EDITORIAL: HEALTHCARE: STATE FAILURE

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Introduction

It is often argued by politicians, journalists and academics that healthcare is a unique area of human activity and that it therefore requires substantial amounts of state intervention. Citing reasons of egalitarian social justice, the problem of asymmetric information and the logic of social costs and externalities, a statist paradigm is invariably promoted which encourages ever more interventionism.

For libertarians, while all enterprises are unique, this is no reason for them to be organised or directed by government. Instead, free marketeers believe that the more important something is the more it should be provided in a genuine and open market.

Countering the populist view that healthcare is 'too important to be left to the market', David Friedman argues that the market provides 'the best set of institutions we know of for producing and distributing things. The more important the good is the stronger the argument for having it produced by the market':

> 'Both barbers and physicians are licensed; both professions have for decades used licensing to keep their numbers down and their salaries up. Government regulation of barbers makes haircuts more expensive; one result, presumably, is that we have fewer haircuts and longer hair. Government regulation of physicians makes medical care more expensive; one result, presumably, is that we have less medical care and shorter lives. Given the choice of deregulating one profession or the other, I would choose the physicians.'
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> (Friedman, n.d., p. 7)

Today, healthcare debates around the world are invariably couched in terms of the respective merits and de-merits of the public versus private sector. However, wherever you look, both these sectors invariably rest on an essentially nationalised labour force.

In Britain you cannot be a medical doctor without being registered with the statutory monopolist the General Medical Council. And you cannot be a nurse without being registered with the Nursing and Midwifery Council. As the libertarian writer Brian Micklethwait describes:

> 'If you are not or are no longer a "doctor" (as the government, advised by its preferred bunch of doctors, understands the word), then there are three things you may not do. These are, in ascending order of importance: sign death certificates, prescribe drugs, and (in general) take medical risks . . . In other words, medicine is a government sponsored monopoly. You can't practise medicine in any significant way if you can only prescribe insignificant drugs or cures, and only take insignificant risks. So far as I can judge it, things are approximately like this everywhere. In no country on earth is medicine un-interfered by the local state.'
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> (Micklethwait, 1991, p. 2)

For Micklethwait, the demand for healthcare services around the world is not out of sync with supply due to any inherent failure on the part of markets, but because genuine markets are never actually allowed. Political and professional elites invariably get into legislative bed with each other so as to stifle competition. As Adam Smith warned in *The Wealth of Nations*:

> 'People of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public, or in some contrivance to raise prices . . . But though the law cannot hinder people of the same trade from sometimes assembling together, it ought to do nothing to facilitate such assemblies; much less to render them necessary.'
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> (Smith, 1776, Book 1, Ch. X)

The usual problems blamed on markets in healthcare – consumer ignorance, neglect of the poor and chronically sick, externalities and even monopoly – are not only those issues best overcome by markets but of course they are a direct consequence of state interventionism.

While it is popularly believed that because of the superior knowledge of a doctor, consumers face the irrevocable disadvantage of asymmetric information, such a perspective ignores the function and benefits of advertising, brand building and the role of independent third parties.

While it is popularly held that markets would neglect the poor and chronically sick, this perspective invariably ignores the comparative empirical record of the state in healthcare. Instead of recognising that the market mechanism delivers built-in incentives to level social power, erode producer capture and encourage greater inclusion, the market is causally associated with problems that are actually created by the state. In reality, it is the state that neglects the poor and the chronically sick because they hold less voice and power under its auspices. Famously, the health economist Julian Le Grand demonstrated that in the UK, relative to need, professional and managerial groups receive more than 40% more National Health Service spending per illness episode than those people in semi-skilled and unskilled jobs (Benzeval *et al.*, 1995). Dr Eamonn Butler of the Adam Smith Institute rightly comments:

> 'Many of the [NHS's] horror stories are symptomatic of an institution which has an inadequate relationship with its customers. As with all state-run bodies, there is a tendency for producer concerns (often dressed up as "professional judgement") to dominate over responsiveness to customers.'
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> (Butler and Pirie, 2001, p. 9)

Today, there remains little understanding – even amongst most health economists – that in a genuine market new and innovative brands would emerge targeting the poor and chronically sick, and that these would operate in ways that are not currently predictable.

Similarly, while it is widely believed that a free-market approach to healthcare would result in potential negative externalities or third-party effects requiring government regulation (notably doctors and patients ignoring the exposure of others to contagious disease), such a perspective unreasonably assumes that government will respond faster and more effectively to such problems than a genuine market-based system.

Again, it is commonly assumed that a health market is particularly vulnerable to monopoly and producer capture. However, instead of seeing these traits as a result of statism, it is an *a priori* belief amongst most opinion formers that medical professionals should be allowed to capture legislative favour and therefore organise against the consumer. One of the great ironies of the monopoly debate in healthcare (as in other areas) is that those who often appear to be most concerned with this issue invariably suggest that it should be the greatest monopolist of them all – the state – that is used to deal with its perceived problems.

The importance of language

Ever since Roman times, political elites in Britain have sought to control and regulate the provision of medicine. First through the Roman military, then the Christian church, and then the Royal Colleges, Parliament and the timeless granting of legislative favour, the state has always sought to control the various ways in which people access their healthcare. Far from operating in a genuine market, healthcare has always been a highly politicised and controlled activity: one that rests in large measure on coercion and licence.

