

# 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 changing 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 policies 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’) or

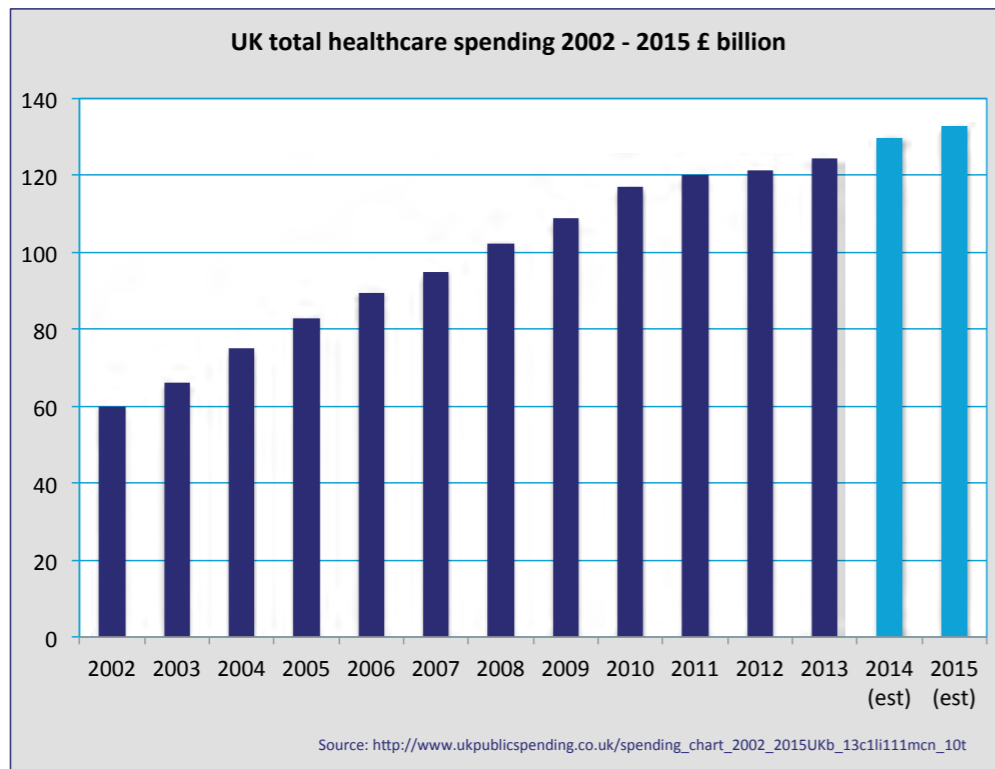
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bureaucratic problems. The response, such as with The Cancer Drugs Fund initiated by the current administration, is to favour an increase in funding (BBC News, 2014).

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 £10,000 per tax payer. Such a rise would not be sustainable without detrimental cuts in other public services, or substantial tax rises – neither of which seem plausible. Some people believe that these pressures are hastening the dismemberment 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 its founding principal 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 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 high because the inter-individual variation is so large. In other words, there is a significant minority of people who become unaffordably sick during their lifetime (Webb and Zhivan, 2010; French and Jones, 2004). Only very few individuals can personally afford the money necessary to treat complex conditions involving novel 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 identify 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 final 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 Bardsley, 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 (Haidt, 2012; Squires, 2011).

Although the effect is likely smaller in the NHS, it seems reasonable to assume that by removing the patient from all cost-benefit decisions, demand is increased and skewed in favour of more expensive interventions. Costs and service planning are managed instead through a large bureaucracy of government departments and quangos including NHS England, NICE, Monitor, CQC, Clinical Commissioning Groups, the Trust

Development Authority, clinical senates and many other (The King's Fund, 2013).

Despite this proliferation of bureaucracy, two entirely different questions tend to predominate in the debate about funding 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). Profiteering and health tourism or 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 removal of patient choice 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 eliminate 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, complex, capital intensive, often life-saving interventions which individuals can not reasonably afford. Examples include intensive care, novel cancer treatments, trauma services, emergency surgery, primary percutaneous cardiac intervention (PCI). Type 1 interventions tend to

be: research driven, dramatic (the stuff of TV documentaries), poorly predictable at 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 provide little 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 prevention, they can contribute only 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 considerations for the entire population through the trauma network. This centralised 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 can likely 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, midwifery services, community services, minor and day-case surgery as well as the majority of mental health services, outpatient services, elective hospital work and rehabilitation services. The list is, unsurprisingly, nearly endless.

The distinction between Type 1 and Type 2 may not, of course, be entirely obvious. 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 inter-individual variation 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 Type 2 healthcare needs. The HSA would be credited yearly with an amount that

would be broadly similar for every individual, but would be increased 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 beyond. Any surplus in the HSA 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 with them a debit card, similar to 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 and a model of patient behaviour, we can only make some broad estimates and offer some examples in order to suggest how this might work.

In 2011 the UK spent £121bn 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). This 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 irrespective of age or any other consideration. This budget also provided all the diverse health promotion and protection 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 settle on 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 roughly £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 delivering total health coverage for the employees and families in a hospital system in Southern Florida (Personal Communication, 2013).

