1 Return to the market: objectives and evolution of New Labour's market reforms

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Market-like mechanisms began to be introduced into the National Health Service (NHS) in England from 2002. Aimed at improving system performance, these interrelated policy changes comprised:

- giving patients a choice of provider
- stronger commissioning (including practice-based commissioning)
- greater provider diversity
- increased autonomy for publicly owned hospitals
- activity-based payments for acute providers (so-called Payment by Results)
- revisions of the regulatory framework.

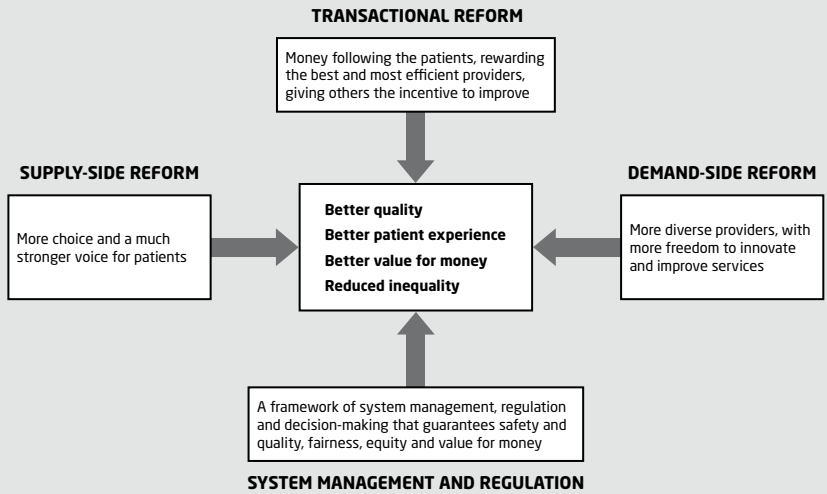
This package of policies was intended to create a system that was patient-centred and 'self-improving' (Department of Health 2005a) (*see* Figure 1 overleaf). The key objectives were better care, better patient experience and better value for money.

Although similar in some respects to the internal market reforms introduced between 1991 and 1997 by the then Conservative government, these changes went further towards creating a market (rather than simply an internal market). For example, because individual patients were now being offered a choice of hospital for elective care, it was their decisions, rather than those of a third-party commissioning organisation, that became the drivers of the allocation of some of the resources.

The aim of this book is to review the evidence on the implementation and impact of the market-related reforms in the English NHS under New Labour. This is important for two reasons:

- New Labour's changes represented a major attempt to improve an iconic public service using market-related incentives
- the coalition government is currently pursuing a very similar logic in its own proposed reforms.

Figure 1 The framework for NHS market reforms begun in 2002



Source: adapted from Department of Health 2005a

The experience of the latter part of the 2000s should therefore provide valuable insights into the challenges and potential benefits that the coalition's changes are likely to bring.

At the core of the review of the evidence are the studies of different aspects of New Labour's reforms that were funded by the Department of Health through the Health Reform Evaluation Programme and undertaken between 2006 and 2010. One of this book's editors (Mays) was the scientific co-ordinator of this programme.

The remainder of this chapter introduces the market reforms and considers how they differed from the internal market of 1991–7. It also discusses the rationale underlying the reforms, and the concerns raised by commentators when they were introduced. It concludes with an overview of the structure of the book, and the approach taken in each chapter to evaluate the market reforms.

The internal market 1991–7

The idea of introducing market-like incentives into the NHS was first posited by Alain Enthoven (1985). It was intended to motivate improvements in efficiency and patient responsiveness while maintaining a tax-financed system that provided universal free access to health services. In 1989, the Conservative government led by Margaret Thatcher published the White Paper *Working for Patients* (Department of Health 1989), which outlined the introduction of an internal market in the NHS. This became law as the NHS and Community Care Act 1990, and the internal market was implemented with effect from April 1991.

It was structured around a novel separation of the roles of purchaser and provider within the NHS. District health authorities (DHAs) became the main purchasers. They were financed according to the needs of their resident populations, and were free to buy hospital and community health services from any provider, whether in the public, private or voluntary sector (although the vast majority of NHS services continued to be provided by the public sector).

