
10 Lessons for future health care reforms in England

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As the National Health Service (NHS) enters a new decade in 2011, it faces one of its toughest financial periods ever. Despite NHS spending being protected from cuts, the equivalent of 0 per cent real growth (or thereabouts after adjusting for inflation) will mean the need to make efficiency savings of around 4 per cent per annum in order to close the estimated £20 billion productivity gap (Appleby *et al* 2009). This is in stark contrast to the 5–6 per cent per annum growth in real terms enjoyed by the NHS during the period of the Labour government.

The general election in May 2010 resulted in the formation of the first coalition government for more than half a century, comprising the Conservative Party and the Liberal Democrats. Before the election, both parties had set out proposals to reform the NHS in their manifestos. A broad statement of the reforms the coalition was intending to implement was then presented in its programme for government. Despite a promise to ‘stop the top-down reorganisations of the NHS that have got in the way of patient care’ (Her Majesty’s Government 2010, p 24), the coalition government proposed a set of wide-reaching and radical reforms to the NHS (Department of Health 2010).

The stated aims are to reduce bureaucracy and empower clinicians to make commissioning decisions on behalf of patients, and to give patients greater choice and access to information. The overall aim appears to be to transform the NHS into a system in which there is greater financial transparency and services are shaped by rules-based market regulation.

The key proposals are to:

- give responsibility for commissioning the majority of health care services to general practitioners (GPs) working in consortia
- create an independent NHS Commissioning Board to allocate resources to and oversee GP consortia
- abolish strategic health authorities (SHAs) and primary care trusts (PCTs)
- introduce an outcomes framework for holding a new NHS Commissioning Board to account instead of targets and performance management

- transfer public health responsibilities to local authorities, and create local health and wellbeing boards to promote integration of health and social care
- set up local HealthWatch groups funded by local government to replace local involvement networks to help the public and patients influence local services, with a national HealthWatch body within the Care Quality Commission (CQC)
- give greater freedoms to publicly owned providers of health care, and an aspiration to see more social enterprises serving NHS patients
- extend individual patient choice of hospital to include specific specialists or clinical teams
- create an economic regulator that will set prices, promote competition and ensure continuity of essential services.

Following consultation on these proposals (Department of Health 2010b, 2010c) and the government's response to the consultation, the government introduced the Health and Social Care Bill to parliament in January 2011. The Bill made clear the intention that choice and competition should play a much greater role in driving and shaping services in future. In April – in an unprecedented move – the government 'paused' the legislative process in order to conduct a listening exercise. This was in part a response to growing opposition from stakeholders and disquiet within the NHS and among the Liberal Democrats about how far and how fast the government was pushing through these competition reforms. The NHS Future Forum was set up and asked to make recommendations about how the Bill should be changed (NHS Future Forum 2011).

In response to the Future Forum the government has introduced a series of amendments to the Health and Social Care Bill (Department of Health 2011a, 2011b). Clinical commissioning groups will be responsible for commissioning care. These will still largely be GP-led but the governing bodies will include other health professionals and patient and public representatives. The economic regulator will tackle anti-competitive behaviour where this is not in the interests of patients rather than specifically promote competition. There are also new duties on various bodies to enable services to be provided in an integrated way.

In intellectual terms, these proposals do represent, to a great extent, an evolution of the NHS market, and do share some similarities with New Labour's market reforms. However, they also involve large-scale organisational disruption. Although it is clear that NHS services do need to change radically in order to deliver the required savings, there is evidence that system-wide structural and organisational reforms (so-called big bang changes) take time to produce savings and, in the short term, are likely to increase costs and distract attention from improving productivity (NHS Confederation 2010; Walshe 2010).

The detail of the proposals is still to be finalised, but the general direction – to create a mixed economy of providers of care, with greater choice for patients, devolved

financial responsibility to clinicians, and more transparent reimbursement mechanisms, underpinned by regulation – is unlikely to be dramatically different. It is hoped that this review of the evidence of the impact and experience of implementing the market reforms introduced by the last Labour government can provide some insights to ensure that both the design and execution of the latest set of competition reforms will be informed by evidence as well as shaped by politics. The lessons from this book will also serve a more general purpose: to inform any future policy-makers seeking to reform the health system about the challenges of success.

In this chapter, for each of the key aspects of reform covered in this book we compare the reforms being proposed by the coalition government with the reforms analysed in this book, and reflect on the evidence presented to suggest what might happen and what needs to happen in order to ensure that the reforms deliver benefits and minimise harm and disruption.

