

QUASI-MARKETS AND BEYOND: The political economy of partial reform in the English National Health Service

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ABSTRACT

The provision of publicly funded health services is an important part of the welfare state in the UK. Expenditure on health services has increased from 7.6% of GDP in 2001 to 9.2% in 2007. Overall, the total public expenditure on the National Health Service (NHS) in England in 2007/8 was £92 billion (€130 billion). As public expenditure has increased attention has been increasingly drawn to the issue of the effectiveness of this spending. The Office for National Statistics has estimated that NHS productivity fell by 2% per annum between 2001 and 2006. Concerns about effectiveness of the NHS have inspired continuous attempts at reforming the centrally planned system of health service provision.

The current round of reforms, which were launched with the NHS Plan of 2000, has aimed at a system-wide redesign of the NHS to deepen the decentralised ‘quasi-market’ first introduced under in the early 1990s. The new reforms are intended to open the NHS to a wide range of new health service provider organisations including private companies, social enterprises as well as transformed incumbent provider organisations. The purpose of this paper is to outline these reforms, and to begin to develop a theoretically informed understanding of the reform process in the NHS over the last twenty years. The paper is based on the initial results of a large scale evaluative research project into the NHS reforms which is being carried out by the authors and is in its initial stages. The paper is divided into four sections.

The first section sets out the basic features of the quasi-market reforms which were introduced in the 1990s under the Thatcher government. The discussion briefly reviews the theory of quasi-markets and the results of evaluation studies that were carried out into its results. The quasi-market debate was about the organisation of the National Health Service (and other sectors of the welfare state) within a publicly financed and publicly owned system (Bartlett and Le Grand, 1993). Under these

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reforms the provision of health services was separated from the financing or 'purchasing' function. This purchaser/provider split took place within the publicly owned and managed NHS. Acute hospitals became NHS Trusts, and a certain arms-length distance was placed between them and the purchasing organisations – health authorities and GP fund-holders. This gave some freedoms to management to organise their hospitals as they saw fit. However, early ideas that these freedoms would extend to substantial business decisions such as selling assets or raising loan finance were soon put to one side. Purchasers and providers drew up contracts with one another, so that the semblance of a market was introduced. The possibility of losing or gaining contracts introduced a competitive element that raised the possibility that technical and allocative efficiency might be increased through competitive pressure, mimicking the effects of a real market. Yet, in practice, most contracts were of the block-contract type which ensured that all risk was borne by the hospital or NHS Trust. If the Trust over-performed it did not increase its income, but simply ran out of money had to cease operations until the beginning of the new financial year. Previous analyses of the quasi-market experiment demonstrated the enduring hierarchical nature of the NHS which prevented the full realisation of market competition (Allen, 2002). Evaluation studies showed little evidence of any improvements in efficiency following the introduction of the new structures (Le Grand et al., 1998).

In the early quasi-market, cost-per-case contracts were rare. These would have allowed Trusts that were more efficient to make a surplus, and would have provided real incentives to improved efficiency. In fact, such contracts were drawn up with GP fund-holders, the other main institutional innovation. These GPs were granted devolved budgets to spend on whichever service from whichever hospital or Trust they considered offered the best value. The GP fund-holders drew up cost-per-case contracts with provider Trusts and this, at the margin, did produce observable increases in efficiency and reduced waiting times (Glennerster and Matsaganis, 1993; Propper et al., 2002). The problem was that not all GPs were fund-holders. Patients of fund-holders went to the head of the queue, ahead of patients of non-fund-holders, and this produced (accurate) allegations of the development of two-tier service.

The second section deals with the reform reversal which took place when the Labour government came to power in 1997, outlines its main features, and situates it within the context of theories which focus on the costs and benefits of reform reversal. The main target of the new Labour government was GP fundholding. Instead of overcoming the two-tier problem by extending fundholding nationwide, fund-holding was abolished. However the purchaser provider split remained. It was renamed but essentially no reversal of the reforms on this dimension took place (Allen, 2002).

