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Health Is Delivered

IN STEP WITH THE ADVANCE of the TC, the second big technological breakthrough of 1975–2025 has been the biological revolution. In 1975, medical knowledge was everywhere advancing, but three hurdles lay in the way. First, most countries had the wrong incentives built into their systems for delivery of health care. Second, most countries had entrenched bureaucracies which delayed instead of expedited the marvellous new opportunities for relieving sickness and pain. Third, drug companies were encouraged to act as monopolies protecting the things they had patented yesterday, instead of using open world-wide telecommuters' research to find new things for tomorrow.

These hurdles were eventually jumped when new market systems became available that made it profitable to spread efficiency-seeking multinational health-maintenance organi-

zations (of a new kind); when the process of opening up bureaucracies to competition after 1990 meant that those who speeded safety checks on new inventions were rewarded rather than those who delayed them; and when the advance of genetic engineering brought new competition with the drug companies. The booming-then-busting genetic engineering companies themselves soon became ossified protectionist institutions, but by then a new entrepreneurialism had entered into therapy.

As these changes occurred in time to catch and spur the biological revolution, millions of people were saved from unnecessary sickness and premature death. Before then, a few statistics will show how muddled and obstructive many incentive systems had become as a result of both right-wing and left-wing distortions during the last years of world over-government. The United States in the mid-1980s spent $1,500 per head a year on health care. Britain spent $375 per head. Singapore spent $200 per head. All three countries by then had the same life expectancy, with Singapore's increasing fastest. Almost incredibly, Singapore already by the mid 1980s had the lowest infant mortality of the three. Britain had the highest sickness rate of the three, or at least the largest number of workdays lost through workers saying they were ill. Britons also had the longest waiting time before they could get into their rather old hospitals, with suffering people sometimes waiting for years before they could get hips replaced or hernias mended or varicose veins dealt with, which meant they stayed sick a long time in great pain.

America's commercial medical system was by far the most wasteful. Until the 1960s it was also very unfair to the poor. In 1960 the children of the richest one-quarter of Americans saw a doctor about twice as frequently as the children of the poorest one-quarter, and infant mortality among black American babies was three times the whites' rate. In 1960–82 America carried through a genuine egalitarian revolution in the provision of medical care. Those were the years when America's per capita expenditure on health rose from $146 a year to $1,365. By the early 1980s poor Americans were seeing a doctor slightly

more frequently than rich Americans, and the rates of surgery had equalized between social classes. Unfortunately, in the process, America's costs of health care had soared out of control. The reason was that America operated its health care under what was called "third-party insurance" plus "fee for service."

By the early 1980s over 90 per cent of the $1 million which was spent in American hospitals every three minutes was paid for by third parties—still usually private insurance (although two-thirds of the premiums were by then paid by employers) with most of the other bills borne by state Medicare for the old and state Medicaid for the poor. Patients in American hospitals therefore soon had an incentive to demand to be treated in the most lavish possible way, since somebody else was paying. American hospitals and doctors also had an incentive to give the most lavish treatment, because they made more money if they did. They might make ten times as much money if they carried out $500 worth of tests which had a 97 per cent chance of diagnosing what was wrong with you, rather than $50 worth of tests which had a 96 per cent chance. Indeed, if a doctor carried out only the $50 worth of tests he was liable to be personally bankrupted through a malpractice suit in the one out of a hundred cases where opting for the $500 would have been right. If you lay dying in a coma in an American hospital in those days, you sometimes had $20,000 worth of medical care pumped into you in your last two weeks. You were not going to wake up to complain; the insurance company paid; the hospital made a profit on the $20,000—and, to be fair, used some of that profit for good works.

Britain's hospitals did not perform extravagant nonsenses like that, but they had gone the other way. In 1948 Britain established the first comprehensive National Health Service in the western world, where everybody was promised he would have the best possible medical care, regardless of cost or ability to pay. In 1949 Britain replaced this by something completely different.

As the NHS had cost 50 per cent more in its first year than

the Health Minister, Bevan, had forecast, the Chancellor of the Exchequer, Cripps, announced the new system in his 1949 budget. He said he would allocate a sum (initially £400 million a year), and then Britons could have the best health care which could be afforded within that figure. For the next forty years British health care was determined by this extraordinary formula. Its quantity was not decided by what customers were demanding, nor by what swiftly changing technology made available, but by how some politician called the chancellor of the exchequer felt on budget day. When it was a Conservative chancellor, he generally felt stingy. When it was a Labour chancellor, he wanted to be more generous; but in practice he was usually caught in an even worse balance-of-payments crisis, so he had to be stingier still. The National Health Service therefore became a method of giving Britain an undersupply of medical care, but then encouraging overdemand for it because there was only minimal charging at the point of sale. The undersupply was therefore rationed by queueing instead of by price.

No competition or advertising as between hospitals was allowed in Britain's socialist medical system. The patient was not told what was the crude curing or killing rate of the hospital or surgeon or other doctor to whom he was virtually assigned. The lack of competition meant hospitals had no experience of what was the most efficient method of staffing or of reducing costs. In the early 1980s British hospitals had far more ancillary workers (porters, cleaning and catering staff) per case treated than hospitals in other countries. As these surplus armies of people were employed within tight budgets, they were underpaid. As they had a monopoly employer (the National Health Service), but were underpaid, they became militant trade unionists. To the horror of Britons and the rest of the world, National Health Service employees started causing great pain to suffering and sick people by some inexcusable strikes.

By the 1980s angry critics said that in socialist medicine countries like Britain, dying patients were wheeled off long waiting lists past pickets of striking porters into under-equipped but over-manned hospitals whose record of infecting rather