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A risky business: the White Paper and the NHS

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Executive Summary

It has recently emerged that Oliver Letwin, Minister of State at the Cabinet Office, has been called in by Number 10 to scrutinise the NHS White Paper and its implementation: in particular the plan to transfer commissioning from PCTs to GP consortia. This report outlines pertinent questions and explains why they should be asked, focusing on the issue of risk.

In summary, the White Paper contains some welcome moves, including:

- An emphasis on clinical leadership and management;
- The reinvigoration of competition (supported by the introduction of competition law; the reinstatement of the principle of impartial commissioning; and the extension of choice to areas outside elective care);
- A commitment to the publication of greater information on clinical performance;
- Broad support for accountability through ‘rules-based regulation’, rather than political imperative.

There is some risk in these moves. The most poignant is whether the White Paper places too much weight on the immediate potential of extending patient choice to areas beyond electives to drive productivity, over and above the influence of strong commissioning. Choice is only going to drive performance if there are alternative options to choose from: it is a gamble to expect new providers to enter a politically uncertain market, without the active encouragement of commissioners prepared to develop a supply base.

However, on the whole, the moves highlighted above have real potential to help the NHS meet its challenging productivity imperative of 4% per annum over the current parliament. The productivity imperative will not be achieved by merely driving efficiency in current systems of care, but through ‘disruptive’, innovative, and fundamentally different service models. Such models are unlikely to just come from existing providers, but from new providers entering the NHS with new ideas, applying pressure on NHS providers to up their game: on the supply side the White Paper provides a framework by which this can happen.

The big risk is the White Paper’s approach to reforming commissioning, i.e. abolishing all PCTs and transferring commissioning responsibility to new ‘GP consortia’ by 2013. It is very uncertain that this approach – particularly the wholesale nature of it – will make commissioning more effective in the short, medium or long-term, over alternatives.

1. There is likely to be a negative effect on the NHS's ability to improve productivity during the transition from PCTs to GP consortia, particularly given the imperative that *all* general practice be in a consortia;
2. The extent to which a universal shift to GP consortia addresses the root causes of why PCT commissioning has been ineffective in many areas;
3. GP consortia could either support or work against the White Paper's wider aim of moving towards a more competitive market in the NHS, particularly because government has not provided a clear definition of what 'commissioning' is;
4. It is questionable whether GP consortia will be adequately accountable to the people they serve, particularly given their interests as providers;
5. Separating the commissioning of primary care (NHSCB) and secondary care (GP consortia, except highly specialist care) risks fragmentation.

In sum, the wholesale reorganisation of commissioning could derail the potentially positive impact of other aspects of the White Paper. This report thus considers an alternative strategy towards reform of commissioning in the NHS: to decentralising control over the evolution of commissioning structures by creating a permissive and flexible framework for locally-initiated change. Such a framework – consistent with the current GP 'pathfinders' *volunteering* to take over commissioning – might entail:

1. Taking the shackles off PCTs, freeing them from interference by Strategic Health Authorities (which the White Paper is right to abolish), and assessing commissioners by the outcomes they achieve, not the processes they follow;
2. To increase clinical input, GPs could be given increased statutory influence over PCTs, including the right to take them over following a rules-based procedure (such as GP 'pathfinders');
3. As part of this, there should be a rules-based failure regime for commissioners: a 90-day notice period in which other PCTs, entrepreneurial groups of GPs or other organisations have the option of taking over a commissioning organisation that is failing;
4. Commissioning organisations should be free to change organisational form and governance structures: to merge and de-merge and, more radically, form as mutuals or cooperatives. Further ideas, like allowing people a choice of commissioning organisation to shift accountability from the state to the individual, could also be tested.

Such an approach would: allow the NHS to build on the best PCT commissioning while permitting entrepreneurs to take over in areas where it is failing or where the desire exists among GPs; significantly reduce risks in transition; and allow the NHS to focus squarely on driving productivity like never before.

Introduction

The reaction to the NHS White Paper, *Equity and Excellence: Liberating the NHS*,¹ has been mixed. Detractors and supporters have expressed concerns on the scope, scale, timescale and context of the proposed reforms; as well as the lack of adequate risk assessment. Recently (30 November 2010), it also emerged that Oliver Letwin, Minister of State at the Cabinet Office, has been called in by Number 10 to scrutinise the policy, amid concerns detailed by one insider that ‘Andrew [Lansley] has all the answers when he is asked the questions about how the implementation of all this will work. We are just not sure they are the right ones.’²

The purpose of this report is to pose a number of questions that Mr Letwin and others might wish to ask of the White Paper, by shedding some light on the issue of risk. Where do the biggest risks lie? Are they acceptable and manageable in relation to potential benefits? And, if the reforms are to be pursued following consultation, where should the focus of government be in order to mitigate such risks and maximise the chances of success? Part 1 deals with risks and opportunities in the reforms ‘as a package’. Part 2 deals with risks and opportunities resulting from specific proposals for reform. The focus throughout is on the White Paper’s potential to drive productivity and performance in the coming years.

PART A: The overall reform package

Q1. Is proper attention being given to the NHS’s productivity imperative?

