
9 Assessing and explaining the impact of New Labour's market reforms

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This chapter summarises the evidence assembled in the previous chapters covering different aspects of the market-related reforms of the English National Health Service (NHS) under New Labour. It tries to assess the extent to which the objectives of the reforms had been met or the concerns of sceptics vindicated by the time that New Labour lost power in May 2010. It concludes by discussing the nature of the evidence available and the challenges of evaluating large-scale, complex, system-level changes against a background of ongoing policy initiatives, parallel policy developments and a large increase in the financial and real resources available to the NHS.

Objectives of the reforms

From analysis of the policy documents discussed in Chapter 1, the main objectives of the market-related changes to the English NHS introduced gradually with effect from financial year 2002/3 can be distilled as follows:

- to improve efficiency, particularly in the acute hospital sector for elective treatment, by paying hospitals using fixed (benchmark) prices per episode, allowing NHS hospitals greater managerial and financial freedom, and encouraging competition between NHS and independent hospitals for individual patients and for contracts from commissioners (competition in and for the NHS market)
- to improve quality, particularly in the acute hospital sector for elective treatment, by encouraging fixed-price, quality-driven competition involving both NHS and independent hospitals, by refining the system of quality regulation of providers and by commissioners tendering for new and innovative models of service
- to improve the responsiveness of acute hospital services (eg, shorter waiting times and better patient experience) by introducing individual patient choice of any willing provider, primarily for elective surgery and diagnostic services, and by paying hospitals for individual episodes of care so that the money followed the patients rather than patient referrals having to follow previously agreed contracts with specific providers

- to increase the rate of clinical and organisational innovation (and thereby improve the quality and efficiency of care) in acute hospitals by allowing high-performing NHS hospitals greater managerial and financial freedom (including the ability to retain surpluses for investment), and by encouraging entry of independent providers to the NHS market, especially for elective surgery
- to increase output (treatment rates) in the acute hospital sector, thereby enabling faster access to treatment, by paying hospitals using fixed prices per unit of output so that, in theory, the more work they did, the more income they received
- to improve socio-economic equity of access by offering individual choice of place of elective care to all NHS patients, not just those able to afford the option of private-sector care as well as NHS care
- to reduce unnecessary demand for hospital care and to develop innovative alternatives to hospitalisation by giving more influence over primary care trust (PCT) commissioning to primary care professionals, especially general practitioners (GPs), through practice-based commissioning (PBC) in which volunteer practices were given an indicative budget by the PCT to be used to commission selected services for their patients.

The key elements in the reforms – entry of independent sector providers, individual patient choice of provider, and output-based hospital reimbursement, so-called Payment by Results (PbR) – were introduced gradually (*see* Chapter 1 and the chapters covering specific reform mechanisms for more details), but were all in place by January 2006, which can therefore be regarded as the date from which the reforms were more or less fully operative (Cooper *et al* 2010). However, they were not described officially as an interrelated package of changes until 2005 (Department of Health 2005a), and free choice of any provider was introduced only in 2008. As a result of the phased implementation and lags in availability of data, the evidence on the effects of the New Labour market reforms considered in this book comes in the main from only three years of fully implemented reforms, 2006/7–2008/9.

Concerns about the reforms

Inevitably, a set of changes designed to make the English NHS operate more like an ordinary consumer market – albeit one with public finance, considerable restrictions on market entry, close financial and managerial regulation, and national level political oversight and accountability – was bound to excite concerns among critical commentators. As described in greater detail in Chapters 1 and 6, the main problems envisaged were the following:

- that the fundamental differences between health care and other markets (eg, the nature of demand, information imbalances between users and providers, the difficulty of assessing the quality of service, barriers to individual and organisational entry, etc) could not be easily circumvented and would prevent effective implementation of a provider market

- that equity of access to health care would be harmed for two contrasting reasons – the offer of individual patient choice would be exploited more effectively by better-off, better-educated, lower-need patients, and the fixed (average) price payment system would encourage discrimination against more costly, higher-need patients
- that competition on the basis of quality rather than price would fail to have the positive effects predicted because there was insufficient robust and easily interpretable information available on the performance of different services and providers, which would therefore allow providers to underinvest in quality-improving initiatives
- that the availability of information on quality of care would be reduced on the grounds of commercial confidentiality in an increasingly competitive market environment involving more private sector players
- that the notion of a provider market driven partly by individual patient choice of provider was based on a misunderstanding of what the majority of NHS patients wanted: they were not interested in shopping around for care, particularly when compromised by ill-health, wanting instead guaranteed access to high-quality local services and being more interested in choosing the type of care than the organisation providing the care
- that the emphasis on implementing a market within the NHS would leave no room for the articulation of the collective, as opposed to individual, preferences necessary to shape a public service paid for from general taxation and delivered locally
- that any decisions about the nature and location of major infrastructure such as hospitals and information technology would be better taken through co-ordinated national and/or regional planning processes, but that these would become impossible in a competitive market, leading to inefficient use of capital, service duplication and inefficiencies as a result of a lack of concentration of services in specialised settings.

