8. Healthcare: to marketise or not to marketise?

> Selfishness beats altruism within groups. Altruistic groups beat selfish groups. The rest is commentary.
>
> David Wilson[1]

Kenneth Arrow won the Nobel Prize in Economics in 1951 for his development of a theory of how effective markets work.[2] A decade later, he set out the root causes of why markets would fail for healthcare in a famous 1963 paper: uncertainty in the incidence of diseases and efficacy of treatments; and doctors (suppliers) not patients ('consumers') frame the demand for care.[3] In that paper he also made the penetrating observation that, although a system like that of the British National Health Service (NHS) looks to be based on altruism and redistribution, it can also be seen as a highly beneficial insurance arrangement that pools risk over generations. This is a working example of John Rawls's social contract. Rawls's theory of *justice as fairness* used the device of a 'veil of ignorance' as a fair and consensual way of agreeing distributional questions in a social contract for a fair society.[4] Behind that 'veil of ignorance', we would not know, for example, what job we might have – an investment banker? A nurse? – in deciding how much we think different jobs should be paid we should choose without knowing which slot would be ours.

For most of us, for most of our lives, we live with no certain knowledge of what our future needs for healthcare might be. Behind that 'veil of ignorance', the NHS makes sense as a social contract that is financed by ability to pay, and gives free access according to health need. The private sector can successfully pool and price idiosyncratic risk for cars and houses, but not the systemic risk of ageing populations and pandemics.[5] Aneurin Bevan recognised the great boon from government organising risk pooling across generations:

> Society becomes more wholesome, more serene and spiritually healthier if it knows that its citizens have at the back of their

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> consciousness the knowledge that not only themselves, but all their fellows, have access, when ill to the best that medical care can provide.[6]

No country has an optimal system of healthcare that satisfies the three objectives that make up its 'iron triangle': cost control, equity of access according to need, and high performance.[7] The first section of this chapter looks at a 'natural experiment' of Canada and the US. That experiment shows the advantages of the way the NHS is financed for effective cost control *and* equity. The abiding weakness of the NHS is the lack of systems that deliver high performance. That is why, paradoxically, the Thatcher government looked at lessons from the United States in trying to marketise the NHS. The second section examines the transaction costs of the model of an NHS internal market (that is, with no change to the way it is financed), which has been tried by Conservative, Labour and coalition governments. This examination shows that the internal market model is designed to fail, which poses the question: if we abandon markets, how do we generate incentives to improve performance? The third section gives evidence of how that can be done by designing systems of public reporting that impact on the reputations of those who deliver healthcare. As there is no prospect of substantial increases in the NHS funding over the next decade, the final section is about how it can manage by developing systems to improve the way we allocate its resources.

8.1 Equity and cost control in Canada but not the US

In 1961, Ronald Reagan raised the alarm about the US abandoning its reliance on private markets to finance healthcare.[8] The target of his criticism was what became, from 1965, the federal programme of Medicare in the US for insuring the elderly (and disabled). Reagan saw this as leading to the hell of 'socialised medicine', and communism. His belief in constraining health demands on government by making people face up to the costs of healthcare was shared by the finance director of a not-for-profit hospital in Greensborough, North Carolina. When I met him, in the summer of 1983, he had to take an urgent phone call. It involved negotiations with a couple over what they would be required to pay, every month, for the rest of their lives, for their baby to be given life-saving care in his hospital's neonatal intensive care unit.

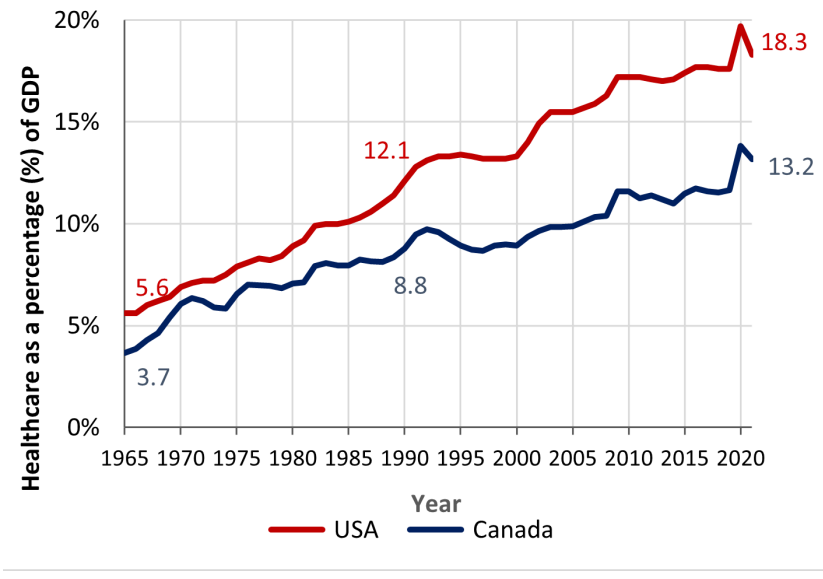
The US's system was designed to produce hardship for the couple and deficits for the neonatal intensive care unit. This was because so many of the babies needing that care were from poor families without health insurance. When, in 2009, President Obama proposed legislation to reduce the number of uninsured Americans he received a citizen's letter that read: 'I don't want government-run healthcare. I don't want socialized medicine. And don't touch my Medicare.'[9]

