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In defence of the National Health Service

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The NHS is under huge pressure, with new reports or news stories appearing constantly about the crisis it faces.[1] In July 2022, the BBC reported a 39 per cent increase in self-funded care, with patients paying the full cost of some procedures, such as knee and hip replacements. Deregulation and charges are openly promoted.[2,3] In the summer, it was reported that Rishi Sunak, the UK prime minister, was advocating financial penalties for missed GP appointments. More recently, it was reported that he is registered with a private GP.

This is sad, especially when there is a strong economic defence to be made for the NHS, one which most UK health economists have signed up to for decades,[4] and simplistic solutions can be easily debunked in favour of what really needs to be done.

Most advanced economies have learned that publicly funded healthcare is both equitable and efficient. Eighty percent of healthcare funding in the UK comes from the public purse. The economic case for this rests on three sources of market failure.[4] In economics, market failure does not equate to a dislike of free markets. Many of us dislike the fact that only some people can afford luxury cars, but rarely do we hear a case made for a National Car Service. The failure of markets arises when they struggle to account fully for important characteristics of commodities; rendering government intervention more optimal. The NHS is an extreme, but justifiable and popular, form of this.

Without government intervention, insurance markets would develop to deal with unpredictable healthcare needs. However, with financial risks mitigated by insurance, costs receive less emphasis in decisions of consumers and providers. Such "moral hazard" is behind historic inflation in US healthcare, exacerbated by administrative costs (of billing and advertising) in market-based systems. These inflate premiums so much that people who would otherwise be insured are priced out of the market. Administrative costs are substantial in private as opposed to public systems,[5] and also rise when the latter adopt market based forms.[6] In public systems, it is easier to control costs and spread administrative burdens across large populations.

Markets work well in maintaining quality when consumers are informed about availability of technologies to meet their needs. This is less so in healthcare. To maintain standards, we, rightly, grant license to qualified professionals. However, this inadvertently creates powerful bodies, particularly the medical profession, which, in a market, can use their knowledge advantage to specify care packages which may not be in line with what a fully-informed consumer would wish. This requires the countervailing collective power of government to step in to negotiate over pay and provision.[7]

Well functioning insurance markets tailor premiums to risk. However, this leads the healthier (usually wealthier) to pay less while those in greater need (usually on lower incomes) are expected to pay more. Many of the latter opt out of coverage and the market segments, leading not only to different quality for different groups but, for some, no coverage at all. These types of "adverse selection" count as market failure because those who can afford care are often willing to pay to ensure access for others. Markets, focusing only on individuals acting on their own behalf, cannot facilitate this. The most effective way to achieve the transfers necessary to ensure universal coverage is through taxation.

User charges are often promoted as means to control costs or reduce waste. However, charges do not work as claimed, simply encouraging existing care providers to do more for those who show up—who, incidentally, are likely to be those less in need. Overall, the costs of the system remain the same with less need met. There is even evidence, in publicly-funded systems, of vulnerable people being put off by user charges, but presenting later with more costly ailments.[8] Ironically, two health systems with consistently severe challenges in controlling healthcare costs make extensive use of charges—France and the USA. Exemptions help with access, but add administrative burden, running counter to cost-saving claims. The same applies to charging for missed appointments; policing this, and chasing down the offenders, will take resources, and for little by way of (financial) return to taxpayers. Furthermore, those offenders are likely to be in less-secure occupations or, perhaps, older people in less of a position to pay. Also, for such gimmicks there is often an equally ridiculous corollary. Should the NHS pay patients for cancelled procedures or when time is wasted due to clinics running late? More seriously, such proposals do little to address either cost pressures or the real health needs of the population.

Healthcare reforms, some of which are intended to instil greater market discipline, have been a constant feature in the UK NHS throughout its existence. But, evidence shows that little has been gained at the cost of significant disruption.[9,10] The oft-lauded social insurance systems may do better simply as a result of higher spending and, when examined closely, have challenges of their own.[11,12] Some, such as the Netherlands, may do better because of factors such as a focus on general practice. This has been eroded in the UK, and is something that could be restored without extensive or disruptive structural reform.

Despite differences across countries, the stunning common feature, internationally, is achievement of (or moves towards) universal coverage through collective, not private, "insurance." The alternative,

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illustrated by the US, is a mixed system of funding, spending twice as much on healthcare per capita in comparison to other advanced economies, with multiple tiers of access and quality. It is the comprehensiveness of market failure in healthcare which sustains the case for public funding as both equitable and efficient. Locking populations in together with respect to funding also means that, despite an element of compulsion, everyone benefits from more vocal and articulate voters who push to maintain standards.[13] If we wish to solve current problems, the solutions are straightforward: spend significantly more on health and social care; integrate primary care, social care and civil society into local decision making over such spending; and, of course, solve human resource issues by rewarding staff appropriately.[14] We just need the courage to raise the money to do this in way that is consistent with "from each according to ability to pay and to each according to their benefit," recognising that the way to do it is through continued and increased taxation. A recent commission on the future of the NHS has shown this to be feasible.[15]

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