
WHY BRITAIN'S CONSERVATIVES SUPPORT A SOCIALIST HEALTH CARE SYSTEM

by Rudolph Klein

Prologue: Britain's National Health Service (NHS) has encountered difficult times under the government of Prime Minister Margaret Thatcher. A conservative who shares many of the philosophical tenets that guide President Reagan, Thatcher has sought to force the NHS to make tougher choices. She also has told the electorate bluntly that the health service does not represent a free lunch. Thatcher declared herself pointedly in this regard during the Conservative Party's annual conference in October 1983. "Let us never forget this fundamental truth: the state has no source of money other than the money that people earn themselves. . . . Let me take the subject on which there has been so much debate—the health service. People talk about a free service. It isn't free. You have to pay for it." Nevertheless, Thatcher and her party colleagues, not unlike all successful politicians in the United Kingdom, seem duty-bound not to be seen as attacking the NHS. After her support of it became an issue in 1982, Thatcher declared at the party's annual conference that year that the service is "safe in our hands"—a comment that helped her win reelection by a landslide. In 1982, the NHS consumed 6.3 percent of Britain's gross national product, compared with 10.6 percent for personal health services in the United States in the same year. On a per capita basis, medical care expenditures in the United Kingdom were \$390 versus \$1,265 in the United States. Rudolph Klein, a professor of social policy at the University of Bath, explains in this essay why so socialistic an instrument as the NHS enjoys the support of the Conservative Party. Klein, a former journalist, has written widely on the NHS and is regarded as a leading British commentator on the health service. His recent book, *The Politics of the National Health Service*, is a primer on the evolution and status of Britain's most popular social program.

The creation of Britain's National Health Service (NHS) in 1948 has been described as "the Labour Government's most intrinsically Socialist proposition."¹ And to this day the NHS symbolizes the Labour Party's vision of a Socialist society. It is a service which offers free access to health care to the entire population as a right of citizenship, regardless of the ability to pay. It is a service which recognizes only one criterion for allocating resources to individual patients, that of need as defined by the professional providers of health care. It is a service, furthermore, which is overwhelmingly financed out of general taxation, and which is thus a powerful instrument for redistributing money from the working population to the sick and to the old. Not surprisingly, therefore, the NHS symbolizes in British eyes social equity and collectivist compassion.

This symbol of socialist principles might, on the face of it, seem to be an affront to everything for which the present Conservative government stands. Margaret Thatcher's government was elected in 1979 on an ideological platform very similar to that of President Reagan's administration. The aim of the new government was to break the mold of post-war British politics by repudiating what it saw as the soggy consensus supporting a welfare society. The frontiers of the state were to be rolled back; public expenditure was going to be reduced in order to permit taxation cuts. Self-help, not collective support, was to be the new watchword. Yet, in the outcome, the Thatcher government has become committed to the NHS. In the 1983 general election, Mrs. Thatcher's theme was "the NHS is safe with US."² By then any idea of dismantling the NHS—and replacing it by an insurance-funded system—had been quietly buried, even though tentatively floated in the party's 1979 election manifesto.

The aim of this article is to explore this seeming paradox of a Conservative government embracing an institution which embodies Socialist principles. In doing so, it not only examines the policies of the Thatcher government but also explores the central paradox of the NHS itself: a health care system which manages to be both parsimonious and popular, and which makes the rationing of health care socially acceptable.

Keeping The Cap On The Budget

Britain's NHS has, without fear of challenge, one distinction. It is the best-buy model of health care in the Western world in the sense that it manages to offer a comprehensive coverage of the entire population at the least cost as measured by the proportion of the national income devoted to health care. Only 6 percent of Britain's national income is devoted to health care, about 50 percent less than the proportion for the United States, Germany, and Sweden. This may be less of an achievement than it sounds if it is assumed that health care is a luxury good with

a high-income elasticity. Cross-national evidence suggests that spending goes up in line with rising per capita income, so that a relatively poor country like Britain would be expected to pay less than richer societies.³

But, even accepting this point, Britain's NHS has a unique capacity for controlling the rate of increase in spending. It is the only Western system which embodies in its method of financing health care and reimbursing health care providers, the capped budget principle. Its global budget is settled nationally every year by the Cabinet, and every administrative unit and every hospital within it has to keep within their allocated budgets. Hospital doctors are salaried; general practitioners are paid on a capitation basis (with some salary elements). Providers have neither the opportunities nor the incentives to maximize spending. The only hole in the budget cap is the open-ended system of prescribing drugs by general practitioners, so that, in effect, the drug bill is uncontrollable. Overall, however, the NHS is essentially a national health maintenance organization (HMO) working within a fixed budget.