Acute hospitals and other NHS providers (eg, of mental health services) became 'trusts', statutory corporations free from DHA control. Trusts were funded on their ability to win contracts to undertake an agreed amount of work for a DHA at a locally negotiated price. The theoretical incentive for providers was, therefore, to minimise costs and maximise quality in order to stay in business.

At the same time, general practitioner (GP) practices could opt to become 'fundholders', allowing them to hold their own budgets for the non-emergency hospital outpatient and elective surgical, diagnostic and pharmaceutical care of the patients on their lists. They were expected to act as informed agents on behalf of their patients, securing timely access to care from providers, and to negotiate their own secondary care contracts, decide which providers, services and patients would benefit from their funds, and keep any surpluses generated (Kay 2002).

Despite being widely heralded as the most radical change in the NHS since its inception (Butler 1992); the NHS internal market did not produce the degree of measurable change predicted by proponents and feared by opponents (Mays *et al* 2000). In terms of efficiency, there is some evidence that the costs of providing hospital services fell faster than in the previous decade (Mulligan 1998) and that productivity (the ratio of outputs to inputs) rose (Söderlund *et al* 1997), although management and administrative costs increased, driven by the need to negotiate and monitor contracts between purchasers and providers (Paton 1995).

In terms of equity, there was little evidence of the discrimination against chronically ill or high-cost patients that critics of the internal market had feared. However, there is little doubt (though also little good research) that a 'two-tier' system did operate. GP fundholders used their budgets to extend the services available within their own premises and, on average, secured shorter hospital waiting times for their patients than did health authorities (Dusheiko *et al* 2004). Nevertheless, the waiting time for inpatient treatment (especially those longer than 18 months) fell for all NHS patients during the 1990s.

There is little evidence on the impact of the internal market on the quality of care. Propper *et al* (2004, 2008a) showed that hospitals in the 1990s operating in areas with higher levels of competition appeared to produce poorer patient outcomes, at least as measured by indicators such as death rates after surgery for heart disease. They concluded that price competition had not resulted in quality improvements.

The principal explanation for the limited impact of the internal market lies in the way it was implemented. As one systematic evaluation concluded: 'the incentives

were too weak and the constraints too strong' (Le Grand *et al* 1998, p 130). Central government limited the impact of competition between providers, particularly because allowing inefficient providers to fail or close might have threatened other goals such as equity of access, or caused political embarrassment. The exception was GP fundholders, who were given the freedom to change the pattern of referrals and shift resources accordingly, in part because they accounted for a relatively small proportion of the workload of any single hospital. During this period, the NHS was driven at least as much by central directives (eg, on reducing waiting times) as by the internal market.

Another limitation of the internal market concerned the provision of information, what Enthoven (2000) calls 'the oxygen of markets' (p 106). This significantly curtailed the potential of the internal market to produce improvements in quality. As Enthoven notes: 'Data on pediatric heart surgery mortality at the Bristol Royal Infirmary, for example, apparently were not available to the local health authority, which meant that the authority could not stop buying services from a provider with an unacceptably high mortality rate' (p 108).

Whatever the internal market might have failed to achieve, it is clear that it brought fundamental changes to the culture and operation of the NHS. Providers had to be far more aware than in the past of the quality and cost of what they provided. Purchasers came to question traditional ways of providing services and encouraged providers to think of new models of care that were more relevant to the needs of patients, such as the development of specialist outreach services in the community, early discharge schemes, shared and intermediate forms of care between hospitals and general practices, the use of skilled nurse practitioners rather than medical staff, and so on. GP fundholding significantly increased the ability of GPs to influence the way in which hospital specialists provided care to their patients. It also increased the degree of communication between primary and secondary care (Glennerster *et al* 1994; Smith *et al* 2004; Smith *et al* 2005).

Labour's approach to the market: the early years

In May 1997, New Labour came to power. Under its leadership, NHS reforms continued, but with a new focus on collaboration rather than the competition-based system that the preceding Conservative government had championed.

