

CIVITAS: Institute for the Study of Civil Society

The impact of the NHS market

An overview of the literature

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Executive Summary

NHS 'internal' or 'quasi' market policies in England have aimed to promote competition among providers in the hope of replicating the benefits markets have been known to bring about in the private sector: decreases in cost, and increases in efficiency, quality, innovation, and provider responsiveness. This briefing presents the results of a large-scale literature search on the effectiveness of these policies over the past 20 years.

Key Findings

The development of a market in the NHS dominated government policy over two periods: 1989-1997 and post 2002. In both periods reforms took on three objectives: demand-side reform (those changes focusing on the ways people or organisations demand or purchase care), supply-side reform (changes focusing on the ways care is provided and organised), and payment system reform (changes to monetary transactions).

1991 Reforms

The reforms of the early 1990s revolutionised the structure of the NHS in separating the functions of care purchasing and care provision, both of which had been previously directed centrally from the Department of Health (DH) via Regional Health Authorities (RHAs). Major demand-side policies included the development of general practitioner (GP) fundholding, whereby GPs were encouraged to take on budgets for purchasing elective (planned) care from hospitals, and a new responsibility for purchasing all other health care services bestowed on regional administrative bodies, to be termed Health Authorities (HAs). Supply-side reforms included the creation of self-governing hospital groups called NHS trusts, thereby removing HAs from the day-to-day management of hospitals.

The following effects are noted:

GP Fundholding

- GP fundholding was deemed to have been the most promising of the 1990s reforms in terms of improving secondary care provider quality and responsiveness, yet the evidence linking the policy to these outcomes is weak.
- Mixed evidence was found regarding the impacts of fundholding on referral rates.
- GP fundholders' overall costs decreased in the first two years but increased thereafter, leaving the policy's impact on costs inconclusive. Mixed evidence was also found regarding the impact of fundholding on prescribing costs.
- GP fundholding was associated with reductions in patient waiting times.
- Fundholding may have led to various inequities in patient care, e.g. hospitals were seen to select fundholders' patients from waiting lists before those of non-fundholders, and patients of fundholders

often had access to certain purchased services (physiotherapy, health visiting, community mental services) that patients of other GPs did not.

- Patients of fundholders reported lower overall satisfaction with care but were more satisfied with additional non-medical services provided by the practice.
- Multiple researchers noted that fundholders were self-selected and tended to be well-organised practices in middle-class areas.

Health Authority (HA) Purchasing

- Prices of hospital services varied between HAs and between geographic areas, as was intended.
- HAs lacked the ability to purchase and to influence providers as effectively as expected (particularly due to weak contracting skills and inadequate ability to market test).ⁱ

NHS Trust Provision

- Productivity increased and costs decreased for NHS trusts more so than for organisations that did not become trusts.
- Post-surgical length of stay declined, and an increase was seen in post-discharge destinations such as nursing homes.
- No evidence was found of impact on equity.

Overall Impacts of 1990s Market Policy

- Effects were difficult to assess due to a lack of monitoring and regulation as well as the fact that reforms were abruptly abolished when Labour came into power in 1997.
- A general increase in patient satisfaction with NHS care was seen throughout the 1990s.
- Patient choice was gradually strengthened as a policy focus throughout the decade, but little evidence exists on its implementation.
- Evidence of the overall impact of market policies on care quality is mixed and inconclusive.
- Barriers to the success of the reforms can be seen as practical manifestations of market failure (i.e. barriers to entry and exit, too much political interference).

Post-2002 Reforms

Although the purchaser/provider split was sustained when Labour came to power in 1997, most of the other 1991 policies were quickly brought to an end. Then, in 2002, the government introduced a new round of market-based reform within the NHS, which was initially focused on increasing choice for patients, decreasing waiting times, and improving quality of care. Demand-side changes saw the creation of Primary Care Trusts (PCTs) to perform a purchasing role similar to that of Health Authorities; and practice-based commissioning (PbC), a re-incarnation of GP fundholding but focused on community-based and specialty services rather than elective care. Patients were

ⁱ Market testing is a means of presenting products or services to a small sample of the intended market to test various strategies and pricing before full implementation.

also given a choice of elective care provider (including non-NHS providers) at the time of referral. Supply-side changes included the introduction of quasi-autonomous foundation trusts, and the encouragement of provider plurality (PCTs could contract with the private and voluntary sector as well as NHS providers, and some areas saw the introduction of DH-led contracts with Independent Sector Treatment Centres, ISTCs). Market-based changes to the secondary care payment system took the form of payment by results (PbR) and the health resource group (HRG) tariff.

The following effects are noted:

Practice-based Commissioning

- PbC implementation is slowly advancing.
- It is being led by a few enthusiastic practices working with supportive PCTs.
- Variation exists in the quality of local relationships and levels of PCT support; with resources and experience often limited at both PbC and PCT level.
- Incentives and infrastructure used to support PbC are not sufficient to engage most GPs in commissioning.
- Many PbC consortia are more interested in self-provision than commissioning new services.
- The quality of the financial infrastructure underpinning PbC programmes is variable, with many practices unclear on how budgets have been set or how financial risk is to be managed.
- Obstacles include the accuracy of information on patient need and treatment use.
- Implementing governance and accountability processes within non-formal PbC collaborations has been difficult.
- Progress depends on co-operation and mutual engagement between PbC consortia and local providers.

PCT Commissioning

- PCTs lack the necessary skills to purchase effectively; poor local management of resources was noted.
- PCTs do not always take full advantage of their potential power in the purchaser/provider relationship.
- Only weak incentives exist for PCT managers to break historical patterns of purchasing.
- There is a lack of community input and satisfaction with commissioning.
- Systemic obstacles exist to the local autonomy of PCTs.
- The World Class Commissioning programme is too new for its impact to be determined.

Patient Choice of Provider

- Studies show the percentage of patients who recall being offered a choice of hospital for their first outpatient appointment was 47% in March 2009, up from 46% in December 2008 and 30% in June 2006.
- 89% of patients offered a choice are able to go to the hospital they choose.
- Choice has contributed to decreased waiting times for elective surgery.
- There is disagreement among researchers on whether choice has had a positive or negative effect on equity.
- Fear of the impact of patient choice (rather than actual impacts of patient choice) has led some NHS providers to advertise services to both patients and GPs.
- In practice, the uptake of choice policy is not yet widely realised, and degree of implementation varies geographically.

- The Choose and Book system may not be enabling as much choice as expected regarding appointment date and time and number of providers offered; GPs may use the system as an online tool to make referrals as usual.
- Patients and GPs desire more information on provider quality.

Plurality of Providers

- Studies exist citing both improved and harmful outcomes of competition. For example, contestability, or the threat of competition, appears to be driving up efficiency and quality, but possibly at the expense of wider inter-professional and inter-organisational collaboration.
- Competition is fostering development of more business-like cultures in NHS hospitals.
- ISTCs provide equal if not better outcomes than NHS providers, and receive higher levels of patient satisfaction; however, they treat a healthier case-mix of patients than NHS providers (as was intended by their contracts).
- ISTCs may have negative effects on NHS surgical training.

Foundation Trusts

- Increased autonomy over certain governance and finance decisions may not currently be a strong enough incentive to encourage further applications for FT status.
- FT lay governors and directors are finding their roles ambiguous and difficult to define.
- Many governors perceive that they have made little impact on the decisions of the trusts to date. However, evidence does show gradual increased involvement of both governors and the public in FT activities.
- FTs have generally performed well financially and have generated surpluses; and they have been high performers in routine NHS financial and quality measures when compared to NHS trusts. However, surpluses have been modest in relation to total revenue; and many FTs were among the highest performing NHS trusts even before status conversion.
- Little robust evidence exists to suggest FTs are using their new status to innovate in a significant way.

PbR and the HRG Tariff

- PbR has been fully embedded across the NHS since 2008.
- Unit costs fell quicker in hospitals once PbR was implemented, although administration costs increased.
- Hospital activity increased as PbR was implemented.
- No association has been found between PbR and quality of care.
- Where increases in efficiency were found post 2002 (e.g. the increase in number of elective surgery patients treated as day cases, decrease in the length of inpatient stays, and reductions in avoidable admissions), authors note other policies and trends have also encouraged such results.
- Many hospitals have improved financial management and have a better understanding of patient costs since PbR implementation, yet a substantial agenda of cost improvement remains for the NHS.
- Mixed evidence exists on prevalence of hospitals 'upcoding' procedures in order to get paid more.
- The fact that the PbR tariff for a procedure is set at average cost encourages hospitals to become 'average' rather than aiming to operate at the level of the most efficient hospitals.
- Being paid per case through PbR produces adverse incentives for hospitals to increase activity beyond affordable levels and possibly induce demand inappropriately.

Overall Impacts of Post-2002 Policy

- Many researchers found difficulty in attributing improvements specifically to market-based reform.
- Improvements in NHS care, such as major reductions in waiting times, have more often been attributed to ‘targets and terror’ together with increased spending, than to competition.
- The lack of a stable policy environment de-motivates staff.
- As yet, there is a lack of patient and public understanding and support for market-based reform.
- Many desired outcomes have not yet been achieved, e.g. few NHS organisations are attempting to deliver innovative models of patient care.

Conclusions

Although there are presently very few studies that evaluate the cumulative effects of market reform in the NHS either 1991-97 or post 2002, there is an abundance of research on the effect of individual policies. While evidence on the impact on quality of care is mixed, research has found attributable impacts in the form of reduced waiting times, improved access for patients, and increased provider efficiency. However, potential confounding factors (such as simultaneous increases in funding and pressure from enforced targets), along with weak monitoring strategies, make attribution to market policies alone questionable.

That said, the market reforms of the past 20 years have had unmistakable effects on the culture of the NHS. In particular, the introduction of competition has developed a system-wide awareness of costs, efficiency and accountability.

However, the reforms have not been proven to bring about the beneficial outcomes that classical economic theory predicts of markets, including provider responsiveness to patients and purchasers; large-scale cost reduction; and innovation in service provision. Many researchers have attributed this to the failure to create a true, functioning market (e.g. due to political interference, weak purchasers, and barriers to exit and entry), as well as a lack of a stable policy environment to inspire staff commitment and enthusiasm.

Further research is clearly needed, but the available research indicates that the NHS may have found itself in a lose-lose situation—taking on the extra costs of competition without yet experiencing the benefits.

I. Introduction

For the past 20 years, healthcare policies of the Blair and Brown governments and of the Conservatives before them have largely focused on what is termed the ‘internal’ or ‘quasi’ market.ⁱⁱ This market within the National Health Service in England refers to the separation of purchaser (insurer) and provider (treatment) functions, which were both previously managed by central government and its regional subsidiaries. The purchaser/provider split was intended to stimulate competition between providers. Providers would no longer be guaranteed a flow of patients; instead, NHS hospitals and other providers of acute and specialist services would need to attract contracts with regional bodies responsible for purchasing care on behalf of their populations.

The policies and specific mechanisms used to facilitate these markets have evolved from those first implemented in the early 1990s, but the rationale has been the same: classical market theory holds that competition between suppliers should reduce costs; improve product quality (in the case of healthcare, health outcomes); increase responsiveness to the needs of consumers (patients and commissioners); allow flexibility to alter supply quickly; improve the rate of innovation; and lead to greater consumer choice and overall satisfaction. However, the use of market mechanisms within a publicly funded system remains controversial, and even more so because little evidence exists on the effects of market policies when applied to healthcare.ⁱⁱⁱ

As we enter a general election year with both the government and its opposition continuing to advocate the existing market structure in the NHS (albeit the current government wavering to some extent on its future role in driving performance)¹, it is important to look at the effects that such policies have had on the health service to date. The purpose of this paper is to review what we do know—what evidence exists regarding the impact of market-based policies on the NHS?

II. Background

1. Market-based reforms of the 1990s

In 1991 the Conservative administration introduced reforms to promote competition between healthcare providers by separating NHS organisations into the roles of purchaser and provider, a restructuring set out in the 1989 White Paper *Working for Patients*.² Although funding would still be collected through general taxation, it was then to be allocated to new types of NHS organisations that would be responsible for purchasing health services on behalf of patients. Two types of purchasers were developed. First, district health authorities (later called health authorities),^{iv} which were originally regional management bodies of the DH, were to be given per capita funding

ⁱⁱ Preferences for the terms ‘quasi’ or ‘internal’ have varied among academics, but in this context we use them synonymously, implying that the government has retained control over the distribution of funds, along with some regulatory powers, which prohibits demand from responding to the ability and willingness to pay of purchasers alone.

ⁱⁱⁱ For a detailed explanation of the theory behind markets and their application to health care, see James Gubb’s recent paper ‘Markets in Health Care’. Available at: http://www.civitas.org.uk/nhs/download/Civitas_Markets_in_healthcare_Dec09.pdf.

^{iv} In 1995 District Health Authorities (DHAs) underwent a further transformation with the passing of the Health Authorities Act, which abolished all previous boundaries for District Health Authorities as well as for Regional Health Authorities and Family

weighted by population demographics in order to purchase hospital services for their respective geographical areas. The second type, GP fundholding, consisted of groups of primary care physicians who chose to take on budgets to buy a subset of elective care for their own patients.³ A few progressive groups of general practices volunteered for the experimental Total Purchasing Pilots (TPP), under which they were given additional responsibility for purchasing secondary and community care not included under the regular fundholding programme.

The intention was for purchasers to choose the most suitable services at the best prices. Healthcare services could be purchased from public (NHS) providers (including new self-governing hospitals called NHS Trusts, other health authorities' hospitals, and health authorities' own self-managed hospitals) and independent suppliers, who were all to compete for contracts. Fundholders were to be motivated by the ability to reinvest any profit gained from efficient purchasing back into general practice, to spend as they liked.

