

Critically discuss the ways in which economic arguments can support the existence of the welfare state. Exemplify your answer by referring to one particular field of social policy

Introduction

A welfare state is one where the state protects the overall well-being and health of its citizens through pensions, grants and other benefits. The UK quasi-market economy is one of the examples of welfare state where the nation's healthcare and social polices integrate with the social and economic principles in order to safeguard people's health. However, economists argue that the provision of transfer payments and basic services eliminates competition within the service providers, which leads to market failure. The following essay will critically analyse these economic viewpoints and examine the manner in which other economists justify the existence of a welfare state with reference to the health and social care policies in the UK.

The essay begins by analysing the arguments which support and challenge the quasi-market economy in the UK and the manner in which healthcare and social polices justify the welfare economic approach followed in the UK quasi-market situation. This will be followed by a critical discussion of the economic relationship between social policies, such as healthcare polices in the UK, and the economic growth and development of the nation. Subsequently, the discussion will move on to discuss critically the concepts of social and private insurance and understand the manner in which economists justify the national healthcare insurance policy in the UK. Towards the end, the essay will observe the key arguments which support government intervention in a welfare state and its impact on market forces.

Quasi-Market

Quasi-market is the feature of an economy where services are provided by competitive providers, as if they are operating in a pure market situation based on supply and demand forces; however, service purchasers are financed from the state (Adam et al., 2006; Barr, 2004). The UK healthcare system has been functioning with a quasi-market approach since the 1980s, and the system was established in full form in the late 1990s (Adam et al., 2006). The economic arguments support the existence of quasi-markets through the aspects of efficient allocation of resources and quality of services, resulting in maximisation of profit and competition (Alcock, 2008; Cohen, 2008). When compared to the monopoly state provision, it is contested that higher quality of services and increased level of competition lead to better

allocation of resources and upholding of the promises of equity, such as healthcare equity in the case of the UK NHS system (Adam et al., 2006; Barr, 2004). However, other economists have challenged the existence of quasi forces on the basis of certain economic failures such as lack of competition, high costs of transaction, externalities and information asymmetry (Stiglitz, 2000).

Further, certain government failures are also predicted in the form of preference aggregation failure, bureaucratic failure and moral hazard problems (Hutton-Schneider, 2008; Stiglitz, 2000). In light of these failures, the existence of a quasi-market in delivering healthcare services is questionable in its ability to attain economic goals initially outlined by the policy-makers. However, other economists have supported that market failure is an essential feature of a quasi-market situation, which is not free from correction approaches (Adam et al., 2006; Barr, 2004; Cohen, 2008). These researchers argue that the moral concerns of providing equal services should be upheld while undertaking measures such as intergovernmental regulations, intergovernmental interventions, prohibition and/or limitation of development incentive, restrictions on boundary change by the local NHS providers and provision for enhanced information for both the users and service providers in order to prevent failure of competition. Further, Cohen (2008) adds that the effective economic performance of a quasi-market has to ensure that users (patients) are able to make choices, new providers are able to enter the market and inefficient services are effectively eliminated.

Social Policies and Economic Growth

At this point it is essential to understand the constructs which comprise the meaning of economic growth. Economic growth is defined as the means of sustainable and continued development in terms of per capita income, along with diversification of production, expansion of economic opportunities for all the citizens and reduction of absolute poverty (Taylor-Gooby, 1999). This viewpoint of economic growth indicates that poverty elimination, health equity and environmental sustainability form the part of economic development (Taylor-Gooby, 1999). Similarly, social policy is defined as those legislative frameworks which promote overall public development of the citizens of a country (LeGrand et al., 2008). The UK Health and Social Care Act is built on similar principles of providing uniformity of access and reducing the cost of

certain diseases through early prevention and intervention (Donaldson, 2009). However, economists have argued that the social policy welfare system and, historically, social policies and economic policies have been presented as the antagonistic ends of the argument (Hay, 2008). Social policies have been criticised by the economists for eliminating competition in the market, which results in poor economic performance (Barr, 2004). For instance, Greener (2009) has criticised the UK public healthcare system for lacking an economic viewpoint of encouraging competition between service providers and harnessing the supply and demand model followed in the US. These researchers support the departure of Keynesian orthodoxy, which advocates the complementary relationship shared between social and economic policies (Hay, 2008; Glennerster, 2009).

However, parallel evidence exists which shows the exaggerated picture of constraints provided by these economists. Other researchers support that social policies do not discourage competition as it is assumed (Adam et al., 2006, Scott et al., 2001). Adam et al. (2006) and Scott et al. (2001) detail the system of transfer payment and mention that these transfers are targeted at those citizens who have the least amount of disposable income, and therefore these recipients are highly likely to spend these transfer payments for staple purchasing, for instance healthcare services, thus creating greater levels of domestic demand when compared to other models of demand management such as reduction in taxation. Further, Stiglitz (2000) and Okun (1975) support that, in a welfare economy, transfer payments promote redistribution of resources from the affluent sections to the poorer sections of the society, thereby leading to production of uniform and sustainable demand. Moving on to the argument of competition, it is strongly argued that lack of understanding of the economic aspects of competition leads to the widespread assumption that competition is solely dependent on the cost for which an economy can supply services (Adam et al., 2006; Donaldson, 2011). Adam et al. (2006) present another viewpoint, that competition in a welfare economy with reduced levels of social disparity is more dependent on the quality of services than on the cost. For instance, competition between different Primary Care Trusts (PCT) is determined by the quality of services, and the concept of quality of services is further subjected to intense debate. This is because the quality of the healthcare services is defined in a multi-dimensional manner, including aspects such as patient experience,

effectiveness of treatment, effective resource management and so on (Donaldson, 2011; Greener, 2009). Therefore, it is proved that a welfare system promotes economic competition between the service providers with reference to the quality of services and not the cost of the services.

