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**Markets and Contracting in Health Care**

by



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# MARKETS AND CONTRACTING IN HEALTH CARE

Ray Robinson and Julian Le Grand<sup>1</sup>

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## INTRODUCTION

Many countries in Europe and elsewhere are experimenting with, or are considering experimenting with, market-type mechanisms for health service delivery (Hurst 1992, Saltman and Von Otter 1992). They include the Netherlands, Sweden, New Zealand, the United Kingdom and almost all the former Soviet block countries of Eastern and Central Europe. Various known as planned markets, quasi-markets, internal markets and public competition, the proposed systems take a variety of forms. However, most involve a split between the purchasers and the providers of health services, and the consequent need for some kind of contracting relationship between purchaser and provider units. It is with this relationship that this paper is primarily concerned.

The discussion takes place in the context of just one of these market-oriented reforms, those affecting the British National Health Service (NHS). Despite this limited focus, it is hoped that there are more general lessons to be learned, lessons that would be of interest to other countries engaged in similar exercises. This is partly because the British reforms are among the furthest along the road of implementation. But they are also of interest because in some ways the change they embody is also among the more extreme of the reform proposals: the 'old' NHS was more like a command economy than almost any other health system in Europe, and the subsequent embrace of the market in the 'new' NHS was, perhaps in consequence, more passionate.

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<sup>1</sup> An earlier version of this paper was presented at a conference on Implementing Planned Markets in Health Care, Swedish Centre for Working Life, Stockholm, September 1993. We are grateful to the participants at the conference for their comments and helpful suggestions many of which have been incorporated into the paper.

For the benefit of those who may not be familiar with them, the paper begins with a brief description of the NHS reforms. It continues with a brief review of the transition from a hierarchical bureaucracy to a contract-based system within the public sector generally and the NHS in particular, followed by a summary of some of the empirical evidence on the experience of contracting during the early period of the NHS reforms. The next section considers some of the complications arising from the form of contracting that has been developed to date. In particular, it draws on the transactions cost literature in order to pose questions about the most appropriate form of contractual arrangements for health care systems. Arising from this discussion, the penultimate section offers some thoughts about directions that contracting of this kind should take if it is to economise on transactions costs, while simultaneously offering an incentive structure which is designed to improve efficiency in the provision of services. In this connection, the ideas of yardstick competition and contestability are discussed. Finally, the concluding section briefly draws together the line of argument developed in the paper.

## **THE BRITISH NHS REFORMS**

The main elements of the British health service reforms introduced on 1 April 1991 have been described in detail elsewhere (see Ham 1992, Tilley 1993, Le Grand and Bartlett 1993, Robinson and Le Grand 1994). On the demand side of the market, the key decision makers are District Health Authorities (DHAs) and General Practice Fundholders (GPFHs). DHAs are government appointed purchasing commissions that have responsibility for assessing the health care needs of their resident populations and for commissioning a mix of secondary and community health services which best meets these needs. Over the last two years there have been a number of amalgamations among DHAs - as they have relinquished their previous provider functions - and several initiatives designed to integrate DHA functions with those of other agencies responsible for the commissioning of primary care (Family Health Service Authorities) and social care (local authority social service departments). Some analysts see these moves as a precursor to the eventual development of unitary, perhaps elected, authorities responsible for commissioning primary, secondary and possibly community care (Audit Commission 1993).

Operating alongside DHAs on the demand side of the market are GP Fundholders. These GPs receive budgets top-sliced from district allocations with which they can purchase a range of diagnostic, out-patient and elective in-patient procedures for patients registered with them. The rate of growth of fundholding has proved to be one of the more unexpected elements of the NHS reforms. From small beginnings, when it was widely regarded as a "bolt-on" to the main reform agenda, fundholding has now grown to a point where some researchers are arguing that it offers the scope for an alternative, more patient-sensitive purchasing arrangement than is offered by the prevailing district model (Glennerster et al 1994; Glennerster, forthcoming).