Diversity of providers

The coalition government proposes to complete the process begun by New Labour to give all publicly owned providers greater autonomy. Although the Labour government made similar commitments, deadlines were revised and repeatedly missed. The evidence suggests that a lack of robust financial planning and governance was often the cause of trusts failing to gain authorisation. The more challenging financial environment is likely to mean that trusts can no longer rely on expanding market share to ensure their financial viability and underpin business plans. This suggests that, for some trusts, the transition to foundation trust status is likely to prove difficult if not impossible. The government is establishing a special health authority to take over responsibility from SHAs to prepare trusts for foundation trust authorisation and to find other solutions for trusts that will not be able to gain it (such as mergers or closures or possibly franchised management).

Given that foundation trusts were higher performing trusts in the first place, it is difficult to establish whether foundation trust status per se has resulted in improvements in quality, and there is very little research on the impact of foundation trust status on quality of care (*see* Chapter 2). Evidence suggests that the process of authorisation itself could result in improvements. This has implications not only for how the authorisation of the remaining foundation trusts is handled, but also for whether the authorisation process for clinical commissioning groups can be structured in such a way that it results in improvements in commissioning over time.

The policy objectives of giving foundation trusts greater freedoms remain the same: to enable them to innovate and be more responsive. In future, foundation trusts will have greater freedoms and there will be less direct oversight as Monitor's role changes. Instead, there will be a stronger role for governors and members in holding the organisation to account. Evidence suggests that foundation trusts have

not made extensive use of their existing freedoms, such as flexibility on pay and conditions. Most have been risk-averse and not sought to invest or borrow. By making the most of first-mover advantage and the freedom to take decisions more swiftly, foundation trusts have been able to expand more quickly than have other providers. Some foundation trusts have generated significant surpluses, which they are able to use to invest in new services or expand existing services. In some cases, this has been at the expense of co-operative and collaborative relationships with other providers and commissioners, although the evidence of whether foundation trusts were more competitive than non-foundation trusts is mixed (see Chapter 4). Finally, governors have been relatively weak and not able to play an effective role in the governance of foundation trusts.

The tighter funding environment means that new foundation trusts are unlikely to be able to generate surpluses and might therefore have more appetite to borrow than existing foundation trusts have done, although borrowing in the current financial climate may be difficult and expensive. If foundation trusts use their freedoms actively to compete and expand, this may well be at the expense of other providers and other parts of the system. There is a real danger that institutions will put their own organisational survival above the interests of the system as a whole.

In the past, commissioners found it difficult to challenge the dominance of acute foundation trusts, and policies to shift more care out of hospital have largely failed to find traction. The scale of productivity improvements now required means that organisations will need to look across care pathways and services – not just within organisations – to reduce waste and eliminate inefficiencies (Appleby *et al* 2010). It is not clear who would lead such processes under the new system. Mergers and acquisitions of trusts by foundation trusts could be positive if they result in improvements in services, but there is also a risk that they will reduce access and savings will fail to be realised (Palmer 2011). The only means of ensuring that foundation trusts operate in the public interest in future will be through their accountability to members. This places a great deal of faith in structures that have, to date, failed to prove their effectiveness.

As part of its wider proposals on public service reform, the government wants up to 25 per cent of all public procurement contracts (by value) to be awarded to small and medium-sized enterprises (Her Majesty's Government 2010, p 10), and is promoting the mutualisation of public services. The government has recently published guidance suggesting that NHS staff would have the 'right to provide' by becoming employee-owned social enterprises (Department of Health 2011c). Although in the past this was an aspiration for community health service providers, few made the transition to social enterprise status. Many of the reasons why this organisational form was not an attractive option, such as risks to NHS pension entitlements, are also likely to be the case for other NHS staff in future (Addicott 2011).

The government is also interested in the private and voluntary sector playing a much bigger role as providers of NHS-funded services. The attitudes of commissioners and

their approach to commissioning will be extremely important. Tendering processes may open up opportunities to new providers, but it will depend on what is being tendered and whether the barriers to entry are high. 'Any qualified provider' might, in theory, facilitate the emergence of new entrants, but the private sector, and to some degree the voluntary sector, will want scale, certainty and scope. Independent-sector treatment centres (ISTCs) were able to enter the market partly because they were offered certainty and a premium to cover the additional costs of setting up a new business. No such offer is on the table for new entrants in future, indeed the government has ruled out giving any unfair advantage to a particular sector.

The period examined in this book was one of growth, both in funding and activity volumes, which meant that new entrants and the growth in provision by the private sector did not destabilise NHS providers. However, the colder economic climate means that a greater diversity of providers and new entrants in the future would necessarily take activity away from incumbent providers.

Financial pressures over the past few years have meant that trusts that have not yet achieved foundation trust status, and even some that have, will struggle to remain viable if they lose activity and funding is removed at full tariff without the ability to downsize (ie, reduce fixed costs). Commissioners may find themselves subsidising local designated (ie, essential) services because other, more lucrative or interdependent, clinical activities have closed as a result of patients and referrers having taken their business elsewhere.

