

At what cost? Paying the price for the market in the English NHS

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Summary

1. Extreme financial pressure upon the English NHS for the foreseeable future makes avoidance of waste imperative. The 'market' in the NHS is a major source of waste. Creating and maintaining markets has incurred huge direct costs and significant 'opportunity costs' – money which could have spent upon patient care and clinical re-design.
2. Not only has evidence to justify 'market reforms' to the English NHS from 1990 to the present-day been absent, but the recent Health and Social Care Act of 2012 actually ignores, or even inverts, evidence which suggests that 'commissioning' by GPs in local markets characterised by separate 'purchasers' and 'providers' is costly and of dubious effectiveness. The only reasonable conclusion is that that market policy is based upon ideological dogma, pressure from commercial interests or both.
3. It has been argued that the only way in which hospitals and other service providers can be reimbursed in a timely manner for their workload, and given the incentive to increase workload and productivity, is through the operation of market forces. This is simply untrue and based on a re-writing of history.
4. The recurrent, annual costs of the market can be estimated (conservatively) at £4.5 billion.
5. The one-off, start-up costs of the various phases of the market (1991-97; 2001-2007; 2010 to date) have run into billions of pounds, with (again, conservative) estimates of the most recent market initiatives under New Labour and then the Coalition government comprising £3 billion each.
6. This paper sets out how the wider costs of the market have included both opportunities foregone and likely harm to the system.
7. Possible benefits from the market are hotly contested in the research community and – even if one grants the benefits claimed by supporters of the market – very small when set against the costs.
8. It would take ideological chutzpah of the most irresponsible sort to suggest that the answer to the failure of the market so far is 'more market'. The paper suggests why.
9. It is possible to have patient choice and high-quality health-care without the market. The paper suggests how.

Introduction

1. The NHS faces a wintry future, in the sense that it is expected to make savings of £30 billion by 2018 in order to free up resources for additional challenges. This funding dilemma straddles mainstream party politics. Were Labour to win the next election, its plans to unify health and social care would mean that the NHS as we know it did not receive more resources than under the Coalition government. It is therefore imperative that resources are not wasted. This paper contends that the cost of the 'market' in the English NHS is such that it has been, and continues to be, an unaffordable ideological luxury which has high direct cost and even higher opportunity cost. Market re-form (the hyphen removes the implication that reform is improvement) absorbs scarce leadership skill but, more importantly, absorbs significant resources which could be spent directly on patient care.

2. For twenty-five years, 'market reform' has been sold to the English NHS as the answer to ill-defined or even unasked questions, and as the solution to emotively-framed yet essentially technical problems. Evidence has played a very minor role in this process, and furthermore has not been used to form evidence-based policy¹.

3. The most recent re-form of the NHS, following the Health and Social Care Act of 2012, was based on an even worse phenomenon – that of evidence-denying policy. What research evidence there is from the only previous attempt to make GPs responsible for the whole health budget^{2,3} tells us that many GPs are not interested in, and therefore not very good at, commissioning comprehensive hospital services; and that should the government wish to invest in and develop such skills, this would be expensive and time-consuming in terms of management development for clinicians, a warning reinforced from recent overseas evidence⁴.

4. Yet the Coalition government has put GPs in the hot seat of commissioning in Clinical Commissioning Groups at a time when money and time for such investment are conspicuously absent. Stretching the bounds of credulity, the Coalition government has gone further and argued that its market policy will actually facilitate the massive cost-saving exercise it has ordered to the tune of £30 billion. This assumes however that GPs will not only extend their role in patient care, including taking overall responsibility for the holistic care of the elderly in order to keep them out of hospital, but will also occupy the linchpin managerial role for the whole NHS. Such an assumption is simply unrealistic.

Introducing markets in the NHS – a dubious rationale

5. There have been two main justifications offered for market reform to the English NHS. Firstly, it is argued that, without the market, resources cannot follow activity e.g. hospitals are not properly reimbursed for the work that they do. This is simply not true⁵. Secondly, it has been argued that a new tide of consumerism created

momentum for the introduction of markets⁶. Yet this was classic, if plausible, ex post rationalisation. The 'crisis' in winter 1987 which led to the Thatcher Review of the NHS (and thence to the internal market) was rooted in a shortage of resources, and the clamour was on the part of the medical profession⁷.

