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THE DENATIONALISATION OF HEALTHCARE

How to replace the NHS with a social health insurance model

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Summary

- Until very recently, Britain's National Health Service used to be beyond argument. The reverence for the health service often precluded anything resembling a rational discussion around it: the social taboos were simply too strong. Yet over the past two years or so, this has begun to change. We can now quite regularly find articles in the mainstream media which openly criticise the NHS, and point to better alternatives.

- In particular, advocacy of Social Health Insurance (SHI) systems has become part of the mainstream debate. SHI systems are market-based, competitive and largely non-state systems, in which the role of the state is not to run healthcare facilities, but to insure universal access.

- In terms of clinical outcomes, these systems tend to outperform the NHS, and they have done so for as long as we have data. This is not simply the result of better funding.

- While examples of a wholesale switch from an NHS-type system to an SHI-type system are rare, they do exist. The Czech Republic and Slovakia did precisely that over the course of the 1990s, and eastern Germany did so in the early 1990s as part of the Reunification process.

- The example of the Netherlands is also instructive. They never had a national health service, but until the mid-2000s, they had a system which, while notionally private, was very NHS-like in practice. Since then, they have replaced that system with a competitive, market-based, private SHI system.

- None of these examples are easily transferable to the UK, but what they do show is that a transition from one healthcare system to another need

not be especially disruptive. It can be done in an orderly fashion, and it has been successfully done.

- The final section of this paper sketches out a potential roadmap from the NHS to an SHI system. The aim is to do so in a way which minimises disruption, and which, to the greatest possible extent, builds on past reforms and existing institutions. The idea is not to close down one system, and build a new one from scratch. Rather, the idea is to allow one system to gently morph into the other.

About the author

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Introduction: Breaking into the Overton Window

The 'Overton Window', named after the American political scientist Joseph Overton, is, roughly speaking, the range of ideas that are considered socially permissible at a given time and place. To say that an idea is 'within the Overton Window' does not have to mean that the idea is widely accepted, let alone that it is popular. It just means that most people would consider it a *legitimate* idea: an idea that is not obviously absurd, or repugnant. It means that those who disagree with it would feel a need to explain *why* they disagree with it, as opposed to dismiss it, ignore it, or get angry with the person expressing it. Thus, an unpopular idea that is widely criticised is within the Overton Window, by virtue of being widely criticised. Because by the mere act of criticising it, its opponents affirm that they consider it worth engaging with.

In the UK, a good example of a point of view that is not popular, but nonetheless clearly within the Overton Window, would be republicanism: the idea that Britain should abolish its monarchy, and adopt a republican form of government instead. Surveys show that this view is not widely shared: most people either support the monarchy, or they are indifferent about it, as opposed to actively favouring a republican alternative. But republicanism is a perfectly respectable minority opinion, which does not violate any social taboo. It can be safely expressed in any mainstream forum.

At any given time and place, the boundaries of the Overton Window feel natural, obvious, and permanent. But they are nothing of the sort. Ideas move in and out of the Overton Window all the time. There are ideas that would have been considered perfectly normal within living memory, and which are now beyond the pale, and there are ideas which have moved in the opposite

direction. This is particularly pronounced when it comes to 'Culture War' topics, but it is true in the sphere of economic and social policy too.

Until very recently, fundamental criticism of Britain's National Health Service was quite clearly outside of the Overton Window. This was a natural flipside of the extremely high regard in which the health service is held. In one survey from 2018, which asked people what made them 'especially proud to be British', more than seven out of ten respondents picked 'Creating the NHS'.[1] This is remarkable insofar as the list contained options that should appeal to progressives (e.g. 'Suffragettes', 'Legalising homosexuality'), options that should appeal to conservatives (e.g. 'Queen's reign', 'Signing Magna Carta'), and options that should appeal to both (e.g. 'Standing against Hitler', 'Abolishing Slavery'). Other surveys on the same subject find different numbers, but the NHS always comes out on top, and it is always picked by an absolute majority of respondents.

This sentiment is not just widely held, but also strongly and deeply. In Britain, it is not seen as weird or cultish when theatre plays glamourise the founding of the NHS[2], when celebrities claim that 'the fact that the NHS exists makes us all better people'[3], when the NHS is awarded the George Cross, or when the Health Secretary describes it as 'the best gift a nation ever gave itself'.[4]

NHS reverence probably reached its apogee during the pandemic, with the weekly clapping for the NHS ritual, with signs saying 'Thank you NHS' popping up everywhere, and with the NHS logo featuring in countless public displays, in a manner almost reminiscent of North Korea.

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1 Twitter/X, 7 February 2018. https://twitter.com/GoodwinMJ/status/961195816068280320

2 'Nye review – Michael Sheen looks back at the difficult birth of the NHS', *The Guardian*, 7 March 2024 (https://www.theguardian.com/stage/2024/mar/07/nye-review-michael-sheen-olivier-theatre)

3 'David Tennant opens up on wife's cancer scare in heartfelt appeal for healthcare change', *The Express*, 27 December 2021 (https://www.express.co.uk/celebrity-news/1541836/david-tennant-wife-Georgia-cancer-appeal-doctor-who-news-latest-update).

4 'Queen awards George Cross to entire NHS for courage during pandemic', *The Telegraph*, 5 July 2021 (https://www.telegraph.co.uk/news/2021/07/04/queen-awards-george-cross-entire-nhs-courage-pandemic/).

An institution which is so revered is clearly beyond argument. And, indeed, until two or three years ago – there virtually was no argument. The NHS was simply not up for debate. There were a handful of NHS critics, but their role, as the writer Ed West puts it, was 'like that of the Middle Eastern wrestlers in WWF [World Wrestling Federation] whose job was to be booed by the crowd when I was a kid'.[5] It was always possible to criticise some individual aspects of it, but not the NHS as such.

And then something happened.

Alternatives to the NHS, especially Social Health Insurance (SHI) systems – more on which later – are now being discussed quite regularly in the British media. This can take several forms. At one end of the spectrum, it can take the form of a straightforward endorsement of SHI systems, with an author presenting SHI as superior to the NHS, and arguing (or at least strongly implying) that Britain would be better off replacing the latter with the former.

For example, in 2022, *The Times* published an article with the unambiguous title 'NHS sacred cow must be put out of its misery', which argued:

> The NHS sucks in an astounding proportion of public money, amounting to about 40 per cent of day-to-day departmental spending. Yet it achieves generally worse health outcomes than do other comparable, high-earning industrial countries. […] [D]espite these woeful outcomes for so much money, no one even raises the idea that the NHS is fundamentally, existentially bust. […]
>
> [T]here is a better alternative. This is […] European social insurance. This delivers goals on which the NHS so grievously fails: access to healthcare and higher standards for all.[6]

A few months later, the *Telegraph* published an article with the equally unambiguous title "The NHS is now no match for its foreign counterparts. These are the alternatives", the main thrust of which was:

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5 'The NHS, the War and the rebirth of Britain', Wrong Side of History, 5 July 2023 (https://www.edwest.co.uk/p/the-nhs-the-war-and-the-rebirth-of).

6 'NHS sacred cow must be put out of its misery', *The Times*, 25 July 2022 (https://www.thetimes.co.uk/article/nhs-sacred-cow-must-be-put-out-of-its-misery-l9pnxnmbf).

> [O]n most [...] outcome measures, the NHS now performs worse than countries like France [or] Germany [...] by some margin.
>
> For everything from cancer [...] to the treatment of heart attack and stroke, we sit at or close to the bottom of the G7 [...]
>
> In many areas, the performance of the NHS is now more typical of former Soviet bloc countries such as Poland and Hungary.[7]

More recently, the paper published an article – penned as 'Telegraph View' – which said:

> European social insurance-based health systems are universal, mostly free when used, though many charge to see a doctor, and have better outcomes often with the same or even less money to spend.

