Middle Articles

IS THERE AN ALTERNATIVE?

The possibility of a large extension of private insurance schemes for health in Britain has often been raised. What schemes are already in existence, in Britain and elsewhere? What problems would be involved in applying them more widely? What are their advantages and disadvantages? In his article Mr. Arthur Seldon discusses the answers to these and some other questions.

Prospects for Private Health Insurance

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Insurance, private and voluntary, is increasingly discussed in Britain as an indispensable method of paying for health services at rising standards because it would introduce additional finances not otherwise available for higher payments to doctors, nurses, and administrators; larger expenditure on treatment, training, and research; and increased outlay on equipment, buildings, and land.

Private insurance could supplement the three other methods of financing medical care—namely, fees, taxation, and charges. Firstly, fees for some services will be increasingly practicable for more people as incomes rise. Secondly, the belief that taxation, with the compulsory national insurance contributions that are more a tax than a premium, will yield the required growing sums is fading.¹ To satisfy Professor Henry Miller's eloquently argued proposal² that £500 million more would have to be found almost immediately from taxation to give medicine in Britain "the relative priority" it enjoys in the United States—that is, to raise expenditure on the N.H.S. from around £1,500 million to £2,000 million—the Government would have to raise tax revenue by a much larger amount, perhaps by £1,500 million, since it could not allocate £500 million more to the N.H.S. and nothing more to State education,³ school welfare services, housing, pensions, family allowances, unemployment, disability and sickness benefits, other social benefits, and neglected public services such as the police.

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¹ The reasons, empirical, analytical, and institutional, are indicated in the author's "Which Way to Welfare?" *Lloyds Bank Review*, October 1966. Briefly: expenditure on medical care has been rising faster than income in the U.S.A. and elsewhere but not in Britain; citizens are not prepared to pay as much in taxes for services shared with others as they demand for themselves; taxes are regarded as deductions from income, not as payment for services. The academic analysis is elaborated in a growing literature on public finance and the economics of medical care by Professor J. M. Buchanan, *The Inconsistencies of the National Health Service*, Occasional Paper 7, I.E.A., 1965; Professors John and Sylvia Jewkes, *Value for Money in Medicine*, 1963, Blackwell; Professor D. S. Lees, *Health Through Choice*, Hobart Paper 14, I.E.A., 1961; Professor R. A. Musgrave, *The Theory of Public Finance*, 1959; a doctoral dissertation at the University of Virginia by Mark Pauly; and others. The argument has also been spreading to the politicians: Messrs. Desmond Donnelly (*Hansard*, 9 June 1967, column 1468), Douglas Houghton (*Paying for the Social Services*, Occasional Paper 16, I.E.A., 1967), and Brian Walden (*Sunday Times*, 25 June 1967).

² "In Fitness and in Health: A Doctor's View of Medicine in Britain," *Encounter*, April 1967.

³ The President of the Association of Education Committees said at its conference on 21 June 1967 that state education had to have £550 m. a year for essential improvements.

⁴ Arthur Seldon, *Pensions in a Free Society*, I.E.A., 1957.

⁵ Discussed in *Paying for the Social Services*.

⁶ Mr. Patrick Gordon Walker, Minister Without Portfolio, speaking to a seminar of the University of Cambridge Board of Extra Mural Studies, 18 June 1967.

Even if national income grew by 3% a year, which is not yet certain, tax revenue would not rise enough to provide State welfare for the increasing number of dependants, children, and old people, or to remove poverty. Tax rates would therefore have to be raised, a policy which diminishing numbers in all parties now think is either economically desirable or politically acceptable.

Politicians in all parties are discussing realistic charges for State health services: not only for medicines and appliances but also for consultation and treatment. Mr. Houghton and Mr. Walden have been most explicit in recent weeks. If charges drew substantial sums of additional revenue into the N.H.S., they might enable it to provide the rising standards of services expected by people with growing incomes, and the demand for private medicine might run down. But the more charges are designed to raise revenue and not only deter over-use, the more they would reduce the gap between the cost of State and independent medical care, and the more they might accelerate the growing demand for private services. (If the choice is between a free N.H.S. and paying the full cost of private medical care, only a few will pay; if the choice is between charges for the N.H.S. and paying for private medical care, more will pay.) Which of these two effects would be the stronger is impossible to forejudge. The economic dilemma of charges is that if they are low they will not draw in much revenue, and the N.H.S. will not improve very much or continue to deteriorate; and if they are at or near the market cost they may encourage private practice and insurance.

Whether charges are introduced or not, and whether they are at nominal or market levels, private health insurance will be able to draw on substantial funds that would not otherwise be attracted to medical care by fees, taxes or charges. Hence the case for examining the scope for private insurance.

Principles of a Practicable Scheme

Private insurance for the costs of consultation, treatment and/or income in sickness is provided for about two million people by the British United Provident Association, the Hospital Service Plan, the Western Provident Association, the Bristol Contributory Welfare Association, Independent Medical Services and several smaller schemes. About four million families (perhaps 15 million people) are insured for supplements to State health services by the Hospital Saving Association and similar organizations that could expand to cover private medicine.

