NHS crisis: time to move away from ‘free at the point of use’

CHRISTOPHER SMALLWOOD

The UK’s tax-based expenditure approach is unlikely to deliver the funds needed to avoid a continuing decline in health standards in the coming years. Christopher Smallwood argues that the solution to the problem is to encourage a system of complementary insurance to supplement the state’s financing of mainstream healthcare.

The ‘NHS crisis’ experienced last winter is not a one-off but marks the beginning of an extended period during which the NHS will be chronically short of finance. The problem is that, given the overriding need to reduce the budget deficit, the Treasury will be either unable or unwilling or both to finance from tax revenues a sufficient rate of growth in health spending even to maintain current standards of healthcare.

Yet at the same time the NHS is pre-empting funds on such a scale that other vital public expenditure programmes are being squeezed on an unprecedented scale – from local authorities’ spending on care homes to the defence budget.

It seems clear therefore that supplementary or indeed alternative sources of funds are needed to replace, at least partly, the health service’s reliance on tax revenues.

The advanced countries of continental Europe offer pointers to the way forward.

PRESSURES ON HEALTH SPENDING
Throughout its history, health spending on the NHS, in real terms, has grown on average by 3.8% per year – notably faster than GDP. Under the last Labour government, spending growth accelerated to an average of 5.6% per year. From 2010, strict limits were imposed on spending, resulting in real growth of 0.8% per year, as a result of which expenditure

The UK’s tax-based expenditure approach is unlikely to deliver the funds needed to avoid a continuing decline in health standards in the coming years. Christopher Smallwood argues that the solution to the problem is to encourage a system of complementary insurance to supplement the state’s financing of mainstream healthcare.

The advanced countries of continental Europe offer pointers to the way forward.

PRESSURES ON HEALTH SPENDING
Throughout its history, health spending on the NHS, in real terms, has grown on average by 3.8% per year – notably faster than GDP. Under the last Labour government, spending growth accelerated to an average of 5.6% per year. From 2010, strict limits were imposed on spending, resulting in real growth of 0.8% per year, as a result of which expenditure

© Adam Gault/Science Photo Library

BLOG
Do you agree or disagree? Join in this discussion and leave your comments on our blog. We would love to know what you think!

Christopher Smallwood, Chairman, St George’s University Hospitals NHS Foundation Trust, London
in real terms is now back in line with its long-term trend.

Increased pressures on spending were accommodated by productivity improvements, which 'made room' for rising demand. This reflected the 'Nicholson challenge', which demanded 4–5% cost savings each year from 2011 and set tariffs (ie the prices paid to providers for different treatments) to enforce this. The NHS met the challenge and more than £20 billion was saved from NHS costs.

This was achievable partly because spending had run ahead of the long-run trend, creating a certain amount of slack, which made it practicable to bear down on costs for a while, while maintaining good-quality services. But spending has now returned to trend and the opportunities for cost reductions on the scale of the past 5 years are simply running out.

In principle, these demand pressures could at least partly be offset by cost savings, but these are becoming steadily more difficult to achieve. And the cost picture is about to change in a fundamental way. The effort to restrain costs, which was remarkably successful in recent years, was hugely assisted by the degree of pay restraint that was achieved. In real terms, the pay of health service employees was frozen or actually fell during the years 2011–15. Pay restraint like this cannot be maintained for ever. It will certainly be impossible now that private sector earnings have started to rise in real terms.

The next question is to what extent these pressures could be accommodated within flat real budgets by 'productivity increases', ie reductions in costs. Over the long run, NHS efficiency gains have been estimated by the OBR at around 0.8% per year.

The system is finally going underwater under the strain and the next government will face some very stark choices in relation to the NHS in consequence. The papers talked about the 'NHS crisis' this winter. In fact, we are at the beginning of a much bigger and more protracted crisis. So, what are the prospects for health spending over the next parliament? How big will the pressures be? There is a substantial consensus about this. A number of studies have been undertaken, all of which come to the same answer. The NHS will need up to an additional £30 billion per year by 2020/21 if it is to maintain international standards and the quality of care.

