Middle Articles

CONTEMPORARY THEMES

Health Services Financing Report: A Review of Appendices A-Q

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In May of this year after three years' work an advisory panel of the B.M.A., with Dr. I. M. Jones in the chair, produced a report on Health Services Financing.¹ A summary appeared in the Annual Report of Council² and a preliminary discussion on the report was held at the B.M.A.'s Annual Representative Meeting in July.³ A full debate was deferred until the committees, divisions, and branches of the Association had had an opportunity to discuss the proposals. Nearly half of the book consists of appendices, commissioned from several economists, which cover the N.H.S. and the health services of 14 Western and some Eastern European countries. Below Professor Dennis Lees reviews these appendices, which formed a major source of information for the authors of the report and therefore have an important bearing on their conclusions.

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A general review of the main text of the report by an advisory panel of the B.M.A. was made by Sir Robert Aitken in an earlier issue.⁴ My purpose is to have a look at the appendices, which cover 250 pages and are a book in themselves. They represent a valuable addition to knowledge in health services generally and deserve to be widely studied.

I must confess to the two initial reactions of relief and perplexity. How comforting to find that the N.H.S. is not alone with its problems! Doctors in Britain will welcome Dr. W. Schreiber's judgement that in West Germany the question of paying medical practitioners remains one of the most difficult problems to be solved. Doctors over here may be overworked and underpaid but they are not on their own. Again, they are on all fours with their professional colleagues in Eastern Europe in being accused of issuing sickness certificates too freely and thus helping malingerers. But despite complaints by doctors in Britain about bureaucracy, they do not have to get involved with "tips" as a result of private practice being completely outlawed. There may not be much scope for private practice in this country but morals are upheld on the margins.

And that leads on to my reaction of perplexity at the extraordinary mosaics that we call "medical care systems" around the world. It could be true, as Dr. Mark Hauser suggests in his scholarly study of Switzerland, that it may not be appropriate to speak even of a Swiss system of medical care, with all its variety and idiosyncrasies. And, at first sight, the differences of principle and detail between countries seem to rule out systematic analysis and general conclusions as some kind of international artefact, a theory in search of a phenomenon.

No Polar Extremes

Nowhere do we find the polar extremes of "free enterprise" and "socialized" medicine—the one with no government and tax finance and the other with nothing else. In fact, in all health systems there is more than a bit of both public and private finance and endeavour. Indeed, the highest proportion of private (non-tax) finance in any country outside the United States was little over half (in Switzerland). Even in the U.S.A. direct tax subsidies are over a quarter of health expenditures and around a third when tax reliefs and the like are taken into account. So, quantitatively, we can say that nowhere is medical care more than two-thirds private and in most places it is less than half. Conversely, private (non-tax)

payments are appreciably greater than zero, even in Communist countries, as Dr. L. Sirc ably shows. In Britain the proportion is 10%, which is much less than other Western countries with "socialized" medicine like Sweden and New Zealand, where private payments are about 20% of the total health bill. So one thing that these studies should do is to cut short the search for some Shangri-la at one end of the ideological spectrum or the other.

Thus, whatever the health system it is going to have a lot of tax finance in it, and on a broad international view tax finance may be predominant. But there is nothing written in the stars that says this must be so, and it is a shortcoming of this whole volume that it does not distinguish at all clearly between those health costs that must be tax financed and those that may be.

For example, it is common ground that the mentally ill and the chronic sick have been and will remain a collective responsibility, a burden that we must all bear together, because private insurance and other voluntary arrangements cannot cope. Where risks are predictable for the individual private insurance is ruled out, and if the costs are high only the rich will be able to meet expenses out of pocket. *Ergo*, tax finance. If only that simple point could be widely understood there would be an end to generalizing from the mentally ill and the chronic sick to socialized medicine. Because voluntary arrangements cannot do the whole job it is purblind and doctrinaire to deny them the chance of doing some of it.