The Labour Party initially campaigned against the internal market, claiming it had fragmented the NHS and distorted incentives.⁴ Upon coming to power in 1997, they published *The New NHS: modern, dependable*, which rejected both the old command-and-control management of the 1970s and 80s, and the Conservatives' internal market. However, the purchaser-provider split was retained and carried on through a new 'third way'. In theory this policy aim endorsed a public/private 'partnership' approach to running the NHS, but in practice it created an intense focus on performance measurement (targets and monitoring). GP fundholding was abolished, and primary care groups (later primary care trusts) were established as the new commissioning bodies, but with a greater focus on needs assessment and accountability to the local community. District health authorities became, simply, health authorities (and later 'strategic health authorities'). Although they initially helped primary care groups with needs assessment, they were to ultimately take on a more managerial role, determining local targets and standards.⁵

2. Market-based reforms of 2002

In 2002 the Labour government began another round of restructuring, outlined in the document *Delivering the NHS Plan: next steps on investment, next steps on reform*. In addition to reinvigorating commissioners as independent buyers of services, changes included plans to give patients the choice, via their GPs, of where and when to receive elective (or non-emergency) treatment. The document states:

For the first time patients in the NHS will have a choice over when they are treated and where they are treated. The reforms we are making will mark an irreversible shift from the 1940s 'take it or leave it' top down service. Hospitals will no longer choose patients. Patients will choose hospitals.⁶

The reformed market consisted of two separate mechanisms: patient choice of provider for elective treatment, and the purchasing of healthcare services by commissioners. Secondary and specialist care providers were intended to compete both to attract individual patients for elective services and for acute contracts with Primary Care Trusts (PCTs) and general practitioners (who could once again volunteer to secure such care on behalf of their

Health Services Authorities, and reorganised the care purchasing structures, newly entitled Health Authorities. See: Health Authorities Act.1995 (c. 17). Available at: http://www.opsi.gov.uk/acts/acts1995/ukpga_19950017_en_1#11g1

patient lists). GP fundholding was re-instated in the form of ‘practice-based commissioning’ (PbC), which was intended to enable GPs to better meet the needs of their local populations and to reduce hospital patient load by moving some of the simpler, more common services into the community. Unlike fundholding, however, GPs were to be given virtual rather than real budgets; instead of allocating funding directly to participating general practices, PCTs would make payments on their behalf according to the GPs’ choices.⁷

Patients were initially given a choice of at least four elective care providers, one of which was to be private, along with information on location and waiting times. They would be able to arrange these appointments online (beginning in 2005) through a national, internet-based Choose and Book system.⁸ By 2008, patients would be able to choose from any willing NHS, private or independent provider registered with the Health Care Commission (now Care Quality Commission).

In order to encourage providers to compete for patients and to decrease waiting times, hospitals were no longer to be paid by annual ‘block’ contracts, but per case according to the number of patients treated. Under this ‘payment by results’ system, competition was not to be based on price as it was in the 1990s, but on quality. Prices for almost all acute procedures were to be set by a national tariff categorised by health resource group (HRG), each of which referred to related conditions or physiological systems, with prices adjusted for a market forces factor.^v

Another change was seen in centrally-led contracting with Independent Sector Treatment Centres (ISTCs)—for-profit healthcare providers paid in advance to carry out a certain number of NHS operations throughout England. Eventually, PCTs and GPs would be able to contract with them locally as well. ISTCs, though providing only a small percentage of elective care nationally, were intended to further stimulate competition and reduce waiting lists for elective surgery; the theory was that patients would be attracted by the option of seeing a private provider, and the ISTCs would carry out high numbers of simple surgeries quickly and for reduced costs.

A final reform intended in part to stimulate competitive quality improvement between providers was the introduction of foundation trust (FT) status. Hospital trusts meeting certain financial and clinical quality standards could apply to be FTs, which would designate them as independent, non-for-profit public benefit corporations providing health care on behalf of the NHS. They would reinvest any profits in services instead of distributing them to shareholders, as would a commercial corporation. Foundation trusts would have the freedom to access private capital (on the basis of affordability) and tailor new governance arrangements to the individual circumstances of their community.⁹ They would have an executive board accountable to a lay council of governors—representatives of patient, staff, and partner organisation constituencies—in addition to a membership of voluntarily registered individuals responsible for electing governors.

As of 2010, these reforms have been subject to various augmentations and minor modifications, but the market structure and major policies described above remain.

^v Market forces factor (MFF) is a way of adjusting allocations to purchasers for unavoidable geographical variations in healthcare costs. MFF takes into consideration cost variations in land, buildings, equipment and staff pay (including London weighting).

III. Methods

We performed two separate searches in order to find research focusing on market-based polices implemented both in the 1990s and after 2002. Search terms were based on the most prominent market reforms of each time period.

1. What are the most commonly cited outcomes of the first attempt at an NHS internal market (1991-97)?

Keywords and MeSH terms^{vi}: NHS internal market, quasi market, mimic market, purchaser-provider split, GP fund-holding, NHS trust, NHS trust status, self-governing trusts, provider competition, patient choice, 1989, 1991 AND: quality of care, outcomes, clinical outcomes, patient satisfaction, access, staff morale, cost-effectiveness, efficiency, waiting times, waiting lists

Limits: country, England

2. What have been the general effects/outcomes resulting from the Labour government's most recent market initiatives (post 2002)?

Keywords and MeSH terms: NHS competition, market, PbR, payment by results, patient choice, PbC, practice-based commissioning, PCT commissioning, world class commissioning, foundation trusts, ISTCs, independent sector treatment centres, provider competition AND: quality of care, outcomes, clinical outcomes, patient satisfaction, access, staff morale, cost-effectiveness, efficiency, waiting times, waiting lists

Limits: publication date 2002 or later, country, England

The above search terms were entered into the following databases: TRIP Database, Cochrane Library, PubMed, EMBASE, JSTOR, King's Fund Library reading lists (PbR and PBC), Database of Abstracts of Reviews of Effects (DARE) at University of York, and NHS Evidence. We also reviewed relevant grey literature including documentation produced by the Department of Health, Audit Commission, Healthcare Commission and Care Quality Commission, as well as academic briefings and publications from health research and consultancy organisations (e.g. The King's Fund, Picker Institute, The Health Foundation, RAND Europe). Additionally, we searched reference lists of relevant articles individually and contacted researchers who have written previously on NHS market policy to ensure we did not miss any recent or soon-to-be published work.

In order to obtain a discrete, workable literature sample, we have restricted the review to those articles presenting primary research: observational or interventional studies, or literature analysis. Selected articles were limited to those focusing on the market for secondary care, including relationships with general practice (e.g. articles focusing on dentistry or community services were excluded except where comparisons could be made with the purchasing or provision of acute care). It also should be clarified that we were only interested in policies relating to the market-based transactions (or initial purchasing) of secondary care; therefore, we did not search for studies focusing on payment for performance schemes (e.g. CQUIN).

^{vi} Medical Subject Headings (MeSH) are broad topics by which literature is categorised in MEDLINE, one of the main databases used.

IV. Limitations

Because of the breadth of issues falling under market reforms and the sheer number of publications covering them, this review is intended to present a representative sample of the available and most commonly cited primary research on the outcomes of the 1991 and post-2002 market reforms. It should not be interpreted as analyses of all potential evidence on the effects of markets on the NHS, but instead as an overview of the existing body of knowledge relating to the main policies and structural changes.

V. Results

This literature search revealed a plethora of opinion pieces, editorials and additional commentary published on both the 1991 and post-2002 NHS reforms, many of which further informed the search. Primary research was not as abundant and, of that conducted, more is available on the 1990s market—most probably due to the relatively recent implementation of the latest reforms (some beginning as recently as 2005, some still yet to become widespread policy). Most available studies have very specific subject focuses, geographic restraints, small sample sizes, or are case studies (restricting external validity). In particular, there is a lack of literature reviewing the cumulative effects of NHS market reforms. Those systematic reviews that are available tend to focus on studies of one or two policies, or on the associations between reforms and very specific outcome measures. For example, a review might cover studies looking at potential effects of payment by results (PbR) and the HRG tariff only, or on patient choice and changes in waiting times. The lack of research on combined effects of market reforms may be due to the extensive resources and time required to carry out an evaluation of all policies and resulting changes, but can most probably be explained by the difficulty of attributing outcomes to market policies alone. Due to the scale of reform implementation and simultaneous changes in NHS finance, politics and society in general, there is no reliable way to establish a causal relationship between these specific policies and national changes in performance or quality indicators.^{vii}

The most common methods used by researchers were grey and clinical literature reviews, case studies, and analyses of existing data sets (e.g. hospital episode statistics, provider finances). A few used surveys, postal questionnaires, and qualitative interviews. Various outcomes analysed in these studies included:

- Accountability
- Admission rates (all hospital or elective only)
- Costs (transaction or total)
- Effectiveness (does the policy do what it is intended to do?)
- Efficiency
- Equity
- GP-provider communication
- Innovation or changes to organisational structure
- Manager or provider incentives
- Medical technology adoption

^{vii} Those studies that did attempt a broad evaluation noted this challenge in their results.

- Patient satisfaction
- Productivity
- Provider responsiveness
- Quality (variously defined)
- Waiting times

Reform policies enacted in both the 1990s and post 2002 can be categorised by one of three economic purposes: demand-side reforms (those changes focusing on the ways people or organisations demand or purchase care), supply-side reforms (changes focusing on the ways care is provided and organised), and payment system reforms (changes to monetary transactions). To maintain structural clarity, we have organised our findings by time of implementation (1991-1997 and post 2002), then by reform purpose (demand side, supply side, or payment), and finally by specific policy.

1. Effects of the first NHS internal market (1991-1997)

Demand-side reforms

As described above, the two major demand-side policies enacted in the development of the 1991 NHS market were the GP Fundholding/Total Purchasing Pilot programme, which allowed general practitioners to take on budgets for purchasing elective care for their patients, and the creation of (district) health authorities (HAs), regional organisations that were to purchase secondary and specialty care for their given populations.

1.1 GP fundholding/Total Purchasing Pilots

Mixed evidence on quality and innovation

The most comprehensive review of research conducted on the reforms of the 1990s is Julian Le Grand, Nicholas Mays and Jo Mulligan's *Learning from the NHS Internal Market*.¹⁰ This systematic review identified and discussed the known outcomes attributable to the internal market in terms of quality, efficiency, choice and responsiveness, and accountability. Although its associations were minor, GP fundholding was deemed to be the most promising of the reforms in terms of bringing about intended market benefits (e.g. increased secondary care provider quality and responsiveness).

Dixon and Glennerster concluded similarly in a 1998 review that although small, system-wide improvements were seen in the speed and convenience of access to medical care in general during the early years of reform, this was seen most of all by the patients of GP fundholders.¹¹ Supporting theories presented by various authors included general practitioners' hard budgets helping them to lever improvements in hospital services,¹² and improved GP-secondary care provider communication, possibly due to better patient tracking necessitated by fundholding contracts (and potentially enabling better coordinated care for such patients).¹³ However, an important point was made by Ray Robinson in his review of the market's impacts between 1991 and 1995, and by the Audit Commission in a similar review: when comparing quality of care received by patients of fundholders and non-fundholders, we should keep in mind that from the start fundholders were self-selected and tended to be larger, well-organised practices in middle-class areas.^{14 15}

One study by Mays and Rosen looked specifically at fundholding and innovation, and found there to be no clear difference in the rate of innovation between fundholders and non-fundholders.¹⁶ However, the Audit Commission found in its 1996 report that although many fundholders were failing to secure expected benefits for patients, the ones who achieved their desired outcomes had made innovative changes to the organisation of service delivery and/or care pathways (condition-specific treatment plans involving multiple providers or levels of care). They were not simply paying for the same services to be provided externally.¹⁷

Mixed evidence on referral rates

Evidence of the impact of fundholding on referral rates is also mixed. Surender et al. compared referral rates of fundholders and non-fundholders before and after the introduction of the policy.¹⁸ They found referral rates of non-fundholders had increased by 26.6 per cent three years on, compared to only a 7.5 per cent increase for those who had become fundholders. However, the authors did note that the percentage increase for fundholding practices may be distorted as the method of initial budget allocation was based on activity level, thereby incentivising practices to inflate referral rates in the preparatory year before switching to fundholding status.¹⁹ Another study found little difference between fundholders and non-fundholders regarding a number of out-patient referral variables, such as attendance, waiting times and patient satisfaction.²⁰ Dusheiko, Gravelle et al.'s investigation into the effect of fundholding on GPs found that referral rates for chargeable elective admissions increased for ex-fundholders after the abolishment of the scheme, suggesting that GPs may have been conservative with referrals while they were fundholders in order to maximise savings.²¹ Alternatively, fundholders may have been provided with incentives to cut out unnecessary referrals.

Fundholding may have reduced GPs' costs

Propper and colleagues found that despite the government maintaining its central management role, market forces may have had the intended impact of lowering the prices GP fundholders paid for hospital services or at least subduing price increases.²² However, fundholders were found to put a low priority on the cost of treatment (and patient convenience) when purchasing services, although they were intended to make it a high priority.^{23 24} Fundholders instead chose providers based on confidence in the consultant's ability, short waiting times and informative feedback from hospitals. Spoor and Munro analysed routine data on 29,423 referrals for elective care made by 129 practices (both fundholding and non-fundholding) to two competing providers of secondary care in one city. The results showed no difference between practices in their propensity to respond to published procedure prices, even when potential savings were very large.²⁵

There is conflicting evidence regarding fundholders and prescribing costs. The Audit Commission's 1996 report, 'What the doctor ordered: a study of GP fundholders in England and Wales', did not find anything to suggest fundholders prescribed more economically, whereas Dixon and Glennerster suggest that giving general practitioners budgets did help to curb the costs of prescribing in primary care.²⁶ Other studies into the prescribing behaviours of fundholding and non-fundholding practices have found that prescribing costs increased in both types of practices, yet the total rise was lower in fundholding practices.^{27 28} This has been attributed to more frequent prescriptions of generic and cheaper drugs.²⁹ Further investigation by Wilson et al. suggested that while the fundholding scheme was responsible for the difference in total rise of prescribing costs between fundholders and non-fundholders, variations in this rise between the general practices were influenced more by their individual practice characteristics, such training status and level of deprivation within their population.³⁰

One study noted that fundholders' lower costs were short-lived. Three years after the policy was introduced, they were spending more on prescribing than non-fundholders.³¹ A review by Dixon et al. suggested overgenerous budgets and difficulty in reducing hospitalisation for elective surgeries as some of the explanations for the inability

of fundholders to reduce costs as much as expected.³²

Reductions in patient waiting times

Multiple studies found slightly reduced waiting times for fundholders' patients. Croxson, Propper, et al. remark in a 2000 report:

Our results indicate that where these doctors paid for their patients' care, they were able to secure reductions in waiting times for their patients relative to all other patients. The magnitude of the reduction was about eight per cent. Some of the reduction in waiting time for GP fundholders' patients was achieved by general practices changing the hospital to which they referred patients. On becoming fundholders, practices were likely to change the hospital to which they referred patients, in those specialities where they achieved significant reductions in waiting times.³³

Dusheiko et al. concluded that the estimated effect of fundholding status was to significantly reduce waiting times for fundholder-contracted elective admissions (compared with patients of non-fundholders) by 4.1 to 6.6 per cent (or 4-7 days).³⁴ A study by Dowling comparing waiting times for elective care patients supported this estimation with significantly lower waiting times for fundholding patients compared to non-fundholding patients.³⁵ Dusheiko (2004) also found that patients of fundholding practices had shorter waits (by 3.7 per cent or 2 days) for non-contracted elective admissions, suggesting that fundholders were ultimately able to obtain shorter waits for all types of elective admissions. Models of supply and demand for elective surgery have shown that waiting times increase with more costly production of care, but the generous budgets received by fundholders may have enabled them to offer higher prices to providers in order to secure shorter waiting times for their patients.³⁶

Fundholding may have led to inequities in patient care

A literature review by Whitehead found little formal evidence of any impact of market reforms on equity overall, but implied fundholding had potentially contributed to increased inequity in primary care.³⁷ She notes that GP fundholding had begun to create a two-tier system in which patients whose GPs were fundholders had access to certain purchased services (for example, physiotherapy, health visiting, community mental services) that those with non-fundholding GPs did not. Another concern was that fundholding contracts tended to benefit only specific groups of patients within the practice (i.e. groups for whom the money was spent, such as diabetics). The Kings Fund found that in fundholding practices, five per cent of patients were responsible for 68 per cent of fundholding budget expenditure. In contrast, it should be noted that one early study by Duckworth et al. showed fundholding allowed GPs to choose the subsets of the populations they deemed to most need special services, or to 'voice the needs of poor patients'.³⁸

Additionally, hospitals had been seen to select fundholders' patients from waiting lists before those of non-fundholders.³⁹ Whitehead (1994) notes that in theory, hospitals could not afford to offer everyone the same services they offered fundholders (possibly discounted or embellished in some way) in order to secure contracts. Fundholding also gave GPs the incentive to 'cream-skim'—to prohibit unhealthy (therefore expensive) patients from joining their lists—although neither the Whitehead study nor any others reviewed here found evidence of this occurring. This may have been because some services were excluded from use within the fundholding budget in order to minimise the possibility of cream-skimming; for example, emergency admissions, certain chronic care, and any expenditure which exceeded £5000 per patient.⁴⁰ Le Grand et al. (1998) similarly found that providers became more responsive to fundholders, but not so much to other purchasers or patients.

