NOW AND THEN **Richard Smith**

Is the NHS three times better than in 1979?

The tripling of NHS spending in 30 years, even in today's prices, has increased unhealthy lifespans

Reading recent accounts in the *BMJ* of how various doctors and managers would make savings in the NHS, I thought back to a series on the same idea that I edited when I first arrived at the *BMJ* in 1979, called "If I was forced to cut." What I thought was the cost of the NHS then was about £35bn (€39bn; $52bn) in today's prices, whereas now it's well over £100bn. What have we got for that near tripling in spend in less than a professional lifetime? Has it been worth it?

My suspicion is that any doctor practising in 1979 will immediately answer "no" to that last question. Things weren't so bad then. Indeed, for many doctors they were much better. Patients were grateful. There was much less bureaucratic hassle. This was long before Bristol and Shipman, and doctors were still seen as part of the solution rather than part of the problem.

There was camaraderie, black humour, lots of alcohol, and plenty of casual sex in that pre-AIDS era. It's all well captured in *The Houseman's Tale* by Colin Douglas, who now writes the prime minister's speeches.

Oddly, I think that most patients would also answer "no." You could see your GP almost any time, and he (they were mostly "he" then) would smile, reassure you, and send you home with a bottle. He would also come and see you at night. You might have had to wait for operations, but once you got into hospital it was rather jolly. Lots of patients were not very sick and so had time to chat and bring each other tea. The nurses were attentive and tucked you up in bed at night. You didn't perhaps live as long, but death was more familiar, less scary.

This must, of course, be an old man thinking back to a golden age that probably wasn't golden at all. But what have we got for that tripling in spend?

Certainly we have a lot more people. In 1979 there were about 40 000 doctors and dentists in the whole NHS (it was one NHS in those days), whereas now there are 122 000 doctors (not dentists) in the English NHS alone. Numbers of nurses have increased less dramatically: from 300 000 in the whole NHS in 1979 to 400 000 in the English NHS now. In particular we have many more specialists. Cardiologists were exotic creatures when I was a junior doctor; now they're a dime a dozen, all busy putting catheters in all day long.

There aren't more buildings and beds. Indeed, there are many fewer. The huge mental hospitals have been turned into luxury flats, and some of the sleepy community hospitals have become GP surgeries, although a remarkable number have managed to survive—kept alive by (probably misplaced) local affection. But the hospitals we do have are bristling with machines that didn't exist in 1979. The first computed tomography scanners appeared in the 1970s, and nobody where I worked knew how to read the resulting scans. In many cities in Britain you were lucky to be dialysed if you had diabetes or were over 60.

So we have lots of people, specialists, machines, tests, activity, and interventions, and we know that inflation in medical costs far outstrips general inflation. But does the extra spend produce value? This is perhaps an unanswerable question, but one answer must be, "Of course it does, otherwise countries would not be willing to pay so much—and every country that can afford it has seen the same kind of increase in spend."

But that answer doesn't satisfy me. The same argument that says that you can't have a proper market in health care because people don't have good information on the value of what they are paying for seems to me to apply at a national level. I fret that people think they are paying to ease suffering and fend off death, but I fear that they are paying for a more existential kind of suffering and for a prolonged period of unhealthy life. Life expectancy may have increased since 1979, but I'm sceptical that much of that increase comes from health care. My biased view is that improvements in public health are increasing healthy lifespans and health care is increasing unhealthy lifespans.

"I fret that people think they are paying to ease suffering and fend off death, but I fear that they are paying for a more existential kind of suffering and for a prolonged period of unhealthy life"

Of course, there is no going back. If we were to go back to a 1979 spend, the massive national debt would be cleared in a few years—but for having to pay redundancy and unemployment benefit to 80 000 doctors and 100 000 nurses. The idea of sacking so many health professionals is clearly ludicrous.

But it's amusing to read what an unnamed paediatrician said to me in an unsigned article in 1979: "Doctors have tended to work in the past as if the NHS had access to a bottomless pit of resources. This attitude cannot continue any longer: we must recognise that resources are finite and we must take decisions about how those resources can best be used" (*BMJ* 1979;ii:1570-1). Or, he might have said, we can spend three times as much on the NHS. People would have thought him crazy.

Richard Smith is director, UnitedHealth Chronic Disease Initiative
richardswsmith@yahoo.co.uk

Cite this as: *BMJ* 2010;340:c1769

bmj.com This article was originally posted on Richard Smith's regular blog on bmj.com. To read other posts on Richard Smith's blog, visit http://blogs.bmj.com/bmj/

US HEALTH REFORM **David U Himmelstein, Steffie Woolhandler**

Obama's reform: no cure for what ails us

Will the new law simply pump funds into a dysfunctional, market driven system?