It ended with a plea for 'ditching the nationalised model, which does not work, for one that does.'[8]

At the opposite end of that spectrum, the Nuffield Trust (Edwards 2022, Reed 2024), the King's Fund (Wickens and Brown 2023) and the Health Foundation (Thorlby and Buzelli 2024) have positioned themselves as critics of SHI systems (more on the content of their criticism later). These critiques of SHI systems are, in a sense, an even better indication of the extent to which the Overton Window has shifted than the endorsements. As alluded to above, to say that an idea has entered the Overton Window is not to say that the idea is now widely accepted, let alone popular. It means that its opponents will now feel the need to explain why they disagree with it, as opposed to dismiss it, ignore it, or denounce it angrily. By the mere act of critiquing SHI systems, the critics are implicitly accepting that the pro-SHI position is a legitimate perspective, and a relevant voice in the debate. For proponents of SHI systems, to be considered worthy of a reasoned rebuttal – to even *have* critics – constitutes progress.

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7 The NHS is now no match for its foreign counterparts. These are the alternatives", *The Telegraph*, 10 December 2022 (https://www.telegraph.co.uk/news/2022/12/10/nhs-used-envy-world-what-went-wrong/).

8 'European healthcare lessons for Wes Streeting', *The Telegraph*, 8 April 2024 (https://www.telegraph.co.uk/opinion/2024/04/08/wes-streeting-healthcare-nhs-labour-party-privatisation/).

In the middle of the spectrum, the BBC published a piece entitled 'Can the NHS learn from Germany's health system?'[9], and Politico a piece entitled 'Is it time for the UK to (whisper it) ditch the NHS? Europe has a range of health system models ripe for the UK to explore'.[10] Neither the BBC nor Politico answer these questions with a 'yes' or a 'no'. They simply give an overview of the NHS-vs-SHI debate, and cite people from both sides, without expressing a final verdict. But, again, this framing, in itself, shows the extent to which the Overton Window has shifted. Presenting two sides of a debate in an even-handed, impartial manner may not sound like a radical editorial decision. But in this context – it very much is. In doing so, they acknowledge that there *is* a debate, and that there *is* more than one side. Five years ago, this would simply not have happened.

The shift in the Overton Window goes beyond the media. The Deputy Chair of NHS England, Wol Kolade, recently said that Britain needed to have a 'big conversation' about how the health system is financed and organised, alluding to SHI or 'some sort of private solution' as a potential alternative.[11] It would be a stretch to interpret Kolade's open-ended and non-committal remarks as a pro-SHI position. But, again, the mere fact that such a senior figure in the NHS can publicly raise such questions marks a major change. This would, again, simply not have happened five years ago.

Last but not least, even some politicians – including a former Health Secretary – have expressed an interest in SHI systems, albeit in a vague and non-committal

9 'Can the NHS learn from Germany's health system?', *BBC News*, 24 September 2022 (https://www.bbc.co.uk/news/health-62986347).

10 'Is it time for the UK to (whisper it) ditch the NHS? Europe has a range of health system models ripe for the UK to explore', *Politico*, 6 February 2023 (https://www.politico.eu/article/uk-is-it-time-to-ditch-nhs-healthcare-model/).

11 'NHS chief says taxes alone can't fund ailing £160billion-a-year service as he hints it might be time for a 'private solution' amid clamour for hospitals to get extra £32bn to get back on track', The Daily Mail, 20 March 2024 (https://www.dailymail.co.uk/health/article-13220155/NHS-chief-taxes-fund-service-hints-time-private-solution.html).

way.[12] Politicians have to be a lot more careful around sensitive issues than media commentators, so no matter how hazy and confused, the mere fact that a politician can say something about the NHS other than showering it with love, adoration, and gratitude, is a radical change.

The parameters for what is permissible to say in public have shifted quite rapidly. This could all be a one-off, fleeting effect, owing to the unusual circumstances of the post-pandemic stress the NHS is experiencing. It is entirely possible that once the backlog is cleared, the NHS will recuperate its old halo, the old taboos will reassert themselves, and the intellectual climate will, once again, become as stifling and conformist as it has been until very recently.

But there is also a chance that this new-found curiosity about alternatives and fundamental, system-level reform could become part of a new normal.

Supporters of SHI systems now have a foot in the door. This is more than we could have hoped for three or four years ago. But now, we also need to do something with it. We cannot just stop here. This paper is an attempt to move this discussion further from here.

Since discussions about alternatives to the NHS have only entered the mainstream very recently, they still suffer from some teething problems.

Firstly, reform-minded commentators are often vague about what exactly their proposed alternative is. Without wishing to pick on any particular individual, it is, for example, not uncommon for media commentators to praise 'social health insurance systems' in the abstract, and then go on to talk about a country which does not actually have a social health insurance system. Others talk about 'European insurance systems' in a broad-brush way, as if they were all the same. This is almost a mirror image of the way some conservative American commentators talk about 'European socialised medicine', apparently assuming that all European health systems are like the British National Health Service!

12 'An insurance-based system is the only way to save the NHS', *The Telegraph*, 2 October 2022 (https://www.telegraph.co.uk/news/2022/10/02/insurance-based-system-way-save-nhs/).

'Former Health Secretary: "Current NHS model is not sustainable"', *Sky News*, 15 December 2022 (https://www.youtube.com/watch?v=qYRBXyHy2Ks).

Secondly, to the extent that they do specify an alternative, reformers usually have little to say about how they want to get from where we are now to where they want to be.

All of which is perfectly fine if the point is merely to start a conversation. But the conversation *has* now started, and critics of SHI systems – not unreasonably – now hold that lack of specificity and direction against us. How are we supposed to move to an SHI system, they ask, if even the proponents of such a system can neither really tell us what that would look like, nor how we would get there? They have a point. If we want to take this discussion further, we will have to address those issues. This is what this paper will try to do.

But first of all, we will reiterate the main argument for system-level reform, the NHS's general inferiority to SHI systems.

NHS outcomes

Nowadays, even the keenest supporters of the NHS – or perhaps *especially* them – would accept that the system is in bad shape. This used to be a highly controversial statement. It no longer is.

Among defenders of the current system, however, a rather different narrative has taken hold. The argument is no longer that the NHS is a top performer, but that it *used to be* a top performer until the early 2010s, and that from then on, a combination of austerity and deliberate fragmentation began to erode its performance. We could call this the 'lost golden age' hypothesis. The alternative hypothesis would be that the NHS has always been a poor performer, and that this has just become more visible, and more socially acceptable to talk about.[13] We will call this the 'always been bad' hypothesis.

To check which of these hypotheses is closer to the truth, this section will not just compare the NHS's current outcomes with those of other health systems, but it will also, where possible, look at how these outcomes have evolved over time. Where outcomes are currently subpar, we will ask whether this has always been the case, or whether there was a time when they were noticeably better.

13 'Attitudes to the NHS are finally catching up with reality', City AM, 29 March 2024 (https://www.cityam.com/attitudes-to-the-nhs-are-finally-catching-up-with-reality/).

Summary measures

Figure 1 shows an estimate of the number of avoidable treatable deaths per 100,000 people in the last year before Covid. This is not a measure of health system performance per se, because it is influenced by other factors, but it takes us several steps into that direction. The UK had the second-highest avoidable mortality rate in Western Europe after Greece, although ahead of the US, and of Central and Eastern Europe (OECD 2024a).