Even some of those who could see the potential advantages of encouraging greater patient choice and provider competition had concerns that the reforms were unduly focused on acute hospital services, and that even within the acute sector, the reforms might work well only for the minority of elective (planned) services where individual patient choice and PbR could conceivably interact to produce desirable forms of inter-hospital competition.

There was therefore a risk that competition for electives could weaken the financial position of a hospital and put at risk access to the emergency services that were essential to the local population. There was also a risk that provider competition might prevent the sort of collaboration between primary and secondary care that was increasingly being seen as the way to improve the care of people with complex, long-term health problems.

In addition, there were the perennial concerns that the changes did little or nothing to empower the commissioners (purchasers) of services (eg, PBC groups would be too small and insufficiently skilled to drive the major service reconfigurations needed to rebalance care away from hospitals) and, if anything, the combination of more autonomous providers in the shape of foundation trusts and payment for activity through PbR would further weaken their position *vis-à-vis* the hospitals.

Irrespective of whether they were for or against the changes, many commentators were also concerned that market-like reforms would pose a major challenge to elected politicians, especially in a Westminster system of government, in following through the logic of markets, which is that inevitably some providers will fail or get into financial difficulties, incurring public disapproval and resistance. The experience of the less radical 1990s internal market in the NHS had been that politicians had intervened to dampen down the impact of market competition precisely where it threatened to bring about significant change in the configuration of hospitals in London. Given the very high political and media profile of the NHS, especially of its hospitals, there seemed few reasons to believe that a similar dynamic would not operate under New Labour.

The next two sections summarise the extent to which New Labour's objectives were met and whether the problems foreseen by critics and sceptics materialised, looking, in turn, at the degree to which the reforms were implemented and the effects of the changes on the performance of the system.

Extent of implementation of the reforms

How far were the reforms put in place? By the time New Labour left office in May 2010, the English NHS was still some distance away from functioning as a fully-fledged provider market for publicly financed care. The system continued to be run by a closely managed hierarchy, while operating in a more market-like way in specific respects. This is scarcely surprising given the tenacity of past relationships and behaviours in all systems under change (Greener and Mannion 2009b), and the relative novelty of the changes in the period studied. For example, PbR required the development and implementation of a completely new way of paying for a large percentage of the hospital services delivered to NHS patients.

Turning first to consider what had changed, there were many indications that the English NHS was operating more like a market:

- the independent sector was more routinely involved in the provision of services to NHS patients, most notably in elective surgery (*see* Chapter 2)
- an increasing proportion of NHS provider organisations was becoming foundation trusts, operating with less ministerial direction and more financial autonomy (Chapter 2)

- half of elective patients reported being offered a choice of provider at the point of referral (Chapter 4)
- by some measures and in some areas, there was greater potential competition between acute hospitals for elective services (Chapter 6)
- reimbursement of providers on the basis of healthcare resource groups (HRGs) under PbR accounted for approximately 40 per cent of the hospital care bought by PCTs (Smith and Charlesworth 2011) (Chapter 5)
- PCTs were devolving parts of their budgets to practice-based commissioners to enable them to take better-informed commissioning decisions that were more closely attuned to the needs of their patients than PCTs could (Chapter 3)
- the quality regulator (the Care Quality Commission [CQC]), the financial regulator of NHS foundation trusts (Monitor) and the Competition and Co-operation Panel were beginning to work together to ensure a more level playing field between public, private and third-sector providers of NHS services based on their ability to provide good-quality services (CQC) at the NHS tariff price and their financial viability (Monitor) (Chapter 7).

Such changes also appeared to be altering the management culture of hospitals in the NHS during the period, from a dominant clan culture towards a more competitive, externally focused, rational one (Mannion *et al* 2009), implying that some of the externally mandated changes were having a more profound effect on NHS-owned organisations.

In contrast, there was also evidence of continuity and the limits to change, such as the modest extent to which services were subject to market forces, the continuing salience of previous, non-market policies, and the persistence of long-standing behaviours that were at variance with market incentives. As described in Chapter 8, the market reforms represented but one layer of policy, and co-existed throughout the second half of the 2000s with very different models of service improvement, sometimes leading to diversion and dilution of management effort.

More specifically, the entry and growth of new providers was limited and had been relatively slow (eg, just under 2 per cent of NHS elective activity was provided by the independent-sector treatment centres (ISTCs) by 2007/8 (Audit Commission and Healthcare Commission 2008) (Chapter 2), and overall the hospital market remained fairly concentrated (Chapter 6). This was reinforced by the tendency of GPs to continue to exercise choice on behalf of their patients and for patients, with the help of their GPs, largely to continue to choose local providers that they knew. Patients were typically offered only a few options and were generally not aware that they could choose a private provider by right (Chapter 4).

Hospital managers identified GPs as more important for patient referrals than the newly empowered patients, and focused their marketing accordingly (Chapter 8).

