

Will Brown be bold enough to let the NHS charge patients?

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Any American willing to comment on Britain's National Health Service must begin by making two points. First, he must stress that he understands that when the NHS was established it filled a crying need in a society that was reeling from the economic consequences of two wars and a slump. The NHS met the financial needs of the great mass of the decidedly unrich British population in need of healthcare. And it met a more important social need – it contributed to social cohesion by devising a system that provided care for all, regardless of financial circumstance. That was no small achievement.

Second, an American must dispel the myth, so comforting to my nation's critics, that 40 million Americans are without healthcare. Not true. They are without health insurance, but can obtain care at no charge from the very same doctors that take care of the affluent at any one of the nation's non-profit hospitals – which means something like 90 per cent of the hospitals in the United States. This is in addition to the coverage provided to the elderly (Medicare) and many of the poor (Medicaid).

That system is far from perfect, but no system of financing healthcare can be. When I was teaching economics we poked fun at Say's Law, the 19th-century theory propounded by Jean Baptiste Say and generally summarised as "supply creates its own demand". Were that true, we taught, we would never have a recession, unsold goods would

never pile up, houses and offices would never stand vacant.

But Say's Law might just describe the healthcare industry. Who, decades ago, had heard of – much less demanded – a hip replacement, or open heart surgery, or any of the procedures now on offer? Who would have dreamed of the expensive life-saving treatments for cancer, or the medications that can alleviate the symptoms of so many diseases? But the medical profession and the pharmaceutical companies built it, and the patients have come. Supply created its own demand.

That process will continue and, as the population ages, more and more people will demand more and more from their healthcare system, all the while requiring that it provides care in a way that strikes the great bulk of the population as fair. Which means two things if the system is not to collapse under its financial burden.

First, it is important to get the incentives right, which the NHS fails to do. Patients have no incentive to limit their demands on the system, or even to keep appointments with providers.

Providers have little incentive to keep costs to an efficient level, since their incomes are unaffected – or so it seems to each of them – by the overall financial health of the system.

Second, it is important to decide just what services are to be made available, and on what terms. Should the system of "free at the point of delivery" include cosmetic surgery, or hip replacements for 90-year-olds, or liver transplants for alcoholics?



Irwin Stelzer

Should queuing be relied on to ration available resources – a method that I am assured by top policymakers in the Government is preferred by British citizens to any other form of rationing?

Perhaps most crucial, just how long should an increasingly affluent nation rely on a health system funded from tax revenues, rather than on one that draws in part at least on the savings and resources of individuals who, in increasing numbers, holiday in Florida, own two cars, and lavish gadgets on their young?

There are no perfect answers to these questions, only imperfect ones, with some less imperfect than others. The core of any solution must be that no one is denied essential healthcare because of lack of means. Decency requires it, and British citizens are notably decent in matters of social policy, at times to the point of insanity (eg, hug a hoodie). For that to be the core of policy, the Government will have to do something no government

likes to do – decide which services are core services, to be available on demand, and which services are not.

Those core services can remain free at the point of use and available to all who cannot pay, with charges levied for other services – Nye Bevan found charges for spectacles and dental care sufficiently unacceptable to resign, but lost that battle to less ideological colleagues. Later Labour governments decided that prescriptions could no longer be filled free of charge for everyone, and today's Government has taken a similar view of telephone calls and the use of television sets by patients.

Having defined this core availability, and recognised that "free at the point of use" was abandoned long ago, the Government must decide who can afford to contribute to his or her medical care. The 21st century is not the 20th, and 2007 is not 1948. Britain is richer; the range of medical treatments has expanded; and the state has proved unable to manage the healthcare system – witness the paltry returns for the loads of money Gordon Brown has lavished on the NHS.

If ever there were a time to consider some method of charging for care, and allowing tax-favoured treatment of private insurance costs, now is that time. For charges would not only relieve the burden on the Exchequer, which can no longer fund the rising demands of consumers of healthcare services, but would restrain unnecessary demands on the system. This should not be anathema to

Labour Party members; after all, it was their predecessors who first agreed to allow charging for some services. The principle has been established; the only question is how far to extend it, and to whom.

Now is also the time to admit that the British public is sophisticated enough, has enough sources of information, to make choices – choices of doctors (and dentists if there were any), of hospitals, and of courses of treatment. Tony Blair has taken a reluctant party party down the road to patient choice, and the real question is whether Gordon Brown will continue that journey – or perhaps leave it to the Tories should they ever recover from past electoral shellshocks and devise a coherent healthcare policy.

Along with patient choice must come the only system that can constrain spiralling costs and inject efficiency into the system: competition. Mr Brown was the first in his party to understand the efficiency-enhancing effect of competition, and to introduce criminal penalties for cartel behaviour. So he must realise that sauce for the private-sector goose is sauce for the public-sector gander, and allow open competition for the patronage of British consumers of healthcare services, a process that is under way, but in a constrained fashion. Competition, not targets, is the road to quality care.

None of these ideas is perfect. There are probably better ones out there. But they won't see the light of day if politicians continue to substitute name-calling for serious policy debate.