1. Introduction

Health policy is collective action. It is action undertaken by a group of people because doing nothing does not bring about the kind of society in which they wish to live. Richard Titmuss said it all: 'Social policy is about social purposes and choices between them' (Titmuss, 1974: 131). Social policy has 'no meaning at all if it is considered to be neutral in terms of values' (Titmuss, 1974: 27). Ideology is on the x-axis. Belief is on the y-axis. Stranded in between, there is thee and me. That is how health policy is made in a liberal democracy that is built upon economic exchange but upon the common identity as well.

Richard Titmuss had public policy in his blood. Adam Smith did not. Adam Smith was in favour of pecuniary self-interest, rational choice and the invisible hand of supply and demand. The consumer and the shopper, he said, could be relied upon to produce the well-being of nations. The discrete individual knows where the shoe pinches. The gain-seeking salesman knows whom he has to satisfy in order to live well: 'By pursuing his own interest he frequently promotes that of the society more effectually than when he really intends to promote it. I have never known much good done by those who affected to trade for the public good' (Smith, 1961 [1776]: I, 448).

Adam Smith looked to goal-orientated exchange to maximise people's well-being, self-perceived. Taken literally, his defence of devolution and factoring-down would suggest that health care is not a topic in public policy at all. The health-holder in need of a recommendation or a procedure buys in the intervention of the specialist even as the butcher buys in beer from the brewer and the brewer buys in bread from the baker. The doctor, the nurse and the anaesthetist serve us not out of benevolence but with a view to their own income, but they do serve us. Supply and demand are enough. Public policy is not needed. The State is not wanted. Shepherds and nannies need not apply. Richard Titmuss need not apply.

This book takes a more pragmatic view. It argues that the free market will normally negotiate a mutually beneficial compromise between supply and demand but that sometimes collective action will be the essential complement to factored-down individualism. Richard Titmuss

said that pooled policies tend to 'reflect the dominant cultural and political characteristics of their societies' (Titmuss, 1974: 22). They do and they must; and one of those characteristics is 'society's will to survive as an organic whole' (Titmuss, 1963: 39). A nation has a shared and felt need for economic efficiency. It has a shared and felt need for other things as well.

Health policy, like all of public policy, is a response to the shared and the felt. It is more than the atom who hires a doctor who fixes a cough. Surrounding the nexus there is the context. There is I. There is We. There is Titmuss. There is Smith. And there is the acid test. Health policy is the acid test. The regulation of toxic banks and the denationalisation of the British Royal Mail are child's play compared with collective action to promote good health. It is a thing apart.

Health care is an unusual commodity. Its special properties make it similar but also different. This book incorporates those special properties into the broader theme of political involvement versus individual autonomy. The book asks if the unique characteristics of health make it uniquely well suited to social regulation and public administration. Perhaps apples and oranges can be left to the buyers and the sellers. Perhaps health care is different.

Definitions come first. Chapters 2, 3 and 4 describe the outcomes, the inputs and the production function.

The outcomes can be approximated by the indicators of morbidity and mortality. Good health is a sneeze arrested, a wheelchair discarded, a life-course prolonged by an organ transplant. Good health is an end in itself for the kidney patient who no longer experiences the disutility of dialysis. It is also the means to an end for the bedridden and the delusional who are empowered by better health to earn a living.

Good health is not just an objective fact but a subjective perception. It extends to the comfort of palliative care where there is no cure, the warmth of human contact where the doctor just listens to the friendless, the reintegration of the marginalised where the community nurse informs the housebound that there are welfare benefits for which they can apply.

Health status is buried in the hidden mind. Questionnaires and surveys separate the cardinal from the ordinal. Induction from willingness to pay calibrates the intervals. Each person is distinct. Each has a right to express a view. No responsible democracy formulates health policy without collecting information on what makes most of its citizens most satisfied in their own estimation.

