Financing the NHS: time to ditch the ideology

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NHS finances are stretched to breaking point and without continuing tax rises the problem will not be solved. Christopher Smallwood proposes an alternative approach.

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It is good that the junior doctors' strike is off for now. But it should never have come to this. Jeremy Hunt's problem was that, with no extra money available to resource the changes properly, he could only achieve his objective of 'a seven-day health service' by stretching existing resources across seven days rather than five. Without more money, this could only be achieved by worsening doctors' conditions of work. The doctors spotted this.

So the fundamental cause of the problem, as so often, was the underfunding of the NHS. Which points up an urgent question: how can we break through the current constraints to a properly resourced health service, offering good working conditions as well as excellent care? The question is a pressing one because the financial squeeze continues to tighten.

The facts are uncontroversial. The annual rise in spending since 2010 averaged 0.8%, compared with an increase in demand and cost pressures associated with an ageing population of between 4% and 5%. After years of stringent economies, health providers finally came to the end of the line and have sunk into deficit, forced to cut services in response. So far so familiar.

Less well appreciated is that, following the recent Comprehensive Spending Review, the outlook over the present parliament is for more of the same. The famous '£8 billion extra for the NHS' amounts to an annual rise in real terms of under 1%. This reality was disguised by 'frontloading' £3.6 billion of the £8 billion for 2016–17, so creating some leeway. But the total commitment is unchanged, so that the increases earmarked for later years are tiny indeed. The underfunding will go on, bringing with it a further erosion of standards.

NEED TO RAISE STANDARDS

Must we accept this? When, in a recent report, the OECD ranks the UK 20th out of 23 countries for cancer survival, 19th out of 31 for stroke, 20th out of 32 for heart attack deaths, it is critical not just to maintain but to improve standards of care. But why should we imagine that we can match standards achieved by countries like Germany, France, Switzerland and Holland, if our government aims to spend 7% of GDP on healthcare when their governments spend 11%? The OECD

calculates that simply to match standards in similar countries the NHS needs 75 000 extra doctors and nurses (which would have avoided the dispute). Where could the extra money come from?

One possibility is higher taxes or National Insurance, but in the longer term this would present difficulties not generally appreciated. Historically, NHS spending has grown more rapidly than GDP. Over the past 30 years, its share of GDP has increased by more than 2.5%, but this has been financed comfortably without a rise in taxes because defence spending has declined by about the same amount. Similarly, a rise in welfare has been accommodated by a fall in debt interest payments.

But the fall in defence spending has come to an end (as has the fall in debt interest payments). So if health spending has to rise faster than GDP to keep pace with demographic pressures, this can only be achieved under the present financing system if there is not just a one-off, but a *continuing* rise in taxes into the indefinite future. The tax/spend picture has fundamentally changed.

NEW INCOME STREAMS

An obvious conclusion follows. If we want standards of healthcare comparable to similar countries, and if at the same time the prospect of continuing tax increases is unacceptable, we must be prepared to contemplate new income streams for the NHS from other sources to supplement tax revenues.

> **We must be prepared to contemplate new income streams for the NHS**

Continental Europe provides a number of different models illustrating how this can be done. In France, mainstream healthcare is mainly financed from public funds, but the percentage of treatment costs covered varies depending on the service provided. Costs not covered are funded by complementary private insurance, which 90% of the population takes out. The other 10%, on low incomes or with chronic conditions, are paid for from special schemes, so that everyone receives the treatment they need.

In Switzerland and the Netherlands, health insurance is required by statute, with insurance companies obliged by the government to cover a basic package of services at a price set by the government. People purchase complementary insurance to pay for costs or treatments not covered by the statutory schemes.

A complementary insurance system here, based on the French model, could in time provide additional funds financing, say, a quarter of NHS activities, which would go a long way to closing the financing gap with similar countries and enable us to maintain international standards.

DITCHING THE IDEOLOGY

But in order to tackle the problems the health service faces, we have to ditch the ideology. The NHS needs more money. To those prejudiced against insurance in any form who say, 'Where insurance is involved the poor will suffer', I say look at those European countries. In every case there is universal access to healthcare, with special provision for those with special needs. No one need suffer.

To those committed to the 'free at the point of use' mantra, I say that in a country five times richer than it was in 1948, we are free to adopt an alternative principle: 'No one should be denied the healthcare they need for financial reasons.' Why not have a system in which those who can make readily affordable contributions to the cost of their care do so, while those who cannot are provided for? How else will we save the health service?

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