Canada used to have similar systems to the US's for insurance and delivery of healthcare. Coverage was incomplete and entailed high user charges. Hospitals and doctors were independent of government and paid according to the services they supplied. From 1971, the Canadian federal government instead became the single payer in a universal system of insurance for hospitals and doctors that was free at the point of delivery, but made no changes to the organisation of the delivery of care. Figure 8.1 shows how the two health systems in the US and Canada operated before and after 1971. In the US system, only 80 per cent of people were insured and they faced high user charges, so conventional (demand and supply) economic analysis would predict that its future costs would be lower than Canada's. However, Figure 8.2

Figure 8.1: Healthcare systems in the United States and Canada

Aspect	US	Canada before 1971	Canada after 1971
Hospitals	Private (funded by charges for all care)		
Doctors	Fee for service		
Insurers	Multiple		Monopoly
Coverage	Incomplete		Universal
Patients	User charges		'Free'

Figure 8.2: Healthcare expenditure as a percentage (%) of GDP in Canada and the US, 1965 to 2021



Source: Centers for Medicare & Medicaid Services (US); Canadian Institute for Health Information, Government of Canada, and CountryEconomy.com (Canada).[10]

shows the outcomes of this 'natural experiment': the costs of the system in the US increasingly escalated well past those of Canada.

Robert Evans (professor of economics at the University of British Columbia) developed an economic explanation of why Canada, by implementing an equitable system, had discovered that it had also implemented a highly effective system of cost control.[11] Health insurance covers the risk of needing healthcare when you are healthy: once you have cancer or a chronic disease and continue to need healthcare, it ceases to be insurance. The US system of multiple health insurers and incomplete coverage is designed to generate incentives for each insurer to shift costs on to another payer, and direct their efforts to risk detection and selection. In any population, the most costly 5 per cent of people typically account for more than 50 per cent of the total annual costs of care.[12] The way that multiple insurers resolved their weakness in negotiations with suppliers of healthcare was by increasing premiums. In Canada, as there was universal coverage, the government avoided the deadweight loss from spending effort on risk selection. And, as a single payer, it had to confront total costs and was empowered to do so. Evans emphasises that, in healthcare, effective cost control is directed at providers. He laments that:

> economic analysis has been largely incapable of grasping this process [and] encouraged a fruitless concern with the prices faced by patients, while ignoring the overwhelming significance of the structure and objectives of the insurer.[13]

In 1971, in the US, the RAND organisation began a quite remarkable experiment to evaluate the impacts of user charges on costs and health outcomes under traditional indemnity insurance.[14] Families were randomly allocated to four levels of medical costs that they would have to pay in the RAND roulette wheel of (mostly) misfortune: only a lucky minority had 'free' care; others had to pay 25, 50 and 95 per cent of their medical costs. (Would that experiment be deemed to be ethical now?) That study found that high user charges did (as expected) deter people from seeking care *and reduced their use of effective acute care by about a third*. User charges as a policy instrument suffer the same conflicts of income-contingent loans for undergraduate university education (detailed in Chapter 7): charges are required to both deter and not deter people from seeking care when they are ill.

The RAND experiment also compared different levels of user charges (under traditional indemnity insurance) with the radically different model of the health maintenance organisation (HMO). That model integrated the roles of insurer and provider of secondary, primary and preventive healthcare. HMOs are financed by capitation: families enrolled with an HMO pay a monthly rate (regardless of services used). They have free access to

a primary care physician (equivalent to a general practitioner), who acts as gatekeeper to specialised services and restricts their choices. Although integration has potential to be an optimal form of organising care, to achieve that requires satisfying a demanding set of conditions.[15] Integration of healthcare is now being developed in less ambitious ways in the US in accountable care organisations.[16] RAND found that the per capita expenditure on health services of those enrolled with the HMO Group Health Cooperative of Puget Sound was 40 per cent lower than free care under traditional indemnity insurance, which was the same as those required to pay 95 per cent of their medical cost. The HMO, however, achieved these cost savings without reducing use of effective care. That is why the RAND study suggested that the NHS arrangement of free access to a GP who acts as a gatekeeper is more appropriate than high user charges as a way of organising access to healthcare.

