
2 Diversity of health care providers

Pauline Allen and Lorelei Jones

Before the introduction of the National Health Service (NHS) in 1948, there was a patchwork of public, private and voluntary provision (Keen *et al* 2001). Since the establishment of the NHS, when hospitals were nationalised, most of the organisations providing health care to NHS patients have been state-owned. General practitioners (GPs) are a notable exception to this, being self-employed and operating largely under a nationally negotiated contract. However, a small proportion of the care of NHS patients, mainly in the areas of mental and sexual health, has continued to be provided by independent organisations, either profit-making or not-for-profit. Moreover, NHS hospitals and commissioners have used spot contracting (ie, *ad hoc* arrangements negotiated locally) with the private sector in order to reduce NHS waiting times (and the number waiting) (Keen *et al* 2001).

Over the past two decades, there has been a marked shift in government policy to introduce a wider diversity in the organisations providing services to NHS patients (Edwards and Lewis 2008). This was formally recognised in 2000, when the government entered into a so-called concordat with private providers (Department of Health 2000a). This allowed NHS commissioners to negotiate locally with private providers for a range of services, including elective surgery and primary care. The size of the private sector providing care to NHS patients was very small at the time: in the late 1990s the NHS spent less than 1 per cent of its budget on purchasing private care for patients (Keen *et al* 2001).

From about 2002, a more systematic approach was taken to introducing more competition into the NHS. As part of this move, there was an explicit decision to increase the diversity of types of providers offering services to NHS patients, including organisations from the independent sector (both for-profit and not-for-profit, so-called third-sector organisations). Most prominent in this policy was the nationally led process of procurement of a number of independent-sector treatment centres (ISTCs) to provide high-volume, low-risk elective surgery to NHS patients. In addition, a new form of NHS organisation, the foundation trust, was introduced, with greater operational and financial freedom than other NHS trusts.

The government also encouraged for-profit providers to supply primary care services, with the intention of increasing capacity in areas with an insufficient

number of GPs, a process that saw for-profit firms and social enterprises gain NHS GP contracts.

In this chapter, we summarise the evidence about the process and impact of increasing the diversity of health care providers offering services to NHS patients. We begin by highlighting some of the concerns that were voiced about giving the independent sector a greater role in providing NHS services.

Concerns about provider diversity

The Labour government's view was that if NHS providers had to compete with private providers for NHS patients (or at least if they felt that there was a threat of new entrants), they would improve efficiency, quality of care and responsiveness to patients. It was also thought that new providers would be more innovative than incumbent NHS providers.

Proponents of foundation trusts saw the new status as offering the opportunity for the more rapid creation of new services, greater patient involvement in decision-making about services, and a more business-like and efficient approach to management. However, a wide range of concerns was raised by politicians and other commentators (eg, House of Commons Health Committee 2006; Pollock and Godden 2008).

Efficiency

Proponents of provider competition argue that it will stimulate overall efficiency in the health care system. Yet the literature on the economics of contracting (Williamson 1985) indicates that transaction costs can be significant and, if these are taken into account, may limit the extent to which competition can increase efficiency. A number of studies of contracting in health care have examined how and why these transaction costs arise (eg, Roberts 1993; Ashton 1998; Croxson 1999; Allen 2002). Health care has a number of features that increase transaction costs between purchasers and providers, notably the difficulties of specifying the quality of services and monitoring that quality standards have been met.

Some proponents of increased diversity believe that independent-sector providers are intrinsically more technically efficient than those in the public sector, particularly because of the profit incentive in for-profit firms. However, as Allen (2009) points out, efficiency gains produced by competition may be vitiated by the loss of donated labour, which may well exist in the public and not-for-profit sectors (Hart *et al* 1997). In services where motivation to serve others is important, and many aspects of those services are not measurable, it is not possible to monitor and enforce all aspects of caring. If staff work in for-profit organisations, this motivation to donate labour is likely to diminish, as the benefits of extra effort will ultimately be accrued by the owners of the business.

