COMMENTARY

Health care: private choice and public provision

RUDOLF KLEIN

Most of the evidence now flowing in to the Royal Commission on the National Health Service shows a remarkable degree of agreement. Nearly everyone starts from the assumption that the NHS is suffering from some sort of crisis, reflecting a mixture of financial malnutrition and organisational obesity. But, equally, there is virtual unanimity that the existing structure is here to stay: that any changes should be carried out within the existing framework of the Service. The differences of opinion are about how best to remodel the old house, not about whether it should be pulled down and replaced by a new building.

But just a few dissenting voices are challenging this consensus. In particular, the directors of the Institute of Economic Affairs, Mr Ralph Harris and Mr Arthur Seldon, have submitted evidence¹ which starts from the assumption that the NHS suffers from "deepseated congenital defects" and which offers an alternative model of health care. Given the constant temptation to settle for the comfortable compromise which will avoid conflict, even if it means perpetuating some of the underlying problems, it is worth analysing this alternative model in some detail to see whether it does indeed offer an acceptable long-term solution.

Alternative model

The evidence, though submitted in a personal capacity, inevitably reflects the classical market economy ideology of the institute. Its starting point is consumer sovereignty. Harris and Seldon argue that it is the individual citizen who knows best what he needs, and how much a particular service is worth to him. In contrast, they point out, the NHS is based on the assumption that it is the medical profession and the administrators who know best. For it is they who ration scarce resources and decide on priorities. Instead of services being shaped by patient preferences, they are determined by technical considerations. From this it follows, if the basic premise is accepted, that the aim of policy ought to be to create a condition in which the individual citizen can express his own preferences by buying such health care as he thinks most appropriate. The providers of health care—like the manufacturers of washing machines or television sets—would then be forced to supply what the market wants, not what they think the consumers ought to have. In practical terms this would mean introducing an insurance-based system, which would allow everyone to choose whether to use the NHS services (for which there would, of course, be charges) or the private sector. Most people would probably rely on private insurance, but there might also be a back-up state insurance scheme: this, after all, is very much the way in which the system of old-age pensions has

developed. And there could always be special provision for those who are too poor or suffering from chronic conditions and who either cannot afford insurance or have exhausted their benefits. Indeed, a BMA panel on health services financing, chaired by Dr Ivor Jones, and with Seldon as one of its members, produced some proposals broadly along these lines in 1970, though the Association got no further than just discussing them.²

Even so, such an approach is feasible. It cannot be dismissed on the grounds that it is impracticable, since a great many countries—France, Germany, and the United States among them—actually operate systems which approximate to the solution proposed by Harris and Seldon. Moreover, the experience of these countries would seem to bear out the argument—invariably used to support the case for an insurance-based system—that it attracts more funds for health care. All these countries spend a higher proportion of their national income on health care than Britain. But, perversely, all these countries are also suffering from a crisis of health care: a crisis of over-spending rather than underfinancing. In the United States, and to a lesser degree in Germany, there is much debate about how best to restrict expenditure: in particular, about how best to limit the ability of the medical profession to act as entrepreneurs in a free market condition. In the case of the United States, for example, there is the development of the PSRO system,³ which is designed at least as much to limit costs as to improve quality.

Puzzling though these trends may appear, there is a possible explanation. It is that these countries have stopped well short of creating a *really* free market in medical care: the consumer is still not sovereign. After all, the medical profession does not permit advertising, nor does it allow competition in fee fixing—all characteristics of the market economy.⁴ More important still, the medical profession is itself a monopoly. It restricts entry to those who are qualified according to its own standards and insists that only its members can deliver medical care. This, clearly, is incompatible with a consumer-sovereignty, market-economy approach. It means, for example, that the consumer cannot choose between expensive but high quality care and cheaper but less reliable care: precisely the sort of choice that is available when it comes to buying a car or any other consumer durable. So it is not surprising that Professor Milton Friedman—the distinguished American economist who is the intellectual patron saint of the Institute of Economic Affairs—has taken the market economy approach to its logical conclusion, and advocated the abolition of medical licensure.⁵ The logic is impeccable and consistent with the evidence. It could well be argued that health care expenditure has soared in the United States (and other countries) because the medical profession remains a

monopoly, since in these cases the service providers rather than the consumers tend to determine the availability, level, and cost of services.

