Why is there public provision of healthcare?

In by far the majority of countries, governments play a role in the provision or funding of healthcare. Although the nature of public sector involvement is often a source of fierce political debate, it is taken for granted that governments need to play a role in the provision of healthcare. Perhaps the most compelling justification for governments to intervene in healthcare is that healthcare, like education, is deemed to be a basic human right or entitlement. An individual's health is inextricably linked to his or her well-being. Most would believe it unjust for the poor to be denied healthcare because they could not afford it, and think that the state seeks to ensure that the vulnerable in society are provided with at least the most rudimentary of healthcare.

There are also notable positive *externalities*[1] in the provision of healthcare – that is the social benefit of providing healthcare to an individual often exceeds the private benefit. This is particularly the case with immunisation programmes where immunising individuals may prevent contagion and an outbreak of disease from spreading. An individual's health not only has a bearing on his or her well-being as discussed above, but also on the value of his or her labour to the economy. Having a healthier workforce reduces the amount of sickness absence and potentially improves labour productivity. These positive externalities suggest that if healthcare provision was left solely to the private market, the amount provided would be less than the socially optimal level. Hence, it is not just fairer but also a more effective use of resources for the state to subsidise healthcare provision.

As well as externalities, the healthcare market is characterised by *asymmetric information*. The healthcare practitioner who provides healthcare typically has more knowledge of the service being provided than the patient who is the consumer. The patient's lack of expertise means he or she is ill-equipped to judge the quality of health care. To make matters worse, quality of health care is notoriously difficult to measure and opinions amongst health care practitioners themselves may vary about what the best quality healthcare is. Consequently, there is no guarantee that in a private healthcare market, it would be the healthcare practitioners providing the best value for money (highest quality health care at the most competitive price) who would survive. Significant losses of well-being would also arise if healthcare practitioners provided poor quality health care. For these reasons, there is often heavy regulation of health care practitioners to ensure that they consistently provide good healthcare. However, regulation does not always necessarily require a high degree of public sector intervention. In the UK, healthcare practitioners tend to be self-regulated as it is in members' interests to keep standards high to maintain their reputation. The British Medical Association will ensure that doctors have reached certain standards before they join the association and will also strike members off their association if their performance jeopardises patients' health.

Although all governments intervene in the provision of healthcare, they do so in many different ways. In the UK, most healthcare provision is paid for by the state and funded by the taxpayer. There does exist a private sector alongside the NHS but an important difference is that though

[1] Definitions for italicised words can be found in the SU Economics Glossary: http://www.parliament.uk/parliamentary_committees/scrutinyunit/suguidetowork.cfm

patients receive public health care for free, when seeking private health care they have to cover the costs of the medical treatment themselves or through private insurance. In other countries such as the USA, the private healthcare market is as large as the public provision[2] and most employees have health insurance which they then rely on to finance their healthcare when they become ill.

The NHS in the UK has many challenges. Having healthcare which is free at point of demand means that there is an excess demand for healthcare, leading to the NHS being constantly over-stretched. Moreover the NHS is often accused of being hugely bureaucratic and unwieldy. The 'Internal Market' was introduced in the NHS following the passing of the '1990 NHS and Community Care Act' to resolve some of these problems. The 'Internal Market' or 'Purchaser/Provider Split', as it was also known, introduced business and market principles into the organisation and delivery of health services. However the jury is still out as to how successful the health care reforms have been in the UK. It is often argued that the huge increase in Government investment in healthcare over the past decade has not had the desired improvement in health outcomes.[3]

The nature of the NHS's work makes it difficult to assess performance. One clear case which demonstrates this is when the Office for National Statistics (ONS) published data showing NHS productivity falling between 2001 and 2005. The ONS compared inputs (staff and resources) with outputs (activities such as prescriptions, appointments or operations). The Department of Health argued that the ONS's definition of 'output' was too narrow and should be related to improving health and well-being rather than simply increasing activity and asserted that productivity measures should reflect clinical outcomes (e.g. how hip-replacement operations have improved patients' mobility), though this is more problematic to measure.[4] This difficulty in quantifying health outputs also adds complexity to NHS investment decisions. In order to make decisions such as, for example, whether to invest more in cancer treatment or in geriatric care, the NHS needs to somehow compare the additional benefit that each treatment would give to society (marginal social benefit). In the private sector, a business would not have to take such social considerations into account – it would decide on whether to invest in geriatric care or cancer treatment on the simple grounds of which one is likely to be more profitable – profitability being a determinant of the price that each treatment could command in the market and the cost incurred to produce it. Where a *perfectly competitive market* operates and there are no externalities, traditional economic theory suggests that this does not matter; *supply* and *demand* will interact to ensure that consumers purchase goods at a price which reflects the marginal benefit to them and the amount produced and consumed would be at the socially optimal level. However as discussed above, healthcare's positive externalities and its status as a basic entitlement make it unacceptable as well as inefficient for its provision to be left solely to the private sector. Thus, the NHS is left to make complex decisions, such as whether to invest more in cancer treatment or geriatric care which in a market context would primarily be determined by the interaction of demand and supply forces.

[2] *The Economist*, June 27th 2009, p 9, Figure 4
[3] *NHS reform: the empire strikes back*, Professor Nick Bosanquet, Henry de Zoete, Andrew Haldenby January 2007
[4] Department of Health, *Departmental Report 2008,* (paras 9.128-9.137)

An alternative to having a national health service is for the majority of people in a country to take out medical insurance and for most healthcare facilities to be privately funded as in the USA. Medical insurance like other types of insurance has intrinsic problems of *adverse selection* and *moral hazard*. Moral hazard occurs with insurance where the insured take greater risks than they would do without it because they know they are protected. The idea behind adverse selection is that those who will insure are those who are the most likely to benefit from insurance. For instance, those who know they have a propensity for ill-health are more likely to demand health insurance than those who believe they are healthy. Thus, the insurer is faced with an adverse selection of candidates. However insurers have found ways of mitigating these problems. For example, to counter adverse selection, they set higher health insurance rates for people who smoke. To limit moral hazard, they offer reduced premiums to people who agree to pay the first so-many pounds of any claim. The significant challenges which remain with health insurance are equity and value for money considerations. Many consider it unjust when people with existing health problems cannot afford to pay premiums for health insurance, which is why the public sector often has to intervene to provide health care, even when insurance markets are active. Also the USA is widely cited as spending more per capita on health with arguably poorer health outcomes than some countries which have national health services, which raises questions about how effective paying for healthcare via insurance is.[5] In private health care, there may be incentives for doctors to over-prescribe as they tend to get paid for more treatment leading to wasteful expenditure on healthcare.

It is clear that there are different problems associated with financing healthcare directly through the public sector and through private insurance payments. However what is apparent is that however a government or society decides to provide healthcare, it is imperative that both equity and efficiency considerations are taken into account.

[5] Congressional Research Service Report for Congress *US health care spending: comparison with other OECD countries*, September 17 2007