For a government like Thatcher's, dedicated to holding back the trend of rising public expenditure, the NHS has an obvious appeal. It is a ready-made instrument for enforcing stringency. And this is how the Conservative government (according to its critics, at any rate) has used it. In constant price terms, expenditure on the NHS increased by 8.3 percent between fiscal years 1978/79 and 1984/85.⁴ This was an annual rate of increase of under 1.5 percent, which is low by the standards of the 1970s when spending was rising twice as fast—and it is a slower growth rate than that experienced in most other West European countries⁵

The problems, and the political controversies, start when it comes to interpreting the significance of these spending figures. From the government perspective, the growth of spending on health care is presented as evidence of its commitment to the NHS. The drop in the growth rate is less important and significant, it is argued, than the fact that there has been any increase at all in spending on the NHS in a period when the overall performance of the British economy has been truly dreadful. Consequently, any increase in expenditure could not be financed out of the dividends of growth but meant a transfer of resources from private consumption to public spending. From the perspective of the government's critics, in contrast, the spending record is evidence of the Conservative's niggardliness which, it is argued, is undermining the NHS. The price of financial stringency, the critics maintain, is cutting the NHS and reducing its ability to respond to need.

The widespread perception of what is indubitably a rise in spending on the NHS, and which has brought about an increased input of real resources, as a cut does not merely reflect political perversity or prejudice. It helps to illuminate both some of the pressures on the NHS and the political dynamics of the health care system. The pressures are both de-

mographic and technological. Thus the Department of Health and Social Security (DHSS) has conveniently assumed that an annual growth rate of about 1.2 percent a year, in real terms, is required to meet the needs of Britain's aging population and to respond to innovations in the technology of medicine.⁶ In a sense, therefore, the rate of growth recorded under the Conservative government represents a standstill budget if account is taken of increasing demands on the NHS.

But within this standstill budget, the NHS has to accommodate policies for change. Successive governments over the decades, both Conservative and Labour, have committed themselves to the principle of promoting equity in the distribution of health care both between different parts of Britain and between the different patient groups served by the NHS. The NHS inherited a geographical distribution of resources heavily biased towards the metropolitan area around London which persisted into the 1970s when a determined effort was launched to redress the balance. A formula for rationing resources was then devised on the basis of demographic factors and mortality statistics.⁷ This provides a benchmark for judging whether any given region or district of the NHS (the two administrative tiers of the service) is below or above its "equity" target. Thus in 1979 the North East Thames region, which takes in large chunks of London with its heavy concentration of expensive teaching hospitals, was reckoned to be 13 percent above target while the North West region, which takes in tracts of Britain's declining industrial heartland, was estimated to be 9 percent below target.

Conceived in the days of optimism about economic growth, the formula has proved something of a political landmine in the era of pessimism about economic growth. For when the drive to equalize the geographic distribution of resources was launched, it was reasonable to assume that this could be achieved painlessly; above target regions would simply have a slower growth rate than below target regions. Now, however, this easy option is no longer available as the scramble for resources has increasingly turned into a zero-sum game. Moreover, the problem is compounded by the maldistribution of resources within regions. If the North East Thames region is relatively overprovided, taken as a whole, the picture changes dramatically when we look at the districts within it. Thus Islington District Health Authority, in inner London, is 25 percent over target, while Southend District Health Authority, a seaside retirement area, is nearly 20 percent below target.⁸ To move towards an equalization of resources within regions, a standstill budget inevitably means cutting services in the relatively overprovided parts of the country. Achieving social justice becomes increasingly expensive politically in a period of economic stagnation.

The politics of redistribution are made more difficult still by another commitment inherited and embraced by the present Conservative

government. This is to give priority to the development of those services, particularly in the community, which serve the elderly, mentally ill, and handicapped.⁹ This includes those groups which, in the past, have tended to be short-changed partly because of their own lack of political clout and partly because of the low position in the medical hierarchy of prestige held by the professionals working in these fields. Once again, developing these services may mean cutting others or at least holding back their advance; better community services may mean fewer coronary artery bypass grafts. If the ability to restrict the growth of expenditure is one side of the coin of capped budgets in the British system, the necessity to make the choices is the other.

