The People's Dividend: A Proposal for a Competitive, Accountable, and Free National Health Service

Executive Summary

The National Health Service (NHS) stands as a monumental achievement of post-war Britain, founded on the unassailable principles of universal access, free at the point of use, and care based on clinical need. Yet, decades after its inception, the system is in a state of profound crisis. Eroding public confidence, unsustainable financial pressures, and systemic inefficiencies threaten to undermine the very covenant the NHS represents. While its founding principles remain as vital as ever, its current structure is failing to deliver. This report finds that the common perception of the NHS as a single monolith is a myth; it is a fragmented federation of hundreds of organisations whose administrative complexity creates friction and waste without the redeeming benefits of competition.

This report proposes a dramatic and significant restructuring of the NHS, entitled the **Universal Competition Model**. This is not a proposal for privatisation, but for a radical modernisation designed to preserve the NHS's core mission. The model introduces managed competition between a new ecosystem of regulated, non-profit **Health Security Funds (HSFs)**. These HSFs will act as champions for patients, competing for their membership based on quality, innovation, and patient experience.

The system will remain funded by general taxation, but this funding will be channelled through a new mechanism: a risk-adjusted **"Citizen Health Dividend."** This is a notional voucher allocated to each citizen, its value determined by their individual health needs. Citizens will direct their Dividend to the HSF of their choice, creating a powerful link between funding and patient satisfaction. This architecture is supported by international evidence from the successful managed competition models in the Netherlands and Switzerland, the administrative efficiency of Taiwan's single-payer system, and the tradition of social solidarity in Germany and France.

To ensure the market is fair, efficient, and serves the public good, the model establishes a new "iron triangle" of independent regulatory bodies: a **National Health Tariff Authority** to set transparent prices, a **Risk Equalisation Fund** to prevent the

"cherry-picking" of healthy patients, and an **Office for Health Competition** to oversee the market and protect consumers. Acknowledging the failures of past "big bang" reforms, this report outlines a carefully phased, decade-long transition to de-risk the process and build public and professional consensus. The Universal Competition Model resolves the paradox of how to introduce the dynamism and accountability of competition while ensuring the NHS remains comprehensive, universal, and free for all.

Section 1: The Anatomy of the NHS Crisis: Beyond the Monolith Myth

1.1 Deconstructing the Current Structure: A Fragmented Federation, Not a Monolith

A persistent public misconception frames the NHS as a single, monolithic organisation.[1] The reality is far more complex. The NHS in England is a sprawling and fragmented federation comprising hundreds of distinct organisations operating at national, regional, and local levels.[2] This structure includes primary care providers like GP practices and dental surgeries, which are often independent businesses contracting with the NHS, alongside acute hospital trusts, mental health trusts, and community trusts.[1]

This complex system is overseen by the Department of Health and Social Care (DHSC), which managed a budget of £192 billion in 2024–25, the vast majority of which is allocated to the NHS.[4] This funding flows to NHS England, an arm's-length body, which in turn distributes resources to local health systems.[4] The most recent structural reform, mandated by the Health and Care Act 2022, replaced Clinical Commissioning Groups (CCGs) with 42 statutory Integrated Care Systems (ICSs).[2] Each ICS is a partnership of organisations intended to plan and deliver joined-up health and care services for a specific geographical population.[2]

This structure creates a paradox. The system is simultaneously highly fragmented from an administrative perspective, yet operates as a functional monopoly from the patient's perspective. The existence of hundreds of separate organisations with their own management and recruitment teams creates significant bureaucratic friction, communication gaps, and coordination challenges.[1] However, because funding channels are centrally controlled and patients have limited effective choice between providers, this fragmentation does not generate the innovation, efficiency, or responsiveness that a competitive market might produce. The result is a system that exhibits many of the drawbacks of decentralisation—such as inconsistent administrative processes and data silos—while retaining the core rigidities of a state-run monopoly.

1.2 Analysis of Systemic Inefficiencies and Financial Distress

The user's premise that the current system "clearly isn't working right" is borne out by extensive evidence of deep-seated inefficiency and financial strain.

Financial Unsustainability: While public spending on health has increased by an average of 3.7% per year in real terms since the 1950s, growth since 2010 has been consistently below this long-term average.[5] This period of relative austerity has occurred while demand has surged due to an ageing population with more complex needs.[8] This structural imbalance is exacerbated by acute cost pressures. Staffing costs account for 49% of day-to-day spending, and unplanned pay awards create significant budgetary challenges.[5] Furthermore, high inflation for non-pay items like energy and medicines has added billions in unbudgeted costs.[9] The result is a system in profound financial distress. Between 2022/23 and 2023/24, deficits across NHS systems doubled from £517 million to £1.4 billion. Analysis shows that NHS trusts received only 90 pence for every £1 spent on patient services, forcing leaders into stark choices, including discussions about reducing safe staffing levels on wards.[9]

Administrative Dysfunction: The financial crisis is compounded by a pervasive and corrosive administrative malaise. Research from The King's Fund describes a "dysfunctional" system where poor administration is rampant.[10] A 2024 poll found that of those who had used the NHS in the last year, nearly two-thirds (64%) had experienced at least one administrative failure.[11] Common issues include having to chase test results (32%), not being kept updated on waiting times (32%), and receiving appointment invitations after the appointment date had already passed (20%).[10]

