Special Article

Back to basics in health care

Douglas Black

Former President, Royal College of Physicians, London

Among the many questions that might be asked about health care, perhaps three stand out:

Is health care a service or a business?
Will it be best achieved by co-operation or by competition?
Are medicine and nursing professions or trades?

There are strong arguments for preferring the first option in each of these questions. On such beliefs the British National Health Service was founded; and I believe they should and would be adhered to by those who work in the service and by those who use it. But the last, and possibly worst legacy of a prime minister who had a fanatical belief in the virtues of competition and of private provision of services, was an array of ‘reforms’ running directly counter to an outlook that had served the country exceptionally well in matters of health.

The reforms have been damaging in two main ways. In place of a coherent system, they have induced fragmentation – at the primary care level, by fund-holding, and at the hospital level, by trusts. Secondly, they have replaced an ethos of dedication and co-operation by a blatant competitive and commercial outlook, expressed wastefully in an artificial ‘internal market’, founded on a split between ‘purchasers’ and ‘providers’. The proposals in the discussion document, Health 2000,1 would take us a considerable distance towards the recovery of a genuine National Health Service, by doing away with fund-holding and trusts; but there is one specific sense in which they do not go far enough. The fragmentation issue is adequately addressed, but the issue of competitiveness and of pseudo-commercialization calls for something more radical than just abandoning the pretence of an ‘internal market’. There has to be a recognized joint responsibility for health, which entails the abolition of any vestige of a purchaser–provider split that spawns the spirit of competition and expresses it in the cumbrous system of contracts, which hampers the free movement of patients on grounds of clinical need.

Like many others, I have discussed the flawed basis of the ‘reforms’ at some length2 and, in face of grass-roots evidence to the contrary, the official statements that they are working well are made so frequently and so petulantly as themselves to give grounds for suspicion. But recognition that the reforms are unsound in theory and in practice does not solve the problems of health care. The object of this paper is to suggest reasons why health care has run into problems in many countries and to discuss possible solutions, preferably those which would not in themselves be harmful.

The shape of the problem

For the first quarter-century of its life, the National Health Service could be described, without irony, as the ‘envy of the world’, with a general entitlement to health care at a cost per head much less than that of less comprehensive health care in Europe or America. Economic reasons for this success included funding predominantly from an existing efficient system of direct taxation; universal effective primary care, including a ‘gateway’ function to limit inappropriate recourse to expensive hospital treatment; very limited payment on a ‘fee for service’ basis, which might encourage unnecessary interventions; a coherent and accountable system; and a monopoly employer willing, indeed anxious, to control wages and salaries. Every bit as important as these economic factors were attitudinal factors: the dedication of doctors, nurses and other health workers to what they perceived as public service; appreciation by the public of general access to health care, which their parents had never enjoyed; and a sensible realization by British people that there are some things that can neither be cured, nor made the basis of litigation – a perception described by American observers as ‘diminished expectations’.

In the past two decades, a number of things have changed. Exaggerated claims for ‘breakthroughs’ in treatment have combined with organized consumerism to raise expectations beyond what is realistic on finite resources. Concurrently, the absolute need for health care has increased because of adverse demography, with more elderly people
dependent on a smaller work force, and a notable increase in unemployment whose risks to health are now clear. Both the scope and the sophistication of available treatment have increased, with much potential benefit to patients, but also at much cost in the consumption of resources. (To give but one example, until the mid-fifties patients with terminal renal failure simply died, with sorrow indeed, but at no great economic cost. Now they remain alive—and thank God for it—but it takes human and economic effort and resources to accomplish this.)

These considerations are common to many developed countries. This country is possibly exceptional in the extent to which it has been prepared, since 1979, to ignore and even exacerbate social deprivations whose association with impairment of health is surely beyond dispute.3 The health disadvantage is not confined to the direct victims of deprivation but spills over to national mortality statistics.4 It is of course good news that a high-level working party is being set up in the Department of Health to consider this matter, recognized as a problem by Richard Titmuss in 1943 in his Birth, Poverty and Wealth, and reported on at intervals ever since. However, the single measure that could do more to help than any other has nothing to do with health services—it would be to reverse the shift from direct taxation (which falls fairly on income) to indirect taxation, such as VAT (which falls unfairly on the poor).

