

Delivering Britain's public services through 'quasi-markets': what we have achieved so far

Julian Le Grand, London School of Economics (LSE) professor and former Downing Street adviser, reflects on the development of ideas about choice and competition in education and healthcare, his role in their implementation as practical policies – and the outcomes for public service quality.

It is rare that academics working in the area of public policy get called to account for their specific policy recommendations. Normally you write your article or book in glorious isolation in your academic ivory tower. Then if you're lucky, on the day of publication, you may get called on to the *Today* programme for what is usually a respectful interview about whatever policy ideas you have come up with. There follows a ripple of interest in the quality press, and then the pool of indifference closes over the ideas, leaving the surface unruffled and government policy unchanged.

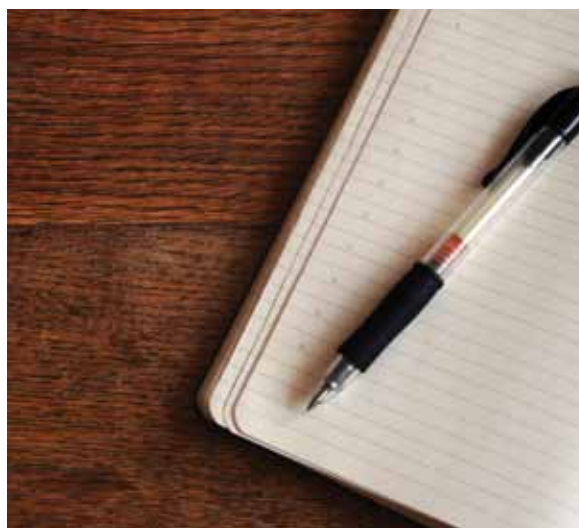
In a way, frustrating though it can be, there is an element of relief in all this. Obviously you believe that your idea will work, but you can never *know* that it will. There is always the risk of failure, the possibility that the grand claims you made for the idea will prove to be empty – or, worse, that the proposal, once implemented, will be counterproductive, creating perverse incentives that make the problem the policy was supposed to resolve worse.

In fact, the testing of policy proposals against the evidence is itself a testing experience, especially for their proponents – as indeed I can now bear witness. In the early 1990s I was lucky enough to work with Carol Propper and other colleagues at the School for Advanced Urban Studies (one of CMPO's precursors at the University of Bristol) on the analysis of a revolution in public provision in Britain (Le Grand and Bartlett, 1993).

The then Conservative government had introduced what we termed 'quasi-markets' into the delivery of public services, including the NHS and schools. Quasi-markets involved retaining state funding for these services, but replacing state monopoly in the provision of these services by a plurality of independent providers who competed for business from state-appointed purchasers (in healthcare) or directly from users (in education).

As a result of the 'quasi-market' reforms, the NHS is providing higher quality healthcare – more efficiently, more responsively and more equitably

Although I was initially fairly sceptical of the likely effectiveness of these measures, as we developed the theory underlying them and analysed their operation in practice, I became increasingly



convinced of their potential to transform public service delivery. Properly designed quasi-market measures could, it seemed to me, simultaneously raise the quality of the service concerned and the efficiency with which it was delivered. In technical terms, they could improve both productive and allocative efficiency.

Moreover, they could stimulate the responsiveness of providers to the needs and wants of their users, and even improve the equity of service delivery through giving the less well off the power of 'exit' from unsatisfactory providers – as the better off had always had through moving house or going private (Le Grand, 2007).

In fact, the actual experience of the Conservatives' quasi-markets was not all that favourable, especially in healthcare (Le Grand et al, 1998). There was some improvement in the productivity of hospitals, and some gains in efficiency in prescribing and hospital referrals from the GP fundholding experiment. But there were not the massive changes that their advocates hoped or their critics feared.

This was basically because in practice the government found it difficult to let go of the reins of central control, and, through the bailing out of inefficient hospitals among other things, blunted the incentive effects of the quasi-market. There was also a somewhat worrying piece of research by Carol Propper and CMPO colleagues, which found that price competition between hospitals appeared to lead to a deterioration in the quality of care (Propper et al, 2004, 2008).

But I judged that the potential for quasi-markets to transform public services was still there – if the central constraints could be removed, and the incentives for quality competition sharpened. With colleagues at the LSE (where I now was) I spent some time trying to convince the Labour Party, then in opposition, of the potential merits of quasi-markets, especially in healthcare and education. But in this we only partly succeeded.

On taking power in 1997, the new government retained some elements of the quasi-market reforms – including the purchaser/provider split – but abolished others – including, ironically, one of the most successful, GP fundholding. But after a few years of health service stagnation, Labour reversed direction, first applying a regime of numerical targets and strong central control (which became known as ‘targets and terror’), and then re-invigorating the quasi-market through introducing new providers, stimulating patient choice and generating competition among providers.

