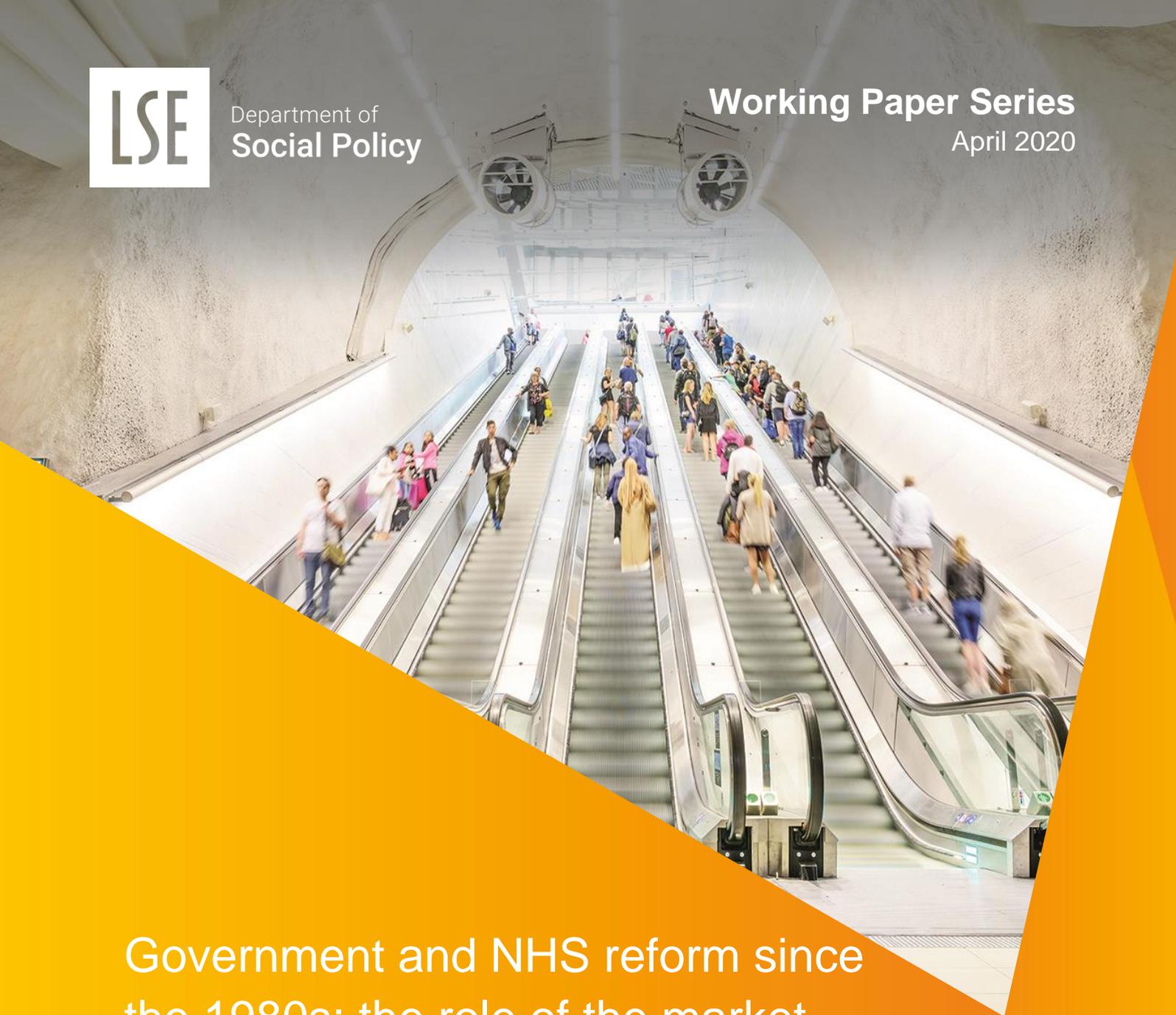




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Government and NHS reform since
the 1980s: the role of the market
vis à vis the state, and of political
ideas about the ‘direction of travel’

Working Paper 05-20

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Abstract

This working paper takes the 'long view' of NHS reform. It uses historical methods to analyse policy documents and speeches by key political actors in order to explore the nature of what became for both the Conservative and Labour Parties a commitment to taking a market approach to NHS reform. The paper focuses on the provision of clinical services.

The belief that taking a market approach will result in both a more efficient and better-quality service has been common to both Conservative and Labour administrations, and there has been substantial continuity in the development of many of the new structural forms that have been introduced (for example, Foundation Trusts) and the mechanisms that have been required (for example, the use of legally binding contracts). The separation of purchasing from provision has been central to facilitating the market in health care. However, the precise nature of the purchaser/provider split and the extent to which external, independent sector providers have been encouraged has been envisaged differently by the main political parties. The paper considers the focus of successive governments in their efforts to implement market-oriented reforms, particularly the importance they have attached to competition on the one hand and to choice on the other.

The paper addresses the debate as to whether the long experiment with the introduction of market principles is best characterised in terms of continuity or change. It argues that while it is possible to read off continuity from the means and mechanisms employed by successive governments, it is important to consider the political ideas informing the desired 'direction of travel' of the main political parties; it is not possible to read off 'ends' from policies. Crucially, the Labour and Conservative Parties have differed in their thinking about the desired relationship between the state and the market and the extent to which they have wanted to distance the state from governing what is a huge, complicated and often politically troublesome public service.

Keywords: English NHS, NHS reform, political ideas, ideas in policymaking

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Introduction

NHS (and other) public service reforms have been dominated by a market approach since the late 1980s under successive Conservative, Labour and Coalition (Conservative and Liberal Democrat) Governments. Few strong doubts about them made their way into official documents until the late 2010s. Indeed, some, but not all, dimensions of markets, particularly perhaps the shift from administrative service agreements to legally binding contracts, have become embedded in the NHS and are now taken for granted.

It is possible to have a market-oriented health care system that remains free at the point of use and publicly funded, involving competition between public providers (Powell, 2019). However given the importance attached to public provision and finance for a universal health service that was part of Labour's post-war settlement, one of the main points of controversy in the debates over NHS reform since the Thatcher Governments of the 1980s has been how far the development of market-oriented reform can be characterised in terms of continuity between Labour and Conservative Parties.

This has proved difficult to assess, whether at the level of a major structural reform, or in relation to each of the policy changes comprising it. Regarding the first of these, there has been disagreement as to whether each major reform has constituted an extension of what has gone before or has broken new ground. Thus Ken Clarke (2012, p.6), who was the Conservative Secretary of State responsible for bringing in the market-oriented health reforms of early 1990s and who was still on the backbenches twenty years later, judged the 2012 Health and Social Care Act introduced by the Coalition Government to have gone further than anyone else had 'dared', a view supported by David Nicholson, the then Chief Executive of the NHS, who said that the 2012 legislation was 'so big a change you could probably see it from space' (cited by Timmins, 2012, p.74). Yet for Julian Le Grand (2010), an academic and adviser to the Blair Government, it represented the completion of the work of the preceding Labour Government and constituted 'a sensible evolution of previous strategies while also advancing choice and competition...'

In part such disagreements stem from the way in which the concept of 'the market' encompasses many dimensions, including private finance, internal competition between publicly run organisations (so-called quasi-markets (Le Grand, 1991)) and/or competition between public and independent sector providers,¹ as well as different degrees of patient choice. There has also been an accompanying lack of agreed criteria by which to judge or measure 'marketisation'. The extent to which each market dimension has been emphasised, and the ways in which they have been put together has differed over time. This means that it is not always possible to reach conclusions about the degree and nature of continuity simply from an analysis of the policies at the heart of the reforms, for example, the priority accorded competition or choice might change over time. In addition, the policy goals of each constituent policy in any major reform effort may also be different. Thus, for example, what the Labour Government wanted from the introduction of Independent Sector Treatment Centres (ISTCs) as part of a Government strategy to reduce waiting lists as well as to give patients more choice, and what the subsequent Conservative Government wanted

¹ The term 'independent sector' usually refers to private and third sector provision, see below p.14 for further comment.

ISTCs to be - part of a Government strategy to reduce the role state provision and to rely more on market disciplines - was different and was related to the difference in the Parties' broader ideas regarding the role of the state.

This suggests that simple continuity may not adequately characterise the structural changes that have taken place in the NHS over almost a thirty-year period. Tuohy (2018) has expanded the possible categories of change beyond 'big bang' change or incrementalism, while also suggesting that the classification of the nature of change is a matter of scholarly judgement. Klein (2013) has nevertheless argued for continuity in NHS reforms since the early 1990s, suggesting that while it is possible to see differences between what the Conservatives and Labour actually did, these sit within a broader consensus in favour of market-oriented reform. However, as Webster (1990) warned, means and ends must be differentiated. It is not possible to read off 'ends' from policies. Policies introduced by different Governments may articulate similar broad goals – often in terms of improving quality and containing costs – but the big, often slow-moving ideas (Pierson, 2004; Tuohy, 2018) behind them may differ. Big ideas play a major part in determining the desired "direction of travel" which it is only possible to discern over a longer time period. Thus Hunter (2016, p.55) has suggested that the Conservative Party has been 'in it for the long haul' in respect of shrinking the role of the state as a provider of health services, and while Hockley (2012, p.25) has concluded that the Conservatives muddled through, he nevertheless argues that they did so purposefully 'with a strategic goal in mind...'.

