**Alan Maynard: a sceptical economist and his view of health care and health policy**

**Abstract**

Professor Alan Maynard applied both his wit and wisdom to the analysis of health care and health policy for over five decades. As a leading health economist, he made an immense contribution to the analysis and understanding of many of the key issues that are still at the heart of the current debates about the NHS. His academic interests were wide ranging, including health systems and reform, performance, workforce, regulation, public health and the pharmaceutical industry. Alan’s natural ability to communicate with varied audiences established the relevance of health economics thinking and language to policy and practice, both nationally and internationally.

**Key words**: National Health Service, Health Care, Health Policy, Economics, Reforms

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**Introduction**

Alan Maynard, who died in February 2018, spent 50 years applying economic thinking and a sceptical approach to policy and practice in the field of health and health care. Recent celebrations of the 70th anniversary of the NHS provide a chance to reflect on health policy in England over recent decades, and Alan’s contribution to its development. One notable change is the language used in public debate – open discussion of finite resources, rationing, efficiency and productivity of NHS services - is now widely accepted. This is in no small part due to Alan’s gift for making ideas accessible to varied audiences, and his contribution to public understanding, bringing health economic concepts into everyday discussions about the NHS and helping to shape the way society thinks about health and health care. Long into his illness, Alan continued to debate these ideas, particularly using Twitter, a medium which he embraced with characteristic enthusiasm and humour.

An exceptional and compassionate economist, Alan made a substantial individual academic contribution, but he also led the creation and development of the sub-discipline of health economics, taking it from a niche interest in a small number of university economics departments to a thriving and influential profession. At the University of York he founded an MSc programme in health economics, creating a cadre of researchers who have since infiltrated governments, academia, health care organisations and pharmaceutical companies around the world. In 1983 he founded the Centre for Health Economics (CHE), where he was Director until 1995. One of the first university departments of its kind, CHE has been a leading influence on health policy ever since.

He contributed to many aspects of health policy - reflecting long-standing research interests in addiction, public health, health workforce and the pharmaceutical industry, as well as more general contributions to health systems and health reform.1 We can only hope to cover a few of these here and we focus particularly on current issues to which Alan’s thinking is most relevant.

**Can we afford the NHS?**

A major strand of the current debate poses the question, ‘can we afford the NHS?’. A plethora of research reports, reviews from think tanks, and investigations by government committees have raised - and less frequently, sought to answer - this important question about financial sustainability in the face of rising demand. Economists are typically interested in two aspects - how funding for the NHS is generated and how these funds are spent. Alan influenced thinking in both key areas.

Turning first to the issue of the generation of finance, the alternative routes broadly are taxation, social insurance, private insurance and direct user charges, with most healthcare systems across the world using a mixture of one or more of these. The NHS is financed mainly through general taxation and national insurance contributions, with relatively modest use of user charges (e.g. for dentistry and prescriptions). There are advantages and disadvantages of each approach, but the underpinning principle of funding through general taxation is that it is an equitable way to pool financial and health risks in order to provide universal access to health care, regardless of ability to pay. Competing pressures on tax funded public sector spending, however, along with the vagaries of political attitudes to the desirability of public sector borrowing, mean that NHS funding settlements have frequently been viewed as challenging or inadequate.

The source and level of funding for a healthcare system is, in essence, a political choice. Alan supported financing the NHS through general taxation, on the grounds of equity and simplicity. He also noted that every debate on level of funding for the NHS prompted debate on alternative sources - particularly advocacy of user charges. Labelled originally by Canadian economist Bob Evans as a ‘policy zombie’ (an idea that keeps coming back to life, no matter how many times it is killed intellectually), Alan viewed these as a tax on the sick. His analysis of alternative funding options in the NHS context was incisive and based often on international evidence: as well as being unfair, evidence on user charges (mainly from the USA) shows that they reduce demand for timely health care, delay treatment and ultimately are likely to increase, rather than reduce, overall pressure on the NHS. Private health insurance is inequitable, complicated and expensive to run; and social insurance, whilst being in large part proportionate to income and thus fairer, passed the burden largely to employers and the employed. The notion of hypothecated or earmarked taxes, he dismissed as naive in the light of historical failures to ensure revenue is directed to the target cause in the face of political pressures for other uses. The recent surge in the debate about the sustainability of NHS funding has given many of these alternatives a fresh hearing, in particular user charges and hypothecated taxes.2

**Objectives of health reform**

Whatever the level of funding allocated to the NHS, increasing demand for health care will mean that the question of how best to *spend* the money is a key element of debate. Alan was critical of attempts to ‘reform’ health systems not just in the UK but further afield. For the Nuffield Trust, he edited two volumes, twenty years apart, analysing ‘The Public-Private Mix for Health Care’.3,4 In his introduction to the 2005 volume, Alan wrote that ‘despite differences in culture, history and resourcing, the nature and performance of healthcare systems worldwide are very similar. Political debates about healthcare reform are dominated by covert ideological arguments, and the policies these debates produce are generally ill-focused in terms of resolving well evidenced common performance and incentive problems. As a consequence, the political necessity is created for the next often-irrelevant ‘redisorganisation’ of structures’.

