

How Fair?

Competition between independent and NHS providers to supply non-emergency hospital care to NHS patients in England

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providers. Where this distinction affects the ‘fairness’ of competition with NHS providers it is highlighted below. But competition issues for the most part affect for-profits and not-for-profits similarly.

There have always been some elements of competition between providers of health care in the UK NHS, e.g. between GPs (primary care physicians) competing for patients and for the capitation fees they bring with them. This did not apply to hospitals, where all staff are salaried employees. Nevertheless professional rivalries have long existed between medical teams in different NHS hospitals. Although ever present, these elements of competition have been heavily constrained by professional and organisational rules and principles and the nature of competition has arguably been more implicit than explicit.

CHAPTER 1 – INTRODUCTION AND POLICY CONTEXT

1.1 Introduction

Competition is firmly established as a tool of public policy in England and is being accorded a growing role within health care. Since 2002 competition has become an actively promoted tool of government health care policy in England, particularly for the provision of hospital care to publicly funded patients. Independent sector (IS)¹ providers of hospital services have been encouraged to compete with the state-owned National Health Service (NHS) providers.

This study focuses on competition between state-owned and independent hospitals to provide care to publicly funded patients. Within the independent sector there are both not-for-profit and for-profit

Policy towards competition has been similar in the tax and social insurance funded health care systems of Europe and in most other high income countries, with reliance on publicly planned and coordinated health care provision rather than on the playing out of market forces. In many of these countries, the majority of providers are publicly owned, at either local or national level. Even where there are significant IS providers these are generally part of a publicly-planned system. The most notable exception has been the US, where there is extensive reliance on the market in hospital care.

To be fully effective, competition needs both to be fair and to be seen to be fair. For the purposes of this paper, “fair competition” exists when equally efficient providers of a given service of a given quality have neither advantages nor disadvantages (e.g. higher costs or restrictions on their business) relative to other providers (Box 1). Potential competitors will be

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¹ The term “independent sector” is used throughout this Briefing in the same way as it is applied to health care in the UK, namely to mean all for-profit and not-for-profit private and charity owned organizations. This covers a wide range of organizational and ownership forms but all have the common feature that they lie outside the public sector.

deterred if they expect others to have unfair advantages over them. Ensuring that all providers can compete on equal terms is, however, not easy in practice. The experience of the NHS in England is revealing the existence of cost differences that arise solely from whether a provider of health care is NHS or privately owned. Two equally efficient providers of the same health care services in the same location and to the same level of quality would experience different costs according to whether they were publicly or privately owned. In this paper I assess the significance of potential obstacles to fair competition – i.e. non-discretionary cost differences – and identify

BOX 1 FAIR COMPETITION

... exists when equally efficient providers of a given service of a given quality have neither advantages nor disadvantages (e.g. higher costs or restrictions on their business) relative to each other.

options for reducing or removing them.

The scale of independent provision of care to NHS patients in England remains small. This, combined with the relative novelty of the policy of encouraging such provision, means that no evidence is yet available as to its impact. The focus here is instead on what implementation of the policy has revealed about the difficulty of ensuring a fair basis for competition in practice between independent and NHS providers of hospital care. Although the institutional specifics will vary between countries, the general issue is likely to have wide international resonance: ensuring fair competition between independent and state owned providers is not easy anywhere.

The following paragraphs describe the history of policy towards independent sector competition to NHS hospitals in England. Chapter 2 reviews the economic principles of competition between hospitals and the constraints on it. The history of independent sector provision of hospital services to NHS-funded patients in practice is charted in Chapter 3. Chapter 4 then analyses the extent of non-discretionary cost differences between public and independent hospitals in England; more details of these differences are provided in the Appendix to the Briefing. Chapter 5 draws conclusions and identifies options for dealing with unfairness in competition.

1.2 The developing policy context

Competition first featured in UK health care policy at the start of the 1990s, with the then Conservative government's creation of an "internal market" in the NHS. Competition was advocated as a way of

achieving higher standards and increased value for money. The NHS internal market was introduced in April 1991 throughout the UK and separated publicly owned and funded purchasers of health care – geographically defined local health authorities/boards – from publicly owned providers called NHS Trusts. As a refinement, GP (primary care physician) practices were offered the option of holding budgets to pay for, among other things, referrals of NHS patients to NHS hospitals, and eventually more than half of GPs became "fundholders". The emphasis in the "internal market" of the 1990s was on NHS Trusts competing with one another on both price and service quality in order to retain or win additional patient referrals. The possible role of competition from IS providers was at best implicit.

The NHS "internal market" was rejected by the incoming Labour government in 1997. Just five months after its election, it published its policy for the NHS – *The New NHS. Modern. Dependable* – announcing on the first page that:

"The introduction of the internal market by the previous Government prevented the health service from properly focusing on the needs of patients. It wasted resources administering competition between hospitals. This White Paper sets out how the internal market will be replaced by a system we have called 'integrated care', based on partnership..." (Department of Health (DH), 1997 – paragraph 1.3). The 1997 White Paper made no mention of IS provision of care to NHS patients. Although the White Paper applied specifically to England, its stance was matched by parallel policy documents in the other countries of the UK. Within a few years however, the independent sector was given an explicit place in health care policy, though only in England. Key dates in the development of policy about the role of competition for NHS funded hospital care in England are listed in Box 2.

Policy in Northern Ireland, Scotland and Wales continues to emphasise state managed and provided health care. In Scotland and, since October 2009, in Wales too the purchaser/provider split essential to the previous NHS "internal market" has been abolished. The purchaser/provider split has, however, so far been retained in Northern Ireland.

In England, *The NHS Plan* was published by the Government in July 2000 (DH, 2000). It set out a programme of reform to accompany an unprecedented growth in public expenditure on the NHS (throughout the UK) of over 7% per annum in real terms for several years in succession. This

BOX 2 KEY DATES

July 2000	The NHS Plan announces first ever “framework for partnership” between the independent sector and the NHS
2000	Concordat between Department of Health and Independent Health Care Association
2002	Patient choice pilots begin, initially for coronary heart disease patients Start of Department of Health procurement of Independent Sector Treatment Centres (ISTCs)
April 2003	Prospective, activity based funding, called Payment by Results commences, initially for a small range of elective surgical procedures
2004	First ISTCs open for NHS patients
April 2006	Payment by Results applies to all NHS hospitals and to most of their elective and emergency hospital care
April 2008	Patients have free choice of all NHS and all willing and registered independent providers
January 2009	Establishment of Cooperation and Competition Panel

spending growth was to bring the share of GDP going on health care in the UK up to the average percentage achieved in the EU as a whole (Towse and Sussex, 2000).

The NHS Plan was couched in the language of cooperation rather than competition: “for the first time there will be a national framework for partnership between the private and voluntary sector and the NHS.” (DH, 2000 – paragraph 11.6). The details were set out in a formal “concordat” between the DH and the Independent Health Care Association (2000). The emphasis was on supplementing the constrained capacity of NHS hospitals, especially during the winter when demand for emergency admissions was highest.

Then, in 2002, competition reappeared as an important element of health care policy in England. It was presented as facilitating patients’ choice of the hospital at which they would receive their (non-emergency) care: “Hospitals will no longer choose patients. Patients will choose hospitals.” (DH, 2002a – paragraph 5.3). Choice of hospital would at first be for patients who had waited more than six months for heart surgery but would progressively extend to all patients requiring non-emergency hospital treatment of any kind and regardless of time spent waiting, and a wider and wider range of hospitals would be available to any patient. In particular, the choice

available to NHS patients would by 2005 encompass not only NHS hospitals but also “private hospitals or even hospitals overseas” (DH, 2002a – paragraph 5.6). That policy has now been implemented in full; since April 2008 NHS patients in England are able to choose from all willing and registered NHS and IS hospitals.

Decisions about which hospital to go to for care thus now take place at two levels. Primary Care Trusts are the NHS organisations responsible for deciding for the population of an area which services will be funded, although they are increasingly sharing this with GP practices as ‘Practice Based Commissioning’ develops. But it is patients, advised by their GPs, who have the choice of where to go for a service. Competitors to provide NHS funded hospital care are therefore competing for the favour of patients and GPs.

Since 2002 competition between providers has again come to be seen by policy makers in England as an important element in ensuring value for money from the NHS budget. Furthermore the role of competition from non-NHS providers is now being stressed, not merely competition within the NHS. Independent sector (IS) competitors to NHS providers are seen as a source not only of additional capacity but also of new ideas and innovation which could spur NHS hospitals to improve their efficiency and quality. However, in contrast to the NHS internal market of the 1990s, the policy focus now is on non-price competition.

The DH commenced in 2002 a process of procuring new independent sector treatment centres (ISTCs) to provide diagnostic and routine surgical services to NHS patients in England (DH, 2002b). The first of these came on line in 2004 and at the time of writing, following two waves of procurement, 36 ISTCs are providing care to NHS patients. (For further discussion of ISTCs see Chapter 3).

It is important to note that provider diversity – provision by IS as well as NHS hospitals – and competition between providers have been introduced in the NHS in England simultaneously with other important and connected reforms. I have already referred to the policy of giving patients choice over where they receive treatment. The other main, linked reform has been the introduction of activity based funding of most hospital care in England (DH, 2002c). Named ‘Payment by Results’ (PbR), it is similar to the activity based funding of hospitals used in many other countries (Sussex and Street, 2004).

PbR is a prospective payment system in which English NHS hospitals are paid according to the number of

cases they treat at a nationally fixed price per case. Thus price competition is not possible. Instead, hospitals are encouraged to compete on the basis of quality: improve quality in order to attract more patients and hence earn more revenue. The size of the payment depends on the casemix and quantity of patient spells provided but not on the results of the treatment or its quality. Prior to PbR, NHS hospitals were largely funded by annual block contracts, with varying degrees of flexibility if activity volumes differed significantly from planned levels, but no automatic link at the margin between work done and revenue received. Thus, PbR means that if a hospital attracts extra patient referrals it will receive a known price for them, and a price which is supposed to be adequate to cover the costs of an averagely efficient NHS provider. PbR was introduced in stages starting in 2003/04 financial year and by 2006/07 applied to all NHS hospitals in England and covered most of the patient care they provided: emergency and non-emergency, inpatients, day cases and outpatients.

Alongside these major policy developments has also been the progressive development of national quality standards in England, monitored and enforced by the Care Quality Commission (formerly the Healthcare Commission), which apply to all providers of health care to NHS funded patients (DH, 2004). Quality improvement has recently been given further emphasis with the creation of financial incentives amounting to 0.5% of providers' income to achieve quality standards agreed with the local commissioners of health care for NHS patients (i.e. Primary Care Trusts – the successors to the health authorities who were the purchasing bodies in the NHS internal market of the 1990s in England). (DH, 2008a)

The seriousness with which the Government now views competition between hospitals, NHS and independent sector, is clearly illustrated by its creation of a formally stated set of principles and rules to govern competition of NHS funded services and of a body whose sole purpose is to advise the DH and other NHS regulatory bodies on competition issues in relation to the application of those principles and rules. The advisory body, created in January 2009, has been named the "Cooperation and Competition Panel" (DH, 2008b) and it is charged with advising on issues relating to the application of the "Principles and Rules of Cooperation and Competition" (DH, 2008c), which are listed in Box 3.

BOX 3 NHS ENGLAND, "PRINCIPLES AND RULES FOR COOPERATION AND COMPETITION"

1. Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population
2. Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability
3. Commissioning and procurement should be transparent and non-discriminatory
4. Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare
5. Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS
6. Providers must not discriminate against patients and must promote equality
7. Payment regimes must be transparent and fair
8. Financial intervention in the system must be transparent and fair
9. Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patients' and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money
10. Vertical integration is permissible when demonstrated to be in patients' and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money

Source: DH, 2007

CHAPTER 2 – WHY COMPETITION?