This in turn suggests that in order to understand the nature of major NHS reforms, analysis must go beyond the policy detail and incorporate an appreciation of the ideas behind the reforms, the importance of which has been well documented (e.g. Beland and Cox, 2011; Campbell, 2002). However, ideas cannot fully explain policy change and as Powell (2016) has argued, it is in any case often difficult fully to grasp their nature and the process by which they become influential or fade. This is certainly the case in the short term. Political actors may adapt particular policies to fit their own ideas (Carstensen, 2011); make compromises regarding reforms in order to accommodate what the electorate is likely to bear, for example, in the early 1990s and again in 2011-12 the Conservatives effectively ruled out major change to the method of NHS financing; or even change their claims as to whether a particular structural reform represents a major change or substantial continuity, depending again on what might sit best with the public. However, none of this necessarily rules out adherence to a long-term desired direction of travel, incorporating a Party's vision of both the role of the market and, alongside it, that of the state. Thus, in the case of the ISTCs for example, the same policy was made to serve different policy goals and found a place in the different directions of travel of both major political parties.

This paper addresses major NHS reforms from those of the last Thatcher administration to those of Simon Stevens (the Chief Executive of NHS England since 2013), using policy documents and speeches by political actors, particularly Secretaries of State for Health, to explore the precise nature of what became a commitment to taking a market approach to NHS reform for both the Conservative and Labour Parties. After introducing the idea of the market, each empirical section reviews first, the ideational focus of each Government since 1989, and second the reforms made. The paper does not seek to assess the effects of market-oriented reform on different parts of the service, rather it seeks to understand the approaches of the two main political parties and to assess the nature of the long-term direction of travel alongside the claims for continuity and

3 Social Policy Working Paper 05-20

consensus. The paper focuses on NHS reform as it applied to clinical services and does not address other crucial policy components of a market approach, for example the private finance initiative (whereby private firms are contracted to complete and manage public capital projects such as hospitals), or the sale of assets.

The Idea of the Market

The economic arguments for markets in health policy have been hugely influential, insisting that they can bring more efficiency, encourage responsiveness to patients, stimulate innovation and identify providers not giving good value for money (OHE, 2012). Competition may be viewed as a means to providing choice, or the emphasis may be put on greater choice driving competition. Privatisation may involve non-government actors in the ownership of provision, the sale of NHS assets, and/or private finance² (Savas, 1989) and inevitably raises issues to do with opportunities for profit and problems to do with the risk of market failure and the closure of a service. Competition, choice and privatisation may require different amounts of change to various dimensions of a public service, including regulation, pricing and payment mechanisms, entry and exit mechanisms, and information systems, as well as involving a move from administrative to legal contracts. Within the NHS, the market reform of the early 1990s involved the application of market principles and competition between internal, public providers, and was quickly dubbed a quasi- or mimic- market (Le Grand and Bartlett, 1993; Klein, 1995, p. 190). Indeed, quasi-markets show that competition does not necessarily require external private providers (Sheaff and Allen, 2016). However, it was not long before the 'compulsory, competitive tendering' of ancillary services such as cleaning was followed by the 'contracting out' of clinical services to private, independent providers. Competition was believed to secure greater efficiency and effectiveness, and private provision was believed to be more efficient and effective than public provision (Deakin and Walsh, 1996). Patient choice can be exercised between public providers as well as between public and private providers. After all patients were able to choose their GP from the inception of the service (and while GPs working in the NHS have always been independent contractors, until the first set of market reforms implemented by the Thatcher Government in the early 1990s they were not part of either an internal or external market involving independent providers). Gingrich (2011) has argued that welfare states are buffers against markets, and that in the case of the NHS, Party preferences have been mediated by the universality and uniformity of the service. However, what is striking is that both main political parties have sought substantially to develop a market in healthcare, involving more autonomy for many public sector providers as well as increasing private provision. With private provision has come competition for the market via tendering as well as competition in the market (OHE, 2012).

The case for markets in health care centring on competition and choice has been made by mainstream economists, who see in the market more hope of both controlling costs and improving outcomes for patients. In particular, a relatively small group of econometric studies (e.g. Cooper et al., 2011; Gaynor et al., 2013; Propper et al., 2008) have been cited in government documents to support market-oriented reforms. Bevan and Skellern's (2011, p.3) review of the economic literature concluded that the econometric studies show a 'seemingly causal relation' between

² While the NHS remains tax-funded, use of the private finance initiative resulted in many Foundation Trust hospitals carrying large debts.

greater competition and lower hospital mortality. However, particular outcomes can rarely if ever be attributed to a particular reform, because the context is usually complicated (Paton, 2014; Peters, 2018). For example, in the early 2000s, Labour developed the market approach to NHS reform, but also set top-down performance targets and increased the level of funding. Which reform resulted in which outcome is far from clear. Furthermore, as Greener et al. (2014) have pointed out, other forms of evidence showing how difficult it is to achieve successful structural health care reorganisation have grown over time. For example, qualitative studies have investigated what patients are actually 'choosing' if they are offered a choice of hospital, for example geographical proximity might trump clinical outcomes, and on the basis of what information (Fotaki, 2014; Greener and Mannion, 2009; Peckham et al., 2012; Turner et al., 2011). However, these have tended to be ignored by government documents.

While faith in a particular form of economic analysis showing the capacity of markets to deliver a better and cheaper service has been hugely influential, the problems raised by building and operating markets in health care within a publicly funded, universally and (relatively) uniformly available service have been many for medical professionals, patients and strategic planners, albeit that these have gone largely unrecognised by an influential section of the economics literature. For example, the Office of Health Economics (OHE, 2012) denied that competition had hampered the integration of care, a position that was being questioned by 2019. In fact, it was suggested relatively early on that competition may affect the public ethos of the service and cooperation between professionals, as well as impacting the influence exerted by the medical profession (e.g. Bennett and Ferlie, 1996). It is also difficult to assume that patients can make and are willing to make informed choices about care for health problems (which by definition they tend to know little about) on the basis of often poor information. In addition, while the greater capacity resulting from the involvement of the private sector may help to make choice possible, it may end up being an expensive luxury for a publicly funded system to have surplus capacity (Palmer, 2006). Market relationships also make strategic planning, particularly for ageing populations, more difficult (Mays et al., 2011). In short, an individualist consumer model is difficult to apply to a universal, publicly funded service that needs to control costs and to promote equity.

Thus, it is important to understand the nature of the lure of the market in and for health care for political parties. Both main parties could agree on many of their hopes for what NHS reform would achieve, but as the next empirical sections will show, they tended to differ in respect of how they approached market reform, particularly on the relative importance they attached to choice or competition, and on why they wanted to develop a market approach, which in turn depended greatly on their larger ideas as to the nature of relationship between state and market that they wished to promote.

Conservative Reforms in the late 1980s and early 1990s: The Internal Market

The Conservative Party leadership accepted Labour's introduction of the NHS in 1948 as part of the post-war settlement, but significant numbers of the middle and lower ranks of the Party in particular did not fully accept that anything was finally settled (Green, 2002; see also Jones and Kandiah, 1996). From 1970, ideas about the economy, the public services and the state came more and more to resemble those underpinning 'Thatcherism' in the 1980s and 1990s. Thus in 1974 Keith Joseph called for 'a new settlement based on state withdrawal from

5 Social Policy Working Paper 05-20

micromanagement...’, and characterised the mixed economy as semi-socialism that could not work (Bogdanor, 2013³). In the end, the reforms that were enacted were considerably less radical than those proposed in the 1980s by Party luminaries, but they nevertheless represented a crucial step on the road to the market-oriented reform of provision in particular.

Conservative Government ideas

Soon after the Conservative Party came to power in 1979, The Central Policy Review Staff were asked by Margaret Thatcher and Geoffrey Howe (then Chancellor of the Exchequer) to review public expenditure in health, education and social security. The resulting confidential 1982 Memo suggested that in respect of healthcare, the Government could aim to end state provision over an extended period, with those unable to pay for private insurance having their charges met by state rebates. The leak of this controversial Memo resulted in Thatcher having to declare support for the NHS at the party Conference of 1982. Ferdinand Mount (then the Head of the Number 10 Policy Unit) commented on the difficulties the leak presented for policy and suggested that public services should be frozen rather than cut, with a boost for private provision via tax reliefs and the contracting out of both ancillary services, such as cleaning, and clinical services such as dentistry, to private providers.⁴ This amounted to an early call for taking steps towards a new vision for health services focused more on private than state provision and finance.

