For and against

Social insurance—the right way forward for health care in the United Kingdom?

The NHS in the United Kingdom is struggling to meet the needs of patients as costs continue to rise. Does the current system of funding need to change? David G Green and Benedict Irvine argue for a system based on social insurance, while Martin McKee and colleagues suggest that a tax based system is more equitable

Civitas (Institute for the Study of Civil Society), Elizabeth House, London SE1 7NQ
David G Green *director*
Benedict Irvine *project manager, Civitas Health Unit*
Correspondence to: D G Green david.green@civil-society.org.uk

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FOR Comparing systems of funding healthcare is controversial. We suggest, however, that the following six questions should help to put the controversy on an evidence based footing. We believe that the case for social insurance deserves a more serious hearing than the British government has so far given it.

Value for money—Can individuals tell whether they are getting good value for money? It is impossible for taxpayers to make a well informed judgment about value for money because they have no knowledge of the amount being paid nor any ability to vary it. Social insurance schemes allow individuals to see clearly (usually on pay slips) how much they are paying towards care. In Germany employers and employees make equal payments (totalling on average about 13% of the salary) to the independent sickness fund chosen by each individual. In France sickness funds are usually run by a board comprising employers and trade unions, and individuals cannot choose which sickness fund to use. In the past, employers in France paid about two thirds of the premium, but recently the share paid by individuals has been increased. In Switzerland there are competing insurers, and premiums are paid solely by individuals.

Standard of care—Do poor people enjoy a high standard of care? The standard of care is generally lower for people of all incomes in the United Kingdom than other European countries of similar wealth. In 1993 Wagstaff and van Doorslaer tentatively noted that higher healthcare spending in Europe seemed to "buy" some reduction in health inequality.[1] They also concluded that countries that spend more per capita on health may have lower levels of income related inequality in morbidity. France and Germany have never claimed that their systems are egalitarian, in the sense of aiming to provide a uniform standard across each country. Their objective has been "solidarity" rather than equality: they aimed to ensure that everyone would receive the high standard of care that middle income people chose for themselves while accepting that more affluent individuals should be free to pay for extras. In practice, pursuit of formal equality in the United Kingdom has meant that the poorest people ended up receiving a lower standard than was normal in mainland Europe.

Patients as customers—Does the funding system put the consumer in a weak or strong position? When people in Britain pay the Treasury, the provider has our money "up front" and we must put up with whatever service we get. Under social insurance, the payment goes to a third party, which will pay any provider chosen by the consumer. Normand and Busse note that social insurance systems treat patients as valued customers.[2] This may go some way to explaining why satisfaction rates are generally higher in countries that have a social insurance scheme.[3]

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French patients pay into a sickness fund

Incentives—What incentives are there for providers to offer a high standard of care? Treasury restrictions on expenditure have an impact on UK health outcomes.[4] In Germany and France, care standards are high, but their systems are criticised for failing to encourage good value for money. The funds were founded at a time when the priority for policy makers was access. Insurers pay agreed costs incurred by "any willing provider," but the disadvantage of such unfettered choice is that insurers cannot weed out providers whose standards are too low. To overcome this problem, France and Germany have taken different routes. France is intent on central regulation, whereas Germany has relied on increasing competition between sickness funds.

Effect on professional duty—Does the system have an impact on the professional duty of clinicians to act in the best interest of patients? Owing to political interference, clinicians in the United Kingdom often cannot act in the best interests of patients. Doctors have increasingly made their dissatisfaction public. Professional autonomy is more fully respected under a social insurance scheme, although a brief period of controversy followed efforts by the German government to restrict access to drugs in the 1990s. Mossialos and Le Grand compare priority setting decision making in the European Union and note that in Germany and the Netherlands (which also has a social insurance system) there are several

stakeholders who can veto decisions and who are not beholden to the government.[5]

Balancing expectations and resources—Has the system proved able over time to bring the expectations of individuals into balance with the capacity of providers to treat patients? The UK Treasury has interests of its own that do not necessarily coincide with those of consumers. Funding health care from general taxes has proved to be an ineffective way of bringing the expectations of patients into balance with the treatment capacity of the system. The Wanless report put the accumulated underinvestment at £267bn ($417bn; €425bn).[6] Separation of healthcare finance from other government expenditure allows spending levels to rise according to demand; social insurance systems tend to lead to higher spending than tax based systems.[7] In 2000, the World Health Organization ranked countries according to the responsiveness of their health systems to needs: Switzerland, Luxembourg, Germany, and the Netherlands (all with social insurance systems) ranked second, third, fifth, and ninth in the world. Of the tax based systems in western Europe, only Denmark (with its highly decentralised system funded by local taxation) achieves a similar ranking—fourth. The United Kingdom languished in twenty sixth position.[8]—David G Green, Benedict Irvine

