Getting back your health

Rebate financing for medical care

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Executive summary

It is a common belief that tax funding is the only way to guarantee good healthcare for all. And yet statistics show that, after 50 years of just such a policy, our National Health Service (NHS) actually delivers for UK citizens one of the poorest-quality health systems in the developed world. Like other tax-funded industries of the postwar era, it is burdened by bureaucracy, politicisation, low wages, a lack of customer responsiveness, low rates of innovation, queuing, and mis-directed resources.

But recent initiatives to deal with these problems, though sincere, have tried to work within today's tax-funding model, instead of asking whether that system itself should be reformed or even replaced. The Wanless report, for example, did not explore how the funding base could be widened nor whether fair access could be preserved through some other method. It did not separate provision from funding, nor funding from access.

In line with this, current reform strategies have been top-down, centralized attempts to control and set targets within a closed system, rather than to open up the system to new methods of funding, and greater customer power.

The majority of people believe that the NHS has certain desirable attributes. But it is unlikely to be able to build on them unless the power to control moves away from politicians and officials to those who use and rely upon its services.

There is a simple way to achieve this: a ***rebate***. The cost of NHS care should be defined, and given back to citizens for them to decide how to spend as they think best. That will give them the power to obtain the kind of service they want, rather than the kind selected for them by the providers.

To work well, the rebate must be simple. It must be a set amount, which people can take and put towards the cost of company or individual health and long-term care plans. People should be free to add their own money to buy more expensive policies if they choose to, or to pocket the difference if they can find a qualifying plan more cheaply.

It would be larger for women and elderly people, reflecting their greater cost to the NHS; but not people's personal health status: there would be no medical. But those who wanted to stay in the state system could do so. Indeed, if the rebate were slightly below the real cost of NHS the care foregone by the leavers, the NHS would actually retain more money to focus on the needs of those who stay.

Coupled with liberalising reforms in the way NHS services are managed and provided, the rebate would give everyone at least some incentive to take responsibility for their own health and the opportunity to access the kind of quality health service they are currently denied.

Introduction

According to the figures, the National Health Service (NHS) in the UK provides one of the poorest services of any health service in the developed world.

This should not be a surprise. Poor service, queues, cost inefficiency and an absence of innovation are features of services that are provided by the state, on a monopoly or near-monopoly basis. Other examples include education, social services and roads.

There is a popular belief that we cannot provide health services in any other way — a belief that is bolstered by the fact that there is very little private healthcare in the UK. But again, this should be no surprise. It is hard for any private-sector provider to compete against an alternative that comes in at zero cost to the user. And yet it is an indictment of the NHS that despite the fact that the government alternative is "free", many people still go private: indeed, private spending on healthcare is now over 15% of government spending.[1]

It is not clear why the belief should be so widely held that healthcare must be financed only through taxes and provided only by the state. There have been a number of high profile government reports that have looked indirectly or directly at the issue of funding healthcare. They have reached similar conclusions with very little or no economic analysis of the problem. For example, in the Royal Commission Report on long-term care for the elderly (Royal Commission, 1999), it was stated that, "a number of experts strongly put to the Commission that the NHS represented a more efficient means of providing healthcare than the market could offer if left to itself" (paras 3.13 and 3.15). Restating the assertions of others is used as a substitute for serious analysis. Wanless (2002a) makes similar assertions: these will be examined in greater detail below.

The form of healthcare provision that now prevails in the UK has in fact existed for only 50 years or so in this country, and exists in virtually no other developed country. The system chosen in 1947 was designed to be at the extreme, statist, end of the options available (see Lawlor, 2001). With the state then dominating not only the provision of healthcare but also the flow of information about it, the debate became rather one-sided.

When asked to consider alternative forms of healthcare financing and provision, it is natural for people to compare NHS care today with health provision 60 years ago and conclude that the NHS has done enormously well. There has been huge progress in healthcare, and people may attribute that progress to state provision. But there has also been huge progress and innovation in ***all*** sectors of our economy. The health sector has, in fact, lagged behind.