A ‘stepped’ approach to privatisation was highlighted in some of the influential pamphlets published on reform of the public sector and the NHS in particular at the end of the 1980s, reminiscent of Nicholas Ridley’s (1977, p.22) report on how to denationalise the nationalised industries, in which he advocated ‘return to the private sector by stealth’. Oliver Letwin (1988, p.45) advocated the privatisation of public services in terms of contracting out, deregulation and the sale of public assets, which made ‘appropriate contractual and tendering arrangements’ and re-regulation to change the competitive environment crucial, together with the end of state responsibility for financing public services. But in a pamphlet co-authored with John Redwood solely on the NHS, he argued for a political programme that moved as slowly as needs be through a number of options: making the NHS an independent trust, increasing joint ventures with the private sector, extending charging, introducing a system of health credits (or vouchers), and finally moving to an insurance scheme (Letwin and Redwood, 1985). The end point of this pamphlet – changing the whole nature of the tax-funded system – has still not been reached, but many of the earlier points were broadly addressed in the 2012 Health and Social Care Act: increased autonomy for publicly funded providers, increased involvement of the private sector and ‘economic regulation’ to ensure competition in the healthcare market (see below, p.10 et seq), suggesting that a long game has, as Hunter (2016) suggested, been played.

Conservative Reforms

The focus of the reforms during the Thatcher period was not articulated in terms of securing competition and choice, which dominated subsequent reform agendas, but rather emphasised

³ See also Keith Joseph, ‘This is not the Time to be Mealy-Mouthed: Intervention is Destroying us’, speech delivered in Upminster, 22 June 1974. Margaret Thatcher Foundation.

⁴ F. Mount ‘Public Expenditure in the Longer Term’. Minute to Margaret Thatcher, 8 October, 1982, National Archives, PREM 19/718 F38.

making the NHS more 'business-like', which culminated in the setting up an internal quasi-market in 1991, together with support for some compulsory competitive tendering.

The initial changes to the NHS proposed by Roy Griffiths (a director of J. Sainsbury's PLC) in Thatcher's first term focused on making the management of the NHS more business-like and less consensual, but stopped short of making it an independent corporation. However, by 1989, The Secretary of State, Ken Clarke, was able to say that the review team on the NHS had taken work on internal markets further than most other teams (HoC, Debates, 1989), with the aim of making the service more responsive to the needs of patients by encouraging self-governing hospitals, delegating responsibility to the local level and allowing money to follow the patient (DH, 1989). Hospital trusts would earn revenue, and thus have an incentive to attract patients, which would in turn require contracts that spelled out price, quality and the nature of services. Nevertheless, contracts remained NHS Service Level Agreements, no national contract or price system was set up, and established relationships between what became (public sector) 'purchasers and providers' tended to continue (Turner and Powell, 2016; Klein, 2013), albeit that collaboration and cooperation between professionals was no longer an explicit policy goal. The most striking change involved GP Fundholding, whereby the GPs who chose to become fundholders held real budgets and purchased primarily non-urgent elective hospital care and community services. This was shown to advantage their patients who were treated faster, but at the expense of creating a two-tier service (Dixon and Glennerster, 1995).

Nevertheless, competition remained weak; Le Grand et al. (1998) argued that this was because the incentives were too weak and the constraints too strong. The encouragement given to private providers was also weak, although Alain Enthoven (1991), the American academic adviser on the changes, maintained that he had recommended an internal market model which could work with no private sector at all. Indeed, the last Conservative White Paper on the NHS prior to the 1997 general election put more emphasis on cooperation and a 'seamless service' than on choice and competition (DH, 1996).

As Webster (2002, p.197) has commented, the Conservative Government sometimes spoke as if its reforms were '...merely a logical continuation of the Government's rolling programme of housekeeping measures; at other times they insisted that the changes would constitute the biggest shake-up the health service had ever seen.' Commentators also differed on whether they saw the reforms as constituting change in a relatively minor key – in policy instruments - or as a much larger 'paradigm shift' (Greener, 2002). Taking the long view, the establishment of a purchaser/provider split and in particular the new contractual arrangements demanded by it were highly significant and were linked to substantial rises in management and transaction costs after 1991 (Turner and Powell, 2016; HoC Select Committee on Health, 2010). While the Government's claim for 'continuity' can be seen as electorally pragmatic, the claim for a major 'shake-up' was real not least in terms of where the Party wanted to be at some point in the future, as evidenced by their published pamphlets.

The problems to be solved in the late 1980s revolved around rising demand, cost and variable quality, which were, in short, similar to those faced by the Labour Government in 1997. There were various ways of tackling them, but the Conservatives brought a conviction that the solution should focus on decentralising control away from central government and introducing market principles,

7 Social Policy Working Paper 05-20

which would in turn secure better value for money. The reforms constituted a first step in long experiment with markets in public services. Klein (1985, p.56) pointed out that Thatcher's acceptance of the NHS was 'the tribute paid by ideological bias to political necessity', but this does not strike down the case for these reforms setting the direction of travel towards 'more market'. For as Letwin (1988, p.29) recognised, such ideas are 'in origin a political rather than an economic or financial act'.

New Labour Reforms 1997-2010: Choice and Competition

Labour began in 1997 by rejecting the internal market (DH, 1997), but swiftly returned to it, elaborating reforms based on central control in the form of setting targets alongside promoting partnerships with the private sector and decentralisation (DH, 1998), characterised at the time as part of a 'Third Way' approach. However, GP Fundholding, which had been found to have delivered improvements for patients at the expense of equity (Dixon and Glennerster, 1995), was abolished. Powell (1998, p.172) characterised this approach as 'a shift along the managed market continuum'.

Certainly, Labour's insistence on and commitment to developing policies to 'modernise' public services (The Treasury, 1998) including the NHS looked more like continuity and a substantial development of the use of market principles rather than change. However, reading off 'continuity' from policies can be misleading. Light (1997) insisted that Labour's approach consisted of 'managed cooperation' in contrast to the 'managed competition' favoured by the Conservatives in their 1991 legislation. Certainly, the ideas behind Labour's approach were different.

New Labour ideas

Labour was committed to the NHS and repeatedly rehearsed its founding principles. Gordon Brown (2004), then Chancellor of the Exchequer, recognised clearly that healthcare was not a commodity like any other because the consumer is not sovereign and because use and risk are unpredictable. This in turn justified Labour's emphasis on the need for universal coverage and public provision. But a commitment to modernisation involving greater autonomy for providers, including the private sector, was felt to be necessary in order to be able to justify spending more money on a service which had low satisfaction ratings (Murray, 2018), especially in respect of the overwhelming chorus of complaint about waiting times. Labour's fear of being labelled spendthrift resulted in its commitment to match Conservative spending limits in the election of 1997. Only in 2000 did Prime Minister Tony Blair promise in an interview on television (with David Frost, Panorama, BBC1, 16 January 2000) to bring spending levels up to the European Union average. More money was to be justified by better performance, which was to be secured by setting performance targets plus market-oriented reform (DH, 2000, p.8), involving a greater plurality of providers in order to meet patient need.

Thus Secretary of State Alan Milburn's rolling programme of reform in the early 2000s stressed that targets to ensure 'national standards' would come first, followed by greater choice for patients, because 'at its heart the problem for today's NHS is that it is not sufficiently designed around the convenience and concerns of the patient' (DH, 2000, p.15). The Concordat signed with private sector providers in 2000, welcomed '...the direction of travel: to reshape the NHS from a patient's

point of view' (DH and Independent Healthcare Association, 2000, p.3). The idea of choice was particularly important for Labour, and while it did not have to encompass the use of the private sector, the need to increase capacity quickly and attack the long waiting lists made more plural provision attractive. However, increasing private provision was accompanied by other reforms and new ways of running the service which were compatible with the reform instincts of the Conservatives.

Choice was not automatically linked to competition in the key Government documents or in Milburn's speeches (although later on Blair (2010, p.265) clearly linked the two concepts). Rather, the appeal in the 2000s was to harness the private sector to the service of the NHS. This was perhaps the critical difference in thinking between Labour and Conservatives. Nevertheless, both Parties accepted the view that plural provision and more autonomy for providers would also be more efficient than a wholly publicly provided service run on hierarchical lines. However, Labour's driving idea was speedily to improve service delivery as the only means of justifying significantly more expenditure on the service to the electorate and as the key way of keeping it universal. In a speech to the New Local Government Network and the New Health Network, Milburn (2003) stressed that '...if we fail to match high and sustained investment with real and radical reform it will be the Centre-Left's argument that public services can both be modern and fair, consumer orientated and collectively provided that will face extinction'. It is particularly noteworthy that in a speech to the Social Market Foundation Milburn (2003b) said: 'the trap we must avoid is that identified by Richard Titmuss four decades ago of so many people opting out of publicly provided health and education that public services become only for the poor and then end up themselves being poor services'. Labour believed that in an 'avidly consumerist world' people expected choice (Timmins, 2002, p.133). The speeches given by Milburn between 2000 and 2006 repeatedly referred to the 'consumer age'. Keeping the middle class 'in' the NHS was crucial to preserving the founding principles of a universal and uniform service.⁵ Nevertheless, the assumption that patients wanted and were able to make clinical choices has been shown to be problematic (see above p.4) and may also be a source of inequality in that the better educated are more likely to access information on quality (Dixon et al. 2010).