As fundholding has spread, however, some concerns have been expressed about the existence of dual agencies with the responsibility for purchasing secondary care: one basing its decisions on individual patients' needs (GPFHs), with the other seeking to base its decisions on population health needs (DHAs). Critics of fundholding argue that comprehensive service provision and the achievement of equity objectives require population-based purchasing. Against this view, supporters of fundholding contest the distinction between 'population' needs and the needs of patients, and point to the efficiency gains that have already been achieved through the greater responsiveness of providers to GPs with actual purchasing power.

Recent attempts to resolve the dilemma of dual responsibility for purchasing have sought to use administrative guidelines in order to integrate GPFHs' purchasing plans more closely with those of DHAs. In some regions responsibility for certain of the management functions governing fundholders has been devolved to DHAs. Elsewhere a number of DHAs have set out to counteract the attractions of fundholding by devolving notional budgets to non-fundholding GPs in an effort to offer them the opportunity to influence purchasing decisions more directly without actually becoming fundholders. However, somewhat against this trend towards greater co-ordination of GP (both fundholders and non-fundholders) and DHA decisions, some existing fundholders have started to group together in consortia or "superfunds". With the appointment of superfund managers, they aim to undertake centrally many of the management functions of individual fundholders - including negotiations with providers - and thereby reap economies of scale.

Taken together, it is clear that a far more complex configuration of purchasing organisations has developed than was envisaged when the NHS reforms were announced originally. Not surprisingly, this plurality of purchasing has introduced a number of additional complications into the purchasing and contracting process.

In comparison with the demand side, the supply side of the market is more straightforward. Its key feature has been the establishment of NHS Trusts. These are quasi-independent, non-governmental organisations providing secondary and community health services. They are directly accountable to the Secretary of State for Health, and NHS Executive Regional Offices now monitor Trusts to operationalise this accountability. Compared to units that were directly managed by DHAs, Trusts have greater autonomy and freedom of action. This autonomy includes the ability to set the pay and conditions of service of their workforce; to decide upon the size and skill mix of their staff; and to exercise some limited new freedoms in relation to capital expenditure. By April 1994 95% of hospital and community services in the UK were provided by NHS Trusts (Bartlett and Le Grand 1994).

Such are the essential features of the NHS quasi-market. Within this market, it is service contracts that constitute the essential link between purchasers and providers. They make clear what services are to be provided and the terms on which they are to be supplied. In an uncertain world, they also have the important function of clarifying risk sharing arrangements which may become relevant in the face of unplanned events on either the purchaser or provider side. In short, in theory at least, contracting has replaced management hierarchy in the NHS as the principal instrument of policy implementation. This is in fact part of a wider phenomenon in the British public sector, which we must now briefly consider.

## **FROM HIERARCHY TO CONTRACT**

Towards the end of the 1980s, the British Government took a new direction in its efforts to reshape the public sector (Le Grand and Bartlett 1993). An essential element of the new approach was a move away from hierarchical or vertically integrated, forms of organisation towards quasi-market models based upon purchaser-provider separation and contractual

relationships. While contracting was not entirely new to the NHS - indeed there had been elements of competitive tendering for ancillary and for some clinical services throughout the 1980s (Ascher 1987, Ranade and Appleby 1989) - what was new was the scope of the new arrangements.

There are a number of possible explanations for this shift. But as Glennerster and Le Grand (1994) have argued, the principal motivation was probably the need to find a response to the tension between more demanding consumers of public services and limited resources. That aim led in turn to two other objectives (Harrison 1993) - objectives which, to some extent, conflict with each other. On the one hand, there was the intention to delegate more responsibility down the line of management so that lower-level managers would be given greater scope for using their own initiative. On the other hand, there was the intention of exerting more control in order to ensure efficient performance. To some extent, the apparent conflict between these two objectives was resolved by the purchaser-provider split which offered greater autonomy but within which supply-side competition was designed to exert pressure on providers for efficiency similar to the process held to operate in the private sector.