Another study explored inpatient and outpatient per capita funding distributions between GP fundholders and non-fundholders in the North West Thames region.⁴¹ Fundholding practices seem to have been funded more generously than non-fundholding practices in the area, as fundholding practices received more per patient for hospital care than health authorities received for the equivalent care of patients of non-fundholding practices.

Lower patient satisfaction

Slightly lower satisfaction was found among patients of fundholders. Dusheiko et al. examined the effect fundholding had on patients' satisfaction with their practice, using a cross section of 4441 patients from 60 practices, surveyed in the last year of GP fundholding (1998).⁴² Patients of fundholders were less satisfied with the opening hours of their practice, their GP's knowledge of their medical history, with their GP's ability to arrange tests and willingness to refer to a specialist, and were more likely to agree that their doctor was more concerned about keeping costs down. However, fundholder practices performed better on a number of process measures of care, and fundholding patients were more satisfied with additional non-medical services provided by the practice. Overall, the probability that patients were very satisfied with their GP practice was smaller in fundholding practices, though it was unclear whether the patients of the fundholding practices had lower satisfaction levels before the policy was implemented.

In exploring choice of hospital for elective referrals, Anne Mason and colleagues sent postal questionnaires to GPs, GP fundholders and patients.⁴³ She concluded that although fundholders were more willing to refer patients greater distances for elective care and more likely to take patients preferences into account, fundholding had little effect on patient choice, and patients were dissatisfied with process. Total purchasers were less likely than fundholders to consult patients directly.

However, in contradiction with the above, one early study found patient satisfaction had increased in both types of practices, but the fundholders scored higher.⁴⁴

Fundholding abolished before full impacts could be evaluated

Overall, the GP fundholding scheme was introduced and abolished before researchers could review all valid evidence of its effects. The political nature of the policy (as with all of the market reforms) is well documented and may have been responsible for the lack of evidence used in its development and evaluation. As Adrian Kay noted in the British Journal of General Practice in 2002, research and policy became disconnected, and the period between major reforms of the NHS becomes increasingly short.⁴⁵ The most common conclusion of research exploring the effects of GP fundholding is expressed well by Roland Petchey in a 1995 Lancet article: 'Few reliable conclusions about fundholding, either positive or negative, can be drawn from existing research'.⁴⁶ Smith and Wilton similarly state in a 1998 report: 'Evidence concerning the success or otherwise of general practice fundholding over the past six years is incomplete and mixed. The major deficiency concerns any effect on health outcomes that may be the result of fundholding. Until such research is conducted, the jury will have to remain out on whether fundholding has secured improved efficiency in the delivery of health care'.⁴⁷

1.2 Health Authority (HA) purchasing

Little overall impact of HA purchasing

Evidence from the 1990s suggests that, as with the other reforms, the purchasing function given to HAs made little significant impact on services for patients or shifts in the pattern of hospital provision.⁴⁸ The one identifiable outcome noted was that prices did vary between buyers of hospital services and between markets, as was intended.⁴⁹

HAs lacked ability to purchase and influence effectively

Health authority contracting was a common research focus. Pauline Allen and colleagues found that HAs lacked the ability to develop strong contracts with clear accountability,⁵⁰ while Forder concluded that some contracts created incentives for providers to misrepresent user characteristics (the sample used elderly residential care).⁵¹ Both authors portray problems with contracting as a potential obstacle to achieving market benefits through the purchaser/provider split. A similar point was made by Florida-James in 1997: health authorities lacked data to 'market-test' effectively.⁵² (Market testing is a means of presenting services to a small sample of the intended market to test various strategies and pricing before fully offering such services). This prevented them from operating with the same strengths and abilities of businesses in other industries. Enthoven (1999) agreed there was a lack of reliable data for purchasers to use, concluding that the internal market empowered regional Health Authorities to demand service improvements but did not supply them with the resources and the political backing needed to do their jobs well.⁵³ He stated: 'If buyers and sellers do not have reliable information on costs and quality, they are fumbling in the dark, not driving quality and economy'.

Regarding provider adoption of new medical technologies, Rosen and Mays found purchasers had only limited influence on the short term clinical and organisational objectives pursued by providers. Further authority and direction on the part of HAs had been an anticipated benefit of the purchaser/provider split.⁵⁴

Allen et al. (2002) investigated the involvement of infection control professionals in, and their views about, the formal processes of contracting for infection control services.⁵⁵ They found that infection control clinicians employed by both hospital trusts and health authorities felt they were not involved in their organisation's contracting, and many felt that the professional networks designed for them to provide related input did not entirely compensate for their lack of individual involvement in the process. This makes a larger point about the involvement of clinicians in specialty contracting and whether health authorities (and provider trusts) took full advantage of clinical input.

Supply-side Reforms

1.3 NHS trust provision

The primary supply-side focus of market-based reform in 1991 was the creation of NHS Trusts. While hospitals had previously been managed by district health authorities, they were now given the choice of self management by taking on trust status—allowing them, among other things, greater autonomy over capital expenditure and staffing.

Increases in productivity

The 1990s saw an increase in productivity for the NHS as a whole and particularly for those organisations that chose to become trusts.^{56 57 58} However, it is difficult to attribute this outcome to trust status itself, as hospitals may have chosen to become trusts because they were already increasing productivity and could foresee themselves benefiting from the associated freedoms. Effects on quality were not as clear. According to a survey of GP fundholders, the substantial variations in secondary care provider quality that were present before the reforms were just as evident three years later in 1994, regardless of NHS trust status.⁵⁹

Hamilton and Bramley-Harker's investigation into patient waiting times and outcomes for hip fracture surgeries before and after the purchaser-provider split (1989 and 1995) found a sharp decline in post-surgical length of stay

and an increase in discharge destinations such as nursing homes (as opposed to the patient's home) following the implementation of trust status. Length of stay for patients discharged home also fell, suggesting the competitive market created by the reform may have led to greater efficiency within hospitals hoping to win contracts—leaving questions about implications for quality of care.⁶⁰

Decreases in costs for trusts

A 1997 study by Soderlund et al. reviewed hospital cost and activity data taken from routinely collected Hospital Episode Statistics (HES) and financial returns data for acute NHS hospitals in England for 1991-2 to 1993-4. Their results showed costs decreased significantly for hospitals that changed to trust status from being directly managed by health authorities. However, increases in the proportions of small purchasers (i.e. GP fundholders and fundholding groups) were associated with increases in costs for all hospitals.⁶¹

No evidence of impact on equity

Cookson, Dusheiko et al. examined the effects of hospital competition on healthcare inequality, as measured by utilisation for hip replacement and revascularisation.⁶² Because health authorities paid providers in lump sum 'block contracts' for a minimum volume of activity, hospitals had an innate incentive to select low cost, short-staying patients in order to complete the required activity level while minimising costs and waiting times. The researchers used this hypothesis to examine geographical variation and change in hospital concentration (a measure reflecting the number of hospitals in a defined area) between 1991 and 2001, alongside the natural experiment provided by the introduction of the internal market. They compared data on 'potentially competitive' and 'non-competitive' local hospital markets to evaluate the association between electoral ward utilisation rates and socio-economic status, controlling for need and supply. In a soon-to-be published paper, the authors conclude that no evidence has been found to indicate competition has any effect on health care inequality.

No evidence of negative impacts on staff; little change in management processes

The impact on staff morale and well-being resulting from the organisational change required in converting to an NHS trust was the focus of a study by Litwinenko and Cooper.⁶³ They used a prospective longitudinal design incorporating pre- and post-trust measures, finding that the transition itself did not result in negative outcomes for the organisation as a whole, as measured by levels of sickness absence. A similarly themed study by Arrowsmith and Sisson looked at the decentralisation of management arrangements in the NHS from the 1990s onwards.⁶⁴ A major objective underlying the development of NHS trusts was to devolve responsibility for human resources management (especially staff payment and related policy), which had previously been carried out centrally, to local level. Their study indicated that while managers at NHS trusts sought to improve employment flexibility and reduce costs, few trusts fully embraced the employment freedoms associated with trust status. Their failure to develop local payment policy was found to be due to 'contingencies outside the control of local trust managers relating to the financial and contracting environment, and the perpetuation of the national industrial relations frameworks.' Senior managers were also consumed with issues such as trust mergers and generally did not want to provoke confrontation with the main staff groups.

As for local accountability, a major aim of trust status, Le Grand, Mays and Mulligan (1998) found no evidence that the new governance freedoms of trusts enabled them to become more accountable to needs of local populations.

1.4 General outcomes of research on the 1991 NHS market

Effects hard to measure

Le Grand et al. (1998) concluded that little actual change was discernable from the primary research conducted on the 1990s reforms. Because the reforms were controversial and politically charged, they state, 'anecdote and prejudice have generally substituted for systematic evaluation'. Many of the new policies were voluntary (e.g. fundholding, trust application), and therefore comparisons between the self-selecting organisations and others is prone to bias. Still, Le Grand et al. argued that the purchaser/provider split was broadly successful and should remain in some form. Finally, there was no system of evaluation or monitoring set up alongside the government reforms, and many of the suspected outcomes were not easy to measure. Measuring the impact of managed competition was difficult partly because trusts were allowed to develop their own data systems and to give what information they wanted to purchasers. According to Donald Light, 'This led to scores of different computer and software systems being bought, a series of costly mistakes and scandals concerning computer systems that did not work, and data-babble in which systems could not 'talk' to one another'.⁶⁵

Changes that were detected were difficult to attribute to the policy reforms alone. Le Grand et al. (1998) note in their review that it was nearly impossible to say whether the reforms had a positive or negative effect as a whole because evaluation of multiple changes and attribution of possible outcomes to these policies alone has been difficult. A dramatic increase in resources to the NHS was seen over the same period: 6.2 per cent in 1991/92 and 5.5 per cent in 1992/93.⁶⁶ Because of this, it was hard to tell if any tangible, positive change (e.g. reduction in waiting lists, provision of a greater range of services) was the result of policy reforms or due simply to an increase in financial resources. Potentially confounding policies, although unrelated to the quasi-market, were implemented simultaneously. For example, the Patients' Charter; private finance initiatives or PFIs (schemes in which private investors provide capital funding for new hospitals in return for long-term part-ownership, usually of 30-60 years); a trend in shifting responsibility for long-term care away from the NHS and into the realm of social and community services in the late 1980s and early 90s; and broader managerial reforms originating in 1983 were all significant confounding factors.⁶⁷

Some research noted the impact on quality may have been negative

Of the outcomes that were detected, small increases in speed and convenience of access were significant because at the time they were the main deficiencies of the NHS in the eyes of UK consumers.⁶⁸ Speed, convenience and efficiency were the clearest goals possible to discern from the 1989 white paper *Working for Patients*. In contrast with the current policy objectives of the internal market, quality improvement was not a publicised priority.

A few studies noted competition may actually have been detrimental to improving the quality of care provision. Propper et al. examined whether early competition between hospitals led to better outcomes for patients, as measured by death rates after treatment for heart attack. Using data on mortality as a measure of hospital quality and analysing this data before and after 1990s policy change, they found that the relationship between competition and quality of care was negative. Controlling for patient mix and other observed characteristics of the hospital and the catchment area, greater competition was associated with higher death rates. This result suggests that hospitals in competitive markets may have reduced waiting times at the expense of quality.⁶⁹

Mark Exworthy found localism, and the social relations associated with it, had prevented the paradigm shift intended by the 1991 reforms.⁷⁰ Instead, the tendency was to move toward longer term contracts, risk-sharing and cooperation, rather than competition. Flynn et al. came to a similar conclusion when analysing purchaser/provider relationships in community health services.⁷¹ The relationships, they noted, had less in common with markets and hierarchies than with 'clans' and 'networks', which required more collaboration and less adversarial association.

They identified an inherent paradox in the quasi-market, especially regarding community health; the model provides motivation to focus on short-term gains (from searching for better deals), whereas some interviewees felt that development of high quality community health services can only be gained through the cultivation of long-term relationships of trust and cooperation. Similar reasoning could be applied to the purchasing and provision of secondary care. Another concern was voiced by Moore and Dalziel, who emphasised that short-term, market-based decisions may have unforeseen, long-term implications for patients services.⁷² There was a prevailing cultural feel among both purchasers and providers of the need for service interdependency rather than competition.⁷³

Much of the other available literature does not indicate that quality either improved or deteriorated with the introduction of competition in the NHS, and by the late 1990s there was still equally little evidence of its effects on health systems elsewhere.^{74 75}

Reforms may have contributed to increased efficiency

Research showed a slight increase in NHS efficiency between 1991 and 1998, but it was not clearly attributable to the market reforms.⁷⁶ Julian Le Grand wrote in a 1999 article that the only indicator of overall efficiency for the NHS as a whole is the cost-weighted activity index (CWAI), which is obtained by aggregating activities such as outpatient attendances and hospital inpatient stays, weighted by their cost. The CWAI is a crude indicator of health service output; for example, it does not take account of differences in quality or case-mix, or of effectiveness in terms of health gain. However, an index of the CWAI showed an annual rate of growth of 2.3 per cent from 1980–1981 to 1990–1991, but 4.1 per cent for the post-reform period 1991–1992 to 1995–1996. Dividing this by the changes in real resources over the same two periods gives a crude measure of the average annual change in productive efficiency: 2 per cent after reform, compared with 1.5 per cent before.⁷⁷

Reforms had little significant impact on patient choice

Working for Patients stated that an ultimate aim of the 1991 reforms would be ‘to give patients, wherever they live in the UK, better health care and greater choice of services available’.⁷⁸ Although not a prominent feature of the early market, patient choice of provider and time of treatment began to appear in policy objectives in the late 1990s, and it was either a variable or outcome considered in multiple studies reviewed.

