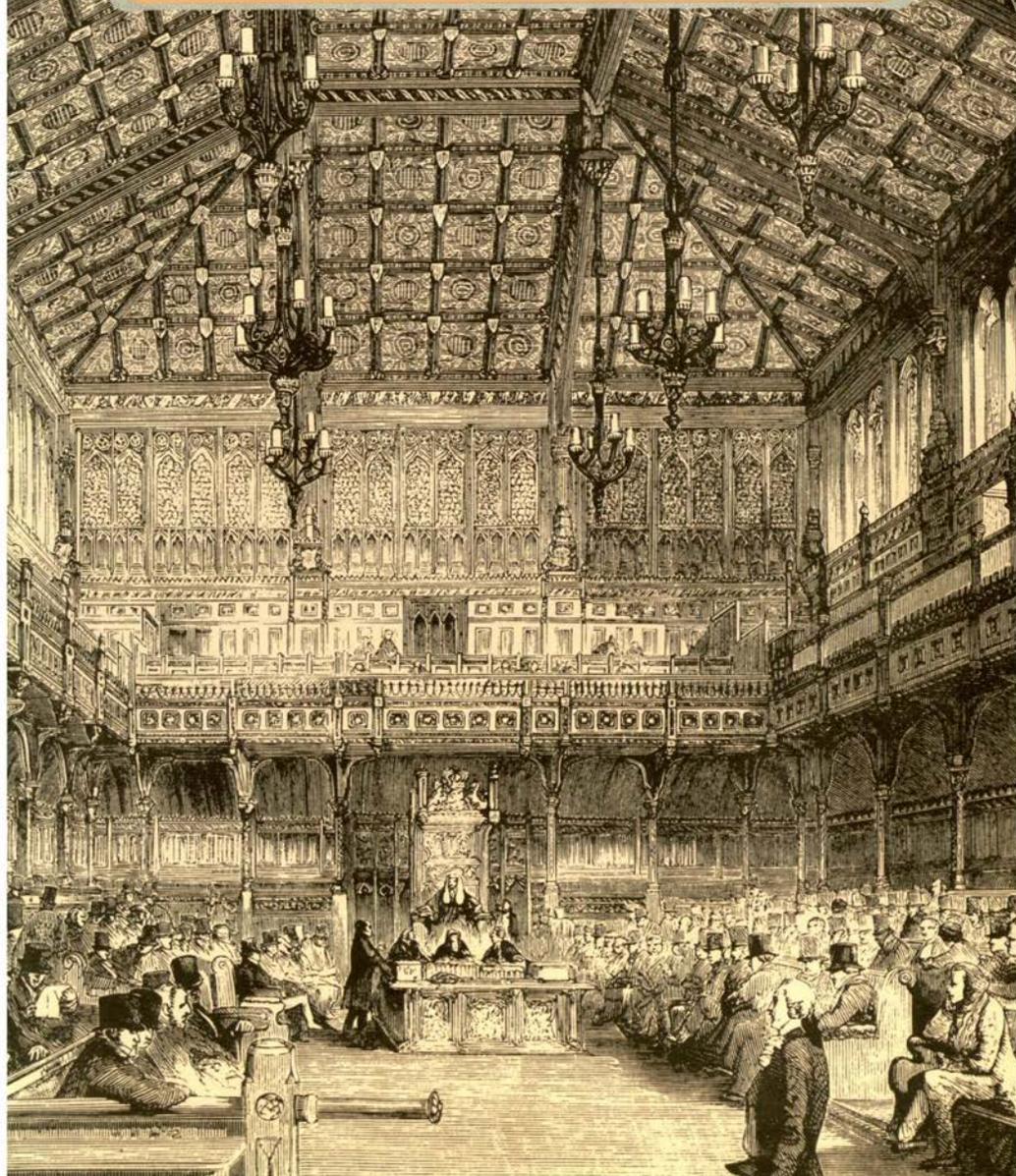


HEALTH THE POLITICIAN'S DILEMMA



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Office of Health Economics
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No 81 in a series of papers on current health problems published by the Office of Health Economics. Copies are available at £1.00. For previous papers see pages 21 and 22.

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ISSN 0473 8837

Written by George Teeling Smith.

Foreword

This paper from the Office of Health Economics contains some of the newer ideas which have been floated in order to tackle the economic problems urgently facing the National Health Service in 1986. It is postulated on the belief that the service not only needs additional public funds, but also needs to look at new economic principles in relation to its organisation. Above all there needs to be a better informed debate about the economics of health.

This paper does not contain definitive solutions. Rather it is a precursor to a discussion of the economic problems of health care in Britain from a variety of points of view. The Office of Health Economics intends to take an active part in this discussion in order to try to help to solve the problems which are described in this paper.

