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**Policy Briefing 2/11**

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**Price and Competition in Health  
Care in England**

**17 March 2011**

## Introduction

This briefing brings together a selection of the empirical evidence on the impact of price competition in health.<sup>1</sup> This is increasingly relevant now as the NHS in England undergoes reforms which include the scope for price competition or in terms set out in the Health and Social Care Bill 2011, given discussion on setting a maximum tariff. This bill has prompted questions on whether price competition is a good thing or not. For example, will it lead to lower quality and a 'race to the bottom' as providers try to cut costs and hence offer lower prices to commissioners? Or will this be avoided by having checks and balances in the system?

Some have urged a closer look at evidence to inform the debate about competition.<sup>2</sup> This briefing looks at some of the evidence but also looks more broadly at funding and financing in the English NHS because setting a price for some activity is just one part of the jigsaw.

Economic theory suggests that competition may be beneficial (because it can 'sharpen' incentives to deliver efficiently at a given level of quality) but it crucially depends upon how the market operates in practice.<sup>3</sup> In healthcare there has been much discussion of 'managed' competition<sup>4</sup> which is intended to bring about the best of competition in the context of health care. This is because health care is different to other markets<sup>5</sup> and hence the usual approaches are not fit for purpose. Competition can be thought of in different ways:

- **Competition *within* the market;** essentially where patients are given the opportunity to make choices between different providers (as occurs in the NHS in England for some elective activity, e.g. hip and knee operations)<sup>6</sup>
- **Competition *for* the market;** essentially where commissioners may choose different providers on behalf of the population of patients that they are responsible for<sup>7</sup> (which is how other countries have decided to operate their healthcare system, such as Germany and the Netherlands)

The ways in which competition operates in practice are a function of a variety of factors; the way in which prices are determined, the incentives in the contracting approach, and checks and balances such as regulation etc.

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<sup>1</sup> By no means systematic but rather resources that are freely available

<sup>2</sup> Nigel Edwards calls for constructive dialogue on competition, HSJ, 31<sup>st</sup> January 2011  
<http://www.hsj.co.uk/news/policy/nigel-edwards-calls-for-constructive-dialogue-on-competition/5024841.article?referrer=RSS> (Accessed 16/03/11)

<sup>3</sup> Gaynor, M Antitrust and Competition in Healthcare Markets, Chapter in Culyer, A and Newhouse, JP (Eds) Handbook of Health Economics, Amsterdam: North-Holland 1999

<sup>4</sup> Enthoven, Alan C The history and principles of managed competition, Health Affairs Supplement 1993

<sup>5</sup> For example, there is imperfect information on what interventions work for whom. See Uwe Reinhardt's discussion:  
<http://economix.blogs.nytimes.com/2010/08/13/health-care-uncertainty-and-morality/#more-77633> and  
<http://economix.blogs.nytimes.com/2010/08/06/is-health-care-special/> (Accessed 16/03/11)

<sup>6</sup> Via the Independent Sector Extended Choice Network and the Free Choice Network Provider  
<http://www.nhsidentity.nhs.uk/all-guidelines/guidelines/extended-and-free-choice-network/introduction> (Accessed 16/03/11)

<sup>7</sup> More akin to the option of choosing a health insurer as seen in other countries such as the Netherlands see Hendricks, M et al Dutch healthcare reform: did it result in performance improvement of health plans? A comparison of consumer experiences over time BMC Health Services Research 2009;9:167 <http://www.biomedcentral.com/1472-6963/9/167> (Accessed 16/03/11)

There is an intrinsic link between competition and choice; there needs to be some form of choice in order to give providers something to compete for (and win and lose). However, there are complexities in terms of ensuring that choice is supported (e.g. through appropriate information) and that choice is not unduly influenced by the vested interests of providers. There may also be circumstances where it is less efficient to provide choice, and where it may make sense to have more limited choices (e.g. where centralisation may deliver better health outcomes than many smaller provider units<sup>8</sup>).