Strategic options

So there would appear to be two strategic options. The first is, as urged by Friedman, to adopt a wholehearted market-economy approach. This means breaking the monopoly of the medical profession, permitting advertising, encouraging fee competition, and allowing non-qualified people to enter the health care market. The second is state regulation of the medical monopoly: back, in other words, to bureaucratic interference, rationing, and the application of technical criteria of efficiency. This, of course, is precisely the direction in which the United States, Germany, and the other countries which operate an insurance-based health care system are moving—and it is indeed tempting to conclude that, if the NHS did not exist in Britain, it would be necessary to invent it. But, before accepting this comfortable conclusion, we ought to examine one further argument in favour of the free market. The fact that it has proved impossible to establish a really free market anywhere may, after all, simply confirm the conspiracy theory of the medical profession. It may tell us something about the power of the medical profession; it does not, however, tell us anything about whether its monopoly is desirable from the consumer's point of view. If Professor Friedman and Ivan Illich⁶ had their way, would the consumer actually benefit?

The answer to this question depends, crucially, on the view taken about the capacity of the consumer of health care. Fundamental to the Harris/Seldon thesis is the assumption that—"except in extremis"—the patient is as capable of shopping around, and choosing between different sources of medical advice and services, as he is in choosing between different sorts of mechanical or electrical equipment. But is he? There are, surely, some fundamental differences. Even in the case of electrical or mechanical equipment, the consumer increasingly has to lean on the advice of independent sources of expertise like *Which?* Given the inability of the medical profession itself to decide on criteria of quality,⁷ is it possible to conceive of a method for "testing" competing brands of health care? Moreover, a defective coffee grinder can be discarded; a faulty car can be returned to the manufacturers. A similar remedy for a botched operation or a wrong diagnosis would be difficult to find: consulting another doctor may simply show that the mistake is irreparable or that the condition is no longer remediable. To make these points is not to suggest that the consumer of health care is incompetent to

make any judgments: it is simply to underline the fact that the model of the consumer as a shopper is misleading. In certain circumstances the consumer can sensibly shop around—for example, when choosing his GP. Similarly, the consumer is better placed than the professional to assess the services being provided in terms of accessibility, humanity, and courtesy. But for much of the time, he moves in a twilight world of uncertainty, lacking the information required to come to any firm conclusion about the quality of the care provided.

The solution of the Institute of Economic Affairs does not, therefore, provide a short cut to some ideal health service. The problem of the NHS, as of any other health service, remains that of striking a balance between safeguarding the consumer without treating him or her as an idiot child in need of care and protection: that of devising a system which does not rest on the misleadingly oversimplified picture of the consumer as an omniscient shopper while yet resisting the temptation to put all the power in the hands of omniscient professional experts. The answer would seem to be to recognise, with Harris and Seldon, the importance of choice in health care while yet rejecting their free market model. Indeed, their evidence to the Royal Commission is perhaps most useful as a reminder of the streak of paternalism implicit in so much thinking about the NHS. There is much rhetoric about the need of freedom of choice for patients. But the reality is that the opportunity for choice has, if anything, been contracting. There are fewer, bigger hospitals. There are fewer, bigger group practices. Indeed, the trend is in much the same direction as in industry, with the all important difference that, while it may not matter all that much if there are only a few standardised television models on the market, it does matter a great deal if the package available becomes standardised in so personal and heterogeneous a service as medical care.

Moreover, there are two current trends which are likely to inhibit choice still further. Firstly, the emphasis on planning—which means providing services for defined populations and catchment areas—may mean that individuals who want to cross boundaries will increasingly be seen as grit in the machinery. Secondly, economic scarcity inevitably constrains choice: it means more, not less, reliance on rationing through the queue. But to emphasise choice is also to accept the mixed economy in health care. It is to recognise that the private sector does have a positive role in widening the area of choice for consumers of health care. Hence, of course, the case for encouraging the growth of the private sector, as argued by BUPA in its evidence to the Royal Commission.⁶ Without adopting the free market model, BUPA discusses a number of policy options—ranging from the exclusion of the more affluent groups from the coverage of the NHS to subsidies for the private sector.

Supplement or substitute?

