



**Towards greater partnership in  
healthcare funding:  
The rise of health consumerism in  
British and other European healthcare systems**

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## Introduction

This report demonstrates that below the radar screen of popular politics in Britain and elsewhere in Europe, healthcare is increasingly being seen by members of the public as an area that demands greater consumer empowerment and ultimately greater personal choice in healthcare funding.

In Britain some thirteen million people have private medical insurance and private health cash plans.<sup>1</sup> Millions more are protected from the financial constraints of ill health through the purchase of critical illness and permanent health insurance. Others have no formal coverage, preferring instead to self fund as and when the need arises. In 2000, more than a quarter of a million British people chose privately to self-fund for independent acute surgery without private insurance.<sup>2</sup>

According to research published in The Daily Telegraph,<sup>3</sup> more than 3.5 million British trade unionists – more than 50 per cent of the Trade Union Congress's 6.8 million members – were covered by medical insurance or health cash plan schemes.<sup>4</sup>

At the dawn of the twenty first century, more than eight million Britons pay privately for a range of complementary therapies. And in dentistry, more than a third of the population relies on the private sector for its care.

Similar trends are to be found in other European healthcare systems. With significant reform underway in Sweden, Germany, Finland (to name but a few) and much of Central and Eastern Europe the case for greater health consumerism and private funding continues to mount.

Across Europe governments are increasingly turning to the independent sector to provide the delivery of healthcare. In Britain, the NHS is well on its way to being redefined as a regulator and funder of healthcare but no longer the owner of the institutions in which healthcare is provided. Partnership with independent hospitals, the rise of independent treatment centres and the plan to give all NHS hospitals independent foundation status by 2008 signal the arrival of a new era. While greater volumes of work for private sector providers will inevitably mean narrower margins, this new and competitive world is destined to provide huge benefits for patients be they NHS or privately funded.

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<sup>1</sup> Health cash plans that pay for services that include items such as dentistry, ophthalmics, physiotherapy, chiropody, podiatry, maternity services, allergy testing, hospital in-patient stays, nursing home stays, hospital day case admissions, convalescence, home help, mental health and psychiatric treatment, and even the use of an ambulance.

<sup>2</sup> This unpublished information was obtained from the Independent Healthcare Association.

<sup>3</sup> Daniel Kruger, 'Why half the members of trade unions have private health care', The Daily Telegraph, 11 September 2001.

<sup>4</sup> For a sound history of trade union and friendly society involvement in independent healthcare see: David Green (1985) Working Class Patients and the Medical Establishment – Self Help in Britain from the mid-nineteenth century to 1948, Aldershot, Gower Publishing Company Ltd.

As consumer expectations continue to out-pace the capacity of national governments to fund health provision, this paper asserts that the time is fast approaching when new and innovative forms of funding partnerships will move centre stage. It argues that in Britain, this process will begin after the forthcoming general election and offers a number of recommendations designed to stimulate further thought and debate before the election.

# 1. Rise of market-oriented reform in modern British healthcare

## Old politics of failure

Beatrice Webb first supported the concept of a free health service for all in Britain in her minority report of the Poor Law inquiry of 1909.<sup>5</sup> However, it fell to Sir William Beveridge fully to articulate such a plan and to lay the foundations for such a service in his 1942 paper *Social Insurance and Allied Services*.<sup>6</sup>

Arguing that the state should establish a “national health service for the prevention and comprehensive treatment available to all members of the community.”<sup>7</sup> Beveridge understood the political implications of his proposals. Prior to publication on 1 December 1942 he told *The Daily Telegraph* that his proposals would take Britain “...half-way to Moscow.”<sup>8</sup>

Significantly, after the second world war, two papers marked ‘secret’ and providing a detailed commentary on Beveridge’s plan were found in Hitler’s bunker. One ordered that publicity should be avoided but, if mentioned, the report should be used as “...obvious proof that our enemies are taking over national-socialist ideas.”<sup>9</sup> The other provided an official assessment of the plans as no ‘botch-up’: “a consistent system...of remarkable simplicity, superior to the current German social insurance in almost all points.”<sup>10</sup>

In February 1944 the British government published a white paper entitled *A National Health Service*. It proposed that everybody “...irrespective of means, age, sex or occupation shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available; that the service should be ‘comprehensive’ for all who wanted it; that it should be ‘free of charge’; and that it should promote good health ‘rather than only the treatment of bad’.”<sup>11</sup>

In 1948, just weeks before the appointed day of the National Health Service’s launch, the government issued a leaflet to every home in the country. It promised that the NHS “will provide you with all medical, dental and nursing care. Everyone – rich or poor – can use it.”<sup>12</sup> Today, more than half a century on, it is clear that the NHS has never delivered on its promise.