One of the challenges of comparing the quality of care and performance of public and private providers under New Labour was the lack of standardised data available for such a purpose. It is vital that throughout the regulatory and contracting process, the information and data requirements are the same for all NHS-funded care to ensure that, for the purposes of both commissioning and evaluation, these comparisons can be made robustly in future, taking differences in casemix into account.

The ownership status of providers appears not to have a differential effect on quality of care, but there remains a danger of fragmentation when providers are competing for patients. The question remains as to whether the system can encourage new partnerships and joint ventures between public and private organisations. Rather than collaboration (or collusion), there need to be more overt partnerships, in which the risks and rewards to each party are more clearly defined, and the financial risk and gain-sharing arrangements are clear.

The emphasis of policy to date has been on creating a mixed market of providers. If the objective is greater responsiveness and more innovation, then a true diversity of provision, meaning different models of care, is needed. In future, there are likely to be new forms of primary care, such as federations and integrated care organisations. Academic health science centres may develop further into larger integrated delivery systems, and, depending on future contract negotiations, chambers and multispecialty groups of clinicians may evolve as separate operating companies.

Much will depend on how the other parts of the system develop, for example, the attitude of commissioners and their approach to commissioning, the structure and basis of tariffs and resource allocation, and the regulatory framework. Providers will change and adapt to meet the changing incentives and requirements created by the system within the constraints set by regulation.

Overall, the extent and impact of provider-side reforms at the end of the period of the Labour government was limited. The proportion of NHS-funded activity in the private sector remained small, with entry limited largely to ISTCs, which benefitted from secure contract terms. Almost half of trusts had not become foundation trusts, and those that had achieved authorisation were slow to use their freedoms. Finally, few community health service providers had opted to become social enterprises, with many preferring to stay under NHS ownership.

Looking ahead to a tighter funding environment, the coalition government's ambition to see a greater plurality of provision, the mutualisation of public services, and the transfer of all publicly owned providers to foundation trust status seems unlikely to be realised. Unless barriers to entry are reduced, incumbent providers are displaced or allowed to fail, and issues such as the transferability of public-sector pensions and terms and conditions are tackled, NHS-funded care is likely to continue to be largely provided by publicly owned providers. The evidence on differences in performance on cost and quality between public and private providers also remains largely unknown, so the case for plurality is hard to make definitively.

Commissioning

PCTs are to be abolished and commissioning responsibilities devolved to clinical commissioning groups. Some specialist commissioning will be undertaken directly by the NHS Commissioning Board, which will also authorise local commissioning groups and hold national contracts for primary medical services. The government's proposals build on previous initiatives – GP fundholding and total purchasing pilots in the 1990s, and practice-based commissioning (PBC) in the past decade, which enabled groups of GPs to take on responsibility for commissioning some services on a voluntary basis. However, they go much further by making membership compulsory and giving full budgetary responsibility for commissioning the majority of services.

Evidence suggests there is no one right level at which commissioning of all health services should take place (Smith *et al* 2004). This may explain why there have been numerous reorganisations of commissioning, and why both devolved structures (PBC) and collaborative structures (clusters) have been created. Repeated reorganisations seriously undermined the ability of commissioners to mature and operate effectively as commissioners. It is therefore unfortunate that in an effort to improve commissioning, the government has embarked on another major restructuring. Although these changes could address the lack of clinical engagement

in commissioning – a key weakness of PCTs – there is a high chance that, over time, they will come to look very similar to PCTs but with GPs and other clinicians more actively involved (at least for a while) in the governance of the groups.

PBC sought to try to devolve clinical and financial responsibility to GPs, but the lack of hard budgets limited the incentives for better use of resources, and GPs felt frustrated by the probity requirements placed on them by PCTs to produce business cases to justify service changes affecting primary care. The vast majority of service changes associated with PBC were focused on the provision of primary care and community-based services rather than shaping secondary care. Although the incentives on member practices to live within a budget are likely to be greater, concerns have been expressed that, if too strong, GPs may make decisions based on financial grounds rather than in the best interests of individual patients.

The reality is that all decisions necessarily combine a financial and clinical component. By having clearer budgetary responsibility, the financial considerations are more explicit. There is a danger that, for most ordinary GPs, clinical commissioning groups will feel remote, and few will have either the interest or skills to engage in commissioning more complex secondary and tertiary services. As providers, GPs wanting to provide extended or new services in the community will most likely have to tender for these contracts. This may feel as bureaucratic as the business-case process they were forced to go through under PBC. Although there is some evidence that GPs may feel more accountable to their peers than they did to PCTs, particularly for elements such as referrals and prescribing, there is a danger that those leading the consortia will have little authority or leverage to tackle practices that consistently underperform.

