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HEALTH CHECK:

The NHS and Market Reforms

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Summary

- Since the early 2000s, the NHS has improved according to most measures of quality and performance. Survival rates for major diseases have increased, waiting lists have been shortened, and the prevalence of hospital infections has been reduced.
- This improvement has come from a very low base so that the performance of the NHS is still poor in international terms. For example, the UK ranks 20th out of 24 developed countries for cancer survival and 19th out of 23 for mortality amenable to healthcare. In league tables, the UK consistently ranks close to the post-communist countries of Central and Eastern Europe rather than to Western European countries. If the UK drew level with the 10th best-performing country in terms of mortality amenable to healthcare (Spain), at least 16 unnecessary deaths for every 100,000 inhabitants could be avoided each year – i.e. a total of about 10,000 deaths.
- The recent Commonwealth Fund study, which ranked the NHS well, has its merits, but it is structurally designed to favour an NHS-style model of healthcare. The study's limitations are perhaps best, albeit unintentionally, captured by The Guardian's coverage of the report which stated: 'The only serious black mark against the NHS was its poor record on keeping people alive.'
- The UK comes 24th out of 30 high- and upper/middle-income countries for efficiency of the healthcare system. If the UK reached the efficiency level of the 5th best-performing country (Japan),

life expectancy in the UK could be increased by more than two years without any additional healthcare spending and without people adopting healthier lifestyles.

- The reforms of the early 21st century gave well-performing hospitals more independence and introduced competition through a 'payment by results' formula. These reforms improved the service but they did not go far enough and have since stalled.
- The introduction of patient choice did lead patients to discriminate in favour of hospitals that had a better record. For example, post-reform, a given increase in mortality after heart bypass operations led to a loss of market share for a hospital that was ten times greater than would have happened pre-reform.
- Scotland did not pursue the same healthcare reforms as England. The evidence shows that Scotland spends more per capita than England; it has larger numbers of hospital, dental, nursing, midwifery, health visiting, hospital management and support staff; and it has higher numbers of hospital beds and inpatient admissions. At the same time, Scotland has longer waiting times for inpatient and outpatient appointments, and longer ambulance response times. Scotland fares worse on outcome measures across the board.
- The intention of the reforms of the 2000s was that almost all healthcare spending would be channelled through the payment by results scheme and that the vast majority of hospitals would be Foundation Trusts. This has not materialised and the reforms need to be reinvigorated.
- Although non-NHS providers now account for around 9 per cent of the secondary care budget this still comes nowhere near the level of provider plurality observed in Continental European systems. For example, in Germany, the voluntary not-for-profit sector accounts for more than a third of all hospital beds, and the private for-profit sector for almost a fifth. The private sector also accounts for 38 per cent of all hospital beds in France and 30 per cent in Austria.

- As well as reinvigorating the reform programme of the early 21st century, in order to promote greater efficiency and quality of care, a number of second generation reforms are required:
 - Patients should be able to choose between different primary care providers and commissioners. They should be able to do this not just on the basis of where they live. Instead, they may, for example, choose a chain which runs branches near their place of work, or an ‘identity group’ based on a civil society or religious organisation. There is evidence that this approach will improve care.
 - Care commissioners and primary care providers should be able to vertically integrate with secondary and tertiary care providers such as hospitals.
 - Hospitals and other provider organisations must be allowed to go bankrupt.
 - Ultimately, the health service should allow complete freedom of choice so that people can choose private providers and private commissioners without restraint at all stages of healthcare. A funding system will be needed that compensates providers and commissioners according to the costs and risks that apply to different types of patients in order to prevent ‘cherry picking’. Such mechanisms have long been used in other countries, and could easily be transferred to the UK.

Introduction

Recent reforms to the NHS, which have introduced some degree of choice and competition, have sharpened incentives to provide better care more efficiently. The evidence is very clear from a number of sources that the reforms have worked. Nevertheless, the UK health service still languishes low in the 'league tables' when it comes to metrics such as deaths of cancer and stroke patients, efficiency and mortality amenable to healthcare.

Unfortunately the reforms of the early 21st century stalled and/or did not go far enough. The government should reinvigorate the reform process and introduce second-generation reforms that allow individuals to have meaningful choice in relation to their healthcare commissioners and primary care providers. Primary care providers and commissioners, in turn, should be able to determine their own institutional arrangements, for example with hospitals and treatment centres. Such reforms should be a precursor to opening up healthcare to full consumer choice with private insurers and providers being able to compete with the NHS on equal terms.

This paper begins by reviewing the performance of the NHS and comparing it with that of other health systems. The reforms to the system and their success are then examined. Finally, the shortcomings of the reform process are discussed, together with proposals that would produce meaningful competition as a way to improve healthcare in England.

Stocktaking: Where do we stand?

Since the early 2000s, the NHS has improved on most measures of quality and performance, and on many of them it has improved considerably. Survival rates for major diseases have increased, waiting lists for hospital and specialist treatment have been shortened, and the prevalence of hospital infections has been reduced. NHS facilities have been modernised, innovative medicines and healthcare technologies have become more widely available, and activity levels have increased across the board. The NHS treats more patients, and it treats them with greater success, than in previous decades. The service has shown a greater capacity for improvement and reform than critics would have deemed possible.

And yet on most measures, the NHS is still an international laggard, even if it no longer lags as far behind the health systems of comparable countries as it used to. It is now playing in the same league as the healthcare systems of other industrialised countries, but, within that league, it is an also-ran.

Cancer survival rates

Perhaps the most high-profile set of performance indicators concern cancer survival rates, or their inverse: the probability of dying from cancer within a specified time of being diagnosed. Table 1 shows this probability, on an age-standardised basis, for three of the most

common types of cancer, for high- and upper/middle-income countries. On each measure, the UK ranks 20th out of 24 countries. Judging from cancer survival probabilities alone, one could easily mistake the UK for a Central/Eastern European country, as it consistently ranks in the vicinity of Latvia, Poland and the Czech Republic. It is outperformed by all Western European countries except Ireland. For a British cervical cancer patient, the average chance of survival would be five percentage points higher if they were treated in the tenth best-performing country (Denmark), and nine percentage points higher if they were treated in the 5th best (Japan).

