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DIAGNOSIS: OVERRATED

An analysis of the structural flaws in the NHS

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This five year project will provide a fundamental reassessment of what government should – and should not – do. It will put every area of government activity under the microscope and analyse the failure of current policies.

The project will put forward clear and considered solutions to the UK's problems. It will also identify the areas of government activity that can be put back in the hands of individuals, families, civil society, local government, charities and markets.

The Paragon Initiative will create a blueprint for a better, freer Britain - and provide a clear vision of a new relationship between the state and society.

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Summary

- The NHS is part of the UK's national story – a founding myth of post-war Britain. But like most founding myths, the popular NHS story is only very loosely based on actual events. The belief that the foundation of the NHS was a manifestation of 'people power' is completely untrue. Contemporary sources from the 1930s and 1940s show no evidence of popular demand for a government takeover of healthcare.
- The NHS's status as a sacrosanct institution promotes 'groupthink' and undermines the ability to detect and correct instances of failure, and to adapt to changing circumstances. This was most immediately evident after the Mid-Staffs scandal.
- Despite some catching-up, the NHS still lags behind the health systems of most comparable countries in terms of health outcomes, healthcare quality measures, waiting times and efficiency indicators.
- A number of systems similar to the NHS suffer from the same shortcomings. The systems with the best outcomes tend to be pluralistic, competitive systems based on consumer sovereignty and freedom of choice.
- The NHS is a nationalised monopoly which, despite the 'quasi-market' reforms in the 2000s, offers relatively little in the way of genuine patient choice and competition.
- The idea that 'we', the public, run the NHS 'collectively' is a popular illusion. Democratic accountability in the system is so vague and roundabout that it is almost meaningless in practice. There is almost zero overlap between the health policies proposed in general election

campaigns and those enacted afterwards. The insistence that 'the people' are really in charge is empty rhetoric. The health service is run by the political class, senior bureaucrats and the medical establishment.

- Since healthcare in the UK is provided free at the point of use, there is little pressure for harnessing technological innovations for cost-cutting, which is why cost-inflating innovations dominate and one reason why the productivity and efficiency performance in healthcare is so poor generally.
- The fact that the NHS is a tax-funded system leads to a significant lack of transparency, since it is almost impossible for a taxpayer to work out how much they actually pay for healthcare. It also means funding decisions tend to be more politicised than in other systems. Raising funds through taxation also brings significant deadweight costs.
- The NHS is in an almost constant state of reorganisation, and these – often rather pointless – reorganisations seem to be primarily motivated by a political desire to 'leave a mark'.
- Since the NHS is financed on a pure pay-as-you-go basis, all current expenditure is paid out of current revenue, without any old-age reserves. Against the backdrop of an ageing population, this is a very unstable financing method, which is highly vulnerable to demographic changes.
- A national, centralised health system is also less likely to be able to deal with the transition in how care is delivered given an ageing population. Too often in the NHS, patients, especially the elderly, are treated as homogenous units going through the system, rather than individual patients with their own wants and needs. This prevents innovation in care and healthcare structures, and the use of new technologies.

Introduction: a British founding myth

Every 14 July, celebrations are held across France to commemorate the storming of the Bastille, which marked the beginning of the French Revolution. 'Bastille Day' is not just a bank holiday. It is part of France's national story, and it is the founding myth of French Republicanism. It is a story of ordinary people rising up and overthrowing an oppressive elite.

It is not, however, a true story. The history that is 'remembered' on Bastille Day is only very loosely based on actual events.

The historical storming of the Bastille was a somewhat pointless exercise. The French state had already decommissioned the building anyway, and was in the process of winding it down. So only seven captives were liberated by the rebels, none of whom was a political prisoner.

More importantly, far from ushering an age of liberty, equality and fraternity, the French Revolution produced a state of lawlessness and mob rule, which was then followed by the Jacobins' Reign of Terror. Indirectly, it led to the autocratic rule of Napoleon, to years of Europe-wide war and bloodshed, and ultimately to a restoration of the monarchy. Elsewhere in Europe, by providing such a terrible example, the French revolution may well have done more harm than good to the republican cause.

And yet, if a historian presented such arguments on Bastille Day, they would be rightfully dismissed as a pedant, a bore and a killjoy. Bastille Day is a founding myth, and judging a founding myth by how historically accurate it is would completely miss the point. The purpose of a founding myth is *not* to remember or understand what happened in the past, but to foster a 'team spirit' here and now. Political movements usually have

founding myths; nations, regions and cities sometimes do, and even a football club, a university or a school can have one. A founding myth generates 'social capital'; it strengthens social bonds through shared stories and shared reference points. It is largely irrelevant whether it is a *true* story, as long it is a *shared* story; a story that serves a team building function (see Haidt 2012: 189-199; 221-269).

In the UK, the National Health Service serves such a function. It is part of the national story and the main component of post-war Britain's founding myth. It is a story of how people who had been through the horrors of war together discovered a new spirit of social solidarity, and of how that spirit found its finest expression in the formation of the health service.

Despite all the privations and suffering that people were enduring, so the story goes, they made a conscious decision to pool their resources, organise healthcare collectively, and provide it to everybody on the basis of need, not profitability or ability to pay. When the actor Roger Lloyd-Pack said 'The NHS is like God to me, it's the thing we should be most proud of in this country'¹, he was not trying to be melodramatic. He was expressing a founding story sentiment. So was RAF veteran Harry Leslie Smith, who, in 2014, became a minor political celebrity by recounting his version of the NHS founding story at a party conference:

[The time before the NHS] was an uncivilised time because public healthcare didn't exist. Back then, hospitals, doctors and medicine were for the privileged few. Because they were run by profit rather than for vital state service that keeps a nation, its citizens and workers, fit and healthy. [...] Sadly, rampant poverty, and no healthcare, were the norm for the Britain of my youth. That injustice galvanised my generation, to become, after the Second World War, the tide that raised all boats. [...] Election Day 1945 was one of the proudest days of my life. I felt that I was finally getting a chance to grab destiny by the shirt collar. And that is why I voted [...] for the creation of the NHS'.²

1 'TV star: Do we want to pay first like in America?' *Evening Standard*, 28 May 2011

2 Speech by Harry Leslie Smith at the Labour Party Conference, 24 September 2014. Available at <https://www.youtube.com/watch?v=E0FIFsgxJV4> See also: 'Hunger, filth, fear and death: remembering life before the NHS'. *New Statesman*, 31 October 2014.

Columnist Owen Jones tells the same story, but wraps it into a broader ordinary-people-vs-elites narrative:

‘The welfare state, the NHS, workers’ rights: these were the culmination of generations of struggle, not least by a labour movement that had set up the Labour party – controversially at the time – to give working people a voice.’³

It is a powerful story that arouses strong feelings. But just like the popular version of Bastille Day, it is also almost completely untrue. The creation of the NHS had nothing to do with pressure ‘from below’; it was not a change that ‘ordinary people’ had fought for. Far from being ‘People Power’ in action, the NHS was a brainchild of social elites, to which the general public passively acquiesced. The idea that the organised working classes were demanding a government takeover of healthcare is a post-hoc rationalisation: it simply projects the fondness for the NHS which the public *subsequently* developed back into the period of its creation. The general public is *currently* strongly attached to the NHS, ergo, the argument goes, they must *always* have been attached to the idea; indeed, they must have been the catalysts of its very creation.

Except, they were not. Hayes (2012) reviews contemporary survey evidence from around the time of the NHS’s inception. He finds that while the idea of government *paying* for a greater share of healthcare was indeed popular, and while people felt that various aspects of the inter-war system needed reform, there is no indication of widespread popular demand for a government takeover of healthcare provision. If anything, there is much evidence to the contrary. As one contemporary source put it:

‘[T]he evidence before us seems to indicate a fairly large amount of resistance to State interference in the field of medicine ... roughly half the population was opposed to any major change on the health front, a quarter disinterested and a quarter in favour of State intervention’ (ibid: 659)

Hayes concludes: ‘[I]t is clear that little evidence exists to support those seeking to claim an inclusive popular mandate for radical reform as a justification for implementing contentious policy’ (ibid).

3 ‘Sorry, David Cameron, but your British history is not mine’. *The Guardian*, 15 June 2014.

In a comparative historical analysis, Hacker (1998) examines the political factors behind the emergence of publicly funded healthcare systems, or healthcare programmes, in the UK, Canada and the US. He also finds that:

[F]ew of the scholars who have addressed this period have attempted to show that the passage of compulsory health insurance in other countries was a response to widespread popular pressure. In fact, this would be difficult to do, since the overwhelming evidence is that these early programs were promulgated by government elites well in advance of public demands' (ibid: 63).

It is equally a myth that the NHS opened up the benefits of modern medicine to everybody, while under the preceding system only the rich had access to healthcare. Of course there were substantial improvements in health after the creation of the NHS – but there were also substantial improvements in health before the creation of the NHS and substantial improvements in health in other countries without an NHS. In long-term time series of population health data, the impact of the introduction of the NHS is not discernible. Pre-NHS trends and patterns, positive and negative ones, mostly continued. Median life expectancy, for example, had already been increasing steadily since the 1860s, from around 45 years back then to over 70 years at around the time the NHS was founded (ONS 2012a).⁴ From then on, the rate of increase actually slowed down – not because the NHS was generally worse than the system that preceded it, but because it was introduced at a time when the major advances against infectious diseases had already been made (ONS 2012b: 2).

Nor has the creation of the NHS changed trends in aggregate health outcomes among the poorest. Gregory (2009) analyses the link between poverty and health outcomes in both the early 1900s and early 2000s. He finds that while there have been huge improvements in health across the board, there has been no narrowing of the 'health gap':

'The 20th century has seen a dramatic decline in mortality, but, despite this, the link between mortality and deprivation across England and Wales remains as strong today as it was a century ago. [...] [T]here is no evidence that [...] the relation between mortality and deprivation has lessened to any significant degree' (ibid: 6)

4 The trend for average life expectancy is about the same, but median life expectancy is arguably a more relevant measure. In earlier centuries, levels of infant mortality were so high that they completely dominate average life expectancy figures.

Webster (2002: 57) also finds:

‘The NHS [...] tended to mirror and perpetuate the accumulated idiosyncrasies and inequalities in health-care provision contained in the inherited system.’

Of course, the introduction of the NHS could still have improved people’s health, and poor people’s health in particular, in ways that are less measurable. Also, it almost certainly relieved a lot of people from the financial worries associated with health. On balance, the NHS may well have been an improvement over the system that preceded it. But it was not the watershed moment that turned an ‘uncivilised’ nation into a ‘civilised’ one.

Founding stories do not have to be true stories, as long as they are shared stories – so why would any of this matter? The reason is that the NHS is, in one important sense, very different from most other founding myths. The collective memory of the French Revolution has no obvious tangible impact on modern French politics, so there is no reason why people should *not* remember it in a romanticised way. They have nothing to gain, and a lot to lose, from adopting a more sober interpretation. The NHS, however, is not *just* a founding myth. It is also an actual health system that treats people, here and now. The founding myth can therefore directly affect policy and how we judge NHS failures.

This probably became clearest when the revelations about large numbers of avoidable deaths at Mid Staffordshire hospital emerged. If the NHS were merely a mechanism to deliver healthcare, whistleblowers and critics, even harsh critics, would find a sympathetic ear, since these are the people who can expose failures and overcome groupthink. But that was not the whistleblowers’ experience.