The inputs are the jabs and the plasters, the beds and pharmacists. They are not the only ones. A tax on cigarettes paternalistically buffers the impressionable against a hospital stay. Role models encourage the

couch potato to keep fit with a jog but not to slip into excessive weight loss which even the supermodels eschew. Dark chocolate contributes to good health. So does fat-free ratatouille served up by a supportive spouse. All of human life is there. All of human life has an effect on health.

People want good health. Good health, however, is not for sale. What is for sale are the inputs in the production function. The demand for health care is derived from the demand for health status which is not an economic tradeable. People have a strong resistance to pain, disease, impairment of faculties, permanent disability, premature death. They believe that health care is the wonder drug that will turn the tables on misfortune and drive the Grim Reaper from the door.

Even when there is no proof, their wishful thinking is a self-perpetuating psychological constant. Just as people believe in God, they also believe in the shaman who can make miracles happen. The appeal of the medicine man is emotive and non-rational. The doctors themselves are uncertain and the treatments not guaranteed. The link between life, death and care is imprecise, but still it is a link that is universally and eternally a source of satisfaction. No one likes to think that their life hangs by a thread or that their tremours will never stop. Health care is different from other commodities. People like to believe that someone, somewhere knows what to do.

Chapters 5, 6 and 7 say that the demand for care is a triangle of forces. It is the compromise negotiated through a continuing debate between the consumers, the producers and the community. All three constituencies believe that they have a valid contribution to make.

The liberal economics of Smith, Mill and Pareto makes the assumption that the autonomous individual is the best judge of their own well-being. Only the free-standing ego can compare the pain with the price or decide if the side-effects are compatible with one's lifestyle. Only the one-off consumer can do it. The outside observer cannot. Yet health care is a thing apart. In the case of oranges, remembered learning-by-doing has given the decision-maker a basis for rational expectations. In the case of an appendectomy, a heart attack or even a fractured clavicle the naked Adam is more likely to be on his own.

The argument for tolerance and consumer sovereignty is called into question by ignorance, uncertainty and information asymmetry. Individuals may not be in a position to distinguish their wants from their needs or to protect themselves from the supplier-induced demand of medical practitioners with a for-profit goal-function of their own.

Principals are at the mercy of their agents. Consumers do not know if they are harbouring an asymptomatic malfunction or what tests are

required for von Ossobeyne's Disease or where to go for a top-quality specialist. They are too anxious to calculate the percentage change in quantity divided by the percentage change in price. They do not know what to do in uncharted territory where best practice varies, suppliers are differentiated, markets are segmented and finance makes the world go round. Intervention is instantaneous: the patient consumes the operation in the real time that it takes for the surgeon to produce it. Intervention is lagged: the patient actively invests their own time and money in keeping their body capital up to the mark. Intervention, most of all, is unbalanced. The doctor knows best. Every patient knows that.

The temptation to palm off a 'lemon' as a 'peach' is a fact of life. Yet the doctor at the same time has a professional ethic which pulls them back from lucrative mendacity. Asymmetrical information may for that reason be a greater threat when the consumer is buying a used car or deciding if a chicken is fresh than when they are being advised to take a sternum test for anticoagulants in the cortex. The doctor's role as healer and carer makes them see themself as the agent of a purposive teleology that is more than crass money-making alone. Like an emergency clinic, a medical professional will not turn away a desperate patient even if they know that the debt will go bad. The backslider who cuts corners on health and survival will experience a spoiled self-image. No sensitive doctor wants to feel bad about themself.

Medical services are often provided in a not-for-profit setting such as, in Britain, the National Health Service. They are often hedged about with regulations that circumscribe what the clinics can and cannot do. Morality restricts flexibility and licensure filters entry. Competitive pricing, manipulative advertising and entrepreneurial innovation can in the limit get a hospital delisted and a professional struck off. The butcher may have an instinct of workmanship but no one would say they had sworn a Hippocratic Oath that amplifies the law of contract. Health care, however, is different.