## Funding, costs, competition and nursing

The NHS in England is funded via general taxation and national insurance. Those funds are then allocated to providers of services via different contracts which have different ways for paying for different services. The main options have tended to be:

- **Pay for activity/fee for service** – which sets out a fixed amount of funding per activity (or price per activity) and hence revenue differs according to total activity over a given period of time. This applies to some secondary care activity under Payment by Results (PbR) with tariffs set for broadly comparable activities. This approach requires central setting of the ‘price’ (tariff) based upon information provided to the centre by providers, supplemented with negotiation between commissioners and providers on volumes
- **Block contracts** – which set out the funding for a given service and do not differ according to activity over a given period of time. This applies to some community services for example, but also to some secondary care activities where there is no tariff or where tariff is not mandatory. This approach does not require central setting of the ‘price’ but rather more negotiation between commissioners and providers on both price and volumes, although price is sometimes more implicit than explicit as in fee for service
- **Per capita** – which sets out an amount of funds to cover each patient over a given period of time to cover all their health care needs. This applies to primary care

These are the main mechanisms but there are a variety of ways that they are applied and considerable complexity in analysing and setting the amounts of money that should flow to different parts of the NHS and the incentives that then operate. In addition, there are now a range of other tools available which affect funding flows including:

- Commissioning for Quality and Innovation (CQUIN) – which allows commissioners to link a proportion of payment to providers to achievement of local quality improvement goals<sup>9</sup>

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<sup>8</sup> Boyle, R Mending Hearts and Brains, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_072493.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_072493.pdf) (Accessed 16/03/11)

<sup>9</sup> DH, Using the Commissioning for Quality and Innovation (CQUIN) payment framework [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091443](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443) (Accessed 16/03/11)

- Best Practice Tariffs (BPT) – which allows a different payment based upon agreement with clinicians on what constitutes best practice, with monitoring to ensure that practice is in line with best clinical practice<sup>10</sup>
- Best Value Tariffs (BVT) – which allows a different payment based upon best practice but without monitoring against best clinical practice<sup>11</sup>
- Quality and Outcomes Framework (QoF) – which links a proportion of payment to General Practices to performance against agreed indicators<sup>12</sup>

From these funding sources providers then have to cover the costs of delivering services. Staff account for a large amount of these costs.<sup>13</sup> This means that in times of financial constraint managers and policy makers will look at staffing in general, including nursing<sup>14</sup>, to look at how much value for money this expenditure delivers and what more can be done to increase productivity (doing more from the same amount of resources) or if they can lower costs. This does not necessarily mean cutting nursing staff, but it can do, especially when this is not a full analysis and where a short term perspective is taken; basically where cutting nurse numbers can temporarily help to reduce costs to the NHS. However if cut too low it may perversely reduce quality of care, and in the extreme can lead to the tragic example of Mid Staffordshire and other Trusts. The RCN's Frontline First work has highlighted that 27,000 nursing posts across the UK are at risk, so this is a real concern.<sup>15 16</sup>

The link to price competition comes in when we look more widely at how the system as a whole encourages efficiency and how it is funded. If funding is too low it can lead to inappropriate cuts; when there are no incentives for productivity it can mean wasting money. This money comes from all taxpayers and hence Government and politicians must account for how it is spent, and consider what more could have been done had it been used most efficiently (and this could mean more treatments in the NHS, or even more teachers or other types of public sector spending). Competition is often considered as part of incentives for efficiency; where hospitals compete for patients the theory is that they will be more efficient. And where price is part of that competition, in theory, the incentives for efficiency can be even stronger. But where price is able to fall too low it may not cover the costs for delivering quality care; once again this may mean that there are too few nurses and patients don't get the nursing care they need.

## Evidence from the English NHS

<sup>10</sup> DH, Best Practice Tariffs, [http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH\\_105080](http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_105080) (Accessed 16/03/11)

<sup>11</sup> DH, Best Practice Tariffs, [http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH\\_105080](http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_105080) (Accessed 16/03/11)

<sup>12</sup> NHS Information Centre, Quality and Outcomes Framework, <http://www.qof.ic.nhs.uk/> (Accessed 16/03/11)