This is not a mere inconvenience. Patients report that these failures cause stress, anxiety, and deteriorating mental health, and can directly risk patient safety by causing missed or delayed diagnoses and treatments.[10] The system's administrative wiring is designed from an organisational, not a patient, perspective, leading to a lack of coordination and a sense that admin is "everyone's business but no-one's responsibility".[12] This critical function is often handled by a low-status, overlooked workforce, creating a barrier to systemic improvement.[12]

1.3 The Patient Experience: A Crisis of Confidence

The combination of financial pressure and administrative failure has precipitated a collapse in public confidence. Public satisfaction with the NHS plummeted to an all-time low of 24% in 2023, and further to just 21% in 2024.[12] This represents a startling drop of 39 percentage points from pre-pandemic levels.[13]

The primary drivers of this dissatisfaction are long waiting times for GPs and A&E, and a widespread belief that the service is wasteful.[13] Only 14% of the public believe the NHS spends its money efficiently.[13] This perception of waste, directly fueled by personal experiences of dysfunctional administration [10], creates a dangerous feedback loop. The public's willingness to pay more in tax to fund the NHS has fallen from 61% in 2017 to 43% in 2022, while the proportion who believe the NHS should "live within its budget" has nearly doubled.[14] The system's visible failures are eroding the political and public consent required to secure the very funding it needs to fix its underlying problems.

Crucially, however, this deep dissatisfaction with performance has not translated into a rejection of the NHS's founding ideals. An overwhelming majority of the public still believe the service should be free at the point of delivery (90%), available to everyone (89%), and funded primarily through taxation (84%).[14] The challenge, therefore, is not to replace the principles of the NHS, but to design a system that can actually deliver on them.

Section 2: Ghosts of Markets Past: Why the 1990s Internal Market Failed

To design a successful new model, it is imperative to understand why previous attempts at reform failed. The most significant of these was the "internal market" introduced by the National Health Service and Community Care Act 1990. This reform sought to inject market-style incentives into the NHS by separating the roles of "purchasers" of healthcare (such as Health Authorities and later, GP Fundholders) from the "providers" (newly established, semi-autonomous NHS Trusts).[15] The theory was that this split would foster competition, driving up efficiency and quality while maintaining a system funded by taxation and free at the point of use.[15]

2.1 A Critical Post-Mortem: The Purchaser-Provider Split

The internal market was, in practice, a flawed and incomplete experiment. As one of its intellectual architects, Alain Enthoven, later concluded, the essential conditions for a market to operate were never fulfilled.[15] The reforms were implemented as a "big bang" with little preparation; they were rushed, lacked proper pilot studies, and crucial guidance was not published until years after the system went live.[17] This chaotic rollout was a foundational error from which the system never recovered.

2.2 Identifying the Fatal Flaws

The internal market was plagued by a series of fundamental design failures that rendered it ineffective and ultimately unsustainable.

- **Failure of Competition:** Genuine competition never materialised. The ultimate market discipline—the risk of failure—was absent. It was politically and socially unacceptable for an underperforming hospital to go bankrupt and close, as this would lead to an immediate breakdown in local healthcare provision.[16] Without this credible threat, the incentive for inefficient providers to improve was severely blunted. The failure of the private company Circle to profitably manage

Hinchingbrooke Hospital serves as a powerful example; even a commercial entity could not succeed within the deeply flawed market structure, ultimately walking away from the contract after incurring significant losses.[18]

- **Failure of Funding Mechanism:** The core principle that "money would follow the patient" was largely a myth.[17] In practice, purchasers often continued to issue block contracts to providers, meaning hospitals received a fixed sum regardless of the number of patients treated.[19] There was no robust, universally applied mechanism to link payment to specific episodes of care, which neutered the financial incentives for providers to attract more patients by offering better or more efficient services.[17]
- **Perverse Incentives and Increased Bureaucracy:** Rather than streamlining the service, the internal market created a costly new layer of bureaucracy. The need to negotiate and manage contracts between hundreds of purchasers and providers led to a significant increase in administrative and transaction costs, with some estimates suggesting a rise from 5% to 14% of total NHS expenditure.[16] This fragmented system also created perverse incentives, with a focus on financial metrics over patient well-being, a dynamic implicated in care scandals such as that at Mid Staffordshire Hospital.[21]
- **Absence of Risk Management:** Perhaps the most critical technical omission was the lack of any sophisticated risk-adjustment mechanism. In any competitive health insurance market, there is a powerful incentive for insurers or providers to "cherry-pick" healthy, low-cost individuals and avoid sicker, high-cost patients.[23] The internal market had no effective tool to counteract this. Without a system to adjust payments based on the health status of the population being served, a truly fair and equitable market was impossible from the outset.

2.3 The Retreat from Competition: The Rise of ICSs

The manifest failures of the internal market have led to a decades-long policy retreat from competition. Successive governments, both Labour and Conservative, have progressively dismantled its core components.[16] This culminated in the Health and Care Act 2022, which formally abolished the purchaser-provider split and established Integrated Care Systems (ICSs) across England.[2] This move, prioritising local collaboration and population-based planning, represents an official abandonment of the competitive model and a return to an integrated, non-competitive framework.[16]

This history has created a "competition allergy" within the UK policy establishment.

The conclusion drawn from the 1990s experiment was not that a *poorly designed market* had failed, but that *all market-based competition* is inherently unsuitable for the NHS. This misdiagnosis has trapped the UK in a false dichotomy between a failed 1990s model and a return to a monolithic state-run approach, which risks re-entrenching the very inefficiencies the reforms were meant to solve. The crucial lesson is not that competition is wrong, but that its design is paramount.

