

ANALYSIS

NHS AT 70

What models of funding are best for a healthy and just society?

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The National Health Service was created in 1948 with the aim of ensuring that access to healthcare would depend on need and not ability to pay. “The essence of a satisfactory health service” wrote the health minister Aneurin Bevan, “is that the rich and the poor are treated alike, that poverty is not a disability, and wealth is not advantaged.”¹ In Bevan’s view, this required a healthcare system paid for out of general taxation rather than, say, a ringfenced tax or insurance with contributions tied to benefits. From the beginning, then, the link between payment for and consumption of healthcare was deliberately broken. Equality of access was to be accompanied by inequality in financing, with contributions based on people’s ability to pay. And there, you could argue, the story ends. Apart from some minor adjustments, the source of funding for the NHS has remained the general pot of taxes, with a small amount of additional revenue from patient charges. But there is now a growing sense that things might have to change.

Current funding gap

After eight years of historically low funding growth for the NHS (with per capita increases slowing from 4.4% to just 0.1% a year since 2009-10),² coupled with unabating demand pressures, the NHS is finding it increasingly difficult to maintain performance on several high profile targets.³ This is despite a fifth consecutive year of substantial overspending by trusts in the English NHS.⁴

The immediate prospects on funding do not look good either. The extra money announced last autumn amounts to a per capita boost of 0.7% next year, with next to nothing thereafter, and is offset by cuts elsewhere, including the public health budget.⁵ Against this background, the prime minister, Theresa May, has promised more money,⁶ but with the government intent on continuing its deficit and debt reduction path, and Brexit posing uncertainty for economic growth, it is unclear how any extra spending can be financed.

Principles of fair funding

This raises a fundamental question: what do we want the funding system to achieve?

Fortunately, there are some principles to guide us. Firstly, in a service based on the principle of equal treatment for equal need, financial status should impose no restrictions on access. This rules out a system reliant on out-of-pocket payments or private insurance since both link access to the ability to pay. The problem is aggravated by the inverse relation between socioeconomic status and health, making healthcare costs or insurance premiums highest for those with the least.

About 10.6% of the UK population have private health insurance, usually as a benefit provided by an employer. Being insured is strongly related to income, so that 38% of the top fifth of earners have insurance compared with only 8% of the bottom fifth.⁷ All countries recognise the inequalities associated with private finance. Even in the US, taxpayer funding in one form (Medicare and Medicaid) or another (subsidies and tax breaks for insurance costs) is substantial, accounting for about half of total health expenditure in 2016.⁸ Funding sources are also always and everywhere diverse: general taxation, forms of compulsory social insurance, and combinations of direct payments and subsidies to protect particular groups are the norm in most comparable countries, including France, Germany, and the Netherlands.

A question therefore is what might be the right balance between different sources of funding? Are there some benefits in, for example, expanding user charges—not just to raise funds but to reduce “frivolous” or unnecessary demand?

Charges do raise money, of course, and they reduce demand. The problem is that charges can only play a modest role in raising money otherwise they erode the goal of equity of access. As well as deterring overuse, the famous RAND Health Insurance experiments in the 1980s found that charging deters

legitimate use, particularly among the poorest, eldest and sickest patients.⁹ Consistent with this, the UK—with its limited charging regime—has much lower shares of the population that do not pick up prescriptions, do not visit the doctor, and do not get recommended for care compared to most other countries.²

A second principle to underpin any funding system is that it is fair. But what do we mean by fair?

This could mean that the wealthy should pay more than the less wealthy. Is the sum of taxes and revenues currently raised by government fair in this sense? If we look at income tax alone, the tax system is strikingly progressive, with the top 10% of earners contributing 59% of revenues in 2015-16.¹⁰ However, the NHS is funded by all taxes, not just income tax, and the other major sources of income—VAT and national insurance—are regressive.

Across all taxes, the top 10% of earners paid 27% of tax in 2015-16, which is in line with their gross income. Indeed, every decile pays tax almost exactly in line with gross income, so that the burden as a whole is neither progressive nor regressive but proportional to income.¹⁰

However, when the social gradient in the use of services is considered, the overall incidence of costs and benefits is redistributive. Poorer people die at a younger age but use NHS services more, and cost the NHS more, over their lifetimes than richer people.¹¹ Reflecting this, the formula for resource allocation to specific geographical areas has always been adjusted to account for area deprivation.¹² This is a feature (not a bug) of a collective system that seeks to diminish financial barriers to access and insure against the costs of care.

A third principle to guide us is that the system should raise “enough” funds to enable the provision of services at the quality and quantity that society, taken as a whole, has the willingness and ability to pay for. Over the past 70 years NHS spending has grown 10-fold in real terms and doubled the share of gross domestic product it accounts for (fig 1). Has this been enough?