In 2001, Uwe Reinhardt (professor of political economy at Princeton University) argued that, since the publication of Arrow's 1963 paper, health economics and health policy in the US had been fuelled by the vain hope that:

> with the aid of better information technology … the efficient allocation of health care resources could be entrusted to the 'invisible hand' of a price-competitive marketplace, which economists are uniquely qualified to understand.[17]

The outcomes of this market failure have been appalling outcomes on all three vertices of the 'iron triangle':

- Inequity: the US is one of the three OECD countries (with Mexico and Poland) with the lowest percentage of population coverage for core health services.
- Poor performance: the US is the only OECD country to report a fall in life expectancy between 2012 and 2017.
- Failure to control costs: the US has the highest spend on healthcare (nearly 17 per cent in 2018, compared with 9.8 per cent for the UK).[18]

The 2021 report from the Commonwealth Fund found that, compared to 10 other countries, 'Americans of all incomes have the hardest time affording the healthcare they need' and the system 'ranks at the bottom on health care outcomes'.[19] The US's system of employer-based health insurance is a tax on jobs: in 2019, the annual cost for insuring an employee's family would be about $21,000.[20] As Anne Case and Angus Deaton argued, this stymies attempts to develop new opportunities for employment in the areas that have experienced deindustrialisation.[21]

8.2 An internal market for hospitals: a concept lost in translation?

In 1985, Alain Enthoven (a Stanford professor who had worked for RAND) described England's NHS as suffering from 'gridlock'.[22] For the US, he had been a strong advocate of the competing HMO model as a means of developing universal coverage.[23] He proposed for the NHS that the government implemented two changes.[24] First, it should transform the existing 200 local district health authorities (districts) into the HMO model (as described above), but without competition and defined geographically (Figure 8.3a). In the NHS in 1985, districts were responsible for secondary, community and preventive healthcare but primary care was delivered by independent contractors. Enthoven argued strongly for making districts responsible for integrating primary and secondary care. Second, he recommended creating an 'internal market', in which each district could threaten those suppliers (hospitals or GPs) providing poor services with loss of jobs by outsourcing to other providers.

One reason why the US spends so much on healthcare is that it has such a high rate of pay for doctors and nurses. OECD estimated that, in 2017, hospital prices in the US were nearly twice those of the UK.[25] After making prices comparable, Richard Feachem et al found in 2002 that a Californian HMO, Kaiser Permanente, achieved:

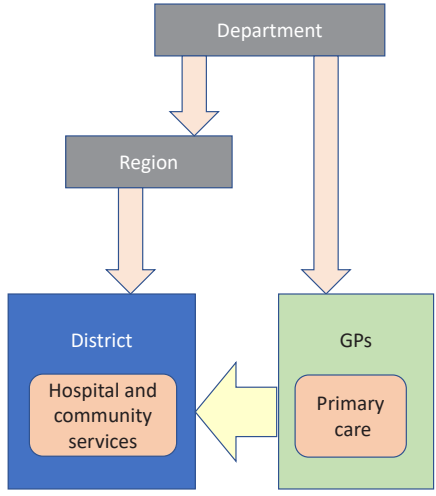
> better performance at roughly the same cost as the NHS because of integration throughout the system, efficient management of hospital use, the benefits of competition, and greater investment in information technology.[26]

A year later, Ham et al reported that the use of hospital beds in the NHS for 11 leading causes of admission was three and a half times that of Kaiser's standardised rate. They highlighted the reasons for Kaiser's superior performance were the integration of all elements along care pathways of prevention, diagnosis and treatment in primary, inpatient and outpatient care.[27]

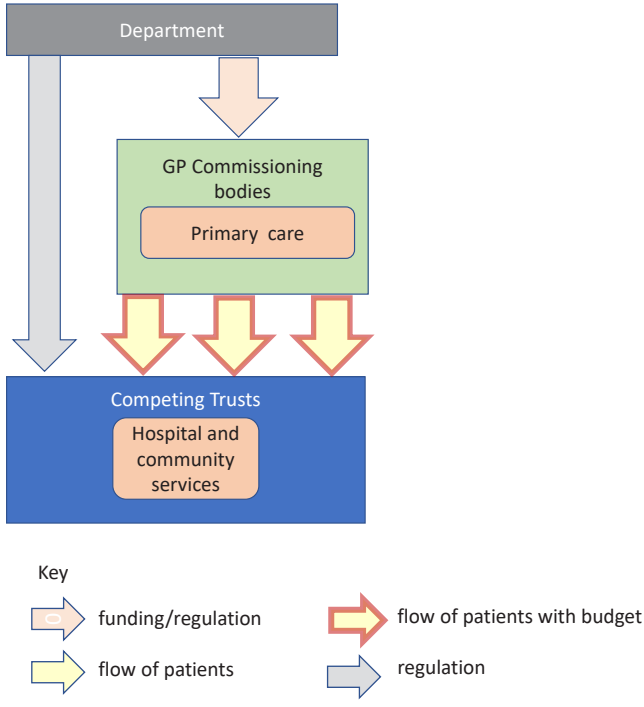
Under the influence of neoliberal and 'new public management' thinking, the Thatcher government implemented an 'internal market' based on a 'purchaser/provider' split. Districts were the principal purchasers; providers were local hospitals and community service units that became self-governing providers. Districts as 'purchasers' were to assess the needs of their local populations and meet them by contracting selectively with providers that were to compete on price and quality. The governments of Margaret Thatcher in 1989, Tony Blair in 2002, and the coalition in 2010 tried to develop hospital competition under different arrangements in which GPs were on the purchaser side of the split.[28] The failures of the Thatcher and Blair internal markets were described in Chapter 1. The third attempt by the coalition in legislation

