Editorial

Making competition work in the English NHS: the case for maintaining regulated prices

Over the last 20 years NHS policy-makers have increasingly relied on provider competition as a tool to drive improvements in hospital performance. This effort to promote competition began with the internal market in the 1990s, which separated the purchasers of care from the providers of care. It was followed in the mid-2000s by efforts to increase patient choice, expand the role of private sector providers, grant hospitals additional financial and managerial autonomy, and create a reimbursement system where money follows patients' choices under fixed prices (Payment by Results). Now, the current coalition government is seeking to further expand the role of competition in the English NHS.

The recent Health and Social Care Bill shifts purchasing power from primary care trusts (PCTs) to newly formed GP consortia, encourages private sector providers to play a more active role in health care provision and creates an economic regulator to manage competition in the NHS.[1] Ultimately, the challenge that the current government is facing is deciding how to build on the market created by their predecessors, which researchers suggest is yielding positive results, within a much more cash constrained environment.[2–4]

One key element of the current government's reforms that has concerned us greatly is the proposal, outlined in both the Bill and the 2011–12 NHS Operating Framework, to shift from fixed prices to maximum prices, thereby allowing price competition.[5,6] In response to growing concerns about their proposals, the government recently announced plans to amend the Bill to remove all reference to maximum prices.[7] This was a sensible change in the legislation that the government should be given credit for making.

We were concerned about introducing price competition in the NHS not because of an ideological opposition to the idea. Far from it – our concern is how best to incentivize providers to improve their quality and productivity. Indeed, we expect that in the years to come, it may be quite justified to introduce price competition in certain sectors of the health service. However, we are reticent about price competition in the Bill because the research evidence suggests that introducing price competition in environments where quality is difficult to measure and purchasers face significant pressure to constrain costs can harm clinical quality.[8]

The hospital competition literature has drawn a sharp distinction between markets where hospitals can compete on both price and quality, and markets where prices are fixed by a regulator and hospitals can only compete on quality. In markets which allow quality and price competition, theory predicts that hospital competition may either increase or decrease quality.[8] Here, the response of providers depends very much on the preferences of patients, who often have hugely varying tastes and preferences about tradeoffs between costs and quality. In addition, in hospital markets, where quality is often vastly more difficult to measure than price, competition may harm quality as providers choose to differentiate themselves on the elements of care that purchasers of health care can easily observe (i.e. price) at the expense of those that they cannot (i.e. clinical quality).

The theory that price competition can be harmful to clinical quality is supported by empirical research from the USA by Volpp and colleagues, who looked at the impact of price competition in New Jersey and found that it significantly increased mortality rates.[9] Propper and colleagues looked at similar issues in the 1990s NHS internal market, which allowed price competition.[10,11] Both UK studies found that during the internal market, greater competition was associated with lower clinical quality.

In contrast, the theory about hospitals' response to competition in markets with regulated prices is more straightforward.[8] Theory predicts that faced with competition, as long as reimbursement rates are greater than hospitals' marginal costs, hospitals will increase their quality in an effort to increase market share until their profits approach zero.

Evidence from the USA broadly supports the idea that quality competition prompts hospitals to improve their performance. A range of studies, the most well know of which was by Kessler and McClellan, found that hospital competition prompts lower death rates and improvements in other aspects of clinical performance.[12] Indeed, analyses of the impact of recent efforts to increase competition based on quality in the NHS have found similar results: hospitals exposed to greater potential competition as a result of the 2000s reforms was associated with improved quality and efficiency at a faster rate after the reforms took force in 2006.[3,4,13] Likewise, Bloom and colleagues found that hospitals in England facing more potential competition was associated with better managed care and lower death rates.[2]

With this evidence in mind, while we support competition as a tool for improvement, we do not support reintroducing of price competition in to the NHS at this point.

Given that the current market appears to be working positively, the challenge for the government is to build

upon their predecessor's success and sharpen incentives for efficiency without risking falls in quality. At the core of any proposals must be efforts to: bolster the quality and range of data comparing provider performance; raise the quality of commissioning; and develop strategies to link funding and reimbursement rates to clinical performance.

In the short- and mid-term, here are several steps the current government can take to improve upon the current market. First, the government should focus relentlessly on measuring and publishing more measures of quality (clinical effectiveness, safety, patient experience) and make this a hallmark of their time in office. During their tenure in office, the government should set out to make the English NHS the best-measured health system in the world. This information is the key for any further steps to truly link payment to performance.

