

The Coalition NHS Reforms – Insurance, Incentives and Decentralisation

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Introduction

The provision of healthcare in Britain has become a fraught issue over the last 30 years, as first one government and then another has attempted to reform how it is provided (Socialist Health Association 2010), either on the grounds of cost, access or of quality. The main changes have centred around incentives for providers, rather than radical changes in the mode of funding which has remained as an unhypothecated slice of general tax revenues; the total determined by the Treasury and then distributed by a centralised Department of Health. This centralisation in funding and direction dates from the establishment of the National Health Service (NHS) in 1947 as part of the post-war solidarity settlement. As such, it has proved difficult for governments to approach any changes to this centralisation without strong responses from political opponents, workers within the NHS, and the general public. The consequence is that debate about the NHS's future is confined within quite narrow boundaries.

Many of the changes involve attempts to emulate the apparent efficiency of businesses in providing goods and services in the quantities and quality demanded in a timely fashion and relatively cheaply. The changes instituted by the Conservative governments from 1979 until 1997 can be seen to have followed this course. First they introduced 'general management expertise' into the NHS and then allowed the private tendering for 'ancillary' services. Later on they handed individual budgets to GP practices (fundholding) that wished to do so and met certain criteria, allowing them

to choose the providers of secondary care of their choice. Finally they gave hospitals a degree of financial and operational independence as ‘NHS Trusts’, providing services to fundholders and Health Authorities. It’s not really clear whether these market changes brought benefit or not – partly because little systematic assessment was done (Kay 2001), and partly because the effects of healthcare systems are multi-dimensional and value-laden (Donabedian 1966). In any case, the incoming Labour government of 1997 was committed to rolling back some of these ‘market’ mechanisms, in particular the abolition of fund-holding, and replacing them with more collaborative working in the form of Primary Care Groups alongside more statutory advisory agencies such as the National Institute for Clinical Excellence (NICE).

In fact it wasn’t long before the Labour Government too, decided that market-style splits between purchasers and providers, along with limited financial incentives, was a route to reform of quality and costs. They introduced autonomous Foundation Trust secondary (hospital) care providers, and Primary Care Trusts to manage community health and GPs budgets. This went alongside a series of process targets that were imposed on providers, such as the various waiting time directives. Eventually we seemed to have come full circle with encouragement of Practice-Based Commissioning through which practices would once again be able to make free choices of provider, with funds under their control ‘following the patient’.

On this background the current proposals for reform of the new Conservative-Liberal Democrat coalition must be seen (Department of Health 2010b). In part they are a continuation of an unsteady trend toward an NHS that is publicly funded through taxation as it has always been, but where the use of those public funds are determined by choices based on ‘quality’ and cost made by at least semi-autonomous organisations charged with that responsibility on behalf of patients and communities. On another level they suggest an increasing part to be played by non-public

providers, and the freeing of many restrictions on the ways the purchasers and providers operate within this framework. In acknowledgement of the risks and uncertainty associated with this approach, which will be unique among major industrialised countries, there will be a network of organisations with various levels of public accountability in existence to oversee the various outcomes of the new system.

Economics of Healthcare

Before considering the proposed reforms in detail, let's consider the nature of healthcare that makes it such a contentious issue in almost all developed countries. Let's start by considering problems of Demand. I group these issues under three headings: Information; Paying For It; and Externalities.

Demand Issues

Information

Choosing healthcare is difficult compared to many goods and services because

1. The decision to consume it (ie decision to accept assessment and/or treatment), the choice of provider and the choice of treatment often need information and skills not easily accessible to the general public (Hart et.al. 1997). Even after treatment, it may be impossible for the patient him or herself assess whether that treatment was of the best possible quality. In technical terms this makes much of healthcare a 'credence' good – and this has well-recognised problems for markets (Hahn et. al. 2005, p37; Dulleck and Kerschbamer 2006).
2. For most people, many healthcare interventions will be needed rarely if at all, and aspects of their treatment will be unique to them. There is therefore often very little, if any, possibility of adjusting one's choices in the light of experience, even that of others, as one can do with many consumer goods and services.

