COMMENTARY

International perspectives on the NHS

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Seen from an international perspective, Britain's National Health Service is a remarkable success story. It has managed to do what most other health care systems in the advanced industrial countries of the Western world have failed to achieve: to contain costs. Yet seen from a national perspective Britain's NHS is often perceived to be a failure, particularly by those working in it. It has managed to contain costs all too successfully, so it is argued, with the result that standards of health care are inadequate.

Should the NHS, therefore, be rated a success or failure? In exploring the problems concerned in trying to answer this question, a useful starting point is the recently published report from the Organisation for Economic Co-operation and Development (OECD).¹ This surveys and analyses public expenditure on health in the 24 member countries of OECD. And although the footnotes are a constant reminder of the hazards of such international comparisons—and the difficulties posed by differences in national definitions and data—the report is a unique attempt to provide a framework for looking at the performance of a variety of countries in providing health care.

Most obviously, the OECD survey confirms Britain's position as a low spender in terms of the proportion of national income devoted to health. As table I shows, for a selected group of countries, Britain spent only 5.2% of the gross domestic product on health care in the mid-seventies as against 6.7% in Germany, 6.9% in France, 7.3% in Sweden, and 7.4% in the United States. Partly this reflects the fact that private expenditure on health is much less than in most of the other countries concerned. More important, though, public expenditure on health in Britain tends to rise more slowly for any given increase in the national income than in other countries. For the period 1962 to 1974 public spending on health in Britain rose 42% faster than the increase in national income, while the equivalent figures were 72% in France, 85% in Sweden, 109% in Germany, and 154% in the United States.

These figures give an exaggerated impression of British parsimony. In the case of Germany and the United States, in particular, much of the increase in spending reflects a switch from the private to the public sector of health care, as a result of widening the scope of public health insurance and care through such schemes as Medicare and Medicaid. Further, the OECD report suggests that expenditure on health is much like spending on consumer durables—for example, washing machines and cars—in that it tends to rise in line with national income. In other words, countries tend to spend a higher proportion of their national income on health care as they get richer: national differences appear to reflect less the relative priority given to health care, as against other claims on national resources,

than the total wealth of the countries concerned. Indeed, Britain's level of expenditure could roughly be predicted simply by looking at the income per head: there's very little wrong with the NHS, it is therefore tempting to conclude, that could not be cured by a higher economic growth rate.

But, once again, this conclusion must be qualified. As countries get richer, so the cost of delivering a unit of health care or providing a given level of service appears to rise. That is, the price of medical services tends to increase faster than prices generally: the so-called relative price effect. In particular, in most countries labour costs have risen sharply over the past decade, with nursing and ancillary staff improving their position relative to the rest of the labour force.

Consequently, therefore, the proportion of national income spent on health may be a misleading measure of Britain's position in the international league table in terms of actual service provision. For example, Britain's doctors are notoriously cheaper than in the most advanced industrial countries. The ratio of doctor's income to per capita income is 4.5:1 in Britain, as against 4.6 in Sweden, 6.7 in the United States, 7.0 in France, and 8.5 in Germany. These figures confirm the position of Britain's doctors as the proletariat of the international medical community, and so help to explain the current state of morale. But they also indicate that the level of care provided by the NHS may not be as inadequate in international comparative terms as the proportion of national income devoted to health care suggests. Similarly, the OECD report shows that the price of drugs in Britain is lower than in many other countries, so that once again the NHS appears to be getting better value for money than many other systems. For example, British pharmaceutical prices are only 76% of Germany's (though France's are even lower).

Success of NHS

Interestingly, the NHS appears to be a success story even in terms of limiting expenditure on administration, despite all the alarm about the rise in costs consequent on reorganisation. The OECD figures (table II) are unsatisfactory in that national definitions of administrative costs tend to vary considerably and that they are based on "the costs attached to the co-ordination of the system, operating the social security element in terms of collecting contributions, making reimbursements, making payments to the producers of medical services etc." Thus they exclude hospital administrative costs. Hence the British figure in the OECD report is much lower than any of the estimates given by the Department of Health and Social Security.² But even so the

comparison does seem to point to an interesting conclusion: that, while the NHS may have an expensively elaborate managerial structure, it is outstandingly efficient in terms of collecting and distributing its funds. That is, it scores over other systems—like the French—because it collects its money very cheaply through the tax system, instead of working through insurance companies or funds, and does not make a multiplicity of individual charges and reimbursements. So any move towards a system based on fees, charges, or insurance seems (whatever the other merits of the case) certain to increase the number of bureaucrats and the costs of administration.