Following the death of her mother at Mid Staffordshire, Julie Bailey, a café owner from Stafford, set up a campaign group to investigate and publicise the failings of the hospital trust. This provoked a backlash from local residents: ‘People have been coming into the cafe shouting that nothing happened at Stafford, that I am lying and there were no unnecessary deaths [...] This is a classic case of shooting the messenger’.⁵ Although the official inquiry later vindicated her position, the hostility against Bailey

5 ‘Sickening: Death threats. Her mother’s grave desecrated. Her business destroyed. The whistleblower who exposed Mid-Staffs scandal is driven from her home’. *Daily Mail*, 26 June 2013.

did not abate. In the end, she left the town altogether: 'I am having to leave my home, my livelihood and my friends [...] The final straw for me was the desecration of my mum's grave.'⁶ Again, the residents' response would seem baffling if one viewed the NHS as merely a mechanism to deliver healthcare, but far less so if one views it as a founding myth.

Parts of the media also responded to 'Mid Staffs' not by inquiring about the causes and implications, but by redoubling their efforts to shield the NHS from criticism. Their main worry, it seemed, was not that Mid Staffs may be the extreme end of a spectrum, but that the events might play into the hands of the service's perceived 'enemies'. In the *Independent*, Yasmin Alibhai-Brown argued:

To speak of "normalisation of cruelty", in Mr Hunt's words [...] is plainly unfair though very helpful to Tory ideologues. They are hellbent on disabling the institution to justify and facilitate privatisation and profiteering [...]

A student, a relative, nearly died last year because of dreadful mistakes made by a reputable hospital. [...] She refused to [sue]: "They cocked up badly, shouldn't have. It's my NHS. Why should I take money from them? How many times have I had brill treatment?" Wise words from the mouth of a teen.'

In a *Guardian* article titled 'NHS enemies will declare the service broken. But it is not' and subtitled 'Mid Staffs will be used to justify further reforms – and of the very kind that contributed to that horror in the first place', Polly Toynbee argued:

'Surely, MPs said, running a ward is easy? [...] But it's not easy at all. [...] [It is] a remarkably tough managerial job to care for 36 patients with different conditions, on a rapid turnover. Simple things – from ordering pens, fixing a printer or mending a bash in the wall made by a clumsy porter – take many calls and much frustration.'⁷

6 *Health Service Journal: HSJ Live*, 24 June 2013.

7 'NHS enemies will declare the service broken. But it is not', subtitle: 'Mid Staffs will be used to justify further reforms – and of the very kind that contributed to that horror in the first place'. *The Guardian*, 7 February 2013.

These are fair points, but one suspects that the author would never have accepted this reasoning if similar events had occurred at a private facility, although staff at private facilities also have pens to order and printers to fix.

In another *Guardian* article, Jonathan Freedland pointed out that there were also recorded instances of patient neglect in Victorian workhouses, before the NHS,⁸ while Colin Leys pointed out that one can also find examples of failures at private hospitals.⁹

These attempts to relativise the events through 'whataboutery' missed the key point: the massive difference in the social dynamics surrounding NHS and private sector failure. Had Mid Staffordshire been a private hospital, criticism would have been actively socially encouraged, not shouted down, and whistleblowers like Julie Bailey would have been cheered on, not hounded.

Mid Staffordshire was never representative of overall NHS standards, but it is an example of how the NHS's role as a national institution conflicts with its role as an actual healthcare system. The broader problem is not new. Analysing the service's evolution in its early years (1948-1964), Webster (2002: 35) finds that the political consensus which rapidly evolved around it was a mixed blessing:

'The inferior status of the health service was disguised by the political rhetoric; this effectively induced a sense of complacency concerning the state of the NHS, which vanished from the headlines. Owing to the effectiveness of this propaganda [...] habitual stoicism and misplaced confidence among the public [...] and a general disinclination to criticize a cherished national institution, the new health service drifted into a political limbo'

This paper is the equivalent of the above-mentioned nitpicker-bore who ruins the Bastille Day festivities with pedantry. It is a systematic overview of some of the NHS's structural problems. However, not all of the problems described in this paper are unique to the NHS, or even to single-payer healthcare systems more generally. Some of them are shared by various

8 'Neglect of the weak was not invented with the National Health Service. The Stafford hospital scandal is far from unprecedented. Dickens and Gladstone would have recognised this human weakness'. *The Guardian*, 29 March 2013.

9 'It's not just Mid Staffordshire. Private hospitals fail, too'. *The Guardian*, 28 October 2013.

healthcare systems, and some of them are more or less common to *all* healthcare systems in the developed world. The point of this paper is not to develop detailed policy solutions, which is the subject of previous (see, for example, Niemi² 2014; Niemi² 2015a; Niemi² 2015b) and forthcoming work. Instead, this paper has a simple aim: to diagnose the failures, inadequacies and structural problems associated with the UK's current model of healthcare. Alternatives will only be presented in very broad strokes, so that hopefully even readers who would strongly disagree with the author's favoured solutions can still find some common ground with the diagnosis.

Health outcomes

When politicians and media commentators extol the virtues of the NHS, their focus tends to be almost exclusively on the service's perceived intentions and its supposed 'public service ethos'. Health *outcomes* receive almost no attention, or if they do, the bar is set absurdly low, for example by comparing the health outcomes of modern Britain to those of 1920s Britain¹⁰, or to those of a contemporary underdeveloped country.¹¹ This means that the health system is evaluated almost like one would evaluate a Christmas present: by the presumed intention of the giver, and the amount of effort they seem to have put into it, not by its practical use.

An outcome-focused evaluation would lead to very different results. We have shown in previous papers that despite some catching-up since the early 2000s, the NHS generally still lags behind the health systems of other high-income and upper-middle income countries in terms of health outcomes (Niemietz 2014: 12-19; Niemietz 2015a: 20-27; Niemietz 2015b: 17-20).¹² For the sake of completeness, some of these results are reproduced here. The outcomes of the UK will be compared to the the twelve best-performing countries in each respective category.

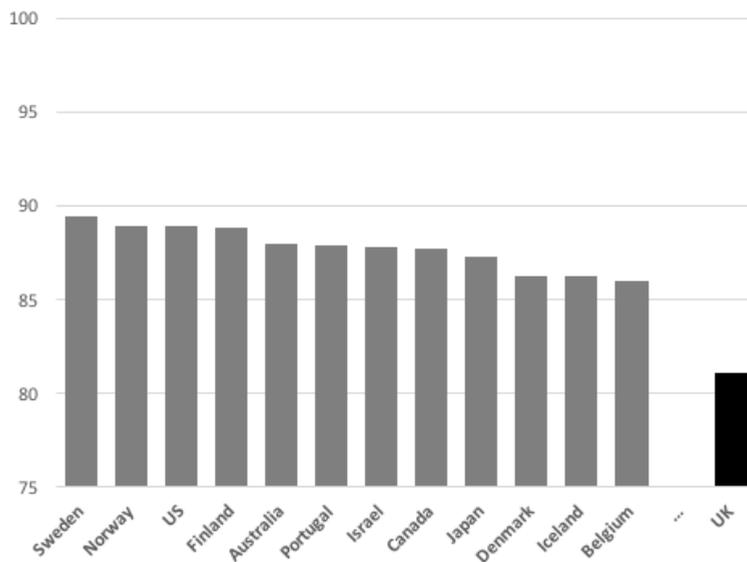
For age-standardised cancer survival rates, shown in the three graphs below, the short summary is that the UK never comes close to the Top 12, with survival chances several percentage points below those of the best performers.

10 "Hunger, filth, fear and death": remembering life before the NHS'. *New Statesman*, 31 October 2014.

11 'Bruce Keogh: time to end open season on the NHS'. *The Guardian*, 29 March 2013.

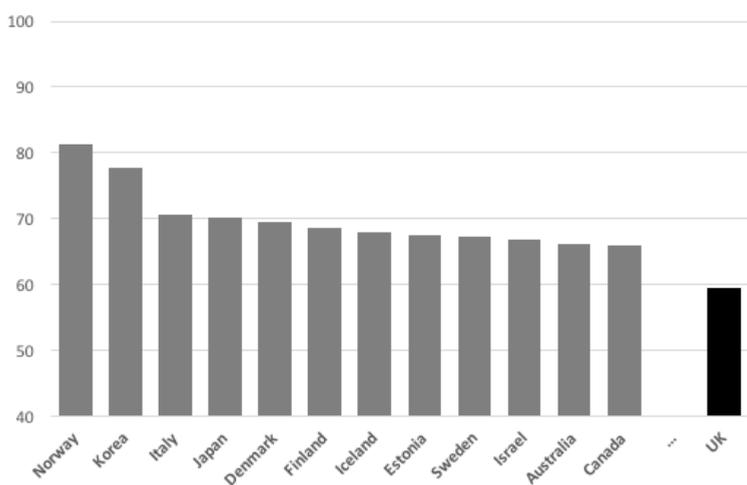
12 In this paper, 'high and upper-middle income countries' has been defined, somewhat arbitrarily, to mean 'countries with a PPP-adjusted GDP per capita above 25,000 International Dollars' (World Bank 2015).

Figure 1: Age-standardised five-year breast cancer survival rates, 2008-2013 (or latest available five-year period)



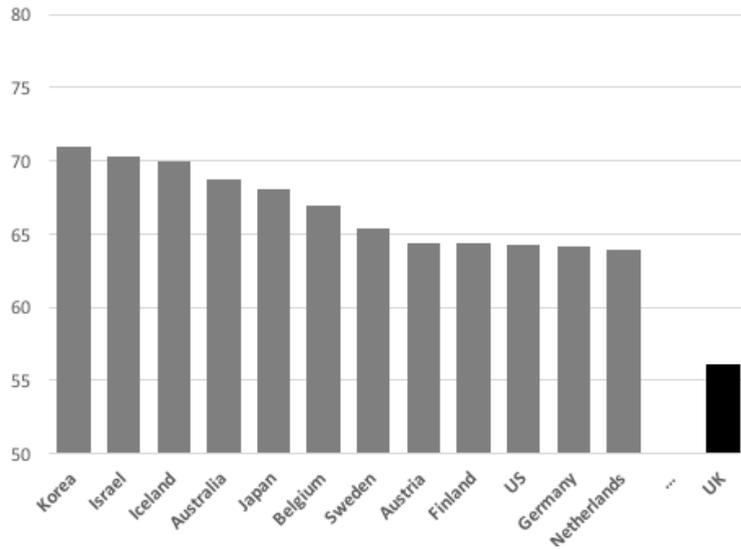
Based on data from OECD (2015)

Figure 2: Age-standardised five-year cervical cancer survival rates, 2008-2013 (or latest available five-year period)



Based on data from OECD (2015)