It also hopes to stimulate economic experiments within Britain to test some of the new approaches which economists and others have recently suggested to try to tackle the urgent problems of the National Health Service.

GEORGE TEELING SMITH

Office of Health Economics

The Office of Health Economics was founded in 1962 by the Association of the British Pharmaceutical Industry. Its terms of reference are:

To undertake research on the economic aspects of medical care.

To investigate other health and social problems.

To collect data from other countries.

To publish results, data and conclusions relevant to the above.

The Office of Health Economics welcomes financial support and discussions on research problems with any persons or bodies interested in its work.

Introduction

The dilemma of the political economy of the Health Service is inherent in the twin objectives of medicine as a science and as an art. The science of medicine is the pursuit of knowledge to conquer disease, and the problems facing medical research in this context were fully discussed in the recent OHE paper on 'Crisis in Research' (Wells; 1986). The art of medicine, or medical practice, is the treatment of patients, and it is here that the acute problem of shortages in recent years has tended to undermine the morale of those working within the National Health Service.

The dilemma has been accentuated over the past thirty years by the success of the science of medicine, which has steadily expanded the scope for its practice. Large numbers of previously untreatable diseases have become treatable. This has led to a steadily rising demand for more and more advanced forms of medical care.

If science could be held back, the economic problems of the health service could be largely solved. But this is not what people want. In consequence, public and professional expectations have led to the appearance of the growing inadequacy of the National Health Service. In addition, the sluggish British economy has contributed to the limitation of resources to meet expanding demands. This in turn has added further to the dilemma.

This paper first looks at the international pattern of expenditure on health as a percentage of national wealth. It shows that Britain has fallen from the middle of the international range in 1960 to the bottom position amongst comparable countries by 1982. Furthermore, there is substantial evidence of a shortfall of health care in Britain, much of which is due to a shortage of resources. In the future, demographic changes and advances in the science of medicine are likely to widen the gap between what would be technically possible and what is affordable within the existing Health Service level of funding.

Nevertheless, despite this background, it is unlikely that any political party in power could sufficiently increase the proportion of tax funded expenditure on the National Health Service to meet *all* demands, although offers to meet some extra demands would be attractive to the electorate. Already over the past thirty years health has fared better than defence or housing, for example, in terms of public expenditure. Thus it is important to look in other directions as well as public funds for improvements in the quality of care under the National Health Service.

The first possibility is greater efficiency, and it has been argued that significant improvements could most readily be achieved by the introduction of what has been called an 'internal market' in the Health Service. This could help to overcome the inefficiencies which are liable to occur in any massive bureaucracy, in spite of recent attempts to improve efficiency in hospitals. Secondly, resources could be more rationally allocated, to ensure that those treatments which were most

beneficial were given appropriate priority. There are undoubtedly still a few unnecessary forms of health care being provided for purely historical reasons; but more importantly, scarce resources are not always allocated to areas where they will yield the greatest benefits.

Thirdly, those responsible for providing health care could seek alternative sources of funds and could make better use of voluntary and charitable services. Too often, this approach has been neglected because it appears to undermine the principle of a free National Health Service. In reality, it could strengthen rather than weaken the universal provision of health care for the population as a whole.

This raises a central feature of the dilemma for the politicians. Many measures which could help to improve the quality of care under the National Health Service appear to be unpopular both among the health professions and with the electorate as a whole. Thus a government which has to function within a five year electoral span finds it difficult to introduce rational policies to improve the National Health Service.

A possible approach, in addition to extra public finance, is as follows. There should be a major campaign of public education to explain the economic realities for the National Health Service in Britain in the 1980s. Following this, it would be valuable to stimulate objective discussion of the policies which could lead to better health care. These must develop within an economic framework which accepts the fact that it is impossible to allocate from public funds all the money which could theoretically be spent on better health care. Given this approach, the National Health Service in Britain could once again become the envy of the world, as it often was in the 1950s. To a large extent, in that decade, the increasing demands on the health service could be met out of existing resources because of the dramatic economic savings resulting from the development of modern vaccines and antibiotics to control the infectious diseases. There are fewer equally dramatic economic savings with the newer medicines, which tend instead to improve the quality of life especially amongst the elderly; hence the need for the new economic approach which is discussed in this paper.

The evidence of shortage

Table 1 shows the proportion of gross domestic product spent in total on health for a range of comparable countries in 1960 and 1982. In the former year, the United Kingdom lay in fifth equal position amongst the eleven countries. By 1982, the UK had fallen to the bottom place in the Table. To some extent this merely reflects the declining affluence of Britain; it has been clear for some years that poorer countries spend a lower *proportion* of their wealth on community services such as health. Nevertheless, the contrast between 1960 and 1982 is striking. The health services in Britain are clearly underfunded by international standards.

