
CIVITAS: Institute for the Study of Civil Society

Markets in health care

The theory behind the policy

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Executive Summary

In its current state, the NHS functions on the basis of what has been variously called a 'quasi', 'mimic' or 'internal' market, where providers – NHS, voluntary and private – are theoretically competing and placed on an even footing. With debate around this principle intensifying,ⁱ this paper revisits the anticipated benefits of the use of market mechanisms; asks on what theory they rest; and where the NHS currently stands.

Markets vs. monopoly

Health care, due to its high upfront costs and centrality to humankind, is often considered 'different' and best left outside the domain of markets. But such blanket opposition ignores valid reasons for not dismissing the value markets could bring:

- i. **Efficiency.** In a market environment people can demonstrate their preferences for different goods and services by exercising choice. This both generates highly precise information about their preferences, so providers are motivated to supply the services people want (**allocative efficiency**), and provides the incentive for providers to be as efficient as possible in order to undercut competitors (**technical efficiency**).
- ii. **Customer service and innovation.** In markets there is always the opportunity for people to come forward with new ideas to meet an unmet need: a powerful incentive to experiment, innovate and focus squarely on service users.
- iii. **Resiliency.** A major criticism of government action in the field of public policy is that it has followed 'utopian social engineering', resulting in any wrong decision being felt hard and universally. In markets, where there are so many participants, it would be remarkable if all made the same mistakes.

ⁱ In a speech to the King's Fund think-tank on 17 September 2009, the Secretary of State for Health, Andy Burnham, MP, stated that 'the NHS is our preferred provider', which was later re-affirmed in a pledge to the TUC on 22 October that non-NHS providers would only be contracted as a last resort.

- iv. **Voluntary co-operation.** Markets form part of a sphere that is based on voluntary co-operation, in that the decisions of businesses, individuals and researchers are not forced on anyone else. This contrasts with monopoly where there are few alternative options.
- v. **Equity.** In centrally-planned systems, where there is no *formal* choice, middle and upper class people typically are better at *creating* choices and negotiating a better deal. With an appropriate redistribution of resources, markets give *everyone* this opportunity.

There is another side to the coin, however. Markets do not work well in all situations; and in health care they suffer from a number of limitations:

- i. **Underpowered consumers.** Because health care costs are often exorbitant, most of us will not pay for services upfront, but rely on a third-party insurer to smooth costs over lifetimes and spread risk. This opens up a can of worms:
 - If people know more about their expected health expenditure than insurers, insurers will want to raise premiums to all in order to guard against the costs of having unhealthy people on their books. Healthy people may choose not to buy insurance (**adverse selection**).
 - When insured, people's behaviour may change because they no longer bear the full consequences of their decisions (**moral hazard**).
 - If insurers do, in fact, know the health profiles of their clientele, they have the incentive to dump (refuse to insure unhealthy people); cream-skin (seek to attract healthier patients); and skimp (provide a sub-optimal, but less costly, service) (**risk selection**). This applies to providers too.
 - **Information is imperfect.** Data on health outcomes, access and the effectiveness of various treatment options remains non-existent, inadequate or inappropriately risk-adjusted in most health systems. Thus

people will often defer decision-making authority to professionals; people are not 'sovereign'.

- ii. **Monopoly.** Pluralism may not always be preferable to monopoly. To take two examples: evidence suggests health outcomes are improved in high-volume specialist centres; and in rural areas demand may be sufficient for only one hospital to survive while just covering costs.
- iii. **Externalities.** One person's 'consumption' of health care may well have beneficial effects for others – particularly where infectious diseases are concerned. Yet if, as markets typically assume, individuals and providers only have regard for themselves, then there is likely to be both under-consumption and under-provision of services such as vaccinations.
- iv. **Compassion.** Market failure aside, the reason why health care is collectivised to some extent in all developed countries has more to do with what we consider to be fair and just in a free society. The vast majority of us would demand that everyone has access to health care, regardless of income or status – something that markets alone cannot guarantee.

However, these quandaries do not necessarily mean we must simultaneously lose all the benefits markets can bring:

- i. **Market failure is everywhere.** Market failure exists in all markets, yet on the whole they function pretty well.
- **Individuals cooperate.** We are not just individualistic 'utility maximisers' as market theory assumes, but are also altruistic and concerned with social norms. The individualism promoted by markets has not prevented cooperative behaviour; indeed, effective markets both require and generate it.
- **'Imperfect' information.** In most transactions, be it choosing a restaurant to eat in, or buying a computer, we will have imperfect information about how things work and are engineered. Yet we make such decisions with

relative confidence; often, in fact, in collaboration with people who know more about it than we do.

- **Consumers are not always sovereign.** Many, if not most, market transactions in fact take place between *companies and organisations* as part of the process of creating a product/service. Most transactions in health care are between insurers/commissioners and providers.
 - **Markets require regulation.** Without the belief – supported by trust and regulation – on the part of both the buyer and seller that a transaction will be honoured, most will not take place.
- ii. **The alternatives to markets have their own pitfalls.** While markets are not perfect, they are often the ‘least worst’ option when compared with others that lack any ‘power of exit’:
- **Trust.** Professionalism is often enough to ensure care processes are centred on the needs and wants of patients, but there is forever a risk that the interests of providers and professional groups are sometimes put first.
 - **State provision: ‘targets and performance management’.** Developing a sophisticated central machinery to drive performance is unlikely to succeed because central planners will not be ‘value-neutral’; providers will always have more ‘soft’ information that doesn’t get computed; and patient ‘need’ changes every time a new drug or service comes on stream.
 - **Voice.** Patient feedback provides a rich source of information, but there are few concrete incentives for the disinterested provider to improve. Relying purely on voice is also likely to be inequitable because it is the wealthy and more educated who tend to be more articulate, confident and comfortable speaking to doctors.

Market-driven health care

The central challenge for policymakers in health care, then, is best framed less as a choice between markets and the alternatives; more as to the optimum balance between them. *Markets can deliver real benefits, but only in an environment that is both committed to letting them work; and carefully regulated in order to correct for market failure and uphold certain collective choices.*

A glance around the globe suggests the most successful health systems pay attention to:

- i. **Political space.** There is the political space for those providing an inadequate or unnecessary service to exit the market; and for those that can provide a better one to enter it.
- ii. **Information.** There is adequate information about activity, cost and quality of care to make investment decisions.
- iii. **Motivated purchasers free to buy selectively.** Purchasers have the analytic capacity and freedom to contract with alternative providers in instances of poor service.
- iv. **Providers capable of responding to market forces.** Providers are able to invest to improve services and be paid more, or be rewarded with more custom, if patients think they are doing a better job than others.
- v. **Regulatory framework.** Regulation ensures that: *universal coverage is protected and assured*; minimum standards of quality and finance are met; and competition policy is enforced.
- vi. **Capital markets.** Providers and insurers/commissioners are able to retain savings and generate capital in order to finance expansion.
- vii. **Common language and currency.** There is a common unit in which services are paid for, commissioned and 'sold'.

- viii. **Local wage determination.** There is competition not only for custom, but also for staff, enabling providers to send a powerful signal that wages depend on success.
- ix. **Culture.** Staff consider quality and 'customer service' to be the name of the game; and are operating in an environment where pluralism and freedom of action is valued. Markets do not work so well, if at all, when immediate priorities are elsewhere.

The market in the NHS

The imperative and rationale for market-based reform in the NHS was a genuine attempt to harness the benefits of markets along the lines described. As *Delivering the NHS Plan* (2002) put it:

'The reforms we are making will mark an irreversible shift from the 1940s "take it or leave it" top-down service. Hospitals will no longer choose patients. Patients will choose hospitals. Patients will be in the driving seat.

'The real power and resources will move to the NHS frontline. Locally run Primary Care Trusts... will be free to commission care with decisions on providers increasingly informed by the choices which patients themselves make.'

Accompanying this came new payment systems; increased independence for providers; and a more independent regulatory framework. But there are a number of tensions that remain unresolved:

- i. **Enduring political control.** The fact that funds are still raised centrally through general taxation means that the government retains considerable sway, most clearly represented by the recent announcement by the Secretary of State for Health, Andy Burnham MP, that the NHS is to be the 'preferred provider' of services, which contradicts existing regulation.
- ii. **Prices.** Much of the market in the NHS (at least in secondary care) relies on the payment-by-results tariff, which sets a fixed price for a given service.

This assumes the centre knows the 'average' price; and prevents efficient providers from passing on lower prices to commissioners.

- iii. **Information.** Large amounts of data does not automatically equate to large volumes of *useful information*. Looking at key data on payment-by-results coding in 2008/09, for example, the Audit Commission uncovered error rates in some NHS trusts of up to 40 per cent.
- iv. **Commissioning.** In the absence of feedback provided either through local democratic means or choice of commissioner (Primary Care Trust or PCT in the NHS), how do PCTs know what to commission, how to do it and whether they are providing a good service?
- v. **Competitive tendering.** Tendering is not just a question of accepting the lowest bid; it is the *quality* of the bid that is vital; and contracts must be drawn up carefully to specify expected volume, quality and outcomes. Many PCTs are immature operators in this area.
- vi. **Providers.** Providers must have the capability – entrepreneurial and practical – to respond to the demands of contracts and rapidly changing market conditions; yet just 50 per cent of acute and 64 per cent of mental health trusts (as of June 2009) have met the prerequisite standards of finance and governance to become quasi-independent foundation trusts.
- vii. **Regulation.** Question marks remain over its adequacy. The volume and overlap of regulation is significant; much 'inspection' is reliant on self-reporting and review; and it is unclear whether the Competition and Collaboration Panel has the teeth to enforce competition policy.
- viii. **Culture.** In the past, the NHS has tended to reward those who are willing to conform. A shift to values more aligned with customer service, entrepreneurialism and cost-appreciation remains in its infancy.

The NHS is in the throes of learning from theory, other sectors and other health systems about the use of markets. Combined, these suggest markets can proffer real

benefits – efficiency, innovation, responsiveness to need, equity and customer service – when allowed to work within the correct framework. With a period of real-term cuts in funding in the offing from 2011, this potential should not be ignored. But the question remains: is there either the political appetite or necessary apparatus to realise it?

Introduction

Since its inception in 1948 the NHS in England has gradually evolved (and devolved) into a very different being. No longer is it – in the words of health policy analyst Rudolf Klein – the ‘secular church’, maintained and presided over by disciples of its founder, Aneurin Bevan.¹ In its current state, the NHS functions on the basis of what has been variously called a ‘quasi’, ‘mimic’ or ‘internal’ market.²

Primary Care Trusts (PCTs) and groups of GPs known as practice-based commissioners buy services from competing providers on behalf of their local population and practice lists; patients – at least for electives (planned procedures) – have free choice of the hospital they are referred to; and the Department of Health is cast as a supervisory, rather than directly managerial, body. It is competition between providers, rather than central cajoling or a pure reliance on professional standards, which is increasingly considered the route to a more responsive service. Decisions on service design and treatment are supposed to be driven by consumer preference as much as, if not more than, expert opinion or technocratic management.

The reasons for this shift are complex and can be linked as much to wider trends in society as to processes of ‘policy learning’ within the system. If one thing stands out, however, it is the sheer frustration of government at the lack of improvement deriving from extra pounds of taxpayer money being pumped into the health service. If neither a reign of ‘targets and terror’ nor a reliance on the professionalism of doctors and nurses could do it, then perhaps markets could. At the most basic level, then, the aim was to combine the theoretical benefits of markets realised in other sectors (with respect to pluralism, free inquiry, efficiency, innovation, responsiveness to need and customer service) with the traditional values of the NHS: universal access, free at the point of delivery, and funded almost entirely by general taxation.

