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Competition in the UK National Health Service



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Has it Led to the Progress We Hoped For?

Over the last two decades, successive policies have aimed to increase competition within the UK National Health Service (NHS) with the aim of improving outcomes and efficiency. This article reviews the successes and failures of these reforms, to assess whether the introduction of competition in the NHS has resulted in the progress hoped for by policymakers.

The private sector has long been viewed as a beacon of efficiency by public policymakers. Within healthcare, initiatives have been introduced in many systems that have aimed to use private sector practices to improve efficiency and outcomes. Of these, the introduction of competition has played a prominent role. The NHS is the largest public sector organisation in the UK and its sustainability is an issue that has remained at the heart of British politics since its inception. Increasing demands on its services have led to the adaptation of various policies to improve efficiency and ensure sustainability. There are few public sector bodies in the world that better exemplify the conflict between the challenges faced by the public sector and the attempts to rebalance with private sector initiatives.

Analysis of NHS policy over the last 30 years demonstrates that successive governments have introduced various reforms that have aimed to reproduce private sector practices with the aim of improving efficiency. The most common recurring theme has been an emphasis on introducing competition within the NHS to “eliminate inefficient providers and provide incentives for the adoption of productivity enhancing techniques” (Dawson et al. 2001).

However, there still remains uncertainty as to whether these reforms have led to the outcomes that were hoped for. The Health and Social Care Act (UK 2012) was widely criticised as a bill which aimed to privatise the NHS. However, evaluation of previous initiatives demonstrates that this was not the first time that policy had been redesigned to encourage competition in the NHS. Since the 1980s consecutive Conservative and Labour governments introduced private sector initiatives. These initiatives and policy changes are analysed below.

The Internal Market

The creation of the NHS internal market in 1991 led to the introduction of full price costing for healthcare. The aim was to increase efficiency through introducing a purchaser provider split to stimulate provider competition and improve productive efficiency (Propper and Söderlund 1998). Providers would develop contracts priced on cost so that these prices reflected resource use. Purchasers would then be guided by these prices to choose the most efficient provider. It was hoped that introducing price competition would tackle the inefficiencies that had resulted from the monopoly power of purchasers and providers, eventually leading to price reductions.

A number of problems arose through the internal market, on both practical and conceptual levels. For price to truly function as an indicator of comparative performance, accurate costing practices had to be in place. Little of this information was available when the internal market was introduced. In 1991/1992, a survey of hospitals in the West Midlands revealed vast variations in speciality prices between hospitals. Despite the development of guidelines (NHS Management Executive 1993), a repeat survey did not show real improvement (Ellwood 1996). This highlighted the difficult nature of costing healthcare, an essential component of competition in the free market.

The evidence regarding productivity in the internal market is mixed. Söderlund et al. (1997) did not find a significant increase in productivity secondary to competition in the first three years of the internal market. Maniadakis et al. (1999) did demonstrate improved productivity, but felt this was due to technical changes rather than efficiency gains.

So why did competition fail to yield the productivity gains expected? It has been proposed that full price NHS costing was unrealistic due to the very nature of the market itself. The number of purchasers and providers steadily decreased after the introduction of the internal market, leading to the formation of local monopolies, which dampened incentives to compete on price (Dawson et al. 2001). Inter-organisational bargaining became the main approach to contract negotiation instead of selective contracting based on full price costing. Listed prices became irrelevant, as they did not reflect true negotiated prices. The lack of transparency regarding these negotiated prices was particularly pertinent in the NHS, due to the absence of an external regulating body to monitor competitive behaviour and monopoly pricing. The internal market had been structured so that the NHS Management Executive could regulate monopoly pricing through monitoring listed prices. As these prices did not reflect the prices

actually negotiated, their relevance was doubtful (Ellwood 1996).

Although the internal market was eventually disbanded, arguments have been made in its favour. Whilst the effects were not immediate, the introduction of competition led to lower prices for some low cost procedures (Propper and Söderlund 1998). Opponents of the internal market argued that inter-organisational bargaining undermined the value of listed prices. However, if the internal market was modelled to reflect the private sector, then these private negotiations were perhaps inevitable. Indeed, a dynamic market does not actually require open information on prices. Propper and Söderlund (1998) argued that listed prices were still a useful indicator of the impact of competition on prices, especially in regions where there were a large number of providers.

It is argued by many that the internal market did not stimulate significant competition or create effective incentives for hospitals (Cooper et al. 2010). Whilst its successes and failures continue to be debated, it undoubtedly had a key role in shaping future policy. Certain regions experienced a significant reduction in provider price due to the monopsony power of single purchasers in these locations (Propper and Söderlund 1998). The pricing power of a single purchaser over multiple providers is a tool that has subsequently been adapted in health reforms, including the current Health and Social Care Act (2012). However, perhaps the biggest impact of the internal market was to put the doctrine of cost transparency into the public arena and consciousness of policy makers.