<sup>13</sup> Estimates vary but the Kings Fund suggests around 40%. [http://www.kingsfund.org.uk/current\\_projects/general\\_election\\_2010/frequently\\_asked.html#ahow\\_much\\_of\\_the\\_nhs\\_budget\\_is\\_spent\\_on\\_the\\_workforce](http://www.kingsfund.org.uk/current_projects/general_election_2010/frequently_asked.html#ahow_much_of_the_nhs_budget_is_spent_on_the_workforce) (Accessed 16/03/11) and NHS Choices suggest 60% <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx> (Accessed 16/03/11)

<sup>14</sup> Nursing staff accounts for close to 30% of all NHS staff. Calculated from Information Centre data tables for September 2010 from <http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/provisional-monthly-nhs-hospital-and-community-health-service-hchs-workforce-statistics-in-england> (Accessed 16/03/11). This excludes primary care staff

<sup>15</sup> RCN, Frontline First, Interim Report, [http://royalnursing.3cdn.net/a647f8a6538a76b60b\\_eum6iv7pe.pdf](http://royalnursing.3cdn.net/a647f8a6538a76b60b_eum6iv7pe.pdf) (Accessed 16/03/11)

<sup>16</sup> Both in terms of detriment to quality of care for patients, but also in terms of lost expertise and the cost of training staff

Competition within the English NHS has been a policy option pursued, with less or more enthusiasm, over the past two decades. This includes:

- The internal market from 1991 to 1997 with voluntary GP fundholders purchasing some care from their covered population and District Health Authorities purchasing care with scope for competition between hospitals as they competed for contracts
- A 'third' way from 1997 with the evolution to voluntary Practice Based Commissioning (replacing GP fundholding) and Primary Care Trusts (replacing District Health Authorities) and more recently in 2010 and ongoing, the requirement for PCTs to divest their provider arms to more clearly separate commissioning from provision under Transforming Community Services. In addition more choice for patients who can choose which hospital to go to for some elective surgery

These reforms have been focused upon competition within the market, and not competition for the market.

These reforms have enabled research to test the impact upon quality from the introduction of competition. A distinction can be made in relation to the nature of that competition; whether it is both price and quality competition or just quality competition because price is externally fixed (set by the Department of Health (DH)). Despite significant challenges to assessing the impact of competition, research suggests:

- Competition introduced during the early 1990s (which did not use a fixed price but instead block contracts) was negatively related to quality (as proxied by mortality following heart attack)<sup>17 18</sup>
- Competition during the early 1990s may have led to greater efficiency<sup>19</sup> (based on very crude measures of efficiency)
- Competition during the later 1990s (which did use a fixed price<sup>20</sup>) was positively related to quality (as proxied by mortality following heart attack)<sup>21</sup> The evidence suggests that patients were less likely to die, had shorter lengths of stay and were treated at the same cost as hospitals where there was less scope for competition<sup>22</sup>

<sup>17</sup> Propper, C, Burgess, S, and Gossage, D Competition and Quality: Evidence from the NHS Internal Market 1991-1999 CMPO Working Paper May 2003

<sup>18</sup> Propper, C, Burgess, S, and Green, K Does Competition between Hospitals Improve the Quality of Care? Hospital Death Rates and the NHS Internal Market CMPO Working Paper Series No. 00/27

<sup>19</sup> Le Grand, J Competition, Cooperation, Or Control? Tales From The British National Health Service Health Affairs May/June 1999 27-39

<sup>20</sup> Note that this means that there is no relationship between volume and price variation since price was explicitly not permitted to vary

<sup>21</sup> Cooper, Z et al Does hospital competition save lives? Evidence from the English NHS Patient Choice Reforms LSE Health Working Paper 16 January 2010

<sup>22</sup> Martin Gaynor, Rodrigo Moreno-Serra and Carol Propper Death by Market Power Reform, Competition and Patient Outcomes in the National Health Service Working Paper No. 10/242 <http://www.bristol.ac.uk/cmipo/publications/papers/2010/wp242.pdf> (Accessed 16/03/11)

The inference from this research is that price competition in health care is damaging<sup>23</sup>, but quality competition with a fixed price is beneficial.<sup>24</sup>

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<sup>23</sup> See also Frontier Economics, Choice and Competition in Public Services: A Guide for Policy Makers, A Report for the Office of Fair Trading (2010)

<sup>24</sup> But note the next discussion of the limits to the evidence base.