National Insurance versus Private Insurance

The word insurance describes the transfer programmes, as it deals with transactions pertaining to unexpected risks, in the case of this essay unexpected healthcare expenditures (LeGrand et al., 2008). The key difference between social and private insurance is that participation in social insurance is mandatory (Cohen, 2008). The economists who support private insurance healthcare systems such as the one in the US identify that private insurance firms attract customers by reducing costs and delivering good service (Connolly-Munro, 1999), parameters which are largely constant in the state-wide insurance systems such as national health insurance in the UK (Adam et al., 2006). The demands for certain healthcare expenditure can fluctuate because of its inclusion in the private healthcare insurance scheme (Cohen, 2008). On the other hand, the treatments provided by national healthcare insurance in the UK are definitive, and any modification requires an extensive procedure of changes in the national policies (LeGrand et al., 2008). However, the private healthcare insurance service providers and users face certain issues in relation to the moral procedure of selection and cost (LeGrand et al., 2008; Cohen, 2008). Private healthcare insurance firms are frequently found to be practising an immoral procedure of selection, with hidden information which is not readily understood by the consumer at the time of purchase (LeGrand et al., 2008; Cohen, 2008). On the other hand, social insurance schemes do not encounter such issues, and maintain better adherence to ethical and moral standards (Okun, 1975). Further, the economists argue that the conventional principle of economic supply and demand should not be considered as directly applicable for certain social services such as healthcare (Cohen, 2008; Hay, 2008; Okun, 1975). Others support that welfare states invest in these services with non-profit motives in order to provide security and solidarity, and to safeguard the overall well-being of their citizens (LeGrand et al., 2008).

Public Sector Intervention

Government intervention in the market is recognised as one of the most characteristic features of a welfare economy (Alcock, 2008). Hay (2008) proposes that government intervention can be supported with economic arguments of equity of public goods distribution, externalities and spillovers, prevention of imperfect information leading to imperfect competition, and prevention of coordination problems. One of the examples of UK government intervention is the policies for healthcare Research and Development (R&D) (Donaldson, 2011). The government combines the R&D measures of different firms and universities in order to share costs and internalise benefits, with wider application of results (Greener, 2009). However, other economists argue that this collaboration of firms in a welfare state leads to dampening of innovation and competition between firms (Donaldson, 2011). The concept of patent is an essential motivator for creativity, and in the absence of monetary incentives, firms will not be sufficiently encouraged to develop innovative healthcare techniques and drugs (Donaldson, 2011).

Another government tool for intervention in healthcare is subsidies on tax credits (Adam et al., 2006; Connolly-Munro, 1999; Glennerster, 2009). Adam et al. (2006) support that, in a welfare economy, tax credits act as the motivator for better performance; for instance, fewer waiting time targets achieved by a particular NHS trust. However, these measures also prevent sharing of information between firms and organisations in order to spread the effective measures of exploiting economies of scale (Greener, 2009). Therefore, the role of tax subsidies in the UK healthcare system is not established to achieve the best economic outcomes. Nonetheless, the government's intervention is unarguably established to reduce the inequalities between rich and poor in a welfare state, known as horizontal equity (Okun, 1975). The veracity of this statement can be observed in the improved and uniform access to healthcare services provided to UK residents (Greener, 2009). Similarly, vertical equity is achieved by fair distribution of the market outcomes between the rich and the poor sections of society, which is ensured by government interventions of taxation and income support (LeGrand et al., 2008). However, Cohen (2008) argues that the public sector in a welfare economy will have to be considerate towards economic efficiency and undertake measures to ensure that in-kind benefits have the expected levels of consumption. For instance, the treatments covered by the NHS

should have the required demand in the market in order for effective management of resources and utilisation of economies of scale to be undertaken.

Conclusion

This essay has discussed the manner in which economists support the existence of welfare social policy of healthcare in the UK with reference to significant economic arguments of equity, competition, prevention of market failure, uniform distribution of resources and quality of the services, leading to uniform demand. The arguments pertaining to a quasi-market economy in the UK support that higher quality of healthcare services and resultant completion will lead to better distribution of resources between the rich and poor, whilst upholding the ethos of equity. Another key argument presented by the economists highlights that market failures in the welfare economy can be appropriately addressed with government interventions, regulations and limitations on development incentives to prevent failure of completion in a welfare economy. Further, these researchers strongly support that welfare social policies, such as the health and social care policies in the UK, include the aims of overall well-being of their citizens, good health outcomes and prevention of long-term conditions within the framework of their economic agendas, while following the Keynesian orthodoxy. Therefore, application of conventional supply and demand economic models is not justified in these economies. It is also interesting to note the manner in which these economists support government intervention in a welfare economy as the means of preventing market failure, providing uniform access to healthcare services to the rich and poor sections, and achieving vertical and horizontal equity.

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