

introducing  
social insurance  
to the UK

THE SOCIAL MARKET FOUNDATION  
HEALTH COMMISSION – REPORT 2B

The Commission would like to thank Sally Williams, Secretary to the Commission until December 2003, and subsequently Niall Maclean, for their hard work in preparing this report.

## Members of the SMF Health Commission



**Lord David Lipsey** is Chairman of the Social Market Foundation. He is also Chair of the British Greyhound Racing Board, and of Make Votes Count and of the Shadow Racing Trust; and is a Non-Executive Director of the Advertising Standards Authority and London Weekend Television. Lord Lipsey has previously served as a member of the Davies Panel looking into the funding of the BBC, the Jenkins Commission on Electoral Reform and the Royal Commission on Long Term Care of the Elderly. Prior to becoming a Peer in 1999, Lord Lipsey was Political Editor at The Economist and was formerly a Special Adviser to the Rt Hon Anthony Crosland.



**Rabbi Julia Neuberger DBE** was formerly Chief Executive of the King's Fund. She is a member of the Committee on Standards in Public Life and a Trustee of the Imperial War Museum. She has been a member of the General Medical Council, the Medical Research Council, a trustee of the Runnymede Trust and a member of the Board of Visitors of Memorial Church, Harvard University. She holds honorary doctorates from ten universities, is an honorary fellow of Mansfield College, Oxford and was Chancellor of the University of Ulster from 1994-2000. She received a damehood in the 2003 honours list.



**Professor Ray Robinson** is a Professor of Health Policy at the London School of Economics Health and Social Care Department. He is also currently chairman of the York Health Economics Consortium. Prior to this he was Professor of Health Policy and Director of the Institute for Health Policy Studies at the University of Southampton. Earlier in his career, Professor Robinson worked as an economist in HM Treasury and was a Reader of Economics at the University of Sussex. From 1990-1995 he was a health authority non-executive director and, from 1993-1995, Vice Chair of East Sussex Health Authority.



**Dr Chai Patel CBE** is Chief Executive of Priory Healthcare, the UK's largest independent mental health services group. He has been a member of the Government's Better Regulation Task Force and the Department of Health's Task Force for Older People. Dr Patel is also a Fellow of the Royal College of Physicians, a Fellow of the Royal Society of Arts, a member of the Institute of Directors, a Companion of the Institute of Management and has received an Honorary Doctorate from the Open University. In 1999 he was awarded a CBE in the Queen's Birthday Honours List for his services to the development of social care policies.



**Dr Bill Robinson** is the Head UK Business Economist at PricewaterhouseCoopers. From 1978-1986, he was a Senior Research Fellow at the London Business School, and Editor of the LBS Economic Outlook; from 1982-1986 he was a Special Adviser to the Treasury Committee. From 1986-1991 he was Director of the Institute for Fiscal Studies. He also advised on the Budgets of 1991-1993 as the Special Adviser to the Chancellor of the Exchequer.



**Fergus Kee** is Managing Director of BUPA's health insurance businesses in the UK and Ireland. He has worked for BUPA in a variety of roles since 1992. Prior to that he worked with Proctor & Gamble, the Burton Group and KPMG.



**Niall Maclean** is a Research Fellow at the Social Market Foundation, and was involved in the final drafting of this paper. Prior to the SMF, he worked as a Researcher in the Public Health Sciences Department of King's College, University of London. During his time with King's he published in several academic journals, including the BMJ and Social Science and Medicine.

## The Social Market Foundation

The Foundation's main activity is to commission and publish original papers by independent academic and other experts on key topics in the economic and social fields, with a view to stimulating public discussion on the performance of markets and the social framework within which they operate.

The Foundation is a registered charity and a company limited by guarantee. It is independent of any political party or group and is financed by the sales of publications and by voluntary donations from individuals, organisations and companies.

The views expressed in publications are those of the authors and do not represent a corporate opinion of the Foundation.