Siciliani and Martin, looking at 120 English NHS hospitals over the period 1999–2001, found more choice to be significantly associated with lower waiting times at the sample mean (where GPs offered five hospitals from which patients could choose). However, an extra hospital in a catchment area only reduced waiting by at most a few days (a 1–2 per cent reduction). They also found some evidence that increases in choice can boost waiting times when the degree of choice is very high (i.e. when more than 11 hospitals are included in the catchment area).⁷⁹ This seems to suggest diminishing returns on decreased waiting time when patients are given a choice between more than five hospitals.

Through a series of qualitative interviews with patients and cataract surgery providers, Mariana Fotaki found the purchaser/provider split had resulted in a change of attitude among providers. They began to think more along the lines of ‘serving customers’, to have a marketing strategy, and to take a more ‘user friendly approach’ to health services than before the reforms.⁸⁰ She detected an increase in the amount and type of information providers gave to both purchasers and patients, although as far as patients were concerned, the demand for information had not been fully satisfied. Both patients and purchasers actually reported experiencing less choice than before the reforms. This is supported by the conclusions of Le Grande, Mays and Mulligan (1998) that choice for patients had not increased by 1997.

Political interference obstructed market functioning

In the hospital sector, market forces were limited by the political sensitivity surrounding major provider changes, the need to control medical manpower and reduce junior medical staff working hours, and the alleged vulnerability of hospitals when particular specialties are decommissioned.⁸¹ Light concluded in his 2001 article that the reforms were simply too politically charged and suffered from too much government intervention for the market to bring its desired benefits:

‘Managed competition made health care more politicised than before, with a greater chance that some market player would make a mistake and create a front-page embarrassment. The government therefore found itself in the position of having to watch every player and every move in order to spot slips so that it could catch them before they became embarrassing falls’.⁸²

Market mechanisms functioned within a centrally directed, centrally funded, and centrally accountable government hierarchy, which Le Grand et al. (1998) concluded led to an unstable, constantly changing system. Similarly, Enthoven (1999) drew particular attention to the fact, explaining that the fear of political cross-fire continued to frustrate much needed progress in developing a model for the NHS which would allow it to succeed in the 21st century.⁸³ He recommended re-inventing the internal market in a way which allowed the NHS to achieve modernisation through consumer choice, competition and substantially more resources (all of which were attempted with greater rigour in the post-2002 reforms).

Conversely, some authors found there may have been a lack of necessary government support to aid the reforms. With the introduction of the internal market, the DH placed greater emphasis on managers to improve efficiency and productivity; however, system support to bring about these changes seemed to be lacking. This was particularly evident where NHS trust managers were found to have the entrepreneurial skills necessary to participate in a competitive environment but felt constrained by poor communication infrastructure, lack of information on system-level supply and demand, and lack of data on purchasers.⁸⁴ Quality related information in the NHS remained virtually non-existent.

Additional causes of market failure

Quite a few studies concluded that obstacles to the success of the 90s reforms could be seen as practical manifestations of market failure.^{85 86} For example, there were barriers to entry (e.g. government control over medical school admission, and costs of building a new hospital or offering a new service were often prohibitively high) and exit (taking over or closing services was met with strong political resistance); and smaller purchasers and providers were less able to compete than larger ones with larger risk pools, more managerial support and capacity. Additionally, most commercial markets operate with some spare capacity, which enables businesses to take customers from competitors, but NHS hospitals had spent the past 40 years working to full capacity. A further barrier to success was that the NHS market did not encourage competitive pricing. Observations of pricing found it to be highly variable between providers, with widespread disregard of the average pricing rules, although lower prices were offered to small purchasers such as fundholders.⁸⁷ There was a lack of true contestability.

Another widely cited, broad scale review of the 90s reforms entitled ‘The British quasi-market in health care: a balance sheet of the evidence’ similarly stated that the incentives were generally too weak and the constraints too strong to generate the consequences predicted by either proponents or critics of the quasi-market.⁸⁸

NHS cultural change

Several changes in the organisational culture of the NHS were noted. The balance of power in terms of DH focus shifted from hospital specialists to general practitioners as primary care was held up as the foundation of the health system, and more generally, from providers to purchasers (who were to hold providers accountable by the ability to take business elsewhere).⁸⁹ There was an increase in cost-consciousness throughout the NHS, and physicians saw their historically unquestioned authority at times equalled by, at times surpassed by, NHS managers.^{90 91 92} For the first time, it seemed, the concepts of consumerism, value for money, and accountability for output permeated the NHS.⁹³ Donald Light wrote in 2001: 'Managed competition has left an enduring legacy of accountability to purchasers in economic terms such as efficiency, transaction costs, and cost effectiveness'.⁹⁴ While Kirkup and Donaldson (1994) observed early on that many of the reforms failed to realise their full potential to achieve beneficial change partly because traditional behaviours had not yet adapted to the new system of care, Rudolf Klein considered these changes to be so significant that 'No future government [could] return to the pre-1991 situation'.^{95 96} This cultural shift remains the most unquestioned outcome of the first NHS quasi market.

2. Effects of the post-2002 market reforms

Labour's 2002 NHS reforms intended to bring about the market benefits that failed to emerge in the 1990s. Commissioning by primary care trusts; payment by results and patient choice in elective surgery; independent sector treatment centres; foundation trusts; and practice-based commissioning were concentrated primarily on further devolving decision making to regional and local levels, and strengthening incentives for provider competition. The reforms were intended to operate as a package, with responsive commissioners, autonomous providers, and informed patients coming together to best meet need while ensuring efficient use of resources.⁹⁷

Demand-side reforms

Changes to the demand-side of the market included once again reforming the organisations responsible for purchasing care. Primary Care Trusts became responsible for assessing the needs of their populations and purchasing the highest quality, best value secondary and specialty healthcare services to meet those needs. GP fundholding was restored in the form of practice-based commissioning, allowing GPs (mostly in groups or collaborations) to choose how the PCT should use funding allocated for community and speciality care (e.g. mental health, certain geriatric services) for their own patient lists. Finally, patients were given a concrete choice of provider for elective treatment through the national, computerised Choose and Book programme.

2.1 Practice-based commissioning

Learning from GP Fundholding

Some early literature reviews on the post-2002 reforms looked at GP fundholding (GPFH) and its implications for the success of practice-based commissioning (PbC). Mannion (2005) looked at both fundholding and total purchasing pilots (TPP) and suggested the available evidences points to the following potential beneficial outcomes for variants of PbC:⁹⁸

- Lower elective referral/admission rates (GPFH and TPPs)
- Reduced emergency related occupied bed days (TPPs)

- Lower waiting times for non-emergency treatment (GPFH and TPPs)
- Improved coordination of primary, intermediate and community support services (GPFH and TPPs)
- Improvements in financial risk management (TPPs)
- Reductions in the growth in prescribing costs (GPFH and TPPs)
- Engagement of clinicians in the commissioning process (GPGH and TPPs)

He also found drawbacks and limitations to GP fundholding that might also apply to PbC. There is evidence to suggest that PbC may induce limited or even adverse outcomes for patients and the delivery of care, including:

- Reduced patient satisfaction (GPFH)
- Increased management and transaction costs (GPFH and TPPs)
- Inequities of access (GPFH and TPPs)
- Little impact on the way hospital care is organised and delivered (GPFH and TPPs)

In 2004, Smith, Mays, et al. carried out a similarly broad review of the effectiveness of past primary care-led commissioning with a focus on what it meant for PbC.⁹⁹ They found little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services as intended. Primary care-led commissioning can, however, secure improved responsiveness such as shorter waiting times for treatment and more information on patients' progress.

Factors found to facilitate effective primary care commissioning included stability in the organisation of the commissioning body, sufficient time to enable clinicians to become engaged, and strategies for commissioning to be developed and implemented.¹⁰⁰ Policies that support offering patients and commissioners a choice of providers and enable resources to be shifted between providers and services also lead to effective commissioning, as did a local primary care system that is sufficiently developed to provide additional services. Effective management and information support, and appropriate regulation to minimise conflicts of interest arising from general practitioners being both commissioners and providers, were also crucial.

Dusheiko et al. (2008) showed that elective referrals from primary care organisations (PCOs) and GP practices became significantly more concentrated^{viii} across hospitals between 1997/98 and 2002/03.¹⁰¹ In other words, there was a reduction in the average number of hospitals used by PCOs and GPs and an increase in the average share of admissions accounted for by the main hospital. The researchers conclude that around one tenth of the increase in concentration in practice-level referrals was due to the abolition of fundholding in April 1999. Fundholding GPs were found to have had less concentrated elective admission patterns (i.e. they referred to a greater number of providers) than non-fundholders whose admissions were paid for by their PCO.

Smith and Mays emphasised that incentives needed to be strong enough to encourage general practitioners and practices to seek to develop new forms of care across the primary-secondary care interface. At the time of their review (2004), surveys showed about half of general practitioners were not interested in taking on a commissioning budget. They suggested this might be overcome by linking part of GP income with the responsibility of managing a PbC budget (which is now indeed part of the PbC scheme).

^{viii} Concentration refers to the proportion of a market held by one or more providers, in this case, hospitals.

PbC implementation still ongoing

The Audit Commission found in 2006 that the majority of general practices that had taken up PbC budgets were working together as localities or consortia for commissioning purposes (as opposed to working on their own).¹⁰² The benefits of working in this way and pooling expertise were starting to be realised in the form of relatively small, local pathway redesign projects, and better demand management and activity monitoring. In 2007, the Commission published a more in depth study of PbC.¹⁰³ Looking at the second year of practice based commissioning (2006-7) within 16 primary care trusts, the research was based on semi-structured interviews with trust staff, selected general practitioners, and selected practice managers, in addition to a survey of local general practitioners. They found progress in implementing PbC had been made within all 16 PCTs. The combination of an incentive payment to practices, together with the requirement on PCTs to provide a supporting infrastructure, had helped to ignite the programme. During 2006/07 nearly all participating practices received incentive payments, totalling an estimated £98 million. Still, the Commission concluded that engagement of practices in 2006 was variable. PbC was largely being led by a few enthusiastic practices working with supportive PCTs.

In 2008 the King's Fund published the results of an extensive study into the implementation of PbC to date.¹⁰⁴ Research included a series of in-depth interviews with a range of PCT staff, hospital staff, GPs and practice managers from various case study sites. Findings were then tested with a group of policy-makers, representatives from PCTs, and academics to find out whether they were representative of the situation nationally. The researchers suggested that only modest progress had been made in implementing practice-based commissioning and echoed the Audit Commission's conclusion that PbC was being led by a few enthusiastic practices working with supportive primary care trusts. Very few PbC-led initiatives had been established, and there was limited impact in terms of better services for patients or more efficient use of resources. Where initiatives had been developed, they tended to have been small-scale, local pilots focusing on providing hospital services in community settings. On the positive side, general practices had a better understanding of the financial consequences of their decisions and engaged more in managing their patients' use of secondary care (demand management) since a previous review.

The Audit and Healthcare Commissions concluded in 2008 that incentives and infrastructure used to support PbC were still not sufficient to engage most GPs in commissioning.¹⁰⁵ In contrast, however, a September 2009 DH survey found that nine out of 10 GP practices (92 per cent) said they are part of a PbC group, and three quarters of practices (75 per cent) said they had been offered a participation incentive scheme by their PCTs.¹⁰⁶

Many PbC consortia more interested in self-provision than service commissioning

Both the King's Fund (2008) and the Audit Commission (2006) found that many practices saw PbC more as a way to fund an increase in their provision of new services than as a means to commission health care from others or manage financial risk. Another recent, large study into PbC by the National Primary Care Research and Development Centre (NPCRDC) also found a large number of new services set up in the name of PbC.¹⁰⁷ These ranged from local, practice-level services (e.g. electrocardiographs) to much larger schemes (e.g. new clinics across localities). Not all of these were established solely as the result of PbC, but PbC provided a convenient vehicle for their ongoing development management, governance and financing. However, the King's Fund noted that the ability of practice-based commissioners to commission services from themselves requires robust governance arrangements that have often yet to be fully tested fully in practice. Their review concludes that there are currently few signs of PbC bringing about the scale of service change envisaged by the Department of Health.

Variation in local relationships and levels of PCT support

The King's Fund (2008) found PbC has had a positive impact on both personal and organisational relationships in the sites studied. In general the scheme fostered more collaborative working relationships among GPs, opened up channels of communication between GPs and PCTs and, in some cases, between GPs and hospital staff. However, the September 2009 DH survey explored local experiences of PbC groups and found many general practices had concerns with their PCTs regarding levels of management support received for PbC, but a large majority (82 per cent) of GP commissioning leads claimed to have good relationships with their PCTs.¹⁰⁸ The King's Fund (2008) noted that in a few cases PbC had caused already poor relationships to deteriorate further. GP enthusiasm waned slightly between 2007 and 2008, with some GPs being deterred by the lack of tangible progress in improving services for patients. There was little evidence of practices engaging with public health staff and local authorities on the broader population health agenda, which presented a risk that resources would not be aligned with primary care trusts' strategic objectives. Although the lack of national guidance on the respective roles of GPs and PCTs offered flexibility with PbC, it had also led to disagreement. GPs and PCTs often had different visions, and there had been struggles for control over local agendas. Checkland et al. noted GPs had limited time to engage in commissioning and often lacked the requisite skills (for example, in data analysis). They needed considerable support from PCTs, but there were often limited resources and experience with such processes at PCT level as well.¹⁰⁹

Jones and Lakasing (2007) presented a case study looking at a single GP PbC attempt, which highlighted the need for supportive relationships between practice-based commissioners and local consultants.¹¹⁰ The proposal studied was denied by the local PCT, claiming it did not have the support of relevant secondary care providers in the necessary pathway. The authors conclude that consultants may never accept that primary care can deliver high quality solutions, and they cite other examples of PCTs cutting PbC initiatives first when cutting budgets.

More generally, the Audit Commission (2006) found the quality of the financial infrastructure underpinning PbC programmes to be variable, with many practices unclear on how their budgets had been set or how financial risk was to be managed. Many were critical of the information available to them and of the support provided by PCTs to help them properly manage budgets and resources. Arrangements for sharing and using any savings, which were important incentives for many practices, were also still theoretical, unclear or criticised—particularly where savings would be taken by the PCT to fund any overall deficit. The NPCRDC study (2009) found budget setting was often a source of contention between GP groups and PCTs.¹¹¹ They state: 'The extent of the budget devolved under PbC plays a part in determining the scope of the action possible, and in general we found an appetite in PbC consortia for greater access to community or mental health budgets, as these are areas that have a very direct impact on the work of GPs.' Adequate management resources were found to be important in all sites studied. They found a variety of management models, including seconded staff, directly employed staff and the employment of external consultants. None of these models was in itself clearly associated with better or worse outcomes.