How successful such reforms have been, and how successful they are likely to be in the future, remains a sticking point. Numerous studies point to real difficulties in

disentangling ‘market effects’ from the impact of other policy drivers (such as targets and regulation) and from factors specific to individual organisations.³ Studies that have provided meaningful analysis have tended to disappoint both advocates and opponents of markets alike, drawing somewhat ambiguous conclusions. In truth, market structures have probably not been in place long enough to be conclusive. The structure of an ‘internal’ market was first introduced by the Conservatives in 1991, but was abandoned (at least in rhetoric) by New Labour in 1997 only to be re-introduced in a more vigorous form in 2002, being explicitly opened up to non-NHS providers. Thus, in effect, there have been two very different markets, the first of which lasted little longer than five years; the second of which is yet really to bed down and is the subject of intense political debate.ⁱⁱ

This report does not seek to analyse whether the anticipated benefits have been realised thus far.ⁱⁱⁱ What it tries to do instead is to ask more theoretical questions: what were/are the anticipated benefits of the use of market mechanisms in the NHS; on what theory does this rest; and what problems might we anticipate in their application? To provide clarity, a three-part structure is adopted by way of response. The first looks at the theoretical pros and cons of using markets in health care; the second looks at what, in light of this, the parameters of a successful market are likely to be; and the third analyses the extent to which the NHS (in its present form) pays adequate attention to these.

ⁱⁱ In a speech to the King’s Fund think-tank on 17 September 2009, the Secretary of State for Health, Andy Burnham, MP, stated that ‘the NHS is our preferred provider’, which was later re-affirmed in a pledge to the TUC on 22 October that non-NHS providers would only be contracted as a last resort.

ⁱⁱⁱ This piece provides a theoretical backdrop for a wider study into the effects the market is having in practice.

Chapter 1: Markets and monopoly

A market is simply a structure that allows buyers and sellers to exchange a good, service or piece of information.

However, when we talk about ‘using’ markets or refer to market *economies* we generally mean those in which the price of goods and services is determined in a free system, through supply and demand, rather than being set externally (be it by a monopoly supplier or the government). The ‘freer’ a market is and the more ‘perfect’ competition is, the more exchanges between buyers and sellers happen voluntarily, at a price agreed by both, as opposed to by force, by virtue of prices being fixed by an external party, or through a lack of alternative options.

Take the following as an example. An office worker, in going out for lunch in London, chooses to buy a cheese sandwich for £2.00 from the local shop. The crucial point is that he didn’t have to buy it and could have gone to the shop next door – or even to a street five minutes down the road – for alternative options, but, for what it was, thought it was a reasonable deal. People have choices and suppliers compete for business on price, but also on quality of product, reliability of service, trustworthiness and customer service. For this reason we can say that the sandwich market is free; that when an exchange takes place between our office worker and shopkeeper, it is voluntary and has occurred at an agreed price.

In free markets, this price is determined by the choices made by numerous people like our office worker, and by the scarcity of the goods or services in question. If word gets around that the shop referred to produces the best cheese sandwich in town, demand for this shop’s sandwiches will tend to increase, and prices are likely to rise to dampen this. Furthermore, if the weather causes the wheat crop to fail, wheat will become more expensive, sandwiches become more expensive to make and prices again will tend to rise. That said, with a number of suppliers seeking to win custom by offering people better value for money, and with informed purchasers seeking the best deal (in this example hungry people who know what

they want to eat and what's on offer), prices will tend to stay at the lowest possible level consistent with suppliers staying in business.

At the other end of the scale (in terms of market concentration) is monopoly and central planning. Here, a specific individual, enterprise or government has sufficient control over the production and sale of a particular product or service to determine significantly the terms on which others have access to it. Prices tend to be fixed (because sellers cannot be undercut by competitors), and the exchange between buyers and sellers tends to be 'forced' rather than voluntary. If there is only one supplier of cheese sandwiches in the country and our office worker wants one, then he must pay whatever price happens to be going.

Monopoly providers thus have substantial power. In some circumstances – particularly in the provision of certain public services – this may be justified on grounds of efficiency, economies of scale^{iv} and collective decisions about the nature of the society we want. Monopolists, such as many local hospitals, may very well be motivated by altruism, solidarity and a profound desire to serve society. However, without the checks provided by markets, there is also the risk that they become captured by sectional interests, greed and the perpetuation of political power. It is to the pros and cons of markets and monopoly, competition and central planning, that we now turn, with a particular focus on health care.

Market Power

Health care, due to its high upfront costs and centrality to humankind, is often considered 'different' and best left outside the domain of markets. There are, as we shall see in the next section, valid reasons for such thinking. However, there are equally valid reasons for not dismissing the value markets could bring. Here we document why markets may be preferable to monopoly in health care, drawing in particular on the effects they often have on an organisation's behaviour and, in turn, performance.

^{iv} This is the principle that as scale is increased average cost per unit of output falls. This is particularly pertinent in many aspects of health care where there are high fixed costs in specialist buildings and equipment.

Resource allocation and efficiency

Allocative efficiency

The economist's utopia is allocative efficiency; a situation in which no resources are 'wasted' in the sense that it is impossible to improve the lot of one person without someone else becoming worse off.⁴ So, assuming trade takes place because it is mutually beneficial – our office worker swaps his income for a cheese sandwich because, in crude terms, he wants the sandwich and the shopkeeper wants the money to buy other goods and services – then allocative efficiency is achieved when there are no exchanges of goods and services left that could improve the lot of *everyone* to some degree. In this respect, capital and labour are put to their most rewarding use in society.

Crucially, it is through the 'invisible hand' of the competition which is facilitated by markets – or at least when competition is 'perfect', in that there are many suppliers of relatively homogenous products that are competing for many customers – that this situation is most likely to occur. Why? Because in a market environment people can demonstrate their preferences for different goods and services by exercising choice. In essence, consumers can punish poor service and reward good, which generates highly precise information about their preferences. If businesses price their wares too high, or produce a good or service people do not want, they will start to lose custom to others and become unviable. By contrast, businesses that drive costs (and prices) down, and produce innovative and desirable goods and services, will tend to gain custom.

Through this means, scarce resources tend to be used to produce the goods and services that people want; and prices are driven down to the level where the value consumers place on them equals the cost of the resources used up in production (i.e. trade takes place until it is no longer mutually beneficial).

Of course, it should be said that if any government planner could produce and manage such precise information about individual preference, then central planning (i.e. socialism) would be more efficient at allocating resources than competition

because you wouldn't get the duplication, waste and transaction costs of firms entering and exiting markets.^v History, however, suggests this is near impossible, because the transmission mechanism needed to generate this information – created through people making choices and providers responding to them – is simply not there.^{vi} Central planners have always found it easy to redirect resources to produce large amounts of a particular product, but in doing so the supply of others invariably falls – regardless of the demand.

This is most clearly exemplified in the NHS. In the last decade the government has prioritised, and set numerous targets around, coronary heart disease; cancer; and waiting times. All have improved quite significantly, but as performance in these areas has got better, others have either remained static or got worse: audiology; mental health; and long-term care for the elderly, where patients regularly end up paying out-of-pocket.⁵ And there are problems with individual targets too. After targets were introduced for inpatient and outpatient waiting times, for example, median waits increased,⁶ waiting time was shifted to diagnostics,⁷ and bed occupancy rose to levels associated with excessive risk of infection.⁸

The root of the problem is that, with monopoly and central planning, there is no satisfactory mechanism by which need, and the preferences of consumers, are revealed. Instead, services tend to be rationed according to *perceived* need using proxies such as targets, which produces many perverse results such as those outlined above.⁹ It is remarkable, as the economist John Kay observed, 'not only that the question "Who is in charge of the supply of bread to New York?" has no answer, but that the supply of bread to New York is better managed by a system in which there is no answer than by one in which there is'.¹⁰

^v In competitive markets, allocative efficiency is, as the above description suggests, only reached through a somewhat anarchic process with many firms producing the same things, and inefficient ones constantly exiting as new ones enter – both of which imply deadweight cost.

^{vi} The division of Germany into two economic zones post-Second World War represents perhaps the closest thing ever in social science to a controlled experiment on this front. Within a few years, West Germany, embracing pluralism and markets, was again among the richest and most productive economies in the world; East Germany was anything but.

Internal (technical) efficiency

As well as engineering outcomes that are allocatively efficient, markets are also likely to have powerful effects on the individual firm. We mentioned in the previous section that, across the board, markets tend to drive quality up and costs and price down; what we are concerned with here is the dynamics of why this tends to be so, with technical efficiency – the *internal* efficiency of a firm's operating process.

It is often said that the greatest of all monopoly profits is the 'quiet life' (though it is questionable whether this holds in health care, being heavily politicised), because performance is hidden by an asymmetry of information between the managers of a monopoly, consumers and the government or regulator.¹¹ With no competition and little systematic incentive to be efficient, it becomes possible for monopolists to charge exorbitant prices, which often leads to government intervention in the form of price regulation. But here, again, monopolists are in a powerful position to positively influence political decision-making in their favour, through using the weight of their employees' opinion and their market share.

The advantage of markets, seen in this light, is that they break this monopoly on information and influence, and force detail about performance out into the open. The fact that there are other firms producing similar goods and services (and there is the ever-present threat of new entrants) means those with excessive production costs – often referred to as having 'X-inefficiency' – will be exposed as inefficient, because for a given level of quality they will have to charge higher prices than the norm in order to be financially viable. What's more, even if a firm is in a market with few competitors, it is often enough to simply know there *could be* competition tomorrow for them to keep a watchful eye on price, cost and quality. Through such means, markets provide what the economists John Vickers and George Yarrow have dubbed a 'disciplining effect', which tends to spur firms to drive internal efficiency.¹²

We can see evidence of this in health care. The threat of competition alone appears to be an important determinant of hospitals' efficiency; in the US for example, research has shown that the more efficient a hospital is, the greater the average

efficiency of its peers is likely to be.¹³ And a similar trend has been observed in the UK in recent years with the Independent Sector Treatment Centre (ISTC) programme. In many areas where ISTCs were introduced, incumbent providers (both public and private sector) subsequently 're-tooled' their businesses to become more competitive.¹⁴ In Exeter, for example, anecdotal evidence shows NHS patients who had been told they would have to wait months for a hip replacement suddenly found themselves being offered one at the local hospital within days or weeks of an ISTC opening up on the doorstep.¹⁵ The crucial point is that in markets the minority tend to force the majority to do what they may not want to do, whether it's working harder or changing habits.

Customer service and innovation

To frame the benefits of markets purely in terms of efficiency – technical or allocative – is, however, a mistake. Allocative efficiency, in particular, may be a valuable end-result, but the 'greater genius' of markets over the long-term is that they tend to encourage people and businesses to focus squarely on their customers, innovate, and adopt flexibility as a natural standpoint.¹⁶ This relies on the opportunity to meet need; that businesses and people with new ideas are free to develop them and to enter markets; that profit and the intrinsic satisfaction of serving customers better lies in wait for those who break out of the mould.

This is vital. Technology and the impact of our social, political and environmental surroundings, as well as our own preferences as consumers, are constantly shifting. It is not obvious in advance who will turn out to be good at making a particular product or providing a particular service. Nor, in fact, is it obvious in advance which products or services people will want. Minidisks, for example, were hailed as the next big thing but were overtaken by digital technology and fell by the wayside, whereas text messaging initially looked like it would flop, but has proved to be one of the most successful innovations of the 21st century. In a similar vein, many of the most important innovations do not come from incumbent firms, but from new entrants.