Hospital Building

Again, it is a fact common to all countries that the bulk of hospital construction is financed from public funds. A theoretical explanation of this phenomenon is more subtle and is contained in the essay on the United States by Professor J. Buchanan and Professor C. M. Lindsay. Briefly, the argument holds that non-profit voluntary hospitals—the traditional private provision—are operationally inefficient and tend to be oriented towards the needs of those who control them rather than the patients they serve. They thus have difficulty in raising capital for maintenance and expansion; philanthropy is not what it was; hence taxes again logically fill the gap.

If these and other categories of health expenditures which necessarily rely on tax finance are excluded from national medical costs, then the proportion financed from private sources rises sharply. The general dominance of government would look very different in this sector, where communities have a real choice between public and private finance. This

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line of thought could be pushed further by excluding other high-risk categories from the private arena, and particularly the aged. Over the long pull it should be possible to devise voluntary mechanisms whereby people prepay during their working lifetimes for the higher health costs of old age. But at the present time there is necessarily a tendency in all countries, no matter what the character of their health services, to make special provision for the old out of public funds. And it is specious to suppose that exercises of this kind are an apology for private medicine. They are crucial to clear thinking about what has to be done and what the real alternatives are.

There are clear cut differences between countries with broadly similar social outlooks. Thus both Holland and Belgium have compulsory health insurance, but, whereas in Holland there is an active private insurance market covering two million people, in Belgium there is virtually no scope for it at all. Again, health services in Norway and Sweden are based on the principle of local responsibility. The local authorities levy taxes to meet medical costs and the central governments channel other tax resources through them. Yet in Sweden 20% of all medical bills are met by private payments—a far higher proportion than in Norway, which from the tax finance point of view is more like the United Kingdom. The principle of local responsibility is shared by Switzerland, which in all other respects is more like the United States. Dr. Hauser sums up on the Swiss system as follows:

“Thus, the present arrangements offer a comparatively high degree of choice to consumers with respect to the amount, type and standard of medical care which they are able to purchase for themselves and their dependants. It relies heavily on private responsibility and places great value on private effort and initiative, and by so doing probably helps to preserve and foster such responsibility and effort. Moreover, it is relatively flexible in its capacity to reflect differing regional and local circumstances and to adapt itself to new developments and conditions in the field of new methods of treatment and medical research. These advantages are worth safeguarding.”

Direct Payment by Patient

It will now be evident that direct, out-of-pocket payments by patients are common to all medical care systems. Though they vary in degree these payments are broadly significant in three ways. Firstly, they may provide, in contrast to the U.K., a means of paying doctors that avoids direct conflict with the State. Doctors may well prefer a situation in which they are free to negotiate fees with patients, with perhaps some general guidelines from medical societies and with patients recouping all or a proportion of the fees from the State, as an alternative to sporadic and unseemly battles with a monopoly employer. They could gain some knowledge and comfort from experience in countries as varied in their medical systems as the United States, Canada, and New Zealand, where there has been little trouble and doctors carry on peacefully practising. But doctors on the Continent have, to say the least, had severe and continuing friction with insurance funds of one kind and another with whom they have to negotiate fees collectively. Fee-for-service without a free market, as there is in some sectors of Holland and Switzerland, is evidently no guarantee of medical tranquillity.

Secondly, direct payments by patients are a means of cutting demand—particularly frivolous demand—and making better use of valuable resources. Both Mr. A. J. Culyer and Mr. M. H. Cooper, who survey the N.H.S., and Professor Buchanan and Professor Lindsay for the United States, rightly insist that the fact that markets do not work perfectly is no reason for not using them at all. Some signals are better than no signals. Medical care is a costly business. The resources available for its provision are precious and they should be conserved and rationed judiciously. Dr. G. Rosch, in his excellent survey of France, doubts whether prices have very

much effect on demand and there is an obvious need for more empirical work in this area. We still seem to be in the old ideological mush that enables people to maintain at one and the same time that prices do not affect demand but act as a “financial barrier.”

