Appendix to chapter 5

Has it ever happened?

The National Health Service as a universal benefit

The book is about the tax and benefits systems, but it would do no harm to give a few lines to the UK's highly successful provision of universal, unconditional and nonwithdrawable healthcare. Completely free to every UK citizen are visits to a General Practitioner (GP) and inpatient and outpatient treatment in hospital. Prescriptions and dental care are subsidized.

In order to understand how efficient the NHS is, we need to examine the conditions under which any healthcare system operates. If I go to a GP because I think I have a health problem, then the doctor needs to decide what is wrong. They might prescribe tests, and on the basis of the results, and on the basis of their own knowledge and experience, they will make a diagnosis and prescribe treatment. Either they will administer the treatment, or they will arrange for me to attend a hospital. At every stage, medical staff are likely to possess more knowledge and experience than the patient. We therefore have a situation of asymmetric information: that is, medical staff are making the decisions because they have more information than I do. I cannot negotiate as I have no basis on which to do so. (This is also true of the so-called 'choice' that patients are now supposed to have in relation to which hospital they will attend for treatment. I might have read published league-tables, and I might have heard from friends and relatives who have attended a variety of hospitals, but I still do not possess sufficient knowledge or experience to enable me to make a rational decision as to which hospital to attend. My GP will have more relevant knowledge and experience than I have, so the rational course of action is to ask the GP to decide which hospital I should attend.)

In such a system of asymmetric information, a privately funded healthcare system can only disadvantage the patient. Medical staff will have an interest in prescribing tests and treatment, for which the patient will have to pay, and the patient will have no grounds on which to negotiate. This is what we call an exploitative market. The market will also have the characteristics of a monopoly (a market in which there is only one vendor of a product or service) because the patient will be unable to evaluate alternatives, will find it difficult to compare prices for the same product or service (because every medical provider will be offering what they choose to offer, at the price that they choose), and will therefore not have the option of choosing between differently priced examples of the same product or service. The patient not only has to accept the product or service that the professional offers, but also has to accept the price at which it is offered.

When insurance companies enter the field, the situation becomes even more complex. For obvious reasons, no insurer will cover you for a condition over which you have some control, whether or not you suffer from that condition. The problem is called 'moral hazard'. If I am insured against some event happening, and if by my actions I can determine to some extent whether it does happen, then I might not try to avoid that event happening with as much care as I might have done if I had not been insured. And again, asymmetric information is a problem. This time the patient might know more than the insurance company: for instance, about whether they might be predisposed to a particular condition. In order to avoid these problems, there is usually a list of conditions and events that insurance companies choose not to insure. Here is just one such list:

AIDS/HIV
Allergies or allergic disorders
Birth control, conception, sexual problems and sex changes
Chronic conditions
Complications from excluded or restricted conditions/treatment
Contamination, wars and riots
Convalescence, rehabilitation and general nursing care
Cosmetic, reconstructive or weight loss treatment
Deafness
Dental/oral treatment (such as fillings, gum disease, jaw shrinkage etc...)
Dialysis
Drugs and dressings for out-patient or take-home use
Experimental drugs and treatments
Treatment to correct eyesight (e.g. long or short sight)
HRT and bone densitometry
Intensive care
Learning difficulties, behavioural and developmental problems
Overseas treatment and repatriation
Physical aids and devices
Pre-existing or special conditions
Pregnancy and childbirth
Puberty, menopause and ageing
Screening, monitoring and preventative treatment
Sleep problems and disorders
Speech disorders
Telephone consultations
Temporary relief of symptoms
Unrecognised providers or facilities [1]