Society, meanwhile, has values and objectives, norms and visions, to which even the selfish dyad of market exchange is expected to conform. Consensus lays down the pitch, the court and the rules of the game. It establishes the baseline. It legitimates the patterns. The We gives the wandering self a home in time and space. It is the common bond.

Health care is other people. Fellow citizens want contagious externalities and third-party spillovers to be contained by State and not just medical intervention. Public opinion wants the ethical absolutes of social justice and Kantian respect to complement the market economist's maximand of input–output efficiency. Our central value system is what makes us teammates and integrated cooperators rather than anomic

isolates whose only purpose is to turn a penny wherever a gull is to be twisted. A new hat satisfies a personal need. A linctus satisfies a personal need, but a social need as well. Health care, in other words, is not the same.

Chapters 8 and 9 discuss the business economics of third-party reimbursement. In the case of fresh fruit the transaction is complete when the buyer and the seller exchange goods for money. In the case of health care there is very often a further step. Where the nervous risk-averter has entered into a probability-sharing pool, it will be other people who will share the cost. Uncertainty is endemic to the human condition. Insurance is the rational response to the unknown and the unknowable.

There are no free-riders when the baker sells bread to the butcher. All the costs and benefits are internalised in their contract. Pre-paid care is an open door. It is socialism for sale in the capitalist market. Precisely because the use of the commons is free at the point of consumption to anyone who had the foresight to pre-purchase an entry ticket, there is a hidden temptation to translate cross-subsidisation into overconsumption. At a buffet the diners can eat as much as they like. At the margin they can continue to dine free. The diner has the peace of mind that comes from knowing it is the club that will pay.

Fire and theft are unambiguous negativities. They allow for little discretion and less judgement. Medicine is more nebulous. Policyholders look to health insurance to cover an open-ended spectrum of alternative therapies, conflicting opinions and differing amenities. Even if the small print is very small, still the contract can become a blank cheque if the patients and the practitioners demand nothing but the best.

Nor is that all. The carriers are exposed to adverse selection: the sickly will do well to sign up while the healthy will prudently save at interest instead. The carriers are vulnerable to moral hazard: the healthy will tend to debase their risk profile because the costless antidote is on the shelf. It is an actuarial jungle. The only solution is for the commercial carrier to refuse cover to all applicants likely to prove a profit-sapping drain. Money is money. Loss-makers do not balance the books. The response to the gap has, historically speaking, had to be national insurance. A national scheme ensures that no citizen, high-risk or low, is forced to pay more than he or she can afford for care.

Private cover is frequently supplied as a fringe benefit through work. Where health insurance can be set against tax, both the employer and the employee have an economic incentive to substitute insurance for pay. The tax-free status of the merit good means that it is in receipt *de facto* of a cost-inflating subsidy from the State.

Tax revenue foregone is not the only subsidy. Treatment centres will sometimes receive direct funding from the national budget because of the medical and social services they supply. In a universalist system clinical attention is delivered in citizenship-class institutions which strengthen the sense of community. In a residual system at least the deprived and the rejected are means-tested up into the medical minimum. Universalism or residualism, general or selective, the public subsidy makes possible a basic floor below which no human being can be allowed to fall. The facilities are the material embodiment of fraternal duty and a social right. No one but a beggar expects a handout when he walks into a butchery, a bakery or a pub. Health care, however, is different.

Chapters 10, 11, 12, 13 and 14 continue the discussion of membership, entitlement, equity and sharing. Equal access to cinemas, motorcars and pins is pure communism which is seldom advocated outside the family circle. A level road to the doctors and the hospitals is, however, a social objective that is more likely to command popular support.