Alan frequently cut through the covert (or indeed overt) ideological waffle surrounding health care, summarising the objectives which are always pursued by health systems and health reform: cost containment, equity and efficiency. The NHS, he believed, achieved the first two objectives in principle (although not always in practice). Funding from general taxation creates a ‘single pipe’ financial structure, permitting control of costs, and this is supplemented by payment systems for doctors which generally avoid incentives for over-treatment, unlike fee-for-service payment in countries like the US. Equity in NHS funding is encouraged by a weighted capitation formula and equity in access to health care is maximised by a system where services are largely free at the point of use. Despite these efforts, Alan would frequently remind policy makers of the unwarranted variations in health care provision - equity of health outcomes remains a challenge even in publicly dominated systems like the NHS.

The final objective, efficiency, is perhaps the most elusive and resistant to policy intervention. NHS structures, created in 1948 and largely unchanged until the 1990s, essentially funnelled funds from central government to hospitals (through block grants) and to health care professionals (in simple salaries for hospital-based clinicians and capitation systems in general practice). While avoiding incentives for cost inflation, such systems provided no incentives for efficiency, a situation that was frequently criticised by Alan and others. For the first 40 years of the NHS, hospitals had no reason to reduce patient lengths of stay and improve throughput, indeed if they did, they were more likely to run out of funds before the financial year end. Hospital consultants had generous salaries, supplemented by ‘merit awards’ allocated not on any objective measure of performance but by secret processes which rewarded particular sub-groups of the profession. The contract for General Practitioners (GPs) was opaque in the extreme: its requirement that a GP should ‘render those services to her patients which were normally provided by GPs’ prompted Alan to label it the ‘John Wayne contract’ – a GP’s got to do what a GP’s got to do. Since 1990, the majority of health reforms in England - reorganisations and (as Alan would say) redisorganisations - have focused on efficiency, particularly in creating, developing and regulating an ‘internal market’ in the NHS, and changing the incentives facing NHS GPs. While supporting the underlying need for such developments, Alan remained sceptical of much of their design and implementation, arguing that without better understanding of variations in clinical practice, and better measurement of the outcomes of health care (as measured by patients themselves), policy makers were at risk of ‘jumping on the spot’.5

**The NHS internal market**

The introduction of an internal market/quasi-market to the NHS in the early 1990s was a fundamental policy shift, involving the separation of the role of purchasers (or commissioners) of healthcare from that of the providers of care. Rather than just altering structures, the realignment of incentives was a core proposition of these reforms, to improve performance and enhance efficiency. The intention was to harness the potential of competition to sharpen incentives: district health authorities (and to a limited degree, GPs) were to become intelligent purchasers of services to meet the health care needs of their population/practice, from providers (mainly hospitals) that would compete for business on grounds of quality, rather than price. The fixed budgets of health authorities would drive them to obtain best value for money and competition between hospitals would encourage them to be responsive and efficient. Although these were market-based reforms, reflecting to some degree the sort of system seen in other countries, no-one - not even economists - argued for the unfettered operation of competition. Many of the features of the healthcare ‘market’, such as the lack of market prices and good indicators of quality, the existence of economies of scale and scope which favour monopoly provision, the need to avoid excess capacity and duplication and the lack of good information on which to base decisions, suggested that the NHS would be a managed or ‘quasi’ market. Alan wrote extensively about constraints on competition, and although a proponent of the power of market-type incentives to change behaviour, argued that there was limited evidence to suggest that unfettered competition was the most efficient way of organising health care services.6 Over successive governments and reforms, the rhetoric of the market has waxed and waned according to the political context, with the language of competition and markets shifting to that of co-operation and integration, although in essence the most fundamental element of the original 1991 reform - the purchaser/provider split - endures.