Trying To Square The Financial Circle

How can choices be made less painful, short of relaxing financial stringency and allowing the budget of the NHS to expand faster? In trying to square this circle, the Conservative government has tried three strategies, with variable success. First, it has explored the possibility of raising extra revenue—and relieving the burden on public expenditure—by increasing direct charges (copayments) to patients. Second, it has initiated an efficiency drive in the NHS designed to cut costs. Lastly, it has encouraged the growth of the private sector of health care in order to relieve the pressures on the NHS.

Raising extra revenue. Ideologically the Labour Party in Britain has traditionally been opposed to copayments, just as ideologically the Conservatives have been biased towards them. In both cases, ideology has been forced to yield to expediency. The Labour Party, while always proclaiming its opposition to the charges for prescriptions, spectacles, and dental treatment which were introduced in the 1950s has been unwilling to deprive itself of this source of revenue while in office. The Conservative Party, while in principle anxious to increase the yield of copayments and to extend them by making hotel charges for hospital inpatients, has been unwilling to incur in practice the administrative costs of extending the system of charges. In this, the Thatcher administration has been no different from its Conservative predecessors. When it took office, the yield from charges represented 2.1 percent of the NHS's total budget (as against a peak of 5.3 percent in the mid-fifties). The proportion has now crept up to 3.0 percent, an increase which reflects a rise in the level of the existing charges, not an extension of the system.¹⁰

The reason is simple. Under the British system, there is a clear conflict between competing policy objectives. If the aim of policy is to increase revenue while maintaining the principle that no one should be deterred from access to health care for lack of money, then the simplest method for doing so is to offer blanket exemption to those groups of the popula-

tion who are deemed to be poor. This is how the system of prescription charges works, with the old, the unemployed, and those on social security having automatic exemptions; over 60 percent of all prescriptions are issued free of charge. But this erodes the revenue base, so governments face a further policy dilemma. If the aim is to maximize income by setting high charges, then inevitably there has to be a system of means testing so as to avoid imposing a disproportionate burden on those health service users whose income just takes them out of the exempt categories. But operating means tests is administratively expensive. However, fixing charges at a level low enough to obviate the need for means tests while yet conceding automatic exemption to large groups inevitably means that the total yield of any copayment is going to be modest in the extreme. It is not surprising, therefore, that the Thatcher government has effectively abandoned any idea that copayments offer a way out of its policy problems as distinct from a sliver of marginal income.

The quest for efficiency. Frustrated in its hopes of finding extra sources of revenue, the Thatcher government has concentrated on trying to make the NHS more efficient. This, increasingly, has become its main theme. In presenting its annual expenditure plans, the government has even included an element explicitly labeled "efficiency savings." This is a notional sum which, assuming the government's target of increased productivity and cost-cutting is met, is supposed to be available for increasing the services provided by the NHS. Thus in fiscal year 1983/84, it was assumed that such savings would add a further 0.5 percent to the NHS's budget, over and above the increase allowed for in terms of the cash allocated to the service.¹¹

But exhorting everyone to be more efficient—and hoping that, by squeezing the budget, the resulting pressures will persuade health service providers to cut costs rather than standards of care—would seem to be no more than a political rain dance. And, in fairness to the Conservative government, the rhetoric of efficiency has been buttressed by a number of initiatives designed to turn it into a reality. First, in 1982 the Conservatives reorganized the administrative structure of the NHS. The structure they inherited (the creation of a previous Conservative administration) consisted of three tiers below the DHSS: regions, areas, and districts. The new structure eliminated the middle tier of the areas with the intent of cutting bureaucracy and speeding up decisions;¹² however, the number of administrative and clerical staff has not fallen.

