Chris Huhne
Liberator Article – September 2004

No to social insurance

Continental-style social insurance schemes, recently advocated with some differences by David Laws in the Orange Book, were carefully considered by the public services policy commission in 2001-2. After exhaustive discussion, and a paper put forward by two members advocating their advantages, the option was overwhelmingly rejected. Only two participants voted in favour. Why did we instead prefer the option of radical decentralisation of a tax-funded National Health Service, the option subsequently endorsed by conference and that, thankfully, remains party policy?

True, continental social insurance schemes have one great advantage: because the patient has to claim for many treatments, he or she is able to understand the full costs of health care and is therefore a little more responsible, perhaps, about setting up appointments with GPs and then missing them. But that advantage is bought at the cost of three key disadvantages, admirably set out in the paper on the NHS and the lessons of continental schemes by Nick Bromley for the Centre for Reform.

The first is that insurance schemes usually insist on co-payment. Thus patients pay nearly a third of primary care themselves in France, and in Germany the sick pay charges for the first period they spend in hospital, rather like an insurance excess in this country. The result is inevitably to exclude some of the poor. These schemes do not ensure universal access to health care when and where people need it.

The second problem is that social insurance schemes are surprisingly bureaucratic. Far from abolishing NHS administration, insurance schemes require more paperwork by both GPs and hospitals so that they can ensure proper reimbursement of insured costs, but no more. This is the flip side of the patient knowing how much operations cost, but it is itself costly and time-consuming for the health professionals.

The third difficulty is that they also involve a separate and often expensive premium collection system, and even supposedly universal schemes based around employment suffer holes. Although much more comprehensive than the United States reliance on private health insurance – where some 45 million people currently have no health insurance at all – the safety net is not universal.

Moreover, if people are allowed to top up either spending or insurance payments, there can be the rapid development of a two-tier service. There would be choice and quality for the well-off, but a rump service for the rest. (This is effectively what the Tories have been proposing with their patient passport).

Chris Huhne MEP chaired the public services policy commission from 2001 to 2002.

David Laws' proposal deals with this third objection by agreeing with the policy commission that the Government should pay everyone's basic healthcare charge through a National Health Insurance Tax (NHIT). The main difference with what was proposed by the commission is that we wanted the tax devolved to national parliaments and regional assemblies (where they exist) which would also take on the role of the strategic health authorities.

The principal difference comes in how the money would be spent: David Laws suggests that people could opt in to a range of different providers rather like US-style Health Maintenance Organisation (HMOs). Quality would be ensured by competition: if someone was dissatisfied with their HMO at the end of the year, they could switch to another.

This is certainly a health model that a region could try out if it wanted to (and the commission stressed the importance of experimentation as a key reason for decentralising the giantist NHS). No Liberal Democrat should be against choice. But US experience suggests that choice between HMOs is not greatly empowering to patients, as they are having to buy a whole package of health care some of which may be good, and some awful.

The alternative model is patient choice based on the advice of their GPs, where this is possible, combined with a much more open attitude towards health providers (including mutuals). Even so, there are limits to the extent that choice can act as a stimulus to quality in health. First, only those in urban areas are likely to have a real choice of hospitals, for example. And those who suddenly need emergency services are hardly likely to perk up as the ambulance takes them away and insist that they are taken to the casualty department at Salisbury rather than Southampton General.

That is why, ultimately, health decisions cannot merely be delegated even to a carefully rigged marketplace. The biggest single problem of the National Health Service is that the only politician who is responsible is the Secretary of State. How can one person sitting miles away in Whitehall possibly know local circumstances or judge the success of local delivery in a system that employs a million people? If we are to save the idea of a high level of public provision from its Conservative enemies, we have to insist on decision-making on a human scale.

The most successful health system in Europe – as measured by patient satisfaction – is Denmark's NHS. Like ours, it is funded from taxation. Unlike ours, it has been properly funded. Also unlike ours, it is decentralised into 14 counties and 2 cities each with their own decision-making responsibilities even though the population of Denmark is only a little more than 5 million people. Now that the funding battle has been won, the big issue in health care is democratic local control, not phoney markets.

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