No discussion of the White Paper can begin without proper attention to its context. As part of the imperative to cut the budget deficit, the NHS has been promised increases in funding of just 0.1% per annum in real terms for the duration of the current parliament.³ This carries profound implications: in order to meet increased demand for care,^a the NHS will have to improve productivity by around 4% per year for the next five years, according to the King’s Fund.⁴ This figure could well grow if pay restraint proves impossible, and if budget cuts in other areas namely housing, social care and welfare benefits have negative impacts on health. As an interim measure, the Coalition Government has called for the NHS to make at least £20bn of efficiency savings by 2014.⁵

Achieving such productivity improvement is no easy task. It is worth remembering what it entails: that after the NHS has achieved 4% more output per unit of input in the first year, it will have to do the same in the second year, dealing with inputs that are already 4% leaner than the first; the same in the third year with inputs that are 4% leaner again and so on until the fifth year. To provide an indication of how difficult this will be, average productivity across UK private sector industry increased by 2.3% per annum over the past decade;⁶ some two percentage points less than that now required in the NHS. By contrast, NHS productivity declined by an average of 0.4% per annum between 2001 and 2008, according to the Office for National Statistics.⁷ There is undoubtedly ‘low hanging fruit’ in the form of obvious inefficiencies in the NHS to meet the necessary productivity improvements in the first one or two years, but after that new, ‘disruptive’, innovative, and fundamentally different service models will be required to meet the challenge. This is unlikely just to come from existing NHS providers, but through competitive pressure and new providers entering the NHS with new ideas.⁸

In the context of this productivity imperative, there is widespread agreement that, as a recent Nuffield Trust publication put it, ‘the reforms outlined in the White Paper are substantial and will result in fundamental changes to the organisation and delivery of care to patients in the NHS in England’.⁹ The focus of the White Paper is less on productivity, more on structural change. This applies most specifically to the wholesale replacement of PCTs as commissioning organisations with GP consortia,

^a The increased demand is likely to be the result of an aging population, increased consumerism and advances in medical technology making more diseases treatable. Demand may also increase as a result of cuts to other services, such as social care.

which could well detract attention from improving productivity. There are two overriding risks: that reorganisation is costly and may lead to dips in performance; and that reorganisation fails to achieve its goals. Both would carry profound implications for the NHS, specifically a return to rationing and long waits.

Q2. What will be the likely cost and impact on performance of the proposed reorganisation of commissioning?

In a study of reorganisations of central government departments, the National Audit Office (NAO) estimated the gross cost of the 51 restructurings they surveyed to be £780m. This was considered an underestimate, because it was not possible to capture all direct and indirect costs.¹⁰

Looking specifically at the NHS, no reliable estimates are available of the financial costs of past reorganisations. However, on the basis of the NAO data, Kieran Walshe, Professor of Health Policy and Management at Manchester Business School, estimates the planned reorganisation of commissioning could cost as much as between £2bn and £3bn to implement.¹¹ This is due to the cost of closing down or merging organisations (redundancies, early retirements and redeployment); and the cost of building new organisations and systems (new staff, buildings and IT systems; training; developing new and appropriate procedures and protocols; developing constructive relationships with other commissioning organisations and providers; revising existing contracts and drawing up new ones).^b Consistent with this, it has been reported that the Department of Health has set aside £1.7bn of surplus funds from previous years' budgets to help fund the changes.¹² Clearly, £1.7bn spent in this way carries significant opportunity cost; it would, for example, fund around half of the required efficiency savings this coming year, or 212,500 coronary artery bypass grafts.^c

Perhaps the greater danger, however, is not the upfront financial cost, but that the reorganisation adversely affects the performance of healthcare organisations. This may be temporary (i.e. in transition), due to a loss of control as responsibilities are transferred from one organisation to another and focus is diverted from driving quality and productivity to putting new structures in place.^d It may also be semi-permanent, if new organisations and structures suffer from dysfunctional effects, such as tension and distrust between staff or inappropriate incentives.^{13 e}

The temporary negative effect on performance is what happened the last time commissioning was reorganised, when 222 PCTs were merged at the behest of the DH in 2006. A Civitas study looking at Healthcare Commission Annual Health Check ratings on 'quality of services' and 'use of resources' pre- and post-mergers, showed that mergers led to: 1) on average, an absolute drop in performance on 'quality of service' and 'use of resources' lasting at least one year in PCTs that were merged, compared with improved performance on both indicators for PCTs that were not merged; and 2) a period of three

^b These were the main costs reported by the NAO in their study of central government restructuring.

^c Calculated using NHS reference cost data, 2008/09, where the price of a coronary artery bypass graft (first time) is listed as £7,959.

^d Sir David Nicholson, the NHS Chief Executive, recently conceded to the Health Select Committee that some PCTs were 'in meltdown', with 'Stalinist' central control necessary to keep a grip on finances in the transition. This is likely to involve mergers of PCTs; however, as documented in the following paragraph, mergers themselves carry significant risk.

^e The Francis Report into Mid Staffordshire NHS Foundation Trust, for example, drew a link between the poor oversight provided by South Staffordshire PCT and it being recently formed from a merger of five other PCTs, reporting: 'several comments criticise the national reorganisation of PCTs in 2006/07, along with the resultant lack of capacity and organisational memory'. Francis, R, *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009*, Vol 1., London: TSO, 2010, p.374

years before the relative performance of PCTs that were merged reached pre-merger (i.e. 2005/06) levels against those that were not.^{f 14}

The danger, then, is this: if the kind of performance drop seen with the merging of PCTs in 2006 – a comparatively minor change compared with that being proposed for commissioning in the White Paper – is repeated this time around, the bulk of proposed NHS efficiency savings will not be made. This is for the simple reason that the savings rely on strong commissioning, either to effectively manage contracts and put pressure on providers to drive performance, or, more fundamentally, to shift services to more productive providers and settings.¹⁵

Q3. What is the likelihood the White Paper will achieve its aims?