As far as the delegation of responsibility downwards was concerned, the case for pursuing this strategy was expressed in the government's White Paper, Competing for Quality (HMSO 1991) in the following terms:

*"Greater competition over the past decade has gone hand in hand with fundamental management reform of the public sector. This means moving away from the traditional pyramid structure of public sector management. The defects of the old approach have been widely recognised: excessively long lines of management with blurred responsibility and accountability; lack of incentives to initiative and innovation; a culture that was more often concerned with procedures than performance. As a result, public services will increasingly move to a culture where relationships are contractual rather than bureaucratic."*

Harrison also points out that, as well as reducing the burden of control that hierarchies impose, the move to contracting has placed greater emphasis on local choice and performance assessment. As far as choice is concerned, the internal market is based upon the assumption

that purchasers will have choice between competing providers. Whether choice actually exists in a number of quasi-monopoly markets and whether the DHA purchasing function allows choice to be extended down to the level of the individual patient is far less clear. Certainly, the popularity and growth of GP fundholding appears to have been stimulated by GPs' desire to maintain freedom to refer patients to hospitals of their choice rather than to be constrained by monolithic DHA decisions. On the other hand, some effort has been made by DHAs to operate a system of extra contractual referrals - whereby patients of non-fundholders can be referred to providers with whom the host DHA does not have a contract - with a view towards offering choice to individual patients with non-standard needs.

On the issue of performance assessment, the contract model places considerable emphasis upon performance indicators and monitoring. In principle, contracts offer an explicit format with which standards of performance can be specified and assessed. Once again, though, whether information systems are sufficiently well developed to allow for accurate monitoring is questionable (Keen 1993).

The second objective for moving from hierarchies to contracting identified by Harrison is the desire of government to exert more control over providers to ensure that they operate in the public interest. At first sight this may seem surprising as it might be thought that more control could be exerted within a hierarchial system. However, with many public sector hierarchies, it is argued, lines of accountability have become overextended with the result that self-serving provider or service-led cultures have developed. In short, provider interests dominate rather than those of users. By separating responsibility for purchasing from responsibility for providing, it is intended that this hegemony should be broken down. Certainly recent ministerial statements have reasserted the role of purchasers as champions of the people who are expected to drive the system (NHSME 1993). Whether this role is achievable will depend in part on how well purchasers actually reflect the interests of users; a perennial issue in the British system, which has never offered much power or discretion to users themselves. It will also depend, to a large extent, on the way that contracting is developed. It is to this subject that we now turn.

## CONTRACTS: THE EARLY EVIDENCE

During the first two years of the quasi-market, contracts between purchasers and providers varied a good deal according to local circumstances. However, they were all based upon three main categories: block, cost and volume, and cost per case.

Under block contract arrangements, access to a defined range of services and facilities is provided in return for an annual fee. This form of contract was particularly suited to the first year of the reforms because the NHS Executive sought to avoid major upheavals by requiring health authorities to pursue a policy of "steady state". Thus guidance offered by the Executive stated that:

*"Dramatic changes in activity would be likely to disrupt patient services, so that specifications in 1991/92 will need to describe activity based on the current pattern of services, except where planned changes have been agreed with providers."*  
NHSME (1991)

This guidance allowed new systems to be put in place but was designed to minimise changes in patient flows and patterns of service delivery. As such, block contracts were able to reflect - albeit in contractual form - levels and patterns of activity that were already taking place. They also had the important practical advantage of being the least demanding in terms of information requirements. As a result, many purchasers simply took out block contracts with their local providers which reflected levels of activity and funding that were previously supplied by the provider within the pre-reform, unitary health authority. At the same time, however, even block contracts were more specific than the old style arrangements in terms of the requirements placed upon providers.

Variations in activity around indicative volumes were expected to be one of the main problems in operating block contracts. Providers might fail to use capacity to the full or treat more cases than had been agreed and funded. To cope with this problem, most block contracts specified ceilings and floors which permitted some variation around the expected level of activity. If actual activity fell outside this range, cost and volume arrangements came into operation.