Figure 8.3: The NHS as a hierarchy (in 1980) and its 'internal market' form (in 2012)

(a) Pre-reform (1980) structure



(b) Post-2012 reform structure



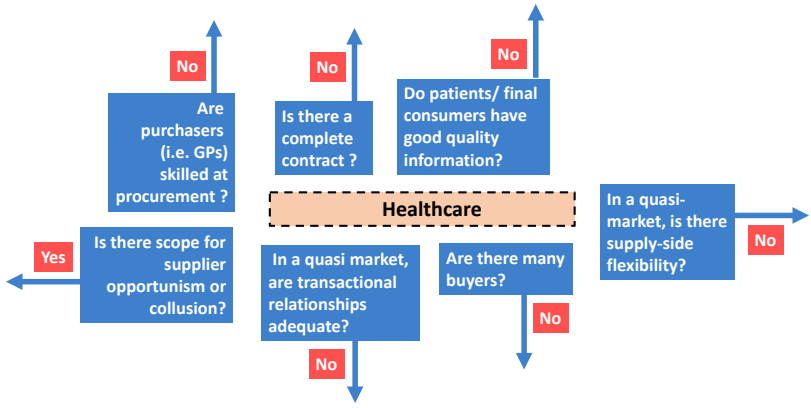
Source: Author.

was described as 'Dr Lansley's monster' (Andrew Lansley was the minister responsible).[29] In the Lansley model, which was implemented in 2012, funding went primarily to the grouping of GP practices. They ran primary care directly and 'commissioned' hospital care and community services from competing NHS and independent providers (Figure 8.3b). It was so controversial that it was subjected to an unprecedented 'pause', whilst the proposals were reviewed, and subjected to 2,000 amendments.[30] It was criticised by an unprecedented joint editorial condemning the bill in the leading journals for the medical profession (*British Medical Journal*), managers (*Health Service Journal*) and nurses (*Nursing Times*), for resulting in upheaval that 'has been unnecessary, poorly conceived, badly communicated, and a dangerous distraction at a time when the NHS is required to make unprecedented savings'.[31] Thus, Enthoven's 1985 proposals for care integration on HMO lines were completely lost in translation by the Thatcher government in 1989 and subsequent 'reforms'.[32] Such integration is particularly important for the effective management of chronic diseases in an ageing population. Dr Lansley's monster was abandoned because it obstructed the integration needed in caring for an ageing population.[33]

Figures 8.4 and 8.5 apply my translation of Williamson's framework to examine the model of local districts or GP commissioners contracting selectively with hospitals for the care of their populations. They show that asking NHS purchasers to contract with hospitals raises a red flag on all six of Williamson's criteria. Districts and GP commissioners alike have faced profound uncertainty over the future complex needs of their populations – as shown so vividly by the changing impacts of the global pandemic of Covid-19 on admissions to hospitals and intensive care units (ICUs) (see Chapter 9). Hence contracts were necessarily incomplete. The asymmetry of information was so difficult to overcome because 'purchasers' depended on hospitals to determine the need for patients' care once they were referred or admitted as an emergency and lacked data on the quality of most of the care provided. There was little supply-side flexibility. The assets of a hospital are highly specific and for most services (emergency and chronic care) they need to be local. That created problems even in closing hospital departments, and ruled out letting 'failing' hospitals exit the market. Although hospital care is provided frequently, Chapter 1 gave examples showing that this did not enable 'purchasers' to become more skilled in contracting and monitoring. Reviews consistently found systemic weaknesses in commissioning or contracting where this has been tried in several country cases.[34] It was one of those sad cases where contracting over 10 years is one year's experience 10 times over.

The 'atmosphere' in which patients are treated is crucial. Timothy Besley and Maitreesh Ghatak argue that high performance of public services follows from matching their missions to the motivation of those who deliver them.[35] So, for example, teachers who derive intense satisfaction from educating the

Figure 8.4: Causes of high transaction costs in contracting with hospitals



Source: Author.

Figure 8.5: Describing the high transaction costs of contracting with hospitals

Question	High transaction costs in using a market
1. Can a complete contract be specified?	No. The 'purchaser' is uncertain over when and at what scale a service will be needed and the service needed is too complex to be specified in advance.
2. Is the buyer able to assess the adequacy of the quality and costs of what is supplied?	No. Hospitals can supply services that a well-informed purchaser would not want to pay for, and 'quality shade' services in ways that purchasers would find very hard to detect.
3. Is there supply-side flexibility?	No. There are few accessible local hospitals, those that fail do not exit the market, and the dominant suppliers are not challenged by new entrants.
4. Are there many buyers?	No. Hospitals have had to invest in assets (equipment and staff) that are specific to the 'purchaser'.
5. Is the transactional relationship between buyer and supplier adequate to cover all aspects?	No. The quality of service supplied is impaired by a transactional relationship – 'atmosphere' matters.
6. Is there scope for suppliers to behave with opportunism?	Yes: the 'purchaser' is vulnerable to being exploited by being overcharged for an excessive or inadequate volume of services of poor quality.
7. Is the buyer a skilled purchaser?	No. The service is so complex and uncertain that there is no 'learning by doing' from contracting over time.

young will not seek large financial rewards. Much of modern medical professionalism stress how vital it is that healthcare is delivered by committed staff who continuously put patients' interests first. The scandal described in Chapter 1 at Mid Staffordshire hospital showed the appalling consequences of running a hospital that had lost sight of Florence Nightingale's first principle, to do the sick no harm. So, in the NHS, the contracts between purchasers and hospitals can only work if they are not transactional but relational and built on trust. But a hospital will only enter into a relational contract without the threat of competition.