Second, the government needs to create penalties for poor performance and sharpen incentives for quality and efficiency. In this context, we welcome the government's proposals to structure the tariff so that hospitals are not paid for unplanned re-admissions within 30 days of an elective procedure and to introduce a marginal tariff for emergency admissions above a threshold rate. But, we think there is scope to develop the payment system further and pay more for care delivered at facilities that, for instance, use cost-effective pathways, have protocols in place to lower central line infection rates or have systems in place for staff to report adverse events and patient safety issues. We welcome the introduction of 'Best Practice Tariffs', which do just that, and they need to be expanded across the health service.

In addition, the tariffs should start moving towards wider use of bundled payments that pay providers for whole pathways of care, from referral through to rehabilitation, which would shift some financial risk to providers. This type of bundled payment, currently being promoted in the USA, rewards providers for delivering integrated care, and create incentives for hospitals to effectively communicate laboratory findings, discharge reports and consultant post-discharge care plans in order to reduce costs. If the providers saw fit, they could themselves contract with other providers for specific items in the care pathway.

More broadly, the new economic regulator should also learn from the experience of price regulation in utilities, such as gas and water, to begin to ratchet down tariff prices, paying hospitals according to the cost of the most efficient models of care across the NHS, rather than simply basing the tariff on average costs.

At present, given the state of quality measurement in the NHS, and the period of profound flux affecting both purchasers and providers of care, introducing price competition alongside the other elements of the reform package the government is proposing would have been too much too fast. Prospectively, as more measures of provider quality are developed and commissioners become more experienced, there may well be a role for price competition in the NHS, particularly for some specific aspects of care where quality will be easier to measure. However, as the government continues to expand the role of patient choice and provider competition, ministers must proceed with an eye on international evidence and remain keenly aware of the current financial climate in the NHS, which will ultimately be a key arbiter of how their reforms play out.

Anita Charlesworth
The Nuffield Trust
Zack Cooper
The Centre for Economic Performance
The London School of Economics
London, UK
Email: z.cooper@lse.ac.uk
DOI: 10.1258/jhsrp.2011.011038

References

1 Lansley A. House of Commons. *Health and Social Care Bill 2010–2011*. London: Stationery Office, 2011
2 Bloom N, Propper C, Seiler S, Van Reenan J. *The Impact of Competition on Management Quality: Evidence from Public Hospitals*. London: London School of Economics, 2010
3 Cooper Z, Gibbons S, Jones S, McGuire A. Does Hospital Competition Save Lives: Evidence from the English NHS Patient Choice Reforms. *Economic Journal* 2011;**121**:F228–66
4 Gaynor M, Moreno-Serra R, Propper C. *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Services*. Bristol: Bristol University, 2010
5 Department of Health. *The Operating Framework for the NHS in England 2011/2012*. London: Department of Health, 2010
6 Department of Health. *Equity and Excellence: Liberating the NHS*. London: Department of Health, 2010
7 Timmins N. U-Turn on NHS Pricing Welcomed. *Financial Times* 4 March 2011
8 Gaynor M. Competition and quality in hospital markets. What do we know? What don't we know? *Economie Publique* 2004;**15**:3–40
9 Volpp KG, Williams SV, Waldfogel J, *et al*. Market reform in New Jersey and the effect on mortality from acute myocardial infarction. *Health Services Research* 2003;**38**:515–33
10 Propper C, Burgess S, Green K. Does Competition Between Hospitals Improve the Quality of Care? Hospital Death Rates and the NHS Internal Market. *Journal of Public Economics* 2004;**88**:1247–72
11 Propper C, Burgess S, Gossage D. Competition and Quality: Evidence from the NHS Internal Market 1991–1996. *The Economic Journal* 2008;**118**:138–70
12 Kessler DP, McClellan MB. Is Hospital Competition Socially Wasteful? *The Quarterly Journal of Economics* 2000;**115**: 577–615
13 Cooper ZN, Gibbons S, Jones S, McGuire A. *Does Hospital Competition Improve Efficiency? An Analysis of the Recent Market-based Reforms to the English NHS*. London: Centre for Economic Performance, 2010