

This section looks back to some ground-breaking contributions to public health, reproducing them in their original form and adding a commentary on their significance from a modern-day perspective. To complement this month's theme of the *Bulletin*, Philip Musgrove reviews the 1942 report *Social insurance and allied services* by Sir William Beveridge.

Health insurance: the influence of the Beveridge Report

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The National Health Service (NHS) of the United Kingdom was created by an Act of 1946, based on the recommendations of Sir William Beveridge's report (1). Seldom has any report to a government been so influential. The NHS is the pioneer of universal, publicly financed health insurance, and could probably be credited with much of the improvement in the health of the British population since its creation. It is admired and in varying degrees imitated worldwide, especially but not exclusively in former British colonies. And it continues to inspire study, debate and proposals for improvement (2). That alone makes the Beveridge Report a public health classic, even though it has little to say about medical care and nothing whatever to say about disease. It is something of a literary classic in the best British civil servant style and in Beveridge's forthright assumption of responsibility for every recommendation and every word in it. And it has perhaps become a classic according to Mark Twain's definition of "something that everyone wants to have read and that no one wants to read" (3).

The extracts reproduced for this issue of the *Bulletin* concentrate on the principles proposed for the improvement of the health services, which are described as inferior both to the other forms of social protection which the United Kingdom offered its citizens before the Second World War and to the public health insurance of some other nations. Where the other forms of insurance are concerned, the report also provides an exercise in accounting, but there is little in the way of numerical estimates regarding utilization or costs for health care. And there is scant discussion of how health services might be organized, beyond the observations that provision and finance ought to be considered together and that different ways of organizing services and paying

providers might affect their costs of service and financial viability. Contrary to what public health specialists might assume, the report is not primarily about health interventions but treats them as among the "allied services" included in a comprehensive scheme whose chief concern is the maintenance of employment and income. This is hardly surprising in view of the experience of the Depression and the fear of an economic collapse once the wartime stimulus ended. Health care is important to that scheme largely as a means of protecting or restoring people's capacity to work: hence the emphasis on postmedical and rehabilitative care.

Beveridge had been Director of the London School of Economics (1919–37) and at the time of the report was President of the Royal Statistical Society, but the report contains almost no economics in the theoretical sense and no statistical sophistication. Friedrich Hayek, who had been Beveridge's colleague and became a virulent opponent of the welfare state, claimed that Beveridge "knew no economics whatever" (4); but the economics that Hayek preached, particularly the importance of competitive market prices to provide information for efficient allocative decisions, while generally correct, applies less well in the health sector than anywhere else. The paucity of economic theory in the report is explained rather by the fact that it predated by more than 20 years Arrow's (5) elucidation of the role of uncertainty and information in health markets and the beginnings of modern health economics in the work of Klarman (6) and others.

The Beveridge Report does not mention information asymmetry (when different actors in a health delivery system — such as providers and patients — do not have the same information or amount of information about an aspect of health, e.g. the prognosis of a disease or the effectiveness of a medical technology) or other sources of market failure (a situation where a free market will not lead to efficient outcomes). It refers only once to potential moral hazard, to question "whether persons in receipt of disability benefit, on

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entering an institution, should be required to make any payment towards the cost of their board”, since they might otherwise profit financially by staying longer than necessary in hospital. There is also a clear recognition of the problem now known as adverse selection, meaning that under voluntary insurance those with lower health risks would seek to pay less because they expect to use services less. The report rejects outright any discrimination among persons according to their health risks, allowing only that contributions might be greater for workers in particularly unhealthy occupations “to give a stimulus for avoidance of danger”. Otherwise prices are to play no role for consumers. Nowadays, in contrast, anyone proposing the creation of a comprehensive, publicly financed health insurance would feel compelled to explain why competitive markets are inefficient as well as inequitable as a way of financing and providing health care, and to review the reasons why the state must play a substantial role in the health sector, particularly in regulating and financing it (7). Beveridge not only assumed such a role for government, but anticipated that private medical practice might entirely disappear. However, even before market-based reforms were introduced into the NHS in 1989, making general practitioners into fundholders, public money was paid to private providers.

Today the NHS is regarded as the epitome of a tax-financed public health insurance — the “Beveridge model” — and routinely contrasted with the “Bismarck model” of contribution-based, employment-related social security. But the model Beveridge proposed resembles more a social security system than what the NHS actually is — with the difference from the Bismarck model that there is only one insurer. The report discusses the alternatives of financing by general taxation and by defined contributions, and comes down squarely in favour of the latter. It admits that taxes may have to bear part of the cost of social insurance, to limit regressivity, but insists on the contributory principle as a significant source of finance. (In a “regressive” insurance system, members with larger incomes pay smaller shares of their income as contributions to the system. The converse is a “progressive” system; in a “proportional” system all members contribute the same proportion of their income.) The contributory principle was advocated by many persons and agencies consulted in the preparation of the report, but the main argument is that, for the British public, “payment of a substantial part of the cost of benefit as a contribution irrespective of the

means of the contributor is the firm basis of a claim to benefit irrespective of means”. It allows the contributor to regard his or her payment as “my money”, not public money. The emphasis on contributions also underscores the expectation that full employment would be maintained and there would be a contributor in nearly every household.

Doing away with a means test was a major step, since both public and private hospitals were accustomed to charge according to the patient’s ability to pay. It was also a major step to eliminate the distinction between medical and dental services, and another one to bring hospital services fully into the scheme, when they were only beginning to be covered by voluntary insurance. Today any discussion would start with hospitals, so great is their role in the health system.

Just as the NHS is now a tax-financed system, the social security systems of such countries as Argentina, Brazil, Colombia and Costa Rica have supplemented contributions with general revenues in order to bring those without formal employment into a more universal scheme. The alternative is a permanently segmented system (8) with very unequal benefits as one is insured by social security or by the ministry of health. The principal virtue of the NHS is to have been universal from the start; it is easier to modify the financing or other features of a system if that does not also involve changing coverage or moving or erasing boundaries between organizations.

The NHS is sometimes derided by conservatives as part of the “nanny state”, which presumes to know better what individuals need than they can determine for themselves, and which stifles freedom and initiative. That was certainly not Beveridge’s view, as he took pains to make clear at the beginning and the end of the report. The report goes so far as to insist that “the individual should recognise the duty to be well” and that “restoration of a sick person to health is a duty of the State and the sick person”. And the duty of the state includes leaving the individual free to provide more protection and more care than that guaranteed by public insurance; free also to take initiative and risks. Together, the insistence on universal coverage without distinction, on an adequate minimum and on not preventing people from rising above that minimum constitute an architectural plan for the health system that the Beveridge Report championed: a solid and level floor, no interior walls, and a roof that need not be level but whose height is determined only by people’s own wishes and means. ■

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