It was a stirring scene: President Obama signing the new health reform law before a cheering crowd, and a beaming vice president whispering in his ear, "This is a big fucking deal." As doctors who have laboured for universal health care we'd like to join the celebration, but we can't. Morphine has been dispensed for the treatment of cancer—the reform may offer a bit of temporary relief, but it is certainly no cure.

The new law will pump additional funds into the currently dysfunctional, market driven system, pushing up health costs that are already twice those in most other wealthy nations. The Medicaid public insurance programme for poor people will expand to cover an additional 16 million poor Americans, while a similar number of uninsured people with higher incomes will be forced to buy private policies. For the "near poor" the government will pay part of these private premiums, channelling $447bn (£300bn; €330bn) in taxpayer funds to private insurers over the next decade.

Unfortunately, private insurers win in the marketplace not through efficiency or quality but by maximising revenues from premiums while minimising outlays. They pursue this goal by avoiding the sick and forcing doctors and patients to navigate a byzantine payment bureaucracy that currently consumes 31% of total health spending.[1] The health reform bill's requirement that uninsured people buy insurers' defective products will fortify these firms financially and politically.

Meanwhile insurers will exploit loopholes to dodge the law's restrictions on their misbehaviours. For instance, the limit on administrative overheads will predictably elicit accounting gimmickry, for example by relabelling some insurance personnel as "clinical care managers." While insurers are prohibited from "cherry picking"—selectively enrolling healthy, profitable patients—they've circumvented similar prohibitions in the Medicare health maintenance organisations (HMOs).[2] The ban on revoking policies after an individual falls ill similarly replicates existing but ineffective state bans.

Sadly, even if the reform works as planned, 23 million people will remain uninsured in 2019. Meanwhile the public and other safety net hospitals that uninsured people rely on will have to endure a $36bn cut in federal government funding.

Moreover, many Americans will be left with coverage so skimpy that a serious illness could lead to financial ruin. At present, illness and medical bills contribute to 62% of all bankruptcies, with three quarters of the medically bankrupt being insured.[3] The reform does little to upgrade this inadequate coverage; it mandates that private policies need cover only 70% of expected medical costs. The president has often promised that "if you like your current coverage you can keep it." Yet Americans who now get job based insurance will be required to keep it—whether they like it or not. And many who receive full coverage from an employer will face a steep tax on their health benefits from 2018.

Soaring costs and rising financial strains seem inevitable, despite claims that the reform will "bend the cost curve."[4] Computer vendors have trumpeted imminent cost savings for half a century. Prevention, though laudable, does not generally reduce costs.[5] Windfalls from prosecuting fraud and abuse have been promised before.[6] The new Medicare advisory board merely tweaks an existing panel. Without an enforcement mechanism, stepping up comparative effectiveness research cannot overcome drug and equipment makers' promotion of profligate care. Existing insurance exchanges where patients can compare and shop among private plans haven't slowed growth in costs for public workers nationally or in California.[7] And the mandated experiments with capitated payment systems are warmed-over versions of President Nixon's pro-HMO policies and subsequent failed initiatives to fix America's health cost crisis through managed care.

> **"Morphine has been dispensed for the treatment of cancer—the reform may offer a bit of temporary relief, but it is certainly no cure"**

Experience with reforms in Massachusetts in 2006—the template for the national bill—is instructive. Our state's costs, already the highest of any state, grew by 15% in the first two years after reform,[8] twice the national rate. Moreover, capitated physician groups had costs at least as high as those who were paid on a fee for service basis.[9] Meanwhile, after initial improvements in the state, access to care has begun to deteriorate,[10] and the state has begun to cut back coverage.

Overall, President Obama's is a conservative bill, drafted in close consultation with the drug and insurance industries. Its modest salutary provisions—such as an extra $1bn a year for community health centres and the expansion of Medicaid—mirror measures that have been passed even under Republican regimes.

Throughout the reform debate we, and the 17 000 others who've joined Physicians for a National Health Program, advocated for a far more thoroughgoing reform: a non-profit, single payer national health insurance programme. We will continue to do so. Our healthcare system has not been cured or even stabilised. For now, we will continue to practise under a financing system that obstructs good patient care and squanders vast resources on profit and bureaucracy.

Passage of the health reform law was a major political event. But for most doctors and patients it's no "big fucking deal."

David U Himmelstein is associate professor of medicine and Steffie Woolhandler is professor of medicine at Harvard Medical School and Cambridge Hospital, Massachusetts; both are co-founders of Physicians for a National Health Program david_himmelstein@hms.harvard.edu

Cite this as: *BMJ* 2010;340:c1778

A longer version of this article with references is available on bmj.com

See also NEWS, p 727