Sovereign Health Funds

A ‘Sovereign Health Fund’ may appear superficially attractive, but – in most if not all of the ways in which such a fund would be implemented – it would, in effect, *be almost entirely about moving money between different NHS budgets***.** As we explain in this paper, **a ‘sovereign health fund’ would result in money being taken out of NHS budgets, rather than minimising costs to the NHS overall.**

If fully implemented, the call in the Goldacre Review for Reproducible Analytical Pipelines (RAPs) and modern ways of working would reduce the ability for anyone to make a disproportionate profit out of keeping outputs secret, and/or charging multiple Trusts for the same work.

The Goldacre Review describes how RAPs would reduce costs to the NHS overall and increase efficiency, even if it would reduce the returns for commercial entities which profit from increasing inefficiency and secrecy in and around the NHS.

TL;DR: Where do you think the revenues of a sovereign health fund come from?

What is a sovereign health fund?

Often idealised as being somewhere between Norway’s or Saudi Arabia’s sovereign wealth fund (from selling oil) and the Wellcome Trust’s investment portfolio, the goal being that some of the profits currently going to commercial companies which make money from research and development using NHS data – what Ministers and others term “innovation” – should flow back into ‘public benefit R&D’ to benefit the NHS further.

This notion is entirely noble but inherently limited.

In practice, will the money in this fund be new money, or would a sovereign health fund effectively end up ‘recycling’ money that the NHS *already* spends with suppliers in one area – putting it back into another part of the NHS economy, where it will be treated as further investment for other areas? The problem being that any such ‘investment’ is a zero sum game. For won’t any ‘profit’ to the sovereign health fund end up being an additional cost to other NHS budgets?

[N.B. In this paper, we entirely ignore principled Treasury objections around hypothecated funding, and revenues flowing into the general fund for disbursement by Parliament under the direction of the House of Commons.]

A relevant example here would be the process of research, investment, and industry behaviour that led to drugs to treat cystic fibrosis, including Orkambi, as detailed in the book ‘Breath from Salt’. This book is recommended reading not only because of the way it covers the issues in detail, but for showing why a sovereign health fund is a good idea... for organisations that feel their research field is underfunded.

Many organisations believe they could ‘solve’ their condition with only a tiny slice of NHS England’s £110 billion annual budget; ‘Breath from Salt’ shows how some of them are likely correct.

The goal of a sovereign health fund is the problem

The development of Orkambi (lumacaftor / ivacaftor) was funded by a US charity, which then sold the revenue rights to an investment fund, to fund further research. US residents who could not afford the price of Orkambi were able to get it via the charity, but in the UK the NHS had to pay huge amounts to get access to the drug.

Holding a position in a price-gouging company might well deliver dividends for further investment; getting a slice of its profits would do so too. But neither would stop your own (or others') budgets from being gouged.

Even were one to exclude / ignore the effects of international markets, the end result of a sovereign health fund in the UK (or even just England) would still largely be a redistribution of money from existing NHS budgets. The real prize for the *entire* health service is not a fund, but rather **minimised commodity pricing for all**.

A sovereign health fund might aim to be innovative, and might aim to save cash elsewhere – indeed, it might even achieve both of those things – but every pound speculatively diverted into a sovereign health fund is a pound that could otherwise have been going into care.

And a sovereign health fund that took (or diverted) a slice of each Trust's spending on innovation to create a pool of money would further stretch every budget in the NHS – in practice, *slowing* the deployment of new approaches by *increasing the cost* of rolling them out.

Revenues that feed a sovereign health fund represent money that is not going into care; the Chancellor, Health Secretary and George Freeman might get their photo-ops with their favourite profitable companies, but it would be at the expense of other areas of care.

An alternative approach: minimise costs to the NHS

The cost to the NHS of any technology – drug, tool, device, treatment, etc. – developed using NHS resources should be on a **'cost plus' basis**, facilitated via *guaranteed access to a competitive market for technologies that have been shown to work*.

More than a big pot, filled with a top slice from already limited budgets, what is really required for useful innovation is a combination of funding diversity and strategic vision. And, as the Goldacre Review points out, open competitive funding is also an essential driver of open ways of working.

There should be no monopolies or monopoly players in data-driven health technologies. And monopolies aren't prevented by simply banning "exclusive" data deals. If a large (colourful) company tries to roll up smaller companies – ultimately costing the NHS more, through reduced innovation – then where regulators fail, as they too often do around tech, the NHS should use its purchasing power to create space for more (smaller) competitors.

The innovation win-win is not unicorns, but the highest quality healthcare made available at minimised cost for all.