2.1 The market presumption and market failures

The core tenet of market economics is that competition or contest between providers of goods and services to well-informed price- and quality-sensitive customers is necessary to achieve allocative and technical efficiency: in essence the right mix and quantities of goods and services being produced at minimum cost. Belief in the benefits of such an approach underlies much recent public policy in the UK: “Using a market-based mechanism in place of traditional policy designs can create significant benefits, in the form of lower costs and better services. These benefits come from greater competition among suppliers and greater choice for consumers.” (Department of Trade and Industry, 2005).

In the hospital care context competition would mean that hospital managers were motivated – by being allowed to keep any surplus between revenues and costs and/or by a desire to be seen as the best by their peers and by the population at large – to try and attract more patients rather than see them go to other providers. As a result, hospitals would in theory have an incentive to be more efficient and to be more responsive to patients and provide services of a better quality than their rivals.

Hence, competition is presumed to be desirable unless markets are subject to major failures. The existence of market failures in the case of health care is beyond reasonable doubt. See Rice (2002) for a thorough review of this topic. In particular, there are major information problems and externalities in health care markets, which may mean that the free play of market forces is socially unacceptable.

At the point when a decision is made about where to go for (which) treatment, patients lack full information about the characteristics of different providers and the treatments they offer, and providers lack full information about the characteristics of the individual patient they might treat. Furthermore, most societies rich enough to afford extensive health care display a ‘caring externality’: they would not want someone to go without health care just because they lack adequate means to pay for it, or because they have not purchased adequate insurance in advance. Consequently, most rich countries provide publicly funded (via taxation or social insurance) health care cover for the large majority of their populations. But this has the effect that the patient seeking health care

generally does not face the financial consequences if they go to a more expensive provider – the third party insurer or tax funded health care system picks up the bill.

There may also be institutional factors that create barriers to competition between hospitals, such as state regulation of the numbers and pay rates of health care professionals. If key staff are in short supply and there is no flexibility to pay them more, it may not be possible to recruit the staff needed to do extra work, thereby removing the incentive to attract extra patients. Similarly if access to capital to invest in new buildings and equipment is restricted and/or its price controlled, competition may be blocked or constrained.

Even the most sophisticated economic theories of competition – allowing for product differentiation and/or limited numbers of providers with various assumed strategies for anticipating and reacting to rivals’ actions – do not provide a clear answer as to the impact of competition in health care on social welfare overall (Cookson and Dawson, 2006; Dranove and Satterthwaite, 2000).

But there is little doubt that perfect regulation or perfect planning is as unattainable as perfect competition or contest. ‘Government failure’ or ‘regulatory failure’ is also evident. Thus the policy choice is not between competition and regulation, but rather is to find the best balance between the two (and identify the specific form of regulation desired) that is likely to lead to the best outcomes for society.

2.2 Evidence on the impact of competition

In the NHS internal market of the 1990s, the focus was on competition between different NHS providers. NHS Trusts could compete with each other both on price and quality. The jury is still out on the extent to which this (a) happened; and (b) had desirable or undesirable results. A review and analysis of published studies at the point where the NHS internal market had been abandoned by the new Labour government showed that, viewed overall, studies attempting to determine the existence and impact of competition between acute hospitals in the post-1991 NHS had proven indeterminate (Sussex, 1998).

Propper and colleagues have since published work that implies that competition between NHS Trusts in the internal market in the 1990s may have led to increased mortality for patients treated for acute myocardial infarction (Propper et al., 2004). Other studies of the impact of competition have found that it led in some circumstances to shorter waiting times for patients (e.g. Dusheiko et al., 2004)² or to lower costs (Soderlund et al., 1997).

A review of international empirical evidence by Gaynor in 2006 led him to conclude that for publicly funded hospital care in the US, “the bulk of the empirical evidence for Medicare patients shows that quality is higher in more competitive markets”. This is the opposite of the Propper et al. (2004) finding for England in the 1990s. Overall, Gaynor concludes that: “The empirical literature on competition and quality in health care markets is for the most part fairly recent, and growing rapidly. The results from empirical research are not uniform.” (Gaynor, 2006; page 27).

2.3 Non-price competition

An important caveat to the renewed policy interest in competition in the NHS is that now it is intended solely to be on the basis of quality. Price competition between providers is ruled out, with the prices of most NHS funded hospital activity in England fixed centrally by the Department of Health (DH, 2002c). Providers are expected to compete with each other solely on the basis of the quality of the health care services they supply.

Pope (1989) demonstrated that hospital non-price competition in a prospective payment system, such as the NHS in England now has with Payment by Results, “can play an important role Both by increasing quality and reducing slack.” (Page 163). Pope defines quality broadly to include all desired aspects of services, not just clinical quality of care. By “reducing slack” he means that under non-price competition hospitals may be able to increase quality without increasing costs (so as not to reduce their financial surplus given the existence of fixed prices).

2.4 Market entry

As the following chapter will make clear, the potential for independent sector (IS) entry into the market for NHS funded hospital care from 2002 onwards was constrained by starting from a very small base. For IS competition to have more than a small and localised impact would require substantial new entry by independent hospitals into the NHS market. But entry is often an unattractive business proposition where there is a large incumbent, and is even less attractive when that incumbent is state owned and state funded. Even if a new entrant considered itself capable of winning publicly paid for patients away from the publicly owned incumbent, it might doubt how far politicians would allow it to do so in practice if that were to threaten the finances of the incumbent public hospital and raise the possibility of a politically highly sensitive and unpopular closure of NHS services.

In general, three groups of factors can act as impediments to market entry (Oster, 1999), potentially making the prospects too risky for a new entrant to want to try their fortune:

- expectations of incumbents’ reactions;
- incumbent advantages;
- exit costs.

Of central importance are factors affecting a potential new entrant’s expectations concerning the likely reactions of the incumbent hospitals to entry. Where prices are not fixed this may largely be uncertainty about whether incumbents could credibly react to new entry by cutting prices to levels that would make the market unprofitable for the new entrant. Where prices are fixed this may translate into concern whether the incumbent will react to new entry by investing in costly quality improvements, although this will be constrained by the financial stability requirements placed on all NHS providers – they are not allowed to run a persistent financial loss.

New entrants may find themselves at a disadvantage if incumbents enjoy ‘first mover advantages’, such as:

- precommitment contracts with suppliers or customers, which have the effect of excluding new entrants from supplies of key inputs or from access to parts of the market for a period of time. This is an important issue for IS providers competing with NHS hospitals. The supply of key medical and other health care professional staff has historically been constrained in the NHS. Indeed when the government initially procured increased elective treatment and diagnostic capacity from the independent sector it obliged bidders to not recruit their staff from among current NHS employees (DH, 2002b);
- learning curve effects. These would, however, not be significant if the bidder is already providing hospital services in another market or markets, e.g. to the private hospital care market in the UK or to hospital care markets (public or private) in other countries;
- pioneering brand advantages. These are important for so-called “experience goods”, i.e. products whose characteristics can only be judged once they have been purchased and used (as opposed to “search goods” which can be judged simply by inspection, prior to purchase). Hospital care has “experience good” elements. If a tried and trusted hospital already exists in an

² Studies of waiting times suffer from measurement effects due to not all patients’ waits being recorded in published data and not all elements of the total lengths of their waits between initial referral and eventual treatment. Propper et al. (2008) is an example of a more sophisticated attempt to allow for some of these effects, but it refers to the period 1997/98-2003/04, for most of which competition was not actively pursued in the NHS, and focuses on “targets and terror” rather than competition as a policy to reduce waiting times.

area, patients and/or their medical advisers may not even consider the possibility of going elsewhere, and if they do they might be reluctant to risk a different one on the off chance that it might be better.

Entry carries with it some probability of failure. If exit costs are low, failure is not a great problem: 'hit and run' entry is then possible. However, if exit costs are high, then failure will be costly. Thus, high exit costs discourage entry. The main determinant of exit costs is the extent and specificity of the capital required. A hospital represents a bundle of assets with few alternative high value uses apart perhaps from different types of hospital care. The costs of exit from the NHS funded hospital care market therefore depend on the ability to switch from one type of hospital care to another, e.g. from orthopaedic surgery to ophthalmology, and on the extent of non-NHS markets for hospital services. In the UK the non-NHS hospital care market is relatively small and already fully served by private hospitals and private wings of NHS hospitals. Consequently, exit costs may be high and the financial risks of entry may be considerable.

The way in which IS provision of hospital care to NHS funded patients has developed in practice in the light of these issues, and how policy has developed to attempt to overcome barriers to competition, is described in the following chapter.

CHAPTER 3 – PRACTICAL EXPERIENCE OF INDEPENDENT SECTOR PROVISION OF NHS FUNDED CARE

3.1 Spot purchasing and the Concordat

The independent sector has for many years provided a small fraction of acute hospital care services to NHS patients in England. The NHS has sought to meet two main needs from IS providers:

- some highly specialised services not available locally in the NHS; and
- spot purchasing of elective treatments to deal with exceptionally long waiting lists or short term capacity problems at NHS hospitals.

The focus of the discussion in this Briefing is on non-psychiatric provision, but the independent sector has also been a provider of specialist psychiatric services to NHS funded patients, in which sector it continues to be seen more as a complement to NHS providers

than as a competitor with them.

During the 1990s, IS provision of NHS funded acute (non-psychiatric) hospital care grew from 0.5% of NHS acute non-psychiatric spend in England at the start of the decade, to 0.8% by 2000/01 (Goddard and Sussex, 2002 – Table 1). IS providers were, thus, small players in the NHS overall. The NHS was more significant to the IS providers than the other way around, but even so the NHS provided only a small fraction of IS hospitals' total business. Even by 2000, IS non-psychiatric hospitals were receiving only 8% of their revenues from the NHS (Goddard and Sussex, 2002 – Table 1).

The 2000 Concordat between the DH and the then trade association for IS hospitals, the Independent Health Care Association, sought to move the NHS/IS relationship from ad hoc spot purchasing to one of long-term collaboration and planning to meet the needs of NHS patients (DH and Independent Health Care Association, 2000). The Concordat policy faced reluctance among some NHS managers who continued to use the IS as provider of last resort when demand from elective surgical patients was outstripping the physical, but not financial, capacity of the NHS (Goddard and Sussex, 2002).

Goddard and Sussex surveyed over 100 NHS managers in 2001 about the benefits from, and obstacles to, a greater role for IS providers of hospital care. The main barrier perceived by NHS managers to be deterring greater use of IS providers was that the latter's prices were then significantly higher than NHS costs of providing the same treatments. An absence of IS provider capacity locally or shortages of key (e.g. medical) labour locally were mentioned as obstacles by a substantial minority of NHS managers, and one third of them cited opposition to the IS from key NHS staff as a barrier.

The DH agreed with the parliamentary Health Select Committee that IS prices were around 40% above NHS average cost levels in 2001/02 (Health Committee, 2003). But that price level would have been affected by the unplanned, 'spot', and small-scale nature of purchases by NHS hospitals subcontracting work they found themselves unable to do at short notice, or of NHS health authorities (purchasers of care) seeking short term alternatives to their capacity-constrained local NHS hospital. Prices for planned, predictably timed, and greater volumes of, activity would presumably have been lower than the spot prices.

Table 1 shows that in 2007 the NHS was spending £615 million on IS acute non-psychiatric hospitals, up from £96 million a decade earlier. Although this is a rapid rate of increase, NHS purchases from IS hospitals remain a small percentage of total NHS acute hospital spending. IS hospitals received 1.7% of NHS acute non-psychiatric hospital care expenditure in 2006 compared with 0.6% in 1997. Income from the NHS is increasingly important to IS hospitals, making up nearly one fifth of their revenues in 2007 (last column of Table 1), an increase from 7.6% of their revenues a decade earlier.

3.2 Market entry: Independent Sector Treatment Centres

The main growth in NHS use of IS hospitals has occurred since 2004. This results not so much from the 2000 Concordat but rather from two waves of DH-run procurement of “independent sector treatment centres (ISTCs)” and, to a lesser extent, from the extension of NHS patient choice to encompass IS as well as NHS hospitals. The DH announced in 2002 its intention to procure ISTCs to fill perceived gaps in NHS capacity, initially focused on cataracts and other ophthalmology procedures, orthopaedics and day surgery (DH, 2002b). Two waves of contracts have been let by the DH as a result. The first ISTCs commenced treatment of NHS patients in October 2003.

