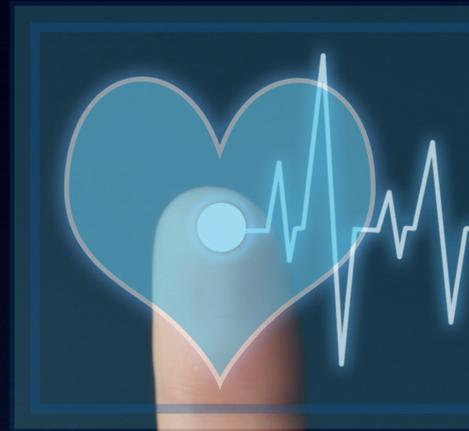


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A PATIENT APPROACH

Putting the consumer at the heart
of UK healthcare

Kristian Niemietz



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Dr Kristian Niemi is Head of Health and Welfare at the Institute of Economic Affairs. He studied Economics at the Humboldt-Universität zu Berlin and the Universidad de Salamanca, graduating in 2007 as *Diplom-Volkswirt* (MSc in Economics). He also studied Political Economy at King's College London, graduating in 2013 with a PhD.

As a graduate student, Kristian interned at the Central Bank of Bolivia and the National Statistics Office of Paraguay. As a postgraduate student, he taught Economics at King's College London.

Kristian is the author of the IEA monographs *Redefining the Poverty Debate*, *A New Understanding of Poverty*, and a number of other IEA publications, including *Health check: The NHS and market reforms* and *What are we afraid of? Universal healthcare in market-oriented health systems*. He is a regular contributor to various newspapers and magazines in the UK, Germany and Switzerland.

Summary

- In recent years, the healthcare debate has been dominated by allegations that the 'privatisation of the NHS' was in full swing. But this is not a new phenomenon at all. For as long as the health service has existed, there have been periodic outbreaks of 'NHS privatisation fears'.
- Public attitudes to healthcare could be described as a combination of 'macro-level absolutism' and 'micro-level pragmatism': When people are asked about their commitment to the NHS in the abstract, support is almost unanimous and strongly felt. But when people are asked whether treatment should be provided privately or publicly, the majority are either indifferent, or even in favour of private provision.
- Supporters of a competitive, consumer-driven health system should try to build on this pragmatism. There will never be a democratic mandate for a privatisation programme involving healthcare facilities in the UK, but there already is an appetite for choice and pluralism.
- In the pluralistic systems of France, Australia, Luxembourg, Japan, South Korea, Germany, the Netherlands and Switzerland, patients enjoy free choice among a range of providers, including a large private sector. These systems record some of the best health outcomes in the world, without any obvious downsides relative to the NHS.
- The quasi-market reforms of the mid-2000s have already taken us some way towards a pluralistic system. Going 'the whole hog' would not require a revolution. It merely requires building on those reforms, and straightening out inconsistencies in them.
- The whole concept of 'catchment areas' should be abolished. Patients should be able to register directly with any Clinical Commissioning Group (CCG) they see fit, and choose freely among primary care providers. Meanwhile, CCGs should be able to operate nationally,

and to merge and de-merge with other CCGs, as well as provider organisations. CCGs would effectively become social health insurers, and the sector should be opened to private insurers as well.

- The 'Payment by Results' (PbR) formula should be reformed in such a way that funding truly follows patients. In particular, PbR tariffs should cover a proportion of fixed costs as well, and they should be set in such a way that the vast majority of providers could economically survive on the basis of these activity-based payments alone. This should be coupled with a strict no-bailout clause. Hospital bankruptcies, mergers and takeovers would become a normal occurrence.
- CCGs and other financing agencies should be able to offer selective rebates for patients who voluntarily accept co-payments, deductibles, or inclusion in a 'managed care' plan. The default option would still be a situation in which healthcare is free at the point of use, but people could change that default option in exchange for a tax/premium rebate.
- CCGs and other financing agencies should be required to build up old-age reserves for their members while they are young, and draw upon those reserves in later years. This would mean a transition to a pre-funded health system, in which, on a lifetime basis, each generation 'pays its way'.
- The new system would continue to offer universal and equitable access to healthcare, regardless of ability to pay. But the role of the state would largely be limited to guaranteeing that access. Healthcare would otherwise be provided in a competitive marketplace.

Attitudes to the NHS: macro-level absolutism versus micro-level pragmatism

'It is no exaggeration to say that the Health Service is now under serious threat. [...] Until now, the private section of medicine has been contained and liveable with. [...] The strategy of government ministers has been obvious. Starve the NHS of vital cash and resources then force patients to look to the growing private sector [...] It is clear that had the government carried out a direct onslaught on the NHS the political and public outcry would have been deafening. So their policy has been more subtle, and because of that, more dangerous. There is no doubt in my mind that the NHS is in danger and over the next five years we could find ourselves drifting towards American-type [healthcare].'¹

The above quote could easily be from any of today's newspapers. But it is, in fact, from a *Times* article published in 1980. Old articles about the imminent demise of the NHS, and about secret plans to privatise it, often have an illusory ring of topicality. The following article, also in *The Times*, is another example:

'[The reforms] "clear the way for a massive shift of resources" from the NHS to private companies. [...] [P]rivate companies (Labour says) are to be enabled to asset-strip the NHS. [...] [T]he private sector [will] be allowed to pillage NHS resources.'²

1 'The Tory threat to the health service', *The Times*, 1 December 1980.

2 'Partnership with private sector would help NHS, circular says', *The Times*, 1 June 1983.

It is from 1983, but it could just as easily pass as a current affairs story. Apart from the names, so could this report from the annual conference of the National Association of Health Authorities, published in the same year:

“There has been a great deal of talk about hidden manifestoes and the threat of an attack on the welfare state. That is simply not true”, Mr Fowler [the Secretary of State for Social Services] said. [...] His statement did little to convince some of the 500 delegates. [...] Dr Rory O’Moore, chairman of the City and East London Family Practitioner Committee said: “The health service is up for grabs. [...] [T]he future of the health service [is] open to doubt.”³

Or this report, from the annual representative meeting of the British Medical Association in 1974:

‘Private practice [...] and the possibility of a breakdown of the NHS will dominate discussion’⁴

Or this one, also from a medical conference, but from 1970:

‘Dr. Murray [of the Socialist Medical Association] gave a warning that the health service would come under attack from the Tories in government because the service had proved that socialism worked.’⁵

Such sentiments can be traced back to the NHS’s very beginnings. Already in 1950, Health Minister Bevan accused the opposition of harbouring a covert anti-NHS agenda.⁶

‘It’s all the same, only the names will change’, sang Jon Bon Jovi in 1986.⁷ He probably did not have British health policy debates in mind, but he might as well have had. In today’s news, headlines like ‘Farewell to the NHS, 1948-2013: a dear and trusted friend finally murdered by Tory ideologues’ (*Independent*, 31 March 2013), ‘The NHS is on the brink of extinction – we need to shout about it’ (*The Guardian*, 8 January 2014), ‘TTIP could make NHS privatisation “irreversible”, warns Unite union’

3 ‘Renewed pledge on preserving strong NHS’, *The Times*, 25 June 1983.

4 ‘Private practice and possibility of NHS breakdown expected to dominate “doctors’ parliament”’, *The Times*, 10 July 1974.

5 ‘Private insurance seen as threat to health service’, *The Times*, 2 October 1970.

6 ‘Tighter control of health service costs’, *The Times*, 15 March 1950.

7 ‘Wanted dead or alive’, from the album *Slippery when wet*, 1986, Mercury Records.

(*Huffington Post*, 3 July 2014), 'Privatisation is ripping the NHS from our hands' (*The Guardian*, 6 August 2014), 'NHS "Jarrow March": Hundreds protest against "privatisation"' (*BBC News*, 16 August 2014), 'Why privatisation Is killing the NHS' (*Huffington Post*, 23 September 2014), 'The NHS privatisation experiment is unravelling before our eyes' (*New Statesman*, 9 January 2015), and 'NHS sell-out: Tories sign largest privatisation deal in history worth £780MILLION' (*Daily Mirror*, 12 March 2015) abound. Book titles such as *The End of the NHS* (Pollock [forthcoming]), *NHS For Sale: Myths, lies and deception* (Davis et al. 2015), *How to Dismantle the NHS in 10 Easy Steps* (El-Gingihy 2015), *NHS SOS: How the NHS was betrayed - and how we can save it* (Davis and Tallis 2013), *The Plot Against the NHS* (Player and Leys 2011), *Betraying the NHS: Health abandoned* (Mandelstam 2007) and *NHS Plc: The privatisation of our health care* (Pollock 2004) have set the tone of the debate in no uncertain terms.

