Give the patients the money: a fairer system of overt healthcare rationing in the NHS  

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Abstract
In this paper, problems with future NHS funding and current rationing are explored. A new system is proposed which suggests splitting funding into two streams, one for centrally planned services, one for patient-chosen services. In this new system, both streams are free at the point of care. High-intensity, high cost services are planned and delivered in a fashion largely unchanged from the current NHS. Patient-chosen services, on the other hand, are delivered through a personalised system of individual healthcare savings accounts (HSAs) similar to the Personal Healthcare Budgets (PHBs) currently in place for long term conditions. This new payment system would be centrally funded and would allow patients free choice of the less expensive services within a market of NHS licensed and regulated providers. The advantages and objections to this system are discussed with some thoughts on costs and implementation.

Introduction
The National Health Service (NHS) is a universally popular institution within the United Kingdom (UK) (Ipsos Mori, 2014). It is so popular that politicians approach it with trepidation (Lawson, 1992). And it is a favoured institution for good reason: it embodies the compassion that we all need when sick or vulnerable. It is – in a country renowned for its sang froid – our “expression of kinship” (Ballatt, 2011).

Since 1948 the NHS has demonstrated that it is possible and workable to create a universal system of healthcare, free at the point of delivery and funded directly through central taxation. The NHS was one of the first – and remains one of the few – health services funded in this way (Roemer 1993; National Audit Office, 2003; Porter, 2010).

In order for this to be feasible, the NHS necessarily rations the supply of free health services. This is done using a variety of mechanisms, some more overt than others. There are outright exclusions, such as aesthetic surgery, exclusions governed by NICE guidelines (NICE, 2013) and there are some part-payment elements such as NHS dentistry and prescription charges (NHS.UK, 2014). As well as these there are more covert barriers: GPs act as ‘gateways’ to specialist services, limiting demand; waiting lists cause delays to treatment; and, in England, clinical commissioning groups (CCGs) plan, and thereby restrict, healthcare provision at a regional level (NHS England, 2013).

Despite this, the universal model pioneered by the NHS is now under threat from three major factors (Economist Intelligence Unit, 2011). First, the burden of chronic disease is rising rapidly. It is estimated that 15m adults in the UK, have at least one long term condition and the number of over 65s living with three or more long term conditions is also on the march (Department of Health, 2012). Secondly, shifting demography means that the UK population is living longer and having fewer babies. The percentage of adults over 75 is likely to increase from 8% to 10% in the next decade and by 2030 there may be over 60,000 people who are over 100 years old (Office for National Statistics, 2013). All of this means there will be fewer taxable workers and more dependent elderly people, many of them very frail.

Finally, demand is changing with technology and culture: when new operations or medications are devised, demand appears; there is increasing medicalisation of previously ‘social’ problems such as childhood behaviour and addiction (Conrad, 2007); and there are large increases in the number of consultations (Nuffield Trust, 2014). Where once a family might bear-out or self-treat – or have taken grandmother’s advice – patients now seek-out the professional reassurance, often in hospital emergency departments rather than at the family doctor.

In summary, patients are living longer with a greater burden of disease for which they expect all treatments, many of them unimaginable in 1948, to be available immediately. The combination of these three factors is causing an exponential rise in healthcare cost. Politicians have so far been unable to devise a system which openly rations healthcare. Any overt polices are easily criticised for being unfair on one group or another. Rationing can be painted as an infringement of human rights, as lacking compassion or simply as unreasonable (Leslie P. Scheunemann, 2011). As a result, many governments have been caught-out, often by geographic variability (the ‘postcode lottery’).
bureaucratic problems. The response, such as with The Cancer Drugs Fund initiative, is the current administration’s plan to favour the right increase in funding (BBC News, 2014). The budget for the NHS has doubled in the last decade (HM Treasury, 2013). If it doubles again in the next 10 years, it will cost something near to £1,000 per tax payer. Such a rise would not be sustainable within the national public service or substantial tax rises – neither of which seem plausible. Some people believe that these pressures are hastening the deregiment of the NHS and that there are plans for a radical shift towards privatisation (Leys and Player, 2011).