6. The internal market introduced in 1991 was, despite the rhetoric, an 'anti-choice' policy. Patient power was floated symbolically e.g. in the title of the White Paper, *Working for Patients*,⁸ for public consumption - to distract attention from the fact that the market being created did not have patients but health agencies as customers. Indeed, it restricted referrals of patients to where contracts existed between these health agencies (purchasers) and providers of services.

7. When New Labour launched its own version of the market in the early 2000s⁹, Prime Minister Tony Blair believed that the NHS had to cater for demanding middle-class consumers in order to retain its political legitimacy. Ironically, however, the government did not understand that the possibility of choice of provider had existed in the NHS from 1948 to 1991, and that it was a technical not ideological challenge to enable this choice more effectively. Just as policy could have been adapted without radical upheaval in 1991, New Labour's 'new market' represented further root-and-branch re-organisation which cost a lot and produced little.

8. The essence of the market in the NHS – in all its variants - has been the 'purchaser-provider split', which has requires an NHS agency (not the patient) as purchaser. These agencies have ranged from Health Authorities and GP Fundholders in the 1990s, through various sizes of Primary Care Trusts and their subsequent sub-contractors, Practice-Based Commissioners (GPs), in the 2000s, to the present Clinical Commissioning Groups and (for specialist services) Area Teams of NHS England, the national quango which both commissions specialist services and is responsible for the performance of the Clinical Commissioning Groups for local services.

9. Whenever patient choice has come into conflict with purchasing/commissioning (which limits care to that allowed by contracts between purchasers and providers), the latter has prevailed. This is because free patient choice is unaffordable. It has to be 'managed' to control referrals. What is more. as the NHS's funding crisis bites harder and hospitals are further 'rationalised' into specialist centres, patient choice as 'sold' by politicians will become even less meaningful and possible.

Direct Costs of the Market

10. There is much evidence that market structures in the NHS - the purchaser-provider split, with 'commissioning' or purchasing on one side of the fence, and both separate management of, and competition among, diverse providers, on the other side - have cost a lot and delivered little (if indeed anything) positive. The opportunity to measure directly the total costs of market reform over 25 years or the costs of particular reforms along the way has been lost, not least because no

government has wished or dared to do so and independent research has been too small-scale to do so. Yet nonetheless some illustrations of the vastly increased costs of the NHS's administrative costs in the market era are possible.

11. The House of Commons Select Committee on Health reported in 2010, based on a York University study¹⁰, that the administrative costs (i.e. recurring annual costs) of the NHS in England were 14% of the total budget, by 2005. This may be compared to 5% before the 1980s¹¹. Even here it should be noted that the York analysis pre-dated the full rolling out of Labour's market and may underestimate administrative costs accumulated by 2010. Many, if not all, of the recent costs may be attributed to commissioning per se (i.e. the existence, staffing and running of agencies separate from the provision of care), the management and administration of commissioning-provider contractual relations and other institutional and behavioural features of 'the market'.

12. To be scrupulously fair, one should note: the changing definitions of 'management costs' over time; increased relative remuneration for managers; increased investment over time in new management structures which predated or were separate from 'the market' (e.g. the Griffiths reforms introducing general management after 1983); and intelligence for management e.g. information systems.

13. Yet allowing these factors to explain half the increased management overhead for the NHS (surely an overestimate – i.e. half the difference between £5 billion in the 1970s and £14 billion in 2003 at today's prices taking the total NHS budget as £100 billion) leaves £4.5 billion per year on servicing the market. Furthermore, factors such as reclassification of management costs have probably been used to seek to minimise management costs post-market. Additionally, 'information for management', while including important strategic information about outcomes, services and costs, also includes much disaggregated information about individual patient and service costs, which is not necessary for effective management of the NHS and is necessitated only by the administrative paper-chase of the market.

14. Therefore we may estimate that at least £5 billion of the NHS's recurrent i.e. continuing, year-on-year running costs relate to the market. This is enough to pay for ten specialist hospitals or – perhaps more appositely - mount a major investment in community based services and advance dramatically the integration of health and social care.