There is a certain kind of NHS narrative which resembles fantasy novels that are based on a literary technique called 'thinning'. These novels are set in a world which is in a perpetual state of decline, and where the end of days is always imminent, but somehow never quite arrives. In these novels, the dismal current state of the thinning world is often contrasted with a lost golden age of innocence, set in a distant past. According to the *Encyclopedia of Fantasy*:

[T]he Secondary World is almost constantly under some threat of lessening, a threat frequently accompanied by mourning [...] and/or a sense of Wrongness. [...] [T]hinning can be seen as a reduction of the healthy Land to a Parody of itself, and the thinning agent – ultimately, in most instances, the Dark Lord – can be seen as inflicting this damage upon the land out of envy.⁸

The NHS thinning story could be summarised like this:

Once upon a time, when the NHS was true to its founding principles, it was the envy of the world, providing the best that modern medicine had to offer to rich and poor alike (= 'the healthy land'). Although it may have looked highly centralised and hierarchical, it was also somehow a 'grassroots organisation', run by the people for the people. But at some point, the

8 *Encyclopedia of Fantasy* (1997): 'Thinning', available at <http://sf-encyclopedia.uk/fe.php?nm=thinning>

corrupting forces of profit-seeking (= 'the thinning agent') began to enter this once innocent world, and contaminate it from within. Increasingly, the uncorrupted parts of the health service came under attack from these forces, because by their very example, these parts still demonstrate the superiority of the service's founding principles (= 'inflicting this damage upon the land out of envy'). At the moment, the enemies of the NHS are preparing for the decisive attack, and in this, they are aided by the government of the day. The government is pursuing a health reform which, on the face of it, looks like a mere set of technical changes. But it is really a Trojan horse which will disable the health system's defences, preparing it for a corporate takeover and a conversion into a profit-driven system (= the 'parody of itself'). Only a select few are able to join the dots and see what is really happening; to the general public, this will only become apparent when it is already too late.

It does not take a lot to trigger anxieties about an imminent privatisation of the NHS. The 1980 *Times* article cited above, for example, hinged mostly on the following two observations:

It refers to a speech in which the then Secretary of State for Social Services had reaffirmed the government's commitment to the NHS, but had also, at some point, used the words 'for the foreseeable future'. This is presented as a giveaway, the moment when the mask slipped for a second. Secondly, the article points out that the then Minister of Health had recently delivered a speech on the same day on which a think tank in Westminster had published a report discussing health insurance systems. This timing, the article argues, is too much of a coincidence; it has to be part of an orchestrated anti-NHS campaign.

More recent examples have stood on an equally flimsy basis. It is a frequently heard claim that since the passage of the 2012 Health and Social Care Act (HSCA), the share of healthcare contracts awarded to private companies has risen to one third.⁹ What is frequently omitted is that the bulk of these contracts cover relatively simple, routine procedures, which is why the sums involved are mostly trivial. Even the King's Fund, which has been among the HSCA's most outspoken critics, argues:

9 For example: 'Far more NHS contracts going to private firms than ministers admit, figures show', *The Guardian*, 25 April 2015; *BBC News*: A third of NHS contracts awarded to private firms – report, 14 December 2014; 'Third of NHS contracts go to private sector', *Financial Times*, 10 December 2014; 'Since the government's reforms, a third of NHS contracts have gone to the private sector', *New Statesman*, 10 December 2014. 'NHS being 'atomised' by expansion of private sector's role, say doctors', *The Guardian*, 6 January 2013.

‘[T]he Department of Health’s annual accounts suggest some £10 billion of the total NHS budget of £113 billion is spent on care from non-NHS providers [...] suggesting that claims of widespread privatisation are exaggerated. [...] Arguments about privatisation distract from the much more important and damaging impacts of the reforms’ (Ham et al. 2015: 17-22).

Insofar as there was an increase in private sector participation, part of it was due to a rather accidental one-off effect. In 2013, GP-led Clinical Commissioning Groups (CCGs) replaced Primary Care Trusts (PCTs) as the main commissioning bodies to allocate funding within the NHS. But CCGs were not just renamed PCTs. CCGs were meant to specialise exclusively on the commissioning of secondary and tertiary healthcare, while the old PCTs had a broader remit; they were also providers of some public health and community health services. During the transition to the new commissioning system, most of these provider functions were reallocated to local authorities, but others did not find a place in the post-reorganisation landscape. For lack of a better solution, those units were converted into stand-alone, non-profit ‘social enterprises’ (ibid.). While this probably changed little in practice, technically, it meant that these organisations were now part of the much-reviled private sector.

Those who peddle the NHS thinning story like to present themselves as lone voices in the wilderness, but they are more influential than they realise. They may have little discernible influence on the day-to-day running of the health service. But they help to ensure that in healthcare policy, the Overton Window – the range of policy ideas which can be at least publicly debated, even if they are not necessarily popular – remains narrow, and locked tightly around a ‘purist’ vision of the NHS. In a lot of countries with deep-seated ‘statist’ political traditions, where the general climate of opinion is much more hostile to economic liberalism than it is in the UK (e.g. France, Italy, Germany), policy options like the privatisation of state-owned healthcare facilities are part of the mainstream political debate.¹⁰ That does not necessarily mean that privatisations in the health sector are popular in these countries, but it does mean that advocates of privatisation are not considered ‘radical’ or ‘extreme’. In the UK, such ideas are well outside of the Overton Window.

¹⁰ In France and Italy, the private for-profit sector accounts for about one quarter of hospital beds. In Germany, the share is almost one third (OECD Stat.Extracts 2015).

Against this backdrop, advocates of a pluralistic, competitive and consumer-driven healthcare system in the UK tend to believe that theirs is a lost cause. Indeed, Deepak Lal (2012) dedicates a chapter of his book *Lost Causes: The Retreat from Classical Liberalism* to the NHS, and Daniel Hannan, one of the very few British politicians who have critiqued the NHS at the system level, recently wrote:

'[W]e are where we are. In a democracy, voters are never wrong. A clear majority wants to keep the NHS as it is. [...] [P]eople have made up their minds to keep the system as it is, which is why every party [...] opposes systemic change. [...] We're getting exactly the system we're asking for.'¹¹

It is easy to see why. If the tone of the debate is so hostile towards market-oriented reforms when such reforms are not even happening – how fierce would that hostility become if market-oriented reforms actually *were* to happen?

And yet, upon a closer look, public opinion on healthcare is more multidimensional than the media coverage and the political debate around the subject suggest. The British Social Attitudes Survey (BSA) reveals a marked contrast between 'macro level' and 'micro level' preferences. On the one hand, when people are asked about their commitment to the NHS in the abstract, support is indeed near-unanimous and strongly felt (Gershlick et al. 2015). This is in line with previous findings. As Taylor (2013: 7-8) explains:

'Compared with the rest of the world, few people in Britain call into question the healthcare system. In one 2012 study, only 3 per cent of people felt the system needed to be overhauled. The next most satisfied country has more than twice as many people questioning their arrangements.'

¹¹ Hannan, D., 'Stop complaining about the NHS. You're getting what you asked for', *ConservativeHome*, 21 January 2015.

But on the other hand, when people are asked about whether they would personally prefer to be treated by an NHS provider, a private for-profit or a private non-profit provider, a relative majority (43 per cent) indicate that they have no general preference for either sector. A further 18 per cent even express an active preference *for* independent sector providers. This is a remarkable result given that 'social desirability bias' surely works against these options. And for demographic reasons alone, the majority of those with no general preference for NHS providers is set to grow stronger over time, because the question also reveals a generational divide. The preference for NHS providers is strongest among those born before or during World War 2, with about half of respondents in this group choosing this option. Among the Baby Boomers, preferences are already more mixed, and among those born in 1980 or after, only about a third have a general preference for NHS providers.¹² In short, people express a near-unanimous and strongly felt support for the NHS in the abstract, but most are quite pragmatic about who provides their own healthcare. This pragmatism offers a basis on which reformers should try to build.

¹² 'Baby Boomers' and 'Generation X' are somewhere in between, but a bit closer to 'Generation Y'. The pro-NHS stance appears to be most uncompromising among those who have some memory of a time when the NHS was still new.

Health reform with the grain

Is there a conflict between the ‘macro-level absolutism’ (about the abstract principles embodied in the health service) and the ‘micro-level pragmatism’ (about how exactly healthcare is delivered) that characterise public opinion on healthcare? The answer depends on how broadly or narrowly one defines the NHS’s ‘core values’ or ‘founding values’, a concept often invoked but rarely well defined. At its broadest, this may simply refer to the principle of universality, i.e. the idea that every citizen should have access to a high standard of healthcare regardless of their ability to pay. That, of course, is *not* a distinct NHS value. It is a value which can be embodied in a wide range of otherwise completely different health systems, including systems in which provision is largely private and market-based. Empirically, this is exactly what we observe. Health systems in developed countries differ in a lot of respects, but regardless of how they are organised, virtually *all* of them – the US system being a notable outlier – offer universal access to a broad package of healthcare treatments (OECD 2012). So do plenty of middle-income countries. Thus, universality does not, in any way, set the UK apart from comparable countries.¹³ Still, if the term ‘NHS values’ is understood in this very broad sense, there is no contradiction whatsoever between a strong social consensus around the principle of universality and widespread indifference about who provides healthcare.

