The Doctor and the State

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"No more pernicious situation could be conceived than that in which a majority of doctors are more or less entirely dependent upon the state for their income and for their employment."

IN A highly developed country like Britain, with steadily rising educational and living standards, it is surely something of a paradox that governments should seek to relieve the individual of more direct responsibility for personal welfare. Indeed, at a time when people are being encouraged as never before to exercise judgment and choice in the purchase of both the luxuries and necessities of life, we find an officious and grandmotherly state tending to take responsibility for a growing proportion of the more intimate and fundamental things.

In this context it is hardly surprising that there is growing tension between the doctor and the state. Medicine and politics make unhappy bed-fellows, and a state near-monopoly in medicine, such as now exists in Britain, creates many serious problems for the doctors which deserve both urgent and critical examination.

The urgency of this task is underlined by the growing realisation that the state is incapable of living up to the glib and extravagant promises made by vote-seeking politicians. We have the most neglected hospitals in Europe; a hospital building programme that is more of a political phantasmagoria than a serious attempt to remedy many years of neglect; a totally inadequate allocation of funds for new and essential medical equipment: a largely demoralised family doctor service; a continued and unprecedentedly high rate of medical emigration, affecting not only the young but also relatively well-established doctors; and the burden of a huge, expensive and time-wasting bureaucracy battened onto the medical services.

All of this can only spell disaster for medicine in Britain unless immediate action is taken to remedy this critical situation.

It is rarely appreciated what a revolutionary and thorough-going piece of socialist planning was set in action by the National Health Service Act of 1946. The concept of a state-provided one hundred per cent. comprehensive and almost one hundred per cent. free (at the time) medical service represents the most complete fulfilment of socialist aspirations that this country has ever seen. Most doctors were slow to appreciate the loss of personal freedom they had suffered, and the public has been slower still to recognise the implications of such profound state interference in medicine.

At this point it is timely to refer to two misleadingly emotive terms beloved of certain politicians. The first of these is the so-called "financial barrier," and the second is embraced by the pejorative phrase "two standards of medical care."

To socialist eyes, at least in Britain, the provision of all medical services free at the time is the *sine qua non* of a National Health Service. This is surely rather a curious concept since other socialist countries abroad see nothing incongruous in requiring patients to pay directly for certain items of medical care. Moreover, it is surely odd that so emotive a term as "financial barrier" should be applied to the monetary tie-up between the provision and the cost of medical care. One does not refer to the price of food as a financial barrier against proper nutrition, nor to the price of clothing or housing as a financial barrier against protection from exposure.

It is surely tendentious and mischievous to refer to "two standards" of medical care when in medicine, as in other realms of human activity, there are manifestly many different standards. Our primary concern should be with the encouragement of *quality* and not the enforcement of *equality*. Indeed, any politician who perseverates on the supposed virtues of equality of consumption of medical care can only be regarded as a knave or a fool.

It is perfectly reasonable for the state to aim at all-round achievement of an agreed minimum standard of medical care, but quite wrong to seek to enforce one standard. It is for the individual citizen to decide in what way he, or she, may wish to supplement or extend that basic service.

The almost universal provision of services and materials free at the time has certainly perverted the sense of responsibility of the public. Just picture the state of affairs if the Ministry of Food were to be revived and operated on the same basis. What a spate of gluttony would ensue, and what a lot of rotting food would be found in the nation's larders and dustbins. And how could any country remain solvent on such a dangerously irresponsible philosophy?

The unfortunate effects on the medical profession of a public bent upon securing "free" benefits for which they have already been mulcted in compulsory contributions and taxes is but one aspect of the problem. The consequences of sheltering doctors themselves from normal market forces can be equally serious. A general practitioner who has no direct stake in the consequences of his prescribing habits, and specialists who are divorced from normal economic factors, must inevitably become less and less conscious of costs and prices. Proper appreciation of the economic facts of life and a responsible use of

both personal and national resources demands constant practical contact with normal market situations. No amount of propaganda by the Ministry of Health, or cajoling by politicians can prevent or remedy the ill-effects and demoralisation produced by the present system. As D. S. Lees (Fellowship for Freedom in Medicine, Bulletin No. 51, January 1963) has said: "A price is a price and we ought not to foul up clear thinking by dubbing it a financial barrier."