Thirdly, direct payments by patients may provide a source of income independent of political control and thus ease monolithic tendencies and bureaucratic strains. In fact, the studies under review suggest very little evidence for this effect outside the United States, Switzerland, and Australia (on which Arthur Seldon writes with customary insight and exuberance). The main reason is that outside these countries inpatient hospital care is provided virtually free and financed by taxes or compulsory contributions. In this way most countries closely resemble the United Kingdom.

Medical Technology v Medical Organization

Finally, before returning home from this whistle-stop tour of health services overseas, there is evidence in all countries of a clash between medical technology and medical organization. Dr. Rosch (France) sees “the means of [medical] production still entangled in archaic structures. Practically all developments of any size depend on Public Authorities, local or national, that is on civil servants who have little experience, ability and taste for large-scale innovation and production.”

Dr. Schreiber (West Germany) feels that doctors “have in practice put themselves beyond the market. According to their ideology, their service is primarily rendered to the suffering fellow citizen and only secondarily as a source of income.” And Professor Buchanan and Professor Lindsay judge that “the medical profession has been permitted to use its monopoly powers to retain its nineteenth-century journeyman’s organization while technological progress has made medicine one of the most specialized of modern industries.” Evidently there is a cosmic consensus that doctors everywhere should get into the twentieth century.

There are then quite a number of features common to all health systems and many apparent differences in kind turn out on closer inspection to be differences of degree. This is salutary and it is always helpful to have things in proper perspective. But there are two major differences between systems—the degree of central government control and the extent of direct (point-of-purchase) payment by users. These are critical and account for most of the controversy about the performance of the N.H.S.

Central Control and Equality

In the N.H.S. central control over allocation of resources is intended to be complete, not only to eliminate the alleged wastes of competition but to ensure, in conjunction with “free” services, equality of consumption by all in similar medical circumstances. There is therefore to be none of the local responsibility of Norway, Sweden, and Switzerland—which may ease political decision-making—and none of the market forces of the United States and Australia—which would ease the problems of the allocation of resources.

It is now ten years since I timidly put forward the proposition that the effect of the N.H.S. was to keep total health expenditure lower than it would have been under a more market-oriented system. This view was greeted with derision by Left and Right alike—the one was the rage of Caliban at seeing its own face in the glass, the other the rage of Caliban at not seeing its own face in the glass. And there was a firm belief even among friends that the mental hospitals, though overcrowded, could surely find room for just one more.

Well, that was a long while ago, and the proposition is now an orthodox truth and hence without intellectual interest. But

it is of profound human importance whether more resources can be injected into the N.H.S. while retaining its basic features of exclusive reliance on tax finance. Professor A. T. Peacock and Professor J. Wiseman, who consider alternatives in the public sector, are pessimistic. In a purely arithmetical sense more resources could be found in three ways: by cutting other items of public expenditure and reallocating to health; by raising tax rates; and by appropriating tax revenues from more rapid economic growth. Now some ways—cutting other public expenditure or raising tax rates, or both—are simply not on. Among other obstacles social services themselves account for half of total public expenditure and to cut down on slum schools in favour of slum hospitals is robbing Peter to pay Paul. And tax rates are, if anything, beyond their feasible limit.

This leaves us with economic growth, which Professor Peacock and Professor Wiseman say must be about 3.7% per year if past health allocations are to be maintained. With the dismal non-growth record of the past five years the chances of this being attained are zero. The proportion of health expenditure to national income already puts us in the international second division and, unless new sources of finance are found, we shall be relegated still further.

Money from Private Sector

So there is unlikely to be any joy from the public sector and Mr. Arthur Seldon examines the scope for drawing additional finance from private expenditure. Again in an arithmetic sense this looks easy: private health expenditure is only 0.2% of private consumption and if it could be raised to around 5% the health resource situation would be transformed. Tax finance would be cut back and, Mr. Seldon finds, people would be more willing to pay for medical care as an item of household expenditure rather than a compulsory levy. And this of course is the Lees paradox of ten years ago: a rise in prices from zero leads to an increase in total demand. But it is not a paradox; what happens is that a "commodity" price is substituted to some extent for a "tax" price. At present the N.H.S. is an extreme example where the "tax" price is 100% and the "commodity" price is zero. What Mr. Seldon is advocating is a different set of price proportions with, say, "tax" and "commodity" prices around 50%. In this way the evidence suggests that the total people are prepared to spend

on health services will rise, and with it the amount of resources available for use in our health system. The direct payments could be covered by voluntary insurance, supported by tax finance, along the lines of Swiss and Australian models.