As at May 2008, 26 ISTC contracts from “Wave 1” of the national procurement were in operation (a further contract had already terminated), plus 10 contracts from “Phase 2”. In the financial year 2007/08, ISTCs provided 98,000 procedures and 95,000 diagnostics to NHS funded patients. Total NHS expenditure on ISTCs that year amounted to £314 million, which constituted half of total NHS expenditure on non-psychiatric IS hospital care. Table 2 shows the growth in NHS spend on ISTCs by financial year since 2003/04 compared with total NHS spend on acute IS hospital care.

The ISTC programme not only increased the role of the independent sector but also brought IS prices closer to NHS costs, reflecting the planned, rather than ‘spot’, nature of the ISTC purchases. The “Wave 1” contracts were all on a ‘take or pay basis’: i.e. the ISTC provider receives a guaranteed payment for the five-year contract term for provision of activity up to an agreed level of capacity, and the same payment would be made regardless of the extent to which the capacity was actually used. The DH estimated, on the assumption that ISTC capacity was used in full by the NHS, that the prices it had negotiated in “Wave 1” would average an 11.2% premium above the equivalent average NHS cost (Health Committee, 2007 – Ev70). In practice an average of 85% of the contracted capacity had been used over the period to May 2008 (Health Committee, 2008 – Table 17a), which implies that

Table 1: NHS purchases from independent sector non-psychiatric hospitals (money of the day), England

	NHS purchase of acute medical and surgical care from IS hospitals, England (£million)			% of IS acute medical and surgical hospitals' revenues that is from the NHS*
	£ million*	% change	% of NHS 'General & Acute' hospital spend**	
1997	96	-	0.64%	7.6%
1998	108	12.5%	0.67%	7.7%
1999	149	38.0%	0.89%	9.8%
2000	136	(8.7%)	0.75%	8.2%
2001	170	25.0%	0.87%	9.2%
2002	190	11.8%	0.88%	9.1%
2003	205	7.9%	0.86%	9.1%
2004	255	24.4%	n/a	10.2%
2005	405	58.8%	1.48%	14.3%
2006	470	16.0%	1.71%	15.8%
2007	615	30.9%	n/a	19.1%

Notes:

* Source: Calendar year data from Laing and Buisson, 2008 – Table 2.1

** Source: Department of Health annual “Departmental Reports” from 2000 to 2008 inclusive. There is a break in the data series after 2004/05 and no figure is provided for that year. Department of Health data are for financial years, e.g. ‘1997’ figure is for the financial year commencing 1 April 1997.

Table 2: NHS expenditure in England on IS non-psychiatric hospitals split between ISTCs and other IS providers (money of the day)

	*Estimated total NHS spend on IS non-psychiatric hospitals £ million	**ISTCs		***Other IS	
		£ million	% of total	£ million	% of total
2002/03	194	0	0%	194	100%
2003/04	218	4	2%	214	98%
2004/05	293	14	5%	279	95%
2005/06	421	116	28%	305	72%
2006/07	506	200	39%	306	61%
2007/08	624	314	50%	310	50%

Notes:

* 2002/03-2006/07 financial year figures interpolated from calendar year figures in Table 1 (source: Laing and Buisson, 2008). 2007/08 figure estimated from the DH figure for purchases from ISTCs in that financial year (source: Health Committee, 2008 – Table 16b) plus Laing and Buisson’s estimate of other IS non-psychiatric hospital purchases by the NHS in 2007 (Laing and Buisson, 2008 – p65).

** Source for figures to 2006/07 inclusive is Health Committee, 2007 – Ev70. Source for 2007/08 figure is Health Committee, 2008 – Table 16b.

*** Figures for 2002/03-2006/07 calculated as residual between total spend on IS and spend on ISTCs. See note * for explanation of the 2007/08 figure.

effective prices per patient actually treated are around 30% above average NHS costs.

All “Phase 2” contracts include a take or pay element too, but one which is less than 100% of the total contract value – the exact percentage has not been stated publicly. The DH estimates that the prices it had negotiated for “Phase 2” would average out at 7.3% lower than average NHS equivalent costs, assuming that the take or pay element of capacity is fully utilised (Health Committee, 2008 – Ev40).

The House of Commons Health Committee reported its investigation of ISTCs in 2006. The Committee was sceptical about the impact of ISTCs at that stage but concluded that:

“ISTCs have had a significant effect on the spot purchase price and increased patient choice, offering more locations and earlier treatments. However, without information relating to clinical quality, patients are not offered an informed choice. We found that ISTCs have embodied good practice and introduced innovative techniques, but good practice and innovation can also be found in NHS Treatment Centres and other parts of the NHS. ISTCs are not necessarily more efficient than NHS Treatment Centres..... The threat of competition from the ISTCs may have had a significant effect on the NHS, but the evidence is largely anecdotal.” (Health Committee, 2006)

The premium prices paid to “Wave 1” ISTC contractors, and the take or pay provisions in both

ISTC phases, were understandably unpopular with many in the NHS and are still controversial (Pollock and Kirkwood, 2009). But they could be interpreted as reflecting the difficulties of entering the NHS market, i.e. without them the new providers would presumably not have invested in increased capacity as the DH wished. Exit costs are significant (there are few if any alternative markets for additional hospital capacity in England); NHS incumbents with a substantial local “brand loyalty” are in place; and limits on the availability of key staff combined with government-imposed restrictions on IS providers to deter them from employing existing NHS staff made it tricky to find staff, many specialist clinicians being recruited overseas as a result. But the lower “Phase 2” prices may signal that the ISTC market is maturing.

After the initial five-year contract periods, ISTCs are expected to be subject to the same nationally fixed tariff of prices as are NHS providers. IS hospitals providing services outside the ISTC procurement are already in that position. Table 2 shows that about half of IS revenues from treating NHS patients is received outside the ISTC contracts. Much of this work, worth around £305 million in 2007 (source: Laing and Buisson, 2008), represents subcontracting by NHS Trusts to IS providers, in other words a continuation of the ad hoc purchasing that predated the ISTCs and the 2000 Concordat. However, a small but rapidly growing element represents treatment of NHS patients who have chosen of their own accord to be referred to an IS provider rather than to an NHS hospital.

3.3 Patient choice of hospital

Since January 2006, NHS patients in England have had the explicit right to choose the hospital to which they are referred for elective treatment. Initially PCTs were only obliged to offer patients resident in their areas the choice of four hospitals of the PCT's choice. But patient choice has since been progressively extended to an "extended choice network" including ISTCs and other nationally appointed IS hospitals. Since April 2008 NHS patients have had a free choice over all NHS hospitals and all registered IS hospitals. Whichever provider the patient chooses is paid the national tariff DH-fixed price.

This looks likely to increase the volume and value of NHS funded patient care that is undertaken in independent hospitals, but again starting from a very small base level of activity. Laing and Buisson (2008) report that around £10 million of IS hospital income in 2007 was for treating NHS patients who came to them under 'extended choice' and 'free choice'. They go on to report that the signs in early 2008 were that this was growing rapidly and likely to reach £50 million in 2008 – though this would still be less than 0.2% of total NHS spend on acute non-psychiatric hospital care.

3.4 Summary

The recent experience in practice of IS hospital provision of care to NHS funded patients in England has been one of DH-policy-driven growth from a very small base of spot purchased activity. Market entry by new IS providers has been the result of active IS-specific procurement by DH. The experience of the "Wave 1" ISTC procurement has already highlighted some of the cost barriers that have to be overcome before competition can be effective. The "Phase 2" ISTC experience suggests these barriers can diminish over time. The creation of the free choice network of IS, as well as NHS, providers offers the prospect of future growth in competition between providers.

The next chapter demonstrates, however, that even when the policy environment is favourable to competition for NHS funded hospital care, there are many potential institutional and other details which can obstruct it.

In normal market situations the fairness of competition, in line with the definition in Box 1 above, rests on competition law. The introduction of elements of competition into a health care system creates a potential locus for competition law to apply also to it. The UK's well established legal framework for trying to ensure that competition is fair and effective in promoting the interests of consumers is encapsulated in the 1998 Competition Act, enforced by the Office of Fair Trading. The 1998 Act applies to non-government service providers, including IS providers of hospital care to NHS funded patients, but not usually to government bodies such as NHS Trusts.

The 1998 Act closely follows EU law. The latter governs cross-border trade between EU Member States rather than activities within Member States, but it is nevertheless having a growing influence on the NHS in the UK. In a case brought by a private company supplying nursing home services to an NHS purchaser in Northern Ireland, complaining that the purchaser was abusing its dominant position to try and impose unreasonably low prices and unfair contract terms, EU criteria for defining an undertaking and economic activity were used (see the discussion of *Bettercare Group Ltd v Director General of Fair Trading*, 1 August 2002, in Dawson and Mountford, 2008). The recently issued European Commission Directive on the application of patients' rights in cross-border health care increases the likelihood of legal challenge to arrangements with the NHS, even though the numbers of patients crossing national borders to receive (home) state-funded health care are tiny (Dawson and Mountford, 2008). A challenge requires only that one non-UK based provider feels disadvantaged in its ability to offer treatment to UK residents at a fair price.

Government concern with the need to ensure fair competition within the NHS, combined with the growing scope for such competition, led it to establish, in January 2009, the "Co-operation and Competition Panel for NHS-Funded Services". The Panel has no legal powers, which remain with the Office of Fair Trading and the European Commission (for within-UK and EU cross-border competition issues respectively). The Panel's job is to advise the Secretary of State for Health and the bodies that regulate NHS commissioners and providers of care in England (i.e. Strategic Health Authorities and 'Monitor', the regulator of NHS Foundation Trusts) on competition matters. Specifically, the Panel is to advise whether the "principles and rules for cooperation and competition" (defined in Box 3 above) have been breached.

CHAPTER 4 – IS COMPETITION FOR NHS FUNDED HOSPITAL CARE AS FAIR AS IT COULD BE?

4.1 Legal, regulatory and advisory structures

Thus, legal, regulatory and advisory structures are in place to try to ensure that fair competition takes place in the NHS and, as we have already seen, government policy is explicitly in favour of competition as an aid to efficiency, high quality and patient responsiveness in NHS funded care. But the attempt to introduce into the NHS competition from the independent hospital sector has highlighted a number of practical difficulties. Achieving totally fair competition is difficult and can be costly, e.g. in terms of regulatory burden and administrative costs. It is then a matter of judgement how far the prospective benefits of competition justify the costs of 'levelling the playing field'.

4.2 Implications of the ISTC experience

As described in Chapter 3, the DH deliberately offered premium prices and advantageous 'take or pay' contract terms in the first wave of its procurement of ISTCs, which were not offered to NHS owned providers. The government's intention was to achieve both an increase in capacity for provision of elective hospital care and diagnostics to NHS patients to help reduce patient waiting lists and waiting times for treatment, and to install IS providers in the market to spur NHS providers to improved performance. The DH saw favourable treatment of ISTC providers as not only necessary to achieve that but evidently also a price that was on balance worth paying.

The Wave 1 contracts did not require ISTCs to train clinical staff and although some did most did not (Health Committee, 2006 – para.83). This gave ISTCs a potential cost advantage over NHS providers who were bearing the costs of training. Likewise, the casemix of patients to be treated by ISTCs was likely to be less costly on average than that in NHS hospitals, which might convey some financial advantage – e.g. high risk patients could not be treated in ISTCs, which lack appropriate intensive care facilities.

But the balance of advantage was not all in ISTCs' favour. IS providers were constrained from accessing the same labour market which was available to NHS incumbents. In Wave 1, ISTCs were forbidden to recruit anyone who currently worked for an NHS secondary care organisation, or who had worked for such an organisation within the previous six months. According to the Department of Health, this restriction "was designed to prevent a draining of NHS human resource capacity" and to ensure that the new (ISTC) capacity was genuinely 'additional' (Health Committee, 2006 – para.58). This made most of the UK health care professional labour force unavailable to ISTCs. They were constrained instead to recruit a substantial

proportion of medical staff overseas – although arguably they might have chose to do that anyway, as UK clinicians were seen by ISTC bidders as high cost relative to their non-UK counterparts (Health Committee, 2006 – para.86).