If, however, a more specific definition is used – if the NHS is defined in terms of characteristics that set it apart from most comparable health systems, rather than the ones that it shares with almost all of them – the

13 Even in the US, the lack of universal coverage is an accidental feature rather than a deliberate omission. In theory, the Medicaid programme was supposed to provide basic coverage to those who could not obtain healthcare on the market. The uninsured are people who are not covered by an employer-sponsored or an individual health insurance plan, but who are not poor enough to qualify for Medicaid.

two levels are indeed in conflict. What really distinguishes the NHS from the health systems of comparable countries is not universal coverage, but what one scholar described as the

‘conspicuously political character of the UK health service. To a greater degree than elsewhere, funding and policy became the province of the politician and the civil servant. Everywhere else health care was subject to political intervention, but the UK was unusual in the extent to which politicians assumed command and took over the levers of control for the entire health care system.’
(Webster 2002: 1)

When defined in this way, the NHS is incompatible with any notions of patient choice and case-by-case pragmatism. If patients are given effective provider choice, and if the funding closely follows the patient, then central planning in healthcare becomes impossible, because unless patient’s preferences coincide with those of the planners, their choices will jumble the plans. It would be like trying to play a game of chess with chess pieces that are automotive, and move around freely across the chessboard all the time.¹⁴ What is more, if that choice extends to independent sector providers, and if a significant minority of patients choose them, then the system will inevitably turn into a ‘mixed economy’. To stay within the metaphor, this would be the equivalent of a game in which the chess pieces are able to exit the chessboard altogether, and move around wherever they want. It is impossible to maintain a system of monolithic state-controlled healthcare under conditions of extensive and effective patient choice.

Webster’s characterisation of the NHS is now somewhat dated, given that it precedes the quasi-market reforms of the mid-2000s, and the more recent creation of ‘NHS England’ as a nominally politically independent commissioning board. But in an international context, it still broadly holds. The OECD’s multidimensional system of classifying healthcare systems attempts to quantify various system characteristics (on a scale from 0 to 6). In the categories ‘Degree of patient choice among providers’ and ‘Degree of private provision’, the NHS ranks towards the lower end of the spectrum.

14 The chessboard metaphor was used by Adam Smith in *The Theory of Moral Sentiments* (1759).

Table 1: Provider choice vs. plurality of provision

Degree of patient choice among providers → Degree of private provision ↓	Low (≤ 4) ¹⁵	High (≥ 5)
Low (≤ 2)	Spain Portugal Finland New Zealand UK	Italy Sweden Iceland
High (≥ 3)	Denmark Austria Belgium Greece	South Korea Australia Luxembourg France Japan Germany Switzerland Netherlands

Joumard et al. (2010)

A health system in line with the preferences expressed in the BSA – one in five respondents preferring independent sector providers, two in five being ‘sector-neutral’ – would have to be in the bottom-right quadrant, together with countries such as Australia, Luxembourg, France, Japan, South Korea, Germany, Switzerland and the Netherlands.

But these countries do not have national health services. The Netherlands, Switzerland and Germany have social health insurance (SHI) systems (see Niemietz 2015a), and the others combine public insurance with mixed provider markets. They are pluralistic systems, in which patients can freely

¹⁵ There is no particular reason for the choice of the cut-off values for ‘high’ and ‘low’. They have simply been chosen in such a way that there are enough countries in each group, and that few of them are exactly at the borderline.

choose among competing providers, including independent sector providers. One cannot 'convert' the NHS into such a system. If the NHS became similar to any of these health systems, *it would no longer be* 'the NHS'. The remainder of paper will, in broad strokes, sketch out what a transition to a pluralistic healthcare system of the kind we see in the bottom-right quadrant of Table 1 could look like. Critics will denounce it as a 'privatisation plan', and in a sense, they will be right. If adopted, this paper really would represent the type of agenda which NHS purists have been crying wolf about since the service's inception: a set of technical changes which would initially make little difference, but which would, over time, replace the NHS with a competitive, market-based system. And yet, it is the exact opposite of a secretive agenda which tries to bypass public opinion. Rather, as will become clear, it is an agenda which seeks to *weaponise* public opinion and turn it into a catalyst of change.

This paper is not about 1980s-style privatisations, i.e. politicians selecting state-owned assets and putting them up or sale, even if in principle, such privatisation programmes can work in the healthcare sector as well. For example, in the 1990s and early 2000s, various German state governments sold some of their hospitals to private investors, and in this way, the share of private for-profit hospitals increased from 15 per cent in 1991 to 30 per cent in 2007 (Schulten and Böhlke 2009). Still, this paper does not propose anything along those lines. A privatisation programme of that kind would never enjoy democratic legitimacy in the UK, and will therefore not be considered here.

This paper proposes a far more moderate agenda, although its effects could be just as far-reaching. In theory, the quasi-market reforms of the mid-2000s have already converted the NHS into a system in which patients can freely choose providers, and in which funding follows patients. If these principles were consistently applied, the NHS would gradually be replaced by a mixed system – but the drivers of this conversion would not be politicians. The drivers would be individual patients. Funding would follow patients, so every time a patient chose a private over a public provider, funding would follow them from the NHS to the private sector.

Under this arrangement, the never-ending story of hidden agendas and secret privatisation plans could be completely turned on its head. In a system in which funding is effectively allocated by patients, through the choices they make, the market share of private companies could only increase if, and only to the extent that, patients actively chose them over

NHS providers. As long as patients made no such choice, there would be no diversion of NHS funds to the private sector. (There would, for that matter, be no such thing as a private sector.) NHS purists have so far managed to portray themselves as the true voice of ‘the people’, guarding an institution which the public cherishes against attacks from corporate interests and a political elite blinded by ‘neoliberal’ dogma. The current system allows NHS purists to portray any increase in private sector participation as a self-evidently bad thing, regardless of how those providers perform, or how they obtained their market share in the first place. This is because the purists are able to present this increase as the result of a top-down political decision taken behind closed doors, for which the public has never given its consent. This is not generally true even in the current system, but in a very literal sense, it contains a grain of truth. There has never been a referendum in which the option ‘The independent sector should play a greater role in healthcare’ appeared on the ballot box.

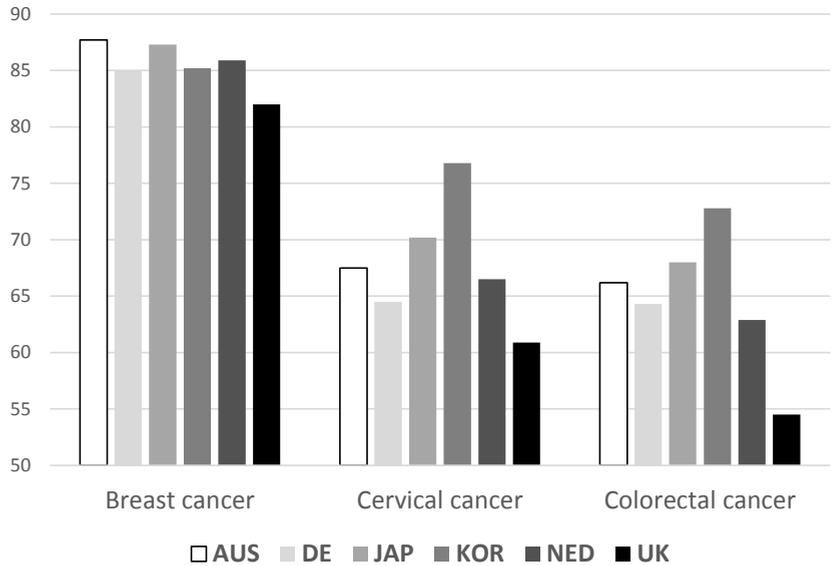
Such objections would not apply to the system proposed here. Healthcare funding would be allocated solely on the basis of people’s preferences – but unlike in the current system, *revealed* preferences, the choices people actually make, would trump *stated* preferences. Choice at the micro level would become the catalyst of wider systemic change, and if NHS purists wanted to defend the state monopoly over healthcare, they would be forced to ‘come out of the closet’ and attack the principle of patient choice openly. The authoritarian character of NHS purism, and its incompatibility with any notion of ‘empowering patients’, would finally become visible.

Pluralistic health systems versus the NHS: outcomes

The rhetoric of NHS purists relies heavily on the US healthcare system as an off-putting example. This is a strange choice, both on a practical and on an analytical level. On a practical level, there is, to the best of this author's knowledge, nobody in the UK who proposes an emulation of the US system. It is therefore not clear why the UK healthcare debate should be so dominated by an alternative which nobody even advocates. But the US model is also an international outlier in so many respects that it is hard to draw conclusions from it which are readily transferable to other countries.

This section therefore concentrates on more relevant comparators, namely the relatively liberal and pluralistic systems in the bottom-right quadrant of Table 1. An overview of these systems' health outcomes suggests that a move towards a pluralistic health system is nothing to be dreaded. For a start, insofar as comparable data are available, a patient diagnosed with a common type of cancer has a better chance of survival in any of these countries than in the UK (Figure 1).