Even if there are short-term transitional costs, it is however entirely reasonable to justify reorganisation on the basis that it will result in significant medium- to long-term improvements. This case is made by the Coalition Government to support the reforms in the White Paper; there is some evidence to support them.

Taking Richard Titmuss Professor of Social Policy Julian Le Grand's typology of ways of 'running' the NHS – choice (associated with competition), voice (associated with democratic accountability), trust (associated with professionalism) and mistrust (associated with central direction) – the White Paper represents a broad shift away from mistrust to choice and trust, with a slight increase in emphasis on voice. This is seen through: an emphasis on clinical leadership and, particularly, clinically-led commissioning (the shift from PCTs to GP consortia); the introduction of competition law to ensure tendering is competitive, impartial between NHS and non-NHS providers and that monopoly power is not abused; the extension of choice to areas outside elective care; an increased emphasis on the publication of high-quality information on performance; and broad support for accountability through 'rules-based regulation', rather than central direction. Such moves draw on evidence suggesting that: competition in the NHS, although currently limited, has had a positive impact overall;¹⁶ increased clinical engagement and participation in management generally leads to higher performance;¹⁷ open publication of information, so long as properly risk-adjusted, can spur improvement in clinical practice;¹⁸ and greater certainty created through rules-based regulation is typically preferable to the idiosyncrasies of central direction. There are also positives to take from experiments in GP-led commissioning in the NHS in the 1990s: GP fundholding and total purchasing pilots.¹⁹ §

However, the significant and mandatory change to the architecture of the health system proposed in the White Paper inevitably creates uncertainty, which in turn creates the real risk that anticipated benefits will not be realised. Negative effects are possible. Two overarching possibilities present themselves. The first is that the White Paper has simply laid out the wrong direction for the NHS and health care in England to secure improved quality and productivity. Specific risks are covered in greater detail in the next section. However, the greatest risk is almost certainly the shift of commissioning responsibility

^f Where PCTs were merged in 2006 'quality of services' dropped sharply the year after, with the percentage of merged PCTs rated 'good' or 'excellent' falling from 34% in 2005/06 to 12% in 2006/07. The percentage of merged PCTs rated 'good' or 'excellent' on 'use of resources' also fell, from 5% to 4%. This compares with significantly improved performance in 80 PCTs that were not merged. In terms of 'use of resources', the number of PCTs that were not merged rated 'good' or 'excellent' jumped from 15% to 34% between 2005/06 and 2006/07. In terms of 'quality of services', the number rated 'good' or 'excellent' improved from 35% to 39%.

[§] Under GP fundholding, volunteer groups of general practice held budgets for elective care from c.1991-98. It was broadly associated with: improvements in speed, access and responsiveness of secondary care; reductions in waiting times; slight reductions in referral rates and costs; and widening the range of available services. Under total purchasing pilots, fundholding general practices could receive a delegated budget from their local health authority to purchase potentially all hospital and community health services for their patients. These showed promise before they were abolished by Labour upon coming to power, but the level of achievement and responsibility between pilots varied widely.

from PCTs to GP consortia. Here, the evidence-base, at least for the universal nature of the reforms, is arguably weakest. Despite some achievements in the fundholding era, both total purchasers and GP fundholders were self-selected volunteers, enthusiastic about taking on commissioning budgets.²⁰ They also only bore responsibility for commissioning relatively small sub-sets of care. As such, it is questionable whether the evidence translates to the possible benefits of GP consortia that must: incorporate every general practice in the country; take on responsibility for commissioning the vast majority of care; and do it within three years, as is proposed in the White Paper. In the United States, where physician-led commissioning has been tried more systematically, only one in 10 associations succeeded both financially and in terms of improving patient care, according to the Nuffield Trust.²¹ More fundamentally, the commissioning changes in the White Paper do not break what many perceive to be a key weakness in the NHS: hierarchical lines of accountability. GP consortia, as with PCTs, will remain predominantly accountable to the Secretary of State for Health, via the NHS Commissioning Board (NHSCB), rather than to the people and patients they will serve.^h

The second possibility, however, is that the White Paper's prescription is broadly right, but that we never have the opportunity to find out. This may sound spurious, but it is pertinent in the NHS context. The NHS has a long history of reorganisation particularly involving the creation, merging and abolition of health bodies and the changing of incentives and emphasis within Le Grand's typology, with at least 15 major structural changes identified in the NHS over the past 30 years.²² Put simply, the frequency of reorganisation in the NHS has meant that structures are often in place for too short a time for their effect to be realised or properly evaluated: no system-wide restructuring has had clear-cut benefits. There are many reasons for the rapid changes,²³ including poor health system 'design', but it is also at least partly explained by the Government having lost its nerve with respect to a reform programme and/or reform being captured or derailed by vested interests – typically NHS providers or the British Medical Association (BMA) – resulting in a change of direction or reassertion of central control. This applies particularly to White Paper moves to create a market in the NHS that have twice floundered (in 1997 when New Labour came to power and in 2007 when Gordon Brown took over as Prime Minister from Tony Blair). Will the Government hold its nerve this time around, particularly when productivity gains are a must, and would it be sensible to?

Part B: Specifics of the White Paper

Where the previous section was concerned primarily with macro-issues concerning reorganisation, this section is concerned more with the minutiae of the White Paper. Risk is considered relating to reforms to the commissioning structure, provider landscape and regulatory framework.