Section 3: A New Blueprint: The Universal Competition Model

In response to the systemic failures of the current structure and the flawed reforms of the past, this report proposes a new framework: the **Universal Competition Model**. This is a dramatic and significant reimagining of the NHS, designed to introduce the dynamism of competition and choice while rigorously upholding its founding principles.

3.1 Core Principles: Re-affirming the NHS Covenant

The model is built upon the three timeless Bevanite principles: it must provide universal access to all residents, be free at the point of use, and be based on clinical need, not the ability to pay.[4]

To these, it adds three new, complementary principles for the 21st century:

1. **Citizen Choice:** The system must empower patients, giving them a meaningful and active role in directing their healthcare.
2. **Provider Competition:** The system must foster genuine competition between a diverse range of healthcare providers on the grounds of quality, efficiency, and patient experience.
3. **Radical Transparency:** The system must operate with a high degree of transparency, with performance data on all organisations made publicly available to inform choice and drive accountability.

This is explicitly not a model of privatisation. It is a system of *managed competition* between regulated, non-profit entities, funded entirely by public taxation. It draws inspiration from the successful "third way" healthcare systems of countries like the Netherlands and Switzerland, which have demonstrated that it is possible to blend market mechanisms with social solidarity.[26]

3.2 The Architecture: Three Foundational Pillars

The model rests on three interdependent pillars that separate the functions of Funder, Patient Champion, and Carer.

Pillar 1: The Citizen Health Dividend (The Funder)

The overall NHS budget will continue to be determined by Parliament and funded from general taxation and National Insurance contributions, as it is today.[5] However, this national funding pot will be translated into a per-capita entitlement for every resident: the **Citizen Health Dividend**. This is not a cash payment to individuals. It is a notional, risk-adjusted voucher representing the state's healthcare spending on that individual for the year. The value of each citizen's Dividend will be calculated annually by a new independent body, the Risk Equalisation Fund. Using sophisticated models based on age, geography, and diagnosed health conditions, the system ensures that funding is precisely matched to need.[28] A healthy young person will have a lower Dividend value than an older person with multiple chronic illnesses, ensuring the system is inherently equitable.

Pillar 2: Health Security Funds (The Champions)

A new ecosystem of competing, regulated, non-profit **Health Security Funds (HSFs)** will be created. These organisations will be the cornerstone of the new system, acting as the patient's champion and insurer. Potential HSFs could be formed from the expertise within existing NHS commissioning bodies, be established by major patient charities (e.g., Age UK, Macmillan Cancer Support), or be new mutual organisations owned by their members.

Every UK resident must actively choose an HSF to manage their Health Dividend for the year. This choice will be made annually during a national "NHS Open Enrolment" period. HSFs will compete for citizens' membership not on price (which is free to the citizen) but on the quality and nature of the service they offer. One HSF might offer an extensive network of providers and rapid access to specialists; another might focus on outstanding digital health tools and at-home care; a third might specialise in managing specific chronic diseases like diabetes or heart conditions. This is modelled on the successful system of competing, regulated insurers in the Netherlands.[30]

Pillar 3: The Independent Provider Network (The Carers)

All healthcare providers will operate as independent entities competing for contracts from the Health Security Funds. This network will include reconstituted NHS Foundation Trusts, GP partnerships, community health organisations, mental health specialists, and approved independent sector providers. An HSF, acting on behalf of its members, will be free to contract with any provider that meets its standards for quality and cost-effectiveness. It might contract with a leading NHS Trust for its world-class cancer services, a highly efficient private hospital for routine elective surgery, and a network of local GP practices for primary care. This creates a genuine, competitive market where money truly follows the patient's choice of HSF, and the HSF's choice of the best provider, fixing a fatal flaw of the 1990s internal market.[17]

3.3 The Patient Journey: How it Works in Practice

The journey for a patient within the Universal Competition Model is designed to be empowering and seamless:

- **Step 1 (Enrolment):** Once a year, during the Open Enrolment period, every citizen uses a simple, government-run online portal to compare the offerings of all licensed HSFs. They can review performance data, patient satisfaction scores, provider networks, and special programs before selecting the HSF that best meets their needs for the coming year.
- **Step 2 (Funding):** Once the choice is made, the citizen's personalised, risk-adjusted Health Dividend is automatically transferred from the Treasury to their chosen HSF. The citizen pays nothing.
- **Step 3 (Accessing Care):** The patient feels unwell and needs to see a GP. They use their HSF's app or website to find a contracted GP in their area and book an appointment. At the surgery, they present their new "NHS Card"—a smart card inspired by Taiwan's highly successful system [32]—which holds their HSF membership details. No payment is made. The GP practice bills the patient's HSF directly.
- **Step 4 (Referral):** The GP determines the patient needs a hip replacement and initiates a referral. The HSF's care management team then provides the patient with a choice of approved hospitals (which could be NHS or independent providers) that meet its quality and cost criteria, along with transparent data on

waiting times and outcomes for each. The patient makes the final choice.
- **Step 5 (Treatment):** The patient undergoes the surgery at their chosen hospital. The hospital bills the HSF for the procedure based on a pre-agreed national price. The patient pays nothing. The HSF is responsible for managing the entire care pathway, from pre-operative assessments to post-operative rehabilitation, ensuring a coordinated and seamless experience.