Table 1: Relative¹ five-year mortality rates of cancer patients, 2007-2012 (or latest available period)

| | Breast cancer | | Cervical cancer | | Colorectal cancer | |
|---|---------------|-----------|-----------------|-----------|-------------------|-----------|
| | rate | rank | rate | rank | rate | rank |
| Australia | 12% | 2 | 32% | 7 | 34% | 4 |
| Austria | 16% | 17 | 32% | 6 | 37% | 12 |
| Belgium | 15% | 14 | 34% | 11 | 35% | 6 |
| Canada | 12% | 3 | 34% | 12 | 36% | 10 |
| Czech Republic | 19% | 21 | 35% | 14 | 47% | 21 |
| Denmark | 18% | 19 | 34% | 10 | 44% | 19 |
| Finland | 14% | 10 | 35% | 13 | 36% | 9 |
| Germany | 15% | 15 | 35% | 16 | 36% | 7 |
| Iceland | 13% | 6 | 29% | 4 | n/a | n/a |
| Ireland | 19% | 23 | 43% | 23 | 41% | 17 |
| Israel | 14% | 8 | 29% | 2 | 33% | 3 |
| Japan | 13% | 5 | 30% | 5 | 32% | 2 |
| Korea | 15% | 12 | 29% | 1 | 27% | 1 |
| Latvia | 19% | 22 | 42% | 22 | 51% | 22 |
| Netherlands | 14% | 11 | 33% | 9 | 37% | 13 |
| New Zealand | 14% | 7 | 35% | 15 | 37% | 11 |
| Norway | 14% | 9 | 29% | 3 | 37% | 14 |
| Poland | 26% | 24 | 47% | 24 | 52% | 23 |
| Portugal | 17% | 18 | 36% | 17 | 42% | 18 |
| Singapore | 15% | 16 | 39% | 21 | 41% | 16 |
| Slovenia | 15% | 13 | 37% | 18 | 37% | 15 |
| Sweden | 13% | 4 | 33% | 8 | 36% | 8 |
| UK | 18% | 20 | 39% | 20 | 45% | 20 |
| US | 11% | 1 | 38% | 19 | 35% | 5 |
| Difference UK – 10 th best country | 4pp (Finland) | | 5pp (Denmark) | | 9pp (Canada) | |
| Difference UK – 5 th best country | 5pp (Japan) | | 9pp (Japan) | | 10pp (USA) | |

Based on data from OECDStat.Extracts (2014)

1 'Relative' means relative to the average mortality rate of a comparable group in the same population (see OECD, n.d.).

It must be emphasised, though, that these figures represent good news, given where the British system is coming from. In the late 1990s and early 2000s, the UK's performance was far worse in both relative and absolute terms.

Stroke survival rates

Table 2 shows another set of high-profile indicators of health system performance, namely stroke mortality rates. The UK never makes it into the top 20 and comes in the bottom third on all three measures. For a British patient suffering from a haemorrhagic stroke, the average chance of survival would be 12 percentage points higher if they were treated in the 10th best-performing country (Denmark), and 15 percentage points higher if they were treated in the 5th best (Norway). The British figures look, again, more like those of a Central/Eastern European country than those of a Western European country.

Table 2: Age-/sex-adjusted 30-day in-hospital mortality rate of stroke patients, 2012 or latest available year

| | Acute Myocardial Infarction | | Haemorrhagic stroke | | Ischemic stroke | |
|----------------|-----------------------------|-----------|---------------------|-----------|-----------------|-----------|
| | rate | rank | rate | rank | rate | rank |
| Australia | 4% | 2 | 22% | 13 | 9% | 19 |
| Austria | 8% | 21 | 14% | 4 | 6% | 7 |
| Belgium | 8% | 19 | 31% | 27 | 9% | 18 |
| Canada | 6% | 8 | 22% | 14 | 10% | 22 |
| Czech Republic | 7% | 13 | 25% | 18 | 10% | 20 |
| Denmark | 3% | 1 | 18% | 10 | 4% | 3 |
| Finland | 7% | 16 | 13% | 2 | 5% | 6 |
| France | 6% | 12 | 24% | 17 | 9% | 16 |
| Germany | 9% | 26 | 18% | 9 | 7% | 11 |
| Hungary | 14% | 30 | 41% | 28 | 10% | 21 |
| Iceland | 6% | 9 | 17% | 8 | 7% | 13 |
| Ireland | 7% | 14 | 26% | 22 | 10% | 23 |
| Israel | 7% | 18 | 25% | 19 | 6% | 8 |
| Italy | 6% | 10 | 20% | 12 | 7% | 10 |
| Japan | 12% | 28 | 12% | 1 | 3% | 1 |
| Korea | 9% | 27 | 14% | 3 | 3% | 2 |
| Latvia | 14% | 31 | n/a | n/a | 19% | 30 |
| Luxembourg | 9% | 25 | 18% | 11 | 11% | 27 |
| Netherlands | 7% | 15 | 26% | 21 | 8% | 14 |
| New Zealand | 5% | 3 | 25% | 20 | 9% | 17 |
| Norway | 5% | 4 | 15% | 5 | 5% | 5 |
| Poland | 5% | 6 | n/a | n/a | n/a | n/a |
| Portugal | 8% | 23 | 24% | 16 | 11% | 26 |
| Singapore | 13% | 29 | n/a | n/a | 8% | 15 |
| Slovakia | 8% | 20 | 28% | 24 | 11% | 28 |
| Slovenia | 7% | 17 | 29% | 25 | 13% | 29 |
| Spain | 9% | 24 | 26% | 23 | 10% | 24 |
| Sweden | 5% | 5 | 16% | 6 | 6% | 9 |
| Switzerland | 6% | 11 | 17% | 7 | 7% | 12 |
| UK | 8% | 22 | 30% | 26 | 10% | 25 |

| | | | | | | |
|---|--------------|---|----------------|----|--------------|---|
| US | 6% | 7 | 22% | 15 | 4% | 4 |
| Difference UK – 10 th best country | 2pp (Italy) | | 12pp (Denmark) | | 3pp (Italy) | |
| Difference UK – 5 th best country | 3pp (Sweden) | | 15pp (Norway) | | 5pp (Norway) | |

Based on data from OECDStat.Extracts (2014)

Again, it is important to note that the UK has made huge advances since the early 2000s (see Taylor 2013: 125-128).

Mortality amenable to healthcare

There are no convincing measures for the overall performance of healthcare systems, but the concept of ‘mortality amenable to health care’ (MAHC), while still problematic (see Gay et al. 2011), is at least helpful. MAHC compares the mortality rates we actually observe with the hypothetical rates we would observe in an idealised health system, in which all diseases that *could* in principle be successfully treated (before a certain age) *are being* successfully treated. It thereby strips out premature deaths attributable to causes that are completely external to the healthcare system, or which could not have been treated under the best of circumstances at a given state of medical technology. Still, the concept of ‘amenable to healthcare’ does not necessarily mean ‘attributable to the healthcare system’. What this measure cannot do is control for cross-country differences in lifestyle, genetic, socio-economic and environmental factors, which probably explain a greater share of health outcomes than the health system itself. There is only so much that a healthcare system can do to compensate for poor diet, sedentary everyday lives etc. But MAHC is at least controlling for those factors that are most obviously outside the control of the health system.

Table 3 shows the annual number of avoidable deaths per 100,000 inhabitants, according to two different specifications of MAHC. The UK comes 19th out of 23 developed countries in both versions. If the UK drew level with the 10th best-performing country (Spain), 16

deaths for every 100,000 inhabitants could be avoided each year. For the country as a whole, this would amount to over 10,000 fewer avoidable deaths.

