

Are health care resources in the developed country context really scarce?



by Albert Weale

It is often said – indeed I have said it myself on a number of occasions – that the problem of the fair and efficient allocation of health care resources stems from the fact of scarcity. I should like to use the splendid and notable occasion of the tenth birthday party of *Health Economics, Policy and Law* publicly to repent of this heresy. Instead, I shall suggest to you that the problem of the fair and efficient allocation of health care resources is *not* one of scarcity. There potentially is a problem of *shortages*, a problem that is likely to affect some health care systems more than others, depending upon how they are organised and financed. It is, I think, a problem for the UK's NHS, because of its highly centralised nature. How far it characterises other systems is a matter of empirical investigation.

The distinction between scarcity and shortages derives from the study of planned economies. Alec Nove pointed that administrative planners can only feasibly substitute their judgement about the priorities for production when they are aware of the social value of *each* product, in terms of the forgone production in one line of activity that is incurred by production in another line of activity. This does not simply mean that they have to be aware of the costs of producing certain types of goods in general, for example that of footwear or of agricultural machinery. Rather they must know the costs of production associated with *specific kinds* of shoes or of ploughs.

A similar lesson can be gleaned from German experience between 1936 and 1948 when the means of production were left in private hands. To suppress inflation, the authorities started to control prices, leading to shortages that in turn had to be dealt with by administrators. In particular, where raw materials for production could not be introduced in sufficient quantities to meet demand, the authorities had to ration the supply of those materials according to their own priorities. In such a situation the business decisions of producing units become incalculable, since no one operating an enterprise can plan on the basis of the availability of material for production or take advantage of the flexibility of the price system at the margin.

Both analyses distinguish scarcity from shortages. Scarcity exists when demand unlimited by price or by rationing exceeds supply. Scarcity in this sense defines *the* economic problem outside a utopian fantasy of economic abundance. Shortages, by contrast, exist when individuals, whether private consumers or enterprise managers, cannot obtain what they want or need, *even though they have the money*. Under planning shortages are endemic.

In the UK the planned administrative suppression of inflation is variously known as 'efficiency savings' by the Treasury, the 'Nicholson challenge' by the managers and 'the cuts' by the public. To be sure, efficiency savings can be presented as compatible with decentralised decision making, since they ostensibly leave the implementation of the savings to local bodies who are supposed to have their own priorities within an overall budget limit. However, this appearance is misleading. Efficiency savings are necessarily a crude planning framework, and in a situation in which hospitals have few other sources of revenue – car parking, fatty food outlets and charges for copies of pregnancy scans come to mind – they lead to shortages of beds, convalescent facilities and staff. When centrally determined targets are super-imposed upon the financial constraints, shortages are made worse, even when local populations would be willing collectively to pay more.

The problem is not solved by economic analyses that identify the marginal cost-effectiveness ratios of interventions, as with the analyses conducted by NICE. Such analyses do not look at the

total cost implications of all appraised interventions taken together. Using such a decision procedure is inflationary, augmenting the problems of administratively suppressed inflation, well-illustrated with NICE's recommendations on statins in 2014.

In making these points, I am not of course advocating a replacement of collective universal health coverage by market mechanisms. The problems associated with market mechanisms in health care are well known. However, I am suggesting a research and policy agenda in which the balance between the centralised administrative determination of priorities and decentralised processes of budget-setting and revenue-raising is central. Perhaps there already are systems in which a feasible and well-functioning form of this balance has been found.

Where does that leave the problem of scarcity? The standard economic paradigm makes scarcity and limits evils to be overcome. But limits – whether budgetary limits or the limits of the discipline of professional practice – are what give meaning to life. Just think how boring tennis would be without the limits of the net. The problem of health care is not to find a form of organisation in which limits are removed; it is to find a form of organisation in which the meaningful limits of human finitude are not unnecessarily burdened by the shortages induced by the misbegotten priorities of central planners.

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