The conclusion is that the UK must learn to ration NHS services more rigorously if the institution is to survive and maintain the founding principle of universal healthcare free to all at the point of need. The question this paper seeks to answer is whether, in the face of accelerating need and seemingly unlimited demand for healthcare, there is a way to ration the provision of services that is overt, reasonable and compassionate yet also acceptable to the UK electorate?

The systemic problem with health insurance

Because most people are never unaffordably sick, the lifetime cost of healthcare is, on average, affordable. However, the risk of unaffordable bills is non-trivial because the intra-individual variation is so large. In other words, there is a significant minority of people who become unaffordably sick during their lifetime (Wibb and Zhives, 2010; French and Jones, 2004). Only very few individuals can personally afford the money necessary to treat complex conditions, even with obvious drugs or expensive therapies. This cost-spread means that almost all healthcare is funded through insurance, either private or public.

Private insurance companies manage the inter-individual variation through risk pooling, and by identifying high-risk patients before insuring them or charging them higher premiums (Claxton and Lundy, 2008). Public insurance systems have no need to do this, since they are inclusive and spread the risk over much larger populations (Smith and Witter, 2004).

Both systems, though, have a systemic disadvantage: because the consumer doesn’t pay the full bill they eliminate direct cost competition in the provision of services. Responsibility for managing the cost of provision is transferred to the insurer (the NHS in the UK) and competition is transferred to the insurance market where one exists. As a result, in the UK, the average consumer has little idea of the costs of the healthcare they consume. Even providers find it difficult (Blunt and Bardicly, 2012).

In either case, both private and public systems of insurance remove the consumer from value judgements about the cost benefit of healthcare interventions and thereby remove a significant constraint on inefficiency and cost. With a predominance of private insurance this problem can accelerate costs and inefficiencies, since higher provider costs translate into more profitable insurance premiums. This can be seen in the motor insurance market in the UK where accident and mortality rates on the road have decreased in the last 50 years by 80% (House of Commons, 2013a) while premiums have risen dramatically. Ironically given the subject of this paper, much of this increase has been due to medicalisation of claims (This is Money, 2012). The most spectacular example of healthcare cost inflation is in the US healthcare market, where private insurance predominates, and where costs are several times higher than in any other industrialised country (Hartl, 2012; Squires, 2011).

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Development Authority, clinical senates and many other (The King’s Fund, 2013). Despite this proliferation of bureaucracy, two entirely different questions tend to be conflated: the right level of spending on the NHS. The first is privatisation: the degree to which the NHS should invite private providers to bid for publicly funded provision. The current and previous governments have been accused of allowing ‘privatisation by the back door’, providing private profit from public funds (BBC News, 2013; Leys and Player, 2011). The second question is the extent to which certain population or visitor groups should or should-not be funded (BBC News, 2012). Profilingering of health care or tourism both invoke a sense that unfair advantage is being taken of public money.

We will return to these questions later in this paper, but it is the view of this author that they miss the much wider problems posed by the funding challenges raised in the previous section, and the inefficiencies, covert rationing and the remaining public funding which stem from the total reliance on insurance. The pressing change that is needed is an adjustment to the system of funding in order to manage this systemic driver of cost inflation and inefficiency. In order to do that, we must look at the underlying driver of the insurance need itself: the prohibitive cost to individual patients of certain healthcare interventions.

A two-part funding system

To combat the systemic problem with insurance, both public and private, this paper suggests dividing healthcare interventions into two types – those that are prohibitively expensive and those that are not – and funding them differently. In deference to the traditions of medical nosology, we suggest calling these Type 1 and Type 2, respectively.

Type 1 healthcare

‘Type 1’ healthcare interventions are, by definition, the high cost, high complex, capital intensive, often life-saving interventions which individuals can not reasonably afford. Examples include intensive care, novel cancer treatments, trauma services and emergency surgery, primary percutaneous cardiac intervention (PCI). Type 1 interventions tend to be: research driven, dramatic (the stuff of documentaries and poor people), costly, predictable, the individual level and personally catastrophic for the patient.

This last characteristic is important because Type 1 healthcare is not something that patients would seek-out and therefore not interventions over which they would wish to exercise consumer choice. As a result, Type 1 interventions are limited in demand since they are limited by the number of cases.

