Education and debate

Funding the NHS Is the NHS sustainable?

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This is the last in a series of articles discussing how the NHS is funded.

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Abstract

The survival of the NHS lies largely in the hands of government, and this article suggests steps that it should take to deal with pressures on the NHS in terms of funding, managing efficiency, and demands. Changes to the system of funding may be unfeasible, but management could be improved by research to allow greater understanding of the local effects of national policies. Alternatively health authorities could be given more freedom to manage funds, although this would have to be accompanied by stiff sanctions for those who failed. Demand could be contained by strengthening policies to ensure that new technologies are cost effective. The government could try to reduce demands arising from increased expectations by encouraging informed public debate about priorities and influencing the availability of private health care. All these efforts should be guided by the values underpinning the NHS, which should be debated and decided collectively and confirmed in a new charter for NHS's 50th anniversary in 1998.

Introduction

Whether the NHS will be able to cope in future depends largely on how far the NHS can control and respond to the pressures on it.^{1 2} Arguments about the adequacy of funding are likely to continue because it is matter of value judgment, which of necessity is made by government.³ But the government also has the ability to modify the pressures on the NHS, and so how well the NHS copes is at least partly a function of political choice.

Obviously these choices will not be straightforward or easy, but it is important to try to identify those which may give the NHS a good chance of continuing to offer a quality of service which is acceptable enough to sustain public support. In this article we consider changes that could be made in three areas: funding, efficiency in use of resources, and demands.

Funding

The existing system of funding—a global budget under the control of a single agency (central government)—has been highly effective at containing spending and creating a general pressure to improve efficiency. Success in future will mean retaining a similar strong grip on spending. The government should therefore

ignore suggestions of other methods of financing that undermine the ability to contain overall costs.^{4 5}

But at the same time funding should not be constrained so far that the NHS becomes unacceptable to users. The central drawback at present is that there is no direct way in which voters can signal a desire for more spending on the NHS and their willingness to pay for it. In principle a hypothecated tax (a tax earmarked for health care) could do this, but it would need to have its own system of voting. In addition, there are considerable practical objections.⁶

So, could the existing system of public finance be modified to make it easier for the NHS to avoid national or local funding crises? Growth in funding has been erratic and the current widespread perception of severe financial pressure can partly be attributed to low growth this financial year combined with a redistribution of resources occurring as a result of changes in the national resource allocation formula.² It would thus be highly desirable for NHS finance to be partially insulated from the year on year pressures on the national budget and for health authorities (and general practice fundholders) to be protected from sudden changes in funds allocated to them. However, the pledge made by the present government to maintain year on year increases in real NHS funding was probably as far as any government is likely to go.⁷ Further protection of health authority budgets—for example, by making changes to the national resource allocation formula or slowing the pace of change of its impact—has to be balanced against the objective of ensuring resources match local needs. Significant improvements in the mechanisms of NHS funding are therefore, at present, unlikely to be politically feasible.

Efficiency

There are no readymade alternatives to the efficiency measures currently in use, but it is essential that the ability of the NHS Executive to maintain pressure for increased efficiency and its understanding of the effects of its policies are improved. As a start the government could, through the NHS research and development initiative, set up a national centre to develop a programme of research designed to improve central management of the NHS. Basic issues to be investigated could include the effect of the purchaser efficiency index; why there is a sharp rise in hospital

activity when morbidity seems to be rising slowly; and the effect of new technologies on overall NHS costs.

If improved central management seems too remote a prospect an alternative strategy might be tried. Although the 1991 reforms were said to be aimed at creating structures that were better designed to meet local needs, the reality has been quite different. The obligation to meet central targets has decreased local flexibility to experiment.

The government could change this. For example, if purchasers and providers in Glasgow have a good idea for restructuring services in the city which runs ahead of current policy, why not allow experimentation? To help, the government should outline the basic aims of purchasing and allow local freedom to decide how best these could be achieved, including relaxing the requirement to achieve national targets for a specified period. And unlike fundholding, these freedoms should be coupled with both monitoring (perhaps by regional offices) and evaluation against agreed objectives such as those set out below.

The price of this freedom would have to be a tougher regime for those trusts or purchasers which seem to be failing. This might involve extending the role of the Audit Commission to comprise external clinical audit. It would also require stronger sanctions in the case of failure—for example, replacing senior management teams as is done in schools. This would in effect mean the end of trust status in the case of providers.

Demands

The main demands affecting the ability of the NHS to cope are changes in demography and morbidity, introduction of new technology, and rising expectations.¹

Demography and morbidity

In principle the Health of the Nation initiative and preventive measures such as the breast and cervical screening programmes could affect both mortality (and hence demographic trends) and morbidity. But recent evidence makes it hard to be optimistic about the likely effect of The Health of the Nation on mortality or morbidity.⁸ Even if mortality were reduced, morbidity and service use may increase.⁹

An alternative strategy of increasing the individual's responsibility for health care to stem demand on the NHS might offer more hope. This would aim to reduce care seeking behaviour rather than illness.¹ Such behaviour might be partly influenced by means the government has already begun to use such as increasing users' knowledge, extending the use of over the counter medicines, and developing the notion of the doctor-patient partnership.¹⁰ But these efforts may instead fuel an increase in service use, such as that seen in recent years. If this were the case there would be a greater need to strengthen the criteria for rationing NHS resources.