Table 1 Health as a percentage of GDP.

1960		1982	
USA	5.3	USA	10.6
Germany	4.8	Sweden	9.3
Sweden	4.7	France	9.3
France	4.3	Netherland	8.7
UK	3.9	Germany	8.2
		Switzerland	7.8
Italy	3.9	Italy	7.2
Netherlands	3.9	Denmark	6.8
Denmark	3.6	Japan	6.6
Belgium	3.4	Belgium	6.2
Switzerland	3.3	UK	5.9
Japan	3.0		

Source: OECD

Table 2 Acceptance rates for end-stage renal failure patients per million total population 1984.

Belgium	67.8	Spain	54.3
Switzerland	66.4	Netherlands	49.7
West Germany	62.1	France	46.7
Austria	61.7	UK	35.9
Sweden	59.2		

Source: EDTA Registry

The effect of this low expenditure in Britain is evident in a number of ways. It is, however, important to see these 'shortages' in perspective. Much is already being done in the 1980s which would have been both technically and economically impossible in the 1950s. For example, hip-replacement operations are transforming the quality of life for many elderly people who would have remained housebound and in severe pain in the conditions of thirty years ago. Transplant and open-heart surgery, with all their benefits, were in their infancy in the 1950s. Nevertheless, there is substantial evidence that there is great scope for spending more on health and consequently further extending the benefits of medical science in the 1980s. Five examples demonstrate the point.

First, with the treatment of end-stage renal failure Table 2 shows the number of new cases accepted for treatment per million total population in a number of countries in 1984. These figures include both transplants and dialysis treatment. Once again it is clear that Britain is at the bottom of the league table. The European Dialysis and Transplant Association, which is the source of the figures, believes that the Belgian rate of almost 70 cases per million population represents a measure of the true 'need' which would also apply in Britain. If all cases were to be

treated, regardless of age and medical circumstances, the potential 'demand' would be nearer 150 cases per million population.

A comparison between the age-specific treatment rates in Belgium and the United Kingdom provides an interesting analysis. For patients under the age of 65 the difference between the figures for the two countries suggests a shortfall below the age of 65 of 1,230 cases for treatment in the UK. This can be taken as an estimate of the number of people below the age of male retirement who are dying unnecessarily in the United Kingdom because dialysis or transplant facilities are not available for them. In the 15-44 year age group the comparative rates of new patients treated per million population are 29.3 for the UK and 41.7 for Belgium.

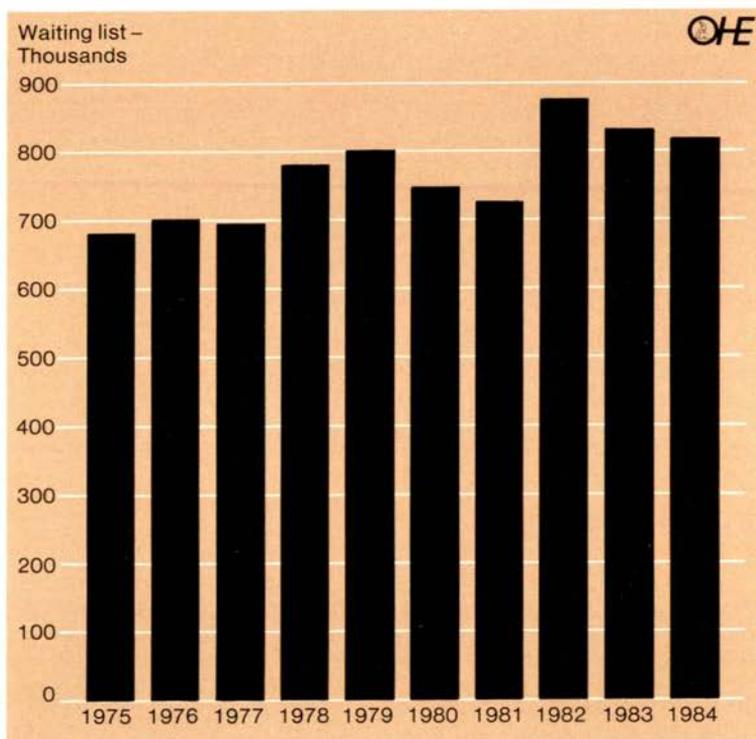
The second example indicating the scope for more extensive treatment in Britain is for coronary artery bypass graft (CABG) heart surgery. It has recently been pointed out that the rate for CABG operations in the United Kingdom is approximately one seventh of that in the United States (English 1984). Even if it is accepted that the Americans may be too enthusiastic in carrying out this operation in cases where medication would be equally effective, a seven-fold difference in the rates for the two countries suggests a serious under-provision in the United Kingdom. Indeed a consensus development conference on the operation in 1984 recommended that the UK rate should at least be trebled (Consensus Development Panel: 1984).