A cost and volume contract specifies that a provider will supply a given number of treatments or cases at an agreed price. It allows the service specifications to be made more specific than is generally the case with a block contract. Greater emphasis is placed upon services defined in terms of 'outputs', that is, patients treated, rather than in terms of 'inputs', that is, the facilities provided. If the number of cases exceeds the cost and volume agreement, extra cases have usually been funded on a cost per case basis.

Cost per case contracts are defined at the level of the individual patient. Because they obviously involve a considerable level of transactions costs, health authorities have mainly used cost per case contracts to fund treatments that fall outside of block or cost per volume contracts. Referrals by GPs to providers with whom districts do not have prospective contracts, that is, 'extra-contractual' referrals, have been the main form of district purchasing covered by cost per case contracts. Many services bought by GP fundholders have also been covered by cost per case contracts.

Not surprisingly, the majority of contracts taken out by DHAs in 1991/92 were block contracts. Table 1 shows that 83% of contracts for acute services, by volume, were in this form - either simple block contracts or contracts specifying ceiling and floor levels of activity. In terms of value, the dominance of block contracts was even greater - accounting for 94% of the total value of contracted services.

**Table 1: Contracts for Acute Services 1991/92**

Contract Type	Number	Value (£m)	% of Number	% of Value
Block	1131	4346.5	40.7	60.4
Block with ceiling and floor	1179	2434.5	42.4	33.8
Cost and volume	169	314.1	6.1	4.4
Cost per case	108	17.6	3.9	0.2
RHA agency contracts on behalf of DHA	191	85.9	6.9	1.2
Total	2778	7198.6	100.0	100.0

**Note:** Based upon returns from 101 DHAs.

**Source:** NAHAT, Purchasers Survey, 1992.

Moreover, the steady state requirement meant that most contracts replicated existing patient flows. Thus, as Table 2 indicates, block contracts placed with providers within the purchaser's own district accounted for the bulk of services, in value terms, in 1991/92. The size of these contracts - at an average value of £11.5 million - meant that they represented nearly 80% of the total value of contracted services although they accounted for only 18% of the total number of contracts.

**Table 2: Providers for Acute Services Contracts, 1991/92**

Type of Provider	Number of Contracts	Value (£m)	% of Number	% of Value
NHS provider within district	488	5610.1	17.8	78.6
NHS provider outside district	2161	1503.4	78.6	21.1
Private sector	13	1.5	0.5	0.0
Voluntary sector	67	9.4	2.4	0.1
Other	19	12	0.7	0.2
Total	2748	7136.4	100.0	100.0

**Note:** Based upon returns from 101 DHAs.

**Source:** NAHAT, Purchasers Survey, 1992.

As the steady state requirements were relaxed, however, there were signs that some DHAs started to use the contracting system in order to change the mix of services they commissioned and the terms on which they received them. A national questionnaire survey of DHAs' intentions for 1992/93 carried out by NAHAT (Appleby *et al* 1992) showed that 61% of purchasers aimed to terminate some of their existing contracts and that 71% intended to contract with new providers. Another survey by NAHAT (Appleby *op cit*) also showed that among providers in the West Midlands Region (the largest Region in the country covering a population of 5.2 million people) more detailed cost and volume contracts were due to increase from 1.7% to 10% of the total between 1991/92 and 1992/93 with block contracts falling from 97% to 89% of the total over the same period. The proportion of block contracts still remained large, however.

The rapid implementation of contracting encountered a number of problems, most notably the lack of good information. Thus when the same survey questioned DHAs about the difficulties they had experienced in the contracting process, obtaining accurate data on

comparative costs, on patient flows, and on GP referrals were all cited as major problems by over 50% of districts. Monitoring performance was also proving difficult with over 90% of DHAs citing the late arrival and poor quality of information supplied by providers as a major source of difficulty.