TABLE I—Expenditure on health as percentage of gross domestic product (mid-seventies)

	Private	Public	Total
Britain	0.6	4.6	5.2
Germany	1.5	5.2	6.7
France	1.6	5.3	6.9
Sweden	0.6	6.7	7.3
United States	4.3	3.0	7.4

TABLE II—General administrative costs as percentage of total expenditure

Britain	..	2.6	Sweden	..	7.6
Germany	..	5.0	United States	..	5.3
France	..	10.8			

The OECD report is, however, not only concerned to provide data about differences between countries and past trends in public expenditure: it also analyses what the latter imply for the future. And it concludes that spending on health will go on increasing, as a proportion of national income, in all the countries concerned—though the precise figures vary considerably depending on what assumptions are made about demands and prices. From this the report argues that the main problem facing the OECD countries is not inadequate levels of spending but how best to reduce the rate of increase: a conclusion which is particularly interesting from the British perspective—since it implies that the NHS is a leader, rather than a laggard, on this criterion. Indeed the NHS is also something of a model in another respect: the OECD report argues that the best means of curbing the rate of increase in spending is by limiting the supplies of medical care provided, though it also discusses the possibility of limiting demand by charges. It points out that, in the absence of rationing by price, the only alternative policy option is "rationing by queueing or rationing by the medical profession (or more likely some combination of the two)." This seems an apt description of the British system.

This emphasis on constraining growth on health spending may seem strange to British ears. Yet it follows logically from the fact that the OECD report is only one of a series which has been examining expenditures on public services. Previous ones have examined expenditure on education³ and income maintenance.⁴ Each of these reports has concluded that these social services are likely—given present policies—to absorb an increasing share of national income. In the case of education, the drop in the birth rate may relieve some of the pressure. But in the case of income maintenance programmes, dominated by pensions, demographic factors are likely to exert an upward pressure—which, of course, is also evident in health. Expenditure on health has therefore to be seen in the context of these competing demands on public resources, and the growth of public resistance to the taxes required to raise the necessary funds. If it is thought desirable to increase expenditure on health, then either other social services will have to be cut back or ways will have to be devised of parting people from their money which do not result in inflationary wage and salary claims (since there seems to be a widespread determination to preserve the value of take-home pay, net of taxes, and to seek compensation for any rise in the cost of living index such as might be caused by imposing higher charges).

Difficulty of comparison

Such a general conclusion, based on international trends, does not of course necessarily apply to any one country. Furthermore, international comparisons of expenditure are so difficult to interpret that they tend to become weapons of political rhetoric rather than means of settling arguments: as we have seen, Britain's comparative expenditure performance can be used to support the view either that spending is inadequate or that this country is leading the field in its ability to ration scarce resources. The view taken on this issue is likely to depend on where one sits: in the Treasury or in the doctor's surgery.

But, in any case, there is a further limitation on this kind of exercise in comparative analysis. It is that, in the last resort, the adequacy or otherwise of expenditure cannot be measured in terms of the money spent. The real question is, given two countries with different levels of expenditure, which of them is delivering the better health care to its population? And, in turn, how should health care be assessed? Should it be assessed in terms of standards of technical care provided or in accessibility to patients? Can it be translated into measures of impact on the population's health?

Like other international studies,^{5,6} the OECD report finds it easier to pose such questions than to answer them. As it recognises, there seems to be little relationship between rising levels of expenditure and changes in indicators of health such as life expectancy, illness, and disability. For instance, it quotes a European survey which shows that the sickness absence rate in Britain is much lower than in France but considerably higher than in Germany. But, then, this only illustrates the problem that self-defined illness may reflect social or attitudinal factors rather than the availability or effectiveness of medical services. Again, given an aging population, inevitably a rising proportion of health expenditure will be devoted to providing

care, support, and relief for people suffering from chronic conditions, rather than curing illness or remedying disability. So perhaps the effectiveness of different health care systems can best be assessed not in terms of their overall performance but in the light of specific and limited criteria. For example, it might be possible to compare their relative success in reducing infant mortality or providing particular, clearly defined services—like hip replacement surgery. But this method of assessment raises the danger that the pattern of service could be distorted by concentrating on those areas and procedures where a clear return can be seen, at the expense of those aspects of health care where measurement of success is more difficult or impossible.