Quality

There was also a concern that providers with strong incentives to cut costs (such as for-profit providers) might reduce quality of care without commissioners being able to detect this or enforce improvements in quality through contracts (Preker *et al* 2000). In particular, concerns were voiced by professional associations and trade unions about the quality of care delivered by ISTCs. Some of these related to the use of overseas staff (made necessary by the additionality requirement; *see* the section on ISTCs below), which raised concerns about clinical quality (House of Commons Health Committee 2006). Disquiet was also expressed specifically about the effect on quality of care of introducing new forms of primary care provider as a result of changes in regulatory mechanisms and lines of accountability (Pollock *et al* 2007).

Equity

It was feared that giving autonomy to better-performing foundation trusts might compromise equity of access to the hospital sector: foundation trusts might expand their activities, reducing the funding available for other acute providers and for community and primary care; and foundation trusts might not co-operate with other NHS bodies, thereby compromising service integration (Mohan 2003; House of Commons Health Committee 2008).

ISTCs have also been criticised for their potential to compromise equity of access as a result of their being able to select or cherry-pick the more profitable cases because they were set up specifically to treat low-risk, elective patients rather than high-risk, high-cost patients (Bartlett *et al* 2011).

The introduction of for-profit providers in general practice has not so far been found to harm equity of access. However, where for-profit providers found it difficult to make a profit, or realised their business model was ill-fitted to primary care, they withdrew and closed their primary care clinics (Iacobucci 2009), leaving the primary care trust (PCT) to find other practices willing to take the patients. This could harm equity of access to primary care since for-profit providers tended to be established in areas with an insufficient number of GPs.

Accountability

The payment of public money to independent organisations raised concerns about a possible diminution in public accountability (Hodge 2000). It is more difficult to ensure that those in independent organisations making decisions about services delivered to the public (using public money) can be held to account for those decisions (Vincent-Jones 2006). The mechanisms for holding public-sector staff to account are well rehearsed, and include legal action, formal complaints procedures and elections. The legal status of contracted-out services militates against the effectiveness of many of these remedies (Vincent-Jones 2006). There may well be a tension between the entrepreneurialism encouraged in these supply-side reforms and the need for accountability (Groot and Budding 2008).

For-profit providers: ISTCs

The most significant type of new for-profit provider in the NHS was the ISTC. As already mentioned, care had been provided for NHS patients by for-profit hospitals before ISTCs, but this had been mainly on an *ad hoc* basis, determined at local level. ISTCs formed the first nationally planned programme of for-profit hospital provision for NHS patients.

The specific aim of the ISTC programme was to provide the extra capacity needed to reduce waiting times for elective surgery (Department of Health 2002b). In subsequent policy documents, the Department of Health stressed that ISTCs would also increase patient choice, introduce innovative models of service delivery, and stimulate efficiency through competition (Department of Health 2005b; Anderson 2006).

Implementation of ISTCs

The introduction of ISTCs followed a capacity-planning exercise in which strategic health authorities (SHAs) were asked to identify, in conjunction with their respective PCTs, what capacity was needed to meet the 2005 waiting-time targets.

The first ISTC opened in October 2003. Contracts were negotiated at national level, and initial contracts were for five years. A minimum level of income was guaranteed to providers (the contracts were known as 'take or pay'). Once contracts were agreed, the relevant local PCT was responsible for ensuring that the commissioned activity was used. The staffing of ISTCs was based on the principle of additionality, which required staff to be external to the existing NHS workforce. This was intended to help meet the objective of creating more surgical capacity (Department of Health 2002b). Initially, in recognition of initial market entry costs, payments to ISTCs were approximately 11 per cent more than the national tariff paid to NHS providers (Audit Commission and Healthcare Commission 2008). Sussex (2009) has confirmed that this additional payment was indeed required.

A second phase of procurement was launched in March 2005, incorporating a number of changes to the policy in response to concerns raised by the House of Commons Health Committee (2006). These included a requirement for ISTCs to contribute to staff training like other NHS providers, and changes to the requirement for additionality. With the exception of certain shortage specialties, NHS staff could now work in ISTCs and all NHS staff, regardless of specialty, could work in ISTCs outside their contracted NHS hours. Changes were also made to the funding arrangements. ISTCs were still guaranteed a minimum income, but the relevant PCT would only be obliged to pay for care actually provided to patients, and the Department of Health would pay any shortfall to bring the sum up to the guaranteed amount.

