

NHS Contribute Extra

A return to the NHS's core values

Christoph Lees & Edmund Stubbs

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Christoph Lees has taken an interest in medical regulation, healthcare funding and access to high cost treatments since being one of the founding member of Doctors for Reform (2002-2012) and more recently the Civitas Doctors' Policy Research Group (2013-to present). Christoph is a Consultant in Obstetrics & Fetal-Maternal Medicine in London and Visiting Professor at KU Leuven, Belgium. He authored *Pregnancy Questions and Answers* (Dorling Kindersley 1997, 2001 & 2007), *Making Sense of Obstetric Doppler* (Arnold 2002) and has 130+ research papers in prenatal diagnosis and ultrasound.

Edmund Stubbs is Healthcare Researcher at Civitas. He studied Biomedical Science at the University of Sheffield and has a Master's degree in Health, Population and Society from the London School of Economics and Political Science. Edmund also worked as a healthcare assistant for four years at Addenbrooke's Hospital, Cambridge and as a freelance health consultant for one year.



55 Tufton Street, London SW1P 3QL
T: 020 7799 6677
E: info@civitas.org.uk

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Foreword

David Green, Director of Civitas

The NHS has never been under more acute financial pressure and yet political debate about how best to organise health care is paralysed by pre-election positioning. Discussion has been reduced to the shallowest emotional level: my party cares about the NHS; the others don't care. Any questioning of the 1948 model is treated as a kind of religious heresy.

Commitment to the NHS does resemble religious faith to some extent, but Western Christians long ago learned to distinguish between faith itself and different methods of worship. You could still be good Christian whether you believed that prayers should be said standing up, or you maintained that they should be said only while kneeling. Our political leaders should separate commitment to the ideal of universal access for everyone, which is our equivalent of religious faith, from the various business methods of achieving it. Faith in the ideal of health care for all is not challenged by anyone in Britain, but if you suggest that this ideal does not require the government to run all the hospitals or that insurance has a part to play, you will be treated like a non-believer. This frame of mind is that of religious fanatics who want to suppress all rival opinions. And yet, any calm observer can see that the people of countries such as France, Germany, the Netherlands and Switzerland are just as committed to universal access as we are, while supporting other methods of funding health care, most notably social insurance. Paradoxically, hostility to alternative methods of funding has prevented the British people from spending as much on health as citizens of other developed countries.

Perhaps this is why a recent opinion poll found that many people were open minded about both private provision and insurance. A survey by Lord Ashcroft Polls in January 2015 asked people what steps the government should consider to help fund the NHS in the future. 42 per cent said it should definitely or probably consider asking everyone to pay into an insurance scheme to cover their future healthcare needs. Nor were the majority hostile to private provision: 79 per cent agreed with the statement 'it is fine for the NHS to use private companies to provide services to patients as long as they meet NHS standards, the cost to the NHS is the same or lower, and services remain free at the point of use to patients'. Only 21 per cent took the alternative view that: 'private companies should not be

allowed to provide NHS services even if this would save money and improve treatment for patients'.¹

It is revealing that the Beveridge report – the blueprint for the post-war welfare state – warned against the dangers of state monopoly. In *Social Insurance and Allied Services* Beveridge said:

Social security must be achieved by co-operation between the state and the individual. The state should offer security for service and contribution. The state in organising security should not stifle incentive, opportunity, responsibility; in establishing a national minimum, it should leave room and encouragement for voluntary action by each individual to provide more than that minimum.²

His 1948 book, *Voluntary Action*, made the point even more strongly:

In a totalitarian state or in a field already made into a state monopoly, those dissatisfied with the institutions that they find can seek a remedy only by seeking to change the government of the country. In a free society ... they have a different remedy; discontented individuals with new ideas can make a new institution to meet their needs. The field is open to experiment and success or failure.³

He was particularly critical of the decision of the post-war government to ignore his recommendation to allow non-government organisations, such as friendly societies, to administer benefits, including medical services:

The marriage of 1911 between the state ... and the voluntary agencies with a hundred years' experience ... has been followed in 1946 by complete divorce. ... The state is now engaged in constructing a complete and exclusive administrative machine of its own.⁴

The Beveridge report did not lay out a final plan for financing his proposed comprehensive health service, but he expressed a strong preference for insurance in his early remarks:

benefit in return for contributions, rather than free allowances from the state, is what the people of Britain desire. This desire is shown both by the established popularity of compulsory insurance and by the phenomenal growth of voluntary insurance against sickness, against death and for endowment, and most recently for hospital treatment.⁵

And later in the section of the report on comprehensive health care he said:

One of the reasons why it is preferable to pay for disease and accident openly and directly in the form of insurance benefits, rather than indirectly, is that this emphasises the cost and should give a stimulus to prevention.⁶

He argued that financial considerations should not delay treatment and that to achieve this aim 'previous contribution is the ideal, better even than free service supported by the taxpayer'.⁷ He opposed a 'treatment charge' but was in favour of payment for 'hotel expenses' while in hospital. He reasoned that cash benefits were being paid for food and fuel in the home and, if the individual was in hospital, it was 'equitable' and expedient that the institution should receive reimbursement.⁸

Under the 1948 model, funding the NHS is a political decision made by political parties who allocate taxpayer funds, usually accompanied by a claim that their preferred level of funding proves how compassionate they are. Rival parties often promise even greater taxpayer funding as proof that they care even more. The British people deserve a bit more respect. In the long term we need to reflect on whether or not systems based on social insurance more effectively fulfil the NHS ideal, but today we need a reform that will allow individuals immediately to invest more in the NHS. Our suggestion is a voluntary NHS contribution fee. It will not only allow a rapid injection of extra money, but also open up the possibility of breaking free from the child-like constraints of the prevailing party-political debate.

Executive summary

The NHS is in urgent need of increased funding. It is currently struggling to maintain its essential services⁹ with a £30 billion funding gap predicted to exist by 2020,¹⁰ daily reports of Trusts in severe financial difficulties and unacceptable A&E waiting times. Following the 2008 financial crisis, efficiency drives have only led to annual savings of 0.4 per cent before 2010 and 0.8 per cent in recent years.¹¹ Achieving the greater two to three per cent efficiency gain needed to close the predicted funding gap is unrealistic without large systematic changes to funding policy being implemented.¹²

Public support: There is a public appetite for increased contributions to the NHS with a July 2014 survey revealing that the public are willing to pay more for healthcare; 60 per cent would be willing to pay increased income tax to support the NHS.¹³ In a survey of existing patients, 54 per cent said taxes *should* be raised to pay for healthcare.¹⁴

Back to Beveridge: The proposed voluntary contribution scheme will aid the restoration of the current NHS model to its original founding values, as envisaged by William Beveridge. The scheme will enable healthcare will be built more upon cooperation between the state and individuals, with the opportunity for individuals to voluntarily enhance their care above a substantial and secure minimum level that is already firmly established in the UK. Enhanced choice will ensure that people who are left unhappy with health services in their area will have a wide variety of options at their disposal, not simply voting for a new government in the hope that healthcare reforms could take place. Importantly, this will enfranchise those for whom completely 'private' healthcare would never be affordable.

Voluntary affordable contribution: A proposed NHS contribution scheme would raise funds in a progressive way through introducing a *voluntary* 0.5 per cent income deduction direct from payroll. It is projected that this measure would realistically generate up to £3.5 billion of extra revenue each year for the NHS. Citizens wholly reliant on benefits would be able to access the benefits had by other contributors for an extremely small charge, their payments being subsidised by the fees from more wealthy income groups.