### Chairman

David Lipsey (Lord Lipsey of Tooting Bec)

### Members of the Board

Viscount Chandos  
Gavyn Davies  
David Edmonds  
John McFadden  
Baroness Noakes  
Brian Pomeroy

### Director

Philip Collins

### Deputy Director

Beth Breeze

### Director of Research

Ann Rossiter

First published by The Social Market Foundation, January 2004

ISBN 1 874097 62 3

The Social Market Foundation  
11 Tufton Street  
London SW1P 3QB

Copyright ©The Social Market Foundation

Design by Beaufort 5

## Contents

Introducing social insurance to the UK: key points	6
What we mean by social insurance	6
European models	7
The attractions of social insurance	8
The disadvantages of social insurance	9
What sort of social insurance scheme might work in the UK context?	10
The Commission's view	11

## Introducing social insurance to the UK

### KEY POINTS:

- The main attractions of social insurance schemes are greater consumer responsiveness, choice, and transparency.
- A number of adapted models have been suggested for the UK. These try to address some of the pitfalls of traditional schemes and demonstrate that employer-based institutions are not necessary.
- There are respectable arguments for and against social insurance, just as there are for tax funded systems. The suitability of either system depends fundamentally on the country's starting point, traditions and institutional structures.
- It is the Commission's view that the UK lacks the social institutions to support a social insurance scheme. The key benefits of these schemes can and ought to be sought within the existing NHS framework. The NHS is increasingly well-funded, and it would be perverse to embark on costly restructuring work to secure benefits that could be secured within the existing framework.

Social health insurance has attracted more attention from the likes of think tanks and academics than perhaps any other healthcare finance mechanism. It is often hailed as being able to secure more resources for healthcare, more choice, more consumer responsiveness and greater transparency than tax funded systems. Social health insurance schemes also tend to be popular; both politically and with the populations they serve.

But social insurance schemes are very much the product of the welfare traditions and institutions of the countries in which they originate. Therefore it is often difficult to see how they could be grafted onto our healthcare system. A number of models have been suggested that adapt traditional social insurance for the UK and seek to overcome some of the disadvantages associated with the European schemes.

This paper considers these models as part of the wider case for introducing social insurance to the UK.

---

### WHAT WE MEAN BY SOCIAL INSURANCE

---

It is possible to isolate two characteristics that mark off social insurances schemes from other healthcare financing arrangements. First, insured individuals make regular, mostly income-related contributions that are not tied to the cost of the service they use, and which are mandatory for a majority or for the whole of the population. Second, these contributions are administered by some type of quasi-independent public body, normally with statutory responsibilities, and often termed a 'sickness fund' that acts as the payer or purchaser of care. (Busse et al)

Existing social insurance systems share certain features. They tend to be financed by compulsory contributions from employees and employers, calculated as a proportion of earned income and independent of an individual's risk of needing treatment or the cost of the service they use. Contributions are paid into and managed by social insurance funds ('sickness funds') that purchase health services on behalf of their members. Usually, the government will cover the premiums of the unemployed, older people and others unable to afford contributions and therefore considered exempt.

There is often a well-defined benefit package, covering most curative services, and access is usually explicitly stated.

Despite these commonalities, it is important to be aware of the ways in which social insurance schemes can differ. These differences stem from the history and culture of the nation in question, together with its infrastructure for funding flows and governance. The most salient of these differences concern:

- the extent and nature of government regulation of the scheme;
- whether the scheme is employment or non-employment based;
- whether there is a state added subsidy, and, where there is, the extent and nature of this subsidy;
- the extent to which the schemes are able to engage in competitive activity (such as selecting members, setting premiums and differentiating benefits);
- the ways in which the concept of 'core services' is used; whether or not individuals are excluded (or are allowed to opt out) of the scheme when their income reaches a certain threshold;
- the extent to which individuals are free to choose between schemes;
- the extent to which individuals are free to use their own resources to 'top up' their health insurance (perhaps in the private healthcare sector).

These differences are significant, and can produce very different consequences (McKee [2000]).

In thinking about the future of healthcare financing in the UK, it is pointless to think about whether 'social insurance' represents an attractive model. Rather, our thinking ought to be guided by this question: which elements of the diverse forms of social insurance schemes represent attractive options for the UK? In pursuing this question, it will be helpful to concretise the rather abstract differences between social insurance schemes outlined above. To this end, we ought to consider in some detail the up-and-running social insurance schemes implemented in other European countries.