- James Black first developed the beta-blocker when working for ICI's pharmaceutical division, but the company then refused to grant him the freedom to investigate wider applications for the drug. He went to Smith Kline and developed Tagamet, an anti-ulcerant which became one of the best-selling and effective drugs in the history of the pharmaceutical industry.¹⁷
- Three of the biggest companies in the world, IBM, General Electric and RCA reportedly turned down Chester Carlson's proposals for the photocopier, which then created millions for the Haloid Company (re-named as Xerox) and revolutionised office working.¹⁸
- None of the major manufacturers bought James Dyson's idea of using cyclonic separation to stop vacuum cleaners losing suction as they pick up dirt, so he went it alone. The product now outsells many of the companies that rejected his idea and has become one of the most popular brands in the UK.¹⁹
- An examination by the University of London of UK manufacturing plants in the 1980s concluded that the entry of new providers and the exit of old ones generated much of the efficiencies, and increased productivity by 50 per cent.²⁰

The advantage of markets, put in this context, derives from the fact that they permit pluralism and act as a forum for new ideas. In effect they support a multitude of competing providers, each of whom are conducting small-scale experiments in the hope of gaining more custom. Turning to the NHS, there is some evidence that greater diversity is encouraging this. The NHS Partners Network and the CBI have, for example, documented how innovations such as the P3 Lavage Tray and use of state-of-the-art air filtration systems to minimise infection, and one-stop clinics with surgeon, nurse and physiotherapy assessments and imaging as required, have been pioneered by new entrants.²¹

Incumbent providers have started to follow suit. In a market economy, innovation is likely to have powerful knock-on effects on other providers. If consumers reward innovators by switching to new products or services, other firms will want to mimic it. If they don't, they will fast start to lose business. In this way, the successful experiment – in products, technology and organisation – is quickly imitated, while the unsuccessful quickly folds. Computers replace typewriters, email replaces letter, diabetics pack miniature blood glucose meters with them instead of visiting the doctor for a blood test and all providers ultimately embrace the technology.

Of course, it is tempting to believe that if we just entrusted the future of our companies, industry and health services to the right people, or could just assemble all necessary information and the cleverest people in one place to debate the issues at length, we would be led unerringly to the promised land. This is highly unlikely, if not utopian. As we have seen in this section, many innovations creep in from unexpected quarters and even extraordinarily talented people miss opportunities, being focused on doing the same things better. Bill Gates missed the significance of the internet and William Morris rejected the opportunity to take over the Volkswagen plant at Wolfsburg (and with it designs for the most successful car of the post-war era).²² Historically a monopoly supplier, the NHS has helped pioneer advances such as minimal invasive surgery and MRI scanning, and places a heavy emphasis on innovation, but is widely acknowledged to lag behind other health systems in the uptake of new technology and drugs.²³ More generally, there is much evidence to suggest major institutions have overshot the level of care actually needed or used by the vast majority of patients. As the professor of business administration Clayton Christensen has put it, many seem 'in a lockstep march toward the most scientifically demanding challenges', rather than learning to provide the health care that most of us need in a way that is simpler, more convenient and less costly.²⁴

The point is that there are always well-founded objections to any new proposed course of action; there is always a proposal that might be better; and rational processes may produce decisions different from those that emerge from intuitive, speedier ones.²⁵ Without pluralism, many ideas will be missed. To borrow the

words of Friedrich Hayek, markets tend to ‘lead, under favourable conditions, to the use of more skill and knowledge than any other known procedure’.²⁶

Resiliency

A further advantage of markets is that the greater pluralism they support creates greater resilience.

In light of the global recession that has seen high street banks and large businesses – particularly in the automobile industry – running to the government for loans and bail-outs, this may seem an ironic statement. However, banks aside, while some businesses will inevitably go under as the credit crunch bites, a much greater number will either prosper in niche markets or be forced to take a long, hard, look at themselves, reorganise processes, design new products and come back fighting.^{vii} In doing so, new opportunities are created and prosperity is restored. As Paul Volcker, an economic advisor to President Obama, said ‘I like to think of the crisis as an opportunity to do some things that in ordinary circumstances... would not begin to be possible.’²⁷ In markets, where there are so many participants and the door is forever open to more, it would be remarkable if all made the same mistakes.

Let us contrast this with monopoly and central planning. Here, if an incorrect decision is taken, consequences will be felt hard and universally. Indeed, a major criticism of government action in the field of public policy is that it has followed what the philosopher Karl Popper has called ‘utopian social engineering’.²⁸ This has not only led to errors on a large scale (where government has got things wrong) and crowded out local initiatives, but has also made the evaluation of results and adaptation to failure or success impossibly difficult. There are many examples of this in health care, most poignantly in the NHS with Modernising Medical Careers (MMC)^{viii} and the National Programme for Information Technology (NPfIT);^{ix}

^{vii} Indeed, it could be argued that it is precisely because banking has become monopolised by a few very large players that we have ended up in the situation we have.

^{viii} MMC effectively nationalised postgraduate medical education under the auspices of the Postgraduate Medical and Education Training Board. It oversaw the introduction of the online application system MTAS that left thousands of junior doctors without posts. In 2008 responsibility for recruitment was handed back to the 13 deaneries; and responsibility for postgraduate and medical education training has now been transferred to the General Medical Council (GMC).

centralised programmes for postgraduate medical education and IT respectively. The subject of severe criticism in recent years, both have effectively been shelved in favour of more localised, pluralistic, approaches.

This is entirely in line with Popper's thinking. Pluralism and 'piecemeal social engineering' is likely to deliver greater benefit than monopoly and central planning, precisely because they are concerned with reform on a scale small enough to allow cause and effect to be unravelled. This is something the public sector can do at the local level, but that markets (in the absence of monopoly power) tend to encourage as a rule.

Voluntary co-operation

In most Western countries there is an assumption that the freedom of individuals should be respected. While it is agreed there are many things that should be decided and enforced by an elected government – laws defining acceptable behaviour and policing, for example – the state's essential characteristic, at least for liberals, is that it exerts (legitimate) *compulsion* through general laws that apply equally to all. In other words, there is a presumption against government interference, because the implied centralisation of power carries significant risks. As John Stuart Mill outlined:

- Modern democracy involves a struggle for power that tends to produce a tightening of control at the expense of local discretion (particularly to 'meet' central goals, such as waiting-time targets in the NHS).
- Political decisions often involve compromises, which can breed incoherence and a vulnerability to being captured by powerful interest groups.
- Over-concentration of power tends to both crowd out experimentation with alternatives and legitimate criticism, slowing the rate of improvement and growth of new knowledge.

^{ix} NPfIT is a national IT programme for the NHS, projected to cost at least £12.4 billion by 2013/14. It is at least four years behind schedule. David Nicholson, the NHS chief executive, recently conceded in evidence to the House of Commons Health Committee: 'if we don't make progress relatively soon we really are going to have to think it through again'.

- Citizens become more likely to look to the government to solve problems, instead of their own idealism, skill and initiative.²⁹

The advantage of markets, seen in this context, is that they form part of a sphere that is based less on coercion, more on voluntary co-operation. Although, as we shall see later on, markets require a well-developed social, political and cultural context to function effectively, the decisions of businesses, individuals and researchers are not forced on anyone else. Instead, members of the public are in effect offered a host of different goods and ways of doing things, which they can accept or reject as they choose.

Similarly, workers have the option of working elsewhere if they are unhappy or do not feel they are fulfilling their potential (indeed, businesses for some time now have rejected Taylorism^x and recognised the truth of the maxim that happy staff equals happy customers). People have the freedom to follow their own judgement and act on non-materialist as well as materialist motivations; accepting greater responsibility for their actions as they do. Indeed, the freedom associated with the thrill of discovery has probably been a more important stimulus to major innovations than profit-seeking.³⁰

In such ways, the voluntary nature of markets can release considerable initiative, for employers, their workers and their customers. Evidence from health care research, for one, suggests that giving patients more responsibility can reduce risks, improve outcomes and may even cost less.³¹

Equity

The voluntarism of markets does, however, depend on everyone having the opportunity and means to enter transactions *voluntarily*. There is nothing in market theory, or indeed practice, that makes this inevitable, or even likely. Markets, justifiably, have been criticised on a grand scale for being *inequitable*.³² Unaided, they are likely to engineer outcomes that are unacceptable in a free society –

^x In sociological terms, Taylorism is usually referred to as the division of labour pushed to its logical extreme, often associated with a consequent de-skilling of the worker and dehumanisation of the workplace.

particularly in spheres such as education, pensions, transport and health care where choices are typically made based on collective decisions about the nature of society, not just individual preference. A market outcome may well be ‘optimal’ in terms of allocative efficiency (see p.8), but deplorable in terms of equity.

Why, then, is equity included as an ‘advantage’ of markets? There are two reasons. First, economic theory suggests that by altering the initial distribution of income through transfers (a system of welfare) it should be possible to reach an outcome that is both allocatively efficient and more equitable.^{xi} In other words, it may be possible for government to have a role in ensuring equity, through re-distributing resources, while simultaneously harnessing the power of markets to innovate, provide customer service and deliver the goods and services people want.^{xii} Redistribution means the ‘free market’ ideal is lost, but the ‘power’ of markets described elsewhere in this section can remain.

Second, it may well be the case that through institutionalising choice, markets have procedural benefits over central planning in terms of equity. As Julian Le Grand, professor of social policy at the London School of Economics, has argued with regard to health care, in centrally-planned systems where there is no *formal* choice, middle and upper class people typically are better at *creating* choices and negotiating a better deal.³³ In the NHS, this is seen in the inverse care law, first articulated by Julian Tudor Hart: that the provision of health care tends to be inversely related to need.³⁴ Poorer patients, confined to the services that exist in their immediate geographical vicinity, do not always receive the same quality of service as the rich. For example, patients in deprived areas in England, despite having a greater clinical need for

^{xi} This is known as the Second Theorem of Welfare Economics. In economic jargon it reads that any Pareto (or allocative) efficient allocation can be sustained by a competitive equilibrium. The First Theorem follows the analysis in previous paragraphs, and states that any competitive equilibrium leads to a Pareto (or allocative) efficient allocation of resources.

^{xii} This assumes, of course, that there is no trade-off between efficiency and equity, which there might be. In reality, lump-sum transfers are difficult to enforce and rarely used. The proportional taxes (such as income tax or VAT) used instead may have large distortionary effects, epitomised in Arthur Okun’s ‘leaky bucket’: that the act of transferring wealth may generate disincentives that discourage productive effort. What’s more, as we shall see, there is no guarantee that the outcome will be equitable or acceptable.

coronary heart bypasses and hip replacements, are less likely to get them than those in higher socio-economic groups.³⁵

In this context, markets can help confer accountability to all. Everyone can do something about poor quality or service, because the same power of exit that is already enjoyed by the middle and upper-classes is given to others, and providers are then directly incentivised to respond to every individual's needs. The vast majority of surveys on choice in public services, for example, show that support is stronger among people from less affluent backgrounds.³⁶ And Le Grand's research suggests that the recent introduction of choice for elective services in the NHS has reduced variation in waiting times across socio-economic groups, in favour of the least well-off.³⁷ It may also be the case that the health expectations of more deprived populations improve, through having a greater sense of control over their lives (though, equally – and this applies to all people – it is possible that they may become burdened with information they do not want and cannot understand).³⁸

On the theory presented thus far, then, the 'invisible hand' of markets and the concomitant freedom they afford appear superior to monopoly and central planning, even in health care – at least when accompanied with a reasonable redistribution of income. Five reasons have been put forward. Markets tend to drive allocative and technical efficiency; focus attention on customer service and innovation; are resilient; are based on a set of values that support a society based on voluntary cooperation; and, under the right circumstances, can actually advance equity.

It has, however, been hinted that markets have drawbacks that, particularly where health care is concerned, may temper our enthusiasm. It is to these that we now turn.

Market Failure

It is important to realise that markets do not work well in all situations; that the benefits attributed to them in the previous section will not spring forth like manna from heaven. Instead, broadly speaking, markets work best where a number of conditions are met: the environment is competitive; consumers have good

knowledge of available alternatives and can sensibly make comparative decisions; there is no major information asymmetry either in favour of the consumer or the supplier; the product being bought is a private good, not a public issue; and businesses are free to define their unique selling points, 'select' their customers and, ultimately, go bust if they fail.³⁹

To some extent or another, health care falls down on every count. As this section documents: consumers tend to be underpowered; providers are likely to be monopolistic; and there are significant 'externalities' at hand. Even more important, however, is that in a free society the vast majority of us demand that everyone has access to health care – a goal that no market can guarantee.

Underpowered consumers

Implicit in the analysis of the previous section is that people have the power and resources to make decisions about which good or service they want; and to spend their money accordingly. In economic terms, they are 'sovereign'; and it is only because of this that preferences are revealed to providers and the market works optimally.

However, when it comes to health care there are a number of reasons why 'consumer sovereignty' may not hold. First, when we get seriously ill, the costs of health care are likely to be exorbitant: very few of us are able to afford a five-figure sum for complex surgical procedures up front. What's more, individuals can very rarely (if ever) predict when they will become ill and what their future healthcare needs will be.