Table 3: Age-standardised rates of mortality amenable to healthcare (deaths per 100,000), 2007 or latest available year

| | Nolte & McKee's measure | | Tobias & Yeh's measure | |
|---|-------------------------|------|------------------------|------|
| | rate | rank | rate | rank |
| Australia | 82 | 12 | 68 | 7 |
| Austria | 82 | 9 | 69 | 8 |
| Canada | 87 | 15 | 74 | 11 |
| Denmark | 106 | 20 | 87 | 21 |
| Finland | 86 | 14 | 79 | 13 |
| France | 64 | 2 | 59 | 1 |
| Germany | 88 | 16 | 81 | 16 |
| Greece | 79 | 6 | 79 | 14 |
| Iceland | 72 | 4 | 61 | 2 |
| Ireland | 95 | 18 | 82 | 17 |
| Israel | 94 | 17 | 81 | 15 |
| Italy | 71 | 3 | 65 | 3 |
| Japan | 62 | 1 | 66 | 4 |
| Korea | 82 | 10 | 86 | 20 |
| Luxembourg | 81 | 8 | 75 | 12 |
| Netherlands | 82 | 11 | 68 | 6 |
| New Zealand | 107 | 21 | 85 | 18 |
| Norway | 84 | 13 | 70 | 9 |
| Portugal | 108 | 22 | 108 | 23 |
| Spain | 80 | 7 | 70 | 10 |
| Sweden | 78 | 5 | 68 | 5 |
| UK | 102 | 19 | 86 | 19 |
| US | 124 | 23 | 103 | 22 |
| Difference UK – 10 th best country | 20 (Korea) | | 16 (Spain) | |
| Difference UK – 5 th best country | 24 (Sweden) | | 18 (Sweden) | |

Based on data from Gay et al. (2011)

Once again, it is important to point out that while these figures seem mediocre, they have improved. Indeed, the UK has been making faster progress in cutting MAHC than almost all comparable countries since 1997.

The Commonwealth Fund study

So far, all measures of performance suggest a similar pattern for the UK: impressive improvements from a very low level with current outcomes still mediocre to poor. But assessing the performance of healthcare systems is notoriously difficult, and the degree of consistency across different studies is not very high, so unsurprisingly, one can also easily find counter examples. In the health system studies of the Commonwealth Fund (CF), the UK has ranked very highly for a number of years, and even came out 1st out of 11 developed countries in the most recent edition (Davis et al. 2014). Due to the dynamics of ‘confirmation bias’, the CF study has, naturally, received much greater media attention than studies with more sobering findings, and has been widely interpreted as a vindication of the NHS model. As commentator Owen Jones put it: ‘Read the Commonwealth Fund report and weep into your Milton Friedman textbook.’²

The CF study is different from most others in two respects. It is mostly based on inputs and procedures as opposed to outcomes, and it is mostly based on doctors’ and patients’ survey responses as opposed to clinical data. Only one category is about outcomes, and in that category, predictably, the UK comes out second to last. There is much to be said for the CF methodology. The problem with health outcomes is that they often tell us more about lifestyle habits and other factors exogenous to the health system than about the health system itself. The CF study avoids this problem by looking directly at what happens inside the ‘black box’ of the health system. The study also provides an account from people who, as patients or health workers, actually experience the respective health systems,

2 Owen Jones: ‘A £10 charge to visit a GP would be just the start of a slippery slope for the NHS’, *The Guardian*, 18 June 2014.

a perspective which is arguably under-represented in conventional comparisons. And yet, there are also a number of problems with it. The CF study uses a very specific protocol of how healthcare ought to be delivered, and judges health systems by the extent to which they comply with it. Deviations count as indications of poor healthcare. For example, one criterion by which the CF study evaluates safety is whether a doctor ‘routinely receives a computerized alert or prompt about a potential problem with drug dose or interaction.’ On this measure, the UK performs excellently, while Norway and Switzerland perform poorly. But it is a leap of faith to conclude that the latter two countries offer low standards of drug safety – they may simply handle drug safety issues in other ways. Thus, part of the reason for the UK’s stellar performance is simply that NHS guidelines largely coincide with the CF’s script.

The parts of the study which measure accessibility of healthcare, and equitability of access, are designed in a way that automatically favours single-payer systems that are fully free at the point of use. All health systems limit healthcare consumption in some way, through a mix of explicit measures (for example, co-payments, coverage limits set by insurers) and implicit ones (for example, restrictive prescription guidelines, low levels of investment in innovative medical technology, low staffing levels). What is unusual about the NHS is that it relies almost exclusively upon the latter form of restriction, while the CF study only takes account of the former in a negative way. For example, assume that a cancer drug was widely available in the US, but only at a substantial co-payment; assume further that, in the UK, the same drug was either not available at all, or limited to a few extremely severe cases. The CF study would then record high access barriers in the US, but none at all in the UK because the treatment is not available. The UK is virtually bound to come out on top in this sub-ranking, simply because of the way the study is designed.

Finally, the study makes no attempt to control for the ‘social desirability bias’ in survey responses, which can be a problem when sentiments towards health systems differ across countries. Survey responses from the UK, where criticism of the NHS is heavily socially

discouraged (see Taylor 2013: 7-9) and perhaps expectations low, may not be directly comparable with surveys from countries where people speak more frankly about their health systems' shortcomings.

In short, the CF study is a useful complement that highlights some – possibly under-appreciated – strengths of the NHS. But the claim that the NHS is the top-ranking healthcare system must not be taken at face value. The study's limitations are perhaps best, albeit unintentionally, captured in *The Guardian's* coverage of the report: 'The only serious black mark against the NHS was its poor record on keeping people alive.'³

Efficiency

In a systematic evaluation of overall health system efficiency, Joumard et al. (2010) have modelled health systems as 'production functions' which turn inputs (healthcare spending, healthcare staff) into outputs (life expectancy at birth, additional life expectancy at age 65, minimisation of mortality amenable to healthcare). The model attempts to control, at least crudely, for differences in lifestyle, education levels, economic and environmental influences, and so on. Where health outcomes fall short of the outcomes predicted by the model, the difference is ascribed to inefficiency.

In the efficiency ranking, the UK comes 24th out of 30 high- and upper/middle-income countries. If the UK reached the efficiency level of the fifth best-performing country (Japan), life expectancy in the UK could be increased by more than two years – without any additional healthcare spending, and without people adopting healthier lifestyles. Conditional life expectancy at age 65 would also rise by more than a year, and the number of avoidable deaths would be reduced by around 5 per cent. Changes in the model specification can change the country ranking, but they have little impact on the relative standing of the UK. The fact that the average length of hospital stays is also relatively long in the UK (e.g. Häkkinen and Joumard 2007) is a further indication of inefficiency.

3 'NHS comes top in healthcare survey', *The Guardian*, 17 June 2014.

Overall, it would appear that the NHS is still lagging behind the health systems of comparable countries on important measures. Even in the Commonwealth Fund rankings, the NHS is near the bottom of the league when it comes to health outcomes. It also performs relatively poorly on measures of efficiency. On the other hand, trends since the early 2000s have been positive. The next sections will take a look at how the NHS has changed since then, and how those changes relate to the improvements in performance.