This model fundamentally re-routes power from a distant state bureaucracy to the individual citizen. The Citizen Health Dividend is not merely a funding mechanism; it is a political instrument that reframes healthcare funding as an individual entitlement. HSFs are accountable directly to the citizens they serve; if they perform poorly, they will lose members and funding in the next enrolment cycle. This creates a democratic and responsive feedback loop that is entirely absent in the current system.

Furthermore, this structure creates a genuine market for "health," not just "treatment." In the current system, providers are paid for activity—the more procedures they do, the more they earn.[34] In the Universal Competition Model, an HSF receives a fixed, risk-adjusted annual sum for each member. Its financial viability depends not on maximising treatments, but on keeping its members as healthy as possible for as long as possible. This creates a powerful financial incentive to invest in preventative care, chronic disease management, and innovative digital health solutions that reduce the need for costly hospital admissions—goals the current system espouses but struggles to deliver.[35]

Section 4: International Evidence for a New British Model

The Universal Competition Model is not a theoretical abstraction. It is a pragmatic synthesis of proven, successful components from some of the world's best-performing healthcare systems. It deliberately avoids ideological purity in favour of an evidence-based hybrid approach designed to achieve the best possible outcomes.

4.1 Managed Competition in Practice: The Dutch and Swiss Synthesis

The core architecture of competing Health Security Funds is drawn directly from the managed competition models of the Netherlands and Switzerland.

- **The Netherlands:** The landmark 2006 Dutch reform transformed the country's healthcare system into one based on mandatory private insurance and regulated competition.[26] The key lessons are compelling. Risk-bearing insurers have proven effective at controlling cost growth, which has slowed relative to neighbouring countries since the reform.[36] The Dutch experience also underscores the critical importance of powerful, independent regulatory agencies to oversee the market and ensure it functions in the public interest.[30] Most importantly, the Netherlands has demonstrated that it is possible to maintain universal access and social solidarity within a competitive framework.[37] The proposed UK model learns from Dutch challenges, such as high administrative burdens [36], by proposing a more streamlined single-payer administrative backbone.
- **Switzerland:** The Swiss system, known as LAMal, similarly requires all residents to purchase basic health insurance from a field of competing, non-profit insurers.[27] The Swiss model provides valuable lessons in the successful use of a legally defined basic benefits package, ensuring all citizens have access to a comprehensive standard of care regardless of their insurer.[27] It also proves the viability of extensive patient choice among providers.[27] However, the Swiss system involves significant out-of-pocket costs for patients in the form of high deductibles and co-payments.[27] The Universal Competition Model explicitly rejects this feature to remain true to the NHS's core principle of being free at the point of use.

4.2 Single-Payer Efficiency: Lessons from Taiwan

While the proposed model incorporates competing funders, its administrative and technological backbone is inspired by Taiwan's world-leading single-payer system, the National Health Insurance (NHI).[32] Taiwan's NHI acts as a single government insurer that contracts with a competitive market of mostly private providers.[32]

Key learnings for the UK model include:

- **Administrative Efficiency:** Taiwan's single-payer administration operates with costs of less than 2% of total healthcare spending, a remarkable achievement and a benchmark for the proposed UK regulatory bodies to aspire to.[33]
- **Technology Integration:** Every Taiwanese citizen carries an NHI IC smart card,

which contains their insurance details and medical history. This simple piece of technology streamlines administration, reduces fraud, and provides invaluable data for health system planning.[32] The proposed "NHS Card" is a direct adoption of this proven concept.

- **Global Budgeting:** The Taiwanese government successfully contains overall costs by negotiating an annual global budget for the entire health system.[33] The UK Treasury would adopt a similar approach to determine the total funding envelope for the Citizen Health Dividend each year.

4.3 The Social Insurance Tradition: Lessons from Germany and France

The long-standing social insurance systems of Germany and France provide crucial evidence of the stability and public acceptance of a pluralistic, multi-funder universal system.

- **Germany:** As the world's oldest social health insurance system, Germany's model is built on the principles of solidarity and subsidiarity, delivered through a decentralized network of over 100 public and private "sickness funds".[43] For over a century, it has successfully integrated a mix of public, charitable, and private providers, demonstrating the long-term viability of the pluralistic approach that underpins the HSF concept.[43]
- **France:** The French system provides universal coverage through a complex social insurance framework.[45] While its reimbursement model, where patients often pay upfront and are refunded, is not suitable for the UK [47], its powerful lesson lies in the successful management of patient choice. French citizens enjoy significant freedom in choosing their GP, specialists, and hospitals, whether public or private.[48] This proves that empowering patient choice within a universal system is not only achievable but can coexist with high standards of care.

The Universal Competition Model is therefore a deliberate hybrid. It is not a direct copy of any single country's system but a careful synthesis of their most successful elements, tailored to the unique cultural context and values of the UK. It takes the competitive funding model from the Dutch and Swiss, the administrative efficiency and technological focus from the Taiwanese, and the deep-rooted commitment to social solidarity from the German and French traditions. This pragmatic, evidence-based approach is its greatest strength and its most robust defense against

purely ideological critiques.

Section 5: The Regulatory and Financial Engine Room

A competitive healthcare market cannot be left to its own devices. To ensure it serves patients, promotes equity, and delivers value for the taxpayer, it must be governed by a powerful, independent, and interlocking set of regulatory bodies. The failure of the 1990s internal market was, in large part, a failure of regulation. The Universal Competition Model corrects this by establishing an "iron triangle" of three new, purpose-built institutions.

