ROUTLEDGE REVIVALS

Rationing Health Care

Michael H. Cooper

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First published in 1975, *Rationing Health Care* by Michael H. Cooper provides a critical analysis of the challenges in balancing healthcare demand, need, and supply. The book delves into key topics such as expenditure, service provision, infrastructure, and the availability of medical professionals. Cooper examines the necessity of rationing healthcare, its practical implementation, and the inequalities and management issues within the system. He also explores the evolving administrative structures and offers insights into future priorities, including changes in healthcare delivery, patient demands, and financial strategies. With a focus on planning and management, this book remains a valuable resource for understanding the complexities of healthcare systems.

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RATIONING HEALTH CARE

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In loving memory of my
father
Robert John Cooper

PREFACE

This book is basically a development of the ideas contained in a paper delivered to the International Economics Association meeting on the 'Economics of Health and Medical Care' held in Tokyo in April 1973. It has accordingly benefited from the discussions which took place at that meeting and from the subsequent comments of friends and colleagues. In particular I have received valuable observations and suggestions from David Stafford, Dr R.S. Inch, Professor W.J.H. Butterfield and Professor David Walker. My main debts are to Tony Culyer, Professor Dennis Lees and George Teeling-Smith who over the years have greatly added to my better understanding of socioeconomic health affairs. I thank them all most warmly whilst totally absolving them from any responsibility for the analysis and opinions which follow. Finally I should like to thank my wife and daughters for all their encouragement and numerous cups of tea which saw me through the drafting stage of this endeavour.

M.H.C.

September 1974

1 INTRODUCTION

By any set of criteria the British National Health Service is a major enterprise and yet, despite its twenty-six years of existence, there exists to date no major overall economic review of its nature and problems. The NHS currently costs the nation over £3,000m. a year (5½ per cent of the gross national product and ten per cent of public spending) and it employs over 900,000 people (five per cent of the work force). In any one year we can each expect on average to consult our general practitioner four times (representing on aggregate about thirty consultations per day per doctor) and make one visit to hospital outpatients. Over a lifetime we spend on average eight spells in hospital of approximately three and a half weeks duration each.

Further, by the very nature of its ill-defined and illusive product, the industry presents special and highly intriguing problems. The basic intention of the National Health Service Act 1946 was to establish access to health care resources for all those in need as a 'human right.' Health care resources were to be no longer rationed amongst competing claims by the ability or otherwise to pay a market price. This human right was to be made a reality as the result of the nationalisation of all health care resources and their subsequent allocation at zero or near zero prices at the point of consumption. Nationalisation was to ensure that sufficient resources were made available to meet all genuine need and, further, that they were made available efficiently and rationally. Zero prices would ensure that no one in need was deterred from demanding attention. In short, health care would become truly a social responsibility paid for by the Exchequer and equally available to all.

The need for health care was seen as finite and quantifiable. Once established, the medical profession would be charged with the task of actually determining need in individual cases and preventing the abuse of the system by those not genuinely in need. Public opinion through the ballot box would ensure adequate total provision but, within that

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overall constraint, doctors were guaranteed complete clinical freedom to treat each and every patient as they saw fit.

In an important and fundamental sense the story of the NHS is one of success. To a very great extent financial worry has been taken out of sickness. Bankruptcy is not the inevitable outcome of major acute or chronic illness. If private practice is any barometer of success the NHS scores heavily. On the appointed day (5 July 1948) private practice shrank from being the normal form of medicine for over fifty per cent of the population to less than four per cent. Although this four per cent has persisted over the years, it has shown little sign of any marked tendency to increase. There are currently about 2¼ million people covered by private medical insurance schemes and although the revenue of these schemes has doubled over the past five years to £27m., this is largely due to higher premium levels plus the growth of group plans (particularly those paid for by employers).

The principle of zero prices has been breached many times but nevertheless direct charges to the patient still make up only some five per cent of finances, eighty-six per cent coming direct from the Exchequer and Local Authorities and nine per cent from the health component of the weekly national insurance contribution. It is the smallness of direct charges to the patient plus the system's universal coverage which, more than anything else, gives the NHS its claim to uniqueness. No other system in the world has such a heavy dependence upon the Exchequer and so few financial barriers between the individual in need and access to treatment and advice.

The fundamental success of the NHS is almost universally acknowledged and its' performance compares favourably with that of other countries and their health care delivery systems. Many of the hopes and aspirations of its founders, however, have in practice proved to be either unobtainable or based upon false premises. Expenditure upon health care has proved anything but a self-eliminating expense. Need as assessed by medical practitioners is not finite. Further, even in the relatively rare instances in which the profession has formed a consensus view as to adequacy, such levels of provision have proved in practice to be inconsistent with competing claims upon national resources. Exercises reported elsewhere have shown that the total cost

of achieving even the main goals of different social agencies can amount to many times a country's total national income (Dror, 1968).

Although the NHS has proved popular with the population at large (PEP, 1961; Forsyth, 1967) the staff who have worked in it have forecast its imminent collapse almost annually. In the words of Enoch Powell 'one of the most striking features of the NHS is the continual, deafening chorus of complaint which rises day and night from every part of it' (Powell, 1966). Doctors, nurses and other professional groups have found themselves in the front line of a system which seemingly could not deliver what it had promised. Having set out to provide the impossible, namely the elimination of unmet need, the professions have found themselves increasingly fulfilling the role of assessing relative needs and rationing scarce health resources amongst them. It is with the need for this rationing and the methods by which it takes place, that economics is concerned.

The aim of this book is primarily diagnostic rather than prescriptive although in practice these are frequently inseparable. It is only from accurate diagnosis that sensible blue-prints for change are likely to flow. The following three Chapters are concerned with the variables which influence and determine the demand for and the supply of, health care resources. Chapters 5 and 6 discuss rationing in both theory and practice whilst subsequent chapters discuss management and planning problems, and, finally, some probable future trends in health care provision. Although this book is primarily about the NHS, most, if not all, of the problems discussed are common to all health care delivery systems in the developed world.