The entitlement: Contributors would be under no obligation to call on their voluntary contribution entitlement and would be eligible for all NHS services exactly as now. However, they could choose to spend their 'personal NHS budget' with NHS providers or approved non-NHS service providers. The NHS contribution fee gives the individual entitlement to use the value of the tariff for a particular procedure or care package and transfer it to another provider without making any extra payment (in practice this is most likely to be another NHS provider). They could also transfer it and 'top up' any higher payments required in order to use non-NHS providers or Foundation Trusts offering extras. The fee would cover the administrative cost of making a transfer of funding to another NHS or non-NHS provider. It is likely that the fee would be administered by a commissioning group, and if, as envisaged, there were surplus funds then these would be re-invested into local NHS services in a way that the administering CCG (Clinical Commissioning Group) saw fit.

Using the entitlement in the NHS and not 'topping up': Though theoretically it should be possible to request referral to another NHS provider within the NHS commissioning framework, in practice many referrals are not possible due to a lack of funds and uncertainty by providers as to whether they will be paid. Referral management systems also seek to limit referrals, particularly in the case of some specialist services.

Personal responsibility: Contributors would receive extras such as gym membership vouchers. They would be encouraged to take responsibility for and engage in the preservation of their own health and wellbeing through annual 'health MOTs', where they would be set personal fitness targets in relation to their age and physical condition. Such targets might include weight loss or increased exercise levels for the coming year.

Closing the NHS funding shortfall: A voluntary contribution fee could contribute to the closure of the NHS's predicted £30 billion funding gap by 2020/21. The currently overstretched system increases costs and causes wastage. By reducing demand on healthcare providers (by letting people access alternative providers) less agency staff and locum doctors (temporarily employed doctors, without a permanent contract) would have to be used. NHS staff would also have less demands on their time, and thus could work more carefully and effectively with patients in order to refer them to the most appropriate team or ward for their

condition; reducing costly medical complications (such as readmissions) and improving outcomes, thereby saving the NHS money. Secondly the scheme would provide an increase in annual revenue for the NHS. Such a reduction in demand with increased revenue could make a valuable contribution to overall efforts to close the funding deficit.

Equity: The proposed NHS contribution scheme would help safeguard the NHS's core commitment to meeting the needs of everyone. Where NHS services are known to be poor, the alternative of seeking treatment elsewhere will be available to patients. This is one means of challenging the existing 'postcode lottery' where patients have widely differing quality of NHS treatment in different areas of the country.¹⁵ Money raised from the contribution fee could then be invested in these weak or inefficient NHS services, improving the level of care for those who use them, including those who do not contribute to the scheme.

No more reform: The NHS has been reformed too often and requires a period of stability and investment. Implementation of the voluntary NHS contribution scheme does not require the tendering out of any services, or seek to change the current logistical structure of the NHS. It would simply act as an add-on; allowing individual patients who chose to contribute an increased personal choice of provider instead of *having* to use those providers made available by the present block tendering out of services by commissioners.

A way of enhancing future goals: An NHS contribution scheme would work in harmony with, and indeed would enhance progress towards achieving the goals of current healthcare policy priorities such as the provision of more integrated care, more patient empowerment, the expansion of preventive healthcare, better out-of-hours care, and faster access to mental health services.

Introduction

The NHS is threatened by a funding gap which has been extremely well publicised and could potentially be as large as £30 billion per year by 2020.¹⁶ Even if current yearly efficiency gains were doubled (the NHS is already striving to maximise efficiency¹⁷) by 2020, we could still be looking at an annual funding gap of £16 billion.¹⁸ Further savings due to efficiency improvement seems optimistic, considering our ageing population and rising levels of chronic disease.¹⁹ Efficiency gains in the NHS amounted to only an average of 0.4 per cent per year between 1995 and 2010,²⁰ whereas it is estimated that efficiency gains would have to increase by two to three per cent to close the funding gap. The contemporary health care needs of the British population have greatly changed since Beveridge's day. His 1941 'giants of too little' (want, disease, squalor, ignorance and idleness)²¹ threatening the health of the population have been replaced with Le Grand's 2014 'giants of excess' – those of over-eating, excessive tobacco consumption and high levels of sedentary activity.²² The NHS, which has had no structural overhaul since its formation, is struggling to treat 21st century diseases such as cancer, diabetes and cardiovascular disease with the same approach used in Beveridge's day to treat communicable diseases.²³

It is hard to exaggerate the need for increased funding; over a quarter of healthcare trusts finished the 2013/14 financial year in deficit, directly threatening the provision of services in some areas.²⁴ The NHS's rising financial unsustainability²⁵ could threaten its very existence unless we are bold enough to take effective action. We need patients to take more responsibility for their own healthcare and health affecting behaviour.²⁶

An NHS contribution scheme could generate increased income in a progressive manner while reducing overall demand for already stretched services. It would encourage patients to become involved in their healthcare and thus modify their lifestyles. Contributors would be highly aware of their own 'standard care budget', using it, with increased flexibility, at NHS or non-NHS providers of their choice, sometimes with extra, out-of-pocket payments.

The key features of the NHS Contribute Extra

The fee is a solidarity contribution which gives the payer greater choice and options of enhanced care. Key features include:

- A progressive, *optional* monthly contribution fee enabling contributors to have choice over any provider for approved clinical treatment and obtain non-clinical extras.
- After paying four months' fees (to avoid individuals contributing only when illness arises) contributors would gain control of their personal NHS budget, defined by the NHS tariff for their health condition. This budget would be transferable to obtain treatment at *any* NHS, or approved non-NHS, providers.
- Extras such as gym membership vouchers or yearly health MOTs to set personal health and wellbeing targets would be offered to contributors.
- Social solidarity would be enhanced in two ways:
 1. Contribution fees would subsidise those wholly reliant on welfare benefits to have the same extras and provider choice for a modest charge.
 2. Fee revenue is expected to vastly exceed the cost of administering the benefits, with surplus monies being re-invested in NHS services at the discretion of administering CCGs.

This report will assess the need for change, the case for a new funding strategy and the way any such strategy might accord with current health policy priorities.

Background

Today's NHS

The Accident and Emergency Departments of hospitals in England are struggling to cope with increasing levels of demand. The situation has necessitated a government allocation of hundreds of millions of pounds in emergency funding in order to prevent system failure over the winter period.²⁷ Increasing numbers of patients have been waiting for considerable periods on trolleys (for up to 12 hours) before being seen or admitted. Numbers of such unacceptable waits have increased from 2,600 to 6,000 in the last year and four hour waiting targets are missed increasingly often.²⁸ Bed occupancy, even during the less busy summer months of 2014, reached 87.6 per cent; above the recommended level of 85 per cent. High occupancy implies that hospitals will be less able to cope with sudden spikes in admissions while full wards cause increases in cross-infection risks.²⁹ GPs are complaining of reduced funding in the face of increased demand, with patients often waiting over two weeks for appointments.³⁰

Previous research undertaken by Civitas has discovered that, according to a variety of outcome measures and patient care indicators, the UK still lags behind many of its peers in Europe.³¹ Considering both physicians and hospital beds per 1,000 citizens, the UK is especially deficient,³² ranked 12th in the 2012 Euro Health Consumer Index, consistently scoring less than most west European countries.³³ The NHS is hindered in its effectiveness by a lack of integrated (well-coordinated) care. Separate health and social care budgets mean patients are not always allocated to the provider best able to meet their needs,³⁴ leading to operational inefficiency and putting patients at risk.³⁵

What are the NHS's core values?