As a result, for the vast majority of people, a third-party insurer will be necessary to smooth costs over lifetimes and spread risk. This, however, opens up a can of worms: immediately, people are no longer 'sovereign' in the sense there is unlikely to be a substantial and direct exchange of money between consumer and provider. Instead, in most healthcare markets, the bulk of a person's expenditure on health care will go on an insurance premium and it will be the insurer that pays out when

medical costs are incurred. Such arrangements are problematic for at least three reasons:

- i. **Adverse selection.** People may know more about their expected health expenditure than insurers. To guard against the risk of having a number of unhealthy and expensive customers on their books, insurers (not knowing the 'healthiness' of their clientele) will as a result want to raise premiums to all. However, the very act of doing so is likely to cause healthy people, who anticipate lower upfront health costs than the increased cost of health insurance, to drop out of the insurance market entirely.

This creates at least two problems. First, what happens if those that are uninsured then get seriously ill? Who pays if they cannot afford upfront costs? Second, insurers will know that if they do raise premiums, those who still take out health insurance are either more likely to be ill or think they are likely to get ill, and use health services more. Insurers then have the incentive to raise premiums even further.

- ii. **Moral hazard.** When individuals are insured their behaviour may change, because they no longer bear the full consequences of their decisions. Either they become more risky (or, in the case of health care, lead more unhealthy lifestyles) or they ask insurers to pay for more than they would otherwise have consumed if they had to pay all costs upfront.^{xiii}

The latter is particularly common in health care. The Dartmouth Atlas team in the USA have shown, for example, that there are marked regional differences in spending, even after careful adjustment for health status, largely due to physicians in higher-spending regions being more likely to recommend discretionary services.⁴⁰ And a large-scale, randomised, experiment conducted by the research organisation RAND showed that insurance packages including co-payments resulted in a reduction in

^{xiii} The same, also, can be said of providers, who under fee-for-service systems have a clear incentive to over-provide health care, leading to excess costs for insurers.

demand for all services over free-at-the-point-of-use plans, with little adverse effect on participants' health.⁴¹ Both studies suggest that insurance can lead both to excess consumption and an imperfect allocation of resources.

iii. **Risk selection.** The opposite to adverse selection. In this case, insurers – either through looking at medical histories, requiring certain tests or looking at other discriminatory factors such as age – have reasonable knowledge of the characteristics of the people that come to them. Knowing more about the 'products' they are selling than their customers, insurers have the incentive to pursue three practices that may well carry adverse consequences for patients:

- a. **Dump.** Refuse to insure – or charge exorbitant amounts to – less healthy patients who are likely to use services in excess of their premiums.
- b. **Cream-skim.** Seek to attract healthier patients who will almost certainly use services costing less than their premiums.^{xiv}
- c. **Skimp.** Provide a less than optimal quality or quantity of service for a given condition in a given time period.⁴²

Evidence of all three is found in reality. Numerous studies point to concerns, for example, that the health insurance market in the USA and *substitutive* private health insurance markets in the UK and Europe are characterised by competition on who can cream-skim the best, as much as on quality.⁴³ Indeed, the risk that the unhealthy – often the elderly or poor – are priced out of the market and left uninsured (and almost certainly unable to pay upfront costs) is the very reason why the USA has state-funded Medicare and Medicaid cover for the elderly and poor respectively, in an otherwise private health insurance system.

^{xiv} Insurers in the USA, for example, have been known to advertise their services in places only frequented by young, healthy individuals.

Nor is the problem confined to insurers. Providers, too, may well find it profitable to dump, cream-skim and skimp if payment is insufficiently adjusted for the complexity of a particular patient's case. When faced with commercial incentives, they will not want to treat patients who cost more than they get paid.⁴⁴ One criticism of opening up elective surgery to the independent sector in England, for example, is that new providers may have cream-skimmed the easier cases and left NHS providers with the more difficult and less profitable.⁴⁵

- iv. **Asymmetric information.** Underlying all the difficulties described in this section is a wider problem: information. If consumers, providers and insurers all had 'perfect' information about health status and the quality of care on offer then many of the perverse incentives described could be overridden. Skimping, for example, would be difficult because insurers and patients would *know* it was happening.

Yet despite the dawn of 'Google medicine', data on health outcomes, access and the effectiveness of various treatment options remains non-existent, inadequate or inappropriately risk-adjusted in most health systems. What's more even where information does exist *and* is presented clearly (see, for example, the Dr Foster Hospital Guide)⁴⁶ it is often difficult for the average person to interpret. Why? Because people lack information on how the choices they make will affect their *individual* well-being. Despite the increasing evidence-base to medicine, there remains great uncertainty regarding the incidence, diagnosis and progression of disease, as well as the efficacy of treatments in a given individual. Health care, to use the economic terminology, is something of a 'credence good', in that a patient must decide to 'consume' it based on his or her belief in what the outcome *is likely to be* rather than what it actually is.

The upshot of this is that for all the modern mantra of the 'empowered' or 'expert' patient, people will often want to defer decision-making authority to trained professionals, the doctors and nurses (and, of course,

a person may be simply too ill to decide for him or herself).⁴⁷ Instead of direct consumer power, then, effective markets in health care must rely to some extent on healthcare professionals acting as ‘perfect agents’ for their patients; i.e. that professionals choose exactly the same treatment options as patients would have, if only they possessed the knowledge.

Despite being at the heart of modern-day professionalism,⁴⁸ this will rarely, if ever, be the case. No two people’s preferences are the same and there will always be conflicting priorities, professional egos and rate-limiting steps to acquiring knowledge in a consultation. In other words, the policy environment and role of insurers and doctors will not be neutral. Insurers will have costs to control that may well infringe on options available to doctor and patient, and doctors may well have the incentive to create what might be called supplier-induced demand in order to gain more business.^{xv}

Taken together, then, the problems of adverse selection, moral hazard, risk selection and information asymmetry mean that, in health care, markets may not produce the benefits we typically ascribe to them (or at least not without careful attention to regulation). Without all-powerful consumers, the transmission mechanism described in the section on ‘market power’ is at least partly broken. There is no guarantee that competition will occur along the ‘right lines’; that it will not just lead to the fragmentation of care, cost-shifting and the cream-skimming we have described, as individual providers seek to maximise profits.⁴⁹ What’s more, with the need to tackle perverse incentives, transaction costs –between insurers and providers; and insurers and consumers – such as billing, contracting, and the monitoring of contracts, will be significant.

^{xv} There is a widespread view, supported by work carried out by the Dartmouth Atlas Project in particular, that empty beds in hospitals will be filled through discretionary decisions by physicians to admit patients.

Monopoly

Thus far there has been a general assumption that pluralism is preferable to monopoly; indeed, this is a large part of the platform on which support for markets is based. However, while monopolies sometimes exist in health care for no good reason at all – and could be addressed by an effective competition policy – there are instances where conferring differing degrees of monopoly power may be justified:

- Pharmaceutical firms hold (monopoly) patents for certain drugs in order to cover the costs of, and incentivise, innovation.
- Licensing laws and other forms of regulation restrict entry into the healthcare profession, but are almost certainly required in order to provide the public with the reassurance that a minimum standard of quality is being provided.
- Health outcomes for many clinical specialties, particularly serious conditions such as stroke and trauma, are improved in high-volume, specialist, centres – yet this risks creating *de facto* monopolies.⁵⁰
- Health insurers tend to consolidate into large groups (such as BUPA, AXA-PPP and PruHealth in the UK private health insurance market) because they need a relatively large number of customers in order to adequately spread risk.
- Where the population is spread sparsely there is little need for numerous providers and demand may be sufficient for only one hospital (or even general practice) to survive while just covering costs.

This is a problem for market theory because although there is a sound rationale for such pharmaceutical companies, insurers, hospitals and physicians having a degree of monopoly power, there is also the risk that they will abuse it. With consumers having fewer (or no) places to go if they are dissatisfied with the service on offer, it becomes possible for providers to determine substantially the terms of trade; to simultaneously lower quality and increase price without necessarily losing custom. Markets, in effect, no longer generate the information necessary to drive performance

and guide resource allocation and we must rely on other means, such as professional integrity and regulation – perhaps to the extent of controlling prices.^{xvi}

Externalities

An externality, or spillover, occurs when an economic transaction has a *direct* impact on someone not involved in it (not that the money could have been better spent elsewhere, but that spending it on item *x* has a *direct* affect on others). In health care such externalities are typically of the positive kind, meaning that one person's 'consumption' of health care may well have beneficial effects for others.

Indeed, there is a whole field of health care, public health, which is concerned with the health of communities as a whole. Vaccination is the stereotypical example – people who are not immunised will benefit from others being so because it minimises contagion – but there are also positive externalities associated with the treatment of disease. Treating someone with an infectious disease such as tuberculosis or swine flu should minimise the risk of it spreading to others. More generally, any expenditure on health care – that may be as simple as buying antibiotics to cure an infection – which enables someone to return to work is likely to bring significant benefits for society, in terms of productivity, participation and welfare.

Externalities are seen on the provider side too, most specifically in reporting comparable data on performance – an activity that individual providers may consider against their interests, but which is likely to drive improvement in quality across the board.⁵¹

The existence of such externalities has important implications for markets. If – as is assumed in market theory – individuals only have regard for themselves when

^{xvi} We say 'perhaps' because while it can be shown that price controls can theoretically reduce any welfare loss caused by monopoly, this ignores the possibility of government failure. Government must accurately estimate both the demand for a particular procedure and the cost of it. This is likely to be somewhat utopian, not least because case mix will vary, a typical hospital or physician will provide many different services; and both demand and technology will change constantly. The professional motivation of clinicians must forever be factored in too; this may well prevent quality dropping substantially. Government intervention might only be justified in the case of true monopolies.

making decisions between competing ends, and providers only have regard to themselves, then there is likely to be both under-consumption and under-provision where there are positive effects on the wider population. Indeed, this is why the World Health Organisation (WHO) defines ‘intelligence’ – assessing performance and sharing information – as fundamental to health systems; and virtually every government in the world assumes a role in public health, epidemiology, the promotion of healthy living and the maintenance of a safe environment.⁵²

A glance at economic theory, then, implies that there are legitimate reasons to question whether or not markets can produce the benefits typically attributed to them – with respect to pluralism, free inquiry, efficiency, innovation, responsiveness to need and customer service – when it comes to health care. Indeed, the evidence that exists on the ground suggests that in health care the impact of markets on quality is, as yet, equivocal.⁵³ The lack of consumer sovereignty, justifications for monopoly and the presence of externalities all mitigate against their effectiveness; and serve as a rationale for government intervention to protect patients and guarantee minimum standards of access and quality *on grounds of efficiency and quality alone*.

Compassion

That said, a discussion of the disadvantages of markets wrapped purely in terms of market failure does miss the point slightly when it comes to health care.

Information asymmetries, monopoly and externalities are all abstract concepts that may justify intervention to some degree or another. However, the reason why health care is collectivised to some extent or another in all developed countries has less to do with market failure and more to do with what we consider to be fair and just in a free society. In this sense it is ‘special’. People, for example, make careers in medicine at least in part for non-materialistic reasons; and we would not want the motives of those who deliver treatment to be forever trumped by commercial decisions. Health *care* relies as much on the ministrations of those who care as it does on pills and surgery.

Similarly, it is to the good of society that we are willing to give up some of our income to help ‘a suffering fellow’.⁵⁴ As far back as George Eliot’s *Middlemarch* (1871) well-to-do local people helped to maintain hospitals, and doctors tailored their fees to the means of their patients. In modern times, the vast majority of us would demand that everyone has access to a fairly comprehensive package of health care to give everyone an equal chance to participate fully in society. Even if people lead lifestyles that result in ill-health, or income that has been redistributed to enable all to purchase health insurance is frittered away elsewhere, very few of us would let people die on the street.

