Can Americans Say No? A British Perspective

by Alan Maynard

It is evident that particularly for the rich, dying is an un-American activity! This accounts in part for Americans’ spending twice as much per capita on health care as the British do. The British reluctantly accept two facts of life. First, they are all suffering from a terminal, sexually transmitted disease called life. Second, with death inevitable and resources finite, health care rationing is inevitable. Rationing involves depriving patients of care from which they could benefit and which they wish to consume. The British are much more vigorous than Americans are in “drawing the line,” as Henry Aaron, William Schwartz, and Melissa Cox show in Can We Say No? But even with Americans’ higher levels of health spending, rationing in the United States is also inevitable.

Victor Fuchs articulated the explicit and implicit criteria that determine who will die and who will live, and in what degree of pain and discomfort, three decades ago.1 Because of affluence and political chicanery common to all governments assaulted by the inevitability of rationing, Americans (despite the Oregon experiment and other policies) have lost their focus on rationing, but this new book might destroy these illusions.

Can We Say No? is a follow-up study of Aaron and Schwartz’s 1984 book, The Painful Prescription.2 Both books analyze the workings of the United Kingdom’s National Health Service (NHS) as seen through American eyes. Then and now the authors show that the British spend less on health care and consequently provide less care for their citizens. They also show that in the twenty-first century, the NHS is changing rapidly, largely because of the Blair government’s massive increases in public investment since 2000.

Despite this growth in funding, the relative gaps in provision remain large and have increased since the 1984 book. So while the funding of care for patients with chronic renal failure in the NHS has given elderly patients increased access to dialysis, provision in this and other specialist areas remains inferior to that in the United States.

The authors examine relative provision in a number of other areas—including hemophilia, stem cell transplantation, hip replacement, cardiac revascularization, and intensive care—which affect the relative quality and length of life of patients in the two countries. In all of these areas, although the United Kingdom is providing absolutely more care than in 1984, the gap between British frugality and American generosity is widening.

An interesting issue explored by the authors is how, given an evidence base of clinical effectiveness, U.K. clinicians accept and explain their frugality. The authors report that NHS physicians believe that they are always doing what is appropriate for patients even though their treatment choices might result in shorter, lower-quality lives than achieved for similar patients in the United States.

Of particular interest to U.S. readers is the issue of waiting times. One method of rationing health care in the NHS is to treat emergencies promptly if relatively frugally and to ration resources for elective care by making patients wait. The political pressures created by waiting lists and waiting times is one of the primary causes of the Blair reforms, which will double NHS spending in a decade and drive the share of gross domestic product (GDP) spent on the NHS to the European average of 8–9 percent. However, increases in funding take time to translate into service provision,

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especially when it takes years to train additional physicians. Despite evidence of short-term rent seeking (involving increased payment for inputs of unchanged quantity and quality), waiting times in England are declining, with a current median waiting time of two and a half months, no patients waiting more than six months by the year's end, and none to wait more than twelve weeks in 2008.

To increase elective capacity, the NHS is investing in private capacity. However, although the private hospital sector is growing, the private health insurance sector is under considerable pressure. The principal rationale for the purchase of private health insurance is NHS waiting times for elective care. With this declining, insurers have to compete for market share by controlling fees and increasing the micromanagement of practice.

The authors analyze these issues quite well, although at times their qualitative evidence appears to be rather London-oriented. And although their use of British research literature is fairly limited, they present some solid policy quandaries.

For example, in quantifying the U.S.-U.K. health care gap, the resource gap is inevitably large. The Blair reforms have increased spending, but rationing remains in evidence, and with the likelihood of the current funding bonanza ending in 2008, there is concern about future provision standards.

This highlights some common U.K.-U.S. problems with regard to continuing inefficiency in both systems. The variations in clinical activity chronicled by John Wennberg and his Dartmouth colleagues in the United States are replicated in the United Kingdom. The deficiencies in delivering inexpensive, cost-effective, appropriate care for the chronically ill, as demonstrated by RAND in the United States, are replicated in Britain, although generous financial incentives for U.K. general practitioners (GPs) are now reducing NHS deficiencies. Medical errors create avoidable morbidity and premature mortality in both systems. Also, despite the advocacy of Ernest Codman (U.S.) and Florence Nightingale (U.K.), neither country measures success routinely in clinical practice with health-related quality-of-life instruments, preferring to focus on measures of failure (such as mortality). Consequently, there is scope, if incentives can be improved, to reduce waste in both health care systems. However, this will not remove the need to ration, only moderate its effects.

With relative parsimony in the NHS and relative generosity in the U.S. health care system, rationing remains ubiquitous and unavoidable. The American rich clearly do not like this notion even though spendthrift, evidence-free care can create a damnable quality of life and an unpleasant death.

This book is a well-written and insightful analysis of the challenges facing decision-makers in both countries. The authors’ focus on the inevitability of rationing, on funding what is a proven benefit to patients, and on the better incentivization of efficiency is welcome. God grant us all a humane and well-supported demise with a minimum of evidence-free, expensive high-technology intervention when we die in our affluent societies!

NOTES
4. E.A. Kerr et al., “Profiling the Quality of Care in Twelve Communities: Results from the CQI Study,” Health Affairs 23, no. 3 (2004): 247–256.