If I have private health insurance, and I go to a doctor for treatment for an insured risk, then who decides what is to be done? The doctor. The insurance company therefore has little control over how many resources are expended in my treatment, so here the insurance company is suffering from asymmetric information. At the same time, the insurance company is setting the insurance premium, and comparing one insurer with another is difficult because in order to compare the prices charged by different companies we would need the insurance products to be identical. They never are, especially now that each company offers a wide variety of options from which their customers can choose. We can fairly easily compare the prices of different options from one company, but comparing prices between companies requires expertise that the customer is unlikely to have. Again, asymmetric information is the result. The outcome is a two-stage exploitative market, with both the economically self-interested health providers and the insurance companies having considerable freedom to decide on the products offered and the prices charged. Very few of their customers have the ability to negotiate over any of it. It is in the interests of the healthcare providers to provide more treatment than is necessary, but only insured treatments; and it is in the interests of the insurer to maximize the premium by offering as wide a range of options as possible, thus making comparison with other companies almost impossible. The worst of it is that, having paid premiums over many years, a customer can find that their kidneys fail, they experience a chronic muscle condition, they go deaf, they find that they are not covered for any of it, and they then contract a condition that the insurance company decides is ‘special’.

The reason that UK insurance companies can behave in this way is because the NHS provides universal, unconditional, and nonwithdrawable healthcare: so the insurance companies, and the medical staff and facilities for which they pay, can pick and choose what they will treat, and can leave the expensive, the long-term, and the difficult, to the NHS. Those who suffer are the insurance companies' customers, who will on average be receiving more treatment than they need for insurable conditions, and who will be paying high premiums for little benefit. In one sense this is not too much of a problem because presumably they can afford to suffer the consequences of asymmetric information, but it is a problem: because if something goes wrong with private treatment then the NHS has to pay for continuing care; because more medical resources will be used than need to be; and because the NHS is paying for all of the medical and nursing training from which the private system benefits and from which the NHS therefore no longer benefits.

In those countries in which insurance policies are the only means of paying for healthcare, problems are far deeper than this. Insurers have no wish to insure existing conditions, nor chronic ones. People who have existing conditions, or who contract chronic conditions, are likely to have lower incomes than the average; but they will also experience higher premiums, or they might have no insurance options at all. So those most in need of healthcare will be the least likely to be insured. Where insurance policies are the more normal funding route, and the Government and charitable foundations provide a safety net, then the charitable sector will be limited by the money it can raise, and the Government will want as many people as possible to be in the insured sector and so will provide in the public and voluntary sectors a service of lower quality than that provided by the insured sector. The insured will end up with too many operations, and those not insured with too little healthcare.

On top of all of that inefficiency, we have to ask where the money is going. The proceeds of insurance premiums go to medical and nursing staff, to health providers' managements, to private health providers' shareholders, and to insurance company staff and managements. The UK's National Health Service is funded by the Exchequer, which pays all of the medical, nursing and hospital costs for the entire population, and subsidizes dental care and prescriptions. Now that private companies are providing some of the services, the managements and shareholders of those companies are receiving some of that money, which is a pity: but still there are no insurance company staffs, managements or shareholders to pay, and because budgets are limited by the treasury, the number of treatments available is limited. This requires medical staff and health service managements to prioritize, which reduces the resources expended. So even though all illnesses are covered, including chronic and expensive long-term ones, the average cost per head of healthcare in the UK's universal system is less than half that in the United States' mainly insurance-based system. The United States has about the same number of doctors per head of population as the UK, but fewer nurses and midwives (94 per 10,000 people: the UK has 128), fewer hospital beds (31 per 10,000 people: the UK has 39), and lower life expectancy (78 years at birth, compared to the UK's 80 years). [2] Nobody looking at the costs of healthcare in the USA and in the UK, at these statistics, and at the regulatory and other problems that an insurance-based system would impose, would think it a good idea to abandon our universal healthcare system for an insurance-based one.

