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Systems and Organisations

Have new NHS market reforms learned from failings of old?

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Introduction

The 1990 NHS and Community Care Act represented one of the most radical and significant reforms of the NHS since its creation in 1948. However, despite its high profile nature, which attracted worldwide attention, its attempt to introduce competition with the introduction of the internal market largely failed to deliver what had been hoped for.[1–3] As such, upon their election in 1997, New Labour promptly announced the end of the 'ill conceived' internal market. In place of the competitive environment would instead be an emphasis upon co-operation.[2] Despite this systematic change, more recent reforms sweeping through the NHS such as 'patient choice' and 'payment by results' appear to have resulted in a return to market mechanisms and the re-introduction of competition as a driver for improvement.

This article will examine this apparent 'u-turn' and ask, have the new methods of introducing competition into the NHS learnt from the failings of old? This will be done by examining how and why the reforms failed to deliver what was expected. It will then go on to outline the current reforms/changes being introduced and seek to identify whether there are fundamental differences between new and old, and what (if anything) has been done to ensure that the causes of previous failures do not occur again this time around. In short, it will ask if the Labour government has learnt from the past.

The internal market

The 'internal market', as proposed by Alain Enthoven,[4] aimed to create a more effective and efficient healthcare system, similar to reforms in the US which had resulted in a better quality of care.[5] Furthermore, the white paper, *Working for Patients*[6] and subsequent working papers prophesised that the internal market would deliver many extra benefits such as a greater range of services, decreasing drug expenditure, a reduction in waiting times, a better use of resources as money followed patients, more information for patients about practices, the ability of patients to change practice more easily and more power delegated to managers.[7] All of this would be achieved because service providers would become more productive and deliver a higher level of service due to fear that purchasers would go elsewhere if they did not.

Although the NHS internal market had grand intentions, it largely failed to deliver what was anticipated or expected.[8] The first reason for this failure relates to its design; it appears that the internal market was a rushed and forced political movement – there had been no mention of the intended plans in the Conservative manifesto. Furthermore, two weeks before the then Prime Minister, Margaret Thatcher, announced that an internal market was to be introduced, the then Secretary of State for Health, John Moore, had delivered a speech to the House of Commons about the future of the NHS and had not mentioned an internal market. Furthermore, the government also refused to allow any pilot studies to see how it would work and to identify any potential issues. Similarly, they refused to consult with the medical profession because the following Secretary of State for Health, Ken Clarke, felt that doctors would seek to sabotage it and prevent its implementation and as such, 'ministers decided amongst themselves what they wanted to do and acted accordingly',[9] and groups such as the British Medical Association (BMA) were not included in the process.[10]

The next set of reasons for the failure of the internal market relate to its implementation, as it was rolled out across the country very quickly with little time to adjust and/or prepare. Furthermore, guidance about its operation was not published until 1994, three years after its implementation. As such this would mean that health professionals had already begun working in a particular way and changing this would be hard.

Because of this, Timmins commented that politicians were, 'making it up as they went along'.[11]

The final set of reasons for the failure of the internal market is down to the operational problems and flaws that existed. The first problem was that money did not follow the patient, contrary to what was intended with the purchaser-provider split. This was because patients were tied in to the block contracts which had been agreed and signed.

The next operational issue was caused by the large amount of political involvement and interference. Politicians, whose jobs depended upon the success of the NHS and who were answerable to the electorate, were unwilling to leave decision making to managers and doctors, with Lewis commenting that the only freedom managers had was to do as they were told.[12] Also, unlike in *real* markets, hospitals that were unsuccessful were not allowed to close, with ministers preventing this from happening, which eliminated any incentive/need to compete. It was the above reasons that led West to assert that it was 'politically impossible' for the NHS internal market to succeed.[13]

The third operational issue lay in the difficulty of actually creating the sought after competition; hospitals had been designed and located in a way so as to avoid repetition and duplication. As such Le Grand argued that there was little incentive/opportunity to compete, so in effect 18% of hospitals were monopolies in the period 1991–1999.[14] Furthermore, Propper asserts that the UK hospital market is monopolistic more broadly.[15]

Another key operational issue was that that the internal market was seen as a way of saving money and becoming more efficient. However, cost reductions could have been achieved by cutting corners and efficiency gains may have been wiped out by adjustment costs such as shifting resources, capital equipment, staff, consultancy and legal fees, etc.[16]

The final operational problem was the difficulty that existed when it came to assessing and measuring the performance and effectiveness of the reforms. No performance data were collected and consequently no results published. As such, as well as preventing performance measurement, it also meant that there was no way to identify and spread best practice.