Whilst the NHS was created to treat the whole population in an equitable manner and according to need, in practice, the historical evidence suggests

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<sup>5</sup> Nicholas Timmins (2001) *The Five Giants: A Biography of the Welfare State*, Harper Collins, London, p. 15.

<sup>6</sup> William Beveridge, *Social Insurance and Allied Services*, HMSO, 1942.

<sup>7</sup> Fraser, D., (1973) *The Evolution of the British Welfare State*, Macmillan, p. 265.

<sup>8</sup> Nicholas Timmins, *op.cit.*, p.41.

<sup>9</sup> *Ibid.*, p.25

<sup>10</sup> Fritz Grunder, *Beveridge Meets Bismarck*, York Papers, Vol.1, p. 69.

<sup>11</sup> Michael Foot, *Aneurin Bevan, A Biography*. Vol One: 1879-1945, Vol Two 1945-60, Four Square, 1966, 1973, p. 131.

<sup>12</sup> Department of Health leaflet announcing the NHS June/July 1948.

its impact has been otherwise. Professor Julian Le Grand has shown that relative to need people in the professional and managerial classes receive more than 40 per cent more NHS spending per illness episode than those in the lower semi- and un-skilled classifications.<sup>13</sup>

Today, the NHS has one million people on its waiting lists. Each year in its hospitals, more than 100,000 patients contract infections and illnesses that they did not have prior to being admitted.<sup>14</sup> And according to the Malnutrition Advisory Group up to 40 per cent of NHS hospital patients were under-nourished during inpatient stays.<sup>15</sup>

### **Political economy of health rationing**

Back in 1944, Bevan's White Paper, *A National Health Service*, estimated that the service would cost taxpayers £132 million per year. However, this was revised upwards to £152 million in 1946 and again to £230 million just before the Act came into force in July 1948. In its first year of operation, 1949-50, the NHS actually ended up costing the taxpayer £305 million and required a supplementary estimate of £98 million.<sup>16</sup>

The inaccuracy of the estimates can be attributed to a number of factors. The first was that the early projections of cost assumed that demand would remain roughly constant despite there being no price constraints on demand – the service being 'free' at the point of use. Secondly, contemporary social and medical developments exacerbated the problems created by an absence of any price constraints on demand, not least because medical advances at the time meant that there was a dramatic expansion in the type and range of health services that could be made available.<sup>17</sup>

To keep demand in check the service deliberately rationed supply – through scarcity rather than price. While doctors who worked in NHS hospitals had been encouraged at first to treat their patients according to need the imposition of cash limits soon turned them into allocators of scarce resources. More than minimal care was denied to cases where there was little chance of successful recovery, particularly to young children or the elderly with serious

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<sup>13</sup> Michael Benzeval, Ken Judge and Margaret Whitehead, (1995) *Tackling Inequalities*, London, Kings Fund, p. 104.

<sup>14</sup> 'Hospital infection rates in England out of control', *British Medical Journal*, 26<sup>th</sup> February 2000.

<sup>15</sup> 'New screening tool for malnutrition', *The Pharmaceutical Journal*, Vol. 265, No. 7128 December 2000, p. 909. Also, see the Malnutrition Advisory Group report on UK hospital malnutrition at [http://www.bapen.org.uk/pdfs/newsletters/bapen\\_news08.pdf](http://www.bapen.org.uk/pdfs/newsletters/bapen_news08.pdf)

<sup>16</sup> Rudolf Klein, (1989) *The Politics of the National Health Service*, London, Longman, p. 35.