8.3 Designing public reporting systems to improve performance

Most people want good local public services – for them, having choice is of secondary importance. Those who advocate choice in markets argue that is the key means to the end of providing good local public services. The choice mechanism would improve the quality of hospital care if those needing care were well-informed about differences in the quality of different hospitals, and could exercise choice and go to those with high quality of care.[36] But systematic reviews of public reporting of hospital performance in the US found that it had no impact on choice of hospitals by patients; and, after hospitals had been publicly reported as performing poorly, sometimes they improved quality and sometimes they did not.[37]

Judith Hibbard's explanation of this puzzle was that public reporting could generate powerful incentives for a poorly performing hospital to improve if it were designed to inflict damage on its reputation. She cites her study of a controlled experiment in Wisconsin, which specified four requirements for public reporting to drive improvements through its impacts on reputations:

- performance needs to be ranked;
- the ranking has to be designed to make clear where performance is good or poor;
- the information has to be published in forms that are easily and widely accessible for all to see; and
- performance information must be produced regularly.[38]

In healthcare, three different systems of public reporting that satisfied those criteria have given strong evidence of the power of reputation, even though each system was initially designed to drive change through market mechanisms.

The first system is the Cardiac Surgery Reporting System (CSRS) of estimating risk-adjusted mortality rates (RAMRs) by surgeon and hospital, which began in 1989 in New York State. Those who benefit most from cardiac surgery are at highest risk of dying from the operation. So, the skilled surgeons

who operate on difficult cases tend to have the highest mortality rates. That was why Mark Chassin, who was then the commissioner for health in New York State, developed a good method of risk adjustment for public reporting. Over the next three years, New York State's risk-adjusted mortality fell by 41 per cent.[39] It 'had the lowest risk-adjusted mortality rate of any state in the nation and the most rapid rate of decline of any state with below-average mortality'.[40] Chassin emphasised that market forces played no role in driving that improvement. Patients did not switch from hospitals that were statistical outliers with high mortality, nor to those with low mortality. Nor did HMOs switch their contracts for their insured populations.[41] The CSRS was designed to inflict reputational damage on hospitals that were statistical outliers with high mortality. And Chassin found that it was those hospitals that made efforts to improve their quality of care.[42]

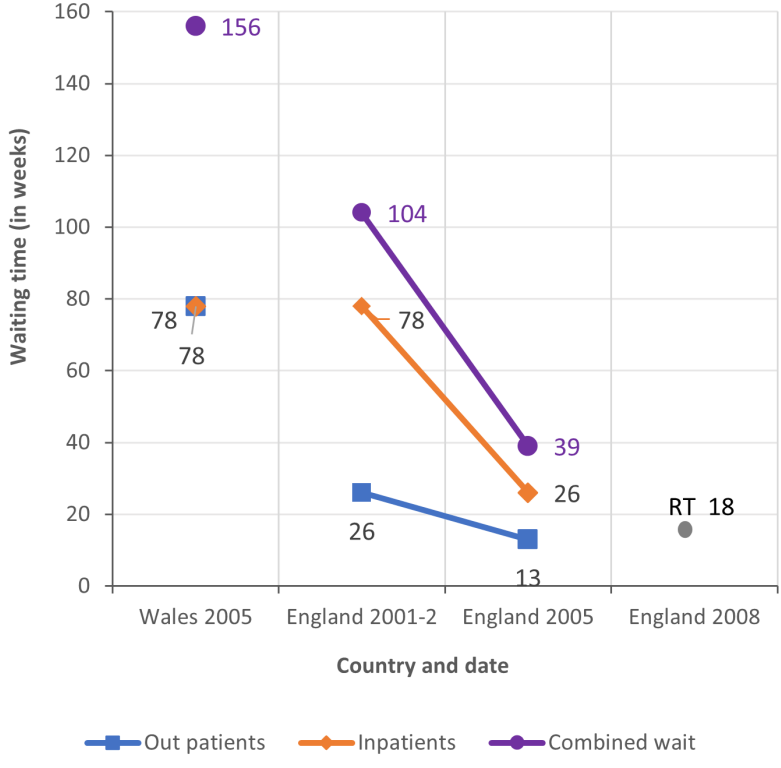
The second system is the regime of 'star ratings' that was implemented in the NHS in England from 2000 to 2005 (as mentioned in Chapter 1). Figure 1.1 showed the scale at which the Blair government threw money at the NHS from 2000 onwards, which applied to England, Scotland, Wales and Northern Ireland.[43] After the election of the Blair government in 1997, under governance by 'trust and altruism' (see Chapter 1), hospitals that failed to meet targets for reducing waiting times received extra funding. This system of perverse incentives rewarded failure, and continued, after 2000, in the devolved governments in Scotland, Wales and Northern Ireland.[44] Only in England, however, did the government require fundamental change in its implicit contract with the NHS to transform its performance. *The NHS Plan* of 2000 set out demanding targets for reducing hospital waiting times in England as set by the Prime Minister's Delivery Unit. The Department of Health changed the rules of the game to ensure these targets were met. Under England's 'star rating' regime, those who worked in hospitals that missed the targets were no longer rewarded with more money but punished instead.[45] In the 'star rating' regime, NHS trusts that 'failed' were zero-rated, and 'high-performing' NHS trusts were awarded three stars. The chief executives of 'failing' trusts were at high risk of being sacked, as happened to six of the 12 failing hospitals ('the dirty dozen') in the first set of 'star ratings'. This threat was initially seen to be the key driver to deliver the required transformation in NHS performance. I was involved in the development of 'star ratings' when I worked at the Commission for Health Improvement. In the meetings I had with those running acute hospitals, I came to understand the power of the reputational impacts of publishing 'star ratings'. One chief executive told me that what she most feared about her hospital being demoted from a three-star to a two-star trust was how that would be the lead story in her local newspaper at the weekend.