Coleman, Harrison and Checkland examined the relationship between local authority Overview and Scrutiny Committees (OSCs)—groups of interested lay community members responsible for overseeing and monitoring local health services—and practice-based commissioners in the NHS.¹¹² The authors suggest that PbC was introduced so that front-line medical staff could be involved in commissioning health care services for their local areas, but that such decisions are currently accountable only to local PCTs, not to OSCs. In practice, most practice-based commissioning is carried out by groups of surgeries joining together to form consortia, which would make OSC involvement more practicable, but these consortia are not statutory bodies and therefore cannot be compelled to attend health OSCs. The researchers suggest that PbC consortia should become formally involved with the health scrutiny process.

Additional obstacles to PbC

In 2006, use and accuracy of information was a challenge even at the more advanced GP PbC sites.¹¹³ The Audit Commission (2006) suggested that practices were concerned about reliability of activity data and had reservations about extending the scope of their indicative budgets while this was the case. They were further frustrated by the timeliness and quality of discharge summaries received from acute trusts, which affected their ability to monitor patients and validate payments.

The King's Fund (2008) also supported the finding that GPs faced a lack of reliable, up-to-date population and treatment information. This limited both GPs' ability to develop commissioning ideas and PCTs' willingness to approve these ideas. It also created problems with setting and managing practice-based commissioners' virtual budgets. PCTs are responsible for creating a robust governance framework to allow the financial and clinical risks involved in PbC to be managed appropriately, but in all sites studied, the complexities of setting up governance and accountability arrangements considerably delayed the implementation of PbC.

The NPCRDC study (2009) found that although PbC consortia tended to make savings, they still faced problems with budget calculations and lack of support in analysis of hospital statistics.¹¹⁴ There was often no overall consensus about how savings should be calculated, or about whether or not it was meaningful to regard savings as 'planned' or 'unplanned'. PbC consortia often complained that they had insufficient support in analysing and responding to detailed hospital activity statistics. However, GPs were also often unclear as to exactly what they wanted from their data analysts.

NPCRDC researchers concluded that the most important factor in ensuring clinical engagement with PbC (at different organisational levels) was that the local PbC project should be seen as legitimate by all players. Factors that seemed to undermine the perceived legitimacy of PbC were: concern that national policy might substantially alter or abolish PbC at any time; and excessively tight control by PCTs, characterised by overly bureaucratic processes or a failure to support innovation. They also noted that much of the progress made had depended on co-operative work between PbC consortia and local providers.

The King's Fund carried out a follow-up survey of GPs and practice managers in 2009.¹¹⁵ They concluded that although commitment to PbC remains high among GPs, more than half of clinicians who responded reported feeling 'not at all' or 'not very' engaged with the process. Progress is still hampered by a lack of local vision, a persisting lack of clarity over roles and responsibilities, and bureaucratic governance processes.

2.2 Primary Care Trust (PCT) commissioning

PCTs may lack necessary skills and resources

Similar to the research on Health Authority purchasing in the 1990s, literature on commissioning reported that PCTs often lack the ability or resources to purchase effectively and bring about intended benefits for the health system. For example, in a recent literature review, Lewis, et al. state that much ineffective purchasing is the result of PCTs not taking full advantage of their potential power in the purchaser/provider relationship. Instead, PCTs have tended to sustain historical purchasing patterns with familiar providers, which are often older organisations with more experience in contract negotiation. PCTs have also struggled with an information deficit in carrying out population needs assessments and often experience a lack of support from the DH.¹¹⁶

Other studies indicated poor management may not be the only contributor to ineffective purchasing. Badrinath et al. studied factors that could explain the difference between PCTs experiencing financial deficit and those

experiencing surplus, prompted by the government blaming financial deficits on poor local management of resources.¹¹⁷ The authors found that PCTs in deficit were more likely to be located in rural and more affluent areas, and concluded that poor management alone is unlikely to be the cause of deficits. Potential reasons for deficits include the challenges of providing for rural communities and increased demand for health services among more affluent populations.

Marshall et al. explored the potential tension between the need for PCT managers to improve performance and the skills required to produce cultural change, and how the organisations are attempting to deal with this tension.¹¹⁸ They looked specifically at primary care, but the results may be useful in analysing PCT responsibilities regarding secondary care as well. Using a purposive sample of six PCTs to represent a range of cultural, structural, geographical, and demographic characteristics, the researchers found two distinct and polarised styles of management. One style, primarily preferred by senior managers, could be described as 'directive', challenging the prevailing norms and values of GPs. This group seemed to be driven mostly by the imperative to deliver a political agenda. The second style was more popular with middle managers and consisted of a desire to work with the prevailing cultures found in general practice—an attempt to facilitate change from within rather than forcing change from outside. The middle managers seemed to act as buffers between the demands of senior managers and their own perception of the ability and willingness of health professionals to cope with change. These different approaches can lead to tension and dysfunction between tiers of PCT management.

Cookson et al. note in a recent publication that PCTs have weak incentives and inadequate management capacity as purchasers, when contrasted with those organisations that hold similar roles in European social insurance health systems.¹¹⁹ These insurers, or sickness funds, operate within systems of 'managed competition' that incentivise the development of greater management capacity because their income depends on attracting enrolees (by offering lower premiums and higher quality for their insurance plans). PCTs, on the other hand, do not compete for enrolees—their populations are fixed by catchment areas, and their income streams are fixed by capitation funding formulae—leaving them no strong incentive to drive aggressive bargains with hospitals, as was intended by DH policy.

Lack of community input and satisfaction

Nick Goodwin concluded in a 2007 literature and policy review that PCTs are being entrusted with developing care pathway models that aim to substantially reinvest in community-based care services in order to tackle long-term conditions. However, as commissioners, they remain in a relatively weak position to achieve these goals.¹²⁰ Additionally, this has had a negative effect on community satisfaction. National Voices and the Royal College of Nursing carried out an online survey of 226 patient and voluntary groups based throughout England in 2008.¹²¹ They found that commissioning has shown limited ability to engage patients and the public in health policy-making, and pays too little attention to many disease-specific issues. Less than half of the respondent groups indicated any involvement with commissioning, and of these, only a few estimated they had made a meaningful contribution to the process. They cite one mental health group as saying:

We are invited to attend [commissioning] meetings that discuss strategies. But our input is often overruled or ignored, and we are merely a box ticked that service users have been involved—with no opportunity taken to genuinely and meaningfully involve service users, or to ensure the feedback and information imparted by us on behalf of service users.

Overall, the groups felt PCT commissioning had not brought about beneficial change in many of the areas singled out as important by the Department of Health—particularly the scale of services provided at home, seamless care between providers, and that complex care needs were met by the right professionals.

Similarly, a recent survey published by Picker Institute Europe reported that neither patients nor frontline staff, such as GPs and primary care nurses, have had a strong influence on the direction of the most recent strategies to involve patients and the public in local commissioning. Any attempts to involve others in purchasers' commissioning decisions have so far penetrated only trust management.¹²²

Obstacles to local autonomy

The purchaser/provider split was intended to empower both types of organisation to operate autonomously and pursue self-interest; however, multiple studies on post-2002 policy highlight obstacles in meeting this objective. Wilson, Sussex, et al. (2007) looked at a case study pilot of a prioritisation mechanism in a single PCT, which was capable of accommodating a wide variety of evidence to rank service developments by cost and weighted benefit. In addition to proving the tested mechanism to be valuable, the authors highlighted divergences in relative priority between nationally mandated service developments and local healthcare priorities. PCTs face difficulties in providing the most beneficial services to their local populations when they are at odds with NICE-approved services.^{ix 123}

Relationships between NHS organisations are complex. An evaluation by Exworthy and Frosini (2008) suggested that for PCTs, vertical autonomy is always conditional as long as the NHS retains a centralised funding role.¹²⁴ The fact that foundation trusts are empowered to make their own investment decisions has implications for the ability of PCTs to reconfigure the provision of services around the needs of their population. This is further influenced by the degree of organisational capacity within a PCT and the local health economy in which it is operating. The authors state in conclusion: 'This analysis has implications for the ability of the government to achieve its objectives of creating a self-sustaining programme of reform. It suggests that the NHS needs to be more definitive in its settlement [of a power balance] between the centre and locality'.

World Class Commissioning too new to determine impacts

The King's Fund is currently researching the role and impact of external organisations on World Class Commissioning (WCC)—the DH's relatively new framework for supporting and regulating PCT commissioning. It holds them accountable for commissioning competencies, governance and certain outcomes, and rewards improvement.¹²⁵ The first strand of the project, a national survey of primary care trusts (PCTs), was completed early in 2009. Ninety-six responses were received. Findings include:

- Around three quarters of PCTs have used external support for commissioning.
- The majority of these currently hold several contracts with external organisations, with a quarter holding five or more contracts.
- Most external support is procured outside of the Department of Health's Framework for procuring External Support for Commissioning (FESC).
- Respondents were largely positive about their experiences of using external support.

^{ix} The National Institute of Health and Clinical Excellence (NICE) is the government body responsible for advising on and approving medical treatments for use in the NHS. The DH expects PCTs to follow NICE guidance and make approved treatments available for their populations.

WCC is still a very young policy, and whether it will have a positive impact on commissioning outcomes is yet to be seen.

2.3 Patient choice of provider

Evidence on implementation

Since January 2006, all patients referred by their GP for elective surgery (excluding those for whom the speed of access to diagnosis and treatment is particularly important, e.g. cancer, chest pain) should have been offered a choice of four or more providers commissioned by their PCT. As of April 2008, this has been extended to any clinically appropriate hospital provider that meets NHS standards and agrees to the PbR tariff for that procedure. Patient choice of provider became a legal right in April 2009, set out in the NHS Constitution.¹²⁶ Most available studies of patient choice focus on pre-2008 policy, and there is currently not enough evidence to discern effects of the most recent policy to routinely offer free choice of provider to all non-urgent patients.

In 2005, patients living in the South East (excluding London), East Anglia, an area south of Bristol, or in Cornwall, had the lowest choice of provider for elective care, and would need to travel further to exercise meaningful choice of hospital.¹²⁷ These findings by Damiani and Propper implied that subsidising travel for people located in the areas identified may make choice of provider more attractive. They also found that the supply of acute beds in non-NHS facilities was too small to make an important contribution to patient choice. Propper et al. (2007) found that there is considerable variation in the distances travelled for hospital admission between electoral wards.¹²⁸ Some of this is explained by geographical location: individuals living in more rural areas travel further for elective (median 27.2 versus 15.0 km), emergency (25.3 versus 13.9 km) and maternity (25.0 versus 13.9 km) admissions. But individuals located in highly deprived wards travel less far, and this shorter distance is not explained simply by the closer location of hospitals to these wards. The authors conclude that before the introduction of more patient choice, there were considerable differences between individuals in the distances they travelled for hospital care. An increase in patient choice may be disproportionately benefiting people from less deprived areas.

The DH has been carrying out National Patient Choice Surveys for England since 2006. The surveys, conducted by Ipsos MORI on behalf of the Department, monitor patient awareness of choice and recollection of having been offered a choice of hospital for their first outpatient appointment. They were designed to provide a national overview of choice and summary results at PCT level (initially bi-monthly and now quarterly) and generally have an effective response rate of around 30 per cent. The most recent report, published in August 2009, provides results from around 93,000 responses. Findings were as follows:¹²⁹

- The percentage of patients recalling being offered a choice of hospital for their first outpatient appointment was 47 per cent in March 2009, up from 46 per cent in December 2008 and 30 per cent in the first survey (May/June 2006).
- 50 per cent of patients were aware before they visited their GP that they had a choice of hospitals for their first appointment, the same as in December 2008 and up from 29 per cent in the May/June 2006 survey.
- 62 per cent of patients who were aware of choice recalled being offered choice, whereas 32 per cent of those not aware of choice recalled being offered it, similar to the December survey (61 per cent and 32 per cent respectively).

- 89 per cent of patients offered a choice were able to go to the hospital they wanted, with a further 4 per cent having no preference (compared with 46 per cent of patients not offered choice able to go where they wanted and 41 per cent having no preference).
- 76 per cent of patients were satisfied with how long they had to wait from the time their GP referred them to when they saw the hospital specialist.
- Hospital cleanliness and low infection rates were selected most often (74 per cent of patients) as an important factor when choosing a hospital.

Overall observations were that in practice, uptake of choice policy is not yet widely realised, and degree of implementation varies geographically.

Choose and Book may not be enabling as much choice as expected

In 2008, Green et al. published the results of a survey of patients' experience of choice in an NHS hospital in London.¹³⁰ One hundred and four patients at their first outpatient appointment completed the questionnaire, 47 of whom had been referred through Choose and Book. Among the Choose and Book patients, 66% reported not being given a choice of appointment date, 66% reported not being given a choice of appointment time, 86% reported being given a choice of fewer than four hospitals in total, and 32% reported not being given any choice of hospital. Among those who reported being given a choice, there was no statistically significant difference in satisfaction with the experience between Choose and Book and conventionally referred patients. For both groups, the median response was 'fairly satisfied'. The researchers concluded that patients did not experience the degree of choice that Choose and Book was designed to deliver.

Patients/GPs desire more information on provider quality

Coulter, Maistre, et al. carried out an evaluation of the London Patient Choice (LPC) scheme, published by Picker Institute Europe in 2005.¹³¹ LPC was a pilot programme testing the feasibility of offering patients facing a wait of more than eight months for elective surgery the option of going to an alternative London provider that could offer faster treatment. This study, part of a wider evaluation of LPC, focused on patients' experiences of the scheme. Patients from the waiting lists of five trusts were sent postal questionnaires before they had been offered a choice of an alternative provider, and after they had been discharged from hospital. In-depth interviews were carried out with a sub-sample in each group, and a record review was carried out to determine rates of acceptance of the offer of an alternative hospital.

An overwhelming majority (97 per cent) of patients who had opted to go to an alternative hospital said they would recommend the scheme to others. However, the main problem, as far as patients were concerned, was the failure to provide sufficient information on quality and performance in the various alternative providers in order to enable fully informed decision-making. The authors conclude: 'Market incentives will only help to drive up quality standards if patients are able to act as discerning consumers. To enable them to discriminate between different providers, they and their GPs will require reliable unbiased information about quality standards'.

Choice has contributed to lower waiting times for elective surgery

Lorelei Jones and Nick Mays recently published a systematic literature review on patient choice policy to date within the English NHS.¹³² They found evidence on patient choice of provider to be dominated by studies of pilots (local or temporary programmes run for the purpose of testing) that differed significantly from current choice policy. Evidence from the pilots undertaken in the early 2000s hinted that choice of provider should contribute to further reductions in waiting times. For example, a study by Dawson et al. focusing on the London Patient Choice

project found LPC led to shorter average waiting times in the London region and a convergence in waiting times among London hospitals.¹³³

Variations in patient experience and preferences in exercising choice

There seems to be greater interest in choice among the elderly than was originally anticipated by policy makers. Weir et al. conclude in a 2007 study that the desire for choice among older patients is fuelled by perceived variability in hospital service provision.¹³⁴ However, the immediacy of decision making imposed by the Choose and Book system could impair the ability of elderly patients to make independent choices, and the time needed to overcome this could create its own problems for GPs' consultation schedules. While good information tools are needed to aid the choice process, they may not improve patient satisfaction or anxiety levels.