<sup>17</sup> In many ways, the NHS was designed to provide a style of health care that was more appropriate to the 19<sup>th</sup> century rather than the 20<sup>th</sup> century. Previous improvements in health had been brought about through large scale immunization and better sanitation. These measures had been relatively inexpensive, easy to administer and subject to large economies of scale. Many of them had been introduced by private sector companies and organisations.

conditions. Indeed, health care for everyone else was provided sparingly by international standards.<sup>18</sup>

The supply of health care has again been rationed still further by queuing. Crowded waiting rooms are common in most general practices and out-patient departments. And queues have become a fact of life for in-patients, often with long waiting periods for those operations given priority.

Certain health services have never been provided by the NHS, reducing the demand on its resources still further. Most forms of cosmetic surgery have rarely been available and face lifts, liposuction, hair transplants and sex change operations have never been provided except where they have been deemed necessary for reasons of health or as part of some other form of treatment. Other services have been provided on a minimal basis too. Much psychiatry, the treatment of infertility and substance misuse services remain cases in point.

More than half a century on since the NHS's inception it is clear that in reality people have never had a meaningful right to free and equal treatment on demand. What they have had – in the main – is an unlimited right of access to a waiting list from which – with a few exceptions – they will not be excluded.

### **Tip-toeing back to market**

As part of the 1946 Act's nationalisation process, NHS hospital building was to be financed by central government grants and funded out of general taxation and national insurance contributions.

However, in the early years, the government made very little investment in its nationalised health estate. Not until the mid-1950s did a gradual release of funding allow new hospital building in some areas – and only then on a very limited basis.

Then, in July 1960, Enoch Powell became the Minister of Health. He arrived at a time of growing economic concern which in government circles culminated in the 1961 Plowden report.<sup>19</sup> It attempted to reconcile the Treasury's requirement for an annual budget in order to control spending with the demands of state welfare policy, including the NHS. The result was a five-year rolling programme which was approved each year by the Expenditure Survey Committee but was then subject to revision in each annual bid – the so-called PESC round.

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<sup>18</sup> In the late 1970s for example coronary artery by-pass operations were performed about ten times more frequently pro rata in America than in Britain. And, where these did not increase life expectancy, they tended to reduce adverse symptoms such as pain. While American doctors responded to complaints about pain, British doctors have tended to pay more attention to the probable increases in life expectancy, or the improvements in a 'quality of life' (not always synonymous with an absence of serious discomfort). For more information see: Henry J Aron and William R. Schwartz, *The Painful Prescription: Rationing Hospital Care*, Brookings Institute, Washington DC, 1984, p.67.

<sup>19</sup> Report on the Control of Public Expenditure (The Plowden Report), Cmnd 1432, HMSO, 1961.

It was this work that started to address the fundamental issue of expenditure and the NHS's problems concerning capital investment. For during the first decade of the NHS, not a single new hospital had been built. None had even been approved until 1956.<sup>20</sup>

In the early 1960s the hospital estate that was in use was either that inherited from the independent sector or from local government. To address the problem Powell raised a number of NHS charges:

“including a doubling of the prescription charge from 1s. 0d. To 2s 0d (10p) an item.”<sup>21</sup>

The higher charges were in part to finance the great ‘Hospital Plan’ which was finally launched in January 1962. It aimed at a £500 million programme over a decade to build 90 new hospitals, drastically remodel 134 more and provide 356 further improvement schemes each costing over £100,000.

While there had been a few hospital extensions, new theatres, out-patient departments and other refurbishments, in the thirteen years from 1948 only £157 million had been spent nationally well under a third of the figure now being proposed.

Explaining the parlous situation Timmins has observed:

“NHS hospitals had, quite simply, lost out to new schools and housing. In the fourteen New Towns, for example, new schools had to be provided for children; patients, however, could still be told to travel for treatment and in 1953 they had boasted ‘not a hospital between them’.”<sup>22</sup>

From the mid-1960s onwards evidence continued to mount that the consensual pragmatism of the post-war settlement was under strain. As Britain's economic performance declined and academics, journalists and other opinion formers questioned its overall direction so government's ability to keep up with required NHS investment (particularly in terms of capital expenditure) came under pressure.

The 1964 balance of payments crisis; the sterling crisis of 1965 and 1966; the devaluation of the pound in 1967; the industrial strife of the early 1970s; the International Monetary Fund loan of 1976; the winter of discontent in 1978-9. All these milestones act as a testimony to the fact that the ambitions of the political class were no longer being met given the sobering realities of the nation's economy.