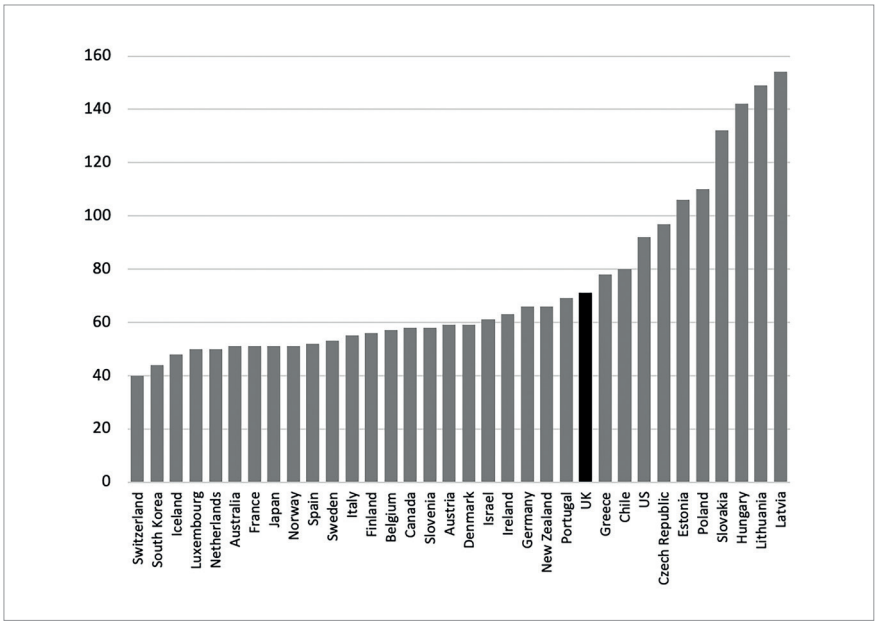

Figure 1 **Treatable mortality amenable to healthcare: avoidable deaths per 100,000 people, 2019**

Source: OECD (2024a)

While an avoidable mortality rate of 71 per 100,000 people is high by Western European standards, for the UK it is the lowest it has ever been, down from 84 in 2010, and from 120 in 2001 (the first year for which UK data are available). The UK's ranking has changed little over that period (ibid.), which speaks against the 'lost golden age' hypothesis, but which is compatible with the 'always been bad' hypothesis.

Table 1 shows how different countries score on the Healthcare Access and Quality Index (HAQ). This index takes a version of the above-mentioned estimate of avoidable treatable mortality as a starting point, and tries to drill further down by controlling, to some extent, for country-specific health risk factors. It would still be a stretch to call this 'a measure of health system performance', but, again, it takes us a few steps further in that direction. The UK scores 90.5 on a scale from 0 to 100, and ranks 23rd. This is above the North American average, but below the averages for Western Europe (92.6), Australasia (95.5), and the high-income Asia-Pacific countries (93.2). These differences are all statistically significant. Over time, though, it represents an improvement. The UK score was 83.9 in 2000, and 78.0 in 1990. Again, this is much more easily compatible with the 'always been bad' hypothesis than with the 'lost golden age' hypothesis.

Table 1 **The Healthcare Access and Quality Index (HAQ) (scale: 0-100), 2016**

Rank	Country	Score	Rank	Country	Score
1	Iceland	97.1	21	Slovenia	90.8
2	Norway	96.6	22	Singapore	90.6
3	Netherlands	96.1	23	UK	90.5
4	Luxembourg	96.0	24	Greece	90.4
5	Australia	95.9	25	South Korea	90.3
6	Finland	95.9	26	Cyprus	90.3
7	Switzerland	95.6	27	Malta	89.9
	Australasia average	95.5		North America average	89.1
8	Sweden	95.5	28	Czech Republic	89.0
9	Italy	94.9	29	USA	88.7
10	Andorra	94.7	30	Croatia	86.9
11	Ireland	94.6	31	Estonia	85.9
12	Japan	94.1	32	Portugal	85.7
13	Austria	93.9	33	Lebanon	85.6
14	Canada	93.8	34	Taiwan	85.4
	High-income Asia Pacific average	93.2	35	Israel	84.8
15	Belgium	92.9	36	Slovakia	83.3
	Western Europe average	92.6	37	Bermuda	83.1
16	New Zealand	92.4	38	Puerto Rico	82.7
17	Denmark	92.1	39	Poland	82.4
18	Germany	92.0	40	Hungary	82.1
19	Spain	91.9		Central Europe average	80.6
20	France	91.7			

Source: Fullman et al. (2018)

Table 2 shows how different countries rank in the Commonwealth Fund study's 'Health Care Outcomes' category, which the Commonwealth Fund defines as 'those health outcomes that are most likely to be responsive to health care' (Schneider et al. 2021: 9). It includes several versions of the aforementioned measure of mortality amenable to health, the proportion of adults under the age of 65 with two or more common chronic health conditions, and additional life expectancy at age 60, among others.

Whether it is a good measure of health system performance is debatable, but we include it here because the Commonwealth Fund study regularly receives high levels of media coverage in the UK, and it has long been the preferred study of NHS defenders. This is because in its overall ranking ('Health Care Outcomes' is just one category among five), the NHS has occupied the top spot in four out of seven editions of the study, which is typically reported in the style of 'NHS best healthcare system in the world, study finds'. NHS supporters cannot reasonably take the study's headline findings at face value, but then dismiss its arguably most important category.

Table 2 **'Health Care Outcomes' category (previously 'Healthy Lives') in the Commonwealth Fund study**

	2021	2017	2014	2010	2007
1	Australia	Australia	France	Australia	Australia
2	Norway	Sweden	Sweden	Canada	Germany
3	Switzerland	Norway	Switzerland	Germany	Canada
4	Netherlands	Switzerland	Australia	Netherlands	New Zealand & UK (tied)
5	Sweden	France	Netherlands	New Zealand	
6	France	Netherlands	Norway	UK	US
7	Germany	New Zealand	Germany	US	–
8	New Zealand	Germany	Canada	–	–
9	UK	Canada	New Zealand	–	–
10	Canada	UK	UK	–	–
11	US	US	US	–	–

Source: Schneider et al. (2017, 2021); Davis et al. (2007, 2010, 2014)

In the most recent edition, the UK ranked ninth out of eleven in the outcomes category. This means that even the Commonwealth Fund study, which, of all

the international rankings, is the one that is most flattering for the NHS, does not dispute the fact that the NHS compares poorly on health outcomes. The category has also been included in four previous editions, going back to 2007, and the NHS has been second-to-last in all of those. This means that, once again, we can find no evidence for the 'lost golden age' hypothesis, and no reason to reject the 'always been bad' hypothesis.

Individual measures

In this section, we will look at survival rates – or their inverse, mortality rates – for the leading causes of death. These are *not* measures of population health. We are not looking at how many people suffer from these conditions (because this has more to do with lifestyle factors than the healthcare system). We are looking at their chances of surviving them or not, once they do suffer from them.

(It should be noted that the data presentation has a slight pro-NHS bias. UK data is available for 2022, while for some of the other systems, data from previous years had to be used. Since these measures tend to improve over time, older data does not capture the most recent improvements.)

Figure 2 shows 30-day mortality rates for heart attacks, adjusted for differences in the age profile of the patients. On this measure, the UK is not especially bad: worse than the Western European average, but almost two percentage points better than Germany (OECD 2024b). Over time, the UK has made progress on this measure, cutting the mortality rate by more than two percentage points since 2008 (the first year for which UK data are available). This does not sit well with the 'lost golden age' hypothesis, but not with the 'always been bad' hypothesis either.