They also reported that waiting times and financial targets loomed far larger than the incentives theoretically generated by the NHS market.

Concentration was also reinforced by national initiatives in a number of service areas to plan referral patterns and care at a regional level in order to improve patient outcomes. For example, in critical care and care for patients with heart disease, stroke and cancer, efforts had been made to ensure that a higher proportion of patients was treated at fewer, more specialised, regional centres with higher throughput and potentially better outcomes (Darzi 2007).

Implementation of the market-related changes therefore also varied by specialty and by area, with a stronger market focus on elective care (Chapter 8) than on other specialties. This was partly because the chosen model of market reform, particularly the use of activity-driven payment of hospitals, appeared to fit elective hospital services – such as surgery and diagnostics – much better than it did other service areas, and to operate more strongly in locations where there was more potential or actual competition between providers (Chapters 6 and 8). By contrast, services such as those for people with mental health problems and community health services (eg, district nursing) appeared relatively untouched by the market changes and remained outside the PbR system (Chapters 5 and 8). The goal of extending PbR to the majority of hospital services was far from being met (Chapter 5), and the share of NHS spending covered by PbR had altered little since 2006/7 (Smith and Charlesworth 2011).

Likewise, the reforms were seen as marginal by those working in places where there was a monopoly provider and a history of collaborative working relationships (Chapter 8). The approach to competition and hospital payment adopted by New Labour was also seen as irrelevant to improving the care of people with more complex and longer-term conditions, for which better co-ordination of care between providers, especially across the primary–secondary care divide, was increasingly seen as important (Curry and Ham 2010) but hampered by PbR (Chapter 5).

Waiting-time targets remained in place as reminders of the persistence of New Labour's successful pre-market policies of centralised objective-setting backed by tough, hierarchical performance management and of the continuing importance of non-market mechanisms and relationships in maintaining and improving the English NHS (Chapters 4 and 7).

Indeed, the combination of reforms from different periods in the life of the New Labour administrations (so-called layering) seems to have confused local actors and weakened the ability of the NHS at local level to pursue the necessary market-related changes (Chapter 8). In particular, there is evidence that the delivery of national waiting time and financial targets diverted attention and energy from vigorously implementing the later market-based changes and could even have impeded them. It is also clear that local health care system actors frequently faced imperatives that rivalled those related to generating provider competition. For example, on occasion,

both commissioners and providers gave priority to the financial and clinical health of the wider health care system rather than competing with one another, and there was increasing evidence towards the end of New Labour's term in office of organisations in local health economies working together rather than competing in order to ensure their survival in hard financial times (Chapter 8).

Finally, there was evidence of an imbalance in the implementation of the different elements in the reforms, with developments in commissioning (with the exception of individual patient choice of place of elective care) lagging behind the rest. Right at the end of the period, there were reports that commissioners' performance against the Department of Health's world class commissioning criteria was improving (NHS Confederation 2010), but, for most of the time, PCTs were widely seen as the weakest link in the system (Chapter 3). For example, the progress and achievements of PCTs and, in particular, of PBC schemes appeared to be limited to small-scale, somewhat marginal changes in local health services when assessed in relation to the main challenges facing the NHS, such as large-scale hospital service redesign and reducing reliance on hospital services. On the other hand, commissioning underwent near-continuous reorganisation while the other market mechanisms were being rolled out, making it difficult for the commissioning organisations to make a concerted impact. Commissioners also struggled to manage spending since they lacked control over clinical decisions such as GP referrals.

Given the incompleteness of implementation by 2010, it is not surprising that Brereton and Gubb (2010, p xii) were forced to conclude at the end of the New Labour period, from a free-market perspective: 'We found isolated examples of the NHS market delivering the benefits that were anticipated; however, the market, by and large, has failed thus far to deliver such benefits on any meaningful or systemic scale.'

The modest scale of impact perceived by Brereton and Gubb (2010) is partly attributable to variation in the extent of implementation of the changes in different geographic areas, and to differences between providers in the degree to which the reforms challenged their previous ways of operating. For instance, different providers (predominantly hospitals in this period) provided different service mixes and thus faced differing degrees of exposure to, for example, competition for elective surgical patients to maintain or increase their incomes (Dixon *et al* 2010a).

It is also apparent that implementation of the market reforms played out differently in urban, suburban and rural areas, as well as within local health care systems facing financial difficulties (eg, due to apparent hospital overcapacity) compared with those in better financial circumstances (Chapter 8). For example, the largest increases in spatial competition between hospitals appeared to have occurred in the semi-rural areas between the conurbations rather than in the cities where there had always been considerable *de facto* choice of providers (Chapter 6).

Implementation of the reforms was further affected at local level by the concerns of patients, commissioners and providers that an excessive focus on competition could destabilise the local health care system (Chapter 8). For example, a focus on short-term competition in the market for elective treatment might be perceived as risking reducing the income of a district acute hospital, thereby threatening its financial viability as a provider of emergency and urgent care to a population reliant on its services. In such circumstances, the already sticky (resistant to short-term change) referral patterns between GPs and hospital specialists might be even less likely to alter in response to opportunities for patient choice and competition for elective care.