How we got there: Key NHS reforms and their results

The internal market

The first attempt to inject a dose of market forces into the NHS was the 'internal market' project of the early 1990s. Its main ingredient was the separation of the health service's two main functions, which are the pooling and allocation of funding on the one hand, and the actual provision of healthcare services on the other hand (the 'purchaser-provider split'). Splitting those two functions meant that NHS providers would hitherto have to compete for NHS funding, in a process not wholly unlike competitive tendering, even if they were still part of the same organisation. The internal market led to improvements in some respects (e.g. Söderlund et al. 1997; Propper et al. 2002), but the attempt to harness competitive forces in order to improve quality failed (Propper et al. 2004; Propper et al. 2008). The main obstacle was the dearth of information on provider quality. Indispensable data such as case-mix adjusted mortality rates, infection rates etc. were not generally available, or at least not in a comparable format. Under those circumstances, providers responded to competition not by increasing their efforts to improve outcomes, but by rebalancing their efforts, improving observable outcomes at the expense of unobservable ones. Hence, there were improvements in waiting times and financial outcomes (which were observable), but the reduction in mortality rates (which were unobservable) stalled.

Command and control

After the 1997 election, the internal market was scrapped and replaced by a policy aimed at establishing uniform national standards through centralised performance management. This period saw the establishment of what is now the National Institute for Health and Care Excellence (NICE), of the National Service Frameworks (NSF), and of what is now the Care Quality Commission (CQC). It saw the introduction of national performance targets, star ratings for hospitals, and a 'performance fund' which channelled investment towards providers that did well on those metrics. Those policies, and especially performance management via central targets, were more successful than they are generally given credit for. There is evidence that targets succeeded in speeding up access to care, cutting infection rates, and improving some outcomes (Crisp 2011: 55-70; Bevan and Hamblin 2009: 169; Hauck and Street 2006). But, in the early 2000s, top-down performance management was probably taken to its limit. Further improvements had to come from somewhere else.

Some choice and some independence for hospitals

Hence, the mid-2000s witnessed another major health policy shift, namely a slow and tacit return to market-oriented policies not unlike the ones that had been abruptly ended in 1997. A key element was the introduction of patient choice. From 2006 on, upon referral, GPs had to offer their patients a choice of four or five different providers, rather than simply referring them to the provider they saw fit. These options had to include an independent sector provider. In 2008, patient choice at the point of referral was extended to any eligible provider. Two online initiatives were launched to facilitate patient choice: the online appointment booking system 'Choose and Book', and 'NHS Choices', a site which collected information on the performance of individual providers. Informed choice was meant to become a convenient and accessible option.

The situation on paper was not quite matched by how things worked out on the ground. For patients, the NHS had been a choice-free environment for most of its history, and many GPs were uncomfortable with attempts to change that. According to one survey among doctors, nearly four out of five GPs described their attitudes to the Choose and Book system as 'very negative' or 'a little negative' (Dixon and Robertson 2011: 55).⁴ Many of them boycotted the new system. Surveys among patients suggest that about half of them were never offered a choice by their GP, and those that were given a choice were not necessarily offered the full range. In particular, private providers were almost never included among the options (ibid: 54).

Thus, the implementation of patient choice was incomplete, and it probably still is. And yet, in many other sectors, relatively low rates of provider switching can be sufficient to stimulate intense competition.

Patient choice only became meaningful because it was coupled with a wholesale reform of the payment system. Until 2003, NHS hospitals had been paid through annual block contracts. In practice, this meant that the main determinant of a hospital's budget in any given year was its budget in the year before. Since the link between a hospital's revenue and its level of activity was weak, hospitals had no incentive to attract patients. This changed in 2003 when the gradual rolling out of an alternative payment system, termed 'Payment by Results' (PbR), began. Payment by Results is a misnomer for a system that should really be called 'Payment by Activity'. It is a prospective payment system under which providers are paid a standardised tariff per case, set on the basis of average cost, with some adjustment for case severity and regional wage/price variation. The basic idea behind PbR is that hospitals should be incentivised to attract more patients, but not to 'over-treat' a given patient. Attracting an additional patient would lead to additional revenue, but a long hospital stay and/or extravagant additional treatments would not.

4 This does not necessarily mean that all of them were opposed to the idea of patient choice in principle. Part of the hostility must have been explained by more mundane factors, such as IT glitches in the roll-out of the online booking system.

The introduction of PbR has made the NHS more similar to Continental European social insurance systems, although the latter have come from the opposite end. Those systems, as well as the US system, have traditionally run pure fee-for-service reimbursement schemes, where providers were paid for every individual service they performed. While the old British system provided incentives for under-treatment, the fee-for-service systems provided incentives for over-treatment. It would usually pay to keep a patient in hospital for an extra day, recommend an additional test etc. Thus, in the Continental European context, the move towards prospective payment systems represents a move towards greater standardisation; in the UK context, it represented a move towards greater differentiation.

PbR initially covered only selected treatments in selected hospitals, with the remainder of hospital revenue still coming through the old block contract system. But it was subsequently expanded to more providers and more procedures. By 2006, about 60 per cent of hospital revenue came from PbR payments (Gaynor et al. 2011: 11). In one sense, however, implementation has stalled. The original intention was that at some point, almost all healthcare spending, not just hospital spending, would be channelled through the PbR system. This has not materialised. In 2010, PbR spending still only accounted for about a quarter of total health spending (Farrar et al. 2011: 68).

The third major ingredient in this reform package was the creation of 'Foundation Trust' (FT) status hospitals, which are largely self-governing entities. Hospitals could apply for FT status when they met specified standards of clinical and financial performance ('earned autonomy'). The first conversions to FT status occurred in 2004 and, by 2010, 131 NHS hospitals had become FTs (Allen and Jones 2011: 25). But, again, the process stalled. The original intention was that virtually all hospitals would eventually acquire FT status, which has not been achieved.

Despite the fact that Labour's health policy developed in a very haphazard way, this package of market-oriented reforms shows a

remarkable degree of internal consistency. The combination of patient choice and PbR created a system in which ‘the money followed the patient’: patients could now choose providers, and the choices they made had a real financial impact on those providers. For the first time since 1948, the revenue of healthcare providers would, to a considerable extent, depend on the free choices of patients, giving providers a good reason to be responsive to those patients’ needs. It is only in this context that the introduction of FT status also became sensible. Now that providers were more directly accountable to their patients (and potential patients), government interference with their day-to-day operations became less necessary. The discipline of the quasi-market could replace government-imposed discipline. Competition made greater autonomy possible, and indeed, necessary. If providers were to cope with competitive pressures, they also had to be given the leeway to respond to those pressures. They had to be given the managerial autonomy to reshape their organisations accordingly.

Does competition work?

The empirical literature

A number of studies have investigated the impact of choice-driven competition on the quality and efficiency of hospital care. There is no control group as such, as the reforms progressed at a uniform speed England-wide. But the intensity of competition differed across the country, which makes it possible to do well-controlled statistical studies. For example, Bloom et al. (2010) study the relationship between the intensity of competition and the quality of hospital care, approximated by mortality rates from Acute Myocardial Infarction (AMI) and emergency surgery. They find: 'hospitals facing more competition have significantly fewer deaths following emergency AMI admissions. [...] [T]here appears to be a causal effect whereby adding one extra hospital reduces death rates by 1.83 percentage points' (p. 14). They also find that competition lowers the death rate from emergency surgery. The work of Gaynor et al. (2011) confirms these findings. They find:

'higher market concentration (a larger HHI⁵) leads to lower quality. A 10% increase in the HHI leads to an increase of 2.91% in the AMI death rate. [...] The estimate [for the all-cause mortality rate] again shows a significant relationship between quality and market concentration. The magnitude is smaller than that for AMI but precisely estimated.' (p. 20)

5 HHI = Herfindahl-Hirschman Index, a measure of market concentration, with lower values indicating more intense competition.