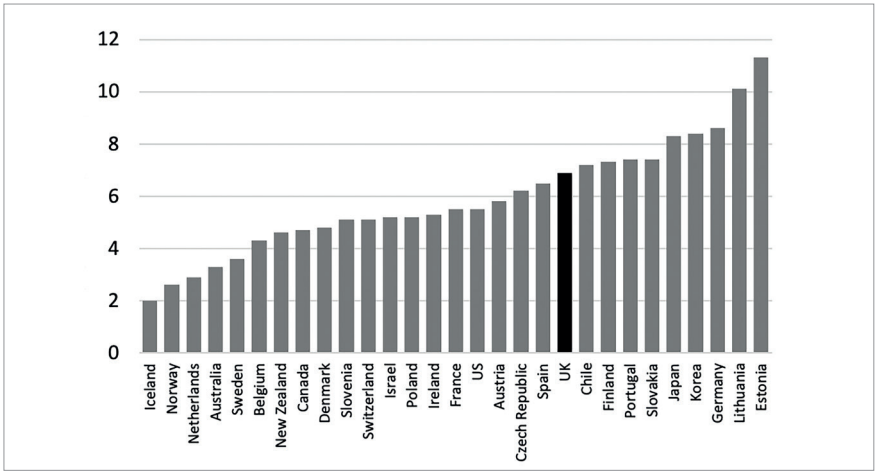

Figure 2 **Age-adjusted one-month heart attack (acute myocardial infarction) mortality rate, 2022 or latest available year**

Source: OECD (2024b)

Figure 3 shows age-adjusted one-month mortality rates for haemorrhagic strokes. Here, the UK rate is the second-highest in Western Europe after Spain, more than three percentage points above the Dutch and the German, more than four percentage points above the French, and more than eleven percentage points above the Swiss and the Swedish rates (OECD 2024c). Over time, though, this represents progress: the UK has cut its mortality rate by over four percentage points since 2008. This is more easily compatible with the 'always been bad' hypothesis than with the 'lost golden age' hypothesis.

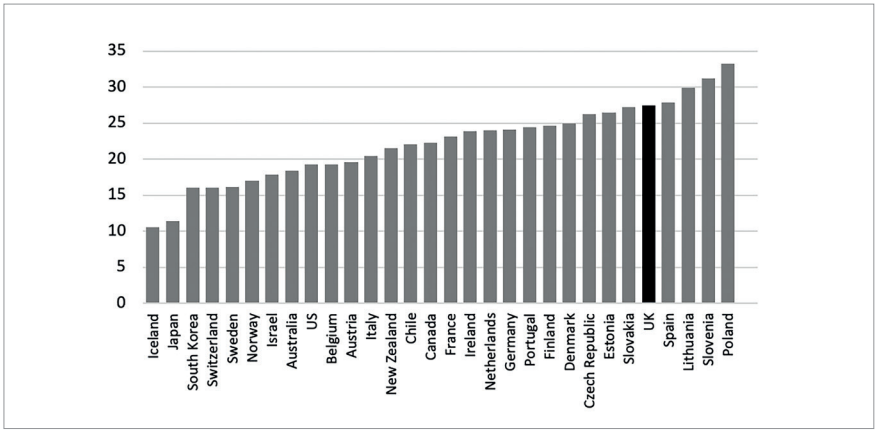

Figure 3 **Age-adjusted one-month haemorrhagic stroke mortality rate, 2022 or latest available year**

Source: OECD (2024c)

Figure 4 shows the same for ischaemic strokes. The UK's rate is the third-highest in Western Europe, after Spain's and Portugal's, more than two and a half percentage points above the Austrian and the German, more than three and a half percentage points above the Swiss and the Swedish, and more than four percentage points above the Dutch rates (OECD 2024d).

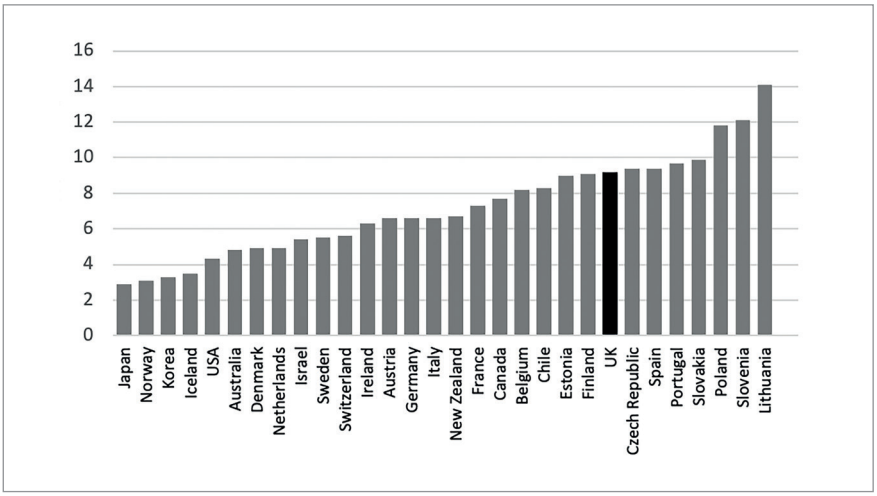

Figure 4 **Age-adjusted one-month ischaemic stroke mortality rate, 2022 or latest available**

Source: OECD (2024d)

But, again, it represents an improvement over time, with the UK cutting its mortality rate by about six percentage points since 2008. There is no 'lost golden age' detectable in the data.

Cancer survival rates have, unfortunately, not been updated in a long time: the most recent figures are for the 2010–14 period. But the pattern for those is similar to what we have seen in Figures 2, 3 and 4. For all the most common types of cancer, the UK's survival rates are among the lowest in Western Europe, typically not far ahead of the Czech Republic and Slovenia. But they are also the highest they have ever been, several percentage points ahead of where they were in the 2000s (OECD 2024e). Where we find the NHS lagging behind its peers, this is not new. It is not the result of a recent deterioration.

Waiting times

On waiting times, exact data are only available for a small number of countries, and SHI systems are heavily underrepresented. A notable exception is the Netherlands.

Like in every other country in the sample, waiting times in the Netherlands shot up during the pandemic. They have still not fully recovered. For the UK, the data series ends in 2019, so it does not yet capture the impact of the pandemic.

Figure 5 compares average Dutch waiting times in 2023 to UK waiting times in 2019, or, in other words, it compares the Dutch system as it recovers from the pandemic with the UK system under normal circumstances. For most procedures, the Netherlands still offered faster access to treatment (OECD 2024f).

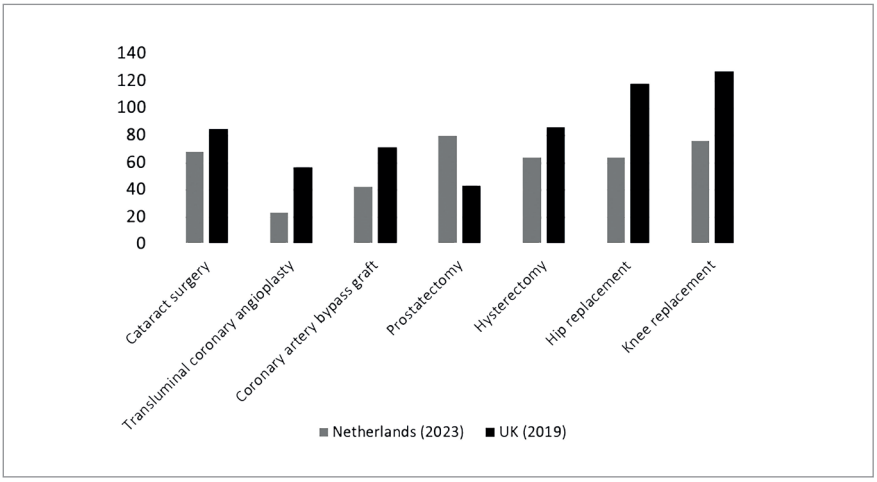

Figure 5 **Average waiting times (referral to treatment) in days: UK before Covid vs Netherlands during Covid**

Source: OECD (2024f)

For waiting times, however, it is true to say that the situation in the NHS has not always been this bad. UK data stretch back to 2000, and we can see a clear trend reversal in or just after 2010. Waiting times fell across the board in the 2000s, and crept back up again in the 2010s, until, in 2019, they were back to where they had last been around 2005–07.

We can also see the same trend in the macro-level figures. The total number of people on NHS waiting lists fell until 2010, and then began to creep up again, until, by 2019, it had gone back to a level last seen in 2007 (BMA 2023).

Thus, waiting times is the indicator that best fits the 'lost golden age' hypothesis. There is an identifiable watershed moment before which things improve, and after which they worsen. But it is also worth pointing out that even in 2010, UK waiting times were still about twice as long as Dutch waiting times for the same procedure, so the NHS's golden age would not have seemed especially golden to a Dutch citizen living in the UK.