Any reforms and improvements in the NHS must, under present conditions, depend upon political and Treasury decisions. The only way of introducing a greater element of freedom and variety is by the growth of the private sector and the exercise of what one must call "consumer choice." Mere decentralisation of the administrative hierarchy of the NHS, though highly desirable, would not result in any significant betterment of conditions so long as the service remained largely dependent on Treasury funds. The abolition of regional hospital boards, or the creation of area health boards (as recommended by the Porritt Committee) could certainly help to link up general practice, public health and hospital services more closely at a local level: but, unless this was accompanied by a substantial injection of non-exchequer funds, it could do little to make the service more enterprising and responsive to local needs.

In planning any reforms of the existing service our aim should surely be to encourage doctors and patients to cope with the common and more straightforward things. The state should be left to subsidise, and in certain instances to cover completely, the costs of the more expensive and complex items, as well as the ordinary medical expenses of the truly indigent.

It may be as well to enunciate what appear to me to be the basic principles of any reforms aimed at improving both the quality of medical service available to the public and also the relationship between doctor and state.

1. The state should concentrate its efforts on items of high priority.
2. Treasury funds should be responsible for a much smaller proportion of the total costs of medical care.
3. Private insurance should cover a greater proportion of the total medical expenses.
4. Direct charges to the public should also cover a larger proportion of the total cost.
5. The medical profession in general should not be placed in direct financial relationship with the state.

There could be no plainer evidence or the need for the state to concentrate upon getting its priorities right than a study of the present situation in the NHS. New hospital building, hospital equipment and maintenance continue to be starved of essential funds that just cannot be raised from other sources. In addition a sum of roughly £50 million per annum will have to be found to cover the recent abolition of prescription charges and the increased cost of free-at-the-time drugs.

Growing personal payment and private insurance would not only allow the public to exercise a wider degree of consumer choice, but would also allow the government to preserve its fund for the really essential things. At the same time it would be possible for an increased proportion of the gross national product to be invested in the health services. All this could be achieved without the government of the day being frantically exercised in raising all the funds.

This, and not the allegedly deterrent effect of charges, is the strongest possible argument for establishing a direct financial bond between patient and doctor. Surely the ideal to be aimed at in a modern democracy is the achievement of a true partnership between government, private enterprise and individual effort.

At the present time most private medical insurance is used to cover the costs of specialist medical care. However, there are certainly many patients who would appreciate effective cover for the family doctor services. This would be greatly facilitated by the provision of drugs for private patients, though anything approaching the present free-at-the-time principle would not be a sensible way of encouraging a responsible attitude on the part of the private patient.

It would also be of help if patients could secure tax relief on *bona fide* medical expenses, as in the United States. We should aim at private insurance covering up to 40 per cent. of the total cost of medical care on the lines of the Australian system.

It is highly desirable, in state no less than in private insurance schemes, that the patient should normally make some direct contribution towards his medical expenses. This makes the patient a responsible partner in the transaction and stimulates him to exercise at least some control over the costs of medical care. This principle was firmly enunciated by the late Sir Earle Page, one-time Minister of Health in Australia, who emphasised that people do not appreciate the value of a service which they appear to obtain for nothing, and that there is not the same check on dishonest suppliers as when the patient makes a direct contribution. Such direct charges might well cover up to 15 per cent. of the total cost of medical care, as opposed to an estimated 3.9 per cent. of NHS costs in 1961.

No more pernicious situation could be conceived than that in which the majority of doctors are more or less entirely dependent upon the state for their income and their employment. So far as any exchequer element is concerned it is the patient and not the doctor who should be placed in financial relationship with the state. Although salaried employment may be preferred by some doctors, the majority are happier with the stimulus of some competition and with reasonable financial incentives.

When politicians express surprise that doctors should seem concerned about proper economic rewards, and when they plaintively ask what has happened to the profession's sense of dedication, let doctors beware. Such politicians are really not concerned about the doctors' idealism, but only with securing their services as cheaply as possible.