Hugh Clegg, one of the *BMJ*'s most distinguished editors, spelt this out in an article now always kept in readiness in our office: "A wise old friend of mine said to me after I had been editor for two years or so: 'I hope you have been getting into trouble with your bosses.'"

"Why ever do you say that?" I asked.

"Well if you haven't," he replied, 'it means you are not doing your job properly.'"⁶

If editors never trouble their bosses then the whole organisation runs the risk of losing touch with important political realities. We can see this happening in South Africa, where the editor of the *South African Medical Journal* is forbidden to publish letters or articles from members of the National Medical and Dental Association, which speaks out internationally on the dangers of apartheid to health.

We can empathise with the problems in Ireland because in the past the *BMJ* has come into conflict with the British Medical Association. Thankfully, this has not happened for many years, and the association has written into its bylaws that the editor "shall be responsible for all that appears [in the *BMJ*]." But there were calls in the 1880s to dismiss the ebullient Ernest Hart (for breaking confidentiality by publishing letters written by the dying emperor of Germany, among other misdeeds), and, in 1911-13, Dawson Williams (for his stance on the Lloyd George Insurance Act), but these were rejected by the representative body. The most recent attempt to muzzle the editor arose in 1956 out of an anonymous editorial in the *BMJ* written by Hugh Clegg. "The Gold-headed Cane" castigated the inertia of the Royal College of Physicians and the excessive time spent as

president by Sir Russell Brain. Clegg was right—and achieved reforms—but his leader came at a time of delicate negotiations on pay between the government and a joint committee headed by Brain and the then chairman of the General Medical Services Committee. Proposals then to restrict the editor's freedom—in particular to have a committee to scrutinise the content of all editorials—were overwhelmingly rejected at the next meeting of the representative body.

The issue of editorial freedom, a large one unlikely to go away, is much more difficult outside medicine than within it: we have at the moment, for example, a BBC cowed by the present government into an anxiety state and trying to rediscover its previous independence. Today matters are perhaps easier in medicine now that most editorials are signed and that most medicopolitical organisations have separate newsletters to get their views across. But, to return to the case in question, given that in Eoin O'Brien there is an editor as well as a cardiologist of international repute, should not a country that has produced Grattan, Burke, and Connolly—not to mention Swift, Shaw, and Yeats—think again?

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Regular Review

Financing health care: the three options

RUDOLF KLEIN

At the heart of the present "crisis of the National Health Service," that much overworked phrase that has surfaced roughly every five years throughout its history, there is a paradox. A campaign designed to strengthen the NHS—with calls from MPs for immediate extra funds of up to £1 billion¹—could yet end up by undermining it. For the 1988 "crisis" is different from its predecessors in one respect. It has provoked an acute epidemic of thinking the unthinkable. Indeed, the Prime Minister, having been pushed into reviewing NHS financing, may be tempted to seize the opportunity to endorse a radical solution. So if the NHS has really been brought to the edge of breakdown because of chronic underfunding, which is far from self evident,² it becomes sensible to look at alternative ways of financing health care. Those may not necessarily be compatible with the continued existence of the NHS in its present form as a universal, free at the point of use, and tax financed health care system.

There has already been a spate of proposals from within the Conservative party.³⁻⁶ And more reports are on the way.

But the number of policy options for raising additional funds for health care are limited: most of the tunes are old though some of the variations are new. Governments have previously resisted them because the political costs of so doing would have been too high, given public support for the NHS. Interestingly, however, the political costs of ignoring the options for change may now be too high, given the success of those working in the NHS in convincing the public that it is about to collapse. It is therefore worth examining the three main strategies available for raising more money for health care. They are discussed here in order of their impact on the existing structure of the NHS, starting with the option that has the least dramatic implications: user charges.

User charges

The debate about user charges is as old as the NHS itself. The arguments for them are familiar: they bring in more

revenue, make patients cost conscious, and deter frivolous demands. The arguments against them are equally familiar. They hit the poorest hardest, thus offending against the principle of equal treatment for all regardless of means, and are liable to have perverse effects on costs by deterring people from seeking early treatment and so discourage preventive medicine. There is nothing new to be said about any of these arguments, and, interestingly, charges feature very little in most of the recent literature. But, given the pressure on ministers for some sort of visible change and given also the government's willingness to adopt this strategy in the case of the dental and ophthalmic services, it is important to note one crucial point about user charges. Most of the objections against them can be overcome but only at the price of sharply diminishing their potential yield and increasing administrative costs.