A further intention of the 1982 reorganization was to devolve more responsibility to the periphery, that is, to the districts. "We are determined to see that as many decisions are taken at the local level," the then secretary of state, Patrick Jenkin proclaimed.¹³ In the outcome, however, the strategy of devolving responsibility to the periphery—a strategy of

blame diffusion, designed to make sure that any brickbats for shortcomings will be directed at those in charge locally rather than at the Ministers of the center—has been preempted by the new emphasis on efficiency.¹⁴ The DHSS has introduced a set of national performance indicators which presents, for every district in the country and for every hospital within each district, statistics about the way in which resources are used: lengths-of-stay, costs per case broken down into the various components, manpower, and so on.¹⁵ In turn, these statistics are used as the basis for an annual review of performance; the secretary of state summons each regional chairman to discuss the performance indicators, and then, in turn, each regional chairman goes through the same process with the district chairman. Within two years, therefore, the Conservative government has moved from the rhetoric of localism to the reality of bureaucratic centralization.

The third major initiative of the Conservative government has flowed from a report commissioned by the present secretary of state, Norman Fowler, from Roy Griffiths, the chairman of one of Britain's largest grocery chains.¹⁶ This report diagnosed the NHS's problems, brutally and simply, as stemming largely from the lack of effective management. At the national level, it proposed that the NHS should be run by a management board, under the guidance of a supervisory board which would set objectives and take strategic decisions. At the local level, it proposed that each district should appoint a general manager and so on down the line to each individual hospital. The emphasis throughout the report was learning from business on setting objectives, evaluating performance, and assessing the effectiveness with which the NHS is meeting the needs and expectations of the people it serves. "Businessmen have a keen sense of how well they are looking after their customers," the Griffiths report commented. "Whether the NHS is meeting the needs of the patient, and the community, is open to question."

The recommendations of the Griffiths report have been accepted by the secretary of state and are now being implemented. The fact that this is a cause for surprise—and is being done despite the suspicions, verging on hostility, of the British Medical Association and other organizations representing health service producers—is itself extremely revealing of the organizational problems of the NHS. The organizational structure of the NHS reflects a belief in consensus, a faith in participation by health service providers (notably doctors) in decision making and in consultation before change is introduced. Thus, at present, districts are run by a team which includes not only the administrator, the treasurer, and the chief nursing officer, but also representatives of the hospital consultants and of general practitioners on the consensus principle. Each member has, in theory at least, a right of veto. It is a system which tends to encourage risk-avoiding rather than risk-taking, which is biased to incremental ad-

justments of the status quo rather than to radical change, and which tends to breed consultative committees.

The Griffiths recommendations therefore represent a direct challenge to the style in which the NHS has been run since its foundation. It switches the emphasis from the mobilization of consent to the management of conflict, from committee work to entrepreneurship.¹⁷ Whether the recommendations will succeed in achieving a managerial style, as distinct from a proliferation of managerial titles, remains to be seen, however. If there is cause for agnosticism on this point, the reason has little to do with the details of the Griffiths proposals. It has everything to do with the fact that the present organizational style accurately mirrors the present balance of power within the NHS. If the NHS is in many respects a syndicalist organization with built-in veto powers for the professional providers of health care, it is largely because of the power of the medical profession. If active purposeful management is difficult in the NHS, it is largely because British hospital doctors enjoy a larger degree of clinical autonomy than their American counterparts. While they are constrained by fixed budgets, they enjoy virtually total freedom within them with no review system or medical audits to challenge their practices. Introducing the Griffiths recommendations may therefore be a necessary condition for achieving greater efficiency, but it is certainly not a sufficient one, and it remains to be seen whether the Conservative government is prepared for the long, hard slog involved in making the consequential changes that will be needed to make the new managers effective.

In all this, the NHS faces a central difficulty. The British system, as already argued, offers no incentive to providers to maximize activities. It is this which makes it such an effective instrument of cost containment. But, on the other side of the balance sheet, the British system does not offer any incentives to maximize efficiency or the services provided to consumers. If "businessmen have a keen sense of how well they are looking after their customers," in the words of the Griffiths report, it is because they may go bankrupt if they ignore their consumers or if their costs are out of line with those of their competitors. But the NHS conspicuously lacks any such sanction. The national performance indicators are, in a sense, a statistical exercise in competition between the different administrative units of the NHS. They show, for example, that districts vary greatly in their costs per acute case, after allowing for differences in the specialty mix. The most expensive district's cost per case is 58 percent above what would be expected if it conformed to national norms, while at the other end of the distribution, the cost is 33 percent less than would be expected. But, as the persistence of such differences over the lifetime of the NHS would indicate, there are no direct incentives or sanctions calculated to ensure change. If the rhetoric of decentralization has throughout the history of the NHS been betrayed in practice by the reality of

bureaucratic centralization, it is in part because of the lack of alternative instruments for promoting efficiency and change at the periphery, as well as the need for accountability to the center in a system financed out of taxation.