And a small number are insured by a dozen or so insurance offices for medical costs or income during disability. In all private insurers assemble perhaps £15 million a year in subscriptions and premiums. However much the N.H.S. may be able to supplement its £1,500 million by charges, there would seem substantial scope for tapping the £15,000 million spent on everyday or household consumption.

The experience of private insurance in Australasia, North America, Europe, and even Africa could also indicate lessons and warnings—provided differences in national economic and social conditions are allowed for in adapting methods and machinery. Australia seems to offer examples of insurance schemes with attractive characteristics; schemes adopted in Britain might incorporate some features of Australian schemes and adapt features of schemes in the U.S.A., Canada, Norway, France, Ireland and other countries. At this stage it would seem possible to discern several generally desirable characteristics.

Market Price

All services, State and private, should work towards charging the full market price to cover current and capital costs. It is here—in charging less than market price—that the two main weaknesses, under-supply and over-demand, originate. For a time it may be necessary for the State, centrally or locally, to provide capital at less than market rates of interest. Ultimately, prices or charges should be sufficient to cover capital costs at market rates of interest.

State Subsidy to Consumer

State "subsidies," to replace the insurable parts of the free N.H.S., should be paid not to the suppliers of health services but direct to consumers in the form of cash or vouchers with which to insure for State or private services. There is no problem of the "deprived" who cannot pay or the irresponsible who will not pay. Other health services would continue to be provided by public authority.

Payment By Patient

Payment to the doctor or hospital for individual units of service should be made, so far as is administratively possible, and except in emergency, by the patient—as it has been in France, Sweden, and Norway, not by the insurer—as in Denmark, Germany, and Switzerland. Machinery for rapid reimbursement, or better still prepayment, of the patient would be desirable.

Patient's Fraction ("Deductible")

The patient should bear part of the cost of each bill—a larger proportion of small bills, a smaller proportion of large bills. In Australia the patient's fraction has been at least 10 per cent. In France it has been 20 per cent. (recently proposed at 30 per cent.) and in Sweden 25 per cent. The "deprived" would pay less or nothing. An income coding to yield a reverse tax—i.e., an automatic supplement to low incomes, discussed in principle by the American economist, Henry C. Simons, advocated in Britain for at least 10 years,⁴ persuasively urged by Mr. Houghton recently,⁵ and now examined by the Government,⁶ would identify people with low incomes, mostly pensioners but also heads of larger families and others, to whom the State could return the patient's fraction as expeditiously as private insurers the amount covered by insurance.

Specialist or Composite Insurers

There could be specialist or composite insurers for (a) costs of general-practitioner consultations, medicines, and treatment; (b) specialist consultation; (c) hospital treatment; and (d) income during disability.

State as "Long-Stop"

Private insurers would cover a growing range of risks (in Switzerland poliomyelitis has been added), but some claims for long-term treatment for physical or mental ailments might have to be reinsured with the State as "long-stop."

Competition

Insurers should be both mutual and commercial, profit-making and non-profit-making, State (but not subsidized) or private, provided they satisfy State standards. The aim should be to facilitate competition so that the schemes with lowest costs and highest consumer preference can be discovered.

Experience Rating

Insurance premiums would probably emerge as a mixture of "community rating" (average for varying risks) and "experience rating" (refined to the risks of individual groups) according to the size of the insurers, the degree of competition, and the form of State subsidy as producer or consumer subvention. "Community rating" in a private scheme may be essential or desirable in a small or growing country, but in operating a "private welfare state" the organization may be vulnerable to State influence or control. The danger has been avoided in Australia but it might not be in Britain.

Publicity

Insurers should be encouraged to advertise their schemes by any means allowed under law. If health insurance is desirable there should be no inhibition in publicizing the premiums and benefits of individual schemes.

Compulsory Insurance?

Since 95% of people in Britain have never experienced voluntary insurance for private medical care it is arguable that private insurance should be compulsory for an initial period of five to seven years. Thereafter it could be voluntary, as in Denmark and Australia.

Advantages

The advantages and disadvantages of a scheme of private insurance as outlined, particularly the voucher component, could not be learned until it is established. Results observed in other countries might not be reproduced in the sometimes dissimilar British setting. The general assumptions made by economists about human motives, administrative organization, and the working of markets suggest a number of advantages.

Private insurance would go as far as is feasible to take medicine out of politics. The State would continue to provide environmental paramedical services; it would require preventive consultation and treatment; it might provide personal services—for fees or charges—in competition with private services, as it now does in transport and fuel; and it would finance consumers by vouchers, reimbursement of "patients' fractions," and the full costs of long-term treatment. But the doctor and the hospital would be paid by the patient for the mass of medical care.

Patients and doctors would know the full costs of the services they bought and sold. The tendency of patients to over-use free or partly free medical services and of doctors to over-prescribe for importunate patients would be checked.

The maximum practicable choice of doctor by patient and patient by doctor would be facilitated. The doctor-patient relationship would become more flexible. Doctors could vary charges according to individual and local circumstances. Less satisfactory doctors would go out of practice. More troublesome patients would pay more.