5.1 The National Health Tariff Authority (NHTA)

The first pillar of the regulatory framework is the National Health Tariff Authority (NHTA). This independent body will be responsible for developing, maintaining, and publishing the **National Health Tariff**—a comprehensive and transparent price list for all healthcare activities provided in the UK. This builds upon the concept of the existing NHS National Tariff but grants it greater independence and scope.[20]

The NHTA will use national cost collection data from all providers to establish a fair base price for thousands of procedures, consultations, and diagnostic tests.[49] These prices will not be static. They will be dynamically adjusted to drive desirable behaviours, incorporating:

- **Efficiency Factors:** To encourage providers to deliver care more cost-effectively over time.
- **Quality Modifiers:** To reward providers who demonstrate superior patient outcomes, safety records, and patient experience with a price uplift, while penalising poor performers.
- **Regional Adjustments:** To account for unavoidable geographical differences in the cost of providing care, such as higher staff and property costs in London (a "Market Forces Factor").[16]

This transparent, rules-based tariff creates a level playing field, allowing all providers—NHS, private, or third-sector—to compete on a fair basis. It replaces opaque block contracts with a clear system where HSFs know exactly what they are paying for, and providers know exactly what they will be paid.

Table 1: Sample National Tariff Structure					
HRG Code	**Procedure Description**	**Base Tariff Price**	**Quality Modifier**	**Regional Adjustment (MFF)**	**Final Payable Price**
HZ41Z	Primary Hip Replacement, Cemented, with Major Complications	£7,500	+5% (Top Decile Outcomes)	+15% (Inner London)	£9,084.38
DZ11B	Outpatient Consultation, Cardiology, First Attendance	£250	-2% (Below Avg. Patient Exp.)	+5% (Outer London)	£257.25
RD23Z	MRI Scan, One Area, with Contrast	£450	0% (National Average)	0% (National Average)	£450.00
AA05Z	A&E Attendance, Category 3	£180	+3% (Top Quartile Wait Times)	+15% (Inner London)	£213.21

5.2 The Risk Equalisation Fund (REF): The System's Cornerstone

The second and most critical regulatory body is the Risk Equalisation Fund (REF). Its sole purpose is to manage the risk-adjustment mechanism that underpins the entire system's fairness and equity. Risk adjustment is the technical solution to the problem of "cherry-picking".[24] It ensures that HSFs are compensated for enrolling sicker, higher-cost members, thereby incentivising them to compete to provide the best care for the most vulnerable patients, rather than avoiding them.

The REF will be an independent statistical agency responsible for:

1. **Developing and maintaining the risk-adjustment model:** This model will use anonymised data for every citizen—including demographics (age, gender), geography, and clinically coded diagnoses from their health record—to calculate an individual risk score.[50]
2. **Using a sophisticated classification system:** The model will be based on a proven methodology like the Hierarchical Condition Categories (HCC) system, which groups thousands of diagnoses into clinically meaningful categories and assigns a weight to each based on its predicted healthcare cost.[52]
3. **Calculating the Citizen Health Dividend:** Each year, the REF will multiply the national average per-capita health budget by each citizen's individual risk score. The result is the final value of that person's Citizen Health Dividend, which is the amount of money their chosen HSF will receive to manage their care for the year.

This mechanism fundamentally changes market incentives. An HSF that successfully attracts patients with complex chronic diseases will receive commensurately higher funding, giving it the resources to provide the specialised, high-quality care those patients need.

Table 2: Illustrative Risk Adjustment Calculation for the Citizen Health Dividend				
Patient Profile	**Base Capitation (UK Average)**	**Key Risk Adjusters (Multipliers)**	**Final Risk Score**	**Final Annual Citizen Health Dividend**
Patient A: Healthy 30-year-old male, no chronic conditions	£3,500	Age/Gender: 0.85 Clinical (HCCs): 0.00	0.85	£2,975
Patient B: 55-year-old female with managed Type 2	£3,500	Age/Gender: 1.20 Clinical (HCCs): Diabetes	2.00	£7,000

Diabetes		(+0.80)		
Patient C: 75-year-old male with Congestive Heart Failure, Cancer (in treatment), and COPD	£3,500	Age/Gender: 2.10 Clinical (HCCs): CHF (+1.50), Cancer (+2.50), COPD (+0.75)	6.85	£23,975

5.3 The Office for Health Competition (OfHC)

The third pillar is the Office for Health Competition (OfHC), a powerful, independent regulator with a mandate to ensure the market is competitive, fair, and transparent.[54] Its responsibilities will include:

- **Licensing and Quality Assurance:** The OfHC will license all HSFs and providers, setting stringent minimum standards for financial stability, governance, and quality of care. It will have the power to fine or de-licence any organisation that fails to meet these standards.
- **Antitrust and Market Oversight:** The OfHC will act as the competition authority for the healthcare sector, preventing the formation of provider monopolies or excessive HSF consolidation that would harm patient choice and value.[54] It will have a specific remit to scrutinise private equity involvement to prevent the kind of exploitative dealmaking and asset-stripping that has been seen in other sectors.[57]
- **Information and Transparency:** A core function of the OfHC will be to mandate the collection and publication of standardised performance data. It will create and manage a public-facing portal—a "Rightmove for Healthcare"—where citizens can easily compare HSFs and providers on metrics like waiting times, patient-reported outcomes, infection rates, and satisfaction scores.
- **Consumer Protection:** The OfHC will serve as the ultimate arbiter of complaints, with the power to compel HSFs and providers to remedy issues and compensate patients for poor service or care failures.

