

How to Save the NHS in 1000 Days

Policy Exchange 

Adopting a Dutch-style social insurance model for healthcare

Gareth Lyon

Foreword by Hans Hoogervorst



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Foreword

By Hans Hoogervorst, Netherlands Minister of Health, Welfare and Sport
(May 2003-February 2007)

It is high time for a serious conversation about the future of healthcare provision in the UK.

That is why I very much welcome this excellent paper from Policy Exchange setting out a practical, realistic and much needed road map for reforming this country's healthcare system.

Our experience in the Netherlands was that you can only achieve sustained improvements in health outcomes and value for money by getting the system right, making sure the incentives work and putting patients in control.

As a result of the changes we made the Netherlands now has one of the best healthcare systems in the world. New providers have entered the system, resources are better targeted and more efficiently used, patients get seen sooner and are provided with great treatments over which they have more choice.

All of this has been achieved while spending a lower proportion of GDP than in the UK.

It takes determined leadership to make these kinds of changes, but they are desperately needed – and I encourage policymakers in the UK to rise to the challenge.

It also takes a plan. We spent significant time before going into Government preparing for the reforms, publicly making the case for change and meticulously planning every aspect of the legal, administrative and policy changes we would need.

This road map provides such a plan and gives policymakers in the UK the best possible chance of seeing these reforms through successfully to adopting a Dutch style social insurance policy for universal healthcare.

In the Netherlands we achieved reform because multiple parties were prepared to make the brave and clear-sighted decision to undertake major change to our healthcare system. I hope that a similar broad cross-party support for the need for change can emerge soon in the UK and that patients will be soon to benefit as we did.

Whichever party or parties choose to progress with these reforms forward, Policy Exchange's road map presents the best way forward for healthcare in this country and is worthy of serious consideration by any future Health Secretary.

Executive summary

In Policy Exchange's report – *The NHS – A Suitable Case for Treatment?* we analysed the major challenges facing the NHS and considered a range of alternative models which could secure the future for universal healthcare in this country.¹ We identified the Dutch social insurance system as being the best fit due to the health outcomes it achieves, the value for money it delivers and the similarities between the politics, economy and cultures of the two countries.

This road map is intended as a practical and ready-to-use guide for policymakers for English healthcare seeking to follow this recommendation and to move towards a Dutch style social insurance system in order to improve health outcomes, achieve value for money and preserve what people value most about the NHS. The principles and benefits laid out could be applied with equal success to other parts of the United Kingdom but due to the devolved status of health as a policy area this plan focusses on application in England.

To achieve these outcomes politicians are encouraged to learn the lessons of reform from the Netherlands, where a system very similar to the one being proposed was introduced twenty years ago and to adopt not just the Dutch-style social insurance system itself but also much of the successful approach Dutch reformers used to secure reform.



Insights into effective system reform in this country are also incorporated based on the highly successful “schools revolution” under the 2010 Coalition Government and from the challenges faced by attempts to reform some structures of the healthcare system under the same Government.

To be entirely clear – neither Policy Exchange's [previous paper](#) which looked at different models of healthcare around the world, including the Dutch system, nor this one is in any way proposing the US healthcare system which fails to deliver better health outcomes or value for money.

The Netherlands is similar to the UK in culture, development and politics and thus what is practically possible. Prior to reform the Dutch encountered many of the same challenges the UK now faces with the NHS – long waiting lists, increased rationing, attempts at cost-control and spiralling cost. Now the Netherlands has one of the best performing healthcare systems in the world – beating the UK on nearly every metric (including avoidable mortality, self-reported ill-health, satisfaction rates, waiting times and survival rates) , while sending a lower proportion of GDP every year paying for it.

1. <https://policyexchange.org.uk/publication/the-nhs-a-suitable-case-for-treatment/>

Figure 1 – Healthcare systems performance comparison – UK v Netherlands²

		
	United Kingdom	Netherlands
GDP spent on healthcare (2023)	11.1% ³	9.8% ⁴
Public spending on healthcare (2023)	£242 Billion ⁵ £3552 per capita	E 105 Billion ⁶ (£91.3 Billion ⁷) £503 per capita
Life expectancy	81	81.9
Avoidable mortality per 100,000	227	149
Diabetes prevalence rates amongst adults (2022)	8.8	6.4
Cancer mortality (2021-22 age standardised per 100,000)	216 ⁸	211 ⁹
Self-reported bad/very bad health	8.3%	6%
Population satisfied with availability of quality healthcare	61%	83%
Population reporting unmet needs for medical care	4.5%	0.6%
Avoidable hospital admissions per 100,000 people	447	364
Mamography screening within last two years (women 50-69)	66.4%	70.2%
Infant mortality per 1,000	4.1	3.4
30 day mortality after heart attack	6.4%	2.9%
30 day mortality after stroke	8.5%	5.1%
5-year cancer survival rates	<ul style="list-style-type: none"> • Colon 60% • Stomach 21% • Lung 13% • Rectal 63%¹⁰ 	<ul style="list-style-type: none"> • Colon 63% • Stomach 25% • Lung 17% • Rectal 65%¹¹

2. https://www.oecd.org/content/dam/oecd/en/publications/reports/2025/11/health-at-a-glance-2025_a894f72e/8f9e3f98-en.pdf

3. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2023and2024>

4. https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statistics_-_overview

5. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2023and2024#healthcare-expenditure-in-2023> (adjusted figures using Treasury GDP deflator)

6. <https://www.cbs.nl/en-gb/news/2025/22/spending-on-health-care-up-by-8-1-percent-in-2024>

7. <https://www.ons.gov.uk/economy/nationalaccounts/balanceofpayments/timeseries/thap/mret>

8. https://www.oecd.org/en/publications/2025/11/health-at-a-glance-2025_a894f72e/full-report/cancer-incidence-and-mortality_efaedf06.html

9. https://www.oecd.org/en/publications/2025/11/health-at-a-glance-2025_a894f72e/full-report/cancer-incidence-and-mortality_efaedf06.html

10. OECD Data Explorer, data for 2010-2014, Archive Healthcare Quality Indicators

11. OECD Data Explorer, data for 2010-2014, Archive Healthcare Quality Indicators

Patients waiting over a year for non-emergency elective treatments	19%. ¹²	0%. ¹³
Patients waiting less than a month for non-emergency elective treatments	31%. ¹⁴	58%. ¹⁵
Patients reporting “always or often” receiving a response from their GP in the same day as contacted	53%. ¹⁶	81%. ¹⁷

Crucially, the Dutch Government was successful in implementing the reforms which drove these outcomes fairly rapidly and then in sustaining momentum behind them over a decade of gradual bedding in.

The sheer scale of the political challenge a Government in this country would face in trying to replicate these reforms should not be underestimated. There is a decades-long suspicion of any structural attempts to introduce more competition, charging, choice or co-payment into the system with such reforms being unfairly caricatured as attempts to replicate the US healthcare system.

This is in part due to the unique veneration with which the UK views its healthcare system – it is highly embedded in the national psyche, so much so that it has been described as the “national religion¹⁸”, making reform extremely difficult and politically challenging.

Nevertheless, this road map sets out our view on the best path to ensure that these reforms succeed.

Too often good policy ideas remain just that and never get implemented in the real world. To secure the future of the healthcare system it is essential that this not be allowed to happen – reform is certainly needed.

This report builds on the recommendations and findings of Policy Exchange’s report *The NHS: a Suitable Case for Treatment* and sets out a detailed, 22 step plan for how this could be achieved. It focusses on the key legislative and governance changes required to carry out the reforms, the institutional changes needed to support them and the key steps to ensure that the Government has a mandate for reform.

It sets these out in a phased step-by-step guide starting in the year ahead of an election and continuing beyond the implementation date. As it is based on the assumption that a reforming Government would need a clear mandate to undertake reform on this scale it takes as its assumption that the reforms would be carried out by a Government after a General Election. As such the road map takes the day of the General Election the point from which the plan is measured and is phased in such a way as to avoid causing anxiety to patients through a ‘Big Bang’ approach – instead the reforms are broken down into three phases. A summary is as set out below:

18. <https://www.kingsfund.org.uk/in-sight-and-analysis/blogs/30-years-public-views-nhs-public-spending#:~:text=Former%20Chancellor%20of%20the%20Exchequer,added%20to%20the%20survey%20choices>).

12. Health foundation analysis of Commonwealth Fund 2023 International Health Policy Survey of adults in 10 countries

13. Health foundation analysis of Commonwealth Fund 2023 International Health Policy Survey of adults in 10 countries

14. Health foundation analysis of Commonwealth Fund 2023 International Health Policy Survey of adults in 10 countries

15. Health foundation analysis of Commonwealth Fund 2023 International Health Policy Survey of adults in 10 countries

16. <https://www.health.org.uk/reports-and-analysis/briefings/feeling-the-pressure-what-the-2023-commonwealth-fund-survey-reveals>

17. <https://www.health.org.uk/reports-and-analysis/briefings/feeling-the-pressure-what-the-2023-commonwealth-fund-survey-reveals>

Figure 2 – Top level summary of phases and key measures

Phase and timing	Key measures
Phase one – one year pre-election	<ul style="list-style-type: none"> • Communications about the policy including explicit explanation of the health benefits (eg tackling waiting lists, more responsive and flexible treatment, likelihood of access to new treatments, new provider entrants etc) and financial benefits. Manifesto commitment before election and policy explainers afterwards. • Preparation of key modelling and governance documents • Institutional engagement and briefing
Phase one: From election to one year and nine months post-election	<ul style="list-style-type: none"> • Establishing new institutions and teams and making key appointments to guide policy implementation • Introduce key paving legislation for new system. • Tax cuts and rebates announced and communicated in Budget as well as introduction of new specialist savings accounts alongside “statements” detailing cost of ex ante system. • Introduction of standard priced “insurance premiums” in place of a portion of income tax (initially collected by HMRC) • Introduction of co-payments and “excesses” for certain categories of treatment. • Conversion of ICBs into default insurers.
One year and nine months to two years and nine months	<ul style="list-style-type: none"> • Removal of price controls and tariffs for healthcare providers • Entry of new healthcare providers • Removal of central payscales • Public communications on health outcomes and patient guidance on next steps in reform process
Two years and nine months to three years and four months	<ul style="list-style-type: none"> • Entry of new insurance providers into the market and introduction of patient choice over insurers together with direct payments of premiums to insurers and fines for those not taking out policies. • Competition and Markets Authority market study of new system.

1. Introduction and intention

This paper is a follow-up to the Policy Exchange report *The NHS – a Suitable Case for Treatment?* published earlier this year and is intended to provide a clear road map for how the core recommendations of the report can be implemented.¹⁹

The report made a number of recommendations for cost savings totalling £13 billion throughout the UK including:

- Introducing a modest fee for visiting a GP other than for low-income groups. The report notes that if the fee were levied at £20, this measure could potentially raise about £5 bn per annum and also reduce the demand for GP appointments and cut back the number of missed appointments.
- Removing free prescriptions for over 60s except for those whose financial circumstances mean that prescriptions would be unaffordable, as is the case with other citizens with low incomes, potentially saving up to £1 billion per annum.
- Charging for more luxurious hospital accommodation, potentially raising £700 million.
- Reducing the use of expensive agency staff, saving the NHS up to £1 billion net per annum.
- Abandoning centralised pay bargaining in the NHS, thereby allowing regional divergence in pay rates, reflecting local economic conditions with savings of about £2 billion per annum.
- Halving administrative costs by making more and better use of technology, potentially saving the NHS £1.4 billion per annum.

The report also made some further general cost-saving recommendations including:

- Introducing more emphasis on personal responsibility and developing incentives throughout the healthcare system to encourage individuals to have a stake in their own health.
- Levying fines for people who miss appointments.
- Putting more emphasis on preventative healthcare including inducements for individuals to enter into preventative health schemes like screenings, smoking cessation programmes or fitness programmes.

Chiefly though, the report advocated moving the NHS to a more

19. https://policyexchange.org.uk/wp-content/uploads/The.NHS_.A.Suitable.Case_.For_.Treatment.pdf

sustainable funding model in line with the best performing healthcare systems. Specifically, Policy Exchange suggested moving towards a Dutch style social insurance system which combines direct funding for children's healthcare with a compulsory insurance model for adults augmented by subsidies for those on low incomes.

The report made clear, and it is worth reiterating here that while most British people think that moving to an insurance-based model would mean adopting something like the US system, **Policy Exchange does not advocate for this – quite the reverse.**

Instead, it is proposed to seek to move towards a different type of insurance-based model which operates much more effectively and which is similar to that in the Netherlands – but also found in various forms in Switzerland, France, Germany, Australia, Japan and Singapore.

The authors of our earlier report identified the Netherlands model as the best achievable model which the UK could look to adopt.

The Netherlands is comparable to the UK in culture, development and politics and thus what is practically possible. Prior to reform the Dutch encountered many of the same challenges the UK now faces with the NHS – long waiting lists, increased rationing, attempts at cost-control and spiralling cost.

Crucially, the Dutch Government was successful in implementing the reforms fairly rapidly and then in sustaining momentum behind the reforms for over a decade of gradual bedding in despite significant changes in the composition of the ruling coalition.

It is the Dutch experience of the process of securing reform after two decades of stalling policy debate, as much as the outcomes in the Netherlands model healthcare system itself, that justify its use as a model here. The reforming Government in the Netherlands did not take up the task lightly and had put considerable efforts into planning and preparation long before implementation.

The healthcare system in the UK has been in place so long that even though people can see its shortcomings it is very hard for people to imagine any other. It will be very difficult to get across to people how they will be financially better off as well as better off in health terms post reform. With health being such a high-profile political issue in the UK for so long it would take an extraordinary degree of political courage to take on this reforming task – even if it is clearly necessary.

Rather than a series of recommendations for reform it is our proposed road map which we are recommending as a whole.

Much of this paper considers the experience and outcomes of the Netherlands as well as the experience of reformers in the UK – all of which helps to shape our proposed plan. Those with limited time may prefer to start with the plan set out in the final Road map section and to refer back to the rest of the report to understand the context further.