Private sector competition. It is therefore not surprising that the Conservative government has sought to introduce at least an element of competition in its drive to cut costs. All district health authorities have been instructed by the DHSS to seek bids from outside contractors for the "hotel" services provided by hospitals, such as laundry and catering. This may be seen—and denounced, as it has been by the trade unions representing NHS workers—as the ideological knee-jerk reaction of a government committed to the principle of private enterprise. In fact, it can also be interpreted as a pragmatic attempt to overcome the rigidities and inefficiency of a bureaucratic, highly unionized organization like the NHS by introducing competition from more entrepreneurial, less unionized firms. The effects of this initiative remain to be seen. But there is at least some evidence that its impact will be measured less in the total amount of work that is contracted out, which is minute at present, as in preemptive cost-cutting by NHS laundry, catering, and domestic workers anxious not to lose their jobs.

Ideologically the Conservatives are also committed to the private sector of health care provision. But commitment to the principle of encouraging the private sector of health care has, so far at least, not been translated into major policy changes. There have been no major tax concessions to those who insure themselves privately. In contrast to the United States, tax spending on health care is miniscule. And the most important policy change—the introduction of what amounts to an entitlement to private nursing home care for those on social assistance—appears to have been the result of a muddleheaded attempt to tidy up existing anomalies in the system rather than a deliberate move to introduce a new principle.¹⁸

The private sector of health care in Britain therefore remains, despite its recent growth, small and highly specialized.¹⁹ In total, private spending amounts to about 5 percent of total expenditure on health care. And the private provision of health care is heavily biased towards elective surgery; that is, the private sector tends not to cater either to very acute conditions (heart attacks) or to the chronic degenerative conditions of old age. While the private sector therefore offers consumers with the necessary means or insurance cover (about a tenth of Britain's total population) an opportunity to exit from the NHS, it does not offer competition of the kind calculated to make the NHS behave more like a business. On the contrary, it may be argued that the existence of the private sector of health care weakens the incentives within the NHS to strive for greater efficiency and responsiveness by weakening incentives to use its voice. If

the most demanding consumers exit into the private sector, demands for improvements within the NHS are likely to weaken.²⁰ Moreover, from the perspective of the NHS providers, exit by consumers into the private sector is a straight bonus. It means less pressure on them. By those inclined to a conspiratorial view of politics, the Conservative commitment to the private sector is therefore seen as part of a deliberate strategy designed to weaken the NHS by both squeezing its budget and draining off the politically most articulate and powerful consumers into the private sector, so, in turn, making it easier to maintain the squeeze. This strategy, it is argued, is gradually reducing the NHS to a second-class service and edging Britain towards a two-tier system of health care, with the public sector very much the lower tier.

But is the NHS, in fact, being reduced in terms of either its scope or its standards?

Rising Voices Or Falling Standards?

The years of Conservative government since 1979 have been a period of growing protests about falling standards and increasing inadequacies in the NHS. Hardly a week goes by without a television program drawing attention to shortcomings in the services provided. Hardly a week goes by, too, without reports of health service workers occupying hospitals in attempts to prevent their closure or of hospital doctors raising the alarm about the dire consequences of resource constraints. If those working in the NHS are to be believed—and who, after all, should know better—then the NHS is indeed nearing the point of collapse.

But there is reason for agnosticism, if not cynicism, in the face of this chorus of lamentation. As Enoch Powell, a Conservative minister of health in the 1960s, has pointed out, those working in the NHS have a “vested interest in denigration.”²¹ Consequently, the NHS throughout its lifespan has offered “the unique spectacle of an undertaking that is run down by everyone engaged in it.” The reason is simple. Given that the NHS's budget is determined by political decisions, demands for extra resources by health service providers have to be politicized. In other words, health service providers, whether doctors or hospital porters, have a self-interest in advertising any shortcomings in order to secure extra funds for themselves. This is precisely the kind of behavior which might be expected in a bureaucratic organization whose members are budget maximizers and are safeguarding their jobs and their incomes. On such an interpretation, the recent increase in the volume of lamentation can readily be explained as a reaction to the Conservative government's emphasis on increasing efficiency: a euphemism, very often, for cutting jobs.