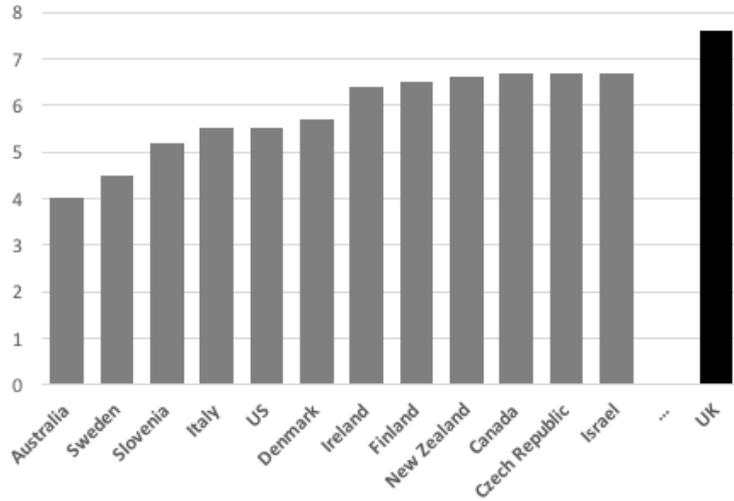
Figure 3: Age- and sex-standardised five-year colorectal cancer survival rates, 2008-2013 (or latest available five-year period)



Based on data from OECD (2015)

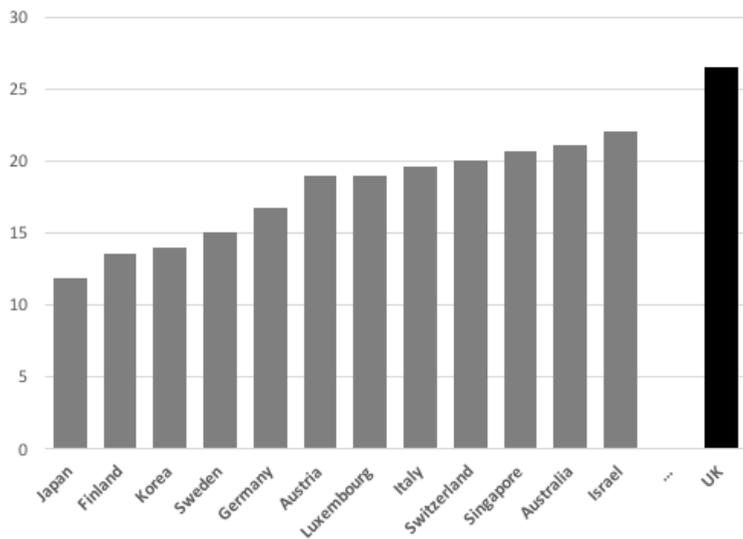
A similar picture is obtained for stroke mortality: The UK is never among the Top 12, and in some cases several percentage points behind.

Figure 4: Age-/sex-standardised 30-day mortality rate for Acute Myocardial Infarction (AMI), 2014 or latest available year



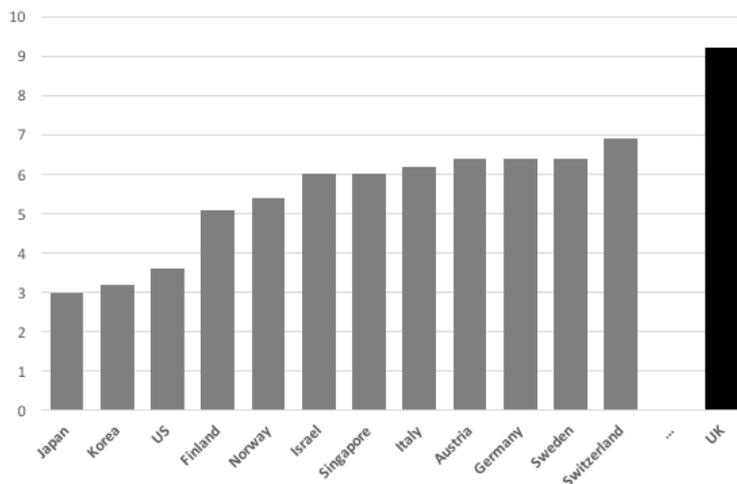
Based on data from OECD (2015)

Figure 5: Age-/sex-standardised 30-day mortality rate for haemorrhagic stroke, 2014 or latest available year



Based on data from OECD (2015)

Figure 6: Age-/sex-standardised 30-day mortality rate for ischemic stroke, 2014 or latest available year

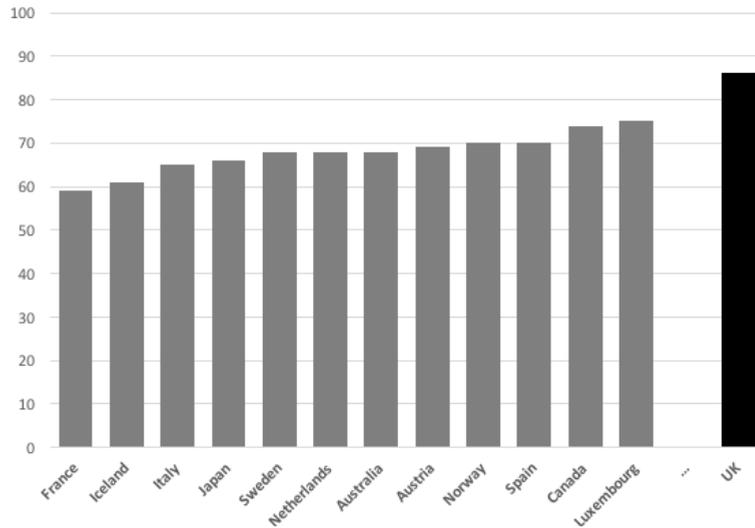


Based on data from OECD (2015)

This is also true for the number of premature deaths that could, in principle, have been prevented through better or timelier healthcare ('mortality amenable to healthcare').¹³

¹³ There are two different versions of this indicator, but the UK occupies the same rank in both versions. Data for Switzerland, which features in some of the other graphs, are not available.

Figure 7: Number of ‘unnecessary’ deaths per 100,000 (mortality amenable to healthcare), 2007 or latest available year

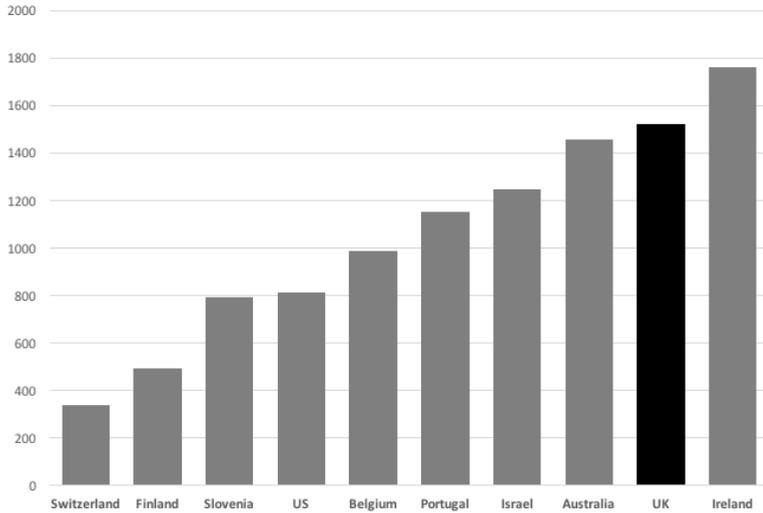


Based on data from Gay et al. (2011)

Mortality rates are crude, binary measures, which do not capture aspects of treatment quality that affect patients’ health and quality of life but stop short of affecting their chance of survival. A possible proxy measure for such aspects of treatment quality would be the frequency of various post-operative complications. They are also an outcome over which healthcare providers can be assumed to have a relatively high degree of control.

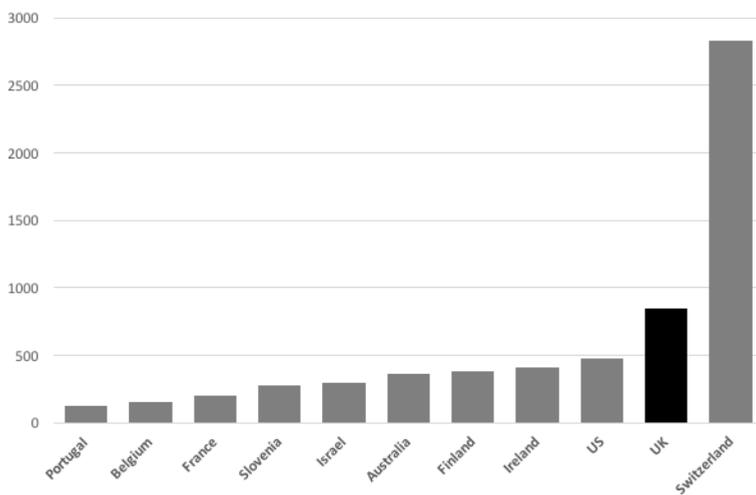
Unfortunately, in this area, data availability is very limited. Comparable data is only available for about a dozen countries, and then only for a few years, which means that we can neither replicate the above approach of comparing the UK to the respective Top 12, nor can we check whether there are any discernible time trends. Thus, we do not draw any strong conclusions from the data. Suffice it to note that the NHS’s performance is not especially poor on any single measure, but overall, it is not in any way impressive either. The exception is post-operative wound dehiscence: on this count, the NHS really is an international top performer.

Figure 8: Post-operative sepsis: cases per 100,000 hospital discharges, 2014 or latest available year



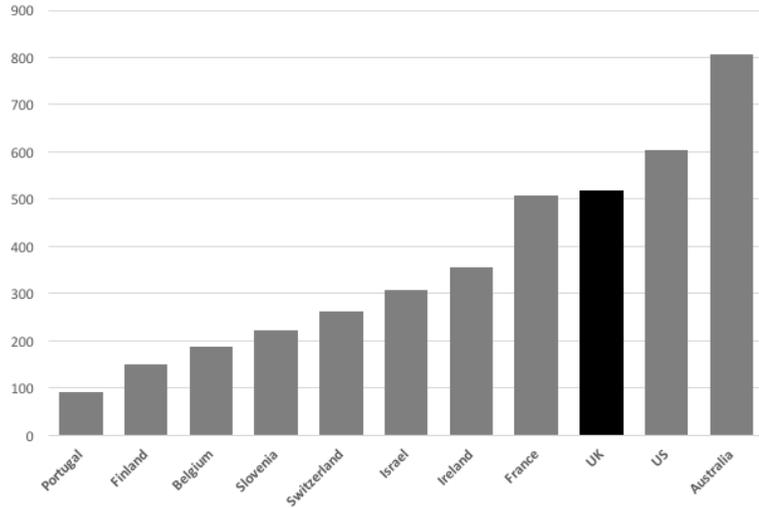
Based on data from OECD (2015)

Figure 9: Post-operative pulmonary embolism: cases per 100,000 hospital discharges, 2014 or latest available year



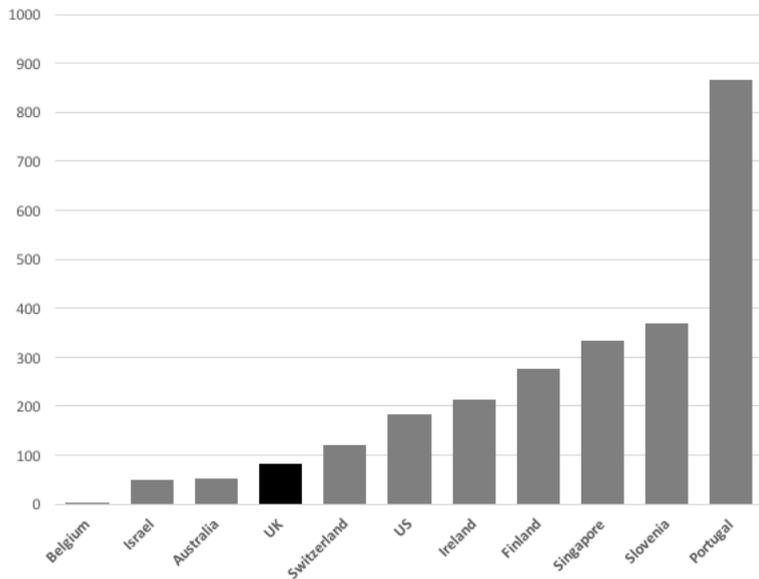
Based on data from OECD (2015)