At the CHI, we were responsible for reviewing the implementation of clinical governance in England and Wales (see Chapter 1). I was stunned by the decision of the government in Wales not to develop any comparable system

of public reporting of performance. I was told by an official that, having abandoned school league tables (see Chapter 7), it was inconceivable that the government in Wales would introduce an analogous system into its NHS. In 2005 the Auditor General for Wales issued three damning reports on the dreadful performance of NHS in Wales as compared with England.[46] In 2005, the sum of the two waiting time targets to be referred to a specialist *and* admitted for an operation was nine months in England and three years in Wales (see Figure 8.6). Furthermore, hospitals hit their targets in England and missed them in Wales. In Wales in 2005 there was no commitment to match the transformation in the performance in England, where (by 2008) hospitals were hitting the target waiting time of 18 weeks from referral by a GP to admission for an elective operation. And, in 2005, ambulances met 75 per cent of life-threatening emergency calls within the target response time of eight minutes in England, whereas this was only 55 per cent in Wales.

The third system is the Tuscan Performance Evaluation System (PES) in Italy's national health service, which is modelled on the UK's NHS. The Italian

Figure 8.6: Waiting time targets (in weeks) in England and Wales



Sources: Auditor General for Wales and Department of Health.[47]

health service is devolved to 21 regions (five are autonomous provinces) that are similar in some respects to the devolved nations of the UK. They are funded centrally but have autonomy over the structure and governance of their health services. Italy's national outcome evaluation programme (NOEP) measures and publicly reports the performance of each region against minimum standards for essential levels of care (Livelli Essenziali di Assistenza or LEAs). They are held to account by central government in a system similar to that of the NHS 'star rating' regime: failure to eliminate financial deficits or to achieve a minimum grid score on its LEAs can result in the sacking of the region's president and the chief executive officers of local providers.

The Tuscan PES began, in 2006, as an initiative by Tuscany's elected regional councillor for health. He funded a research unit, MeSLab, led by Sabina Nuti at the elite Scuola Sant'Anna in Pisa, to develop what became the Tuscan PES. The regional councillor aimed to drive improvement by using that PES in deciding performance-related pay for the chief executives in its 12 local health authorities. They were responsible for planning and running healthcare for their populations.

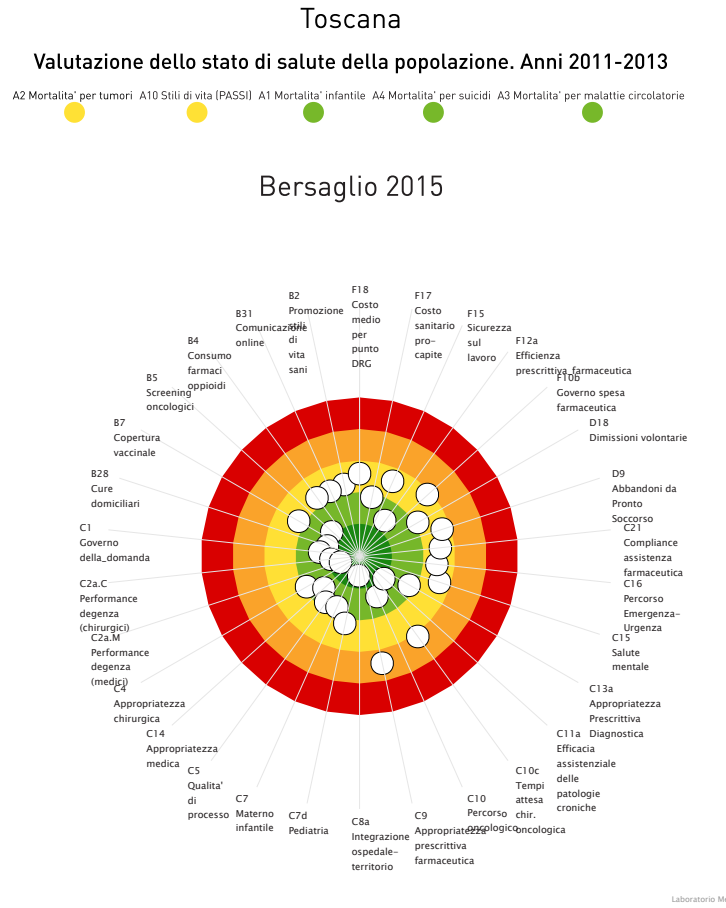
By 2012, 12 'regions' had voluntarily chosen to use the Tuscan PES in the network of the Inter-Regional Performance Evaluation System (IRPES). Each region processed its own data and used the same set of indicators for benchmarking. The results were shown by region and by health authorities.[48] Figure 8.7 shows how the Tuscan dartboard displayed 160 indicators across eight dimensions (population health, efficiency, user and staff satisfaction, meeting strategic goals, types of care, and governance) for the two regions of Marche and Tuscany. The dots represent the performance of the composite indicators and are organised into segments for each dimension of performance. Indicators with excellent performance are in the green zones near the centre of the dartboard; those with poor performance are in the red zone on the outer circle. The health of the population is reported above the dartboard to highlight that it represents the ultimate goal towards of every health district.