Alan was particularly influential as an originator of the ideas underpinning the introduction of GP Fundholding, whereby in the early days of the internal market, a small self-selected group of GPs were given budgets with which to purchase elements of primary and secondary care for their patients.7 The rationale was that by making clinicians into “purchasers” of care with a finite budget, they would be incentivised to take account of the financial implications of their decisions. Evidence from US Health Maintenance Organisations suggested this may improve efficiency. Retrospective research on practice level fundholding suggested that it exerted downward pressure on hospital admissions, especially for elective care, and shortened waiting times, although the impact on equity, and whether the benefits justified the costs of the scheme, remained unclear. Over time, fundholding was extended both in terms of the number of GPs participating and the scope and size of the budgets held, until subsequent reforms in the late 1990s, ‘replaced’ fundholding with larger groups of GPs and others commissioning health care, but many of the key features of fundholding remained and are reflected in the current system of commissioners.

**Regulating markets and performance**

Much of Alan’s recent writing focused on the need for, and difficulties of, sensible regulation of health care providers - including the pharmaceutical industry, hospitals, and individual professionals. His views on regulating the pharmaceutical industry were robust and characteristically economic. He was highly critical of the Pharmaceutical Price Regulation Scheme, as he believed its dual objectives (securing the provision of medicines at reasonable prices to the NHS and promoting a strong UK pharmaceutical industry) were inherently contradictory. In suggesting reforms of this scheme in 1997, he advocated introduction of a ‘fourth hurdle’ where new drugs have to demonstrate cost-effectiveness as well as safety, quality and efficacy, as happened in Australia and parts of Canada. In 1998, the National Institute for Clinical Excellence (NICE) was created, essentially implementing these ideas in full. Alan also advocated increased transparency and access to data generated by pharmaceutical companies’ research programmes, where progress has also been made since, but not fully achieved.

Alan’s view of regulation of NHS quality highlighted different tensions. He believed that responses to NHS shortcomings and scandals were often heavy handed and inefficient. The legalistic Francis report, following problems at mid-Staffordshire NHS Trust, made 290 recommendations, which Alan criticised as not evidenced, not prioritised and not costed. Resulting changes to hospital inspection by the Care Quality Commission, he believed, were consequently complex, poorly designed and costly. Similarly, although in the past he criticised the General Medical Council’s regulation of the medical profession as ‘feeble’, he believed doctors in general to be motivated not by external forces but by duty and reputation. Writing in the Health Service Journal,8 he argued that ‘detailed regulation by well-meaning bureaucrats is likely to undermine patient care. Doctors are mostly highly intelligent and competitive beings. The best form of competition is their rivalry to enhance their performance and improve patient care. The challenge is how to fuel that self-governing process much more vigorously’.

The alternative to more regulation (as advocated by lawyers and public inquiries) is better regulation, Alan argued, which should be based on evidence of outcomes, and transparent economic analysis of variations and performance. Governments should regulate less and regulate better, and changes to the NHS should take place incrementally–with substantial use of piloting and evaluation - rather than subjecting patients and professionals to all-too-frequently unevaluated large-scale organisational reforms.

**Looking to the future**

Seventy years after the NHS was founded, the debate about the future of the NHS remains as lively as ever. The same questions about how funding for the NHS is raised, how it is spent and how the system is organised and regulated, emerge repeatedly, albeit with a different emphasis. Indeed, at times, reforms initially viewed as a solution become part of the problem in the next NHS ‘crisis’.9 The evidence on the impact of the internal market and competition is still mixed and still contested. In more recent years, Alan’s views on some aspects of the NHS had started to turn full circle. Citing the lack of good information to underpin effective healthcare commissioning, fragmentation of different parts of the service, perverse incentives and the high cost of regulating the market, he argued that the internal market was an ‘interesting experiment’ which had not worked.10 This observation was not just the idle musing of an academic in an ivory tower, but was based in part on Alan’s direct NHS experience as a Chair on both ‘sides’ of the internal market, a hospital trust (provider) and a clinical commissioning group (purchaser).

This willingness to change his mind is characteristic of Alan’s approach - he was convinced not by ideology or theory but by real empirical evidence. He was always questioning - of all institutions, not least the medical profession, and of all policy makers, whatever the government of the time. His sceptical approach demanded evidence to support assertions - he wanted evidence-based medicine and evidence-based policy, and a robust economic approach to underpin both. He defended the founding principles of the NHS, funded through taxation and available to all regardless of ability to pay, because it is a demonstrably fair system which also permits cost control. In current debates on the future of the NHS, he would no doubt be calling for an evidenced-based approach and a robust exploration of realistic options. His writing and teaching will have a lasting influence on the NHS and on those of us who think about its future, as summarised in an obituary in the Health Service Journal:11

... there are three ways to live on beyond your death: to create some durable art; to advance good ideas; and to push bad ideas back. For anyone in healthcare who wants to pay attention to Alan Maynard (and that should be everyone trying to run the NHS), he should be more alive than ever.

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