In addition, a cost disadvantage to IS providers relative to NHS hospitals was highlighted by the Wave 1 ISTC contracts. The Health Select Committee report (2006) records that: "A Department of Health official explained that NHS providers benefited from "state aid" in a number of ways, which put them to some degree at a competitive advantage compared to independent providers, and "staff pension costs" was one of these advantages." (para.88)

By the second phase of the ISTC procurement, the DH had reduced prices paid to ISTC providers and also limited slightly the extent of 'take or pay' so that revenues were guaranteed only up to a level equivalent to a little less than 100% of the total capacity contracted for. In other words if a Phase 2 ISTC's activity falls more than a little short of the total capacity contracted for by the DH, they will still receive revenues greater than the NHS equivalent cost of the activity they actually carry out. Thus the financial conditions were less favourable than in Wave 1 but overall "the Department will continue to pay more than the NHS Equivalent Cost for Phase 2 ISTCs." (Health Committee, 2006 – para.136)

In Phase 2 all ISTCs were obliged to offer training provision for NHS staff if required by local needs. The staff additionality requirement was relaxed slightly too, i.e. Phase 2 ISTCs could recruit some currently-NHS staff. Thus access to labour markets was more equal between ISTCs and NHS hospitals than in Wave 1.

Hence, overall, Phase 2 of the DH's contracting of ISTCs reduced, but did not fully remove, the distinctions between the terms applied to ISTC and NHS providers that had been created in Wave 1 of the procurement.

4.3 Competition for patient referrals: the problem of non-discretionary cost differences

The government has made clear that it has no plans for any additional waves of ISTC contracts. Competition between IS and NHS providers is now on the basis of attracting non-emergency patient referrals rather than winning central DH procurement contracts. NHS patients referred to a hospital under 'extended choice' and now 'free choice' bring with them revenue according to centrally fixed prices, the so-called 'Payment by

Results' tariff. But non-discretionary cost differences remain between IS and NHS providers which mean that competition between them is arguably not yet completely fair.

The DH commissioned in 2007 a study by Mason et al. (published in 2008) of factors causing significant differences in the cost structures of NHS and IS providers competing to supply patient care paid for by the NHS in England's 'Payment by Results' tariff, i.e. the majority of hospital care. In practice this is restricted to non-emergency hospital care. I have updated that study and extended it in the areas of taxation, pension costs and the costs of capital and risk, as it is in these areas that the greatest non-discretionary cost differences between IS and NHS hospital care providers appear to lie. My assessment is presented in full detail in the Appendix to this Briefing. The key findings are discussed in the following paragraphs.

There may be many reasons why costs differ between different providers of the same services. Different providers may simply, and at their own discretion, make different decisions about how to deliver services. Such discretionary decisions include: how to organise production; the remuneration packages offered to employees; the scale and scope of capacity; efficiency/waste levels; and service quality levels. Where cost differences arise from such decisions they are not indicative of any unfairness in the conditions for competition.

If health care workers were to have, on average, preferences about working for an NHS rather than an IS employer, other things equal, then IS providers would have to pay higher wages to attract staff. But if this were the case it would not be "unfair" to IS providers. Rather it would be compensation for a genuine (psychic) cost imposed on employees of IS providers.

Some non-discretionary cost differences between different types of provider may arise from the nature of health care markets, specifically from:

- geographical variations in costs of labour, capital and land. A provider in one part of the country may be able to access lower cost resources than a provider located elsewhere;
- economies of scale and scope may be a consequence of the available technologies for providing care. Thus it may be that a hospital treating a larger flow of patients is able to achieve lower average costs per patient than a smaller hospital, however efficient the latter is (economies of scale). Equally, economies of

scope arise because many hospital costs are 'common costs', e.g. the same nursing staff can care for a variety of patients receiving a variety of treatments; and the same operating theatres and theatre staff can be used to provide different kinds of surgery. Thus a hospital offering a wider range of treatments may be able to do so at lower costs per patient than one offering a narrower range;

- non-discretionary differences in patient casemix. The mix of patients presenting at a hospital will inevitably vary between time periods and between locations within time periods. More severely ill patients with more complications and comorbidities cost more to treat. Hence, a hospital that has a more straightforward casemix will incur lower costs per patient. A lower cost casemix may arise both because a hospital restricts the range of patients it will treat or because if complications set in during treatment then that patient is transferred to a more appropriately equipped hospital. The key issue is that the price paid for treating patients must reflect case severity and the extent of the treatment provided. As long as providers get paid differently according to the casemix they accept and according to whether they treat complications themselves or transfer those patients elsewhere, then casemix differences do not present a problem. (The 'Casemix' section of the Appendix provides a more detailed discussion of this issue).

Where cost differences arise from the nature of health care markets, there is no social advantage in attempting to counteract them, other things being equal. For instance, forcing all hospitals to be small because some are, or reducing the range of services individual hospitals are allowed to offer just because some do not have such a wide range, would be wasteful of resources if there are economies of scale and scope and so would be socially undesirable.

But some non-discretionary cost differences between different types of providers of the same hospital services result from institutional arrangements. Ensuring 'fair' competition means trying to minimise the non-discretionary cost differences that are not the 'fault' of the service providers and which are not inevitable due to the nature of health care markets.

In these cases the appropriate policy response may be to try and remove or reduce the source of the non-discretionary cost differences. But if that is costly, e.g. in terms of administrative costs or regulatory burden, it may be more appropriate to live with the difference but compensate the

disadvantaged types of provider, e.g. by offering them a price premium, even if that can only imprecisely offset the cost difference. The socially desirable extent of attempts to remove/reduce at source, or to compensate for, non-discretionary cost differences will inevitably depend on the balance between the cost of doing so (e.g. administrative costs) and the overall efficiency benefits that fairer competition is expected to bring.

4.4 Non-discretionary cost differences between independent and NHS hospitals

Non-discretionary cost differences in the provision of hospital care to NHS-funded patients may result from institutional arrangements concerning any of the following:

- Taxation;
- Regulation and contracting arrangements;
- Labour costs;
- Costs of capital and risk;
- Costs of other inputs (e.g. bought-in goods and services);
- Teaching, training and research arrangements.

In practice, the greatest sources of non-discretionary cost differences between IS and NHS providers of hospital care are taxation, pensions and the cost of capital. (The Appendix provides more detail and considers other sources of cost difference.)

Taxation – Corporation Tax

Corporation Tax applies to the profits of private sector organisations but not to charities and not to NHS bodies in respect of their revenues for NHS work. However, the fact that the private sector makes profits and gets taxed on them but the public and charitable sectors do not, is not itself the issue. Corporation Tax is only at issue because it does not treat an organisation's costs and revenues wholly symmetrically, in particular its capital costs.

If every pound spent on investment by a private firm reduced its tax liability by £X in the year in which the pound was spent, and every pound of income earned increased its tax liability by £X pounds in the year in which the pound was received then the Exchequer would in effect be sharing the cost and returns to the investment equally and the post-tax rate of return to the private investor would be the same as the pre-tax rate of return. But corporation tax rules usually mean that a pound spent on investment today reduces a company's corporation tax liability by less than £X this year. This results in the post-tax rate of return to an investment being smaller than the pre-tax rate of return and so imposes a cost on for-profit providers that is not

borne by public and not-for-profit providers.

Corporation Tax rules are complex but in essence all revenues net of most, but not all, costs are immediately liable for tax. An important exception is that capital expenditure is not 100% offset against income for tax purposes in the year in which the capital expenditure is made. Part can only be offset against future years' revenues. This results in the post-tax rate of return to an investment being lower than the pre-tax rate of return. The difference between pre-tax and post-tax rates of return is known as the 'tax wedge'. Put another way: to achieve any particular post-tax rate of return, all else being equal, a Corporation Tax-paying entity would have to charge higher prices than would an NHS body or charity to achieve the same return on investment.

The DH Commercial Directorate explicitly recognises this and requires NHS bodies to allow for the tax wedge when comparing the prices of private sector bids to provide services to the NHS with the prices bid by competing NHS bodies. Mason et al. (2008) refer to a DH document (DH, 2005) that suggests small adjustments to the price the NHS should be willing to pay to private for-profit providers to allow for the impact of corporation tax: +4% in the case of new build and +2% if there is less capital expenditure than that involved. However, there is not yet a mechanism by which for-profit providers can be compensated under the Payment by Results tariff for this cost disadvantage when they treat NHS patients.

Mason et al. (2008) note that Corporation Tax does not apply to bodies with not-for-profit status and hence the tax could be avoided if corporations were willing to forego profits. This also gives charitable providers an advantage over commercial providers. There are however reasons why investors might choose company rather than charity status, not least the option to distribute profits – the return to investment and risk taking – to investors or to other lines of activity rather than being obliged to reinvest them in health care. Put another way: if independent sector competition is desired for the provision of NHS surpluses, it would considerably narrow the field of potential competitors to exclude the private for-profit sector. If private, for-profit providers are to be included, then the cost disadvantage they face as a result of Corporation Tax should be compensated for.

The Corporation Tax issue could be resolved by making all entities including not-for-profits and public bodies subject to Corporation Tax on their surpluses. This would, however, have major political and economic implications far beyond the health care sector.

A more pragmatic option in the medium term to make competition between for-profit and NHS hospitals fairer would be to include a 'tax premium' on the prices paid to private for-profits, over and above the Payment by Results tariff paid to NHS providers. Consideration would then need to be given to whether central government would pay the premium element directly to the for-profit providers, or whether Primary Care Trusts (PCTs) would pay it as part of the total price for the care. If the latter option were pursued, PCTs would then have a strong case to be compensated from central government funds for the premium element, given that on average the excess will be recouped by government in their Corporation Tax revenues.

Taxation – VAT

In many respects the VAT treatment of IS providers and NHS providers of NHS funded care is the same but some differences do exist (see Appendix). A significant anomaly is that while NHS providers can claim back VAT on certain contracted-out services (e.g. catering, laundry), IS providers, whether for-profit or not-for-profit cannot. Overall, to compensate for what it estimates to be a net VAT disadvantage to IS providers competing with NHS providers, the DH Commercial Directorate's 'equivalent cost methodology' requires a 3.5% premium be allowed on IS providers' prices when assessing the value for money of competing bids (DH, 2005; referenced in Mason et al., 2008 – page 3). Arguably the same premium should be paid on Payment by Results tariff prices if the provider is from the independent sector. As with the idea of a 'Corporation Tax wedge' premium on prices, the question would then arise as to whether the premium should be paid directly by central government or whether payers (PCTs) should be compensated from central government funds to the extent that they pay out this premium.

Harmonisation of VAT rules across the public, private and charitable sectors would remove this source of unfairness in the competition for NHS funded patient care, and hence the need for any compensation of private providers. But as long as these VAT differences remain, they need to be fully compensated to permit fair competition. Empirical research is needed to confirm the magnitudes of any VAT differences between public, charitable and private providers of the same services to NHS patients, and the precise circumstances under which they arise.

Pension costs

Pension schemes for employees of IS providers are required to be fully funded. That is, the contributions collected today from and for an employee should,

subject to projections of returns to investment and of people's longevity, on average be sufficient to provide in full for that employee's future pension. In contrast, the NHS Pension Scheme, which applies to all NHS employees in the UK (apart from a small number who have opted out), is a 'pay as you go' scheme. That is, the pension contributions collected this year from NHS employers and employees are supposed to pay for the future pension benefits being earned by employees this year. But it appears from government publications that the NHS Pension Scheme is significantly underfunded, i.e. the existing accumulation of funds net of benefits already paid out is too small to pay for all future liabilities. Furthermore, the same government documents show that the liability is increasing annually, which means that current annual employee and employer pension contributions are too small even to pay in full for the promised pension benefits being accumulated this year.