Thirdly, the rise in hospital waiting lists under the National Health Service over the past decade is illustrated in Figure 1. Although the waiting list in 1984 was below its peak of 1982, it was nevertheless still 20 per cent higher than in 1975. It is difficult to interpret accurately waiting list figures, because they depend not only on the supply of treatment, but also, for example, on the clinical condition of new patients who are added to the list. Nevertheless the existence of over 800,000 patients who were recorded as needing currently unavailable hospital treatment in 1984 must be a cause of serious concern.

Turning to sickness in the community, the treatment of mild to moderate hypertension is still a subject of some controversy. However, there is no disagreement that people with diastolic blood pressure in excess of 110 mm Hg should receive treatment to reduce their eventual risk of heart disease, stroke and even renal failure. In a new study in the United Kingdom a cohort of 36 year olds (that is, young people) were screened, and it was found that 2.3 per cent of men and 2.0 per cent of women were suffering from this degree of hypertension without receiving treatment (Wadsworth: 1985). Obviously the proportion of such cases can be expected to rise with increasing age, so it can be conservatively estimated that there are about 600,000 untreated cases of severe hypertension in the United Kingdom.

The final example concerns infant mortality. There are many factors in addition to medical care which affect this, but undoubtedly the lack of a positive initiative within the health service aimed at high risk groups is partly responsible for the differences in infant mortality rates

Figure 1 NHS Hospital waiting list, Great Britain.



between the highest and lowest social classes. In England and Wales in 1981, social class I had a rate of 7.7 deaths per 1,000 live births. For social class V the figure was twice as high at 15.8 per 1,000 (HMSO: 1985). If the conditions could be improved so as to make the best rates applicable to the population as a whole over 1,200 infant deaths would be avoided each year.

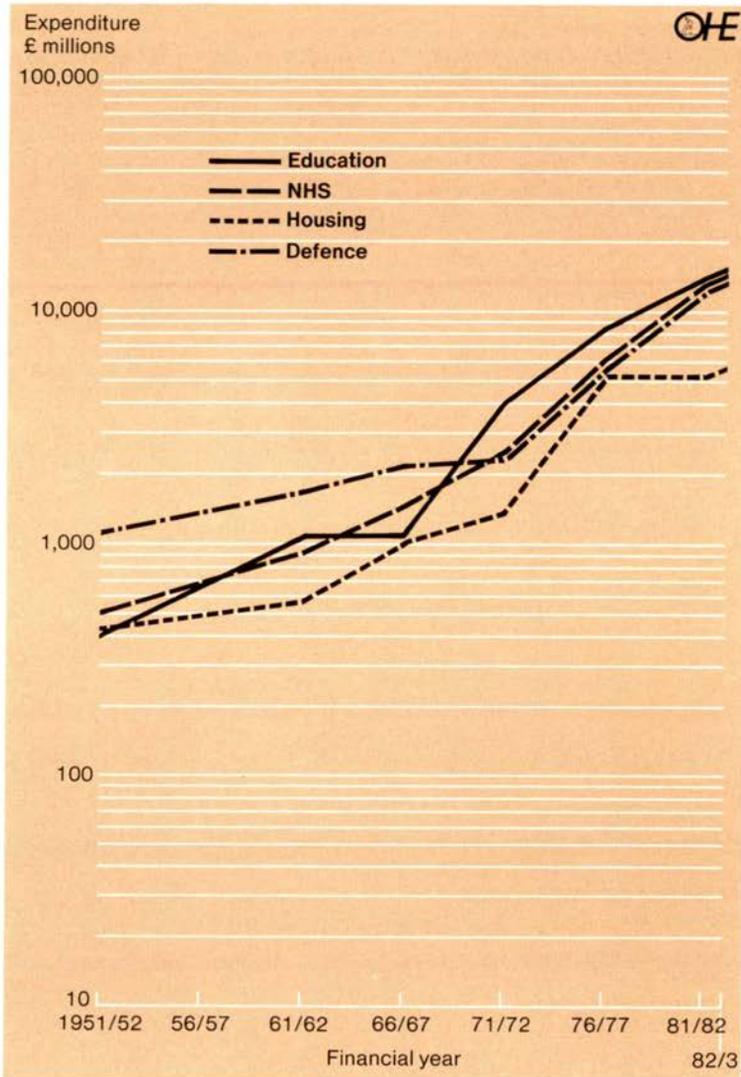
It should be emphasised again that these very real measures of shortage need to be seen in perspective. For one thing there are factors outside the control of the health services which are partly responsible for the apparent failure of the medical services to reach all of those in need. Furthermore, discussion of the short comings of the British Health Service masks the dramatic improvements in health which have occurred in the past thirty years. Nevertheless these five examples serve to highlight the scope for improvement in health care in Britain in the 1980s. It is thus highly inappropriate that so much of the contem-

porary discussion of the health services in Britain and in other Western countries should be concentrated on 'cost-containment' rather than expansion.