There are at least four pressures producing this result. The first comes from the growth of the population — about 0.5% per annum. The second is the ageing of the population, leading to demands for increasingly expensive services. To maintain average real spending per person in each age group requires a real increase in total spending of about 1.2% per year. Third, there is the rising trend of chronic conditions, such as diabetes and obesity, to be accommodated. Fourth, advances in healthcare technology require a real increase in total spending of 4–5% per year. These four factors alone will increase the demand for health funding by well over 3% per year.\footnote{In recent years, during the Nicholson challenge, the NHS has done more than twice as well as this, but the opportunities for maintaining that rate of advance have been diminishing for some time and signs of strain in the system are becoming increasingly visible.}

So what could be achieved? The Five Year Forward View (FYFV)\footnote{The FYFV suggests that the £30 billion gap in 2020/21 could be cut by about a third to £21 billion. It is difficult to believe that in practice the NHS will be able to do better than this in the coming years. This is because the second scenario, under which the extra funding requirement is halved to £16 billion, relies on the rate of efficiency impact of the demand factors listed previously and it is not difficult to arrive at the view that up to another £30 billion will be needed for the health service each year by 2020/21, compared with today's budget of £110 billion for England and £140 billion for the UK.}

For the health service each year by 2020/21, compared with today's budget of £110 billion for England and £140 billion for the UK. In recent years, during the Nicholson challenge, the NHS has done more than twice as well as this, but the opportunities for maintaining that rate of advance have been diminishing for some time and signs of strain in the system are becoming increasingly visible.

The NHS crisis experienced last winter is not a one-off but marks the beginning of an extended period during which the NHS will be chronically short of finance.
Programme of statutory health
Guaranteed universal access to
People take out complementary
Continental Approach to Financing Healthcare
European systems for financing healthcare display significant differences. At the same time, however, they exhibit common features, which can provide pointers to the sort of developments that could be introduced in the UK to generate new streams of finance for our health system (Box 1).

Statutory health insurance
In France, the premiums – like our national insurance contributions – go to the government and mainstream healthcare is financed from public funds, as here. However, coverage is limited to what other countries call a ‘basic package’, and the whole cost of treatment is not necessarily covered; the rate of reimbursement varies across the range of services provided. Moreover, patients have to pay up front and reclaim the money.

In Switzerland and the Netherlands, health insurance is required by statute. It is provided by private companies, regulated by the government to provide a ‘basic package’ of services. In both countries a risk-equalisation body reallocates funds between companies to reflect the risks associated with the client base they have taken on. In Germany, cover for a ‘basic package’ is provided by a large number of competing sickness funds, which, as in Switzerland and the Netherlands, must accept any applicant at a price determined by the authorities. Again, there is a reallocation fund.

One solution to the problem would be to encourage a system of complementary insurance to supplement the state’s financing of mainstream healthcare
to show themselves in moderating rising demands on hospitals’. It is obvious that such changes would be very complicated and involve many agencies working together; a considerable amount of time will be needed for these to engage properly and make the transition to a new system, if indeed it can be done at all.

So it is not surprising that Monitor has declared the NHS to be facing its greatest-ever financial challenge. The coming parliament will find that it is facing a protracted period of financial crisis for the health service, which may well persist as a chronic condition. Either substantial extra funding must be provided on a continuing basis, or standards are set continually to decline.

The emerging question therefore is where the extra funding could come from to see standards of healthcare maintained and indeed enhanced in the coming years. One possibility is by limiting the call of the health service on the public purse. Public spending on health – financed by taxes – could for example be frozen at current levels, and the necessary growth accommodated by alternative sources of finance.

I see two advantages in moving towards continental-style methods of financing healthcare, the first being to enable standards of healthcare to be maintained and indeed enhanced (extremely unlikely under the present arrangements); the second being to make room for essential spending in other areas without large increases in taxation.

requirement for co-payments
In France, people have to make up for the proportion of costs not covered by the national programme of health insurance in relation to mainstream treatments, and to make cash payments (not reclaimable from insurance) designed to encourage cost-consciousness on the part of patients – eg charges for doctors’ visits.

In Switzerland, patients have to pay the excess negotiated with their insurance companies, plus 10% of the remaining costs – ie the insurance covers only 90% of the treatment costs. And in Germany, co-payments are necessary to cover the costs of some pharmaceuticals, dental care and doctors’ visits.