NHS employers are thus being allowed to offer their employees pension benefits that are greater than are justified by the sum of employer and employee contributions being paid. NHS pension benefits are in effect being subsidised by future taxpayers, who will be expected to pay for the shortfall between cumulative contributions and benefits.

The NHS Pension Scheme together with the public sector pension schemes for civil servants, school teachers and the uniformed services comprise the 'unfunded public service pension liabilities', which at 31st March 2006 totalled an estimate £650 billion (HM Treasury, 2008a – page 38). The Treasury does not say how much of the total liability is due to the NHS Pension Scheme but makes clear that it is a significant part (HM Treasury, 2008a – para.4.14). The Treasury also makes plain that the liability of the unfunded public pension schemes has been increasing annually and is expected to continue to do so by around £6-7 billion per year, despite recent changes to NHS pensions for new employees joining from 1 April 2008.

Underfunding is the main pensions issue but NHS Trusts also avoid some of the administration costs of the pension scheme for their staff. The NHS Pension Scheme is administered by the NHS Business Services Authority, which is paid for centrally, not by NHS Trusts. In contrast, the administration costs of pension schemes available to IS providers are part of the price the IS employers have to pay for their employees' pension benefits.

Underfunding of the NHS Pension Scheme, and Trusts' avoidance of administration costs, implies that it costs less for NHS employers to offer a given

pension benefit to an employee than it does an IS employer to offer the same benefit. This remains true regardless of the balance between employer and employee contributions as, if labour markets are functioning reasonably efficiently, higher employee contributions to pensions would be matched by higher employee salaries to pay for them.

Under the new NHS Pension scheme contributions are approximately 14% of salary by the employer and 6.5%-8.5% of salary by the employee (depending on salary – for most staff it is 6.5%). According to the CBI: “Companies have found themselves required to contribute roughly double what the public sector is charged to fund equivalent pension provision.” (CBI, 2008 – page 4). I estimate that this equates to up to 6% or 7% higher total costs for IS providers relative to NHS hospitals’ total costs.

If IS providers to the NHS were offered the option of enrolling their staff in the NHS Pension Scheme and if they then took up that option, that would be clear evidence of the existence of an advantage associated with that option. Such an arrangement is available to IS providers of social services to local government authorities, but the Local Government Pension Scheme, unlike the NHS Pension Scheme, is fully funded so there is no implicit subsidy to the public sector in that case anyway. Hitherto, most for-profit providers of patient care to the NHS have been denied access to the NHS Pension Scheme as a matter of government policy. Until either the continuing underfunding of the NHS Pension Scheme is halted, or IS providers are given the option of enrolling staff employed on NHS work in the NHS Pension Scheme, IS providers will be at a cost disadvantage to NHS Trusts.

Various approaches are possible to try to resolve this unfairness in competition between NHS and IS providers of NHS funded care. Broadly they are to:

- increase pension contribution rates from NHS employers or employees or both so that there is no continuation of the annual underfunding of NHS Pension Scheme benefits; or failing that to
- put a 6%-7% premium on Payment by Result tariff prices paid to IS providers, similarly to the possible premia discussed above to compensate the Corporation Tax wedge and VAT differences between sectors; or
- for government to make ex post payments to IS providers to the extent that they do NHS funded work.

Cost of capital

In essence, IS providers have access to three sources of funds for capital investment:

- Retained earnings – the post-tax difference between revenues and operating costs, or put another way the sum of depreciation plus asset sales plus/minus any post-tax trading profit/loss;
- Debt;
- Equity.

The costs of the latter two types of capital are determined by the market to reflect risk and overall economic conditions. The opportunity cost of investing retained earnings is, at the margin, the return they could have earned by being invested elsewhere in the capital market.

Where NHS Trusts and NHS Foundation Trusts are required to seek PFI finance for their investment, which is the default for most large investment projects such as building and running major new hospital facilities, they are effectively borrowing from the same capital markets as IS providers. Thus for a given project in these circumstances the cost of capital should be the same for each type of provider.

However, a difference opens up between the cost of capital to NHS and to IS providers respectively to the extent that NHS Trusts and Foundation Trusts are able to borrow from the Exchequer at the National Loans Fund (NLF) rate. The NLF rate is determined by the overall interest rate at which the UK Government is able to borrow via sales of gilts (long-term securities). It is a low risk cost of capital. An IS provider will not be able to borrow at such low rates of interest to invest in health care facilities. The NLF rate does not reflect the risks of the particular project that an NHS Trust or Foundation Trust may wish to invest in, whereas the cost of capital to an IS borrower will do. This disadvantage is exacerbated when the provider in question is small relative to the scale of investment they wish to make – i.e. when the investment would add significant risk to the financial viability of the enterprise as a whole – but it remains even for the largest private sector borrower.

Empirical evidence is lacking about the cost of capital for marginal investments in providing hospital services to NHS funded patients. Mason et al. refer to a study by the consultancy PriceWaterhouseCoopers, which estimated that private investors would require an average return on capital of 6.1% (Mason et al., 2008 – page 22). This is presumably a real cost of capital, averaged across both debt and equity finance (see for example, NAO, 2005). But it is not clear for what

level of overall risk it would be the required rate of return. The cost of capital implied in PFI deals is not publicly available information, as it is bundled together with the costs of running and maintaining facilities in the 'unitary charges' that are published. Research is needed to identify the magnitude in practice, in relevant circumstances of risk.

The picture is further muddled by accounting differences between the NHS and the independent sector. However, while different accounting rules create apparent cost differences on paper between NHS and IS providers, these appearances need to be distinguished from the underlying reality. While standardisation of accounting requirements would remove a confusing factor, it would not affect the real terms of competition between IS and NHS providers.

Other sources of non-discretionary cost differences

Further potential sources of non-discretionary cost difference between IS and NHS providers are discussed in the Appendix. They are likely to be less significant than the tax, pensions and capital cost differences discussed above, but may arise from:

- The burden of regulatory monitoring and reporting requirements. These should ideally be standardised so that the requirements are the same for all providers of NHS care, and policy seems to be moving in that direction. It is unclear at present whether IS or NHS providers currently have the greater non-discretionary costs of this kind;
- NHS Trusts and Foundation Trusts being provided with services by central NHS bodies. The possible range is discussed in the Appendix. Where some or all of the cost of these services is covered by central NHS budgets at no charge to the individual NHS Trust then the Trust has been subsidised and given an unfair advantage over an IS competitor. The issue is how material is that subsidy, given the small cost of the services concerned relative to the size of total expenditure on NHS patients. Further research is needed to determine the existence and significance of any such advantages.

CHAPTER 5 – CONCLUSIONS AND OPTIONS

The scale of independent sector involvement in providing hospital care to NHS funded patients in England is small, though growing. It accounted for just 1.7% of total NHS non-psychiatric hospital spending in England in 2006. Approximately half of

this activity was by 'independent sector treatment centres' (ISTCs) procured under central DH contracts that protected them from competition from NHS providers. Nevertheless, competition from IS providers, or the threat of it, in combination with free patient choice of hospital, is expected by policy makers to stimulate efficiency and quality improvement in NHS providers and thereby to have a beneficial impact in excess of the scale of IS provision.

The implementation of the policy of competition from the independent sector has met barriers along the way. Despite the 2000 Concordat, potential NHS commissioners of hospital care remained generally reluctant to increase reliance on the IS. The implementation of the two waves of ISTC contracts was only achieved by the DH offering advantageous financial terms to stimulate market entry – a reflection of the barriers to entry facing relatively small IS organisations contemplating competing with larger and state-backed incumbent NHS hospitals.

No further ISTC procurements are planned and the extent of IS competition will increasingly depend on attracting patients under the policy of free choice of hospital for non-emergency care. In this context, the existence of non-discretionary cost differences between IS and NHS providers represent a constraint on the extent and impact of competition.

There exist cost disadvantages to IS hospitals competing with NHS Trusts and Foundation Trusts to provide patient care. The most significant of these are summarised in Box 4. They arise mainly from the underfunding of NHS pensions, from the tax wedge that results from Corporation Tax rules, from VAT arrangements and from NHS hospitals' access to investment funds at preferential, National Loans Fund, rates of interest.

All else being equal, the additional costs relative to the subsidised NHS Pension Scheme of equivalent private pensions represents a cost disadvantage of up to 6% or 7%. DH advisers have estimated the Corporation Tax wedge as adding 2%-4% to total costs and the VAT arrangements perhaps 3.5%. The additional costs of capital to IS providers are unclear but probably add several percentage points to interest rates, but given that capital represents typically less than 10% of total costs this would add less than 1% to total costs. Overall, these factors taken together could therefore add of the order of 12-15% to IS providers' costs relative to NHS providers of equivalent quality services at equal levels of efficiency to equivalent casemixes of patients.

Such a level of cost disadvantage to IS providers is not huge but is significant. It is certainly large enough to warrant prompt and detailed assessment by DH of the costs and benefits of options for removing (or at least reducing) it.

To make competition completely 'fair' would require either some arrangement for compensating IS providers – ideally without penalising commissioners of care if patients choose to go to IS rather than NHS hospitals, e.g. some form of central fund from which to pay the extra IS costs of treating each patient – or fundamental changes to the NHS Pension Scheme, Corporation Tax and VAT arrangements, capital accounting rules, and the ways in which NHS or IS providers access capital. The latter types of change could have major repercussions beyond the NHS as well as within it.

From the perspective of the independent sector the implication may seem clear: remove the sources of cost difference, or compensate for them, or accept much less IS involvement than efficiency would imply. For policy makers the question is how fair should competition be, given the balance of costs and benefits.

BOX 4 MAIN NON-DISCRETIONARY COST DIFFERENCES BETWEEN IS AND NHS HOSPITALS

Source of cost difference	Estimated average magnitude
<ul style="list-style-type: none"> • Corporation Tax 'wedge' reduces post-tax rate of return of for-profits relative to pre-tax rate of return. Does not affect not-for-profits 	+2% to +4% added to total costs of for-profits
<ul style="list-style-type: none"> • Value Added Tax – IS providers unable to reclaim VAT to same extent as NHS providers 	+3.5% added to IS total costs
<ul style="list-style-type: none"> • Pension costs in NHS Pension Scheme effectively subsidised by future taxpayers as scheme is underfunded 	+6% to +7% added to IS total costs
<ul style="list-style-type: none"> • Cost of capital is lower for NHS bodies when they are allowed to borrow from the Exchequer 	0% to +1% added to IS total costs

APPENDIX – DETAILED ASSESSMENT OF NON-DISCRETIONARY COST DIFFERENCES BETWEEN INDEPENDENT AND NHS PROVIDERS

As in the main text, the term ‘independent’ is used here to encompass all non-public sector providers, regardless of ownership structure or whether for-profit or not-for profit. Where distinction between different independent sector ownership structures is necessary, the terms ‘private’ (excluding charities) and ‘charitable’ are used as appropriate.

In 2007 the Department of Health (DH) commissioned research from economists at the University of York to identify which factors cause significant differences in the cost structures of NHS and independent providers competing to supply patient care paid for by the NHS in England’s ‘Payment by Results’ tariff, i.e. the majority of hospital care: Mason et al., 2008. In practice the independent sector does not compete to provide emergency services and hence the focus of the current paper is on non-emergency hospital care. The emphasis of this note is on the present and future, not the past: what are the unavoidable cost differences, if any, between NHS and IS providers competing today to meet demand for non-emergency hospital care.

The information in this appendix makes frequent reference to the York report but updates and goes beyond it in some areas, particularly concerning the costs of providing pensions to staff, the cost of capital and the impact of taxation.

Many aspects of observed cost differences between NHS and IS providers of hospital care to NHS funded patients are not forced by exogenous factors but are in effect matters of discretion for the owners and managers of the organisations concerned: differences in efficiency, different decisions about quality levels provided and about how to organise services. These aspects are not discussed further here. Our focus is on non-discretionary cost differences.