However, the reality is that in Britain it is unlikely that any political party once in power would be able to raise the taxes necessary to fund adequately the National Health Service. It will be hard for tax funding for the Service to grow much faster than by one or two per cent per year after allowing for inflation, although large sectors of the population would like to see more generous treatment by the government for the health service. On the other hand, the scope for new expenditure – for example on 'routine' heart transplants, improved cancer chemotherapy, and more sophisticated diagnostic techniques – is likely to grow at a faster rate. Furthermore, largely as a consequence of advances in the science of medicine, the proportion of the very old in the population is going to increase. It also seems likely that wage rates within the health service will continue to run ahead of the national rate of inflation. For all these reasons, if no other measures are taken, it seems inevitable that the gap between what is technologically possible and what will be made available from taxation to fund the Health Service will widen between the mid 1980s and the end of the century.

In a way this situation is underlined by the past pattern of public expenditure. Figure 2 shows for education, health, housing and defence the way in which government funding increased between 1951–52 and 1982–83. Much of the increase, of course, is due to inflation, but this does not distort the comparison between the various sectors of the economy. Whereas defence and housing had increased their expenditure by 13.1 times and 14.3 times respectively the National Health Service enjoyed twice this rate of expansion – with a 28.8 fold increase. In 1951–52 defence cost more than twice as much as the National Health Service; by 1982–83 the two expenditures were equal. Of the four sectors, only education, with 36.5 times its 1951–52 expenditure, had a faster rate of expansion than the National Health Service (Social Security also rose faster, but there are obviously special economic factors responsible in that case). However, the more recent trends between 1971–72 and 1982–83 are different. Expenditure on education has been rising less steeply, and health and defence expenditures have kept pace with each other. Nevertheless in the overall picture it is clear that health and education have been relatively well treated in terms of public expenditure since the 1950s. The decline in Britain's international position is not primarily because health expenditure has been selectively restricted under any government over the past thirty years.

Figure 2 Public expenditure; 1951/52–82/83; UK £ million.



Source The Economist Diaries.

Three possible approaches

As was pointed out in the Introduction, three new ideas, in addition to extra tax funds, can be put forward to ease the problem of rising expectations and increasing scope for medical care. These are greater efficiency, a better allocation of resources and the possibility of attracting alternative sources of funds for health care. Unfortunately, the dilemma facing politicians is that all three approaches tend to be unpopular, because they are seen on the one hand as a challenge to the independence of the medical profession and on the other as a threat to the integrity of the National Health Service.

Greater efficiency

It has often been pointed out that there are in principle only two ways of allocating resources. One is through the market, where people buy what they want provided they can afford it. The other is through a bureaucracy, in which resources are allocated centrally, usually in the belief that in that way they will be more equitably distributed.

Unfortunately, it seems to be inevitable that any large bureaucracy should contain pockets of inefficiency. Things are done according to the rule book rather than according to common sense: outdated practices continue because no one has the entrepreneurial initiative to challenge them; and without local ways of measuring efficiency and performance personnel may sometimes be poorly motivated to do what is best for the organisation as a whole.

On the other hand, the market mechanism on its own is wholly inappropriate for the allocation of health care resources. Those most in need are usually those least able to pay for treatment or care. For this reason, almost all of the advanced countries in the world have comprehensive pre-payment schemes for the provision of health services. The British National Health Service is just one variant of the schemes which exist in other countries (Vaizey: 1982).

It has recently been suggested that the conflict between the unfairness of a 'market' system for purchasing health care and the inefficiency of a 'bureaucratic' system of central allocation can be resolved. The proposed solution has been referred to as an 'internal market' within the National Health Service. Two models have been suggested.

The first and most widely discussed model is that proposed by the American economist Enthoven (1985). He suggested that the American experience with Health Maintenance Organisations (HMO's) could be applied in Britain. Under the American HMO's the organisations contract with patients or (more often) groups of patients to provide all necessary medical care. The HMO receives a predetermined per capita fee, which may vary according to the health status of the group, and the organisation must then make the most efficient use of these funds to provide the optimum care for the population it covers. Different HMO's can compete on both price and quality of care, so that desirable 'market forces' exist to ensure competitive efficiency.