Reference Cost Indexing

The new Labour government largely abandoned the internal market in 1998. It introduced radical NHS reforms through a new white paper, describing the internal market as “distorting incentives to such an extent that unfairness and bureaucracy became its defining features” (Department of Health 1997). Whilst the purchaser provider split remained, reforms aimed to encourage collaboration, “moving away from outright competition.” Buyers and sellers now negotiated on price, quality and volume through negotiated annual bulk contracts.

However, promoting efficiency remained a key objective. Whilst encouraging collaboration would no doubt improve certain aspects of healthcare, there was no evidence to suggest it would incentivise hospitals to reduce costs (Dawson et al. 2001). Potential inefficiencies were the before tackled through introducing a reference costing system. Reference Cost Indexing (RCI) aimed to show an organisation’s aggregate activity compared with the national average cost. It aspired to overcome the inadvertent disincentives produced by the efficiency targets of the Internal Market. To meet these previous targets, hospitals had to reduce their costs from the previous year. Successful hospitals faced the same efficiency targets the following year, leading to disincentives for cost reduction (Appleby 1996). RCI was introduced in the hope that through comparing a hospital’s performance to that of other providers, these disincentives would be overcome. It was modelled on ‘yardstick competition,’ which had been used in the U.S. to stimulate indirect competition and drive down prices.

It was argued that comparing the performance of institutions with each other or benchmarking was essential to recreate a public sector results driven culture similar to the private sector to improve efficiency (Dixon 2004). Advocates of RCI emphasised that purchasers would have enhanced power over providers due to the availability of detailed costing information (Northcott and Llewellyn 2003). Proponents also argued that it would result in the sharing of best practices, leading to better quality care (Department of Health 1997).

However, the effect of RCI on efficiency has been strongly debated. The availability of cost information per se will not reduce costs unless incentives exist for providers to respond to this information. Under RCI reforms, incentives were targeted at individual hospital managers who lost their jobs if targets were not met. These reforms were flawed on two levels: through incentivising managers, a ‘them versus us’ culture developed between clinical and management staff. A perception that hospital managers were following a political rather than clinical agenda led to a natural distrust between clinicians and managers, with inevitably negative consequences on institutional reform (Garelick and Fagin 2005). Secondly, whilst managers developed strategies to help hospitals meet targets, there was little incentive to perform beyond set targets (Dawson et al. 2001). Indeed, the use of averages to produce targets led to a lack of a true benchmark or gold standard. Northcott and Llewellyn (2003) argue that these targets led to complacency rather than performance improvement.

There were also practical problems with RCI and block contracting. Variations in clinical coding practices led to difficulties in comparing institutional efficiency (Dawson and Street 1998; Northcott and Llewellyn 2003). RCI was modelled on yardstick competition which is effective in per case reimbursement, not bulk contract negotiation (Dawson et al. 2001). Although RCI information was available to purchasers, it was not linked to provider payment. Whilst purchasers could technically use the RCI database to challenge provider costs, in practice they were relatively weak in negotiating with hospitals. The terms of a block purchaser provider contract often depended on the negotiating skills of a purchaser and led to national variations in provider payments for the same services (Dawson et al. 2001). Purchasers were, to a certain degree, at a natural disadvantage as the choice of secondary care provider was often limited.

Although direct competition had been abandoned, the importance of comparing institutions with one another was still recognised. RCI was used to ‘name and shame’ poorly performing NHS trusts and hospitals (Northcott and Llewellyn 2004). Despite questions about the sustainability of this approach, publicly outing poorly performing healthcare organisations has remained an attractive political tool (Wright 2012). Whilst the impact of introducing RCI on efficiency and quality may be debatable, the comprehensive data collected has played a key role in shaping future health policy. The data gathered through the National Costing Exercise allowed the development of an ‘average tariff’. This would pave the way for Payment by Results (PbR) and patient choice (NHS Executive 2000).

Payment by Results

The Labour government introduced a seismic shift in health policy by introducing activity-based financing through PbR in 2002. Although RCI was intended to improve efficiency, it became apparent that the concomitant use of block contracts often resulted in inefficiency and poor quality care, as providers could quality skimp or avoid high-risk patients. True efficiency gains and cost containment were the main motivations behind linking payment with activity (Farrar et al. 2009).

PbR was introduced to reward efficiency, reduce negotiating disputes and pay NHS providers on a ‘fair and transparent basis.’ Block agreements where funding was fixed regardless of activity were abandoned (Department of Health 2002). An ‘average tariff’ was developed through the collation of previous cost data. For the first time hospital income was directly linked to activity. Patient choice was also introduced where a patient had a choice of up to five providers for elective secondary care: providers were now in direct competition to attract patients.