It is perhaps worth pointing out that, despite their dramatic and life-saving nature, Type 1 healthcare interventions are relatively simple in the way of public health improvement. Because they are sparse at a population level and are targeted at secondary or tertiary treatment rather than primary care, they can contribute a small fraction to overall improvements in mortality or morbidity.

Within the NHS, these services can and should remain funded in the current fashion. They should be planned and provided under central government control. Given that the demand for these services is limited by cases and that the size of both the capital investment and the populations receiving them are very large, direct government provision seems sensible. Since the NHS already has the infrastructure in place, there seems little benefit in change.

As an example from Emergency Medicine, the author’s own speciality, this would mean that all major trauma would be considered Type 1 healthcare. The government currently provides these services free of any cost consideration to the entire population. The management of trauma has been shown to have significant benefits that could not have been realised by individual institutions working alone (NHS England, 2013b). In any new system, this pattern of service delivery should continue. A similar case for maintaining the status quo is likely to be made for all Type 1 interventions.

Type 2 healthcare

What remains of healthcare provision is – by exclusion – Type 2. These interventions are relatively inexpensive, people instead of capital intensive, life-enhancing rather than life saving, and well understood.

Type 2 interventions include all primary care services, community services, minor and day-case surgery as well as the majority of mental health services, outpatient services, elective and most day-case rehabilitation services. The list is, unsurprisingly, nearly endless.

The distinction between Type 1 and Type 2 services is not entirely clear-cut. There will be overlaps – and the author does not underestimate the difficulty of distinguishing the two at the margin. This is partly because what is today Type 1 may tomorrow become Type 2. Cardiac Artery Bypass Graft (CABG) operations, for instance, were once cutting-edge technology. They are now routinely used as an intervention for patients with poorly controlled ischaemic heart disease (IHD). And even at the same point in time the same intervention may be Type 1 or Type 2. An emergency hip replacement following a fall would be Type 1, while the same elective operation would be Type 2.

What helps to distinguish Type 1 and Type 2 is that Type 1 services have a wide and varied distribution while Type 2 interventions are, by definition, more predictable. Type 2, since they are chosen, are also potentially unlimited in demand – the more so if patients have little regard to the cost of such services. Type 2 are also the most important individual interventions for maintaining public health since they include all the health promotion and illness prevention measures (James Macinko, 2003).

Most importantly, patients actively seek-out Type 2 healthcare and therefore wish to exercise consumer choice as they do in almost all other walks of life. Funding for this type of healthcare would benefit from an approach which, for the reasons outlined above, does not involve insurance.

Health Savings Accounts (HSAs)

The central proposition of this paper is that Type 2 healthcare should be paid for through a personal Healthcare Savings Account (HSA) funded through central taxation.

For every individual, their HSA would: provide a cumulative budget for their healthcare; work for the NHS; have automatic portability; be sustained and maintained throughout one’s life; and be broadly transparent and accountable. A similar case for maintaining the status quo can be made for all Type 1 interventions.

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Source: http://www.independent.co.uk/spending_chart_2002_2015/UK_14181000/main.html
would be broadly similar for every individual, so the HSA would be required for those with increased needs, such as chronic disease or health-related disability. The HSA would accumulate and gather interest during the patient’s lifetime, growing during their healthier younger years in order to provide funds as their health declines in middle age and thereafter. For a severely injured patient—those at the time of death would revert back to the pool of general taxation.

HSA funds could only be spent in approved and regulated care providers on approved healthcare-related products and services. Each patient would carry such a ‘photo-card’, which would work much like a photo-card driving licence, with which they could pay for approved Type-2 services and health-related products directly from their personal HSA. No payment from the HSA would be required for Type 1 healthcare or its sequelae.

Would this system save money and make the NHS more efficient? To answer that question in the absence of a suitable pilot study, we can only make some broad estimates and offer some examples in order to suggest how this might work.

In 2011 the UK spent £211bn on the NHS (HM Treasury, 2014). That equates to about £2,000 for each of the 62.2m people who live in the country (Office for National Statistics, 2012) or roughly £4,000 for each of the 30m people who pay income tax (HMRC, 2014). That equates to around £11 per day for each income tax payer. With this, the NHS employed 1.4m people and insured everyone, including visitors, against disease and ill health anywhere in the UK or any other consideration. This budget also provided all the diverse health professions and services of the NHS – including, to name just a few, all vaccination programmes, community midwifery services, disease surveillance and district nursing.

