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Headline	The Five Parameters
Subhead	Phil Hutchinson and Rupert Read consider the nation's health
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Photos	
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Should the provision of healthcare be left to those who choose to sell it to those consumers who can afford it, where available? Is healthcare not simply another service that should be subject to “market forces”? Or should we see the provision of healthcare as one of the marks of an advanced, civilized culture, and therefore something that should be provided equitably to all by a single, state provider?

In countries such as the US (think Obamacare) and the UK (where the state has been gradually reducing its direct provision of healthcare), this is one of the greatest public questions of our time. Surely philosophers should have something to say about the subject.

Let us apply the five parameters we have developed to the question of the nation's health. Let us seek to tell the true tale of two ways of organizing healthcare.

1. PRECAUTION. History shows us that infectious disease can wipe out huge swathes of human populations; it can lead to great suffering and long term or permanent disability.

Recent history also shows that we can make truly life-saving and life-transforming progress in medical science and develop vaccines (think Polio, TB, Smallpox) and other types of biomedical interventions (think antibiotics, antiretrovirals for HIV, steroid treatments developed in the twentieth century, etc) which can cure or radically improve the prognosis for many of those who contract an infection, or who are born with or develop a chronic condition.

The development of such treatment demands investment and support for medical research programs. It demands infrastructure for public health programs, including medically trained professionals. We would argue that the development of such treatments and the infrastructure for their administration requires forward looking precautionary strategies which the logic of the market does not support.

Consider HIV. Where there is a strong market for antiretrovirals for the treatment of HIV, what is the market incentive for finding a *cure*? A cure would destroy a lucrative market for very expensive drugs that need to be taken daily for the remainder of the patient's life, so that they might keep the virus suppressed. This is not so much a comment on the ethics of pharmaceutical corporations (though see also "Political Economy", below) but rather a point about the precautionary (un-)viability of leaving biomedical research to the vagaries – and the dictates – of the profit-seeking market.

What we have just outlined is surely a strong consideration and a basis for concern, but let's get a little more precise. As we have made clear in previous articles, there are two levels of strength to precautionary considerations. Precautionary considerations are, plainly, *relevant* as a parameter whenever they apply. But they are *decisive* only when they apply so as to head off a risk of ruin, a risk of something truly worth calling not just a bad thing but a disaster. Are there health-risks which fall into this latter category?

There *are* public health catastrophes: especially pandemics. (As HIV/AIDS originally threatened to be, for example.) Health-risks where there may be decisive precautionary considerations are above all those health-risks which risk getting out of control, becoming runaway: and out-of-control epidemics -- pandemics -- are the starkest such case. This is why vaccination against potentially-pandemic diseases is a genuinely and one might even argue necessary precautionary measure: because it preserves "herd-immunity". We need to think *as a society*; and this is just what market-thinking makes impossible. Resistance to vaccination is most common among "New Age rebels", who might seem to have little in common with Hayekians or neoliberals: but actually such "rebellion" is nothing more than the logical outcome of individualist market consumerism. It is the spirit of the 60s transmuted into homo economicus. "If I choose not to 'consume' a vaccine, who are you to tell me otherwise?!" This is the essence of the self-righteous consumer; it is a total failure as the would-be basis for thinking about healthcare policy.

The same line of thought as we have just outlined also shows why the over-use of antibiotics should be regarded not as a minor matter deserving of casual disapproval but as a serious crime. Just like the *under*-use of vaccination, the *over*-use of antibiotics (whether by farmers or by doctors and patients) risks exposing the whole "herd" to the potential pandemics of the future: especially, to antibiotic-resistant super-bugs that could make modern medicine as we know it impossible, and hospitals dangerous places to be avoided at almost all costs.

The first parameter by means of which to measure the claims of market-based and of state-based healthcare systems is precaution, and market-based systems fail on this measure, catastrophically and decisively. They are *at best* potential public health disasters waiting to happen.

2 EVIDENCE. Moving on now from what might be to what is, how do different existing healthcare systems compare? Compare, say, the US healthcare system (primarily market-based) with the UK healthcare system (primarily state-based, though becoming steadily less so under successive governments since the 1980s). As we explain in more detail below, the case is pretty clear: the US spends far more on its healthcare, nearly twice as much, for worse outcomes, except for the richest. (See these World Bank figures: data.worldbank.org/indicator/SH.XPD.TOTL.ZS, or take a look at this analysis from the generally pro-market publication *The Economist*: economist.com/blogs/economist-explains/2014/06/economist-explains-16 (in particular, see paragraph 3).

Why is this so? This evidence does seem to counter the “common-sense” of our time: the argument from efficiencies. The argument from efficiencies is often advanced to justify privatization; it is based in orthodox neoclassical and “public choice” economics, and is founded of course in a commitment, widespread in mainstream politics today, to the thought that privatization leads to greater efficiency. However, even if we accept the argument from efficiencies in theory (i.e. greater “efficiency” is always good), the privatization of healthcare provision simply does not achieve greater efficiency by any respectable measure.