Moreover, this effect is compounded by another feature of the NHS. It is virtually a monopoly employer of such skilled labor as doctors and

nurses, given the small size of the private sector and the sharp decline in the opportunities to emigrate to other countries. This position has, over the years, been exploited to keep down the incomes of health service providers, a success which helps to explain both the NHS's ability to keep down costs and the tactics of those employed in the service.²² When doctors, nurses, and hospital workers campaign for higher salaries and wages—and all these groups have been involved in battling with the Thatcher government for higher pay—then they have every incentive to point to (and perhaps exaggerate) shortcomings in the NHS for use as ammunition in their struggle.

The real difficulty lies in cutting through the babble of voices and identifying the kind of evidence which could resolve the controversy about whether the standards of the NHS are being eroded. There is no doubt that, as the Conservative government tirelessly claims, there has been no diminution in the NHS's activities. On the contrary, the number of acute patients treated has gone up at a rate of 1.2 percent a year under the Conservatives, and there has been an expansion of the community services designed to keep people out of hospital.²³ This expansion of activity has been possible, even at a time of constrained budgetary growth, because there does appear to have been an increase in efficiency, at least as measured by such indicators as the number of patients treated per available hospital bed and average lengths-of-stay; the former has increased by 11.1 percent since 1978, while the latter have fallen by 8.5 percent. However, such statistics tell us nothing about either the quality of the activities or the adequacy of the services being provided. Increasing activity is, in principle, compatible both with falling standards of care or declining standards of adequacy if the rise in demand is outpacing the increase in the supply of health services.

As far as the quality of care provided by the NHS is concerned, evidence is conspicuous by its absence. Performance indicators published by the DHSS, referred to above, are concerned with efficiency in the very narrow sense of cutting costs, and do not contain any measure of quality. Indeed, the whole exercise has been criticized on the grounds that it may encourage cost-cutting through reducing standards. But, of course, the problem of assessing health care standards is not limited to the NHS. Assessing the quality of care is a notorious conceptual minefield, particularly when it comes to trying to measure the overall performance of a health care system as distinct from looking at specific medical interventions.²⁴ If process indicators such as the number of diagnostic tests carried out are used, then this itself may all too easily become a recipe for health care cost inflation. The temptation is to deduce quality of care from the quantity of inputs. If, on the other hand, outcome indicators are used, that is, the impact of a health care system on a population's health, then it becomes very difficult to disentangle the effects of medical

intervention from other factors, notably the socioeconomic environment (nutrition and housing) and personal behavior (exercise and smoking).

The ambiguities involved in using process indicators are well illustrated by the most recent American study of the British health care system, that by Aaron and Schwartz.²⁵ This points out that "the United States performs nearly two times more x-ray examinations per capita and uses four times as much film as does Britain." Furthermore, the study points out that the equipment used in Britain is less sophisticated than in the United States. But, as Aaron and Schwartz concede, "the effect on health care is hard to assess." In Britain, resource constraints mean that diagnostic information may not be provided as accurately or quickly as in the United States, and that tests which are expected to yield a relatively low pay-off in terms of extra information may not be carried out. In the United States, fear of malpractice suits and the incentives of the fee-for-service system may mean that patients may undergo too many x-ray texts and so have to suffer the additional risks entailed by extra exposure. Given these sorts of trade-offs, it would therefore be rash indeed to come to any firm conclusions about quality on the basis of such process indicators.

Nor are outcome indicators, as applied to the population as a whole, very helpful as a guide to the quality of the service provided. On such indicators as infant mortality and age-specific mortality rates for particular conditions, Britain does better than the United States.²⁶ However, it would be stretching the evidence to claim that this demonstrates that the NHS provides superior quality medical care to that supplied in the United States. The same reservation applies to looking at the performance of one health care system over time. In fact, the health of the British population on indicators such as infant mortality has continued to improve in recent years. But, as with international comparisons, it would be mistaken to apportion the entire credit to the health care system, given the importance of other factors. At best, therefore, an agnostic conclusion would seem to be indicated. There is no hard evidence of declining standards in the NHS, but all that may tell us is that we lack the appropriate measuring instruments.