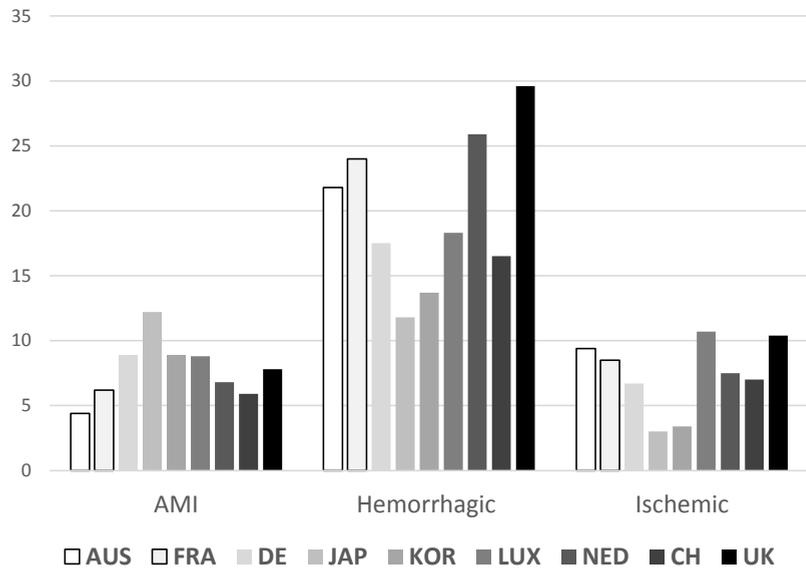
Figure 1: Age-adjusted 5-year cancer survival rates, 2007-2012 or latest available year



Based on data from OECD Stat.Extracts (2015)

The UK also has the country sample's highest mortality rate among patients who suffered from a haemorrhagic stroke, and the second-highest for ischemic strokes (Figure 2). Only for Acute Myocardial Infarctions (AMIs) is the NHS performance middling.

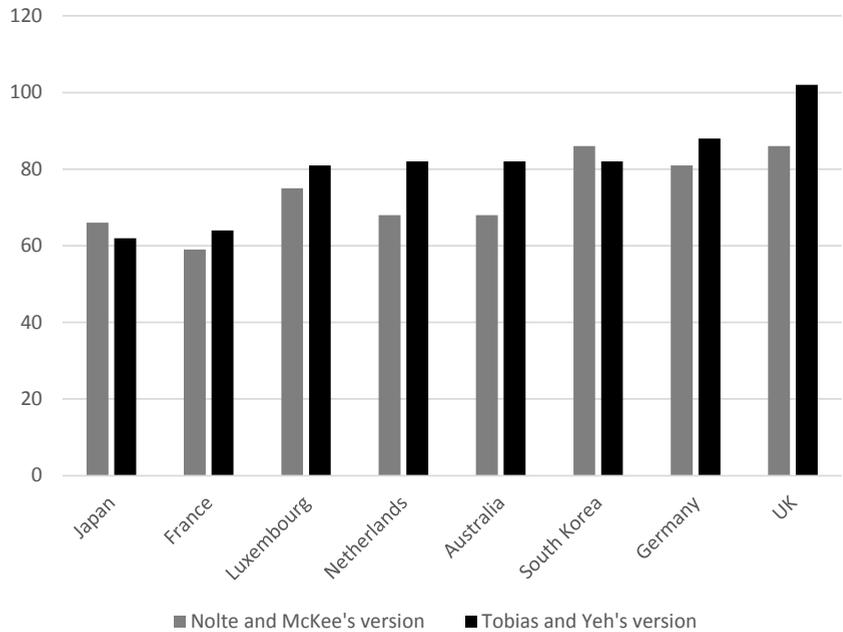
Figure 2: Age-/sex-adjusted 30-day in-hospital stroke mortality rates, 2012 or latest available year



Based on data from OECD Stat.Extracts (2015)

Of course, all healthcare systems perform poorly in some respects. But the NHS is also behind the others in terms of Mortality Amenable to Health Care (MAHC), an attempt to measure health system performance in a more holistic way. MAHC measures estimate the annual number of 'avoidable' deaths, where 'avoidable' means that these deaths could, in principle, have been averted through better or timelier treatment. The UK comes out last under one version of MAHC, and in joint last place under a different version (Figure 3).

Figure 3: Age-adjusted annual number of avoidable deaths per 100,000 people (Mortality Amenable to Health Care), 2007



Gay et al. (2011)

Supporters of the NHS frequently cite the Commonwealth Fund study, which rates and ranks healthcare systems according to a number of criteria, and which has so far always put the UK in the Top 3. But in the Commonwealth Fund study, only one category refers to health outcomes (the 'Healthy Lives' category), while the rest is concerned with inputs and procedures (for a more detailed critique of the Commonwealth Fund study, see Niemietz (2014: 19-21) and Niemietz (2015a: 25-27). In said outcome-related category, the UK ranks once again close to the bottom. So even in NHS-supporters' preferred study, the pluralistic systems (insofar as they are included) outperform the NHS on this account.

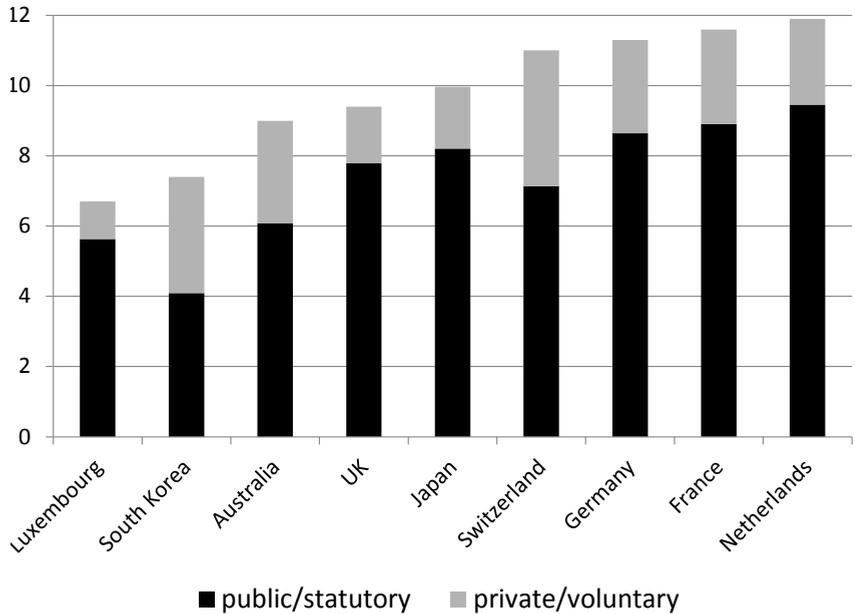
Table 2: The Commonwealth Fund's ranking in the outcome-related category ('Healthy Lives')

	Rank
France	1
Switzerland	3
Australia	4
Netherlands	5
Germany	7
UK	10

Davis et al. (2014)

Insofar as NHS supporters concede that these shortcomings in health outcomes exist, they blame them on 'inadequate' funding: if only the NHS were 'adequately' funded, it would outperform any other system in the world. It is true that at just under 10 per cent of GDP, healthcare spending in the UK is not especially high by the standards of developed countries (although it is not at the lower end either). Would the NHS rise to, for example, French standards if UK healthcare spending matched French levels?

Figure 4: Health expenditure in per cent of GDP



Based on data from WHO (2014)

Unsurprisingly, there is no exact way of modelling what would happen to health outcomes in country X if it adopted the spending levels of country Y. But the OECD study by Joumard et al. (2010), which is probably the most comprehensive estimate of health system efficiency, offers some important hints. This study models healthcare systems as ‘production functions’ which, subject to a number of external constraints – lifestyle factors, environmental conditions, economic conditions, education levels etc. – translates healthcare inputs into outcomes (life expectancy, conditional life expectancy at age 65, minimised MAHC). Among other things, this enables them to estimate how far health outcomes could be improved through efficiency improvements alone, while holding current levels of healthcare spending, lifestyle habits and other factors constant. They find that all countries have efficiency reserves, but there are stark differences in magnitude. In Australia, Switzerland and South Korea, potential gains in average life expectancy from pure efficiency improvements amount to less than one year. In the UK, the equivalent figure is about three and a half years. The UK also has greater potential to raise conditional life expectancy at age 65, and to decrease MAHC, through efficiency improvements.

Table 3: Years of average life expectancy lost due to system inefficiency

Number of years	
<1	Australia, Switzerland, South Korea
1–2	Japan, France
2-3	Netherlands, Germany
>3	Luxembourg, UK

Joumard et al. (2010)

This does *not* invalidate NHS supporters' argument that increasing spending would improve outcomes. But it strongly suggests that the NHS is further away than the other systems in the sample from making the most of the funding it already gets. It seems a sensible rule of thumb that whatever the current spending level, countries which are far away from the 'efficiency frontier' should try to move closer to said frontier through structural reforms before considering spending increases.

Besides, Figure 4 also shows that a substantial part of the difference between the UK and the high-spending countries is explained by *private* spending, with the difference in public/statutory spending being much narrower. This is because insurance-based systems often make it easy for patients to supplement statutory healthcare with privately purchased add-ons. For example, in the Swiss and the German system, the term *Komfortmedizin* ('convenience medicine') describes medical products and services that are not covered by statutory insurance because they have too little impact on clinical outcomes, but which some patients are nonetheless prepared to pay for. Examples would be single room accommodation in a hospital, general anaesthesia for procedures for which local anaesthesia would be sufficient, or an expensive drug that minimises unpleasant side effects without being clinically more effective than the standard medication. Since the NHS is built on an egalitarian ethos, it does not usually offer *Komfortmedizin*. The purchase of upgrades and add-ons is heavily discouraged, and often not possible at all (see NHS Choices n.d.).