The new government began by claiming to abolish the internal market, which it regarded as an administratively wasteful failure. However, one core feature remained intact – the separation of purchasers and providers – although the term 'purchasing' was removed from the NHS lexicon to be replaced by 'commissioning', in order to reflect a shift away from simply buying from the existing range of services offered by providers, towards developing new and better services by working with providers to improve their ability to meet the needs of the local population.

GP fundholding was abolished on the grounds that it had led to a 'two-tier' service, and primary care groups involving all GPs were established. These groups had indicative budgets, and were intended gradually to take over the responsiblility for commissioning from the health authorities. They eventually became statutory bodies with their own budgets in the shape of primary care trusts (PCTs), and replaced health authorities as the principal commissioners of NHS services at local level.

In this way, New Labour appeared to share the Conservatives' support for the concept of giving primary care providers responsibility for purchasing and organising most of the health care needed by their patients. However, during the first term of the New Labour government, particularly when Frank Dobson was Secretary of State for Health, the focus of health policy was on securing national standards of quality, and against provider competition of any kind. Between 1999 and 2002, two new regulatory and oversight organisations were established – the Commission for Health Improvement (CHI) (which later became the Healthcare Commission and is now the Care Quality Commission(CQC)) and the National Institute for Clinical Excellence (which later joined with the Health Development Agency to become the National Institute for Health and Clinical Excellence) – and the first national service frameworks (NSFs) were introduced. The last were evidence- and professional consensus-based articulations of what a 'good' service for a particular condition or patient group should look like, and were influential with both commissioners and providers.

During this time, the thrust of reforms was marked by a strong focus on top-down policy-making that saw the setting of national standards (through NSFs) and targets (eg, for reducing waiting times) as a means of standardising care across providers (Stevens 2004).

The period was also one in which the government stuck with the tight spending plans for the NHS that it had inherited from the Conservatives. It was not until 2000, following Tony Blair's announcement that per capita spending on the NHS would rise to match the EU average, that there was significant growth in the NHS budget.

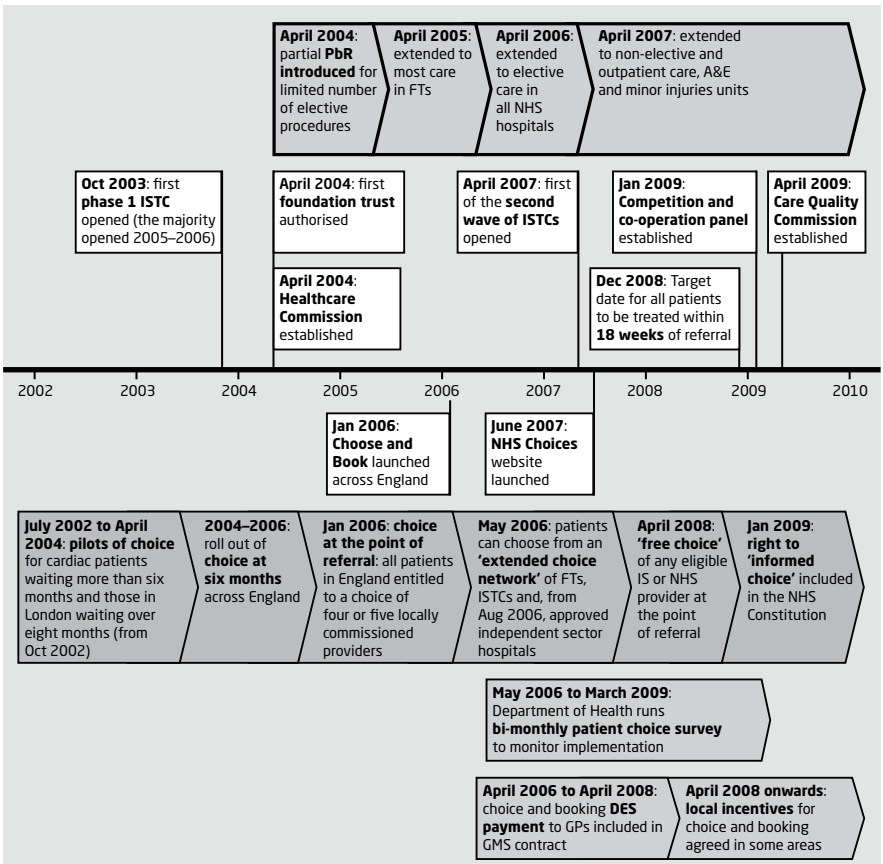
The Labour government decided to pursue a policy of 'investment and reform' in the English NHS (with effect from 1999 the responsibility for NHS policy in Wales and Scotland had passed to the Welsh Assembly and Scottish Parliament, respectively) to ensure that the increased spending delivered the desired results, particularly on the 1997 election promise to shorten waiting times. By 2002, a consensus appears to have formed among ministers and their advisers that the existing 'command and control' policies, such as the setting and enforcement of targets, had reached their limit of likely impact and needed to be augmented by other policy instruments. There were fears that the increased resources would be dissipated and would not generate a commensurate improvement in performance without further support. The conclusion was reached that a return to a greater emphasis on supplier competition was required to make the most efficient use of resources and meet