These three bodies form an indivisible regulatory system. The Tariff Authority's prices are only meaningful if the Risk Fund ensures fair payment for complex cases. Fair risk-adjusted payments are only effective if the Competition Office ensures providers

cannot merge into monopolies and dictate their own terms. And the Competition Office can only enforce pro-competitive behaviour if it has clear rules on pricing and risk to work with. This integrated design is the essential safeguard that was missing from all previous attempts at reform.

Section 6: A Ten-Year Transition: A Phased and Deliberate Rollout

Radical change requires careful implementation. The "big bang" approach that characterised the chaotic introduction of the 1990s internal market provides a stark lesson in what to avoid.[17] A reform of this magnitude must be gradual, evidence-led, and phased over a decade to manage risk, build confidence, and ensure a stable transition for patients and staff.

6.1 Learning from Failure: Avoiding the "Big Bang"

The proposed transition is designed as a deliberate process of testing, learning, and scaling. This is not just a technical necessity but a political strategy. A long, phased rollout de-risks the reform for any government, transforming it from a high-stakes ideological gamble into a prudent, evidence-based process of system improvement. By demonstrating success in pilot regions before a national rollout, this approach can build a broad coalition of support among the public, clinicians, and local leaders, inoculating the reform against the inevitable political attacks that would doom a more precipitous change.

6.2 The Implementation Roadmap

The transition to the Universal Competition Model will follow a clear, three-phase roadmap over ten years.

Phase 1 (Years 1-2): Foundation Building

This initial phase is dedicated to creating the legal and institutional architecture for the new system.

- **Legislation:** Parliament will pass a new "NHS Covenant Act," providing the

statutory framework for the Universal Competition Model and establishing the three new regulatory bodies.
- **Institution Building:** The National Health Tariff Authority (NHTA), Risk Equalisation Fund (REF), and Office for Health Competition (OfHC) will be established in shadow form. They will begin the technical work of developing the first iteration of the National Health Tariff and the risk-adjustment model.
- **Information Campaign:** A major national public information campaign will be launched to explain the principles of the new system, the concept of the Citizen Health Dividend, and the role of Health Security Funds.

Phase 2 (Years 3-5): Regional Piloting

This phase will test the new model in the real world on a limited scale.

- **Pilot Site Selection:** Three to four diverse regions of England will be selected as pilot sites—for example, a major metropolitan area like Greater Manchester, a largely rural area like Cornwall, and a post-industrial region in the North East.
- **Pathfinder HSFs:** The existing Integrated Care Systems (ICSs) in these pilot regions will be converted into the first "pathfinder" HSFs. Citizens within these regions will be guided through the first annual "Open Enrolment" process, choosing which pathfinder HSF will manage their care.
- **Evaluation and Refinement:** The pilot phase will be subject to intensive, independent evaluation. Data on cost, quality, patient experience, and operational challenges will be used to refine the National Tariff, the risk-adjustment model, and the regulatory rulebook before any wider implementation.

Phase 3 (Years 6-10): National Rollout and System Maturity

Based on the evidence and lessons from the pilots, the model will be rolled out nationally in a staged, region-by-region process.

- **Staged Rollout:** The system will be expanded to the rest of the country over a five-year period, allowing for managed dissolution of the old commissioning structures.
- **Market Opening:** As the national system matures, the OfHC will begin licensing

new entrants to the HSF market, allowing charities, mutuals, and other non-profit organisations to compete for members.
- **Continuous Improvement:** The three regulatory bodies will be fully operational, continuously monitoring the system's performance, refining the rules, and ensuring the market delivers on its promise of higher quality, more responsive, and equitable healthcare for all.

Conclusion: Forging a 21st-Century NHS

The Universal Competition Model is a radical and ambitious proposal, but it is one born of necessity. The current NHS structure, a paradox of fragmentation and monopoly, is failing to meet the challenges of the 21st century. It is financially unsustainable, administratively dysfunctional, and is losing the confidence of the public it was created to serve. Minor fixes and incremental reforms have been tried and have failed to address the fundamental structural flaws.

This proposal is not an abandonment of the NHS, but a bold attempt to save it by making it fit for purpose. It preserves the sacred principles of a universal service, free at the point of need and funded by taxation, while building a new architecture capable of delivering on that promise sustainably. By separating the core functions of the system, it introduces clarity and accountability at every level.

- **The Funder** remains the taxpayer, with the Treasury setting a fair and transparent national budget.
- **The Champion** becomes the citizen, empowered by their Health Dividend to choose a Health Security Fund that is directly accountable to them for quality and service.
- **The Carers**—the doctors, nurses, and entire provider network—are liberated to compete on the quality of their care within a fair and transparent market.

This model resolves the central tension that has plagued NHS reform for decades: how to introduce the discipline and innovation of competition without sacrificing the equity and security of a universal system. It learns from the failures of the past and draws on the successes of the present, both at home and abroad. It honours Aneurin Bevan's vision not by clinging to the structures of 1948, but by forging a new architecture capable of delivering world-class, equitable, and free healthcare for all

citizens for the century to come.