The general picture to emerge from these early findings is of an erstwhile hierarchy-based service grappling with the problems of rapid implementation of a new style contracting system over an extremely tight timetable. Despite adherence to the steady state requirement in the first year of contracting, a number of difficulties were encountered. Over time, however, expertise is increasing and a perceptible movement away from the coarse mechanism of block contracting is taking place. In the future, as information systems become more sophisticated, less reliance will be placed on block contracts. For example, as better quality cost information becomes available, price tariffs based on more refined costings can be expected. In this connection, the national case-mix office of the NHS Executive has already made a software package of health related groups (HRGs - the UK version of DRGs) available to NHS providers as a basis for costings.

But these developments are not without their own problems. As contracting becomes more precise it may well lead to steeply rising transactions costs. The early evidence of cost per case contracting in connection with extra contractual referrals and GP fundholder patients already confirms this tendency. This raises questions about the most appropriate contractual arrangements for the longer term.

## CONTRACTS AND TRANSACTIONS COSTS

It has already become clear that the contracting process has incurred substantial costs. Setting up systems for recording, costing and billing has involved large investments in information systems. Many of these items of expenditure are non-recurring and will not be a source of higher costs in the future. But other costs will persist, particularly those associated with continuing transactions between purchasers and providers. These will constitute an additional category of expenditure that was not incurred under the pre-reform, unitary system.



In fact, the possibility that excessive transactions costs may be a source of inefficiency for market or quasi-market mechanisms has attracted the attention of a number of economists over the years. In particular, the work of Williamson (1975, 1986) has sought to identify those factors which, if present, mean that market contracts will be expensive to write, complicated to execute and difficult to enforce. If these conditions apply, firms may choose to bypass the market and rely upon internal, hierarchical forms of organisation instead. Hence, transactions that would otherwise have taken place in the market are dealt with internally through administrative processes. Put another way, management hierarchies and markets can be viewed as alternative methods of economic organisation for dealing with transactions. The choice between them should depend upon their relative efficiency.

In his work, Williamson identifies three features which, taken together, can be expected to favour internal organisation over market transactions. These are bounded rationality, opportunism and asset specificity.

Bounded rationality means that decision makers, whilst seeking to act in a rational manner, can only be expected to do so to a limited extent. The bounded nature of behaviour arises because the capacity for individuals to formulate and solve complex problems is necessarily limited. These limitations become particularly important when faced with uncertainty about the future. If it becomes very costly or impossible to identify all future contingencies, and to specify adaptations to them, it may be more efficient to replace contract arrangements with internal, hierarchical organisations.

Opportunism refers to behaviour whereby individuals can be expected to pursue their interests through devious means. They may seek to derive advantage from the selective or distorted disclosure of information, or from making false promises. Information may be manipulated in a strategic fashion and intentions may be misrepresented. The existence of opportunism means that uncertainty is introduced into contractual arrangements as neither party can rely on the other one honouring non-legally binding promises. In such a world, internal organisation may be a more effective means of controlling opportunism. It permits additional incentive techniques to be developed in order to curb opportunistic behaviour. In the limit, this may be achieved by fiat.

Asset specificity arises when transactions require investment in assets - both physical and human - that are specific to these transactions. As such, the parties to a contract have a continuing interest in each other because the nature of the commodity being traded depends upon an ongoing supply relationship. This arrangement is the converse of a spot market, where deals are struck by anonymous buyers and sellers. With asset specificity, market competition is liable to break down, as existing suppliers will enjoy advantages in relation to new entrants.

Hence the transactions cost approach suggests that when bounded rationality, opportunism and asset specificity are all present, internal organisation may be more efficient method of economic organisation than market-type contracting between separate units. In the context of market-oriented health service reforms, this consideration raises the obvious question: Will transactions involving health services display these characteristics?

On the first characteristic - that of bounded rationality - there seems to be little doubt that this applies to health services. The nature of health and social care is highly complex, with major areas of uncertainty regarding, *inter alia*, the cost of individual services, their quality and, most important of all, measures of their outcome.