Comparing two regions, Figure 8.7 clearly shows that, on most indicators, Tuscany had better performance than Marche. The dartboard ranks performance but avoids the crudity of systems that aggregate performance across multiple indicators to give a single rank (as in star rating and the annual health check). Such crude rankings cast an unjustified shadow on those delivering a high-quality service in an organisation with a poor ranking in aggregate and vice-versa.

In the Tuscany region, MeSLab presented results to six-monthly stock-take meetings of the senior managers and clinicians, and heads of departments of the districts and region. Managers and clinicians in Tuscany were closely involved in the development of the indicators and were trained by the Sant'Anna School of Advanced Studies in the use of this information. Those whose service performed poorly on an indicator could learn from those who performed well.

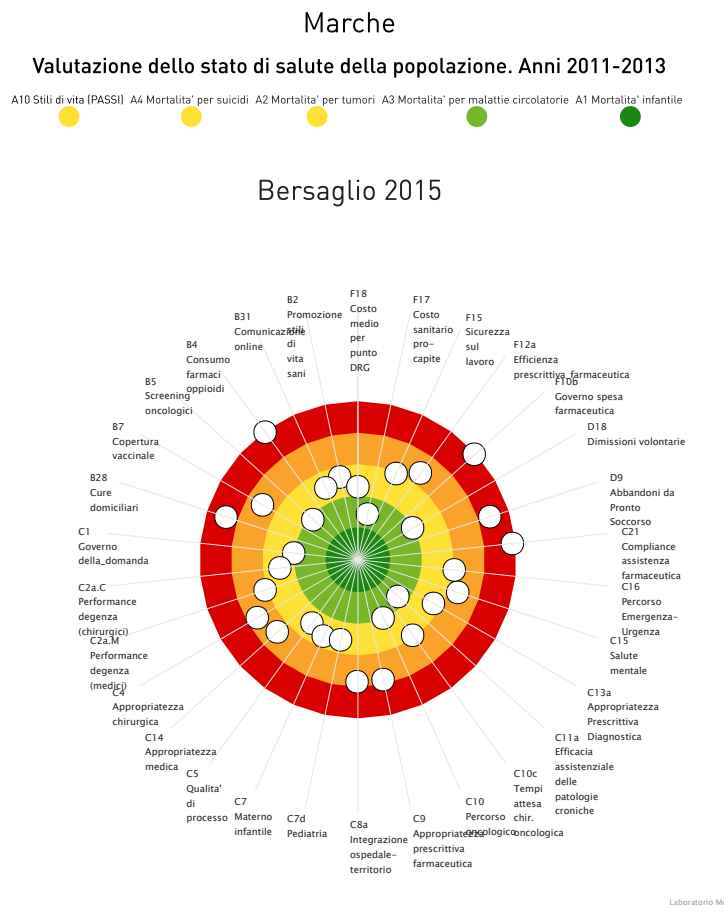
Figure 8.7: The Tuscan system dartboards displaying the health performance of two regions, Tuscany and Marche, in 2015

(a) Tuscany



One evaluation of Italy's 'natural experiment' with different systems of governance in its 21 'regions' compared performance across 14 indicators in 2007 and how that had changed over the next five years.[49] This showed that all five 'regions' that published rankings improved their performance. The performance of Lombardy deteriorated markedly. This is the only region in Italy that has persisted with trying to make hospital competition work.[50] Tuscany had good performance in 2007 and improved to be the best in 2012. In 2015 the regional councillor for health decided to end its system of performance-related pay for chief executives in making savings in response to a financial crisis. However, this change had no effect because its performance evaluation system was still used to hold them to account for performance and had become embedded in a social process of collegial benchmark competition.