Progress with ISTC policy was slower than originally planned. In 2005, the Department of Health anticipated that ISTCs would contribute 15 per cent of

NHS elective surgical procedures (Department of Health 2005b). In fact, ISTCs contributed less than 2 per cent of total elective activity by 2008 (Audit Commission and Healthcare Commission 2008). In November 2007, low utilisation of ISTCs led the then Secretary of State for Health, Alan Johnson, to announce that six out of 16 phase-two schemes would not be procured. An existing contract was also terminated due to low use (5 per cent) (Department of Health 2007a).

In the summer of 2007, responsibility for procurement of ISTCs was transferred from the national to the local level in recognition of the need for procurement decisions to be aligned with local needs. Data published by the Department of Health in 2008 showed that 85 per cent of the elective work that had been paid for had been undertaken, but only 25 per cent of the diagnostic work (Department of Health 2008b, 2008c).

Evidence of impact

Evaluation of the performance of ISTCs is hampered by significant problems with the quality of data collected from ISTCs (and, to a lesser extent, from NHS providers). The Healthcare Commission found that the information collected from ISTCs was generally not comparable with that from NHS organisations. A follow-up report published in 2008 found some improvement, although patient coding was still poor for aspects such as diagnosis, ethnicity and the treatment provided (Healthcare Commission 2007a, 2008a).

Efficiency

There have been no quantitative studies of the technical efficiency of ISTCs, although there has been one study of the overall efficiency effects on the NHS of increasing competition, which appeared to show that competition has, in fact, increased efficiency among NHS providers (Cooper *et al* 2010).

A study using interviews with staff concerning the performance of diverse providers to the NHS (Bartlett *et al* 2011) identified a number of characteristics of ISTCs that *might* contribute to greater efficiency. The limited range of services these organisations provided (eg, routine elective procedures or diagnostic services), and their status as new organisations, meant that the management could specify efficient, streamlined operating practices and then recruit clinicians who could slot into this predefined system of care.

The market reforms introduced into the NHS were based on the assumption that competition would create an incentive for providers to become more efficient, but it should be noted that competition between different types of provider was only partial – different organisations provided different types of services, not all of which substituted for each other. For example, Bartlett *et al* (2011) found that, as envisaged by policy-makers, ISTCs only competed with NHS hospitals in respect

of routine, non-urgent surgery. Nevertheless, they also found that some NHS providers had sought to mimic the more efficient operating practices of ISTCs (Turner *et al* 2011).

Quality

The only comparative study to date of clinical quality in ISTCs found no significant differences between ISTCs and NHS providers. Browne *et al* (2008) were able to compare 769 patients treated in six ISTCs with 1,895 patients treated by 20 NHS providers during 2006/7. The study involved patients undergoing various types of routine surgery, who reported their health status using several validated outcome measures. After adjusting for casemix, patients reported similar improvements following hernia repair, varicose-vein surgery and knee replacement in ISTCs and NHS providers. Improvements following cataract surgery and hip replacement were slightly greater in patients treated in ISTCs.

There have been two studies comparing patient experience in ISTCs and NHS providers, each using different approaches. First, a study by the Healthcare Commission (2007a) involved analysis of routine data, patient survey, focus groups, site visits and interviews. It found that patients in ISTCs rated their care highly (97 per cent rated their overall care as 'excellent' or 'good'). A number of variables was rated higher than in NHS organisations, including time of admission and no change to admission arrangements, involvement in decisions about their care, and the provision of information and explanations about their care. There were occasional difficulties in ensuring co-ordinated care where responsibility for care moved between ISTCs and NHS providers and systems for following up patients were not always in place and not always included in contracts.

More recently, data on patient experiences were analysed by Pérotin *et al* (2011, forthcoming). Analysing the 2007 NHS trust inpatient surveys and the ISTC inpatient and day case patient surveys from 2007 and 2008 using econometric techniques, Pérotin and colleagues found that differences in ownership between ISTCs and NHS hospitals could not explain differences in patient experience. They found that ISTCs provided better all-round quality, fewer delays in discharge and more comfort than NHS hospitals, while NHS hospitals were rated better on the information given to patients. However, these differences were entirely due to differences in the types of cases admitted by the ISTCs and the NHS.