Much the same conclusion follows when we look at the adequacy of NHS services, that is, the gap between demands and supply. However, in addressing this issue, it is important to note one crucial difference between the NHS and the American health care system. The NHS, in contrast to the American system, is not led by consumer demands. It responds to professionally defined need. The crucial decisions about who gets what are made not by consumers but by the professionals, in this case, the doctors. Access to the expensive hospital sector of care is through general practitioners, with whom every British citizen is registered. It is the GPs who act as gatekeepers to the system as a whole, redefining demands (patients coming to consult them) as needs (patients deemed to

require further treatment according to professional criteria). The NHS is therefore a machinery not only for rationing care but also for screening out demands, operated by professionals whose incentives are, as already stressed, to minimize rather than to maximize their own activities.

It is therefore extremely difficult to devise anything remotely resembling an independent measure of demand in the British system. The waiting lists are conventionally quoted as an example of unsatisfied demand. At any one time, something like 600,000 to 700,000 British patients are in line for hospital treatments such as hernias, varicose veins, and arthroplasty. But such statistics are a notoriously unsatisfactory indicator of inadequate facilities; for example, they measure as much the expectations of GPs about the likely availability of treatment as the demands of consumers. And as far as demand at the point of entry into the British system is concerned, the evidence suggests that this is falling. The number of times the average British citizen consults his or her GP has fallen slightly over the years.

The evidence about inadequacies in the supply of health care are stronger, though difficult to relate to the budgetary constraints of recent years, when it comes to the provision of specific procedures. As demonstrated in the Aaron and Schwartz study already cited, the overall treatment of chronic renal failure in Britain is less than half that in the United States, while the rate of coronary artery surgery is only 10 percent that of the United States. But, again, caution is required in interpreting such figures. In part, such differences reflect differences in the availability of resources. In part, however, they also reflect differences in the culture of health care. If the United States is a country which believes in the perfectibility of man, Britain is a society which believes in original sin. Or, to translate this into the language of health care, the United States is a country which believes that everything possible must be done to try to cure any disease or illness, while Britain is a society which accepts more readily the inevitability of illness and debility. In the former case, this culture translates, as Aaron and Schwartz point out, into an aggressive, action-oriented style of medicine, while in the latter case it helps to create a humane conservatism in medical practice, designed to minimize suffering rather than to indulge in heroics. In turn, such differences are reflected in, and reinforced by, the incentives built into the systems of health care finance in the two countries.

More directly relevant to recent developments in the NHS is the evidence offered by the expansion of the private health care sector over the past few years (see above). This clearly reflects a rising level of dissatisfaction with the services offered by the NHS. But, once again, this conclusion requires qualification. The private sector, as noted earlier, is highly specialized in that it deals overwhelmingly, though not exclusively, with non-life-threatening conditions. Its growth would therefore suggest that

the NHS has coped with resource constraints by giving relatively less priority to those forms of medical intervention which are designed to improve quality of life and which are most highly valued by members of the working population, for whom the financial costs of disabling conditions are highest, and who also have the resources required to exit into the private sector.

But the growth of the private sector in Britain may also reflect discontent with the quality of care provided in the NHS, to return to our earlier theme, if in a very specific and limited sense of that term. The phrase "quality of care" requires unpacking. It can be taken to refer to the quality of the technical care provided, and it is in this sense that it has been discussed so far. It can also mean, however, the quality of the environment in which medical care is dispensed, ranging from the availability and friendliness of nurses to the palatability and variety of the food. And it may well be that while the NHS has succeeded in maintaining quality in the first sense, it has done so at the cost of falling quality in the second sense. One of the reasons why more people are using the private sector may well be that it offers far better hotel facilities and individual attention. Indeed, to the extent that the NHS reflects professional priorities as distinct from consumer priorities, this is precisely what would be expected. In tight times, priority is given to what the professionals think is most important, which is why, inevitably, the managerial imperatives of the NHS are not the same as those of grocery chains. This conclusion is further reinforced by comparing the British and American health care systems.²⁷ The latter, responding to consumer demands, spends far more on buildings, and staffs its hospitals more generously. The former, responding to professional priorities, still houses some of its patients in ancient monuments in which Florence Nightingale would still be at home, and stints on its hotel costs.

So the evidence presented in this section leads to a somewhat different (if still very tentative) conclusion from that of Britain's health care providers. It suggests that, in hard times, the professional providers have been able to defend their own standards—the technical quality of the medical care offered in Britain—but that the costs of stringency may have been carried by the consumers, who have had to put up with a shabby environment and hard-pressed doctors and nurses. It is a conclusion which makes the central paradox of the NHS—its continuing popularity—all the more puzzling.

