Notes on Inequalities in Health and Health Care, and the Limits of Capitalism

Following Jean de Kervasdoue's thought-provoking paper on these subjects, herewith a few specific points on inequalities and then a more general one on capitalism as it operates in health care.

Inequalities in Health Care

I was intrigued by the difference that Jean pointed out between what was legally prescribed in France and the reality of inequality. It reminded me of the reaction to my first major piece of research: one that showed that the better off - professionals, managers, employers and their families - got 40% more health care relative to their need than the worse off - unskilled workers and their families. These results were widely reported in the press, and were greeted with a chorus of disbelief. Civll servants, academics said in so many words that it cannot be true - that the much vaunted British health service, free at the point of use and designed to provider care independent of income or class, was actually benefiting the rich. After all, the NHS was an essential part of the so-called Strategy of Equality - the use of public services to counteract the inequalities generated by capitalism. It simply couldn't fail - and therefore did not fail.

The power of belief in what ought to be true can so often overpower reality: especially , and most damagingly, in the world of policy and politics.

Inequalities in Health

A specific point here. Jean makes the point that public health measures often affect the better off more than the less well off and so worsen health inequality. He also points out that taxes designed to promote public health, such as tobacco taxes, often impact more on the poor. This is true: tobacco taxes particularly are generally regressive. However there was an interesting piece of research that examined the reactions of different income groups to a rise in the price of cigarettes caused by a tax rise and found significant differences between rich and poor. Specifically the poor reduced their purchases by much more than the rich - in technical terms, their price elasticity was much greater. To exaggerate a little: the poor gave up smoking while the rich carried on. In technical terms again, while the average tax rate is indeed regressive, the marginal tax rate is progressive. If true moe widely, this is good news; for it means that we might have a means of promoting public health that reduces health inequalities rather than increases it.

Capitalism and the Role of Profit

The general point concerns the engine of capitalism: the role of profit. There is a big debate in England at the moment concerning the so-called privatisation of public services; in fact not just in England, but in other parts of the United Kingdom - the danger of the supposed privatisation of the national health service played an important part in the Scottish referendum on independence for Scotland. The role of private providers, especially of health care, has been very controversial, inviting savage criticism and horror stories from all parts of the political spectrum.

Now Jean has pointed out that the privatisation of finance of health care has all sorts of problems and should not be encouraged; and he is absolutely right. However, I think both he and I have rather more sympathy with the private - or perhaps one should say, independent - provision of health care. For instance,he points out that private hospitals are significantly more efficient than public ones in France; a consequence, as he says, of the fact that they have to be more efficient to survive. If that is generally true, then why not encourage more private provision? For then we would get better quality health care for less resources: a

double win. Jean quotes Deng Xia-Peng: if a cat is good at catching mice then who cares if it is black or white?

As I said, I am rather sympathetic to this argument, and, in consequence, have been a little puzzled by the widespread revulsion against private provision or, more generally,against profit. I don't think that people who share this hostility to profit can really or consistently believe that no-one should make a living out of providing health care: after all, almost everyone here derives an income of some kind from the provision of health care, and, for them, and indeed for us all, the benefits of getting that income presumably outweigh the costs: since benefits greater than costs is one definition of profit, in that sense we are all making a profit from health care.

No, I think the real objection is not so much to the making of profit but to the distribution of profit - and in particular the distribution of profits to share-holders. It is large share-holder-owned corporations that seem to attract the most hostility - from pharmaceutical companies to large hospital chains. And I am coming round the view that there may be a good reason for this.

There are two objections to share-holding corporations providing health care. One concerns the distribution of money in dividends: this is public money that was raised from taxpayers to provide health care but is ending up in the pockets of, mostly, already wealthy private individuals to spend as they wish.

The other, more important objection concerns trust and motivation. For reasons we all know, users of health care find it difficult if not impossible to assess the quality of the care they receive. Generally they have to trust the provider to be motivated to help them; not to exploit their ignorance to cut costs and quality but to provide them with the best quality health care possible from limited resources. Now if they think that the principal - or indeed the only - aim of the provider is to maximise
share-holder value, then they might well feel that their trust is misplaced - and they may have a point!

This may be a potential problem not just for health care, but in all areas where the user of a service has to have a measure of trust in the provider: banking and investment comes to mind. Could it be that one of the foundation stones of capitalism - that of share-ownership - is flawed, especially when applied in areas where the user can be easily exploited - as in many public services and perhaps even wider?

If we do accept this argument, then what is the solution - especially if, like Jean and myself, one does not like heavily centralised state control and management. Well, the answer may lie in an idea that has been prevalent in France and in Spain and Italy, though not, I think, much exploited in public services: that of the service collective. This is where, in the case of health care, doctors, nurses and other staff to form a collective or a professional partnership to provide the service. The UK government has a programme supporting the development of such collectives in a variety of public services, including in several community health care. These have been very successful, pleasing users and workers- and as yet none has failed!

So I leave you with two questions. Should we try to move away from large shareholding corporations providing health care? And, if so, should we try and replace them with some form of professional partnership or public service collective?

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