Another way of putting this is that we consider an amount of health care to be something of an individual ‘right’, which poses a problem for the (free) market thesis. This is because the essence of a right is that it is not commensurable, which would imply that at least some healthcare expenditure – guaranteed by a third party (typically government) – has to be ‘reserved’ before choices between other competing ends are left to the marketplace. Of course, we then get into deep philosophical debates about the volume of health care that constitutes this ‘right’ – is it just emergency medicine, curative medicine, or a maximal definition of need such as Tony Culyer and Adam Wagstaff’s ‘expenditure required to effect the maximum possible health improvement’⁵⁵ – and how much weight we give health care in relation to private consumption and other public policy such as education and policing?^{xvii} But the wider point stands: health care’s centrality to humanity surely says that while markets may well have benefits, we cannot solely rely on them in this field.

Re-framing markets

^{xvii} There is a huge volume of literature on this subject. A satisfactory answer depends both on the wider theory of social justice that is preferred, such as utilitarianism, Rawls, or classical/modern liberalism, and on exactly how healthcare ‘needs’ are defined. Some economists will also disagree that health care is somehow ‘special’ and prefer to express the point made in this section as an illustration of a ‘charitable externality’ that can be tackled as a general case of market failure. For a useful discussion of these issues see: Newdick, C. *Who Should We Treat?* (2nd Edition) Oxford University Press, 2005.

Where, then, does this leave us? Clearly simply ‘letting the market rip’ would be inappropriate in health care. As we have seen, market failure is widespread and, unaided, markets neither protect the weak, disadvantaged or unlucky, nor say anything about whether the original or ‘end’ distribution of resources is fair.⁵⁶ In a free society, a universal mandate covering a fairly comprehensive range of services should be non-negotiable; and almost certainly must be guaranteed by the state.^{xviii}

But is this concession the end-game for markets? Does it mean we must simultaneously lose all the benefits we have seen that markets can bring, and have brought in other sectors? In this section we ask whether this is so; questioning, in particular, the severity of the market failure thesis and looking at flaws in other possible mechanisms for driving performance and innovation. The debate, we conclude, is perhaps best framed less as a battle between markets and monopoly (or central control), more how the power of markets can be galvanised in a way that protects and preserves collective decisions about the health system we want.

Flaws in the market failure thesis

The first point to make is that the market failure thesis – universal guarantee and faults in the purely private medical insurance model aside – is probably not as powerful as it may first appear, when set in the right institutional context. ‘Perfect’ competition does not exist in reality, which is to say that market failure exists to some extent or another in all markets, yet on the whole they function pretty well. So, why not in health care?

i. Individuals cooperate

As already mentioned, we are not just individualistic ‘utility maximisers’ as market theory in its purist form assumes, but are also altruistic, concerned with social norms

^{xviii} Of the alternatives, philanthropy, though having a valuable place, is unlikely to be able to raise sufficient funds over time. And, even with substantial income redistribution, the prevalence of market failure means sole reliance on private medical insurance – without risk adjustment to compensate insurers for taking on high-risk people – would be folly. Indeed, private medical insurance may become increasingly unfeasible as medical knowledge advances; insurers will want to steer clear of people with biological factors and genetic defects that identify predisposition to illness. And any substantial up-front payment (known as a co-payment in health circles) carries the risk of individuals cutting back on essential health services.

and, generally, are happy to help others – particularly in times of misfortune, such as ill-health.^{xix} The individualism promoted by markets has not prevented cooperative behaviour in the interests of social goals; indeed, effective markets both require and generate it. Irrational and inconsistent attitudes to risk, for example, were originally managed in health care through community risk-sharing initiatives that have since been ramped up to nation-wide social insurance and welfare programmes; programmes that also succeed in removing many of the externalities outlined above. In many areas, in fact, we cooperate as much as we work on our own, even where our work may be copied or there are incentives to ‘free-ride’ on the work of others. Five Academic Health Science Centres (AHSCs) have recently been formed in England, for example, incorporating organisations that in other fields are competing with each other for patients. Often, the principle driver of innovation in health care is neither money or commercial gain, but the excitement of discovery and prospect of social reward.

ii. ‘Imperfect’ information

Wherever we look imperfect information is pervasive. Consider even relatively simple decisions such as choosing a restaurant to eat in. How many of us will have any idea how the food is prepared or where it has come from? Similarly, when buying a car or a computer, how many of us have sufficient knowledge of the engineering behind the product to know it will work? Very few. For every one of us who pores over *Which?* magazine looking at the exact specification, reliability and performance of the latest laptops, there is another who walks into the nearest shop and asks the assistant to tell them which they think is the most suitable.^{xx} Many choices we make – over treatment options, which course of legal action to take, whether to fix a car part – are made in collaboration with professionals, even in highly competitive industries, so we cannot just use this as a blanket objection to the

^{xix} Indeed, it is one of the oddest things in health care that the sickest patients often apologise for taking up doctors’ time that ‘could be used for others’.

^{xx} There is a widespread misconception too that markets require *everyone* to be making choices to work. This is not true. Microeconomic theory predicts that an ‘exit’ of between five and ten per cent of service users will send powerful signals to providers to raise standards. In other words, the service received by those who do not exercise choice is likely to be positively affected by those that do.

idea of choice in health care. Often, in fact, it is the *ability* of people to ‘exit’ if the service is poor that has a more powerful influence on providers than people actually doing so.⁵⁷ And, although health outcomes are difficult to measure, big strides are now being taken, such as that by the Society for Cardiothoracic Surgery in publishing carefully risk-adjusted outcomes in cardiac surgery; and the Department of Health in requiring organisations to publish patient-reported outcome measures (PROMs).^{xxi}

iii. Consumers are not always sovereign

Related to this, it is also important to realise that consumers often require no knowledge or information at all, because they simply are not involved in many transactions. Many, if not most, market transactions in fact take place between *companies and organisations*. In building the iPod, for example, Apple will put out tenders for the various constituent parts;⁵⁸ as will Toyota in building a new car;⁵⁹ or a hospital for new diagnostic equipment. Effective markets in health care thus need not always rely on direct ‘consumer’ choice of service or insurer. Many services, particularly specialist ones such as neurology and cardiac surgery that serve large populations, will function through insurers (or commissioners such as PCTs in the NHS) issuing tenders that providers compete for on the basis of quality and cost.⁶⁰ This, for example, is how the consultancy, Ernst & Young, envisage the situation:

^{xxi} Lord Darzi, in his report for redesigning healthcare across London, alluded to new systems that appeal to clinicians, and begin to recombine management and clinical intelligence as a unified theory, rather than an adversarial battleground: “whilst existing outcome data is sometimes mistrusted by clinicians, there are more sophisticated outcome measures being developed all the time. For example, Copeland’s Risk Adjusted Barometer ... relies on locally-collected data (improving its accuracy) and incorporates a sophisticated analysis of a patient’s presenting risk, together with an assessment of the complexity of the operation and any complications that arise ... it can identify outcomes that are better than expected as well as those that are worse, and thus can be used as an improvement tool as well as to assure clinicians and others of the standard of care being provided, and to measure productivity”.

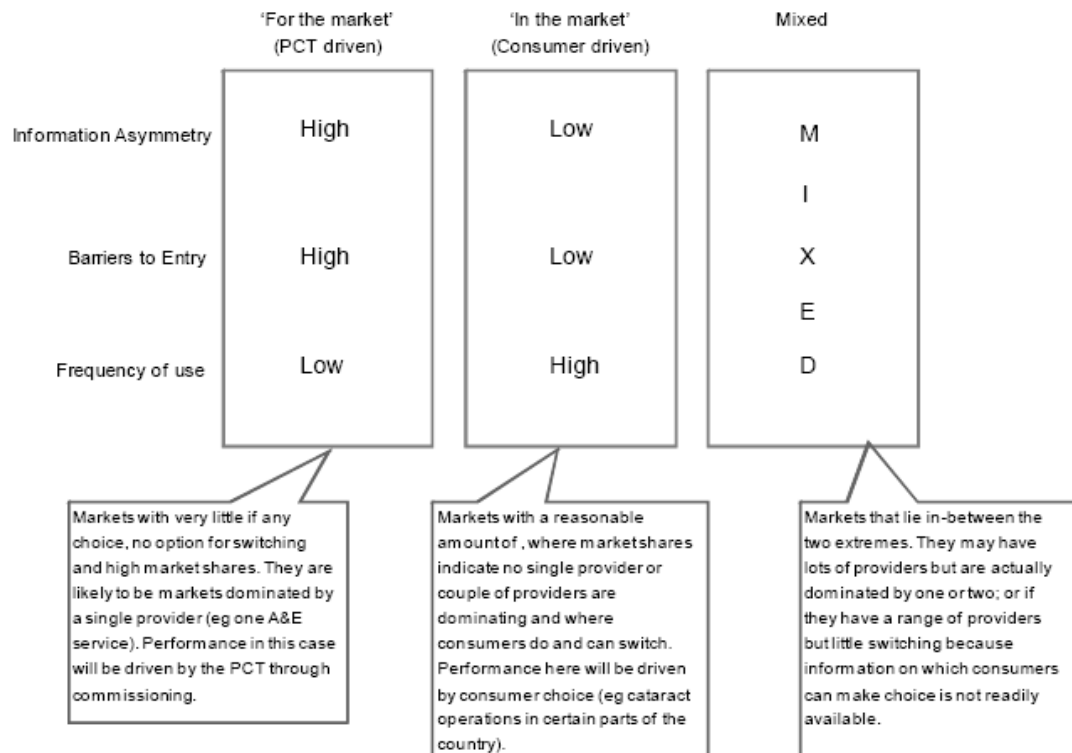


Figure 1: Market archetypes

There is, in essence, no 'stereotypical' market.

iv. Markets require regulation

It should also be realised that markets do not preclude regulation; in fact they almost certainly require it to function effectively. Adam Smith, widely regarded as the 'father of modern economics', assumed a particular 'moral' underpinning (based on trust) and framework for any market, without which in all probability it would fail.⁶¹ This makes sense; without the belief on the part of the seller that a transaction will be honoured and the belief on the part of the buyer that the product or service being sold will do what is expected, many, if not most, transactions would not take place. Today, this guarantee is provided by a combination of regulation and of trust.

On a global scale markets are supported by standards and kitemarks that have emerged either through competition, 'imposition' or industrial agreements that serve to reassure customers.^{xxii} Knowledge, also, is regulated by rules, patents, copyright

^{xxii} In England, the Care Quality Commission's new registration requirements for all NHS, private and voluntary sector providers are attempting to do something similar in health care.

and trademarks. Price acts not just as a signal of scarcity, but also of quality.^{xxiii} At the same time – and particularly at the local level – markets rely heavily on reputation and professional ethos; reputations that companies and individuals have a strong incentive to uphold and build on in order to maintain their customer-base. Few of us will return to, or recommend, a GP we mistrust or is rude, just as with a company that has provided a poor service.⁶²

The point is that, in reality, effective markets depend less on the ‘ideal’ of perfect competition, more on a commitment to pluralism and on the supporting social, political and cultural context.⁶³ This is not to say that market failure doesn’t exist, that it isn’t more severe in health care and that it doesn’t require affirmative action (particularly to ensure competition is acting along the ‘right lines’), but we should be aware that institutions and norms can, have and do emerge to dampen market failure and enable markets to work.

Pitfalls in the alternatives

Any discussion of markets should also give proper attention to pitfalls in alternative models, best summarised with respect to public services by Julian Le Grand as ‘trust’ (or professionalism), ‘targets and performance management’ and ‘voice’.⁶⁴ Indeed, the strongest argument for markets is not that they are perfect – they are not – but that they are the ‘least worst’ option. This is largely because all other structures lack the consumer, or purchaser, power that markets embrace to drive improvements in efficiency and customer service. Service improvement tends to rely instead on a combination of professionalism (as it also does to a significant extent in market economies), central cajoling and heavy regulation.

i. Trust

First, let us consider trust, which, when it comes to health care, is encapsulated in one word: professionalism. Particularly in health care – which is dominated by a profession that has patient care and altruism at its core – many organisations and

^{xxiii} In complex industries such as health care there is unlikely to be significant price competition, for if the price drops too low people will start to think there’s something wrong with the service on offer.

individuals, minus external incentives or rewards, will be ‘knights’ and centre their care processes on the needs and wants of patients for no other reason than intrinsic reward. Many will forever innovate, reach out and want to adopt new ways of working, and many will organise for multi-disciplinary problem solving with patients at the centre of their thinking.