Given the pattern of chronic disease, the yearly standard HSA credit would need to be less than this average figure of £1,500. A rough approximation might therefore 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 her work. For her arthroscopy she could choose any CQC licensed orthopaedic facility, advised by her GP, on the basis of cost, convenience and reputation. This would, allow her to 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 thus be free at the point of need. 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 'tariff' or 'standard reasonable charge' or post-hoc charges would undermine the reason for having 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 it is now – would be free at the point of delivery, but the cost would be visible and would therefore play a part in her decision-making.

Would this save the taxpayer money? Providing, as emphasised above, that costs are visible beforehand, and that the patient can make choices based on those 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 before the operation, she will 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, chronic obstructive 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 might now be £1,750, to take account of his long term conditions. With this he may need to pay for eye surgery, substantial prescription charges, possible elective hip replacement, and, in the long run perhaps, home oxygen therapy. Add to this the cost of outpatient and GP consultations, transport to and from his hospital and his financial need starts to seem considerable. Handing-over the cost management of such a diverse array of conditions to the patient may sound onerous, but such patients are required to 'manage the system' at the moment – a bureaucratic system which is rarely flexible or responsive to their personal needs. In this new system he need only present his HSA card where he chooses to seek advice and treatment in order for his savings account to be debited. It is possible that he may not 'shop around' for these, but some patients will – and he is likely to exercise choice in some areas more assiduously than in others.

He will, no doubt, benefit from retaining his GP as primary health care advisor who 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 deciding what treatments he receives, when and from whom.

Would this situation save money for the NHS? Clearly it is far more difficult 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 in the first example. There is strong evidence from the work on Personal Health Budgets (PHBs) that patients make better choices and improve their own health more actively if given a budget to do so. Their conclusion is that giving people control over their health spending improves their level of satisfaction with services and were cost effective (Jones et al., 2014; Forder et al, 2012).

Finally, let us imagine a third patient: an 86 year old woman with multiple co-morbidities and dementia who requires residential care and lacks capacity to make her own decisions. Her care and end-of-life choices must now be managed through her family or legal advocates. In this new system, as her life draws to a close, the government will provide something in the region of £2,000 – £3,000 per year for her medical care. Her degree of dependency and the chronicity and severity of her co-morbidities will determine the amount, and this in turn will govern the choices that are made in her best interest. Not much will change for the patient under the new system, but for most patients' families the ability to influence the decisions will be much increased since the 'integration agenda' and 'personalisation' – subjects which exercise and employ so many public servants at the moment – will fall directly into the hands of those who know 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 to the patients' detriment. There is no shortage of testimony from adult carers and families on the difficulty in

making the NHS system work for the patient (Patientvoices.org.uk, 2014). In this new system, such difficulties would be lessened since so much more power would be in the hands of the patients or their relatives. For this reason, as much as any other, it is the opinion of this author, bearing in mind some considerations set out in the next section, that this new system would be a more compassionate and responsive system while openly addressing the need for rationing.

The most important question is whether the sums involved would be sufficient for the needs of each of these patients? In the first case, clearly the patient has enough money – with plenty to spare. 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 study would help to fix the amounts at suitable levels. Overall, the aim would be:

*to give maximum responsibility and choice to patients, therefore requiring them to spend their own money rather than that of governments or insurers, but to make sure that nobody faced catastrophic medical bills and to make sure 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 cost-control and thereby 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 with it 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 where 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 as in the current Payment By Results system (Appleby et al, 2012). Assuming no distorting government constraints on the

market, this competition would drive up standards of service and allow providers to innovate in places where they are currently mired in bureaucracy.

Commentators argue that the benefit of market forces in healthcare are largely unproven or, at worse, shown to be unworkable (Nichols et al., 2004). This author would agree that market forces cannot and should not be used in the provision of Type1 healthcare. No severely injured patient wants to choose the trauma unit to which they are airlifted – and in this system such nonsense would not arise. But a market in Type 2 healthcare seems reasonable, providing that patients can judge which services 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 possible, the system is not – indeed can not be – responsive to individuals' needs. Personalisation is a near impossibility within such a large bureaucracy. A frustrating problem familiar to the author and to all acute-care service providers is the overly-lengthy 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 could free up to 3% of all hospital 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 cost of healthcare (NHS England Hospital Activity, 2014). It is true that giving patients times when they can attend, rather than a computer-generated slot might help this problem, but charging patients for missed appointments – a long-held desire of many managers – would now be possible with HSAs.

As suggested above, in the longer term, a system of HSAs would likely also encourage patients to make healthier choices, knowing that their government-funded healthcare is limited. There is substantial body of evidence

that 'Patient Activation' has a positive effect on health outcomes and reduces healthcare costs (Hibbard and Gilbert 2014; James, 2013; Coulter and Ellins, 2006). Patient activation involves much more than giving patients control over cost – it includes patient education and inclusion in shared decision making and more. Nonetheless, and HSA would surely encourage patient activation like no other intervention. Evidence 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 underspending and overspending. Some patients may anxiously hoard their HSA in anticipation of rainy-days to come, missing out on important Type 2 interventions that would keep them healthier. Specifically, they may not engage in health promotion or screening activities considered in the public interest. It may, in this case, be sensible to persuade patients to take-up such interventions through government information campaigns or to offer them free if they are deemed sufficiently important. It is likely that neonatal screening and health visiting may fall into a category of such 'essential' type 2 interventions.