3. Healthcare is often needed at a time when we are least capable of making an informed choice – when we are very young, ill, distressed or in extreme old age.

Paying For It

How to arrange for the payment of healthcare is difficult because

1. There is wide variation in need between individuals, which is often dependent on personal characteristics and features of their own environment, some of which can be recognised and some not.
2. It is usually difficult to predict when we are likely to need healthcare, and how much of it we will need, when we do.

Externalities

There are many elements of healthcare that have impacts beyond the person who is receiving treatment:

1. *Health Externalities*: Prompt and effective treatment (and prevention) of infectious diseases prevents their spread.
2. *Social/Economic Externalities*: Prompt and effective treatment of illnesses can prevent loss of economically and socially productive time, as well as lengthening the working lives of productive workers and family providers and carers.
3. *Moral Externalities*: Many, perhaps most, people think that ill people should receive quality medical treatment irrespective of their personal circumstances or lifestyle.

There are also problems on the supply side for healthcare. They are primarily flexibility and scale considerations.

Supply Issues

Flexibility

Providing healthcare safely and effectively demands huge investment in skills and equipment. It takes at least a decade to train a hospital specialist doctor, nearly as long to train a general practitioner and perhaps half of that to fully train most other healthcare professionals to be able to practise independently. Much of the equipment needed for modern healthcare, including drug treatments, is technologically complex and in a state of continual development. The ability for new providers to be set up or for existing providers to adapt to changing choices may be severely limited by these factors.

Scale

The unpredictability of healthcare demand for less common illnesses (and sometimes more common ones such as influenza) requires organisation on a large scale, while the ability to have genuine *competition* between providers requires the existence of several that are able and willing to replace those that are unsatisfactory on the grounds of costs or quality. The concept of *contestability*, by which the benefits of competition can be brought about by potential new providers rather than existing ones is relevant but may be militated against by the flexibility problem (Morrison and Winston 1987).

Another general problem with healthcare is that less need for it is a good thing for everyone except health care providers themselves, and if market-based incentives are important this might de-emphasise prevention as a priority when this is an integral part of much care.

The Role of Health Insurance

The solution chosen in many developed countries to some of the problems of healthcare demand is through the purchase of insurance. In particular this can help to deal with the problem of

unpredictable and variable need, and the possibility of unexpected large expenditures. It achieves this by allowing frequent small(er) payments by a wide pool of individuals that can collectively obtain enough resources to cover the expected healthcare needs of that pool. By concentrating information costs and experience of multiple episodes of care with the insurer, some impact can also be made on assessing the quality of care that the insurance fund provides - albeit at one stage removed from the patient. It is also possible to deal with *some* of the externalities, by insisting on universal acceptance by insurers combined with payments to compensate for unequal risks.

Private insurance funds cannot address all problems however. There remains the problem that even insurance companies cannot fully ensure that the care and treatment given by doctors is precisely of the quantity and quality that the patient needs on every occasion. Competition among insurance funds is both potentially beneficial, as they seek to improve quality and lower costs to attract clients, and potentially harmful, as they seek to avoid insuring those on low incomes or with characteristics that make them relatively high risks for ill-health, or by doing their utmost to exclude specific risks or deny claims when they are made (Bybee 2007). These sort of problems are predicted to become particularly acute as genetic advances increase the predictability of much illness (Wray 2010). Another social feature that makes private health insurance problematic is rising income and health inequality. As the gap between high-earning low-risk people and low-earning high-risk ones increases, the willingness for the former to subsidise the latter must surely reduce. Other social divisions may exacerbate this problem. For these reasons, in all developed countries, the state plays some role in funding and usually regulating healthcare even when it plays little part in actually providing it.