As well as reintroducing competition, PbR was a huge stride in modernising costing. Paying providers on a per case basis incentivised them to increase revenue through treating more patients. For the first time, a hospital’s income was directly linked to the number of patients treated and complexity of cases. PbR incentivised good performance through withholding some payment until results were delivered (Audit Commission 2012). The average tariffs more accurately reflected workload and forced providers to optimise information collection (Dixon 2004). Prices were designed to change practice, with incentives for hospitals to undertake work in cheaper day case settings (Street and Maynard 2007). The success of this was demonstrated in a study showing reduced unit costs and length of stay. (Farrar et al 2009).

However, PbR was not without its own problems. Its structure led to incentives for 'gaming' by providers. Rogers et al. (2005) found that PbR-reimbursed hospitals had a disproportionate increase in short stay admissions through using more complex healthcare reference groups (HRGs) to increase revenue. The use of average cost to determine reimbursement has been criticised due to the variations in hospital performance. It is questionable whether averages truly reflect the performance of most hospitals. As with RCI, it has been argued that providers are encouraged to become average performers rather than truly excel.

The impact of PbR on quality has also been debated. Opponents argued it encouraged providers to increase profit through quality skimming. The DoH sought to address this through the introduction of patient choice as a means to encourage non-price provider competition. As prices were fixed, it was intended that providers would compete on non-price factors such as quality. The evidence on the impact of PbR on quality is mixed. Farrar et al. (2009) analysed mortality and readmission rates and found no significant impact of PbR on quality. However, a later study by Gaynor et al. (2010) did demonstrate improved quality outcomes (mortality and length of stay) through PbR and patient choice.

What is the true impact of PBR? It may still be too early to assess whether it has been successful. On balance, there is a general consensus that it has led to the achievement of preset performance targets. Its effects on overall health expenditure are, however, less clear. Its use in primary care led to £200 million extra spending due to the achievement of performance targets (Timmins, 2005). PbR has accelerated the expansion of HRG codes which have increased in number from 48 to 1400 (Health and Social Care Information Centre n.d.). The expansion of HRGs and the use of PBR have undoubtedly played an important role in the current healthcare reforms underway in the UK.

The Health and Social Care Act

The 2011 budget of the current UK government saw NHS cuts of almost £1bn (Campbell, 2011). Against this backdrop of financial austerity, major NHS reforms were introduced in the 2010 White Paper (Department of Health 2010). These centred on expanding patient choice, introducing price competition between providers and giving GPs responsibility for commissioning healthcare. The White Paper proved extremely controversial, with opposition from healthcare professionals (Royal College of Nursing 2011). After extensive media coverage and political debate, the Health and Social Care Act was passed in 2012.

The impact of these reforms remains to be seen, but there is little doubt that they have had a divisive effect on public opinion. Prior to its passing, the Bill was one of the most scrutinised in the last decade. Its advocates highlight that competition can stimulate innovation and increase productivity, as previous evidence has demonstrated that competition can lead to improved outcomes in mortality (Cooper et al. 2010). Quality improvement has thus been emphasised as a major driver behind the reforms, and quality indicators have been incorporated into payment incentives (Department of Health 2010). However, as is the case for healthcare systems across the world, effects on quality are difficult to measure, raising questions about the true value of this evidence (Söderlund et al. 1997).

Conclusion

The last four decades have seen a number of NHS reforms with varying degrees of success. The introduction and failure of the internal market demonstrated the importance of accurate costing and accounting. Subsequent reforms have only been possible through the development of these practices. The collation of cost data has enabled the quantification of inputs and outputs, providing a measure of efficiency.

However, various considerations need to be made before introducing new reforms. Cost containment and efficiency measures are viewed with suspicion by healthcare professionals, who are trained to treat patients without consideration of cost (Kurunmäki and Miller 2008). The sustainability of any reforms will depend on cooperation with health professionals. It is also important to understand the differences between the private and public sector to assess which practices can be successfully adapted.

Has the introduction of competition improved NHS performance? In an assessment of seven nations, the NHS scored highly on efficiency, equity and quality (Davis et al. 2010). Whilst it is difficult to assess the impact of individual reforms, it can be argued that the NHS is a successful public sector organisation, which has improved its performance over the last four decades, during which time reforms to increase competition have been gradually adapted.

The future of the NHS in light of the current reforms remains to be seen. Given the consistent improvements in NHS performance, major restructuring may be inappropriate. Successful organisations focus on consistency in strategy and stable leadership rather than repeated policy change (Dixon and Ham 2010). This may go in some way to explain the divisive public reaction to the current reforms. However, the majority of arguments against the reforms are more ideological. The NHS has a unique position in the British psyche. Public misgivings are rooted in the distrust of using a private sector tool to improve a hugely important public sector organisation. As such, any reforms to improve performance need to be considered in light of political and public opinion.

Key Points

- Private sector practices have been introduced to the UK NHS to improve efficiency and increase competition.
- The 2012 Health and Social Care Act was viewed by some as an attempt to "privatise" the NHS.
- Review of the effects of attempts by governments since the 1980s to introduce competition to the NHS.

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