The Sources Of Support

Next to the monarchy, the NHS is Britain's most popular institution. With remarkable consistency through the history of the NHS, some 90 percent of the population have, when asked in public opinion surveys,

declared themselves to be satisfied with the NHS. There are some signs that satisfaction, particularly among the younger sections of the population, may be on the decline. In a 1983 study, 25 percent of those interviewed declared themselves to be dissatisfied with the performance of the NHS.²⁸ But the same survey showed that, when asked which public service should get priority if the government decided to spend any extra money, people gave first place to the NHS. So while there may be rising dissatisfaction with the performance of the NHS (which may be influenced as much by media activity as by personal experience), there is no sign of decline in support for the NHS as an institution.

This high level of support reflects, no doubt, a variety of factors. All health care systems tend to be popular. They create their own constituencies of support and mold the expectations of their consumers. The perceptions of what is desirable tend to be shaped by what is available. But there remains the nagging question of why Britain's NHS, despite the fact that it rations health care and actually turns people away to die, despite the fact that it makes patients queue, despite the fact that it often offers a depressing physical environment, still maintains its capacity to mobilize support to a degree sufficient to make a convert of Thatcher and her Conservative administration. In trying to explain this phenomenon, two hypotheses are offered. First, its success reflects its ability to transmute political decisions about resources into medical decisions about the clinically desirable. Second, its popularity reflects its embodiment of the equity principle; it has made rationing acceptable because it is perceived to be fair.

The medicalization of political decisions. Britain's medical profession, as argued earlier, enjoys a unique degree of autonomy in that it is virtually immune from scrutiny. In return, however, the medical profession accepts full responsibility for its clinical decisions. Tragic choices about which lives to save are therefore seen to be clinical decisions.²⁹ The result is to transform collective decisions about resource allocation into clinical decisions about the appropriateness of treatment in individual cases, thus diffusing responsibility. If the language of American health care is that of rights and entitlements, the language of British health care is that of needs—as defined by doctors. The link between budgetary decisions at the center and individual decisions at the periphery is blurred.

Making rationing acceptable. The NHS clearly offers many of its patients less than the optimal package of medical care, as Aaron and Schwartz have argued. But the same is true of the United States and every other health care system.³⁰ The real difference between the two countries lies in the criteria used for rationing. In the United States, as Aaron and Schwartz point out, “several million Americans lack adequate insurance cover or personal means and therefore face obstacles to obtaining hospital care.” In other words, access to health care is rationed. In Britain, in

contrast, there is no attempt to ration access according to means. All the evidence suggests that equity in access to health care has been achieved across the population, although the articulate and knowledgeable middle classes may well obtain better quality care through their ability to manipulate the system once they are in it.³¹ In short, Britain's achievement lies in the distributional dimension of rationing. Paradoxically, the NHS may have to ration expensive medical procedures more stringently than the United States not only because of budgetary constraints, but because it has been more successful than the United States in universalizing access to the adequate. There is no rationing by exclusion.

From this perspective, the success of the NHS in maintaining its support derives from its use of the queue rather than cash as its device for rationing access. The fact that people have to line up for care in the NHS, so often cited in evidence against it, is its greatest strength in terms of commanding social and political support, for the queue is a great social leveler (even allowing for the fact that the time costs of people vary). In the queue for health care in Britain, everyone has the same chance of getting treatment, irrespective of their income and social class, depending only on their needs as defined by the medical profession. If rationing is acceptable, it is because it is seen as being socially equitable.

There can, of course, be no certainty that this social consensus, both embodied in, and reinforced by, the NHS, will survive. For the medical profession, the cost-benefit equation between autonomy and accepting responsibility for rationing may change as the tensions between budgetary constraints and the opportunities created by technological developments becomes more acute. And indeed the collectivist values which support the NHS—the emphasis on social equity—may become eroded if the Conservative government succeeds in making entrepreneurial individualism the prevailing public philosophy. But for the time being, the best evidence of the continuing strength of the consensus supporting Britain's existing health care system comes precisely from the Thatcher government's born-again enthusiasm for the NHS: an enthusiasm all the more significant because it represents the tribute paid by ideological bias to political necessity.

NOTES

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