6 Health and Markets

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The subject of ‘Health and Markets’ could hardly be more topical. Britain has just introduced – in April 1991 – a range of reforms that have been portrayed as bringing a number of more business-like, market-type mechanisms into the operation of the National Health Service and the provision of health and community care more generally.

Most households in the UK have received through the post a small booklet called The NHS Reforms and You which set out to provide some information about what the reforms originally elaborated in the document Working for Patients of 1990 might mean to Britain, and to reassure us (with the aid of lots of friendly little cartoon characters and a number of carefully phrased questions and answers) that the proposed changes ‘are designed to give you a more efficient and an even better service – above all, a service that puts you, the patient, first. They are intended to reinforce the main aim of the National Health Service – to help people live longer and enjoy a better quality of life.’ (HSR6, p. 2). A little further down the page, printed in blue ink for extra emphasis, the booklet promises: ‘As now, the NHS will continue to be open to all, regardless of income, and paid for mainly out of general taxation. NHS services will continue to be largely free at the point of use.’

Given the controversial nature of (some of) the new reforms, and the interests and concerns that surround them, it would be rather strange if I were to talk about ‘Health and Markets’ without spending at least some time looking at various of the proposals in more detail; and in due course this is precisely what I intend to do.

For example, there was the announcement in mid-July 1990 that the community care reforms, which had been closely associated with the NHS reforms and which were also scheduled to come into effect in April 1991, would now be phased in over three years. Then at the beginning of August, the NHS Chief Executive, Mr Duncan Nichol, announced that the reduction of waiting lists would be given a top priority, and indicated that the performance-linked element in health service managers’ salaries might well be substantially affected by their success or failure in shortening these waiting lists. Later, Secretary of State Kenneth Clarke announced that 65 organisations had applied for the status of NHS Trusts and that he expected to make...
decisions on these applications before the end of November 1990: subsequently he has done so, approving almost all of the applications for self-governing status.

In due course I shall return to these issues. But first I want to set my remarks about current health care policy in the context of a (necessarily brief) review of the key issues arising from an economic analysis of the scope and limitations of markets in the field of health.

THE COMMODITY IN QUESTION

When discussing the way any particular market operates – or fails to operate – it is often helpful to begin by considering the nature of the commodity being produced and consumed. In the present case, it is not merely helpful, but essential.

The first point to note is that although the title of this chapter is 'Health and Markets', there is really no question of a market for health per se. You cannot buy and sell good health itself any more than you can buy and sell a clear conscience or a sense of humour. What can be produced and consumed is health care, by which I mean a range of goods and services whose main purpose is to try to improve people’s mental and/or physical health. The question then is to what extent market mechanisms are the most appropriate means of organising the production, distribution and consumption of the very broad spectrum of health care goods and services.

However, before tackling that question, there is another important point to be made. Although most industrialised societies devote a substantial part of their human and technological resources to health care, and although many people have great faith in (or at least, high hopes for) what the health care sector can do to improve the length and quality of their lives, the evidence suggests that health care is only one of the factors that affects people’s health – and is not necessarily the most important. The quantity and quality of what people eat and drink, the level of public and private hygiene, housing conditions, working conditions, and other aspects of what might sweepingly be called ‘lifestyle’ may all play a greater or lesser role in determining people’s states of health.

As if to illustrate this point, on the day after Mr Nichol’s statement about waiting lists, the Daily Telegraph (2 August 1990, p. 6) not only published details of the waiting list figures, but also reported some data from the latest of a long catalogue of studies showing continuing differences in life expectancy between different sections of the population of Britain today which are attributable to social and economic disparities of one kind or another. These