Enthoven proposed that the District Health Authorities under the British National Health Service should operate as HMO's, receiving a per capita allocation of resources which would depend on the demographic pattern of the population which they covered. The Districts would then be free to provide or to purchase from other organisations the necessary care for their population. More efficient Districts could 'sell' services to less efficient Districts, and all of them would be free to buy services from Regional Specialist Units or even from private medical organisations. Enthoven argued that the market forces which this system would introduce would overcome much of the inefficiency which he observed in the existing National Health Service. Greater efficiency clearly implies a better quality of care, and opens the way to overcoming the type of shortages of health care which were described above.

The second model has been advanced by the British economist Maynard, and was discussed at an Office of Health Economics meeting in 1984 (Teeling Smith 1984). Maynard suggested that the general practitioners should effectively become the 'budget holders' for the National Health Service. Thus when a general practitioner sent a

Table 3 Efficiency savings in the NHS: £ millions.

<i>Regional Health Authority</i>	<i>*1981/82</i>	<i>*1982/83</i>	<i>†1983/84</i>	<i>§1984/85</i>
Northern	1.2	2.1	2.7	4.0
Yorkshire	0.6	2.0	3.1	7.1
Trent	1.5	2.1	3.7	8.0
East Anglian	0.8	0.6	1.6	3.3
North West Thames	1.2	1.8	3.3	10.6
North East Thames	1.5	4.1	4.2	11.7
South East Thames	2.1	3.0	3.6	14.0
South West Thames	1.2	1.2	2.8	6.9
Wessex	0.2	1.3	2.2	4.2
Oxford	0.2	0.6	1.8	3.7
South Western	1.0	1.0	2.7	4.7
West Midlands	1.3	1.4	4.2	13.5
Mersey	1.1	2.0	2.3	7.6
North Western	1.3	2.3	3.8	7.5
Total	15.2	25.5	42.0	106.8

* Cash savings reported by regions.

† In 1983-84, regional health authorities were expected to achieve the efficiency savings shown, equivalent to some 0.5 per cent of their cash allocations, but detailed returns on their achievements were not requested.

§ From 1984-85, regional health authorities have been required to include planned cost improvements in their short-term programmes and to report on their achievements. The table shows the cost improvements achieved.

Source *Hansard*, 14 February 1986, column 596.

patient to hospital, the practitioner would at the same time be allocating part of his budget to cover the cost of the hospital treatment. Thus Health Service funds would flow 'upwards' from the general practitioner to the hospital, instead of being allocated 'downwards' from the Regions and Districts.

On this model, it is argued that the more efficient hospital departments would attract extra patients, and, at the same time, extra funds. Less efficient units would attract fewer patients and would decline and eventually be closed. There would still need to be some central overall control to ensure a fair geographical distribution of resources, but within a much looser central planning system market forces would again stimulate efficiency and improve the quality of care.

Table 3 shows the 'efficiency savings' reported for the National Health Service between 1981-82 and 1984-85. Although the figures have been rising substantially, the saving of just over £100 million in 1984-85 looks disappointing against a total health service expenditure of about £17 billion. It supports the argument that new fundamental economic principles are needed if greater efficiency is to contribute substantially to solving the problem of shortages in medical care under the National Health Service.

General practitioners should also be encouraged to compete with one another, for example, by publishing information to demonstrate the quality of care which they provide. This could show, for example, their good record of preventive medicine in the practice, and the convenience of their accessibility to patients. Already some practices produce literature of this sort, and where patients have a practical geographical choice of alternative general practitioners they should be encouraged to study the relative attractiveness of the services on offer.

There may be other alternative features of different 'internal market' systems within the overall framework of a free and tax-funded Health Service. The important point is that the introduction of the motives for efficiency implied by a market could greatly improve the performance of all those working within the National Health Service. However the economic discipline which is also implied by the existence of a 'market' might not be immediately attractive to some of those who have so far enjoyed the relatively protected conditions of employment which tend to exist in a central bureaucracy.

Allocation of resources

One of the problems with a 'market economy' of any sort in health care is that it is extraordinarily difficult for the 'purchaser' to know the value of the treatment which he is obtaining. This is self-evident in the case of the patient himself, who clearly does not have the necessary specialist knowledge to choose, for example, between alternative treatments for diabetes, cancer or Parkinson's disease. However, in a situation where all competing demands for medical care cannot be met, it is also now becoming obvious that even doctors require help in deciding on the relative value of different forms of medical care.

The principle has in fact been accepted since the 1950s, when randomised clinical trials (RCT) started to be generally introduced. The RCT indicates, under carefully controlled conditions, whether a particular treatment is effective or, alternatively, which of two or three alternative treatments is the most effective. Since the 1950s, the 'clinical impressions' on which medical judgements were formerly based have gradually been replaced by scientific assessments using an RCT. The RCT, which has for many years been mandatory for any new medicine, is now often also applied to surgery or to other medical procedures. Thus by the 1980s most treatments provided under the National Health Service are of proven clinical value.

