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What principles should underlie healthcare financing and what are the options available? **Howard Lyons** offers insights on a debate that goes far wider than simply what's right for Britain.

Funding Healthcare

Former Group Chief Executive of Natwest Derek Wanless with a copy of his report on the future financing of Britain's National Health Service (NHS).

Christians have been in the vanguard of providing healthcare to those in need - regardless of their ability to pay - for nearly 2000 years. We have much still to offer

Ever since January 2000, when the Prime Minister Tony Blair was bounced into a commitment in a TV interview to raise spending on healthcare in Britain to the European average, healthcare funding has been a major issue for debate in this country.

The Chancellor Gordon Brown almost stifled the debate at the outset when he assured Parliament that the fundamental basis of funding the National Health Service from central taxation would not change, but the recent publication of the Wanless Report and the Chancellor's commitment to increase NHS spending by 7.2% per year over the next five years have brought the subject right to the forefront of people's minds.

The question being asked is: will this massive increase in spending, funded by increases in taxation, actually deliver health services in Britain which are at least equal to our European neighbours, notably France, Germany and Holland?

Almost ever since the introduction of the National Health Service in 1948, expenditure on healthcare as a percentage of Gross Domestic Product has fallen behind our European rivals (see chart 1) but the NHS was hailed as such a momentous social experiment removing, at a stroke, the financial burden which the threat and onset of illness imposed that few dared to criticise the concept.

The main options

In most Western (OECD) countries there are four main options for funding healthcare systems: **central taxation**, **social insurance**, **local taxation** and **private medical insurance**.

The NHS is the most obvious example of funding by **central taxation**. The Beveridge model of providing a comprehensive range of healthcare services free at the point of use with universal access and no co-payments or user fees was adopted, in different shapes and forms, by many Commonwealth countries from the 1950s onwards. Few countries, however, have adhered to the basic principles as rigidly and obsessively as the United Kingdom.

The most common alternative is social insurance. One of the first **social insurance** schemes, or Earmarked Payroll Tax as it is sometimes known, was introduced in Germany by Chancellor Bismarck in the 1880s requiring employers and workers to contribute a fixed percentage of their salary into a ***hypothecated fund*** which would then be used exclusively to provide healthcare services for employees and their families. It was also used to pay workers' compensation and pensions according to size of contributions made. Most continental European countries adopted social insurance. So have Latin American countries who came under the influence of European colonial powers.

Local taxation is a system much like our rates or council tax and gives much greater local accountability and responsiveness. Scandinavian countries like Denmark still retain a significant amount of local funding and accountability.

Private medical insurance involves individuals buying insurance cover from commercial or not-for-profit companies with the level of premiums dependent on the health risk of the individual and the range of cover required. The United States is the best-known example of a system which relies heavily on individual private medical insurance cover with the inevitable adverse consequences for the indigent and those at greatest risk.

The Wanless Report has come down decisively in favour of a continuation of central taxation as the main method of funding. However Gordon Brown's latest budget transferred more of the taxation burden to employers and employees by increasing the National Insurance contribution.

Key principles

The inescapable truth is that, whichever system of healthcare funding is used, it will involve a trade-off of basic principles held dear. In some ways, health is a commodity just like any other and can be purchased as such (eg. a hip replacement or an obstetric delivery). But in other ways, healthcare is unique. If I go to the supermarket for a bag of sugar, I'm unlikely to be told by the check-out assistant that I need five bags. This illustrates the concept of ***information asymmetry*** prevalent in healthcare, whereby the doctor/supplier usually knows better than the patient/consumer what the consumer needs. Pricing and funding of healthcare therefore can't be left to basic market principles as they might to sugar, tinned beans, cars or houses.

Healthcare is unique in the way it is likely to be needed most by those least able to pay. That is why the concept of ***risk-pooling*** must be a fundamental element of any government-sponsored system. The woman who touched Jesus' cloak (Luke 8:43) had spent all she had on doctors. It's salutary to remember that for many people this was the situation which applied in Britain before 1948. It left millions in dread of contracting an untreatable illness and this remains true today in many developing countries.

Equity should encompass vertical equity whereby unequals are treated unequally and where contributions are related directly to the ability to pay. It should also encompass horizontal equity whereby equals are treated equally and those with equal means make an equal contribution. Someone who succumbs to a chronic illness should never have to pay more than someone who never has a day's illness in their life. And someone who uses health services twenty times a year should not have to pay any more than someone who only visits their GP once a year. But then the concept of ***moral hazard*** applies whereby free services are more likely to be abused than those for which people have to pay something. For this reason, systems have been supplemented by user fees but this unfortunately can discriminate against the poorest.