[1] Depending on how private healthcare is defined, between 7.25 and 20 million people use private provision (the higher figure including private dentistry).

What is wrong with the NHS?

There are many ***a priori*** reasons to assume that nationalised healthcare will let people down. These reasons include:

- inefficiency in provision
- consumer needs will not be discovered and met
- the likely absence of much beneficial innovation
- the mis-allocation of labour and other resources because of monopsony and monopoly power
- the holding down of wages because of monopsony power
- the failure to meet consumer needs because of the absurd system of "queuing".

Gage (2001) reviews how these problems manifest themselves in the NHS in practice. Problems include old and shabby facilities; hospitals working above capacity; staff shortages; waiting lists; hurried consultations; inadequate rehabilitative services and the absence of consumer power. Dixon (2001) points to an "NHS looking worthy but relatively clapped out" with the UK having fewer doctors and nurses than other countries and restricted access to new technologies. Some (including Dixon) argue that some of these problems reflect the lack of money spent on healthcare in the UK. Spending is, of course, constrained within our nationalised system, since spending must respond to the needs of the median voter rather than to the preferences of service users. But regardless of the amount of money spent, the current system is sub-optimal: greater consumer satisfaction could be achieved within current spending levels. Gage also notes that many of the benefits that we expect to see from a nationalised service are not materialising in the NHS: care is not uniform; all are not treated; elements of care are charged for.

There has been no shortage of review and reform within the current framework. Administrative reform has involved changing, creating and destroying different layers of management in the hope of increasing efficiency. This could be described as a ***managerial*** approach to reform. The last Conservative government tried a ***quasi market*** approach to reform and introduced the internal market, hospital trusts and fund holding for GPs. Elements of that strategy worked but its development was hampered because the contradiction between a bureaucratic approach and a market-led approach to management could not be reconciled. Furthermore, trusts were not given fundamental freedoms (to set terms and conditions of employment, for example), and users of the service were not given the freedom to use alternative providers.

The current government has tried a centralising approach to reform. Predictably, this has failed too. The National Institute for Clinical Excellence has been set up and made responsible for assessing different treatments and recommending whether they are funded on a national basis. More funds have been ring-fenced for specific purposes

determined by the government. Volume and success targets have been set for various activities that the politicians deem especially important. As Bosanquet and Hockley (1998) point out, this preoccupation with central assessments and targets is a “fascination” extended by the current government but inherited from the previous one. However, it is clearly not possible to meet the diverse needs and preferences of 60 million individuals through the process of setting national targets for limited objectives.

Milburn (2002), in the Government’s proposals to deliver the “Plan for the NHS” suggests a mixture of all three approaches, whilst suggesting that the NHS will learn from the mistakes of the past in implementing this eclectic approach.

The whole approach reminds one of the story of the Soviet nail factory. When the Central Planning Committee decided it was not producing enough nails they set increased targets for production. These targets were met by the factory producing millions of tiny nails. So the planners set a new target, based on the weight of nails produced and the factory started producing twelve-inch leaden spikes. Whether the targets are waiting lists, waiting times or the number of cancer patients treated, centralised target setting and centralised allocation of resources cannot succeed in repairing the problems within the health service.

Lawlor (2001) cites the bureaucratisation of the health service as a further problem. This is a difficult area because nationalised industries are just as likely to be under-managed or have their professional staff under-supported by non-qualified staff, as they are to be over-managed. However, her evidence that only 39% of NHS staff are nurses or consultants and that the number of senior managers has increased by over one-third between 1995 and 2000, seems to provide strong support for her view.