2. Lessons from the Netherlands

An overview of the background of the Netherlands healthcare system and its health and financial outcomes

The experience of the Netherlands in 2006, introducing more competition and greater patient choice was highly impressive and, with the right conditions, shows what is potentially possible.

The reforms have demonstrated a great degree of success and Dutch healthcare costs are significantly lower as percentage of GDP than those in the UK, waiting lists are lower, life expectancy is higher and health outcomes better²⁰.

Figure 1 – Healthcare systems performance comparison – UK v Netherlands²¹

		
	United Kingdom	Netherlands
GDP spent on healthcare (2023)	11.1% ²²	9.8% ²³
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Diabetes prevalence rates amongst adults (2022)	8.8	6.4
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20. https://policyexchange.org.uk/wp-content/uploads/The.NHS_.A.Suitable.Case_.For_.Treatment.pdf

21. https://www.oecd.org/content/dam/oecd/en/publications/reports/2025/11/health-at-a-glance-2025_a894f72e/8f9e3f98-en.pdf

22. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2023and2024>

23. https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statistics_-_overview

24. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2023and2024#healthcare-expenditure-in-2023> (adjusted figures using Treasury GDP deflator)

25. <https://www.cbs.nl/en-gb/news/2025/22/spending-on-health-care-up-by-8-1-percent-in-2024>

26. <https://www.ons.gov.uk/economy/nationalaccounts/balanceofpayments/timeseries/thap/mret>

27. https://www.oecd.org/en/publications/2025/11/health-at-a-glance-2025_a894f72e/full-report/cancer-incidence-and-mortality_efaedf06.html

28. https://www.oecd.org/en/publications/2025/11/health-at-a-glance-2025_a894f72e/full-report/cancer-incidence-and-mortality_efaedf06.html

Population satisfied with availability of quality healthcare	61%	83%
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5-year cancer survival rates	<ul style="list-style-type: none"> • Colon 60% • Stomach 21% • Lung 13% • Rectal 63%²⁹ 	<ul style="list-style-type: none"> • Colon 63% • Stomach 25% • Lung 17% • Rectal 65%³⁰
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Patients waiting less than a month for non-emergency elective treatments	31%. ³³	58%. ³⁴
Patients reporting “always or often” receiving a response from their GP in the same day as contacted	53%. ³⁵	81%. ³⁶

The Netherlands healthcare system outperforms its counterpart in the UK – in several cases by quite considerable margins. This is despite the Netherlands spending a significantly lower proportion of GDP on healthcare than the UK does.

Health outcomes have also improved in the Netherlands since healthcare reforms were introduced in 2006. The way in which these reforms were carried out and the factors which contributed to their success will be covered in the next section.

It is certainly not the case that the healthcare system in the Netherlands is perfect or that its structures and ethos can be entirely transferred to an

29. OECD Data Explorer, data for 2010-2014, Archive Healthcare Quality Indicators

30. OECD Data Explorer, data for 2010-2014, Archive Healthcare Quality Indicators

31. Health foundation analysis of Commonwealth Fund 2023 International Health Policy Survey of adults in 10 countries

32. Health foundation analysis of Commonwealth Fund 2023 International Health Policy Survey of adults in 10 countries

33. Health foundation analysis of Commonwealth Fund 2023 International Health Policy Survey of adults in 10 countries

34. Health foundation analysis of Commonwealth Fund 2023 International Health Policy Survey of adults in 10 countries

35. <https://www.health.org.uk/reports-and-analysis/briefings/feeling-the-pressure-what-the-2023-commonwealth-fund-survey-reveals>

36. <https://www.health.org.uk/reports-and-analysis/briefings/feeling-the-pressure-what-the-2023-commonwealth-fund-survey-reveals>

English context. Healthcare inflation, ageing populations and other cost pressures present across all developed countries and also inevitably apply in the Netherlands. There are however lessons to be learned from the high performance of the system in the Netherlands and the progress which has been made since they moved to a new structure— demonstrating how it is possible to move from a more state-orientated model to a mixed system in which patient choice, competition and incentives towards efficiency play a role in helping to control costs and improve healthcare outcomes for patients at the same time.

How it works

The core legislation for the Netherlands healthcare system is the 2006 Health Insurance Act (*Zorgverzekeringswet*) which created a universal compulsory health insurance system replacing two previous funding systems (the Sick Funds and Private Insurance).

There is a genuine mixed model in the Netherlands when it comes to healthcare funding. There are a number of sources of finance including insurance premiums, income-related contributions, co-payments and subsidies through the tax system amounting to 45% of funding.³⁷ The combination of these income sources funds the good quality provision of universal coverage while making more effective use of demand-side restraint to deliver greater affordability, and financial sustainability than funding models which depend entirely on funding through general taxation.³⁸

The same basic insurance is required for everyone over the age of 18 (with premiums being subsidised for low-earners out of taxation). Premiums are community risk-rated (so the same price is charged for everyone regardless of circumstances or risk factors). The Government compensates insurers for enrolling high-risk individuals through a system of subsidies, ensuring that an equitable system exists while still enabling competition – insurers are not incentivised to take on lower risk people and to avoid higher risk ones. Children are covered by state funding.

There is extensive use of co-payments or “mandatory deductibles” throughout the system under the basic insurance plan in order to disincentivise wasteful or missed appointments. People can secure a standard lower price on their basic insurance policy if they agree to a higher mandatory deductible. There are also additional co-payments for certain services and for treatment outside of the insurer’s approved network of providers.

Insurers are able to compete with each other on price but must offer the same price to everyone, regardless of their health or risk profiles – insurers are not allowed to refuse insurance to anyone.

People can ‘shop around’ amongst insurers – not just on the basis of price but also on other factors such as quality of care and treatment, customer service, efficiency, convenience, breadth of network and in their record or achieving health outcomes for policyholders. They have considerable choice, not just between providers but between different types of plans.

37. <https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands>

38. <https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands>

One option is a “benefit-in-kind plan” (naturapolis), which entitles the citizen to a certain quality of care as needed at the expense of the insurer. A second option is a “cost-reimbursement plan” (restitutiepolis) in which the citizen sources their treatment from any given provider and is entitled to reclaim “normal costs” against the provider. The third option is a “managed care plan” (budgetpolis) which relies on an “in-network” procedure to provide a lower cost plan in exchange for access to a more limited set of providers.³⁹

People can also choose to opt for higher co-payments or excesses in exchange for lower premiums, but the scope for these are limited by the Government.

There is significant movement between insurers year-on-year – an important element of competition which is made easier because of the “one price” approach which prevents exclusions for pre-existing conditions. Anyone who does not take out a health insurance policy faces fines.

While there are a range of prices in the market, reflecting its competitive nature, average premiums for the basic insurance package in 2024 were around €1,800 a year. Those who do not take out such a policy, or who are not in an exempt group, can face heavy fines.⁴⁰ The annual maximum excess set by Government on these policies has stayed steady at roughly €385 for a number of years with a maximum voluntary excess for those seeking cheaper insurance premiums set at €885.

The services covered by basic insurance include most essential services such as primary care, emergency care, preventative healthcare such as vaccinations, necessary surgical procedures, and rehabilitation care. Services which are not covered include dental care (dental care is provided out of general taxation for under-18s), elective or non-urgent treatments, cosmetic surgery, or optical care (optical care is provided for under-18s from general taxation). In addition to this there is a secondary market in non-compulsory “supplementary insurance” which can cover or subsidise the cost of a wide variety of other treatments and services such as dental services, social care and better hospital rooms.⁴¹

While a minimum network coverage threshold is demanded by Government, insurers compete extensively to attract customers on the basis of network extent and quality. As a result of this network competition there is a wide variety of types of provision with new specialist clinics delivering high quality services set up since the reforms were introduced in 2006.

There is a highly complex system behind risk equalisation which has been adjusted a number of times over the years. It relies on calculation a standard actuarial risk score based on risk factors such as age, gender and health status of policyholders. The Risk Equalisation Fund is financed partly through general tax revenues and partly through a system of income-related contributions charged to policyholders on top of their insurance premiums. Households under an earnings threshold receive some additional support through an annual allowance to help reduce their premiums. These features of the Netherlands healthcare system reflect the

39. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

40. https://static.heritage.org/2010/pdf/bg2435.pdf?_gl=1*1wkcche*_gcl_au*MT-M4NzlwNDlwMi4xNzM3MDMyOTM4*_ga*MjA1NTM1NDM2OC4xNzM3MDMyOTM4*_ga_W14BT6YQ87*MTczOTIwNDgxNy41LjAuMTczOTIwNDgxNy42M-C4wLjA

41. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

Dutch commitment to “solidarity” in public services – and represent a significant departure from many other insurance-based systems.

Support for those with daily care requirements is managed through a separate system.

Because quality of care is such an important differentiator between insurers and to help increase their market power relative to providers, they are permitted to engage in “active purchasing” – selectively contracting with certain providers and negotiating quality criteria with those providers. Insurers have the freedom to determine which providers they work with, and there is considerable competition in the provider space. Since the reform process began in 2006 the market has seen a significant level of entry from specialist surgeries and clinics with a growing proportion of overall procedures moving from hospital settings to clinics – especially in dermatology and cataract surgery. It should however be noted that certain providers – including some key hospitals, are still seen as exercising too much market power and thereby limiting consumer benefit.

This system only applies to Dutch/ EU citizens and registered long-term visitors to the Netherlands. A separate state funded system is in place to support asylum-seekers but is more limited in scope. An even more limited system of support applies to undocumented migrants, predominantly covering emergency care. Temporary visitors are expected to arrange relevant insurance for their stay.

It is possible to supplement basic insurance policies with additional voluntary insurance policies which can help to cover co-payments – these are not however cost controlled in the same way as the basic insurance policy. These policies can also be used to widen access to more providers. There is very high take up of this supplemental insurance and it is used extensively towards optical and dental care.

Both the insurance and the provision side are highly regulated. The Authority for Consumers and Markets (ACM) and the Dutch Healthcare Authority (Nza) protect consumers and ensure smooth market operation while the National Health Care Institute plays a similar role to the National Institute for Health and Clinical Excellence (NICE) in the UK – assessing health/economic value of treatments and advising on future inclusion in basic plans, while the Health Care Inspectorate is similar to the UK’s Care Quality Commission – inspecting and regulating treatment quality and clinical safety.

In this system the role of Government is to enforce compulsory insurance, to ensure that the basic plans which form the basis of the compulsory insurance system cover a sufficiently broad range of treatments, in regulating the maximum annual excesses, in regulating hospitals and in providing subsidies to cover costs associated with high-risk individuals and children.

Social care

Long-term adult social care in the Netherlands is not covered by the compulsory insurance model. Instead, the Long Term Care Act (WLZ)⁴² introduced in 2015 ensures that these costs – particularly for those with chronic conditions or older people – are state funded through general taxation for those who meet financial criteria.

Eligibility is however confined to those with the most serious care needs, and to qualify, recipients must be medically assessed. A system of co-payments and insurances applies for those in higher income groups.

Short-term or minor care services are covered either through the basic insurance package voluntary additional insurances.

42. <https://ageing-policies.unece.org/browse-policy/2711>

3. How they did it: an overview of the Dutch reform process and interviews with one of the architects

Prior to the healthcare reforms of the early 2000s, the key governing legislation for the Dutch healthcare system was the Sick Fund Act 1964 which codified the system which had been in place since World War Two. The first serious attempts towards reform happened in the late 1980s but these were ultimately unsuccessful. The period 2003-2006 was the crucial period for implementing reform legislation and a number of key developments have happened since then in the system which have helped it to bed-in and ensured its ongoing effectiveness.

Figure 3 – Timeline of the reforms in the Netherlands

Year	Key reform developments
October 1964	Sickness Fund Act passed which updated payment models and served as the key legislative underpinning of the Dutch system for the next 40 years.
August 1986	Centre right coalition seeks to address rising healthcare costs and falling satisfaction rates – Dekker Commission formed.
June 1987	Dekker Commission report “Willingness to change” calls for system of universal compulsory insurance and co-payments as well as greater patient choice and more competition. Reforms fail to secure Parliamentary support before centre-right coalition loses power.
January 2003	Elections in which new main coalition partners pledge healthcare reform in their election pitches amidst continued public dissatisfaction with the health service.
September 2003	Sector consultation on proposed reforms
May 2004	Zorgverzekeringswet Health Insurance Bill introduced to House of Representatives

3. How they did it: an overview of the Dutch reform process and interviews with one of the architects

December 2004	House of Representatives passes Health Insurance Bill and it moves to the Senate
June 2005	Senate passes Health Insurance Bill to come into effect on 1 January the following year
January 2006	Health Insurance Act becomes law
November 2006	Elections in which VVD Party lose seats and a new Right-Left CDA- PvdA coalition takes power and continues committed to the reforms
January 2008	Extension of compulsory health insurance cover to new specialisms, including mental health
October 2008	Hospital Planning Act repealed to encourage greater provider competition
January 2015	Further extension of system through the Long-Term Care Act (Wet langdurige zorg) to cover community nursing and care.

Background

The key piece of legislation in the pre-2006 Netherlands healthcare system was the Sickness Fund Act 1964 (amended 1986) which updated payment models which had been in place since the 1940s.⁴³ The Sick Fund scheme was a means of ensuring universality beyond the private insurance system which only covered a minority of the population (Sick Fund schemes covered about 63% of the population, with the private insurance system covering the remaining 37%).⁴⁴

The Sick Funds which covered the majority of people were financed out of general taxation. Patients had very little choice over healthcare providers.

The insurance-based part of the pre-2006 system was also intensely state regulated with very minimal competition. Those in employment and over an income threshold paid a mixture of tax contributions and additional premiums taken out of salaries.