---

### EUROPEAN MODELS

---

Countries with social insurance systems include Austria, Belgium, France, Germany, Luxembourg and the Netherlands. For each country, the system has grown out of different welfare traditions and rests in different institutions. This is demonstrated in the three examples below.

#### France

The French are not able to choose their insurer. Instead they are automatically affiliated to a scheme on the basis of their professional status and place of residence. Three main insurance schemes cover 96 per cent of the population: the general scheme covers salaried employees in commerce and industry and their families; the agricultural scheme covers agricultural farmers and employees; and there is a scheme for non-agricultural self-employed people. Other small schemes exist for certain categories, such as miners and seamen (European Observatory on Health Care Systems 2002).

Dixon and Mossialos (2001) describe how France has shifted away from a reliance on social health insurance contributions towards a pluralistic system funded through hypothecated taxes and insurance-type funds. These changes originate from concerns that social insurance contributions were inhibiting job creation and that high wage costs were deterring foreign investment. France has also introduced the Universal Health Coverage Act in response to concerns about access for low income groups. This ensures that the small proportion of people without public health insurance is entitled to coverage. Meanwhile, the French Parliament has given itself the power to set a global budget for healthcare (Wanless 2002).

## Germany

Under Germany's system, 88 per cent of the population are covered by statutory health insurance. All those in 'gainful employment', as well as other groups including the unemployed, pensioners, farmers, students and artists, are required to be insured under the statutory scheme. Employees whose income reaches a certain level, together with permanent civil servants, soldiers and a few others, are exempt from this requirement. Those with incomes above the ceiling may choose whether or not to remain within the statutory health insurance scheme.

In 2000, the statutory system consisted of 420 sickness funds, legally differentiated into seven different groups: 17 general regional funds; 12 substitute funds subdivided into seven 'white-collar' and five 'blue-collar' funds; 337 company-based funds; 32 guild funds; 20 farmers' funds; one miners fund; and one sailors' fund.

Previously most people had no choice over their sickness fund and were assigned to a fund according to region and/or occupational characteristics. This resulted in large differences in contribution rates due to different income and risk profiles (Dixon & Mossialos 2001). So the focus in recent years has been on imposing greater competitive pressures between sickness funds in order to reduce both labour costs and variations in contribution rates. Today every insured person has the right to choose a sickness fund and to change between funds on an annual basis – this excludes the farmers' funds, the miners' fund and the sailors' fund, which retain the system of assigned membership (European Observatory on Health Care Systems 2002).

## The Netherlands

Citizens of the Netherlands have a choice of 24 sickness funds and may change fund annually. There are three components of health insurance. First, long-term care and high-cost treatments are covered by the Exceptional Medical Expenses Act, which covers practically all residents and non-residents who are subject to Dutch income tax. Second, normal, necessary medical care is covered by a variety of insurance arrangements. People whose annual salary is below a statutory ceiling and all those who receive social security benefits are compulsorily insured under the Sickness Funds Act up to the age of 65. Other health insurance schemes cover various categories of civil servants. Those who are not covered by the Sickness Funds Act or the schemes for civil servants can get cover from a private health insurer on a voluntary basis. Third, care deemed 'less necessary' is covered by sickness funds and private health insurers in the form of complementary or supplementary voluntary health insurance (European Observatory on Health Care Systems 2002).

Like France and Germany, the Netherlands has introduced greater competition between social insurers in a bid to make funds more efficient and to rationalise the system. Regional restrictions on sickness-fund activity have been abolished and new entrants, including private insurers, have been allowed into the market. Choice of funds has prompted an accelerated process of mergers and acquisitions (Dixon & Mossialos 2001).

---

## THE ATTRACTIONS OF SOCIAL INSURANCE

The diversity of the various systems means there is a danger of making inappropriate generalisations when identifying the pros and cons of social insurance. Much depends on how the system in a particular country is organised. However, broadly speaking, a number of advantages are associated with social insurance.

- Consumer responsiveness. Where there is choice of sickness funds consumer responsiveness is enhanced. Patients bring money with them creating strong incentives for healthcare providers to develop services that patients want and need.