The weaknesses of Wanless

The government commissioned a report on the provision of healthcare by Sir Derek Wanless. He concluded in his interim report that there were no significant advantages of private over government finance, although, as with the Royal Commission (1999), there was no serious economic analysis of the issue. Furthermore, Wanless concluded that government finance would provide better quality healthcare for any given level of resource inputs than private finance. He also regarded the funding base from taxation as better than social insurance alternatives. After concluding that finance through the tax system was preferable, much of the rest of the report was about how nationalised health provision could be planned more effectively.

There were several weaknesses in the reasoning in this report. It did not consider funding and provision as two separate issues. It did not consider how some form of social insurance levy could be charged on a wider tax base. It did not investigate means other than taxation through which the redistributive aspects of the current method of finance could be preserved.

The report also considered the issue of efficiency of provision in a purely administrative sense. It has long been the argument of central planners that a service could be nationalised, administrative and marketing costs saved and the nationalised service be more efficient than private provision. But experience has shown that such gains are generally illusory and, insofar as they exist at all, temporary. The market excels at discovering new ways of meeting customer need more efficiently and effectively. At best, nationalised industries tend to fossilise a ***status quo*** while allowing efficiency gradually to decay: the NHS is no exception.

When looking at insurance-based forms of funding, Wanless did not consider the special (often regulatory) features of the US system that raise costs, and it compared the current forms of private provision in the UK with the NHS. Clearly, such a comparison is invalid. Private provision is used for a very specific and rather limited purpose in the UK because of the existence of the NHS as a potential “stop loss” insurer. But new forms of long-term policies are showing much lower administration and marketing costs and better cost control. Such polices have been available in more liberal countries such as the Netherlands for much longer than in the UK.

Yet the fundamental weakness of Wanless is that it fails to appreciate these two key points:

- that the issue of funding can be separated from the issue of provision; and
- that the issue of access to care for all can be separated from the method of funding.

The final report (Wanless, 2002b), reads very much like the discredited “National Plan” authored by the Rt. Hon. George Brown in 1965. Both documents, take a top down view

of how industry will evolve, what the challenges are and how it will respond to those challenges in terms of productivity, responding to labour shortages etc. In both cases, the aim is to inform a process of central planning where bureaucrats, using the very limited information that is available, try to allocate resources more effectively than the market mechanism with its millions of consumers and producers all responding to their own personal preferences and using the vast amount of decentralised information that is available to them. We know from experience that the central planning approach fails, wherever it is tried. Today, the National Plan reads like a fairy story of a great munificent master creating a prosperous society. If it does not do so already today, in 37 years time, Wanless will seem just as quaint.

Points worth preserving

In developing a way forward for funding healthcare, it is important to separate aspects of health provision that many people find desirable and that ***happen*** to be a feature of the current system from those that are ***intrinsic*** features of the current system. For most of the features that many people find desirable about NHS provision could be provided in a different way.

The NHS provides treatment more or less free at the point of use. This is not an issue of principle: charges are made for certain services. Nevertheless, “pay as you use” is not what most people seem to want. But equally, we must remember that only a small proportion of those who use the private sector do so on a “pay as you use” basis. Most pay annual insurance premiums and leave the insurer to settle their medical bills. Access to care, free at the point of use, is a feature of all the mixed systems that exist in developed countries and was an aspect of the mixed system that existed before the war in the UK. Indeed, it is at the root of insurance: a concept that predates nationalised healthcare by many centuries.

The current system also provides care to all regardless of income. Again, there is a belief that this requires nationalised provision. And again, this is a myth. The mixed system that once existed in the UK, and similar systems that currently exist in other countries, generally provide better healthcare for the poor than the does the NHS. Healthcare for the less well off can be financed by general income redistribution or by the provision of government finance to allow the less well off to obtain private insurance. Indeed, the voluntary sector is often more effective than the state in providing assistance to the less well off. Changes to the structure within which healthcare is delivered in the UK could benefit all and end the ***equality of misery*** from which we suffer at the moment. Today’s system of allocating resources through the political system does not benefit the poor: it benefits the articulate, and those in the more prosperous areas that have the least difficulty attracting medical staff.