The authors demonstrate that this divergence is not a continuation of a previously existing trend, but a new trend that started when competition became effective. And while the percentage point differences in death rates are modest, for a relatively frequent condition such as AMI, they still translate into noticeable numbers of lives saved. As they comment: 'This amounts to [...] a little over 8 fewer AMI deaths annually per hospital, or approximately 1,000 fewer total deaths per year over all 135 hospitals in our sample' (p. 21).

In a similar model which also uses the difference-in-differences in AMI death rate as a proxy for hospital quality, Cooper et al. (2011) find:

'30-day AMI mortality fell 0.31 percentage points faster per year after the reforms for patients treated in more competitive markets [...] Framed differently, the shift from a market with two equally sized providers to one with four equally sized providers after the reforms would have resulted in a 0.39 percentage point faster reduction in AMI mortality per year from 2006 onwards.' (p. 244)

They, too, rule out the possibility that this was merely a continuation of a pre-existing trend, or an artefact of how 'competitiveness' was measured:

'An essential observation [...] is that the pre-policy trend in AMI mortality in areas with uncompetitive market structures is not statistically different from the trend in markets with competitive structures [...] Our findings remain consistent and significant across the seven different measures of market structure.' (p. 244-245)

Models of this type have also been used to study the relationship between competition and hospital efficiency. Gaynor et al. (2011) used average length of stay (ALOS) as a proxy for efficiency, alongside information on hospital expenditure per activity. They find that hospitals in more competitive markets have recorded greater productivity improvements:

'The estimated coefficient implies that a 10% fall in a hospital's HHI on average results in a 2.3% fall in length-of-stay. [...] Taken together, the findings for quality [...] and resource utilization [...] suggest that hospitals facing more competitive pressure were able to find ways

to marshal resources more efficiently to produce better patient outcomes.’ (ibid., p. 22)

Cooper et al. (2012) use a similar model to test the same relationship, with the addition that they also test whether ALOS reductions represent genuine efficiency improvements, or whether they are simply a result of patients being discharged sooner than is clinically appropriate. They do this by splitting ALOS into a pre-surgery and a post-surgery component, arguing that the former, the time from a patient’s arrival at the hospital to the commencement of the actual procedure, can only be shortened through genuine improvements in the hospital’s internal workflow. They find that competition leads to efficiency improvements:

‘a one standard deviation decrease in market concentration pre-reform was associated with a reduction in overall LOS of between 2% and 6% relative to the mean LOS over that period. [...] Framed differently, the addition of one hospital to a hospital market lowered the LOS for patients treated in that area by approximately 0.4 days.’ (p. 18)

However, the authors’ also find that the inclusion of private hospitals has a negative effect on nearby public hospitals. Their explanation is that the former probably attract patients who are generally healthier, and that the PbR formula, which is meant to compensate for such differences through case-severity adjustments, is not yet fine-grained enough to create a truly level-playing field.

On the whole, there is good evidence that the market reforms of the 2000s have increased quality and efficiency in the NHS. Some studies have also taken a closer look at the transmission mechanisms from the reforms to the results, to find out not just *whether* competition and choice have led to improvements, but also *how* they have done so.

One part of the answer is that patients, once they were able exercise choice in a meaningful way, became more discriminating and quality-conscious. Gaynor et al. (2011) explain:

'If patients became more responsive to quality post-policy we should see better hospitals (those in the bottom quartile of the mortality distribution) attracting more patients relative to worse hospitals (those in the top quartile). That is exactly what the data show [...] [T]he share of patients bypassing their nearest hospital increased for better hospitals while it clearly decreased for worse hospitals. This provides reassurance that there is a patient response to quality and that it increased during the reform.' (p. 19)

A paper by Gaynor et al. (2012) examines patient behaviour in greater detail. They estimate the elasticity of demand with regard to quality, with quality being approximated by mortality rates, for patients undergoing coronary artery bypass graft surgery. In other words, they estimate to what extent hospitals that record low (high) mortality rates experience an increase (decrease) in demand in subsequent years. The authors find that, before the introduction of choice, when patient demand was mediated through GPs' decisions, the elasticity of demand was indistinguishable from zero. After the introduction of patient choice, it fell to -0.12: patients did discriminate against underperforming hospitals. The authors also estimate how far a hospital's mortality rate affects its market share in subsequent years. Again, in the pre-reform period, there was little connection between these two variables. An increase in the mortality rate by one standard deviation only reduced a hospital's market share by 0.36 per cent. After the reform, the same increase in mortality was punished with a 4.9 per cent loss in market share (ibid: 24).

This evidence contradicts the widespread notion that healthcare was not amenable to choice because of its complexity. The data suggest that people generally make quite reasonable choices. For example, sicker patients are more responsive to quality differences than healthier ones, as one would expect given that more is at stake for them. Income, on the other hand, is a poor predictor of responsiveness: low-earners are not less responsive to quality differences than people elsewhere in the income distribution. Fears that the well-educated middle classes would choose the best hospitals and leave the less well-off behind did not materialise.

Bloom et al (2010) took a closer look at what happens inside hospitals, applying an 'index of management quality'. This is arguably

a misnomer: their index does not measure management *quality*, which is an outcome; it measures the extent to which an organisation's senior staff *attempt* to manage the organisation sensibly. It measures the extent to which formalised procedures of quality control, monitoring, reporting, accountability etc. are in place. That said, the authors show that, in other sectors, their index correlates with desirable outcome measures, so it does seem to have some predictive power. This is true in healthcare as well. The authors show that hospitals that are 'better managed' according to their indicator also record lower mortality rates, shorter waiting lists, lower MRSA infection rates, higher operating margins, and higher levels of job satisfaction among employees (ibid: 11-12, 23). Crucially, they find that management quality is systematically higher in hospitals that face greater exposure to competition. Government targets may, to some extent, have incentivised hospitals to 'cut corners' and game the system, but competition has incentivised them to improve internal procedures, thus driving genuine improvements in quality and efficiency.

England versus Wales and Scotland

It is also helpful to compare the evolution of the English NHS to that of its counterparts in Scotland, Wales and Northern Ireland. The devolved regions are not ideal control groups, because they differ from England on many dimensions other than healthcare. But they have experienced the same or larger increases in funding; and they have, after some delay, introduced similar performance targets. What distinguishes them most clearly from England is that they have not introduced the market-oriented reforms discussed above, or at least not the full package. Scotland, in particular, is probably closest to the 'old English NHS'.