However, the risk in all this is that, be it due to a desire to do academic research, maximise leisure time or simply an attachment to the status quo, the interests of providers and professional groups sometimes trump those of patients – particularly those from more disadvantaged backgrounds, who are likely to be less articulate and adept at working complex systems.⁶⁵ Peer pressure can counter this, but it may not always suffice. Incentives to be efficient are typically weak when ‘doing good’ is sufficient motivation,⁶⁶ with the result that certain services, particularly those that are specialist and hospital-based, are often over-provided creating waste; whereas others, particularly those for the elderly and management of chronic conditions, are under-provided and can be unresponsive.⁶⁷ There is no shortage of evidence, too, describing deficiencies in care: one in 10 patients admitted to hospital experiences iatrogenic harm;⁶⁸ wide variations in quality of care exist;⁶⁹ care is often poorly coordinated and patients do not always experience the level of care that doctors would regard as acceptable for themselves or their families.⁷⁰

To put it bluntly, left to their devices, the medical profession have not always stepped up to the plate. In particular, despite evidence that poor quality often has as much to do with quality across systems and organisations, as with the individual,⁷¹ there remains something of an attachment to the historic idea that ‘there can be no question of telling surgeons how long their patients should be in hospital’.⁷²

ii. **State provision: ‘targets and performance management’**

Another alternative, then, is that government, regulators and the apparatus of the state become more heavily involved. Wouldn’t it be best, for example, if a sophisticated central machinery could be developed, armed with a multitude of

performance information and plentiful incentive mechanisms, to motivate improvement in quality and productivity?

It is a grand idea, but as we have seen, even if such machinery could be engineered, it is unlikely to succeed – particularly in such a dynamic context as health care. At root this is because getting the overall allocation of resources right, without the information generated through market mechanisms, means central planners must assess not only what the needs of patients are, but also the capabilities of providers: a utopian task, for at least three reasons.

For a start, central planners are unlikely to be ‘value-neutral’. Typically, they operate in highly politicised environments where worthwhile projects, such as hospital reconfiguration, may be blocked while others may be given too much support at the cost of better alternatives. In addition to this, government is likely to be captured by the interests of providers, which tend to be more concentrated than those of consumers. Regulation, for example, is just as likely to reflect the particular preferences of the beneficiaries, moderated by the opposition of those that stand to lose, as it is to tackle inefficiency.⁷³

Second, providers, being closest to the work, will always have more ‘soft’ information about performance, that doesn’t get computed, than the government. This is problematic in a world of central planning because providers will have the incentive to underplay their capabilities and overplay their achievements in order to get more resources. And third, patient ‘need’ changes every time a new drug or service comes on stream.

As a result of such difficulties, governments typically rely on proxy measures to drive performance, such as setting targets and priorities – usually linked to carrots and sticks (promotion, pay increases or the sack). The problems here are well documented: you can require people to meet goals, but there is no guarantee that this will encourage them to meet the obligations behind the goals, and other services are likely to be conferred relative neglect. Waiting times may fall, but whether the service that patients receive is better or worse is another matter entirely.⁷⁴ Accident

& Emergency is a case in point. While official statistics show 98 per cent of patients ‘turned around’ in under the four-hour target set by the government,⁷⁵ academics have used queuing theory – a mathematical analysis of waiting time statistics – to show this can only have been achieved by ‘the employment of dubious management tactics’.⁷⁶ Well documented examples, confirmed in surveys by the British Medical Association,⁷⁷ include moving patients to ‘clinical decision units’, making patients wait in ambulances, admitting patients unnecessarily, discharging people too early and miscoding data.⁷⁸ The net result is that, in satisfying today’s requirements, a culture of being ‘helpful’ to the state, rather than of customer service and innovation, is too easily supported.⁷⁹

iii. **Voice**

What if, instead of relying on ‘targets and terror’ or trust, performance instead is driven by ‘voice’; by users expressing their dissatisfaction (or indeed satisfaction) through some form of direct communication with providers? This could take a number of forms: informal face-to-face talks; complaints procedure; board membership; consultative forums; petitions; and, of course, direct elections. There are many advantages to this, not least a rich source of information for providers to use to drive performance without either the bureaucracy and distortion of targets, or the ‘anarchy’ of markets.

However, there are real problems. First, what, without the ultimate threat of exit that exists in markets, or threat of sanctions that exists in state direction, ultimately incentivises the disinterested provider to improve? It may only be a groundswell of collective ‘complaint’, which is often difficult to mobilise. And second, relying purely on voice is, in fact, likely to be inequitable because it is the wealthy and more educated that tend to be more articulate, more confident and more comfortable speaking to doctors. As a result, they tend to be more persuasive in negotiating for more, and better, care. To provide a snapshot: at the turn of the century the unemployed, and individuals with low income and poor educational qualifications, used health services in the UK less relative to need than the employed, the rich and the better educated; intervention rates for coronary artery bypass grafts or

angiography following heart attack were 30 per cent lower in the lowest group than the highest; and 20 per cent fewer hip replacements were performed on lower income groups despite a 30 per cent higher need.⁸⁰

Markets, on the other hand, can proffer advantages over all three alternatives: trust, 'targets and performance management', and voice. First, through the threat of losing business and the desire to gain more, professionals are encouraged to research and innovate, but in such a way that services tend to be designed to meet the needs of customers, rather than providers. Second, through patients choosing the goods and services most appropriate to their needs, markets provide a mechanism that coordinates large quantities of information, even where the environment is rapidly changing. And third, through exercising choice, everyone, not just the wealthy and articulate, can do something about poor service.

Conclusion

The arguments put forward here should not be used to suggest markets can cure all ills in health care. They cannot. But the fact social norms have developed to dampen market failure, and that there are very real flaws in alternative models to markets (trust, 'targets and performance management', and voice), present a powerful case that markets should not be ignored. As the economist John Kay has put it, the historic error has too often been to 'conflate the need for collective choices and collective action with central direction and political control'.⁸¹

The optimal route in health care, instead, is likely to be something of a compromise. We want a health system that provides a collective framework to ensure universal provision and a health system that properly regulates for market failure. But proper recognition of the limits of government and the 'failure of market failure' means we do not have to accept the power of markets is lost and irrelevant. For this reason the central challenge for policymakers in health care is increasingly being framed less as a choice between central planning and markets, more as how the 'power' of markets can be harnessed within. It is to these ideas that we now turn.

Chapter 2: Market-driven health care

The acceptance that markets may bring benefits in health care and can, at least in theory, work in a health system that provides universal coverage does not however mean there is, or ever could be, a precise boundary between the four models outlined in the previous section: markets, targets and performance management, trust and voice. There is a large middle ground between the utopian beliefs that any one option alone will cure all ills. Any market in health care will, for example, require considerable investment in basic institutions and governance; and battles will forever rage on two interrelated fronts:

- i. Over the extent of government involvement in not just the funding, but also the regulation and provision of health care, that is required to guarantee universal provision, control costs and correct for market failure. Is it simply a matter of subsidising health insurance for those who cannot afford it and compensating insurers for taking on higher risks, or does government need to control payment regimes and subsidise hospitals as well? Is requiring the publication of information enough, or is more hefty regulation necessary to ensure quality?
- ii. Over exactly what a market in such an environment would entail. Is it a market for insurance or just provision? Is it the more expansive idea of competition between multiple providers/insurers on quality and price, or is it the more restrictive use of 'market forces' (read financial incentives) by policymakers?

In this section we look at how various health systems that meet our prerequisite of providing universal coverage, have sought to address these quandaries. We then point towards the structures that might be required for markets to bring about the benefits attributed to them.

A glance at health systems around the globe

It is important to recognise that different health systems – often for no other reason than historic accident – have chosen different answers to the questions we pose.

Markets are employed in pretty much every health system in the developed world, but more often than not in different forms. Here we take a brief look at the alternatives.

i. The NHS and the Nordic countries

Possibly the most restrictive use of markets is in the NHS in England where the government largely controls the funding, provision, resource allocation and regulation of health care. The market, instead, is ‘mimicked’ through a split between organisations that purchase care and those that provide it; although there is a more genuine market for electives, in that patients have direct choice of provider (though no price competition is allowed). ‘Market forces’ are also employed through the use of financial incentives to achieve a particular outcome. Interestingly, Nordic countries such as Sweden and Denmark have followed a similar path, although the major difference here is that funds are largely raised through local taxes and health care is the responsibility of local authorities.

ii. Bismarckian social insurance models

In most other Western European countries, however, health systems are insurance-based, with far greater plurality in provision. Typically, at least 50 per cent of providers are for-profit or non-profit (i.e. not state-run) and government is cast in more of a regulatory role: underwriting training; guaranteeing universal coverage; supervising payment regimes; overseeing relations between insurers and providers; and regulating quality.⁸² In France, Germany, Switzerland and the Netherlands, for example, there is little or no distinction between public and private providers, and patients generally have free choice of doctor, specialist and hospital.^{xxiv} The major

^{xxiv} There are nuances here. The Netherlands uses a ‘gatekeeper’ system similar to the UK, in that GPs control access to secondary care (France is moving more towards this too), whereas in the other countries a patient can go straight to a specialist; and in Switzerland certain insurance policies will restrict choice *à la* the Health Maintenance Organisation (HMO) model in the US. Also in Switzerland, public providers receive significant government subsidies and the state restricts the number of

difference between them is the extent to which there is a market for health insurance. In France and Germany, health insurance (for the employed) comes out of the wage packet in the form of a hypothecated tax. In France this is administered by not-for-profit *occupation-based* insurance. In Germany people can choose between around 300 competing sickness funds.^{83 xxv} In the Netherlands and Switzerland, health insurance is not taken out of the wage packet, but is paid directly by consumers to a private insurer, and into a health plan of their choice.^{84 xxvi} In all four countries, however, the state guarantees coverage for anyone who cannot afford insurance and mandates a minimum package of cover that all health plans drawn up by insurers must offer. In Germany, Switzerland and the Netherlands, where insurers are competing, there are also central risk-adjustment pools to ensure insurers are adequately compensated for taking on higher risk patients.⁸⁵ No insurer can refuse to insure anyone who opts for their plans.

iii. Outcomes

The outcomes these health systems achieve vary. It is not easy to discern whither or why they do; data comparability, differences in climate and lifestyle, culture, historic health spending and mere accidents of history all come into play. Indeed, many parameters used by commentators to ‘explain’ effectiveness are often explained more by social factors than health systems *per se*. And, even the best on paper will be worse than others when it comes to particular specialties, and suffer inefficiencies in different areas. That said, there does seem to be something in the argument that, while the level of health spending is clearly important, those countries with systems that are more decentralised and market-based outperform the UK:

providers that can be reimbursed for treatment under the ‘basic package’. In all countries the state has a role in regulating prices.

^{xxv} These are under a statutory obligation to be financially self-sufficient. People with incomes over a mandatory threshold also have the option to opt out into private medical insurance schemes.

^{xxvi} Subject to regulatory oversight, insurers can compete on price; levels of deductibles; whether or not to offer free choice of provider; no-claims discounts and service levels. There are varying levels of upfront, or co-payments, with France having the highest level. In all countries, there are also vibrant supplementary insurance markets, which, in the Netherlands, cover as much as 93 per cent of the population.

Fig. 2.⁸⁶

	% GDP spent on health (1=greatest percentage) ⁸⁷	WHO rank (1=highest) ⁸⁸	Amenable mortality rank (1=lowest mortality) ⁸⁹	Patient satisfaction rank (1=highest satisfaction) ⁹⁰	Infant mortality rank (1=lowest mortality) ⁹¹	Life expectancy rank (1=highest expectancy) ⁹²
Denmark	5	7	5	2	1=	6=
France	2	1	1	6	3=	2=
Germany	4	6	4	3	3=	4=
Netherlands	6	2	2=	1	3=	4=
Sweden	7	5	2=	5	1=	2=
Switzerland	3	4	no data	4	3=	1
UK	8	3	6	7	7	6=
USA	1	8	7	no data	8	8

The Netherlands, for example, has the second lowest health expenditure, yet the highest patient satisfaction and the second highest WHO efficiency ranking out of the health systems referred to.