Q4. GP-led commissioning

The evidence surrounding the broad merits of GP-led commissioning was covered above; as was the issue of transition from PCTs to GP consortia. Looking at the minutiae of the current proposals on GP consortia, the following additional questions pose themselves:

a. How will funding be distributed?

The consultation document *Commissioning for Patients* states:

^h There are significant changes to the hierarchy of the NHS. The Secretary of State's influence over the NHS will be reduced if powers over economic regulation are transferred to Monitor and his/her influence over the NHS Commissioning Board is confined to priority-setting in the Health Bill. However, ultimately, the strongest line of accountability for consortia, as statutory bodies, will be upwards to the NHS Commissioning Board which is to have powers to authorise, hold to account and, ultimately, intervene in GP consortia. The NHS Commissioning Board, in turn, is accountable to the Secretary of State for Health, who also remains the final arbiter in disputes over reconfiguration.

‘The NHS Commissioning Board will calculate practice-level budgets and allocate these budgets directly to consortia. These budgets will need to reflect an appropriate share of healthcare resources to include both people registered with practices in the consortium and local residents who are not registered with any GP practice.’²⁴

It is important to realise that this comes in a context where patients have a choice of general practice unrestricted by geography,²⁵ which, in effect, also gives them choice of GP consortia. There are four difficulties in calculating budgets for consortia in such an environment.

1. In order to facilitate choice, person-based, risk-adjusted, budgets would need to be developed so that people, in choosing their GP, in effect carry with them a sum of money proportionate to their health needs. As Mervyn Stone, Emeritus Professor of Statistics at UCL, has pointed out in past publications for Civitas, while necessary and desirable, this is no easy task because person-specific data is needed for accurate calculations: socio-economic indicators do not suffice.²⁶ Moreover, if any new person-based formula derives a significantly different allocation to that currently used for PCTs, consortia could find themselves in real financial difficulties when existing contracts are handed over to them.
2. To avoid ‘cream-skimming’ of patients, any person-based allocation that draws funds into a consortium through a person’s registration at a general practice will need to be supplemented by estimates of the health needs and costs of care for those not currently registered, but living within the consortia’s boundaries. This, again, is no easy task, due to migration of people in and out of areas, as documented by the Office of the Chief Analyst’s recent report on homelessness and health care.²⁷
3. Under the White Paper proposals, before budgets for consortia are calculated, appropriate funds for public health and those services to be commissioned by the NHSCBⁱ must be ringfenced from consortia budgets. The risk is that this could be poorly coordinated and will act as a break on the integration of primary/secondary care.
4. There is the question of what to do in regions where PCTs – i.e. the current commissioners of care – are running a deficit. It is hard to believe that a GP consortium would agree to take on significant deficits from the outset, meaning central government would need to write-off debt at a cost to the taxpayer.²⁸

b. Are incentives for involvement appropriate?

The White Paper makes it clear that ‘it will be a requirement for every GP practice to be part of a consortium...’.²⁹ As a last resort, the NHS Commissioning Board is to hold a reserve power to assign practices to consortia.³⁰ However, it is apparent from evidence collected from GP fundholding and total purchasing pilots in the UK, and experience of GP commissioning in the US, that coercing GPs into commissioning structures is unlikely to lead to positive results.³¹ ^j

If this is to be so, although only a minority of GPs will be actively involved in ‘doing’ commissioning, every general practice must have some involvement and incentives must be strong enough, but also appropriate and sensitive enough, to reward them, and gain the support of the medical profession.

ⁱ Primary medical care (i.e. general practice income for *providing* services), primary dental services, community pharmacy, primary ophthalmic services, national and regional specialised commissioning, maternity services and health services for those in prison or custody, under the consultation proposals.

^j Of the failure of physician group commissioning in the US, Larry Casalino wrote: ‘policies essentially forced physicians into risk contracting; thousands of disgruntled physicians ended tens of thousands of patient visits every day by telling patients how the new policies were harmful to patients and physicians’.

Larry Casalino, a professor at Cornell Medical College who reviewed US evidence around GP commissioning, suggests this requires a focus on a combination of: quality of care (not just costs); doctors' income; the quality of doctors' working day; and respect from medical peers.³² At least four risks present themselves here:

1. Increasing doctors' income is likely to be impossible in the current financial climate;
2. The Coalition Government has, in any case, invested considerable political capital in presenting salaries of public managers that are higher than the Prime Minister's salary as unjustified;³³
3. The White Paper makes clear that consortia income will be kept separate from GP practice income, which may reduce any financial incentive for GPs to engage in commissioning (though this is mitigated by proposals to link a proportion of practice income to outcomes achieved by consortia);³⁴
4. Clinicians going into management is still considered in certain quarters to constitute going over to the 'dark side' and a threat to the professional autonomy that doctors in particular have traditionally held.³⁵

c. *Are incentives for driving performance appropriate?*

It is imperative the Coalition Government also consider the appropriate blend of risks and incentives to be carried by consortia to drive efficiency and quality of care, and stay within budget. Due to provider-interests, the motivations of GPs in commissioning will not necessarily align with those of patients: there must be appropriate rewards for good performance and commensurate penalties for failure.