However, choice was central to Labour's thinking on reform, and as Greener (2009, pp.318 and 321) has pointed out, even when patient choice agendas are 'not inextricably associated with competition-based reforms...' they often end up being intrinsically linked: 'A model of health reform in which choice drives responsiveness carries with it the implication that competition will be the mechanism for achieving this'. Indeed, after 2010 the emphasis shifted to competition, just as policies became more explicitly market-oriented in and for themselves.

New Labour Reforms

Labour's most important structural changes established Primary Care Trusts in 2002, with the responsibility for 'commissioning' services in the NHS (Turner and Powell, 2013). Hospitals running a financial surplus could become Foundation Trusts (FTs), that is, public benefit corporations, described by Milburn (2002) in a speech to NHS Foundation Hospitals, as a '...middle ground within public service and between state-run public and shareholder-led private structures...'.

⁵ Korpi and Palme (1998) used comparative evidence to support this point.

9 Social Policy Working Paper 05-20

Foundation Trusts were permitted to retain the proceeds from asset disposal and any operating surpluses to invest in new services, and could raise capital from the public and private sectors. In other words, they were given more autonomy and were overseen by a new regulator, Monitor, rather than the Secretary of State. FTs were supposed to be able to take decisions about innovations and organisation more easily in the absence of direct hierarchical control from the Department of Health, but as the House of Commons (HoC) Select Committee on Health (2008) noted, it was difficult to assess the benefits of FTs given that they had been, by definition, the most successful hospitals.

A national tariff was introduced (seen by Labour as an important rejection of competition on the basis of price favoured by the Conservatives), together with 'payment by results' (more accurately, 'payment by activity'), which replaced block contracts (because these were unlikely to reward hospitals for attracting extra patients at the margin, thus making it difficult to reduce waiting lists). Private provision was encouraged by a number of initiatives, for example, via the requirement that the choice of provider offered to a patient had to include an independent sector provider, and by commissioning private providers to expand NHS capacity, which was the basis for introducing Independent Sector Treatment Centres (ISTCs) from 2004. Nevertheless, the new NHS Principles and Rules for Cooperation and Competition (PRCC) issued by the Department of Health in 2007 recognised the need for cooperation as well as competition in order to deliver seamless and sustainable care to patients. Public satisfaction with the service increased from 38 percent in 2001 to 70 percent in 2010 (Murray, 2018), while the percentage of private providers operating within the NHS rose (Spence, 2015) and the purchase of private health care outside the NHS directly by patients shrank.

Labour's main goal was to strengthen the NHS, but there is a case to be made that they failed fully to appreciate either all the implications of some of these measures for other dimensions of the health care system, or how some of their changes could be made to serve the Conservative direction of travel. Two brief examples of problems issuing from new structural forms follow.⁶

First, by the mid-2000s the Government favoured a clearer purchaser-provider split, with Primary Care Trusts (PCTs) taking on a large commissioning role. Indeed, the structure set up by Labour depended greatly on the quality of commissioning. However, PCTs were widely regarded as having substantial weaknesses in this regard (e.g. Smith and Curry, 2011). The HoC Select Committee on Health (2010, p.3) raised severe doubts about the lack of clear and consistent data on transaction costs, as well as PCTs' lack of skills in commissioning. The use of private consultancy companies increased (Naylor and Goodwin, 2011) and from 2007 Labour encouraged the outsourcing of support via the Framework for Procuring External Support for Commissioners, which had the potential to affect the direction taken by commissioners and possibly the balance of public and private provision. Furthermore, as Smith (2003) warned, the way in which commissioning was carried out in the context of the purchaser/provider split might not result in the best care for patients with complex conditions and needing integrated care, while Ham and Smith (2010) observed that policy on choice and competition seemed at times to lack the 'sophistication' needed to enable integrated, person-centred, coordinated care and support in the community and

⁶ It should also be noted that the explosion of more traditional hierarchical target-setting also introduced substantial distortions (Webster 2002; Hood, 2006; Greener et al. 2014).

in hospitals. More broadly, the increased fragmentation resulting from the purchaser-provider split was argued to damage trust between local actors.

Second, the ISTCs did not just simply increase capacity. Their tendency to take younger, healthier and thinner patients with fewer complications (Sheaff and Allen, 2016) had implications for training, which remained confined to NHS hospitals. The Royal College of Surgeons of England (2006) and the British Orthopaedic Association (2006) stressed the lack of training opportunities when ISTCs took the 'easy' cases. Turner et al.'s (2011) qualitative study reported that ISTCs represented weaker learning environments and tended not to produce cooperation across organisational boundaries to the same extent as NHS providers. Importantly, this study commented on competing managerial and professional cultures in hospitals, characterising ISTCs as 'machine-bureaucracies' carrying out standardised routine work within a performance regime that required high volume and low cost patients, and also disrupted the apprenticeship model of training. Le Grand's (2006) praise for the efficiency of the ISTCs - citing surveys that showed patients not greatly minding whether provision was public or private so long as it was free at the point of delivery - missed consideration of the characteristics of the patients being treated and the threats posed by this model to professional practice and the public ethos of the service. Thus it was possible for an apparently simple independent sector 'add-on' to reverberate more widely through the healthcare system.

Labour's approach to the NHS was not consistent insofar that initially it moved away from the purchaser-provider split, abandoning GP fundholding, before developing a more market-based approach, and then again retreated somewhat just before the 2010 election in favour of promoting an NHS 'preferred provider' model, which would have confined competition to mainly internal, public sector providers. In any case, it has proved difficult to arrive at the precise cause of Labour's success in reducing waiting times and increasing public satisfaction with the service. Le Grand (2006) acknowledged that top down performance management had, to his surprise, played a part, while Greener (2018) has argued that the increase in the NHS budget was the key factor. The part played by a market approach to provision has been the main focus of a relatively small number of econometric studies looking at a narrow range of conditions (see above p. 4), but the precise contribution of 'markets' is impossible to establish.

Labour favoured a market approach during most of its time in government as a way of securing public services by maintaining public support for them (by providing choice and legitimising new spending by increasing productivity). Labour did not share the Conservatives' desire to minimise responsibility for the NHS. Nevertheless, towards the end of the period of Labour's reforms, Patricia Hewitt (2006) (the Secretary of State) spoke of the goal of a 'self-sustaining' system, with in-built incentives whereby improvements would become continuous, which seemed to resemble the Conservative dream of achieving political distance from a tax financed service. However, Labour always wanted to remain in the NHS driving seat. It favoured devolution and more autonomy for local NHS organisations, as per Foundation Trusts, but it had no wish dramatically to shrink state responsibility for the service.

During the next period of Conservative political dominance, it is again possible to read off continuity from policies, but the ideas driving them were very different. Labour had used primary

11 Social Policy Working Paper 05-20

legislation very little to carry out its reforms, but this was to change after 2010 in order to embed a fully competitive system of provision involving independent and public providers.

The Conservative-Liberal Democrat Coalition, 2010-2015: Competition and Choice

In 2010 there was no immediate, large scale, pressing NHS problem to be addressed as there had been in 1997 (King's Fund, 2010). Moreover, pressing long-term issues, particularly meeting the needs of an ageing population, were not addressed (Glennister, 2015). Yet the 2012 Health and Social Care Act proved to be a highly controversial structural change. In terms of specific policies, it is relatively easy to make a case for continuity between the Conservative-dominated Coalition and the previous Labour Government, for example in respect of ISTCs and FTs, together with Clinical Commissioning Groups (CCGs) as a further development of commissioning by PCTs. The House of Commons Select Committee on Health (2011, p. 16) was 'struck by elements of both continuity and discontinuity'. As Dixon and Mays (2011, p.144) observed: 'In intellectual terms these proposals do represent, to a great extent, an evolution of the NHS market, and do share some similarities with New Labour's market reforms. However, they also involve large-scale disruption'. It was the scale and pace of change that struck most commentators (e.g. Klein, 2013b). Tuohy (2018) chose to characterise it as rapid, multiple and simultaneous – 'mosaic' – change, and also noted that the scale and pace of reform is important because it can raise the ideational stakes. In addition, the 2012 Act was implemented under conditions of austerity, which not only made levels of public expenditure comparable to leading EU countries impossible (Taylor Gooby and Stoker, 2011), but was also arguably un conducive to the development of patient choice, which requires a surplus of provision (Sheaff and Allen, 2016). Yet it was probably the ideas about the role of the state and the part to be played by the market – the direction of travel – that were most significant. Much of what the new Conservative Secretary of State, Andrew Lansley, wanted could have been accomplished without primary legislation, but the most controversial part of the 2012 Act (Section 75), designed to embed market principles in the NHS, could not.