Much of the evidence has focused on the structures of commissioning rather than evaluating how effectively commissioners actually commission or the adequacy of the tools and approaches available to them to carry out their key functions. Other than information from CQC assessments and world class commissioning assurance, there is almost no academic research about the effectiveness of commissioning under New Labour (*see* Chapter 3). The Department of Health provided PCTs with national contracts, but these were organisational contracts (eg, for acute providers, mental health trusts and community services) that focused on volumes of service. PCTs also had to use a fixed tariff for a range of services (*see* below) as the basis of payment, and did not use what little flexibility they had to bundle or unbundle these defined episodes of care. Much of the contracting process was focused on validating the invoices; there was much less attention paid to monitoring the quality of services delivered. PCTs that were interested in redesigning services had to undertake this locally – drawing up the service specification or care pathway (often involving clinicians in this process) and then contracting for bits of the service or care pathway with different organisations using different payments. If the new local commissioning bodies attempt this they will not be able to live within their management allowance, and the duplication of activity could be worse than it is currently.

What is really needed is a renewed understanding of what commissioning is and how to do it – an approach that promotes integration of services, particularly for people with multiple conditions and complex care needs. This could be led by the NHS Commissioning Board, which, if it chose to, could provide more sophisticated and specialist support to local commissioners than the Department of Health was able to do.

The current national standard contracts do not provide local commissioners with the tools to do the job effectively, and the design of tariffs and price-setting limits the ability of local commissioners to incentivise integration and innovation. Commissioners need to focus on the key functions of:

- assessing need
- setting priorities
- allocating resources
- contracting for services
- measuring performance against those contracts.

To do this, they need to set some outcomes (together with some intermediate measures that allow performance to be tracked and monitored over shorter time periods), and to have methods of reimbursement that transfer risk and the incentives for efficiency and quality to providers. Transactional contracting requires its own bureaucracy to manage and police it, and the information asymmetries that exist are difficult for commissioners to overcome. There is a need for commissioners to move to longer-term relational contracts so as to allow more mature commissioner–provider relationships to evolve. Service redesign then becomes a provider-led activity in response to the priorities, outcomes and resource decisions taken by commissioners.

The key tests will be whether clinical commissioning groups are any more effective in creating an environment in which there are opportunities for providers to develop new models of care and which encourage providers to form partnerships and joint ventures to take on greater financial risk and responsibility. The tighter financial context means commissioners will again have to face more difficult decisions about which services to commission. The spectre of rationing and priority-setting looms large, and commissioners will have to use more sophisticated approaches to engage the public, patients and clinicians in these difficult choices.

An alternative policy direction would be to reverse the trends of recent years and to allow greater commissioner–provider integration. As others have demonstrated (Smith *et al* 2010), the purity of commissioning has rarely existed in practice, and providers play a significant role in the commissioning process because of their generally superior knowledge of the services in question. The original intentions behind devolving budgets to groups of GPs was to allow them to take so-called make

or buy decisions. There is still a lack of clarity about whether public procurement rules and European Union (EU) competition law will allow this, and it will obviously require conflicts of interest to be handled in a transparent way (Ham 2011).

The evidence on commissioning, both from the period covered here (*see* Chapter 3) and also internationally, suggests it is very challenging to do commissioning well. PCTs and PBC were beginning to develop skills towards the end of the period. There is a risk that the current restructuring of PCTs will result in a loss of expertise, setting commissioning back yet again, and that the development of new clinical commissioning groups will take a long time.

Evidence suggests that devolving financial responsibility to clinicians, can bring benefits, but also that there is a need to commission at different levels. This suggests the focus should be less on getting the right structures and governance arrangements, and more on what and how services are commissioned.

Choice

The government is committed to extending patient choice of provider, but has also put a renewed focus on involving patients more in decisions about their care and treatment (Department of Health 2010d). Patient choice is to be extended in primary care with the abolition of practice boundaries, and the government has indicated that it wishes to extend free choice (under an any willing provider arrangement similar to that in place currently for choice at point of referral to secondary care) to other services, including community health services. The government is committed to publishing more information on performance and quality of care, including feedback from other patients and patient-reported outcomes.

Evidence suggests that although few patients actually exercise choice and go to an alternative to their local NHS provider, they still value having a choice and appear to use it to avoid attending a local hospital where they have had a bad experience on a previous occasion. Available evidence is largely based on choice at the point of referral for a specialist consultation, and it is not clear how generalisable the findings are to other types of choice. For example, in general practice, patients with a minor problem may value convenience and speed of access, whereas patients with ongoing medical conditions may value a trusted relationship and be loyal to their registered practice and usual doctor. If, as is proposed, choice is at the point of registration rather than the point of access, then patients are unlikely to switch frequently.