Figure 10: Post-operative deep vein thrombosis: cases per 100,000 hospital discharges, 2014 or latest available year



Based on data from OECD (2015)

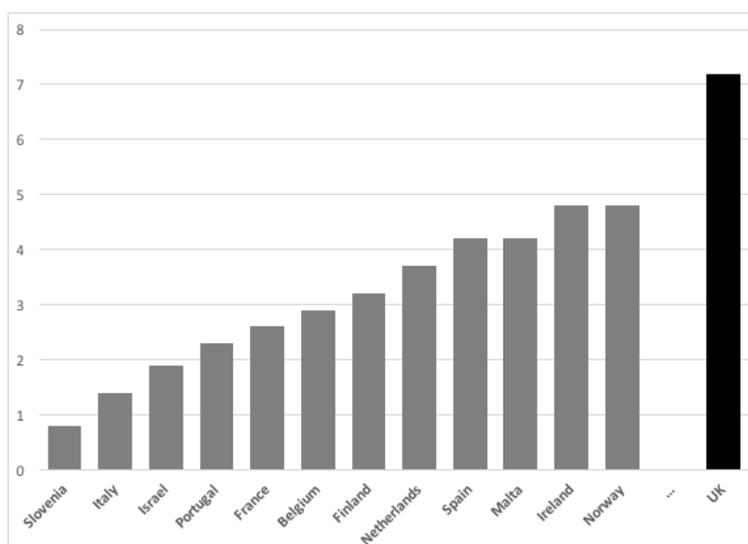
Figure 11: Post-operative wound dehiscence: cases per 100,000 hospital discharges, 2014 or latest available year



Based on data from OECD (2015)

Finally, one possible quality measure for which more data is available is the frequency of obstetric traumas after deliveries. Here, the familiar pattern is repeated: The NHS is far behind the twelve best-performing countries.

Figure 12: Obstetric trauma: cases per 100 deliveries, 2014 or latest available year



Based on data from OECD (2015)

International data on waiting times are also very limited. The surveys carried out for the Euro Health Consumer Index (Björnberg 2015: 67-72) are probably the closest thing, although they are far from perfect. They rely on patients' assessments, rather than official records, and for access to GPs and specialists the questions are open to interpretation. It is quite possible that, for example, news coverage of waiting times affects the responses ('availability bias'). But they are the best measures available. The Euro Health Consumer Index ranks countries and groups them into three categories, namely 'green' (=best), 'yellow' and 'red' (=worst). The outcomes are shown below. It turns out that while long waiting times are not a specifically British problem, the NHS is quite consistently among the poorer performers.

Table 1: Accessibility of healthcare

	Green	Yellow	Red
GP	Luxembourg Italy Belgium Portugal France Denmark	Austria Germany Netherlands Switzerland Ireland Norway	England Spain Finland Iceland Greece Sweden
Specialist	Iceland Luxembourg Greece Austria Belgium Germany Switzerland	France Denmark Italy	Finland Sweden Portugal Spain Netherlands England Norway
Elective surgery	Switzerland Luxembourg Belgium Denmark Germany France Netherlands Finland	Italy Greece Norway England Austria	Sweden Portugal Spain Iceland Ireland
CT scan	Switzerland Netherlands Belgium Finland	Germany Greece France Denmark Norway	Sweden Portugal England Austria Spain Luxembourg Ireland Italy

A & E	Norway Belgium Switzerland Denmark Finland Portugal Iceland Netherlands	Germany Greece Austria Luxembourg Spain	France England Italy Sweden Ireland
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Based on Björnberg (2015)

Efficiency

Defenders of the current system argue that the NHS is merely ‘underfunded’ and that ‘proper’ or ‘adequate’ funding would sort out any remaining shortcomings. The argument is not per se implausible. The NHS is not among the best-performing systems, but it is not among the best-funded systems either. So ‘you get what you pay for’ seems like a fair argument: if you want Swiss outcomes, you have to be prepared to accept Swiss funding levels.

However, in efficiency rankings, the NHS performs just as poorly as it does in outcome rankings. The OECD study by Joumard et al. (2010) attempts to estimate the potential gains in health outcomes that countries could achieve through pure efficiency improvements. Factors like healthcare spending and lifestyles (dietary habits, alcohol and tobacco consumption) are controlled for.

The results make clear that for some countries, it is indeed fair to say that their health systems are primarily held back by a lack of resources. Mexico and Turkey lag behind the other countries in the sample on outcomes, but do well in the efficiency rankings, suggesting that they are using their constrained resources rather well.¹⁴ The opposite is true for the US system, which ranks at or close to the lower end despite having some of the best cancer survival rates (see above). The reason is simply that US health spending is extremely high.

But the OECD study also makes clear that low spending cannot automatically be equated with efficiency, and that high spending cannot automatically be equated with inefficiency. Switzerland has one of the world’s highest

¹⁴ The independent effect of wealth per se is accounted for.

levels of healthcare spending, but also occupies top places in the efficiency ranking, illustrating the (perhaps obvious) point that in healthcare, it is possible to spend a lot of money wisely. The opposite is true for countries such as Hungary and Slovakia, where spending is relatively low, and which also do poorly in the efficiency rankings. They spend relatively little, but they also seem far away from making the most of what they spend.

Table 2: Efficiency rankings¹⁵

Rank	Turning inputs into years of life expectancy	Turning inputs into years of additional life expectancy at 65	Turning inputs into minimised Mortality Amenable to Healthcare
1	Australia	Australia	Japan
2	Switzerland	Switzerland	France
3	South Korea	Japan	Italy
4	Iceland	France	Australia
5	Japan	Turkey	Korea
6	Mexico	South Korea	Iceland
7	France	Iceland	Sweden
8	Turkey	Poland	New Zealand
9	Portugal	Mexico	Greece
10	Italy	Canada	Canada
...
24/25/21	UK	UK	UK

Based on Joumard et al. (2010)

15 Another way of reading this table is: the higher a country ranks, the closer its health system is to the 'efficiency frontier'. If Australia and Switzerland want further improvements in life expectancy at birth and/or at age 65, they have to increase healthcare spending, adopt healthier lifestyles, or change some other factor. At the given level of funding, the given lifestyle habits etc, there is not much room for further improvement. The lower a country ranks, the further it is away from the efficiency frontier. There is still room for improvement *without* extra spending and *without* adopting healthier lifestyles.

The NHS is also in the bottom third of the efficiency ranking. Of course, estimating the efficiency of a health system is an extremely daunting task, and the evidence to date must be seen as tentative. But to say the least, we have no reason to believe that the NHS is operating anywhere near the efficiency frontier. Healthcare spending in the UK is lower than in a number of Western European countries, but this does not mean that the NHS would rise to their standards if its funding rose to their levels.

The lack of choice and competition

The NHS is one of the few remaining nationalised industries. Competition and consumer choice, which are part and parcel of economic life in other sectors, only play a limited role in healthcare, and this has important implications. Competition serves several functions in the economy, the two most important ones being:

- Competition prevents the accumulation of economic power in the hands of producers. Nationalised industries (and incontestable private monopolies) are prone to ‘producer capture’; they end up being run for the benefit of those working in them, not those using them.
- Competition acts as a constant trial-and-error process in which different organisational forms, business models, management styles, contractual relationships etc. can be tried and tested, and which enables constant learning from best practice. This is why Hayek spoke of ‘competition as a discovery procedure’.

Supporting competition in healthcare does not necessarily mean supporting privatisation and free markets. The limited pro-competition reforms that have already been enacted in the UK (more on which later) have been based on the theories of economists Alain Enthoven (Timmins and Davies 2015: 68) and Julian Le Grand, who are advocates of ‘managed competition’ or ‘quasi-markets’ (Le Grand 2003: 95-106), but not of privatisation and free markets in healthcare. A quasi-market is a system of regulated competition along politically determined lines. In a quasi-market, healthcare is still fully tax-funded, most health provision is still public, the decision about which treatments should be offered is still a political decision, and some key parameters – especially prices – are taken out of the competitive process altogether.

Due to the reforms inspired by this quasi-market theory, healthcare in the UK is no longer the competition-free zone it once was. NHS providers now compete for patients and funding, mostly with one another but also, at the margin, with independent sector providers. In addition, there has always been a degree of competition between GPs, while the markets for pharmaceuticals and medical devices have always been fairly competitive.

Still, severe limits to competition remain. The OECD quantifies various health system characteristics on a scale from 0 to 6, and in the categories 'patient choice among providers' and 'degree of private provision', the UK ranks in the bottom third.

Table 3: Competition and choice in healthcare

→ Degree of patient choice ↓ Degree of private provision		≤4	≥4.5
	≤2	Finland Spain Portugal New Zealand UK	Iceland Italy Sweden
	≥3	Denmark Austria Greece	Switzerland Belgium South Korea Netherlands Australia Germany France Japan Luxembourg Norway

There are several obstacles which prevent real competition in healthcare in the UK:

- On paper, patients have been enjoying free choice of provider at the point of referral since 2008. In reality, most GPs simply continue to refer patients as they see fit. According to patient surveys, only about one in three patients is being offered a choice of provider upon referral (Ham et al. 2015: 51). If anything, this proportion appears to be falling, not rising, so it cannot just be explained by the fact that patient choice is still relatively novel.
- Providers are partly paid on the basis of activity, especially through the 'Payment by Results' (PbR) formula. This means that funding follows patients, and that providers compete for patients in order to attract funding. But this competition-enhancing effect of PbR is undermined by other payment streams, especially discretionary funding from the Department of Health.
- The healthcare commissioning side is still exempt from competition altogether. People are covered by Clinical Commissioning Groups (CCGs) that purchase healthcare services on their behalf, but they cannot directly choose between CCGs. They register with a GP in their catchment area, and in this way, they also register indirectly with a CCG (because every GP belongs to a CCG). For most forms of primary care, competition is also confined by catchment area boundaries.

Again, this is *not* about whether one thinks that healthcare can, or should, be provided in a free market setting. The point of this section is not that the UK is far away from a free market in healthcare – that much is obvious – but that it is far away from a competitive setting of any kind. One could go a lot further in promoting competition and still remain firmly within an Enthoven/Le Grand theoretical framework. As long as this does not happen, British patients will not be able to enjoy the benefits of competition.

The lack of competition in healthcare is not a uniquely British problem, so one cannot single out the NHS in this respect. But it is fair to say that a lot of comparable countries – in particular, those in the bottom-right quadrant of Table 2 – have gone much further in promoting competition in healthcare. These countries tend to be among the top performers in both the health outcome rankings and the efficiency rankings.

'Our' NHS? The myth of democratic accountability'

In the 1980s, left-wing intellectuals who opposed the government's privatisation programmes did so not primarily on economic grounds, but as a matter of principle. The argument was that the industries in question rightfully belonged to 'the people' and should be accountable to 'the people' – not private shareholders. They ought to be part of the collective sphere, owned and run by all of us together.