However, in a situation of both potential and both real shortages the principles of comparative evaluation of treatments need to go further. Not even effective treatments can be automatically made available. Within the past few years economists and doctors have therefore worked together in developing what has been called 'cost utility analysis'. This is based on the economist's concept of 'utility' as a measure of worth irrespective of what an individual is able to pay. Thus in economic terms, a person's degree of wellbeing has a 'utility' to that individual, even though it has no 'price'. Economists and doctors have produced rather sophisticated methods of measuring the quality of life of individuals, to supplement the traditional measurement of mortality as a way of assessing the value of a particular type of medical treatment. These have been fully discussed elsewhere by the Office of Health Economics. (Teeling Smith, 1985).

It needs to be emphasised that these measurements of 'utility' or 'quality of life' do not by themselves indicate how scarce medical resources should be allocated. Other factors must be taken into account and in any case these developments are still at a tentative stage in economic theory. However unless the relative benefits of different forms of medical care are judged in this sort of way, it will be very difficult to introduce a rational mechanism for ensuring that scarce medical resources are used to the best advantage.

The allocation of resources in accordance with the principles of 'maximising utility' in society as a whole is not in conflict with the earlier argument in favour of market principles. Although in a private market different individuals may maximise their individual 'utility' in different ways (eg choosing to buy clothes, or travel, or better housing) in a public service the objective is to maximise utility for the population as a whole. Thus if a hip replacement represents better value than renal dialysis, as Williams (1985) has argued that it does, greater priority should be given to orthopaedic surgery than to renal surgery. Although the priorities of individual patients (and hence their doctors) must inevitably be different, if the medical profession as a whole understands and applies the principles of maximising collective utility, resources should automatically tend to be allocated to the treatments bringing greatest benefit. The earlier traditional view that doctors should disregard economic factors, and think only in terms of each

individual patient, has now seriously to be challenged in the economic situation facing the National Health Service in the 1980s. But, once again, this is an extremely unpopular reality which doctors and surgeons have to face.

Alternative funds

There are two ways in which the National Health Service can benefit from private finance. The first is by direct payment by some patients for the treatment received with the Health Service. The second is by a lightening of the Health Service workload by a shift of patients into the private sector. This involves the private provision of facilities for care to supplement those provided under the National Health Service. Both of these approaches have been the subject of considerable political controversy in the past, but more recently there have been developments which seem to have attracted rather less political comment.

In both the dental and ophthalmic services a considerable shift to alternative sources of finance has taken place. In dentistry it is estimated that about 10 per cent is financed and provided privately, and a further 25 per cent is paid for through patient payments for Health Service work. Thus only 65 per cent is provided and paid for publicly (Laing 1985). For ophthalmic work, even more is privately financed. It is estimated that 49 per cent is privately provided and paid. A further 10 per cent is paid privately for Health Service spectacles, leaving only 41 per cent which is both provided and paid for publicly.

Laing's study also reveals the extent of private involvement in the institutional care of the elderly. In that case, 55 per cent is provided in public institutions and paid for out of public funds. Almost half as much – 24 per cent – is both privately provided and privately financed. A further 10 per cent of the cost is met out of public funds for old people in private homes and the remaining 11 per cent is accounted for by private finance covering people in publicly provided institutions. It seems possible that this mix of public and private finance and provision of services is likely to be a model for other parts of the Health Service in the future. It is remarkable that the fact that 45 per cent of the elderly in institutions are either privately financed or else in private institutions (or both) seems to have attracted little comment.

As another example, already 13 per cent of all non-urgent surgery is paid for privately in Britain. About 9 per cent is carried out in private hospitals and about 4 per cent in National Health Service hospitals.

Perhaps the most interesting development of all to have taken place in recent years is the acceptance with a minimum of discussion of the principle of 'means testing' institutional care for the elderly. If the old person has personal financial means they are expected to pay part or all of the cost of their care even if they are in publicly provided old peoples' accommodation. Conversely, old people in private homes will be supported out of public funds if they cannot pay for themselves.

Thus in elective surgery, care of the elderly, dental treatment and ophthalmic treatment the principle is already well established that

funds raised from taxation can often be supplemented by private payment.

In pharmaceuticals, in 1985, the imposition of a 'limited list' of prescribable items in therapeutic categories such as laxatives, analgesics and cough preparations also introduced the principle that patients should be expected to pay for themselves if they wished a particular medicine rather than a cheap Health Service alternative. In all of these ways the original concept of a totally free and universal Health Service has gradually been eroded. It can be argued that in a very different social structure in Britain in the 1980s, Beveridge's and Bevan's principles of universal free public provision are indeed no longer appropriate. There appears to be substantial scope for exploring the possibility of extending private provision and private finance for medical care in the future.