All this is not to suggest that international comparisons cannot yield illuminating insights into the problems of national health care systems. They can, and do. They can provide yardsticks against which to measure national performance on such factors as admission rates, the accessibility of services regardless of income and education, the use of expensive hospital resources, and so on. But they do not provide a simple answer to the question of how much a particular country should be spending on health care, and how much of that money

should come out of the public purse as distinct from private household income. This, in the last resort, will depend on professional and political values—and the particular, national resolution of the inevitable and international conflict between the desire of the medical profession to maximise the care provided for individual patients and the desire of the politicians to minimise the resources devoted to health care, so as to pursue other socially desirable aims of policy.

References

- ¹ OECD, *Public Expenditure on Health*. Paris, July, 1977.
- ² House of Commons, *Ninth Report from the Expenditure Committee Session 1976*, Chapter V. HMSO, London, 1977.
- ³ OECD, *Public Expenditure on Education*. Paris, July, 1976.
- ⁴ OECD, *Public Expenditure on Income Maintenance Programmes*. Paris, July, 1976.
- ⁵ Anderson, Odin W, *Health Care: Can There Be Equity?* New York, John Wiley and Sons, 1972.
- ⁶ *Health Care: An International Study*, ed Robert Kohn and Kerr L White. London, Oxford University Press, 1976.

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Dr Cameron around the divisions

The Chairman of Council has addressed several BMA divisions since the start of the 1977-8 medicopolitical session. We publish here quotes from some of his speeches.

Rotherham

"... Doctors feel beleaguered at the moment and I believe we have every right to do so. We are trying to preserve professional standards in an atmosphere of criticism. There are those who believe that doctors 'need to be cut down to size.' What this really means is that independence of any kind arouses particular opposition. . . ."

"... I do not believe that medicine should be political but I do believe that today more than ever before the impartial judgment of a doctor can stand between his patient and an otherwise impersonal system. . . ."

"... I firmly believe that the existence of the vast majority of doctors in this country is inevitably bound up with the future of the Health Service. But all of us, in general practice particularly, know that the level of expectation of patients has never been higher, while the ability of the NHS to deliver gets less and less. . . ." (14 October)

Bromley

"... For many hospital staff the future problems . . . will be associated with making the doctor more and more part of a team. For the doctor the solution will be to push his way through a clutter of committees that appear to stand between him and his desire to do the best he can for his patient. . . ."

"... Frustration in the profession over a great many work problems frequently takes outward and visible form in an explosion over pay. . . ."

"... Some of you will inevitably be apprehensive about . . . new arrangements and about the future of professionalism in a changing climate of opinion. Our colleagues in other countries . . . work in a variety of political climates and yet manage to retain their self-respect. I believe that we too can hold fast to our own independence and professional standards. . . ." (29 October)

Lambeth and Southwark

"... In common with all trade unions the BMA operates with three objectives in mind: (1) to provide information and personal services to its membership; (2) to negotiate improved terms and conditions of service for its membership; and (3) to ensure that its membership is as large as possible. . . ."

"... With the help of our troubleshooters, our expert negotiators, and an active legal department we are now even better placed to advise, represent, and take up cases before courts and tribunals of individuals and groups of members. All this the BMA is able to do because of its considerable resources. We are a big business with a multi-million-pound turnover. If these resources were increased we could do more. . . ."

"... The fact that we are not protected by the closed shop but have to rely on our record in providing personal services and in negotiation to provide the necessary stimulus to membership at least gives us the advantage of putting us on our mettle. . . ."

"... Our greatest problem is that we are faced with a monopoly employer who is using his monopolistic powers in an increasingly irresponsible manner. The NHS as an employer is faced with financial constraints on its actions. This finance, as the BMA has said in evidence to the Royal Commission, is inadequate. . . ." (23 November)