The results between the nations diverge sharply. The devolved regions, especially Scotland, record higher levels of healthcare spending per capita. Relative to population size, they employ larger numbers of hospital, dental, nursing, midwifery, health visiting, hospital management and support staff. They record higher numbers of hospital beds and inpatient admissions. And yet they record

longer waiting times for inpatient and outpatient appointments, and longer ambulance response times. They fare worse on outcome measures across the board, and differences in efficiency have to explain a large share of that. In England, many more hospital patients are treated as day cases, and activity levels are far higher when expressed in per member of staff terms (Connolly et al. 2010). England's better health outcomes may have many other determinants that lie outside the health system's reach but, when it comes to efficiency, there is no other plausible candidate in sight: the reforms of the 2000s have greatly improved the English NHS, and they have left a solid legacy that can be built on.

Scottish independence might have had many merits. However, the desire of the 'yes' campaign to protect Scotland from the greater efficiency of the English health system⁶ was a strange line of argument.

6 See: <http://www.yesscotland.net/answers/what-about-nhs-independent-scotland>

How the market reforms of the 2000s can be built on

The reforms of the 2000s have moved the British health system into the same league as the health systems of other industrialised countries. The next step has to be to give it some prominence within that league. This will have to happen against a background of demographic pressures. It has been projected that, by the early 2020s, a funding gap of between £44bn and £45bn will have opened (Roberts et al. 2012: 24). In the absence of productivity increases, this is the amount of extra funding the NHS would require only to maintain current standards, never mind improvements. Productivity increases are possible. The market reforms certainly raised productivity, but there were also unprecedented increases in spending and much of this additional money was spent on a still largely unreformed service. NHS providers suddenly found themselves awash with extra funding for new staff, equipment and premises, much of which was spent in a haste (Crisp 2011: 139-141). As a result, productivity fell.

Overall, the reforms of the 2000s have left a legacy from which we can learn and on which we can build. They have brought major improvements, but the reforms are best thought of as 'unfinished business'. The unfinished bits can be roughly split into three categories (although in practice, these categories are not totally distinct):

- Some objectives have not been achieved because the implementation of sensible reforms has stalled at some point. This is relatively easy to remedy.

- Some objectives have not been achieved even though there was no lack of ambition. Rather, the reforms themselves have been incomplete or inadequate to reach a given objective, even if they had been implemented perfectly.
- Some objectives have not been achieved, simply because appropriate reforms have never been tried.

Stalled implementation

The Payment by Results (PbR) scheme was not meant to be just an addition to the old block contract system, and Foundation Trust (FT) status was not meant to create just another type of hospital. Rather, the idea was that, at some point, all or almost all hospitals would be FTs, and almost all healthcare spending would be channelled through the PbR system. This has not materialised, but neither are there any obvious fundamental obstacles to implementation. It appears that these reforms have simply slipped off the radar, and could be resumed again.

The incomplete implementation of patient choice could also be included in this category. Patient choice does not have to mean that any patient can choose any provider in the country at any time. There can be good reasons for setting up networks of providers, with internally established patterns of referral and information sharing, such as an integrated care pathway system. Patients would then choose between networks of providers rather than individual providers. Most markets work in this way. We choose between supermarkets, but once inside, our choice is limited by the pre-selection that that supermarket has made. Supermarket A does not offer all the products that are available in supermarket B, but this does not mean that supermarket A is somehow 'undermining' its customers' freedom of choice. Pre-selections can be well justified. But they should be made explicit. Patients should know when they opt into a provider network which places limitations on choice.

But GPs setting up an integrated care pathway system is very different from GPs arbitrarily limiting their patients' choices. To

remain within the supermarket analogy: it is perfectly fine for supermarkets to pre-select products for their customers, but once a supermarket has made its selection, it would not permit individual staff members to arbitrarily narrow it down further. Staff members would not be permitted to hide products which they thought customers should not choose. Unless alternative arrangements are made and announced, the default position should be unlimited provider choice. Clinical Commissioning Groups (CCGs) should enforce this policy, including with financial penalties for GPs who refuse to adhere to it.

Finally, to address the concerns raised by Cooper et al. (2012), it should also be double-checked whether the PbR formula's severity adjustments are sufficient to reflect cost differences attributable to differences in patients' health status. The PbR formula should be calibrated in such a way that a provider cannot gain any financial advantages from 'cherry-picking' the easier cases.

Incomplete reforms

The Labour government also harboured ambitions to move to a more pluralistic health system, in which public, private for-profit and private non-profit providers competed on a level-playing field. This has not been achieved, and this is not simply a matter of going further in implementing existing reforms.

There has been some progress. In 2011, non-NHS providers accounted for 9.2 per cent of PCT's total secondary care budget (based on data from Arora et al. 2013: 12-15). Spending on private sector providers, in particular, has gone up more than two-and-a-half-fold in real terms since the introduction of patient choice. But this still comes nowhere near the level of provider plurality observed in Continental European social insurance systems. In Germany, the voluntary not-for-profit sector accounts for more than a third of all hospital beds, and the private for-profit sector for almost a fifth (Statistisches Bundesamt 2013). The private sector also accounts for 38 per cent of all hospital beds in France and 30 per cent in Austria (WHO Europe 2014).

Private providers are not per se better than public providers. But, as shown above, competitive markets are clearly preferable to uncompetitive ones, and it is difficult to see how competition could be intensified further without the entry of private providers. The main impediment to competition is that the current hospital 'market' is still an 'internal market': a market with almost no entry or exit. This is reflected in the methodology of the above-reviewed studies on the impact of competition. All these studies use measures of industry concentration as proxies for the intensity of competition, which is perfectly appropriate for a static market such as the English hospital market, where a fixed set of competitors shift market shares between them. But it would be much less appropriate for a more dynamic market with entry and exits. Rogge (1979: 19-24) illustrates the distinction, using the example of the US market for diuretic drugs in the 1950s, when the market was always dominated by a small number of big players. Throughout the decade, the four largest companies held a combined market share of more than 80 per cent. When using a measure of industry concentration as a proxy for competition, this market would have seemed uncompetitive. And yet, in reality, it was a fiercely competitive market, because no company remained among the 'big four' companies for long. It was a dynamic market in which big players came and went. None of the four companies that had dominated the market in 1951 continued to be among the big players by 1959.

Healthcare markets should evolve in this direction. The way to further intensify competition is not to split existing providers, or even to prevent mergers, which would interfere with the aim of exploiting economies of scale. The way to intensify competition is to allow exits, entries, takeovers and reconfigurations.

Lack of trying

Hospital efficiency has improved but, arguably, there is still an over-reliance on the hospital sector which is, in itself, a major source of inefficiency. This cannot be improved by narrowly focusing on efficiency within the hospital sector. Instead, we need to ensure that mechanisms exist to take activities out of that sector altogether

if it is more efficient to do so. This links to the more general issue of subsidiarity in healthcare. During the early 2000s, there have been attempts to create lower tiers of healthcare provision (Crisp 2011: 66-67), where the less complicated cases could be dealt with through low-cost interventions. This kind of 'downward-shifting' can result in large efficiency improvements if it means that routine cases are dealt with at lower cost, and the expensive upper tiers are reserved for the most complicated cases. The setting up of NHS Direct, NHS Direct Online, Walk-In Centres, Treatment Centres and Independent Sector Treatment Centres can be seen in this light.

