In this case, the Commonwealth Fund study *would* register an access barrier.

However, despite the fact that the Commonwealth Fund study is, arguably, somewhat biased against insurance systems (or at the very least, against insurance systems which use co-payments) by design, the SHI systems have consistently ranked among the best in all previous editions in which they have been included.

**Table 1: Country rankings in the Commonwealth Fund study**

	2006	2007	2010	2014
Germany	1	2	4	5
Netherlands	-	-	1	5
Switzerland	-	-	-	2
UK	3	1	2	1

Davis et al (2014, p. 13)

Whatever the strengths and weaknesses of the Commonwealth Fund study, it is notable that it only enjoys prominence in the British media as long as it produces the desired outcome. When the NHS is ranked top, media commentators draw sweeping conclusions, presenting it as the definitive proof that the NHS model really is the 'envy of the world'. No corresponding conclusions are drawn when the Dutch system or the German system rank top, as both have in previous editions.

## Notable features of the Dutch system<sup>4</sup>

So far, we have looked at ‘the SHI countries’ as a group. The remainder of this briefing will look at each system in more detail.

SHI systems are compatible with varying degrees of market-orientation. They differ in the extent to which government interferes with the contractual relationships between patients, providers and insurers, and in the extent to which they allow private sector participation<sup>5</sup>. For most of its history, the Dutch system was at the more ‘statist’ end of the spectrum until, in the years leading up to 2006, it moved to the opposite end.

In the Netherlands, all health insurers are private organisations operating under private law, which can be run on a for-profit or on a non-profit basis (Schäfer et al, 2010, p. 31). They can contract providers selectively, and are relatively free in negotiating prices and volumes. In recent years, this has led to a reconfiguration of delivery patterns, in particular, it has sped up various forms of vertical and horizontal integration. Some insurers have acquired their own pharmacies, one insurance company has taken over a hospital, and others are now directly employing GPs (Bijlsma et al, n.d.; Canoy & Sauter, 2009). There has also been a consolidation within the

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4 Unless otherwise indicated, the information in this section is based on Schäfer et al (2010)

5 SHI system can be quite laissez-faire in some respects, and quite state-dominated in other respects, so they could not simply be ranked according to some ‘Index of Healthcare Freedom’. For example, in the Netherlands, acute hospitals must not be operated on a for-profit basis, whereas the German system is much more relaxed about the profit motive in the hospital sector. In this sense, the German system would seem much more market-oriented than the Dutch one. However, in the Dutch system, there is no such thing as ‘hospital planning’ – the hospital sector is shaped by negotiations between hospitals and insurers.

insurance industry as well as in the hospital sector. Insurers' contracting and purchasing activities do not have to be limited to domestic providers: some have contracted with hospitals in the Dutch-speaking part of Belgium and in Germany (Schäfer et al, 2010, p. 51).

The existence of selective contracting means that, by choosing an insurer, patients also choose a network of providers and, while these networks mostly overlap, they can differ across insurers. Patients can still access providers with which their insurer has no contract, but if that provider's fees exceed the insurer's reimbursement rate, patients have to pay the difference out of pocket.

There is now no 'hospital planning' as such, and government funding of hospitals has been reduced to a residual. The post-reform hospital landscape is determined by contractual arrangements between providers and insurers, not government decisions. Like insurers, hospitals operate under private law, although for-profit hospitals are banned: all Dutch acute-care hospitals are private not-for-profit organisations.

What is most notable about the Dutch healthcare system is that it allows strong elements of a market discovery process, where different models of healthcare delivery can be tried and tested in competition with one another.

## Notable features of the Swiss system<sup>6</sup>

The Swiss system is, in principle, similar to the Dutch one but, because of regulation, both the insurance markets and the provider markets are more compartmentalised along cantonal lines. The profit motive is allowed in the hospital sector, but it is banned for statutory insurance.

Regional fragmentation of markets has been shown to weaken competition and lower efficiency (Daley & Gubb, 2013, p. 7). But while the Swiss system offers, in this sense, less choice for patients than the Dutch system, it offers much greater choice between different health plans in any given region. People can vary the depth and scope of coverage, as well as the degree of provider choice, with more restricted options leading to premium rebates.