Coverage

The most popular aspect of the NHS is its universal character. If we think of the NHS as an implicit insurance mechanism, it is an insurance that covers every citizen and every legal resident of the UK.

The claim is true – but it is an aspect of the NHS that is not in any way distinctive, or unusual. In high-income countries, universal health system coverage is the norm, not a special achievement (see Figure 6). It is the non-universal system of the US that is the outlier in this regard.

Figure 6 **Health system coverage, 2023 or latest available year**

Source: OECD (2024g)

The fact that so many systems, which are so different from one another, have converged on universality shows that that is really not the issue.

Healthcare spending

The UK spends just under 11% of GDP on healthcare, similar to the Netherlands, Belgium, Sweden and Austria (see Figure 7).

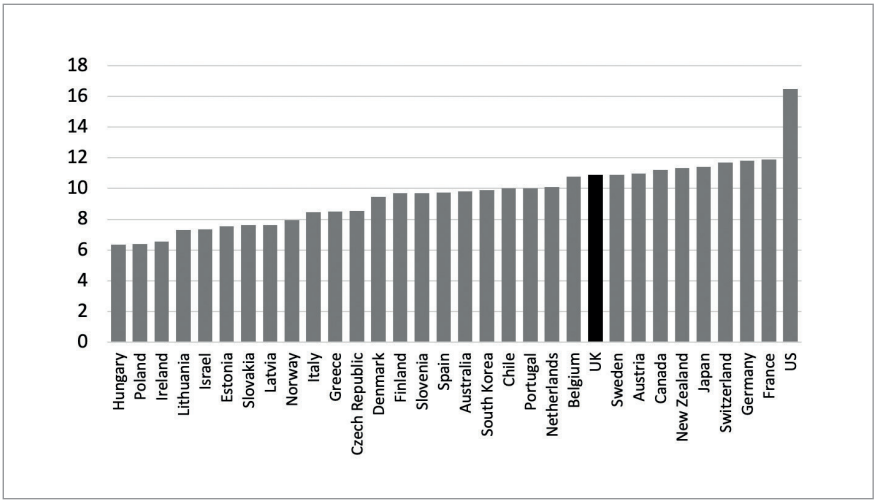

Figure 7 **Total healthcare spending in per cent of GDP, 2023 or latest available year**

Source: OECD (2023h)

Historically, the NHS used to be a relatively austere system (OECD 2024h). The New Labour government then oversaw a huge expansion: NHS spending per capita doubled in real terms over the period, with most of the increase happening in the early years. During the 2010s, however, it only grew by another 10 per cent, more than half of which was immediately eaten up again by increased demand caused by demographic change (Appleby and Gainsbury 2022).

It is therefore true to say that the 2010s were a decade of relative spending restraint, and one can certainly criticise that drastic change of pace. But it is also true to say that this period of restraint followed an unusually expansionary period, and we cannot realistically expect the NHS budget to double in real terms every decade.

Still, some of the health systems that the NHS has been unfavourably compared with, such as the French, the Swiss and the German systems, have long been among the world's top spenders. Some of the criticisms levelled against the NHS are therefore somewhat unfair.

For example, in 2022, the *Telegraph* reported an anecdote about a woman from the southwest German state of Baden-Württemberg, who, suffering from knee pain, booked an appointment directly with an orthopaedist, got an MRI scan on the first visit, and scheduled a knee replacement operation:

> [W]aiting was not an issue, even in the midst of Covid. She spent four days in hospital, sharing a room with one other patient, then went to a rehabilitation clinic, in the lakeside town of Bad Waldsee – which offers thermal baths as part of its recovery programme. [...] Irina's four-week stay in the rehabilitation clinic was paid for in full by her insurance, as was her operation and a fitness regime at a specialist gym once she returned home.[14]

Lakeside spas with thermal baths, specialist gyms and double bedroom accommodation are, of course, nice to have, and so are direct access to specialist care and short waiting times for non-urgent treatment. But these things are expensive, irrespective of whether a country has a national health service, an SHI system, or something else. Supporters of SHI systems should not imply that switching to such a system would automatically mean free lakeside spas with thermal baths and specialist gyms for everyone.

But it would be equally fallacious to conclude that the two systems cannot be compared at all until they spend the exact same amount. What the *Telegraph* article illustrates is what extra money can buy once a country spends well above the OECD average, namely speed, comfort, and convenience. These are

14 'The NHS is now no match for its foreign counterparts. These are the alternatives', *The Telegraph*, 10 December 2022 (https://www.telegraph.co.uk/news/2022/12/10/nhs-used-envy-world-what-went-wrong/).

all desirable, but they are not going to show up in measurable health outcomes. Thermal baths in lakeside spas are not going to decrease amenable mortality rates, or change a country's ranking in the HAQ index. (Nor do they need to: that is not their purpose.)

The *Telegraph* article compares the two systems in terms of *generosity*, not outcomes. On those terms, the German system wins easily, but this does not tell us much, because it is clearly a better-resourced system.

In this paper, however, we have focused on measurable outcomes, not nice-to-have comforts and conveniences. It is therefore not an unfair comparison at all. It would be one thing if the NHS could be described as an austere but efficient system, which gets the basics right, but which does not offer any bells and whistles: the Ryanair of the healthcare systems. The problem is that the NHS is very much *not* like that. It struggles with the basics, and it is not particularly cheap either.

In summary: apart from the issue of waiting times (and even there, only with major qualifications), we have found little evidence of a lost golden age. Where the NHS currently performs poorly, that performance is nonetheless the best it has ever been.

How Social Health Insurance systems work

The fact that mainstream journalists – and even senior figures within the NHS – are now openly praising SHI systems is a major change. But, as we have seen, it is often not quite clear what exactly they mean by that. What exactly is an SHI system, and what makes it different from the NHS? In this section, we will provide some clarification on this matter.

SHI looks, at first sight, very much like conventional private insurance. Under both models, 'sickness' is treated as an insurable risk like any other, much like the risk of a car accident, fire, burglary or flooding. We choose among competing insurers and insurance policies to insure ourselves against that risk, and when misfortune strikes, we choose among competing damage remediation providers. We do not pay for the cost of damage remediation: we pass on the bill to the insurer.

But there are a couple of subtle yet important differences between conventional insurance and social insurance. Most importantly, in conventional insurance markets, the premiums we pay reflect our individual risks. People who represent high risks pay more than people who represent low risks. In the case of commercial health insurance, premiums depend on demographic risk factors (e.g. age) as well as individual ones (e.g. our personal medical history).

In a social insurance system, this is not the case. People in bad health do not pay more than people in good health. Insurers cannot discriminate on the basis of health status, and they cannot turn down an applicant. Nor do they have a reason to: insurers with a disproportionate number of good risks have to compensate insurers with a disproportionate number of bad risks. The effect of

this scheme is that, from the perspective of the insurer, it is irrelevant whether a client is 20 years old and in perfect health, or whether they are 80 years old and in constant need of complex medical care. The latter obviously causes much higher costs, but the insurer also receives a compensation payment to cover that extra cost. The former causes almost no costs, but the insurer has to make a compensation payment on their behalf. After those payments have been taken into account, both clients are equally lucrative to insure.

In conventional insurance markets, insurers can refuse coverage for pre-existing conditions, or introduce qualifying periods. In SHI systems, that is not the case. There is a statutory minimum health benefit package, which all insurers must offer to all applicants, irrespective of whatever 'medical baggage' they may bring with them. They can go above that minimum, offering additional benefits (and they often do: that is one of the points of a competitive system), but they cannot refuse coverage for anything within it.

SHI systems offer support with premium payments, to ensure that everyone can afford them. This can be done on a means-tested basis; it can be done by making premiums income-contingent so that poorer people automatically pay less; or it can be done through a combination of the two.

