Personal health CARE budgets as a transition state to profit-driven care

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When the idea of introducing Personal Health Budgets (PHBs) in this country was first voiced, the Director of the King's Fund warned that the concept conflicts with a fundamental NHS principle, equity of care[1]. Sixty-eight pilots were nevertheless set up. Now the roll-out of PHBs for everyone from late 2012 has been announced[2].

The introductory-phase budgets are generous, and more choice for patients has been welcomed. As PHBs outsource administration of care to patients themselves, they benefit more-independent patients and dependent patients with trustworthy, motivated, and competent carers. However, as Van Ginneken and McKee document in a recent BMJ article, Dutch PHBs have diverted public funds to ineffective therapies, consumer spending, and unscrupulous brokers[3].

Substantial fraud and abuse emerged in the now-discontinued Dutch PHB experiment[3]. Early evaluations of English pilots reported that budgets failed to cover the previous level of service for some patients, and NHS teams no longer resolved problems with suppliers[4]. The DH predicted problems with PHBs, including exclusion of hard-to-reach groups, widening of inequalities, safeguarding issues, and public resistance to the rationing of access to healthcare involved and the fact that budgets will be too low to fund best practice interventions[5]. They also noted lack of transparency and means to measure outcomes. Furthermore, the switch to individual patient accounts destroys the national system of universal risk pooling and exposes each of us to financial risk from ill-health if the PHB turns out to be finite, as "budgets" tend to.

Will news of the drawbacks of PHBs convince UK policy-makers to drop their roll-out? Perhaps not: PHBs fit within a transition to an insurance-based model of care provision, part of a wider NHS marketisation plan[6]. The DH report[7] recommending PHB pilots discussed their role in increasing competition within health services, postulating three options:

> *1. Notional personal health budget - patients made aware of the options available within the budget constraint. The NHS retains all contracting and service coordination functions.*
>
> *2. Personal health budget held by an intermediary on the patient's behalf.*
>
> *3. Healthcare direct payment with which to purchase and to manage services. New legislation would be required for this model, which will only be appropriate for some.*

When our leaders guarantee NHS care "*continuing to be free at the point of need*" we hear "*nothing's changing*". But this "guarantee" equally fits an NHS-funded/private health insurance-based system, centred on option 2 above. As explained to potential investors by a former DH Commissioning Director:

> *"In future, the NHS will be a state insurance provider, not a state deliverer*[8].

PHBs are transferable government subsidies from the NHS budget to the private healthcare and health insurance industries. CGGs are being set up at public expense with the PHB-centred administration systems needed for compatibility with such transfers. Have you noticed the current abundance of advertisements for top-up private health insurance? If patients allocate their PHBs to their insurance companies not to CCGs, a two-tier service in English hospitals will result.

In 2004 Oliver Letwin reportedly told constituents that "*the NHS will not exist any more*" within five years of a Conservative victory, but would be just a "*funding stream handing out money to pay people where they want to go for their healthcare*"[9].

This final top-down NHS reform, or dissolution, would deliver a state-subsidised US–style insurance-based private healthcare market. The DH has targets to maximise the proportion of non-public sector providers commissioned[10]. Soon all the NHS hospitals will have exited Monitor's pipeline into the private sector. Thereafter "NHS" will be just a branding for "Any Qualified Providers", all of whom will be privately owned.

We will have a plethora of "choices" of service provision packages to research when purchasing service access from among struggling NHS-only local CCGs and booming nationally-based insurance companies. Healthy young men will be showered with bargain top-up insurance offers seeking to attract their PHBs. Cover may be denied to people with "pre-existing conditions", diseases manifested before the last premium was paid, leaving them exposed to medical bills alongside the uninsured.

A luxury service will offer high-tech medicine for private patients, including more medical tourists, as our Prime Minister seeks *"to drive the NHS to be a great business"*[11]. Prices will rise, and so will overtreatment. Our US-derived diagnosis-based tariff system ("Health-Related Groups") promotes overcharging, over-investigation and over-treatment mediated through supplier-induced demand and data manipulation. Coding patients for more aggressive treatment than they need makes the outcome statistics look good, triggers bonuses, and makes money for the hospital[12] but also increases morbidity and mortality: no treatment is devoid of risks. In meta-analyses of US healthcare statistics, costs were 19% higher[13] and death rates 2% higher[14] in for-profit compared to not-for-profit hospitals.

There will be second rate and patchy provision for the rest of us. Where PHBs must be overspent for needed care, in future the patient rather than the government can be charged. Spending of PHBs on ineffective therapies may at once waste the funds needed for acute care and raise the risk of its necessity, increasing mortality. The proportion of satisfied users will shrink rapidly unless PHBs rise proportionally with cost increases in medical provision; this does not seem a realistic scenario.

This "modernisation"[13] threatens to roll English health provision back seven decades.

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