Impact of the market reforms versus other changes under New Labour

If the extent to which the market changes had been put in place by 2010 was mixed, what of the evidence of their impact on the efficiency, equity and responsiveness of the system? Did the concerns of critics or the benefits predicted by proponents come to pass?

The evidence presented in the preceding chapters shows broadly that the market-related changes introduced from 2002 by New Labour tended to have the effects predicted by proponents and that most of the feared undesirable impacts had not materialised to any extent, at least by early in 2010. However, the scale of the market-related effects was modest compared with the overall improvements in the performance of the NHS from 1997 associated with other policies, such as service modernisation and targets, and these effects were realised in a benign period of strongly growing NHS spending.

Before and during the period of the staged reintroduction of a provider market into the English NHS, its performance had been improving. Indeed, a large part of the rationale for the revival of supply-side competition in 2002/3 was to sustain and accelerate these already improving trends (Stevens 2004). Advisers close to Prime Minister Tony Blair became convinced that the pressure for further improvement could only come from using new policy instruments alongside those already in place, such as investment, so-called modernisation, and targets.

As a result, many of the gains made before and after 2002/3 were unrelated to competition, patient choice and the rest of the market reform package. Indeed, the predominant narrative on New Labour's period as custodian of the English NHS must focus on the increases in spending and the size of the workforce (eg, 50,000 more doctors and 100,000 more nurses and midwives) after 2000, together with strongly enforced targets, leading to improvements in performance (Bevan and Hood 2006a; Boyle 2011). For example, it is clear from studies comparing the performance of the NHS in England with that in Scotland that the faster waiting-time reductions in England were the result of time-limited, quantified waiting-time

targets backed by vigorous performance management (Propper *et al* 2004; Propper *et al* 2008a; Connolly *et al* 2010). Again, hospital activity rates appeared to increase faster in England than in Scotland, but this was observed for services both within and outside the PBR tariff scheme (Farrar *et al* 2009), suggesting that these trends were primarily the result of other non-market policies, particularly the pressure to hit waiting-time targets.

General NHS performance trends

The general indicators of improvement from 1997 onwards that were not necessarily directly related to the market, were:

- major and sustained improvements in waiting lists and waiting times for hospital and primary care services
- a reduction in the rate of the two leading causes of hospital-acquired infection
- a reduction in smoking rates
- better support in primary care for those with chronic conditions, including incentives for GPs to manage patients with chronic conditions
- greatly improved waiting times for cancer diagnosis and treatment, improved access to cost-effective drugs and better post-treatment survival rates for most cancers
- notable improvements in access to cardiac surgery and recommended standards of stroke care contributing to falling mortality for cardiovascular disease
- better access to specialist early intervention and crisis resolution teams for acute mental illness
- increases in overall public satisfaction with the NHS
- reduced infant mortality and longer life expectancy for all social groups, but with progress faster among less deprived groups leading to widening health inequalities (Thorlby and Maybin 2010).

New Labour had made considerably less progress by 2010 in improving the NHS in terms of:

- reducing the harm attributable to the misuse of alcohol and overeating
- reducing avoidable causes of hospital use
- reducing unjustified variations in processes and outcomes of care (eg, in radiotherapy, cardiovascular surgery and stroke care)
- reducing health inequalities between more and less deprived areas and people
- ensuring equitable access to services.

Perhaps the biggest weakness under New Labour lay in the apparent decline in NHS productivity in the 2000s and the substantial scope remaining in the system for more efficient delivery of services. On first inspection, this could be interpreted as an obvious indication that the reintroduction of the market had failed in that the combination of activity-driven payments through PbR and inter-hospital competition, particularly for electives, might have been expected to increase output, reduce unit costs and thence improve productivity. In fact, the fall in measured productivity was largely due to the big increase in NHS funding, leading to more staff and higher wages that were not compensated for by increases in measurable output. In addition, there were higher capital costs and increases in costs associated with requirements for improvements in care (eg, through implementation of national service frameworks and National Institute for Health and Clinical Excellence recommendations) (Boyle 2011).

These increases overwhelmed in scale any potentially positive impact of the NHS market reforms. Furthermore, in most of the period there was little emphasis on raising productivity in return for the additional resources. Instead, the focus was on increasing spending and staffing levels per capita so that they were closer to the European average through old-style input planning.

Specific impact of the market changes

However, far from having failed, the evidence in this book suggests that NHS performance in terms of efficiency and productivity would have been weaker in the absence of New Labour's market reforms. Furthermore, there was also no obvious sign of the market-related changes hampering or reversing the improving trends in other areas of performance. In other words, the reintroduction of a more explicitly pro-competitive approach within the English NHS most likely did help to make better use of the large increase in resources, even though it did not improve productivity enough to offset the resource increases.