Two reasons why these attempts did not go further in creating a more cost-effective health service can be identified. The first is that the commissioning side has been characterised as relatively weak in the face of strong providers. Studies find that while there were local examples of PCTs changing healthcare delivery patterns and pathways in their areas, effective commissioning has not become the national norm (Smith and Curry 2011; Ham et al. 2011). Secondly, PCTs were unable to use financial incentives to redirect patients to those low-cost tiers.

The replacement of PCTs by Clinical Commissioning Groups (CCGs) has not changed the basic problem: CCGs are local monopolies, as were PCTs before them. PCTs were meant to stimulate competition between secondary and tertiary care providers, and to some extent, they have. But PCTs were never subject to any competitive pressures themselves, and neither are CCGs. Nor has the primary care sector been opened up to competition. Patients can choose between hospitals, but not between commissioners, and their range of choice in primary care remains tightly confined by 'catchment area' boundaries.

Policymakers have gone to great lengths to promote patient choice and competition in the sphere of provision, but there has never been the slightest attempt to allow competition on the commissioning side. The idea that patients should be allocated to hospitals purely on the basis of geography has been abandoned as anachronistic, but patients are still allocated to commissioners, and GPs, on

precisely that basis. Patients can access a broad range of information about the performance of providers, but not about the performance of commissioners. The entry of Independent Sector Treatment Centres has been actively promoted, but the existence of 'independent sector commissioners' has not even been considered.

Quite rightfully, Higgins (2007) has called it '[o]ne of the most puzzling aspects' of the current system 'that commissioners must be defined by geography and by resident population.' By extension, the same can be said about CCGs. As Higgins explains, '[c]ommissioners in other countries can be organised around communities of interest (such as employment based health plans) [...] There is no reason, in principle, why a commissioner based in Hastings could not purchase services in Halifax for a subscriber who lived there' (p. 23).

Breaking the link between geography and commissioning is not just feasible, but highly desirable: 'Experience from other countries suggests that developing competition between commissioners can really empower patients as well as create incentives to improve needs analysis, responsiveness to patients, cost effectiveness, better information, and choice' (ibid: 22).

Moreover, the fact that CCGs are local monopolies has necessitated regulation aimed at preventing them from abusing that monopoly position, but those regulations come with their own costs and side-effects. CCGs have been obliged to 'divest' their shares in local providers (other than Walk-In Centres), to prevent conflicts of interest in commissioning. However, a full or partial integration of commissioners and providers can sometimes make economic sense. For example, if transaction costs for some types of commissioning are high, allowing commissioners of care to provide care is sensible. Indeed, the existence of highly integrated 'managed care' organisations in many parts of the world suggests that this model has a *raison d'être*. The purchaser-provider split of the early 1990s was a good and necessary step at the time because it paved the ground for at least some degree of competition. But it highlights, once again, the difference between a managerialist concept of competition, in which the government determines an industry

structure and allows competition along predefined lines, and a Hayekian concept of competition, in which the industry structure is itself determined by competitive forces.

Finally, as already noted, there have been attempts to organise healthcare in a more subsidiary manner, by creating lower-cost tiers (Walk-In Centres, NHS Direct etc.). But this has been limited to supply-side changes. There have never been any attempts to match these attempts with corresponding demand-side incentives to use cheaper alternatives. Patients can use the low-cost tiers, but they have no economic reason for doing so as the cost savings of shifting to more economic modes of healthcare consumption do not accrue in any way to the patient. Cost-sharing arrangements could lead to greater incentives to use low-cost health interventions where they are beneficial, but they have never been tried in the NHS. In this respect, the UK is an international outlier. Almost all developed countries operate some form of cost-sharing (Cawston and Corrie 2013: 17-22). Since such schemes are always coupled with exemptions for the poor and the long-term sick, they are easily reconcilable with the principle of universal access to healthcare. They should be introduced in the UK as well.

Where next? The need for competition amongst providers and commissioners

Competition on the provider side

The rolling-out of PbR should be completed so that NHS providers receive virtually all their revenue from PbR payments. The conversion of all hospitals into FTs should be completed as well. This should then be coupled with a strict no-bailout clause. If a hospital, a treatment centre, a diagnostic centre or any other healthcare provider cannot survive economically on the basis of activity-based payments, they should not survive.

Bankruptcies should become a normal occurrence in the healthcare sector. This does not mean, of course, that organisations would physically close down. Rather, it would mean that they would find themselves 'under new management'. Mergers and takeovers would become the norm. The provider landscape would become more dynamic, witnessing entries and exits like other markets. This would mean that a private provider could take over a failing NHS facility. For that matter, a failing private provider could be taken over by a thriving NHS Foundation Trust. NHS trusts would become more like universities – independent institutions that received funding from the state in return for services provided.

Private takeovers of NHS facilities will often be met with protests from local 'keep our NHS public' campaigns. As political campaigns,

such initiatives would become ineffective in the proposed system, as takeovers would no longer be under the government's control. But this does not mean that local protest groups could not have a say in other ways. They could raise their own funds for keeping an ailing hospital afloat or, of course, take it over themselves, thus turning it into a consumer co-operative. In the same way, ailing NHS hospitals could be taken over by their own staff who could then run it as a conventional co-operative.

Competition on the commissioner side and in primary care

The link between geography and commissioning should be broken, and so should the link between geography and primary care. The very concept of 'catchment areas' should be abolished altogether. People should be free to register with any CCG they like, wherever it is based. There would still be a home bias, as it is quite unlikely that commissioners based in Hastings would suddenly become active in shaping healthcare delivery in Halifax. But even in the short term, there could be at least regional competition between commissioners with overlapping radiuses.

On its own, free choice could lead to imbalances in risk structure of the patients for which commissioners are responsible. Some commissioners may be more attractive to relatively healthy people and others to people in poorer health. For example, commissioners based close to commuter stations might be more attractive to people in good health who are relatively young. Social insurance systems normally combine freedom of choice with some kind of redistribution mechanism using compensation funds. These are funds that redistribute premium revenue between insurers on the basis of the risk profile of their policyholders. Organisations that insure a high proportion of people in poor health will be net recipients and organisations that insure a high proportion of people in good health will be net contributors to the fund. Essentially, the fund simulates a situation in which all insurers covered populations with identical risk profiles. The fund makes insurers indifferent to a (potential) client's health status. Insuring a sick person costs more, but enrolling them also entitles the insurer to additional revenue from the fund.

Insuring a healthy person costs less, but enrolling them also obliges the insurer to increase their payments into the fund. Ex ante, both clients are equally profitable to the insurer. In other words, the fund redistributes risk surcharges (and risk discounts) that would otherwise be added to (or subtracted from) individual premiums.

CCGs are not, strictly speaking, insurers. However, there is no reason why such a system should not work within the NHS as well. Risk-structure compensation is a complicated business but, given that social insurance systems already have elaborate systems to perform this task, there is no need to reinvent the wheel. The NHS could simply import the risk-structure compensation template from, for example, Switzerland or Germany, and insert British figures (for treatment costs etc.) in a somewhat different institutional environment.