In discussing such options, it is important to distinguish between two quite different aims of policy. On the one hand, the private sector can be seen as a safety valve: a supplement to the NHS. On the other hand, it can be seen as a rival service: a partial substitute for the NHS. Depending on which

of these two views are taken, quite different sets of arguments apply. As a safety valve, the private sector undoubtedly plays an important part. The NHS is expensive in people's time: the currency of its charges is delay. The private sector is expensive in people's cash: the currency of its charges is money. Thus, while the NHS has a bias towards the old and the poor (whose time costs are negligible or low), the private sector has a bias towards the active and the well off (whose time costs are high). Its existence, therefore, allows people to trade money for time. Again, the private sector is often able to meet new demands in a way in which the NHS cannot. For example, the intentions of Parliament in liberalising the abortion laws would have been frustrated if the private sector had not developed the capacity to meet the consequent demand. As a substitute for the NHS, even a partial one, the private sector is less convincing. Indeed, the BUPA evidence implicitly recognises this, when it points out that the main capacity of the private sector is in meeting the demand for elective medicine and surgery. In other words, its contribution can be only marginal. Indeed, the paradox would seem to be that the private sector is likely to be successful in meeting this demand only to the extent that there is a comprehensive NHS capable of dealing with more complex or chronic conditions. If the private sector is "cost-effective" in meeting this demand, as BUPA argues, it is precisely because the existence of the NHS allows it to specialise in relatively routine procedures.

To recognise this point is not to criticise the private sector: its existence clearly offers positive advantages. But it is to recognise that no Government, whether Labour or Conservative, is likely to encourage policies calculated to switch resources from the public to the private sector; indeed, the advantage of the private sector, from the point of view of politicians, is that it allows frustrated expectations to find an outlet without imposing any burden on the NHS. Moreover, while encouraging private insurance may appear a cheap way of adding to the resources devoted to health care, it is certainly not costless. The cheapest way of raising money yet invented is through taxation: increasing revenue by putting up existing taxes is virtually costless. In contrast, private insurance imposes extra administrative costs: the BUPA evidence, for instance, shows that over 10% of its 1975 income was devoted to "administration and development" (though it is not clear what is included under this general heading and how comparable, therefore, this figure is with the 6% of the NHS budget devoted to administration).

Overall it therefore seems probable that the Royal Commission will avoid the kind of "root and branch re-examination" demanded by Harris and Seldon, and that it will rightly stick to the middle of the road consensus. Any health service has to meet contradictory demands: for more individual choice and for more comprehensive planning, for higher quality and lower costs, for consumer preferences and professionals' autonomy. So, almost inevitably, the solution adopted will fail to meet the expectations of those who want a system based on intellectual symmetry and logic. But, if the price of compromise is blurring the edges, and avoiding some of the awkward issues, there is also one inestimable advantage. Only a consensus solution can guarantee long-term stability for the NHS and avoid the kind of chopping and changing, reflecting electoral swings, which has afflicted the steel industry

and other sectors of the economy caught in the cross-fire of party ideology.

References

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Centre for Studies in Social Policy, London WC1N 2LS

RUDOLF KLEIN, MA, senior fellow

In brief . . .

Reciprocity with East Germany

Britons visiting the German Democratic Republic will be able to get urgent medical treatment free under a reciprocal health co-operation agreement signed in East Berlin on 15 April. The agreement covers all urgent medical treatment except any arising from road accidents, where charges are made. The agreement also provides for the exchange of visits by British and medical experts from the GDR. In addition to the health care arrangements available within the EEC, there are now reciprocal health care arrangements (providing urgent medical treatment free or at reduced cost) with Austria, Bulgaria, the Channel Islands, Czechoslovakia, Gibraltar, Malta, New Zealand, Norway, Poland, Romania, Sweden, the USSR, and Yugoslavia.

Family planning doctors

The joint negotiating body for doctors in community medicine and community health has agreed the terms and conditions of service for doctors doing family planning work in community health service clinics. This includes clinics transferred from the Family Planning Association to the NHS. The relevant circular (HC(PC) (77)1) does not cover doctors working in the hospital service though some community health service clinics are, for convenience, sited on hospital premises.

ARM Glasgow

The RAMC Luncheon will be at the University of Strathclyde Staff Club, 347 Cathedral Street, Glasgow (not the Ingram Hotel), on Saturday, 23 July, at 12.45 for 1.15 pm. The cost will be £3 inclusive of wine. Mr Magnus Magnusson, Rector of the University of Edinburgh, will be the guest of honour at the Edinburgh Graduates' Dinner on Tuesday, 19 July.