The hospital market changes with largely fixed-price competition through activity-based reimbursement together with individual patient choice of place of care for electives did appear to have had some measurable positive effects in the direction predicted from theory and previous experience, particularly in relation to efficiency, and without obviously harming equity of use of services. The evidence for a positive impact on quality (outcomes) is more contentious, although suggestive (*see below*). It is extremely difficult to assess the impacts of individual components of the reforms, particularly the contribution of PCT commissioning and PBC since any effects are mediated by the response of providers to their commissioning strategies.

The clearest evidence of impact is probably that from the evaluation of PbR discussed in Chapter 4, since this study included not only a controlled before and after analysis in England as PbR was extended over time to new specialties and new

hospitals, but also longitudinal comparisons between England's NHS with PbR and Scotland's avowedly non-competitive NHS without PbR (Farrar *et al* 2009). The introduction of PbR was associated with reductions in unit costs as indicated by reductions in inpatient length of stay and increases in the proportion of treatment provided as day cases, although the scale of the effects was small. The quality of care, as measured using patient-level administrative data (eg, in-hospital and 30-day mortality rates), was not obviously adversely affected by the introduction of PbR, indicating an overall improvement in efficiency that would not otherwise have occurred.

Despite the widely held view that the incentives in PbR consistently encouraged more hospital investigation and treatment, and inflated recorded levels of activity (Chapters 5 and 8), the evidence is less straightforward. For example, the comparison in 2004/5 of the activity in foundation trusts (subject to PbR) with that of non-foundation trusts (then not yet eligible to use PbR) showed that foundation trusts' spells did not increase relative to those of the non-foundation trusts (Farrar *et al* 2009). It is highly likely that policies other than PbR, such as waiting-time targets, stimulated the growth in the volume of care.

Further key findings from the evidence on the market reforms are that between 2003 and 2010:

- hospitals in areas with market structures where competition was more likely appeared to have experienced faster improvements in patient outcomes as assessed by mortality rates than those in areas with a less potentially competitive market structure, and without increasing their costs (Chapter 6)
- the offer of patient choice of place of elective treatment was made to about half of the eligible patients, was generally valued, seemed to have been made relatively equally to all patient groups (although selection of a non-local hospital was greater among the better educated) and was associated with faster reductions in waiting times in patients from lower socio-economic groups (Chapter 4)
- diverse (non-NHS owned) providers appeared to perform as well as NHS-owned providers, although the amount of evidence on the relative quality and efficiency of services was small (Chapter 2)
- the greater freedom given to NHS foundation trusts appeared to enable them to improve services through faster decision-making and the ability to invest any surpluses, although there was no evidence that the superior performance of foundation trusts compared with that of ordinary NHS trusts related to their status, as they had been chosen to become foundation trusts on the basis of stronger performance (Chapter 2)
- PCTs appeared to be influential in encouraging or discouraging new entrants in the local health system and in how they were managed to produce high-quality care (Chapter 2)

- there was no evidence that socio-economic equity of use of care had been harmed by the changes, at least in terms of the use of common elective services (Cookson *et al* 2010a, 2010b) (*see below for more on equity*).

One aspect of the reform package that appeared to have contributed little at system level was the entry of independent-sector providers both of hospital and ambulatory care services (Chapter 2). This was primarily because of the small share of activity provided by the independent sector in the period. As a result of the poor quality of the tendering process for the ISTCs, there is evidence that the NHS paid excessively for treatments, particularly from the first wave of ISTCs, without commensurately higher quality of care (Pollock and Kirkwood 2009).

There were some particularly unexpected effects, most notably that the most marked increase in the potential for competition between hospitals (Chapter 6) and take-up of individual patient choice (Chapter 4) appeared to occur outside the main urban areas rather than within them (this was obvious in retrospect, perhaps, given that there has always been greater scope for choice and potential for competition in the cities). There were also hints in the evidence of a difference between national and local studies, and between those tapping participants' perceptions of change and those using routine quantitative indicators of change. Crudely, the national, quantitative studies tended to show impacts of the reforms in the direction expected (Farrar *et al* 2009; Cooper *et al* 2010, 2011; Gaynor *et al* 2011), whereas more local studies that included qualitative data (Dixon *et al* 2010a; Powell *et al* 2011) tended to indicate that the market reforms were far from salient in the minds of many participants, were generally regarded as less important than other policies (particularly waiting time and financial targets), and were extensively critiqued and sometimes resisted. Many local actors emphasised their reluctance to allow competition to disrupt long-standing relationships in the local health care system, and highlighted the value of co-operation and collaboration across the local system as a preferred strategy for managing in a worsening financial environment while maintaining the quality of local services (Chapter 8).

One possible explanation for the differences between different types of studies is that they were differentially sensitive to the effects of other policy changes unrelated to the reintroduction of the market into the English NHS that also affected performance, thus making it very difficult to isolate the contribution of market competition, patient choice and activity-based payment of hospitals from other previous, parallel and later changes. This conjecture is taken up later in the chapter.

