'The political economy of health care: a clinical perspective'

Julian Tudor Hart

(2006), The Policy Press, University of Bristol,
ISBN-10 1 86134 808 8 paperback price £14.99320 pages

Review by Janet Shapiro

This scholarly and well-researched book analyses all aspects of the political economy of health care. Only an author with Tudor Hart's considerable experience as health practitioner, researcher and who has a political and historical understanding fostered in the Welsh coal-fields could produce this substantial volume filled with dense argument. A single review can hardly do it justice.

The book is not confined to the National Health Service (NHS), but it makes a close examination of why and how the NHS as set up in 1948 worked so well. Further it exposes how government policy, adopted first by the Conservative regime and established further under New Labour, has been dismantling the NHS. This process is not publicly admitted but the incremental steps of fragmenting services and reconfiguring the workforce continue.

Statistical evidence is frequently used in the text. In addition to the index and 31 pages of references, cited sources are further expanded in the notes following each chapter. This arrangement enables the argument to flow freely but the reader has to flip back and forth to locate notes referenced within the chapter. I found that post-it notes inserted between sections made this easier.

In the first two chapters, Tudor Hart sets out clear objectives for healthcare and examines what makes healthcare work most effectively. He identifies the 'gift economy', that enables risk sharing through the tax-funded nature of the NHS, to be its true strength, noting this is a quality understood and approved of by the general public.

In international terms, healthcare spending has traditionally been low in the UK (see Table 1). This could be interpreted as under-funding or as efficiency relative to systems funded differently. Only since the reforms under New Labour is the UK approaching the level of healthcare spending common in the rest of Europe.

Table 1. *Five countries selected from eighteen tabulated on p. 33*
Health expenditures 1980-92 in OECD countries as % of GDP

	1980	*1985*	*1990*	*1992*
US	9.3	10.5	12.3	13.5
Germany	8.7	8.5	8.6	9.1
France	7.7	8.2	8.9	9.2
UK	**5.9**	**5.8**	**6.3**	**6.7**
Spain	5.8	5.5	6.9	7.1

'Managed health care', or private healthcare for profit as practised in the United States, is examined. Tudor Hart notes that 'managed health care' is only profitable where the average call on treatment occurs once a year. Thus healthcare companies will seek to avoid recruiting the chronically ill or those with high dependency.

He notes that US practice influenced UK government policy in the 1980s when, without public debate, the care of chronically sick older people was removed from the NHS. Privately-run care homes took on the most profitable institutional care leaving more expensive high-dependency provision to the NHS and local authorities. Another break with the 'gift economy' concept was the Private Finance Initiative (PFI) introduced in 1996, whereby investors, supposedly taking on the risk, built hospitals and leased them back expensively to the NHS [Root, Pollock et al]. Such schemes continue to be used even though no democratic group within the Labour Party has endorsed it. Tudor Hart notes that ' *Costs to the NHS of PFI schemes were between 9.1% and 18% of initial construction costs where as government could, under traditional Treasury rules, borrow at interest rates between 3.0% and 3.5%.'* As well as being expensive, such schemes have reduced provision.

Tudor Hart describes his own early attempts to identify costs in providing health care; he concluded that precise costing of individual treatment pathways is difficult if not impossible and certainly irrelevant in a 'gift economy'; but that in a market economy prices depend upon what people are willing to pay. Likewise he doubts the validity and scope of research attempting to assess the health gain of medical intervention. The section on lost potential in the UK is packed with references on how much more could be done to combat chronic conditions. Tudor Hart suggests that the 'Rule of Halves' applies: '*roughly half of most common chronic disorders in the English-speaking world are undetected, half of those detected are not treated, and half of those treated are not controlled'*. To combat this, Tudor Hart began a screening programme in 1968 for important treatable health risks in

Glyncorrywg (Wales). The effectiveness of this programme was demonstrated in records for 1981-86, published in 1987, that showed reduced death rates for under-65s, 28% lower than for a similar neighbouring community that had received traditional demand-led health care.

His exposition of the developing philosophy of health care concludes that patients and staff are co-producers for net health gain. Our NHS is envied for its valuable resource of clinical records collected for a stable registered population for primary care and invaluable for the assessment of treatment effectiveness. It is desirable for patients to have free access to their own computerised records. However, the conflict of interests in the more fragmented secondary care sector (i.e. hospital trusts) may frustrate the development of a unified IT system for patient records. With the involvement of private providers there are issues of confidentiality and ownership of data.

A detailed historical description of the early days of the NHS informs the author's analysis of today's crisis. The robust nature of the NHS is attributed to the survival advantages conferred by 'solidarity' – or pooled risk - recognised in all societies. Social investment funds the NHS, although taxation, including indirect taxes, continues to bear hardest on the poorest (see Table 2).

Table 2. Tax rate as a percentage of gross income for non-retired households (Economic Trends, April 2000)

(*extracted from note 28 on p. 227)*

Year	Poorest 20%	Richest 20%
1995	39.3%	35.2%
1998 - 99	41.9%	36.4%

Tudor Hart notes that *'Governments that claim to have shifted the burdens of necessary social investments from taxpayers to private investors have not shifted the risks.'* In one form or another, the public must ultimately bail out a failing PFI hospital. This observation is pertinent in his detailed evaluation of the political economy within the pharmaceutical industry. He indicates a complex interaction of control and investment between governments and speculative investors. Tudor Hart points out that our NHS has the advantage of being a monopoly purchaser, guaranteeing high profit levels for companies but able to negotiate lower prices than the fragmented private providers in the US can achieve. Tudor Hart makes a radical recommendation that would flout new EU and WTO laws; he advocates the benefits of the

NHS undertaking research, development and production of its own medications in competition with commercial companies.

Tudor Hart concludes with an optimistic picture of what can happen as people become aware of their common ownership of the NHS and the value of solidarity in preserving this precious model of social cohesion.

References

Root A. (2005), Review of 'The Private Finance Initiative Built on Sand – A report for Unison by Prof. Allyson Pollock, David Price and Stewart Player'. Radical Statistics #90

Pollock A., Leys C., Price D., Rowland D., & Gnani S., (2004), 'NHS plc The Privatisation of Our Health Care', Verso,

Janet Shapiro
editors@radstats.org.uk