The most straightforward type of coverage restriction is a deductible/excess. There is a standard deductible of CHF300<sup>7</sup>, which can be increased to up to CHF2,500, with higher deductibles leading to higher rebates. Up to the level of the chosen deductible, medical expenses (with a few exceptions) have to be paid out of pocket. People with a high-deductible plan are still protected from serious financial risks, but they have every incentive to economise on healthcare consumption. Since deductible levels can be freely chosen, people can also be expected to self-select according to health status: the long-term sick, for example, will not choose a high deductible plan, as it is only attractive for those who have a realistic chance of keeping their health expenses below the rebate received.

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6 Unless otherwise indicated, the information in this section is based on European Observatory on Health Care Systems (2000) and Daley & Gubb (2013).

7 At the time of writing, 1 Swiss Franc is about equal to £1.30.

Uniform deductibles would risk penalising the long-term sick, but voluntarily chosen deductibles avoid this problem. They ensure that those with the greatest degree of control over their healthcare expenses face the strongest incentives to economise.<sup>8</sup>

The other health insurance plans involve a voluntary narrowing of provider choice. In the Swiss system, the default option is that patients have free choice of hospitals and specialists, and direct access without the need for a referral. People can, however, opt into various forms of ‘gatekeeping’ models with more restricted provider choice in exchange for premium rebates. Under the ‘Telmed model’, people cannot see a doctor unless they have had a telephone consultation first. Under the ‘GP model’, people cannot access a secondary or tertiary provider unless they obtain a referral from their GP first. Under the ‘HMO model’, people commit to seeking treatment at an integrated health centre or from a network of providers, unless they are being referred to an external provider.

Thus, the Swiss system allows ‘meta-choice’: people choose how much choice (of providers) they want to have. They also choose how extensive they want their coverage to be, albeit in a quite different way from the Dutch system. The Swiss system also allows a market discovery process between different methods of healthcare delivery: models of integrated, managed care can exist alongside a model in which the patient is a sovereign consumer. As a side effect, it also squares the circle of providing intelligent incentives for economising on healthcare consumption without penalising people in poor health.

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8 It should be noted that ‘economise’ does not necessarily mean seeking less treatment. Preventive check-ups, for example, are often automatically covered, even in high-deductible plans. What it does mean is that there is a strong incentive to seek the most cost-effective options, such as replacing a branded drug with a generic drug where appropriate.

## Notable features of the German system

While generally similar to the systems of the Netherlands and Switzerland, the German system offers less scope for a market discovery process. Relationships between insurers and providers are more rigidly regulated (in particular, options for selective contracting are limited), and differences between health insurance plans are small. This system, however, allows the profit motive in the hospital sector and private sector participation in general is encouraged.

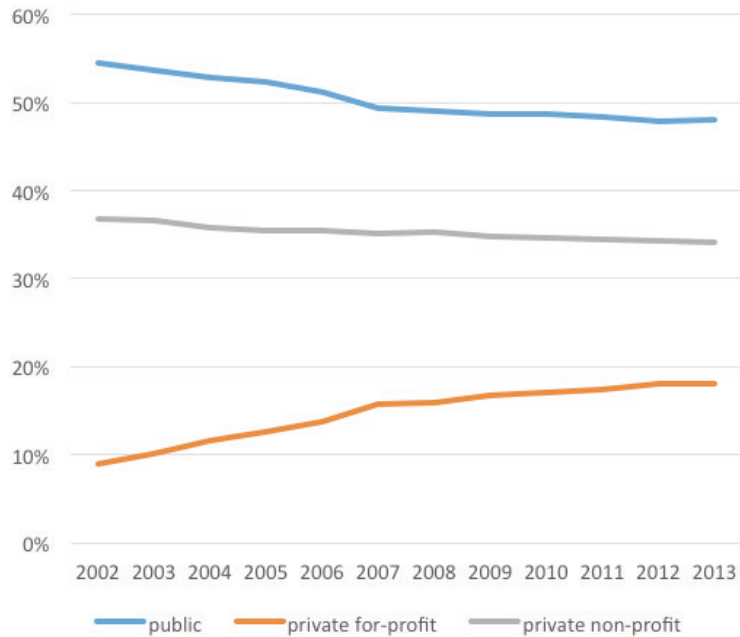
Independent sector providers have always been a part of the German system, as there has never been an equivalent of the Attlee government's full-scale nationalisation of hospitals. Church-owned hospitals existed even in the former East Germany.<sup>9</sup> For-profit hospital chains, however, only appeared in the early 1990s, when various state governments began to sell off public hospitals. As a result of this privatisation programme, for-profit hospitals now account for almost a fifth of the hospital sector, while the share of the public sector has fallen to under half.