The multivariate analysis found that older patients, and patients in some specialties, were more satisfied with care in NHS hospitals, and patients in other specialties with care in ISTCs, all else being equal. Overall, regression analysis found no differences in the level of satisfaction reported by patients on the basis of provider ownership per se once patient characteristics, state of health and length of stay, hospital specialty, the selection process of patients into either sector, and individual hospitals' characteristics were taken into account. The analysis was unable to

identify which features of providers accounted for differences in patient experience, but suggestions included the qualifications held by staff, resources and equipment.

Effect on the local health economy

There is some local evidence that using ISTCs might financially destabilise NHS providers. The latter have expressed concern that diverting more profitable, routine work to ISTCs leaves NHS organisations with the essential, complex and emergency care, which they had previously been cross-subsidising with revenue from routine work (Bartlett *et al* 2011).

Patient choice

A key objective of increasing the diversity of health care providers in the NHS was to increase choice for patients. However, a study of GP referrals (Rosen *et al* 2007) found that in some areas this may not have been realised because of the nature of the contracts, which obliged PCTs to send all patients with a specific condition to the nearest ISTC in order to ensure that funds that had to be paid to the ISTC were used for patient care. Another study (Imison *et al* 2008) found similar results in one study site where the PCT had ceased efforts to shift services between providers after a local ISTC had opened.

Summary of evidence

The evaluation of the performance of ISTCs has been hampered by the absence of comparable data for NHS providers and ISTCs, and the fact that there was only partial competition between ISTCs and incumbent NHS providers. The lack of data, plus the fact that contracts with ISTCs have not been made public, has also restricted accountability in respect of various issues, most importantly value for money.

The sole quantitative study of clinical outcomes suggests that quality of care in ISTCs is as least as good as in the NHS. Patient satisfaction with care provided by ISTCs is high. Higher prices, coupled with low utilisation rates of ISTCs while guaranteeing minimum payments to their owners, may have wasted public resources and failed to deliver value for money from these contracts.

For-profit providers: primary care

As well as developing treatment centres for elective surgical care, the Labour government also encouraged new entrants into the NHS to provide GP services. One of the reasons for this was to increase the capacity to deliver primary care in areas with an insufficient number of GPs (similar to the idea of ISTCs increasing available capacity) or where no conventional general practice could be found to replace a retiree. Both for-profit firms and social enterprises entered this market (Ellins *et al* 2008). Davidson and Evans (2010) reported that, in 2009,

23 commercial companies had multiple contracts with the NHS, and were running 227 GP surgeries. Although most of these companies run fewer than 10 practices (and can be described as GP-led despite being for-profit because they are owned by GPs), there is a small number of larger firms with a sizeable portfolio of NHS general practice contracts. For example, two publicly traded companies (Care UK and Assura) run at least 12 practices each.

There does not appear to be any systematic evidence about the performance of these organisations, although Ellins *et al* (2008) reported that, in 2008, in cases where contracts had been in place for a sufficient amount of time to tell, PCTs were generally positive about how these practices were being run, and there was some evidence of innovative approaches to service delivery. On the other hand, both Ellins *et al* (2008) and Bartlett *et al* (2011) found that some for-profit primary care providers were finding it difficult to make a profit, as the business models they had developed did not coincide with the realities of service delivery, or the terms of the contract offered by the PCT were disadvantageous. Some companies entered the NHS market only to close their NHS primary care facilities after a few years (Iacobucci 2009).

Third-sector organisations

One of the important strands of New Labour's supply-side reforms in the NHS was the policy that, in addition to the corporate for-profit sector, commissioners should engage with new providers from the so-called 'social economy', including local voluntary groups, registered charities, foundations, trusts, social enterprises and co-operatives (Department of Health 2006a). These groups are collectively known as the third sector.

Third-sector organisations exhibit a range of governance characteristics, the most salient being that they are independent of the state and have social aims. Third-sector organisations can take a wide variety of legal forms, including limited companies, charities, co-operatives and community interest companies (Allen *et al* 2011b), and some do make profits. The difference between for-profit organisations and third-sector organisations is that the latter do not distribute profits to non-participant shareholders.

The New Labour government was particularly interested in the contribution of social enterprises, which it defined as businesses 'with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners' (Department of Trade and Industry 2002, p 7).