The NHS's core principles demand that the service 'meets the needs of everyone', 'is free at the point of delivery' and 'is based on clinical need, rather than ability to pay'.³⁶ These principles are related to funding as much as to provision. Hence, they relate to the NHS's risk pooling strategy, where the whole nation shares the financial burden of treatment costs. The service provision aspect of the NHS has often been labelled inefficient and poorly structured to treat contemporary types of disease³⁷ and, as mentioned earlier, is struggling to increase efficiency.³⁸ Any changes made to the provision side of the NHS would not necessarily challenge its

core principles. Such changes would simply make efficient, quality care easier or more difficult to realise. Beveridge's original proposals, which outlined the principles for a new post-war national insurance system accepted that individual recipients of health cover 'may be required to make larger contributions if the Fund proves inadequate'.³⁹ It might well be, based on recent experience, that contributions now need to be increased considerably. Beveridge's report also stated that 'Citizens, as insured persons, should realise that they cannot get more than certain benefits for certain contributions' but are free to spend over that.⁴⁰ It is the contention of this paper that a proposed voluntary NHS contribution fee will enable patients to augment NHS funds, thus enhancing the quality of its services while remaining committed to the NHS's core principles as outlined above.

What the NHS needs

Another administrative reorganisation of the NHS is likely to do more harm than good. It is impossible to test the true quality of a health system subjected to the level and frequency of reorganisation experienced recently in the UK, which has left staff 'dancing on a moving carpet whilst trying to care for patients'.⁴¹ A proposed NHS Contribute Extra scheme would not change the operational care delivery structures of the NHS, it would simply add an additional administrative mechanism to the existing structure, providing increased choice in both NHS and non-NHS provision, including enabling those whose incomes would not normally allow them access to non-NHS services, thereby providing a 'safety valve' to vent excess service demand. This would be a timely measure in a time of crisis where capacity constraints lead to bottlenecks. By increasing mobility and choice we could make the kind of incident observed recently in Colchester's general hospital, where admissions were stopped in an emergency measure to prevent system overload, much less likely to happen.⁴²

Rationale

Surveys show that the British public recognise that the demand for healthcare has increased and that this is largely due to an ageing population, the adoption of unhealthy lifestyles, and increased numbers suffering from chronic conditions.⁴³ Technological change has also expanded vastly the range of treatments available to patients, in turn making healthcare generally more expensive.⁴⁴ A survey taken in July 2014 revealed a public willing to pay more for healthcare. 49 per cent of participants were willing to pay extra income tax to support the NHS (this rises to

60 per cent when excluding participants who answered 'don't know').⁴⁵ Additionally, over half (51 per cent) of healthcare senior managers agree that the NHS needs to make 'large scale changes' to maintain current care standards, and most were 'highly concerned' at the growing pressures on the system.⁴⁶

The public has similarly expressed support for additional, voluntary payments in order to finance non-clinical aspects of care. Almost all those questioned in a recent study by *The King's Fund* said they would be willing to pay extra for luxuries such as finer quality bed linen, single rooms and better food.⁴⁷

A survey participant in the 27-37 year old group from Leeds stated:

You need a clean service. But if you want extra luxury you should pay for it.⁴⁸

The view was commonly expressed that the NHS's purpose was not necessarily to provide the latest available products or top of the range treatments. Some extras, such as branded drugs should be paid for out of the patient's own pocket if wanted.⁴⁹

Another participant in the same age category stated:

My friend has a prosthetic leg. It is OK and works. The NHS could have paid thousands more and given her one that is more comfortable and easier to walk in. But the NHS is there to fix you. It would be like crashing a 'normal car' and replacing it with a Lamborghini.⁵⁰

These and similar views indicate that some might welcome the introduction of the NHS Contribute Extra. The fee would not affect the quality of standard clinical procedures; it would simply enable patients to avoid (and consequently shorten for others) long waiting lists for non-urgent procedures, or to secure luxury non-treatment-related extras such as better food, accommodation etc. As an example, the Surrey and Sussex Healthcare NHS Trust has recently opened amenity beds with hotel facilities costing £250 per night to accommodate patients *while* they are receiving NHS treatment.⁵¹ While positive public opinion towards the introduction of an NHS contribution fee evidently exists, a lack of political support for such a measure has been an obstruction to the implementation of many previous innovative ideas for enhanced funding of the NHS.⁵²

The NHS Contribute Extra

About

Citizens who contribute to the proposed NHS Contribute Extra scheme would become entitled to access their personal treatment budget after paying four consecutive monthly premiums (to avoid individuals contributing only when anticipating illness). Contributors would then be entitled to access services to the value of the tariff that NHS commissioners pay to current providers of that particular required service, and to port this tariff between NHS hospitals, sometimes those providing enhanced services (effectively part paying for private services) such as NHS Foundation Trusts, or to use an independent approved private provider. This entitlement would not have to be utilised. However, when it was, it would enable many more individuals to access NHS treatment unavailable in their local provider as well as non-NHS treatment that would have previously been unaffordable to them. Theoretically, NHS referrals can be made between all care providers in the NHS free of charge. However, in reality, funding issues and administrative costs often prevent this from happening; this is especially true for specialist care. Extra charges for luxuries could be financed out-of-pocket by the patients themselves or by their claiming against relatively inexpensive supplementary health insurance packages (as is presently the case in France)⁵³ which would likely become available as a result of the implementation of the contribution scheme.

It is important to note that everyone would benefit from such a scheme with the availability of an additional, reliable income stream giving both NHS and private providers the confidence to increase their capacity. In particular, the additional income could encourage investment in separate facilities for elective procedures that are often cancelled at short notice when there is pressure on A&E departments.⁵⁴

Contributors could also benefit from extras aimed at improving public health and the engagement in personal health by individuals. These would be in the form of vouchers offsetting the cost of gym membership, or annual 'health MOTs' where basic clinical measurements such as pulse rate, blood pressure and percentage body fat would be taken, with personalised targets for improvement or maintenance being set in relation to physical condition. Such measures would encourage contributors to safeguard their own health and wellbeing. It is envisaged

that different extra packages could be offered depending on individual lifestyle preferences.

A large proportion of the additional revenue generated by the contribution fee would be invested in NHS services; consequently *all* UK citizens should experience a noticeable improvement in the quality of their health care. NHS foundation trusts might further cater for contributors (prepared to pay more) by offering a treatment package with added non-clinical extras, thereby increasing trust revenue, ultimately to the benefit of all patients.

What services would be covered?

The NHS constantly revises its tariffs, adjusts costing and gives various service uplifts on a yearly basis.⁵⁵ It uses groupings termed Healthcare Resource Groups (HRGs) to facilitate this process. HRGs enable medical interventions requiring similar levels of resources to be grouped together into cost categories. This procedure largely determines the budget hospitals will receive each year and approximately 1,400 such categories exist at present.⁵⁶ All services covered in these HRG categories therefore have an allocated tariff and thus in theory, could be transferred, by the contributor, to any accredited healthcare provider at that cost.

Service tariffs that could potentially be transferred personally to the patient include:

Surgery: from hip replacements and hernia repair to complex brain or heart surgery. Patients often feel unhappy with the present 18 week average waiting time for surgery in the UK,⁵⁷ and thus, might want to have the process accelerated by seeking non-NHS provision or provision with a less busy NHS provider located further away. Patients might also wish to pay extra for better hotel services during their stay in hospital.

Outpatient procedures: such as chemotherapy and dialysis. Dialysis must be conducted on average three times a week and each session normally lasts for approximately four hours.⁵⁸ For a treatment taking up such large amounts of time on a weekly basis patients may be willing to pay extra to use dialysis centres closer to home, to obtain better meals and facilities, or to hire home dialysis equipment. Similar alternative or additional services might be equally appropriate for other chronic conditions.

Diagnostics: the NHS aims to ensure that patients do not have to wait longer than six weeks for a diagnostic test. However, the number of patients waiting six weeks or longer for such tests increased by 5,100 in just one year (2013-14), and now stands at 12,500. Health concerns cause high levels of anxiety for individuals and their families; many patients might welcome the opportunity to be tested more rapidly in non-NHS facilities or to join a shorter queue at a provider further away. A knock-on effect from this might be to speed up diagnosis for standard NHS patients as numbers waiting are thereby reduced.