Coalition ideas

As Lord Rea said in the House of Lords (2011,) it was possible 'to trace the development of the ideas behind the Bill in Conservative think tanks dating back more than 20 years'. By 2005, the Conservative Party was stressing the importance of 'breaking down barriers between private and public provision, in effect denationalising the provision of health care in Britain' (Hunt, 2005, p. 78). The Party's proposals for NHS legislation (Conservative Party, 2007) and its Renewal Plan for the NHS (Conservative Party, 2008) envisaged a 'post-bureaucratic', decentralised NHS, and returned to a major theme of the 1988 pamphlets (see especially Froggatt, Paulley and Serebriakoff, 1988) when it stressed that the NHS could not be managed from the top down and insisted on autonomy for the service. Oliver Letwin, also an influential writer in the late 1980s (see above, p.5), insisted that the Conservatives wanted to strengthen society rather than the state. These positions appealed strongly to Liberal Democrats, some of whom had also signalled strong support for a market approach in the early 2000s (Laws, 2004).

The Coalition agreement (Cabinet Office, 2010) made much of attacking big government and top down control and promised to avoid any top-down reorganisation of the NHS, which made subsequent justification of the 2012 Act additionally difficult. A rapidly produced White Paper (DH,

2010, p.5), stressed autonomy for the service, choice for patients and the ambition to 'create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say..'. The last part of this statement linked to the Prime Minister's (unfulfilled) promise of a Big Society with a major role for the third sector. In fact, following the legislation's emphasis on competition, the importance of contract became paramount and the role of private providers within the independent sector became more significant than that of the third sector in terms of the value of the contracts they won.

It is notable that as the long and difficult passage of the 2012 Health and Social Care Act began (2000 amendments were made over 50 days of debate) Lansley began to argue more strongly that his Bill was 'not an upheaval, it is an empowerment' and sought to emphasise evolution rather than change (HoC Select Committee on Health, 2011, p.16), something that the Conservative spokesman for health in the House of Lords, Earl Howe, stressed when he said that competition, choice and more plurality in service provision 'has long been the right direction of travel' (HoL, 2011b, my ital).

Lansley was careful from the first to commit to the values of the NHS, which meant that his reforms could be presented as non-threatening: it did not matter who delivered the service so long as universal access, together with universal provision free at the point of access were preserved.⁷ Competition was key and would, he argued, enable choice if accompanied by greater freedom for providers. For Labour, choice had taken first place, with competition perceived as a means to a stronger NHS and to securing choice for patients. Whether mistakenly or not, Labour wanted to 'use' markets in the service of the NHS, and while it committed to market principles, it nevertheless acknowledged the importance of cooperation between service providers. Lansley made competition the main focus, assuming (as was common after the market approach adopted by the Thatcher Government) that it would ensure that costs were cut and quality improved. Market competition was central to the 2012 Act - designed to enforce market disciplines and get politics out of the NHS of the future - and as such it required a firm purchaser/provider split and autonomy for commissioners and providers.

Patient choice also figured heavily in Lansley's speeches and in Government documents, but the precise nature of its relationship with competition was not always clear. It was often described as driving competition, with competition driving quality. As Davies (2013) remarked, the thinking seemed to be that the patient would choose the best designed service that had been commissioned, but this tended not to be the basis for the choices made by (what was only a minority) of patients (see above, p.4). However, competition was also described as making choice possible.

For Lansley, greater autonomy for purchasers and providers was seen as the key to establishing an NHS market and was more likely to be bracketed with competition than was choice. Indeed, the Impact Assessment issued by the Department of Health (DH, 2011) said that the problem the legislation was addressing was that of decision-making being too far removed from patients, something Lansley referred to when arguing for decentralisation and local autonomy. Lansley also insisted that poor productivity in the NHS was the result of too much central government control

⁷ Some economists have made similar points, e.g. Le Grand (2006).

and bureaucracy, together with insufficient use of markets and ineffective purchasing. Central to his approach was the idea that government should retreat from involvement with the NHS and that markets would ensure autonomy and stimulate a self-sustaining health care system. As Deakin and Walsh (1996) had observed in respect of the Thatcher administration's reforms of the early 1990s, Conservative politicians welcomed the possibility of getting the politics out of healthcare reform. Lansley admitted that many of his changes did not require legislation (HoC, Debates, 2011). However, he wanted primary legislation that would complete the purchaser/provider split as the means of embedding competition and thus ensuring the autonomy of an NHS based wholly on market principles.

Lansley's assumptions about the desirability of market principles and organisation were strikingly simple given the complexity of changes in population needs, NHS structures and organisation, and the management of more top down change under austerity (which meant that reform had to be justified in terms of securing greater productivity rather than - as under Labour in the 2000s - as payback for greater investment). Indeed, Timmins (2018, p.41) has suggested that Lansley did not pay enough attention to the problems that austerity was likely to pose, e.g. for Foundation Trusts whose autonomy was curtailed when Government exerted more financial control.

Lansley tended not to use ideological language in his public pronouncements, indeed he often started with a reference to fundamental NHS values. However, his main reference point was what he viewed as the successful privatisation of the utility companies, a comparison that the HoC Select Committee on Health (2011b, p.35) 'did not find ... either accurate or helpful', for as Arrow (1963) observed health is 'different' (see also Gilbert et al., 2014; Reisman, 2017, Greener, 2008). In a speech to the NHS Confederation (of commissioning organisations), Lansley (2005) said that the introduction of competition with a strong independent regulator had 'delivered immense consumer value and economic benefits' for telecoms, water, railways and the Post Office. Effective competition was 'a tide which lifts every boat' and would unleash the power of patient choice. In addition, getting rid of top-down targets would set professionals free.

Lansley moderated his tone and ambitions in the course of the long Parliamentary struggle over his Bill. Competition on the basis of price rather than quality, for example, was abandoned. Lansley (2011) told NHS staff that '...we need to make sure that we have the right sort of competition in the Health Service. Not competition for its own sake, not cherry picking the lowest hanging fruit, not giving preference to the private sector over and above the NHS'. The need for service integration also began to pepper his speeches, although his main argument was that this would be furthered by choice and competition, and in another speech delivered in 2011 he reached again for an analogy with consumer goods, this time with mobile phones: smartphone companies 'offer the greatest possible degree of integration', with the possibility of transferring a SIM card from an iPhone to a Samsung or Nokia phone, adding that 'the same can be true of health care. Only here we don't call it a supply chain, we call it a care pathway' (Lansley, 2011b). The issues raised by making an analogy between manufacturing and the problems of providing unpredictable care in a human service went unaddressed. Indeed, care quality remained subject to regulation that was top-down and predominantly managerial. In addition, as the OHE (2012) recognised, some of the

incentives introduced to enable competition, for instance, new payment mechanisms, could prove inimical to 'the intrinsic motivation' to care.⁸

The consultation – the Future Forum - that took place during the 'Pause' that was called in the middle of the Parliamentary Debate on the Bill showed that many professionals as well as MPs continued to think of competition as a tool to support choice (Field, 2011, p.11), rather than the primary focus. However, no significant change was made in the crucial section of the legislation on competition (Section 75) as a result of the 'Pause'. Furthermore, in his speeches Lansley made very little mention of cooperation or service integration.

Coalition Reforms

Lansley's ideas and approach determined the content of the 2012 Act, making him a good example of what Carstensen and Schmidt (2016) have referred to in terms of the importance of 'first actors'. Compared to Milburn, who spearheaded the series of important changes in the service under Labour in the early 2000s,⁹ Lansley carried out little by way of consultation and gave relatively few speeches to health professionals, despite his insistence on their importance (of GPs in particular) and their need for more autonomy. His Bill resulted in an avalanche of professional as well as political opposition, most of it focused on Section 75 and the new arrangements for embedding competition in primary legislation.

The reforms can be represented in terms of continuity involving further development of PCTs, FTs and the regulator, Monitor, but this misses the significance of the main ideas driving the reforms: the promotion of full market competition between public and private providers and with it more autonomy for the service. It was intended that the responsibilities of the Secretary of State (and the Department of Health) would wither in face of a self-sustaining healthcare market.

In brief, the 2012 Act replaced 152 PCTs with 211 Clinical Commissioning Groups (CCGs), with GPs required to become commissioners. Commissioning thus became a clinical responsibility, albeit that crucial commissioning support was provided by a variety of non-clinicians, including many former staff of the PCTs, and was sometimes outsourced to private companies. The CCGs were made directly accountable to what became NHS England in 2013 rather than the Department of Health, which was intended to distance the NHS from political intervention. The layer of Strategic Health Authorities (SHAs) which had existed above the PCTs was stripped away, making decentralisation more complete and resulting in greater fragmentation of commissioning and services. But if the main issue had been to increase the control exercised by GPs via clinical commissioning, this could have been achieved through the existing structures of the NHS. CCGs were in fact part and parcel of what was designed as the final step to achieving a complete purchaser/provider split. Yet this was taking place not long after the Select Committee on Health had cast major doubt over the capacity of (the much larger) PCTs to commission efficiently and effectively (see above, p.9).