There is some evidence to suggest that patients may value choice of provider at a later stage in the care pathway, when the decision is taken to undergo more invasive or high-risk treatment, and this is also a stage when patients could benefit from more support to consider the risks and benefits as part of shared decision-making. If more direct access diagnostics are available in primary care in future, this might change the decision point.

Making more information available will not necessarily mean that it is used to inform decisions. Neither patients nor GPs currently make use of the published data that are available to inform their decisions, relying instead on personal knowledge and experience. Measures of clinical quality are also difficult to understand and interpret, and, although there are ways of presenting information that can help (Boyce *et al* 2010), patients are likely to pay more attention to other patients' feedback.

There is at least some evidence to suggest that GPs believe choice of treatment or care plan is more important than where that treatment or care is accessed. It is important that any information strategy recognises this, and invests in reliable information and decision support about treatment and care options as well as quality information about different providers. There is a possibility that, as more people become aware of quality differences between providers, they might be willing to travel further to access better care, particularly if GPs advise patients to do so on clinical grounds. However, clinically led reconfigurations of services may result in some more specialist services being concentrated in fewer centres, thus reducing the number of choices and meaning patients have to travel further to access services.

In general, the evidence suggests that GPs are reluctant to offer patients choice routinely, and have their own views about when and for whom it is relevant. GPs are also powerful agents – when they do offer choice, patients rely on their recommendations to inform their own decisions. There is a risk that, with greater budgetary accountability, there will be increasing pressure on GPs not to refer. If patients perceive GPs to have such conflicts of interest, they may no longer trust them to be independent advisers to support their choice.

GPs are likely to continue to play an important role in supporting patients to make decisions about where to go and, increasingly, in making choices about their lifestyle, care plans and treatment choices (Coulter and Collins 2011). There is a need to be clear about when it is appropriate to offer patients a choice and what sort of choices, what and how many options to make available, and how best to support the decision with advice and information.

Evidence suggests that patients and GPs are generally loyal to local providers. This, combined with the reluctance of GPs to support choice, suggests that the system should not rely on patient choice alone to drive competition in future. Furthermore, despite the availability of increasing amounts of information on the quality of providers, this does not appear to drive quality competition through choice, but rather through reputational effects and peer competition.

Pricing and reimbursement

In future, price-setting through Payment by Results (PbR) is to be undertaken jointly by Monitor and the NHS Commissioning Board. The intention appears to be to move away from an activity-based payment system calculated using average costs,

to one that rewards quality and promotes efficiency using more detailed patient-level costing data from a sample of providers. This builds on developments already implemented, such as best practice tariffs, as well as schemes such as commissioning for quality and innovation (CQUIN) and the decision not to pay for a list of so-called never events, or for readmissions within 30 days of hospital discharge.

Evidence suggests that the use of fixed prices has led to improvements in outcomes because it promotes quality competition. In addition to setting fixed prices, the Bill originally allowed Monitor to specify a maximum tariff, thus enabling the introduction of competition on price as well as quality. Experience from the United States (Gaynor 2004) and from the internal market in the NHS in the early 1990s (Propper *et al* 2008a) suggests that hospital price competition may reduce quality as providers seek to lower costs. It could also increase transaction costs, with commissioners and providers spending significant amounts of time negotiating prices. Price competition has now been ruled out, at least where services are to be offered under an any qualified provider arrangement. Where services are tendered, commissioners will be able to use their purchasing power to get value for money.

Despite commitments to roll out PbR to other services including mental health, implementation has been slow. It is important that policy-makers recognise that some types of care are not suited to activity-based payments and may need to be purchased under block contracts (eg, intensive care beds, for which the key issue is availability rather than throughput) or other reimbursement models.

The current trend has been to unbundle in order to be able to pay a different provider for a different part of the care pathway in a different setting. This places an incredible burden on the commissioner and generates high transaction costs. Tariffs in future can comprise one or more services, suggesting a move away from narrowly defined tariffs based on episodes of care, to more aggregated or bundled payments. It is not clear to what extent national bodies or indeed local commissioners could commission a year of care for a diabetic patient, or go further and contract with a lead provider or a consortium of organisations to take on a risk-based capitation payment in return for meeting a wide range of care needs for a defined population.

In a more market-based system, price-setting is a very important policy instrument with potentially powerful effects. The main concerns with fixed prices were that PbR might lead to risk selection (ie, providers would try to shun patients who were poor with more complex needs), upcoding, and quality skimping. There appears to be little evidence of these behaviours having been widespread. Indeed, the evidence points to benefits in terms of improved technical efficiency and no deterioration in quality. Monitor will need to continue to scrutinise the impact of its pricing to ensure that it does not provide incentives for these undesirable behaviours.