The Specifics of the Proposed Reforms

In the introduction to the White Paper outlining these changes it is stated that 'it [the NHS] can be

so much better - for both patients and professionals' (Department of Health 2010b). They then go on to say that they 'will make the NHS more accountable to patients' and 'free staff from excessive bureaucracy and top-down control'. This is to be achieved by placing 'patients at the heart of everything we do' giving them 'more choice and control, helped by easy access to the information they need about the best GPs and hospitals.' The coalition plan to shift the measurement of success in the NHS as a whole from 'bureaucratic process targets' to 'results...such as improving cancer and stroke survival rates'. They expect this success to be achieved as a result of a drive to 'empower health professionals...with ownership and decision-making in the hands of professionals and patients'. It's difficult to take exception to any of these aims, and much of the recent rhetoric, if not the actions, of the previous government were along the same lines. It is likely that some of the urgency is driven by the desire to drive down costs in the face of a large public sector deficit (although the costs of re-organisation would seem to run counter to this aim) and from the findings of the Mid-Staffordshire Inquiry that revealed serious care and management failings in a Foundation Trust that may have led to significantly increased hospital mortality rates (Francis 2009). But what of the details?

Patient Choice and Control

The aim is that patients will have a choice of 'any willing provider, choice of consultant-led team, choice of GP practice, irrespective of where they live, and choice of treatment'. They will be helped in making these decisions by increased quantity, quality and transparency of information about the outcomes of healthcare providers. There will be comprehensive 'patient ratings' collected and published, and collective input for public and patients through local authorities and through a new body 'Healthwatch England' that will have local branches. The government claim that evidence shows improved outcomes and reduced costs from such involvement.

Outcome Measurement

The NHS as a whole will be held to account via ‘clinically credible and evidence-based outcome measures’ rather than process targets such as waiting times and treatment volumes. These outcomes will conform to key principles of accountability and transparency, balance, focus on what matters to healthcare professionals, outcomes that the NHS can influence (with or without other bodies) and internationally comparability. Five ‘domains’ of outcomes have initially been proposed, covering:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill-health or following injury;
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm (Department of Health 2010c).

Already the centralised 18-week waiting time and 48 hour GP access targets have been dropped (Department of Health 2010a) , although the coalition expect that GP commissioners will enforce acceptable performance on access criteria. The Care Quality Commission will continue to act as an inspectorate for health and social care, fulfilling the role of licensing for existing or potential providers of care funded by the NHS.

Empowering Health Professionals

The intention is to transfer the main decision-making about the provision of health care to GP Consortia, of an as yet undetermined size. They will have ‘responsibilities for clinical decisions and for the financial consequences of those decisions’. Primary Care Trusts will disappear, as will Strategic Health Authorities. The activities of GP-led commissioning will be overseen and

supported by an NHS Commissioning Board. In particular this body will ensure that ‘commissioning decisions are fair and transparent and will promote competition’. GP-commissioners will, it is claimed, be free to contract with ‘any willing provider’ for the aspects of care (encompassing almost all community and secondary care) they will control. Currently existing providers will all be converted into Foundation Trusts giving them responsibility for their own management and financial affairs – to the extent that overspending will not be ‘bailed-out’. In particular the cap on income from other services (currently set at 2% of total revenue) will be lifted, merger between Trusts will be enabled and governance arrangements will be made flexible to the extent of including ‘employee-led social enterprises’. An ‘effective payment system’ will be established that ensures that the GP-commissioners’ chosen providers will be paid for carrying out ‘best-practice’ care with incentives for quality and fines for poor performance according to agreed criteria. The market for secondary care that is thus created is to be policed by ‘Monitor’, the Foundation Trust regulator, which will be charged with ensuring ‘effective competition’, price regulation and overseeing the contracting of services. It will also have ‘powers to protect assets and facilities’, powers to levy providers for contributions to a risk pool and powers to trigger special administration regimes. It will also be charged with investigating ‘anti-competitive purchasing’, which will include failing to tender for services or discriminating in favour of incumbent providers.