Technologies

The government has taken a series of measures within the framework of the NHS research and development initiative which are likely to increase the capacity of the NHS to resist the introduction of new technologies before their worth has been proved.^{11 12} Essentially these measures encourage prompter identification of new technologies as they are introduced, better evalua-

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New technology must be thoroughly evaluated before it is introduced

tion of their costs and benefits, and guidance to purchasers on their effectiveness. But the existing policies need to be strengthened to require more technologies to be evaluated as a condition of introduction—for example, licensing criteria for drugs could include a test of cost effectiveness.¹³

Expectations

The government could attempt to shape demands on and expectations for the NHS and promote more meaningful debate in the media by encouraging a public debate about priorities in health care; encouraging greater openness and democracy; and influencing the level of private care available.

Setting priorities

No healthcare system can provide everything which could be of benefit to those in need, and furthermore it may not be appropriate to do so.³ The government should acknowledge this and stimulate discussion about who should be involved in rationing decisions, the principles on which rationing decisions should be based, and the level at which rationing should occur (implying what is the acceptable level of funding). This may result in specific services not being available on the NHS or, more likely, being available only if specific criteria such as proved cost effectiveness are met.

This approach could either help to stem pressures on resources or lead to unease and encourage greater use of private health insurance, thus undermining the NHS. But the current environment, where decisions on rationing are becoming more visibly arbitrary, transmits more unease than is likely if decisions were to be more explicit and systematic and grounded in principle rather than financial expediency.

Democracy

Patients now take a more active role in decisions affecting their treatment, but consultation in decisions about what services to provide is not so well developed. Though there are well recognised dangers in simplistically involving lay people in decision making, new methods are being piloted to include citizens in more sophisticated ways—for example, citizen's juries¹⁴ and deliberative polling, in which random samples of people are recruited from local communities to discuss

Consulting patients about treatment is far more advanced than consulting about services

public policy issues over an extended period, aided by information and advice from experts.

All of these efforts will contribute to more sophisticated expectations and debate among the public and the NHS. However, the risk remains that the greater awareness could result in more pressure on services.

Private insurance

The links between the NHS and privately financed care are complex and hence the net benefit to the NHS from the current balance of care is hard to disentangle. The treatments available outside the NHS (for example, in the private sector and in other countries) will influence the expectations of the public as well as NHS staff. However, the success of trusts in gaining income from private beds has made it easier for them to maintain NHS services, and the private sector can relieve financial pressure by paying for services otherwise paid by the NHS (such as elective surgery). But if the private sector grows rapidly it will make it harder to maintain across the board public support.

If public support appeared threatened more rigorous measures might be considered. For example, in Ontario private insurance is not allowed for any service available free via publicly funded insurance. Less draconian would be a gradual tightening of medical contracts, making it harder to combine public and private work, or fiscal measures designed to increase the cost of taking out private insurance.

NHS charter

The 50th anniversary of the NHS in 1998 presents an opportunity to develop some of the suggestions mentioned above into a new and more comprehensive NHS charter. This would identify the most important features of the NHS which should be preserved or changed. It should cover the values which should underpin the NHS (such as fairness); access to care (for example, whether care should be free at the point of use); the range of services to be paid for collectively and those which should be a private responsibility; the role of individual choice (including the rights and responsibilities of users); and the merits or otherwise of using existing democratic structures to enable the public to influence spending on the NHS directly, at a national level or a local level.

Such a charter would have limited value if it was confined simply to a statement of broad principles and objectives such as that contained in the annual

Planning and Priorities Guidance for the NHS.¹⁵ It would have to embody commitments both to specific policies and to indicators by which their success might be measured. As far as policies are concerned, this government could justifiably claim that it has been more innovative than other national governments, all of which face similar pressures. But in terms of true efficiency measures, external clinical audit, control of technology, the role of private medicine, and new forms of public participation it has been cautious or even negative. It has been slow, too, to develop a useable definition of high level objectives such as equity, despite its place as a core NHS value.

The government should encourage key interest groups to sign up to the charter stressing their responsibility for preserving the NHS. This public activity may serve to shape the expectations of the NHS by providers, the public, and therefore the media at least in the immediate future. As our needs and expectations change the exercise may need to be repeated in future.

Conclusion

Funding will continue to be an issue in the NHS, as in any healthcare system. Demands inevitably outstrip supply and an uneasy balance has to be struck. Whether this balance will remain acceptable enough to maintain public support is open to question, although in this series we have shown that there is no obvious reason why the NHS cannot continue to enjoy such support.

The pressures which have always faced the NHS are, to an extent, amenable to control. This article outlines some of the areas that a government could tackle to put the NHS in a better position to respond to current and future challenges. These suggestions are very different from those in the recent white paper,⁷ but we believe they must be tackled. Whether they are will depend on the capacity of government to recognise that further innovation is required and on the political will to implement them.

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