This helps to keep total expenditure low, but only by preventing some patients from buying goods and services they are prepared to pay for.

Choice and provider plurality may also give rise to other, less tangible benefits. At least some patients appear to value choice and plurality in their own right, that is, over and above what can be explained by improved outcomes. Costa-Font and Zigante (2012) attempt to identify the drivers of choice/competition-based reforms in a number of developed countries, and show that while quality and efficiency improvements are indeed major policy objectives, they cannot explain everything.

All in all, the pluralistic systems are superior to the NHS in terms of a range of health outcomes and in terms of efficiency estimates. There is no obvious way of telling to what extent these differences can be attributed to differences in the way the health systems are organised, so the above comparisons do not 'prove' that the pluralistic systems do better *because* they are pluralistic systems. But at the very least, it is safe to say that NHS purists' dire warnings against the use of market mechanisms and the involvement of private companies have no obvious factual basis. Supporters of the status quo claim that even small steps towards a market-based system would result in 'Wild West medicine', but they cannot explain why it is that some of the countries which have gone furthest in pursuing such reforms record some of the best outcomes in the world. Nor, for that matter, can they explain why, to the limited extent that the UK has pursued reforms based on choice and competition, it has led to improved health outcomes and efficiency gains (Bloom et al. 2010; Cooper et al. 2011; Cooper et al. 2012; Gaynor et al. 2011; Le Grand 2012).

A pluralistic, market-based health system is not a dystopia to be dreaded, but a desirable alternative to be worked towards. But this leaves the question of how to get there. Healthcare systems are heavily path-dependent. Apart from periods of major historical breaks, there are very few examples of countries abandoning one type of healthcare system and replacing it with another. As explained, however, this paper does not propose any revolutionary system-level changes. It merely proposes a broadening of patient choice, and a number of changes in funding arrangements, to create the conditions under which people's micro-level choices will eventually change the overall character of the system.

Abolishing catchment areas

Since 2013, the responsibility for allocating healthcare funding has been mostly devolved to Clinical Commissioning Groups (CCGs) led by General Practitioners. These groups purchase healthcare services on the NHS's 'internal market', and occasionally from independent sector providers. Thus, even in the current setting, the role of CCGs is not wholly incomparable to that of insurers in social health insurance systems, for example the *Krankenkassen* in Switzerland and Germany, and the *Ziektekostenverzekering* in the Netherlands. A big difference, however, is that British patients cannot directly choose between CCGs, because they do not register directly with a CCG. Rather, every GP belongs to a CCG, and when patients register with a GP in their catchment area, they also automatically sign up to their GP's CCG. So even though CCGs are not defined by geographic boundaries in the same way in which the old Primary Care Trusts (PCTs) were, they do not operate in a competitive setting.

Another huge difference is that in SHI systems, insurers (or at least the larger ones) are recognisable brands with distinct brand identities. This is not the case at all for CCGs, no doubt partly due to their novelty, but under the current system, they have neither the means nor the incentives to develop a distinctive profile.

This situation could be changed relatively easily. Patients should be allowed to register directly with any CCG they see fit, regardless of place of residence. Meanwhile, CCGs should be free to develop their own profiles and specialities, and build up brand recognition. They should also be free to merge and de-merge as they see fit, especially with other CCGs, and at a later stage, with provider organisations as well. This would lead to the development of an 'internal market' on the commissioning side. CCGs would begin to compete for patients, and their 'optimal' size and scope would be discovered through a competitive process as opposed to political

or bureaucratic fiat. The HSCA has, among other things, led to a centralisation of some commissioning activities (Ham et al. 2015: 12). This would have to be reversed. The right geographical level and scale of commissioning activities ought to be discovered through competition, not political decisions.

In other words, commissioning activities would no longer be shaped by politically determined geographical boundaries. CCGs would be able to negotiate and contract with providers up and down the country, or, for that matter, internationally. In the more liberal SHI systems, cross-border commissioning is already happening, at least where distance and language barriers do not play too large a role. Dutch health insurers maintain contracts with 12 providers in the Dutch-speaking part of Belgium, and with 42 providers in Germany (VGZ 2013).¹⁶

In order for competition to work in the desired way, two preconditions must be fulfilled. Firstly, the budgets of CCGs have to correspond much more closely to the health profiles of the populations they cover. The budget of a CCG which covers a disproportionate number of people with say diabetes or asthma must be systematically higher than the budget of a CCG which covers a disproportionate number of people in robust health, and the difference must be commensurate to the difference in expected costs. Under a risk-adjusted funding formula, 'cherry-picking' of healthy patients becomes economically pointless. CCGs would compete on the services they offer, not on their ability to attract the healthiest people.

This is the basic idea behind the risk structure compensation schemes which underpin social health insurance (SHI) systems. The Dutch system can serve as an illustrative example for how this adjustment works. Dutch insurers do not receive all of their premium revenue directly from their policyholders, rather, part of it is mediated through a risk structure compensation fund. Table 4 shows the payments they receive from that fund for two fictitious people with different health profiles. In this particular example, the main adjustment occurs through the difference in the basic rate, which reflects the difference in average treatment costs of people in the respective demographic groups. There are further, more individualised adjustments for chronic conditions and recent history of hospitalisation, as well as some minor adjustments for area of residence and employment status.

¹⁶ There are also a number of contracts with (mostly primary care) providers in Spain, presumably aimed at Dutch retirees living there.

Table 4: Risk adjustment: an example from the Dutch system

	Man, 19		Woman, 67	
Basic rate	€389		€970	
Chronic conditions	None	-€109	Thyroid disorder	+€174
Hospitalisations in previous year	None	-€97	None	-€97
Area of residence	Urban	+€36	Rural	-€31
Employment status	Employed	-€20	Retired	±€0
TOTAL	€199		€1,016	

Schäfer et al. (2010: 81-83)

In a system without risk-adjustment and with flat-rate insurance premiums, a 19-year old man without chronic conditions would be vastly more attractive to an insurer than a 67-old woman with a thyroid disorder. But after the adjustment (provided it is actuarially sound), an insurer should be indifferent between the two. Generally speaking, the more fine-grained the risk-equivalisation scheme is, the less of an issue adverse selection becomes, and the freer can be the insurance market. Historically, as long as risk-structure compensation was absent or incomplete, SHI systems controlled movements between health insurers in order to maintain balanced risk pools. In the German SHI system, risk structure compensation was only introduced in 1994, and until then, choice of insurer was severely restricted (Breyer et al. 2005: 297-298; Oberender et al. 2002: 80). In the Swiss system, risk adjustment is still rather crude¹⁷, and in this system, choice and competition in health insurance are still more restricted than in the other SHI systems.¹⁸ If the UK were to adopt risk equivalisation, it would be sensible to go ‘the whole hog’ and introduce a comprehensive scheme (like the Dutch one), rather than settle for a halfway house (like the Swiss one).

17 The Swiss system adjusts only for age, region and sex, and only since recently, for hospitalisation in the previous year as well. The German system is more similar to the Dutch one (Felder 2013).

18 Competition is confined by cantonal boundaries, and insurers are barred from making profits from operations related to basic health insurance. In the Netherlands, in contrast, health insurers compete in a nationwide marketplace, and while most insurers are non-profit organisations, for-profit insurance is available as well.

The second precondition is the specification of an explicit minimum 'healthcare basket' which all CCGs have to offer. In insurance systems, there is typically a set list of medical products and services, which enables policyholders to find out exactly what they are and what they are not entitled to. In the UK, this has not been the case in the past. NHS 'branches' have had considerable discretion over which services they were prepared to fund, and what their clinical priorities were, but there would have been no way for any given NHS patient to find out whether, for example, a particular drug was 'covered' by the NHS or not. Since the end of the 1990s, there have been some steps towards formalising this process and reducing discretion (see Mason 2005). From here, it would be a relatively small step towards defining a healthcare basket. All CCGs would, as a minimum, have to offer everything included in this basket, and they would be free to offer additional services on top.

Once these two preconditions have been met – a risk equivalisation scheme is up and running, and a minimum healthcare basket has been specified – there is no reason why the commissioning/insurance side should not be opened to non-NHS actors, for-profit or non-profit. Obvious candidates would be patients' associations, trade unions and professional associations, health insurance companies and integrated healthcare groups with in-house providers, and perhaps other types of organisations. Mergers and takeovers between CCGs and any of these organisations should be permitted (subject to competition law), and a legal framework for an orderly default of a commissioner/insurer would have to be created. None of this involves reinventing the wheel, as these features have long been standard fare in SHI systems.

Critics have branded the 2012 Health and Social Care Act, which led to the creation of CCGs, as 'free-market fundamentalism'. It was nothing of the sort. The HSCA replaced one politically determined structure of healthcare commissioning and delivery with another politically determined structure of healthcare commissioning and delivery. The whole point of any market-oriented reform worthy of the name is to challenge the primacy of politics, and move away from politically determined structures altogether. The HSCA has not done so.