There was little evidence of inequities arising as a result of pricing. It is not possible to observe whether patient selection did not occur because there were no incentives to do so (ie, the casemix adjustment was adequate or the overall financial environment

was sufficiently benign), or because the decision-making by clinicians did not allow this to occur in practice. On the whole, the private sector treated a less complex casemix, which is partly explained by an overt selection process for ISTCs due to their lack of intensive care facilities. The less complex casemix in the private sector is not, in itself, a problem, but rather depends on whether prices are adequately adjusted to ensure that these providers do not make a windfall profit at the expense of public providers whose case severity and acuity is higher.

There was little evidence of extensive upcoding, but some evidence that the quality of coding improved. It is not clear whether this was because the incentives to do so did not penetrate to the people responsible for coding, or whether the threat of action for such behaviour was sufficient. What is clear is that there are considerable administrative costs associated with monitoring providers' coding and billing through utilisation review and resolving billing disputes. A real test of the new system will be whether such transaction costs can be reduced, either through bundling payments and transferring risk to the providers, or because, clinicians will be more aware of the appropriateness of treatment and therefore more able to challenge overuse than were administrators in PCTs.

Despite a belief, particularly among commissioners, that PbR has resulted in increased activity in hospitals, the evidence suggests that other factors probably account for a good part of the rise in hospital activity in England, such as waiting-time targets for elective care and greater acuity of problems in older people for emergency admissions. The tariff means that hospitals were paid for the increased levels of activity, but it did not necessarily act as an incentive to increase activity, particularly among providers whose costs were generally above tariff levels. If the imperative now is to reduce hospital activity, then the challenge is for commissioners, working with providers, to ensure that referrals for treatment are appropriate, and that care is in place to support frail older people and those with complex needs so as to prevent admission. There has been a tendency among commissioners to blame PbR and foundation trusts for the growth in hospital activity, despite the lack of strong evidence.

Currently, data to support more sophisticated and accurate price-setting are not available across the public and private sectors, although providing such data is likely to become a condition of being licensed by Monitor in future. Price-setting is not simply a technical exercise, but requires difficult trade-offs to be made between quality, efficiency, access and affordability. How these issues will be reconciled among the NHS Commissioning Board, the CQC and Monitor is not entirely clear. Monitor will need to model the impacts of pricing carefully – if prices are set too low, quality might be driven down or providers might withdraw services; if the price is set too high, commissioners could be bankrupted.

It appears that PbR rewarded hospitals that increased their activity in response to the targets to reduce waiting times, but did not itself drive activity. Access as a problem has largely been resolved, although the current fiscal tightening could see

it reappear as an issue. The main challenge facing the health system in the future is the management of chronic illness. The objectives of the pricing and reimbursement arrangements need to adjust to this, too. The adverse impacts and gaming were not as bad as feared, but these need to be carefully monitored under any future system.

Regulation and competition

From April 2012, Monitor will become an economic regulator for health and social care. The Health and Social Care Bill gives Monitor wide-ranging powers to impose licence conditions to prevent anti-competitive behaviour, to apply sanctions to enforce competition law, and to refer malfunctioning markets to the Competition Commission. The proposals introduce a clearer system of special administration to deal with providers that fail financially, that is, become insolvent.

The policies discussed above to encourage a greater diversity of providers, to extend patient choice and to allow any willing provider to offer specific NHS-funded services, might suggest that competition will increase. However, there is likely to be considerable consolidation of providers over the next few years, particularly in acute hospital care, as a result of the financial context, clearer rules on provider failure, the deadline for foundation trusts, the clinical and financial case for reconfiguration, and better management of patients outside hospital. This could reduce spatial competition, increase the concentration of markets in specialist services and, where mergers take place, reduce the number of competitors.

The type of competition promoted under the New Labour reforms was mainly between hospitals for individual patients. In some areas and to a more limited extent, there was also competition for contracts for out-of-hospital services. Concerns about the impact of competition, particularly that it will result in greater fragmentation, assume that competition will be largely *in* the market, between single providers for discrete items of service (eg, hip surgery). There is nothing inherent in competition or the rules that are used to enforce it that mean competition needs to be of this sort. For example, the unit of competition does not need to be a hospital, but could be between integrated delivery systems or networks of providers. It could be for a whole package of care rather than a single part of the care pathway, and tendering does not need to result in selective contracting with a single provider. There is probably a need to combine both approaches to competition. For example, through tendering and procurement a commissioner could require providers to compete to be ‘in network’, and then encourage competition between providers in the network for patients, thus allowing for both price competition (via tendering) and quality competition (via choice). An integrated care provider could be prevented from restricting choice, and might be required to allow patients to deviate from the pathway or package of care and go outside the integrated care organisation. If this is the case, integrated providers would have to win the loyalty of patients for them to remain within the network.