SHI systems can be found in the Netherlands, Belgium, Germany, Switzerland, the Czech Republic, Slovakia and Israel (for a more detailed description, see Niemietz 2016: 90–118). Then, there are systems that have elements of SHI, but that are not, in themselves, SHI systems. France and Australia, for example, have state monopoly insurers that cover the entire population, and that people cannot opt out of. But most people also have social insurance on top of that, on a voluntary basis. Austria has a system that one could describe as SHI, but that differs from its SHI neighbours in one crucial respect: people cannot freely choose their own health insurer. And most Mediterranean and Scandinavian countries run tax-funded regional and/or local health services, which can be thought of as decentralised relatives of the NHS – *not* SHI systems.

As we have seen, an SHI system is not a free market system. The state plays a substantial role. It does not 'run' the health system, but, at the very least, it mandates health insurance, it defines what exactly that must include, and it guarantees universal access through a complex mix of subsidies, discrimination bans and compensation payments. This goes beyond the role the state plays in most other sectors of the economy.

But SHI systems are compatible with varying degrees of market orientation. We could think of them as a spectrum of systems rather than a single system. At the most market-oriented end of the spectrum, the role of the state would be limited to the above-described functions. It would otherwise leave the health system's actors free to arrange their affairs as they see fit. At the opposite end of the spectrum, the state would actively coordinate what happens in the healthcare system. Individual actors may be notionally private entities, but they would have little individual autonomy. A system at that end of the spectrum would, in practice, not be all that different from a national health service.

Introducing Social Health Insurance systems

As mentioned in the introduction, over the past two years, the Nuffield Trust (Edwards 2022, Reed 2024), the King's Fund (Wickens and Brown 2023) and the Health Foundation (Thorlby and Buzelli 2024) have positioned themselves as critics of SHI systems. From a pro-SHI perspective, this is to be welcomed. It is our rite of passage into the Overton Window. Ideas within the Overton Window have critics. Ideas outside of the Overton Window are not deemed worthy of reasoned criticism: they are dismissed, ignored, or angrily denounced.

But now, having entered the Overton Window – we also need to be able to respond to our critics.

It is worth noting that none of the SHI-critics are saying that SHI systems are terrible, or that it would be a disaster if the UK were to introduce one. Rather, their criticism can be summarised as follows:

1. While some SHI systems may outperform the NHS, it is not true across the board that SHI-type systems always outperform NHS-type systems. Some tax-funded state-run health services –the Swedish one is often singled out – can match the best SHI systems on outcomes. Thus, the comparison should not be with the NHS as it currently is, but with the NHS as it could be, if it matched the best systems within its own family of systems.

2. SHI systems and NHS systems are not as different from each other as SHI proponents claim. 'SHI' and 'NHS' are useful textbook models, but in practice, SHI-systems have NHS-like features, and NHS-systems have SHI-like features.

3. Replacing the NHS with an SHI system would be so disruptive that it would cancel out any benefits. The cost of the transition is simply too high. We are better off just improving the system we already have.

There is some conflict between the second and the third point. If NHS-systems have already introduced some SHI-features, why should it be beyond the wit of man to go all the way?

There is some conflict between the first and the third point as well. It is undoubtedly true that replacing the NHS with an SHI system would be challenging when compared to the alternative of doing nothing. But SHI critics are not suggesting doing nothing. They are suggesting reforms as well, even if they would prefer to remain within the current family of systems. That would not be without challenges of its own: the NHS could not easily be made to resemble the Swedish system, which is a system of overlapping local health services that are, in large part, funded through local taxation. Turning the NHS into such a system would, among other things, require an overhaul of the British tax system, introducing a system of municipal taxation which currently barely exists. So it is not that we are comparing a difficult reform to doing nothing; we are comparing one difficult reform to another difficult reform.

For SHI critics, it is the third point that carries most of the weight. The most vocal proponent of this line of argument is the CEO of the Nuffield Trust, Prof Nigel Edwards. Prof Edwards would probably object to being labelled a 'critic of SHI systems': he has, after all, said that that 'the Netherlands has one of the best healthcare systems',[15] and he describes the German system as 'venerable'.[16] But he is highly pessimistic about the difficulties, costs and risks associated with *transitioning* to such a system. Prof Edwards is not against *having* an SHI system; he is against trying to *introduce* one.

And he is right to be cautious. Health systems are path-dependent, and examples of radical, system-level changes are hard to find, at least in countries that already have well-developed healthcare systems. Most healthcare systems

15 *Twitter/X*, 2 April 2023 (https://twitter.com/nedwards_1/status/1642562604978647042).

16 Edwards, N. (2022) 'Myth #3: "We should copy other countries and adopt a social insurance model"', *Nuffield Trust*, 1 November 2022 (https://www.nuffieldtrust.org.uk/news-item/myth-3-we-should-copy-other-countries-and-adopt-a-social-insurance-model).

in the developed world were introduced at a time when the healthcare sector was much smaller, and far less complex, than it is today.

Nonetheless – there are a few examples in recent history of transitions to SHI systems. There are no *good* examples, if, by 'good', we mean 'easily applicable to the present-day UK context'. But even the bad ones can offer some lessons.

Czechoslovakia in the early 1990s

Like other Eastern Bloc countries, the former Czechoslovak Socialist Republic (CSSR) used to have a state-run health service modelled on the Soviet one. In 1990, as part of its post-socialist transition, Czechoslovakia began moving towards a system of multiple competing health insurers, and a competitive market in healthcare provision (Kinkorová and Topolčan 2012: 3; Mihalyi 2013: 24–6). After the partition, this process was, in different ways, continued in both the Czech Republic and Slovakia.

It started with the privatisation of primary care providers and pharmacies, and the transfer of hospital ownership from the national to local governments. Free choice of healthcare provider was introduced.

As a next step, a public health insurer, which initially covered the entire population, was set up. People were then given the freedom to switch, and competing health insurers soon emerged. By the end of the decade, a quarter of the Czech population had switched to competing smaller health insurers (Mihalyi 2013: 28). While both countries still saw major reforms in the 2000s, these can be seen as reforms within an SHI system. It is fair to say that by the end of the 1990s (if not earlier) the basic outlines of the new system were in place.

Evaluating how well or badly managed the transition process was would be beyond the scope of this paper (not to mention beyond the expertise of the author). But with regard to the Czech Republic, Kinkorová and Topolčan (2012: 3) conclude that 'the implementation process has been remarkably smooth. A complete reconstruction [...] has been achieved and a health insurance system has been created.'

Meanwhile, Hlavacka, Wágner and Riesberg (2004: 14) argue that 'Slovakia had achieved a relatively painless transition from socialist central planning to a pluralistic health insurance-based health care system'.

Such evaluations need to be heavily qualified. In that period, Czechoslovakia introduced a completely new political system, a completely new economic system, and, as if that were still not enough, it also partitioned the country and created two new ones. Against this backdrop, the creation of a new healthcare system was probably the least memorable event.

But it still happened. It happened within less than a decade, and while neither the Czech Republic nor Slovakia have fully caught up with their Western European neighbours in terms of healthcare outcomes, they seem to come closer than most.

Eastern Germany in the early 1990s

The old Bismarckian system of the German Empire, created with the 1883 Health Insurance Act, was the original SHI system, and remains the grandfather of all SHI systems today. The German healthcare system of today is generally considered a direct descendant of it.

This characterisation is not wrong, but it glosses over a major discontinuity. While the post-war West German system more or less picked up where the Weimar Republic had left off, the East German one very much did not. The German Democratic Republic (GDR) set up a completely different healthcare system, and only reverted to the Bismarckian tradition in the last few months of its existence, in 1990, as part of the reunification process.

This latter step was, in effect, a switch from a state-run health service to a semi-marketised, semi-privatised SHI system.

One might object that this does not really count as an example, because it was not an introduction of a 'new' system: it was just an eastward expansion of the already existing West German one.

But that system *was* new on East German soil. It *was* new from the perspective of the East German patients and health workers who had to get used to it.