There has also been a considerable growth in charitably funded care in recent years to supplement that available under the National Health Service. Table 4 shows the income of the medical research charities between 1977 and 1984. Although the largest part of their funds – £89 million in 1984 – is spent on research, there is also a substantial element of welfare or 'caring' expenditure on their part. Table 5 shows the amounts spent specifically on care by some of the major research charities in 1984. In addition to their expenditure of just under £40 million, there are also substantial amounts spent by charities which concentrate primarily on welfare rather than research such as Age Concern.

In addition, individual voluntary work has made an important contribution to the quality of life of patients both in hospital and in the community. The spirit of the original 'welfare state' of the 1950s, in which government was expected to accept total responsibility for welfare, seems to be gradually giving way to a return to the earlier concept that private voluntary care for the under-privileged and sick has an important part to play alongside a better funded and more efficient National Health Service.

Table 4 Medical charities: total income and research expenditure: £ million.

	<i>Total income</i>	<i>Research</i>	<i>*Residual</i>
1977	37	25	12
1978	58	32	26
1979	76	33	43
1980	85	54	31
1981	100	65	35
1982	115	70	45
1983	128	77	51
1984	150	89	61

*Expenditure on welfare, plus administrative costs and balance of income retained.

Source Association of Medical Research Charities.

Table 5 'Welfare' expenditure by some Medical Research Charities; 1984.

	<i>£m</i>
Spastics	28.2
Multiple Sclerosis	3.0
Heart Disease	1.7
Arthritis and Rheumatism	1.7
Diabetes	1.4
Leprosy	0.7
Chest, Heart and Stroke	0.6
Spina Bifida	0.6
Muscular Distrophy	0.5
Asthma	0.1
Migraine	0.1
	£ 38.6

Source OHE estimates from the Handbook of the Association of Medical Research Charities 1985-86.

The political dilemma

Greater efficiency, a more rational allocation of resources, the introduction of alternative sources of finance and extra taxes all seem to be potential ways of helping to tackle the short fall of health care in Britain discussed at the start of this paper. The problem is that each of these approaches has its potential opponents, both within the Health Service and outside it. For instance, there are still those who hanker for a return to the principles of a universally free and comprehensive National Health Service.

More practically, many doctors and other health professionals resent the suggestion that their pattern of behaviour should be modified in order to provide better value for money in the Health Service. The opposition in some quarters to any form of financial incentives for improved performance in general practice is an example of the resistance to change from amongst the professions. The opposition to the reintroduction of more private pay beds in National Health Service hospitals is another example of resistance to economically rational developments.

Thus the politicians face an unenviable dilemma. If they attempt to improve the quality of health care in Britain by other means in addition to better public funding they are likely to face problems. Governments have to work within the time-scale of a maximum of five years between elections. If they attempt to introduce politically unpopular moves within this time period, they may well lose office at the next election, and find that a politically more timid alternative government reverses their health care policies.

It has been suggested, following this line of argument, that the National Health Service should be 'taken out of politics'. But this is unrealistic. A service which in 1985 cost the taxpayers about £17 billion cannot be run without political accountability.

The better approach seems to be to stimulate much more widespread and rational debate about the economic realities facing the National Health Service in the 1980s. How widely is it known, for example, that some aspects of medical and quasimedical care already attract almost half their funding from private payments? How many of those responsible for the management of the Health Service fully understand the principles of an 'internal market' or 'cost utility analysis'?

The British National Health Service was the envy of the world in the 1950s. It was an unrivalled social development totally appropriate to the mood and social conditions of an immediately post-war Britain. But the Health Service can no longer proudly claim to be the best in the world. Like many other health services in other countries it has severe economic problems. Britain could once again set an example by introducing a more rational approach to help to solve the problems of the Health Service. But it will need courage and determination on the part of the politicians to educate the public and the professions over the urgent need to introduce changes, involving not simply a greater allocation of public funds but also some experiment with new economic approaches.

In conclusion, nothing should undermine the basic principle that first class health care should be available free of charge, provided at the taxpayer's expense, for all those genuinely in need. However, if the Health Service continues unchanged in its present pattern it is going to drift further and further away from achieving that highly desirable goal.

The National Health Service was created on the premises that there would be full employment and stable economic growth in Britain and that demand for medical care would be self-limiting. None of these premises have proved true in the 1980's. There is still, however, a fundamental and widespread belief that the National Health Service is one of Britain's most valuable institutions, and this needs to be reflected in more generous support through public expenditure as well as the encouragement of new economic philosophies in relation to health care for the 1980s.

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