Provider prices and terms for treatment were standardised, along with salary levels and cross-charging, meaning that little provider competition was possible or incentivised. It was not possible for insurers to tailor their provision or to take any providers out of network, as all providers in designated geographies were in scope, further reducing the incentives for cost or outcome performance. Government played a significant role in remuneration for providers and cross-charging to insurers and sick funds, as well as in ensuring that subscriptions were paid.⁴⁵

Throughout the 1970s and 1980s there was growing dissatisfaction at the ability of the system to manage costs, to eliminate waste and overprovision and to ensure quality and service standards. Because of the lack of competition and choice there was limited scope for innovation, efficiencies or design improvements. This, coupled with an ageing population was leading to growing cost pressures on the system which efforts around rationing were unable to contain. There was also

43. https://natlex.ilo.org/dyn/natlex2/r/natlex/fe/details?p3_isn=2173

44. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

45. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

dissatisfaction around the bifurcated system causing inefficiencies, delays and perceived unfairness for people transitioning between the systems or when their life situations changed. Even the private health insurance system was largely unresponsive to its customers and patients had very little choice over their healthcare providers, while this choice was entirely absent for those covered by the Sick Funds.

Early attempts at reform

The first moves towards reform started in 1986 as economic pressures were intensified and the economy suffered. The Christian Democratic Appeal Party (CDA) and the People's Party for Freedom and Democracy (VVD), the centre-right parties then leading the Government sought to address the long-standing issues and set up a commission led by the well-regarded Chairman of one of the country's largest companies – Wisse Dekker of Philips. The commission issued a report in 1987 entitled "Willingness to Change", which recommended a fundamental change in the funding structures with a move to a system of regulated competition, provider independence and greater patient choice in order to promote innovation, responsiveness and greater efficiency, which it saw as the most effective means of controlling costs.⁴⁶

The report from the Dekker Committee highlighted a number of key issues with healthcare funding and provision including a lack of choice and responsiveness, a lack of efficiency and flexibility as well as a lack of incentives for innovation or cost control.⁴⁷ The report also set out the problems caused by the bifurcated funding structures and associated concerns about a lack of patient-centredness, a lack of choice and producer capture leading to inefficient allocation of resources within the system.

The Dekker Committee made several key recommendations, including replacing the two parallel funding models with a cohesive single compulsory health insurance scheme that would cover the whole population. While the insurance would be compulsory and the extent of treatments available under it centrally prescribed, individuals would have choice over their insurer – and competition would prevail by way of single-quoted prices, reputation and the providers in network. The aim was that this basic insurance model would cover 85% of healthcare spending, with the other 15% being financed by voluntary additional insurances for non-covered treatments. A crucial element in this structure which was intended to control prices and improve responsiveness and efficiency was competition between insurers and healthcare providers, especially the most costly treatments in hospitals.

Despite being far reaching in scope, the Committee's report did not address politically sensitive questions, such as risk equalisation and the shape of new reimbursement procedures for healthcare providers. There was also no clear road map set out for how the existing system could transition to the new arrangements.⁴⁸

The CDA/VVD-led Government of the day responded positively to the report and consulted the public and stakeholders on potential

46. Roland Marnix Bertens, "Care, Cost and Questions of Control: Dutch Health Care Reform 1987-2006", MA Thesis, Utrecht University, 2016

47. CSFG (Commissie Structuur en Financiering van de Gezondheidszorg) (1987), *Bereidheid tot verandering [Willingness to change]*. The Hague

48. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

implementation, including developing further plans around potential implementation. Wider public and stakeholder support was lacking though, with patient concerns combining with opposition from doctors, unions and regulators, including the influential price regulator – the Central Healthcare Tariffs Agency and the Sick Funds.⁴⁹ There was also some opposition from private insurers concerned about it eroding their existing market position. One of the biggest themes of opposition was the impact on “solidarity” and on the least well off in society.⁵⁰

The Government remedied some of these issues in its own response to the committee but political developments in the late 1980s made reform unviable. The 1989 election saw the more enthusiastic proponents of reform, the VVD Party losing seats and the CDA going into coalition with the Labour Party instead. The new coalition issued a revised, more state-subsidised version of the Dekker Plan with fewer competitive elements, which in turn did not secure sufficient political support. While some administrative changes were made, no large-scale programme of reform was attempted again until after 2003 when a centre-right coalition returned to Government.

As waiting times continued to lengthen and as the administrative and rationing reforms over the period were seen to be insufficient public support for, and political will to consider system reform returned. One reform which did help to restrain costs during this period was the Government moving out of the direct hospital provision space, gradually setting these up as trusts, but this was not without its own problems and institutional opposition from the hospitals was growing.

Cost and public pressure on waiting lists became particularly acute after a court ruling determined that long waiting times constituted a violation of people’s right to healthcare – forcing the Government to significantly increase spending.

This pressure, together with reports from statutory agencies calling for a compulsory insurance based model led to the coalition Government of the late 1990s producing a position paper in 2001, titled “A question of demand” (Vraag aan bod) which reiterated many of the original recommendations of the Dekker report. Recognising the continuing controversy around the proposals the Government bought itself time and attempted to mitigate opposition through extensive consultation exercises which continued up to the 2002 election.⁵¹

In the 2002 election healthcare was the second most important issue given by voters in how they voted, after crime and security.⁵² The coalition which emerged amongst parties on the right had all campaigned for healthcare reform in various forms and accordingly made healthcare a major theme of their agreed post-election platform. Despite a rapid disintegration of the coalition and subsequent snap elections in January 2003 healthcare remained a major issue both in the election and for the centre-right coalition Government which emerged after further negotiations in May 2003. This was reflected in the appointment of heavyweight former Finance Minister Hans Hoogervorst as Health Minister at that point. At

49. Patrick Jeurissen and Hans Maarse, “The Market Reform in Dutch Healthcare: Results, Lessons and Prospects”, 2021, p18

50. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

51. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

52. <https://pure.rug.nl/ws/portalfiles/portal/20915732/lpf.pdf>

this point the Government was highly committed to healthcare reform, despite holding only a slim majority and having to deal with a high degree of political instability over issues such as immigration and integration.

The political landscape prior to reform

Before considering the specific approach taken around the 2006 healthcare reforms it is worth noting three factors about the background which shaped the way in which the Government acted.

Firstly, as noted earlier, it took two decades for reform to move from a discussion in the public sphere to reform legislation. The ground was prepared over a very long period, and intensive debate had already taken place. On one hand this was an advantage as a considerable body of research and policy development had already taken place, on the other hand it had also allowed opponents of the reforms to entrench and to develop their arguments against it.

Secondly, although the initial waves of reform moved at pace through the Dutch legislature, they were designed intentionally to avoid a “big bang” moment of transition. Many residents didn’t switch providers immediately, allowing an opportunity for the reforms to bed-in and for the insurers not to be overwhelmed too early on and for public confidence to be maintained even while very significant structural changes were taking place beneath the surface. Existing institutions, such as the Sick Funds, were reshaped and repurposed but from the patient perspective saw no gap in coverage or provision. There was also reassurance in the fact that the Government was continuing to play a significant role in healthcare – albeit in setting the parameters of the new markets and policies, in regulating insurers and in ensuring quality amongst providers, rather than acting as a provider or funder itself.

Finally, sources of institutional opposition had been tempered over the preceding period. Since the 1990s all hospitals in the Netherlands had been private institutions, rather than Government owned facilities. This had made the transition to the new model easier and avoided some institutional inertia. In addition, the Sick Funds already playing such a central role in healthcare funding in the Netherlands provided the base institutions and mechanisms which could be used as the basis for the new system, albeit with significant changes.

Throughout the late 1990s when public consternation about waiting lists and rising health spend was growing, the parties on the centre-right, particularly the VVD, made a concerted effort to tap into this and to sustain the popular support and political will necessary for reform. This was done by clearly rooting reforms in widely held public concerns about the increasing health spending during the 1970s and 1980s which numerous alternative policies, budgetary interventions including spending limits, price controls and increasing co-payment had proved insufficient to control. Introducing more competition and patient choice was therefore widely seen as being a more likely effective mechanism to control cost and to maintain quality.⁵³

53. <https://www.ncbi.nlm.nih.gov/books/NBK577821/>

Care was taken throughout the early stages of policy development around potential reforms, in the later legislative progress and particularly around the enactment, to communicate clearly and specifically with the public about the policy aims and public benefits of the programme as well as the problems it sought to solve – addressing public concerns including securing high-quality care, sustaining universal access, achieving financial sustainability and to improve freedom of choice⁵⁴.

As such, when the centre right coalition began to navigate through its programme of health insurance reform in 2003-2005 there was already a strong expectation that it would do so. The coalition parties and in particular the VVD had made the need for healthcare reform a major issue in the election and had a public mandate for action, albeit with a very limited majority in the legislature. Once a suitable Minister was found to navigate the reforms through Parliament, a thoroughly worked-up bill was ready to be presented in fairly rapid order.

The Government started from a position of clarity on its guiding principles in healthcare reform. The Government was convinced that competition could play a significant role in driving down prices, while regulation could ensure the level of protections needed to ensure universality and risk sharing. It was also clear on the role that Government and the relevant institutions should play in the new model with Government becoming more focussed on being a guarantor and regulator, with social-purpose-driven dedicated organisations playing the role of providers and funders.

Clarity over the core principles of the policy allowed for a sure-footed approach to the intense and two-pronged consultation programme with stakeholders and institutions which took place in the early days of the new Government. Engagement with private health insurers was a crucial step in securing a coalition of support. Simultaneously potential sources of opposition were countered with through detailed conversations with provider organisations, medical groups and patients around structures, safeguards, mitigations and transitions. These helped to address specific concerns about how payment systems would work.

As well as prioritising securing as much institutional support throughout the healthcare system as possible before undertaking the changes the governing parties also undertook further engagement within the parties forming the Government itself to identify and address any potential fissures in its political support. The result of this was a set of more gradual and less dramatic changes but also more consensus leading to greater stability and certainty in the future of the reforms, even after changes of Ministers and Government.

Potential obstacles were identified as early as possible, including exploring and mitigating potential legal concerns. Of particular concern was the question of European Competition Law applying to the insurance system, since the new model would not meet the EU definition of social insurance.⁵⁵ Clarity was sought and secured through the Dutch Government's representative on the European Commission and this was deemed sufficient to proceed.

54. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

55. <https://ec.europa.eu/eurostat/esa2010/chapter/view/17/>

It was also recognised at the time the reforms were being formulated that extending the system to social care would significantly heighten the levels of concern and political resistance being encountered, as social care in the Netherlands was, and remains, well regarded and not subject to the same public concern as health faced at the time. As such the decision was made to focus the reforms on areas where the most immediate impact was possible - healthcare exclusively.

The Health Insurance Bill was introduced to the legislature in 2004 and the lower and upper houses gave approval for the bill in 2004 and 2005 respectively – a remarkable achievement given the very tight parliamentary arithmetic but demonstrative of the clear recognition by then of the need for reform. The Health Insurance Act (*Zorgverzekeringswet*) came into effect on 1 January 2006, almost twenty years after the Dekker Committee published its report but in the first few years of a Government firmly committing itself to a programme of reform. It was the central pillar but not the only element of the Government’s healthcare reform programme.

Implementation of the act and ongoing reform

The Health Insurance Act 2006 was the centrepiece of reforms to how healthcare was funded and delivered in the Netherlands, and it remains the legal basis for most of the new system. Key elements of the act were:

- the establishment of the compulsory basic insurance healthcare funding model
- determining the system of “mandatory deductibles”
- introducing the statutory limits for co-payments and charges and the means through which they can be varied in future
- setting out the extent of concessions to the principles of “solidarity” through state subsidies to cover healthcare costs for low earners
- establishing the core elements of the basic healthcare package to be covered by the basic health insurance policy
- establishing the principles on which competition between insurers and between providers would operate.

All existing Sickness Funds were integrated into the new scheme as insurers, ending the complex two-tier system which had previously existed.

One area where the reforms were considerably restrained at first was around the pricing of procedures and volumes in hospitals – with so called “free pricing” encountering political opposition. It was therefore at first determined that the regulator should review any extension of procedure pricing prior to any further extensions to an initial limited range of procedures – with most competition in this area being constrained until a major extension was approved by a future minister in 2009.

Reforms continued after the 2006 election in 2008-2009 with the decision to repeal the Hospital Planning Act (*Wet Ziekenhuisvoorzieningen*) in 2008, which had previously empowered the Government to manage

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the supply of hospital facilities and care homes. Previously this had been considered a necessary element of health system management to avoid oversupply in certain areas and adequate regional distribution in others. The act had proved burdensome and bureaucratic - requiring providers to apply for a licence to build a new hospital and closely regulating the number of specialisms each hospital could operate in. Underpinning this was a procedure under the old system whereby hospitals could pass on in-patient costs to the Government, thereby eliminating any incentives for efficiency.⁵⁶

The 2006 elections saw the most enthusiastic advocates for healthcare reform, the VVD, losing seats (it does not appear that the healthcare reforms were a major factor in this) and being ejected from the governing coalition, being replaced by the previously opposed PvdA (Labour) Party. Encouragingly though, although there had been a change in political leadership at this stage, there was now cross-party acceptance of the governing principles behind the healthcare changes. By this point the political debate had moved on to how to ensure that the reforms were as effective as possible – including ensuring the most effective competition possible between providers and the repeal of the Hospital Planning Act. This resulted in a significant increase in the flexibility hospitals had to adapt to patient needs and strengthened the financial connection between performance and return on investment.

This process was also in line with the new role imagined for the state in healthcare provision – rather than being responsible for individual facilities (which were intended to develop financial planning capabilities of their own) the Government moved to a position of “system responsibility” – taking a more strategic overview to ensure system-level availability of care. Accordingly, the Government ceased to automatically play a role when providers went bankrupt – whilst still retaining a role if particular market circumstances and patient need justified it.⁵⁷

As provider competition has increased there has been a managed decline in the number of hospitals of about 30% since 2000. This reflects previous over-provision in some areas but more significantly a shift towards new models of provision.

This is most marked in the rapid growth of independent treatment centres (ITCs), which specialise in high-volume routine treatments or diagnostics and which have rapidly become significant players in particular specialisms, covering 20% of treatment in cataract surgeries and dermatology.⁵⁸ There has also been evidence of increased efficiency and procedural innovation amongst existing providers as they respond to the competition from these new entrants.

2008 also saw the extension of coverage under the Health Insurance Act to mental health. By 2013 all mental health care shorter than three years as well as geriatric rehabilitation was covered.