Some non-discretionary cost differences may result from institutional arrangements in the UK:

- Taxation
- Regulation and contracting arrangements

- Labour costs
- Costs of capital and risk
- Costs of other inputs (e.g. bought-in goods and services)
- Teaching, training and research arrangements

while other cost differences may arise from the nature of health care markets:

- Geographical variations in the costs of inputs: labour, capital and land
- Economies of scope and scale in providing patient care
- Patient casemix.

The rest of the Appendix look at cost differences under each of these headings in turn.

Taxation

The UK’s taxation system creates cost differences between NHS and private providers as a result of both corporation tax and value added tax (VAT). Although these are transfer payments rather than opportunity costs (i.e. they are not a net cost per se to the UK as a whole), they do impose a competitive disadvantage on some types of providers relative to others.

Corporation Tax

Corporation Tax applies to private sector organisations but not to charities and not to NHS bodies in respect of their revenues for NHS work (although their non-NHS revenues will in future very likely be subject to Corporation Tax). However, the fact that the private sector makes profits and gets taxed on them but the public and charitable sectors do not, is not itself the issue. Corporation Tax becomes an issue, rather, because it does not treat an organisation’s costs and revenues wholly symmetrically, in particular its capital costs. For example, capital allowances may not be immediately realisable depending on an organisation’s profits and tax history.

Corporation Tax rules are complex but in essence all revenues net of most, but not all, costs are immediately liable for tax. However, capital expenditure is not 100% offset against income for tax purposes in the year in which the capital expenditure is made. Part of it can be offset straight away but part can only be offset against next year’s revenues, or those the year after, or the year after that. This means that for a tax-paying entity, the post-tax rate of return to an investment is lower than the pre-tax rate of return. The difference between post- and pre-tax rates of return is called the ‘tax wedge’. The tax wedge is bigger the more capital intensive is the activity, i.e. the greater the capital expenditure as a proportion of total expenditures. Put another way: to

achieve any particular post-tax rate of return, and with all other things equal (including efficiency and quality), a Corporation Tax-paying entity would have to charge higher prices than would an NHS body to achieve the same return on investment. Fair competition requires an offset to that.

To ensure fair competition it would be necessary to adjust for the extent to which a private provider's supply prices are raised by this tax wedge. The UK Treasury's guide to all government organisations, including the NHS, on how to appraise expenditure options states: "where the tax regimes applying to different options vary substantially, this should not be allowed to distort option choice" (HM Treasury, 2003 – paragraph 55). The DH Commercial Directorate explicitly recognises this too; its guidance requires NHS bodies to allow for the tax wedge when comparing private sector bids with those of competing NHS bodies. The York report references a DH document (DH, 2005) which suggests small adjustments to the price which the NHS should be willing to pay to private providers, to allow for the impact of corporation tax: +4% in the case of new build and +2% if there is less capital expenditure than that involved. However, there is not yet a mechanism by which private providers can be compensated under the Payment by Results tariff for this cost disadvantage when they treat NHS patients.

Mason et al. (2008) note that corporation tax does not apply to bodies with (not for profit) charitable status and hence the tax could be avoided if corporations were willing to forego profits. This also gives charitable providers an advantage over private providers. There are however reasons why investors might choose corporate status, not least the option to distribute profits – the return to investment and risk taking – to investors or to other lines of activity rather than obliging them to be reinvested in health care. Put another way: if independent sector competition is desired for the provision of NHS surpluses, it would considerably narrow the field of potential competitors to exclude the private for-profit sector. If private, for-profit providers are to be included, then the cost disadvantage they face as a result of corporation tax should be compensated for. The magnitude of such compensation needs to be reassessed by empirical research at regular intervals.

VAT

VAT is a complex area. In many respects the VAT treatment of IS providers' provision of NHS funded care is the same as the VAT treatment of NHS providers supplying comparable care services. But differences exist between NHS and private providers and between private and charitable providers. An example of the latter is that charitable providers are not normally able to reclaim the VAT element of the

prices they pay for inputs, whereas private providers can (CBI, 2006). The Confederation of British Industry (CBI) has emphasised the complexity of VAT rules and concluded in 2006 that: "The government should address the taxation and regulation of different providers [of public services in the UK]. Because of its complexity, a separate review of VAT and its application to the public-private interface may be required." (CBI, 2006 – page 35).

A significant anomaly identified by the Department of Health and referred to in the York report is that while NHS providers can claim back VAT on certain contracted-out services (e.g. catering, laundry), IS providers cannot reclaim this cost (Mason et al., 2008 – page 14). Overall, to compensate for what it estimates to be a net VAT disadvantage to IS providers competing with NHS providers, the DH Commercial Directorate's 'equivalent cost methodology' requires a 3.5% premium be allowed on IS providers' prices when assessing the value for money of competing bids (DH, 2005; referenced in Mason et al., 2008 – page 3).

It is clear that the eventual solution requires harmonisation of VAT rules across the public, private and charitable sectors. This would remove an evident unfairness in the competition for NHS funded patient care. Until that happens, empirical research is needed to confirm the magnitudes of any VAT differences between public, charitable and private providers of the same services to NHS patients, and the precise circumstances under which they arise. As long as these VAT differences remain, they need to be fully compensated to permit fair competition.

Regulation and contracting arrangements

Health care organisations, public, charitable and private, are subject to various obligations to report to regulators and other stakeholders on aspects of their performance, their finances and some dimensions of the quality of their services. These obligations are not entirely harmonised, although a major step in that direction has been taken by the Health and Social Care Act 2008, which establishes the Care Quality Commission as the single integrated regulator for health and adult social care in England, with the duty to ensure safe and high quality services.

Standardised obligations and standardised reporting requirements should remove unevenness in the cost burdens that regulatory and monitoring requirements impose on different types of organisations.

The York report notes that IS providers of hospital services to NHS patients need not only to comply with the same standards as apply to NHS providers

but also with “more prescriptive” national minimum standards which apply only to the independent sector (Mason et al., 2008 – page 16). IS organisations have to pay fees to register with the Healthcare Commission (to be merged into the new Care Quality Commission on 1 April 2009), but NHS bodies do not pay fees. However, all organisations bear costs of providing information to, and of being inspected by, regulators including the Department of Health; and NHS trusts, but not IS providers, have to meet the costs of reporting to Monitor if they are Foundation Trusts, or to NHS Strategic Health Authorities if they are not.

The magnitude and direction of any overall difference between organisation types in terms of costs of meeting regulatory and reporting requirements is unclear and would merit research to gather evidence. Fair competition requires that such differences either be removed – by full harmonisation of requirements – or be compensated for. However, these cost differences are unaffected by the quantity of NHS work that an organisation does. Hence any compensation should be via fixed payments rather than the price paid per patient treated.

As noted in the York report, an aspect of the arrangements for administering payments to NHS compared with IS providers for the NHS funded patient care they provide introduces an unnecessary and hence unfair difference between providers in those sectors. NHS providers receive regular monthly payments, at the same time each month. IS providers, however, are only paid on submission of an invoice and then only on a 30-day settlement basis. This imposes a small cost disadvantage on IS providers. Furthermore, some payments to IS providers may not in practice be made within the 30-day period, which brings further financing costs to IS providers. These payment disadvantages could be tackled by improving payment arrangements for IS providers to parity with those for NHS providers.

Labour

Health care is a labour intensive activity. In the NHS hospital sector labour costs are around 60% of total costs (OHE, 2009 – Table 2.18). The way in which labour is employed and rewarded is therefore a major focus of attention for health care providers seeking a source of competitive advantage. NHS employers were for many years effectively constrained by national agreements as to the wages and other terms and conditions they could offer individual employees. But there is now much greater flexibility for NHS bodies in determining remuneration levels for their staff. It is unclear to what extent NHS employers are yet using the

flexibility available to them, but in principle they have it.

Thus, the existence today of differences in pay levels, or in the balance of salary versus pensions versus other forms of staff reward, is not in itself evidence of unfair conditions of competition disadvantaging either NHS or IS providers. Different IS providers have the discretion to make different decisions from each other and from NHS providers: e.g. by offering higher or lower remuneration altogether, or higher wages but poorer pensions, or vice versa. To the extent that all providers of care to NHS patients, public and independent, are recruiting staff in the same labour markets there is no unfairness. However, institutional arrangements have created some differences in labour costs between NHS and IS providers.

In the first wave of NHS contracts for independent sector treatment centres (ISTCs), which commenced in 2002, IS bidders were required to undertake not to recruit anyone who had worked for the NHS in the preceding six months. The primary purpose of this wave of contracts was to increase capacity in the provision of elective surgery and diagnostics to NHS patients. Moving existing NHS employees to new employers would not help to meet that objective. The DH evidently feared that constraints on the supply of skilled labour would lead either to staff shortages in the NHS or to wage escalation if IS providers were allowed to try and recruit staff already working for the NHS. Consequently the IS providers recruited heavily from overseas for its medical and other key staff. Subsequently, as labour supply conditions have eased, the DH has relaxed this ‘additionality’ requirement. As a result, NHS and IS providers are all recruiting from the same pools of labour – UK and international.

Nevertheless a large incumbent provider of hospital care in a particular location, which means in practice an NHS Trust or NHS Foundation Trust, may have advantages in recruitment or retention of key staff by virtue of its size and incumbency. It may well be seen by prospective employees as offering greater security of employment and a larger community of colleagues to work with. However, any such advantages for a large NHS incumbent in competing with a much smaller IS challenger might be impractical or counterproductive (from a societal perspective) to remove given the economies of scope and scale in provision of hospital care (see below).

A set of institutional arrangements that continues to impose a cost disadvantage on IS competitors with NHS Trusts, however, concerns the NHS Pension Scheme.

Pension costs

Pension schemes for employees of IS providers, whether 'defined benefit' or (more commonly these days) 'defined contribution' schemes, are required to be fully funded, i.e. the contributions collected today from and for an employee should, subject to projections of returns to investment and people's longevity, on average be sufficient to provide in full for that employee's future pension.

The NHS Pension Scheme applies to all NHS employees in the UK, apart from a small number who have opted out, and provides 'defined benefits' related to employees' final salaries prior to retirement. In contrast to pension schemes in the independent sector, the NHS Pension Scheme is a 'pay as you go' scheme. That is, the pension contributions collected this year from NHS employers and employees are supposed to pay for the future pension benefits being earned by employees this year. That money is then in practice drawn on to pay benefits to current pensioners. But, as explained below, it appears from government publications that the NHS Pension Scheme is significantly underfunded, i.e. the existing accumulation of funds net of benefits already paid out is too small to pay for future liabilities. Furthermore, the same government documents show that the liability is increasing annually, which means that current employee and employer pension contributions are too small even to pay in full for the promised pension benefits being accumulated this year. Thus, NHS employers are able to offer their employees pension benefits that are greater than is justified by the sum of employer and employee contributions paid. NHS pension benefits are being subsidised in effect by future taxpayers who will be expected to pay for the shortfall between contributions and benefits.

The evidence of underfunding is discussed in the Treasury's March 2008 "Long-term Public Finance Report: an Analysis of Fiscal Sustainability". The NHS Pension Scheme together with the public sector pension schemes for civil servants, school teachers and the uniformed services comprise the 'unfunded public service pension liabilities', which at 31st March 2006 totalled an estimate £650 billion (HM Treasury, 2008a – page 38). The Treasury does not say how much of the total liability is due to the NHS Pension Scheme. But when discussing the need to increase the amount of the UK's national income spent on public service provisions from 1.5% of GDP in 2007/08 to 2.0% by 2027/28, it highlights the NHS Pension Scheme: "The projected increase reflects recent changes in the size of the public service workforce, improved life expectancy and the fact that some schemes, and in particular the National Health Service (NHS) scheme, are not yet

mature." (HM Treasury, 2008a – paragraph 4.14).

The Treasury also makes plain that the liability of the unfunded public pension schemes has been increasing annually and is expected to continue to do so by around £6-7 billion per year, see Table A1 based on data published in HM Treasury's "Public Expenditure Statistical Analyses 2008".