Nor does a health system simply expand itself. If, for whatever implausible reason, a German region became part of the UK, this does not mean that a new branch of the NHS would suddenly spring up there from the ground. That region would still have the old system it inherited, irrespective of whether it

is part of this country or that country, and replicating NHS structures there would still take major reforms.

In the same way, there was nothing 'automatic' about the GDR's transition to the West German healthcare system. This did not just happen on its own, as a by-product of reunification. It happened because policymakers and health system stakeholders made it happen, through a series of reforms (Bundestiftung Aufarbeit 2023a; Bundestiftung Aufarbeit 2023b).

This involved the setting up of new health insurers – an institution that was unknown in the GDR – in the East, which became operational in 1991. The default option was that people would be auto-enrolled with a health insurer run by their local government, but some alternatives were available right from the start, and five years later, people were given complete freedom of choice. As in neighbouring Czechoslovakia, the transition also involved the privatisation of primary care and pharmacies, and the transfer of hospital ownership to state and local governments. This was often a prelude for privatisation.

To the extent that the transition was disruptive and controversial, this was not because it was too quick or 'too radical'. It was because the West German system itself was not market-oriented *enough*. The GDR had an ideological aversion against self-employment, which is why the vast majority of doctors were employed by large polyclinics. In West Germany, on the other hand, self-employment was the norm in the medical profession. During the reunification negotiations, the East German side wanted to save some of the polyclinics, while the West German side wanted to split them up. In a market-based system, this should never have been a political issue at all. Health policy should set an overall framework and ensure universal access, but it should not discriminate against or in favour of any particular business model. The sectoral composition should be decided by the market, not by political haggling between Bonn and East Berlin.

The West German government's intransigence unnecessarily complicated the reform process. It meant that, alongside adopting a completely different healthcare system, East Germany also had to reorganise the entire primary care delivery structure.

But even with this added complication, health system reform was smooth and rapid, at least compared with everything else that was going on. In 1992, the federal government announced that the process was 'practically finished' (cited in Roth 2009).

The Netherlands in the mid-to-late 2000s

The Netherlands never had a state-run health service. Its health system has always been largely private. The reform process we describe in this subsection therefore has little to do with privatisation, because there was never much to privatise to begin with.

But as mentioned already in this paper, 'SHI' is best thought of as a spectrum of systems rather than a single system, and for most of its history, the Dutch system used to be at the most 'NHS-like' end of that spectrum. With the 2006 Health Insurance Act and a series of subsequent reforms, it moved most of the way towards the opposite end (Jeurissen and Maarse 2021; Niemietz 2016: 101–7).

The pre-2006 system was a private system, but it was not a market-oriented one. It was a heavily regulated system based on collective agreements between an association representing health insurers and associations representing healthcare providers. This led to a high degree of standardisation.

Until the early 1990s, people could not choose their own health insurer: these were, instead, organised as regional statutory monopolies. As a logical correlate, insurers were not permitted to set their own premiums. The introduction of notional choice in the early 1990s did not change much on its own. The system remained regulated in such a way that all insurers offered largely the same benefit package, contracted with the same healthcare providers, and paid them via the same reimbursement formulas. People could choose, but only from a range of near-identical options.

From 2006 on, insurers were, step by step, permitted to deviate from collective contracting and negotiate their own individual agreements with individual

healthcare providers instead. The government no longer got involved in these agreements. It simply specified a minimum benefit package, which all health insurers had to be able to cover. In order to be able to do that, they had to maintain a network of contracts with a sufficient number of healthcare providers, and the right mix of specialties. How they were going to achieve that was, however, up to them.

Healthcare providers were also given greater freedom, such as negotiating their own prices with health insurers, and making their own investment decisions. State hospital planning was phased out. With increased freedom came increased responsibility: hospitals can now go bankrupt, and this has happened on several occasions.

The Dutch example does not quite fit our purposes, because it did not 'introduce' an SHI system. It has always had an SHI system of sorts. What it did was move from the most NHS-like end of the SHI-spectrum to the end that is furthest away from that. An equivalent UK reform would be more challenging, because it would require a 'prequel': we would, first of all, have to get to where the Netherlands already was in 2006. From then on, however, the Dutch reform path could serve as a blueprint.

A Social Health Insurance system for UK

In this section, we will try to sketch out, at least in very rough outlines, what the transition from the NHS to an SHI system could look like in practice. We will try to do this in a way which takes account of the warnings of SHI-critics. We will therefore steer well clear of 'big bang'-type changes, which divide our timeline into a 'before' and an 'after'. The adoption of an SHI system should be a process, not an event. It should not mean ditching one system, and setting up a new one. Rather, it should mean creating conditions under which one system can, over time, gently morph into the other.

We can identify three broad principles for the reform path:

- Safe 'do nothing' default options
  Wherever possible, there should be a safe 'do nothing' default option for those who are happy with current arrangements, those who are risk-averse, those who feel that they are not in a position to make an informed choice, or those who, for whatever reason, do not want to make an active decision.

- Institutional continuity
  When faced with a choice between making use of an existing institution and setting up a new one, a prima facie preference should be given to the former option. Where possible, the new system should try to build on what is already there, even if what is already there is not what we would have chosen from first principles.

- Existing precedents
  When in doubt, preference should be given to arrangements that have already been tried and tested somewhere. There is a lot of variation between SHI systems, so a preference for established precedents would still give policymakers a menu of options to choose from. But when policymakers try too hard to reinvent the wheel, the risk of them getting it wrong increases, which is why they should not do so for the sake of it.

There have been a number of health reforms in recent decades that, even though that was never their intention, could be built upon to transform the NHS into an SHI system. Since the Internal Market reform of 1990/91, the NHS has been operating a system of internal commissioning and contracting (Niemietz 2015b). The NHS is subject to frequent reorganisations (and enamoured with three-letter acronyms), which is why the name – as well as the composition and precise function – of its internal commissioners has changed over time: District Health Authorities (DHAs), then Primary Care Trusts (PCTs), then Clinical Commissioning Groups (CCGs), and now Integrated Care Boards (ICBs). But whatever their exact incarnation, these NHS-internal commissioners fulfil a role not wholly unlike that of an insurer in an SHI system. It would therefore not be such a gigantic step to convert them, explicitly and officially, into non-profit statutory health insurers. ICBs may not be ideally suited for this task, but they are the starting point we have, and if we were to stick to the above-mentioned principle of institutional continuity, they are the starting point we would use.

People would receive a letter from their local ICB, informing them of this change and what it means, much like the kind of letter one receives from a bank or utility provider that is in the process of being taken over by a different one. That letter should have a clear 'You do not need to do anything' message. Although the introduction of free choice of health insurer is an important next step, there should always be a safe default option of staying put, and doing nothing. People will be given the right to change health insurer, but nobody should feel obliged to become an active consumer who shops around chasing the best offer.

Around the same time, the funding mechanism should be changed, replacing taxes with health insurance contributions. Again, this could be done in a minimally disruptive way, because at first, it would not need to be much more than an accounting change. Insurance premiums could still be deducted

at source, very much like income tax and national insurance contributions – indeed, they could be directly carved out of those. There would be a new item labelled 'Health insurance premium' on people's payslips, and income tax and/or national insurance contributions would be reduced commensurably. If done in this way, the switch would be broadly cost-neutral for the vast majority of people. This would require premiums to be income-dependent.

Again, this might not be the way we would want to do things if we built a new health system from scratch, and from first principles. We may prefer a system like the Swiss one, where health insurers have to collect their premiums themselves, and where the insurance premium is a flat fee, independent of income. There is a support system, but it is means-tested and targeted, limited to people in, roughly, the bottom third of the income distribution. But this would open a wholly separate debate. The tax collection system is already there, and the level of tax progressivity is given. Applying the above-mentioned principle of institutional continuity would mean working with what we already have.