Jones and Mays (2009) concluded that patients exercising choice have tended to report a higher perceived quality of care, suggesting wider patient choice may also lead to improved satisfaction with care quality.¹³⁵ They also cited evidence that specialist providers are responding to patient choice out of concern for organisational reputation and are making efforts to improve patient experience. Factors most likely to be taken into account by patients exercising choice in 2008 were perceptions of cleanliness/low levels of hospital-acquired infection and quality of care.

Reductions in waiting times below 10 weeks (from GP referral to treatment) were not valued by patients and exerted no influence over choice of hospital, according to a survey of 1000 people across England by Burge et al. (2006).¹³⁶ As waiting times increased above 10 weeks, they were then found to have an increasingly negative influence on the likelihood of an individual choosing the hospital. Additional findings by Burge and colleagues included: negative advice from a GP was given a higher weight than positive advice in favour of a particular provider, and there was a general preference for shorter travel times and lower travel costs regardless of eligibility for refunds. Certain respondent characteristics such as poor health or typically travelling to the local hospital by bus, were associated with 'loyalty' (i.e. a higher propensity to select the local provider). Other patient characteristics such as having internet access or a poor perception of the local hospital were associated with disloyalty. In addition to these patient-specific characteristics, there was an inherent bias towards the local provider that affected all respondents.

Patients may not place a high priority on choice of provider

Fotaki, Roland and colleagues at the University of Manchester's National Primary Care Research and Development Centre carried out a 2008 literature review on the benefits choice could bring to patients.¹³⁷ They reported that choosing between hospitals or primary care providers is not currently a high priority for the public, except where local services are poor (e.g. they have long waiting times) and where individual patients' circumstances do not limit their ability to travel. Patients do want to be more involved in decisions about their own treatment and generally participate much less in these decisions than they indicate they would wish. When patients become ill, however, they are increasingly likely to wish to rely on a trusted health practitioner to choose their treatment.

In a 2007 review, asking 'Are the assumptions underlying patients choice realistic?' Ian Greener found many theoretical aspects of patient choice were still under-researched.¹³⁸ The scope of choices required by and available to patients may be over-estimated by the present policy. Patients do want choices about when they are treated but are reticent to take responsibility for choosing where they are treated or for choosing the treatment they will receive. As such, as presently implemented, Choose and Book is more likely to be concerned with times rather than places for treatment. As other authors have noted, the absence of detailed comparative clinical information means patients are currently intended to make choices on the basis of other factors. One possibility is that patients will continue to decide on the basis of non-clinical information instead, but Greener notes this leaves doubts as to

whether the policy as it is can lead to an improvement in patient care.

Disagreement on inequities resulting from choice policy

Burge et al. also found that hospitals said to provide higher clinical quality of care (measured in terms of impact on patients' health) tended to be chosen more often than others, all other things being equal. However, patients without formal educational qualifications (GCSE/O level and above) placed significantly less weight on increases in this factor above an 'average' quality level, compared with those patients who had such qualifications. The authors concluded that because loyalty to the local hospital was related to respondent characteristics, there is likely to be a social gradient in the way that patients make choices. Such a social gradient will mean that under choice, there may be a consistent bias between social groups, with choices being more heavily influenced by clinical performance for some groups than others, for example. This could widen inequalities of access to high performing hospitals and the 'market' signals sent to providers by patients' choices would be inconsistent. Fotaki et al. (2008) also found that better educated populations make greater use of information and are more likely to exercise choice in health care.¹³⁹

Contrary to this argument were the findings of Cooper et al., who recently looked at waiting time data for patients having elective knee replacements, hip replacements, and cataract repairs between 1997 and 2007.¹⁴⁰ Mean and median waiting times rose initially and then fell steadily over time. In 1997 waiting times and deprivation tended to be positively related (i.e. statistically, the more deprived the patient, the longer the wait for treatment). By 2007 variation in waiting times across the population tended to be lower, but the relation between deprivation and waiting time was less pronounced. In some cases, patients from the most deprived fifth of the population were waiting less time than patients from the most advantaged fifth. The authors concluded that although it is impossible to attribute changes in waiting times to market policy reforms alone, it can be said that patient choice (along with provider competition and increased hospital capacity) did not harm equity.

GP feelings toward patient choice

Rosen, Florin and colleagues at the Kings Fund carried out a study exploring GPs' views about the introduction of choice at the point of referral.¹⁴¹ Using a combination of telephone interviews and focus groups, the researchers focused on the influences of choice policy on referral behaviour, and early experiences of Choose and Book. The study found GPs generally supported extending patient choice, but the extent of active support varied considerably. Four factors influenced the degree of this support: the availability and quality of formal and informal information about services; GPs' views of their professional role; patient preferences; and local PCT policies that might restrict choice.

The researchers found most GPs made choices on the patient's behalf (with or without Choose and Book) unless the patient expressed a preference. GPs typically only tried to override patient preferences in order to steer them towards what they perceive to be high quality providers or away from providers about whom they had concerns. Very few GPs had used Choose and Book to actively engage patients in discussions about choice of provider. However, the study did find that patients and GPs seek overlapping but different characteristics when choosing a hospital. GPs' advice to patients typically balances soft information about clinical quality with patient preferences or published data about waiting times and convenience of access. Most GPs distrusted official sources of information (e.g. waiting list data). They considered this sort of government-produced information to be manipulated to meet targets and subject to political 'spin' while some also had reservations on methods used to obtain data. There was no consensus among interviewees about the type of information GPs wanted to support patient choice or about how it should be presented.

Other studies focusing on GPs' opinion of Choose and Book produced mixed results.^{142 143} While the system

allowed GPs to make appointments on the spot, informed patients of approximate waiting times, improved attendance at outpatient appointments and enabled referral tracking, it also increased workload, created technical difficulties, and led to uneven distribution of hospital appointment placements. In some instances, Choose and Book was implemented as an add-on to other processes—essentially as a back-up system to prevent information from going missing, to ensure confidential data transfer, or to provide a clear audit trail. This may imply the system is not fully functioning in the capacity it was intended to and is instead being used as an additional technological tool for administrative purposes.

Patient choice and cultural change within hospitals

An in-depth case study on the effects of patient choice on health economies was carried out by Greener and Mannion (2009).¹⁴⁴ Over the two-year period between 2006 and 2008, the authors undertook over 60 interviews across different staff groups at all levels of a single hospital trust in the north of England. They recorded observations of meetings and hospital life in general, in addition to informal discussions with staff in public locations of the trust about a range of issues. The trust provided access to a wide range of documents from board minutes through to more sensitive internal inquiries over a number of years. Existing referral patterns within the local area appeared to be strongly ingrained, even when the patterns did not appear to be entirely rational. GPs referred to the trust even when it was not the closest or most convenient, simply because they had historically done so. Patients were very loyal to the hospital and believed that it was part of their community. Satisfaction levels did not fall even when reported during a period of ant infestation.

Although Greener and Mannion sensed a slight cultural shift to a more business-like ethos within the trust, they found that an externally focused, pro-market approach had not taken root within the organisation, despite considerable potential for a healthcare market to develop in the trust's area—the edge of a large city. Managers were vague about what exactly patients wanted, and a view prevailed that GPs (not patients) were the real 'customers' of the hospital. Staff sensed that a new 'macho-type' management culture was being ushered in, characterised by a need for managers to show they were prepared to close down services and make staff redundant. Managers agreed they felt they were expected to take on this attitude. The authors also noted a shift to a more risk-averse culture focused on short-term gains.

The Audit Commission and Healthcare Commission noted in their 2008 review *Is the Treatment Working?* that the fear of the impact of patient choice, rather than actual choice, appeared to be driving a change in attitude among some NHS providers—leading them to feel they should be advertising services to both patients and GPs.¹⁴⁵

Supply-side reforms

The post-2002 market policies that focused on reforming the supply of secondary care included encouragement of independent organisations (both private and voluntary) to provide services to the NHS, and encouragement of NHS hospital providers to apply to become Foundation Trusts—independently managed, locally accountable organisations with the ability to keep and reinvest their own surpluses.

2.4 Provider plurality

This section discusses the evidence available on the development of provider plurality—the existence of multiple NHS, private and voluntary secondary care providers competing for patients. Most available studies focus on aspects of competition for individual elective patients or on centrally negotiated contracts with commissioners,

such as those signed by independent sector treatment centres (ISTCs). There seems to be a lack of research on competition between providers for acute care contracts.

Mixed evidence on the impact of competition on quality

Contestability, or the threat of competition, may be driving up efficiency but perhaps at the expense of inter-professional and inter-organisational collaboration, Lewis and Dixon concluded in a 2005 report.¹⁴⁶ Such collaboration is often a prerequisite for high-quality services, especially in the operation of condition-specific care pathways. Clinical integration is likely to be more easily achieved if supported by stable relationships between organisations.

In a 2006 study mentioned earlier, Propper, Wilson et al. conclude there is neither strong theoretical nor empirical support for the benefits of provider competition, but that there are cases where competition has improved outcomes.¹⁴⁷ They argue that the difference between purchaser- and patient-driven choice is blurred in political rhetoric and predict conflict between the two will become more apparent as purchaser-driven choice is further developed. Propper and Wilson state:

‘At best, the literature suggests that greater competition between hospitals can potentially improve outcomes, but the institutional design is critical. With respect to the current English arrangements, it is first clear that, to promote hospital competition, there will need to be stronger pro-competition strategies than operated during the internal market of the 1990s’.

However, the most recent study looking at the impact of the introduction of competition post-2006 on quality in the NHS found that mortality from acute myocardial infarction (AMI) fell more quickly for patients living in more competitive markets. Cooper et al. (2010) conclude ‘hospital competition in markets with fixed prices can lead to improvements in clinical quality’.¹⁴⁸

Competition forcing more business-like cultures on NHS hospitals

Mannion et al. (2009) examined how senior management culture within English NHS acute hospital trusts has changed since 2001—the period through which DH policy has revived hospital competition.¹⁴⁹ Over the five-year period between 2001–2002 and 2006–2007, ‘clan’ cultures (cultures defined by cohesive leaders bonded by loyalty and an emphasis on morale) remained the most dominant type of senior management team culture, though it declined in prevalence (53 per cent and 46 per cent of trusts, respectively). Its decline corresponded with a large rise in ‘hierarchical’ cultures—cultures bonded by rules, policies and order (4% in 2001 to 13% in 2006–2007). Over the same period, so-called ‘rational’ cultures (goal-orientated, bonded by competition and an emphasis on winning) accounted for a consistent proportion of hospitals (30 per cent and 31 per cent, respectively). The proportion of ‘developmental’ cultures (bonded by entrepreneurship, creativity and innovation) also remained relatively constant, albeit small. However, just one year later in 2007–2008, rational culture had overtaken clan to become the most frequently reported dominant culture type (40 per cent of trusts). They conclude that the appearance of rational cultures as the most frequent type is consistent with a policy context in which provider competition is promoted.

Various impacts of provider competition on health economies

Burgess and Gossage (2003) found that high private-to-public pay ratios for nurses within a given area will exert a significant negative influence on NHS trust performance.¹⁵⁰ They found that the pay relativity between what the average NHS nurse is paid and what he or she might receive in the private sector was negatively associated with achieving over one quarter of individual targets in past star ratings. The implications of these results are that part

of NHS trust performance may be less attributable to managerial ability than to the labour market in which the trust is located. This, in turn, suggests greater flexibility of pay at regional level may be one way to improve the performance of the NHS.

The British Medical Association (BMA) (2005) examined the impact of treatment centres, both NHS and independent sector (ISTCs), on local health economies in England.¹⁵¹ They sent a survey to various NHS trust clinical directors who had a treatment centre in their trust catchment area, with the aim of gathering information regarding the impact, if any, on the integration of services or any potential concerns regarding clinical outcomes. The majority of respondents agreed that the treatment centre had benefited patients in terms of improved access to care and shorter waiting times, with NHS treatment centres being seen as benefiting patients more than ISTCs. Almost three-quarters of respondents reported that their trust was affected by a treatment centre, and four out of five reported their clinical directorate was affected.

Two-thirds of respondents to the BMA survey reported they had never been consulted by the relevant PCT as to the suitability of patients choosing to be transferred to a treatment centre, and more than three-quarters of respondents reported they were aware of patients that have been rejected for treatment by a treatment centre. Rejections were more frequent from ISTCs and amongst orthopaedic patients. Half of respondents expressed concern about the general quality of care provided by treatment centres overall, but with significantly greater concern regarding the quality of care in ISTCs than in NHS treatment centres. Over 80 per cent of respondents said there was either no formal arrangement for reporting concerns regarding patient care and clinical governance to ISTCs, or that they were unaware of such processes. Over 50 per cent of respondents reported that a treatment centre had a negative impact on the facilities/service provided by their trust. Respondents claimed ISTCs 'cherry-picked' patients, resulting in an imbalanced case-mix, loss of potential income for the NHS, and low NHS staff morale.

Regarding relations between trusts and PCTs, Gray and Bailey analysed a national postal survey sent to contract managers at NHS trusts.¹⁵² Results suggested those NHS trusts offering either volume discounts or non-price competitive incentives to purchasers, those that had a strong belief in long-term relationships with purchasers, and those who had a specific marketing/management function involved in the contracting process, were all significantly more likely to offer augmented services over and above contractual minima. Those NHS Trusts strongly believing in the importance of non-price factors (such as contract augmentation or quality) in the contracting process were also more likely to offer customisation of generic services.

Abbott et al. (2009) drew on three qualitative case studies of primary care organisations (PCOs) in England and Wales to investigate whether PCO personnel interviewed in 2005/6 concurred with the DH perception that the market was weak because it was characterised by 'relational' or cooperative long-term relationships rather than true competition.¹⁵³ Overall, the PCO commissioners felt relationships between themselves and hospital service providers were unbalanced in favour of the latter, despite a shared framework of central government policy. PCOs were seen as generally weak, and providers were judged to be generally unresponsive to the PCOs' wishes. They felt hospitals regarded top-down pressure by government as more important than PCO commissioning power in shaping hospital services.

ISTCs may have negative effects on NHS surgical training

Continuing on from above, the 2005 BMA report also stated that two out of five clinical directors' felt the education and training of junior doctors had been adversely affected by the presence of a treatment centre within their catchment area. Clamp, Baliu et al. came to similar conclusions, stating ISTCs may adversely affect specialist registrar (SpR) training in primary joint arthroplasty.¹⁵⁴ The authors conducted a retrospective case note and radiograph analysis of patients receiving primary hip and knee arthroplasty in a teaching hospital, before and after

the establishment of a local ISTC. Corresponding radiographs were assessed and the severity of the disease process assessed. They found fewer primary hip and knee replacements were performed by SpRs in the teaching hospital in the time period after the establishment of the ISTC.