And that is exactly its weakness. It is very much an open question whether GPs are the most suitable actors to lead commissioning bodies, whether commissioning and provision should be strictly separated, whether the commissioning of primary care and of hospital/specialist care should be

performed by different organisations, what the optimal scale of commissioning/insurance organisations is, and what their exact relationship should be with other stakeholders. A market-oriented reform would create a framework in which such questions could be settled through an open-ended trial-and-error process.

If the HSCA was at all intended to strengthen market mechanisms, it could be described as the equivalent of fixing the display of a balance before stepping on it. Just as a balance is a device to *find out* one's weight, a market is a device to *find out* which delivery structures are appropriate for a particular sector. 'Telling' a balance in advance what weight it 'ought to' show defeats the whole point of having a balance in the first place, and 'telling' a market what its structure 'ought to' be defeats the point of having a market.

Market solutions are not about 'getting it right' the first time round, but about giving the relevant actors scope and incentives for self-correction and 'learning on the job'. In contrast, the structures that have been put in place by the HSCA can only be changed through further political decisions and political reorganisations, as they contain no mechanism for self-correction. The HSCA did not introduce market mechanisms. It would be more accurate to describe it as just another top-down reorganisation.

The above-proposed changes would, eventually, unleash a market discovery process. It would mean the end of political reorganisations, and the beginning of reorganisation by the market. However, healthcare is characterised by a high degree of inertia and status-quo bias. Even in the Dutch system with its well-established, matured market for health insurance, only about one in twenty people switch insurers every year (Schäfer et al. 2010: 174). Thus, even if the legal framework for a Dutch-style insurance marketplace were established overnight in the UK, it would probably take years before these changes would be felt on the ground. The transition would therefore be slow and gradual, and it would probably cause less upheaval than a 'typical' NHS reorganisation.

The provider side: free entry and exit

In the mid-2000s, the Labour government phased in a new reimbursement system called 'Payment by Results' (PbR), arguably a misnomer because it really pays providers by activity levels, not 'results' (Niemietz 2015b: 100-101; Niemietz 2014: 24-27). The PbR system splits patients into groups on the basis of their diagnosis, and assigns a reimbursement level to each group. This level is based on the average cost of the treatment required by patients in the respective diagnosis group, with some adjustment for case-specific particularities. In this, the UK followed a broader international trend towards so-called 'diagnosis-related group' (DRG) payment systems, i.e. payment systems with standardised tariffs. The purpose of DRG systems is to incentivise providers to attract more patients, whilst at the same time disincentivising overtreatment and unnecessarily costly treatment for a given patient.

In the UK, the system currently works in such a way that PbR payments will more or less cover a provider's variable costs, but providers could not survive on the basis of PbR payments alone. This limits the effectiveness of a DRG system. While PbR is often described as a system in which 'the money follows the patient', it would be more accurate to describe it as one in which 'some money follows some patients'. In this, it stands in contrast with the Dutch DRG system, which has a much broader scope: in the Netherlands, DRG tariffs do not just cover variable costs, but also a proportion of the fixed costs. Dutch providers can therefore sustain themselves on the basis of activity-based payments alone, provided they attract a critical minimum number of patients. This is not an option in the UK, which is why 'many [providers] have effectively become dependent on the Department of Health for financial support' (Ham et al. 2015: 37).

To increase the PbR system's effectiveness, it should become more like its Dutch equivalent. Tariffs should be extended to cover fixed costs as well, and their levels should be set in such a way that the vast majority of providers can be self-sustaining on the basis of activity-based payments alone.

Crucially, this change in the funding method would have to be coupled with a non-negotiable no-bailout clause. If a provider fails to attract enough patients to survive economically, it should not survive economically. Bankruptcies and takeovers of failing providers by better-performing ones would then become a normal occurrence.

In the Dutch system, the absence of a no-bailout clause was initially a critical omission, which is why a number of providers that were unable to sustain themselves on the basis of DRG payments were bailed out in various ways (Kocsis et al: 2012). More recently, the government declared its intention not to intervene prior to a bankruptcy anymore. Whether this declaration is credible remains to be seen, but when a large hospital near Rotterdam failed in 2013, the government did not come to its rescue.¹⁹ (The hospital in question was immediately taken over by three other ones.)

Takeovers of this kind, and even closures, *can* occur in the UK as well, and on an ad-hoc basis, they do (see Ham et al. 2015: 13-15). But they are not a regular feature of the UK healthcare landscape, because they are not hardwired into the system. A broadening of the PbR-system, coupled with a no-bailout clause and, potentially, a clarification of the legal framework for orderly defaults and takeovers, would rectify this situation.

The intense resistance against letting a healthcare provider fail are a stark example of Bastiat's 'what is seen and what is not seen' fallacy: the benefits of bailing out a failing provider are tangible, concentrated and immediately apparent. The costs are more dispersed and highly abstract; they cannot be known exactly because this would require knowledge of a hypothetical counterfactual. What is seen is the disruption that the bankruptcy of a provider would cause to the local healthcare setting, the inconvenience for patients if there is no immediate and smooth takeover, the negative impact on the local health workforce, and in some cases, the negative impact on the local economy as a whole. What is not seen is that if underperforming providers are preserved at all cost, better-performing ones will never be given room to expand.

19 DutchNews.nl: 'Spijkensisse hospital goes bankrupt, can't pay staff', 24 June 2013, available at: http://www.dutchnews.nl/news/archives/2013/06/spijkensisse_hospital_goes_bank/

If bankruptcies and takeovers of health providers became a regular occurrence in the UK, it would clear the way for new entrants and new models of healthcare provision. In itself, this process is neutral with regard to the institutional composition of the sector. An ailing private for-profit provider could be taken over, or replaced, by a flourishing NHS Foundation Trust, just as the same could happen in reverse. What type of provider mix would ultimately result is a completely open question. But given that the starting point is a wholly state-dominated provider side, it seems very likely that a much more balanced provider mix would be the long-term outcome.

This is not a particularly radical proposal. The rollout of the PbR system was started over a decade ago, and the proposal outlined here would do no more than carry this reform to its logical conclusion. Due to the inertia in healthcare, it would, again, probably take several years until the consequences were felt on the ground. But it could eventually turn out to be transformative.

Freedom of choice over the depth of coverage

All healthcare systems necessarily limit the consumption of healthcare services in one way or another. Most do so through some combination of financial incentives (e.g. co-payments, deductibles, reimbursement limits) and rationing decisions. The NHS is different from most other health systems insofar as it relies almost exclusively on the latter. In most OECD countries, patients who are financially able to do so are expected to make some modest contribution towards the cost of their primary care, or hospital care, or both. In the UK, there is only a minimal flat rate prescription charge, and much of the population is exempt (Cawston and Carrie 2013).

The absence of user charges is a major disadvantage of the British health system. There are a number of risks associated with user charges: poorly implemented, they can discourage people from seeking treatment at the early stages of a disease, when interventions will usually be the most cost-effective. They can also have a disproportionate impact on low-income earners. However, when well defined, user charges can be a sensible tool to discourage unnecessary demand and to encourage cost-conscious behaviour (e.g. Drummond and Towse 2012; Breyer et al. 2005: 263-267; Chiappori et al. 1998). For example, in the UK, there have been ongoing political efforts to shift healthcare from relatively cost-ineffective to relatively cost-effective options (Niemietz 2014: 40), and the success of such measures has so far been limited. Arguably, these efforts would have been more fruitful if user charges had given patients some 'skin in the game'.

But in the UK, there is also a very strong social consensus around the principle of healthcare being free at the point of use, and it is unlikely that there will ever be popular support for a general change to this status. Making the case for a general introduction of user charges is therefore probably a waste of time.

But user-charge systems come in different shapes and sizes, and some of them would probably be more palatable in the UK than others. A comparison between the French system and the Swiss system can be seen as instructive in this regard. In France, at less than 0.8 per cent of GDP, out-of-pocket payments represent a relatively small part of healthcare spending (based on figures from WHO 2014). In Switzerland, at almost 3 per cent of GDP, out-of-pocket payments are far more substantial. Yet there are reasons to believe that at least in some aspects, the French system would be more controversial in the UK than the Swiss system.

One of the main differences between these systems is their default option. The French system is a system of partial insurance. Statutory insurance covers the bulk of healthcare costs, but not all of it. If people want their healthcare to be free, or nearly free, at the point of use, they have to take out complementary health insurance to cover the remainder. Such complementary insurance is readily available – 96 per cent of the population have it (OECD 2012) – but the default option is that patients pay a substantial excess.

In Switzerland, it is the other way round. The default option for health insurance is a low-deductible policy. But people then have the option to voluntarily increase this deductible (up to a ceiling of CHF 2,500), and those who do so receive a premium rebate from their insurer, with higher deductibles leading to higher rebates (Comparis 2015).²⁰ This means that in Switzerland, for a lot of patients, healthcare is nowhere near being free at the point of use. Some patients pay substantial amounts out of pocket – *but only if they have voluntarily opted for a high-deductible policy*. Nobody is forced to do so, and unless people make an active choice to raise their deductible, they will always remain in the low-deductible standard contract.