- Patient choice. Depending on the system, patient choice can be a feature, with patients able to choose between funds within the social insurance system, as well as self-referral to a specialist and choice of hospital.
- Transparency & connectivity. People can see on their pay slips how much they are paying for healthcare and decide for themselves whether this constitutes value for money (Nera & Norwich Union Healthcare 2002, Green 2002). Therefore social insurance can lead to much greater 'connectivity' between what people pay for healthcare and how the money gets spent, making the incentives for individuals to spend more on healthcare clearer and stronger. Connecting consumers to the financing of healthcare is also thought to encourage greater personal responsibility for health and in their use of health services.
- Supply side competition. Where there is choice of sickness funds, competition between insurers and between healthcare providers should create pressure to keep costs down (Browne & Young 2002).
- Social solidarity. It is often claimed that people on low incomes receive better treatment under social health insurance schemes than under other systems, as they can access the same services, treatments and doctors as the more wealthy.
- Depoliticisation. Depending on the level of involvement, supervision and enforcement exercised by government, social insurance schemes are more decentralised and depoliticised than other healthcare systems. Day-to-day accountability for healthcare is moved away from government and towards insurers and their members.

---

## THE DISADVANTAGES OF SOCIAL INSURANCE

The main disadvantages of social insurance schemes are:

- Higher costs & inefficiencies. Social health insurance systems are relatively expensive. Costs are pushed up due to the fact that such systems tend to be administratively complex (HM Treasury 2001). The existence of multiple sickness funds, a competitive insurance market and fragmentation in healthcare purchasing can further drive up costs (Wanless 2002). However, in many countries the market hasn't operated as intended and efficiency benefits haven't been realised. Few people have the choice of opting out of the state system and in practice the choice provided between different funds can be constrained (Brown 2002). The Wanless Report (2002), for example, argued that there is little incentive in traditional systems for sickness funds to contain the payments they make to healthcare providers because of their ability to raise contribution rates. Often there is little use of tools, such as GP gatekeepers, to constrain expenditure. Wanless also argued that benefits packages tend to be the same or very similar across insurers, with little choice between contribution rates and available benefits. These points are borne out in many of the countries that operate social insurance schemes (Busse et al). Policymakers in these countries have come under pressure to reassess efficiency, quality and the levels of patient responsiveness under their social insurance systems, as well as the contribution to overall health gain. Although the French system is often held up as a shining example of well-functioning social insurance based healthcare financing, since the 1970's successive French governments have actively sought to decrease expenditure. The French public have picked up the deficit – since the 1960's the proportion of the population paying privately for supplementary health insurance has risen from about 30% to around 85%. Germany and the Netherlands have also undertaken various reforms of their systems, again with the aim of controlling the overall level of health spending.

- A tax on business. Opponents claim that social insurance systems tend to bear disproportionately on employers, which could have a negative impact on the labour market, including wage-inflation and unemployment. Where employers end up footing much of the bill any advantages in terms of enhanced transparency and connectivity are also likely to be undermined.
- Perpetuate inequities. Equity of access is compromised in some social health insurance systems. The Treasury (2002) argues that social health insurance systems deny some sectors of the population the full range of benefits and create anomalies. The BMA's Funding Review (2001) found it difficult to see how social insurance can be introduced without compromising the principle of equity or reducing the standard service to a safety net for the poor. Ultimately the degree to which social insurance is equitable (or inequitable) depends on the nature of the particular system – whether contributions are based on income, whether premiums are capped, if cost sharing is required and arrangements for risk adjustment, for example.
- Sustainability. Policy-makers are reported to be concerned about the long-term sustainability of traditional social insurance systems. Wanless (2002) concluded that, because the revenue base is more concentrated (on employment), economic distortions and disincentives might be more pronounced in systems dominated by social insurance than for general taxation. He also argued that social insurance systems are likely to be as vulnerable to periods of economic downturn as tax-financed systems, resulting in reduced revenues into the sickness funds.
- Overemphasis on the curative. The defined benefits package insurers guarantee to deliver tends to be based on curative services. As a result concern has been expressed about the relative lack of emphasis on health promotion, prevention and public health services in social insurance systems (Busse et al).