The White Paper outlines such a framework, but there are many unanswered questions.^k In particular:

1. The stringency of oversight by the NHSCB and the exact makeup of the assurance process. With the abolition of PCTs, it is envisaged GP consortia will have responsibility for much of the NHS budget at a time when the NHS faces unprecedented financial challenge. Given that consortia will be new and inexperienced organisations, there is significant risk that unsupported they will fail to control spending and commission effectively. Conversely, as referred to in the previous section, if consortia are tightly controlled it is unlikely they will do much other than re-invent the wheel. The measures chosen to gauge the success of consortia will be crucial.
2. When a failure regime will be invoked and what it will involve. It is likely, indeed probable, that a number of consortia will fail and/or make mistakes leading to overspend and dips in performance on quality. There is a fine balance to strike between allowing time for mistakes as competent consortia develop and enforcing a proper failure regime that provides penalties for poor performance and incentives to improve.
3. Appropriate rewards for consortia that improve performance and stay within budget through good financial management. The NHS has a history of top-slicing the surpluses of organisations that manage resources well to bail out those that have overspent, which creates perverse

^k The NHS Commissioning Board is to be 'responsible for developing an assurance process that enables consortia to be accountable for the outcomes they achieve [health outcomes and quality of care, including patient-reported outcome measures and patient experience], their stewardship of resources, and their fulfilment of duties placed upon them'. This will include a staged failure regime to be invoked in the event of financial failure or systemic failure to meet the health needs of patients; oversight of risk pooling between consortia to guard against 'insurance risk'; and principles for managing underspends and overspends. An 'accountable officer' will also be part of the makeup of all GP consortia.

incentives to overspend and retain inefficiencies, rather than invest for the long-run.³⁶ Consortia should be allowed to retain surpluses.

4. The ability of consortia to drive performance in areas outside of their immediate contractual influence. The majority of general practice has, in effect, a contract ‘for life’ under the terms of the General Medical Services (GMS) contract. There are also real conflicts of interest resulting from GPs acting as both commissioners and providers (the danger being that GPs simply expand the services they offer in order to increase their income when there may be better options available). The decision to house responsibility for the commissioning of primary care with the NHS Commissioning Board, rather than with consortia, is thus understandable. However, this decision risks dissuading consortia – or any frontline commissioner – investing in and contracting new models of primary care (including integrating primary and secondary care) that would be beneficial to patients.^l
- d. Is ‘commissioning’ appropriately defined, and will GP consortia have the requisite skills to do it?**

The rationale for replacing PCTs with GP consortia is presented in the White Paper as ‘to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients’ advocates and support them in their healthcare choices’.³⁷ Indeed, the Coalition Government increasingly refers to commissioning as impacting on the decision-making of clinicians (particularly those that commit resources) and the configuration of care pathways. In this sense it seems a logical step for GPs, being ‘gatekeepers’ to secondary care, to commission care in order to better align financial and clinical incentives.

However, the broader purpose of commissioning should be to secure services that offer the best value – in terms of quality and cost – to meet the needs of the local population; services that may not be commissioned currently. This is the bigger task of a commissioner, involving: assessing health needs across populations; deciding on the best services to meet such needs; developing a competitive supplier base; contracting services; managing contracts and relationships; data analysis; and monitoring performance.^m Much of this may be delegated to managers or commissioning support groups; some GPs will have developed baseline skills from involvement in practice-based commissioning and GP fundholding before that; but GPs leading consortia will need to develop greater skills in this area – and fast – if the NHS is to achieve the required productivity in the next few years.

Drawing on the US experience, Casalino emphasises:

‘Managing a [physician group] of any size is not a job for amateurs... US physician groups that succeeded in risk contracting invested substantial funds to pay for leadership, information technology, and staff infrastructure to analyse data, implement organised processes to improve care, and... to engage in paying strong claims and in contracting with specialist physicians and hospitals.’³⁸

The White Paper only briefly mentions how such skills will be nurtured; instead there is a general attack on management along with a proposition that management costs be cut by 45% across the NHS over

^l The second issue is public health. Coalition Government proposals entail responsibility (and ringfenced budgets) for public health – or ‘local health improvement’ – be transferred to local authorities. There is good rationale for this as health and wellbeing is as much, if not more, a function of factors such as employment, housing and educational attainment as it is health care, but the makeup of health care does still play an important role. The White Paper proposes that ‘Health and Wellbeing Boards’ facilitate joint-working between local authorities and consortia, but being outside the remit and strict accountability of consortia there is a risk of poor engagement.

^m Of course, not all GPs will be directly involved in commissioning and GPs will no doubt appoint effective management to do a lot of the ‘nitty-gritty’ of commissioning, but it is essential those involved have at least a basic knowledge.

the next four years. This creates the risk that GP consortia will not have the administrative power to: train GPs in commissioning skills; properly analyse their performance and the performance of the providers they are contracting; and provide accurate information to fuel the ‘information revolution’ in the NHS otherwise promised in the White Paper.³⁹

e. Will GP consortia have adequate accountability, particularly to the people they will serve?

The consultation document, *Commissioning for Patients*, states the Coalition Government ‘do not intend to set out detailed or prescriptive requirements in relation to internal governance of a consortium’. Instead, consortia are to come together organically and decide governance processes to fit the healthcare needs of the local population.⁴⁰

In this environment, it is envisaged that the accountability of consortia will lead three ways. Local accountability is strengthened by Health and Wellbeing Boardsⁿ which will provide local authorities with a degree of oversight, and there is the possibility of direct accountability by patients through their ability to effectively exercise choice of consortia (through their having a choice of general practice), but both mechanisms are comparatively weak in the ways in which they are configured.^o The predominant line of accountability is hierarchical: GP consortia will be ‘statutory public bodies, with powers and responsibilities set through primary and secondary legislation’,⁴¹ as such consortia will be accountable primarily to the NHS Commissioning Board and, in turn, to the Secretary of State for Health.