⁸ Intrinsic motivation is contested concept, but the difficulty of delivering high quality care work under market disciplines is not (Lewis, 2014).

⁹ Alan Milburn achieved impressive buy-in from professional, trade union, policy and voluntary sector organisations for his 2000 NHS Plan (DH, 2000, p.7).

Hospital and community service providers were initially slated to become Foundation Trusts by 2014, something that was made additionally difficult by the Government's policy of austerity and the growing indebtedness of Trusts burdened by Private Finance Initiative contracts, which meant that providers could not rely on being able to expand market share (the problem of sustainability for Trusts was acknowledged by a National Audit Office's Report (Comptroller and Auditor General, 2014)). Monitor continued to oversee the work of Foundation Trusts and was also given concurrent powers with the Office of Fair Trading to apply the 1998 Competition Act. Indeed, it was initially expected to apply commercial insolvency law, something that was set aside after the long and difficult Parliamentary debates on the Bill. Monitor had been set up by Labour (see above p.8), but under the 2012 legislation its role expanded from oversight of the Foundation Trusts to that of a broad sector regulator as part of the necessary re-regulation of the completed purchaser/provider split, which involved more independent sector providers. Its directors came mainly from management consultancy and anti-trust enforcement. When the House of Commons (HoC) Public Accounts Committee (2014) looked at the regulation of Foundation Trusts they found that only 21 of Monitor's 337 staff had an NHS operational background and only 7 a clinical background. In addition, the cost of consultants accounted for £9m of a £48m budget for 2013-14. The new Chair of Monitor, David Bennett, who had been a senior partner in McKinsey's management consultancy company, expressed his understanding of Monitor under the new legislation in terms that harked back to those of Lansley: 'We did it in gas, we did it in power, we did it in telecoms. We've done it in rail, we've done it in water. So, there is 20 years of taking on monopolistic monolithic markets and providers and exposing them to economic regulation' (Smyth, 2011). As the sector regulator, Monitor was initially given the task of stopping anti-competitive behaviour and of 'promoting' competition; after the Pause in the Parliamentary Debates to consult more widely, the promotion of 'integrated' services was also added to its remit. The potential for antagonism between these two tasks, highlighted by the House of Commons Committee on Health (2011b, p. 38), would become more evident by the end of the Coalition Government.

The Secretary of State remained accountable for securing a comprehensive service, but not for providing services, something that passed mainly to CCG commissioners (HoL Select Committee on the Constitution, 2011). This was in line with the new duty of autonomy that the Secretary of State was required to promote. Lansley's successors, Jeremy Hunt from 2013 and Matthew Hancock from 2018, did not refrain from comment on the NHS, but endeavoured to steer clear of many core issues, focusing on clinical errors in patient care in the case of Hunt, and public health and technology issues in the case of Hancock. Nevertheless, post-2012 Secretaries of State did not escape responsibility; public financing made this impossible. However, as Timmins (2018) noted, they often paid as much or more attention to operational issues rather than to strategic ones, as the new structures that emerged after the passing of the Act assumed greater importance (see below, p.16 et seq.).

Many Parliamentarians and commentators feared that the more robust approach to competition enacted in 2012 also meant more privatisation. For example, Lord Owen, who had favoured an internal market for the NHS, said that he had 'never believed that it would lead to an external market', and protested that health was not a public utility, it was 'different'¹⁰ (HoL Debates, 2012). But in fact, Earl Howe (2011) had already told Laing and Buisson's Independent Healthcare Forum

¹⁰ This echoed Arrow (1963), see above p.12.

in 2011 that '[t]he opening up of the NHS presents genuine opportunity for those...who can offer patients high quality, convenient services that compete favourably with current care...'. The King's Fund however, played down the issue of increasing private provision (Ham et al., 2015). Powell (2016b, p. 25) has concluded that while it is not possible to identify a tipping point towards privatisation, it can be argued that the 2012 Act provided a clear enabling point.

Many commentators have tended to dismiss the increase in the greater involvement of the independent sector (e.g. Timmins, 2019), but the money going to them increased inexorably after 2012. The BMA's (2016) analysis of 3,494 contracts awarded in 2013/14 showed that 45 per cent of these went to non-NHS providers, and 41 per cent of the 195 contracts that went out to tender, albeit that 85 per cent of the value went to NHS providers. Updating these figures, the BMA (2018) showed a further 33 per cent increase in the money going to the independent sector providers between 2013/14 and 2015/16. By 2016/17 the money going on non-NHS provision (including local authority and voluntary organisations) had increased to 12.7 per cent from 9.5 per cent in 2013/14, with 44 per cent of expenditure going to independent sector providers of community services. The generally accepted (including by the Department of Health) percentage of the health budget going to the private sector was 7.7 per cent in 2016/17, compared to 2.8% in 2006/7. Private provision of some elective hospital procedures, e.g. hip replacements cataracts and inguinal hernia repairs has also increased significantly (Stoye, 2019), but the difficulties experienced by private sector providers in providing acute services in hospitals,¹¹ especially after payments were reduced as part of the austerity regime, has made bidding for community services and 'back office' functions more popular. The second of these included commissioning support, which as Davies (2013) has pointed out carried implications for the accountability of CCGs.

However, the King's Fund (2019) has noted the difficulties in arriving at figures of this kind, for example, there is an absence of detailed information at a national level about individual local contracts. Indeed, Rowland (Director of the Centre for Health and the Public Interest) (2019) has suggested that in 2018/19 as much 26 per cent of total expenditure on the NHS went to the independent sector.

As Davies (2013) has noted, the nature of the NHS market after 2012, with its framework of competition and regulation by legal rather than administrative contract enforced by Monitor as the sector regulator, has made the involvement of the private sector increasingly a technical rather than political matter. Yet many issues to do with risk, profit and whether there are measurable improved outcomes can be raised by contracting with private providers using public finance (e.g. Woolhandler and Himmelstein, 2007; Tuohy, 2018). Private providers may complain to Monitor if they are excluded from tendering and may sue the relevant CCG(s) following failure to get a contract (as Virgin did in 2016 when it failed to win a contract to provide children's services across Surrey). In addition, private providers can invoke commercial confidentiality in respect of the nature of their contracts and are not subject to Freedom of Information Requests. The House of Commons Public Accounts Committee (2014b), the National Audit Office (Comptroller and Auditor General, 2016) and the BMA (2018) have been particularly concerned about the capacity of CCGs to draw up and manage contracts with private providers, just as the HoC Select Committee on

¹¹ Hinchingsbrooke Hospital is perhaps the best known example: Circle Health won a 10 year contract to run the whole hospital in late 2010, but reneged on the contract and passed the hospital back to the NHS in 2015 with a £14m deficit, higher than when it had been taken over by the private provider.

17 Social Policy Working Paper 05-20

Health was in 2010 (see above, p.9), as well as about the potentially destabilising effect of clinical services being hived off to private providers. In addition, with the increased use of tendering, the costs of procurement have also continued to rise.

The main idea driving the 2012 Act was to strengthen market-based reforms, with the emphasis on securing internal and external competition, even though as Gregory, Dixon and Ham (2012) observed, there was little evidence for this or for choice as effective drivers of performance or the more innovative models of care that had originally been thought would result from the purchaser/provider split. Indeed, the political and public debate moved on rapidly to focus on the extent to which any possible benefits were being eclipsed by the fragmentation of services produced by the reforms.

During the Parliamentary Debates on the Bill, Lansley sought to modify his early insistence that his Bill represented a radical change and to suggest that competition and the involvement of the private sector ‘...should only ever be a means to improve services for patients, not ends in themselves’ and thus to justify his reform in terms more acceptable to the turn of the public debate (HoC Debates, 2011b). However, there were instances when the requirement to promote competition clearly came into conflict with the interests of patients, for example in respect of hospital mergers, such as that between Bournemouth and Poole which went to court in 2013 (Spencelayh and Dixon, 2014). This merger was designed to improve patient care, but fell foul of the regulator, which was obliged to promote competition. The NHS market became ‘more real and more autonomous’ after 2012 (Davies, 2013, p. 585) and the dominance of the public ethos and professional work culture was threatened by the shift to economic regulation and legal contract in the context of demoralisation due to pay being held down under austerity, with the implications for patient care largely unknown.

The Conservative Government 2015-2019: From Competition First to Integration First?

The 2012 Act embedded market principles in the NHS and was widely agreed to have completed the journey begun in 1991 with the creation of the internal market and the purchaser/provider split. Yet remarkably soon after it became law, the effects of competition – particularly the increasing fragmentation of services - came under sustained attack and the approach to NHS reform was substantially modified, but at the initiative of the Chief Executive of NHS England rather than a politician. Nevertheless, crucial dimensions of a market approach remain, namely a role for the private sector, although how big and in what form may be more open to question, and the use of legal contract, which seems to have become normative.