The aim of introducing third-sector organisations was to develop the entrepreneurial impulse within health and social care, encourage entry of new providers, improve quality and promote innovation. There are two reasons why third-sector organisations may deliver higher-quality services than for-profit organisations. The

first is that non-profit organisations do not face the same incentive as for-profits to minimise costs (Hart *et al* 1997; Grout and Stevens 2003). The second is that where third-sector organisations are client-led, they find it easier to respond to clients' needs (Weisbrod 1988).

In 2007, there were about 35,000 third-sector organisations in England providing health and social care services valued at £12 billion, while a further 1,600 planned to enter the market in the near future (Department of Health 2007a). Most currently provide services in the fields of mental health, disability, learning difficulties or long-term care. The government showed special interest in supporting the entry of new social enterprises to the NHS. In 2006, the Department of Health established a Social Enterprise Unit, allocating it a £100 million investment fund over the four years to 2010/11. This was designed to stimulate the growth of social enterprises through access to start-up capital, business and legal advice, and training. The unit also launched a so-called pathfinder programme for 26 social enterprises to act as demonstrator projects. In addition to encouraging entry to the NHS of new providers from the third sector, the government also encouraged existing NHS-owned community health services organisations to transform themselves into social enterprises (Department of Health 2007c; Tribal Newchurch 2009).

There do not appear to be any quantitative studies comparing the performance of not-for-profit providers of health care to NHS patients with the performance of state-owned NHS providers. This may be due to the fact that, until recently, there had been limited participation in mainstream NHS provision by third-sector organisations. (Contracted services had been mainly in the areas of mental health and the termination of pregnancy.) Where third-sector organisations did enter the NHS market, this tended to be in the area of community health services, and the routine data concerning these services are very limited.

There is one interesting study of users' views comparing public, for-profit and third-sector organisations' provision of services. The National Consumer Council undertook a study for the government's Office of the Third Sector (Hopkins 2007). This did not include health services, but domiciliary social care for older people was included. The study found that older people thought that private-sector providers were slightly better at providing what they wanted compared with the public-sector and third-sector organisations. There was little difference between the public-sector and third-sector organisations, except that the latter were distinctive compared with public-sector providers in two ways: keeping their promises; and having staff who were prepared to go out of their way to help.

An evaluation of the social enterprise pathfinders in the NHS (Tribal Newchurch 2009) found that it was too early in their development to be able to tell how they were performing.

In terms of international evidence, it has been argued that, in relation to efficiency, the level of competition that all organisations face is more important than the

ownership of the organisation (Sloan *et al* 2001; Eggleston *et al* 2006). There is no evidence in the health care sector that third-sector organisations are less efficient than for-profit organisations (Vining and Globerman 1999).

NHS foundation trusts

NHS foundation trusts were set up in 2004. They were conceived as a new kind of public organisation, still part of the NHS but modelled on co-operative and mutual traditions (Department of Health 2005a). They are different from other NHS trusts in two distinct ways:

- they have greater autonomy – instead of being accountable to SHAs and the Department of Health, foundation trusts are overseen by the independent regulator, Monitor
- they have different governance arrangements – members drawn from the public, patients and staff elect governors including the chair of governors, who is also chair of the board (Allen *et al* 2011b).

Foundation trust policy thus contains two mechanisms intended to improve performance:

- that the prospect of enhanced autonomy will motivate staff to improve performance
- that organisational and financial freedoms, combined with new governance arrangements that focus on involving patients and the public, will facilitate innovation and enable organisations to develop services that are more responsive to patients and local communities.

In the second point above, public and patient involvement is seen as a *means* of achieving improvements in performance. Public and patient involvement has also been proposed as an *end* in itself, enhancing local democracy or active citizenship (Allen 2006).

The focus of this chapter is on the role of foundation trusts in the creation of a more diverse supply-side to the quasi-market for health care in the NHS. Findings with regard to public involvement are addressed elsewhere (Allen *et al* 2011b).

Implementation of foundation trust policy

Foundation trusts were introduced in a phased manner. An initial wave of ten foundation trusts became operational in April 2004, followed by a second wave of ten in July 2004. By 2010, there were 131 foundation trusts in England, of which 40 were mental health care providers (Monitor 2010). The government's original aim was for all NHS trusts to become foundation trusts by 2008. The Department of Health maintained that all care would be delivered by foundation trusts 'with the

implication that foundation trusts will merge with or buy out the remaining non-foundation hospitals' (House of Commons Health Committee 2008, p 45).