Rehabilitation: from orthopaedic procedure recovery to stroke rehabilitation, some patients might be willing to pay for more regular attention, or even for better quality accommodation and meals. If they play sport they might want to have the same physiotherapist dealing with their recovery 'on and off pitch'.

Pharmaceuticals: the NHS Business Services Authority produces a monthly PDF document listing tariffs for approved drugs.⁵⁹ This document could be used to determine the amount that the NHS would give to contributors deciding to use a branded version or even an alternative approved drug for the treatment of a specific ailment. Patients would only be allowed to choose from drugs known to produce equal or better outcomes e.g. for those cancer drugs currently unaffordable for the NHS.

Home care: patients who qualify for NHS continuing care might wish to pay extra to a non-NHS provider for longer, more regular home visits and/or the delivery of better quality meals.

Maternity services: from routine births to more complex situations, some couples may wish to top up their NHS allowance to receive non-NHS extras such as ultrasound scans, their own midwife or obstetrician.

Mental health services: even after recent government commitments to service improvement there remains a period of 18 weeks before people with common mental health disorders such as anxiety and depression have the legal right to receive treatment.⁶⁰ Consequently some potential patients simply go without, and indeed, 40 per cent harm themselves while waiting for treatment. One in six attempt suicide.⁶¹ It seems likely that many contributors may decide to take control of their budget and travel further to access NHS services at another provider or

perhaps pay extra to address their health crisis privately (aiding those remaining on long NHS waiting lists to be seen faster).

Palliative care: those close to the end of their life may also choose to pay for upgraded accommodation or more frequent home care services.

Means of payment

The NHS contribution fee could be deducted directly from an individual's salary in a similar way to national insurance or pension contributions. The optional payment would be set at 0.5 per cent of annual income and the maximum payment for any income group would be set at the equivalent of £104.17 a month or £1,250 per year. A lower amount would pertain for those wholly reliant on benefits.

Administration fees

The handing over of personalised budgets to patients would undoubtedly require a considerable level of administration. Tariffs would need to be transferred between NHS providers and from NHS to non-NHS providers. Thus some of the revenue gained from the contribution fee would be used to establish a comprehensive administrative service, dedicated to this function. The new administrative body could be called the Personalised Budget Support Service. This service might be provided by completely new public sector bodies, or by non-profit making social enterprises (mutuals) or community interest companies. Some existing CCGs might include specialised groups of staff providing administrative support for the scheme in their own CCG and neighbouring CCG areas. Additional staff would be needed to carry out these functions, paid for by part of the revenue generated by the contribution fee.

As regards obtaining treatment, a patient's GP or consultant would be required to give consent (electronically) for any procedure to be carried out (i.e. to confirm its necessity). As soon as contributors, with appropriate advice, have selected an approved provider, and this provider has committed to undertake the procedure, payment would be transferred. The selection and payment processes would be electronic and every contributor would have their own personal HRG code to track their progress through the system. The 2012 Health and Social Care Act has already specified that all payments for the provision of NHS health care services must be given at the nationally agreed tariff.⁶² As more national and local tariffs are

set (by the sector regulatory body, Monitor) it will make an increasing number of services available to NHS contributors. A similar administrative arrangement allowing patients access to services already exists in countries such as France,⁶³ Germany⁶⁴ and Switzerland,⁶⁵ where providers are paid for their services by national insurance bodies. Using the same model in Britain, the administration of and payment for contributor-chosen services could be devolved to the kind of administrative bodies outlined above.

National and local level funding

Funds raised centrally (through payroll deductions for contributors) could be redistributed according to the recognised levels of health need in local areas. The Personalised Budget Support Service for the area (whether joined on to a CCG or as its own social enterprise) could make decisions as to where contribution fee income should be spent (e.g. on failing services, preventive care etc.). As stated earlier, each contributor would receive vouchers for such extras as local gym membership and health MOTs to promote healthy lifestyle. These vouchers would have a code that could be redeemed electronically through the Personalised Budget Support Service and paid directly to chosen, approved providers.

Strength of intrinsic motivation

The contribution fee is proposed as being:

- Optional: priced competitively to allow those on low incomes to benefit while remaining attractive to those on high incomes.
- Equitable: contribution fees would provide funds that the NHS would not otherwise obtain and these would be reinvested in the overall service to the benefit of all users. Further, it is envisaged that the scheme would reduce pressure on waiting lists. Thus, those who choose not to join the scheme would also benefit from an improved service.
- Encouraging of healthy behaviour: through the provision of health MOTs and gym membership subsidies to help individuals focus on improving their personal health.

Anticipated benefits

1. Present under-performing hospitals (where many contributors might often seek non-NHS care as an alternative to using them) could experience a decreased demand for their services and therefore would be able to use this window of reduced demand, in conjunction with additional revenue generated by contributions, to invest in and improve their services. They might then attract more patients back *when* services have improved.
2. Patents would have much more choice over which NHS providers they use, with the NHS Contribute Extra fee facilitating the transfer of tariffs over all NHS services without providers involved losing money from having to pay for the necessary admin themselves.
3. Few can currently afford private health care in the UK,⁶⁶ with only 11 per cent of UK citizens having any form of private cover.⁶⁷ An NHS contribution scheme would enable more people to afford access to enhanced or alternative care if they so wish.
4. The contribution fee could create a much more stable funding stream for NHS providers while non-NHS providers could expect an increased demand for their services and thus a new and reliable source of income. This in turn would allow them to make more certain projections for the future and encourage new investments in services and research, thereby expanding the availability and quality of healthcare provision in the UK.
5. NHS Contribute Extra would promote equity by enabling people who are wholly reliant on welfare benefits to take control of their personal health care budget.
6. The contribution fee would be progressive with individuals contributing according to their level of income.
7. The scheme would reduce overall demand for NHS clinical services, resulting in increased bed availability and reduced waiting lists.

Four month exclusion period

In order to prevent a situation where some individuals become contributors only when they become ill and are in need of treatment, the NHS Contribute Extra will

have a four month exclusion period before tariffs are permitted to be transferred to other providers. This will not apply for pre-diagnosed chronic conditions and contributors will still receive all extras (health MOTs etc.) in these four months.

How much revenue would the contribution fee raise?

Income bracket lower limit ⁷⁴	Bracket mid-point	No. of earners in bracket ⁷⁴	Average cost of fee, monthly	Average cost of fee, annually	Total annual revenue
£9,440	£9,720	474,000	£3.80	£46.60	£22,088,400
£10,000	£12,500	6,700,000	£5.20	£62.50	£418,750,000
£15,000	£17,500	5,680,000	£7.29	£87.50	£497,000,000
£20,000	£25,000	7,400,000	£10.42	£125	£925,000,000
£30,000	£40,000	6,350,000	£16.67	£200	£1,270,000,000
£50,000	£75,000	2,430,000	£31.25	£375	£911,250,000
£100,000	£125,000	422,000	£52.08	£625	£263,750,000
£150,000	£175,000	132,000	£72.92	£875	£115,500,000
£200,000	£250,000	161,000	£104.17	£1,250	£201,250,000
£500,000	£750,000	29,000	£104.17	£1,250	£36,250,000
£1m	£1,500,000	11,000	£104.17	£1,250	£13,750,000
£2m	N/A	5,000	£104.17	£1,250	£6,250,000
Total		29,800,000			£4,680,838,400
England					£3,936,585,094

Table 1. Potential maximum NHS revenue generated from different income groups based on 100 per cent uptake for the entire UK (Based on 2013-14 Income Tax Liabilities)

As the above table indicates, the introduction of the NHS contribution scheme would have to be approved separately in Scotland, Wales and Northern Ireland, whose combined citizenship constitutes 15.9 per cent of the UK population.⁶⁸ Therefore, to make a realistic projection of possible revenue gained for the English NHS as opposed to that of the UK as a whole, we must discount projected fee revenues from those countries. Scotland has an average per capita income similar to that of England.⁶⁹ Wales, although slightly poorer, still has an average per capita income seven eighths that of England.⁷⁰ Due to Wales having only 4.8 per cent of the UK population,⁷¹ compared to Scotland's 8.3per cent,⁷² its potential contribution will influence any overall estimate of NHS contribution income less. Northern Ireland, although marginally poorer than Wales,⁷⁷ has only 2.8 per cent of the population of the UK.⁷³ In summary therefore, removing 15.9 per cent of the total contribution from the overall estimated NHS income gain would still suggest

substantial potential revenue to be gained from the contribution fee for England. If the contribution fee were to be compulsory for all English taxpayers then an annual revenue of £3.9 billion could be obtained.