15. When the House of Commons Select Committee on Health report¹² was publicised, the response from both the Department of Health and some 'independent' commentators was complacent in the extreme. The Department of Health replied¹³ to the Select Committee that "commissioning is improving" – although MPs had been "appalled" that its top four officials had been "unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in primary care trusts and provider NHS trusts". Ironically, costs after the York research are likely to have escalated owing to the hubristically-named 'World Class

Commissioning' initiative of the Department up to 2010 which, evidence to a later Select Committee investigation suggested, was about process rather than outcome¹⁴. Jennifer Dixon, Director of the Nuffield Trust, commented that a 14% outlay on management was not high by the standards of international health systems¹⁵. But this was bizarre: a major comparative advantage of the NHS had been its low administrative and management costs by comparison with 'international health systems' most of which involved wasteful market and or insurance mechanisms.

16. There was a semi-official evaluation of New Labour's market reforms¹⁶ but this concluded that the costs were unknowable. Yet the absence of a definitive figure for the cost of all or any of the individual NHS re-organizations in pursuit of the market has allowed 'pro-market' researchers to point to alleged minor benefits without reference to costs¹⁷ – a strange stance for economists, and one which therefore ignores the opportunity cost of the market i.e. the benefits which could have been derived from alternative uses of the money.

17. However, it is possible to consider the nature, scope and scale of the costs, if not a precise quantification. Market reform has included:

(1) preparations for, and investment in, policy implementation (non-recurring costs, but likely to consist in various stages);

(2) management and leadership development through large-scale external consultancy (mainly non-recurring costs but with a recurring element);

(3) creation of market structures - new institutions, such as Self-Governing Trusts, Foundation Trusts, GP Fundholding groups, Primary Care Trusts, Clinical Commissioning Groups, external regulators such as Monitor et al (both non-recurring and recurring, especially as a 'market NHS' requires more purchasers/commissioners and more providers than an integrated, planned NHS requires agencies);

(4) the significant costs of redundancy and changing employment arrangements (non-recurring);

(5) pump-priming of new entrants to the market to make it 'competitive'. 'Market-making' has led to the subsidy of private providers to create competition where it does not exist, money which would arguably have been better spent on increasing and enhancing NHS provision (mostly non-recurring);

(6) development and maintenance of information required to run a market (to be distinguished conceptually from the legitimate information requirements of a modern health service) (non-recurring and recurring);

(7) the transactions costs of the 'purchaser/provider split' – advertising, negotiating, contracting, invoicing, billing, monitoring contracts and resolving disputes whether

legally or bureaucratically within the NHS, and hiring and employing additional staff as well as paying for the time of senior managers who are inevitably drawn into the process (recurring);

and

(8) the major 'opportunity cost' of the resources devoted to the market overall – what else might they have been spent on, and what that might have achieved by comparison with the 'achievements' of the market. While opportunity cost is, by one way of thinking, a direct cost of expenditure on the market, it is considered below in a wider context - in discussing the amalgam of benefit and harm which may have resulted from the market.

18. It should be noted that these costs include both recurring (i.e. continuous annual) costs, such as contracting, and non-recurring (i.e. one-off or start-up) costs such as the development of new roles and institutions. The non-recurring costs are additional to the conservative estimate of £5 billion per year made above. Let us consider these further.

19. When one takes three episodes - the 1990s' internal market; New Labour's market in the 2000s; and the market further developed following the Coalition's Health and Social Care Act of 2012 – it is clear that the non-recurring costs run cumulatively into billions.

20. To start with the most recent first, the extant non-recurring cost of the current reforms (2010-2013 and beyond) is likely to be at least £3 billion. The official figure was agreed by Health Secretary Andrew Lansley as early as January 2011 to be £1.4 billion¹⁸. But this official figure leaves out huge swathes of cost outlined in the paragraphs above. Furthermore, the savings promised will not materialise, as they consisted in the removal of Primary Care Trusts and Strategic Health Authorities. NHS England (formerly the NHS Commissioning Board) had had to reinvent both in the form of its Area Teams and Regional offices. Additionally, there is now a patchwork of regulators and overseers concerned with the performance of the English NHS which are both costly in themselves and in the transactions costs of their complex relationships.