As the 2011 Parliamentary Debates over the Health and Social Care Bill and the Future Forum’s consultations during the ‘Pause’ in the Debates made clear, the main tension within the reform was between competition and integration. Significantly, the NHS Principles and Rules for Cooperation and Competition launched by Labour in 2007, became NHS (Procurement, Patient Choice and Competition) Regulations in 2013 (Statutory Instrument no. 257), reflecting the priority given to competition over collaboration/integration. A report on competition by the Future Forum (Bubb 2011) said that it should only be used as a tool for supporting choice, integration of services and quality. The main report of the Future Forum (Field, 2011, p.25) reiterated this but, like David Nicholson (DH, 2011b) the Chief Executive of what became NHS England in 2013, concluded that

there was no real antipathy between competition and integration because it was possible to commission for the latter. Nevertheless, Shaw et al's (2011) report from the Nuffield Trust on integrated care pointed out that fragmentation – made inevitable by devolution to the large number of CCGs - was in essence antithetical to integration, a view that was similar to Lewis and Glennerster's (1996) concern about the difficulty of integrating health and social care under the system of GP Fundholding introduced in the early 1990s. This concern became increasingly dominant among NHS managers and clinicians by the end of the Coalition Government in 2015 . As Timmins (2018 and 2019) noted, fragmentation resulted in no overall oversight of the NHS and made collaboration difficult.

Moving away from the 2012 Act?

Simon Stevens succeeded Sir David Nicholson as Chief Executive of NHS England in 2013, having previously advised the Blair Government before joining the American healthcare company, UnitedHealth. Stevens (2014) stated his commitment to the founding principles of the NHS and said that he wanted to test practical new models for care that would promote integration and would not require structural reorganisation. His goal was to unleash innovation and improvement and he said that he was prepared to draw on ideas from elsewhere to achieve it. It was Stevens rather than the Secretary of State who brought out the key strategic policy document - the *Five Year Forward View* - in 2014, which set out a number of new care delivery options from which local communities would be able to choose, involving, for example, the integration of community services, of acute services, or of primary and acute care services (Care Quality Commission et al., 2014). Change was envisaged as being evolutionary rather than 'big bang' (NHS England, 2017, p.29). Indeed, at the local level, CCGs varied as to how far they endorsed the shift from competition to integration. For example, in its CCG Procurement Policy for 2016/17, Wandsworth CCG in London continued to foreground the importance of choice and competition, whereas neighbouring Lambeth CCG's procurement policy for 2016-2019 emphasised integration, innovation and best value. However, in general, clinical leaders welcomed the focus on integration.

Stevens was optimistic as to the possibility of achieving both the £22bn of cost savings required by the Government together with quality improvement. The King's Fund supported the idea of reforming the NHS from within, and the idea of service rather than organisational integration (Ham, 2014). However, the National Audit Office (Comptroller and Auditor General, 2017) warned of the lack of compelling evidence to show that integration would lead to sustainable savings or reduced hospital activity. The HoC Health and Social Care Committee (2018, p.2) expressed scepticism about the possibility of achieving successful integration and about the barriers to change contained in the 2012 Act, but were assured by Stevens that his reform agenda was not intended to be a mere 'reshuffling of the administrative deckchairs'.

The *Five Year Forward View* focused firmly on integration rather than competition, and this required changes to the competition-focused framework set up in 2012, for example in the form of new payment methods and ways of commissioning, as well as new ways of providing services. Integration required a focus on person-centred, coordinated care and support, rather than discrete interventions which could be commissioned, costed and charged for separately. Nevertheless, Monitor (2015) continued to deny that integration was at odds with competition.

However, changes were made in the organisation of the regulatory bodies whereby Monitor and NHS Trust Development became part of NHS Improvement in 2016, with a further merger between NHS England and NHS Improvement announced in 2018. These changes served substantially to moderate the priority accorded to promoting competition. The focus on integration also drew attention to the problems raised by the autonomy promised to Foundation Trusts which were expected to compete, when integration required collaboration and cooperation which involved partnership working. As early as 2015 the King's Fund stressed the need to avoid the 'distractions' of mergers and acquisitions among Trusts in favour of a focus on cooperation: '...NHS leaders need political support to avoid falling foul of stakeholders who see moves to stimulate collaboration between NHS providers as a way of frustrating competition and the entry of new care providers' (Ham, 2015). The HoC Health and Social Care Committee (2018, p.4) reiterated that 'we support the move away from a competitive landscape of autonomous providers towards more integrated, collaborative and place-based care', and criticised the perverse incentives of competition law.

Stevens set up pilot projects for the new models of care, followed in 2016 by the creation of 44 Sustainability and Transformation Partnerships (STPs), which often required the merger of CCGs in order to align with their boundaries. The STPs were to focus on establishing the new models of care, but in the context of austerity they were often feared by health professionals and campaigners to be vehicles for privatisation and cuts (Iacobucci, 2018). As the World Health Organisation had commented as early as 2008, integration could not be a cure for inadequate resources (see also Comptroller and Auditor General, 2018). The most advanced STPs became Accountable Care Systems (ACSs) from 2017 and Stevens envisaged these eventually becoming Accountable Care Organisations (ACOs), on the American model. Indeed, in a speech to the American Brookings Institution, Lansley (2011c) had linked CCGs in the NHS with American ACOs, describing both as focusing on the benefits of bringing together clinical decision making and control over resources. ACOs can be characterised as integrated systems with responsibility for population health and resources (Tu et al., 2015; Charles, 2018). However, the policy context of the US health care system with its heavy reliance on independent sector providers and insurance funding could not be more different from that of the UK. Furthermore, the King's Fund saw the danger of associating reform in the UK with the US because it would increase suspicions that more healthcare provision in England would be privatised (Shortell et al., 2014).¹² In 2018, the term Integrated Care System (ICS) replaced that of ACO, which the King's Fund welcomed (Ham, 2018).

This series of changes designed to facilitate the integration of services was hampered by the lack of effective governance and by the continued barriers to integration thrown up by competition law. The Conservative Party Manifesto of 2017 promised to review the operation of the market and make non-legislative changes to remove barriers to the integration of care. Stevens told first the House of Commons Public Accounts Committee (2017, p.11) and later the HoC on Health and Social Care Committee (2018, p.76) that he was not insisting on legal changes and that 'workarounds' were possible, but the Committee on Health and Social Care felt that 'the law will need to change', not least because the new structures that were needed to deliver new models of

¹² Indeed, two legal challenges were mounted to ACOs by campaigners, see Bate (2018). Both challenges failed.

care faced problems of accountability. Indeed, the view that the law needed to change gathered force among professionals as well as in NHS England.

Stevens assured the HoC Public Accounts Committee (2017, Q93) that when STPs became fully fledged integrated care systems this would ‘...for the first time since 1990 effectively end the purchaser-provider split, bringing about integrated funding and delivery for a given geographical population...’. This assurance was all the more striking given that the purchaser/provider split had only recently been completed by the 2012 legislation. But Steven’s direction of travel was not a complete departure from that of Lansley. While the *Five Year Forward View* was increasingly seen as incompatible with the focus on market competition, it remained compatible with privatisation and contract. However, the HoC Committee on Health and Social Care (2018, p.44) said that it did not want any future integrated care organisation to be run by private agencies and suggested that they should be ‘NHS bodies established in primary legislation’. Similarly, the BMA (2018b) expressed concern that if the new integrated care organisations were to be made subject to competitive tender, ‘whole health economies could, in theory, be taken over by commercial providers, and with ten-year contracts with exit clauses that could both fragment and disrupt services’. The King’s Fund joined the chorus demanding that the new organisations - ICSs - should be established in law as NHS bodies (Ham and Murray, 2018, p.18), having long noted that integration required relational contracts and more commissioner/provider cooperation and collaboration (Dixon and Mays, 2011). A second major review of health and care by Lord Darzi (2018, p.39), ten years after his first, stated plainly that the 2012 Act had been ‘a set-back’ and constituted one of the biggest barriers to reform because it fragmented commissioning functions. The fate of choice in all this was not clear, but with a return to an emphasis on population planning within what continued to be a universal, relatively uniform and publicly funded health care system, choice was bound to be circumscribed (e.g. Kar, 2019).

During 2019 the tone became tougher still. In January, the NHS Long Term Plan (NHS England, 2019 p.30), which had to be published before the injection of substantial Government funds took place (not that integration was likely to stop hospital costs rising), said that it was expected that contracts for ICSs would be with public not private organisations. This document also made clear that while the changes set out in the Plan could generally be achieved within the current statutory framework (in other words, by the ‘workarounds’ Stevens had referred to in 2017 and 2018), legislative change, particularly the removal of the general competition rules and powers in the 2012 legislation, would support more rapid progress (NHS England, 2019, p.113). It was also recognised that the 2012 legislation gave ‘considerable weight to individual institutions working autonomously when the success of our Plan depends mainly on collective endeavour’ (ibid, p. 112). In February 2019 it was reported that a meeting of the Boards of NHS England and NHS Improvement wanted Section 75 of the Lansley Act revoked and the barriers it created for CCGs, local authorities and the NHS wishing to work together removed (Dodge and Dyson, 2019). The Chief Executive of NHS Providers said that it made sense to look at the tensions between the ‘current legislative framework and the desired direction of travel’ (Hopson, 2019). However, it is noteworthy that the recommendations of the Boards of NHS England and NHS Improvement (2019) for an NHS Integrated Care Bill have focused firmly on the problem posed by competition and the need to repeal Section 75 of the 2012 legislation without addressing the issue of privatisation, which campaigners and some commentators believed to be as problematic for the future of ICSs (see above, p.18).