Prerequisites for an effective market

So, where does this leave us? Are there parameters we can highlight across theory and practice to suggest more specifically what an effective market structure might require in a *universal* health system? Perhaps the worthiest attempt is provided by Alain Enthoven, professor of healthcare management at Stanford University. As he emphasises – and this has been a constant theme throughout this piece –everything that is outlined does not need to be present in perfection for markets to work. All are matters of degree and many, also, depend to some extent on each other. However, as a guide, there are several things we should be paying attention to:

- i. **Political space.** As the economist Charles Schultze once said of the theory underlying markets, ‘those who may suffer losses are not usually able to stand in the way of change. As a consequence, efficiency-creating changes are not seriously impeded’. In other words, those providing an inadequate or unnecessary service must be able to exit the market and those that can provide a better one must be able to enter it. More often

than not this condition has not been satisfied in health care, where even to speak of a hospital closing draws the wrath of not just the public, but also political classes. Markets, too, do not align themselves with political timescales, which poses the problem that governments looking for politically helpful results find markets usually fail to deliver the goods to fit nicely with elections and manifestos.

- ii. **Information.** In order for insurers (PCTs or commissioners in the NHS) to drive performance, and for providers to benchmark and tailor services to patient need in a market environment, there must be adequate information about activity, cost and quality of care. Without this, markets cannot do the things we ascribe to them (as we saw in chapter 1). Insurers, and consumers, will be wandering around in the dark and, not knowing where they (or anyone else) stand, poor performers cannot be motivated to improve.
- iii. **Motivated purchasers free to buy selectively.** Given the inevitable third party involvement in health care, the insurers or commissioners that will more often than not purchase services on behalf of patients need clear criteria on which to do so – particularly in the face of entrenched provider interests. Purchasers must, for example, have significant analytic capacity – through such tools as needs mapping, programme budgeting and marginal analysis – and have the freedom to contract with alternative providers in instances of poor service.
- iv. **Providers capable of responding to market forces.** In essence, there must be a culture that supports customer service. Providers must be able to invest to improve services and be paid more, or be rewarded with more custom, if patients think they are doing a better job than others. Likewise, destabilisation must be possible; the unwise investor or business offering a poor service must be able to suffer the consequences.

- v. **Regulatory framework.** There has been much discussion of market failure in this piece and, despite arguments that in some instances they may not be as severe as theory suggest, there must be a regulatory framework to tackle market failure where necessary. First, there must be comprehensive guarantees that universal coverage is protected and assured. Particularly, regulation should also seek to ensure: that there is transparency of information on activity, quality and costs; that monopolies do not develop and, where they are unavoidable, that they do not exploit their dominant position; that there is a framework in place to resolve disputes between purchasers and providers; that the price of services is reasonable (particularly in the case of emergency hospitalisation where 'shopping around' is not possible); that minimum standards of performance apply to all parties and are incorporated by reference in contracts; that mergers are scrutinised by a competition policy; and that there is an adequate failure regime if providers do go under.
- vi. **Capital markets.** In order to be competitive and develop services, both providers and insurers/commissioners must be able to retain savings and generate capital to finance expansion. Government should not be relied on as the sole determinant of where capital can and cannot be spent, because there is a risk both of unwise borrowing and of projects that are 'risky' but worthy of backing not being funded.
- vii. **Common language and currency.** To put it simply, there must be a common unit in which services are paid for, commissioned and 'sold'. Markets will not function well if buyers and sellers cannot communicate on common terms and if sellers cannot relate their costs to the units being sold. This may sound obvious, but how, for example, are the 'outputs' of hospitals best defined so that they are relatively resistant to manipulation for financial gain: per service, per diem or per admission (likely to be

adjusted for case-mix, such as Healthcare Resource Groups as currently used in the NHS)?

- viii. **Local wage determination.** Markets depend not only on competition for custom, but also for staff. In a labour-intensive industry such as health care wages form the bulk of costs. There are thus likely to be significant gains in terms of efficiency from allowing purchasers and providers to set wages that are appropriate to local market conditions – and attract the best staff. To be able to do so sends a powerful signal that wages depend on success, not whatever rate is agreed at the national level.⁹³

- ix. **Culture.** Underlying all the points listed thus far are deep cultural issues. Markets work best where people consider ‘customer service’ to be the name of the game; and where pluralism and freedom of action is valued. They do not work so well, if at all, when more immediate priorities are elsewhere – such as meeting targets set by government or going through top-down restructuring – or where organisations do not control all their assets. Changing from operating in one culture to operating in another will, also, take time. As we have seen, markets are neither inherently adversarial, nor inherently collaborative, and mature attitudes to business are required.

There exists, then, the possibility that markets could work in health care, given a proper framework that respects collective choices. The final part of our analysis takes a more specific look at how the NHS fits into this. How does the NHS seek to use the market? And can we make any predictions, based on theory and what we have learnt thus far, as to how effective the current setup is likely to be?

Chapter 3: Markets in the NHS

Historically, the NHS has been based on the principles of central planning and what might be called technocratic rationalism; there was little attention paid to using markets. Instead, ‘experts’ determined needs, priorities and implemented policies, with doctors helping to decide who ultimately gets what.⁹⁴ However, since the 1991 White Paper *Working for Patients*, market mechanisms have gradually been introduced. After a brief period of backtracking by New Labour after their election in 1997, this culminated in the 2002 command paper *Delivering the NHS Plan: next steps on investment, next steps on reform*, which laid out the structure in which the market was to operate. Here we take a look at what has emerged, before using the framework outlined in the previous section to suggest whether or not the theoretical advantages of markets are likely to be realised; and where problems may lie.

Rhetoric and structure

The first thing to recognise is that the imperative and rationale for market-based reform was consistent with the advantages we have described: increased efficiency, increased responsiveness to need, flexibility, innovation, choice and less unhelpful meddling by central planners.⁹⁵ As *Delivering the NHS Plan* said:

‘For fifty years the NHS has been subject to day-to-day running from Whitehall. A million strong service cannot be run in this way. If it is to better respond to the needs of patients the NHS can no longer be run as a monolithic, top-down, monopoly provider.

‘The NHS has huge strengths – not least its ethos and its staff – but it has some profound and historic weaknesses: chronic capacity shortages; weak or perverse incentives that inhibit performance; an absence of explicit patient choice; lack of co-operation between public and private provision exacerbated by separate regulatory systems; a top-down, centralised system that inhibits local innovation; health and social care systems that work against each other when older people particularly need them to work together; out-dated working practices which have prevented a more

rational design of services and deployment of staff; lack of attention to the rights and responsibilities of patients; and weak local and national accountability.’⁹⁶

In particular, the government and the Department of Health drew attention to the benefits of pluralism, free inquiry and ‘patient power’ that could derive from a market in health care:

‘The reforms we are making will mark an irreversible shift from the 1940s “take it or leave it” top-down service. Hospitals will no longer choose patients. Patients will choose hospitals. Patients will be in the driving seat.

‘The real power and resources will move to the NHS frontline. Locally run Primary Care Trusts... will be free to commission care with decisions on providers increasingly informed by the choices which patients themselves make. This could be from primary care or hospital care, from a local NHS hospital or another NHS hospital, from the public, the private or the voluntary sectors.

‘Changes to the funding flows and incentives will support a greater choice for patients, improve efficiency and enable all providers – public or private – who offer good quality and value for money to more easily provide services for NHS patients... power needs to be devolved to locally run services with the freedom to innovate and improve care for patients.’⁹⁷

The upshot is that there are now a number of different ‘markets’ in the NHS, some of which are more developed – geographically as well as by specialty – than others. In elective (planned) hospital care, for example, there is genuine ‘consumer power’ and real competition *in* the market, in that all registered providers (including the independent and voluntary sectors) can provide services at a given tariff and a patient’s choice between them should be unrestricted.

Elsewhere, however, competition is largely *for* the market, through competitive tendering by PCTs and practice-based commissioners. Contracts are offered to providers who can present the best deal on quality and cost and, following this, patients may or may not have a choice between providers, depending on geographic

proximity and points/means of access.^{98 xxvii} The theory is that such tendering will force providers to continually seek to improve in order to retain contracts and win more. Commissioners, for their part, are divorced from the influence of providers to assess the health needs of their local populations and wield collective buying power to ensure the best, and most appropriate services, are provided to meet them. In essence, the pursuit of allocative efficiency (i.e. which services are best provided) is left to commissioners, while technical efficiency (i.e. how best to produce services) is left to providers.⁹⁹

That said, the NHS is by no means a ‘free’ market. Commissioners, for one, remain local monopolies in that patients cannot choose between them and competition on price is restricted. Recognising a number of market failures, *Delivering the NHS Plan* also worked both to create a comprehensive regulatory framework and to require the publication of certain information:

‘A market structure in which most areas are served by only one or two local general hospitals means that competitive pressure alone is insufficient to guarantee high standards across all services for all patients. The stroke or heart attack patient is likely to be admitted to the nearest local A&E department come what may. That is why we have put in place new national standards, inspections systems and help to spread best practice.’¹⁰⁰

Subsequently, too, the Department of Health has introduced rules around co-operation and competition,¹⁰¹ to be regulated by the Co-operation and Competition Panel (CCP),¹⁰² and is currently consulting on a failure regime for unsustainable NHS providers.¹⁰³

The ultimate aim then, as the 2002 command paper put it, was to ‘uphold the founding principle of the NHS – that it is free at the point of use based on need, not ability to pay – ... but [embrace] a completely new way of running the service (devolved, offering wider choice and greater diversity, bound together by common standards, tough inspection and NHS values)’.¹⁰⁴ It is, in effect, a genuine attempt to

^{xxvii} Markets for most community health services, specialist secondary care and A&E care are, for example, largely dominated by local monopoly NHS providers.

tackle the very quandary that has been at the heart of this paper: how to provide universal coverage and correct for market failure without losing the benefits that markets can bring. But is it a successful compromise?

The best or the worst of both worlds?

Before we embark on this discussion, it is important to emphasise that what is attempted here is not a wholesale quantitative or qualitative analysis of the effects the ‘market’ in the NHS has had. Instead – and accepting that economic theory can only ever be a partial guide to what happens in reality – what follows is an exposition of certain *theoretical* tensions, based on chapter 2, that practical studies would do well to bear in mind. The following are a few of the major ones:

Enduring political control

Despite market-based reform, the fact that funds are still raised centrally through general taxation means that the government retains considerable sway: through setting targets and guidelines on the way resources should be used; through constraining the use of capital; and through setting prices and wages.

Coupled with this, health care is very much a political ‘hot potato’. There are many vested interests in the system that remain resistant to the idea of new providers entering the market, existing providers going bust (or deciding particular services are no longer financially viable) and the general ‘commercialisation’ of health care. Expectations are likely to be multiple and conflicting, most clearly represented by the recent announcement by the Secretary of State for Health, Andy Burnham, that the NHS is to be the ‘preferred provider’ of services,¹⁰⁵ which flies in the face of existing policy and terms and conditions of the CCP.

Whether or not the true benefits of markets can be realised in such a framework remains an open question. Do providers, for example, have the freedom to innovate and commissioners the freedom to choose openly and effectively, even where decisions may be politically unpopular?

Prices

Much of the market in the NHS (at least in secondary care) relies on the payment-by-results tariff, through which providers get paid a flat-rate for the procedures that they carry out, adjusted for casemix and a market forces factor.^{xxviii} This may succeed in reducing local transaction costs and encourage organisations to compete on quality rather than price, but it could also inhibit the functioning of an effective market.