Works cited

1. Structure of the NHS - Step Into Health, accessed on July 2, 2025, https://www.militarystepintohealth.nhs.uk/structure-of-the-nhs/
2. Structure of the NHS - NHS England, accessed on July 2, 2025, https://www.england.nhs.uk/long-read/structure-of-the-nhs/
3. www.england.nhs.uk, accessed on July 2, 2025, https://www.england.nhs.uk/long-read/structure-of-the-nhs/#:~:text=The%20NHS%20in%20England%20is,with%20different%20roles%20and%20responsibilities.
4. National Health Service (England) - Wikipedia, accessed on July 2, 2025, https://en.wikipedia.org/wiki/National_Health_Service_(England)
5. The NHS Budget And How It Has Changed | The King's Fund, accessed on July 2, 2025, https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-budget-nutshell
6. NHS funding and expenditure - UK Parliament, accessed on July 2, 2025, https://researchbriefings.files.parliament.uk/documents/SN00724/SN00724.pdf
7. An introduction to the NHS - NHS England, accessed on July 2, 2025, https://www.england.nhs.uk/get-involved/nhs/
8. Health funding data analysis - BMA, accessed on July 2, 2025, https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/funding/health-funding-data-analysis
9. Tight budgets and tough choices: the reality of an NHS living within its financial means, accessed on July 2, 2025, https://www.kingsfund.org.uk/insight-and-analysis/long-reads/tight-budgets-tough-choices
10. Patients put off seeking care due to 'dysfunctional' NHS admin - The King's Fund, accessed on July 2, 2025, https://www.kingsfund.org.uk/insight-and-analysis/press-releases/patients-put-off-seeking-care-dysfunctional-nhs-admin
11. Patients put off seeking care due to 'dysfunctional' NHS admin, warn patient groups and healthcare experts - Healthwatch, accessed on July 2, 2025, https://www.healthwatch.co.uk/news/2025-02-17/patients-put-seeking-care-due-dysfunctional-nhs-admin-warn-patient-groups-and
12. Lost In The System: The Need For Better NHS Admin | The King's Fund, accessed on July 2, 2025, https://www.kingsfund.org.uk/insight-and-analysis/long-reads/lost-in-system-need-for-better-admin
13. Startling Collapse In NHS Satisfaction Since Pandemic | The King's Fund, accessed on July 2, 2025, https://www.kingsfund.org.uk/insight-and-analysis/press-releases/startling-collapse-nhs-satisfaction-pandemic
14. The NHS at 75: The past and future of its funding model - House of Lords Library,

accessed on July 2, 2025, https://lordslibrary.parliament.uk/the-nhs-at-75-the-past-and-future-of-its-funding-model/
15. In Pursuit Of An Improving National Health Service | Health Affairs, accessed on July 2, 2025, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.19.3.102
16. NHS internal market - Wikipedia, accessed on July 2, 2025, https://en.wikipedia.org/wiki/NHS_internal_market
17. Have new NHS market reforms learned from failings of old? - PMC - PubMed Central, accessed on July 2, 2025, https://pmc.ncbi.nlm.nih.gov/articles/PMC4222149/
18. The English NHS: from market failure to trust, professionalism and democracy, accessed on July 2, 2025, https://journals.lwbooks.co.uk/soundings/vol-2016-issue-64/article-7520/
19. How Does NHS Funding Flow? - Scott McKenzie Consultancy, accessed on July 2, 2025, https://scottmckenzieconsultancy.com/how-does-nhs-funding-flow/
20. Introduction to the 2022/23 National Tariff - NHS England, accessed on July 2, 2025, https://www.england.nhs.uk/wp-content/uploads/2020/11/22-23NT_Introduction-to-the-national-tariff.pdf
21. We should scrap the internal market | The BMJ, accessed on July 2, 2025, https://www.bmj.com/content/361/bmj.k2791/rr
22. The NHS Is Failing Because It's Not Public Enough - Jacobin, accessed on July 2, 2025, https://jacobin.com/2021/12/uk-britain-national-health-service-neoliberalism-austerity
23. What Is Risk Adjustment In Health Care? - MD Compliance Solutions, accessed on July 2, 2025, https://mdcompliancesolutions.com/what-is-risk-adjustment-in-health-care/
24. Ensuring Effective Risk Adjustment | Center on Budget and Policy Priorities, accessed on July 2, 2025, https://www.cbpp.org/research/ensuring-effective-risk-adjustment
25. The strange death of the NHS market? - Centre for Health and the Public Interest, accessed on July 2, 2025, https://www.chpi.org.uk/blog/strange-death-nhs-market
26. Managed competition in the Dutch Health Care System: Preconditions and experiences so far - IDEAS/RePEc, accessed on July 2, 2025, https://ideas.repec.org/a/mof/journl/ppr016c.html
27. Healthcare in Switzerland - Wikipedia, accessed on July 2, 2025, https://en.wikipedia.org/wiki/Healthcare_in_Switzerland
28. Risk Adjustment In Competitive Health Plan Markets - ResearchGate, accessed on July 2, 2025, https://www.researchgate.net/publication/4952935_Risk_Adjustment_In_Competitive_Health_Plan_Markets
29. How Changes to Health Insurance Market Rules Would Affect Risk Adjustment - Actuary.org, accessed on July 2, 2025,