Most people probably believe that all, irrespective of their achievement-based ability to pay, should enjoy equal access to at least a minimum medical package. There will not be universal consensus on the precise make-up of the entitlement or on the inclusion of peripheral alongside essential services. Where there will be universal consensus is on the action clause, that something should be done to level up the opportunities, the *joie de vivre* and the life-chances of all people in our nation and beyond. The moral imperative casts a long shadow before.

It does this most of all in societies with religious values that preach compassion, altruism and solidarity, with historical traditions that are imbued with responsibility, overlap and a common culture. In Britain, the nation-building impact of the Second World War was the stepping stone to the Welfare State. However, even in societies that have invested heavily in meritocracy, acquisition and living standards, there has always been an interest in fairness, access and basic health.

That commitment in itself politicises the debate. Freedom is not just freedom from the State. It is the freedom to develop, to unfold, to become truly and fully oneself. It is the freedom to attend comprehensive schools and to live in well-maintained public housing. It is the freedom to harness the amicable Leviathan in the agreed-upon interests of the All.

Mortality and morbidity are not random but patterned. Disparities in health are not just a reflection of individual assiduity versus private sloth. They are also social facts, correlated with occupational hierarchy and geographical location. Low incomes make it difficult for the deprived to pay for proper nutrition and salubrious accommodation. Subcultural mores mean that some strata are socialised into deferred gratification

while other peer groups grow up with live-for-today. The job function explains why roofers have more falls and middle-ranking civil servants more heart attacks. Medical attention too is a cause of the dispersion in outcome indicators. Ability to pay can be a deterrent. People who cannot afford Disneyland do not go to Disneyland. But health care is different.

Where there is consensus that the invisible hand is letting the community down, the State will be expected to correct a market failure. Low incomes will be supplemented through housing allowances and child benefits. Subcultural conventions will be challenged through uninhibited mixing and health education. Occupational differences will be narrowed through works clinics and stringent bylaws. Medical care will be made a citizenship entitlement through community-rated insurance and a National Health Service.

The State will correct a market failure but it will also build on market success. Never sufficient but always necessary, economic growth ensures that public goods can expand without the need for private consumption to be crowded out. Continuous increase augments the taxable resources that can be devoted to the collective infrastructure. Capitalist gain and socialist cohesion can work together. The Fabian and the financier are both part of a sustainable health policy. That does not mean that they have to become good friends. The devotees of social integration and the avatars of paper appreciation do not normally go on holiday together or buy each other drinks in the bar. But they can work together; and that is enough.

Chapters 15, 16 and 17 issue a reminder that the cost of care is rising. It is rising as a share of the domestic product, a share of total public spending and a share of the household budget. $1 in every $6 spent in the United States is being spent on health. It was $1 in every $20 in 1960. What is being spent on health care is not being spent on battleships and beefsteaks. The escalation in the cost of care can impose an excessive burden on the other good things in life.

Health care has been expanding rapidly because of third-party payment, rising expectations, rising incomes, an ageing population, the development of new technology. There have been supply-side imperfections such as professional associations, local monopolies, protracted training, excess capacity, the entry barrier of capital overheads. The State, by licensing the hospitals and limiting the beds, has unnecessarily restricted the quantities and artificially inflated the price. The State has contributed to the rise. It is required nonetheless to take a lead in the containment of cost.

Relying on the free market, the government could encourage entry, rivalry and innovation. It could eliminate counter-productive restrictions

that feather-bed the rent-seekers. Relying on the visible hand, it could ration demand through charges and waits. It could offer pecuniary incentives to hospitals that cut the average cost. It could employ utilisation review to expose and countervail the power to exploit. It could nationalise the treatment centres in order to minimise wasteful duplication and administrative deadweight.

Health policy could redirect total spending even as it caps the budget. Allocation in line with social criteria and not only the priorities set by the unequal ability to pay has the great advantage that effective demand will not be allowed to starve the social organism of higher-order utilities. Motorcars and cinemas do not present so great a challenge as to necessitate a collectively coordinated response. But health care is different. It is a thing apart.