Further extensions took place in 2015 with the transfer of community nursing and care as part of the reform of long-term care to the insurer system.

56. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

57. <https://iris.who.int/server/api/core/bitstreams/78ffa515-6362-4058-9361-dfa99e1c3473/content>

58. <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13201?msoc-id=0a2282bc20626cdf1a9396c4215a6d61>

System impact

As set out in *The NHS, a Suitable Case for Treatment* – these reforms:

“...have proved effective at holding down growth in healthcare expenditure. From 2006 to 2019, real healthcare expenditure grew at an average annual rate of 2.1%, compared with 4.6% from 1989 to 2005.⁵⁹ The Dutch reforms have also played a role in keeping the overall proportion of Government spending on healthcare under control.

“Healthcare outcomes in the Netherlands have improved vastly too – not in spite of the HIA, but because of it. The structural changes and reforms have promoted innovation, efficiency, and better demand management. Waiting times fell almost across the board after 2006, and although they have been on the rise again since 2013, they remain vastly lower than in the UK across a range of treatments⁶⁰.”

There has been clear evidence of increased competition in the insurance market in the Netherlands during this period. Annual changing was permitted prior to 2006 but the rate of switching was relatively minor – between 2% and 4% a year. Since then this has more than doubled to 8.2% in 2023⁶¹.

There has also been evidence of rapid progress from a patient perspective since 2006, with regulated competition between providers and between insurers on the basis of services leading to significant falls in waiting list times.

Although private for-profit providers have operated in the Dutch healthcare system for some time – particularly in GP provision, dental care, community nursing and social care, there has been a long-term aversion to extending the scope of private-for-profit provision and this was not included in the first wave of reforms in 2006. Although arguments have been made for extending their role subsequently, particularly to facilitate the entry of new providers and capital investment into the market, political support has been lacking.

Private for-profit insurers are however permitted under the 2006 Act – although several efforts have been made since to limit the ability of insurers to pay dividends. Most insurers remain not-for-profit.

Patient impact

Throughout 2005 the Ministry of Health, Welfare and Sport worked closely with insurers and the Sick Funds to ensure that they were ready for the new system to go live at the start of 2006. As a result of close working between the department and industry, all Sick Funds (now in a new status as insurers) and private health insurers had new policies ready to offer patients in December 2005 which met the requirements of the Basic Plan.

To inform patients about their rights and responsibilities under the new scheme a brochure was published by the Netherlands Ministry of Health and sent to all households along with a letter from the Minister outlining the new policy. Alongside this there was a major communications

59. https://policyexchange.org.uk/wp-content/uploads/The.NHS._A.Suitable.Case_.For_.Treatment.pdf

60. https://policyexchange.org.uk/wp-content/uploads/The.NHS._A.Suitable.Case_.For_.Treatment.pdf

61. Patrick Jeurissen and Hans Maarse, *The Market Reform in Dutch Healthcare: Results, Lessons and Prospects*, 2021 p52

campaign including websites, newspaper articles, media interviews and advertising – as well as a series of smaller explainer leaflets.⁶²

Patients were given the opportunity to move to a new insurance provider at the end of 2005 (extended into early 2006). If patients did not choose to move then when the new system was introduced in 2006 the cover they started out with was automatically covered by their existing Sick Fund or Insurer.

The first year saw high levels of switching at 19% driven by extensive Government information campaigns, highly competitive pricing, and marketing from insurers. The threat of fines for those not taking out insurance also played a significant role in driving consumer interest and behaviour.

As of 2019, 50% of all consumers had never switched their insurance provider while the new system has been in place, whereas at the other end of the scale, 4% have switched multiple times with higher levels of switching being seen amongst younger people, people with better health or people with better education. Levels of switching have fluctuated in recent years between 6%-7%. Evidence suggests insurer awareness of consumer price-sensitivity has caused them to have a strong focus on cost-containment during this period.

In the first year of operation of the new system there was a rapid drop in the number of private health insurers, from 58 in 2005 to 33 by the end of 2006. This was a result both of market consolidation, with smaller insurers selling up to larger ones, and of Sick Funds being able to close the separate insurance businesses they had been required to run under the old system. This consolidation has continued since then – with 24 insurers operating by the end of 2019 – with over 80% of the market now being concentrated amongst the four largest insurers.

At the same time there has been a proliferation in the range of plans open to consumers and there were 59 different options available by the end of 2019.

Key points from interview with Mr Hans Hoogervorst, Former Minister of Health, Welfare and Sport in The Netherlands, May 2003 – February 2007

One of the most important figures in the changes which took place in the Dutch healthcare system in the crucial 2004-2006 period was the then Minister for Health, Welfare and Sport, Mr Hans Hoogervorst. It was Mr Hoogervorst who was responsible for shaping the reforms, gaining political and popular support for them, communicating them and determining the strategy and timing used to roll them out.

Policy Exchange has carried out an exclusive interview with Mr Hoogervorst which has helped to shape this paper. The authors are sincerely grateful to Mr Hoogervorst for his time and insights. A condensed summary of his main reflections on healthcare reform in the Netherlands and advice to UK policymakers is set out in Figure 2 below.

62. https://www.researchgate.net/publication/228233364_Universal_Private_Health_Insurance_in_the_Netherlands_The_First_Year

Figure 4 – Reflections from Mr Hans Hoogervorst, former Minister for Health, Welfare and Sport during the period of healthcare reform

On the reform experience in the Netherlands

Mr Hoogervorst highlighted the significant long-term public interest in healthcare as an issue in the Netherlands – that it consistently appeared as a major issue in opinion polls but also that there were widespread concerns about funding and the financial impacts of any possible reforms.

He pointed to the importance of the previous attempts at reform in the previous decades in making it easier to have the conversation with the public about reform, whilst emphasising how even then it remained a very difficult issue politically and that his and his colleagues’ experience of navigating the then highly fractious world of Dutch legislative politics was essential in ensuring its success, and avoiding potential pitfalls that might have stopped less experienced politicians.

He emphasised the importance of the steadfast top-level political commitment from all three of the then coalition partners to ensure that the reforms succeeded and were able to bed-in following changes in coalition partners in subsequent years.

Helpfully, all three coalition partners agreed on the set of principles which should guide the system and were prepared to be quite radical and to avoid the politically easier but less rigorous social democrat approaches previously explored. This meant for example that, while subsidies and support were put in place for very low earners and for children, they were able resist proposals for even more subsidies and state funding which would have undermined the incentives the system depended on.

Mr Hoogervorst emphasised the importance of the tax cuts and savings for individuals which the Government introduced at the same time - “the oil in the system” - so that it was possible to demonstrate how people were better off, or how additional costs would be mitigated (for example for younger people who may otherwise have been able to secure lower insurance premiums) while also pointing out that getting the system right should benefit everyone in the long-term. He emphasised how important clear, transparent information about these costs was in building trust in and credibility in the system even though there were inevitably still scare stories and exaggerated concerns in some quarters about additional costs.

Overall Mr Hoogervorst was pleased with the outcome in the Netherlands while accepting that it was never going to be a “miracle cure” and that some hospitals continued to have too much market power in many cases, making it difficult for insurers to negotiate about potentially excluding them from their networks. He was also pleased with the public reaction as they saw that fears about potential impacts were misplaced.

Overall Mr Hoogervorst was pleased with the outcome in the Netherlands while accepting that it was never going to be a “miracle

cure” and that some hospitals continued to have too much market power in many cases, making it difficult for insurers to negotiate about potentially excluding them from their networks. He was also pleased with the public reaction as they saw that fears about potential impacts were misplaced.

On the outcome

Mr Hoogervorst talked of the importance he placed on the reforms abolishing the two-tier system which had previously existed while still ensuring social cohesion through guaranteed prices. He noted how one of the biggest impacts of the reforms was to instil a lot more cost-consciousness in the whole system and in particular how insurers worked hard to reduce their own internal costs while also negotiating hard to secure better value from hospitals. He explained how GPs were also playing an important role in improving effective prescribing (including increased use of generic alternatives to branded medicines) and referrals and managing demand.

He explained how the effect of these reforms has been to considerably constrain cost-inflation over time, despite the pressures of an ageing population and medical inflation from driven by innovation and new treatments.

He was also pleased to see the amount of switching which takes place every year as consumers shop around for insurers – giving incentives a strong incentive to remain attractive to consumers on price and quality.

Advice to UK policymakers

Mr Hoogervorst expressed his surprise at the lack of current political debate in the UK about the future of the health service and the challenges of the current institutional structure. As such he noted that moving to the Dutch-style social insurance system would be enormously difficult – much more so than was the case for his Government twenty years ago.

He noted the difficulty in getting more price awareness into the UK health system – for patients in particular – with the perception of healthcare as being “free” even though it is increasingly costly, and because so many lower earners in the UK contribute comparatively little in tax.

Even if UK policymakers decide not to proceed with a full reform programme along the lines of the Netherlands model Mr Hoogervorst advises introducing many more co-payments, charges and deductibles – both as a means of introducing cost-consciousness into the system and incidentally as a way of raising revenue for the NHS. This would still leave a lack of cost-consciousness throughout the system in providers and commissioners.

His main piece of advice though was that if the UK did undertake these reforms that policymakers should go “all in” and seek to minimise the role which general taxation plays and for premiums to immediately assume the key role in funding the system.

4. The outline of a new English system

The Dutch-style social insurance system with universal coverage which we are proposing, and which was outlined in [The NHS, a Suitable Case for Treatment](#), would have the following features:

1. Regulated and assured standards of treatment and access in universal provision: the reformed healthcare system would guarantee universal, affordable coverage, so that no one loses access to treatment or faces unacceptable financial strain to access healthcare. This in turn requires:

- A requirement for a “one price” model for each insurer in which all policyholders are charged the same price regardless of health or risk profile but with insurers being free to compete against each other on price.
- Subsidies towards the cost of insurance policies for those on the lowest incomes.
- A separate funding structure for children out of general taxation.
- Safeguards to ensure that those with long-term conditions or with higher health risk profiles are not penalised or avoided by insurers.
- A role for Government in ensuring high standards of provision, patient safety and more patient-centred provision with greater choice over providers and a consumer orientated well governed market in basic health insurance. As now, the Care Quality Commission (CQC) would play the provider regulator role for quality and safety.
- Universal free-at-the-point-of-use emergency care and treatment provided under standardised conditions.

2. Compulsory insurance with regulated charges and co-payments with insurers covering provider costs and taking associated financial risk: In the proposed system the basic health insurance policy would be compulsory, with people having a choice over which insurer they signed up to (once the system was fully implemented) – with competition taking place over price between insurers, network coverage and other factors such as customer service and reputation. People would pay premiums directly to their insurer. There would be a capped annual excess regulated by Government; this intervention would have the effect of reducing waste in the system and to help generate additional funding.

- Co-payments would operate for a range of services including GP appointments and prescriptions as a further means of managing demand and reducing waste and raising revenue. A new financial product “Health Savings Accounts” would be created as a tax-efficient way for people to put funds aside for co-payments and excesses.
- Prices would be the same for everyone, regardless of individual circumstances or risk factors and insurers would not be permitted to refuse individuals coverage. This would be underpinned by community-risk-rating and risk equalisation, with ongoing Government subsidies supporting the additional costs to insurers associated with covering people with higher health risks.
- This risk-equalisation mechanism would need to function so that insurers who end up with a higher proportion of policyholders with a higher risk profile are not financially disadvantaged and to avoid insurers “cherry-picking” healthier or lower-risk customers.
- The scope for competition amongst insurers would be on the basis of price (to all subscribers) and of providers in their network. Insurers would also have the option to compete on additional services and provision beyond the basic plan but would not be allowed to drop below it.
- Insurers meanwhile will have to be regulated from a financial side by the Financial Conduct Authority (FCA) to ensure that they honour claims correctly, have adequate financial capability and are not engaging in sharp practice at the expense of policyholders and by the Competition and Markets Authority (CMA) to ensure that competitive market pressures apply.

3. Guaranteed services: One of the areas where ongoing Government involvement would be required would be in determining and reviewing the range of treatments and services to be covered in the basic insurance plan. This would include setting out a maximum level of co-payments permitted under the policy. This would be modelled on current core NHS services with some possible exclusions including:

- Requiring a degree of co-payment for GP appointments and prescriptions alongside costs covered by insurers as a means of reducing unnecessary and missed appointments.
- Some elective treatments – potentially including dental care, ophthalmology, and some orthopaedic treatments - could either be covered by voluntary additional policies or through the voucher mechanism set out in *Pulling Teeth*.⁶³

4. Lower tax: The additional funding sources identified in this model would lead to a saving from general tax revenues. This saving would need to be passed on to taxpayers in tax cuts in such a way that they are immediately felt, visible and seen to be both substantial and beneficial to

63. <https://policyexchange.org.uk/publication/pulling-teeth/>

all.

If introduced as a cut in Income Tax or National Insurance then this “health dividend” should be clearly marked on tax returns and payslips as well as highlighted in a communications campaign.

4. Competitive: Essential to the success of the reforms will be introducing competitive pressures in both providers and funders to ensure that efficiencies are found, investments made, innovations sought and productivity generally increased throughout the health service. This means that there need to be sufficient numbers of insurers competing for subscribers that they will be motivated enough to compete on price and quality. It also means that insurers need to have enough market power to be able to exclude providers which are not offering sufficient quality and value. To support this:

- Integrated Care Boards (ICBs) would be converted into regional health insurers along the same lines as happened with the Sick Funds in the Netherlands (in line with proposals in *A Suitable Case for Treatment*).⁶⁴ They would serve as the default insurer at first until new providers enter the market.
- Prior to introducing legislative changes engagement would ideally take place with private insurance providers, trade unions and employers to encourage them to prepare to enter the market.
- Insurers must be given a high level of freedom over which providers they contract with, with the Government and provider both taking responsibility to ensure quality and standards.
- All NHS providers would be converted to not-for-profit foundations, along the lines of what happened in the Netherlands. Also as happened in the Netherlands, new providers like specialist clinics or centres would be encouraged to enter the market, thereby enhancing competition. Providers and insurers would be free to agree their own price tariffs, rates and pay scales.
- Because of the need to ensure an excellent level of emergency service coverage, all emergency service providers including ambulances would need to be incorporated into all networks at a standard universal rate linked by a formula to the prevailing market rates in other parts of the health system.