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1 Wagstaff A, van Doorslaer E. Equity in the delivery of health care: methods and findings. In: Wagstaff A, van Doorslaer E, Rutten F, eds. *Equity in the finance and delivery of health care: an international perspective*. Oxford University Press, 1993.
2 Normand C, Busse R. Social health insurance financing. In: Mossialos E, Dixon A, Fugueras J, Kutzin J, eds. *Funding health care: options for Europe*. Buckingham: Open University Press, 2002.
3 Mossialos E. *Citizens and health systems: main results from a Eurobarometer survey*. Brussels: European Commission Directorate General for Health and Consumer Protection, 1998.
4 Or Z. *Summary of results from breast cancer disease study. What is best and at what cost?* Paris: Organisation for Economic Co-operation and Development, 2002.
5 Mossialos E, Le Grand J. *Health care and cost containment in the European Union*. Aldershot: Ashgate Press, 1999.
6 Wanless D. *Securing our future health: taking a long-term view, final report*. London: HM Treasury, 2002.
7 Organisation for Economic Co-operation and Development. *Health data, 2001. A comparative analysis of 29 countries*. Paris: OECD, 2001.
8 World Health Organization. *World health report 2000*. Geneva: WHO, 2000.

AGAINST After years of debate about containing spending on health care in the United Kingdom a consensus has emerged that it should be increasing. Unfortunately, this breaks down when the debate is about how the extra funds should be raised. The Treasury argues for continued funding from taxes and national insurance contributions.[1] Others argue for a shift to social health insurance, accompanied by higher spending by individuals through user charges and private insurance, on the grounds that funding from taxation is unsustainable.[2] We believe that the arguments for change are flawed.

Supporters of change contend that Britain is out of step with the rest of the world. Yet other countries in Europe rely largely on taxation. The organisation of social insurance systems also differ considerably from each other.[3] Every system is, in some way, unique. And no western European country has changed from a tax based funding system to an insurance based system, although several—including France, Italy, and Spain—have moved or are moving in the opposite direction.[4]

Impact on the economy

Some commentators argue that social insurance systems spend more on health care, but some tax based systems, such as Sweden's, seem able to spend at least as much as social insurance systems. However, how the resources are spent and the output and outcomes achieved is surely more important. Denmark, a tax funded system, does not spend as much as France or Germany, but neither does it face the problems (such as long waiting lists and staff shortages) seen in Britain.

Others have argued that the impact of the necessary additional spending on income tax would be politically unacceptable. Yet income tax now accounts for only £118bn ($184bn; €188bn) of a total tax revenue of £407bn,[5] so the consequences for income tax need not be excessive. Retaining the ability to raise taxes from various sources, including investment income and company profits, makes it possible to compensate for imbalances across the economic cycle.

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German care standards are high, but are they good value?

In contrast, social insurance seems less sustainable. It is more vulnerable to economic cycles and is levied on earned income, which is growing more slowly than investment income. Of course, shifting to earned income would benefit those who have reduced their tax bill by taking most of their income as dividends. Furthermore, the cost it imposes on employment is greater. Many firms in France and Germany already find the cost of employment extremely burdensome. Given industry's reaction to a small increase in national insurance contributions in Britain, raising the entire health budget this way would presumably cause an immediate exodus of firms to countries where labour costs are lower.

Private sources of funding

Some people suggest that patients should pay more. In France and the Netherlands about 20% of total health

London School of Hygiene and Tropical Medicine, London WC1E 7HT

Martin McKee
professor of European public health

London School of Economics and Political Science, London WC2A 2AE

Anna Dixon
lecturer in European health policy

LSE Health and Social Care, London School of Economics and Political Science

Elias Mossialos
codirector

expenditure is from private sources (patient charges and private health insurance). Charging patients is simply a tax on service users, who are more likely to be poor or unemployed. No evidence exists that charges deter only unnecessary use, and evidence from Sweden shows that they reduce access.[6]

Expansion of private medical insurance is a possibility, but the decline in individual contracts over the past five years—with stability the result of increasing group insurance[7]—suggests little popular enthusiasm. Tax incentives would subsidise the better off, who are most likely to purchase private insurance. As with patient charges, this effectively transfers resources from the poor to the rich.