---

#### WHAT SORT OF SOCIAL INSURANCE SCHEME MIGHT WORK IN THE UK CONTEXT?

---

A number of adapted social insurance models have been proposed that are designed to apply social insurance within the UK context and overcome some of the disadvantages of traditional, continental schemes. For example, such models generally propose making insurers legally obliged to accept anyone seeking insurance, regardless of their health status, in order to avoid the problems of cream skimming. Likewise, to address accusations that social insurance is a tax on business, the adapted models tend to advocate that social insurance premiums should be paid by individuals rather than employers and therefore do not need an employer-based institutional framework.

In a report for Norwich Union Healthcare, NERA (2000) outlined proposals for 'Stakeholder Healthcare'. Three years later, these proposals were fleshed out in a second report in which NERA (2003) stated: 'The aim in the stakeholder model is to look at what works well in other countries, and combine them with many of the strengths of the NHS. Many of the general criticisms levelled at social insurance-based systems then become less relevant.'

Under Stakeholder Healthcare, the NHS acts as an insurer (NHS Insurance, NHSI) and competes with private health insurers (similar to social insurers and called 'stakeholder insurers'), to provide a guaranteed standard package of services to members. Insurers, both private and NHSI, would purchase services from NHS and private hospitals, although the NHS would be expected to remain the dominant provider. Membership with an insurer would be compulsory for all and insurers would be required to accept all applicants. Premiums would be community-rated, set as a proportion of income and could differ from insurer to insurer. NHSI and all insurers participating in the scheme would offer the same

core package of comprehensive health services as a minimum. Additional services (such as better hotel facilities) could be charged for, allowing insurers to compete on quality, price and level of coverage (subject to a minimum).

Similarly, Browne & Young (2002) recommend a system of competing social insurance schemes on behalf of the Adam Smith Institute. Under their proposals membership would be compulsory for all and social insurers would be banned from refusing anyone. Premiums would be based on a proportion of total income (including investments) and paid by individuals rather than companies. Like NERA, the authors anticipate that tax funding would flow into the system, to subsidise premiums and provide cover for the poorest. All insurers would be obliged to offer a comprehensive minimum set of services, free at the point of access, but people could choose to pay in order to reduce monthly premiums or buy extras. Patients could choose which scheme to belong to, as well as which hospital or doctor to receive treatment from (although some schemes may offer a discount for agreeing to go to a 'preferred-provider'). Providers would offer services to patients irrespective of insurer. Insurers would be independent from government, but could be run by unions, employers' groups, or mutual organisations. Vertical integration would be banned, preventing insurers from owning any hospitals.

Civitas's Health Policy Consensus Group (2003) recently concluded: 'there is no serious constituency in the UK for employment-based social insurance.' However, it believed that an individually contracted social insurance system could be introduced, with community rated premiums, open enrolment, an obligation on insurers to accept any customer and a system of risk adjustment. The expectation would be that, in time, premiums may vary considerably and that insurers would offer a variety of deductibles, co-payment options and no-claims bonuses, which would all serve to increase price consciousness.

The Group also proposed a system of purchasing co-operatives, which would give people the choice of becoming 'mutual members' of the NHS or remaining as 'ordinary members'. As mutual members they would gain more choice and control over their own social insurance cover, but would directly bear the cost of covering the poorer members of society. In return for taking personal responsibility for their healthcare costs by contracting into a purchasing co-operative, mutual members would receive a tax credit representing part of the tax they had paid for the NHS. They would then be free to purchase insurance to cover the cost of their own care. The purchasing co-operative would make available to its members a range of insurance policies offered by competing private insurers. It would aid consumer choice by providing independent advice about the insurers (such as about exclusions) and ask insurers to price the same package of services so that consumers could compare like with like. Mutual members of the NHS would then choose their insurer and pay any additional costs out of pocket to the co-operative. In the long term, everyone would be expected to join the co-operative system.

---

#### THE COMMISSION'S VIEW

---

The main attractions of social insurance schemes are transparency, consumer responsiveness, and patient choice.