https://actuary.org/how-changes-to-health-insurance-market-rules-would-affect-risk-adjustment/
30. Healthcare reform in the Netherlands: after 15 years of regulated competition | Health Economics, Policy and Law | Cambridge Core, accessed on July 2, 2025, https://www.cambridge.org/core/journals/health-economics-policy-and-law/article/healthcare-reform-in-the-netherlands-after-15-years-of-regulated-competition/486C6E928E2E4C8300511A6A10F39638
31. Netherlands | International Health Care System Profiles ..., accessed on July 2, 2025, https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands
32. Healthcare in Taiwan - Wikipedia, accessed on July 2, 2025, https://en.wikipedia.org/wiki/Healthcare_in_Taiwan
33. An overview of the healthcare system in Taiwan - PMC, accessed on July 2, 2025, https://pmc.ncbi.nlm.nih.gov/articles/PMC3960712/
34. Introduction to the 2021/22 national tariff - NHS England, accessed on July 2, 2025, https://www.england.nhs.uk/wp-content/uploads/2020/11/21-22NT_Introduction-to-the-national-tariff.pdf
35. Overview and summary - NHS Long Term Plan, accessed on July 2, 2025, https://www.longtermplan.nhs.uk/online-version/overview-and-summary/
36. The market reform in Dutch health care: Results, lessons and prospects, accessed on July 2, 2025, https://eurohealthobservatory.who.int/publications/i/the-market-reform-in-dutch-health-care-results-lessons-and-prospects
37. Managed competition: health care reform in the Netherlands RAY ROBINSON - Taylor & Francis eBooks, accessed on July 2, 2025, https://api.taylorfrancis.com/content/chapters/edit/download?identifierName=doi&identifierValue=10.4324/9781315842226-8&type=chapterpdf
38. Going Dutch: Choice, Competition and Equity in Healthcare - C.D. Howe Institute, accessed on July 2, 2025, https://www.cdhowe.org/wp-content/uploads/2024/12/Commentary_621-1-20241220-040559.pdf
39. Health insurance, accessed on July 2, 2025, https://www.eda.admin.ch/missions/mission-onu-geneve/en/home/manual-regime-privileges-and-immunities/introduction/manual-insurance/manual-insurance.html
40. Switzerland | International Health Care System Profiles ..., accessed on July 2, 2025, https://www.commonwealthfund.org/international-health-policy-center/countries/switzerland
41. How Does Swiss Health Insurance Work? A Guide for U.S. Expats, accessed on July 2, 2025, https://www.connectedfinancialplanning.com/swiss-health-insurance
42. Taiwan | International Health Care System Profiles - Commonwealth Fund,

accessed on July 2, 2025, https://www.commonwealthfund.org/international-health-policy-center/countries/taiwan
43. Healthcare in Germany - Wikipedia, accessed on July 2, 2025, https://en.wikipedia.org/wiki/Healthcare_in_Germany
44. Comparisons of Health Care Systems in the United States, Germany and Canada - PMC, accessed on July 2, 2025, https://pmc.ncbi.nlm.nih.gov/articles/PMC3633404/
45. France health system information, accessed on July 2, 2025, https://eurohealthobservatory.who.int/countries/france
46. France | International Health Care System Profiles | Commonwealth ..., accessed on July 2, 2025, https://www.commonwealthfund.org/international-health-policy-center/countries/france
47. Understanding the French Healthcare System 101: A Guide for Expats, accessed on July 2, 2025, https://www.fabfrenchinsurance.com/health/understanding-the-french-healthcare-system-101-a-guide-for-expats/
48. The French health care system - Cleiss, accessed on July 2, 2025, https://www.cleiss.fr/particuliers/venir/soins/ue/systeme-de-sante-en-france_en.html
49. Basics of Clinical Coding and HRGs • Ensuring accurate coding • Cost vs Price • How Tariffs are worked out (National Cost Collection) - One NHS Finance, accessed on July 2, 2025, https://onenhsfinance.nhs.uk/documents-reports/costing/
50. A Review on Methods of Risk Adjustment and their Use in Integrated Healthcare Systems, accessed on July 2, 2025, https://pmc.ncbi.nlm.nih.gov/articles/PMC5354219/
51. Risk adjustment in healthcare: The ultimate guide for payers - Arcadia.io, accessed on July 2, 2025, https://arcadia.io/resources/risk-adjustment-healthcare
52. Improving the Performance of Risk Adjustment Systems: Constrained Regressions, Reinsurance, and Variable Selection - PubMed Central, accessed on July 2, 2025, https://pmc.ncbi.nlm.nih.gov/articles/PMC8635414/
53. Risk adjustment strategies for payers and providers - Navina's AI, accessed on July 2, 2025, https://www.navina.ai/articles/risk-adjustment-strategies-for-payers-and-providers
54. Making Health Care Markets Work Better: The Role of Regulation | Commonwealth Fund, accessed on July 2, 2025, https://www.commonwealthfund.org/blog/2017/making-health-care-markets-work-better-role-regulation
55. Balancing between competition and regulation in healthcare markets - PubMed, accessed on July 2, 2025, https://pubmed.ncbi.nlm.nih.gov/38124549/
56. Preventing Anticompetitive Contracting Practices in Healthcare Markets - CT.gov, accessed on July 2, 2025,

https://portal.ct.gov/-/media/OHS/Healthcare-Cabinet/2021-Meetings/March-9/Gudiksen_2020_Preventing-Anticompetitive-Contracting-Practices-in-Healthcare-Markets-FINAL.pdf
57. Federal regulators, clinicians make their case against private equity in healthcare, accessed on July 2, 2025, https://www.fiercehealthcare.com/regulatory/federal-regulators-clinicians-make-their-case-against-private-equity-healthcare