Ultimately, the tariff is set by Whitehall, which assumes the civil servants can accurately ‘guess’ the operating costs of providers. This is unlikely to be the case. All providers will have different costs and, even if the government manages to ‘guess’ correctly at one point in time (the tariff is set annually), the costs of providers will not be static – new procedures will come onstream and, over the long-run, one would expect efficiency to rise. Also, is it realistic to package health care into neat ‘boxes’ as the tariff assumes? Care for many chronic conditions may, for example, require more integrated and holistic payment over longer periods rather than for isolated episodes.

More fundamentally, a uniform tariff means that more efficient and innovative providers are unable to pass on the benefit to commissioners by lowering prices – thereby undercutting the price of others –and offering different products. Given that markets rely on price as a signal of demand and quality, this may well constrain their pluralism, dynamism and efficiency.

Information

Particularly with price competition not allowed in many areas, high quality information becomes even more important as a basis for commissioners and patients to make decisions about which services to opt for. Without it, they simply cannot know what is a good or bad service.

^{xxviii} The market forces factor is an index of the relative differences in unavoidable costs faced by NHS organisations; for example, a procedure carried out in central London would have higher overhead costs than the same procedure carried out in Devon.

In recent years the NHS has invested considerable amounts in mandating data collections and increasing public availability of data, both on process measures – such as waiting times, average length of stay and levels of hospital-acquired infections – and clinical outcome measures – such as mortality rates and patient reported outcomes measures (PROMs). Numerous regulators also collect and publish data on quality of care and financial performance.

However, large volumes of data do not automatically equate to large volumes of *information*. Data must be properly coded and translated to metrics that can usefully inform patients and commissioners, as well as drive quality improvement and cost reduction in providers. Implications must also be acted on and understood. It is unclear that this point has been reached. Looking at key data on payment-by-results in 2008/09, for example, the Audit Commission uncovered error rates in coding in some NHS trusts of up to 40 per cent, with the average being 8.1 per cent.¹⁰⁶ In the next sections several implications of this are addressed.

Commissioning

The theoretical benefits of the NHS market rely heavily on the ability of the commissioners to drive value and ‘fit’ services to the needs of patients.

However, unlike in Germany, the Netherlands and Switzerland, there is no choice of insurer; unlike in France there is no direct exchange of money between patient and insurer; and unlike in Sweden and Denmark there is no local democratic mandate. The ultimate question is: in the absence of such direct links, and in the absence of any ‘power of exit’ for patients, how do PCTs know what to commission, how to commission and whether they are providing a good service? Similarly, do GPs have the capacity, enthusiasm and know-how to drive performance through practice-based commissioning? And what, ultimately, motivates GPs and PCTs to genuinely represent the interests of their ‘customers’?

On a more practical level, commissioning also requires a whole new skill set: prioritising investment, procurement skills, stimulating markets and managing the local health system. Given that poor commissioning was widely considered to be the

‘weak link’ in the internal market of the 1990s, are PCTs – and, for that matter, practice-based commissioners – up to the task this time around?

Competitive tendering

A significant part of this task is the ability of PCTs to tender competitively and effectively – otherwise the increased transaction costs associated with tendering will doubtless outweigh any benefits of selecting either new providers or spurring on existing ones. This again is not a skill that can be learnt overnight. As the professor of healthcare management Chris Ham has written:

‘Because health services tend to be complex, are difficult to define in clear contractual terms, exhibit marked information asymmetries between buyer and seller, involve the exercise of professional discretion, require lengthy training to deliver, frequently rest on long-term relationships between patients and professionals and, for some services, are subject to problems of local monopoly, there are major obstacles to the efficient operation of systems in which the roles of commissioners and providers are separated.’¹⁰⁷

In the process of tendering, transaction costs and costs of monitoring contracts, are likely to be high. It is not just a question of putting out a tender and accepting the lowest bid; mechanical comparisons must be avoided for it is the *quality* of the bid that is vital, and the impact on other services at existing providers must be considered. Contracts then must be drawn up carefully to take account of volume, quality and casemix, and must contain detailed performance specifications and expectations. And, all the while, it should be remembered that effective tendering is not unambiguously adversarial. Re-tendering and re-commissioning services is expensive and in some areas – particularly rural regions and highly specialist services – the potential for competition may well be limited. Here, building effective long-term relationships is likely to be more important than the ‘threat’ of withdrawing business.

Providers

The flip-side of commissioning is, of course, that providers have the capability to respond to the demands of contracts and rapidly changing market conditions. This entails flexibility and entrepreneurialism, but also that organisations have sufficient quality of information to make market decisions. Autonomy from officialdom may be a prerequisite, but will not suffice on its own, for with autonomy comes responsibility.

Providers will not be able to run to the state every time there is a cash shortage or overspend, so must know what their true baseline is. They must have adequate corporate governance, risk management, strategic planning, treasury management and capital budgeting in place, as well as meet regulatory requirements. They will not just need to know costs for the organisation as a whole, but also the true cost (including variable *and* fixed) for every patient, 'service line' and procedure, in order to benchmark costs against price, develop cultures of continuous improvement and enable clinicians to lead service development.

With just 50 per cent of acute and 64 per cent of mental health trusts (as of June 2009) having passed the application process to become foundation trusts, which might be considered a minimum standard of finance and governance, there is a considerable distance yet to travel.¹⁰⁸

Regulation

Alongside engineering a market, the government also has put in place a comprehensive regulatory regime, covering quality, finance, safety, and competition policy. However, question marks remain over its adequacy on at least three related fronts.

First, there is the possibility that the volume of regulation is excessive and that the overlap between different regulators places too onerous a burden on providers and commissioners.^{xxix}

Second, there is the question of the type of regulation used. Much ‘inspection’ of providers is almost wholly reliant on organisations reporting the necessary data to satisfy requirements, on internal assurance processes and self-review. Whether this captures the real quality of care is questionable; in 2009, for example, Dr Foster Intelligence showed a marked discrepancy between quality of care ratings awarded by the watchdog, the Care Quality Commission, and hospital standardised mortality rates.¹⁰⁹

Third, are we regulating the right things? Does the Competition and Collaboration Panel have the teeth to ensure entrance for new providers is possible, that exit can take place, that mergers which may create monopolies are properly scrutinised, and that cream-skimming is guarded against?¹¹⁰ There is, as ever, a delicate balance that needs to be struck.

Culture

Perhaps the biggest challenge posed by the marketisation of the NHS, though, is cultural. Traditionally, the NHS has been dominated by the interests of government, managers and the medical profession; a combination that has not always acted in the interests of patients. The system has tended to reward those who are willing to conform and ‘play the game’, rather than those who are willing to break the mould. Few people, for example, have had experience of buying and selling health services; nor of a service being decommissioned because it is not good enough. Patients, above all, have had little real power.

As we have seen – and while unscrupulous operators must always be guarded against – markets tend to reward the reverse: customer service, pluralism and entrepreneurialism. The most successful businesses are not successful because they

^{xxix} The NHS Confederation, for example, estimates that at least 69 bodies, from the Healthcare Commission to the Environment Agency, currently regulate, inspect, audit or demand information from NHS organisations; many of whom are asking similar questions.

satisfy internal processes, but because they provide services that customers want. A shift to such values will take time and energy, but without it the benefits that having a market in the NHS might bring will not be realised, even with a 'perfect' structure. So, while the NHS has committed to developing a market, there is likely to be some way to go until we can expect to realise the benefits – if, that is, the structure is sound.

Concluding thoughts

Utter the word 'market' in the corridors of a hospital or the staff room of a GP surgery in the NHS and you wouldn't be too surprised to see brows creased and hear mutters of disapproval. Utter the word 'targets' or 'Whitehall', however, and you'd probably get the same reaction.

As this theoretical analysis has shown, taken to the extreme, both markets and central planning offer unsavoury options where health care is concerned. Market failure is endemic and at the very least requires regulation. But more importantly, markets say nothing about whether the outcome will be fair. In a free society, universal health care should be a must and the state is probably the only body that can, when it comes to the crunch, guarantee this. So we lean towards central planning.

Yet, as we have seen across history, central planning tends to be inefficient, inflexible, inherently controlling, and almost certainly ends up stifling innovation and individual initiative. Providers tend to turn inwards and provide what the centre, rather than the customer, requires. While the neoliberal maxim that every individual market outcome is superior to every individual planned outcome is not true, taken as a whole, market economies have proved far more effective than planned economies. In health care, of course, there are other ideas to which we can appeal, specifically trust (or professionalism) and voice. Combined, these are likely to counter the worst of the extremes of either central planning or markets, but are unlikely to suffice; without external incentives that carry real weight there is always the risk of professional self-interest trumping that of patients.

The solution, instead, is likely to lie somewhere in the large 'grey area' in between; where the state accepts responsibility for upholding collective choices, correcting for market failure and guaranteeing universal provision, but equally accepts that this does not necessitate, or indeed entail, central direction and political control.

Ministers, for example, cannot know and should not decide which treatments should

be provided or, indeed, who provides them. Such decisions, instead, are most effectively made by markets, professionals and patients.

Health care is a complex case, but properly construed and properly regulated markets should, through supporting pluralism and conferring responsibility on those delivering frontline services, enable professionals to take responsibility, use their knowledge to the fullest extent and be 'entrepreneurs'. In this sense, markets dovetail with modern-day professionalism by helping to ensure that it works for patients; that patients (customers) rather than the government, doctors or nurses, ultimately decide the parameters of success. Through a patient's ability to switch services, and reward the good hospital and punish the bad, providers (and insurers) are forever kept on their toes and encouraged to develop services that are tailored to the needs of patients.

The downside of course is that there will be duplication, transactions costs, regulatory costs and waste along the way, because this is the only way in which markets work; in which the successful 'experiment' spreads and the unsuccessful folds. However, such costs are unlikely to be higher than the bureaucracy and inherent inefficiency of central planning. The difference with markets is that, with the right preconditions, the sustained achievement has been to drive innovation and efficiency; and to empower those at the 'coal face' and deliver customer service.

This paradigm is now widely recognised in health systems, and by policymakers, internationally, with the vast majority conducting their own research into whether and how the theoretical advantages of markets can be delivered in health care. Some prefer a far greater role for markets than others, but all recognise the power of the idea. The NHS is no different. Within a framework of central funding, PCTs and practice-based commissioners now buy services from competing providers on behalf of their local population; and patients – at least for electives – have free choice of the hospital they are referred to.

The question remains, however, as to whether the market the NHS is buying into permits enough room for it to 'work' and deliver the benefits typically we ascribe to

them: pluralism, free inquiry, efficiency, innovation, responsiveness to need and customer service. As Nigel Edwards, policy director of the NHS Confederation, wrote in an insightful piece for the *British Medical Journal*:

‘... although market mechanisms are undoubtedly effective in terms of increasing responsiveness and efficiency, some caution is required as much of the evidence [when it comes to health care] is debateable or unclear and little of it comes from systems with fixed administratively set prices of the sort [in] the English NHS. Furthermore, economic theory is only a partial guide to what may happen.

‘It is difficult to identify where the trade-offs between the costs and benefits of competitive systems are balanced.’¹¹¹

It is possible that we have captured ‘the best of both worlds’: the market works its wonders on the supply-side and central planning corrects for market failure on the demand-side. Not having multiple insurers, for example, is likely to reduce transaction costs and saves, for the most part, the need for hefty regulation to properly risk-adjust casemix and preserve universal coverage. Having fixed prices may also encourage providers to compete solely on quality, rather than price.¹¹²

However, a glance at market theory suggests the current structure could also capture the ‘worst of both worlds’: the extra costs of markets minus the benefits that could be delivered.¹¹³ Political control endures; prices are fixed; information deficiencies persist; there are only very weak links between commissioners and the people they serve; and it is not clear that regulation is aimed at the right things or is of the right form. Above all else, culture, too, must shift from one that rewards ‘playing the game’ to one that rewards business and customer service.

With the NHS due to enter a period of real-term cuts in funding from 2011, equivalent to a £15 billion shortfall over five years,¹¹⁴ it is imperative that sound and forthright analysis is conducted into how things are playing out in reality. There is a widespread view that doing more of the same will not suffice; that health care in the UK needs to be open to new ideas, new providers and new ways of working.¹¹⁵ The question is, is there either the political appetite or necessary apparatus to realise it?

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