Gerlinger, in Dingeldey and Rothgang's *Governance of Welfare State Reform: A Cross National and Cross Sectoral Comparison of Policy and Politics*, [3] discusses changes in the regulation of health insurance systems in Germany, Switzerland and the Netherlands. He does not discuss the UK. Indeed, he could not have done so, because the universal NHS avoids the need for state regulation of health care insurance. Here is yet another cost saving. But, more significantly, the

editors of the book offer a concluding chapter that draws together the conclusions of the different chapters into a picture of continuing diversity within which a few trends are identifiable, and in particular 'a withdrawal of the state from service provision and a simultaneous extension of the state's responsibilities for guaranteeing the delivery of an access to services'. [4] I draw an additional conclusion. [5] A five page discussion of the Netherlands pension system [6] gives four lines to the residence-based flat-rate Citizen's Pension and five pages to the funded industry-based sector, in spite of the fact that it is the residence-based state system that contributes so much to income maintenance and poverty reduction. [7] The internal governance of Britain's NHS is discussed but not its universal provision or its insuranceless funding, which is what really ought to have been compared with insurance-based healthcare systems. The UK's Child Benefit does not get a mention, even where it would have been highly relevant. [8] The editors and authors clearly regard universal provision as not worth discussing, yet it has been a highly successful welfare system in its own right, particularly in relation to its low administrative costs and its capacity to reduce poverty and provide income security. So here is a hypothesis: Universal provision is so successful when implemented that it creates no problems. It is problems, not successes, which demand the attention of policymakers and academics. Therefore universal provision drops off the policy agenda. This means that universal provision is not considered as an option when welfare reform options are discussed. This is a pity. The National Health Service is universal, unconditional, and nonwithdrawable, and it is both efficient and effective. It should be the model for healthcare everywhere.

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[1] BUPA, *Bupa by you: in detail*, BUPA Insurance Services, 2011, www.bupa.co.uk/jahia/webdav/site/bupacouk/shared/Documents/PDFs/Individual/BBY/FINAL%20-%20BBY%20PRODUCT%20SUMMARY%20150711.pdf, 22/09/11

[2] 2006 per capita healthcare costs as follows ($): USA, 6719; UK, 2815. Life expectancy at birth is 80 years in the UK, and 78 years in the USA. Figures extracted from World Health Organisation, *World Health Statistics*, 2009, pp.108-115, figures for 2006, www.who.int/whosis/whostat/EN_WHS09_Table7.pdf

[3] Thomas Gerlinger, 'Competitive Transformation and the State Regulation of Health Insurance Systems: Germany, Switzerland and the Netherlands Compared', pp.145-175 in Irene Dingeldey and Heinz Rothgang (eds.), *Governance of Welfare State Reform: A Cross National and Cross Sectoral Comparison of Policy and Politics*, Edward Elgar, London, 2009

[4] Heinz Rothgang and Irene Dingeldey, 'Conclusion: The Governance of Welfare State Reform', pp.238-250 in Irene Dingeldey and Heinz Rothgang (eds.), *Governance of Welfare State Reform: A Cross National and Cross Sectoral Comparison of Policy and Politics*, Edward Elgar, London, 2009, p.250.

[5] *Citizen's Income Newsletter*, issue 2 for 2010, Citizen's Income Trust, London, 2010, p.10.

[6] Thorsten Hippe, 'Vanishing Variety? The Regulation of Funded Pension Schemes in Comparative Perspective', pp.43-68 in Irene Dingeldey and Heinz Rothgang (eds.), *Governance of Welfare State Reform: A Cross National and Cross Sectoral Comparison of Policy and Politics*, Edward Elgar, London, 2009, pp.52-7.

[7] Karl Hinrichs and Matteo Jessoula, 'Flexible Today, Secure Tomorrow?', in Karl Hinrichs and Matteo Jessoula (eds), *Labour Market Flexibility and Pension Reforms: Flexible Today, Secure Tomorrow?* Palgrave Macmillan, Basingstoke, 2012, pp.233-250, p.244

[8] Irene Dingeldey, 'Changing Forms of Governance as Welfare State Restructuring: Activating Labour Market Policies in Denmark, the UK and Germany', pp.69-93 in Irene Dingeldey and Heinz Rothgang (eds.), *Governance of Welfare State Reform: A Cross National and Cross Sectoral Comparison of Policy and Politics*, Edward Elgar, London, 2009, pp.75-7.