The risk is that placing GP consortia in such a framework undermines the Coalition Government’s aim of ‘liberating’ commissioning from ‘excessive bureaucracy and political control’ by handing power to GPs, who have over the past 60 years run their practices as small businesses. As Paul Corrigan, a former health advisor to Tony Blair when he was Prime Minister, has written:

‘You do not get rid of the state by making new GP commissioning organisations state organisations. You do not liberate GPs from the state by nationalising them. You really don’t.’⁴²

f. Will GP consortia be of sufficient size to commission effectively?

A further concern is the likely size of GP consortia. The White Paper, though emphasising that the Coalition Government does not want to be ‘unduly prescriptive about the size of consortia’, states consortia must be of a sufficient size to manage financial risk. There is debate over what such a size must be (most consider it to be at least 100,000 people).⁴³ However, it is possible there will be a proliferation of commissioning organisations of smaller size than current PCTs. There is little evidence for this – in fact, the trend in PCTs has been towards forming larger collaborations to increase purchasing power *vis-à-vis* providers and take advantage of economies of scale. The international trend, too, is towards larger commissioning organisations: in nine out of ten European countries surveyed by Civitas in a recent study, the average population coverage of a commissioner was over 300,000 – considerably higher than the likely population coverage of GP consortia.⁴⁴

Q5. The provider landscape

As referred to in part A, the White Paper’s emphasis is on a switch from ‘mistrust’ (associated with central direction) to ‘choice’ (associated with competition) and ‘trust’ (associated with professionalism). The predominant mechanism for driving performance in providers is envisaged to be competition, within

ⁿ Health and Wellbeing Boards will act as a bridge between GP consortia and local authorities. This is particularly important given the latter’s new responsibility for public health.

^o As mentioned above, GPs operating under the GMS contract also have, in effect, a contract ‘for life’, minimising any competitive effect here.

a rules-based regulatory framework, fuelled by strong commissioning, patient choice and the open publication of information. The vision is expressed as follows:

*'Providers will no longer be part of a system of top-down management, subject to political interference. Instead, they will be governed by a stable, transparent and rules-based system of regulation. Our aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market.'*⁴⁵

In other industries, competition, when placed in the appropriate regulatory framework, typically has driven productivity in a way no other system has.⁴⁶ This applies also to certain industries that were previously dominated by the state: regulatory reforms that introduced competition into UK water, gas and electricity markets, for example, led to 'phenomenal rates' of productivity increase in the 1990s of over 10% per annum.⁴⁷ The White Paper's hope is that, with the injection of market forces, similar results will be seen in the NHS. However, this depends substantially on getting structures, incentives and the regulatory framework right: though there is evidence of positive effects of competition in health care, it is not as compelling as in other industries.⁴⁸ There are question marks as to whether the White Paper has done this.

a. Does the move from PCTs to GP consortia address key weaknesses in commissioning as things stand currently?

The effectiveness of a market and competition in the NHS depends significantly on the approach and performance of commissioners not least in: the decision to tender; how a tender is carried out; and the effective monitoring of resulting contracts. There is reasonable evidence that PCT-led commissioning has not delivered the benefits that were anticipated in this regard – at least on any significant scale.⁴⁹ The question is why this is so and whether switching commissioning from PCTs to GP consortia addresses the root causes of weakness. As summarised by a recent report by Civitas, weakness in PCT commissioning can be attributed to:

- The lack of a consistent vision and support on the part of government for PCTs as commissioners.
- A lack of clinical input in commissioning and ability to influence primary care.
- A lack of commercial skills on the part of PCTs and NHS providers.
- A structural imbalance of power between PCTs and NHS providers in favour of the latter, explained among other things by a disparity in size, skills and political support.
- Significant barriers to entry and exit.
- The bureaucratic and overly-prescriptive nature of the tendering process.
- Cultural reverence for the NHS as a system of nationalised provision, promulgated by politicians and the DH. This has acted as a powerful break on PCTs' ability to bring in alternative providers with new ideas to challenge NHS providers.⁵⁰

Aside from increasing clinical input, it is uncertain that replacing all PCTs with GP consortia will address these weaknesses. GP consortia led by entrepreneurial GPs with a clear vision may well do a better job,

but others may not. In the latter, weaknesses well could be more acute under GP consortia than under PCTs, and be addressed without structural change.^p First, it is yet to be seen whether the Coalition Government will form a clear narrative when it comes to ‘commissioning’ in the NHS (see p.7): a key weakness with PCT commissioning.^q Second, the fact GP consortia may well be smaller than PCTs could increase the structural imbalance of power *vis-à-vis* large NHS acute trusts (though the clinical clout of GPs may act as something of a counter-balance). Third, in handing control of commissioning to GPs, the Coalition Government do risk blocking their own emphasis on choice and competition due to the BMA’s long-standing opposition to a market in the NHS.^r Fourth, instability and confusion in the transition from PCTs to GP consortia (and, potentially, across the ‘new’ system with key services such as primary care and pharmacy being commissioned centrally and the remainder by GP consortia) is also likely to be a significant problem: effective commissioning is likely to require clarity and stability.

b. Will patient choice be a powerful enough lever to drive performance?