There has also been some confusion about whether the government's reforms will open up the health care system to EU competition law more than it is currently. By bringing the NHS under the aegis of the Office of Fair Trading, it is clear that EU competition law will now apply. This covers issues such as state aid, mergers, cartels and preventing monopoly. However, EU competition law applies only to so-called undertakings. There is no legal clarity on the definition of an undertaking, but foundation trusts are likely to be regarded as such, particularly as they are allowed to compete for private patients. The lifting of the private patient cap will make this more likely. Case law has established that purchasers of public services that operate with social objectives are not considered to be undertakings, so neither PCTs nor other statutory commissioning bodies are likely to be subject to competition law, although, again, this is not clear. EU procurement principles already apply to PCTs, and would require commissioners to be compliant in future. There is no requirement under these principles to tender services. A public body could decide to provide the services itself, but if it decides to tender, then it must comply with the principles. However, the Department of Health's own procurement guidance (Department of Health 2010f) does go further in this regard, and might limit the ability of clinical commissioning groups to take make or buy decisions.

It is likely that there will continue to be a mix of competition in the market (ie, for patients) and for the market (ie, for contracts). In what circumstances these two modes are used, and for which types of services, will be key in determining the nature and impact of competition. Recent policy discussions have clarified that this will be a matter for commissioners (House of Commons Health Select Committee 2011). It must be remembered, however, that the evidence on choice suggests that patients (and GPs) are loyal to local providers, and this so-called stickiness could limit the extent of competition in the market. Although some benefits have been demonstrated in terms of quality, more research is needed to understand where and how to apply competition so that it delivers benefits.

No new changes are proposed to the CQC, which will continue to register service providers across health and social care and the public and private sectors. The CQC has had to downsize and rationalise its activities. The government planned to continue to adopt a risk-based approach to inspection, relying on self-assessments and CQC's own risk profiling using routine data. However, as this book was going to press, CQC announced revised plans to include unannounced site visits, suggesting a shift away from 'light touch' regulation. The evidence suggests that without regular inspections it is difficult for regulators to be assured that quality standards are being met – they need to see and hear things on the ground (*see* Chapter 7). Light touch regulation also relies on the ability of the governance boards of providers to engage with issues of clinical quality and safety, and on strong internal governance. The CQC has stronger sanctioning powers than did its predecessors, and is likely to have to intervene more often in future.

The application of competition rules to the NHS by the Co-operation and Competition Panel was introduced relatively late in the process of reforms, and the cases referred to it have not been reviewed here. There is little evidence so far on which to judge the proposals for an economic regulator. More relevant perhaps is the evidence from the utilities' regulators and from countries such as The Netherlands where there is a health sector-specific competition authority. The system of regulation developed during this period focused on licensing all providers on quality and safety grounds. The evidence presented here suggests that there may need to be more investment in the process of monitoring and inspection if the regulator is going to be able to detect failures and breaches in standards.

Building blocks of a market-based health system

This chapter has reflected on the evidence on the impact of market reforms under Labour (summarised in Chapter 9), and the implications for the continuation and strengthening of the market in health care as proposed by the coalition government. These point to a number of key points that need attention if the system is to deliver, and a number of areas where further research is needed:

- ensuring robust governance of foundation trusts and rectifying the lack of meaningful local public accountability; further research is needed into the effectiveness of their boards and what the key factors are that determine their ability to monitor and assure both clinical and financial performance
- improving the routinely available data and indicators of the quality of care offered by different providers so that patients and commissioners are able to make better-informed choices, and so that competition is genuinely on the basis of quality; this would also allow meaningful comparisons of the costs and quality of services delivered by different types of provider organisations (eg, foundation trusts versus independent sector hospitals, social enterprises versus professional partnerships versus community foundation trusts in the delivery of community health services, etc)
- developing more sophisticated approaches to commissioning and providing support to commissioners so that they operate more effectively; more evidence about how to commission for outcomes, use of risk-based payments and risk-sharing agreements, and different contracting models that promote integration would be timely
- finding a way of recognising the importance of strategic commissioning and planning, not just clinical involvement in commissioning at local level; there has been little research into the effectiveness of commissioning of different types of services and at different scales of population; some that looks at the ability of PCTs to bring about their planned service changes is nearing publication, but

more research is needed to inform the development of commissioning including clinical senates which are intended to augment the range of clinical advice available locally