Whether opportunism will be a problem is less clear. Health service provision is traditionally viewed as embodying a set of values - based upon professional ethics and caring - which might be expected to exclude self-seeking and opportunistic behaviour. On the other hand, it would be naive to suggest that the strategic pursuit of self-interest has not always represented an element of health service provider behaviour, whether through corporate or professional vested interests. Whatever else it achieves, it seems extremely likely that the introduction of a more market-based approach will increase the incidence of this behaviour, and hence the potential for opportunism.

Asset specificity is another characteristic which seems to apply with particular force to health care services. Few of these services correspond to the simple type of consumer good which allows a person to enter a store, choose an item from the shelf, pay for it and disappear into

the anonymity of private consumption. Much health care is a continuous, or at least a long term, process involving treatment by a variety of agencies in many different contexts. This is especially true of long term care and the treatment of chronic conditions. Even in the case of elective surgery, however, there is a complex chain stretching from pre-admission assessment through in-patient or day case treatment to post-discharge care. All of these considerations suggest that continuity in relations between purchasers and providers is likely to be important.

Taken together, therefore, there are strong reasons for believing that the conditions highlighted by the transactions cost approach are present in health services. One interpretation of how this might be expected to influence the contracting process between purchasers and providers has been put forward by Bartlett (1991). As he points out, block contracts have been the dominant form of contract in the NHS in the short run. These specify an annual fee in return for access to a defined range of services. They are broad-brush and do not endeavour to specify prices for every eventuality. For this reason, they are necessarily incomplete and subject to opportunism. In particular, Bartlett believes that, despite the creation of mechanisms for measuring performance, opportunistic behaviour could lead to reductions in the quality of service provision, to an over-emphasis on prestige treatments, and to an increase in organisational slack in the form of increased perks and side payments to staff. These can all be expected to raise the cost of services above the efficient level.

All of these considerations may be taken to suggest that efforts to create a quasi-market with a separation of purchaser and provider functions might be misplaced. Paradoxically, the transactions costs approach seems to suggest that the pre-reform hierarchical structure within a unitary health authority may have been the more efficient organisational structure, after all.

However, before reaching this judgement, some additional considerations need to be taken into account. Most notably, there is the role to be assigned to incentives.

## INCENTIVES AND PERFORMANCE

Much of the case for the kind of internal market introduced in the British NHS rests upon the belief that supply-side competition between rival providers will be a source of increased efficiency. It is recognised that there may well be extra transactions costs. However, the government believes that efficiency gains in service delivery due to competition will more than offset these. Whether they will or not is an empirical question that cannot be answered with certainty at the moment. But the case for introducing an incentive structure for increased efficiency is a powerful one. Indeed, Williamson himself points out that the vertical integration of firms must take place within the context of a competitive market for their final products and also for capital funds. These conditions provide external checks on the firm's efficiency. Now it is precisely the absence of such checks which led to the proposal for an internal market in the first place (Enthoven 1985). Without separate purchaser and provider functions, there would be no scope for the counterpart of competition in a final product market.

How can these apparently conflicting requirements be resolved? How can incentives be preserved but, in the light of transactions costs, the most efficient form of purchaser-provider organisation be devised? Consideration of the theoretical literature and available empirical evidence (usefully reviewed in Propper 1993a) suggests that one approach would be to encourage purchasers and providers to enter into longer-term, contractual relationships rather than to view their task as one of making spot market deals. This would avoid excessive transactions costs. Certainly, modern approaches to industrial organisation and marketing emphasise the essentially collaborative nature of purchaser-provider relations (Davies 1991). Collaboration is a pre-requisite for the effective sharing of information. In practice, this takes place far more widely in the private sector than discussions within the NHS generally allow.

With a move towards longer-term contractual arrangements, competition for markets - at the time of periodic contract negotiation - replaces competition within markets. In other words, there is competition through franchising. At the same time, however, mechanisms for ensuring efficient behaviour over the duration of a contract period are still required.

Responsibility for monitoring the performance of the market and undertaking remedial action where necessary falls most logically to some form of regulatory agency (Propper 1993b). At the time of writing, it is unclear how this role will be performed within the NHS. But whatever organisational structure is chosen two particular concepts are likely to be relevant to the ways in which regulatory agencies carry out their work; namely, yardstick competition and contestability.