Non-tax Finance a Sin?

Apart from odd sociological outposts we have now happily got rid of the asinine incantation that the National Health Service is "the finest in the world," and the hysterical denunciation of non-tax finance as a sin against the light. There is now a calmer, if apprehensive, awareness that the N.H.S. is just another health system among many, and that something apart from heresy can be imported from abroad. The intellectual xenophobia of the 1950's in particular should intrigue future social historians.

But in addition, as Mr. Cooper and Mr. Culyer show, the N.H.S. has failed by its own lights. The fundamental objective of the N.H.S. is equality of consumption of health services regardless of means. It is that objective that makes logical sense of the abolition of prices, the discouragement of market forces, and almost complete reliance on tax finance. But these investigators marshal a formidable and compelling array of evidence that shows beyond reasonable doubt that equality has not been achieved nor is it being approached. A major reason for the disparity between intention and outcome is this: that the monolithic control by central government is restricted to total finance and does not apply to the particular parts making up the whole. The conflict, for example, between clinical freedom and economic efficiency has no more been solved in this country than elsewhere and it is pure eyewash to say that it has.

Thus the noble conception of rational resource allocation for the good of all without regard to means turns out to be an illusion, a confidence trick against ourselves. Small wonder that, for Homer, men were the saddest of the beasts in the field and, for Shakespeare, full of sound and fury, signifying nothing.

REFERENCES

- 1 Advisory Panel of the British Medical Association, *Health Services Financing*, London, B.M.A., 1970.
- 2 *British Medical Journal Supplement* 1970, 2, 86.
- 3 *British Medical Journal Supplement* 1970, 3, 50.
- 4 *British Medical Journal* 1970, 2, 229.

ONE HUNDRED YEARS AGO

Notes from a Report in the British Medical Journal, 29 October 1870

POOR-LAW RELIEF AT BETHNAL GREEN

SOME very serious facts were elicited this week at an inquest on William J. Watson, a house-painter, who resided in the above parish. It appears that a short time ago his wife died, leaving two children: soon afterwards he fell into distressed circumstances, becoming very ill with painter's colic. His brother applied to the relieving officer for an order for the attendance of the parish surgeon. That officer was from home, and the applicant learnt that he would not return for several hours. The next day, the landlady again applied—this time with success—and the order was at once taken to the medical officer, Mr. Massingham, who forwarded it to his assistant, Mr. Rogerson. That gentleman not calling, three applications were made at his surgery, and once at his house, for his attendance. Between three and four in the afternoon of the day the brother saw him, when he stated that he would not be a minute, and told him to give the sick man some castor-oil. He did not call until half-past five, when the man was dead. Mr. Rogerson, in his evidence, stated that he received the order at half-past twelve; but though it was endorsed "Said to be urgent", he did not notice the endorsement; if he had, he would have made

a push to have got there before half-past five. He got there as soon as he could. He had forty-six pauper patients to see that day, and to attend three women in labour, and had been on his feet all day from morning till night. Besides attending the pauper patients, he had charge of the practice of two other medical men—his own and Mr. Massingham's. It further appeared that, after the death of the father, the children were left with the corpse all night, and on the next day (Sunday) were found in his room in a starving condition, and had to be removed to the workhouse. This evidence suggests questions which call urgently for official reply. Why was the relieving officer absent from his home for hours, leaving no one to represent him? How did it happen that the medical officer, having an order handed him marked "urgent", should have sent on it to his assistant without drawing his attention to the endorsement? Finally, how comes it that a gentleman holding such a multiplicity of offices should be the authorised assistant of the medical officer? We feel that an explanation other than that which appears in the report from which we have quoted is demanded. . . .