Voluntary deductibles are an elegant way of exploiting the advantages of cost-sharing arrangements whilst avoiding the risks. The system encourages self-selection, with healthier patients choosing higher deductibles. This would mean that the people who have least control over their healthcare consumption – for example, the long-term sick – will still be fully protected against the financial risk of illness, while those with the highest degree of control over their healthcare consumption will also face the strongest incentives to economise. Empirically, this seems to be exactly what

20 Comparis (2015): 'Krankenkassen vergleichen und Geld sparen', *Comparis*, available at: <https://www.comparis.ch/krankenkassen/default.aspx>

happens. There is a substantial difference in medical costs between people on high-deductibles and people on low-deductible plans, and according to one estimate, about three quarters of this difference is due to self-selection, and one quarter due to incentive effects (Gardiol et al. 2005). Unsurprisingly, the exact decomposition is a matter of debate. Some studies find stronger incentive effects (Werblow 2002), some find weaker ones (Schellhorn 2002a; Schellhorn 2002b), whilst others are more or less compatible with Gardiol's assessment (Gerfin and Schellhorn 2005). But whoever is 'right' on this, the Swiss system demonstrates that it is possible to combine strong financial protections for those in poor health with financial incentives to economise on healthcare spending.

The UK could adopt a variant of this system of voluntarily user charges. Unlike in the Swiss system, where there are always at least a small deductible and some co-payment, the default option would have to be the current status quo of free-at-the-point-of-use healthcare. But CCGs (and other financing agents) should be allowed to offer alternative plans with deductibles, co-payments or other forms of user charges, and offer rebates for those who choose those plans.

Another interesting feature of the Swiss system, which could find its UK equivalence, is 'meta-choice': Swiss patients choose how much choice they want to have. The default option is an insurance policy which offers unrestricted provider choice, and which contains no gatekeeping mechanisms. But people can opt into various forms of managed care plans, in which some restrictions apply, again in exchange for premium rebates. One option is the *Hausarztmodell*, a British-style gatekeeper model under which patients register with one single GP at a time, and can only seek appointments with that GP unless they register with a different one. More importantly, under this option, they waive the right to access specialist care directly. Another option is the *Telmedmodell*, which is also a gatekeeper model, under which patients must have a telephone consultation first before visiting a doctor. Thirdly, there is the HMO model, under which patients restrict themselves to an integrated health centre unless they are referred to an outside provider.

Apart from the *Hausarztmodell* (which is already how the NHS works anyway), similar options could be introduced in the UK. Even if strictly voluntary, this proposal would, no doubt, spark controversies. NHS ‘purists’ will fear that even if few people choose alternative policies, their mere existence would, over time, erode the widespread deferential attitudes towards the NHS. Once we start to make individual trade-offs in this area, healthcare would quickly become subject to quite mundane financial calculations. At the margin, people would literally trade off healthcare coverage against holidays and restaurant visits. This would clash with the purist vision of health as a good of infinite value, which should never be subject to petty-minded, philistine economic considerations. The effect would be strongest among those who actually chose a deductible, because up to the point where that deductible is reached, they would purchase healthcare like they purchase any other good or service.

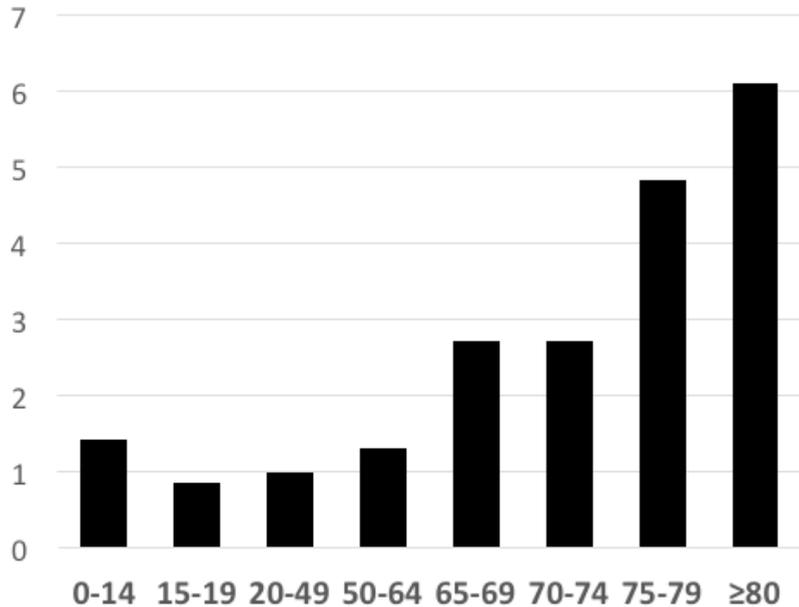
The trade-offs described here are, of course, always present in *any* health system. A political decision to increase healthcare spending entails a higher tax burden, and a reduction in private consumption, so the trade-off is exactly the same. But in the current system, these are decisions made *for* people, not *by* them. The romantic idea of the NHS as a ‘publicly’ owned service (‘our’ NHS) holds that ‘we’ make such choices collectively rather than individually, but the link between voting habits, healthcare spending and tax levels is so tenuous that voters are highly unlikely to think of their decisions in such terms. The current system therefore promotes the illusion of healthcare as an ‘extra-economic’ good, while voluntary deductibles would challenge it.

Thus, NHS purists would have to defend the system precisely on the basis of its lack of transparency. They would have to attack voluntary deductibles for their demystifying effect, and present the clarity that would come with them as dangerous. Again, framing the debate in those terms would bring the authoritarian character of NHS purism to the fore. From the perspective of those who support pluralism and choice in healthcare, this could turn out to be the policy’s main advantage, quite apart from the more immediate effect of efficiency savings.

Long-term sustainability through prefunding

Healthcare costs rise systematically over people's lifecycle. They are relatively stable during, roughly, the first five decades of life, and begin to rise exponentially afterwards (Figure 5). On average, healthcare costs for people aged around 70 are almost three times as high as for people aged between 20 and 50. For people in their late 70s, that multiple rises to about five, and for people aged over 80 it rises to over six. Healthcare systems are, in this sense, a lot like pay-as-you-go financed pension systems, in that most healthcare spending represents a transfer from the working-age generation to the retired generation. In societies where the ratio of the latter to the former (the old-age dependency ratio) is rising, healthcare systems run into the same sustainability problems as PAYGO pension systems.

Figure 5: Healthcare costs as multiples of those aged 20-49



(Hagist and Kotlikoff 2005)

In the UK, that ratio is forecast to rise from about 1:4 today to about 2:3 by the late 2030s. This will create pressure to either raise tax burdens on the working-age population substantially, cut back on healthcare entitlements, or hike the retirement age (or some combination of these measures). The problem with the latter two options is that, ironically, the same population ageing process which makes these measures economically more pressing also makes them politically less likely to happen. An increase in the old-age dependency ratio also means an increase in the political power of the 'grey vote', and thus in the ability of this electoral group to block fiscal changes unfavourable to them (Booth 2008). The first option may be politically more feasible, but it is already hitting economic limits: there is good evidence to suggest that the UK is not too far away from reaching its maximum taxing capacities (Smith 2007; Minford and Wang 2011; Smith 2011).

As with pensions, the only root-and-branch solution would be to move from a PAYGO-system to a prefunded one. Healthcare financing agencies (insurers or otherwise) would build up a capital stock for their members while they are

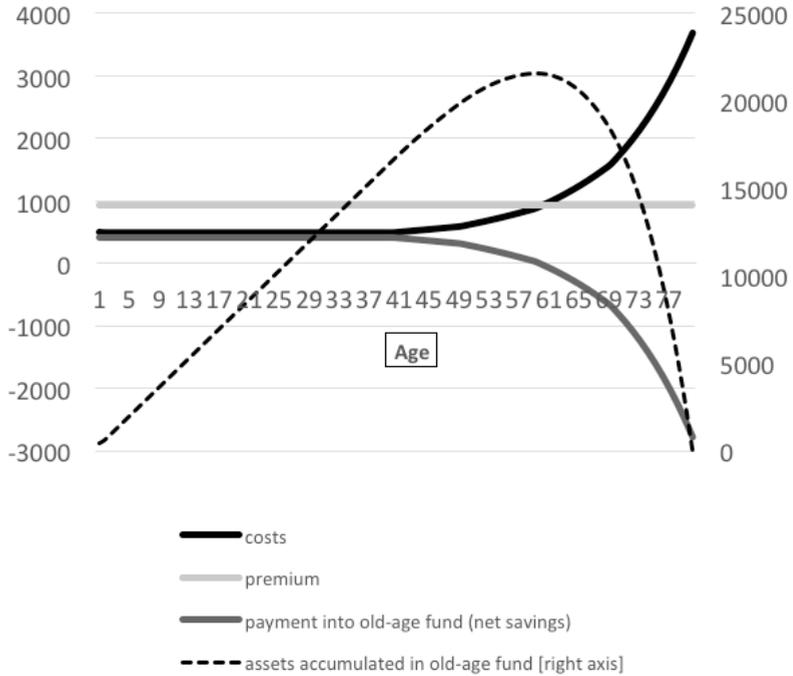
young, and draw on it when their members reach old-age. But while there are a number of countries with at least partly prefunded pension systems, prefunded healthcare is extremely rare (see Niemiets 2015c). The difficulties, however, are entirely to do with the politics around it. Economically, prefunding health expenditure is perfectly feasible. In Germany, about 8 million people have prefunded healthcare plans.