Nevertheless, to obtain a more realistic projection of increased NHS Contribute Extra funding for the NHS we need to establish a range of scenarios and incorporate other, non-working, groups:

Pessimistic Scenario

- All tax payers earning over £200,000pa do not join the scheme and seek totally private health care provision.
- Only 25 per cent of those earning under £20,000pa decide to contribute.
- Similarly only 25 per cent earning over £20,000 but under £200,000pa contribute.
- Only 25 per cent of pensioners contribute.
- Lastly, 25 per cent of people with independent means contribute.

It seems quite possible, however, that at least some individuals in higher income groups would choose to enrol in the NHS Contribute Extra scheme. Also, that the low monthly contribution premium for those in groups earning under £20,000 per annum (£3.80 to £7.30 per month), combined with the prospect of obtaining contributor extras, could encourage many people in lower income categories to become contributors.

Optimistic Scenario

- 50 per cent of those earning over £200,000pa decide to contribute.
- 50 per cent of those earning under £20,000pa also contribute.
- 75 per cent of those earning between £20,000 and £200,000pa contribute.
- 75 per cent of pensioners contribute.
- 50 per cent of those with independent means similarly contribute.

Pensioners

As regards non-working groups of the population, pensioners often have a reasonable level of affluence with an average gross weekly income of £477.⁷⁴ They are also the most frequent users of healthcare services.⁷⁵ In 2013 there were over

8.7 million pensioners in the UK, with 4.25 million couples and 4.5 million single pensioners.⁷⁶ As with working age persons, pensioners would have the option of joining the NHS contribution scheme, calculated as a percentage of their total income e.g. they could choose for 0.5 per cent of their state pension to be transferred to the NHS contribution scheme, while all other pension income or earnings would also be subject to a 0.5 per cent deduction, should they choose to become contributors.

Average weekly income	Average yearly income	Number of pensioners	Average monthly premium	Average yearly premium	Total potential revenue
£477	£22,889	8,700,000	£9.54	£114.45	£995,715,000

It must be remembered once again to remove the 15.9 per cent contribution generated by Wales, Scotland, and Northern Ireland (assuming relatively homogenous distributions of age groups across the United Kingdom). If the scheme was limited to England only, such a revenue gain from pensioners might amount to £837,396,315.

We will assume that either 25 per cent or 75 per cent of pensioners might wish to partake in the contribution scheme. However it seems likely that many elderly people would see a payment of under £10 a month as being good value for the high usage this age group is likely to make of enhanced health services. A realistic estimate of income raised in England from pensioners' contributions might therefore range between £249 million and £747 million, but is more likely to be at the higher limit of this range.

People of independent means

22.3 per cent of the population are of working age, yet not looking for work.⁷⁷ Assuming that many in this group would wish to partake in the NHS Contribute Extra scheme, they would be eligible to make contributions at a rate equivalent to those in the lowest employment income bracket amounting to just £46.60 a year.

Average Income	Average yearly income	Number of persons	Average monthly premium	Average yearly premium	Total potential revenue
N/A	N/A	9,060,000	£3.80	£46.60	£422,196,000

Again we will consider between 25 per cent and 50 per cent of this group contributing (subtracting the 15.9 per cent of the UK population living in Scotland, Wales and Northern Ireland), England could expect to generate been £105,549,000 and £211,098,000 extra per year for NHS funding.

This would take our final range for revenue generated in *England only* to between **£1.2 billion (pessimistic scenario) and £3.5 billion (optimistic scenario)**. However the lower range of this estimate does indeed seem pessimistic, especially when considering the sizeable advantages for relatively little expenditure that elderly, high service using, groups in the population would obtain.

Those wholly reliant on benefits

Those wholly reliant on benefit payments would have the option to voluntarily allocate 0.25 per cent of their benefit payments to the NHS contribution scheme in order to join. This group would then benefit from all contribution extras (such as the yearly health MOT) that other groups receive, with more wealthy contributors' payments subsidising the costs.

Children

NHS Contribute Extra for children would be deemed as being funded by their parents' or guardians' contributions, remaining so until the children reach the age of 16, or 18 if in full time education.

Bridging the funding gap: How a voluntary contribution scheme might help

As mentioned earlier, NHS England's 'Five Year Forward' report states that, depending on the extent to which the NHS manages its efficiency gains, there will undoubtedly be a considerable annual NHS funding deficit by 2020/21. Current 0.8 per cent per year efficiency gains would, it is held, result in a deficit of £30 billion by that year, whereas a 1.5 per cent efficiency gain would lead to a projected deficit of £16 billion; if achievable, a two to three per cent yearly efficiency gain would, if maintained, close the funding gap altogether.⁷⁸

A proposed contribution fee, linked with enhanced and alternative service provision as outlined above, might make higher levels of efficiency possible by decreasing demand where NHS services are overstretched. Many NHS services are currently

running at '110 per cent'; this is neither efficient nor safe.⁷⁹ Once patients can choose which provider to use, it is predicted that those operating over capacity will have patients transferring to use less crowded services further away. A less pressurised provider will be able to use fewer locum and agency staff, while being able to focus on reducing mistakes and improving outcomes, thus saving money lost from costly readmissions and complications. It is also hoped that once staff are not 'running just to stand still'⁸⁰ in terms of patient care, they will have more time to improve the efficiency in what they are doing, with managers able to plan ahead instead of simply 'coping' with demand.

Extras, as already stated, contribute to existing (and stimulate new) initiatives aimed at preventing disease and would consequently reduce demand for NHS services, something that public health initiatives have, to date, singularly failed to do.⁸¹

In summary, the proposed NHS Contribute Extra would have two modes of action: increased funding and reduced demand. These would work together to reduce the NHS deficit and free-up staff to focus on increasing efficiency and improving quality of service.

Value of the scheme's extras

The value of NHS extras would be set at a level proportional to the average contribution of all those paying into the scheme. This would pay for the personal annual health MOT as well as financing discount vouchers towards the cost of gym membership.

Fictional examples

(costs quoted are indicative only)

Richard, 71

Richard is 71 years old and a keen gardener. However, his osteoarthritis has gradually worsened until it has become extremely hard for him to walk. Gardening has consequently become impossible. He finally decides to request a hip replacement but discovers that the wait for treatment in his region is presently over 12 weeks. His daughter however finds an NHS provider in his local area that has a 'private wing' where the cost of hip replacement would be £7,500. As Richard

contributes to the scheme he is eligible to receive the £5,500 that the NHS would have paid for his operation. His daughter offers to pay the outstanding fee for her father in order that he can receive the replacement right away and thus recover in time to enjoy the summer months in his garden. As an added consequence, the routine hip replacement waiting list is reduced for someone else and some of the £2,000 extra paid by Richard's daughter is used by the NHS provider to improve its standard services.