Only the NHS provides free accident and emergency services. The private sector, in the constricted form in which it has been allowed to develop in the UK, does not (generally speaking) provide accident and emergency services. But there is no inherent or inescapable reason why such services should not be privately provided. For example, the emergency fire service in the UK predates state provision; there are private fire, ambulance, security and coastguard services in many countries; and many countries where healthcare is largely delivered through the private sector still oblige providers to offer accident and emergency services. It certainly seems reasonable to hope that accident and emergency services should remain free in any reformed system in the UK; but there is no reason to suppose that only the NHS of today can provide this.

Funding healthcare

There are three main ways of funding healthcare whilst ensuring that we retain those features of the NHS discussed above:

- general taxation
- national or social insurance contributions
- private means of funding with the state refunding the cost for those of a certain income level.

In principle, National Insurance contributions should reinforce the concept of the NHS as a nationalised service paid for through insurance premiums. However, there are a number of problems of using the current national-insurance system. Whereas the Beveridge scheme related contributions to benefits (for example requiring flat-rate contributions for flat-rate pensions) the current National Insurance system makes no link between contributions and benefits. Furthermore, the mechanism of redistribution within the system is wholly opaque. National Insurance contributions are also only levied on income from work for those below retirement age. Clearly there is a rationale for this in respect of pensions and in-work benefits. However, the finance base for health should be wider if this is going to be used as the means of financing healthcare. There is no reason why a “national health insurance contribution” could not be developed that was taken from a wider tax base than current national-insurance contributions. Indeed, the contribution could relate closely to benefits (such as by making the contribution flat rate), with other aspects of the tax system being adjusted to preserve the redistributive principles inherent in the current system.

Or we could take up the model used by many other countries and finance private insurance through a system of means-tested payments. This could be administratively very expensive and quite arbitrary. Nevertheless, it would give consumers real power.

Thus different methods of funding can be used to achieve the same objectives as taxed-based funding. But in fact, the method of funding is hardly relevant to the issue of giving those who use the NHS more choice: the issue of funding can be separated from the issue of provision. Wanless did not understand this key point. Milburn (2002) did, in fact, recognise this point when he suggested that, “There are those who claim that a tax funded national system of health care can never deliver choice for patients. The example of Scandinavia proves those critics wrong.” Unfortunately, the remainder of the “Delivering the NHS Plan” document simply concentrated on how the Secretary of State for Health hoped to improve health care provision within the NHS framework whilst not, in any meaningful sense, allowing choice (although see below).

Encouraging diversity through rebates

For the consumer to be empowered and the nationalised monopoly broken, all that is required is that the cost of the nationalised service should be defined and returned to all those who choose not use it.

The anomalous position of healthcare

This is the same principle that is followed in the system of rebates from the State Earnings Related Pension Scheme. The rebate or “opt out” approach is conceptually more logical when the system is financed through earmarked, National Insurance contributions. However, there is no reason why the idea could not be applied to a tax-funded NHS. It is important to note that through this approach, any redistribution inherent in the current tax-funded healthcare system could be maintained intact. This approach would separate the issue of redistribution (or ensuring that all had access to healthcare) from that of compulsory provision of a particular service.

The anomalous nature of current health policy is brought into sharper focus by the use of the private sector to perform NHS operations. Given the current policy, this is laudable. However, the situation now prevails whereby private-sector care can be obtained free, but only if the nationalised service is used as an intermediary! ***Delivering the NHS Plan*** contains proposals to use this approach as the main mechanism for promoting choice, for patients who have had long waiting times: this is a very limited extension of the concept of patient choice.

Instead, those who wish to make their own health provision and opt out of the nationalised service should receive a National Insurance or tax repayment that reflects the cost of the NHS provision that they forgo. The rebate would be directed as premium or part payment of premium to their preferred provider. Such rebates would be payable to everyone, including those who did not earn enough to pay tax or National Insurance (this would, of course, include children).