Yet these arguments did not catch on widely. There was, of course, widespread opposition to privatisation, but it was based on bread-and-butter arguments, not philosophical matters. The idea that privatisation would entail a loss of democratic control did not travel far beyond the seminar room. State-owned industries nominally belonged to 'the people', but apparently, not many people felt that these industries were truly 'theirs', and this is sometimes recognised even among supporters of renationalisation. Owen Jones (2014: 305), for example, argues that 'Margaret Thatcher was able to privatize [...] with little popular outcry, because of the lack of a sense of shared ownership among the population. To many, once publicly owned assets [...] seemed remote, run by faceless apparatchiks'.¹⁶

16 Jones is, however, convinced that if the respective industries were renationalised today, this time, the public would consider these industries to be truly 'theirs'. All it would take to replace industries 'run by faceless apparatchiks' with proper 'people's industries' would be to increase the representation of workers and consumers on the companies' boards (ibid).

Nationalisations had *not* empowered ordinary citizens; they had only expanded the power of the political class, the state bureaucracy and the senior management of the industries themselves. And this could not have been otherwise. As Seldon (2004 [1990]: 179) explained:

[T]he notion that “society as a whole” can control “its productive resources” is common in socialist writing but is patently unrealistic. The machinery of social control has never been devised. There is no conceivable way in which the British citizen can control the controllers of “his” state railway or NHS, except so indirectly that it is in effect inoperative.’

Seldon contrasted this illusory ‘public’ ownership to real – i.e. private – ownership:

[T]he employees who bought shares in the National Freight Corporation (NFC) had a much more vivid sense of ownership, not least because they could sell their NFC private shares, than the nominal political owners have in their public ownership of the NHS. This is the reply to the radio interviewer who asked innocently, “Why do we want to buy shares in the water industry that we already own?” “We” do not **effectively** own nationalized industry; we own private industry effectively.’ (ibid: 180; emphasis in the original)

And yet healthcare is one of the few areas where the ‘democratic accountability’ argument has survived unscathed. The most frequent argument against private sector involvement remains that it would lead to a loss of ‘democratic accountability’. In this view, the NHS may *look* centralised and hierarchical, but it is really a grassroots organisation, owned and run by ‘the people’. Perhaps the best expression of this sentiment is the frequent use of the possessive pronoun: *our* NHS, not *the* NHS.

This mind-set is expressed by the campaign group ‘Our NHS’, one of the many groups fighting against (actual and imaginary) market-oriented health reform proposals. ‘Our NHS’ also opposes the idea of turning NHS facilities into staff-owned mutuals, cooperative social enterprises, on the grounds that ‘We all already own the NHS – the latest “mutual” spin is about taking it out of our hands’.¹⁷ The organisation also argues:

17 ‘We all already own the NHS - the latest “mutual” spin is about taking it out of our hands’. *Our NHS*, 15 July 2014. <https://www.opendemocracy.net/ournhs/caroline-molloy/we-all-already-own-nhs-latest-mutual-spin-is-about-taking-it-out-of-our-hands>

'the government has created new ways to marketise and privatise the health economy - extending personal health budgets, patient choice, piecemeal outsourcing, "commissioning", and private or "social" investment. Mutuals and "social enterprises" are a key new pathway to market-based services. [...] The transfer of health services into social enterprises extends rather than challenges the use of commissioning, competition and markets. [...] There is a loss of direct democratic control and accountability.'¹⁸

The idea is expressed in the constitution of the National Health Action Party (NHA 2015):

'The NHS marked out a space in society where the dictates of commerce and the market were held in check so as to give expression to socially directed goals, for individuals and society as a whole.'

To proponents of this view, even the relative lack of patient choice is not seen as a problem, because collective choice is considered a more-than-adequate substitute for individual choice. Fotaki (2007: 1061) sees the NHS as run on the basis of 'collectivist values such as equity and the supremacy of community-defined needs where individual choice is not as important (see, for example, Hirschman 1970; Titmuss 1970).'

Yet nothing suggests that 'democratic control' is any stronger in healthcare than it was in the steel industry or the airline industry. Indeed, it is notable that the democratic accountability argument is usually only presented in the abstract – its proponents rarely spell out how exactly accountability through the political process is supposed to work, let alone provide examples of the process in action. 'Supremacy of community-defined needs' sounds appealing, but how exactly does 'the community' as a whole agree on what its health needs are, and on how they are best met?

Democratic accountability exists in the sense that health policy is always a prominent subject in General Election campaigns, and if there were a perception that a government had catastrophically mismanaged the service, it would have great difficulties getting re-elected. But the correlation between the health policies that parties outline prior to a General Election, and the policies they implement once in power, is notoriously weak. There

18 'Should we turn the NHS into co-ops and mutuals?' *Our NHS*, 14 November 2013. <https://www.opendemocracy.net/ournhs/dexter-whitfield/should-we-turn-nhs-into-co-ops-and-mutuals>

have been various major turning points in health policy over the past few decades, but none of them was announced, let alone debated, in the preceding election.

One of the most significant changes in the NHS's history was the 1990/91 purchaser-provider split. This created the so-called 'internal market', in which NHS commissioners selectively bought healthcare services from NHS providers, who were, at least notionally, in competition with one another. Thus, it injected market-mechanisms, or at least a mimicking thereof, into what was hitherto a traditional public sector monopoly (see Niemietz 2015c: 94-95).

The Conservative Party's 1987 General Election manifesto (see Conservative Party 1987) had not said a word about this. It contained a relatively detailed overview of the government's health policy record up until then, but apart from a general more-of-the-same tone, it contained little that was forward-looking. On structural reforms, the manifesto was particularly lightweight ('The NHS is a large and complex organisation. It needs good management').

During the first term of the New Labour government, the health service went through a period of re-centralisation and standardisation, with the 'N' in NHS taking central stage once again. Those years saw the introduction 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). Perhaps the most important change was the 2000 NHS plan, which led to a regime of management by targets, of 'star ratings' for NHS hospitals, and of 'naming and shaming' underperforming hospitals (Niemietz 2015c: 97-99).

Again, none of these changes had been announced in the preceding election manifesto (see Labour Party 1997). The manifesto made it clear what it was *against*, containing an explicit repudiation of the internal market reforms. But it had much less to say on what it was *for*, apart from very general statements of intent ('GPs and nurses will take the lead in combining together locally to plan local health services more efficiently' [...] 'Health authorities will [...] monitor services, spread best practice and ensure rising standards of care'), and a focus on 'healthy lifestyles'.

The next milestone in health policy was the slow return to market mechanisms, beginning in 2002/03 (Niemietz 2015: 99-101). The important steps were the introduction of patient choice, the creation of a new funding system in which money follows patients, the conversion of well-performing hospitals into semi-autonomous 'Foundation Trusts', and the inclusion of private sector providers. The preceding Election Manifesto had not announced these changes (see Labour Party 2001). It did mention patient choice, but only in the context of providers cancelling appointments at short notice. It did mention private providers, but only in the context of local NHS capacity shortages. From reading this manifesto, even a well-informed voter could not have guessed that choice and private sector involvement were to become regular features of healthcare.

The most recent turning point was the 2012 Health and Social Care Act (HSCA), which abolished the existing commissioning infrastructure, and replaced it with doctor-led commissioning groups that all GPs had to join. The Conservative Party's 2010 manifesto had promised an end to top-down reorganisations (Conservative Party 2010), when the HSCA then turned out to be one of the largest reorganisations in the service's history. The manifesto talked vaguely about involving GPs in commissioning decisions, but even with the benefit of hindsight, it would be a stretch to read these manifesto passages as an announcement of what really happened later on.

If one were to search for a pattern that is generous to the idea of 'democratic accountability', one could interpret each General Election at which a governing party was confirmed in office as a retrospective democratic validation of that party's health policies. The manifestoes are quite compatible with this reading, because they usually contain a relatively clear description of the respective party's past health policies, and where applicable, a commitment to continuing them. The Conservative Party's 1992 manifesto contained a clear commitment to a continuation of the internal market reforms; the Labour Party's 2001 manifesto contained a clear commitment to a continuation of the NHS Plan reforms; and the Labour Party's 2005 manifesto contained a clear commitment to a continuation of the quasi-market reforms.

So under the – rather generous – assumptions that voters are sufficiently aware of the parties' manifesto pledges, and that health policy is sufficiently decisive for the election outcome, one could argue that there is some 'retrospective democratic accountability' in the health service. But whichever

factors drove the pivotal changes in health policy, popular demand was not one of them. Even an enthusiastic proponent of the 'our NHS' line of thinking would have difficulty showing how 'we' run 'our' health service together. The most generous interpretation is that the public rubberstamps important reforms once they are already under way.

Supporters of the service would argue that this is merely a matter of making health policy more 'accessible', and of trying harder to 'engage' with the public. But there is more to the 'democratic deficit' than style or presentation. In market-oriented systems, people have good reasons to collect at least some information before choosing, for example, a health insurance plan, even if they do not find the subject matter interesting. They have full control over such decisions, and the benefits of making a sensible choice accrue directly to them. Political choices are very different. No individual vote has a perceptible impact on the overall outcome, and even if it had, there is only a weak connection between macro-level political decisions and healthcare delivery as experienced on the ground. There is simply no incentive to be well-informed about health policy.¹⁹

Supporters might also argue that democratic participation in the health service is about much more than just turning up at the ballot box every five years. People may not have much input in their role as voters, but they can still have input in their role as members of a professional organisation, or some other stakeholder group represented in the decision-making processes at either the national or the local level. Indeed, throughout the NHS's history, there have been genuine attempts to make the service more inclusive, participatory and 'bottom-up'. The problem is not that the people in charge are exceptionally 'power-hungry'.

19 Admittedly, the comparison between the NHS and the former nationalised industries is not entirely fair. With the latter, customers had to accept what they were given, and if they were unhappy with what was on offer, their only option would have been to vote for a party promising to run the industry in a different way. Nationalised healthcare, in contrast, does not automatically mean that all individual choices are replaced with political choices. As discussed earlier, individual patient choice does exist in the NHS, even if not to the same degree as in pluralistic system.

But the sheer complexity of those processes is a hurdle to meaningful participation, a point that was implicitly acknowledged by former Secretary of State for Health, Andrew Lansley:

[N]obody has ever understood the way the NHS works. People who worked in the NHS [...] had no idea what the structure for decision making in the NHS was. If you said to them, "There's a thing called the NHS Executive," they'd go, "Is there really? [...]" Classically we had this ridiculous situation where people were very unhappy about the closure of a ward in their local hospital. So they all went to the primary care trust to complain. The primary care trust said, "It's nothing to do with us, it's all been decided by the strategic health authority." So they went to the strategic health authority who said, "No, it's nothing to do with us" (quoted in Timmins and Davies 2015: 153).

More importantly, efforts to create fora for public participation rely on the assumption that patients have homogeneous preferences. If different group of patients have very different needs, and use stakeholder involvement fora mainly to articulate their own needs, it would simply result in a reallocation of resources towards the articulate, the time-rich and the well-organised (see Le Grand 2003: 82-84).