To sum up the main reasons for the failure of NHS internal market were:

- rushed/forced political movement
- no pilot studies
- no consultation
- rapid implementation
- no mechanism to ensure money followed the patient
- too much political involvement
- failure to actually create competition
- no performance information.

The third way

After 18 years of Conservative government, 1997 saw the election of the New Labour government led by Tony Blair. Along with this change in government came a change in policy with the adoption of 'The Third Way', so called because it would be different from both the internal market of the Thatcher era and the centralised approach from previous Labour governments

Along with the Third Way came the official end of the internal market with the first New Labour Secretary of State for Health, Frank Dobson, announcing that, 'the internal market was a misconceived attempt to tackle the pressures facing the NHS. It created more problems than it solved'. Despite this the publication of *The NHS Plan*[17] and *Delivering the NHS Plan*[18] signified a return to the market in the NHS, as their policies were similar to those that lay behind the internal market.[19] The most significant were; 'patient choice', 'payment by results' and the desire to have a more diverse group of providers.

A return to the market

Despite Frank Dobson announcing the end of the internal market in 1997, and the claim that co-operation would be sought instead of competition, recent NHS reforms, involving choice for consumers, money following the patient and competition between providers, indicate that the market and competition between NHS organisations have made a return. As in the 1990s these policies are intended to create stronger incentives to improve performance and, as hospitals will only get paid for the work they complete, the system aimed to ensure that money really did follow the patient as hospitals compete for business. The residue of competition is also evident in the commitment to collect and publish data on the comparative performance of providers.[20] This view is also shared by none other than Enthoven, as cited in Warwick,[21] the architect of the original internal market who commented that, 'instead of the comparatively timid "Thatcher-Enthoven" internal market, Milburn is describing a wide open market. Whether he really means it or not and whether he can deliver it or not is another question. It is a logical extension of the internal market ideas'. Similarly, Ham[19] argued that the above reforms 'indicate that the wheel has turned back to Labour's 1997 inheritance'. The Kings Fund[22] also asserts that competition between hospitals has now been brought back into the system. As such, it is important to ask whether New Labour's NHS market reforms have learned from

similar previous reforms under the Conservative government.

Labour's policy learning

Has New Labour learnt from the failing of the internal market in its current attempt to introduce competition into the NHS? In order to answer this question, the paper will examine each of the eight factors identified earlier, which were associated with the internal market failing to deliver what was expected of it, and seeing what has been done to ensure that the similar problematic issues do not arise again.

Rushed and forced political movement

The current reform programme underwent much longer planning and preparation than the internal market. For example, initial plans were outlined in *The NHS Plan 2000* before more detail was added in *Delivering the NHS Plan 2002*. Furthermore, the full effects and operation would not be fully implemented until 2008/2009.[18] Finally, the reforms were implemented by a strong government, with a large parliamentary majority and the backing of both the electorate and health profession. As such these reforms are not a rushed or forced political movement. Indeed the Labour government identified the need to plan the reforms properly to avoid the same pitfalls the previous Conservative government suffered from.

No pilot studies

Another criticism of the Conservative internal market was that it was introduced without a pilot study. This was not the case with the current reforms, because pilot studies *were* undertaken across the country, in order to establish how both patient choice and payment by results would work[23] (e.g. 'South Yorkshire Payment by Results Laboratory Project' and Patient Choice pilot studies conducted in Trent, Norfolk, Suffolk and Cambridgeshire; and Dorset and Somerset). This therefore allowed for any problems/issues to be addressed and the system to be altered before it was rolled out across the country.

No consultation

Professionals from the health sector have been involved with the redesign and implementation of current market reforms, in stark contrast to the Conservative approach. Furthermore, expert management consultants have been used (indeed the NHS is now the fourth largest consulting market)[24] and that spending has increased 15-fold in two years.[25] Finally, as it was implemented in a more controlled and gradual way, with pilot studies conducted and performance information published, academics have also been able to research these reforms and provide valuable insight and information, such as the briefings and publications by institutions such as the Kings Fund and the *BMJ*.

