BODY POLITIC Nigel Hawkes

How to tackle NHS funding crisis? Levy charges

Top class healthcare and social care aren't possible without private payment

The hunt for money to sustain the NHS in England is verging on the ridiculous. I thought that the Barker Commission, assembled by the think tank the King's Fund to work out how to pay for merging health and social care,[1] had hoovered up the very scrapings of the barrel. But then I heard Ed Miliband conjuring up farfetched ways to target unpopular people—mansion owners, tobacco companies, hedge funds—to keep the show on the road.[2] And I knew that the game was up.

Neither recipe will raise enough for the NHS to continue on its present course, never mind trying to add social care to the mix. And there's something demeaning in Miliband pretending that a few changes that won't hurt anybody you know but that will bear heavily on a few you don't know will solve a really major problem. It's on a par with Chancellor George Osborne's plan to tax Cornish pasties, which earned him well deserved scorn.

Kate Barker, who chaired the King's Fund commission, at least laid some of the costs on service users through a flat rate prescription charge (with no exemptions) and "hotel charges" (for bed and food) for continuing healthcare.[1] These are good ideas, as was her support for limiting the winter fuel allowance and free TV licences to people on pension credit, because the fuel allowance is expensive (costing £2.1bn a year) and possibly the worst targeted benefit ever invented. I'm getting ever closer to my free TV licence, but I'll bear up bravely if it never arrives.

Changing the rules of national insurance so that pensioners who continue to work pay a rate of 6% is harder to swallow, when we've been promised through a lifetime of work that contributions end at 65, when pensions begin. All's fair in love and taxes, but isn't enough enough?

Barker's report argues that it isn't, because other countries spend more on healthcare as a proportion of gross domestic product than the UK does. Ecological comparisons of this sort are the worst kind of medical evidence, but they suffice for economists. However, those countries that spend more tend to be richer (Switzerland, Germany) or in worse economic straits than us because they have failed to curb spending (France). None of these countries are actually happy to be spending as much as they do, so why recommend that we join them?

Assuming for a moment the NHS really is heading for an existential crisis unless more cash is found, then scratching around for a billion here or there in extra taxes or in benefits forgone is unlikely to avert the disaster. The gap between the UK and those countries used by Barker as comparators is £16bn a year. Currently about half the social care bill is paid by individuals or families from their own resources, and there is no compelling reason to believe that public funding would prove a more reliable long term source. To suggest switching spending from private to public just when the NHS on its own is testing the limits of what taxes can bear is wishful thinking, to put it politely. When I read in the *Health Service Journal* an article by Julian Le Grand, a member of the Barker Commission, headed, "The idea of charging for care may have been killed for good,"[3] my heart sank into my boots. I had him down as a champion of diverse provision in healthcare.

Most developed countries (20 of 29, according to the OECD) levy payments for visiting a GP, and half have some charge for hospital treatment. Even in the NHS, where copayment is anathematised, we have prescription charges, a dental service for which most people pay most of the costs out of their own pockets, and a largely privatised eyecare service where most have to pay for the cost of the tests as well as the glasses. So it's hardly terra incognita. People can learn to pay for services, and it usually makes those services better. Nobody wants disadvantaged people to be denied access to care, but none of these paid-for services are monopolised by the rich. Nor are any difficult to access, unlike primary care.

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Today's elderly people, the major consumers of healthcare and social care, are better off than their predecessors. The majority of their assets are tied up in houses, which represent windfall profits that homeowners neither expected nor did anything to earn. By 2018-19, three quarters of single pensioners will be owner occupiers. Yet in its wisdom parliament has accepted the principle that nobody should be forced to sell their home to pay for care, even when they are too ill to continue living in it. This sets the interests of the inheritors of properties above those of taxpayers, many of whom are so hard pressed that they cannot afford a property of their own. In practice, the Treasury has ensured that the principle is negated by financial limits that mean it will benefit very few, a wise precaution.

Wealthy economies today are like slow moving barges, so heavily freighted with commitments that their gunwales barely clear the waterline. In good times they can make progress, but when the weather changes they quickly take in water. That is the current fate of most of the Eurozone countries used as exemplars by the Barker commission. Even setting interest rates at nominal levels and heroic pump priming by central banks have failed to get some of them moving. The lesson is not to add more freight but to devise ways to shed it—a course so challenging that only Ireland and Greece have had the courage to try.

To believe that this huge funding challenge can be solved by fiddling at the margins is more than an error: it is a crime. If the UK wants top class health and social care it needs to find ways of paying for it that do not add to public spending or to debt. It won't be easy.

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