The German system can be thought of as two parallel health insurance systems. There is a strict (and arguably archaic) separation between 'social insurance' (GKV) and 'private insurance' (PKV), with people being either in one system or the other.²¹ This distinction does not exist in the Netherlands and Switzerland, where everybody is part of the same system, and where 'social insurance' essentially just means 'regulated private insurance' (Niemiets 2015a: 14).

The PKV sub-system is not part of the risk equalisation scheme, so premiums are set according to individual health risks. On its own, this would lead to premiums rising steeply with age, and becoming prohibitively expensive for many elderly people. In order to prevent this, insurers are required to accumulate old-age reserves for their working-age members, and use them to smoothen premiums over their lifetime. In a stylised form, Figure 6 illustrates how premium-smoothing works. The black line shows an individual's annual healthcare costs in relation to their age, which, in this hypothetical example, are constant until the individual reaches age 40, and then begin to grow at an accelerating rate. The individual is assumed to live for 80 years, and their health insurance premium (the light grey line) is held constant throughout that time. In the first three quarters of this person's life, their annual health insurance premium exceeds their annual healthcare costs, and the difference (the dark grey line) is paid into an old-age fund. At age 60, healthcare costs rise above the premium, and from then on, the difference is met by withdrawals from the old-age fund. The same information can also be gleaned by looking at the balance of the old-age-fund, represented by the dashed line (with values on the right-hand axis). The individual is a 'net healthcare saver' for the first three quarters of their life (i.e. their balance keeps growing throughout that time), and becomes a net dissaver from then on (i.e. they start running down the fund).

21 The acronyms stand for *Gesetzliche Krankenversicherung* (statutory health insurance) and *Private Krankenversicherung* (private health insurance).

Figure 6: A prefunded healthcare system (stylised example)



In the German PKV system, the old-age reserves held by all private insurers taken together amount to about €170 billion, equivalent to over €20,000 per PKV policyholder.²² Annual additions to the fund account for about 5 per cent of the country's net savings rate (Schönfelder and Wild 2013: 28-29).

The PKV system has its flaws. Premiums are not supposed to increase with age at all, but, in practice, they do, as insurers have persistently under-estimated medical inflation. And although each person's old-age reserves are supposed to be their personal property (as opposed to the insurer's), they are not portable between insurers. This means that above a certain age, switching insurers ceases to be a realistic option, as it would entail a loss of old-age reserves and a higher premium with the new insurer. This locks people into their given insurance contracts and weakens competition between insurers.

²² The distribution around this average is, of course, extremely skewed, as it is intended to be. Young people will have next to no reserves, and people around retirement age will have very high reserves.

Still, the German PKV shows that, like pension systems, health systems *can* be run on a prefunded basis. There is no reason why this should not also be possible in the UK. What is a bit trickier is the transition from a PAYGO-financed health system to a prefunded one, a transition which has never happened anywhere, so there are no examples from abroad to learn from. But there are examples of countries moving from PAYGO to prefunded *pension* systems (Niemietz 2007), and one can draw inferences from their experience. The transition could work like this:

- From now on, healthcare financing agencies (CCGs or the above-mentioned alternatives) could be required to start building up old-age reserves for every member below a certain age. Every young member would have their own personal old-age account, held by their CCG/insurer, which, unlike in the German PHI system, should be fully portable between CCGs/insurers.
- For those close to retirement age or above it is too late to build up reserves, so for them, healthcare should continue to be financed on a PAYGO basis. There should be no changes for this group.
- Most people will fall somewhere in between: there will still be time to build up *some* reserves for them, but not enough to fully cover their old-age healthcare costs. For them, CCGs/insurers should still set up old-age accounts, and the state should fill the accounts with government bonds in order to make up for the ‘missing’ reserves. This does not imply an increase in government debt; it merely implies a conversion of implicit into explicit debt. The current system contains an implicit promise to those of working age that when they reach old age, they will be entitled to (at least) the same standard of healthcare that the older generation currently enjoys. That promise has a monetary value, and the transition to a funded system would force the government to put a number on it.

As the new system matures, withdrawals from the old-age funds would replace age-related payments from the risk structure compensation fund. Table 4 showed an example of risk structure compensation in which an insurer received an annual basic rate payment of about €400 for a 19-year old person, and about €1000 for a 67-year old, plus/minus various adjustments related to individual health status. If that system were a prefunded one, the latter adjustments would still exist, but there would be no systematic difference in the basic rate, which would be somewhere between €400 and €1,000 for both. The basic rate would not, on its own,

be sufficient to cover the healthcare cost of the elderly person, but they would be 'accompanied' by an old-age fund, from which the difference would be met. Conversely, the basic rate would exceed the healthcare costs of the young person, and the insurer would use the difference to build up the old-age fund.

During the transition, there would be a cash-flow deficit, as the young generation would have to put aside the funds to meet their own future healthcare costs, whilst still having to pay for the healthcare costs of the elderly. This transitional cost could be spread over several generations. There is also at least a small self-financing effect. A shift towards prefunding would lead to an increase in the domestic savings rate, which, in turn, would increase investment and growth (Niemietz 2007).

There are no surveys on public attitudes towards the funding method, but no particular reason to expect that prefunding should be controversial. It is important to note that unlike under a system of individual medical savings accounts, the method of prefunding suggested here would *not* reduce the extent of risk-sharing in healthcare financing. People in good health would still cross-subsidise people in poor health. What would change is the *timing* of healthcare financing. Rather than waiting for healthcare costs to go through the roof, provision would be made in due time.

Conclusion

Market-oriented healthcare reform is not a lost cause in the UK. Public opinion is quite compatible with a pluralistic system. The principle of universality is sacred, but state provision is not.

Supporters of a competitive health system should develop proposals that weaponise public opinion rather than antagonise it. This paper has spelt out one possible strategy of doing so. It has proposed a plan for a gradual transition to a pluralistic system – not as a ‘pie in the sky’ exercise, but in the form of practical steps starting from the current status quo.

The basic logic of this paper is simple. The responsibility to allocate healthcare funding should be shifted from politicians and health sector bureaucrats to individual patients. Funding should closely follow patients, so that patients would allocate funding through the choices they made.

In theory, the quasi-market reforms of the mid-2000s have already created a system compatible with these ideas. This paper has therefore not suggested a revolution, but an extension of reforms that have already been implemented.

Clinical Commissioning Groups, through which most healthcare funding is allocated, should become more like social insurers in a Swiss/Dutch style system. Patients should be given free choice of CCGs, and CCGs should be free to develop their own profiles; they should become recognisable consumer brands. This would have to be coupled with risk-equivalent funding, to ensure that CCGs and providers compete on the basis of quality and efficiency, not their ability to attract the healthiest patients.

The commissioning/insurance side could then also be opened up to non-NHS organisations, such as patient groups, trade unions, professional associations

and private insurers. The relationship between insurers and providers would become subject to a market discovery process. Integrated 'managed care' organisations, which combine insurer with provider functions, would compete with specialised organisations, and anything in between.

On the provider side, the reach of the Payment by Results system and similar activity-based payments should be broadened. Activity-based payments should cover variable and fixed costs, so that providers are enabled to survive on the basis of these payments alone. This should be coupled with a strict no-bailout clause. A legal framework for the orderly bankruptcy and takeover of providers would have to be created. Underperforming providers that cannot attract patients in sufficient numbers would be allowed to fail, and make way for better-performing ones. The provider sector would become a sector with free entry and exit.

CCGs and other insurance organisations would be given the freedom to offer different healthcare plans. Some of these plans could include voluntary deductibles and/or voluntary restrictions of provider choice under managed care models in exchange for rebates, comparable to the Swiss system. Under this system, those with the greatest level of control over their healthcare would face the strongest incentives to economise on healthcare costs, so that healthcare provision becomes more focused on those who need it most.

Financing agencies should also be required to begin building up old-age reserves for their members while they are young, so that they can draw on them later on. Private health insurance in Germany already operates on such a prefunded basis, and can be used as a template, not least for the actuarial calculations of the old-age reserves.

The result would be a health system that is choice-based, pluralistic, competitive and financially sustainable. It would preserve what people value most about the NHS, namely the fact that it offers universal and equitable access to healthcare, regardless of health status, and regardless of ability to pay. These principles are non-negotiable in the UK, and while the proposals in this paper would represent a radical departure from the way healthcare is organised and delivered, they would not, in any way, undermine those principles. Everything else, however, would be desecralised. The vast majority of the population are already far more pragmatic about healthcare delivery than the political debate around the subject suggests. It is time for health policy to catch up with the public's pragmatism.

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The Institute of Economic Affairs
2 Lord North Street
London SW1P 3LB
Tel 020 7799 8900
email iea@iea.org.uk


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