“By the mid-1970s, the wave of capital investment that had inaugurated the hospital plan for the NHS was effectively at an end. The squeeze

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<sup>20</sup> A Hospital Plan for England and Wales, Cmnd 1604, 1962, pp. 1-2, 13.

<sup>21</sup> Timmins, N., op.cit. p. 208.

<sup>22</sup> Ibid., pp. 209-210.

on capital was reflected across all government departments in which, between 1974 and 1998, total net annual capital expenditure fell from £28.8bn to 3.3bn in 1998 prices.”<sup>23</sup>

Today, much of the NHS estate that people see was inherited in the late 1940s and therefore remains largely unchanged:

“Today, the infrastructure still retains many pre-NHS features and a significant proportion of the stock predates the First World War. Capital spending has been insufficient to either replace or maintain outworn and outmoded buildings.”<sup>24</sup>

This reality is significant because Beveridge had originally believed that the NHS would raise the general level of health and fitness of the nation - and increase national prosperity through a reduction of sickness absence – to such a point that it would fundamentally raise people’s productivity. As such, he believed the NHS would broadly pay for itself – or at the very least not be subject to endlessly rising costs. In his 1942 report he had asserted:

“there will actually be some development of the service, and as a consequence of this development a reduction in the number of cases requiring it”.<sup>25</sup>

Most importantly of all, he even went so far as to assume that the NHS would actually cost the same amount of money in 1965 as he tentatively assumed it would cost in 1945 £175m.<sup>26</sup>

In reality, the economic crises of the late 1960s and 1970s led to attempts to find sources of financing other than government borrowing. And, in 1973, regional health authorities were allowed for the first time to use the proceeds from land sales for investment.<sup>27</sup>

As a result of gradual and persistent economic decline and as Declan Gaffney, Allyson Pollock, David Price and Jean Shaoul have pointed out although the principle of major hospital investment was initially adopted in the NHS under Powell’s 1962 hospital plan, even in the 1990s:

“The plan remains unfulfilled, with only a third of the projected 224 schemes completed, and a third not yet started.”<sup>28</sup>

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<sup>23</sup> Gaffney, D., Pollock, A. M., Price, D., Shaoul, J., NHS Capital Expenditure and the Private Finance Initiative – Expansion or Contraction, British Medical Journal, 3 July 1999, 31:48-51. Also see: Table B28: Historical series of government expenditure, (1999) HM Treasury, Financial Statement and Budget Report 1999-2000. London, HMSO.

<sup>24</sup> Gaffney, D., et al., Ibid.

<sup>25</sup> See Timmins, N., op.cit. p. 260.

<sup>26</sup> Cmnd 6404, p. 105; S. P. W. Care in Oxford Textbook of Public Health Vol. I., 1984, pp. 13.14.

<sup>27</sup> Meara, R., (1991) Unfreezing the assets: NHS estate management in the 1980s, King’s Fund Institute Research Report 11, London, Kings Fund.

<sup>28</sup> Gaffney., D., et al., op.cit.

Despite depressed prices in the late 1980s, land sales have become an increasingly important source of capital funding over recent decades. By 1998-9, they accounted for over a third of NHS capital expenditure.<sup>29</sup>

Since 1992, most new capital investment in the NHS has been arranged under a scheme somewhat ironically known as the private finance initiative (PFI). Here the private sector designs, builds, finances, owns and operates key areas of NHS provision – including some clinical services.<sup>30</sup>

Although this policy was initially adopted by John Major's Conservative government, it has since been actively embraced by Tony Blair's Labour administration:

“In the absence of new capital, NHS trusts have no other recourse but to pursue the private finance initiative to finance new investment.”<sup>31</sup>

In recent years, under the rubric of public-private partnerships the government has championed a whole raft of market-oriented NHS reforms. In 2000 the Secretary of State for Health, Alan Milburn, signed a Concordat with the representative body of Britain's independent health and social care sector (the Independent Healthcare Association).<sup>32</sup> Under this agreement, the NHS could send its patients to independent hospitals and clinics for treatment and care.