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9 MDR: 'Vom Elend der Krankenhäuser', 2 July 2012; Tag des Herrn: 'DDR-Geschichte: Zwischen Ideologie und pragmatischer Akzeptanz', 19 December 1999.



**Figure 7: Composition of the German hospital sector  
(% of hospital beds)**



Statistisches Bundesamt (2014)

Empirical findings on the results are mixed. Among smaller hospitals, publicly owned hospitals appear to be more efficiently run than their privately owned counterparts, while among larger hospitals, the reverse is true. Private hospitals appear to be superior in terms of quality, but this could also be the result of over-provision (Tiemann & Schreyögg, 2009). Results may be further complicated by the fact that most public hospitals are now also run under private law, and have been given greater managerial freedom, making the public-private distinction less relevant. It is also not clear to what extent current efficiency differences reflect differences that already existed before privatisation.

In short, sensible critics of privatisation could surely make a reasonable case by highlighting the less favourable parts of the evidence mix, and interpreting the ambiguous results in a pessimistic way. What they could *not* claim is that hospital privatisation has led to anything like the catastrophic results ('profits over people') that would no doubt be predicted in the UK if a similar hospital privatisation programme was contemplated here.

## Conclusion

There is a tendency in the UK to eulogise the NHS for minor achievements, and this is partly because the NHS is held to unrealistically low standards. NHS care is often compared with healthcare as it was prior to 1948, to healthcare in third world countries, to a situation in which all healthcare costs would have to be paid out of pocket, or simply to a situation without any healthcare at all. Given that a social health insurance system would be the most likely alternative to the NHS, the outcomes observed in high-income countries with SHI systems can be seen as a more realistic benchmark.

It turns out that, as soon as a more realistic standard of comparison is adopted, the rose-tinted view of the NHS becomes untenable. Like the NHS, SHI systems also achieve universal access to healthcare and, in fact, health inequalities are smaller in the Netherlands, Switzerland and Germany than in the UK. The SHI countries consistently outperform the NHS on measures of health outcomes, healthcare quality and efficiency. The UK is better at keeping spending under control, but at least part of the reason for this is that SHI countries allow patients to upgrade and top up statutory healthcare privately, which is not permitted on the NHS.

While it would be possible to move the British health system a lot closer to a SHI system without abandoning the NHS entirely (see Niemietz, 2014, pp. 34-46), this briefing paper should not be read as a wholesale endorsement of SHI systems. The health sector is faced with formidable challenges which threaten the viability of tax-funded and SHI systems alike. What this briefing has shown is that there is more than one way to skin a cat, and that the mortal fright of market mechanisms and private initiative in healthcare which characterises the British debate is entirely unwarranted. It is no more than a collective hysteria, which can only subsist because our healthcare debate is so insular and inward-looking.

The Dutch example shows that universal coverage can be achieved in a fully privatised health insurance sector, and that hospital planning need not be a government function at all. The Swiss example shows that giving people freedom of choice over the depth of insurance coverage, and between different models of healthcare delivery, need not come at the expense of equity. The German example shows that handing over large swathes of the hospital sector to private organisations, including for-profit companies, does not undermine the quality of care at all.

A glance across the channel shows that market-oriented systems are capable of providing high-quality healthcare, and of ensuring universal, equitable access to it. In other words, we should not be afraid of market-driven healthcare.

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