In addition to equity and comprehensiveness, any system for funding healthcare should be measured against six further criteria:

Comprehensiveness is a much-lauded feature of the NHS whereby all citizens have access to a full range of healthcare services. Many Commonwealth countries which tried to adopt the NHS model quickly found they could not afford to provide this and now offer a basic package of services including emergency care, obstetrics and primary healthcare. The NHS is gradually restricting the range of services and forcing patients (many of them elderly) to resort to private healthcare and use of their savings.

Chart 1

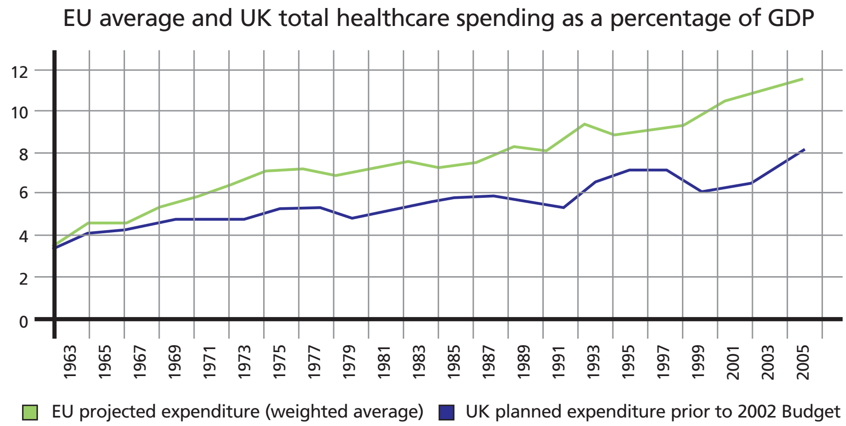

Chart 2

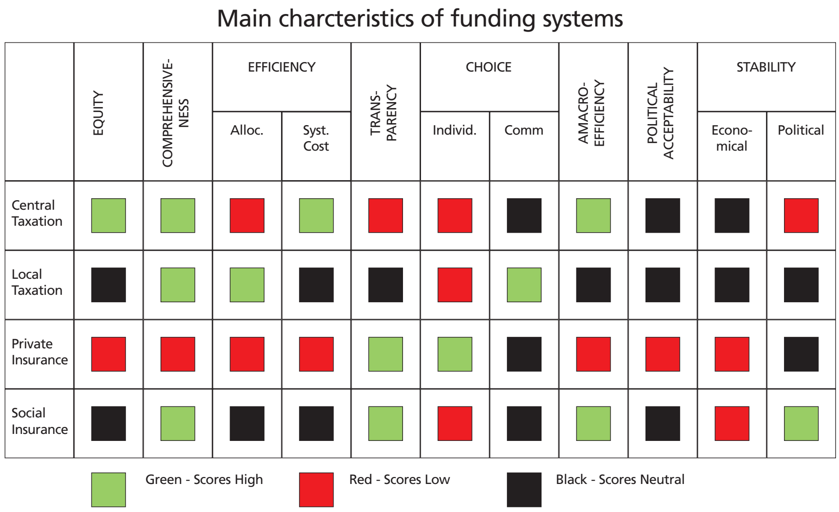

Chart 3

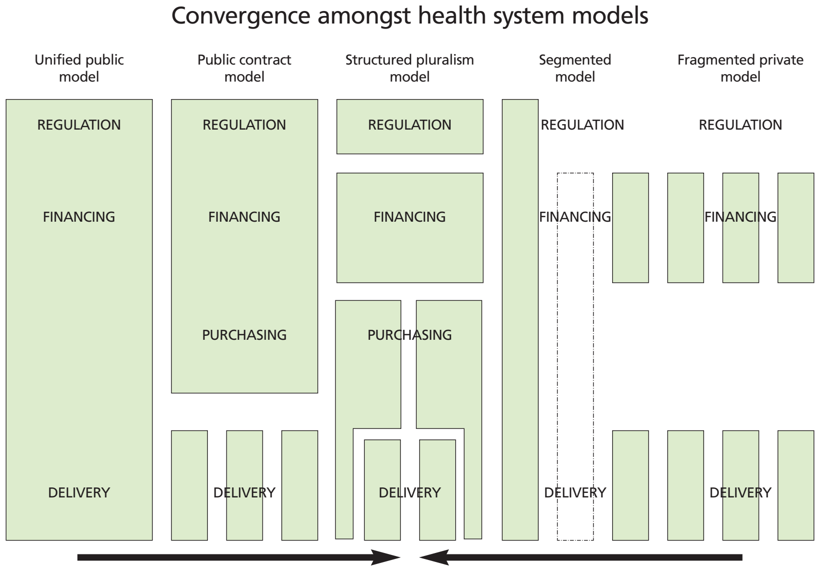

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Photo: PA

KEY POINTS

In Western countries there are four main options for funding healthcare: central taxation, social insurance, local taxation and private medical insurance. The recently published Wanless Report reinforces the government's commitment to the first of these only, but the issue is still being fiercely debated. The ideal healthcare delivery system needs to be equitable, comprehensive, efficient, transparent, politically acceptable, stable and offering consumer choice. As Christian doctors we need to take an active part in the debate and seek a solution which protects the interests of the vulnerable whilst at the same time ensuring that individuals take personal responsibility for their health.