5. Patient choice driven: Universal coverage and the availability of assured-quality standard treatment would be at the core of the system but in addition people would be able to shop around amongst insurance providers on the basis of price, network coverage and services. In addition, within the parameters set by Government people would be able to choose a higher annual excess in return for lower fees. Insurers or providers would also be able to offer access to additional non-medical services in exchange for agreed fees and a range of financial instruments including savings accounts and cash plans to cover co-payments.

64. <https://policyexchange.org.uk/publication/the-nhs-a-suitable-case-for-treatment/>

6. Co-payments for additional services: While insurers would be required to charge the same rate to everyone for their basic plan they would be allowed to offer higher rates for additional voluntary policies for those who wished to access a wider range of treatments, for non-medical service, as well as discounts for those who participate in specified health schemes or who take preventative health measures like screenings, use certain health apps or if relevant take part in smoking cessation programmes. The Government would need to regulate what individual health actions insurers would be able to adjust premium payments on to ensure that the principle of community-based-risk rather than individual risk was not undermined.

As demonstrated in the Dutch system, a healthcare system with an element of compulsory insurance-based funding can be highly flexible, both adapting to the public policy priorities of the country and the health needs of patients – as well as providing greater certainty about the financial sustainability of the overall health system. In our proposed system the Government would retain the ability to alter the levels of subsidies provided, adjust the cap on permitted excesses, or determine how many services are subject to co-payments and it would retain control over the definition of the services covered by the basic insurance plan.

Towards a new role for Government in healthcare – championing patients’ interests

The result of these reforms would be to fundamentally change the role of the UK Government in the healthcare market along the lines already seen in the Netherlands. Rather than playing the role as the main funder and provider of services, the Government would set the terms for market engagement, determine the extent of compulsory insurance coverage and basic insurance coverage, regulate insurers and providers (including specifying minimum network coverage) and provide the subsidies to cover those without the financial means to fund their own policies and those exempt.

This would have advantages too for both providers and medical professionals – effectively allowing more long-term institutional and financial planning by insulating them against a degree of political decision making, whilst allowing the Government to focus more effectively on the strategic, rather than operational, goals on which the public is most likely to judge it, such as the availability of high quality healthcare and the sustainability of the system which delivers it.

The patient perspective – how the reforms would appear to the health system user

From a patient perspective the key reforms and sequencing would be as set out below.

Figure 5 – Patient experience of reform roll-out

Timing	Patient experience
Pre-election	First contact with and understanding of the reforms as they are set out in speeches, political communications and manifesto(es) by the party/parties which will go on to implement it. Exposure to explicit explanation of the health benefits (e.g. tackling waiting lists, more responsive and flexible treatment, likelihood of access to new treatments, new provider entrants etc) and financial benefits.
100 days post-election	Receive booklets and access to online assets explaining the new system which will shortly be coming into effect, reiterating health benefits and financial benefits.
Four months post-election	Informed about precise tax cuts and rebate associated with the healthcare reforms – announced in the Budget and explained in a “statement” received by all taxpayers setting out the cost of the system we are about to move from. Information also received about which ICB you have been initially assigned to as your insurer and about the new Healthcare Savings Accounts which will help you budget for co-payments and excesses.
Nine months post-election	New system comes into effect. No “Big Bang” moment as initially your “premiums” are collected by HMRC and transferred directly to your insurer (former ICB.) These premiums will be at a universal rate (adjusted for subsidies) so will be at a different rate to previous tax payments (some of which will continue to pay for subsidies) Co-payments and excesses come into effect for certain defined categories of treatment. Tax cuts and rebate come into effect.
One year and four months post-election	Further explanatory booklet received explaining the financial savings delivered in-year and how these are continuing to fund the tax cuts announced last year.
One year and nine months post-election	As new healthcare providers enter the market patients will see more choice and variety in treatment options from their insurer.

Two years and four months post-election	Receive a booklet detailing these, the health impact of the reforms so far and setting out next steps with the reforms and encouraging consumers to consider whether to switch insurance provider in the next phase.
Two years and nine months post-election	Benefit from choice – the option of changing insurance provider. Competition very likely to drive down prices even for those who do not switch. Entry of new insurance providers into the market, consumer competition over insurance provider. Premiums now need to be paid directly to insurers. Fines also come into effect for those not taking out a policy.

Social care

While the social care system is also in significant need of reform these measures would apply to the health system only. Social care would need a separate set of reforms.

5. Getting it done in England: lessons from the schools revolution and previous healthcare reforms

To support the translation of the success of the Netherlands' healthcare reforms to England we have drawn on insights into two contrasting public service reforms in this country – one highly successful set of reforms outside of health (the “Schools Revolution” of the early 2010s) and one salutary lesson from attempted reform in healthcare – the Lansley reforms which happened at a similar time. The “Schools Revolution” was carried out in the early years of the Coalition Government in the early 2010s. With the new structures of the English school system demonstrably having a successful lasting system impact⁶⁵ it is widely seen as one of the great successes of that Government in their impact on raising standards and improving outcomes as borne out by the international performance data⁶⁶. By contrast the Lansley healthcare system changes were both highly controversial at the time (as were the education reforms) but have seen substantial change and overhaul in every aspect since then.⁶⁷ Based on interviews with figures involved in both sets of reforms this section seeks the key lessons in order to identify key elements which must be included in the healthcare reform road map in addition to those already derived from the experience in the Netherlands.

Having a public mandate for change

“You need to identify the fundamental problems with the current system – the reason our reforms were successful was this identification of the ideology of progressivism as the principal cause of declining standards in our state schools”

Rt Hon Sir Nick Gibb, Former Schools Minister, Policy Exchange interview

Part of what made the education reforms so successful was that they built on well-articulated public concerns and a clear analysis of existing problems and explanation of how the policies would address them. Even those who opposed the proposed measure understood clearly what the Government was trying to achieve.⁶⁸ The then Education Secretary, his team, and their wider supporters in civic society were clear that English schools were not performing well enough by international standards and

65. <https://policyexchange.org.uk/wp-content/uploads/Academies-and-Free-Schools-in-England.pdf>

66. <https://worldpopulationreview.com/country-rankings/pisa-scores-by-country>

67. <https://www.bmj.com/content/372/bmj.n377>

68. <https://www.bbc.co.uk/news/education-11822208>

that they were not providing enough children with a high enough quality start in life.⁶⁹ Behind this there was considerable body of analysis of the reasons for the failure of the system which existed at the time.⁷⁰ There was also a widespread popular belief that children were not getting a good enough education and that schools were “dumbing down⁷¹ and significant research suggesting that this was the case⁷².”

There was a great degree of coherence and clear principles in the education reforms: choice, autonomy and accountability and a vision for a new role for the state – not as an improvement mechanism but as a means of ensuring accountability and responding to provider failure – adopting very rigorous measures to determine whether schools were succeeding or failing and allowing new leadership teams or providers to step in if needed and a new national curriculum and more of a standardisation over the subjects and methods which were expected to be taught.

Demonstrating the clarity of vision, Rachel Wolf, a former Advisor to the Prime Minister on Education observed in an interview with Policy Exchange that:

“There was a fairly consistent thread throughout the reforms: trying to embed a combination of choice, autonomy and accountability. Those were the three key pillars.”

There was strong and organised opposition to the reforms and public opinion was very divided about the particular policies which the government was pursuing, but extensive efforts were made by the then Shadow Education team ahead of the election to highlight their analysis of the root causes of the issues in education, while during the election campaign itself the reforms were extensively debated and both coalition parties saw it as a central policy priority in their discussions and ultimately in the Coalition Agreement.⁷³

This contrasts significantly with the situation in the lead up to the Lansley reforms - in the health service there wasn't an overwhelming case for change. Public support for the NHS was at all-time highs⁷⁴ and it was not clear to many people that Ministers had a clear diagnosis of what the main problems might be or what was causing them.

As Bill Morgan, former Special Advisor to the Rt Hon Andrew Lansley MP as Secretary of State for Health, observed in our interview:

“I think you need to have a compelling case for change whenever you're doing any health reform, which frankly we didn't have because the NHS had the very highest satisfaction rates in its history.”

The Government's White Paper - *Equity and Excellence: Liberating the NHS* contained a very specific outline of the reforms and set out some theoretical underpinnings but these were not sufficiently tied to current widely perceived issues.⁷⁵

While the Conservative Party manifesto in 2010⁷⁶ included the policies which were to become the Lansley reforms, the Coalition Agreement did not and severe difficulties arose through attempts to merge these policies

69. <https://www.gov.uk/government/publications/the-importance-of-teaching-the-schools-white-paper-2010>

70. <https://www.gov.uk/government/speeches/the-purpose-of-our-school-reforms>

71. <https://www.theguardian.com/education/2009/aug/17/a-levels-results-standards-ib#:~:text=Under%20the%20Conservative%20plans%20schools,against%20applicants%20at%20admission%20time.%22>

72. <https://policyexchange.org.uk/publication/risng-marks-falling-standards/>

73. https://assets.publishing.service.gov.uk/media/5a74a4b3e5274a5294069025/coalition_programme_for_government.pdf

74. <https://www.bbc.co.uk/news/health-12805586>

75. <https://www.gov.uk/government/publications/liberating-the-nhs-white-paper>

76. <https://general-election-2010.co.uk/2010-general-election-manifestos/Conservative-Party-Manifesto-2010.pdf>

with related but different proposals in the Liberal Democrat manifesto.⁷⁷⁷⁸

This meant that once implemented the reforms found it challenging to win public support or to command sustained backing from politicians.

It would be essential for a successful reforming party or parties to have made the case for the benefits of the Dutch-style social insurance system and what they could mean for patients in England for a considerable period of time ahead of an election to secure a clear mandate to act.

This in turn would allow for the development of a new ethos and philosophy for the system – which has played a key role in sustaining the reforms after all of the policymakers responsible have left office.

Building grass-roots, professional and institutional support

“We had a serious cadre of reform minded education leaders. We had head teachers and teachers who wanted to set up new schools. We had parents who wanted a new school in their community and head teachers who wanted the chance to take over other schools and turn them around. It was all done through those people. A critical way to deliver these kinds of reforms is by having a vanguard of reform minded practitioners who are willing to be your spokespeople for it.”

Rachel Wolf, founder of The New Schools Network and former Advisor to the Prime Minister on Education

During the years before the 2010 election the then Shadow Education team spent considerable time on the front-line visiting schools, improving their understanding of how the schools system worked but also meeting education professionals and building their contacts with those who shared the same enthusiasm for reform and higher standards.⁷⁹⁸⁰⁸¹ They discovered that many education professionals and parents were already looking for an opportunity to secure improvements in standards and were prepared to work with them.⁸²

Grass-roots organisations of people supporting free schools and seeking to set them up – including teachers, parents and charitable interests – started to appear locally and nationally and they had some degree of success in securing national media coverage.

This wider ecosystem was seen as essential by reformers – both in terms of providing non-politicians to make the case for the proposed changes and also in acting as a source of intelligence about how the reforms were playing out on the ground and what was being said about them. It also ultimately provided a source of recruits for supportive experts to assist with implementation in Government.

There was also strong and organised opposition to the reforms and public opinion was very divided about the particular policies which the government was pursuing but crucially in education the debate was more balanced – there were respected professional voices on both sides which ultimately helped to win over public opinion, as well as making the

77. https://assets.publishing.service.gov.uk/media/5a74a4b3e5274a5294069025/coalition_programme_for_government.pdf

78. <https://www.kingsfund.org.uk/insight-and-analysis/reports/never-again-health-social-care-act-2012>

79. <https://www.markgarnier.co.uk/news/shadow-secretary-state-education-michael-gove-meets-local-wyre-forest-teachers>

80. http://news.bbc.co.uk/local/shropshire/low/people_and_places/newsid_8647000/8647393.stm

81. Reforming Lessons: Why English Schools Have Improved Since 2010 and How This Was Achieved, Sir Nick Gibb, August 2025

82. <https://www.newschoolsnetwork.org/about-us/our-history/>

reforms more well-informed and successful.⁸³⁸⁴⁸⁵

By contrast in healthcare the debate was rather more one-sided, with healthcare reformers we spoke to identifying the lack of consistent support amongst the profession as a very significant difficulty. GPs favoured some of the proposed fundholding measures but were much less keen on the measures to promote competition in primary care for patients, while the views of clinicians in hospitals were almost the inverse – supporting the greater freedoms which foundation trusts were being offered but being suspicious of the fundholding model.

This meant that although some professional groups supported some distinct elements of the reforms, overall reformers in Government were largely on their own in making the case for the reform package.

Detailed preparatory work – getting the key governance and legislative documents right

“It is a really important to go in as prepared as possible. What we did in opposition was detailed planning: writing the draft legislation, writing the application form for free schools before we got into power, etc.”

Rachel Wolf, founder of The New Schools Network and former Advisor to the Prime Minister on Education, interview with Policy Exchange

A critical factor for the success of the reforms in education was the efforts which were made by reformers to be as prepared as possible before assuming office – engaging in detailed planning before going in to Government, drafting key legislation and governing documents wherever possible in advance and identifying a wide network of trusted experts who could be worked with to develop, test and ultimately to help implement the reforms.

In addition to this it is clear that a strong and relentless attention to detail throughout the process was needed – with thousands of documents involved in policy implementation it was pointed out to us by reformers that one detail missed could have a very detrimental impact on the whole implementation of the policy. This once again points to the need for a strong network of trusted experts to help with this.

As Rt Hon Sir Nick Gibb observed to Policy Exchange in our interview:

“You have to be in the weeds of the detail. You’ve got to be focused –you’ll get hundreds and hundreds of documents about implementing the policy. You have to not just read them, you have to be totally immersed in them and understand what they’re doing, because they will be wrong. I promise you they’ll be wrong. They will not be properly implementing the things you’re trying to do or one document could bring the whole thing down. And you need a network of trusted experts to help guide you through it.”