Private insurance financing would strengthen the independence of the general practitioner. Technical advance will continue to make medicine more "scientific," but social advance will stimulate the expectation of personal service, attention, consideration, choice, timing, convenience, and comfort. And these are largely the province of the general practitioner.

Doctors and patients could make any of a wide variety of arrangements they prefer. Doctors could organize themselves into loose federal arrangements for payment by capitation, case, period (salary), or unit of service.

The transformation of every patient, irrespective of original income, except the mentally or otherwise incapable, from a "beneficiary" into a buyer armed with purchasing power would remove the social divisiveness of a system in which—as now in Britain—the few pay for private services and the many receive a free State service.

Choice, competition, and variety would stimulate voluntary addition of purchasing power to the voucher. The underlying technical standard of medical care would rise as salaries and fees rose, equipment and buildings were improved, and new health centres and hospitals were built; but there could be as many standards of personal service as people were prepared to pay for.

In time independent training and research institutions could be established to diminish the risk of error resulting from the over-centralization of Government forecasting, recommendation, and decision. A repetition of the 1957 Willink error would be less likely.

Disadvantages

The main disadvantages or risks of private insurance would appear to be the following.

Administrative costs would probably be higher—8 per cent. or more—than in a centralized State system—5 per cent. or less. Doctors and hospitals would be paid by hundreds or thousands of patients instead of by one State department. Servicing costs are necessarily higher for a personal than for a standardized service. Moreover, the uncertainty of doctors' income would increase, but this is the obverse of the coin of independence.

The bulk of the patient's payment would be by annual premium out of income supplemented by State cash or voucher unrelated to a specific unit of medical service at the time it is received and experienced. Indirect payment at second hand is a second best to direct payment at first hand as a means of inducing patients to think twice before using a doctor. Indirect payment by annual premium divorced from individual bills also weakens the discipline on medical fees and medicine prices. Complaints of increasing costs outrunning insurance benefits are common or frequent in the U.S.A. and elsewhere. Doctors can alienate the goodwill of the public on whom their livelihood depends if they appear to act as an organized trade association. The remedy is commonly a State schedule of fees and costs; but it may tend to be inflexible and to invite political influence. A better remedy would be competitive pricing by individual doctors and hospitals, perhaps required by a general law against collusive restrictive practices, and possibly larger "deductibles" for smaller bills so that patients would be more sensitive to increases in fees.

Selling costs would be higher than in a uniform State system; but competition would encourage improvement. Voluntary insurance in Britain has low selling costs but also a slow rate of expansion. Field studies conducted for the Institute of

Economic Affairs and B.U.P.A. suggest that far more than two million would have become subscribers by now if private insurance had been publicized more thoroughly.

Initiation of General Private Health Insurance

Health insurance may spread rather faster in the next few years now that there is a little more marketing effort and competition between B.U.P.A. and its smaller competitors. But even if the annual rate of expansion were 20 per cent, it would be 1971 before the number of subscribers rose to 4 million—still only 8 per cent. of the population. Health insurance could be sold by "mutual" and commercial insurance underwriters and brokers. Private beds could be made available in State hospitals, and new private hospitals and nursing homes could be built with endowed and/or commercial capital. The blockage is not so much in supply as in demand. There is no shortage of men or women to train as doctors or nurses, or of bricks, concrete, steel, wood, or glass to erect buildings and equip them with wards, kitchens, and operating theatres. Supply would appear as if from nowhere if the demand were created.

The demand could be stimulated by income tax rebate on insurance premiums or fees—as in Australia and Ireland—or by notional rebates to everyone, income-tax payers or not. But in Britain these methods would probably be too slow, and a more fundamental, dramatic method is required. State payments direct to the consumer, in cash or preferably in vouchers, are the prerequisites for a rapid growth in private health insurance to pay for competing State or private services.

The voucher principle is simple in essence.

Instead of a free State service everyone would have a coupon with which to insure with the medical insurer and service of his choice. If the State hospital service costs £20 per head a year, the "hospital voucher" could be, say, £15 per head to insure for most forms of treatment, leaving £5 with the State to cover long-stay, abnormal maternity, mental and geriatric treatment. If general practitioners cost £3 a head and prescriptions £3 10s., the "family doctor voucher" could be £6 10s. Dental and ophthalmology service could be paid in cash, with remission by income code (although B.U.P.A. insures orthodontic treatment). Local health services, which may cost £4 a head, would continue to be financed out of taxes, unless they could be provided more efficiently by private suppliers.

Vouchers could be varied with income by being taxed: they could vary with regional hospital costs; they could differ for children, adults, and the over 70s.

If people are prepared to pay more for better food, clothing, furnishings, motoring, holidays, it should be possible to enable them to pay more for better medical care. In 1965 23% of a sample of 1,660 people aged 16 to 65 said they would accept a £5 voucher per head of the family and add £5 to pay for private health insurance costing £10 a head; in all they would add £45.4 million. In time it is reasonable to suppose that experience, competition, and rising incomes would raise the amounts added to the voucher out of current expenditure on everyday household consumption.