Another objection may be that patients may not be able or willing to manage their own healthcare budget. Again, this system does not expect them to manage the complexity of Type 1 healthcare, but only to manage the interventions they are themselves seeking-out. It is surely paternalistic to assume that the adult population can manage all other areas in their lives – buying houses, planning travel, voting in elections – but that healthcare is somehow too difficult or too dangerous for adults to manage. Protection in law already exists for the vulnerable and for minors, the rest of us use money every day to make complex choices. We do this with our family, in consultation with our friends and with professional help. There seems little reason why healthcare should be excluded. For the few who are unable to manage their affairs, or for those who decide to abstain, a framework of advocacy would be necessary, as under the current Mental Health legislation. In this case the GP could retain their current role in managing patients' healthcare needs acting as advocate.

The other side of this coin is overspend. One danger is that the profit-motive may encourage firms to tout unnecessary health interventions, push-up costs and create healthcare need where there is none. There are significant concerns about this in the current system that there is an ongoing parliamentary enquiry into health screening (The Guardian, 2014; UK Parliament, 2013). The solution, as now, is to ensure that the system of CQC licensing, NHS regulatory oversight and advertising standards legislation provide enough checks on marketing. If we allow patients access to their own healthcare spending then we necessarily give them the option to make decisions that we might consider unwise. We already do this when providing 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 that stems from the systemic problem with insurance. It is the opinion of the author that this is unlikely. The question we are trying to answer is not whether we can or should dictate spending at the individual level, as we do currently, but whether we can ration healthcare spending overtly, reasonably and compassionately.

Nonetheless, the problem of individual overspend is a serious one. The main concern is what would happen if a patient's HSA 'runs dry', whether through frivolous overspend or misfortune? The answer is that enough subtlety would need to be included in the design of the HSA system to prevent this: overt boundaries would still need to exist (pure aesthetic surgery, for instance, would still be excluded); regulators would need to assure a level of responsibility among clinicians; extra payments would need to be built-in for long-term conditions and disabilities; financial oversight and advice would need to be available to those that were running-low on funds; and, like now, clinical boards could release more money in exceptional circumstances. A small minority of patients would need to take responsibility and change their behaviour. Currently there are very few barriers to patients coming day-after-day, week-after-week to the GP surgery or A/E department (BBC News, 2014)

The question then arises as to whether this system would be fair. Would, 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 this author that the system would not change the inherent health advantage of wealth, which currently allows individuals to buy private health insurance and bypass the NHS altogether or, for much of Type 2 healthcare, simply pay for it directly. Would the system take funds currently spent on poor individuals and families and spend them instead on those who are richer? Currently rich individuals have the choice of private or NHS care. This system does not suggest changing that. However, it would allow poorer patients to choose for themselves the private institutions which are currently used by the rich, if they felt that the cost, and the reputation warranted it in their circumstances. On the face of it, this seems more equal, not less.

Aside from the effects on individual patients, what would these changes mean more widely? Type 1 healthcare would still need to be managed centrally, and the political and administrative challenge of this would remain significant. New machinery would need to be introduced to manage 63m HSAs, along with the cost-visibility and cost-accounting processes. Managing this centrally would probably be a mistake, given the poor record of centralised healthcare IT systems (House of Commons, 2013). It might be simpler and quicker to regulate HSAs as a banking product – similar to Individual Savings Accounts (ISAs) – with rules on payments, standardised charges, and competition for customers, although that approach might be unpopular given the current reputation of banks. Either way, much of the machinery of the NHS would focus on attracting and serving patients as fee-paying customers, rather than dealing with the burden of centralised administration.

It is worth noting, as mentioned in the introduction, that a system of HSAs successfully addresses the two most common political arguments mentioned in the introduction, namely profiteering and health tourism. By splitting our interventions into Type 1 and Type 2 we can ensure that profits are made by private companies only in Type 2 healthcare where cost control is effected by the

patient – and where cost competition, if properly implemented, will drive out excessive profits. Type 1 healthcare would continue to be delivered only by publicly funded, and publicly run entities. The system also ensures that tourists and 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 renege on the commitment of providing free healthcare to all at the point of need by simply eroding the annual HSA 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 done lightly 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 unaffordable, uncommon and limited in demand – and Type 2 – common, affordable and unlimited in demand. The former would be planned and funded centrally in a similar fashion to the current system. Type 2 would be funded 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, nor make much headway in the short term on the prevalence or incidence of chronic disease. Where it is likely to have a significant effect is on efficiency of providers and in shifting 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 2014). This strongly suggests that using HSAs to improve the cost efficiency of the entire system will also improve patient outcomes and patient experience. The system would remove the systemic 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 however, is that we fail to make any change towards fairer and more open rationing. If we don't 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 greatest "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.

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