Assessment

The coalition claim that the reforms will produce ‘more autonomous NHS institutions with clear duties and transparency in their responsibility to patients and their accountabilities’. This is intended to improve the NHS’s poor relative outcomes that result from the ‘lack of a genuinely patient-centred approach in which services are designed around individual needs, lifestyles and aspirations’. As a result of the changes the NHS should less ‘fragmented and working better across boundaries’.

Power will be given to the ‘front-line clinicians and patients to innovate and improve outcomes, having greater incentives to flourish but also know the consequences of failing patients and taxpayers’. Existing providers will be set free and will be in charge of their own destiny without central or regional management or support. The loss of this management is anticipated to reduce NHS management costs by 45% over 4 years. What are the potential risks and barriers to achieving these outcomes?

Choice

Choice is clearly a good thing, although as we have indicated, for it to actually produce benefit it is important that ‘consumers’ have adequate information and that providers can cope with *some* degree of variable demand, particularly in the first two or three years of the system bedding in as GP-commissioners find their feet. As the system is outlined in the coalition’s proposals it does look as though there is a potential conflict between GP-commissioners’ contracts with providers and patients right to seek the services of ‘any willing provider’. While in practice it is unlikely that very many patients would go against the recommendation of their GP, there is risk that that recommendation may sometimes be based on administrative and cost grounds rather than those most relevant to the individual patient. In effect GP commissioners would seem to be fulfilling the role of health insurers in countries such as Germany and Holland where universal healthcare provision is guaranteed making health insurance compulsory for the vast majority of the population. In these countries premiums are determined by a sliding scale according to income, and a risk equalisation system that compensates insurers for recruiting lower-income and higher risk groups is provided. In Germany, the patient has free choice of provider; in Holland the insurer can impose some restrictions (Henke et. al. 1994, Green and Irvine 2001, Rosenau and Lako 2008). In both countries there has been increasing upward pressure on premiums. In 2008 total health expenditure for Holland was 9.9% of GDP; for Germany 10.5%. This compares with 8.7% for the UK (OECD

2010). By analogy, it can be anticipated that there will be pressures either on GP-commissioners to suppress demand, or on UK health spending to increase rather more than anticipated or presumably desired by the present government. An additional reason for increased financial pressures is that in a system more overtly driven by patient choice, the affluent and better educated will seek more than their 'fair' share of resources yet may live in areas where funds allocation based on needs results in somewhat lower levels of funding. This will be a particular problem for a system in which GP consortia are smaller and more numerous, and therefore show wide variations in demographics.

The UK system of global unhyphocated tax funding is likely much less flexible to changing demand pressures, since there is no possibility of affluent consumers switching to higher cost insurance plans or of consumers in general being able to see a direct trade off between improving services and their own contribution to those services. It is clear however that even under insurance systems such as those of Holland and Germany, that while these price signals do exist to some extent, they are considerably blunted by the measures in place to ensure universality of cover.

Incentives

There is plenty of evidence to suggest that the NHS could do better – the Mid-Staffs report giving many glaring examples. But especially given that it is cheaper to run than for many of our European neighbours, just what is the statistical evidence that UK healthcare is worryingly poor? Subjectively, the proportion of the UK population that rate their healthcare services as 'good' is 77%, compared to 79% in Germany and 87% in the Netherlands (European Commission 2007). Objectively, the NHS's performance in rates of death from 'causes amenable to healthcare', such as heart disease, pneumonia, stroke, peptic ulcer and breast cancer is generally lower than the EU median, but it is difficult to know whether this is due to the incidence of those diseases being higher or whether there is a problem with our healthcare system itself (Nolte and McKee 2003). Evidence

from *trends* for these mortalities suggests that the NHS is making progress here at roughly the same rate as or better than other European countries (Treurniet et. al. 2004).

