**Progressive Economics Group (PEG)**
**Policy Brief**

# The limits of market-based reforms in the English NHS

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## Policy Issue

This policy brief examines the rationale, difficulties and effects of introducing market-like mechanisms into the English National Health Service (NHS) since 1990; and it puts forward an alternative hierarchical institutional structure for healthcare governance.

## Should we replace the existing NHS 'quasi-market' with an alternative, more hierarchical structure?

## Analysis

To understand the logic behind introducing market mechanisms into the NHS, it is necessary to understand how perfect markets are meant to work. Assuming that there are sufficient numbers of informed buyers and rational providers of goods and services to allow competition to occur, the price at which goods/services are purchased will be the most efficient one. In perfect markets, demand is expressed by the choices of individuals who receive services and pay their own money for them; and the mechanism by which demand and supply are brought together is a contract. In perfect markets, not only is efficiency assumed to be achieved; so is accountability. This is because each consumer is assumed to make their own decision based on adequate information; and the terms of the agreement between consumer and provider can be enforced by contract law.

However, theories of markets do not concern themselves with issues relating to fairness of the distribution of goods or services.

In contrast to markets, many public services are organised in hierarchies, where there is a group at the top with the most authority; and at each level below, groups have progressively less authority. In this context, rather than directly paying for services, governments collect taxes and use these resources to produce and allocate services. One of the reasons for this arrangement is that notions of need are important determinants in the allocation of public services; and hierarchies are required to make decisions on behalf of different groups of peoples, taking account of these notions.

The market form that was introduced into the NHS was a quasi-market, which sought to combine the supposed advantages of competition between suppliers with the security of retaining public funding to safeguard fairness in access to care. A market for health care was introduced by means of a split between the purchasers of care – the health authorities and General Practice (GP) fund-holders – and its providers. The providers were constituted into relatively autonomous, publicly owned, 'self-governing Trusts' which were supposed to compete with each other, thereby presumably enhancing technical efficiency by ensuring 'value for money' by delivering the highest level of output for the least resources used. Non-state providers of care were also encouraged to enter the market. Decisions about consumption of health care were to be made by parts of the state on behalf of patients; and the system of annual budget allocations to hospitals was to be replaced with one based on negotiated contracts between purchasers and providers.

While a quasi-market was seen by some as the best solution for providing efficient and high quality healthcare, economic and legal theory suggest that serious problems could be encountered in moving to such a system from the pre-existing hierarchical arrangement.

The nature of healthcare means that there is unlikely to be a high degree of competition, especially in respect of specialist hospitals, and in sparsely populated areas. Moreover, as it is impossible to monitor all aspects of healthcare performance, competition involving negotiated prices can be expected to reduce quality, as providers find ways of skimping on unobserved aspects of healthcare in order to lower their costs. In an attempt to avoid this problem, fixed prices were introduced gradually into the NHS quasi-market from 2003/4, in the expectation that competition would be based on quality alone. However, because not all quality can be observed, skimping on quality and intensity of treatment may occur. Also, because the price has to be fixed somehow, other difficulties may arise: If the price is too low, although providers may be encouraged to become more efficient, they may still skimp on quality; and if the price is too high, there is no incentive for providers to become more efficient.

But the inability to monitor all aspects of health care affects more than price-setting; it also has the potential to undermine the effective use of contracts in healthcare markets, both in terms of increasing efficiency and in achieving accountability. Because the transactions costs of contracting for healthcare are significant, if these are taken into account, the supposed increased efficiency produced by competition in a market system is debatable. In healthcare contracting, the very difficulties which lead to high transactions costs also cause problems in using these contracts to achieve full accountability from providers of care. This is because it is not possible to monitor all aspects of performance. The failure to take account of the difficulties in contracting means that the simple model of markets as a method for improving accountability is unlikely to be effective.

Thus, there are potential advantages in retaining hierarchy as the institutional structure for healthcare because market incentives can be detrimental to efficiency and quality of care where those incentives cannot be effectively harnessed for the public good. If, for example, for-profit providers enter the market, they have strong incentives to skimp on quality to increase their profit.

**Evidence on the operation of the quasi-market in the English NHS**[1]

Since introduction of a quasi-market into the English NHS, there has not been a high degree of competition between hospitals; and where competition under negotiated prices has taken place, quality of care has deteriorated. On the other hand, there is some (disputed) evidence that quality of care may have improved in the context of competition under fixed prices.

In theory, the degree to which organisations providing care are free to make their own decisions is considered important in markets. Autonomy is assumed to engender more efficient and higher quality care, as those actually running the organisations have better information about how to organise delivery to respond to patient need and demand. However, the evidence from the more autonomous NHS hospitals – Foundation Trusts (FTs) – that were introduced by New Labour does not bear this out. In practice, FT autonomy has been severely circumscribed; and the national NHS hierarchy still has a strong influence on FT decision-making. Moreover, there is no evidence to suggest that independent providers –whether for-profit or otherwise – are performing better (or indeed, worse) than NHS-owned organisations.

[1] Fuller accounts of the effects of successive governments' quasi-market policies can be found in Le Grand, Mays & Mulligan (1998); Mays Jones & Dixon (2011); and Exworthy, Mannion & Powell (2016).

It is also important to bear in mind the degree to which 'command and control' hierarchical measures have continued to operate concurrently in the English NHS – and that they are in fact necessary to keep the system going. These mechanisms are central to achieving NHS goals of continuity of care for patients (which requires cooperation between providers); meeting national standards for quality; and keeping the whole NHS within nationally-set financial limits.

The Health and Social Care Act 2012 has been seen as a high water mark of pro-market policies for the NHS. Although it contains attempts to increase the force of market mechanisms in the NHS, mainly in respect of promotion of competition and non-state provider market entry, these efforts have been attenuated by its provisions aimed at ensuring that other important goals of the NHS (such as integration and continuity of care) are still taken into account. What is more, since 2014, the NHS has been focussing on improving cooperation between local organisations rather than using market mechanisms to achieve goals of better value for money and improved quality of care.[2]

**Policy Proposal**

In short, it is not possible to construct a market conforming to classical economic principles in respect of healthcare. Nor is it desirable to do so, as goals such as fairness of access to care are also crucial; and these are goals which markets cannot deliver. In this context, a hierarchy is preferable. *Firstly*, in the English political environment – where central government will inevitably be held politically responsible for health services – a hierarchical governance structure is more likely to provide the state the best opportunity to exercise control over the NHS, which will in turn improve accountability. *Secondly*, a hierarchy allows strategic planning and allocatively-efficient decisions to take place at the appropriate level of aggregation. *Thirdly*, hierarchical governance structures are also likely to be efficient in reducing transactions costs for complex services.

**References**

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[2] NHS England (2014).