Choice needs capacity

Some commentators argue that patients should have more choice. One way is to opt completely out of the public system. Few countries permit this as it undermines the sharing of risk and funds between rich and poor and between healthy and sick. In Germany, employees earning over £25 000 can opt out of statutory health insurance but fewer than one in four do, mainly because of the high costs of covering dependants.[8]

Choice can also be between insurers, as in Belgium, Germany, and the Netherlands. The imbalance in risk profile that results requires complex systems of adjustment that are costly to administer.[3] These are often inadequate—for example, in the Netherlands both public and private insurers spend more per capita on selection than on efficiency gains (€10 *v* €3 by public funds and €28 *v* €2 by private funds).[9]

Choice of provider is also possible. This is not related to the funding mechanism and already exists in Britain, although it is currently limited by lack of capacity. Ironically, it may be heavily constrained by competing insurers seeking to contain costs, as in the United States.

It is wrong to think that social insurance eliminates waiting lists. Like Britain, the Netherlands has long waiting lists and sends patients abroad for elective surgery.[10] This is mainly an issue of investment in capacity. Britain also lags behind western Europe in investment in education, transport infrastructure, and housing, suggesting a problem that goes beyond the system of funding.[11]

New challenges

A social insurance model in Britain has some distinct drawbacks. Given the emphasis placed on waiting lists, it is easy to forget that health care involves more than elective surgery. A combination of ageing populations and new treatments increases the number of patients with complex chronic diseases requiring coordinated input from different health professionals. Moreover, technological advances, especially in genetics, will make it possible to screen for an increasing number of disorders. Social insurance systems struggle to respond to both challenges.

It is, however, important not to lose sight of the most important issue, the distribution of costs and benefits of health care in the population. The main advantage of funding from general taxation is that it recognises that those whose needs are greatest are least able to pay for care. The young and the rich subsidise the old and the poor. A shift to competing insurance funds, no matter how well regulated, and an increase in what people themselves pay, will inevitably relieve the rich of this burden. Is this the real issue?—Martin McKee, Anna Dixon, Elias Mossialos

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1 Wanless D. *Securing our future: taking a long-term view*. London: HM Treasury, 2002.
2 Adam Smith Institute. *Partnerships for better health. Funding UK health care*. London: ASI, 2002.
3 Mossialos E, Dixon A, Figueras J. Kutzin J. *Funding health care: options in Europe*. Buckingham: Open University Press, 2002.
4 Dixon A, Mossialos E. Funding health care in Europe: recent experiences. In: Harrison, T, Appleby J, eds. *Health care UK*. London: King's Fund, 2001.
5 HM Treasury. *Budget 2002. The strength to make long-term decisions: investing in an enterprising, fairer Britain*. London: Stationery Office, 2002.
6 Whitehead M, Evandrou M, Haglund B, Diderichsen F. As the health divide widens in Sweden and Britain, what's happening to access to care? *BMJ* 1997;15:1006-9.
7 King D, Mossialos E. *The determinants of private medical insurance prevalence in England*. London: London School of Economics and Political Science, 2002. (LSE Health and Social Care discussion paper 3.)
8 Mossialos E, Thomson S. Voluntary health insurance in the European Union: a critical assessment. *Int J Health Services* 2002;3(2):19-88.
9 Douven R, Westerhout E. Reimbursement systems in Dutch sickness funds. *Quarterly Review of CPB Netherlands Bureau for Economic Policy Analysis* 2000;3:51-5.
10 Sheldon T. Dutch patients travel to Spain for orthopaedic surgery. *BMJ* 2001;322:1565.
11 McKee M, Mossialos E, Dixon A. Paying for the NHS: are we asking the right question? *J R Soc Med* 2002;95:59-60.

The importance of hospital identity

Picture the scene: 12 30 pm on Monday. I had been on call for the weekend and had just spent the past 52 hours within the confines of the hospital. I was still wearing blue theatre scrubs (despite local policy prohibiting me from doing so out of theatres), my white coat, and a stethoscope draped around my neck and was armed with three bleeps (one of which was the arrest bleep) and loaded with pens and scraps of paper, tourniquets, packets of water based lubricant, rubber gloves, and whatever else had found its way into my pockets.

I had managed to have a shave the night before, but still felt pretty ropey, so I decided to get something to eat. My canteen tray was loaded with a chicken wrap with some exotic leaf vegetable I'd never heard of, a bag of salt-and-vinegar crisps, and caffeine enriched soft drink. The customer in front of me paid and walked off. The lady behind the till looked me up and down and, unable to see my identification badge, asked: "Staff or visitor dear?"

James S Dawson *house officer, Peterborough*

We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.