Again there is no dispute that it is a good thing if providers of healthcare, both institutional and professional are incentivised to provide that care cost effectively and to a high standard. What in theory might the incentive improvement mechanisms be in the new NHS? First it is important to consider what should be being encouraged. The Mid-Staffs report indicates that in some areas of the NHS standards of basic care, management and morale have sunk to very low levels. In Mid-Staffs no imaginative innovative solutions were needed, just the willingness of management to focus on problems that were reported by patients and their relatives, rather than those that fitted within the 'strategic' silo that the Trust Board had created for itself; a willingness to engage effectively with professional staff; and the basic competence to plan service changes safely and effectively. If senior healthcare managers cannot be motivated by a substantial basic salary, and their own professional goals to address these issues, it's not clear what incentives could achieve this.

The incentives introduced for providers by the new set-up will be loss/gain of contracts, loss/gain of revenue and the intrinsic motivations of healthcare professional and hopefully managers to provide a good service, and perhaps over time, a better one – although one should be aware of the risks that attempts to achieve the latter can always put the former goal at risk. But a clear problem with the new arrangements is that revenue per procedure for providers will tend to be fixed centrally. This hopefully means that competition between non-profit providers will be purely on quality – and the obvious assumption is that GP-Commissioners will be discerning customers when it comes to judging that quality. But that quality will come with no flexibility over pricing, giving a priority for keeping costs down. To the extent that for-profit providers enter the market, or that non-profit providers wish to achieve a surplus for re-investment, there will be further downward pressure on

costs. Of course minimising costs for a given quality of output is to be desired, but the nature of healthcare – where its true quality after the event, even to the primary care doctors commissioning it, is often opaque – often makes the dividing line between this and quality reductions an extremely difficult one to discern.

Outcomes

While the emphasis on outcomes is welcome, it cannot be the only way of monitoring the effectiveness of healthcare. Outcome data can often show wide variations that have little to do with the actual quality of care provided. This may be due to variations in patient or other characteristics, poor data quality or random statistical variation. Often outcome data reflects care carried out some time prior to the data being collected and analysed (Powell et. al. 2003). Effective monitoring of actual processes of care, and comparing them to validated standards must also be part of maintaining quality (Donabedian 1966).

Conclusions

Abstracting from the coalition's rhetoric and any ideological view for or against markets or profit, one could sum up the main issues here as being about 'consumer' and GP input, decentralisation of control and incentivising high quality care and innovation in care. It should be pointed out from the start that there is no evidence to suggest that more market mechanisms are a necessary condition for improvement. Among developed countries, almost wholly public systems such as those of Denmark and Sweden are among the best on most indicators and an almost wholly private one such as that of the US are among the worst (and by far the most expensive) (European Commission 2007, Schoen et. al. 2007). On this basis it would probably be a reasonable thesis that any failings of the NHS are not due to the lack of market mechanisms, or quite possibly any of its structural features, but a combination of the 10-15% lower spend in relation to GDP compared with countries that appear to

do better and the incessant reorganisation that has been in progress for the last 25 years.

So, a preferred approach may be to explore consumer input, decentralisation of control and incentivising high quality care and innovation in care from within the existing publicly provided and funded set-up of the NHS. This approach chimes with that favoured by many healthcare professionals and patients' representative groups (British Medical Association 2009, 2010). The events of Mid-Staffs show the potential value of more robust pathways for patients, carers and relatives to have their concerns listened to, and acted on when required. If this happens effectively, some of the benefits of the potential switching of providers can be eroded, which in the view of the inevitably high costs of switching may in itself be enough to remove any putative advantage. Add to this the active involvement of GPs in planning care and co-ordinating their patients' needs, whether or not this is formalised as commissioning, there is huge potential for improvement without destabilising threats to providers themselves (and to some extent the communities they serve).