To establish a budget for Type 2 healthcare, we must estimate the proportion of this budget that Type 1 healthcare consumes. In England, we know that about 30% of hospital admissions are emergencies – although not all of them are for Type 1 healthcare. We can perhaps use an approximation of between 15% and 30%, depending on where the line is drawn – and perhaps requiring a further 20% as a gross estimate. The NHS centrally planned budget for Type 1 healthcare would thus be £25bn and for Type 2 healthcare around £97bn. This latter figure equates to £1,500 per person per year. As a cross-reference, it is worth noting that this figure is roughly equal to the per-capita budget set aside for the cost of orthopaedic health care for the employees and families in a hospital system in Southern Florida (Personal Communication, 2013).

A cursory glance at the annual income of the average family shows that this figure would be £1,000 for every year lived plus an additional allowance of £250 per year for each long-term condition.

Three examples

As a first example, let us imagine a 25 year old fitness instructor with no previous medical history. She would have somewhere near £25,000 saved if she were to tear her meniscal cartilage as a result of their work. For her to return to a full time career, she could choose any CQC licensed orthopaedic facility, advised by her GP, on the basis of cost, convenience and reputation. This would mean she could have the operation as quickly as possible in order to return to work without waiting. Initial GP consultations, MRI, arthroscopy, consultant follow-up and physiotherapy might cost her £3,000. None of the money involved in the transactions would be the patient’s own, it would therefore be free at the point of delivery. She would instead hand-over her HSA card whenever she visited the surgeon or other facility.

The system would have to ensure she was quoted the costs of surgery from each facility before making her choice. This cost visibility is necessary for the system to work since a ‘turf’ or ‘standard reasonable charge’ or post-hoc charges would determine the choice. The system would have the option to vary the cost at the HSA. Indeed, rules governing this visibility of charges prior to booking or treatment – rather than rules on costs – would be an essential element since the cost-benefit equation must remain in the hands of the patient.

After the operation she would be able to see a statement of detailed transactions on her HSA, broken down to individual charges. Her treatment – just as much as any other treatment – would be paid for out of delivery, but the cost would be visible and therefore play a part in her decision-making.

Would this save the taxpayer money? Providing, as emphasised above, that costs are visible beforehand, then that the system of health care provision is efficient for the costs and reputation, it seems reasonable that the competition for regular-day-case surgery should be enough to drive up standards of care and drive down prices. Moreover, by ensuring she is back to work without a three-month wait for an NHS knee clinic and a further 3 month wait for her orthopaedic surgeon in a private system, she would be contributing more tax and labour to the economy. As a 25 year old fitness instructor her health would be unlikely to deteriorate in the 7 month window currently forced on many NHS patients, but this might be an economic factor in older people with the same condition.

Getting people back on their feet quickly is not just good for the individual, it’s good for the economy too (Lee et al., 2013).

As a second example, let us now imagine 65 year old, retired farmer with carpal tunnel syndrome, pulmonary disease (COPD), type 2 diabetes, osteoarthritis and glaucoma, who would have received £65,000 in his life, of which he may have spent 25%, leaving around £46,000. His yearly HSA income would now be £1,750, to take account of his long term conditions. With this sum, he could afford substantial prescription charges, possible elective hip replacement, and, in the long run perhaps, home oxygen therapy. For this he would need to go through his GP, outputs and HSA payments, and GP consultations, transport to and from his hospital and his financial needs start to outweigh his capacity and ‘personalisation’ – subjects which exercise and employ so many public servants at the moment – will fall directly into this category. He knows that the individuals needs most intimately making central planning largely redundant.

This author has had considerable experience being part of a system that delivers integration and personalisation in a poor – even Kafkaesque – manner, often by virtue of the sheer complexity of the system. The patient is likely to exercise choice in some areas more assiduously than in others.

He will, no doubt, benefit from retaining his ‘private’ individual, so the patient will be able to help him with making some of the more difficult decisions. What will change is the fact that he himself will be responsible for the terms of any agreement he receives, when and from whom.