Efficiency. Despite constant criticisms of the cost of NHS management, the NHS has the lowest administrative cost of most comparable systems and is much more efficient than private medical insurance.

Transparency. The NHS scores poorly here because of the nature of risk-pooling and the way taxes are raised and disbursed. In contrast, with private medical insurance, it is transparently clear when I take out a policy what my annual premium is and what services I am entitled to.

Choice is a principle cherished by American society and reflects the extent to which consumers (or communities) can exercise choice over the amount paid for healthcare and the providers from which treatment can be obtained. Again, private medical insurance scores well here.

Macro-efficiency is a criterion for assessing the extent to which the funding system allows control to be exercised over total expenditure. Housing, sanitation and education are all determinants of health status so spending too much on healthcare delivery may not bring the same benefits which increasing expenditure on housing and education might bring.

Political Acceptability. Hilary Clinton met opposition when she tried to implement changes to the highly-fragmented and inequitable US system in the 1990s. Here in the UK, employers would be unlikely to welcome a move to social insurance if they ended up bearing most of the burden.

Stability of Funding takes account of the business cycle which often runs counter to the need for healthcare. The unemployed are generally less able to contribute to healthcare funds but more likely to need services. Also a funding system which is safe from the idiosyncrasies of short-term political priorities is likely to be more stable. For over forty years, healthcare was a low priority in government spending in the UK behind education, social security and defence but now it is a top political priority and so is attracting more funding. But for how long?

No single system can hope to satisfy all these criteria and naturally the question of affordability overrides almost all other considerations; but setting the criteria alongside the different funding options (Chart 2) illustrates which systems fare better than others on each of the main characteristics.

A Christian model

From a Christian perspective, our motivation will always be to care for those less fortunate than ourselves and to balance our obligations with an expectation that individuals will take personal responsibility for their health and well-being. The biblical principles of progressive taxation and vertical equity are well-accepted in Britain but much less so in the United States and many developing countries where individuals who require healthcare are left to fend for themselves. The story of the Good Samaritan has inspired many benefactors to 'go and do likewise' and provide for those in need and, on an individual basis, that must be our inspiration as well. But looking at this from a systemic or community perspective, wouldn't the local taxation model be more appropriate for many societies using the Israel of the Old Testament as an example? And the New Testament model from Acts 2:44-45 appears to endorse the idea of community risk-pooling amongst Christians but how does it apply in a 21st century post-modern secular democracy?

I believe we need to move away from the unified system we have clung to in the UK for the past fifty years whereby the four system components of regulation, financing, purchasing and delivery have all come under the monolithic NHS. There is no reason why each of the four components can't be undertaken by separate organisations as is increasingly the trend in Europe, as long as the basic principles of equity and comprehensiveness are met (Chart 3).

Without the vital ingredient of transparency, our system lacks a healthy balance of incentives and disincentives which would encourage patients to look after themselves and not to abuse the availability of 'free' healthcare, whilst healthcare professionals need more checks and balances to ensure they are fairly rewarded for their expertise and effort without being tempted to exploit the system for their own ends.

There are signs of change with Alan Milburn's paper, published days after the Wanless Report, entitled *Implementing the NHS Plan*. It suggested that New Labour's tax and spend U-turn is not simply going to involve pouring bucket loads of money into the NHS without requiring some fundamental reforms. It seems that the Government has belatedly realised that the imperfect vectors of the internal market introduced by the Tories in 1990 and abandoned by New Labour in 1997 nevertheless had some merits, although they would never admit it.

Meanwhile the Tories are currently scouring Europe for new ideas on healthcare for the next general election. There is no doubt that if Labour fails to deliver better health services with vastly increased funding from increased taxes, a variation on social insurance will be the preferred option.

As Christian healthcare professionals we need to take part in the debate in an informed and constructive way, discarding our prejudices about the merits and demerits of the NHS compared with, say, private medical insurance. We have much still to offer in shaping a compassionate and caring health service for Britain in the 21st century.

Howard Lyons MSc BSc(Econ) FIHM MIPD is Managing Director of London International Healthcare and Chairman of MMA HealthServe. He is involved in advising governments on healthcare financing and delivery especially in developing countries.