Consider, for example, the introduction of hotel charges for hospital inpatients, which was one of the illustrative options considered but rejected by the 1979 royal commission.⁷ Unlike charges for general hospital practitioner consultations these are not open to the objection of discouraging early contact. Neither would they deter frivolous demands. The decision to admit a patient is, after all, the doctor's—a reminder that it is medical attitudes not patient demands that determine the use of expensive resources in any health care system. But hotel charges do run into another snag common to all forms of charges. Over 60% of NHS spending is devoted to those groups—the elderly, children, and the mentally and physically handicapped—with the least capacity to pay. The neatest way round this difficulty is simply to make such groups exempt from payments, as with prescription charges. But by the time these groups, plus those on social security, have been exempted the tax base has been seriously eroded. In the case of prescription charges fewer than one fifth of patients actually pay. This means that charges have to be set at a fairly high level in order to make a serious contribution to the NHS's funding. The royal commission's calculations suggest that weekly hotel charges would now have to be £40 in order to raise some £280m a year—plus possible savings as the result of patients refusing to pay for excessive lengths of stay.

If the NHS's financial plight is indeed as serious as it is contended then an extra £280m a year would be well worth having. Given that a high proportion of hospital stays are for less than a week, and given also that it is possible to take out insurance coverage against the risk of incurring such charges, it is difficult to dismiss this option out of hand. But, as with all user charges, such a strategy has some worrying elements of rough justice. On the one hand, it means that the working population with incomes just above what they would get on social security are hit disproportionately hard—that is, they may be better off exempt on social security. On the other hand, it means that some well off people pay nothing just because they are in an exempt group—that is, not all the elderly are poor. In the interests of improving NHS services for the population as a whole such elements of rough justice might be tolerable. But if any extra money is used simply in order to finance wage awards for people working in the NHS, rather than to improve services, then it is difficult to see the moral argument for imposing charges on people who may earn less than those whose incomes go up as a result of introducing the charges.

There is, moreover, a more general objection. It arises from a mis-specification of the problem being tackled. The assumption underlying the search for extra sources of funds

for the NHS is that these are needed because the existing sources of revenue—that is, taxes—are not buoyant enough. But this is not so. At present the government would have no difficulty whatsoever in finding extra revenue for the NHS from taxation. The Chancellor of the Exchequer's only worry is what to do with his surplus. The nature of the problem therefore needs to be redefined. It is, quite simply, that the government does not *want* to spend more money on the NHS. And if that is indeed so then it follows that if extra money were to be raised through charges (or any other means) it might well be used to cut the amount of tax finance now devoted to the NHS—as a former minister for health recently warned in the House of Commons.⁸ Devising clever new formulas for raising extra cash does not, therefore, necessarily imply a net increase in funds for the NHS, a point that is crucial when we turn to the next strategy, which in its various permutations amounts to earmarking a special source of revenue for the NHS.

A tax for the NHS

The assumption shaping the second strategy is that while people dislike paying taxes in general they would be happy to pay higher taxes for the NHS in particular, a view supported by the findings of several public opinion surveys.⁹ So why not, it is argued, devote one particular tax to financing the NHS? If it were a buoyant tax, whose yield increased with the growth of the economy, then the NHS would be assured of an ever rising income. It would be rather like having a pension that rose in line with earnings. However, earnings can also fall: if NHS income had been fixed to the level of earnings between 1979 and 1981 there would have been a crisis indeed. And if the income from this tax were visibly and exclusively devoted to the NHS, it is further asserted, governments would not risk the political odium of trying to cut or divert it. Financing the NHS through earmarked National Insurance contributions is therefore one obvious and favourite candidate. There are several technical problems about this. In particular, National Insurance contributions tend to be regressive because they are not levied across the whole range of incomes so that those with lower incomes pay proportionately more than those with high ones. These could be solved, for example, by turning the National Insurance contributions into a payroll tax. The real difficulties cut deeper. They stem from a basic asymmetry in health care, already noted. This is that the heaviest users of health care are those with the least capacity to pay—that is, the non-working population. Health care necessitates the redistribution of income not only across time in the life of individuals, as in the case of pensions, but also between high and low risk groups in the population. It is therefore not self evident that the best way—or the politically most acceptable way—of effecting such a redistribution is by a tax that is levied exclusively on the wage packets of the working population.