## **REGULATION, YARDSTICKS AND CONTESTABILITY**

Yardstick competition is a device used by regulators which enables them to encourage efficiency in monopoly industries (Vickers and Yarrow 1988, Kay and Vickers 1990). It is a way of bringing firms in distinct markets indirectly into competition with each other. In its simplest form, it operates through the regulation of pricing policy. Thus, when regulators lack information on individual firms' cost structures, the price that any firm may charge is set equal to the industry's average costs. Faced with this constraint, profit-maximising firms will have an incentive to increase productive efficiency because they will thereby be able to increase their profits through cost reductions. Moreover, dynamic efficiency will also be encouraged because, if a firm discovers a new technology, it can reap the benefits of this superior technology until other firms catch up. Conversely, firms that do not catch up incur losses.

The yardstick competition approach is not without problems. There may be special factors beyond management's control which lead to higher costs in some firms. Regulators need to identify these instances and take them into account. Experience suggests that there will be a tendency for all firms to argue that they face special circumstances. There may also be a tendency for firms to collude and thereby avoid the need to cut costs if they perceive yardstick competition as a "zero-sum game". But, possibly most importantly, there may be a danger that firms facing price constraints will try to retain profitability by reducing the quality of their products. If this danger arises, regulators need to extend the yardstick to qualitative features.

How might these ideas be applied to long-term contracting within health services? In their contracts, purchasers and providers could be required to set a price for a particular service based on long-run average cost for that service in the country as a whole. Providers would be free to retain any surpluses they made on the contract; hence they would have an incentive to reduce their costs below the national average. Special prices could be negotiated for providers with above average costs for reasons beyond management control; if, for instance, the higher costs arise because of the geographical location of the provider (such as an inner city site), then setting the yardstick price on a local basis might be more appropriate than on a national one.

If this kind of scheme were applied in the British NHS, it would entail some significant changes. First, it could be used only for cost-per-case and cost-and-volume contracts; purchasers and providers would thus have to shift their contracting procedure towards these and away from block contracts. Second, Trusts are currently only allowed to price according to their own (short-run) average costs, and cannot retain their surpluses. They would now have to price according to the yardstick, and at the same time be given the freedom to retain surpluses. But all these changes in fact seem desirable in any case. The extensive use of block contracts gives free rein to opportunism. Instructions to price according to own average cost may be unenforceable since the regulatory authorities do not have sufficient information properly to assess the costs for each individual provider; providers, particularly those in monopoly positions may well inflate their costs when reporting to the regulator (Ferguson and Palmer 1994). Even more seriously, the inability to retain surpluses gives Trusts little incentive to respond to market signals of any kind. In short the application of yardstick competition to the NHS would not only be of direct benefit in reducing transactions costs and encouraging competition, but would bring useful gains in its wake by refining the operations of the quasi-market in key areas.

In a recent paper Dawson (1994) has claimed that the own-cost pricing regulation currently in force in the NHS is likely to fail. The NHS market is characterised by contestability, small numbers and a high proportion of fixed costs; and the experience of such markets in the private sector, she argues, shows that prices tend to be negotiated between purchasers and providers, tend to be unique to each transaction and are usually secret. Regulators, she

claims, will be unable to enforce behaviour contrary to the underlying incentives generated in these kinds of markets.

Does this argument also apply to yardstick competition of the kind suggested here? We believe not. This is basically because, under yardstick competition, regulators have a much easier task than under an own-cost pricing regime. In order to perform their monitoring role, they do not need to check the costs of each and every provider; they simply need to know the price charged in each transaction to compare it with the yardstick price. This price will be incorporated into the contract document; hence keeping it secret would be difficult if not impossible. The focus for competition would be on quality, not on price; and the incentive for providers would be to cut costs, not to negotiate different prices.