In health this is perhaps another manifestation of the lack of wider professional and grassroots support available to ministers. In addition,

83. <https://www.bbc.co.uk/news/education-16409940>

84. <https://www.theguardian.com/politics/2010/aug/18/coalition-cracks-education-reforms-poll>

85. <https://www.youtube.com/watch?v=Xek-kQ3HG2lg>

while the direction of policy was clear, the exact policy prescriptions to implement them were not even clear to those with responsibility for them.⁸⁶ As a result, potential alternative implementation methods for the policies were surfaced after considerable work had already been done on the reforms.⁸⁷ Ministers ended up conceding that their reforms were not popularly understood or well communicated and Government was ultimately forced to “pause” the passage of legislation to reset engagement and to allow for changes to address concerns which had arisen while it was passing.^{88,89}

While the Government did succeed in carrying through the relevant legislation, after a change in Health Secretary no significant attempt was made to see them through. It is likely that a more effective initial alignment of the governing parties’ policies into a detailed policy platform and greater engagement with the sector in the early days of the Government could have avoided considerable pain later in the process.

Early and focussed legislation

“Generally, reform works better if you do it very fast, because quite rapidly “hated reform” becomes “the new status quo” and you need that to happen before the next election. So you have to get everything done in your first six to nine months. I think that is often underestimated.”

Rachel Wolf, founder of The New Schools Network and former Advisor to the Prime Minister on Education, interview with Policy Exchange

Within weeks of the Coalition Government assuming power in 2010 it had already presented what became the Academies Act to Parliament (on 26 May), securing Royal Assent on 27 July and proceeded to move on at great pace with the legislation designed to permit the structural changes which were vital for the large-scale school reforms to succeed.⁹⁰

Because this legislation was moved so early in the new Parliament there was plenty of time for changes to take effect and for schools to convert to academies and to start producing results before the next general election and for the Education team to move on to the subsequent phases of their reforms including teacher training⁹¹, structural changes⁹², reform of the National Curriculum⁹³, changes to Ofsted⁹⁴ and the introduction of new teaching methodologies⁹⁵ – all of which were designed to complement and support the Government’s central goal of higher standards.

We note from interviews with those involved in the Lansley reforms that the lack of legislation in the early days of the coalition was seen as a major disadvantage, leading to a far wider Act needing to be passed later on in the Parliament – by which time the Government had already lost some of its initial “political capital” and momentum whilst opposition had become more organised. Some of the consequences of this were set out above in the difficulty the Government faced in navigating the Health and Social Care Act 2012 through Parliament.^{96,97} Consequently the movers

86. <https://www.instituteforgovernment.org.uk/ministers-reflect/andrew-lansley>

87. <https://www.bbc.co.uk/news/health-12170336>

88. <https://www.bbc.co.uk/news/health-13063285>

89. <https://www.theguardian.com/society/2011/apr/06/government-pause-listen-reflect-improve-nhs-reform>

90. <https://bills.parliament.uk/bills/642>

91. <https://assets.publishing.service.gov.uk/media/5a7b4029ed915d3ed9063285/CM-7980.pdf>

92. <https://www.gov.uk/government/organisations/qualifications-and-curriculum-development-agency>

93. <https://assets.publishing.service.gov.uk/media/5a7b404c40f0b66a2fc062b1/DFE-RR178.pdf>

94. <https://www.gov.uk/government/publications/2010-to-2015-government-policy-inspections-of-schools-colleges-and-childrens-services/2010-to-2015-government-policy-inspections-of-schools-colleges-and-childrens-services>

95. <https://www.gov.uk/government/publications/year-1-phonics-screening-check-pilot-evaluation>

96. <https://www.legislation.gov.uk/ukpga/2012/7/contents>

97. https://www.ucl.ac.uk/social-historical-sciences/sites/social_historical_sciences/files/2011-defeat-24.pdf

of the Bill had less time to implement the associated reforms in office and significant elements of the reforms remained unimplemented by the time of the next election.

As Bill Morgan observed to Policy Exchange in our interview:

“In hindsight it would have been preferable to take forward a rapid paving Bill shortly after the 2010 election, in order to take advantage of the post-election honeymoon period to implement pro-competition measures. It’s best to act quickly on controversial measures when political capital is high.”

Political support from the Prime Minister downwards

“It is definitely true that support from the top is needed. Michael Gove was fundamentally respected and rated by Cameron and Osborne.”

Rachel Wolf, founder of The New Schools Network and former Advisor to the Prime Minister on Education, interview with Policy Exchange

“The leadership was absolutely essential. It really was. I don’t think we could have done what we did without not just the backing, but the understanding of what we were doing. And Cameron really understood what we were doing because he had been Shadow Education Secretary for six months (just prior to becoming Conservative Party Leader). This thinking about the damage of progressivism was happening even then. So with any controversy that we generated, we knew we had the backing of the Prime Minister.”

Rt Hon Sir Nick Gibb, Former Schools Minister, Policy Exchange interview

Top level political support was vital to the chances of success of the different reform programmes – and clearly something which was in place with the education reforms. A great deal of trust was placed in Michael Gove personally by the Prime Minister and Chancellor. Both the reformers and their party leaders were very clear about what the reforms were trying to achieve – in clear contrast to many attempted structural reforms in health. This made a difference when the reforms came under outside criticism as ministers and their teams knew that they would be backed in education.

In health the Prime Minister repeatedly publicly backed both the reforms and the Health Secretary. There were however persistent media leaks expressing the Prime Minister’s unhappiness with the responsible Minister and the Deputy Prime Minister and his party made efforts to distance themselves from the reforms while ensuring that they were very associated with the pause to them.⁹⁸

The fact that the Health Secretary was replaced in the months after the legislation passed could also be seen as evidence that the Prime Minister’s confidence was not as deep as it was in education.⁹⁹

98. <https://www.theguardian.com/society/2012/feb/08/cameron-lansley-nhs-reform-bill>

99. <https://www.bbc.co.uk/news/uk-politics-19472688>

Demonstrating success and value

“Unfortunately, however, it is not the case – I wish it were – that you get the policy right and the politics comes with it. So, you have to get the politics right.”

“NHS England, from the government’s point of view, is an enormously successful innovation... it does hold providers to account now in ways that the Department for Health was never capable of doing... They can set a 10-year strategy. In 2019, they published a 10-year plan. The NHS has never had such a thing before. The NHS requires NHS workforce plans, and they’ve never had one before, and NHS Education, and now NHS England working with NHS Education, will develop that. A 10-year plan for the NHS will be a striking long-term change for the NHS, and that will be the principal legacy from the 2012 Act.”

Rt Hon Lord Lansley, Secretary of State for Health 2010-2012¹⁰⁰

The education reforms benefited from the fact that there were some fairly rapid and observable outcomes resulting from their policies.¹⁰¹ While not all academies succeeded many, including all of the most high profile new free schools did – and did so in ways which could be easily understood by most people. The outcomes were rapid, measurable, understandable and lasting.¹⁰²

There were high profile examples of academies in deprived areas, and which had previously been performing badly, achieving highly impressive exam results and getting large numbers of children into Oxbridge.¹⁰³

There was substantial system-wide evidence to demonstrate the success of the policies too. Between 2009 and 2023, England’s performance in global PISA rankings has improved from 27th to 11th in maths and from 25th to 13th in reading, with academies and free schools dominating the rankings for measures of value added and with schools forced to academise being more likely to show rapid improvement than local authority run schools.¹⁰⁴

By contrast, in healthcare the evidence of improvement was highly contested – while waiting times during the course of the Coalition Government did reduce on some measures, the number of people on NHS waiting lists increased from 2.5 million to 3 million.¹⁰⁵ Public satisfaction with the NHS fell by 10 percentage points over the same period from 70% to 60% and dissatisfaction rates increased.¹⁰⁶

These changes were not necessarily linked to the reforms which took place, yet it is inevitable that in the public’s mind the reforms would be measured on such measures.

There is a case for the systemic benefits of some of the healthcare reforms of the early 2010s but without full implementation and demonstrable evidence of success which could be felt by patients and clearly articulated in the media it was not possible to sustain the reforms. This reinforces the earlier point about the need for deep and detailed system understanding and rigorous oversight.

100. <https://www.instituteforgovernment.org.uk/ministers-reflect/andrew-lansley>

101. <https://policyexchange.org.uk/publication/a-rising-tide-the-competitive-benefits-of-free-schools/>

102. <https://www.gov.uk/government/speeches/michael-gove-speech-on-academies>

103. <https://www.hackneygazette.co.uk/news/22945749.mossbourne-gets-record-breaking-set-a-level-results/>

104. <https://policyexchange.org.uk/wp-content/uploads/Academies-and-Free-Schools-in-England.pdf>

105. <https://www.bbc.co.uk/news/election-2015-32130437>

106. https://assets.kingsfund.org.uk/f/256914/x/6667869380/public_satisfaction_nhs_bsa_summary_2015.pdf

6. The Operational road map: delivering a Dutch-style social insurance system

Based on the review of the Dutch experience of healthcare reform above and the interviews with reformers in health and education a comprehensive and fully deployable road map has been developed which is set out below.

The intention behind this road map is to provide a future reforming minister of any party and their team with an approach which can be adopted. It is developed on the assumption that a Government would require a fresh democratic mandate to undertake reform on this scale and that significant preparatory work would be needed to build-up public support, to allow reformers to hit the ground running and to avoid getting bogged down in detailed drafting discussions, tangential issues or in heated debates. As such the proposed actions start in the year before a General Election, either in Government or in opposition, guiding them through the reform process and the crucial years after the reforms are implemented and as they bed-in.¹⁰⁷

The key implementation measures would take place over three phases as follows:

Phase 1:

- Securing the mandate
- Key underpinning legislation
- ICBs to be repurposed as insurers and to have patients initially assigned to them
- Establishing the Basic Plan for social insurance and setting up the Office of Community Risk to oversee community risk equalisation
- “Premiums” come into effect (although initially collected by HMRC)
- Co-payments and excesses introduced
- Tax cuts and rebates come into effect
- Introduction of Healthcare Savings Accounts

Phase 2:

- Removal of price controls and tariffs for healthcare providers

107.NB – these proposed reforms address the health system only and social care would need a separate set of measures.

- Entry of newly licensed healthcare providers
- Abolition of pay scales system in healthcare

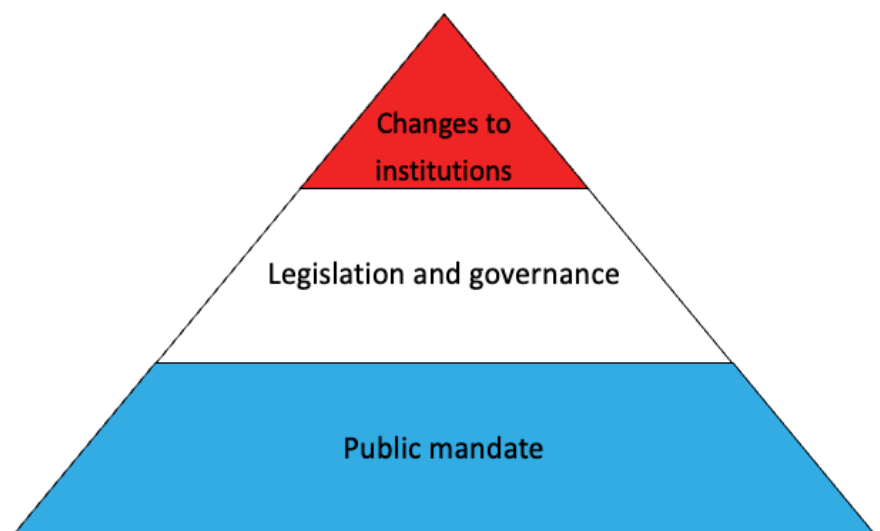
Phase 3:

- Entry of new insurance providers into the market
- Insurance providers free to compete on price
- Introduction of patient choice over insurance provider
- Insurers start collecting premiums directly
- Fines for not taking out policies introduced

There are three key strands to the plan which need to operate and roll-out in parallel they are:

1. Key legislative and governance requirements
2. Reshaping institutions and regulators to deliver the new system
3. Securing and sustaining a public mandate

Figure 6 – relationship between key elements of the road map



While the legislative and governance changes are ultimately at the core of the new system, they will depend in turn on the institutions and regulators being reshaped in order to deliver them, while all of this will rest on a Government securing and maintaining the popular mandate which is absolutely essential to driving through these reforms.

A topline summary of the key steps to secure implementation of the reforms is provided in Figure 3 below. Each of these steps is considered in detail below and is broken down into three phases.

The indicative and illustrative timings for these dates all relate to the day after a General Election in which a hypothetical Government has been elected with a mandate to undertake these reforms.