People would receive a letter from HMRC, explaining that a part of their income tax payment is going to be converted into a health insurance premium payment. Again, that letter would have to contain a clear 'You do not need to do anything' message. Later on, people would be given the right to change health insurers, and if they did so, their premium would be redirected towards their new insurer. But nobody has to do this. There would always be the safe option of simply doing nothing.

For people who do not pay income tax, but receive Universal Credit, Pension Credit or an equivalent support, the situation would be the mirror image of the above. Their benefit payment would be raised by the amount of the new health insurance premium, and then that health insurance premium would be immediately deducted. They would receive the same letter, explaining what these changes mean, but also emphasising that they do not need to do anything.

Premiums would cover not just the person paying them, but also dependent family members (although in a dual-earner household where both partners earn above the relevant threshold, both would have to pay the premiums). This may, again, not be ideal. There is, in principle, no reason why well-off parents should not have to pay for their children's health insurance or, more generally, why larger households should not pay more than smaller ones, if they can afford to do so. But, again, this would open an entirely separate debate,

which would be worth having if we were starting from scratch, but which, for our purposes, would be a distraction.

The government would then have to explicitly define a statutory minimum package of healthcare services that all health insurers have to cover – a task probably best delegated to the National Institute for Health and Care Excellence (NICE). NICE could be asked to do this in a way that broadly codifies the status quo: whatever is currently routinely available on the NHS would be included in the minimum package; everything else would be at the insurer's discretion. The status quo is almost certainly not ideal. The current benefit package may be too large, or too small, or it may contain the wrong things. But, again, we have to start somewhere, and this is somewhere. The minimum benefit package would be periodically reviewed by NICE, which could add new treatments that have become available since the last review (or the cost of which has come down), and take out treatments that are no longer considered best practice.

When premiums are income-related, there is going to be a mismatch between premium payments and expected healthcare costs. Evening this out requires the setting up of a risk-structure compensation scheme, as in other SHI systems. This is a complex task, but we would not be starting from zero. Local NHS budgets are already supposed to reflect the healthcare needs of the local population. The NHS already collects the relevant medical data, and apportions budgets accordingly. This would just have to become a lot more fine-grained. The already existing formulas could be used as a starting point, and augmented by borrowing a formula from abroad. Risk-structure compensation schemes come in more basic and more sophisticated versions (van de Ven et al. 2013: 239–41). The ones at the more sophisticated end of the spectrum (the Dutch, the Belgian and the German ones) are administratively more complex, but they are better at preventing cherry-picking. A country such as the UK, which is characterised by high health and income inequalities, would have to aim for the more sophisticated end of the spectrum. We can imagine the *Guardian* headlines if a large health insurer were involved in a cherry-picking scandal: one such misstep would probably be enough to kill off the scheme for good.

For the same reason, the risk-structure compensation scheme would have to be fully operational before free choice of health insurer could be introduced. But once that has been accomplished, free choice would be the next milestone.

ICBs currently operate as local monopolies, and after their conversion into insurers, this would still be the case. The creation of a health insurance market would mean allowing them to operate nationwide, and to give people the right to sign up with any of them that operates in their area.

But it also means a lot more than that. The health insurance market would have to be opened to other actors. Historically, trade unions, professional associations and large employers used to run health insurance schemes for their members/employees, and in some countries, they still do. Under the new system described here, they would be allowed to do so again. Patient associations, representing people suffering from particular conditions, would be able to set up their own specialised scheme. They would no longer have to lobby politicians to take their concerns seriously: they would be able to take matters into their own hands, and through the risk compensation scheme, they would be given the means to do so. Commercial private health insurers could also try their luck, but they would have to accept the SHI rules: no risk discrimination, full coverage for pre-existing conditions, no demands for pre-authorisation, and no exclusion clauses. This would be quite different from their usual business model. But some of them might adapt, and thrive under this system.

There have also been important reforms in the hospital sector that could be built upon. In the 1990s, NHS hospitals became legal entities in their right, rather than just subunits within the NHS, and were given greater operational autonomy. In the second half of the 2000s, most hospitals were given self-management rights, as they were converted into semi-autonomous 'Foundation Trusts' (Niemietz 2015b).

Both of these changes were widely attacked as Trojan Horses (Niemietz 2022). Critics suspected that the new legal status of those hospitals was really just a springboard for prying them out of the NHS altogether, and turning them into freestanding, independent companies, possibly even for-profit ones. That, as we now know, never happened, and had no chance of happening, because it was never the intention. But if it *became* the intention one day, those changes *could*, belatedly, still be used in such a way. Foundation Trusts could be converted from semi-autonomous into fully autonomous, independent entities.

We have no strong views on who exactly should own hospitals, and what their precise legal form should be. What matters is that ownership and legal form can be changed, so that they end up in the hands of whoever is most capable

of running them, and in the legal form that best suits them. Some of them could be converted into municipal enterprises, as was done in Czechoslovakia and East Germany, provided local authorities always have the option of selling them, or converting them into something else. Some could be converted into staff-owned 'medical cooperatives'. Some could be given a university-like status, and those already closely associated with a university could become subsidiaries of the university.

In principle, there is also nothing wrong with floating some of them on the stock exchange. Lots of state and local governments in Germany – including left-wing governments – did precisely that in the 1990s and early 2000s. However, in a British context, this would be infinitely more controversial. If at all, this could only be done by trusted actors. If the very same doctors who work at a particular hospital take the decision to sell it to private investors, they might be able to get away with it. Politicians would not.

In any case, what is most important is not the ownership structure of hospitals, but what they can do. Turning them into freestanding independent companies must mean phasing out the system of national pay scales, and the introduction of a proper medical labour market. Pay levels, pay structure, pay progression, working conditions and so on would become a matter between individual healthcare providers, as employers in their own right, and their employees (and/or their representatives, such as trade unions and professional associations). Politicians would not be involved in this process at all. There is, in fact, a strong case for doing most of that even now, under the system as it currently is (Goldsmith 2018). This could therefore even be a first step in the reform programme, pursued independently of the others.

We also need a more market-based approach to medical education and training instead of the current system of state workforce planning. The cap on the number of medical students would have to go. Training arrangements would become matters between individual students, individual healthcare providers or networks of them, and individual universities.

What we have described so far is a programme that would get us to a place not too far away from where the Netherlands was in 2006. We would have an SHI system of sorts, but it would not yet feel very different, because we would still be at the most NHS-like end of the SHI-spectrum. From here on, we would be in chartered territory again. From here on, we could follow the Dutch path. The rest would be a matter of, step by step, giving the actors

within the healthcare system the freedom to arrange their own affairs as they see fit. Insurers could contract selectively with some healthcare providers, but not others. They could try to steer healthcare delivery into particular directions, for example towards greater multi-specialty integration, or towards greater emphasis on primary and community care. They could experiment with different types and degrees of vertical and horizontal integration. They could experiment with different incentive schemes. They could offer different health plans, some with limitations of provider choice, or risk-sharing agreements, in return for premium reductions.

Insurers, however, are just intermediaries. They are not the ones who are ultimately in charge in an SHI system. They can offer all kinds of things, but whether any of those becomes viable depends on whether people choose them or not.

In the Dutch example, to the extent that some reformers have expressed disappointment, this is not because the market reforms have produced terrible side-effects that their proponents failed to anticipate. It is because it has turned out that most people are – understandably – quite conservative when it comes to their health. They do not enthusiastically take up radically different models of healthcare delivery. They do not necessarily reward radical innovators and punish slow movers. Therefore, the most common criticism of the market reforms is not that they are a Frankenstein's monster that has got out of control. It is that the system's main actors are not making full use of all the new tools they have been given, and that, therefore, the reforms have not yet fully lived up to their potential (Jeurissen and Maarse 2021).

One can see that as a criticism of market-based SHI systems. But one can also see it as reassuring. Market-based SHI systems respond to people's preferences, not to what health economists, healthcare policymakers or think tank authors think should happen.

What a British version of such a system would ultimately look like is therefore not fully predictable. It would depend on the choices that people would make within it.

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