Between 2000 and 2003 more than 250,000 NHS funded patients annually received treatment and care in the independent sector and others were sent to private hospitals abroad. In 2001, the government made it clear that it wanted the private sector to design, build and operate a new generation of diagnostic and treatment centres (the private sector units are now called independent sector treatment centres) for the benefit of NHS funded patients.

Again, in 2001, the government also made it clear that it wanted to establish a new generation of independent Foundation Hospitals. As such, it wanted the best NHS hospitals to be “set free” from Whitehall control and to have a greater say over how they developed and from where they raised their capital.

In September 2003, the government named the private companies that would bid for the contracts. All of them were foreign new market entrants – thereby underlining a new era of competition in healthcare provision.

Overall, the historic direction of travel in the NHS is clear. Selling off NHS land, the private finance initiative, acceptance of public private partnerships, the Concordat with the independent sector, independent treatment centres and independent foundation trusts all point to an increasingly privatised future.

Today, the NHS has been redefined as a regulator and a key funder of healthcare but it is no longer deemed to be a necessary provider – or owner -

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<sup>29</sup> Ibid.

<sup>30</sup> For more see: Ibid.

<sup>31</sup> Ibid.

<sup>32</sup> This association closed in December 2003.

of the facilities in which health services are delivered. As a recent Secretary of State for Health, Alan Milburn, commented:

“For fifty years the NHS has been subject to day-to-day running from Whitehall. The whole system is top down. There is little freedom for local innovation or risk taking. A million strong health service cannot be run from Whitehall. Indeed, it should not be run from Whitehall. For patient choice to thrive it needs a different environment. One in which there is greater diversity and plurality in local services which have the freedom to innovate and respond to patients’ needs. Our reforms are about redefining what we mean by the National Health Service. Changing it from a monolithic, centrally-run, monopoly provider of services to a values-based system where different health care providers – in the public, private and voluntary sectors – provide comprehensive services to NHS patients. Who provides the service becomes less important than the service that is provided.”<sup>33</sup>

He concluded:

“Just because patients might be treated in a BUPA hospital today or a Foundation Hospital tomorrow that does not mean they cease to be NHS patients. Quite the reverse, patients remain NHS patients treated on NHS principles with care that is free and available according to need. The NHS is not its bricks and mortar. It is not a set of structures. It is fundamentally a set of values. An ethos if you like. We should be resolute in our defence of the values of the NHS but not of its outdated structures.”<sup>34</sup>

In April 2004, the government signed a deal with independent providers Nuffield Hospitals and Catio Healthcare UK. Contracted to perform 25,000 hip, knee and other operations for the state service at NHS prices the new world of supply-side competition is beginning to make its mark. As a new world of higher volume and narrower margins opened up, health secretary John Reid stated:

“This deal represents good value for the NHS because the cost for each operation and associated care is on a par with equivalent NHS prices. The Department’s tough negotiation with independent companies on a planned, national level has allowed us to drive down costs for the NHS.”<sup>35</sup>

In June 2004, the government set a new target. Under the NHS Improvement Plan up to 15 per cent of all NHS operations in 2008 will be delivered by the private sector.

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<sup>33</sup> The Secretary of State for Health, the Rt. Hon. Alan Milburn MP, speech to New Health Network, 15 January 2002.

<sup>34</sup> *Ibid.*

<sup>35</sup> John Reid in DOH Press Release, ‘UK private and not-for-profit hospitals win first major NHS contract’, 21 April 2004.

## **2. Europe's march to market-oriented healthcare reform**

From a domestic policy perspective, it would be easy to imagine that British health trends are unique. However, from a European perspective they are not. Despite systemic national differences the trend towards market-oriented reform in health systems spans the continent.

Across the developed world, people have traditionally insisted that their own nation's health system is the best in the world. Attaching national prowess to health delivery, Germans, Swedes, Fins and Slovaks – to name but a few – have for decades insisted that their own particular health system was unequalled.

Yet today, in all of these countries and in many others besides, this confidence is fading as state-funded healthcare is increasingly seen to be falling behind people's expectations and state provision is exposed for being inherently bureaucratic and unresponsive to consumers. Around the world – and particularly across Europe – a similar story can be told.