The main attraction of greater transparency is that it can bring higher levels of funding for healthcare – if individuals feel personally connected to the process by which their healthcare is funded, they will be more likely to contribute more of their income to healthcare, and will be more likely to use health services responsibly.

However, this particular benefit of social insurance schemes seem less pressing for today's NHS, which is receiving unprecedented levels of funding. Admittedly, the UK needs sustained growth over a

considerable period and has a great deal of catching up to do in terms of the quality of its hospital stock, supply of clinical staff and general infrastructure. However, when we acknowledge that most existing social insurance systems seem increasingly poor at managing costs (witness the real examples cited above) and couple this point to the high costs of moving to a social insurance system, the incentive to shift away from an increasingly well-funded NHS to a social insurance system seems weak. To undertake a major and costly reform of healthcare financing in order to increase funding levels when these levels are already on the up (and when we are yet to fully reap the benefits of the new investment) simply does not seem sensible.

Consider now the claim that social insurance schemes provide greater consumer responsiveness and allow more space for the exercise of patient choice. There is a political will within the current Government to introduce aspects of consumer responsiveness and individual choice into our existing NHS structure. The argument of the preceding paragraph applies here also – it seems highly imprudent to undertake an extensive and costly shift towards social insurance based healthcare financing in order to secure benefits that are being actively sought within the existing NHS structure, especially since that structure is currently receiving greatly increased levels of funding.

Furthermore, certain other advantages of social insurance schemes could feasibly be sought within the existing structure. For example, we are very attracted to the idea of supply side competition, but prefer to explore the possibility of introducing contestability between primary care trusts over the introduction of a social insurance type system (this will be explored further in the Commission's final report). In addition, the third paper in this current series will consider the extent to which the NHS would benefit from the delineation of a 'core package' of services.

It is our view, therefore, that the key benefits of social insurance systems can be sought within the existing NHS structure. Moreover, we believe that they ought to be sought within this structure. The 'ought' derives its force from two sources. First, there is the question of feasibility: serious questions remain over whether the UK has the sorts of social institutions manifest in many European countries that made the adoption of social insurance desirable there (e.g. powerful forms of local government and tripartite industrial systems). Second, there is the issue of prudence. The costs associated with shifting to a social insurance system would be enormous. Given this, it seems perverse to embark on costly modifications to an increasingly well-funded NHS in order to secure a set of benefits that could be secured within the current framework.

#### References

- British Medical Association (2001). Healthcare Funding Review.
- Brown G (2002). Speech given by Chancellor Gordon Brown on economic stability and strong public services to the Social Market Foundation. (20 March)
- Browne A & Young M (2002). NHS reform: towards consensus? Adam Smith Institute
- Busse R, Saltman R, Figueras J (undated). Social health insurance countries in Western Europe. Study proposal. [www.who.dk/observatory/Studies/20020522\\_17](http://www.who.dk/observatory/Studies/20020522_17) (downloaded August 2002)
- Dixon A & Mossialos E (2001). Funding health care in Europe: recent experiences. Health care UK 2001
- European Observatory on Health Care Systems (2002). Health care systems in eight countries: trends and challenges.
- Green D (2002). This is why it never pays to fall ill in Britain. Civitas
- Green D (2001). Stakeholder health insurance: empowering the poorest patients. Civitas
- Green D & Irvine B (undated). Gordon Brown and Wanless are Wrong. Press Briefing on 'Health care in France and Germany: lessons for the UK'. Civitas
- Health Policy Consensus Group (2003). A new consensus for NHS Reform.

HM Treasury (2002). Budget report 2002.

HM Treasury (2001). Pre-budget report: Chancellor's Statement. (27 November)

McKee (2000). Paying for the NHS. British Medical Journal 2000;320:197-198 (22 January)

NERA & Norwich Union Healthcare (2003). Stakeholder Health Care: moving from concept to reality.

NERA & Norwich Union Healthcare (2002). Securing our future: taking a long-term view. Comments on the Interim Wanless Report.

NERA & Norwich Union Healthcare (2000). Towards Stakeholder Health Care.

Wanless D (2002). Securing our future health: taking a long-term view. Final Report.