Amara, 58

Amara is 58 and has renal failure. She requires haemodialysis for three sessions of four hours each week. She wishes to go on holiday to Jamaica, but as Jamaica is not in the European economic area, Switzerland or Australia she must pay for her dialysis while in that country out of her own resources. Thus, two weeks of treatment while on holiday will cost £1,200. However, as she is a contributor Amara is able to draw down two weeks of her NHS dialysis budget amounting to £750. This makes the extra £450 required for her dialysis while on holiday a more manageable sum.

Nathan, 4 ½

Following a severe infection contracted by his mother during pregnancy, it had become apparent by the age of two years that Nathan was affected by cerebral palsy. After hearing of families in a similar situation spending their own money to obtain better physiotherapy in order to improve their children's strength and gait as well as to prevent the wasting of muscle, Nathan's parents, who contribute to the scheme, decided to make use of Nathan's personalised healthcare budget. They were thus able to draw down Nathan's NHS physiotherapy budget and use it to supplement his ongoing treatment. Although still a considerable personal expense, the cost of Nathan's additional treatment is affordable to Nathan's parents without them having to consider re-mortgaging their house, as would have been the case.

Engagement in personal health

Giving contributors 'health MOTs' with yearly improvement or maintenance targets could give people the motivation to make permanent changes in their diet and lifestyle. It has been observed (in relation to recent initiatives such as the Expert Patient Programme) that enormous benefit is gained by engaging patients in their

own (and others) care.⁸² It is envisaged that contributors' health MOTs would encourage patient and clinician to work together to manage any individual's health, thereby avoiding sudden crises.

Possible issues

Issue	Solution
<p>Potential two tier system could be created.</p>	<ul style="list-style-type: none"> • The NHS already has an unequal, tiered system depending on a patient's location in the country. • Health inequality is largely socio-economically and environmentally caused. • All groups will receive improved care from reduced service demand and increased funding.
<p>Loss of advocacy and pressure for improvement from reduced middle class users.</p>	<ul style="list-style-type: none"> • The middle classes only advocate better care for themselves, not for all. • Articulate middle class users often get preferential treatment to poorer groups and ethnic minorities.
<p>NHS Foundation trusts could potentially overly focus on contributors to the proposed scheme and private patients to the detriment of other patients.</p>	<ul style="list-style-type: none"> • The NHS has always treated private patients; however, successful regulation has protected NHS patients against discrimination. • Providing luxury extras to NHS contributors and treating private patients will give NHS foundation trusts much needed additional income to be recycled for the benefit of NHS patients.

<p>A loss of revenue for NHS providers could occur if contributors take their treatment, and hence their budget, elsewhere.</p>	<ul style="list-style-type: none"> • If services are of good quality contributors are likely to stay with the NHS provider in their area. • Thus where many contributors are seeking non-NHS care in preference to an NHS provider this can act as a warning system for poor care. • It also gives failing providers a period of reduced demand to improve services, while having the potential for increased investment from contribution fee revenue. • Patients would still most commonly use NHS providers, so they would simply have better choice of which ones to use. • Not all citizens will be contributors anyway, and thus will continue to use NHS providers as normal.
<p>Due to its optional nature, many people might not join the NHS Contribute Extra scheme.</p>	<ul style="list-style-type: none"> • Opinion polls show a public willing to pay more for the NHS. • Contribution amounts are small for low income groups. • Extras will act as incentives for people to remain contributors.

<p>Complications and errors from non-NHS provider treatments would cause unwell patients to be transferred to NHS providers for additional treatment.</p>	<ul style="list-style-type: none"> • This is currently happening in the NHS anyway. • Some studies have shown non-NHS providers to have better outcomes than NHS ones.
<p>The contribution fee could gradually increase over time.</p>	<ul style="list-style-type: none"> • This could only happen at the same rate as wages due to being a set percentage of income.
<p>People are essentially 'paying to leave the NHS'.</p>	<ul style="list-style-type: none"> • This is not true. The NHS is still funding the majority of each patient's treatment even if they chose to take their tariff to a non-NHS provider. • Many patients will simply transfer their treatment to another NHS provider of their choice or to a Foundation Trust with private services.
<p>Rich income groups may not wish to become contributors as they will have private insurance or could cost the NHS more money by becoming part of the scheme and thus receiving their treatment tariffs.</p>	<ul style="list-style-type: none"> • The wealthy have good health as a population and so will have low levels of service usage. • Their premia are important in subsidising those less well-off as it is they who will be making the largest contributions. • This group is likely to welcome NHS Contribute Extra due to its

	<p>potential to reduce insurance premia.</p> <ul style="list-style-type: none"> • People wealthy enough to have private insurance make up a small proportion of the population.
<p>Worries relating to privatisation of the NHS and to the large administrative costs for commissioners tendering out services to non-NHS providers.</p>	<ul style="list-style-type: none"> • This scheme is entirely based on increasing funding options and does not involve any 'supply side' reform. All administrative costs are covered by the contribution fee. • No tendering out of services happens as a consequence of the NHS Contribute Extra. • The NHS Contribute Extra scheme simply devolves choice to the individual, meaning both NHS and non-NHS providers must compete to attract patients irrespective of NHS commissioning budgets.

Detailed discussion of possible issues

An objection some may have to a proposed contribution fee is the belief that it will generate a 'two tier system'. Poor people will be stuck with standard NHS care while wealthier people will be able to seek care with other providers. However, we already have, in effect, a two or even three tier system where the wealthy have ready access to private care.^{83,84} We live in a highly unequal society.⁸⁵ Only 15-20 per cent of inequalities in British mortality rates are thought to be attributable to health interventions,⁸⁶ the vast majority of deaths are attributable to

environmental⁸⁷ and socioeconomic⁸⁸ factors. To deny genuinely better healthcare to poorer citizens, simply on ideological grounds, would surely be unethical. During the current funding crisis a practical goal would be to provide our population with better healthcare through increasing NHS revenue and decreasing pressure on the system while attempting to safeguard the NHS's core values of treatment being 'free at the point of delivery', 'based on clinical need, rather than ability to pay' and 'meeting the needs of everyone'.⁸⁹ The main socio-economic and environmental inequalities, which appear to cause higher mortalities in certain groups⁹⁰ such as recently recognised obesogenic environments,⁹¹ are what need to be addressed by health care policy makers to effect lasting change. Contributor extras can help to tackle some of these issues by helping to change individuals' lifestyles and social attitudes. The fact that the quality of NHS provision currently varies greatly from hospital to hospital and from region to region is of great concern and urgently needs to be addressed. In addition, 'post code lotteries' currently exist for access to services such as fertility treatments⁹² and weight loss services.⁹³ By directing additional contribution fee revenue towards poorer performing regions or institutions one could perhaps aid the standardisation of the Nation's health care system in terms of quality and reduce the inequalities of provision that have emerged over the past decades.

Another concern of opponents to the introduction of the contribution fee is that without a richer, more influential middle class regularly using standard NHS services there will be reduced advocacy within it for change and improvement. Thus, when services are discontinued, or decline in quality, middle class citizens who are contributors will no longer be affected by these issues to the same extent and consequently will no longer voice concerns. However, this is not a valid assumption. David Cameron recently spoke of a 'sharp elbowed middle class' who 'get in there and get all the services'.⁹⁴ Currently, the middle class do not often expressly try and drive up NHS standards for all. Through the 'virtues of their education, articulacy and general self-confidence' they ensure public systems work to their own advantage, convincing clinicians that their needs can only be properly addressed by specialist services etc.⁹⁵ Indeed a study of six million NHS procedures has shown that patients from deprived areas and from ethnic minorities are more likely to have their operations cancelled than more affluent patients.⁹⁶ This suggests that having a system where richer middle class individuals can no longer gain preferential access to superior services could prove beneficial for the

NHS as a whole. It would mean that instead of competing for the same resources, more money would be available for - and fewer patients would use - standard public services, enhancing the quality of treatment provided to non-middle class users. We must also remember that many middle class patients would continue to use NHS based services or NHS services with extras.