I was part of the quasi-market policy implementation process. I was initially invited into the policy unit in 10 Downing Street to work on choice in healthcare and education, and then appointed as health policy adviser to the prime minister, Tony Blair. Armed with research on the performance of quasi-markets in education by Simon Burgess and in healthcare by Carol Propper and their CMPO colleagues (Burgess et al, 2005), we were able to overcome the entrenched resistance of many powerful players in the worlds of healthcare and education.

Without choice, competition and other incentive measures, the NHS will revert to its old status of an inefficient monolith

In the NHS, we introduced patient choice, ‘payment-by-results’, foundation trusts and independent treatment centres; and in education, there were parental choice and academy schools. I only played a bit part in the development of these specific policies, but nonetheless felt a measure of responsibility for them. For they were the concrete realisation of ideas that I had long advocated, and I was now in a position to influence their implementation and thereby contribute to their eventual success – or failure.

In the light of my opening remarks about the anxieties to which academics who have their ideas taken seriously are prey, readers will not be surprised when I say how relieved I am to record that the reforms do not seem to have failed, at least in healthcare. On the contrary, evaluations by Carol Propper and colleagues at CMPO, LSE and York University suggest that they have succeeded (Gaynor et al, 2010; Bloom et al, 2010; Cooper et al, 2011; Cookson et al, forthcoming).

As a recent book reporting on these and other evaluations concludes: ‘the evidence... shows broadly that the market-related changes introduced by New Labour from 2002 tended to have the effects predicted by proponents’ (Mays et al, 2011). By 2010 the NHS was providing quicker, higher quality care, and doing so in a more efficient and more responsive manner. It was also more equitable in certain key respects, such as waiting times (Cooper et al, 2009).

Although some of these improvements were undoubtedly due to the increase in resources that characterised the later parts of that period, the relatively poor performance of the better-resourced but unreformed Scottish and Welsh health services suggests that there was more going on than simply increased resources. The targets and terror regime that preceded the market-oriented reforms in England also played a considerable part in the improvement (Propper et al, 2010); but the research demonstrates that patient choice and provider competition did have an independent effect.

All this has lessons for the current NHS reform debate (or debacle) generated by the coalition government – in particular, for the backlash against market-oriented reform that seems to have developed as the debate has gone on. The evidence suggests that this reaction is misplaced: provider competition and patient choice must be maintained, and indeed developed further.

If this does not happen, and if other incentive measures such as targets and performance management are also removed, then the NHS will revert to its old status of an inefficient monolith, offering long waits for poor care. This would be bad for patients, bad for those who work in the NHS – and bad for the coalition’s electoral prospects.

Julian Le Grand is the Richard Titmuss Professor of Social Policy at the London School of Economics.

Further reading

Nicholas Bloom et al (2010) *‘The impact of competition on management quality: evidence from public hospitals’*, Centre for Economic Performance Discussion Paper No. 983

Simon Burgess et al (2005) *‘Will more choice improve outcomes in education and health care? The evidence from economic research’*, CMPO (<http://www.bristol.ac.uk/cmipo/publications/publicservices/choice>)

Zack Cooper et al (2009) *‘Equity, waiting times and NHS reforms: retrospective study’*, British Medical Journal (3 September)

Zack Cooper et al (2011) *‘Does hospital competition save lives? Evidence from the English NHS patient choice reforms’*, Economic Journal 121: F228-60

Richard Cookson et al (forthcoming) *‘Effects of the Blair/Brown health reforms on socio-economic equity in healthcare’*, Journal of Health Services Research and Policy

Martin Gaynor et al (2010) *‘Death by market power: reform, competition and patient outcomes in the National Health Service’*, CMPO Working Paper No. 10/242 (<http://www.bris.ac.uk/cmipo/publications/papers/2010/wp244.pdf>)

Julian Le Grand (2007) *‘The Other Invisible Hand: Delivering Public Services through Choice and Competition’*, Princeton University Press

Julian Le Grand and Will Bartlett (eds) (1993) *‘Quasi-Markets and Social Policy’*, Macmillan

Julian Le Grand et al (eds) (1998) *‘Learning from the NHS internal market: a review of the evidence’*, King’s Fund

Nicholas Mays et al (2011) *‘Understanding New Labour’s market reforms of the English NHS’*, King’s Fund

Carol Propper et al (2004) *‘Does competition between hospitals improve the quality of care’*, Journal of Public Economics 88: 1247-72

Carol Propper et al (2008) *‘Competition and quality: evidence from the NHS internal market 1991-9’*, Economic Journal 118(525): 38-170

Carol Propper et al (2010) *‘Incentives and targets in hospital care: evidence from a natural experiment’*, Journal of Public Economics 94(3-4): 318-35