Re-reading In Defence of the NHS after a gap of nearly twenty years has been a salutary experience for me. I suppose I was always aware that the questions so hotly debated in New Zealand since the radical changes to the health service instituted on Budget Day in July 1991 had been hardly new. But this pamphlet, written by a group dedicated to social justice in health care, could have been written yesterday, so pertinent are the issues it raises. I shall select four issues dealt with by these authors, which are crucial ones of our day: the expansion of private health care; part charging; pharmaceutical costs; and the control of the medical profession.

Private Health Care

The notion that private health care will somehow ease the stress on the public service and will result in greater ‘patient choice’ was being promoted by the BMA in the 1970s, in their submissions to a Royal Commission on reform of the NHS. We hear the same arguments today, always from sources who have an obvious interest in the expansion of private practice. One fascinating observation in the pamphlet is the extent of subsidy which the private sector was receiving from the NHS through the provision of so-called ‘pay beds’ in public hospitals. It became obvious in the 1970s that the actual costs to the NHS of providing such facilities, especially when capital investment was considered as well as running costs, was far in excess of what was being charged to private patients for their use by at least a factor of four (see Private Practice and the NHS, above). Moreover, the private sector was heavily dependent on the public sector for a whole range of services, including adequate emergency backup, which they alone could not provide to their subscribers. Rather than easing the strain on the public sector, the private health industry was using it as a cushion to keep its costs down and to serve the convenience of doctors and private patients. In this regard, nothing has really changed, despite the new terminology of contracts and purchaser–provider split. The (New Zealand) Crown Health Enterprises are seeking to sell their ‘spare capacity’ by offering surgical beds to the private sector. This is promoted as good business practice, as shifting some private money into the public domain, and as easing the public service waiting lists by finding patients willing to go the private route. But what is overlooked in such arguments is that the ‘spare capacity’ arises only because of an underfunding of the public sector, and that the patients who are treated by the private route are dealt with faster, not because of any demonstrated priority of need, but merely because of their ability to pay or because they have health insurance. Thus the effect on waiting lists (in terms of dealing with urgent cases speedily) is minimal, and the economic arguments are based on dubious assumptions about the appropriate use of public money. As was the case in Britain in the 1970s, the real driving forces in the expansion
of private medical care are profit and the
convenience of doctors, who do not even have
to shift location in order to earn private fees. To
claim the moral high ground by suggesting that
the public sector is being benefited by these
arrangements is a luxury not supported by the
facts. On the contrary, the more the better off are
offered a publicly subsidised private route to
health care, the less possible it will become to
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The pamphlet also exposes the fallacy of the
claim that private health care improves patient
choice. Such a view is based on the market model
of health care which equates choosing a medical
service or service provider with choosing a TV
set or appliance retailer. As the authors point out
(see Freedom of Choice, above), this model of
health care provision ignores the extent to which
'consumer needs' are themselves defined by the
providers of services, rather than by the 'con-
sumers' of health care. This dependence on the
expertise of the provider means that the scope for
patient choice is very limited. Although super-
ficially one may feel in a stronger position when
paying directly for a service, the reality is that the
important choices are wholly determined by the
provider or the funder. There is powerful
evidence from the USA that tests and interven-
tions are provided according to profit consider-
ations in a fee-for-service situation, and that (in an
insurance based system) they are wholly con-
trolled by the insurer's criteria for reimburse-
ments. In New Zealand at the present time,
increasing awareness of the constraints on the
public system is causing a rapid rise in the
number of people taking out private health care
insurance. Television advertisements play on this
anxiety and subtly suggest that the private sector
will provide all one could desire in a health
system. This illusion would quickly be shattered
if the public were aware of what it is like trying
to pay for medical care when the safety net of the
public system is removed. Paradoxically, the
search for greater choice, which may motivate
people towards private care, could in the end,
because of an erosion of the public system, result
in a dramatic reduction of the choices which
really affect our health and well-being.

Part Charging

One of the more farcical elements of the 1991
innovations to the New Zealand health system
was the introduction of part charging for hospital
stays and for outpatient visits. The arguments in
favour of this change were wholly obscure, and
could be seen only as a tax on the 'rich sick', since
an elaborate system of exemptions was designed
to reduce or eliminate the charges according to
income level (however, the levels for exemption
were set in a way that made the majority of the
population 'rich'). The oddity of this form of
charging is that it introduces a price signal to
people at a time when they have no choice—or, if
they do forego the operation or clinic visit for
reasons of cost, then the effect of the price signal
is increase the costs to the health system in the
long run, as the patient's condition worsens. If
it is merely a way of raising money for a
beleaguered service, then it is blatantly unfair,
since people (who have already paid taxes) are
being made into extra sources of income merely
through the accident of sickness. On purely
economic terms such schemes make little sense,
unless charges are made very large, since the cost
of collecting them and of chasing bad debts has
to be set against the income. It is notable that this
system has been steadily (very quietly) reduced
in the years since its introduction, and now
applies only to clinic visits. The ethical anomaly,
however, remains. All systems of cost recovery
from patients in the public sector deny the
fundamental principle of a national health
service, which relies on the pooling of risk, not
a tax on the sick.

A re-reading of this pamphlet reveals that the
British Medical Association suggested this idea
to the Royal Commission on the NHS back in the
1970s, as a way of making money. The pamphlet
points out (as I have) the unfairness and lack of
economic sense in the scheme. Why, one won-
ders, was it resurrected twenty years later and
imposed on New Zealanders? Perhaps (not for
the first time) we have been the guinea pigs for