Figure 7 – Road map provisions and timings

Timing	Phase and sequential order	Step	Category/ purpose
(Minus 365 days)	1.1	Keynote speech from Party Leader kicking-off an extensive dedicated communications campaign stating intention to make major healthcare reform a key priority in the next Parliament and setting out the health and financial benefits.	Securing and sustaining a public mandate
(Minus 180 days to minus 90 days)	1.2	Develop, undertake and stress test financial modelling of new system with impact set out on all income levels.	Securing and sustaining a public mandate
(Minus 180 days to minus 90 days)	1.3	Work with external experts to develop Risk Equalisation Formula.	Reshaping institutions
(Minus 180 days to minus 90 days)	1.4	Draft Basic Plan (the core compulsory health insurance policy) with expert input.	Reshaping institutions
(Minus 180 days to minus 90 days)	1.5	Pre-engagement with relevant institutions and regulators and pre-brief civil servants on intentions.	Reshaping institutions
(Minus 60 days)	1.6	Clear manifesto commitment to a Dutch-style social insurance system with tangible health and financial benefits.	Securing and sustaining a public mandate
Day 1	1.7	Establish and appoint to key civil service bodies and re-allocate civil service resource: <ul style="list-style-type: none"> • Director General as senior executive policy owner at DHSC • Policy Implementation Unit to oversee and roll-out the reforms • Policy Resilience Unit to secure the reforms 	Reshaping institutions

		against legal and policy challenges.	
Day 1 to Day 90	1.8	Repeat contact programme with relevant institutions and regulators to instruct them.	Reshaping institutions
Day 1 to Day 30	1.9	Establish, and appoint Chair to shadow Office of Community Risk to begin preparatory work in advance of formal authorisation from legislation.	Reshaping institutions
Day 1 to Day 30	1.10	Begin appointments programme for outside experts at DHSC.	Reshaping institutions
Day 7	1.11	Introduce Health (Access and Funding) Bill.	Key legislation and governance
Day 30 to Day 150	1.12	Engagement with providers – ICBs, insurers and new providers encouraging them to enter the market.	Reshaping Institutions
Day 90	1.13	Pass Health (Access and Funding) Act.	Key legislation and governance
Day 100	1.14	Issue booklet and associated online assets explaining new system to all households and the health benefits.	Securing and sustaining a public mandate
Day 120	1.15	First Finance Act/ Budget of new Government to legislate for: <ul style="list-style-type: none"> • tax cuts and rebate associated with reforms. • Creation of new Healthcare Savings Accounts • Creation of the temporary system of transfers from HMRC to ICBs for premiums. 	Key legislation and governance
Day 120	1.16	HMRC to issue statements to all taxpayers setting out the cost of current health services in tax, communicating the level of transfers to take place to ICBs under the new system, details of tax cuts and rebates, details of which ICB	Securing and sustaining a public mandate

6. The Operational road map: delivering a Dutch-style social insurance system

		they would be assigned to as their initial insurer and how they will be likely to benefit under the new system.	
Day 270	1.17	<p>Phase 1 implementation date:</p> <ul style="list-style-type: none"> • ICBs formally assume new roles • “Premiums” come into effect (although initially collected by HMRC) • Co-payments and excesses introduced • Tax cuts and rebates come into effect. 	Reshaping Institutions
Day 485	1.18	Further explanatory booklet covering financial savings and next steps in healthcare reform and outlining the impact of the reforms so far to be issued after second Finance Bill/ Budget.	Securing and sustaining a public mandate
Day 635	2.1	<p>Phase 2 implementation date:</p> <ul style="list-style-type: none"> • Removal of price controls and tariffs for healthcare providers under the provisions of the Health (Access and Funding) Act • Commencement date for newly licensed healthcare providers under the terms of the Health (Access and Funding) Act • Issue Ministerial circular abolishing pay scales system in healthcare. 	Key legislation and governance
Day 850	2.2	Further explanatory booklet covering financial savings and next steps in healthcare reform and outlining the impact of the reforms so far and encouraging consumers to consider whether to switch insurer in the next phase.	Securing and sustaining a public mandate

Day 1000	3.1	Phase 3 implementation date using powers delegated under the Health (Access and Funding) Act: <ul style="list-style-type: none"> • Entry of new insurance providers into the market. • Insurance providers free to compete on price • Patient choice over insurance provider • Insurers start collecting premiums directly • Fines for not taking out policies introduced 	Key legislation and governance
Day 1180	3.2	CMA to be instructed to start full market study in new health insurance and provider system	Key legislation and governance

1. Securing and maintaining a public mandate

The legislative, governance and institutional changes set out will not in themselves be sufficient to secure the success of the reforms. In order to maximise their chances of securing Parliamentary consent and then to ensure that they can outlast any reforming Government a very high degree of public support is required.

So important is this support that this paper assumes that these changes can only be achieved by a Government which has just secured an explicit democratic mandate for them in an election based on a clear popular understanding of the health and financial benefits and on which the Government could ultimately therefore invoke the Salisbury Doctrine if needed.¹⁰⁸

In the first phase:

- **A clear manifesto commitment to healthcare system reform is absolutely vital.** The party or parties committed to healthcare reform of this scale need to spell-out explicitly what they are proposing – drawing on the processes set out above and on the success of the Dutch social insurance system. **This should build on an earlier extensive communications campaign starting with a keynote speech from the party leadership stating a clear intention to make healthcare reform a major policy goal of the next Parliament and including explicit explanation of the health benefits (eg tackling waiting lists, more responsive and flexible treatment, likelihood of access to new treatments, new**

108. <https://www.parliament.uk/site-information/glossary/salisbury-doctrine/>

provider entrants etc) and financial benefits.

- This manifesto commitment would make it easier in Parliamentary terms – to secure the ongoing support of the Government’s own MPs and to reduce the chances of entrenched opposition in the Lords. It would also help to undermine institutional opposition and help to justify the rapid rate of progress set out above.
- Securing a mandate for this policy should start by clearly rooting reforms in widely held public concerns about the current health system, in particular universal coverage and explaining in clear understandable terms how the reforms will address these issues.
- In order to reassure the public that the aspects of the NHS which people value the most will be retained, it is essential that a clear statement of those principles which will be preserved, and those new ones which will be introduced, is set out right from the start of the policy development and clearly communicated at all opportunities until there is a degree of public recognition of them. This should include featuring them in Election Manifestos, in relevant speeches and in official communications about the policy as it rolls-out.
- Parties committed to major health reform would be well advised to do considerable groundwork on this base in the years ahead of an election, helping to build up the evidence base about the unsustainability of the current system, shining a light on how it is letting patients and medical professionals down and building as much of a consensus as possible that major change is needed. Parties should also be testing specific language and ways of presenting the policy with focus groups and be refining these with a view to the election manifesto and election communications.
- Post-election it is also important the Government communication channels are used to explain the policy and its benefits clearly to the public and that they continue to do so as the policy rolls-out and during the first year of its operation. Building on the Netherlands experience, **ministers should consider issuing explanatory booklets and web content about the new policy as the legislation underpinning the reforms passes Parliament** – reassuring people and encouraging them to take advantage of insurer choice when they have the option in future.
- Emphasis should be placed in these communications on the extent to which the reforms empower people as consumers, giving them a choice without presenting them with a cliff-edge or “big bang” moment in which they are forced to make major choices or decisions if they are concerned about doing so. While major policy change is taking place, and quickly, that people would initially remain with their ICB and later would have the option of maintaining a degree of continuity and easing into the new system without being forced to make any decisions if they preferred not to.

- Also, as recommended in our previous paper, *A Suitable Case for Treatment*, raising awareness of the cost of current NHS services to taxpayers would be essential for building support for reform.¹⁰⁹ This could be achieved by **HMRC starting to send each taxpayer a breakdown of their annual tax bill including an estimate of the amount of their tax currently going towards the health service under the status quo ante**. It should also include a calculation of the average cost of healthcare per head (minus that proportion of costs which would be covered by co-payments and excesses) labelled as a premium, with a corresponding amount transferred to the new insurer by HMRC directly. For low earners this would demonstrate the subsidy their insurer is receiving towards their premium beyond what the taxpayer is paying, with associated transfers happening from HMRC. For higher earners it would include a calculation of the subsidy they are contributing.
- The first Budget after the introduction of the new system should also include tax cuts and an in-year rebate to taxpayers representing the savings from co-payments, excesses and efficiencies which are expected in the first year and these should also be communicated directly to taxpayers alongside plans for further tax cuts arising from reforms in Phases 2 and 3.

In the second phase:

- Communications about the health and financial benefits of the new system should continue, including explanations of the further tax cuts arising from further provider competition with and also setting out the timeline of what is happening with the reforms and further online materials being rolled out.
- As phase 3 approaches this communications campaign should intensify to alert people to the choices of provider they will have and making sure that they are aware of the date from which they can make choices.

In the third phase

- This high intensity communications campaign should continue throughout the Parliament with a focus both on the health benefits and on the ongoing financial savings. Ministerial speeches should be used to present these reforms as one of the Government's major achievements going into the next election.

2. Key governance and legislative requirements

Implementing the statutory and administrative changes needed for the new system will require a number of specific actions to be carried out and crucial governance documents drafted as set out:

In the first phase:

¹⁰⁹https://policyexchange.org.uk/wp-content/uploads/The.NHS_.A.Suitable.Case_.For_.Treatment.pdf

- **The Health (Access and Funding) Bill.** The core set of changes required to achieve these reforms would be the Health (Access and Funding) Bill which will need to be a flagship piece of legislation moved early in the term of a Government committed to system reform.

Key provisions of this legislation must include:

- Overarching provisions to define the intended model and framework.
- Creating the enabling legislation to give ministers the powers to define (with reference to Parliament) the categories of treatment to be covered by the basic insurance plan, those treatments excluded from coverage and those for which co-payments would be introduced, as well as an annual mechanism to review coverage (again with reference to Parliament) without the need for further legislation.
- Replacing Part 1 Sections 18-32 of the Health and Social Care Act 2022 which established ICBs in their current form to redefine these bodies as regional insurers.¹¹⁰
- Creating the legal requirement for providers of social insurance to maintain the same core prices for all of their customers (while being free to compete with other insurers on price) on the principle of community-risk rating.
- Introducing the powers for insurers, employers, trade unions, charities and other organisations to enter the market of social insurance.
- Creating the criteria for subsidies towards compulsory insurance – our recommendation would be for 100% subsidy rates for under-18s and a sliding scale of subsidies for the least well off 15% of the population.¹¹¹
- Replacing Part 1 Sections 77-81 of the Health and Social Care Act 2022 with new provisions to enable ICBs and insurers to negotiate prices and fee levels with providers and suppliers.¹¹²
- Replacing Part 1 Sections 48-70 of the Health and Social Care Act 2022 to change the status of Trusts and Foundation Trusts to Charitable Incorporated Organisations and to facilitate the entry of new licensed providers into the market, subject to regulation and inspection by CQC with freedom over operations, budget setting, remuneration and pricing.¹¹³
- Amending part 8 of the Health and Social Care Act 2012 to adjust the role of the National Institute for Health and Care Excellence (NICE) so that treatments which secure NICE approval become part of the Basic Plan and permitting insurers or providers to go beyond such guidance if they choose to.¹¹⁴
- Creating the powers for insurers to collect premiums for social insurance and for the Government to issue fines for those who do not take out a policy.
- Establishing a statutory instrument for ministers to define the

110.<https://www.legislation.gov.uk/ukpga/2022/31/part/1/crossheading/integrated-care-boards>

111.[https://commonslibrary.parliament.uk/research-briefings/sn07096/#:~:text=How%20is%20poverty%20measured?,absolute%20poverty\)%20after%20housing%20costs.](https://commonslibrary.parliament.uk/research-briefings/sn07096/#:~:text=How%20is%20poverty%20measured?,absolute%20poverty)%20after%20housing%20costs.)

112.<https://www.legislation.gov.uk/ukpga/2022/31/part/1/crossheading/nhs-payment-scheme>

113.<https://www.legislation.gov.uk/ukpga/2022/31/part/1/crossheading/nhs-trusts>

114.<https://www.legislation.gov.uk/ukpga/2012/7/part/8>

maximum level of excesses and for an annual review of these.

- Defining the legal default, whereby patients who do not proactively move to a new insurer remain policyholders with their current ICB.
 - Introducing compulsory health insurance.
 - Creating the power for fines to be levied for those who do not subscribe to an insurer.
 - Establishing the commencement date for phase 1.
 - Establishing a statutory instrument for determining the commencement dates for phases 2 and 3.
 - Establishing the Office of Community Risk and vesting it with the authority over the risk equalisation system and with the powers to enforce adherence and associated transfers amongst insurance companies.
- **Defining the basic plan:** A template basic plan is provided in Appendix A modelled on the system in place in the Netherlands. It is recommended that something close to this template be consulted on as one of the first acts of the new Government (alongside establishing it in legislation), and that this plan should remain under annual review with clinician input. This should include an annual review of the application of co-payments and the categories of treatment which sit outside of the policy and amendments to the status of NICE guidance so that while treatments which secure NICE approval are within scope of the Basic Plan, that those outside can be covered by insurers or providers if they choose to do so.

Ministers should alert civil servants as to their intentions to define, consult and refine this plan, ideally even before taking office, so that a consultation can progress rapidly alongside legislation.

It is important that the extent of the plan should be seen to be broad and generous to reassure people that they can have confidence in the extent of health cover to be provided.
 - **Risk equalisation, calculating community risk and establishing the Office of Community Risk (OCR):** A new regulator which will need to be established is the Office of Community Risk (OCR). The OCR would be responsible for the formulation and regular review of the formula which will compensate insurers for taking on higher risk individuals at the same price point as others. The intention behind this would be to eliminate the incentive insurers would otherwise have to target lower risk policyholders. The OCR will need to be established in shadow form in the very early days of the new Government and to maintain a clear and transparent public dialogue with insurers. The body should be formalised and authorised with its powers by the Health (Access and Funding) Act set out above.

- **Instructing key regulators: the Care Quality Commission (CQC), the Financial Conduct Authority (FCA) and the Prudential Regulation Authority (PRA) of the Bank of England:**

As set out above, CQC would continue with the role it plays under the current system – and a Written Ministerial Statement could confirm this along with a letter from the Minister setting out expectations in detail.

A separate WMS and letter could be used to confirm that the remit of the FCA covers the new insurers in line with existing duties for consumer protection (including the transitioned PCBs) and the new policies from existing providers.¹¹⁵ The resource implications from this would have to be met by an in-year budget transfer from DHSC funding and should be met in future departmental budget settlements.

A third WMS and letter could be used to confirm that the remit of the PRA covers the new insurers in line with existing duties to ensure financial capacity (including the transitioned PCBs) and the new policies from existing providers.¹¹⁶ The resource implications from this would have to be met by an in-year budget transfer from DHSC funding and should be met in future departmental budget settlements.

- **Budget/Finance Bill:** An essential pre-condition for the success of the compulsory insurance model would be a transfer of the financial burden from taxation to premiums. In order for this not to represent a further financial cost on the British population, the Government would need to convert the proportion of tax receipts currently used to fund the NHS, minus the continuing funds needed to support those exempt from the insurance system) into tax cuts – effective on the same timescales as the premiums system comes into effect and with an in-year rebate in the first year. The reasoning for and calculations of the tax cuts would need to be clearly communicated at the time they came into effect as set out earlier. This would need to be **included and communicated alongside the first Finance Bill or budget of the reforming Government.**

This legislation should also establish the level of, and system for, transfers of funds collected by HMRC to the new insurers (ex-ICBs) including both the proportion of income tax collected being transferred and the subsidies towards the policies of the least well off.

