Order by Rules
and Rules by Order

Committee 3

THE STATE AND HEALTH CARE

Wilfried von Studnitz

Comment by
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The argument is persuasive. State-provded health services will reel from crisis to crisis as escalated taxes fail to meet the promised commitments.

The failing experiment with the British National (state) Health Service (N.H.S.) has lasted half a century. Sweden is now retreating after a shorter span. And Germany is entrenching itself in a scheme which will inevitable lead, says Professor Von Studnitz, to the familiar pattern in Britain and Sweden.

It is relevant to enlarge on his survey of the N.H.S. and particularly to discuss the recent reforms, the "internal market", to see if they suggest solutions to the rising cost of medical care in Sweden and Germany.

The "little success in the beginning" of the N.H.S., Dr. von Studnitz says, owes something to the euphoria about free wigs and aspirins. There was a no less important reason: drug discoveries by private British pharmateutical manufacturers and the refinement and extensive use of antibiotics. Old people no longer had to die of pneumonia or younger people of

septicaemia or tuberculosis, and children could be inoculated against diphtheria and poliomyolitis.

All these advances were, unsurprisingly but fallaciously, attributed by people generally to the "free" N.H.S. People believed that shorter stays in hospital and earlier recovery from serious illness were due to the beneficence of the N.H.S. And politicians of all Parties worked hard to foster these beliefs. It could be said that never before in the history of the welfare state was post hoc ergo propter hoc put to such effective political use.

After a few years came the bad news. Old people could live longer. New operations became available not only to save lives, like by-pass surgery, but also to make life more comfortable by dealing with arthritic joints, varicose veins, haemorrhoids and cataracts. The increase in the financial tax cost of the N.H.S. went at first almost unnoticed, not least because no-one knew at first how much more financing they required nor who paid.

When modest charging for prescriptions was attempted reluctantly, by a Labour Chancellor of the Exchequer, there was, as in Germany, a wounded outcry from the people who had been taught that medicine was a "right" enacted by generous, compassionate governments. The politicians swiftly excused pensioners, children, nursing mothers and sufferers fron chronic illnesses from the charges, thus reducing the saving in cost.

Swiftly, too, came rationing by waiting for consultations and treatment. The lists are now 18 months for hip, knee and elbow joint replacements.

Understated, but important, is rationing by culture. The middle classes become adept at bypassing waiting lists for appointments and treatment and pushing lower-income people down the lists.

No less unpopular than the waiting lists are the "cost-effective" mixed wards. Now it is common for men and women patients to be placed, without asking whether they agree, in wards according to administrative convenience and financial economy, rather than patient sensitivities.

Although Professor von Studnitz believes that the state owes the obligation to its patients to protect them from medical harm, it is questionable whether it is necessary since most must be assumed to know the risks. It is also difficult to know how medical care is to be made obligatory, nor how much or what quality. Not least it is not clear who should pay.

Advice in doctors'surgeries and clinics, and in the newspapers, radio and television to persuade parents to inoculate their children against infectious diseases is not lacking; there is no clear evidence that general compulsion is justified. The risks of side-effects from some inoculations, particularly whooping cough and measles, were underplayed by Government spokesmen a few years ago because

it was realised that some ethnic groups were particularly vulnerable, so that widespread inoculation of less vulnerable groups would prevent a spread to the vulnerable. This is hardly a good example of the state doing its duty to all its citizens.

The state advertises widely against the dangers of smoking, but it is inconceivable that it would make smoking illegal. Rules here would lead not to order but to disorder.

Before commenting on Dr. Studnitz's preferred solution to the crisis in taxpayer-supplied finance for medical care, I should explain recent reforms in Britain. Many general practitioners (family doctors) have become "fund-holders" given an annual sum by the Ministry of Health varying with the number of patients and liability to require attention (decided by age and other criteria). A patient who requires consultant advice or hospital treatment has his requirments bought by the family doctor who "shops" from a choice of consultants and hospitals. Consultants and hospitals thus compete for family doctor "custom" and indirectly for patient "customers" by offering better service, advanced equipment or shorter waiting lists.

The concerns are several. It is said that family practices may run out of money. Hospital beds may be bought by the more affluent general practices or by those outside the area so that local patients have to wait longer or are displaced. Practices in higher-income residential areas with

many patients who are insured privately have their government funds protected better than practices with numerous patients from lower-income areas. Patients are not aware of the cost of their treatments because the choices are not made by them but by their family doctors.

Dr. von Studnitz may have other fears in mind in refraining from advocating an unbridled free market in medical care: adverse selection, moral hazard, and the agency problem. Adverse selection may occur when health insurers raise all premiums in order to cover bad risks. Moral hazard is possible if ill-health is exaggerated to draw more insurance benefits. The agency relationship may raise hospital costs to insurers who pass them back to insured people. The patient complains of high premiums arising from his failure to monitor his bills.

Yet the free market, with many competing family doctors, consultants, hospitals and medical insurers (who have been growing in Britain with the coming of the "internal market") can overcome these objections more easily and sooner than the state, whose charges, hospital costs and bureaucracy tend to be inflated year by year until the whole system risks collapse.

The new insurers (some from other countries) offer flexible and varied premium scales to suit most income groups and people varying in aversion to risk. More people are insuring with low premiums for private hospital treatment if

they have to wait more than six weeks for the "free" N.H.S. The number insured privately rose by 5% to 6.5 millions in 1994 - an unprecented 12 % of the population. Faster annual increases rising to 10% are predicted for the next five years. More competition from overseas pharmaceutical companies will further lower the cost of medicines.

The "National" Health Service is thus no longer national: it has been rejected by more people down the income scale. They have been taught by the market to value good health more highly than dispensable consumer goods. And the knowledge of costs and prices in an external benefit taught not least to the lower-income people by the market, not by price-less, "free" state medicine. It is not the least discovery of the price-publicising market envisaged by Hayek.

Dr. von Studnitz argues that it is important for each patient to know the costs of medical care. This is hardly likely in a state scheme when bureaucrats, trade unions and the medical profession itself have an interest in witholding such information from patients. Would a dentist, for example, recently fined in England for ten years of malpractice-dental work on healthy teeth paid for by the N.H.S. - have continued his severe damage to patients' mouths and general health if they had fees to pay and therefore had known the costs ? Even without personal payment, it would have occurred to them, if they had known the high cost, that such extensive treatment was peculiar when they had not even

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a small ("cottage") hospital. Families paid a few pennies a week when they could afford it. Friendly Societies paid doctors selected by the votes of members at general meetings to look after women and children not covered by national insurance. Not least, more factory and colliery employers were paying for the health care of their employees.

Such varied private medical services had been growing and improving for 80 years or more before state the created the N.H.S. with the promise that all medical demands would be met without cost from birth until death. It soon proved an illusion.

Dr. von Studnitz believes that every citizen should insure for his medical requirements. It is not clear why the rich should be compelled.

He is concerned that the very poor would not be able to afford the premiums. His solution of a Supervisory Council of worthy people, including representatives from the Inland Revenue and/or government, to assess entitlement to the payment of medical bills is not the only way to help the poor. Health vouchers to pay for medical insurance chosen privately would give the poor something of the sense of choice enjoyed by the rich. It would cost less than free services in a medical monopoly. And the taxpayer would pay less than for a Supervisory Coucil that might rapidly become a bureaucratic office stuffed with social workers organised in a trade union.

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The voucher market solution would give the poor the dignity of individual choice of doctor and hospital. It approaches the realisable ideal of making every man amd woman a consuner who pays rather than a supplicant asking for favours.

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