The stronger patient and GP influence on local care planning and provision is a step toward decentralisation, but these alone leaves a gap that remains to be filled. One of the huge problems of healthcare is the gap that frequently exists between need and demand that is expressed effectively, in financial terms or even at all. In a democratic nation with a level of solidarity that supports the idea that provision of healthcare should depend primarily on need rather the ability to pay, this must always limit the ability of private healthcare providers to provide a comprehensive or equitable service. So a decentralised public system also has to address the problem of unmet need. Either GP-commissioners take on this role, or local authorities, or more likely and efficiently a combination of both. It may well be that this combination will tend toward merger as long as both GPs and public retain their voices.

Responsibility for quality and innovation must be clear and understood. The thrust of the coalition's reforms suggest that only market-type incentives, either at organisational or individual level, are likely to be effective. Yet, there is much evidence from psychological research that this sort of extrinsic motivation may have limited effect or even be counter-productive by suppressing 'intrinsic' motivation, particularly with those that have chosen to work in public sector rather than private sector occupations (Bénabou and Tirole 2003, Houston 2000, Kreps 1997). We should hope and expect that healthcare workers in particular have strong intrinsic motivation to do the best for patients and the quality of care their organisation provides. It is poor leadership, failure to communicate, and a culture of oppression that are likely to be drivers of poor performance, not the lack of any profit or income incentive.

In particular, the concept of organisational market incentives in a publicly-funded healthcare system seems to lack positive justification, and to offer plenty of risk. There is nothing *intrinsically* wrong with a healthcare provider earning a profit, if in doing so it can provide a quality of care and/or a cost that no non-profit provider can match. But there are huge problems with the idea that a provider that cannot influence its cost per unit, and where quality is multidimensional, difficult to contract for and difficult to ascertain, is not going to seek that profit by cutting costs in undesirable ways. Perverse incentives may exist, the most glaring being that a private provider, as an organisation, has very little interest in reducing the need for its services. Even to the extent that incentives for managers work in the right direction, the essence of healthcare is in the interaction between healthcare professional and patients. *Their* incentivisation will probably depend on their empowerment, experience of corporate leadership, or their own personal financial incentives. None of these actually require the organisation to be a corporate profit-seeking entity, although the potential for mutual or partnership structures would seem to be there. An example of a financial incentive that could work within the NHS is the GP 'Good Practice Allowance' as proposed by

Marinker et al. (1986).

The negative example of the US as a system where profit plays a large part extends beyond the poor performance and outcomes, but perhaps surprisingly also in a patchy record of innovation. In fact there turn out to be many barriers to innovation that do not depend on the presence or absence of incentives, but in issues such as treatment licensing and co-ordination between providers, insurers and healthcare professionals. Some of these are features seem to be the *result* of competition rather than the lack of it (Herzlinger 2006).

At least in the US system and other insurance-based systems such as that of France, Germany and Holland there is a mechanism for changing preferences in healthcare to be reflected in changes in funding that has some connection in the minds of consumers. If consumers demand more healthcare, then this can be (imperfectly, and with problematic implications for risk-equalisation) reflected in higher insurance premiums. Such flexibility as this represents is of course absent from the UK system. But once risk-equalisation, mandating of policies, administration costs and the vagaries of the insurance industry are taken into account there seems little advantage of an insurance system. We have the example of two highly effective systems before us, in the form of Sweden and Denmark, where funding is primarily from counties and local authorities (Swedish Health Care 2010, Green D. 2002). Given that this is usually the appropriate level of healthcare organisation, this seems like the logical way to go to improve the connection between payment and provision. There is then a strong incentive for the local authority to provide effective preventive care and lower the costs it passes on to its residents in taxes. We would have to become a little more tolerant of variations in provision between areas (so-called postcode lotteries), but no doubt standard levels of provision would be established. Of course, both these countries are rather smaller than the UK, and it maybe that some intermediate co-ordinating level, or a slightly stronger centre

than in those countries would be required, but there seems no reason why the principle would not be equally effective here.

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