The coalition government's White Paper in July 2010 indicated that foundation trusts were to continue to be a key aspect of the NHS, and that all NHS hospitals were to become foundation trusts by the financial year 2013/14 (Department of Health 2010a). Later policy announcements have softened this tight deadline (Department of Health 2011a,b).

Evidence of impact

The evaluation of foundation trust policy presents a number of challenges. A conventional approach to evaluation would attempt to isolate the effect of foundation trust policy by making comparisons using performance indicators, either of organisations before and after gaining foundation trust status, or between foundation trusts and non-foundation trusts. However, in the case of foundation trusts, this is made difficult by the fact that achieving foundation trust status is contingent on demonstrating high performance. Thus comparisons may reveal foundation trusts to be better performers, but it would be inappropriate to attribute this simply to foundation trust status *per se*, as foundation trusts are a self-selected group of high performers (Marini *et al* 2008).

Process effects of autonomy

There is evidence that foundation trust hospitals performed better than non-foundation trust hospitals, but the better performance predated the change of status (Marini *et al* 2008). A joint report by the Audit Commission and the Healthcare Commission (Audit Commission and Healthcare Commission 2008) found that foundation trust hospitals:

- had business strategies focused on growth and the development of services
- had an increased ability to plan
- used their ability to gain access more quickly to capital investment to improve and develop services.

In this sense, foundation trusts were acting more autonomously, as they did not have to wait for permission to make decisions from other parts of the NHS. But this increased autonomy should not be exaggerated: foundation trusts were still subject to national targets (notably the 18-week waiting-time target), and these had a major effect on the way in which they delivered and planned services (Allen *et al* 2011a).

There was no evidence that foundation trusts were using their flexibility in workforce issues in significant ways, but concern was expressed about the size of unused funds created by generating surpluses (Audit Commission and Healthcare Commission 2008; House of Commons Health Committee 2008). This could have been reducing NHS funding available for other providers.

While foundation trusts were better performing hospitals in the first place, evidence also indicates that the *process of applying* to become a foundation trust improved performance. An analysis commissioned by Monitor (Monitor and Frontier Economics 2010) concluded that Monitor's decision to defer some NHS trusts from achieving foundation trust status on their first application resulted in these organisations revisiting cost-improvement plans, which, over time, delivered significant savings.

Quality

As far as routine measures of quality (such as hospital-acquired infection rates and waiting times) are concerned, foundation trusts were found to perform better than NHS trusts (Audit Commission and Healthcare Commission 2008; Monitor and Frontier Economics 2010). However, there was no evidence that foundation trusts were delivering a higher quality of care as a result of their status, as they were better performers before becoming foundation trusts.

Various studies (Healthcare Commission 2005b; House of Commons Health Committee 2008; Allen *et al* 2011b) found that having more freedom to make decisions at the hospital level led to improvements in services for patients. For example, foundation trusts were able to make quicker decisions on opening additional wards or operating theatres, and focused investment on issues that are important to patients, such as the physical environment and security, car parking and patient information.

As Allen *et al* (2011b, p 69) point out: 'the aim of providing good quality patient care (whether for its own sake, or because it would enhance the reputation of the foundation trust and attract further patients) was clearly articulated'. This supports the earlier findings from Mannion *et al* (2007) that managers were attracted to the autonomy of foundation trust status by the opportunity to provide more responsive services to patients arising from increased discretion over the design of services.

Impact on the local health economy

One of the main determinants of the quality of local relationships between foundation trusts and other NHS bodies was the past history of these relationships (Healthcare Commission 2005b). Foundation trust status did, however, have an effect (Healthcare Commission 2005b; Lewis and Hinton 2008; Allen *et al* 2011a). In cases where there had been a history of poor relationships, these were exacerbated by foundation trust status (Healthcare Commission 2005b). Allen *et al* (2011b) found that foundation trusts were concerned to protect their services and future income streams against other trusts. They were also keen to expand the services they provided, to the detriment of other trusts, although foundation trusts were still co-operating with other hospitals in respect of issues that would improve patient care.