Finally, the Bill should also include provisions to **create Healthcare Savings Accounts, a category of tax-exempt saving products whereby people can save towards co-payments or excesses.**

In the second phase:

115. <https://www.fca.org.uk/publications/corporate-documents/perimeter-report>

116. <https://www.bankofengland.co.uk/prudential-regulation/authorisations/which-firms-does-the-pra-regulate>

- **Departure from central pay scales system:** In order to give providers the flexibility they would need around remuneration, and reflecting the new role DHSC would be playing in the system, the Government would need to **issue a Written Ministerial Statement to abolish NHS pay-scales, abolish the NHS Pay Review Body and end the operation of the Agenda For Change pay bargaining system.**¹¹⁷
- **Removal of price controls:** Ministers should at this stage use the powers provided for under the Health (Access and Funding) Act to liberalise price and reimbursement rates between providers and insurers.
- **Commencement of licences for new providers:** Following a period of pre-authorisation and inspection, new providers should be issued licences to provide health services funded under the social insurance system under powers delegated by the Health (Access and Funding) Act.

In the third phase:

- **Insurer market entry:** Following a period of pre-authorisation and inspection, new insurers should be licensed to provide the Basic Plan under powers delegated by the Health (Access and Funding) Act, and a lead-in period of three months should be used to encourage consumers to consider their provider and to determine whether switching was in their best interests or otherwise.
- **Introduction of direct insurer-to-consumer premium collection:** This phase would also include the introduction under powers delegated by the Health (Access and Funding) Act of direct collection of premiums by insurers from consumers (as well as the payment of subsidies by the Government to insurers for those eligible for support) and the introduction of fines for those who do not take out a policy after warning period of three months.

3. Reshaping institutions and regulators to deliver the new system

In addition to the formal changes to institutions it is at least as important to make sure that the institutions and processes operate in a way which will enable the system to work, that the right people are appointed to key leadership, operational and delivery roles in the current and new system and that all regulators and institutions understand the roles they need to play. This will require the following actions:

In the first phase:

¹¹⁷<https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates>

- **Appointments to key roles and personnel changes**

While clearly due processes need to be followed in relation to appointments, it would be advisable for work to begin early on defining the crucial roles and the capabilities needed to drive change and to identify potential candidates amongst sector and industry professionals and experts who understand the reforms, are committed to them and would be able to enact them on the ground. This would also require significant re-allocation of civil service resources within DHSC to build the capacity needed for implementation.

At the earliest opportunity post-election as many as possible of these reformers should be brought in to key roles in the Government and in health institutions.

Specific key appointments which will need to be made early in the life of the new administration and alongside the Parliamentary progress of the relevant legislation are:

- A Director General within the Department of Health with responsibility for the whole reform programme with an extensive team under them.
- The senior DHSC civil servant with overall responsibility for policy implementation as **Head of the Implementation Unit**.
- Outside specialist advisors including a **Head of the Policy Resilience Unit** and subject matter experts ideally sourced both from within the UK health and insurance sectors and from the Netherlands as well as an advisor dedicated to Parliamentary relations for the Health Bill.
- The **Head of the Office of Community Risk** from a respected health insurance or actuarial background.
- A new **Health Insurance Specialist Director at the FCA**
- A significant number of financial, legal and communications expert appointments to DHSC

Ministers should also closely monitor the performance of all DHSC civil servants involved in the programme and ensure that ICBs are supported with the recruitment they will require.

- **Creation of new units within the Civil Service:** To oversee and conduct the roll-out of the policy a well-staffed **Implementation Unit should be set up**. These should be reinforced over time until a wholesale personnel and cultural shift can be achieved amongst senior managers and key decision makers.

In addition to responsibilities relating to the Basic Plan, Community Risk Calculation and regulator engagement, the Implementation Unit should also be tasked with provider engagement including ICBs and new potential market entrants so that patients would have a wider range of choices and ensuring that patients are all initially assigned the appropriate ICB and informed of such.

In addition, given the unpredictability of judicial preferences and interpretation in the UK any party committed to this kind of reform programme would be well advised to anticipate legal challenges, to prepare for them and to specifically address them in the drafting of the legislation. This should also include identifying well ahead of the election a group of supportive legal and policy experts who can be relied upon to stress test every aspect of the reform programme and in particular the core documents for potential lines of attack and to develop clear and effective responses as far as possible. Post-election the reforming party should look for opportunities to bring these experts into official roles within Government and **rapidly develop a Policy Resilience Unit to respond to legal, stakeholder and policy challenges.**

- **Institutional changes:** The key changes to bodies which will need to be briefed, supported and transitioned to taking on new roles are as follows:

Integrated Care Boards: to be converted into regional insurers, and to serve as default insurers in the first instance, much as happened with the Sick Funds in the Netherlands.

Hospital Trusts and Foundation Trusts: to be re-established as not-for-profit Charitable Incorporated Organisations with more freedom over their operations and remuneration, as well as more commercial opportunities in their negotiations with insurers.

GP surgeries and other primary care practices: those that are not already private businesses should set up as not for profit Charitable Incorporated Organisations. Their role as gatekeepers for the wider system would alter according to the terms of their commercial agreements with insurers – most likely continuing to perform the same role but with a different set of guidance and providers.

Emergency services: To remain as a universal service free at the point of use, now funded at a standardised rate by insurers and subsidies as needed with prices fixed on a national formula.

Primary Care Networks: these would transition to a new role as voluntary associations or confederations of independent providers. There are likely to be a number of professional, administrative, training and support functions which they may take on.

The Medicines and Healthcare products Regulatory Agency: would continue with its current role – with a consultative body for the regulator with representatives of insurers and providers to

streamline approvals processes

The National Institute for Health and Care Excellence: To continue producing guidance for providers and insurers on the value of different treatments and approaches. NICE guidance would apply for entitlements under the Basic Plan but beyond that adherence would be voluntary and providers and insurers should be free to go beyond it and to expand the range of treatments available if they consider the health and health economics case for them to be made, and as a means of differentiating themselves in the market. This could include introducing policies for co-payment for otherwise unavailable treatments.

A full overview of the institutional landscape post reform is set out in Appendix B.

- **Stakeholder engagement:** In order to stay alert to how the reforms are playing out on the ground and to identify any issues early, ministers and advisors should hold regular meetings with regulators, institutions, providers, insurers and patient groups in the early days of the reforms and to continue these throughout the early years.

It is also vital that the key actors in the system (the insurers and medical providers) can have confidence in the rules which govern how they interact. This will encourage greater investment in new healthcare facilities and more market entry and ultimately make the system more robust and durable over time.

- **Market study:** In order to ensure confidence in the system, to secure the development of the reforms in the most effective way, to protect consumers and to deter potential bad actors **ministers should instruct and announce that the CMA will be carrying out a full healthcare market study within the three years of the system's operation and repeating this process as often as needed.**

Appendix A – Template Outline of Basic Health Insurance Policy Coverage

As an illustration of the coverage of the basic insurance policy based on the Netherlands model is which should be developed further, consulted on and clinical input secured to is as follows:

Covered:

- Accident & Emergency care
- Basic medical care; including care provided by general practitioners, medical specialists and obstetricians
- Physiotherapy
- Vaccinations (except for overseas travel)
- Hospital treatment including all NICE approved treatments
- Dental care up to the age of 18
- Maternity care
- Limited therapies such as physiotherapy, speech therapy, occupational therapy and dietary advice
- Medical devices and products
- District nursing
- Dietary advice
- Mental health services
- ADHD medication
- Smoking cessation

A system of co-payments would apply for:

- Check-ups and consultations (over the age of 18)
- Prescriptions (over the age of 18)
- Optical (over the age of 18)
- Dental (possibly covered by our proposals in Pulling Teeth)
- Hearing-aids (over the age of 18)
- Transport

The following categories of treatment would be excluded from the policy but could be covered by additional voluntary insurances:

- Social care

- Cosmetic surgery
- Alternative medicines
- Vaccination for overseas travel
- Contraception
- Gender services
- Treatments not approved by NICE

The extent of this policy and the level of co-payments deemed appropriate should however be subject of Parliamentary scrutiny and subject to annual review by the Secretary of State.

Appendix B – The role of healthcare institutions in the new system

Figure 8

Organisation	Current	Post-reform
Department of Health and Social Care (DHSC)	<p>Principal body tasked with funding NHS providers and in ensuring that sufficient providers are available in all parts of the country.</p> <p>In addition, overseeing and managing a wide range of agencies and organisations to this end.</p>	<p>Leading for the UK Government with a completely new role setting the terms for engagement between providers and insurers, advising Ministers on the extent of compulsory insurance coverage through the Basic Plan, advising regulators such as the Care Quality Commission, Financial Conduct Authority and Competition and Markets authority on Ministerial expectations for the regulation of insurers and providers, managing the subsidies to cover those without the financial means to fund their own policies and those exempt.</p>
Integrated Care Boards (ICBs)	<p>Principal bodies responsible for commissioning and planning local healthcare services, managing networks of providers through Integrated Care Partnerships (ICPs)</p>	<p>As set out in <i>A suitable case for treatment</i>¹¹⁸, ICBs should be converted into regional insurers, and to serve as default insurers in the first instance, much as happened with the Sick Funds in the Netherlands.</p> <p>To ensure that such a transition would work effectively it would be vital for early consultation to take place with these groups to ensure that they have access to the skills</p>

118. https://policyexchange.org.uk/wp-content/uploads/The.NHS_.A.Suitable.Case_.For_.Treatment.pdf

		and capacity needed to take on this role – and to assist with recruitment and developing systems as needed.
Hospital Trusts and Foundation Trusts	Principal organisational structure for secondary care providers in the NHS with a degree of operational and governance freedom.	<p>Continuing to perform the same essential role.</p> <p>These providers should be able to make the transition to the new system relatively easily. They already possess the independent financial and governance systems they need to operate. The proposed new system would go one stage further and set them up as not-for-profit Charitable Incorporated Organisations and would envisage them being given somewhat more freedom over their operations and remuneration, as well as more commercial opportunities in their negotiations with insurers though – and consultation should take place to determine if short-term support would be needed to build any associated capabilities.</p>
GP surgeries and other primary care practices	Mostly independent businesses providing diagnostic and preventative care as well as a wide range of outpatient treatments. Also often the first point of call and gatekeepers for wider NHS access.	<p>For many primary care providers the proposed reforms would not result in any change in their status. Many GP surgeries and nearly all dentists are already private businesses. Those that are not would be assisted to set up as not for profit Charitable Incorporated Organisations. As with Trusts and Foundation Trusts, primary care providers would gain more commercial and operational freedom and should therefore be consulted on the short-term support needed for them to take on these new freedoms.</p> <p>Their role as gatekeepers for</p>

		the wider system would alter according to the terms of their commercial agreements with insurers – most likely continuing to perform the same role but with a different set of guidance and providers.
Emergency services	Universal service free at the point of use funded by the NHS.	Universal service free at the point of use funded by insurers and subsidies as needed with prices fixed on a national formula – in effect that for a patient there would be no loss of service.
Primary Care Networks (PCNs)	Population based collaborative networks of GP practices, coordinating services and managing partnerships with providers including the voluntary sector.	PCNs would transition to a new role as voluntary associations or confederations of independent providers. Funding would now be coming directly through insurers rather than from central Government, but there are likely to be a number of professional, administrative, training and support functions on which primary care providers would welcome cooperation and support. PCNs would be well placed to step into this role and to adapt to offer new services in response to demand. They would no longer need to be limited to particular geographies or limited to population sizes
The Care Quality Commission (CQC)	Independent regulator of health and social care services in England, registering, inspecting, and rating services including hospitals, GPs, care homes, and dentists to ensure they provide safe, effective, and	CQC would retain exactly the same role under new arrangements. The only additional consideration would be the need to inspect and regulate the likely increased number of new providers entering the market.

	high-quality care. The CQC’s role includes monitoring, enforcing standards	
The Medicines and Healthcare products Regulatory Agency (MHRA)	Government authorised licensor, regulator for treatments ensuring their safety, quality, and effectiveness and in undertaking necessary enforcement to protect public health.	MHRA would continue with its current role – it would however be advisable to establish a consultative body for the regulator with representatives of insurers and providers to streamline approvals processes
The National Institute for Health and Care Excellence (NICE)	Independent body providing national guidance and advice to improve health and social care, producing evidence-based recommendations for the NHS and other health and care systems, covering clinical guidance, quality standards, and health technology and value appraisal of new treatments and technologies.	<p>To continue as a health technology appraisal body in the new system, producing guidance for providers and insurers on the value of different treatments and approaches. NICE guidance would apply for treatments covered by the Basic plan but beyond that adherence would be voluntary and providers and insurers should be free to go beyond it and to expand the range of treatments available if they consider the health and health economics case for them to be made, and as a means of differentiating themselves in the market. This could include introducing policies for co-payment for otherwise unavailable treatments.</p> <p>Funding and governance of NICE would gradually move over to a user-led model, with providers and insurers contributing to running costs and able to scrutinise decision making. This should include a change to governance articles to make NICE a partnership</p>

		with shares owned by providers and insurers, with DHSC retaining a share and voice.
Financial Conduct Authority (FCA)	Regulator for financial services, responsible for setting standards, and ensuring firms act fairly towards consumers. Its main objectives are protecting consumers, enhancing market integrity, and promoting competition	Additional responsibilities in ensuring good financial governance and capability amongst providers of basic health insurance policies.
Competition and Markets Authority (CMA)	Competition and consumer protection authority responsibilities include making sure that markets function well for people, businesses, and the UK economy by promoting competition and protecting consumers from unfair behaviour.	During the early years of the operation of the new system the CMA should be tasked with monitoring performance closely to ensure that there is a healthy level of competition between insurers and between providers to ensure value for patients.
Office of Community Risk		New regulator with responsibility for supervising the risk equalisation formula and its application amongst insurers.



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