Did competition improve quality?

On the face of it, the most striking finding from all the evidence collected on the impact of the reintroduction of the market to the English NHS was that higher levels of potential inter-hospital competition appeared to be associated with a faster reduction in hospital mortality rates (Cooper *et al* 2011; Gaynor *et al* 2011).

This has probably been the most discussed and controversial finding from the period as it appears to show a positive effect of scope for competition on quality of care when prices for a proportion of hospital services are fixed under PbR. Research on the 1990s internal market, in which prices were locally determined, showed, by contrast, an association between greater potential competition and higher death rates (Propper *et al* 2008a). The authors of both studies carried out in the setting of New Labour's NHS market regard the contrasting findings from the two decades as a genuine demonstration of the merits of a more competitive health care market, particularly one where prices are fixed rather than negotiated locally. They argue that their findings are consistent with predictions from economic theory and the much larger empirical literature from the United States (Chapter 6).

However, the findings that hospital all-cause mortality and mortality from acute myocardial infarction appear to have improved faster in the latter part of the 2000s in areas with more potential for competition as measured by elective patient flows are puzzling because acute myocardial infarction admissions and treatments are emergencies, whereas New Labour's reinvented market system was meant to be driven by elective patient and GP choice. Why should emergency care be better delivered in potentially more competitive areas when none of the affected patients will have chosen their treatment destination? The authors of both studies point to another study that seems to show that the quality of hospital management is higher in NHS hospitals exposed to higher potential for competition (Bloom *et al* 2010b). They therefore hypothesise that higher-quality hospital management mediates the relationship between competition and lower death rates after emergency treatment across all services in more competitive areas.

The rationale seems to be that hospitals will sharpen their management practices when faced with increased competition or prevailing high levels of competition, and that better-managed hospitals are better both at treating elective and emergency cases because they have more robust systems. These more robust systems can be seen as the product of the higher quality of management in the more competitive areas. Another related possibility is that hospitals in more competitive areas may have taken steps to improve the quality of their elective services in order to retain or increase their market share in the face of PbR, which, in turn, requires changes in the organisation as a whole, affecting the delivery and quality of emergency services such as the treatment of patients with acute myocardial infarction.

While such reasoning is plausible in principle, there is some doubt about whether hospital management and clinical systems could have responded within only three years (the findings cover 2003/4–2007/8) to market policies and related incentives that were not functioning fully until around January 2006 at the earliest, that only applied to 60 per cent of acute hospital income in 2006/7 (Boyle 2007), and that were reported by managers in research interviews as being of only marginal importance compared with other policies such as financial and waiting-time targets (Powell

et al 2011). In addition, throughout the period of study, the NHS budget was growing rapidly, further taking the edge off competitive pressures.

Unsurprisingly, non-economists would tend to look elsewhere to try to explain these perplexing findings, for example, looking to see whether the results could be explained by patterns of clinical innovation unrelated to competition or the expectation of competition. One possible explanation for the pattern of association observed relates to initiatives taken in the 2000s to regionalise hospital care such as in the case of stroke, coronary heart disease, neonatal intensive care, adult critical care and cancers, all services with appreciable mortality (NHS London 2007; Durand *et al* 2010). In each case, the basic idea was to concentrate the more complex treatments in fewer centres in each regional network. It is plausible that these centres would have been selected on the basis of their previous performance, thereby increasing the proportion of patients treated at the best centres in order to try to improve outcomes. In such a situation, it is possible that improvements in outcomes at hospitals receiving more patients from other districts (ie, apparently competing more successfully for patients) were the result of NHS plans to regionalise services.

The Herfindahl-Hirschman index used to measure the potential level of competition in different areas in both studies is based on patient flow data, albeit for elective care since these were the services most likely to be exposed to choice and competition. A change in referral patterns away from the local hospital is interpreted as an increase in spatial competition. So, the effect observed could be related not so much to competition or increases in competition, but rather to the opposite, a planned attempt to direct patients towards high-quality, high-volume centres. For example, adult critical care was 'networked' and achieved significant improvements in quality (mortality) during the 2000s, but there was no element of market forces/competition for that service (Durand *et al* 2010).

Likewise, acute myocardial infarction mortality (used by both Cooper *et al* 2011 and Gaynor *et al* 2011) risks being confounded as an indicator of the impact of competition and/or increases in competition by the introduction of primary angioplasty (a central policy initiative of the Department of Health), which concentrated care in specific providers with the appropriate expertise. As a result, in England and Wales in 2004, for example, only 5 per cent of acute myocardial infarctions were so treated, but by 2007 this had risen to 20 per cent as a result of clinical and organisational policy change (West *et al* 2011). The number of angioplasties for myocardial infarction increased almost eight-fold between 2003 and 2009 (West *et al* 2011). In a recent extension of their analysis, Gaynor and colleagues have tested whether their findings could have been confounded by such changes in cardiac care (Gaynor *et al* 2011). They find no such effect and, in fact, an indication that the competition effect is stronger when controls are introduced for changes in treatment patterns, reinforcing their original conclusion that greater competition is driving improvements in hospital care.