The third section considers the period of renewed reform effort which was initiated following Labour's return to power following the election of 2001 and the passage of the 2002 Health Act, alongside the dramatic increase in public funding of the NHS noted above. The reforms involve centralised price setting, decentralised commissioning, and entry reforms to encourage a diversity of providers with more freedom to innovate and improve service quality (Allen and Riemer Hommel, 2006). Under the new expanded quasi-market, commissioners (i.e. agencies within the NHS with responsibility for purchasing health services) are required to buy health services from any 'willing' provider, whether from the private sector or from third sector organisations (including voluntary organisations, NGOs, charities, foundations, trusts,

non-profit social enterprises, or cooperatives), and from semi-independent self-managed hospital groups within the NHS called 'Foundation Trusts'. The aim of this system transformation is to stimulate innovation, quality and choice in the provision of health services. The justification for the emphasis on the entry of private providers is that they may be more technically efficient than providers from the public sector, as has long been argued in the literature (Vining and Globerman, 1999). However, private for-profit companies may seek to cut quality in order to save costs and raise profits. The reform design therefore also encourages the entry of so-called 'social enterprises' (sometimes also called Third Sector Organisations) which may have less incentive to seek commercial gain from quality reduction (Francois, 2002). Market contestability has been introduced by permitting and encouraging the entry of both private companies and social enterprises. This goes well beyond the former quasi-market model, which was designed as a system of 'managed' (synthetic) competition within the NHS. In addition, so-called 'transaction reforms' have ensured the permanent institutionalisation of cost-per-case payments through the introduction of centrally administered prices for all activities financed and purchased (commissioned) by NHS financial agencies (commissioners). These agencies are known as Primary Care Trusts (PCTs) although the aim is to further devolve this function to the level of GP practices through so-called 'Practice-based Commissioning' (PbC). Finally, a new system of regulation has been established to oversee the new quasi-market mechanism.

The fourth, concluding, section sets out a theoretical framework through which the reforms can be understood. Whereas the quasi-market reforms of the 1990s were essentially 'closed system' reforms, in which the intention was to introduce synthetic competition *within* the public sector, the reforms introduced in the 2000s are 'open system' reforms, which have opened the NHS to competition from the *outside*, through the entry of new independent provider organisations. This opens up the issues of barriers to entry, the responses of incumbent providers to the threat and reality of entry by new providers, their reactions post-entry, as well as the impacts on health system outcomes of entry deterrence by incumbents. The bases for the theoretical framework are the institutional economics models of entry deterrence (Williamson, 1985), contestable markets (Baumol et al., 1988), and the political economy of partial reform in centrally planned systems (Murphy et al., 1992; Kornai and Eggleston, 2001).

The discussion is designed to set the stage for answering the following questions: How have incumbents responded to the threat and reality of entry of new providers? At what point would such entry lead to the systemic transformation of the NHS? What would be the consequences of such a transformation? Would it lead to improved service provision through improved quality, innovation, and productivity? Or, as critics suggest, would it lead to profit-seeking reductions in quality and increased health inequalities? This section does not intend to provide answers to these questions, but rather offers a theoretical framework through which the questions can be answered on the basis of our empirical research project.

References

- Allen, P. (2002) Plus ça change, plus c'est la même chose: to the internal market and back in the British National Health Service, *Applied Health Economics and Health Policy* 1, 171-178.
- Allen, P. and P. Riemer Hommel (2006) What are 'third way' governments learning? Health care consumers and quality in England and Germany, *Health Policy* 76, 202-212.
- Bartlett, W. and J. Le Grand (1993) The theory of quasi-markets. In J. Le Grand and W. Bartlett (eds.), *Quasi-Markets and Social Policy*, pp. 13-34. Basingstoke: Macmillan
- Baumol, W.J., J.C. Panzar and R.D. Willig (1988) *Contestable Markets and the Theory of Industrial Structure, revised edn.*, San Diego: Harcourt, Brace, Jovanovich.
- Francois, P. (2002) Not-for-profit provision of public services, *CMPO Working Paper 03/060*, Bristol: University of Bristol.
- Glennerster, Howard and Manos Matsaganis (1993) The UK health reforms: The fundholding experiment. *Health Policy* 23, 179-191.
- Kornai, J. and Eggleston, K. (2001) *Welfare, Choice and Solidarity in Transition: reforming the health sector in Eastern Europe*, Cambridge: Cambridge University Press.
- Le Grand, J., N. Mays and J. Mulligan (eds.) (1998) *Learning from the NHS Internal Market: a review of the evidence*. London: King's Fund.
- Murphy, K.M., A. Schleifer and R.W. Vishny (1992) The transition to a market economy: pitfalls of partial reform. *The Quarterly Journal of Economics* 107, 889-906.
- Propper, C., B. Croxson and A. Shearer (2002) Waiting times for hospital admissions: the impact of GP fundholding. *Journal of Health Economics* 21, 227-252.
- Vining, A. R. and S. Globerman (1999) Contracting out health care services: a conceptual framework. *Health Policy* 46, 77-96.
- Williamson, O. (1985) *The Economic Institutions of Capitalism*. New York: The Free Press.