Rapid implementation

The current reforms were introduced on a more gradual basis, evident in the fact that patients were originally only able to choose from four hospitals to receive treatment.[18,26] This was being expanded to all providers, both public and private in 2008/2009 however. This therefore allows for more time to adjust to the reforms, become familiar with how they will work, will help health professionals to become familiar, and avoiding too much sudden change and upheaval.

No mechanism to ensure money followed the patient

In order to overcome this obstacle, patient choice and payment by results ensure that money does follow the patient. In the majority of cases, hospitals will only receive payment for services they actually perform, therein providing more incentives to provide services. As such, hospitals must attract patients who exercise their choice in order to generate revenue. Purchasers are unable to buy 'block contracts', as under the Conservative government.

Too much political involvement

In an attempt to reduce political involvement there has been a greater degree of managerialism introduced into the NHS, which has meant expert managers being put in charge of health services. As such, these experts may be more able to be left alone to do their work. Furthermore, high performing hospitals will be given greater autonomy and more freedom to operate as they want to, whereas only underperforming hospitals will have outside teams introduced into them. This process of decentralisation was identified as a priority for Labour upon coming to power, as they sought to create more local responsiveness.[2,27]

Failure to actually create competition

Competition should be ensured by having a greater diversity of service providers, allowing patients to choose where they receive treatment and then ensuring

that money really does follow the patient. Hospitals would have to make sure that they provide key facilities that patients want (such as car parking, acceptable food, etc), that success rates are high, infection rates are low, etc if they are to attract patients and subsequently generate revenue. If they do not, patients will go to a competitor. Furthermore, the use of the private sector in the provision of clinical care goes further than the Conservative internal market which concentrated on privatising peripheral services such as cleaning. Therefore, the system for a truly competitive environment has been put in place.

No performance information

This issue has been addressed thanks to the increasing emphasis placed upon measuring performance, which is a key strand of the managerialist approach and the New Public Management agenda.[28] This is evident through the publishing of league tables, comparative performance data, for example, the 'traffic light' system operated by the Healthcare Commission and Monitor. As such policy makers, academics and health managers should be more able to identify both high and low performing areas so can take action where necessary.

Lessons still to be learned

Although many of the problems associated with the failure of the internal market do appear to have been addressed, some of the issues are still present within the new system. The first area relates to the degree of choice available. A King's Fund survey in 2005 found that only 45% of patients remember being offered a choice of hospital by their GP since the introduction of patient choice. Furthermore, of those 45%, only 27% were given a booklet of comparative information about hospital performance. This is despite the fact that by 2008/2009 the government was hoping that 90% of hospital admissions would be done with the use of patient choice and the 'choose and book' system.[22] This suggests that the majority of patients have not been offered or benefited from any choice since the high profile and expensive introduction of patient choice. However, rather than any kind of policy failure this could be down to the government setting unrealistic and over demanding targets. This needs further research.

Another problem with the internal market was that it was felt that any cost savings could have been achieved through cost cutting measures, and the cost of implementing it could also have taken money away from frontline services. The King's Fund[22] has also warned that cost savings could be sought in the new system by cutting staff numbers.

A final issue relates to the fact that the internal market was criticised due to the political involvement, with Peter West[13] commenting that it was 'politically impossible' for it to operate as a natural market. Similarly, despite the greater autonomy given to managers, there will still always be instances of political interference due to the nature and importance of the NHS, contrary to evidence that it will impede the competitive incentives designed to drive the NHS forward.

Conclusions

The New Labour government has in effect reinvented the Conservative's internal market but in a more sophisticated way, designed to avoid the pitfalls and shortcomings of the original policy. Labour does appear to be learning from the previous system and ensuring the same mistakes are not made the second time around. This has been done by keeping certain aspects of the internal market but designing new, more complex methods to ensure other aspects succeed. For example, the Labour government have decided to opt for 'patient choice', ensuring that choice really is introduced into the system. Furthermore the 'payment by results' system should ensure that money follows the patients and it will also help to ensure that hospitals do not compete on price but on quality. This should then help to allay fears that hospitals will start to cut costs and reduce quality in an attempt to become more competitive because if they do this they will not attract patients. Also, the design and implementation process has been much more rigorous with pilot studies, more consultation and a more co-ordinated and planned introduction, evident in that the fact that reforms were outlined in 2000[17] but were not in full operation until 2008/2009.[18] And during that period pilot studies have been conducted.