patient and public expectations (Stevens 2004). Thus the market reforms can be seen as an attempt to 'sharpen' the incentives in the system to ensure that large increases in funding would deliver tangible improvements in performance.

Labour's market reforms

Labour's reintroduction of explicit market-like mechanisms was a gradual, pragmatic process rather than a one-off overarching 'big bang' set of reforms (*see* Figure 2 below). On the commissioning side of the NHS market, PCTs were established in 2002 (Walshe *et al* 2004) and given the responsibility for commissioning NHS services on behalf of a defined geographical population. Their budgets were allocated in relation to the relative needs of their populations.

Figure 2 Policy timeline



Source: Dixon *et al* 2010a

PbR: Payment by Results; FT: foundation trust; A&E: accident and emergency department; ISTC: independent-sector treatment centre; IS: independent sector; DES: directed enhanced service; GP: general practitioners; GMS: general medical services

From 2004, PCTs were required to devolve part of their budgets to general practices (under a scheme called practice-based commissioning). This once again allowed GPs to shape the pattern of local services directly, although the budgets they were given were indicative and the PCT remained responsible for the contracts and spending of the practice-based commissioners.

Following a reorganisation in 2006, the number of PCTs was reduced from 303 to 152, many of which were co-terminous with local authorities.

From as early as 1999, the Department of Health had introduced NHS diagnostic and treatment centres – stand-alone centres on NHS hospital sites specialising in routine diagnostics and high volumes of low-risk, straightforward operations that did not require hospital admission – in order to accelerate the reduction of waiting lists and times. This programme was extended in 2002 to include nationally commissioned surgical treatment centres provided by the private sector. While the independent-sector treatment centres (ISTCs) were a further contribution to the task of expanding and speeding up elective surgery by increasing the capacity available to the NHS, it was also significant that they represented an alternative to NHS providers, signalling the government's growing willingness to allow greater competition in the treatment of NHS patients in the future.

The NHS Plan (Department of Health 2000b) stated that patients would be able to choose the times and dates of their hospital appointments, but this was initially about increasing convenience for patients, not about driving competition. From 2002, with the publication of *Delivering the NHS Plan: Next steps on investment, next steps on reform*, patients were offered the choice of being treated by an alternative provider if they could not be treated within six months by the NHS, as a way of reducing waiting times and making better use of existing capacity (Department of Health 2002a). In *The NHS Improvement Plan: Putting people at the heart of public services*, published in 2004, the aim of offering patients a choice of provider so as to reduce waiting times was broadened to encompass improving patient responsiveness, increasing efficiency and improving quality (Department of Health 2004d). From January 2006, NHS patients were to be offered a choice of five providers at the point of referral, of which at least one had to be from the independent sector. In January 2008, this was extended yet further to the choice of any accredited provider (so-called 'free choice').