The idea that the NHS is run by 'the people', as a joint endeavour, is a romantic fantasy. The NHS is an elite project, and this could not be otherwise. Collective choice is not a substitute for individual choice and 'voice' is not a substitute for 'exit'. The illusory 'accountability' mediated through the political process cannot come anywhere near the accountability of a marketplace, or of a properly designed quasi-market setting, in which providers stand and fall with the choices consumers make, and depend on them for their very economic survival.

The voice/exit distinction need not be a dichotomy. Rather, it is the very threat of exit that can make providers more willing to listen to their customers. In competitive markets, providers often actively seek out their customers' views, for example through feedback forms or user surveys. But such voice mechanisms are not a substitute for the consumer's right of exit – they are a response to it. Providers devise such mechanisms in order to tap into local knowledge, and detect failures which they are genuinely unaware of. This is completely different from NHS failures. The problem at Mid Staffordshire was not that decision-makers were not 'aware' of the collapse in standards, but that they did not address them.

Under a system of meaningful exit options, patients would not just have had the option to bypass Mid Staffordshire, but funding organisations (e.g. health insurers) would also have had the right to withhold payments, given that Mid Staffordshire was clearly not fulfilling its side of the bargain. A pincer movement of this sort might well have bankrupted the hospital, eventually making room for a more suitable provider. That threat of revenue loss and bankruptcy, not 'democratic accountability', is what brings providers' self-interest into line with patients' interests.

Collective organisation makes sense in relatively small and homogenous groups. In this respect, the pre-NHS system, for all its faults, was vastly superior to the status quo. The old system was a system of working-class collectivism, in which most people were covered by a Friendly Society or a comparable mutual insurance association. These societies, which contracted with healthcare providers or employed them directly, were genuine grassroots organisations which operated on the basis of direct democracy. In particular, contracting decisions would be decided via membership votes during general assemblies. The following advertising brochure from 1880, issued by a physician to the members of a Friendly Society ahead of a vote, serves as an illustration:

'Members of the Grange Club – Vote for Dr Warren, the poor man's friend. Vote for Dr Warren, who attends personally on you when sick. Vote for Dr Warren, who makes up his own medicines for you. Vote for Dr Warren, who, through constant and unwearying attention, saved the life of John H. Coy, when attacked with a disease which has proved so often fatal' (quoted in Green 1985: 119).

Those decisions could be revoked, or would not be extended, if the members were not satisfied with the care they received. It was a system in which consumers were in charge, and in which providers had to court for them. This is why the system was not popular with interest groups representing the medical establishment. As one member of the British Medical Association (BMA) described it:

'[T]he doctor [...] can be dismissed at a moment's notice very often from a friendly society. [...] In the Friendly Society club he is very often treated as a servant. The smallest infringement of their rules means a complaint and a visit from the committee' (BMA n.d.; quoted in Green 1985: 11-12).

The British Medical Journal (BMJ) also described the role of a Friendly Society-contracted doctor as that of a 'subservient servant' (BMJ n.d.; quoted in Green 1985: 117) and, in a different issue, spoke of the 'silent indignation at being sweated by a hundred ignorant and boorish taskmasters' (BMJ n.d.; quoted in Green 1985: 118). The BMJ also took issue with the Friendly Societies' ability to keep doctors' remunerations in check, calling the rates they offered a 'beggarly pittance' (BMJ 1900; quoted in Green 1985: 45). The relationship between the Friendly Societies and the doctors was described as 'a one-sided cooperation' which was 'capable of great tyranny' (BMJ 1894; quoted in Green 1985: 47). *The Lancet* also described the role of doctors as one of 'medical servants of uneducated lay committees' (BMJ n.d.; quoted in Green 1985: 117).

In a BMA members' survey, a doctor complained: 'Club members who come to my house are sometimes tipsy and insolent [...] Yet I dare not complain. [...] Club patients are far more exacting than private patients, and are seldom friendly in feeling towards the doctor' (BMA 1905; quoted in Green 1985: 53). And at a meeting between BMA and Friendly Societies representatives, one of the former described the relationship between the two as one of 'absolute slavery' for doctors (Green 1985: 56).

The hostility of vested interests is not such a bad barometer of the extent to which a system produces genuine democratic accountability and consumer empowerment. Collective organisation and grassroots democracy are possible at the level of relatively small and socially homogenous groups, but what makes sense for a workman's club does not make sense for a nation of 65 million individuals. At the national level, 'democratic accountability' is simply a euphemism for 'state control' and a romanticising of it. A 'democratically accountable NHS' is really an NHS controlled by the political class, senior civil servants and the medical establishment, with lots of colourful trappings and folklore around it to make it look as if 'ordinary people' are in charge.

A responsibility vacuum

One of the main purposes of any health system, regardless of whether it is based on private insurance, public insurance, social insurance, tax-funding or some combination thereof, is to protect people from the financial risk associated with illness. All of these systems pool treatment costs and break them down into manageable instalments, so that people face only minimal costs (or none) at the point of use. A health system which failed to do that, at least for serious cases, would not be much of a healthcare system at all.

But while protection from the financial consequences of illness is clearly desirable, it does have the side effect of creating a responsibility vacuum, because it separates decision-making from liability. Patients and providers decide which healthcare services to consume, but they are not faced with the cost, and this erodes incentives to use healthcare resources sparingly and cost-effectively. It is probably not a coincidence that early forms of health insurance were built around relatively homogenous communities with a strong 'we-feeling' (see, for example, Green 1985), where a combination of loyalty and social control would suppress free-riding.

The immediate effect of collectivising healthcare costs among larger, more anonymous groups need not be large. Healthcare is not a leisure industry; the consumption of healthcare is not 'enjoyable' in its own right, and even if healthcare as such is free at the point of use, it still has opportunity costs. But this does not mean that financial incentives are irrelevant. Suppose there are two possible treatments, X and Y, for a given condition, with X being minimally superior to Y in clinical terms, but vastly more expensive. When costs at the point of use/provision are near zero, patients have no reason to choose Y over X, and providers have no reason to prescribe it. In the longer run, this means that treatments like Y will not be widely rolled out; indeed, they may never be invented in the first place.

This is why in most Western healthcare systems, the ratio of ‘product innovation’ to ‘process innovation’ is different from most other sectors (see Breyer et al. 2005: 509-517; Oberender et al. 2002: 55-56). Product innovations are the type of innovation that enable us to do things we were not previously able to do; process innovations are efficiency improvements that subsequently slash the cost of doing it.²⁰ The invention of the DVD player was a product innovation (at least if one considers it sufficiently different from the VHS player), process innovations then cut the typical retail price of a DVD player from over £200 in the early 2000s to less than £30 a decade later (see ONS 2015). Product innovations tend to increase spending on the respective product category, process innovations reduce it, and in many markets the two roughly balance each other out. We use a lot of consumer electronics that were not yet around in the 1990s, and yet we do not necessarily spend a greater proportion of our budgets on consumer electronics. Process innovations make room in our budgets to accommodate product innovations.

In principle, this is true in the health sector as well. For example, when a drug patent expires, cheaper generics quickly become available, turning a monopolistic market into a competitive one.²¹ But they occur less often and/or spread less rapidly than in other markets (Breyer et al. 2005: 509-517; Oberender et al. 2002: 55-56). This is because neither type of innovation just occurs ‘naturally’. They are the result of risky investment projects, which producers will not undertake unless they see a realistic chance of them paying off. In the market for DVD players, this was clearly the case. Customers, bearing the full cost of the product, were highly price-sensitive, so that even a small difference in price could lead to a large change in market shares. Producers therefore had every reason to invest in process innovations. In a market with near-zero marginal costs, producers have no reason to expect that process innovations will be taken up on a noteworthy scale.

20 ‘Organisational innovations’, roughly, the creation of more efficient organisational structures, are sometimes listed as a third category of innovation. In this paper, they will be subsumed under ‘process innovation’.

21 Strictly speaking, this is not the same as a process innovation, because technologically the manufacturing of generics was already possible before the patent expired. But for all intents and purposes, the expiry of a patent works as *if* a process innovation had occurred at that moment.

In particular, the phenomenon of 'frugal innovation', which one can see as the extreme end of the process innovation spectrum, would not be viable in healthcare. There could be no health sector equivalent of a no-frills airline (like Ryanair or Easyjet), of a discount supermarket (like Aldi or Lidl) or a low-budget pub chain (like Wetherspoon's), because there would be no demand for it.

It is not like this everywhere. In some emerging markets, where patients pay for healthcare, frugal innovation does occur in healthcare no less than in other sectors, and a number of low-budget healthcare providers have successfully established themselves (see, for example, PSP4H 2014; Govindarajan and Ramamurti 2013). This phenomenon is not yet well researched, but it shows that there is nothing intrinsic in healthcare which prevents process innovation.

The conditions under which process innovation in emerging countries occur are clearly undesirable. They are a product of sheer necessity, in a setting in which too many people simply have no alternative. Western healthcare systems offer security and universality, but they have not yet found a way of reconciling those achievements with price-consciousness and a drive for cost-cutting innovation.

Neither have they found ways of organising healthcare in line with the principle of subsidiarity. In the NHS, there have long been ongoing efforts to shift healthcare provision 'downwards', towards the lower (and lower-cost) tiers. Already in the 1950s, government reports talked about a 'shift away from hospital and institutional treatment towards community care' (quoted in Webster 2002: 54). This is still very much a current policy focus (for example, Ham et al. 2008). In other sectors, we automatically move towards subsidiarity, without even realising it. We do not go to a fine dining restaurant when we just want a quick bite; we go to a takeaway, or get a ready meal from a supermarket. Devoid of price signals and clear budgetary responsibilities, the health sector struggles to do the same.

There are two strategies (not mutually exclusive) for filling the responsibility vacuum, stimulating demand for process innovation and introducing greater subsidiarity.

One would be a broad-based cost-sharing arrangement, under which patients would pay a substantial proportion of their healthcare costs out of pocket. This would have to be subject to caps and exemptions – in

particular, preventive healthcare and medical checkups would have to remain free – and combined with special protection measures for the low-paid and the long-term sick. But the vast majority of the population would be required to make a sizeable contribution towards the cost of their healthcare. People would still be protected from the risk of incurring very high health-related expenses, so there would be no such thing as a ‘medical bankruptcy’. But healthcare would no longer be anywhere near being free at the point of use. GPs would have to get used to patients asking them questions like whether a treatment represented ‘value for money’, or whether they could recommend a more cost-effective alternative.

The second strategy would put the squeeze primarily on institutional purchasers and only indirectly on individual patients. Healthcare is not the only sector where consumption is free at the point of use, rather, this is common to areas where pre-paid plans are the norm. A gym is also ‘free at the point of use’, in that members do not pay separately for each exercise or each session, and yet, we do not see a cost escalation in this sector. The reason is that gym-goers *are* cost-conscious, even if not at the point of consumption. They are cost-conscious at the point of choosing a gym and a membership plan, and this cost-consciousness will be reflected in the gym’s purchasing decision. The individual gym member has no incentive to choose say a pair of dumbbells over a stylishly designed, expensive piece of equipment, but the gym would not purchase that equipment in the first place if it believed that its members were not willing to pay for the concomitant increase in membership fees.