As well as the direct effects of competition, in a competitive market there is normally a system of regulation designed to encourage high standards and prevent standards from falling below an agreed minimum level. This is particularly important in health care, in which the quality of services is hard to measure and difficult for users to judge. Unfortunately, the evidence on the performance of the rapidly changing series of quality regulators in the 2000s is limited and hard to interpret, but tends to raise doubts about whether the system of quality regulation was capable of assuring patients and the public that competition was on the basis of a guaranteed high basic standard of care (Chapter 7).

Did competition harm equity?

If the reintroduction of a provider market appears to have been associated with improvements in quality and efficiency, this still leaves the risk of widening inequity in the use of services given that PbR gave hospitals incentives to reduce cost for elective surgery (Chapter 5).

Cookson and Laudicella (2011) examined whether hospital patients living in small areas of low socio-economic status cost more to treat in order to see if there were *a priori* grounds to expect so-called cream-skimming. They found that there were potential incentives for competing hospitals to 'cream-skin'. Despite this, they found no obvious change in socio-economic equity of use from 2001/2 to 2008/9 for elective procedures, and some signs that equity might have improved slightly as inpatient admission rates rose slightly faster in low-income areas than elsewhere (Cookson *et al* 2010b). These findings are also consistent with another recent study using routine patient-level data, which showed that socio-economic equity in colorectal, breast and lung cancer procedures changed little between 1999 and 2006 (Raine *et al* 2010).

Similarly, another longitudinal study using routine NHS hospital data looked at socio-economic variation in NHS hospital waiting times for hip replacement, knee replacement and cataract surgery between 1999 and 2007, a timespan that covered both the period when New Labour drove reform exclusively through targets and top-down performance management, and later when it had reintroduced the quasi-market alongside its other policy instruments (Cooper *et al* 2009). Its authors found that the deprivation gradient of waiting (ie, people in more deprived areas tending to wait slightly longer than those in less deprived areas) at the beginning of the period had disappeared and might even have slightly reversed by 2002 (the heyday of 'targets and terror'), and that little had changed thereafter when the market was reintroduced.

One explanation for the findings of Cookson *et al* (2010) and those of Cooper *et al* (2009) is that the pressure to meet waiting-time targets that began before the market reforms and persisted throughout the reform period was having a greater effect than any consequence of private-sector entry and/or competition. This is consistent with

the findings of local case-study research on the impact of the reform mechanisms by Powell *et al* (2011), and with the Civitas analysis that the NHS market operated in only isolated pockets and for only a small number of services (Brereton and Gubb 2010). It is therefore possible that the lack of any rise in inequity associated with market competition in the 1990s and 2000s occurred not because the NHS market was designed to prevent or even reduce inequity, but because it was operating only weakly. If true, such an inference has major implications for the future impact of the market given that the coalition government aims to implement a fully-functioning market in the English NHS (*see* Chapter 10).

Overall verdict on the impact of the market reform

Despite the strong overlay of previous hierarchical policies driven by targets and performance management, New Labour's market appeared to contain stronger incentives for quality and efficiency than did its 1990s' predecessor – as exemplified in the system of PbR with its encouragement to provider competition for patients, but without any obvious incentives to reduce quality – and these effects seem to have gathered pace during the period up to 2010, as the more recent studies reviewed here tended to find more positive results than did earlier assessments (Audit Commission and Healthcare Commission 2008), suggesting that it took a number of years for the changes announced in 2002/3 to begin to have their impact.

It is interesting in this regard to note the findings of parallel studies of organisational culture in the NHS, which report an increase in the proportion of NHS trusts displaying a so-called entrepreneurial organisational culture and a decrease in the proportion displaying a tribal, inward-looking culture over the same period (Mannion *et al* 2009), suggesting that market thinking and behaviour became more deep-rooted in the 2000s than in the 1990s. This is likely to continue since the coalition government of May 2010 is committed to accelerating and deepening the extent to which the English NHS sees itself and behaves as a regulated provider market.

Quality of, and gaps in, the evidence

During the early 1990s, Kenneth Clarke, as Conservative Secretary of State for Health, resisted pressure both to pilot his radical internal market proposals and then to commission evaluation of the impact of the subsequent legislation. Instead, it was left to The King's Fund to commission its own independent research (Robinson and Le Grand 1994). By contrast, it is to the credit of the New Labour government that, in 2006, it commissioned a programme of evaluation of its post-2002/3 reforms, which has formed the backbone of this book. The studies in the Health Reform Evaluation Programme covered all the reform mechanisms, with the exception of primary research on the impact of the new quality and financial regulators, and, to a lesser extent, attempted to study the interaction of the mechanisms. However,

as is almost always the case with major public policy reform, both proponents and detractors would like more, and more definitive, evidence on the impact and the causal pathways leading to those impacts.