From all of these causes (and no doubt there are others), there is a real problem in maintaining an equitable health service, given that resources are finite, and needs and demands hard to control. I here repeat the claim made in my second paragraph, and more fully elsewhere,2 that the 'reforms' have not been, and indeed cannot be the answer. What are the alternatives?

The shape of a solution?

It would be grossly unfair to the 'reforms' to suggest that they are the only way to impair a viable health service. There are others, which should be noticed, as things to avoid, before making positive proposals. Most would agree that an acceptable health service must be 'fair' or 'equitable'. But equity can be horizontal (the equal treatment of equals), or vertical (the unequal treatment of unequals).5 Horizontal equity is met, to an extent, by equal access to primary health care; and conversely it is transgressed by making access totally dependent on private resources. Vertical equity cannot be so simply satisfied, dependent as it is on the way in which 'unequal' is characterized. One path of danger is to allow resources to be commandeered by pressure groups, demanding priority for a particular group of patients. For example, in relation to its part in the total burden of illness, cancer research is almost certainly overfunded, relative to other areas of need; but happily, funds so dedicated have made great contributions to genetics and molecular biology. Another relevant question is 'Whose equity is it?'. The answer has to be that of patients and potential patients, not that of health professionals, still less that of managers.

Let me start a positive approach from the darkest assumption, that the potential of what can be done will always exceed the resources which can be made available to do it; from which it follows that something will somehow have to be rationed. From the principles of equity, I have just been arguing that the mode of rationing should not be by private purchasing power; by discrimination either for or against categories of illness; or even perhaps by trying to correct social injustice by medical means, when social or fiscal measures would be more direct and effective. So what remains?

I believe that the broad decisions on allocation of resources (which is politically correct speak for rationing) should be national (which accounts for my wish for a coherent service); but open to modulation by concrete local factors [the practicality of such modulation being shown by the RAPW (Resource Allocation Working Party) formula]. I further believe that rationing should fall, not on types of service, still less on categories of patients; but on procedures, using the term broadly to include medical and surgical regimens of treatment, and measures of prevention. I claim no originality for the suggestion, which resembles what is being tried out in the state of Oregon,6 but with differences.

Admittedly, the difficulties in establishing a rank-order of procedures in terms of their 'utility' or 'value' are formidable. While it may not be too difficult to estimate the cost of a procedure, the assessment of benefit is more difficult, and more compounded by variation in the original state of patients and in their response. Account has also to be taken of the prevalence of whatever condition the procedure is designed to correct or prevent; and of the 'seriousness' or 'triviality' of that condition. There is here a real challenge to health professionals and health economists in collaboration. Not surprisingly, the team in Oregon came up with a 'complex formula', to take account of relevant variables, and to an extent of consumer choices. However, they produced a rank order of 688 'medical treatments', of which they excluded from state funding the 120 least economic procedures; but as against that, they made the 'approved' procedures available to citizens not previously entitled to health care. Apparently, the cost of the scheme is exceeding the estimate, suggesting that unmet need is being revealed, as happened at the start of the National Health Service. I do not
regard this necessarily as a point of criticism for the Oregon approach.

However, in this country, we might have certain advantages over a state in the USA. We have had a system of health care in being since 1948, which has both stimulated and facilitated research into the provision of health care and compelled scrutiny of health economics. Much effort has gone into the development and validation of indices of health status, applicable to assessment of ‘outcomes’ to be matched with the costs of ‘process’. By a stroke of fortune, even the ‘reforms’ have given us more sophisticated information systems, set up in pursuit of the ignis fatuus of ‘money following the patient’, but capable of being turned to saner purposes. And we have at last seen the need not simply to establish a Directorate of Research and Development within the Department of Health, but to nourish it financially, and to give it a regional dimension to take account of local problems. It will not be at all easy or rapid to establish a calculus of merit in procedures for health care, but it could be worth doing. I think that in this country we would have good facilities to do it, and especially so if we can regain a national service.

References