In healthcare, the closest equivalent of this would be competing Health Maintenance Organisations (HMOs). The HMO is a model in which the insurer does not just passively reimburse medical costs, but tries to actively shape the delivery of care. Thus, the distinction between ‘provision’ and ‘insurance’ becomes more blurred, and at the extreme end of the spectrum it disappears. At this end, HMO health insurance is not unlike a gym membership: policyholders pay regular membership fees to an integrated health centre and are, in return, entitled to use the in-house facilities (and the services of contracted providers). Patients choose between different HMOs (as well as between HMOs, conventional insurance and in-between solutions), and an HMO that manages to keep costs down can undercut competitors.

Neither of these strategies are in widespread use in Western health systems. The only system which makes extensive use of cost-sharing schemes is the Singaporean one, where private out-of-pocket spending accounts for just under two thirds of total healthcare spending (based on data from WHO 2014). In international league tables of health outcomes, Singapore is rarely among the very best, but almost always in the same league as Western Europe and North America. Healthcare spending, meanwhile, amounts to just 4.2 per cent of GDP (*ibid.*). This is no doubt partly due to relatively favourable demographic conditions, but other developed countries already superseded this level in the 1970s (OECD 2015), when their demographic structure was still much closer to a 'pyramid shape'.

In most other systems, cost-sharing plays only a minor part, and in the UK it is particularly negligible. The only cost-sharing element worth mentioning is the (poorly designed) NHS prescription charge, and even from that, about 90 per cent of prescriptions are exempt (Cawston and Corrie 2015).

Neither are there any HMO-type mechanisms, although in the 1990s, the NHS briefly experimented with a model called 'GP fundholding' which had elements of this. Under this model, GPs could partly opt out of their district health authority's commissioning arrangements, and instead make their own arrangements for the patients registered with them (see Niemietz 2015: 94). Those GPs would receive a commissioning budget equivalent to what the district health authority would otherwise have spent on their patients. GP fundholding changed incentives. The person who was making the referral decisions was also in charge of the budget, so they had good reasons to make sure patients were referred to the most cost-effective tier, which, in some cases, would have meant retaining them for continued treatment at the surgery. It turned GPs into competing commissioners, competing not just with each other, but also with the local NHS district health authority.

GP fundholding was not in place for long, so there is not a lot of evidence on its effects, but from the limited evidence that is available, it seems to have worked in the way just described (Le Grand 2003: 96-101). The current system of healthcare purchasing by Clinical Commissioning Groups (CCGs) contains no comparable mechanisms. Firstly, patients cannot directly choose between CCGs, so an especially cost-effective CCG does not gain any competitive advantage. Secondly, even if CCGs are led by

GPs, from any individual GP's perspective, the CCG's budget is a common pool resource.

The fundholding experiment was ended in the late 1990s, on the grounds that selective opt-outs were not compatible with the NHS' ethos of a unified service. In this, the critics of fundholding were, strictly speaking, right. It is debatable whether a National Health Service with lots of independent commissioners doing 'their own thing' could still be described as a National Health Service. But it is interesting that the reform which may well have been the most promising one of that decade was also the one most out of line with the NHS's ethos.

The downsides of tax-funding

The NHS is almost exclusively funded from general taxation, which is somewhat unusual insofar as most health systems use a mix of funding sources (usually a mix of taxes, social security contributions and out-of-pocket payments) (WHO 2014). This arrangement seems to enjoy high levels of public support (Gershlick et al. 2015: 11-12), and it does have its advantages. Since taxes have to be collected anyway, a tax-funded system does not require a separate revenue collection administration. It also means that the funding base is relatively broad, at least in a country where taxation is as pervasive as in the UK. It is also a very progressive form of funding: broadly speaking, the better-off you are, the more you contribute to the finances of the health system.

This is not automatically the case in insurance-based systems (although it can be arranged within those systems as well). In Switzerland, for example, health insurance premiums are flat-rate fees, i.e. they do not vary with income. Redistribution takes place through tax-funded demand-side subsidies, but it is limited to, roughly, the bottom third of the income distribution. Across most of the distribution, the system is not redistributive: a person who earns just one franc too much to qualify for means-tested support pays the same health insurance premium as Sebastian Vettel. But tax-funding does have its downsides as well.

The deadweight loss

Taxes alter behaviour to a much greater extent than premiums, which means that tax-funding comes with a higher economic deadweight loss than premium funding.

Suppose that in both the UK and Switzerland, healthcare spending rises by one percentage point of GDP, leading to tax increases in the UK and

equivalent premium increases in Switzerland. In Switzerland, this would be perceived as a 'windfall loss', but there would be no further economic costs, because the increase would not elicit behavioural changes. From the perspective of an individual household, health insurance premiums are a fixed cost that they cannot avoid or significantly reduce; the premium does not, for example, depend on the number of hours they work.²² In the UK, meanwhile, the initial increase in taxes would lead to economic knock-on costs further down the line, because tax increases do alter behaviour. A tax is not a fixed cost. It is levied on specific activities, and at the margin, people respond to it by engaging in those activities less frequently and/or less intensely. For the US context, Feldstein (1995) estimates that the deadweight loss of an increase in marginal income tax rates is about twice as large as the corresponding increase in revenue. If the magnitudes are even remotely similar in the UK, it means that the total economic cost of the NHS is vastly greater than the amount actually spent on it. Defenders of the status quo claim that total spending tends to be lower in tax-funded systems, but they never take the deadweight loss of taxation into account.

Lack of transparency

Is spending on the NHS too low? Is it about right? Or is it too high? In a tax-funded system, it is difficult to have an informed discussion about this subject. NHS spending figures are reported quite frequently in the media, but usually in absolute terms, and the figure (about £130 billion) will be far too abstract for this purpose. This is quite different in insurance-based systems, where health insurers raise their own premiums and where those premiums are explicitly listed on people's payslips, making it very easy for an individual household to see how much they pay for healthcare. In these systems, it is also easier to discuss 'costed proposals' around elections: parties will often put forward health reform plans, and give an

22 This statement needs to be qualified. If premiums rise faster than incomes in Switzerland, more people would qualify for means-tested support, which is withdrawn as incomes rise. This creates an implicit marginal tax rate, which has the same effect as an explicit tax rate. Also, those demand-side subsidies obviously have to be paid for, namely through a higher tax burden, which also creates a deadweight loss. So it is not as if the Swiss system does not come with a deadweight loss.

More importantly, the Swiss system's method of flat-rate premiums is also unusual even for a social insurance system. In the German system, premiums are a fixed proportion of incomes, so as people's earnings increase, their health insurance premiums increase as well. Income-dependent premiums work effectively like a flat tax: they still give rise to a deadweight loss, even if to a lesser extent than a progressive tax.

indication of what those proposals will mean for individual premiums. In principle, this problem could be solved within a tax-funded system, namely through the introduction of a hypothecated 'Health Tax' (Le Grand 2003: 161-162). This tax could be carved out of an existing one, for example income tax, and the revenue it raised could be ring-fenced for the NHS. Politicians would not be able to divert it for other purposes.

While such a tax would be perfectly feasible, it would diverge so far from current principles of taxation that it is debatable whether it would still really constitute a 'tax' at all. It would be, for all intents and purposes, indistinguishable from a social security contribution.

Politicisation of funding decisions

Defenders of NHS purism argue that most, if not all of the service's shortcomings are a result of 'underfunding'. As explained above, the NHS's poor performance in efficiency rankings makes this highly doubtful, but even if it were true, it would be wrong to treat funding as an external constraint which cannot be held against the NHS. Funding is an endogenous, not an exogenous variable.

In a tax-funded system, healthcare spending decisions will always, almost by definition, be political decisions. The NHS's budget will always be whatever the government of the day decides it should be. Sometimes we will agree with that government's spending priorities, and sometimes we will not. This is a feature, not a bug. One cannot sensibly advocate a system which vests politicians with so much power and then constantly complain when those politicians do not use that power in the way one wants them to use it.

In insurance-based systems, politicians cannot directly control the level of healthcare spending. Insurers are free to set their own premium rates, and if those rates are insufficient to cover the healthcare services that the public wants and is prepared to pay for, they can raise them. They do not have to ask politicians for permission first, or wait until a government sympathetic to their position is voted in.

In theory, one could imagine the NHS operating in a similar way, with its own revenue-raising powers. But the monopoly status of the NHS makes this unfeasible in practice. Insurers in SHI systems can be given the autonomy to set their own premiums, because competition between insurers prevents them from abusing it. If an insurer charges unreasonably

high premiums, they will lose customers. The NHS, as a single-payer system, would face no such constraints, which is why it cannot be given quasi-tax-raising powers. It will therefore always be reliant on the government of the day for its funding, an arrangement which can easily lead to overspending, but which can just as easily lead to underfunding.

A political football

Health policy is a hotly contested field, in which political parties (and sometimes factions within parties) are eager to differentiate themselves from one another. With this in mind, it may come as a surprise that in the judgement of former (1999-2003) Health Secretary Alan Milburn, health policy is actually characterised by a rather high degree of cross-party agreement:

[B]roadly there is a political consensus, believe it or not. I mean one isn't going to hear much about that in the next few months [during the election campaign]. But broadly, Labour and Tory, in terms of architecture, are broadly on the same page. It's in no one's interest to say that but that's, I think, true' (Timmins and Davies 2015: 104-105).

This assessment is echoed by his indirect (1995-1997) predecessor Stephen Dorrell:

'You've heard me say it, times without number, that actually health policy hasn't changed. Frank Dobson [Health Secretary 1997-1999] would like to have changed it and wasn't able to. But apart from him, no health secretary has wanted to change policy since 1991' (Timmins and Davies 2015: 89).

There is certainly a degree of continuity in health policy, whether it reflects a political consensus or not. The purchaser-provider split of the early 1990s, the quasi-market reforms of the mid-2000s, and the 2012 Health and Social Care Act can be seen as reform agendas building on each other. However, even if there is something of a leitmotif, there have also been far too many deviations from it, and far too many disruptive reorganisations.

During its first term, the New Labour government reversed some of the internal market reforms of its predecessors. It then spent much of its second term bringing market mechanisms back in again. This is not to say that there were no substantive differences between the market-reforms of the 1990s and those of the 2000s: Labour's quasi-market was, in many ways, an improvement over the Conservative's internal market (Niemietz 2015c: 94-97; 99-105). But these improvements could have been achieved within the inherited setup: the dismantling of the existing commissioning structure, and the building up of a new one, was an unnecessary disruption.²³ Something quite similar happened after the 2010 election, when the existing commissioning structure was, once again, dismantled and replaced with a new one built from scratch. Again, this is not to say that the reforms were pointless, but that their objectives could have been achieved within the existing NHS architecture, avoiding the disruption that comes with a root-and-branch reorganisation.

Bevan et al. (2014: 29) speak of an 'appetite of successive secretaries of state for structural reorganisation [...] Timmins rightly observes that this has reached the point at which "organisation, re-organisation and re-disorganisation" almost might be dubbed the English NHS "disease"'.

Dorrell also describes the continual drive for reorganisation as counterproductive:

'the disability, the powerlessness of commissioners, is the result of consistent execution failure. But that's hardly surprising when successive governments have reorganised the commissioner side every five years. Well, of course it doesn't work if you change it every five years' (quoted in Timmins and Davies 2015: 89).

A similar trend can be identified on the management and supervision side. It is not clear what explains this tendency of political restlessness, and there is no hard evidence to draw on. But political incentives seem to point towards creating a tangible legacy, and a way to achieve this is to create new organisations.