International comparisons suggest the UK is a relatively low healthcare spender. A recent analysis found that per capita spending was, at \$3377 a year (£2500; €2800) in 2016, lower than that of the 10 comparable countries (Canada, Germany, Australia, Japan, Sweden, France, Denmark, the Netherlands, Switzerland, and the United States), and over a third lower than the mean among these countries.¹⁵ Consistent with this, the UK employs fewer nurses (8.2 per 1000 population) than the European Union average (9.0) and fewer doctors (2.8 v 3.7), and has fewer computed tomography scanners (8.0 per million population v 31.5).¹⁶

In this context, do the last eight years of strict financial control tell us that our reliance on government funding is letting us down? Some think so. Especially in an era of growing public distrust of government, some have argued for an earmarked (or hypothecated) tax that can help bolster public support for higher levels of funding by clearly linking new or increased taxes to the NHS. The idea has strong support compared with most other areas of publicly funded activity.²

Potential for hypothecation

In one sense this would bring the UK into line with its European neighbours. Many countries fund healthcare through compulsory social health insurance premiums—in effect, a hypothecated tax on wages and employers. However, with the introduction of extensive government subsidies to address gaps in coverage, most of these systems have actually been converging towards the UK model.¹⁸ It is not at all clear what advantage is to be

gained from the UK's moving in the opposite direction. In addition, governments here have tended to balk at the curtailment of budget flexibility that earmarking requires. With “pure” earmarking, in which the amount spent on a service is determined by the amount of money raised from a particular tax, the resulting unpredictability of funding is clearly impractical (although note the effect of economic recessions on NHS spending in fig 1).

An alternative proposal is to set an NHS budget based on independent forecasts of demand and set a tax rate that is expected to raise enough to cover the cost. If it turns out to raise more, or less, then the Treasury keeps the surplus or pays the extra from borrowing or general taxation.¹⁷ There are rumours that the health and social care secretary, Jeremy Hunt, supports the idea of ringfencing national insurance contributions for a similar purpose. But the fact that hypothecation tends to be premised on increases to regressive forms of taxation—such as National Insurance contributions—should give us pause for thought.

A different argument could be made for earmarked taxes on health damaging products such as tobacco, alcohol, or sugar sweetened drinks. In these cases, taxes help to address the behavioural causes of ill health and reduce healthcare demand, as well as raising money. And while the tax burden may be regressive, the distribution of benefits in terms of improvements to health is skewed towards those on lower incomes.

Hypothecation in this sense may help to persuade a sceptical public that an addition to its tax bills is worth paying, in terms of a better and more sustainable NHS. But it is not so clear that such a radical approach—one that, in the form proposed, goes against the grain of recent health system reform in Europe—is needed to persuade the public. Perhaps people are already convinced. Last year, some 61% of respondents to the British Social Attitudes Survey said they would be prepared to pay more tax to fund NHS services.² This may be a good time to take them at their word.

Conclusion

Consensus is growing that the NHS needs more money. The debate about how this might be paid for—from increasing user charges to creating a specific NHS tax—is worth having. But it is hard to see that the benefits claimed for such changes outweigh the costs of moving away from the current source of general taxation. Nonetheless we are clearly at a critical juncture in the history of the health service. The 10-fold increase in funding since 1948 has largely been financed from changes in government spending priorities—notably much reduced spending on defence, housing, and what were previously nationalised industries. There is now much less room for this sort of reallocation. Other areas of public service—including housing, welfare, and education, which are important determinants of health—have already been cut to the bone; extra money will inevitably have to come from new, or higher, taxes. More than ever before, higher taxes are an inevitable consequence of a desire to spend more. The choice, as they say, is ours.

Key messages

There is consensus that the NHS needs more money, but no agreement on where this should come from

After eight years of very low NHS funding growth, the majority of the public supports tax rises to pay for higher spending

Overall, the current burden of taxation is proportional to income but poorer people make more use of NHS services than richer people

The overall pattern of costs and benefits is redistributive, which is consistent with NHS principles and should be protected in any change to the funding regime

We thank the peer reviewers for their useful comments.

Contributors and sources All three authors have expertise in the analysis of health funding in the UK. MH and JA worked together on initially drafting the article, and MT added to and amended this before MH and JA finalised the draft for submission.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare that MT is a member of *The BMJ's* patient panel.

Provenance and peer review: Commissioned; externally peer reviewed.

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Figure

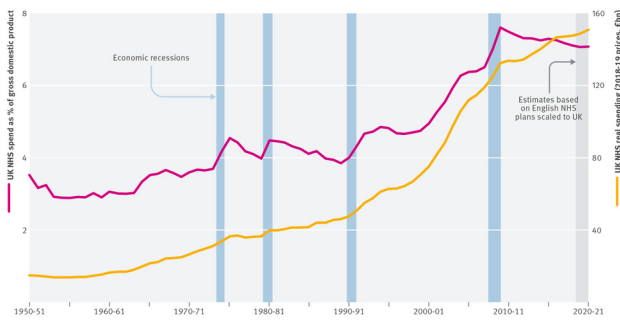


Fig 1 UK NHS spending as a percentage of GDP and in real terms (2018-19 prices): 1950 to 2020.^{13 14} Figures for 2017-18 to 2021 are author calculations (scaling up England NHS planned spend to UK at constant proportion (84%))