In order that money could follow the patients and provide an incentive for efficient providers to increase throughput, the NHS introduced an activity-based payment system for hospitals known as Payment by Results (PbR). The system of fixed national prices was based on health resource groups – the UK adaptation of the US system of diagnosis-related groups. The fixed price for each health resource group was calculated on the basis of average costs.

PbR was gradually introduced from 2003/4, initially in higher-performing NHS trusts known as foundation trusts (*see* below), with the intention of moving, in due

course, to a system in which all NHS activity would be paid for using a standard tariff. It was introduced first for elective care, followed by emergency care, and attendance at and procedures in accident and emergency departments (A&E) and outpatient clinics. By 2006/7, the tariff had been extended across all NHS providers to cover admitted patient care, and outpatient and A&E attendances. However, even within the acute hospital sector, many activities continued to remain outside PbR, including critical care, mental health care, community health services, ambulance services and primary care. In 2009/10, only £26 billion of English NHS activity, out of a total of £105 billion, was paid for under PbR (House of Commons Health Committee 2010b).

From 2003, high-performing NHS trusts were given the opportunity to apply to become free-standing, non-profitmaking, public benefit corporations known as NHS foundation trusts. These remained part of the NHS, but were given greater financial and managerial freedoms (eg, they could borrow from the private sector up to limits set by the regulator, and develop joint ventures with the private sector). Unlike ordinary NHS trusts, the Secretary of State for Health cannot direct foundation trusts. Instead, an independent economic regulator known as Monitor, established in 2004, authorises them and oversees their compliance with authorisation. It was intended that all NHS trusts should achieve foundation status by 2014.

New Labour had already established a quality regulator for NHS trust care before embarking on the gradual reintroduction of market forces. The Commission for Health Improvement had been established in 2000 to oversee the quality of local services and remedy shortcomings. It was replaced in 2004 by the Healthcare Commission, which was responsible for monitoring the performance of NHS providers against a set of quality and safety measures, as well as for ensuring that independent providers met minimum safety and quality standards. In 2009, it was superseded by the Care Quality Commission. Created from an amalgamation of the existing inspectorates responsible for health care, mental health and social care, the Care Quality Commission is responsible for the inspection and quality regulation of all health and social care providers, both public and private, in England.

It is apparent from this very brief narrative that the (re-)emergence of the market under New Labour occurred gradually. It was only fully articulated as a coherent set of reforms in 2005 (*see* Figure 1, p 2). *Health Reform in England: Update and next steps* (Department of Health 2005a) presented the different elements of the emerging market as a package of interrelated reforms designed to 'embed within the healthcare system incentives for continuous improvement (p 15)'. The ambitious aims of these reforms can be summarised as: improving quality of care, improving patient experience, improving value for money, and reducing inequality. The main elements of the reform package are summarised in Table 1, opposite, and are the focus of this book.

Table 1 Components of New Labour's NHS market reforms by 2005

Supply-side	■ The development of more diverse providers of clinical services, including independent-sector treatment centres ■ Greater independence and autonomy for publicly owned providers as foundation trusts
Demand-side	■ Primary care trusts responsible for commissioning the majority of NHS services ■ General practices delegated budgets for specific services, called practice-based commissioning ■ Patients given a choice of provider at the point of referral to secondary care
Transactional	■ Activity-based payment for hospitals called Payment by Results, comprising a fixed price based on average costs
System management and regulation	■ Foundation trusts subject to authorisation by the independent regulator Monitor ■ The performance of primary care trusts assessed by the Care Quality Commission and strategic health authorities ■ Minimum safety and quality standards enforced by the Care Quality Commission

Comparing the internal market of the 1990s with New Labour's market

Table 2, below, summarises the differences between the market introduced by the Conservatives in 1991 and the market reforms instigated by New Labour. Although