Despite the fact that the Department of Health was willing to fund a substantial programme of independent research on the impact of the reforms, the number of studies on the changes is still very small in relation to the extent of change in the period and the potential benefits and risks of the reforms. For example, there is only a handful of quantitative studies of the NHS hospital market as a whole over time (Farrar *et al* 2009; Cooper *et al* 2010, 2011; Gaynor *et al* 2011) compared with the evidence available in countries such as the United States. It is to be hoped that the longitudinal evidence on the impact of market-related policies on a tax-financed system will accumulate rapidly in future as the coalition government continues with market-based reforms.

On the other hand, calls for more, and more definitive, research tend to overlook or downplay the many challenges encountered in evaluating major health care system change, all of which have affected the evidence presented in this book. The main difficulties were:

- dealing with the fact that the reforms were simultaneously introduced across the whole of England rather than being piloted or phased in particular regions
- determining when the market reforms were fully operational and, therefore, should be evaluated for their impact, given that they were introduced in stages over time and that some elements such as the quality regulator were introduced before the market itself had been reconstituted; the entire package of market-related changes was not fully operational until early 2006 at the earliest, leaving a relatively short period of time to fund and undertake studies, and observe changes
- separating out the impact of the different elements in the reforms, particularly the independent contribution of individual patient choice of place of elective treatment versus the staged implementation of PbR, and the impact of changes to commissioning versus policies directly targeting the providers of care
- deciding how to attribute the changes observed to particular policies, and to the market reforms in particular, given the lags between the introduction of the changes and their possible effects, the instability in institutional settings, especially commissioning organisations and regulatory bodies (with constant reorganisation of PCTs and the quality regulator during the 2000s), and the contemporaneous impact of other unrelated policy changes, such as the introduction of a new GP contract involving payment for quality, national service frameworks and increases in funding
- measuring (and trading off) the different impacts of the reforms when many of the studies described in the rest of the book are reliant on national-level

administrative datasets; although there is evidence that these datasets have been improving in the recent past, they frequently lack crucial information, for example, there are few proxy measures of care quality and outcomes in the English hospital episode statistics (eg, in-hospital mortality, wound infection rates), and efficiency (eg, day-case rates and lengths of stay)

- how to interpret the 'black-box' findings of national-level quantitative studies based on administrative data using qualitative case studies based largely on participants' perceptions.

Despite the many difficulties of reaching definitive conclusions on the reforms, their design and implementation held a number of advantages for evaluation that should not be ignored, especially those relating to the:

- phased implementation of the changes over time (eg, the gradual extension of PbR to different specialties in particular)
- the natural experiment of market changes in England, but not in Scotland (eg, there were no comparable market changes such as PbR in Scotland).

Both these characteristics of the implementation of the market reforms were able to be used positively in the evaluation studies in the Health Reform Evaluation Programme. Nonetheless, there are ways in which future evaluation programmes might be improved. In particular, more adaptive models of research could be encouraged that could respond flexibly to a changing policy context. There is much that should be done to speed up access to administrative data and research governance permissions to allow researchers to interview staff and patients. There may also be scope to undertake interviews with policy-makers and implementers in real time to avoid *post hoc* rationalisation of the effects of reforms. Finally, there is an increasing need to undertake studies that explicitly relate large-scale, quantitative analyses using administrative datasets to more in-depth investigations designed to help explain the quantitative findings.

Challenges apparent by 2010 and requiring further development of market policies

Based on the situation of the English NHS at the end of New Labour's time in office, Brereton and Gubb (2010) from free-market think-tank Civitas concluded that there were still too many barriers to the operation of a market for NHS services rather than there being a fatal flaw in the concept. Indeed, arguably, there had been a slowing down and even a partial reversal of pro-market policy in the NHS at the end of the period, when Andy Burnham was Secretary of State. The distortions they highlighted were:

- power imbalances between PCT commissioners and providers, particularly acute NHS trusts

- the lack of a level playing field between NHS and non-NHS providers to the detriment of the latter (Burnham had weakened the government's commitment to any willing provider being able to offer its services to treat NHS patients as long as it could meet NHS quality standards and the PbR tariff price)
- continuing perverse incentives under PbR to admit patients who would be better off out of hospital.

They further argued that there were still too many restrictions on non-NHS providers entering the NHS market, and a lack of skills relevant to working in a market among both commissioners and providers. The implication of their analysis was that freeing up the NHS market further would alter the balance of benefits and costs of the market changes in favour of the former. Arguably, this is exactly what the coalition government's proposed reforms are designed to do (Department of Health 2010). Broadening the scope and degree of provider competition for NHS services raises many challenges, not least a major improvement in the information on the quality of care offered by different providers so that patients and commissioners can make better-informed choices, and the ability to develop services for people with complex chronic conditions requiring co-ordination between providers rather than competition. These and other challenges are discussed in the final chapter in the light of the evidence on the implementation and impact of New Labour's market reforms assembled in the previous chapters.