Would this situation save money for the NHS? And if it does, will the patient be able to assess this, although it seems reasonable to expect that the new system would also provide these services in a more cost-efficient way if there is a degree of cost visibility and therefore competition. His capacity to make his own decisions will have more impact on health promotion than the usual one of waiting before care. In the second and third cases, the system would have to ensure that the farmer will make good health choices, given his budget and the frail elderly lady will have adequate funds to manage the complexity of care that may arise towards the end of life. A pilot would be required to test the amounts at suitable levels. Overall, the aim would be to:  
- give maximum responsibility and choice to patients and to allow them to spend their own money rather than that of governments or insurers, but to make sure that nobody faced catastrophic expenditure.  
- to ensure that even the poor had enough money to buy medical care (Harford, 2006).

Advantages and objections

As outlined in the previous section, the key advantage of funding Type 2 healthcare using HSAs would be to provide an opportunity for patients to exercise control and choice and to undermine the systemic problem with insurance by bringing an element of market rigour and competition into those parts of healthcare provision where it makes sense to do so. This advantage has obvious benefits for patients, since it brings real power to exercise real choice, not the sort of ‘virtual’ choice as presented by the recently defunct Choose and Book system. Patients would be allowed to spend ‘their’ money on health care that they want to and with whom they wish. From a provider’s point of view, the money would come with the patient, not merely follow the patient around but to be spent on the patient and not on the current ‘Payment By Results’ system (Appleby et al, 2012). Assuming no distorting government constraints on the market, this competition would drive up the system to be unworkable (Nichols et al., 2004). There are no shortage of examples of healthcare forces cannot and should not be used in the provision of Type 1 healthcare. No severely injured patient wants to choose the trauma unit to which they are airifted – and in this system such nonsense would not arise. But a market in Type 2 healthcare seems reasonable, providing a system which would allow patients to provide them with benefit. Certainly many services as currently configured would be forced to change, particularly in their attitude to the patient experience.

Waste and inefficiency in the NHS reflect the size of the bureaucracy that has accreted around it (Dixon-Woods et al., 2013). While individuals and local teams try hard to provide the best service and care possible, them can rarely not be – responsive to individuals’ needs. Personalisation is a near impossi- bility within such a large bureaucracy. A more de-centralised system would require a much smaller system to deliver services to the population of the UK and to all acute-care service providers is the overly-long hospital stays which occur while community care is arranged. In the system of HSAs, community care is Type 2, and a market in such care would emerge which would improve the speed of response. It is possible that this alone will help to make care more cost effective at beds in the country. (NHS England, 2014).

Not all inefficiencies lie with providers. Did Not Attend (DNA) rates of 10% across the country may reflect many patient’s poor levels of engagement with the care they receive (NHS England Hospital Activity, 2014). It is true that giving patients times when they can attend, rather than a computer-generated slot may resolve this problem, but a more fundamental cause of the frustration familiar to many managers – and perhaps patients for missed appointments – a high ‘Did Not Attend’ rates of 10% across the country may reflect many patient’s poor levels of engagement with the care they receive (NHS England Hospital Activity, 2014). It is true that giving patients times when they can attend, rather than a computer-generated slot may resolve this problem, but a more fundamental cause of the frustration familiar to the author is that many patients are frustrated with the ‘postcode lottery’ neither the choices, nor the ‘virtual’ choice as presented by the recently defunct Choose and Book system. Patients would be allowed to spend ‘their’ money on health care that they want to and with whom they wish. From a provider’s point of view, the money would come with the patient, not merely follow the patient around but to be spent on the patient and not on the current ‘Payment By Results’ system (Appleby et al, 2012). Assuming no distorting government constraints on the
that ‘Patient Activation’ has a positive effect on patient outcomes, reducing healthcare costs (Hibbard and Gilburt 2014; James,2013; Coulter and Ellins, 2006). Patient activation involves much more than giving patients control over their healthcare spending: it includes patient education and inclusion in shared decision making and outcomes. Nonetheless, and as has been previously observed, HSAs would seem to require no further evidence. Intervention from Singapore, where a similar system of HSA operates at the family level, suggests that this is the case. (Haseltine, 2013)

Despite this, there are two risks we must consider at the individual level, namely patients may choose to uncouple the kinds of care that they need: either patients may consciously or unconsciously decide to exclude their family members, or for those excluded. For the few who are unable to take advantage of HSA, or for those who are not able to understand or make their way around the system, there seems to be no real reason why healthcare should be available only to those who can afford it. For example, patients are likely to be unable to access services more quickly than poor people. They may be excluded from the system simply because of their income. Thus, the current system that there is a risk of divided healthcare spending, with poor people spending on those who are more richly endowed. This is currently individuals who have the choice of private or NHS care. This is likely to be more effective. In practice, however, it would appear that poor patients would choose to use the private institutions which are currently used by the rich, if they felt that the cost, and the reputation warranted it. In the face of this, there seems no reason why we should not have budget accounting, and be able to count the costs and benefits of changes.