Table 2 Differences between the 1991 and 2002 market reforms

NHS market, 1991–97 ■ Patient choice restricted to fundholding GPs	**NHS market, 2002–10** ■ Patient choice of elective provider
Health authority purchasing ■ Contracts not subject to contract law	**Primary care trust commissioning** ■ Contracts legally binding
Fundholding ■ Voluntary ■ Fundholders able to retain surpluses	**Practice-based commissioning** ■ Universal, at least for primary care trusts ■ Intention that any surpluses be shared with primary care trust
NHS trusts ■ Some price competition ■ Unable to retain surpluses ■ In practice, access to new sources of capital restricted and not free to borrow commercially	**Foundation trusts** ■ Paid increasingly using fixed prices under Payment by Results ■ Surpluses can be retained to reinvest ■ Commercial borrowing possible within limits
Evaluation ■ No independent evaluation studies until late in the reform process	**Evaluation** ■ Programme of independent evaluation studies commissioned by Department of Health

the legislation to create the original NHS trusts was similar in many regards to the legislation to create foundation trusts, the latter went further, breaking the link of accountability to the Secretary of State and creating new local governance arrangements. In the internal market, independent regulation and systems of performance management were underdeveloped. The establishment and growth in the number of independent regulators of public services is a marked feature of the Labour government's period in office (Thorlby and Maybin 2010). Under the Conservatives, general practice fundholding was explicitly voluntary, whereas all practices were nominally participants in PCTs and were represented in the professional executive committee of the PCT, because the Labour government wished to bring the advantages of the previous GP fundholding scheme to all registered patients. On the other hand, like fundholding, the later practice-based commissioning scheme was also voluntary to some degree, at least for practices, if not for the PCTs. The government required all PCTs to implement it, but some did so more enthusiastically than others (Curry *et al* 2008).

For all the policy rhetoric about giving patients more choice, the reality for non-fundholding GPs in the 1990s internal market was that their referrals were limited to those hospitals with which their health authority had contracts. Thus for many GPs it seemed as if there were less, not more, choice. Under Labour, patient choice was supported by incentives for GPs and a new electronic referral and booking system called Choose and Book. There was also investment in information support to help patients to choose providers on the basis of indicators of the quality of their care.

Unlike the 1990s internal market, in which prices were negotiated locally, within the New Labour market there was no price competition, at least for the services included in the PbR scheme. By giving patients a choice of provider, and introducing competition under fixed prices, the Labour government sought to strengthen the incentives for efficiency, responsiveness and quality, and address some of the constraints on the impact of the 1990s internal market.

Critique of the market reforms

The market reforms were based on the view that competition among providers creates incentives for them to improve the efficiency and quality of their services to meet the demands of purchasers, and that this process can be made to occur in publicly financed health care markets. However, even advocates of health service markets acknowledge that there are features of health services that make them more susceptible to market failure than are many other goods and services. The emergent, contingent, variable and uncertain nature of health care means that, 'unlike computers or hotel rooms, no clear product can be defined and its price set' (Light 1997). There is also considerable information asymmetry ('quality' of service is hard to define and measure, even for experts, never mind for individual patients, and providers tend to have far better knowledge of the quality of their care), few

buyers and sellers of hospital services, and significant barriers to entry and exit, particularly in the case of hospitals.

For these reasons, both the internal market of the 1990s and New Labour's reforms were designed in ways that attempted to capture the benefits of market incentives while anticipating some market weaknesses through policies to shape and regulate the market. The expectation was that individual patient choice of elective care and well-informed commissioners, when combined with PbR, would encourage hospitals to compete for patients by improving the quality of their services rather than reducing their prices, as prices, at least for services covered by PbR, were fixed. The creation of foundation trusts was intended to give providers the independence and flexibility to respond to changing patterns of demand. The two regulators – Monitor and the Healthcare Commission – were to ensure that providers were managed in a financially prudent manner and did not skimp on quality. The aim was that, on the one hand, providers of all types (public and private) would compete on level terms to attract patients on the basis of the accessibility and quality of their services, and, on the other, commissioners and individual patients, advised by their GPs, would be capable of shaping provision to meet their needs.