Barsam, Heatley and colleagues aimed to determine the effect of ISTCs on microsurgical training.¹⁵⁵ They devised a scoring protocol to stratify patient cases that were suitable for microsurgical training. This was applied to 56 patients who underwent cataract surgery on a single consultant-dedicated training list between September and November 2004 and also to 76 patients who had the same surgery during the same period in 2003, before the ISTC was in operation. The devised scoring protocol showed a statistically significant difference between the scores in the two groups: with Independent Sector Treatment Centre implementation, the percentage of NHS cases suitable only for consultants increased fourfold. The authors concluded that the decrease in suitable cases for training is likely to have serious consequences on microsurgical training in the UK.

ISTCs provide equal if not better outcomes than NHS providers; higher levels of patient satisfaction

Many researchers have compared the treatment of patients at ISTCs with that of patients at NHS hospitals. A prospective cohort study by Browne, Jamieson et al. followed 769 patients treated in six ISTCs and 1,895 treated by 20 NHS providers (acute hospitals and treatment centres) in England during 2006-07.¹⁵⁶ Participants underwent one of three day surgery procedures (inguinal hernia repair, varicose vein surgery, cataract extraction), or hip or knee replacement. Change in patient-reported health status and health related quality of life (measured using a disease-specific and a generic instrument, EQ-5D) was assessed either three months (day surgery) or six months (hip/knee) after surgery. In addition, patient-reported post-operative complications and an overall assessment of the success of surgery were collected. Outcome measures were adjusted (using multivariable regression) for patient characteristics (disease severity, duration of symptoms, age, sex, socioeconomic status, general health, previous similar surgery and co-morbidity).

The authors found post-operative response rates varied by procedure and were similar for those treated in ISTCs and NHS facilities. As was the intention of ISTC contracts, patients treated in ISTCs were healthier, less likely to have any co-morbidity and, for those undergoing cataract surgery or joint replacement, their primary condition was less severe. Those undergoing hernia repair or joint replacement in ISTCs were less likely to have had similar surgery before. When adjustment was made for pre-operative characteristics, patients undergoing cataract surgery or hip replacement in ISTCs achieved a slightly greater improvement in functional status and quality of life than those treated in NHS facilities, while the opposite was true of patients undergoing hernia repair. No significant differences were found for the two other procedures. Patients treated in ISTCs were less likely to report post-operative problems than those treated in NHS facilities for cataract, hernia repair and knee replacement. Most patients described the result of their operation as excellent, very good or good, regardless of where they were treated. However, the authors noted that caution is needed when interpreting the observation that patients treated in ISTCs reported slightly better outcomes, as fewer ISTCs participated and case-mix adjustment might have been insufficient.

While patients treated by ISTCs and NHS providers tend to rate experiences positively, a 2007 Healthcare Commission survey found patients treated in ISTCs are generally more positive about their care than those treated in the NHS.¹⁵⁷ Ninety-six per cent of the patients surveyed rated their overall care as 'excellent' or 'very good' at ISTCs. Of the 33 issues explored in the patient survey, patients assessed ISTCs consistently better than the NHS on 28 of them. Examples of differences in ratings include: 98 per cent of those surveyed said the toilets and bathrooms were 'very clean' or 'fairly clean' in ISTCs, compared to 92 per cent in the NHS; 65 per cent of those surveyed said they were given a choice of admission date in ISTCs compared to 27 per cent in the NHS; 96 per cent said they were told whom to contact if they were worried about their treatment in ISTCs compared to 76 per cent in the NHS; and 98 per cent said there were enough nurses on the wards in ISTCs compared to 92 per cent in the NHS. Overall the views of experienced NHS consultants who accompanied the review team on visits to the 12 ISTC

providers were positive. Most were impressed with the facilities they visited and reported that procedures in the centres broadly matched that of the NHS. Observations during surgery indicated that clinical practice was of a good quality.

Patiar et al. surveyed adult patients undergoing elective tonsillectomy in 2002 and 2003 at The Hampshire Clinic in Basingstoke.¹⁵⁸ Results showed that 95 per cent of patients were happy to travel considerable distances from their local hospital in order to have their operation sooner at the private clinic. Overall, 71% of patients rated the experience of having the operation performed at the clinic as excellent and 25% rated it as satisfactory. Noting the study focused on only one location, the authors concluded that tonsillectomy performed by an NHS consultant in an out-of-region private hospital is associated with a high level of patient satisfaction and is an acceptable way to reduce waiting times provided clear guidelines and safeguards are in place.

Pollock and Godden found otherwise in a 2008 literature, data and policy review.¹⁵⁹ They concluded that the use of NHS funds to deliver clinical services via the private sector lacks evidence and has not been properly evaluated. The government claims that independent sector treatment centres offer high productivity, high quality health care, and value for money, but the authors claim data are lacking. Pollock and Godden state that ISTCs were intended to provide extra capacity and staff, but 23,000 NHS beds in England have closed and many clinical staff have transferred to the private sector since ISTCs were introduced.

2.5 Foundation trusts

Purposes of earned autonomy for NHS trusts

Earned autonomy, or the ability to make independent governance and finance decisions as a reward for meeting certain financial management and clinical quality standards, is the incentive behind trust applications for FT status. The broad aims of converting NHS trusts to foundation trusts are to enable local prioritisation of service improvements and to increase community participation in the planning and running of services (therefore increasing trust responsiveness).

Pauline Allen (2006) explored the literature relating to decentralisation of authority within the NHS and the role of foundation trusts (FTs).¹⁶⁰ Looking at the evidence to date on both the decentralisation of health services and the creation of foundation trusts, Allen concluded that the achievement of these goals seemed uncertain. She states that much of the government rhetoric about devolution of authority and the shift of local service focus from administration to management can be seen instead as a government attempt to devolve responsibility without power: to decentralise blame. An example could be seen in the fierce debate about the cleanliness of hospitals and the spread of healthcare acquired infections during the General Election campaign in 2005; the public's anger was still directed at the government despite their attempts to dissociate themselves from the details of service delivery in the NHS.

Mannion and Goddard found in 2005 that the freedoms on offer may not be a strong enough incentive for trusts to apply for FT status.¹⁶¹ The authors conducted a multi-method study including a postal questionnaire survey of acute trust chief executives in England (173 total) and interviews with a purposive sample of eight senior managers of acute care trusts. Results suggested the incentives associated with foundation trust status were not sufficiently powerful to motivate providers to deliver better performance in order to apply for FT status. Some hospital managers reported that they already enjoyed a large degree of autonomy, regardless of their current performance ratings. Mannion and Goddard also found evidence that objectives of providers may differ from those of both the central government and local purchasers. Therefore, there may be a risk that granting greater autonomy will allow providers to pursue their own objectives which, while not necessarily self-serving, may still jeopardise achievement of the DH's strategic goals.

Foundation trust governance

FT lay governors and directors are finding the new role of foundation trust governor ambiguous and difficult to define, according to Lewis and Hinton (2008).¹⁶² They conducted a one-year case study of a single NHS foundation trust (Homerton Hospital in East London). Using data collected from face-to-face interviews with a sample of governors and directors, as well as non-participant observation of public and private meetings of governors, and documentary analysis, the authors found this lack of clarity on the role of a governor impeded the development of a governance function. Governors perceived that they had made little impact on the decisions of the trust during the year of study. However, evidence was found of increased involvement of both governors and the public in the trust's activities. Lewis and Hinton concluded that government plans to further decentralise accountability of public hospitals to local communities appear problematic, at least in the short term. Unless the effectiveness of the new local governance arrangements is addressed, an accountability 'gap' may emerge as prior mechanisms for public accountability to the centre are dismantled.

A 2008 study by Chris Ham and Peter Hunt found otherwise.¹⁶³ Through interviews with executive board members and lay governors at six foundation trusts, they found the 'hybrid governance model' (independent management with public input and accountability) of FTs to be working increasingly effectively. As the model has developed, there has been greater clarity about the role of the board of governors and how their knowledge and skills can be used to best advantage. The statutory powers of governors have helped to ensure they are taken seriously and are 'not treated as rubber stamps'. However, the researchers found there is less clarity on the role of the greater public membership and on the most effective ways governors can relate to members. NHS foundation trusts are communicating with members in various ways, but they recognise that more needs to be done to become true membership organisations.

Monitor, the organisation responsible for regulating foundation trusts, commissioned research firm Ipsos MORI to carry out a survey of FT lay governors in order to establish an understanding of how well they are representing local interests.¹⁶⁴ Among other things, Monitor was interested in how governors were holding FT executive boards to account and using their statutory powers set out in The Health and Social Care (Community Health and Standards) Act 2003, which include appointing and, if appropriate, removing the auditor, Chair, and other non-executive directors; deciding on remuneration and allowances; approving the appointment of the Chief Executive; and reviewing annual accounts.

Seven out of 10 governors (69 per cent) said they met as a full board four or five times a year, and two-thirds (65 per cent) of governors agreed that their executive board is supportive of the governors body and view it as an asset. About half of the respondent governors had been involved with discussing the business plan and/or major developments at the FT (54 per cent), deciding the remuneration of the chair (52 per cent), appointing one or more non-executive director (49 per cent) or deciding the remuneration of one or more non-executive directors (47 per cent). Those who were more engaged in subcommittees had been in the position longer and felt they could hold their executive board to account. One in ten (11 per cent) governors had not been involved in any activities relating to their statutory powers, but this tended to be because they had not been in the post long or that their trust had only recently gained foundation status.

Foundation trust performance

As the requirements for FT status approval include strong financial planning and reporting, the phased introduction of FTs represents an opportunity to examine whether the new operating structures in FTs have produced any differences in financial performance compared with non-FTs. In a study looking at retained surplus and the Reference Cost Index (RCI) of the first wave of FTs (compared with non-FTs), Marini et al. (2008) concluded that foundation status itself has had limited impact as an instrument to signal strong financial management.¹⁶⁵ They note that this result may reflect the relatively early stage of the FT process from which data was reviewed (2004/2005) or may be due to the fact that all types of Trusts were experiencing a challenging financial environment at the time, including the introduction of a prospective payment system.

A recent report by Monitor presents data on key service performance issues for the 122 FTs authorised as of 30 September 2009.¹⁶⁶ Income and operating costs for all FTs were on average 2 per cent above planned levels, which could both be attributed to increased referrals and A&E admissions. New thresholds for cancer targets were introduced earlier in 2009, which proved challenging for a number of foundation trusts and resulted in lowered governance risk ratings. The number of trusts with a red rating (lowest level) rose from 7 (6 per cent) to 13 (11 per cent) over the period reviewed, with amber-(middle level) rated trusts rising from 19 (16 per cent) to 39 (32 per cent). Foundation trusts continued to perform well against the 18-week referral to treatment targets, although nine FTs were breaching their four-hour A&E waiting time target. Five trusts were struggling to meet infection rate targets relating to MRSA and C. difficile.

In 2008, the House of Commons health select committee held an evidence session on foundation trust operation, regulation, and the wider effects of FTs on the NHS.¹⁶⁷ They reported that FTs have generally performed well financially and generated surpluses, and have been high performers in routine NHS process quality measures. However, they note that surpluses have been modest in relation to total revenue, and that Monitor is encouraging FTs to aim for larger sums in order to take greater advantage of their freedoms and improve services. FTs are now looking to PCTs to collaborate on how these surpluses should be reinvested to improve patient care, yet PCTs are not in a position to give this guidance; poor communication and poor needs assessment data were cited.

The committee also concluded there is little robust evidence to suggest FTs have increased public involvement in service development or that they are using their new freedoms to innovate in a significant way—two major goals of FT policy. In particular there was not much evidence of an increase in the delivery of NHS care outside hospitals, with the exception of mental health trusts. Some witnesses thought it was too soon for FTs to be expected to be generating major innovations when they were still concentrating on achieving and maintaining financial stability; others considered that FTs' ability to innovate was being constrained by commissioners. The committee notes that the situation is not solely attributable to FTs themselves; rather it is a consequence of the introduction of Payment by Results (providing incentives for trusts to carry out as much as possible themselves) and inadequate collaboration between PCTs and FTs to manage demand for acute care.

Comparisons with non-FT performance

A 2007 literature review and financial report analysis by Marini, Miraldo et al. compared FT and NHS trust (non-FT) performance.¹⁶⁸ They state that if FT status were having its intended effect on the ability to make and retain financial surplus, they would expect to see changing behaviour with respect to financial management following the first wave of trusts becoming FTs in 2004/05. Instead they found FTs have always tended to outperform non-FTs, even before being granted FT freedoms, typically by maintaining lower casemix costs relative to the national average.

The Healthcare Commission and Audit Commission's joint publication *Is the Treatment Working?* similarly suggests FTs are providing more care than other NHS trusts, and are providing it more efficiently.¹⁶⁹ Although both FTs and non-FTs increased their overall activity levels between 2003/04 to 2006/07, the increase was greater in FTs by almost three per cent. Between 2003/04 and 2006/07 FTs continued to be lower cost providers and their relative

cost position has been less subject to change than that of other trusts. Similar to Marini and Miraldo's findings above, the commissions conclude it is not clear whether the high-performance of FTs is the result of their changed status or simply a continuation of long-term trends, since providers that have become FTs were the best-performing trusts to begin with. Likewise, although FTs tend to be higher performers in the quality of service ratings in the Healthcare Commission/CQC annual health check, there is not yet any significant evidence that FTs are delivering higher quality of care as a result of their status. The majority of FTs were scoring highly on quality of service before they obtained FT status.

Reforms to the payment system

The 2002 reforms included major changes to the payment transactions between purchasers and secondary care providers, mainly through the introduction of a national tariff, which listed prices the NHS would pay per treatment—categorised by health resource group (HRG). Providers were to be paid prospectively by number of treatments expected to be carried out, and then again retrospectively if they provided more than the agreed number, through the new Payment by Results system.

2.6 Payment by Results and the HRG tariff

The right result? Payment by results 2003–07

The most recent large-scale study into Payment by Results (PbR) was published by the Audit Commission in 2008.¹⁷⁰ The research consisted of fieldwork (qualitative interviews and observation) at foundation trusts, NHS trusts, PCTs and strategic health authorities; as well as analyses of national activity, reference cost and accounts data from 2003/04 to 2006/07; and Payment by Results assurance audits undertaken in 2007/08.

The Audit Commission concluded that although the policy had been fully embedded across the NHS (by 2008), PbR had not yet significantly increased NHS efficiency. Minor indications of efficiency improvement in elective surgery included an average increase in the number of patients treated as day cases and a decrease in the length of time patients spent in hospital. PCTs had also reduced the number of avoidable admissions to hospitals. The authors noted, however, that other policies have also encouraged such trends, particularly the need to meet waiting time targets. Capacity constraints, limitations in the infrastructure underpinning PbR (such as information systems), and significant changes in the tariff during the first two years of the transition period may all partly explain why PbR has not had more impact on activity and efficiency.