The CBI argues that the Treasury's assumptions differ from the assumptions about life expectancy and return on investment usually made in private sector pension schemes, which is what IS employers have to pay for. The CBI's own estimate is that by August 2008 the total liabilities of the unfunded public service pension schemes amounted to £915 billion, of which a significant part is presumably accounted for by the NHS Pension Scheme (CBI, 2008).

There were significant changes to the NHS Pension Scheme from 1 April 2008, although they apply only to new employees from that date (or to existing employees who choose to transfer to the new arrangements). The new scheme, for new NHS employees, has a later retirement age of 65 rather than 60 under the old scheme and so has moved into line with most current IS pension schemes. To offset that blow to employees the new scheme gives them a pension equal to 1/60th of final salary per year of employment rather than 1/80th under the old NHS Pension Scheme. The figures in Table A1 are recent enough to have taken these changes into account for the future years. It remains to be seen whether the advent of the new scheme has any effect on the extent of the hitherto annual and cumulative underfunding of the NHS Pension Scheme implied in the Treasury figures.

Underfunding is the main issue but NHS Trusts also avoid some of the administration costs of the pension scheme. The NHS Pension Scheme is administered by the NHS Business Services Authority, which is paid for centrally, not by NHS Trusts. In contrast, the administration costs of pension schemes available to IS providers are part of the price the IS employers have to pay for;

Underfunding of the NHS Pension Scheme, and Trusts' avoidance of administration costs, implies that it costs less for NHS employers to offer a given pension benefit to an employee than it does an IS employer to offer the same benefit. This remains true regardless of the balance between employer and employee contributions as, if labour markets are functioning reasonably efficiently, higher employee contributions to pensions would be matched by higher employee salaries to pay for them. Under the new NHS Pension scheme contributions are approximately 14% of salary by the employer and

6.5%-8.5% of salary by the employee (depending on salary – for most staff it is 6.5%). According to the CBI: “Companies ... have found themselves required to contribute roughly double what the public sector is charged to fund equivalent pension provision.” (CBI, 2008 – page 4). If so, this equates to a significant cost disadvantage to IS providers relative to NHS providers, perhaps up to as much as plus 6% to 7% relative to NHS hospitals’ total costs (on the basis of staff costs including employers’ National Insurance and pension contributions amounting to about 60% of total NHS hospital costs (source OHE, 2009 – Table 2.18)).

Unions representing NHS employees have argued strongly for protection of pensions and other NHS terms and conditions when NHS employees are transferred to a non-NHS organisation in order to carry on doing the same work as previously for NHS patients. As a result, the greatest form of employee protection, the ‘retention of employment’ model, allows affected NHS staff to remain NHS employees and to merely be seconded to the non-NHS organisation. But this is available only to soft facilities management staff when that function is taken over by a non-NHS organisation as part of a Private Finance Initiative scheme (i.e. where the private sector designs, finances, builds and operates a hospital or other facility for the NHS) or for staff working in an Independent Sector Treatment Centre to serve NHS patients. This option is not available to any other IS staff working to treat NHS patients, whether they transferred from the NHS or not.

Other NHS (and other public sector) staff, transferred to IS providers under TUPE³ arrangements, are not offered the option of remaining in the NHS Pension Scheme, but the new

employer is required to offer ‘broadly comparable’ (as defined by the Government Actuary’s Department) pension arrangements, which have to be certified by an actuary – for a fee of a few thousand pounds per year – to be comparable to the NHS pension (HM Treasury, 2004). However, any new, rather than transferred-from-NHS staff an IS provider takes on are not entitled to become NHS Pension Scheme members. If an IS provider is competing at the margin for extra NHS patients, e.g. under the choice initiative, the staff they take on are unlikely to be NHS transferees.

If IS providers to the NHS were offered the option of enrolling their staff in the NHS Pension Scheme and generally took up that option, that would be clear evidence of an advantage associated with that option, although not of its magnitude. Such an arrangement is available to IS providers of social services to local government authorities, but the Local Government Pension Scheme, unlike the NHS Pension Scheme, is fully funded. Hitherto, most for-profit providers of patient care to the NHS have been denied access to the NHS Pension Scheme as a matter of government policy, although with one small exception. So-called ‘Specialist Personal Medical Service (SPMS)’ providers of specialist medical services to NHS patients in primary care settings may enrol any partner in, or shareholder of, that SPMS provider into the NHS Pension Scheme even if the SPMS provider is a for-profit partnership or a limited company (NHS Pensions Agency, 2007). Until either the continuing underfunding of the NHS Pension Scheme is halted, or IS providers are given the option of enrolling staff employed on NHS work in the NHS Pension Scheme, those providers will be at a non-negligible cost disadvantage to NHS Trusts in remunerating their employees.

Table A1: Annual contributions shortfall in unfunded public service pension schemes

£ million	2005/06 outturn	2006/07 outturn	2007/08 estimated outturn	2008/09 plans	2009/10 plans	2010/11 plans
Change in liability	20,918	21,069	28,996	25,393	26,243	27,204
Contributions received	17,368	17,934	9,030	19,117	19,595	20,175
Shortfall	3,550	3,135	9,966	6,276	6,648	7,029

Source: HM Treasury (2008b) – Table D.1

³ “Transfer of Undertakings (Protection of Employment)” regulations.

Capital

Although provision of hospital care is a labour intensive activity, the cost of capital and the cost of depreciation of assets together represent up to 10% of total costs on average. In essence, IS providers have access to three sources of funds for capital investment:

- Retained earnings – the post-tax difference between revenues and operating costs, or put another way the sum of depreciation plus asset sales plus/minus any post-tax trading profit/loss;
- Debt;
- Equity.

The costs of the latter two types of capital are determined by the market to reflect risk and overall economic conditions. The opportunity cost of investing retained earnings is at the margin effectively the return they could have earned by being invested elsewhere in the capital market.

NHS providers of patient care have, since 1 April 2008, access to the following sources of capital for new investments, with some differences according to whether they have yet achieved Foundation Trust status, see Table A2.

Where NHS Trusts and Foundation Trusts are required to seek PFI finance for their investment, which is the default for most large investment projects such as building and running major new

hospital facilities, they are effectively borrowing from the same capital markets as IS providers. Thus for a given project in these circumstances the cost of capital should be the same for each type of provider.

However, a difference opens up between the cost of capital to NHS and to IS providers respectively to the extent that NHS Trusts and Foundation Trusts are able to borrow from the Exchequer at the National Loans Fund (NLF) rate. The NLF rate is determined by the overall interest rate at which the UK Government is able to borrow via sales of gilts (long-term securities). It is a low risk cost of capital. An IS provider will not be able to borrow at such low rates of interest to invest in health care facilities. The cost of capital the IS provider pays is the rate appropriate to the degree of non-diversifiable risk in the scheme being invested in. This disadvantage is exacerbated when the provider in question is small relative to the scale of investment they wish to make – i.e. when the investment would add significant risk to the financial viability of the enterprise as a whole – but it remains even for the largest private sector borrower.

No private sector borrower, however large and respected, is able to access capital for a given level of non-diversifiable risk at rates quite as fine as the Exchequer: estimates suggest that the Exchequer is usually able to borrow at interest rates around one percentage point or more below even a large and

Table A2: Sources of new capital investment funds for NHS Trusts and Foundation Trusts, 2008/09 onwards

Source of capital	Foundation Trusts	Non-Foundation Trusts
Retained earnings = depreciation +/- surplus/deficit + disposal of surplus assets	Yes	Yes
Private finance initiative (PFI) – indirectly borrowing from private banks and equity, with the capital being raised by the consortium building and operating the facility	For investments requiring £10s-100s millions	For investments requiring £10s-100s millions
Direct commercial borrowing from private banks	Yes – but little used so far	No
Department of Health (i.e. from the Exchequer) – interest charged at the National Loans Fund rate. (Before 2008/09 interest was charged at 3.5% p.a. real.)	See next row...	Yes
Foundation Trust Financing Facility (FTFF), operating at arm's length from Department of Health but borrowing from the Exchequer – interest charged equivalent to the National Loans Fund rate for NHS ('core') business*	Yes	No

Note: Interest rate for FTFF loans for commercial developments by Foundation Trusts is a higher 'market rate' (HFMA, 2008).

low risk private borrower (see Sussex (2001) for a fuller discussion). Furthermore, the NLF rate does not reflect the risks of the particular project that an NHS Trust or Foundation Trust may wish to invest in, whereas the cost of capital to an IS borrower will do. Empirical evidence is lacking about the cost of capital for marginal investments in providing hospital services to NHS funded patients. The York report refers to a study by the consultancy PriceWaterhouseCoopers, which estimated that private investors would require an average return on capital of 6.1%, but it is not clear for what level of risk this is the required rate of return, although seemingly quite low (Mason et al., 2008 – page 22). The cost of capital implied in PFI deals is not publicly available information, as it is bundled together with the costs of running and maintaining facilities in the ‘unitary charges’ that are published.

Thus, while it is clear that an organisation able to borrow from the Exchequer at the National Loans Fund rate will have a cost advantage over an organisation reliant on capital markets, the magnitude of this advantage is unclear, but is likely to be considerably more than one percentage point. Research is needed to identify the magnitude in practice, in relevant circumstances of risk.

As the brief discussion in the preceding paragraphs has indicated, the cost of capital is not straightforward to measure. The picture is further muddled by accounting differences between the NHS and the independent sector. However, while different accounting rules create apparent cost differences on paper between NHS and IS providers, these appearances need to be distinguished from the underlying reality.

For example, IS bodies follow historic cost accounting principles, while the book values of NHS organisations’ assets are revalued annually and depreciation and capital charges on those assets change accordingly, effectively a form of current cost accounting. This could result in an NHS provider recording higher charges than an IS provider for identical assets. But assumed asset lifetimes can also differ between the NHS and the independent sector. This is particularly noticeable for long-lived assets, i.e. buildings, which are typically depreciated over 60 years in NHS accounts but over much shorter periods, typically 30 years, in the independent sector. This would lead to lower depreciation charges, for an asset under 30 years old, in the accounts of an NHS provider than in those of an IS provider, for the same asset. Although after 30 years the IS provider would have fully written the buildings off and so be booking no further depreciation to those assets, while the NHS provider would still be entering a depreciation charge for

another 30 years. However, whatever the accounts say, the two types of organisation would have identical assets in this hypothetical example, worth on the open market an identical amount, and that amount would be depreciating at an identical rate, regardless of whether the asset was NHS or independently owned.

Overall, accounting differences may confuse the issue but they do not in themselves represent true cost differences between NHS and IS providers. Hence, standardisation of accounting requirements would remove an unhelpful confusing factor, but would not affect the real terms of competition between IS and NHS providers.

Other inputs

NHS Trusts and Foundation Trusts are provided with a number of services by central NHS bodies. Where the Trusts pay for these services in full no unfairness is created towards IS competitors. But where some or all of the cost of these services is covered by central NHS budgets at no charge to the individual NHS Trust then the Trust has been subsidised and given an unfair advantage over an unsubsidised (IS) competitor. In the latter case the issue is how material that subsidy is, given the small cost of the services concerned relative to the size of total expenditure on NHS patients.

At the time of writing (February 2009) the Department of Health website lists 23 central, arm’s length bodies working in the NHS in England, which will reduce to 21 from 1 April 2009 when three of them merge to form the Care Quality Commission. Some of the arm’s length bodies are primarily regulators and information gatherers who, as discussed above, impose costs on NHS (and other) providers but do not deliver services as such. Others provide services directly to the public and patients – NHS Direct – or provide information to the public domain – the Information Centre for Health and Social Care, the National Institute for Health and Clinical Excellence (NICE), NHS Institute for Innovation and Improvement (NIH). Excluding those bodies leaves:

- National Patient Safety Agency (NPSA)
- National Treatment Agency for Substance Misuse (NTA)
- NHS Blood and Transplant
- NHS Business Services Authority (NHSBSA), which includes the NHS Pension Agency
- NHS Litigation Authority
- NHS Professionals, which helps the NHS source temporary staff
- NHS Purchasing and Supply Agency (PASA)
- Postgraduate Medical Education and Training Board (PMETB)

There are also other central NHS budgets from which NHS Trusts and Foundation Trusts may derive benefit. Perhaps the largest single example is the centrally funded NHS National Programme for IT and another example is the 'NHS Jobs' online recruitment service for NHS staff in England and Wales.