### **Western Europe**

Across Western Europe, state funded health mechanisms are coming under strain and new forms of provision are being sought to provide solutions and greater efficiency.

### **Sweden**

In Sweden, the shift from a healthcare system characterised by public service monopoly, hierarchy and top-down attitudes to one with diverse providers, networks and consumer power has been profound in recent years – and most striking in the city of Stockholm.<sup>36</sup>

Across Sweden the number of privately contracted healthcare providers is rising, reflecting a new era of consumer choice and a preference on the part of many young doctors and nurses to work for private providers.

Stockholm's revolutionary approach to healthcare – public funding, public-private cooperation in provision and freedom of choice – has started to attract international attention. National and regional officials from states as diverse as Canada, Norway, the Netherlands, Germany, Japan and the UK have all visited Stockholm in recent months.

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<sup>36</sup> Johan Hjertqvist, (2002) The Health Care Revolution in Stockholm, Timbro Health Unit, Stockholm.

## **Germany**

In Germany, pressure is mounting for the government to reform the health care system and to enable people more easily to use private medical insurance.

Already, more than eight million Germans have private medical insurance, some ten per cent of the population, and this figure seems set to increase as German state funded health benefits are restricted under the government's continuing reform process. With comparatively high tax rates, uncompetitive social costs and more than four and a half million unemployed, Germany is increasingly united in the view that private sector solutions are now the only viable alternative to address the funding pressure.

## **Finland**

Over the last decade, privatisation has been used extensively by the governments of many of Europe's smaller states such as Finland. In this country, it has been applied to every sector where the state has been traditionally active and at every level national and municipal.

Since 1995, local authorities have been allowed to buy services from the private sector and, whereas in 1989 the public sector employed some 215,000 people, by 1996 this number had fallen to 127,000.

In healthcare, contracting out has become commonplace – with one municipality recently privatising all of its health provision.

However, this is only just the beginning. As a recent OECD<sup>37</sup> report made clear, if Finland is going to remain competitive and be able to cope with the long term effects of an aging population, it is going to have to become even more radical in its reform process. In time, all municipalities are going to have to contract out healthcare provision to the private sector and then open funding to more consumer empowering private solutions.

## **Portugal**

In recent months, the Portuguese government have been under profound and historic pressure to control an oversized public deficit against a background of sluggish economic growth. As such it is increasingly contracting-out public services and, in many areas of activity, turning to widespread privatisation.

In Portugal, hospitals are being exposed to market reforms as the coalition government of the centre-right Social Democrat Party and the centre-right People's Party search for market-oriented policy solutions.

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Whilst the Union of Portuguese Nurses has lead opposition to the privatisation implicit in recently enacted hospital management legislation, the government is continuing to implement its reform programme. Despite substantial and wide spread trade union protests the Portuguese political class seems to be unerring in its course.

## **Eastern and Central Europe**

Today, across Eastern and Central Europe, there is a newly emergent and booming private health care sector.

After decades of state failure and system neglect, people are beginning to see the emergence of private health brands that they can trust and develop a long term relationship with.

A newly emergent middle class with an increase in personal disposable incomes is well set to support the continuing expansion of a range of private health services.

Across Poland, the Czech Republic, the Baltic States (particularly Estonia) and Hungary private healthcare provision and funding are well placed to rise over the long term.

## **Slovak Republic**

One example of this process is the Slovak Republic. Since September 2003 Slovaks have been given the opportunity to pay for key elements of their healthcare and, therefore, begin to act as empowered consumers.

A health law passed in March 2003 means that health providers now charge a range of direct-to-consumer payments, including Sk:2 per doctor visit, Sk:20 per drug prescription, Sk:2 per kilometre travelled in an ambulance, and Sk:50 per day spent in hospital.

While patients continue to receive some medication 'free' from the state, many medicines are now paid for directly by the people themselves.

### **3. Politics of people paying twice**

As Europeans become less tolerant of inadequate state healthcare funding and provision, and less willing to act as passive recipients 'grateful for what they receive', so the pressure is mounting on politicians to engage in more consumer friendly and economically sustainable private sector solutions.

In many ways, people's attitudes to healthcare have already changed. In a less deferential age where ever larger numbers of people have university educations and people are able to act as consumers in other key areas of their lives, they are more aware than ever of their choices and their powers of exit.