Any move towards financing the NHS through some kind of tax disguised as an insurance contribution would therefore raise some difficult questions. Who, for example, would pay the contributions of the non-working population? Almost certainly the answer would be the Treasury, using general tax revenue. So we would quickly be back to the starting point: the concern of all governments to limit the total amount of public expenditure being devoted to health care. Moreover, it would be surprising if governments could be indifferent to the level of insurance contributions any more than they can

be indifferent to the tax levels since both affect such issues as work incentives.

Many of these problems would be compounded by the variants on the second strategy proposed by Mr Leon Brittain.⁴ This starts with two propositions. Firstly, that the principle of proper health care for all, irrespective of means, must be safeguarded. Secondly, that more money needs to be raised for health care by tapping the willingness of individuals to pay more for this specific purpose. To achieve this he proposes that the NHS should be funded by means of National Insurance contributions but that, on the model of pensions arrangements, people should be allowed to opt out of the state system and buy their own insurance policies. Again, this is to ignore the asymmetrical distribution of risks in health care. The proposed scheme would give low risk individuals every incentive to opt out of the state scheme: they could certainly do so cheaply since no element of redistribution would be involved. But the state system would be left with the high risk population: a recipe, surely, for financial disaster.

Private insurance strategy

The first two strategies so far discussed seek to maintain the fundamental structure and principles of the NHS. The third strategy, which is to opt for a private insurance based system of health care, abandons this framework. In theory, though, NHS hospitals and practitioners could still be the providers of privately financed health care, caring for patients who would then be reimbursed through their private insurance schemes. Alternatively, in variants of this approach,⁵ the units of the NHS would offer themselves as health maintenance organisations in competition with private health maintenance organisations and citizens would enrol themselves in whichever offered the best buy. Several advantages are urged for this strategy: greater choice for consumers, more flexibility, and sharper incentives to efficiency. Here, however, our only concern is whether such a strategy would actually increase the total resources available for health care since that is the starting point for the present debate.

Pumping in more money, however, cannot be equated with increasing the resources for services. If the result is to increase costs or to inflate wages there is no necessary net gain. And, contrary to conventional wisdom, it is not self evident that it would. Given the nature of health care demand, once again something like 60% of it would have to be financed through the tax system anyway. Were we, for example, to move towards a voucher system—with each voucher worth a year's subscription to a private insurance scheme—this would still have to be publicly financed for a large segment of the population. So everything would depend on the willingness of the rest of the population to pay more than they do already through the tax system and

through taking out the private insurance schemes that already cover 10% of the population.¹⁰ It may be that the reservoir is only waiting to be tapped. But while the benefits of making such a radical change are speculative the costs of such a transformation would be only too certain.

In all this there is no difficulty in designing a system that on paper might be preferable to the NHS and which might even be no less equitable (the inequalities of the market place are reflected in the NHS: middle class social confidence and pushiness are just as important a resource as money). And if we were now in 1948, designing a national health care system with the benefit of foresight, we might well decide to go for a less monolithic model. Moreover, the NHS is in many ways a monument to a vanishing age. If hypocrisy is the tribute vice pays to virtue the NHS is the tribute that a non-egalitarian society now pays to social justice.

Less panic, more reshaping

Many of the present strains reflect the fact that Mrs Thatcher's policies are often seen as being at odds with the egalitarian consensus that underpinned the NHS for so long.¹¹ But given the uncertainties and problems inherent in implementing any grand design for a new system of health care and the sources of its finance the most sensible conclusion may be that drawn by the National Association of Health Authorities. Instead of being panicked into searching for a new funding formula the NHS should be changing the present system of using and allocating the available funds in order to relate income to service activity more efficiently and effectively.¹² Even within the context of the present system of public funding for the NHS there is ample scope to move in the direction of making its organisation more pluralistic, more flexible, and more adaptable.¹³ Perhaps the healthy professions should consider this as an achievable objective for improving the NHS alongside their demands for more money.

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