Not surprisingly, the assumptions made by the proponents of the market reforms were not universally shared, and many parts of the reform package were extensively debated. A number of commentators questioned whether a greater choice of provider was really deemed important by patients, arguing that patients would prefer good quality local services (Fotaki *et al* 2005; Clarke *et al* 2006; Greener 2007).

Others challenged the fundamental assumptions underlying patient choice policy, particularly that patients are willing and able to be active consumers making rational choices (Greener 2007; Greener and Mannion 2009b). Greener, for example, argued:

> *… choice processes for health do not operate in the same way as they do in other services – they occur in a social setting where the support of family and friends is crucial, and so, as a result, narrowing them to an individualistic process which does not take account of these factors ignores the importance of individual support networks that are so crucial in welfare.* (Greener 2007, p 256)

Similarly, drawing on a previous empirical study, Clarke concluded that people recognised that health services were 'not like shopping':

> *Such services were needed in conditions of distress or illness (rather than being pursued as a choice); they were viewed as fundamentally relational rather than transactional; and they had a public as well as a personal character – people recognised that services had to deal with multiple and competing demands with finite resources (and that some of those other demands might be more pressing or urgent than their own needs).* (Clarke 2008, p 251)

Others argued that the choice policy did not consider the potential negative effects of (more) choice on individuals. For example, patients might experience anxiety

when faced with having to choose from a range of options, particularly if they did not feel qualified to make such choices or did not wish to choose for themselves (Schwartz 2004; Clarke *et al* 2006).

Other arguments concerned the nature of health care markets in general, and of the NHS in particular, which work to attenuate beneficial incentives and produce undesirable outcomes. For example, some commentators suggested that, in the NHS, patient choice would be limited by capacity constraints, and that increasing capacity (eg, by encouraging new providers from the private sector) could increase costs without improving efficiency (Fotaki *et al* 2005). Indeed the creation of spare capacity could reduce efficiency through stimulating supplier-induced demand as providers attempted to make financially rewarding use of their assets (Edwards 2005).

Another anticipated problem was the lack of available and appropriate public or professional information on the quality of care offered by different providers (Appleby *et al* 2003). Information on the quality of care provided by different providers is essential for informed choice and effective commissioning, but, in health care, providing information for patients, and commissioners, is a complex task. While information on waiting times is relatively straightforward, other performance indicators are more difficult to interpret. For example, does a high rate of medical errors indicate poor quality care or a good safety culture encouraging fuller reporting by staff? The provision of public information may also have unintended consequences. Suppliers may respond by improving performance only in those areas that are measured, by avoiding patients who are likely to harm their performance, or by manipulating performance figures (Smith 1995; Propper *et al* 2006).

Perhaps the primary concern with the market reforms was their potential adverse impact on equity, a key objective of government policy. Competition in other markets places a premium on information and mobility, thus privileging higher socio-economic groups (Besley and Ghatak 2003). It was argued 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.

However, others argued that the offer of individual choice as part of the reforms would improve equity since it would raise the quality of *all* services, not just the services used by the better off. Le Grand (2007), for example, suggested that the movement of as little as 5–10 per cent of users should be enough to provide an incentive for all providers to improve the quality of their services. He also argued that offering individual patient choice to all NHS patients would improve equity since it would make choices available to all rather than only those able to afford to pay for care in the private sector.

There were other ways in which market reforms could create inequalities in access. As Klein observed:

> *The logic of the new NHS model is, in short, that it is the market which will determine the menu of options available to patients: so, for example, it may reduce the options available in any geographical area if it leads to the closure of local hospitals or a cut in the range of services they provide. This raises the question of whether there are any balancing mechanisms that allow collective – as distinct from individual – preferences to be articulated.* (Klein 2006, p 234)

According to economic theory, markets create incentives for improving quality and micro-efficiency, but they cannot necessarily be expected to address the need for strategic planning. On the other hand, the continuing influence of the state on decision-making – inevitable in a tax-financed system where public accountability resides with the Secretary of State and thence to parliament – tends to act to attenuate market incentives. For example, the temptation for central government to intervene to reverse politically unpopular local decisions to close services removes the threat that a service might be terminated on the grounds of weak financial viability.

