

How to afford a just health service

The argument is now, always has been, and always will be about rationing. From the inception of the NHS until quite recently, rationing was mostly achieved by the rough and ready system of waiting. The last government in its days of largesse decided this was intolerable. They threw a lot of money at the problem, created extra capacity by importing staff from overseas, opening new treatment centres, and setting targets, with the result that waiting times have dropped dramatically. However, the 7 years of plenty are over and we are facing 7 years (at least) of famine.

Rationing, what we ration and how we do it, will once again be top of the agenda for commissioning authorities, whatever efforts our political masters make to present the debate in alternative language. It's not clear, at least to me, what this is going to mean. We have increasing expectation from patients, and the ability to do more for them by using better, and more expensive medical technology. If past experience is a guide, the National Institute for Health and Clinical Excellence will continue to approve at least some of the new technologies that it considers and that will oblige commissioning authorities to provide them. The Department of Health will do its best to ensure that waiting lists don't get longer again, and the Care Quality Commission will do its best to ensure that we don't rush to diminish the quality of what is being commissioned. All of this is to be contained within reduced budgets. It is looking inevitable that the only way to keep within budget will be to restrict what is provided. Not to make patients wait for longer, but to declare that some services or procedures will no longer be available.

RESTRICTING SERVICES

Our PCT in Bristol has been trying to identify the least painful ways to accommodate budgetary cuts. For instance, the criteria by which patients qualify for hospital transport have been made much more stringent so that fewer patients get free transport to and from hospital. They will presumably use taxis more, to the benefit of Bristol's genuinely hard-pressed taxi drivers. This is short sighted and commercially foolish. If patients need to get to hospital, it would be much better to run a more liberal service out of the hospital which patients pay for according to need and ability to pay. In other

words a taxi service dedicated for transport to and from health facilities, but with profits (if any) going into the local health economy. Such a solution would run into an immediate and apparently insuperable barrier. It would be seen as a form of co-payment, and the Department of Health continues to promise us that there are no plans for co-payment, now or ever. This is the ultimate hypocrisy. As Michael Rawlins pointed out at the Royal College of General Practitioners (RCGP) conference in October, co-payment was accepted in principle long ago for charges on spectacles and dentistry; and prescription charges for medicines have been levied continuously since 1968. It's not important that the indigent, the old, and the young are exempt from prescription charges; it is important that the principle of co-payment has been part of the NHS for many years. Seen in that context, it would make commercial and moral sense to ask patients who are paying for transport to pay into a service run by and for the local health economy.

SCOPE FOR CO-PAYMENT

Once we get over our historical repugnance, and start to find co-payment acceptable in principle, we might be able to look for other sources of income. To take the most obvious example, we could start to discuss the vexed subject of hotel charges. There is an argument for asking patients to make a contribution to the cost of providing a bed when in hospital. The counter argument is that it's not something over which they have any control; that nobody chooses to be admitted to hospital; and that this would amount to a tax on being ill (analogous, in passing, to the arguments against charging patients for their prescriptions). Charging for meals is however, a different matter. Patients in hospital would be paying to eat if they were in their own homes, and could choose, at least in theory, either not to eat or to have their families bring food in for them. Charging for meals would give further encouragement to hospital catering staff to provide food of high quality, both in

nutritional and gastronomic terms, and at a range of varied but competitive prices. It's interesting to note that Disability Living Allowance and Attendance Allowance are stopped if the recipient is in hospital for 4 weeks or more. It's logical that the benefit system should not support people to be at home when they are in hospital, but it is arguable that this too amounts to a form of co-payment on hotel charges.

Dieticians are in short supply, and here in Bristol there is only a very limited NHS service. There are plenty working in the private sector for those able to afford them, though that is unlikely to include most of my poorer (and overweight) patients. Driving a bigger wedge into the idea of services according to need, and free at the point of delivery, our PCT has decided there shall be no routine NHS surgery for procedures such as carpal tunnel syndrome, early inguinal hernias, or uncomplicated varicose veins. Provided surgery is still available when complications arise that might be seen as acceptable, although waiting for complications rather than intervening early to prevent them is hardly the approach we have all been encouraged to adopt up till now. And all of this has been happening before cuts have really begun to bite.

So already many services are only available to those able to pay for them. Whether this amounts to privatisation depends on your definition. When Andrew Lansley was asked to give his definition at the same RCGP conference in Liverpool he gave the standard politician's answer: while patients are not having to pay for services then privatisation is not happening. An alternative view, and one accepted by the World Health Organization, is that any policy which results in a shift of provision from public to private sector should be seen as privatising. For observers and users of the services, it is a fatal error to get drawn into this interesting, but in the end pointless debate. What matters is how, in a time of austerity, we can provide a service that adheres to the principles that the NHS was originally designed to honour: that medical

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care should be available free of charge, according to need, and as far as possible, equally good wherever patients are living in the UK. The bleak prospect now is that commissioning authorities will be forced to restrict the available services; that knowledge of such restrictions will be a strong incentive for individuals to take out private health insurance to reassure themselves of comprehensive health care; that this will in turn lead to expansion of the private sector in a time of austerity; and this will accentuate health inequalities — in direct contradiction of the stated policy of successive governments.

PROMOTING A MIXED ECONOMY

Recent governments, working in a time of plenty, have sought to improve the service by developing a mixed economy with public money purchasing services from the private sector. When they talk about a mixed economy the deals all work that way round. At a time of government debt and public austerity it makes sense to think about turning the flow of money through 180° and find ways of bringing more private money in to support the public sector. Here many ideas have been discussed in the past, ranging from the almost plausible to the swivel-eyed. We could consider a nominal payment for every GP consultation, perhaps with forfeits for missed appointments. There has been the suggestion of paying for self-inflicted illness, such as those causing road accidents because of excessive alcohol intake, or those with smoking-related illness. The difficulties with all such ideas are not only practical (deciding quite how much personal culpability has contributed to the problem), but also moral, taking both a stern view of people as agents rather than victims of disease, and in monetary terms deeply regressive (with the poor likely to need more in the way of medical services and paying the same amount out of much lower incomes). Here's an idea that is definitely not regressive: with so many already covered by private health insurance there is surely scope to organise a system of co-payment for medical care for anyone using NHS services, but covered by private health insurance. And for anyone who thinks that looks really wacky, it's worth remembering that it's the way many other

countries organise their health care: those in work or with income above certain thresholds obliged to take out private health insurance and the rest funded by government taxes.

Would it be the end of the NHS as we know it? Of course. But campaigns to 'Save the NHS' risk losing sight of the much bigger question of how we provide a comprehensive, affordable, and just system for everyone. Establishing some kind of system of co-payment would be more transparent than what we have now, and part of that debate would include more open discussions about rationing. Trying to make use of private health insurance to pay for NHS services would be a move towards ending what some of us in the UK find most offensive, namely the divide between public and private sectors that currently institutionalises health inequalities and, if the divide continues for the foreseeable future, looks likely to accentuate them. The fundamentals are as I have outlined them: financial austerity; opportunities to ration services very limited; and the principle of co-payment already accepted. If anyone has a better suggestion for providing a service that is comprehensive as well as fair to rich and poor, then I should like to know what it is — and so, I imagine, would Her Majesty's Secretary of State for Health.

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