(b) Marche



Source: Nuti and Vola, MeSLab.[51]
Notes: Each 'dartboard' shows performance in that region on a wide range of different performance indicators, specific to each area of health system operations. The white dot shows how close to the central target aspiration performance got, across five ratings from very good (green) to poor (red). In this figure, Tuscany (with almost outcomes within the green and yellow zones) clearly performs better than Marche (where few results are in green zones, and others spread out more into the orange and red zones).

8.4 Managing the commons

Like all healthcare systems, the NHS struggles with competing demands on its common pool of resources. The nature of that collective action problem was vividly captured by the English economist William Forster Lloyd. In his 1833 pamphlet, he used the analogy of shepherds sharing the commons for grazing their sheep. Each shepherd gains if he can increase his sheep over his allotted number but, if they all do, that results in the unrestrained overgrazing of the

commons and all shepherds then lose any grazing at all. Lloyd's pamphlet was developed by Garrett Hardin into the economic theory of the 'Tragedy of the Commons', which was published in *Science* in 1968. He argued that the only way to resolve the tragedy was by assigning property rights, even though that would result in injustice, because that outcome 'is preferable to total ruin'.[52] Since then, however, Elinor Ostrom's substantial body of empirical research showed that groups of small to moderate size could manage common-pool resources without assigning property rights.[53] The principles of how to do that for healthcare have been developed by Ronald Dworkin, Norman Daniels and James Sabin, and they offer different approaches at the national and local levels.

We generate our common pool of resources for healthcare when we are able to work by paying for others who are too sick, too young or too old to do so. For Ronald Dworkin, that frames our willingness to pay for insurance for healthcare over a lifetime:

> Most young people on reflection would not think it prudent to buy insurance that could keep them alive by expensive medical intervention, for four or five months at the most, if they had already lived into old age. They would think it wiser to spend what that insurance would cost on better health care earlier, or on education, or training or investment that would, provide greater benefit or more important security.[54]

Norman Daniels has argued that we ought to give priority to services directed at the young because that helps them survive into old age and they have greater potential life years to gain from treatment. This is a key way to achieve greater equity in life expectancy.[55] A tension in the NHS constitution is that it aims to be available irrespective of age and 'to promote equality through … particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population'.[56]

The systems of resource allocation in the NHS aim to allocate resources to local populations according to need. But the way those resources are used shows dramatic unwarranted variations in patterns of expenditures and rates of treatment for different types of care.[57] The local systems that deliver healthcare have evolved over time in different ways. They were not designed to make optimal use of our limited resources. To do that we need to reorganise our local healthcare systems (prevention, primary and hospital care, and rehabilitation) for different conditions.

Daniels and Sabin proposed a process for doing this in their 'Accountability for Reasonableness' framework.[58] This requires the development of a rationale, based on relevant evidence, reasons and principles, for making decisions in a process that is publicly accessible and that allows scope for revisions and appeals, and regulation to ensure these conditions are met. A start on doing this was made in the NHS in meetings with stakeholders (including patients,

carers, doctors, nurses, managers, treasurers) to compare the value for money of different interventions along the care pathway for the same condition (for example, stroke, low back pain). These analyses typically show that most resources are consumed by hospital admissions that produce little value. As a result, only limited resources are available for undertaking the early interventions that are high value and can prevent the worsening of people's condition and need for hospitalisation. Hence there is considerable scope to increase the value produced by the NHS by reallocating how we as a society use our resources.[59]

Conclusions

As Arrow explained in 1963, markets will fail for healthcare. There is strong evidence that:

- User charges as a means of cost control belong in the firmament of zombie economics.
- Providing information for insurers and users on the performance of hospitals has little impacts on their market shares.
- Purchasers fail to contract selectively with providers of healthcare.

But there are working examples of effective to alternatives to markets in healthcare. The UK and Canada developed effective systems of cost control based on universal coverage, financed by taxation, free at the point of delivery. These are obviously more equitable than the patchwork of arrangements of incomplete coverage in the US, characterised by high user charges, spending the highest share of GDP across the OECD, and exceptionally having falling life expectancy. We can improve performance of providers of healthcare by developing well-designed systems of public reporting that can lead to improvements. These systems generate high-powered incentives from their impacts on the reputations of those who provide services. (This is also what was found to be the main impact from publishing information on school performance in exams in England and Wales, as described in Chapter 7.)

Looking back to the various radical policies of the coalition government from 2010 to 2015, it is difficult to decide which did most harm: cuts in funding for local government and social care?[60] Universal credit?[61] Finance of undergraduate university education?[62] Abolition of schemes to enable children from poor families to benefit from education?[63] But it seems that, out of this rich cornucopia, the prime minister, David Cameron, believed that it was Dr Lansley's 'monster' reorganisation, which subjected the English NHS to unnecessary and misconceived radical reform (and relegated adult social care to malign neglect). Thankfully, that third abortive attempt to make an internal market work in the NHS has been abandoned. But Lansley's monster also had the collateral damage of fatally undermining England's public health capability to respond to a global pandemic – the subject of the next chapter.

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