We can start to see *why* this is when we consider the following points:

- i. Profit is extracted by companies and partnerships etc. in any or every portion of the healthcare field;
- ii. The demise of the bargaining power that comes from being a monopoly buyer, where being one single large purchaser of goods and services brings greater power to the purchaser;
- iii. The greater difficulties in sharing healthcare information in a balkanized system of private provision;
- iv. Waste results from over-supply and over-capacity, which is structurally unavoidable in a system in which there is competition between different providers.

All four of these lead to greater inefficiencies. The economic argument for a market-based system of healthcare is therefore not really founded in an evidence-based argument from efficiency, as it claims to be, but in an ideological argument regarding the alleged desirability of a market system and the right to profit or capital-accumulation. It is actually, therefore, a (flawed, right-libertarian) “moral” argument masquerading as an argument based in the “science of economics”. The money spent on health as a proportion of GDP is, according to every serious study, quite simply greater in countries that operate some form of privatized and/or private-insurance-based health provision. Compare once more the health spending as a proportion of GDP for the USA and the UK, for example.

The argument from economic efficiency is a lie and demonstrably so. The evidence actually supports state-based healthcare systems, *not* their market-based rivals.

3 POLITICAL ECONOMY. How does marketizing healthcare affect power, in nations where it occurs? The answer isn't hard to find.

A market-based system empowers massive corporations, which then try to resist any attacks on their profits and power. For example, look at the incredible resistance funded by some of these corporations to the modest reforms that Obama has brought into US healthcare provision, and consider the way other such corporations have essentially co-opted Obamacare to work to their benefit. Most worryingly of all perhaps, a market-based system empowers pharmaceutical companies in dangerous ways, and this can add to the pressures which already systematically distort evidence-based medicine (think of the hiding of unwanted (by them!) trial-results) and undermine precautionary medicine (think of the lack of funding for a cure, or even a treatment, for Ebola.)

You might be tempted to retort that this is an unfortunate but acceptable pay-off for the benefits that accrue to the consumer, who can under such a system choose what to purchase and who to purchase from. Well, you might want to see what health consumerism is like in a “health food shop” in the UK, where Bach Flower Remedies are racked-out alongside Homeopathic vials of water. When health is left to consumer choice it often leads to the proliferation of quack remedies.

A final point, under this parameter: a market-based healthcare system is likely to create a more unequal society, because of the way that power follows profit and also of course the way that profit begets accumulation. A “single-payer” healthcare system is likely to create a more equal society, because of the way in which it evens out health-differentials that will otherwise reinforce the economic power of the better-off. Thus a market-based healthcare system will help systematically undermine the health of the nation. We all now know, since reading Wilkinson and Pickett's *The Spirit Level*, that one of the main things one can do to undermine a nation's health is to make that nation more economically unequal, even if you make its denizens richer in the process.

4 ASYMMETRY. Our decisions about healthcare disproportionately -- asymmetrically -- impact upon the very young and very old. Our investment (or lack thereof) in medical research now will have a huge impact upon future generations, as will our policies on antibiotic use or misuse. Our decisions about vaccine availability and policy will have consequences for the whole community, including those who for whatever reason have no say in decisions made by that community.

It can swiftly be seen that there must be a pretty powerful *prima facie* argument under the heading of “asymmetry” against a market-based healthcare system. But we can put the point more strongly. Healthcare is an almost perfect case for developing such an argument, because healthcare is virtually by definition something that one needs more the less one is in a fit place to exercise power over health-policy or even over decisions about one's own healthcare. Many of those who need healthcare most of all are the utterly powerless: the incapacitated,

those with dementia, those in the womb and those who cannot speak yet, plus those who have not yet come into being. Thinking about healthcare carefully provides a sound and serious argument against the political philosophy of liberalism in all its forms: for healthcare requires us to think seriously *for* others. The liberal ideal of an autonomous adult reasoner who is a full member of a polity stands in stark incompatibility with the profound reality of our entire dependence on the care of others in huge tranches of our lives -- including, for any of us, if and when we are struck down or threatened with serious illness.

5 FRAMING. Proponents of private marketised healthcare provision often argue that state provision of healthcare through taxation is increasingly unsustainable. As medical science advances, medical provision becomes more complex and expensive. As people live longer they require more health support for a greater length of time. The proportion of the state budget that healthcare takes becomes larger and larger, and in a context where citizens demand a lower tax burden this is politically unsustainable.

But this might be seen rather as a problem of framing.