Another objection may be that patients may not be able to manage their own healthcare budget. Again, this system does not expect us to manage the complexity of Type 1 healthcare, but only to manage the interventions they are being offered and seek out. It is then possible that patients may be unable to manage their healthcare needs acting as advocate.

The other side of this coin is ours. If patients can only manage their healthcare spending then we necessarily give them the option to make decisions that we would need to have made on their behalf. In this way, they may or may not choose to do this when completing other benefits such as jobseekers-allowance. We allow recipients to spend their benefits on beer and cigarettes even if we don’t approve. We allow it because the alternatives would be unworkable and oppressive. The more relevant question is whether the tendency towards inappropriate healthcare would be stronger than the similar trend from the individual problem with wider implications on the kind of patient that the NHS is.</p><p>The question then arises as to whether the system is working effectively. For instance, rich people be able to access services more quickly than poor people, would it widen or reduce health inequalities? It is the opinion of the author that the system would not change the inherent advantage of wealth, which currently allows individuals to access private health care when they have the resources. Few visitors will receive only Type 1 healthcare in an emergency, which compassion dictates every country should afford to its visitors. The availability and level of funding for HSAs would restrict access to Type 2 healthcare, which is the most costly NHS benefit, to legitimate residents.

Finally, we need to consider if HSAs would allow subsequent governments to remove the personalisation of healthcare to free healthcare at all the point of need simply by eroding the annual NHS credit, using pleas of poverty and thereby dismantling all but emergency NHS services. This is of course possible – there is no accounting for future governments’ decisions – but given the huge importance given to the NHS and to healthcare spending by the UK electorate it seems unlikely that reducing HSA contributions would be held by any government seeking re-election.

Conclusion

This paper has outlined a new system of funding for the NHS which splits healthcare into Type 1 – individually targeted and paid for directly by patients – and Type 2 – communally administered and affordable and unlimited in demand. Type 1 healthcare would continue to be delivered only by publicly funded, and publicly run entities. The system also ensuring that those who need the support received through a new system of Healthcare Savings Accounts (HSAs) which would provide a lifetime budget for individuals. This new HSA system would not change the demographic trends outlined in the introduction. The answer is to get aheadily in the short term on the prevalence or incidence of chronic disease. Where it is likely to have a significant effect is on cross-country differences in the pattern and nature of demand more subtly. The most hopeful sign we have that such HSAs would save money is the recent work done by the Department of Health on Personal Healthcare Budgets (PHBs). The results of the PHB pilot clearly show a cost benefit, and – importantly – a shift in patient satisfaction with the services over which they now have control (Forder et al, 2012; Jones et al 2013). As the system of HSAs to improve the cost efficiency of the entire system will also improve patient outcomes and patient experience. The system would reduce the problem of insurance, which reduces patient choice, undermines patient autonomy and causes costs to rise.

Implementing these changes would be difficult, there is no doubt. Even undertaking a pilot would be challenging, given the lack of cost visibility at the patient level within the NHS. However, none of what is suggested would be impossible, even with the objections outlined above. HSAs would provide many advantages while maintaining the NHS’s founding intention of providing universal healthcare free at the point of need.

The largest challenge will be making the political argument in favour of HSAs, given that the proposal will likely be mistaken for ‘privatisation’ and therefore received with hostility by both clinicians and patients. The risk is, however, that we fail to make any change towards faireed and open rationing. If we do not the NHS will become unaffordable, challenging its very existence. To maintain the NHS’s ambition of universal healthcare, free at the point of need – to maintain greater “expression of kinship” – two-stream funding system based on HSAs may be the only viable answer.

It is time to take the argument to the electorate.

References


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