The size of the rebate

The amount of the rebate that is available to anyone who contracts out should reflect what it costs to provide healthcare to a person of similar age and sex who is in normal health with no pre-existing medical conditions. This means that everyone of the same age and sex will get the same rebate, without having to go through a ‘medical’ — making the system fair, easy to understand, and simple to operate.

Of course, setting the rebate on the basis of what someone in ***normal*** health would cost the NHS would mean that it will be fairly modest in size. It might cover most (or indeed all of) the cost of private insurance for people in good health, but not for people in poor health. Those who face higher private premiums because they are in poor health or who have pre-existing conditions may still welcome the rebate and go private; or they can of course stay within the nationalised system. By setting the rebates conservatively, we ensure that the NHS still has sufficient resources to guarantee the treatment of those in poor health. And at the same time, we keep the rebate system simple, and give everyone at least ***some*** incentive to take on greater responsibility for his or her own healthcare needs.

As a matter of detail, the rebates might also reflect the average costs of healthcare in each person's geographical area, whether primary care provision is privately insured too, and the period for which the person agrees to leave the nationalised system. (This latter point feature will encourage the market for long-term, annual premium insurance policies to develop, as it has in the Netherlands. Such policies give the insured much lower administrative costs and much greater security).

It is worth emphasising that the rebate is based on the cost of NHS healthcare that each individual is likely to forgo — not the amount of tax or National Insurance that they pay. Hence, the redistributive aspects of the current system are preserved. A high earner would receive the same rebate as a low (or non-) earner. The high earner would still be making net tax and National Insurance contributions to the system to pay for the healthcare of those who are less well off. Low or non-earners would pay little or no tax or National Insurance contributions, but would still receive a rebate, reflecting the fact that their healthcare is being subsidised by higher earners, from wherever it is purchased. For example, pensioners on minimum income guarantee would pay little or no tax but would still be entitled to receive NHS care, and so should receive a rebate equal to the cost of that NHS care if they chose instead to use a private-sector provider.

Alternatives that would qualify

There is a range of forms of private provision towards which individuals should be allowed to direct a rebate.

Most health insurance policies in the UK are single-premium policies with annual re-assessment. This allows insurers to keep the cost of policies lower, since those whose health deteriorates and who are required to pay a higher premium can choose to not renew their policies and return to the NHS. It might be desirable for a longer-term policy market to develop, whereby the insurer guaranteed to insure for a given period (indeed, even for life) at a premium that was fixed or linked to an index of medical costs (see below). Such a policy would be more expensive than a single-premium policy because the insurer would be carrying the risk of deterioration in health during the policy term. But if such a private policy were taken out, that risk would be removed from the state. An appropriate actuarial basis for the rebates would have to be calculated that took the

length of the private policy contract (and hence the length of the contracting out period) into account.

It is important that regulations that allow individuals to receive rebates if they opt out of the NHS do not constrain the evolution of innovative forms of private provision. Private provision is extremely limited in the UK, both in terms of the extent of its coverage and in terms of policy types. The reason is that, given the availability of the NHS free at the point of use, private health provision in the UK has tended to provide rather limited functions (such as provision of better quality "hotel facilities" or access to more rapid treatment). Below are some of the forms of provision that should qualify for contracting out rebates.

- company health insurance schemes
- individual health insurance schemes
- long-term annual premium health insurance policies
- cash-benefit policies where the benefit is linked to an index of medical care costs
- policies involving co-payment (with limits on co-payment)
- policies involving an excess payable by the customer (with limits on the excess)
- policies that involved intermediary access control through, for example, health maintenance organisations.

These are broad categories of insurance. We would expect the market to evolve innovative ways of providing health cover (both in terms of finance and in terms of provision). In particular, we would expect innovative ways of mixing primary care, hospital-based care and preventative medicine to develop in the private sector. The private sector has a long-term interest in reducing healthcare costs by providing proper preventative and primary care and advice. The nationalised service has no such incentive (hence its development into what is often called a "sickness service").