One more concern regarding the introduction of the contribution fee arises from anticipated situations where NHS Foundation Trusts compete for private as well as state funded patients. This could cause resources and equipment to be shared disproportionately towards private patients, leading to unsafe staffing levels and unacceptably low care quality. At best, staff may be much less attentive and sympathetic to standard patients, spending most of their time and energies with non-standard patients in a neighbouring ward or private rooms. However, when confronted with this hypothetical scenario we must remember that the NHS already treats many private patients each year. Indeed, since the coalition government removed the cap on trusts' permitted private patient earnings there has been concern that trusts are chasing private patients to the detriment of NHS patient waiting lists.⁹⁷ Nevertheless, trusts are still required to do the majority of their work for the NHS and no negative effects of this revised policy have yet been reported.⁹⁸ Additionally, trust provision for private patients has been highly lucrative, adding much needed revenue to foundation trusts' budgets.⁹⁹ Ideally, an appropriate private/public patient balance should be achievable through precise regulation whereby foundation trusts will be able to benefit from increased market opportunities, post contribution fee, while ensuring that they serve the entire public without chasing higher paying private or semi-private patients at the public's expense.

A loss of revenue might be anticipated for some in-house NHS service provision if many patients choose to be treated by non-NHS providers. Although a sizeable reduction in demand for services might threaten the sustainability of some large NHS clinics with expensive equipment it is reasonable to expect that contributors would often feel content to remain with their normal provider (perhaps choosing to pay for NHS luxury extras) unless treatment quality fell noticeably below acceptable standards. If large numbers of contributor patients were to leave an NHS provider, to the point where its sustainability might be threatened, contribution fee revenue could be used to invest in that provider stimulating it to improve. The NHS Contribute Extra scheme's personal budget would also enable patients to

'vote with their feet'; thereby flagging up poor providers by many seeking treatment elsewhere. It could thus help avoid incidents such as the recent mid-Staffordshire scandal where complaints and feedback from both staff and patients concerning serious problems were given little attention by trust managers, and consequently unrecognised by regulators and national management.¹⁰⁰ Many patients would simply chose to transfer their tariffs to NHS providers further away from their area. This would mean that larger clinics and hospitals with expensive equipment would become magnets for patients, increasing the usage of this equipment and thus giving the NHS better value for money.

Some might also claim that the optional nature of the scheme would mean that the vast majority of people would indeed chose not to join. However, as discussed earlier, the public seem willing to pay more for the NHS if they can see exactly where their money is going.¹⁰¹ In a survey of existing patients this remained the case, with 54 per cent arguing that taxes *should* be raised to pay for healthcare.¹⁰² Many people will surely choose to continue their use of NHS services, and, with extra contribution fee income, the NHS will be in a position to offer services not currently available.

It is frequently argued that complications or failures arising from non-NHS provided procedures will cost the NHS money in their rectification. At present, around 6,000 patients a year are transferred to NHS hospitals following treatment in private hospitals, with 2,600 of these transferred as emergencies.¹⁰³ However, it is entirely feasible to require non-NHS providers wanting to treat NHS patients to commit to taking full responsibility for any complications or failures (including paying the NHS for any emergency admissions that they cause). Providers might insure themselves against such eventualities. Both NHS and private providers are subject to inspection by the CQC;¹⁰⁴ when complications arise in the NHS, it is taxpayers who must foot the bill, if contributors choose other providers, the risk would be transferred, saving the NHS's resources.

Opponents to the NHS Contribute Extra scheme might further be concerned at the possibility of the contribution fee gradually increasing over time, possibly above the rate of inflation. However the choice of a percentage of income as the criterion for fee calculation means that any fee increase above that of salary, even that proposed at governmental level, would have to be justified and would be easily apparent to a critical media and all contributors. We must also remember that the

fee is voluntary. Thus public displeasure at any unjustified premium increases would easily be demonstrated by people leaving the scheme.

Some might claim that in essence paying these contributions means that one is 'paying to leave the NHS'. However, this objection is surely invalid as contributors will simply be able to transfer easily between NHS providers, pay to receive non-clinical extras with NHS providers or to transfer to non-NHS providers. They would continue to receive sizeable benefits from the NHS, as it will remain the principle source of funding for most of an individual's treatment. The fee would simply enable people to pay for luxury, non-clinical extras and a range of different providers for all or part of their treatment.

There is also the issue that the richest individuals in society (who would pay the highest NHS contribution premiums) already often have private health insurance and therefore might not want to become contributors. The State may wish to encourage this group to become contributors. If they did join, it is an unfortunate fact that they are likely to be healthier on average than those in lower income groups¹⁰⁵ and thus will present a lower demand for services while their high premia would contribute large amounts of money to the NHS Contribute Extra fund, enabling further subsidisation for those on low incomes. This group could be encouraged to join due to the reduced private insurance premiums likely to follow from the ability to transfer NHS tariffs for treatment to other providers (normally fully funded by private insurers).

One concern with regard to the tendering out of contracts for services to non-NHS providers is the substantial costs involved for NHS providers in participating in the tendering process itself; some estimates have placed the amount of this process at £10 billion¹⁰⁶ or around 14 per cent of total budget.¹⁰⁷ The expense of bidding for tenders, involving obtaining legal services and costly levels of administration, would constitute a considerable overhead perhaps needing to be covered by increasing charges for clinical services, thus acting to drive up general treatment prices.¹⁰⁸ To evaluate whether these tendering expenditures might prove cost effective in the long run is far outside the scope of this paper. However, the NHS contribution fee would not itself be promoting the tendering out of services. Each individual would be in control of their personal budget and could use any provider. This means that all providers would be competing to attract individual patients not large block tenders.

Some may object in principle to private sector expansion which is thought by them likely to be consequent on the ability of contributors to take their budget to non-NHS providers. They contend that private companies might cherry pick which services to offer and which patients to treat.¹⁰⁹ Easy to treat and therefore more profitable patients will be sought by private services while more unwell patients requiring more expensive treatment would be left to NHS providers. However, we must remember that although the NHS Contribute Extra scheme permits the purchase of non-clinical extras, all approved providers would receive the same treatment tariff. Additional profit can only be gained from offering luxury extras. Thus, offering any service might, in principle, prove profitable. If non-NHS providers choose not to offer a certain service, this will not affect patients who will simply receive NHS treatment. In fact the NHS treatment they receive would be of improved quality, having benefitted from extra investment generated from contribution fee funding.

A final objection to using non-NHS providers comes from the fact that NHS providers are often part of sizeable entities such as hospitals with many departments. For example Addenbrooke's hospital in Cambridge presently offers over 190 different services.¹¹⁰ These services share a lot of the same infrastructure in order to facilitate their care. It is argued that removing some services from the shared infrastructure would increase costs and reduce care quality, thereby threatening the sustainability of other services offered by the large provider. However, it must be emphasised that many non-contributor patients and contributors who are happy with the services offered in their area would still choose to use the NHS, sometimes paying for optional luxury extras provided by that trust. Indeed we anticipate that instead of current block tendering out of contracts, which forces the introduction of private providers, NHS foundation trusts will instead be able to respond to increased choice and 'soak up' demand for enhanced services, as many currently do. It also seems likely that a considerable demand for all NHS provided services would remain after the introduction of the NHS Contribute Extra scheme but that the reduced numbers of patients treated by the NHS would ensure that they receive better quality care and that facilities would not be overburdened as at present. The increased choice contributors could also mean that more patients make use of large hospitals, thus making better use of expensive, specialist equipment. In summary the NHS contribution scheme presents a 'win-

win situation' for both NHS providers, being able to invest in the new demand, and for patients who will have an increased choice of providers.

How does the proposed NHS Contribute Extra scheme relate to current healthcare priorities?