In a global and European world of tax competition, demographic pressures and expensive technological advance, reality is conspiring against the past promises of politicians made in the immediate post-war years.

#### **Crisis of the state**

Significantly, the crisis of the state is not simply restricted to healthcare. European governments are now in trouble in every major area of activity that they remain active.

In pensions, education, and even policing, tax payers and voters are increasingly using their power of exit and actively embracing private sector alternatives.

As in other European countries, a clear majority of British people in their twenties, thirties and forties no longer believe that the government will be there to provide adequate state pensions when they retire. As such, a clear majority now depend upon a range of private alternatives.

#### **Education**

In Britain today, private education is booming as never before. Since 1997, the numbers and proportion of children attending independent schools has risen every year.

Following a boom in US home schooling (which has led to more than 2.5 million children now being educated at home: a figure that is increasing by 10 per cent to 15 per cent a year), the number of British children being home educated now stands at more than 150,000.

According to a New Statesman survey in 2002, in many parts of Britain more than 30 per cent of households with children at state schools now buy in extra private tuition to help bolster their children's chances and performance with exams.

One only has to look at the range of educative computer programs in shops and the array of private and voluntary educational websites available online to see that the market for learning is growing rapidly. The state's traditional near-monopoly has already collapsed. Programs to teach languages, literacy, science, mathematics and arts and crafts are booming. Suppliers in the US are now even selling home educators entire curricula.

Given these fundamental changes, government policy is becoming ever more consumerist. Within weeks of being elected into office in 1997, the government understandably introduced private university tuition fees and abolished the traditional student maintenance grant.

The prime minister then swiftly moved on to announce that new secondary schools would be built in partnership with the private sector and that failing state schools would be taken over and managed by private companies. Initially, it was said that only not-for-profit enterprises would get the work but, within six months, the government publicly embraced the commercial sector too.

Instead of undermining the traditional foe of the Labour party, independent schools, the government has built bridges with them and applied the rhetoric of partnership. Crucially, the government has ruled out anything that might undermine or discourage the traditional independent sector in any way – such as charging value added tax on fees.

Today, well into the government's second term, the direction of travel remains clear. The prime minister knows that, to get an education system to work, people have to be empowered as consumers, they must value what is on offer and they have to be given access to a real market of choice.

## **Policing**

Even in an area traditionally thought of as a core function of the state – policing - the government's monopoly has been irrevocably broken over the last ten years.

In Britain, for every state policeman paid for by the taxpayer there are now at least two private security guards.

In stores, shopping centres, residential developments, schools and many town centres a burgeoning private security industry is being encouraged by an every growing range of clients who are disenchanted with the protection afforded to them by politicians and their taxes. Now going way beyond the world of private prisons, private prisoner escort duties and other contracted out services, many front line community policing duties are increasingly being handed over to a range of privately provided and funded services.

## **Health and the general election**

Today, similar trends are apparent in Europe and across much of the developed world. In welfare, education, policing and healthcare politicians and government are struggling to keep pace with consumer and voter demands. As such, market-oriented reform will continue by dint of there being few possible alternatives.

In this period of history, politicians are like corks bobbing on the tide of history. The moon that governs the tide is consumerist and market-oriented.

As such, the good news for those concerned with healthcare is that today in Britain an increasingly independent infrastructure is being put in place that overtime will further legitimate a substantive reform of healthcare funding.

In a world where private hospitals are now accepted partners, where private companies are set to own and operate independent treatment centres and where all NHS hospitals are destined to become independent foundation hospitals by 2008, the time is fast approaching when the government will be well placed to encourage more consumerist options in health funding and adopt a more partnership-oriented approach.

Irrespective of who wins the next general election, the liberalisation of health funding looks to be increasingly inevitable. Similar to the funding reforms increasingly impacting on higher education, incremental change is set to commence once the election has been won.

## **Britain's health funding revolution**

In many ways, Britain's health funding revolution is already well underway. Whilst in 2003, Labour politicians claimed that it was only the Conservatives who wanted to encourage various forms of private health funding, in Britain today some seven million people have medical insurance and another six million are covered by healthcare cash plans.