Putting aside the effect of commissioning in driving competition and performance, the Coalition Government’s other competitive lever is the extension of choice into a number of different areas of care, including: maternity; some mental health services; diagnostic testing; long-term conditions as part of personalised care planning; and general practice.⁵¹ The hope is that patients choosing which provider they want to go to will act as a powerful incentive for providers that lose business to up their game. There are three potential problems here.

1. Although modest effects on performance have been registered with regard to the patient choice that currently exists in electives,⁵² according to a 2010 study by the King’s Fund ‘it is not yet operating as intended and has not so far acted as a lever to improve quality and increase competition’.⁵³
2. While there may be some intrinsic worth in offering people choices, choice is only going to drive performance on any significant scale if patients have adequate information, choice is offered to patients by GPs and alternative options exist. There is an implicit assumption in the White Paper’s extension of choice that independent sector providers – as well as possible ‘spin-offs’ from NHS providers – will enter the market voluntarily to challenge NHS providers for business. This is a gamble. Without a commitment on behalf of GP consortia to contract new providers with at least an *initial* guarantee of service volume, many will consider the commercial risk to be too great. At the moment: barriers to entry and exit are high; there is no level playing field with NHS providers; there is no guarantee GPs will offer patients choice, and do so impartially; and providers know that at present the market is only as good as a Minister’s word.^s Among other things, it is likely that investment in the supply-base led by strong commissioning would be needed before significant gains from patient choice may be expected.
3. The commitment to extending choice through somewhat voids the influence that GP consortia, as commissioning organisations, may have over providers (in that a consortia must pay for the

^p The White Paper does address some of these independently, such as barriers to entry and exit. The point, however, is whether addressing these would have sufficed to make the NHS more competitive without the need for the switch of commissioning from PCTs to GP consortia.

^q Despite a focus on impartiality in commissioning, for example, the ministerial team have made consistent references to the value of the ‘NHS family’ of providers that tends to act against impartiality.

^r For example, how will the Coalition Government ensure GP consortia commission and tender impartially, without recourse to the blunt instrument of legal action, given that the BMA have publically recommended their members give preference to NHS providers?

^s Monitor, in its new role as economic regulator, will mitigate this to an extent, but it depends on its role and aim being clearly defined. Moreover, individual providers are unlikely to refer cases of anti-competitive practice in any significant number, for fear of losing future business.

treatment at whatever provider a patient chooses). It also takes price out of the equation, insofar as providers must be paid at the national tariff.

There is a possibility that commissioners, through effective tendering, competitive challenge and their ability to move services around based on quality and cost, could have a more powerful influence, at least in the short-term before a supply-base is developed and choice embedded.⁵⁴ [†]

c. Does the proposed regulatory reform provide the right framework for an effective market?

Particularly in the field of public services, the extent to which choice and competition can drive standards depends significantly on the regulatory framework it is placed in.[‡] The Coalition Government claims it has simplified and refined this framework, but again real questions remain:

1. The NHS Commissioning Board (NHSCB) has a wide remit, charged with: policing the shift of commissioning from PCTs to GP consortia at a time when the NHS must drive efficiencies of around 4% per annum over the current parliamentary term; allocating NHS resources; holding GP consortia to account; promoting choice; and commissioning certain services (including primary care). In such a financial climate, there is a real risk that the NHSCB merely becomes the new ‘centraliser’ and/or repeat many of the mistakes the DH made in advocating an overly prescriptive and adversarial approach to tendering.[‡] Its tasks are also not without conflict: its role in commissioning could well conflict with its role of holding GP consortia to account on commissioning performance, because (in)effective commissioning by the NHSCB will inevitably impact on how well a consortia performs.[¶]
2. Monitor is to be reconfigured as an economic regulator. There are two challenges here. First, setting Monitor clear instructions on the job in hand; in particular the desired balance between its terms of reference to promote competition and to ‘ensure continuity of services’. This will be crucial. The ‘continuity of service’ argument can be, and has been, used in the past to quash competition and the potential competition has to drive performance in the NHS; yet, conversely, overly-zealous application of competition law (for example to break up services where monopoly exists and is justified in terms of service capture and economies of scale) could significantly destabilise local health economies at just a time when organisations are already facing acute productivity challenges.[×] Second, it reforming itself, Monitor must drop any natural allegiance it may feel to foundation trusts and accept that its new role in applying competition

[†] If so, there is a sound case to make that choice might be better concentrated at the level of commissioners, thereby shifting the attention of commissioners to patients, rather than the state. Indeed, European health systems where there is such choice, such as the Netherlands and Switzerland, do perform well in the majority of international comparisons.

[‡] For example, the payment-by-results framework, whereby hospital trusts are paid at tariff for the activity they carry out, may be appropriate for elective care, but has been widely criticised for encouraging unnecessary hospital use elsewhere. There is also the potential for providers cutting corners to make profit or surplus, hence the need for a strong regulator of quality; and the need for an economic regulator to guard against anti-competitive practice.

[¶] There are also real questions over how much independence the NHSCB will be given. The White Paper promises the NHSCB will be ‘free from day-to-day political interference’ to effectively carry out its regulatory role. The reality, however, is that the Coalition Government remain accountable for NHS spending (by far the largest category of public spending) and will want to have a say on how this money is spent. Political interference in foundation trusts by the previous government, despite the autonomy conferred on them, shows clear precedent on this.