- determining the relationship and balance between individual patient choice as a driver of efficiency/quality (competition in the market), and commissioners contracting for services by, for instance, tendering (competition for the market)
- developing services for people with complex chronic conditions that require co-ordination between providers in a system hitherto designed primarily to encourage supplier competition in a market for elective care
- developing ways of paying for outcomes and/or quality standards rather than purely for hospital activity (eg, paying for entire services through years of care that require inter-organisational collaboration, or altering the tariff to take account of quality measures)
- identifying the services and situations in which price competition could be positive for quality and efficiency, and those where this was not the case and prices should be fixed, as under PbR
- strengthening the system of quality regulation, and research into the effectiveness of regulation, so that decisions can be taken about whether there is a need for more inspections and greater voice for patients and relatives to express concerns, or whether reliance on triggers from routine performance indicators is sufficient
- identifying situations and services where market competition is clearly positive for quality and efficiency, and where it is not and should be avoided to be replaced by alternatives such as benchmark competition.

Implementation

Although the coalition's policies are still very much in the design phase, it is important that policy-makers consider the issues of implementation at this stage. The key lessons from the review of implementation of the market reforms under New Labour suggest that the government should:

- pay attention to phasing and sequencing – consider which elements need to be in place first for the reforms to succeed
- commission appropriate research to assess the impacts of the main policy changes
- be open to adaptation and refinement of policies in response to the changing context, feedback from implementers and findings of evaluation studies
- have a clear narrative about the reforms and make sure their purpose is clear not only to civil servants but to those responsible for implementing them

- expect the reforms to be diluted during implementation and therefore give them a decent chance to work
- expect there to be unintended consequences and a need to amplify the positive and mitigate the negative
- recognise where the inherent tensions and points of conflict are between objectives and policy instruments, and try to resolve them at least in the minds of those responsible for local implementation
- recognise that ‘context matters’ – while geography might not be such a problem, current market structures will have an impact, as will cultures and institutions – so allow scope for the reforms to look different in different settings
- recognise that choice and competition may have limited application beyond elective care – different approaches and new currencies may be needed to promote better care for people with long-term conditions, complex needs and mental health problems
- not assume that passing new legislation will change the behaviour of those within the system, or not immediately, and not necessarily in the ways predicted
- recognise that new policies are usually layered upon existing policies, thus limiting their effects: the stripping away of performance management under the proposed reforms may mean providers ‘look out rather than up’, as they did during this period of reform under New Labour; active steps will be needed to change managerial cultures and relationships if this is to alter.

Conclusion

Overall, those who were responsible for designing and implementing the market reforms between 2002 and 2010 can take some consolation from the findings presented in this book. The market appears not to have had the most obvious negative effects predicted by many of the critics. Where there has been an effect, it has largely been in line with the expectations of proponents. The problem, if it is a problem, is that these reforms had only a small, sometimes imperceptible, impact in the desired directions. Their scope has also largely been limited to elective services, and their reach has varied geographically: those at local level have not always understood what was intended, or have not responded to the incentives – in some cases actively resisting them.

This lack of a major observed effect may be partly due to the time lag between the reforms being conceived and enacted, their implementation, and the visibility of the impact. The market was only partially functioning for much of this period, and some of the effects that were observed – such as those reported by Gaynor *et al* (2011) – appeared only towards the end of the period.

Although the effects of the Labour government's market reforms (2002–10) set out in this book were not dramatic, there is evidence to suggest that they were beginning to have some positive impact. However, almost nothing is known about the costs of competition or its relative effect compared to other approaches such as targets and performance management. The issue, then, for policy-makers is whether the costs, both financial and political, are worth the effort, if these reforms achieve limited change.

As we have shown, some parts of the reforms are more strongly based on what we have learned than others, and there are important judgements to be made about the extent and pace of any further shift towards a more market-led system.

First, policy-makers need to decide whether the extension and development of the market is suited to a period of consolidation and dramatic financial tightening. The context in which the Labour government's market reforms were implemented was one of growth, in which the main public concern and challenge at the start of the period was timely access to care and, later on in the process, to ensure that new capacity was well used.

Second, policy-makers have to judge whether these reforms help the NHS better meet the needs of an ageing population, many of whom have multiple chronic diseases, some of whom have complex health and social care needs, and an increasing proportion have dementia. Labour's market reforms were largely applied to, and had most effect in, the area of elective surgery. If the priority now is to make the health system responsive to the needs of those with ongoing physical and mental health needs, then competition may need to be complemented by other approaches (eg, various forms of so-called integrated care).

Policy sometimes struggles to adapt to a changing context, while the politicians who conceive of and enact reforms have often already moved on by the time the consequences of their actions become visible. However, over the next decade, the impact of the financial situation the NHS finds itself in is likely to overshadow any consequences of further market reforms.