21. The non-recurring costs of the 2001 reforms¹⁹ have been estimated, again conservatively, at about £3 billion²⁰ – with a major part of the cost incurred by the following elements:

(1) The replacement of 100 Health Authorities (HA) with more than 300 Primary Care Trusts (PCT) as part of Shifting the Balance²¹; Board/senior management replication, with the new PCT officers receiving similar remuneration to those at the previous HAs – arguably £1 billion of direct waste, given (4) below;

(2) Transfer of community Trusts to PCTs – employment/redundancy costs;

(3) Market-making: tenders for Independent Sector Treatment Centres (ISTCs); waste of resources through guaranteed income to ISTCs in order to 'market make' yet referrals through patient choice to NHS providers which are then put under financial pressure and incur potentially irrecoverable financial deficit²².

To the c.£3 billion incurred from the above, one may add the costs of the following 'follow-up' reforms in New Labour's time after 2001:

(4) The merging of more than 300 PCTs into 150 PCTs, incurring major redundancy and transitional costs as part of 'Commissioning a Patient-Led NHS' published in 2005;

(5) The development of commissioning from 2001 to 2008, culminating in major consultancy expenses allocated to 'World Class Commissioning';

(6) The divestment by PCTs of their 'provider functions' - reversing (2) above and creating 'community Trusts' as in the 1990s, justified on the grounds that a 'market' requires health agencies to be solely purchaser or solely provider.

22. Regarding the 1991-1997 internal market reforms, the scale and scope of the main initiatives incurred significant costs²³. While these one-off costs may seem to be lost in the mists of time, if the market does not produce benefit commensurate with cost, (if indeed there is any benefit), then non-recurring costs running into billions, which presage significantly increased recurring costs represent a stark waste of public money. And if the market has produced outcomes which are not beneficial, then this waste is all the more unforgiveable.

Wider Costs of the Market

24. The direct cost of the market in terms of management and managerial transaction is one thing. And perhaps we should talk of administrative, not managerial, cost. For the cost has been not strategic but operational, as it has consisted in servicing cumbersome duplication across 'purchasers' and 'providers' as a result of both the essence and frequent re-iterations of the 'purchaser/provider split', as we have moved from health authorities through the variants of GP Fundholding, 'Total Purchasing', Primary Care Groups, Primary Care Trusts Mark 1 (small), Primary Care Trusts Mark 2 (merged), Practice-Based Commissioners and now Clinical Commissioning Groups.

25. But even more significant are the 'opportunity cost' of the market and the wider costs of harm to the health-care system, respectively. The two are linked. Opportunity cost refers here to what might have been achieved if the resources consumed by the direct costs of the market had been available for other uses. For example, what could have been achieved had the significant time given to devising

and implementing the NHS market by policy-makers, senior managers and clinicians instead been devoted to other purposes?

26. Major substantive problems in health-care which have essentially been unsolved for decades, could have been addressed, such as: the appropriate mix between specialist ‘super hospitals’, local hospitals and community services (now seen as a major priority by NHS England’s Medical Director and Ministers, but hampered by market structures and culture); the pursuit of clinical safety and quality on a consistent basis; and the diminution of inequalities in health.

27. This notion of opportunity cost (opportunities foregone) shades into harm to the system if and when the consequences of creating market structures and a market culture actually retard the solution of, or indeed worsen, major substantive problems. Some of the key leitmotifs of market reform, present in all three key phases of the market (1991-97; 2001-2010; 2010 onwards), are:

- disintegration of both local and regional health communities into constituent parts without leadership of the whole, leading to dysfunctional and uncoordinated ‘local health economies’;
- failure to consider at first how specialised services will be planned (‘commissioned strategically’) if planning is abolished and ‘commissioning’ devolved to local purchasers/commissioners: service concentrations and clinical networks have had to swim against the market tide;
- reliance upon external regulation of individual market agents rather than internal (intra-NHS) strategic planning and whole-system performance management. Regulation and/or management of the market has posed a dilemma: is its aim to damp down market forces where they threaten equity or go beyond the bounds of political acceptability? Or is its aim the reverse: to seek to create competitive markets where, otherwise, ‘market making’ would simply turn a public service into a private monopoly? Policy here has been Janus-faced in all three phases of the English NHS market, primarily because clinical quality and economy require specialisation, concentration and complementarity, whereas competitive markets require excess capacity.