Once this system is in place, entry into the commissioning sector could be completely liberalised. People could be given the freedom to opt out of NHS commissioning, or even NHS provision, altogether, and opt into any alternative arrangement of their choice. The alternative arrangement could be a conventional private insurance policy, and integrated insurer-provider such as BUPA, or it could be one of a number of alternative arrangements that might come into existence. Patient associations organised around specific long-term conditions, for example, could become commissioners in their own right, with a special focus on the conditions that matter most to their members. Opt-outs would offer a range of other benefits as well (see Booth 2002, for an earlier proposal of opt outs in return for tax rebates). It would then also become possible to experiment with a wide variety of incentive schemes to encourage personal responsibility and cost-effectiveness in healthcare consumption (see Spiers 2003; 2008).

Opt-outs would also give a great boost to a process which, at the margins of healthcare, is already underway. There are already examples of alternative healthcare arrangements built around immigrant communities. As *The Economist* reports:

'The My Medyk clinic opened in 2008 and now has 30,000 patients on its rolls. The firm has opened a second branch in London and

wants to open a third. Rivals are multiplying. [...] They have pulled off the remarkable feat of selling medical care to working- and middle-class people who could get it for nothing. [...] Though set up to meet demand from Britain's growing Polish population, the clinics are trying to broaden their appeal. Manchester's Green Surgery has Slovaks, Hungarians and, oddly, Portuguese on its books.⁷

Portable rebates would allow these non-NHS alternatives to thrive, and lead to the creation of thousands like them. What is currently a local curiosity would become a nationwide normality.

Still, opting out of aspects of NHS commissioning and/or NHS care does not mean opting out of collective healthcare financing. Those opting out would receive a tax rebate, but the rebate would only be equivalent to what it would otherwise have cost to treat them on the NHS. To the extent that these people no longer use NHS services, they would be refunded with the corresponding cost savings, but nothing more. Thus, net contributors would still remain net contributors. This NHS opt-out clause would be similar to the 'contracting out' option that existed in the UK's post-war pension system, and that, for decades, enabled private and state old-age provision to grow side by side (see Booth and Niemi 2014). Contracting out of the NHS is more complex than contracting out of the state pension, because there are more variables to consider than just income and contribution record. But if the logic of the contracting-out system could be extended to healthcare, access to care would still be determined by health need, not ability to pay. The contracting-out option would not affect the extent of redistribution from the healthy to the sick, or from the well-off to the poor. This is illustrated below with a stylised example, which deliberately uses the most extreme assumptions that are least favourable to the proposal.

The table shows a hypothetical society in which income is perfectly correlated with health status. There are two equally sized population subgroups: the 'rich and healthy' and the 'poor and sick'. There is

⁷ 'Another kind of health tourism. Health clinics for immigrant Poles reveal the NHS's shortcomings', *The Economist*, 8 June 2013.

a national health service funded through progressive taxation. Given the assumed correlation between income and health status, the population's contribution profile is the exact mirror image of its consumption profile. The rich and healthy contribute most (80 thalers), but use the system least (20 thalers), while the reverse is true for the poor and sick. Thus, the former group heavily subsidises the latter, with a net redistribution of 60 thalers.

Table 4a: Medical consumption and contribution in a hypothetical stylised health system

| | Contribution | Consumption | Net contribution |
|----------------|--------------|-------------|------------------|
| rich & healthy | 80 | 20 | +60 |
| poor & sick | 20 | 80 | -60 |
| SUM | 100 | 100 | 0 |

Now, this society introduces the right to opt out of the health services and receive tax rebates equivalent to medical consumption, in the way described above. The rich and healthy instantaneously opt out en bloc, leaving the public system to deal with the poor and sick. But since the rebates received by the rich and healthy only reflect the value of their medical consumption, net redistribution is unaffected.

Table 4b: Medical consumption and contribution in a hypothetical stylised health system with opt-out

| | Public system | | Private system | | Net contribution |
|----------------|---------------|-------------|----------------|-------------|------------------|
| | Contribution | Consumption | Contribution | Consumption | |
| rich & healthy | 60 | 0 | 20 | 20 | +60 |
| poor & sick | 20 | 80 | 0 | 0 | -60 |
| SUM | 80 | 80 | 20 | 20 | 0 |

Table 5 gives a ballpark indication of the rebates that could be expected for different household types. These figures only reflect demographic risk factors. Individual risk factors would be accounted for through the above-described risk-structure equalisation fund.

Table 5: Indicative annual tax rebates for those opting out of NHS care

| Household type | Rebate |
|--|--------|
| Single adult under 45 | £700 |
| Single parent under 45 with one infant | £1,400 |
| Couple with one child, both parents under 45 | £1,750 |
| Couple with two children, both parents over 45 | £2,450 |
| Single pensioner aged over 85 | £3,750 |
| Pensioner couple, one over 75 | £4,300 |

Based on data from Caley and Sidhu (2010), updated in line with data from ONS (2014)

Conclusion: From 'managerialist competition' to 'Hayekian competition'

Taken together, these proposals would complete the 'internal market' started in the early 1990s, and revived in the 2000s. They would also complement it with an overlapping 'external market', and create a level-playing field between private and public providers, as well as private and public commissioners.

Although a big step in the right direction, the main shortcoming of the current arrangement is that it was built on a very narrow understanding of the economic case for competition. Both in the Conservatives' 'internal market' and in Labour's 'quasi-market', competition was only meant to act as a spur. The hope was that, when faced with some competitive pressure, providers would 'work harder', i.e. put more effort into what they already did.

That is, of course, one possible effect of competition. But competition has a far more important function than that: competition is a discovery process. Competition puts different organisational models and work practices to the test, and enables us to discover what works best in which circumstances. The main benefit of competition is *not* that it makes us 'work harder'. The main benefit of competition is that it creates knowledge about what is most effective and meets the needs and wishes of patients.

It is through competition that we discover which tasks are best split (so that each economic actor can specialise in a small number of them) and which tasks are best bundled (so that economic actors can exploit complementarities between them). It is through competition that we discover which tasks are best handled by smaller, more flexible organisations, and which tasks are better handled by large organisations that are able to exploit economies of scale. Through competition, we discover where co-operation should take the form of a loose network of independent actors, and where it should take the form of more rigid contractual relationships. Through competition, suppliers find out in what areas consumers want a broad range of choice at the point of buying (such as in a supermarket), and where they prefer a specialist purchaser to make a pre-selection for them (such as in a speciality store). Competition is the ultimate field test for different ideas about 'what works', and the fastest way to weed out bad practice.

It is a popular claim that healthcare cannot be left to market forces because it is 'too complex'. The exact opposite is true. If healthcare were a simple matter, the question of whether it should be provided by a public sector monopoly or a competitive process would be far less important. It is not despite, but precisely *because* of the fact that healthcare is so complex, and our knowledge of it so limited, that we stand to benefit hugely from deploying the knowledge-creation machine that is competition.

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