Many other people have no insurance, preferring instead to self fund as and when the need arises. In 2000, more than a quarter of a million British people chose to privately self-fund for independent acute surgery without any other form of cover<sup>38</sup> and since then this number has risen to 300,000 in 2003.<sup>39</sup>

In direct contravention of the original promise that the NHS "would provide all medical, dental and nursing care,"<sup>40</sup> today more than a third of the population has left NHS dentistry instead, relying solely on private treatment.

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<sup>38</sup> This information was obtained from the Independent Healthcare Association.

<sup>39</sup> According to the Independent Healthcare Association, in 2003 the number was close to 300,000 people.

<sup>40</sup> NHS leaflet sent to all British homes in June 1948.

Even more dramatic is the fact that more than eight million people pay privately for a range of complementary medical therapies every year.<sup>41</sup>

Indeed, according to research published in The Daily Telegraph,<sup>42</sup> more than 3.5 million British trade unionists – more than 50 per cent of the Trade Union Congress's 6.8 million members – now enjoy the benefits of personal healthcare schemes.<sup>43</sup>

At a time when the country's political class is trying to extricate itself from past promises by using the rhetoric of public-private partnerships in provision, many commentators have failed to pay appropriate attention to the underlying trends in funding.

In a world away from the heady utopianism of the early twentieth century today's reality is that it would require the equivalent of 4 to 5 pence in the pound on the basic rate of income tax to simply replace current personal spending on healthcare services.<sup>44</sup> To fully replace the broader sector's contribution – from personal health cash benefits and social care - would cost the exchequer much more.<sup>45</sup>

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<sup>41</sup> <http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12303.htm#a3>

<sup>42</sup> Daniel Kruger, 'Why half the members of trade unions have private health care', *Daily Telegraph*, 11 September 2001.

<sup>43</sup> For a sound history of trade union and friendly society involvement in independent healthcare see: David Green, (1985) *Working Class Patients and the Medical Establishment – Self Help in Britain from the mid-nineteenth century to 1948*, Aldershot, Gower Publishing Company Ltd.

<sup>44</sup> Independent Healthcare Association Written Evidence submitted to the House of Commons Health Select Committee Inquiry into the Role of the Private Sector in the NHS, October 2001.

<sup>45</sup> See *Ibid.*

## 4. Way forward in health

Finding a way forward with healthcare reform not only demands that opinion formers catch up with the changes that have already occurred but that all key stakeholders in this process develop new, innovative and politically viable reforms.

Whilst the challenge of change is often difficult it can nevertheless bring new and exciting opportunities.

Today, the challenges for British healthcare are very clear. As in most other European countries the British state is now engaged in a continuing and long-term process of adaptation. In healthcare, the way services are provided and funded have already begun to change in significant ways. In the years ahead, this process will continue.

It is in this context that the authors of this report now wish further to stimulate debate in the run up to the next general election. Recognising the changes that have been made to the infrastructure of health provision in recent years, the challenge now is to think of ways in which consumers can be further empowered when it comes to the funding of healthcare.

To start this process, the authors wish to conclude this report with the following ten points.

Designed to provoke further debate, the authors believe the next government should:

1. Enable NHS independent sector treatment centres to provide acute surgery to insured and self-funded patients over and above the work they are contracted to deliver for the NHS.
2. Enable NHS foundation trusts to launch, in partnership with insurers, their own locally branded personal, corporate health insurance and cash benefit plans.
3. Improve incentives for individuals to hold personal or corporate health coverage.
4. Promote workforce occupational health and rehabilitation services so that employees are kept fit and in work.
5. Assist the development of personal and corporate long-term care products which are integrated with a range of permanent health and pension products.
6. Provide incentives for trades unions, churches and other institutions in civil society to furnish their members with an enhanced range of membership health products.

7. Liberalise the laws that currently preclude doctors and other health professionals from advertising their services. Such a change will not only encourage greater competition with positive supply-side effects, but it will greatly empower patients.
8. Liberalise the laws that currently preclude direct to consumer information about prescription medicines. By better informing and empowering patients, they will be better equipped to take more control of their healthcare choices.
9. Ensure that all healthcare suppliers publish comparable performance data so that consumers can make informed judgements between competing suppliers.