It is important for the government to be protected from the risk that individuals may be under-insured and therefore not be able to obtain the healthcare that they need through the private insurer. However, at the same time, it is important that the market is allowed to develop appropriate risk-sharing arrangements with the insured in order to reduce overall costs by reducing moral hazard. Minimum contract standards would need to be defined. However, there would be complete freedom for consumers to "migrate up the menu" of choices available and obtain better services without the double payment that is required at the moment.

Reforming the NHS

The rebate proposal in this paper should go hand-in-hand with reforms to the NHS. This is important in order to deliver a higher quality of service to those who choose to use the NHS. It is also important as part of a more general move to liberalise the provision of healthcare and free the NHS from the top-down approach to funding and management. Without going into detail, the following list gives an indication of the kinds of reform that are necessary in the NHS:

- the principle of fund holding should be restored to GPs
- trusts should be made fully independent and responsible for setting pay and conditions
- health authorities should be allowed to purchase health services from any provider
- trusts should be allowed to sell health services to any funder (a private insurance company or any health authority).

Milburn (2002), does in fact, make limited progress on some of these points, in terms of statements of principle. However, much will depend on how radical the implementation is and the extent to which the devolution of budgets to “Primary Care Trusts” really does involve devolution to the front line, and how entrepreneurial the PCTs will prove to be.

These reforms would make a significant contribution to the development of a vibrant, innovative and responsive health system where the boundaries between the public and the private sectors are more blurred. Ultimately, it would allow the NHS and the patient care trusts to become intermediary insurers that financed healthcare for those who wished to remain within the system but which purchased services from a range of providers.

Other options

Tax relief. There are a number of important distinctions between the rebate proposal and the use of tax relief on private health insurance premiums. A system of tax relief is better than the ***status quo***, but it pays an arbitrary cash sum to those who decide to use private health insurance. The cash sum is not based on the cost of the state services that are no longer used, but on the individual's marginal rate of tax. Thus the cash sum could be zero, 10%, 22% or 40% depending on where an individual lay on the income scale. The rebate proposal, by contrast, gives everybody the opportunity to opt out of state services. They are rewarded for doing so on an equitable and economically sensible basis: by payment to them of a cash sum equal to the cost of providing the health services they no longer require, to be applied to a form of health provision that they prefer.

Vouchers. There are differences too between the rebate idea and proposals that everyone should receive a voucher towards the cost of their healthcare (whether obtained from public or private sources). Certainly, the voucher extends choice in a similar way, and allows individuals to spend more on healthcare if they want to. And like the rebate proposal, the voucher could have different values (depending on age, sex, or local healthcare costs, for example), that reflect people's differing healthcare costs. But the voucher is more radical, in that it would involve "opting in" to the nationalised service, rather than "opting out". Furthermore, the rebate proposal would deal more effectively with long-term contracting-out using new forms of long-term insurance.

Social insurance. The rebate proposal could help to develop deeper reforms, such as the idea of social insurance put forward in a recent Adam Smith Institute paper, ***NHS Reform: Towards Consensus*** (Brown and Young, 2002). That proposal involved requiring all individuals to purchase social insurance from private intermediaries, with premiums set at a fixed proportion of income. The intermediaries would then determine how to purchase healthcare in order to fulfil their contractual obligations.

As Browne and Young admit, that system may take time to construct. But the rebate proposal could be a stepping-stone towards it, giving people the financial resource to take to the new social insurers.

The rebate system could be implemented with almost immediate effect. All that is required is for the government to define its levels and set the minimum contract conditions for those who opt out of the nationalised system. It may take a few years for capacity to evolve within the market; it may also take a little while before innovative types of insurance and provision develop. But then individuals, looking at the alternatives that are available, can decide whether or not to take the rebate. Demand and supply will grow hand in hand as the market responds to the demands of the consumer.

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