The incentives for foundation trusts to increase their income, coupled with autonomy in decision-making, meant that they were not always felt to be acting co-operatively with commissioners (PCTs) about service developments. Where PCTs were trying to reduce activity to prevent overspends in the local budget, having a foundation trust as one of the local providers was reported to make this task more difficult, as the incentives on foundation trusts were strongly in favour of increasing their income.

Witnesses giving evidence to the House of Commons Health Committee (2008) also cited weaknesses in the commissioning function as the cause of many perceived problems relating to foundation trust status, including foundation trusts not investing their surpluses and the lack of shift of services from hospitals to primary care.

Moreover, their relationships with primary care were complex: in some cases, tensions arose from concern by foundation trusts that GPs would use their commissioning powers (under practice-based commissioning) to reduce the amount of work done by the foundation trust hospital, but, at the same time, there was an incentive for foundation trusts to market their services to GPs and maintain good relationships to ensure the flow of referrals.

Accountability

Unlike NHS trusts which were held to account by the Department of Health and, ultimately, the Secretary of State for Health, foundation trusts are accountable to their members, elected governors and the independent regulator, Monitor.

Early studies indicated that there was a lack of clarity about the role of governors in relation to the board of directors (Day and Klein 2005; Audit Commission and Healthcare Commission 2008; Lewis and Hinton 2008). This appears to have improved over time (Ham and Hunt 2008), but a recent study of the governance of foundation trusts (Allen *et al* 2011b) found that governors had mixed views about how well they were able to hold foundation trust boards and management to account. One issue raised in several of the foundation trusts was that the governors were excluded from board meetings and did not get access to board papers.

Summary of evidence

There is consistent evidence that foundation trust policy met the aim of enabling foundation trusts to develop services that were more responsive to patients and local communities than had previously been the case. Senior managers reported that foundation trust status enabled faster access to capital to develop services. It appears that foundation trust policy combined autonomy with an incentive to become more patient-focused.

The key problem with foundation trust policy relates to the development of stronger providers combined with relatively weak commissioning. There is a risk that the

continuing relative strength of providers in local health economies will vitiate efforts to create a system where the planning and provision of local health services is led by commissioners.

Conclusions

Despite New Labour government initiatives to encourage diverse types of provider to deliver care to NHS patients, a large amount of for-profit or third-sector activity had not materialised by the time of the general election in 2010. Bartlett *et al* (2011) found that, in the small number of local health economies they studied, less than 3 per cent of the local budget was spent on independent health care providers.

The small amount of available evidence indicates that the performance (in respect of quality, in particular) of diverse providers was not inferior to that of NHS providers, and might be superior in some respects. However, the effect of new entrants on the NHS system as a whole remains an area for concern. The policy was implemented by New Labour in a context of record real-terms NHS financial growth. In the current context of substantial cuts in public spending and little or no increase in NHS budgets, any growth in the market share of one organisation is more likely to be at the expense of another organisation. This may result in some existing NHS organisations becoming financially unstable, and difficulties in ensuring seamless care for patients across organisational boundaries.

The attitudes and behaviour of commissioners are important factors, both in the entry and growth of diverse providers, and in how diversity of supply is managed to achieve high-quality care and financial stability for local health economies. The coalition government's plans to reform commissioning (Department of Health 2010a; Her Majesty's Government Bill 2011) are therefore important to the future development of the policy to increase the diversity of provision available to NHS patients. These plans include changing both the arrangements for commissioning health care and the regulatory structure of the NHS. PCTs will be abolished, and consortia of general practices will take over responsibility for most commissioning. It remains to be seen if these new consortia will have the enthusiasm and requisite skills to manage the commissioning of a range of diverse providers in such a way as to maintain financial control and ensure good-quality care.

Regulatory changes will introduce a more competitive environment in which the current regulator of foundation trusts, Monitor, will take on the statutory role of an economic regulator for the entire NHS. Further changes are envisaged in the way in which prices are set for all providers, and risk is shared among them, which will enhance the competitive aspects of the English health care system (Health and Social Care Bill 2011). Although the reforms are intended to create a level playing field, it is not yet clear whether the financial environment and the new regulatory framework will encourage more private- and voluntary-sector organisations to enter the NHS market.