Conclusion

There are many dimensions to market-based reforms. The main focus of NHS reforms during the past three decades in this regard has been the creation of the purchaser/provider split, which was completed via the 2012 Health and Social Care Act, when competition between NHS providers and between NHS and independent sector providers was embedded in primary legislation. However, the problem of prioritising competition within a universal, tax funded service facing the twin challenges of an ageing population and a period of acute austerity proved difficult. Very soon after this legislation was passed questions about the resulting fragmentation of services were raised and the debate focused on the importance of integration and a return to population-based planning, with a growing degree of consensus as to the importance of removing Section 75 of the legislation on market competition in the NHS. However, the debate paid relatively less attention to privatisation and the role of legal contract was assumed, notwithstanding its implications for trust and professional work cultures, including professional training and patient care.

Indeed, the significance of a substantial increase in contracts with private providers since 2010 has tended to be dismissed by key commentators, particularly the King's Fund, but there is no reason at the time of writing (December 2019) to expect that this trend will decrease. In addition, even though influential commentators (including the King's Fund in this instance) have expressed substantial doubts about private bodies taking control of the ICSs, there has been no clear decision as to whether ICSs will be public sector bodies. ICSs are scheduled for introduction throughout the NHS, thus addressing the fragmentation of commissioning but also controlling concomitantly large budgets. It has been strongly argued that it does matter whether public services are publicly owned (Greener, 2015, p.688), the overarching reason being that 'health is different' (see above, p.12) and not easy to subject to market disciplines, not least because the 'consumer' cannot be expected to know what s/he needs/wants and thus there has to be a proxy purchaser.

Underpinning the purchaser/provider split and the increase in plural provision has been acceptance of legal contract. This is despite first, evidence that continues to show the difficulties the service has experienced in drawing up and monitoring such contracts effectively; second, the cost of going out to tender and the extent to which decisions can be challenged, particularly by private companies; and third, the difficulties that can confront service providers who need to collaborate and cooperate. But the role of legal contracts remains deeply embedded within the service.

Taking the long view of three decades of development of a market approach to delivering universal and comprehensive health care under the NHS has shown that there has been substantial continuity between Conservatives and Labour in respect of means, mechanisms and often short-term policy goals (e.g. increasing the number of more autonomous Foundation Trusts). Indeed, it is possible to see NHS reform over this period primarily in terms of the extension and development of 'contracted-out' services (Powell and Miller, 2014). However, this risks paying insufficient attention to the ways in which the purchaser/provider split has been developed and market discipline tightened, particularly under the 2012 Health and Social Care Act, with substantial impact on the service in terms of the political dynamics (Timmins, 2018) and the roles of politicians, managers and the medical profession, as well as fundamental changes in the role of the market and the state.

This paper stresses the importance of the difference in Labour and Conservative ideas about the role of the state vis à vis the market. Labour was clear that the state should continue to oversee the NHS as well as to fund it. The Party's support for a market approach was given on the basis of 'what works' to control costs and improve quality. Prime Minister Blair and Alan Milburn, the Secretary of State who set in motion key reforms in the early 2000s, shared the Conservatives' conviction that competition and more involvement by the private sector would prove more efficient

and more beneficial for patients by enhancing quality. Milburn and Patricia Hewitt, who succeeded him as Labour Secretary of State, showed an enthusiasm for a self-sustaining, market oriented, devolved and more autonomous system, which also characterised Lansley's approach. This was of course risky in terms of the relative paucity of evidence about the effects of market reforms (Gregory et al., 2012) and the likely effects of institutional change based on market principles for professional work cultures, the public ethos and the capacity of the service to address the changing nature of an ageing population's health care needs. In any case, a fully autonomous and self-sustaining system, operating under market disciplines and without political 'interference', was likely to be a chimera given that the NHS has remained a publicly-funded service.

Nevertheless, the differences between Labour and Conservative thinking were important. Labour wanted to 'use' the private sector for the benefit of an NHS that would remain a public service under the explicit control of the state. However, the NHS has always been a very large employer, absorbing considerable amounts of public money and constituting a source of political danger for ministers when crises arise. While the Labour administrations did not want to remove the state from involvement in the NHS, the welcome they gave to the private sector as well as their continued commitment to competition – albeit with an emphasis on this as a means to providing choice – made it easier for the Conservative-led Coalition Government to pick up market reform where it had left off, but with a different set of ideas as to the desired roles of the state and the market. The Conservatives continued to stand by the ideas they made public in the late 1970s and 1980s to reduce the role of the state in favour of the market, although they were prepared to stage their reforms and to describe the changes they made over time as either more evolutionary or more radical in accordance with what was politically and electorally possible. It was because of the fundamental differences between the political parties in this respect that Lansley wanted to ensure that competition and market discipline were embedded in the NHS for the future. While there has been no hard and fast Conservative 'plan', there has been a clutch of organising principles and ideas, plus a great deal of patience in awaiting their execution, although interestingly the 2012 Act attempted more emphatic and controversial change. Thus, while the purchaser/provider split begun in the early 1990s was finally completed in 2012 and competition law has been used to increase the role of private providers, changing the tax finance of the NHS was shelved by the Thatcher administration and remains so. But the differences between the political parties in terms of their underpinning ideas about the role of the state and the market have meant that there has been a fundamental difference about their direction of travel in respect of the NHS.

There have also been unintended consequences of the pursuit of a market approach, particularly for the Conservatives. The priority accorded competition above all by the Coalition Government and its desire to remove the state from the day-to-day management of the service also required the setting-up of more arms-length bodies with new duties. Thus for example, Monitor, established by Labour to oversee Foundation Trusts became an economic sector regulator focusing on ensuring competition above all, and the role of the Department of Health dwindled hugely in comparison with that of NHS England. The idea was that the system should 'run itself' as far as possible. Secretaries of State after Lansley did not entirely keep out of NHS controversies, but publicly they shied away from what had always been the main site for these in the past - funding - choosing instead to highlight issues that were more likely to win public approval, such as care standards.

When Simon Stevens arrived to lead NHS England in 2013, he did not back away from the market-oriented reforms that he had advised the Blair Government about or in any way disown his experience with UnitedHealth in the US that followed. But in the very different context of occupying probably the most important role in running the English NHS he showed an appreciation of the problems thrown up for a universal, publicly funded service by the Conservatives' commitment to wholehearted competition over integration. As the King's Fund observed (Ham et al., 2015 p.58), his *Five Year Forward View* was the first indication that NHS England was 'using its semi-independent status to act as the voice of the NHS in negotiation with the government'. To this

extent, greater autonomy came back to bite the Conservative-led Coalition Government. But Stevens did not reject more plurality of provision involving the private sector or the use of legally binding contract. Setting up the new structures to implement the new models of care will certainly use the latter and, unless legislation is passed to repeal Section 75 of the 2012 Act, may continue to increase the importance of the former. As the NHS Support Federation (2017) has noted, activity in the market for NHS contracts remains high despite the signalled shift away from competition. But Steven's new models of care did push back against the fragmentation of the service that worsened after the passing of Section 75, which had sought to enshrine market principles in law.

Lansley's commitment to autonomy, which was arguably more integral to his view of competition than was choice, has also come into question. The NHS has been shown to need first a hierarchical structure, although the precise form this should take has always been a matter of debate in every major reform since 1946, and second, clear lines of accountability. As Checkland et al. (2018) have commented there is a need for some sort of meso-level oversight from organisations able to 'hold the ring' between competing interests and to take a regional view of the needs of the population. Many commentators have supported the devolution and localisation that were goals of Labour and Conservative reforms, but often in the name of securing more bottom-up change (e.g. Ham, 2014). However, in practice giving Foundation Trusts more autonomy and stripping out the statutory Strategic Health Authorities in 2012 made population planning and the cooperation needed for the successful delivery of services difficult. Nevertheless, the greater influence over policy exerted by NHS England under Stevens aimed at ending fragmentation and promoting integration may well result in a more corporate, managerial approach to NHS reform, possibly more in line with the 'business management' ideas of Roy Griffiths implemented during the first Thatcher administration.

NHS staff yearn for a period of stability, but in the short to medium term Steven's new models of care mean more changes in boundaries – in terms of geography and provision - between CCGs and integrated care providers. In the long term it is as much the gap between the political parties in respect of their ideas about the proper relationship between the market and the state – and hence the direction of travel - as anything else that is likely to make this difficult to achieve.

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27 Social Policy Working Paper 05-20

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