In the case of the NHS Litigation Authority, NHS organisations pay to be covered by the Clinical Negligence Scheme for Trusts (CNST). With the passing of the Health and Social Care Act 2008, membership of the CNST is becoming available to non-NHS providers of NHS care. It was anyway hitherto possible for IS providers to have CNST cover for their NHS funded patients, by the referring health authority (Primary Care Trust, Local Health Board, etc.) paying the CNST contribution on their behalf (and being funded by the DH to do so).

PASA offers NHS organisations the advantage of greater purchasing power in procuring goods and services by collective purchasing. The York report refers to an estimate by PriceWaterhouseCoopers that these savings amount to 9.6%. Similarly, groups of NHS Trusts may also form purchasing consortia (rather than have PASA do it for them) to obtain particular goods or services. The benefit of lower prices for inputs through collective purchasing may be an advantage for the NHS bodies concerned but it is not one that it would be wise from a social welfare perspective to remove. It would be perverse to forego this economy of scale (see the discussion of economies of scale later in this Appendix). It would be preferable to ensure that IS providers are allowed to benefit from PASA's purchasing power, if they wish, when obtaining inputs to treat NHS funded patients.

The NHS National Programme for IT (NPfIT) is funded centrally by the DH to help provide a standardised IT infrastructure across the NHS in England via NHS Connecting for Health (CfH). CfH spends considerable sums on behalf of the NHS running the national contracts and tendering exercises for provision of this infrastructure, but local NHS Trusts are responsible for the costs of IT implementation and operation. IS providers have to meet all of the costs of their IT, which is required to conform, and link, to NHS CfH systems. To the extent that CfH mitigates the costs of setting up and running IT, fair competition requires the same benefits to be offered to IS providers of care to NHS patients. In the words of the York report: "By subsidising NHS but not IS providers, the CfH programme can be considered a form of 'state aid' that may not be competitively neutral" (Mason et al., 2008 – page 31). However, to the extent that the CfH-determined infrastructure requires IT

investments to be made by IS providers to achieve compliance, that is not anti-competitive but rather a condition that applies to all who wish to enter the competition, whether NHS or IS.

It remains possible that other arm's length bodies among those listed also deliver free or subsidised services to NHS providers that are not currently available on such favourable terms to IS providers. It is beyond the scope of this study to investigate the full range of services provided, explicitly or implicitly, by those central bodies and budgets; the funding arrangements for those services; the costs of sourcing them from elsewhere; and the terms on which they are available, if at all, to IS providers. But it is possible that some of them may be a source of some limited competitive advantage to NHS providers compared to IS providers. Further research is needed to determine the existence and, if so, the significance of any such advantages.

Teaching, training and research

The NHS bears the costs of teaching/education for health care staff, i.e. providing the education and practical learning experiences needed to achieve required qualifications. The IS sector does not, but is able to benefit from the availability of qualified staff. However, provided that NHS organisations are appropriately funded to pay for the teaching they deliver, and IS or any other health care providers who do not also provide teaching do not have access to those funds, then no competitiveness unfairness has been created. An issue is therefore whether the funding of NHS organisations for teaching is a fair representation of the incremental costs they incur if they provide teaching relative to if they do not. In the NHS in England these costs are supposed to be met from a central fund and do not enter into the prices charged for caring for patients, e.g. under the Payment by Results tariff. If the funding is inadequate then NHS organisations have a disadvantage when competing with IS providers. If the funding is excessive then it is the IS providers who are at a disadvantage. I have not been able to find an analysis of which of these possible states of the world currently prevails.

However, whatever the position, competition between IS and NHS providers is effectively for additional patients (strictly: spells of care) at the margin, which means that under- or over-funding of education should not be a competition issue, as neither teaching costs nor teaching revenues would vary with the amount of patient care delivered. As prices at which marginal patient spells are reimbursed under Payment by Results are fixed nationally by DH, there is also no scope for a provider who is overfunded for teaching to use that surplus to cross-subsidise its patient care activities.

Training, for post-qualification professional development, is funded by the individual NHS Trust, Foundation Trust or IS provider. Both NHS and IS providers undertake staff training. Therefore the incremental costs incurred in providing training need to be funded separately from payments for patient care so as not to impact on the fairness of competition for that activity. It appears that currently the (average) costs of training may be wrapped up into the prices for NHS funded patient care under the Payment by Results tariff. This would provide a cost advantage to any body, NHS or IS, that bears less than average training costs, and a disadvantage to any NHS or IS body that bears more than average training costs. To overcome this, training needs to be paid for separately from patient care for all providers, NHS and IS.

Research in the NHS, like teaching, is funded out of central budgets. IS providers do not yet receive any of that funding but could do if they were to undertake research for the NHS. Just as for teaching, provision of and payment for research does not impact on competition to provide patient care under the (nationally-fixed-price) Payment by Results tariff.

Geographical variation in input costs

The prices paid by the NHS for patient care are fixed nationally but include an explicit 'market forces factor (MFF)' to allow for geographical variations in costs of labour, capital and land that cannot be avoided given that health care needs to be reasonably accessible to all patients regardless of which region of the country they live in. In England costs are lowest in Cornwall and highest in central London, but the population of London is not expected to travel 300 miles to Cornwall for its health care. The full implementation of patient choice in England has meant that (for non-emergency hospital care) patients can choose to be treated in any NHS hospital and any IS hospital that has signed up to be included – but the patients pay their own travel costs. It is nevertheless possible that some, perhaps most, patients will be influenced by the advice of their GP about where to go for diagnosis and treatment. Some GPs may in turn be influenced by their local Primary Care Trust (PCT) who pays for that care and gives the GPs an indicative 'practice based commissioning (PBC)' budget for the costs of referrals and allows them to reinvest in their practice a proportion of any surplus they make on that budget (DH, 2006).

To avoid an unwanted financial incentive for PCTs and practice based commissioners to steer their patients towards non-local providers in cheaper parts of the country, the DH has, until now, required PCTs only to pay for activity under Payment by Results

at the price it would be charged in the lowest cost part of the country (Cornwall). The MFF element, i.e. the mark-up on that price, due to the care actually being delivered in London, say, has in the past been paid out of central DH funds, when the care provider is an NHS organisation. Thus PCTs and practice based commissioners have had no financial incentive to direct patients to NHS providers in lower cost but more distant places. However, that approach was not adopted when patients went to IS providers – in that case the PCT had to pay the MFF element too (DH, 2008X). This placed IS providers at a competitive disadvantage. Wherever an IS provider locates they should, to ensure competitive fairness, not only receive the same MFF-adjusted price as would a neighbouring NHS provider, but payers should face the same effective price regardless of whether the supplier is an NHS or an IS provider.

This disadvantage has been removed from 1st April 2009, however. From that date the DH no longer pays the MFF element from central funds. PCTs have themselves to pay the MFF element for all providers, NHS as well as IS (DH, 2008Y). This means that PCTs and practice based commissioners do now have an incentive to encourage patients to go to cheaper parts of the country for treatment, but that applies equally to NHS- and IS-provided care. (Arguably, it would have been better to retain central funding of MFF and to have extended that to IS as well as NHS providers.)

Mason et al. (2008 – page 26) record a concern by IS providers that the MFFs exaggerate the extent of geographical cost variations. I have heard the same thing in discussions with senior managers at NHS Trusts. Perhaps in response to such criticism, the range of magnitudes of MFFs that the DH applies to the Payment by Results tariff has been narrowed to 1.00-1.35 from 1 April 2009, compared to a range from 1.00-1.45 before then. Whatever the range, it is important to note that NHS and IS providers would find it equally difficult to match implied MFF cost levels at the low end if the MFFs do in fact exaggerate cost variations. This is not a source of competitive (dis-)advantage for either sector.

Economies of scope and scale

The existence of economies of scale would mean that the average cost per patient treated in one hospital declines as more patients are treated per time period, or that for a given average cost per patient higher quality could be delivered the more patients are treated per time period. Some economies of scale appear to exist in hospital care: for most services it is possible to treat 100 patients a year at lower average cost or to a higher average standard than if only 10 patients are treated per

year. The economic literature on economies of scale is unclear on how great the economies are, i.e. how long before treating more patients per time period leads to rising average costs and/or declining average quality of treatment. But the literature does seem clear that diseconomies of scale should be expected to set in at some point (Posnett, 1999).

Economies of scope may be more significant in hospital care than economies of scale. These are the lower average costs and/or higher average quality that are achieved if services are delivered together in one place rather than separately. An example may be provision of different types of surgery using the same suite of operating theatres and associated facilities, equipment and specialist staff team. Another is the provision of emergency and non-emergency care from the same place with the same facilities and staff teams: when emergency workload is below peak the spare capacity can be used to treat non-emergency cases rather than standing idle.

However, for the purposes of the discussion of fair competition, the existence of economies of scale and scope is simply a feature of health care technology and of the nature of demand for health care which applies equally whether a health care provider is an NHS Trust or an independent organisation. History means that in England the large incumbent provider will always be an NHS Trust, which may be able to achieve scale and/or scope economies (or who may have entered the region of diseconomies). But that does not mean that smaller/ narrower providers should be compensated. There is no social welfare gain in doing so. The welfare maximising position would be to have hospitals of a scale and scope to capture whatever economies are available. It would be perverse to encourage hospitals of suboptimal scale or scope. The relevant policy issue may be to consider contestability for larger volumes, or integrated packages, of services, i.e. for whole hospitals, rather than competition for marginal volumes of activity. But that is a different policy issue from fair competition (see Sussex, 1998).

Casemix

Under Payment by Results, providers receive a price per patient spell within a 'Healthcare Resource Group (HRG)'. Up to 2008/09 the current tariff used around 550 different HRGs; from 1 April 2009 the HRGs were redefined to a finer level of detail such that the number of different HRGs for which there are distinct prices doubled to nearly 1,100. But within each HRG, however defined, there are different individual patients incurring to some extent different costs of treatment. Thus the casemix of patients one hospital treats who are defined to be in HRG 'xyz123' may differ from the casemix within the same HRG that another hospital treats. The costs

that have to be incurred may differ correspondingly between the two hospitals. Thus, to the extent that a hospital is able to affect the within-HRG casemix of the patients it treats, it has a financial incentive to indulge in 'patient selection' by focusing on lower-cost patients because the price it is paid per patient is the same for all patients in that HRG.

Patient selection may be explicit or implicit. Explicit patient selection is achieved by setting exclusion criteria. For example a provider may specify that, perhaps because it lacks the full range of emergency back-up staff and facilities, it cannot accept patients with particular comorbidities or other indicators of heightened risk (e.g. age over 70, body mass index over a certain level). The result will be that, compared with a hospital that takes such patients, it will have a lower cost casemix within the relevant HRGs. Fair competition requires that providers' remuneration reflects casemix. Thus prices should vary according to the exclusion criteria applied, but for any given exclusion criteria the same price should be offered to NHS and IS providers alike.

It may also be that there is de facto patient selection whether or not there are explicit exclusion criteria. Mason and colleagues undertook an analysis, using English data for 2005/06 and 2006/07, of the casemix of NHS hospitals compared with 'treatment centres' that concentrate on a restricted range of more common non-emergency surgical procedures. Some treatment centres are NHS run and others IS. Mason et al. found that: "The evidence suggests there are casemix differences between patients treated in hospitals and treatment centres even though they are classified to the same HRG" with NHS hospitals treating an apparently more complex casemix (Mason et al., 2008 – page 41). They could not tell whether the casemix difference led to a cost difference.

Overall, the issue of casemix and its possible impact on competition implies a need for NHS commissioners of care, i.e. the PCTs who must pay for it, to monitor all providers, IS and NHS, for patient selection by analysing the characteristics of the patients they treat. Preventing patient selection may be more practical than establishing different prices for different casemixes within HRGs.

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