28. For reasons of space, let us consider only the first of these three issues, to illustrate how the market retards integrated care. In the first market, 1991 to 1997, it came to be recognised that, in reality, purchasers had the money whereas providers had the services, leaving an imbalance which led both to play games with each other rather than cooperate sensibly. At the outset of the second market, and especially in 2005-6, this led to beggar-my-neighbour responses to financial crises. My own study of the North Staffordshire health economy²⁴ provided a case-study of beggar-my-neighbour policy par excellence. Individual ‘marketised’ health agencies – NHS Trust and Foundation Trust providers; Primary Care Trust (PCT) purchasers – all sought to break even, or avoid worse deficits, at each other’s expense. Primary Care Trusts in particular sought to ‘dump’ costs at the hospital door, and the GPs referred patients to hospitals in large numbers, effectively transferring costs of treatment away from

GP budgets and onto PCT budgets. Hospital cuts were made by providers on the assumption that community services would be commissioned to replace them; meanwhile, cuts made by purchasers (PCTs) reduced community services²⁵.

29. In 2013, we have seen yet another crisis in emergency care, as Accident and Emergency departments all over England have been pushed to breaking-point. Clinical Commissioning Groups are powerless to prevent this. They have to pay Foundation Trust hospitals legally for care they give, which leaves the CCGs unable to invest in the alternatives. If they avoid paying hospitals for the workload which ends up at hospital doors, they simply push the hospital into financial crisis. This is a consequence of the market in that separate purchasers and providers seek to 'dump' patients, costs and problems on each other. Yet ironically the whole point of the 'purchaser/provider split', especially in the eyes of those of its advocates who did not come from a hard pro-market stance, had been to allow purchasers to prioritise care in the community, in order to obviate hospital admissions where possible and to reduce lengths-of-stay where admission had occurred. 'Beggars my neighbour' behaviour in the marketplace imposed by the Health and Social Care Act of 2012 can be expected to be even worse in the context of the resourcing crisis facing the NHS up to 2018.

Market outcomes – benefit or harm?

30. Huge costs can only be justified if the benefits are even greater. In terms of benefit, there was no evidence-base for the NHS market - let alone cost-benefit projection. The High Speed Rail 2 project, whose evidence base has been severely challenged, is pure science by comparison! The most significant evaluation 'after the event' which deals in hard outcome has made some heroic assumptions in attributing to competition through market choice some small improvement in health outcomes, reduced standardised death rates in one specialty, acute myocardial infarction (heart attacks), of 0.3%,²⁶ and improvements in process efficiency²⁷. The most heroic of all assumptions is in choosing, in order to measure outcomes, a specialty in which there is no choice or competition among providers - emergency care for heart-attacks. There is no plausible explanation for how competition in the specialties where it applies ('cold', elective, routine surgery) could improve emergency outcomes – and indeed there is a plausible case to explain the statistical reverse. Hospitals which are dominated by pressure from their emergency departments often are forced to 'satisfice' as regards elective care due to pressure on beds.

31. When the cost of 'market reform' is taken into account, the benefit-cost ratio of market reform is likely to be very low at best, and at worst a 'double negative' - i.e. lots of cost incurred in doing harm rather than in creating benefit. One might argue: who knows whether an alternative to the market would have been any better? But the counter-factual is not necessarily some wholly unknown and risky policy with unknown costs and benefits. One might instead consider the concept of cost-effectiveness and hypothesize that, instead of the non-recurring (one-off) and also annually recurring costs of the various reforms over 25 years, the NHS in pre-1989

form had seen the same money applied directly to patient care through existing (or incrementally improved) mechanisms. There would have been a bonanza of additional money for direct patient care. One might alternatively estimate how much money would have been needed to bring about the same 'improvement' in services claimed by Cooper and colleagues in their research²⁸ by direct allocation of resources and improved management. It is unlikely to have been anything like as much as the cost of market reform.