'Yardsticks' defining clear standards of performance could also be used to assess the quality of service of different providers, and thereby to restrict opportunistic behaviour. In recent years, NHS performance indicators have been developed for a similar purpose. However, it is unlikely that performance indicators in their present form, that is, measures based primarily on inputs and activities, will provide the information that purchasers require. Similarly, aggregate measures such as the "efficiency index" through which purchasers are currently required to meet annual performance targets are also likely to be inadequate (Appleby and Little 1993). Over time, new indices of performance will need to be developed for assessing the standards of service offered by purchasers and providers (in terms of its cost, quality and outcomes) and for seeking improvements in these standards if they fall behind those achievable elsewhere (Appleby *et al.*, 1993).

Most improvements in standards should be achievable through negotiation and mutually agreed action between purchasers and providers. However, there may be some cases where, for example, a purchaser is unable to obtain the standard of service it believes reasonable from its main provider. In such cases, alternative provider arrangements must be a feasible course of last resort. Unfortunately, the reliance on a long-term contractual relationship with an existing provider may mean that there are no comparable providers in the local market area. A local monopoly may have grown up. This, however, is where the concept of contestability becomes relevant.

Unlike a competitive market, a contestable market does not require the actual presence of a competitor; rather, it is the threat of new entrants to the market that acts as the stimulus for existing firms to act efficiently (Baumol 1982). If existing providers allow their prices to rise too high, or the quality of their service deteriorates too far, new entrants may be attracted to the market in the belief that they will be able to out-perform existing providers. Even here, though, there is a problem. The provision of health care requires substantial investment costs in buildings and equipment, and also considerable expenditure on initial staffing costs. These are likely to constitute a significant barrier to entry for new providers to a market. And so, outside of those services where patients can be expected to travel for treatment, the checks on existing providers offered by contestability may be muted.

One way out of this difficulty is suggested by Culyer and Posnett (1990). They argue that:

*"Although the idea of contestability refers normally to the ease of entry of new firms ... , it is useful also to extend the notion to that of 'managements' which can see similar opportunities. The industrial ownership structure of the NHS lends itself conveniently to this sort of strategy, whether the hospitals whose management may be put out to tender are under the direct control of health authorities or Trusts. The implication is, of course, that some managements may disappear altogether, others may be recycled (probably in reconstituted form) elsewhere in the system, while, for all incumbent managements, there will be a continuing threat of their replacement."*

Thus, Culyer and Posnett envisage the possibility of management teams, and indeed other groups of health workers, bidding for franchises which would periodically be recontracted by regional health authorities or the Department of Health.

How far it would be practicable for policy to proceed in this direction is a matter for debate. Obviously, problems would arise in the transition period from one management to another. There is also the question of asset management: who would be responsible for asset maintenance and investment, returns from which overlapped the length of the franchise? And where would the competing management teams be found? We cannot answer these questions here. But the line of thought does open up a range of possibilities for encouraging efficiency among providers in erstwhile monopoly or quasi-monopoly situations.

## CONCLUDING COMMENTS

This paper has argued that the movement from hierarchical systems of control to quasi-market arrangements based upon contractual arrangements has been a general one within the public sector in the UK during the 1980s. The NHS reforms involving the introduction of an internal market based upon purchaser-provider separation is one aspect of this trend. The government's view is that the traditional hierarchical approach lacked the appropriate incentives for efficiency and led to over-concern with procedures rather than performance.

At the same time, however, while this trend has been in progress, critics have pointed to the excessive transactions costs that are sometimes incurred as part of the contract process. In doing so, the work of economists such as Oliver Williamson has been drawn on to raise the possibility that the former hierarchical approach may actually have been more efficient overall. As far as the NHS is concerned, resolution of this issue clearly depends upon the collection of more empirical evidence about the costs and benefits of alternative systems of organisation.

In the meantime, this paper has sought to offer the outlines of a strategy which seeks to economise on transactions costs but retain incentives for more efficient performance. The essential features of this strategy are longer-term contractual relationships between purchasers and preferred providers, backed up by yardstick competition and management franchising. In many ways, this is a natural development of the model of managed competition that has been developed in the NHS over the last three years.

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