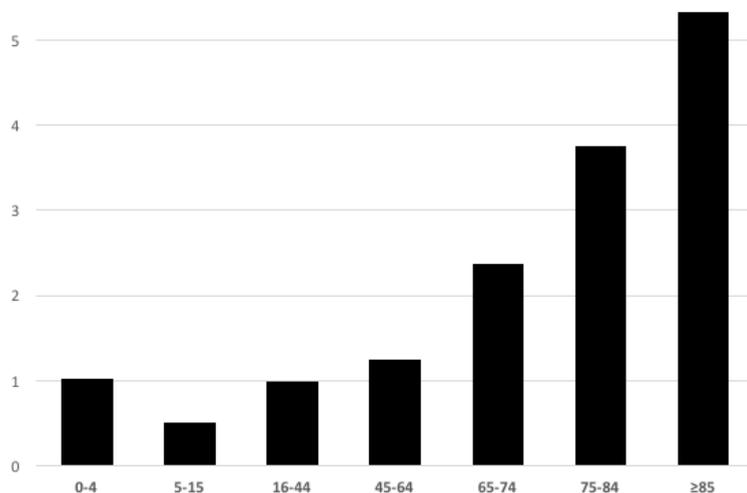
23 The main components of the quasi-market were patient choice at the point of referral, a payment system in which funding follows patients, and greater autonomy for well-managed hospitals (Foundation Trust status). These were not part of the old internal market, but neither were they incompatible with it. They could simply have been introduced within the internal market.

Insofar as defenders of the NHS recognise its failures, they often blame them on 'political mismanagement', and they may have a point. But there is something odd about people advocating a system which puts politicians in charge and then constantly complaining about the way politicians use that power. In a nationalised sector, dependence on the political mood of the day and the vagaries of the political process is a feature, not a bug.

The demographic time-bomb and the lack of old-age reserves

It has long been recognised that the combination of increasing longevity and low birth rates threatens the financial sustainability of pay-as-you-go financed pension systems. What is less often acknowledged is that the implications for healthcare are exactly the same. Almost all healthcare systems in the developed world can be thought of as effectively pay-as-you-go financed, too, because healthcare costs rise exponentially in old age (see graph below), so that most healthcare spending represents an intergenerational transfer from working-age people to retired people.

Figure 10: Healthcare spending per capita by age, as a multiple of those aged 16-44



Based on data from Caley and Sidhu (2011)

Population ageing is therefore a major cost driver, which will put the NHS under considerable financial strain over the coming years and decades. According to one estimate, ageing will add about two thirds of a percentage point to the growth rate of healthcare costs in the years until 2031 (Caley and Sidhu 2011). This estimate refers to the *net* effect of ageing; it is already corrected for the fact that increasing longevity (or rather, the factors that lead to it) will also have cost-decreasing effects. If average life expectancy in 2031 will be measurably higher than today, then a 75-year-old person in 2031 will typically be in a better state of health than a 75-year-old person today, so their healthcare needs will be lower. But such offsetting effects, while substantial, come nowhere near cancelling out the cost-increasing effects of ageing. It is also worth noting that the estimate only refers to the effect of ageing per se, not possible knock-on effects. The same ageing process might also stimulate demand for product innovation and thereby exacerbate the effect of technological progress described earlier.

As a result of this increased pressure on spending, the Office for Budget Responsibility's Fiscal Sustainability Report estimates that on unchanged policies NHS spending in the UK will rise from 7.7 per cent of GDP in 2014/15 to 8.5 per cent of GDP in 2063/64. Yet this in itself is dependent on historically unjustified assumptions about NHS productivity growth – the fruits of the sorts of process innovations outlined earlier. In fact, if NHS productivity growth remains the same as it has been over the past two decades, NHS spending would rise instead to a huge 14.4 per cent of GDP by 2063/64.

The increased costs will have to be borne by a relatively smaller working-age population. There are currently about 31 pensioners for every 100 people of working age. Under the assumption that scheduled increases in state pension age will go ahead (thus increasing the working-age population), this ratio is forecast to increase to about 35 per 100 by 2031 (ONS 2010). The tax burden on the working-age population will therefore, in one way or another, have to rise, which is problematic given that the UK economy already appears to be close to reaching the limits of its tax-raising capacity (Smith 2007; Minford and Wang 2011; Smith 2011).

None of this would be much of a problem if the NHS had been set up on a prefunded basis. Life expectancy does not increase in a sudden, abrupt way; it is not that a cohort which was expected to live for, on average, 80 years will instead live for 85 years. Rather, increases in life expectancy

follow secular trends which can be anticipated and prepared for, if with occasional revisions. In a prefunded system, healthcare financing agencies (whether these are insurance funds or branches of a tax-funded health service) would do precisely that, by building up old-age reserve funds on this basis.

As old-age savings accumulate over a lifetime, people earn interest income on them. This is, implicitly, true in a PAYGO system as well, but in a stagnant or shrinking population, the rate of return is bound to be higher in a prefunded system (Booth and Niemiets 2014: 25-28). An economy with a prefunded healthcare system will also record a higher savings rate, and thus a higher rate of investment and a larger capital stock, than an otherwise identical economy with a PAYGO-financed healthcare system.

Examples of prefunded healthcare are few and far between, but they do exist. Private health insurance in Germany, which covers about 8.8m people, is prefunded. Private insurers have accumulated over €170 billion in old-age reserves on behalf of their members, equivalent to around €20,000 per policyholder. Annual additions to the old-age reserve funds account for about 5 per cent of Germany's net savings rate (Schönfelder and Wild 2013: 28-29). Had the NHS been set up along the same lines, and had it built up the same amount of capital reserves per person, it could now have an old-age reserve fund of over £900 billion at its disposal.²⁴ As things stand, the NHS has no old-age reserves whatsoever, which leaves it ill-prepared to weather the coming demographic storm. It is, of course, still possible to begin building up a reserve fund now. But such a better-late-than-never policy would require a profound rethinking of healthcare financing, which is currently not even part of the debate.

Population ageing also changes the composition of health conditions, namely from acute towards long-term chronic conditions and multi-morbidity. In many cases, this will blur the distinction between health and social care.

Whilst we know that most healthcare spending occurs at the end of life, individual patients are likely to have very different preferences about how

24 This is an extremely crude back-of-the-envelope figure, which is only meant to give an idea of the order of magnitude. In reality, even if this hypothetical prefunded NHS used the exact same actuarial calculations as Germany's private insurers, it would lead to different results, because demographic details, healthcare costs and other relevant variables differ between the countries. But for the sake of the argument, if the NHS had built up old-age reserves averaging £15,000 per person, then for a UK population of 64.6 million, this would work out at £969 billion.

they want to manage their end-of-life experience. Some people may prefer access to the latest medical technology, others may prioritise personal care, while some will have a preference for maximum personal independence and self-monitoring in their own home. At the moment though, patients are thought of and treated too much as a homogenous mass, and too much care is hospital-centred, a setup that has evolved to deal with a completely different population health profile. This lack of ability to deal with the complex needs of older people could be seen during the recent A&E crisis, which has been acknowledged to be partly a result of older people being unable to access more localised primary care services.

To move towards a health system responsive to the wants and needs of patients would require an open, flexible system with less in the way of top-down diktats on protocol and procedures and more empowerment of patients to control their own destinies. Openness is necessary to ensure that the structures of how healthcare is delivered adapt to changing demands, and to facilitate the greater adoption of technological innovations which might improve care and treatment of the elderly. This requires a decentralisation of power generally – not only to more localised units of decision-making, but also, insofar as patients want to take on a more active role, to patients themselves.

Conclusion

It is not unusual for people to take a sense of pride in their country's health system, and to think it superior to other systems. As Taylor (2013: 20) explains:

'The French are just as proud as the British about the fact that, whoever you are, in France, if you need medical attention, you will get it. The Germans do not regard their citizens as any less well cared-for than the British. The Dutch, the Danes, the Swedes, Norwegians and the Finns can say with pride that their commitment to equality in healthcare is second to none.'

But what makes 'NHS patriotism' different from conventional 'health system patriotism' is its defensiveness, its irritability, and its tendency to treat criticism as heresy. Again, Taylor (ibid: 8) explains:

'The social consensus is so strong around the NHS that dissenting voices sound jarring. When a Conservative member of the European Parliament, Daniel Hannan, described the NHS as a "mistake" on US TV, there was genuine shock and surprise back home. David Cameron described his opinion as "eccentric". He was right. People in Britain do not hold views like that.'

The difference between 'NHS patriotism' and conventional 'health system patriotism' is perhaps best explained with reference to Jonathan Haidt's 'moral foundations theory' (see Haidt 2012: 123-154; 167-181). Arguably, the latter rests primarily on what Haidt calls the 'care/harm foundation': in other countries people defend their healthcare system because they believe that it does a good job of taking care of others. NHS patriotism rests on several foundations, of which the care/harm foundation is clearly one. But its mainstay, and this is what makes it special, is the sanctity/

degradation foundation.²⁵ The NHS is seen as a sanctuary of high-mindedness and nobleness. Even small steps towards 'marketisation' are seen as diluting the service's perceived moral purity, and to even talk about mundane considerations like financial incentives in the context of the NHS is seen as profane.

If one views the NHS primarily as a team-building exercise, it must be seen as a phenomenal success. But if one views it primarily as a health system, its outcomes are a lot more sobering. Despite considerable improvements since the early 2000, the NHS still lags behind most comparable countries in terms of health outcomes, quality and efficiency measures, whilst also having longer waiting times. Patient choice and consumer sovereignty, despite, again, considerable improvements since the early 2000s, remain underdeveloped compared to many other health systems. The notion that 'we', the public, run the NHS collectively is an illusion. 'Democratic accountability' in the health service is a statist myth. The almost complete absence of user charges has 'de-economised' the sphere of healthcare, eroding incentives for using healthcare sparingly and cost-effectively, and driving out cost-cutting process innovations. Due to the deadweight loss associated with taxation, a tax-funded system comes at a much higher economic cost than a premium-funded, insurance-based system. Tax-funding is also a much less transparent form of funding, and one which politicises funding decisions to a greater degree than other methods. The complete absence of old-age reserves leaves the NHS (and, for that matter, almost every health system in the developed world) poorly prepared to cope with the coming demographic changes. The health sector in the UK is relatively insulated from the 'creative destruction' process of the market economy, but this has not created a stable environment in which professionals can go about their business undisturbedly. Rather, the highly politicised character of the NHS encourages too many disruptive reorganisations, which break up established patterns of care and/or commissioning, and which often seem to fulfil no other role than signalling that the politicians in charge are 'doing something'.

The combined effect of these flaws is that healthcare in the UK is nowhere near as good as it could be, and that even the current unsatisfactory standard of healthcare is not financially sustainable. Diagnosing the

25 The loyalty/betrayal foundation also plays a role. After the above-mentioned episode, MEP Hannan was called 'unpatriotic' by the then Secretary of State for Health, Andy Burnham. See 'NHS attack by MEP "unpatriotic"'. *BBC News*, 14 August 2009. http://news.bbc.co.uk/1/hi/uk_politics/8200817.stm

problems is, of course, the easier bit. Presumably, quite a few readers will broadly agree with the author's description of the problems, whilst vehemently disagreeing with the author's favoured solutions. Still, speaking more frankly and in more concrete terms about the NHS's problems, i.e. moving the debate beyond platitudes such as 'we need to change the culture' or 'we need to restore the ethos of public service', is a necessary first step.

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