As such, it follows that the way the language of the market is often used in debate is highly dubious. For if what are in reality problems connected with government failure are ascribed to the free market, the entire debate ultimately becomes meaningless. If basic free-market concepts such as private property rights, uncoerced contracting and brand building (through advertising) are not in evidence in a sphere of activity, then it cannot be said in any meaningful sense to be operating under market conditions.

A global problem

Today in Britain, the USA, Canada, across Europe and even further afield, the funding, organisation and delivery of healthcare is universally viewed as being problematic. Yet in a sense this is strange given that we live in a time of unprecedented wealth, peace and advanced medical technology. It is peculiar that at a time of ever greater prosperity people seem increasingly disillusioned with their healthcare systems and deem them to be failing.

Today, the USA is often seen as having the most extreme form of free-market healthcare. Yet in reality, there is little – if any – widespread understanding of the existence of its massive state systems, Medicaid and Medicare. Indeed, so ill-informed is the debate in Europe that most find it hard to believe that the US government has any major state healthcare programmes at all – let alone that it has historically spent a greater proportion of its GDP on them than the British government has over the last 30 years on the NHS.

In Canada, public opinion seems to be increasingly calling into question the government's Medicare system. For example, in *Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System*, Brian Lee Crowley, Dr David Zitner and Nancy Faraday-Smith comment:

> 'While the operating assumption of the political class seems to be that Medicare is the third rail of Canadian politics ("touch it and you die"), in fact public opinion seems to be undergoing something of an evolution in respect of the public health care system. In particular, the idea of more private involvement in health care provision seems to be growing in attractiveness as people become better informed about the costs of the public system and its poor performance, and as a general sense of systemic breakdown grows.'
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> (Crowley *et al.*, 2000, p. 6)

Although there remain significant differences of opinion on what this might mean in practice, and on how and whether it would cost more or less than the current arrangements, the direction of Canadian thinking is clear. As Canadians increasingly find they are more prosperous, so they are dissatisfied with the state healthcare system and want more direct control of those areas of their lives that have up until now been controlled by the public sector. In David Gratzer's seminal work, *Code Blue*, he argues that Canadians are increasingly questioning a system in which:

> 'We hear the horror stories every day: hospital hallways lined with patients; long waiting lists for cancer treatment; a shortage of high-tech equipment.'

He concludes:

> 'No wonder confidence in Medicare, Canada's most cherished social program, has fallen to a historic low.'
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> (Gratzer, 1999)

In Sweden, state healthcare has been under pressure for some years. With public expenditure and the wider welfare state increasingly under strain, private sector providers have taken over the running of a number of hospitals, particularly around Stockholm. Once an icon of progressive West European social democracy, Sweden is today fast turning its back on the traditional model of nationalised health provision and funding (Munkhammer, 2005).

In France, Germany, Italy and elsewhere across Europe the story is similar (ibid.). As the boundaries of public sector funding and capability are reached so people's dissatisfaction with state healthcare is growing ever more vocal.

The utopian promise of genuine health markets

For libertarians the everyday debate about the ownership of hospitals and funding schemes is important but ultimately superficial. A free market would be 'something else entirely', according to Micklethwait (1991, p. 2). He argues that the process of defining who is and who is not a doctor and what risks should be taken should be determined by people offering themselves as doctors and people submitting themselves as patients. This is at the heart of a market, and courts, lawyers and politicians would respect contracts and not overturn them.

By this definition, a market would mean that people are able to take whatever drugs they wanted and medical practitioners would be able to advertise their services (ibid., p. 3):

> 'Far from being obvious to me that a truly free medical market would be disastrous, I believe on the contrary that such arrangements would be of huge benefit to mankind, and that the sooner medicine is done this way the better.
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> 'Things would not, inevitably, be perfect. Some fools would make crass blunders, by ignoring manifestly superior medical services for the most frivolous of reasons, and by patronising the most notoriously incompetent. Some such fools would perish from their foolishness. Others would merely be unlucky. No law can prevent either stupidity or bad luck, although the world is now filled with the particular stupidity which consists of refusing to face this truth, and with the many luckless victims of this stupidity.'

Powerfully, he concludes:

> 'Given that for most people the avoidance of suicide rather than suicide is the objective, a truly free medical market would enable them, for the first time ever, to purchase steadily improving medical advice and medical help, and at a steadily diminishing price.
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> 'One of the most pernicious restrictions on medicine imposed by the current medical regime is the restriction on advertising. In a free market rival medical procedures, rival medical "philosophies", rival views on the relative importance of confidentiality, hygiene, speed of treatment, riskiness of treatment, and so forth, would all battle it out in the market place. "Alternative" therapists would be allowed to prescribe potentially dangerous drugs, as only government favoured therapists may now. It would be up to the patients to pick therapists who seemed to know what they were doing and their look out if they chose badly. The already thriving medical periodical press would assist with voluminous comparative advice, praise and criticism.
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> 'In such a free market, any number of different medical styles could be practised, and patients would make their choices.'

We concur.

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