32. As well as outcome in terms of (clinical) benefit, there is of course efficiency of process. There is some fairly equivocal evidence that the efficiency of the NHS, as gauged by a limited measure of productivity, defined in terms of manpower/cost as input and the crude measure of medical activity known as 'Finished Consultant Episodes' as output, was increased in the 1990s²⁹. There is also some limited statistical evidence of increased efficiency during a part of New Labour's market³⁰. But a real concern is that the 'inputs' in these studies do not capture the full costs either non-recurring or recurring of the market. They consider only the direct costs of manpower etc at the provider level, and not the wider system costs of the policy as outlined above.

33. Pro-competition academics, advocates, advisers and politicians tend to proselytize such studies selectively and shamelessly. Prime Minister Cameron for example seized upon the Cooper study to claim, just as the NHS Future Forum³¹ was re-launching Health Secretary Lansley's re-forms in June 2011 after the infamous 'pause'³², that "LSE research" had shown that competition in a market worked. Yet there is a failure to look at wider contrary evidence. For example, one may compare changes in a measure of health status, Infant Mortality Rate, between three UK countries with differing NHS governance – England via competition and Scotland and Wales via collaboration and co-ordination. Examining IMR in these countries over an 80 year period, since 1930, produces the conclusion that, whereas England was previously better than the other two countries, they have overtaken England in the ten years to date that have been dominated by the market in England.

Where do we go from here?

34. How can the costs of the market be saved, after 25 years of ideological tinkering with the English NHS? Would this not require yet another re-organisation? Yes, but if one is driving in the wrong direction, is it foolish to retrace one's steps or at least tack off in a different direction? The challenge is to do so as parsimoniously as possible.

35. Even if one sets aside the fact that other types of choice in health care appear to be more valued by patients³³, it is perfectly possible to eschew and abolish the market yet enable as much choice of NHS provider as is compatible with quality of care and available resources. Choice of provider is one of many legitimate values which the NHS should respect, but it is of course constrained by the need to concentrate various services, specialist and otherwise, for reasons of clinical quality and safety in a resource-constrained environment. GPs can play their core role

instead of playing at markets: they can refer patients to the NHS provider of choice. This removes the GP's conflict-of-interest created by the Health and Social Care Act of 2012, which makes them custodians of a limited purchasing budget as well as patient advocate. While rationing always existed, the GP before the market could be his/her patient's advocate unequivocally, even if a separate health agency had to limit access.

36. Such a model is not the same as market choice: hospitals and other providers can be planned at regional level, to avoid the costly false prospectus of 'local commissioning'. If patients want to travel to care, then the patient flows which these choices produce in aggregate can be modelled by planners for the purpose of allocating funding to hospitals and other providers. Regions can also be responsible for promoting integrated care and overseeing collaboration between hospitals, community services and primary care. Why should local commissioning groups do this? There are around 150 'patient pathways' which the present Clinical Commissioning Groups have to implement under national and regional instructions in any case. Better, surely, to cut out the middleman, save money and liberate precious GP time for direct patient care such as ensuring integrated care for the over-75s and liaising with social services about specific needs.

37. Additionally, there is a trade-off between investing in the public sector to improve its quality and efficiency, on the one hand, and pump-priming and funding the private sector, on the other. Health authorities have been allowed to purchase private care since 1948, if they choose, and it should be the exception rather than the rule – chosen locally for specific reasons rather than imposed from above in order to create an ideologically-motivated market. The Labour Party is now returning to the NHS as 'preferred provider', and it would save money without affecting quality if competitive tendering was dropped altogether. Even pro-market economists such as Cooper et al³⁴ found that the private sector added nothing in terms of the efficiency improvements which they attribute to patient choice.

37. Just as markets may not involve choice, choice does not require markets except in the basic sense that plural provision exists. Choice existed from 1948 to 1991, after which the market restricted it. The challenge in the 1980s was to improve the resource allocation formula through regional strategy: then the mechanisms to reconcile choice with effective service reconfiguration would have existed. But this agenda seemed dull to the 1980s Thatcherites who wished to marketise the NHS for ideological reasons. And this dull but valuable truth has been lost over 25 years of exciting but damaging market hegemony.

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