From this we can see that the new ways of introducing competition into the NHS have learnt from the failings of old, becoming more sophisticated and developing systems and structures to avoid a recurrence of the same issues. However, the new system still is not a flawless reproduction of the internal market. This is because choice is not being exercised as fully as it should, despite the system that has been put in place and there are still issues relating to political interference. This raises doubts about the applicability of a competitive environment within the NHS because political interference is unlikely to stop.

Despite the problems above, there is evidence that policy learning has taken place which does indicate that the reforms are more likely to be a success. However, future research should look in detail at whether the

reforms are operating successfully, and at how to improve certain aspects, such as the use of 'patient choice' and 'choose and book' so that modifications can be made to optimise and maximise the impact of the reforms so as to benefit the NHS.

ABOUT THE AUTHOR

Peter Dragoonis is currently an MSc student at Warwick University. This paper is based upon his undergraduate dissertation conducted in the Department of Management at Royal Holloway, University of London.

REFERENCES

1 Enthoven A and Vorhaus C. A vision of quality in health care delivery. *Health Affairs* 1997;16(3):44–57.
2 Labour Party. *New Labour Because Britain Deserves Better* (1997 General Election Manifesto). London: Labour Party, 1997.
3 Baggott R. Regulatory Politics, Health Professionals, and the Public Interest. In: *Regulating Health Professionals.* London: Sage, 2002.
4 Enthoven A. *Reflections on the Management of the National Health Service: an American looks at incentives to efficiency in health services management in the UK.* London: Nuffield Provincial Hospitals Trust, 1985.
5 Culyer AJ, Maynard JW and Posnett JW. *Competition in Health Care: reforming the NHS.* London: Macmillan, 1990.
6 Department of Health. *Working for Patients.* London: The Stationery Office, 1989.
7 Jones N. Opinion-After the internal market: public ownership or poisoned chalice. *Journal of Management in Medicine* 1999;13(5):346–51.
8 Enthoven A and Vorhaus C. A vision of quality in health care delivery. *Health Affairs* 1997;16(3):44–57.
9 Ham C. *When Politics and Markets Collide: reforming the English National Health Service.* Health Services Management Centre: University of Birmingham, 2007.
10 Lee-Potter J. *A Damn Bad Business: The NHS Deformed.* London: Trafalgar Square, 1997.
11 Timmins N. *NHS Region May Test Internal Market Plan.* The Independent 14 March, 1988.
12 Lewis R. Back to the future. *BMJ* 2004;329:932. Available at: www.bmj.com/cgi/content/extract/329/7472/932 (accessed 16 November 2009).
13 West P. *Understanding the NHS Reforms: The Creation of incentives?* Buckingham: Open University Press, 1997.
14 LeGrand J. Competition, cooperation, or control? Tales from the British National Health Service. *Health Affairs* 1999;18(3):27–39.
15 Propper C. Market structure and prices: the response of hospitals in the UK National Health Service to competition. *Journal of Public Economics* 1996;61:307–35.
16 LeGrand, Mays and Mulligan. *Learning from the NHS Internal Market: a review of the evidence.* London: King's Fund, 1998.
17 Department of Health. *The NHS Plan.* London: The Stationery Office, 2000.
18 Department of Health. *Delivering the NHS Plan.* London: The Stationery Office, 2002.
19 Ham C. *Health Policy in Britain*, 5th edn. New York: Palgrave Macmillan, 2004.
20 www.performance.doh.gov.uk/
21 Warwick P. Back to the future in NHS reform. *Journal of Health Organisation and Management* 2007;21:194–204.
22 Kings Fund. *Delivering Choice Programme Evaluation.* 2005. Available at: www.kingsfund.org.uk/current_projects/delivering_choice/index.html (accessed 16 November 2009).
23 www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_413813
24 www.accountancyage.com/accountancyage/news/2165327/nhs-becomes-fourth-largest
25 National Audit Office. *Central Government's use of Consultants.* London: The Stationery Office, 2006.
26 www.kingsfund.org.uk/publications/briefings/patient_choice_1.html#section3
27 Department of Health. *Shifting the Balance of Power within the NHS.* London: The Stationery Office, 2005.
28 Ferlie E, Lynn LE and Pollitt C. *The Oxford Handbook of Public Management.* Oxford: Oxford University Press, 2005.

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