Integrated care

There is a broad consensus of agreement that integrated care should be a priority for modern healthcare.¹¹¹ Here, integrated care is defined as ‘a coherent and coordinated set of services, which are planned, managed and delivered to individual service-users across a range of organisations and by a range of cooperating professionals and informal care-givers’.¹¹² Such Integrated care could be enhanced, post introduction of a contribution fee, by the individual-centred nature of the range of care provided. Personalised budgets would ensure that patients become personally involved in their care pathway. After seeing their GP a contributor patient would have the choice between NHS, NHS extra, or non-NHS services for obtaining diagnosis, treatment or rehabilitation. Different bodies would have to co-operate with each other and also with the patient to ensure that they deliver an efficient, high quality service and thus maintain their reputation. Integrated care should also be enhanced for non-contributor patients accessing NHS services. As stated earlier, reduced demand for standard services would mean that professionals would have longer to consider each individual patient’s situation and liaise with previous and subsequent providers of their care.

Patient empowerment

The co-production of care by means of patient and health professional cooperation is gaining prominence as a goal to be achieved both in terms of improving services,¹¹³ and in encouraging effective interaction between patients and clinicians. It involves health professionals and patients playing an equally important role in any individual’s care, with mutual respect for the other’s opinion.¹¹⁴ One of the strengths of NHS Contribute Extra is that it would empower patients, giving them the personal control of their budgets and the subsequent power to ‘vote with their feet’ and leave substandard services. Consequently providers would have to offer a more personalised and responsive service to attract and keep their patients. ‘Voting with one’s feet’ would also help identify areas where NHS standard services (and non-NHS providers) are of poor quality, the evidence for which being many contributors seeking care elsewhere.

Preventive health

In 1978, by the Alma-Ata declaration, many of the world's health provision leaders and policy makers highlighted the importance of promoting a more holistic approach to health promotion, challenging negative economic, social and environmental health determinants.¹¹⁵ As stated earlier, in the UK only 15-20 per cent of health inequalities between social groups are likely to be caused by actual health care.¹¹⁶ Although the purpose of the contribution fee is primarily to improve the standard of care received by patients and save NHS resources, the scheme's extras are designed to encourage improvement in the wider determinants of health. This is a 'much needed' initiative, shifting policy focus towards preventive health care in order to tackle 'lifestyle generated' diseases before they become an expensive problem.¹¹⁷

Efficiency

It could be argued a contribution fee generating increased revenue for hospitals with a concurrent reduction in patient numbers may work against efficiency gains as staff might feel under less day-to-day pressure. In fact, even with revenue from a contribution fee it would remain essential that all staff, managers and clinicians maintain the drive to improve efficiency as, if not, patients would be more likely than before to 'vote with their feet' and choose alternative provision. The NHS is in a severe financial crisis and thus the contribution fee can only be effective in contributing to a complete closure of the projected funding gap if efficiency gains achieve the targets outlined by NHS England's 'Five Year Forward' review as detailed earlier. In fact, increased non-NHS provision could work to stimulate improvement in the public sector. NHS providers would, faced with competition, have a greater need to attract and keep patients, thus providing powerful incentives for achieving a much needed improvement in efficiency.

24/7 healthcare

Hospitals have recently been criticised for operating with reduced staff cover at weekends. As a consequence, according to recent research, patients were found to have a 16 per cent increased risk of mortality if admitted to hospital on a Sunday than on a Wednesday.¹¹⁸ If NHS contributors were able to seek treatment with non-NHS providers, who are likely to offer better weekend care (e.g. with more consultants on duty) then this might set a precedent for British health care in

general, putting pressure on institutions (bolstered by public expectations) to maintain equal staffing levels at all times.

Mental health

one in four people will experience some kind of mental health problem in the course of a year.¹¹⁹ In the under-65 age group nearly half of all ill health is due to mental disorders.¹²⁰ In a recent investigation mental health was found to be on average 50 per cent more debilitating than asthma, angina or diabetes.¹²¹ Despite these statistics, and the fact that mental health is widely recognised as causing or exacerbating physical ill health,¹²² only a quarter of people affected by mental illness receive any help. For such individuals NHS Contribute Extra could help shorten the waiting lists for current therapies by enabling greater use of non-NHS providers. At present, NHS mental health services are grossly underfunded¹²³ and considerable new funding is needed. Hopefully, the speedy treatment of mental health issues might then reduce physical care costs.¹²⁴

Merging health and social care

There is constant and growing support towards the merging of health and social care budgets.¹²⁵ Merging budgets, it is held, would end commonly occurring disputes between the NHS and social care services regarding the point at which the responsibility for patients changes from health care providers to social care. It is estimated that over 30 per cent of acute hospital beds are needlessly occupied (often by frail and elderly people) because of such disputes between health and social care services.¹²⁶ This fact illustrates the difficulty of discharging patients from hospital into social care and that patients are often in the inappropriate place to have their needs best met.¹²⁷ There are fundamental difficulties with merging health and social care budgets as the NHS is centrally funded and free at the point of delivery whereas social care is administered by local authorities and is means-tested.¹²⁸ Concerns are voiced that, once integrated, there could be gradual 'creep' of means testing from social care into some NHS services, and how, in the opposite case, means testing could justifiably be maintained for social care.¹²⁹ Nevertheless, NHS Contribute Extra could aid the transition to integrated budgets by enabling set social care tariffs to be given to each patient from the integrated health and social care budget according to previous means testing. Patients could then top up their budget privately should they possess sufficient resources to fund

care home fees or home care charges.

Conclusions

The proposed voluntary contribution scheme could offer an equitable means of helping to close the present and predicted health care funding gap. It would do so by raising revenue while reducing demand for services. It would combine a solidarity contribution with the expectation of enhanced care. The scheme could also increase our nation's healthcare capacity by ensuring an increased and better guaranteed source of income for both NHS and non-NHS providers in the UK, allowing them to expand and invest in infrastructure. Funds would be raised progressively, relating fees to income and the NHS Contribute Extra scheme would allow people to participate in maintaining a national institution founded on principles in which they strongly believe.

It is essential that any reduced demand for NHS services does not compromise efficiency. Efficiency savings must be made in conjunction with the revenue raised from the proposed contribution fee if we are to contribute to the closure of the funding gap. Improving general public health is also essential if we are to move from a biomedical 'emergency repair' approach for tackling disease to a more preventive and holistic strategy, appropriate for countering 21st century morbidities.

People might feel dismayed at the prospect of contributing yet more money for our health service, but the simple fact is that the NHS *is* very costly! If we wish to maintain the standard of healthcare to which we have become accustomed and indeed wish it to improve, then higher levels of funding will be needed. We must either embrace ambitious, large-scale funding measures such as the voluntary contribution fee proposed in this paper to maintain the social solidarity emphasis of our health funding, or we must decide what user charges to introduce for NHS services, or even what diseases the NHS might no longer be able to afford to treat - a highly undesirable situation.

Restricting the range of NHS treatments on offer would clearly compromise the NHS's core values. These were articulated in 1941 by Sir William Beveridge in his eponymous report as treatment being 'free at the point of delivery', 'based on clinical need, not ability to pay' and 'meeting the needs of everyone',¹³⁰ values that the British public are very unlikely to want to abandon. However, crucially, Beveridge envisaged a system that allowed each citizen to enjoy a basic minimum standard of care, but also allowed them the option to pay more if they so wished.¹³¹

Beveridge, in fact, envisaged a form of social insurance that Aneurin Bevan decided not to adopt with the introduction of the British NHS in 1947, but which was, by contrast, adopted in much of post war continental Europe. In the words of Frank Field, Labour minister for welfare reform 1997-98: 'In no way can we have anything like the NHS we have now if we are running such a huge deficit every year. We have to think about the second phase of the life of the NHS. It has to be reborn'.¹³²

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