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Funding the National Health Service

THIS year marks the fortieth anniversary of the National Health Service. It also sees a recurrence of the 'funding crisis' that has periodically dogged the NHS since its inception. In the very first year of the service, the Minister of Health and the Chancellor of the Exchequer were engaged in exchanges about overspending, the need for a higher allocation and the possibility of charges or increased national insurance contributions as sources of finance.[1]

The Guillebaud committee[2] reported on the escalating costs of the NHS in 1956 and the British Medical Association[3] published a report on alternative sources of financing in 1970. Neither the issues nor the proposed solutions have changed much over the years. However, it is important to recognize that the current debate is not just about the financing of health services but also about the way in which health care is organized and managed. Papers commissioned by the Institute of Health Services Management[4] recognize this point. The papers examine the strengths and weaknesses of the current organization of the NHS and consider the numerous possible changes which have been put forward, such as health maintenance organizations or private health insurance schemes. It would be hard to quarrel with the conclusion that they draw for assessing the options.[5] 'Alternative systems should only be adopted where they: address real current problems; achieve the most effective balance tested against explicit criteria; do not in turn produce a new range of problems which may have greater disadvantages than the current system.'

The difficulty, however, is that there are different perceptions about the current problems of the NHS, and different sets of criteria against which to judge possible changes. The first Institute of Health Services Management working paper[4] identifies equality of access, equity, comprehensiveness and free services at the point of delivery as the objectives of the NHS and the criteria against which other proposed systems should be judged. If these objectives are not accepted, the evidence collected in the subsequent papers to support particular reforms is not persuasive.

There is one glaring omission in the criteria set out in the working papers[4] — the basic principles of funding health care are not considered. In the present debate the type of funding as well as the amount of funding is likely to become a leading issue and needs to be discussed. Chapter 4 of the *Final report*[5] sets out different funding methods but looks only at the practical issues not the principles. Essentially, there are two extreme approaches to funding with a spectrum in between. One approach is the benefit principle of funding, which requires that the amount individuals pay be related to the benefit they can expect to receive. Consumer charges or experience rated insurance payments would conform to the benefit principle. The alternative is the ability to pay principle, which would imply general taxation or insurance premiums related to income rather than health status. The present NHS arrangements lean heavily towards the latter principle, with only 3% of funding arising from charges.

The importance of the funding principle to the debate becomes clearer when the government's likely agenda in the NHS review is considered. One can speculate that the main points being considered are: how to achieve better use of existing NHS resources; how to mobilize additional private, out-of-pocket spending on health care; and how to enable consumers to have greater control over the service they receive.

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The second point may provide the basis for arguing for some shift in funding towards the benefit principle. In comparing UK expenditure on health care with other western countries, it has been observed that a bigger difference exists in private spending than public spending. It can be argued that higher levels of total spending on health care would be generated if individuals could be encouraged to supplement their tax contributions by spending on their own health care requirements.

The counter-view, that individuals would willingly contribute more to a general scheme can be argued just as plausibly. Even though individuals may not require health services now, they will be uncertain about their future needs and may consequently value the existence of an improved service.

Superficially it would appear that greater reliance on the benefit principle of funding would contribute to strengthening the consumer's voice in health care decision making. The idea that giving patients 'purchasing power' will enhance their position in a health care system underlies a number of curent proposals for reform. However, it would be naive to pursue this argument too far. One of the fundamental difficulties in organizing health care services is that the consumer (patient) is purchasing information (diagnosis and prescribed therapy) from the supplier (doctor). Therefore, the extent to which the consumer can effectively 'shop around' and compare alternative providers is limited.

This is a crucial point to keep in mind when assessing the major alternative to the current delivery arrangements; provider markets. Although various models have been proposed, the essential feature of all of them is the buying and selling of services between different parts of the health delivery system as a way of inducing cost-consciousness and, thereby, greater efficiency. One model proposes that general practitioners should hold budgets for all the health care needs of their list of patients. However, this approach also requires that patients could effectively choose between practices that might offer different care packages. The Institute of Health Services Management report concludes sensibly that any use of provider markets should be on an experimental basis.[5]

On funding, the review[5] concludes that the major options are the status quo or hypothecated taxation and compulsory public insurance. Both are firmly based on the ability to pay principle. Unless this principle is accepted by everyone in the debate, then the discussion is likely to proceed at cross purposes. Therefore, in appraising the alternatives on offer it is essential to agree first what the criteria of good health services are and then to use these to judge the likely effect of different systems.

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The challenge of caring for the elderly in the 1990s

ALTHOUGH it is common knowledge that the proportion of the oldest age groups in the population is destined to rise by 80% by 2006,[1] no credible forecasts of the numbers likely to require care from the social services have yet been produced. It has become increasingly clear in the UK that we can no longer consider health care systems separately from social care provision.

It is understandable that the nature of long-term social care for the elderly may not be of commanding interest to young doctors entering vocational training. Its low technological nature, the important role of voluntary organizations in key activities, the involvement of local government in the provision and development of many services and the growing influence of private providers of care combine to depict the care of disabled older people as somewhat outside the mainstream of medicine. Nevertheless, within a year of practising medicine in the community the young general practitioner will be left in no doubt that the management of ill elderly patients at home depends at least as much on the social resources available as upon the patients' medical needs. At present there are more pressing demands on resources than continuing care, and major capital investment on chronic care within the health service is unlikely to be provided. However, there is a clear need to plan for the future, and to define the limits of National Health Service responsibility in this area.

In spite of regional variations in provision of care most general practitioners are acutely aware of the extent of both unmet need and the mismatch between needs and resources. In a system where services have to be applied for, old people often lack the services they need. Such a state of affairs should, in theory, lead to urgent studies of the criteria used to allocate services.

Analyses for 1980,[2] the latest year on which suitable data have been presented, suggest that so far as the home help service is concerned the resources required to serve non-recipients in need far exceed the resources allocated to recipients not in need. In other words, from the financial point of view, umet need is a more important problem than the provision of services to people who may not need them. The home help service, on which more is spent than any other community social service, is inefficient, with home helps spending two-thirds of their time on jobs such as collecting pensions and shopping which could be performed as easily, and more cheaply, by others. Services are often unavailable at the times required, such as weekends and public holidays, and respond too late in deteriorating circumstances.

In Sweden, in 1968, an act was passed requiring local governments to approach every citizen who might need social assistance. From that moment, the authorities began mapping out social needs. Female and male home helps were employed by local authorities, and paid in accordance with an agreement with the Swedish Muncipal Workers Union. These employees usually work in autonomous groups of 10 to 15, and are specially trained to allow the skills of dependants to be retained. Clients may be attended three times a day, and work is even carried out on Saturdays and Sundays, the jobs being distributed so that heavy assignments alternate with easier ones.[3]

It has been suggested that for many elderly chronically sick patients the reality of community care is simply a transfer from one sort of institution to another.[4] For some time in the UK there has been a tendency to warehouse the elderly in the less