The Commission also stated that most hospitals had improved their financial management and had a better understanding of how much it cost them to treat patients. They did not find any evidence to support initial criticism and fear that care would suffer because hospitals would be tempted to cut costs at the expense of quality.

Reductions in costs and increases in efficiency

In a similar piece of research in 2005, the Audit Commission examined the difference in the number of trusts with reference costs above and below the national tariff in 2004 and again in 2005 (after the implementation of PbR). Although the gap between high- and low-cost trusts had narrowed by 2005, there was still a 'substantial agenda' of cost improvement for the NHS and a large-scale transfer of resources was still required.¹⁷¹

Rogers, Williams et al. explored the concept of 'HRG drift' in both foundation and non-foundation trusts, looking at mean episode costs for all patients, and then specifically at fractured neck of femur complications and the number

of inpatients admitted through accident and emergency. HRG (health resource code) drift is the idea that providers may 'upcode' procedures or claim to perform more expensive or complex treatments than are actually provided.¹⁷² The authors found that between April 2003 and September 2004, mean episode costs for all foundation trusts were lower than those for non-foundation trusts. Mean episode costs changed very little over time (less than 2 per cent in each group), but this varied between trusts. HRG drift was not identified for either group regarding femur fracture complications, but possible upcoding was identified among FTs when looking at short stay in-patients admitted through A&E. The numbers of such patients increased by between 16 per cent and 17 per cent in non-FTs, whereas the numbers increased by 24 per cent among FTs. In one foundation trust, numbers of admissions increased by 54 per cent (from 3,089 to 4,742) between the two six-month periods.

Yi, Farrar et al. carried out a national evaluation of payment by results for the DH and found that PbR generally resulted in a reduction in unit costs—which supported the anticipated effect that unit costs would be reduced as a result of the introduction of a fixed national tariff.¹⁷³ The findings suggest that PbR represented a stronger incentive to seek unit cost reduction than those that existed within the financing system it replaced (i.e. block contracts). They also reported that overall quantitative analysis did not support other policy expectations that PbR would improve quality of care (measured as 30-day mortality, and emergency re-admission following hip fracture), but nor was quality of care adversely affected.

Another team led by Farrar at the University of Aberdeen published results of a similar study in 2009. They compared measures of volume, cost and quality of care in hospitals across England (at various stages of implementing payment by results) with providers in Scotland (not implementing payment by results) during 2004/05 and 2005/06.¹⁷⁴ The results support the above study in showing that unit costs fell more quickly where payment by results was implemented. Evidence of an association between the introduction of PbR and growth in acute hospital activity (volume of patients treated) was also found. There was little evidence of any change in the quality of care associated with the introduction of payment by results. No results supported the proposition that quality of care had suffered as a result of the policy. This suggests that cost reductions have been attained through increases in efficiency rather than through reductions in quality, say the authors. They conclude that 'payment by results is capable of achieving, and has in the short time since its adoption actually achieved, real changes in delivery of health care in hospitals in England'.

In 2006 Marini and Street undertook interviews in three hospital trusts and PCTs in London and South Yorkshire in order to gain greater understanding of the impact of PbR on administrative costs.¹⁷⁵ The six organisations had incurred additional annual costs of between £90,000 and £190,000 since implementing PbR. Most of the additional expenditure was due to the recruitment of additional staff, and as such the cost increase was unlikely to prove temporary. They found the introduction of PbR in England was likely to have increased administrative costs by a greater amount than that experienced by other countries with similar policies, because of the NHS's relatively low general management and administration costs, and less sophisticated clinical coding systems. The same authors carried out further interviews for a study published in 2007 and concluded that although replacing block contracting with activity based funding had led to lower costs in terms of negotiation, these are outweighed by higher costs associated with volume control, of data collection, contract monitoring and evaluation, and contract enforcement. There was consensus among interviewees that the new contractual arrangements were preferable, but the benefits will have to be demonstrated formally in future.¹⁷⁶

Admissions and length of stay

In their 2007 study, Yi, Farrar et al. also looked at whether changes in length of stay (LoS) during the first three years of PbR were associated with the tariff funding. They examined 57 million episodes of care from Hospital Episode Statistics (HES) in England and six million episodes of care from Scottish Morbidity Records (SMR) in Scotland, which served as a control as Scotland did not implement PbR during the 2001 to 2005 time period. The

trend in mean LoS for non-elective cases has been downward for both non-Foundation Trusts and FTs, yet LoS has fallen more quickly where PbR has been implemented. Results also showed that between 2002/2003 and 2005/2006, both FTs and non-FTs saw increased numbers of inpatient admissions, but increases were not attributable specifically to PbR.

Adverse incentives

Andrew Street and Alan Maynard report in a 2007 literature review that PbR funding arrangements provide incentives for increasing activity, particularly day surgery.¹⁷⁷ They conclude that without refinement, PbR threatens to undermine expenditure control, divert resources away from primary care, and distort needs-based funding. They also note that prices should not be based on average hospital costs; there has been wide variation in hospital performance for decades, and such a cost target encourages providers to become 'average' rather than to improve performance more dramatically. A more challenging benchmark would provide all hospitals with an incentive to improve performance. As it is, the potential of PbR to improve the quality of care is yet to be exploited.

Mannon, Marini and colleagues echo this finding in a case study analysis. They state that the structure of tariffs under PbR creates strong incentives for providers to increase activity because they are rewarded per case at full average cost. However, there is a danger that hospitals will increase activity beyond affordable levels and possibly induce demand inappropriately.¹⁷⁸ In another literature review, Propper, Wilson et al. (2006) concluded that the strength of the incentives embodied in current PbR policies and hospital league tables may have to be reduced to prevent poorer outcomes for higher severity patients.¹⁷⁹ In contrast, interviews conducted by Sussex and Farrar (2009) indicated that senior trust managers did not plan to increase volume of activity in response to the introduction of PbR.¹⁸⁰ They did express doubt as to whether PbR could provide any additional incentives to increase quality or efficiency.

PbR is intended to provide strong incentives for providers to challenge historical patterns of service delivery and look instead to innovation in order to cut costs. A major tension identified by Miraldo, Goddard et al. is the need for policy makers to strike a balance between exploiting these incentives and the need to avoid wide scale destabilisation of local health economies that would adversely affect patients. PCTs may struggle to achieve this balance when faced with short-term delivery issues.¹⁸¹ Yi, Farrar et al. (2007) noted that both managers and clinicians lacked confidence in the stability of the tariff and said it affected motivation for long-term planning.¹⁸²

2.7 Additional observations on post-2002 reforms

Difficulty in attributing change to reforms

To date, the most comprehensive review of cumulative effects of the post-2002 market reforms is the Audit Commission and Healthcare Commission's 2008 *Is the Treatment Working? Progress with the NHS System Reform Programme*.¹⁸³ The report is based on fieldwork undertaken between May and November 2007, including a literature review; national and local data analysis; national workshops in four different health economies; and interviews with strategic health authorities (SHAs), primary care trusts (PCTs), foundation trusts (FTs), acute trusts, health commentators, providers, regulators, commissioners, strategists and independent sector providers. They concluded that: "Despite limited implementation, the reform programme is having a positive effect on the NHS. NHS patients are beginning to benefit from the existence of a diverse range of providers, and there is anecdotal evidence that competition is improving services for patients in some areas."

However, Wanless et al. note in *Our Future Health Secured?* that throughout the five years following 2002, there were unprecedented levels of government investment in the NHS with an average annual real term growth of 7.4 per cent. Spending on the NHS rose by nearly 50 per cent—a total cash increase of £43.2 billion. In *An Independent Audit of the NHS under Labour (1997-2005)* and *Our Future Health Secured? A Review of NHS Funding and Performance*, The King's Fund discusses the health system outcomes observed between 1997 and 2007.^{184 185} Whether and how much these changes can be attributed to the 2002 market-based reforms is still being debated:

- Waiting lists shortened between 2000 and 2005, and very long waits (more than 12 months) were eliminated. By 2005, more than 96 per cent of Accident and Emergency patients were discharged, transferred or admitted to hospital within four hours.
- Between 1998 and 2005, overall elective admissions to hospital rose by 11 per cent. A decline of more than 4 per cent in the number of people treated as inpatients was offset by a 20 per cent increase in the numbers treated as day cases.
- The largest source of overall growth in hospital activity has been an increase in emergency admissions, with a net increase of around 1.6 million (35 per cent) admissions between 1998 and 2005.
- Labour met its targets to allocate more beds, staff and equipment to services for treating cancer, heart disease and mental health.
- There was a substantial increase in some types of hospital beds, facility upgrading, and in hospital staff across the NHS.
- Mortality from cancer, heart disease and suicide fell (but were falling anyway).
- Progress on preventative measures, such as reducing smoking and improving diet, was slow or non-existent.
- Prescriptions dispensed rose by more than a fifth (135 million items) between 2002 and 2006, with drugs prescribed for cardiovascular conditions – particularly lipid-regulating statins – accounting for the majority of the growth but at a lower-than-expected cost.
- Calls to NHS Direct (the health service's online advice and information portal) seem to have reached a plateau of just under 7 million a year, while NHS Direct Online, launched in 1999, has seen a rapid increase in use and currently receives about 1.5 million visits per month.
- Rates of MRSA remained much higher than in other OECD countries.
- There were improvements in life expectancy, but this trend was apparent under previous governments.

The Audit Commission and Healthcare Commission did find weaknesses in the infrastructure to support and monitor the reforms, particularly relating to data collection.¹⁸⁶ They also note that improvements in NHS care made in the last decade, such as major reductions in the time patients wait for treatment, have been driven largely by 'targets and terror' together with increased spending, not competition.

Lack of stable policy environment

One conclusion made by Ian Greener (2008) was that the continually changing policy agenda caused significant problems for NHS managers, creating cynicism and the need to engage in 'game playing' around performance reporting.¹⁸⁷ PCT managers, nurses, and others employed to care for patients were attempting to forge relationships to put together delivery packages in their local communities and felt constantly under the threat that their organisations could change overnight. Networks of care would have to be substantially rebuilt as a result.

Wanless, Appleby et al. conclude in their 2007 review *Our Health Secured?* that pressure to produce quick results led to some post-2002 policies and initiatives being introduced without adequate preparation. For example, the early design of the Payment by Results system took too little account of international experience.¹⁸⁸ They state that the government has failed to take full account of the impact of new policies on the system as a whole and to understand how the various elements fit together with each other, with the various resources available.

Lack of patient and public understanding and support

Wallace and Taylor-Gooby (2008) interviewed various NHS patients of differing demographics regarding their thoughts on the post-2002 reforms as a whole. They found that patients had a poor understanding of the substance of the newest reforms, and were aware only that there had been changes and sensed an aura of unease surrounding the reforms through news media.¹⁸⁹ Most respondents (26 in total) were unenthusiastic about the introduction of competitive mechanisms within the NHS. As with private involvement, some had a principled objection to competition within the healthcare arena arguing that it contradicted the alleged universalism of the NHS. Patients had the impression that the NHS as an organisation was not as focused on delivering healthcare as it once was, was too preoccupied with budgetary concerns and administrative minutiae, and had been infiltrated by individuals whose actions do not support the social grounding of care deemed to be a key feature of the NHS. The Audit Commission and Healthcare Commission similarly conclude in *Is the Treatment Working?* that many of their interview participants did not fully understand the aims of the reform programme, how the individual elements contributed to the whole, and how they could best be made to work.¹⁹⁰

Additionally, opinions of healthcare staff on the internal market have been less than enthusiastic. A survey carried out on doctors' viewpoints on job satisfaction and the NHS indicates that a large majority were happy with their current position and career opportunities but were not in favour of the NHS internal market.¹⁹¹

VI. Conclusion

Although there is a lack of literature reviewing the cumulative effects of either the 1990s or post-2002 NHS market reforms, many researchers have explored the outcomes of individual policies. The broader reviews that do exist suggest the first quasi market reforms did bring about some of the outcomes the government hoped for: increased speed and convenience in access to treatment, lower transaction costs, and increased service provision for lower costs (i.e. efficiency). However, many potential confounding factors such as recent changes to the management structure of the NHS and a simultaneous influx of funding, make attribution to market policies alone questionable.

Similar findings are seen in research focusing on post-2002 reforms. Shortened waiting lists, increases in staff, and decreases in mortality from many diseases have all occurred since 2002, but are they attributable to market-based policies or to the pressure from centrally enforced targets (or continuations of previous trends)? Some improvement in care quality has been associated with the incentives market-based reforms have produced, yet because the reforms have only been in operation for a few years and have been frequently changed and augmented, their full impact on the NHS is still coming into focus. Adding complexity to this attribution will be the actions taken in light of the NHS budget restraints projected through 2014, and implementation of

recommendations set out in Lord Darzi's 2008 *Next Stage Review*, such as extended choice of GP, mandatory personalised care plans, and personal health budgets for the chronically ill.

That said, market-based reform of the past 20 years has had unmistakable effects on the culture of the NHS. The balance of power (even if only regarding DH focus and resources expended) has shifted from hospital specialists to primary care, and from providers to purchasers. The introduction of competition has brought about a system-wide awareness of costs, efficiency and accountability; even if reforms have not been proven to bring about all benefits classical economic theory attributes to markets—including provider responsiveness to patients and purchasers, large-scale cost reduction, and innovation in service provision. Researchers have attributed this failure to one of three factors:

1. Refusal to create a 'real' market (e.g. existence of political interference, barriers to exit and entry)
2. Weak incentives to engage participants and break historical patterns
3. Lack of a stable enough policy environment to inspire commitment from staff

The government's current wavering on commitment to competition policy does not suggest any of these obstacles will be removed in the near future.

As recently as early 2009, the DH released a commercial operating model to provide guidance for both purchasers and providers on developing commercial skills, and highlighted the need for 'the third and private sectors [to] have a clear and visible point of commercial contact in each region'.¹⁹² Yet, by November 2009, the Secretary of State for Health had announced that, in facing the upcoming budget cuts, purchasers of care should consider NHS organisations as their preferred providers.¹⁹³

Clearly more research is needed on the application of markets within healthcare generally, and specifically within the NHS. Do hospitals currently feel they need to compete to attract business—both for patients through Choose and Book, and for commissioned services from PCTs? If so, is this contestability the major catalyst behind system performance that it was intended to be? Is the quasi market, as it is currently structured, improving the service provided to patients...and can it continue without the commitment of the government? For now, the available evidence indicates that the NHS may have found itself in a lose-lose situation—taking on the extra costs of competition without yet reaping the benefits.

Civitas is currently exploring the impact of the purchaser/provider split and its related policies on secondary care providers in a qualitative study to be published in April 2010.

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