[×] The expectation that the NHSCB will be ‘lean’ also may be a problem if it leads the organisation to be under-staffed: contracting 8,320 general practices in England alone requires significant manpower.

[×] In general, the application of competition law to break up monopolies occurs only in cases where there is evidence of abuse, such as dictating unfair trading terms or engaging in predatory pricing. Monitor also would have to take a view as to whether short-term costs of breaking up a monopoly provider is worth any long-term gain that may derive from increased competition.

law may well lead to difficulties in the institutions it helped to create and police terms of authorisation. This will require cultural change and should be monitored.

3. In seeking to streamline the regulatory framework governing the NHS to four bodies – the Care Quality Commission, NICE, Monitor and the NHSCB – the Coalition Government have taken a welcome step to streamline regulation. However, the four regulators do overlap in their responsibilities and there is an underlying risk that the relationship between them could become uneasy and counter-productive. For example, while the NHSCB is to recommend pathways and procedures that prices are set against, it is Monitor that will ultimately set these prices. If prices are set too high, it may well impinge on the ability of the NHSCB to keep NHS finances in check when strain is placed on GP consortia budgets. If prices are set too low, the CQC may well be concerned that there is a risk of quality being short-cut. Similarly, in Monitor’s enforcement of competition law, there is always the risk of quality suffering in the short-term (a matter that the CQC will be concerned with) and destabilisation in a local health economy (a matter the NHSCB will be concerned with in its oversight of GP consortia). On top of this there is the consideration of exactly how much freedom of manoeuvre each regulator will be afforded by the Secretary of State for Health and which body the Secretary of State would favour in any dispute. How such potential difficulties play out in reality will be significantly influenced by personality and political imperative.

Conclusion

The NHS White Paper contains welcome moves, not least the broad shift away from ‘mistrust’ (associated with central direction) to ‘choice’ (associated with competition) and ‘trust’ (associated with professionalism) as the predominant means for driving performance. The emphasis on clinical leadership and management; the introduction of competition law; the re-instatement of the principle of impartial commissioning; the extension of choice to areas outside elective care; an increased emphasis on the publication of high-quality information on performance; and broad support for accountability through ‘rules-based regulation’; all have real potential to help the NHS meet its productivity imperative. In particular, the disruptive innovation necessary for the NHS to maintain its service offering in coming years is unlikely just to come from existing NHS providers, but from new providers entering the NHS with new ideas, applying pressure on NHS providers to up their game:⁵⁵ the White Paper provides a means by which this can happen. The purpose of this report in the respect of these moves is to highlight possible risk and where attention should be focused.

The big questions, however, are whether the White Paper’s approach to reforming commissioning, i.e. abolishing all PCTs and transferring commissioning responsibility to new ‘GP consortia’ by 2013, will help or hinder; and whether too much weight is being placed on the immediate power of patient choice over and above strong commissioning. The latter appears likely, at least until a market is developed by commissioners. The former is hugely uncertain. The biggest questions are whether:

1. There is likely to be a negative effect on the NHS’s ability to improve productivity during the transition from PCTs to GP consortia, particularly given the imperative that *all* general practice be in a consortia;
2. The extent to which a universal shift to GP consortia addresses the root causes of why PCT commissioning has been ineffective in many areas;

3. GP consortia could either support or work against the White Paper's wider aim of moving towards a more competitive market in the NHS, particularly because government has not provided a clear definition of what 'commissioning' is;
4. It is questionable whether GP consortia will be adequately accountable to the people they serve, particularly given their interests as providers;
5. Separating the commissioning of primary care (NHSCB) and secondary care (GP consortia, except highly specialist care) risks fragmentation.

When this is analysed, an alternative strategy for reforming commissioning may be worthy of consideration. One approach could be to reconsider the idea of mandating a new, universal, commissioning structure in GP consortia. Instead, control over the evolution of commissioning in the NHS could be decentralised by creating a permissive and flexible framework for locally-initiated, and appropriate, change: what the philosopher Sir Karl Popper called 'piecemeal social engineering' instead of the rather 'utopian social engineering' of the White Paper's approach to commissioning. Such a framework might entail:

1. Taking the shackles off PCTs, freeing them from interference by Strategic Health Authorities (which the White Paper is right to abolish), and assessing commissioners by the outcomes they achieve, not the processes they follow;
2. To increase clinical input, GPs could be given increased statutory influence over PCTs, including the right to take them over following a rules-based procedure (such as GP 'pathfinders');
3. As part of this, there should be a rules-based failure regime for commissioners: a 90-day notice period in which other PCTs, entrepreneurial groups of GPs or other organisations have the option of taking over a commissioning organisation that is failing;
4. Commissioning organisations should be free to change organisational form and governance structures: to merge and de-merge and, more radically, form as mutuals or cooperatives. Further ideas, like allowing people a choice of commissioning organisation to shift accountability from the state to the individual, could also be tested.

Such an approach would: allow the NHS to build on the best PCT commissioning while permitting entrepreneurs to take over in areas where it is failing or where the desire exists among GPs; significantly reduce risks in transition; and allow the NHS to focus squarely on driving productivity like never before.

Local experimentation is, after all, what has yielded the success of GP-led commissioning in Cumbria and Nene, two places oft referred to by the Secretary of State in his defence of the White Paper. It is also the longstanding benefit of a more competitive environment that the Secretary of State is rightly seeking to introduce on the supply-side of the NHS: competition, more than any other system, allows the undertaking of the small-scale experiment, the watching of results, the mimicking of what works and the discarding of what doesn't.

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