Indeed, we could argue that in a world where healthcare provision becomes increasingly expensive then that can and should be addressed through more, not less, public provision (cf. e.g. our response to the argument from efficiencies in “Evidence”, above). State provision of drug research and manufacture, for example, would cut out much of the current fiscal exodus to the profits of drug companies. Moreover, the state is in a far better place than “the market” to seek proactively and holistically to *promote* health, by attacking the root *drivers* of ill-health: dangerous climate change, air pollution (especially from motor-vehicles and coal), poor diet and lack of exercise, rising stress, etc.

Put another way, what we are suggesting is that one will only see state health provision as unsustainable owing to increasing costs if one allows the argument to be framed this way. Framed another way, the argument becomes an argument about good communication. Politicians need to make the case persuasively for the best kind of health provision: universal provision financed through taxation. Lay it out for the voting public, starting perhaps with the point that private healthcare provision costs roughly double the state provision of healthcare while it lets those without insurance or the means to pay die. Isn't that a powerful argument? It doesn't even need “sexing up”. *If* factors like an ageing population and increasing complexities lead to an inevitable rise in cost (though this may not be true, if one actually attacks holistically the root causes of ill-health, as only public (as opposed to private) healthcare is in a position to do), then that is not offset by a move to marketised healthcare. The population will still age and healthcare will still increase in complexity. The proposal that we need to move to marketised healthcare to address the problem of a rise in costs can only appear reasonable if one has already mistakenly assumed that marketization leads to greater efficiency. This, as we have shown above, is not the case. The contrary is actually the case. So allowing our considerations to be framed by this erroneous assumption leads us to overlook what we should be doing: making the case for the desirability of funding through taxation.

In this article we have compared market-based with state-based healthcare systems. Excluded by that frame is the possibility of lighter-touch, more flexible co-operative / bottom-up

healthcare systems, such as some of the elements of the UK “system” (such as it was) that pre-existed the NHS, wherein working people (through friendly societies, and the co-operative movement, etc) sought to take care on a purely non-profit basis of their own healthcare needs, and such as is recommended by Ivan Illich (see his book *Medical Nemesis*) and often practiced in parts of the Global South. Implicit in the discussion of the parameters outlined above are some very serious limitations on the likely viability of a system that sought to *replace* state-based-provision with such bottom-up social provision. Such a system, crucially, would find it difficult to act holistically enough, for example, in terms of tackling the drivers of ill-health, and in terms of information-sharing. But it would also have some attractions: it might well be more open to experimental “tinkering” and new thinking than state-based systems; it might be more prone to empower patients and healthcare professionals; it might be easier to run participatorily and “democratically”, on a human scale.

So our closing comments on framing would be this: that the argument between state-based and market-based healthcare systems, the argument that our politics today insists on having, is really a bit of a no-brainer: we will summarize momentarily how market-based loses, hands-down. It would at least be a much more intellectually interesting argument to have, one that would actually be *worth* having, to reframe the healthcare debate in politics as being about state-based “versus” bottom-up mutual provision of healthcare – with market-based systems simply ruled out, eliminated as a non-starter. Outside the frame, because beyond the pale.

One of the worst things about the amount of actual influence (and airtime) given to marketized healthcare is that it crowds out what could be a much more valuable discussion, if reframed as we have suggested here.

Conclusion

There is a decisive precautionary argument against market-based healthcare systems. This alone is enough – it should settle the question. But considering the other parameters has only reinforced, and strongly, that presumptive conclusion. There is a clear evidentiary case in favor of “single-payer” healthcare systems, and against market-based healthcare systems. Likewise, there is a good case in political economy terms for systems such as the NHS (as traditionally conceived) and against the danger of private power in healthcare systems such as in the American system; however, this case again is less than decisive, if considered in isolation, and leaves open (so far as this parameter at least is concerned) the consideration of possible alternative systems, such as a “mutual”-based systems. In terms of asymmetries, there is a very strong case indeed against a market-based system for healthcare: healthcare seems almost the strongest example there could be of a counter-example to individualistic and economic thinking on how to provide what is necessarily a public service, a system that ought to be *designed* to help those suffering from an inability either temporary or permanent to control their own destiny. Finally, we have suggested that, while market-based healthcare catastrophically fails – it loses either badly or decisively on every count – when compared to state-based healthcare, a more interesting discussion might be framed: one that looks at whether there is a case for some aspects at least of healthcare to be provided less by a single titan such as the NHS, and more by charitable / ethical / local / lower-tech “third

sector” *permanently non-profit* initiatives. There are strong, significant arguments against this latter option, arguments that we have only touched on here: but at least there is a discussion to be had. Whereas, frankly, the only reason that the dominant discussion has been over whether to marketize healthcare is that it is almost impossible for some people not to want to talk about something when it produces Pound signs in their own eyes, not to mention oodles of Pounds in their own pockets.