Analyses of the internal market under the Conservative government had suggested that it could best be understood as a 'relational market' (Ferlie 1994; Tuohy 1999). These analyses emphasised the socially embedded nature of the publicly financed health care market where social networks based on trust were used to manage the inherent uncertainty of health care and the interdependence of organisations. The persistence of social ties, manifested as so-called 'sticky' referral patterns and patient loyalty to local providers, also restricted the extent to which a fully functioning market could develop.

Conversely, it was feared that market incentives would eventually create an adversarial environment that would break these social ties, destabilising local health economies and inhibiting the development of integrated forms of care. Commentators argued that while market incentives might be feasible in the case of discrete procedures such as elective surgery, other areas, such as the management of long-term conditions, would require collaboration rather than competition to provide continuity of multidisciplinary care, and that the market as constituted by New Labour was poorly fitted for this task (Ham 2007; Roland 2008). Roland, for example, argues:

> *The greatest demand on the future NHS will be to provide high quality co-ordinated care for patients with multiple chronic diseases. Recent NHS initiatives have increased the range of providers in both primary care (eg, walk-in centres) and secondary care (eg, independent-sector treatment centres). This has the potential to worsen co-ordination of care – an area in which UK performance is already poor compared with other countries.* (Roland 2008, p 626)

Reviewing the evidence on the impact of the market reforms

This book aims to review the implementation and evidence of the impact of the English NHS market reforms introduced under New Labour up to 2010 to see whether the concerns of critics and the hopes of proponents have been realised. It considers the following questions in relation to each element of the reforms:

- What were the intended aims of the reforms?
- How were the reforms implemented?
- To what extent have the intended aims of the reforms been realised?
- Were there any unexpected consequences of the reforms?
- What are the implications for the coalition government's reforms?

The impact of the market reforms is evaluated in terms of their effects on the efficiency, quality and effectiveness, responsiveness and equity of health care provision. These criteria have been chosen to capture the objectives of the New Labour government as well as because of their bearing on the general criteria that would be used to assess the performance of any public health care system. Nonetheless the exercise is not an easy one. The above criteria are subject to different interpretations and can be measured in different ways (Baggott 1997).

Furthermore, the evaluation of specific sets of changes in dynamic systems such as the NHS will always be problematic for the following reasons:

- reforms tend to have multiple, broad objectives, making measurement of impacts difficult because there is rarely a simple 'bottom line'
- reforms are seldom fixed, tend to be 'emergent' and prone to be overtaken by other changes
- it is difficult to disentangle the effects of one set of changes from previous, overlapping and subsequent changes as system reforms are rarely introduced experimentally or with any concern for their evaluation
- it is challenging to assess the relative contribution of each of the reform elements to the overall impacts described
- the processes and impacts of reforms tend to vary depending on the local and service contexts
- reforms tend to be politically and intellectually controversial since deeply held values are often at stake and, as a result, the evidence is subject to detailed criticism and counter-criticism.

With these challenges in mind, the authors have identified and synthesised the available evidence, both qualitative and quantitative, relating to the reforms in order to assess their impact and try to explain how the reforms have worked (or not).

The book begins with a series of chapters dedicated to the individual elements contributing to the reform package: Pauline Allen and Lorelei Jones examine the policies to increase the diversity of providers and introduce foundation trusts; Judith Smith and Natasha Curry examine commissioning; Shelley Farrar, Deokhee Yi and Sean Boyle evaluate PbR; Anna Dixon and Ruth Robertson review the evidence on patient choice of provider; and Gwyn Bevan addresses the issue of regulation and system reform. Carol Propper and Jennifer Dixon consider the overall impact of competition.

However, the reforms were designed to work together as a package of interrelated policies. Therefore, in a subsequent chapter Anna Dixon and Lorelei Jones review the evidence from studies of how the reforms were implemented in different local contexts and in relation to different services. The two concluding chapters seek to understand the overall impact of the reforms, and what can be learned for the future from this innovative and radical period of change in England's NHS.