Complementary private insurance
In France, 90% of the population has such insurance to finance all the areas underfunded by the public system. People opt to cover such co-payments with their own insurance. The same is true in Germany. In the Netherlands and Switzerland, people purchase complementary insurance to pay for areas not covered by the statutory insurance scheme, and in Switzerland to cover the 10% of treatment costs and excesses that they must meet themselves.

Guaranteed universal access to healthcare
In all countries, there are special schemes to ensure that those on low incomes or

TALKING POINTS

Box 1. Basic principles underpinning all European systems for financing healthcare

- Programme of statutory health insurance that finances mainstream health services
- Requirement for co-payments
- People take out complementary private insurance
- Guaranteed universal access to healthcare
with chronic conditions receive the healthcare they need, in the form of tax credits paid directly into their accounts or means-tested payments from social funds. There is a common misconception that insurance-based schemes necessarily imply inadequate care for an underinsured segment of the population, undermining the principle of universal access. This is because people immediately think of the USA as the prime example of an insurance model. But the example of continental European countries demonstrates that insurance-based systems of finance are perfectly compatible with universal access as long as appropriate supplementary arrangements are put in place.

A WAY FORWARD FOR THE UK?
The need is to find supplementary, and to some degree alternative, sources of finance for the NHS. What pointers to an alternative way forward are provided by the continental examples?

We need to begin from where we are and build on it. It is extremely unlikely that our politicians would entertain for a moment a radical, wholesale switch to a Swiss-style insurance system. In the UK, things happen incrementally, and the practical question is whether we could begin to move in the direction of continental complementary insurance and co-payments, while mainstream healthcare continues to be financed primarily by the state. In the longer term, complementary insurance schemes might start to reduce reliance on tax revenues on a larger scale.

If the approach has to be incremental, the first place to look on the continent is France where, as in the UK, the bulk of healthcare is financed from public funds and people pay statutory health insurance similar to our national insurance contributions.

The UK could start to move in the direction of other aspects of the French system. This would involve gradually reducing the government’s health budget, either by restricting the range of treatments funded by the state to a continental-style ‘basic package’ or by declining to pay the full costs of all treatments, or both, hence encouraging or in effect obliging people to take out their own health insurance to bridge the gaps. Such developments could start modestly, but over time could come to account for a significant proportion of health care: 15–25% is the range achieved by the continental models. In the UK context, this would amount to some £21–35 billion per year.

The need to allow and indeed encourage complementary insurance schemes is in my view the main lesson to be drawn from the continental experience. At present, top-up insurance is not allowed for people receiving NHS treatment; the public and the private have to be kept rigorously apart. But when 90% of the population finance part of their healthcare in this way, it is quite wrong to talk about a ‘two-tier’ health service. And when the state continues to pay for the bulk of the cost of treatments, the cost of insurance to cover the rest can be quite modest – readily affordable by most of the population.

The introduction of complementary insurance schemes would provide an additional flow of finance to help fund mainstream services and could also fund areas not covered by the NHS, which might include cosmetic treatments and parts of dentistry as at present.

It would be vital to communicate that none of the countries that have recourse to insurance schemes of this type for part of their health financing fail to provide universal access to healthcare, whether through tax credits or payments from social funds. There would be no question of an ‘uninsured’ segment of the population without access to healthcare.

This approach would of course involve abandoning the mantra that all healthcare should be ‘free at the point of use’. This principle would need to be replaced by another one, which I suggest should be: ‘no one should be denied the healthcare they need for financial reasons’.

The addition of a new stream of finance would enable the UK to maintain health standards in line with other leading European countries, which is otherwise unlikely, and as the proportion of healthcare financed by complementary insurance was steadily, if slowly, increased, could release significant tax revenues for the business of rebuilding other public services – to increase local authority budgets for old people’s homes and other community services, themselves vital to make a success of the strategy embodied in the FYFV; or on another front, to repair the defence budget.

What stands in the way of a rational discussion of the best way forward is ideology. The principle of ‘free at the point of use’ is holding us back. If progress is ever to be made, it is important to put other ideas on the table and discuss them seriously.

Declaration of interests: none declared.

REFERENCES