## Outstanding issues

The role of competition in health care has generated considerable debate and there remain many questions about how theory works in practice; not least of the outstanding issues are:

1. **Appropriately capturing quality**; poorly capturing quality could mean that the findings from empirical studies may be missing the full impact of competition on quality (in either direction)
2. **Appropriately capturing the extent of ‘real’ competition**<sup>25</sup>; this is likely to vary both across different types of activity, different geographies (which can limit choice of provider), perception and reality in terms of barriers to entry in the market, information available to inform choices, and the willingness of patients to engage in choice behaviour
3. **Isolating the ‘pure’ effect of competition** from the other policy changes occurring at the same time (such as targets)
4. **Refining the nature of competition**, for example moving towards ‘value based’ competition where outcomes are rewarded<sup>26 27</sup>
5. **The real or perceived risk of litigation under European Commission competition law**
6. **The success or otherwise of checks and balances in the system** such as the Care Quality Commission (CQC) in assuring minimum standards of quality, Monitor as the new economic regulator including price setting, and a duty to promote competition, and the National Commissioning Board in setting out framework contracts and Commissioners in their role to award contracts to different providers and patient choices as they begin to be offered more choice such as providers of community services under Any Willing Provider policy

## RCN view

The RCN is already concerned that current tariff setting, resulting in the fixed price used for some hospital activity, may not include sufficient funding for nursing<sup>28</sup> and with the NHS Operating Framework allowing for some flexibility in the use of tariff (see box) the RCN continues to call for caution and for funding and staffing not to be allowed to fall below safe levels; this means co-ordinated action between the DH as it current sets tariff (and Monitor in future as it takes on this function), the CQC as the system regulator to look at staffing levels, and the RCN will continue it’s own work on staffing.<sup>29</sup> The RCN

<sup>25</sup> Le Grand, J Competition, Cooperation, Or Control? Tales From The British National Health Service Health Affairs May/June 1999 27-39

<sup>26</sup> Porter, M Redefining Health Care: Creating Value-Based Competition on Results, Presentation 2006

<sup>27</sup> Porter, M and Teisberg, E O Redefining Competition in Healthcare, Harvard Business Review June 2004

<sup>28</sup> RCN Policy Unit Policy Briefing 11/2009, Nursing and Payment by Results, Understanding the Cost of Care, July 2009 [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0004/287779/11.09\\_Nursing\\_and\\_PbR.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0004/287779/11.09_Nursing_and_PbR.pdf) (Accessed 16/03/11)

<sup>29</sup> RCN, Guidance on Safe Staffing Levels in the UK, [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0009/357831/Staffing\\_levels\\_guidance\\_Final\\_web.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0009/357831/Staffing_levels_guidance_Final_web.pdf) (Accessed 16/03/11)

does not currently support price competition, but recognises that quality competition can bring benefits.

The RCN supports the amendment to remove 'maximum' from the Health and Social Bill which will limit price competition for areas that are covered by tariff.<sup>30</sup>

Extract from: DH, The Operating Framework for the NHS in England 2010/11, December 2010

*"One new flexibility being introduced in 2011/12 is the opportunity for providers to offer services to commissioners at less than the published mandatory tariff price, where both commissioner and provider agree. Commissioners will want to be sure that there is no detrimental impact on quality, choice or competition as a result of any such agreement."* (para 5.43, page 54)

## Tell us what you think

This briefing is intended to provide a brief review of the evidence on price competition in health care, and the Policy and International Department would like to receive comments/feedback from as many members as possible on this important issue – [policycontacts@rcn.org.uk](mailto:policycontacts@rcn.org.uk)

For example:

- Has tariff affected the number of nursing staff in your ward?
- Has CQUIN led to your hospital receiving more or less funding?
- Has your hospital been using best practice tariff? Has this enabled you to improve practice?
- Has QoF led to more investment in your general practice?

**Policy & International Department, RCN  
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<sup>30</sup> Department of Health, 4<sup>th</sup> March 2011, [http://www.dh.gov.uk/en/MediaCentre/Statements/DH\\_124867](http://www.dh.gov.uk/en/MediaCentre/Statements/DH_124867) (Accessed 16/03/11)