Available online at www.sciencedirect.com
ScienceDirect
Health Policy 83 (2007) 17–26
HEALTH policy
www.elsevier.com/locate/healthpol

A transaction costs analysis of changing contractual relations in the English NHS

Giorgia Marini, Andrew Street *

Centre for Health Economics, University of York, York YO10 5DD, UK

Abstract

The English National Health Service has replaced locally negotiated block contracting arrangements with a system of national prices to pay for hospital activity. This paper applies a transaction costs approach to quantify and analyse the nature of how contracting costs have changed as a consequence. Data collection was based on semi-structured interviews with key stakeholders from hospitals and Primary Care Trusts, which purchase hospital services. Replacing block contracting with activity based funding has led to lower costs of price negotiation, but these are outweighed by higher costs associated with volume control, of data collection, contract monitoring, and contract enforcement. There was consensus that the new contractual arrangements were preferable, but the benefits will have to be demonstrated formally in future.

Keywords: Contracts; Transactions costs; New institutional economics; Activity based financing; Payment by results; Patient choice; HRGs; DRGs

1. Introduction

The NHS in England is following the USA, Australia and many countries in Europe in introducing activity based funding, a system of paying hospitals and other providers on the basis of the work they do [1]. The key differences to previous contracting arrangements are that prices are fixed nationally, hospital revenue is directly proportional to activity, and activity ceilings have been relaxed. Hospitals receive a fixed payment – the national tariff – for each type of patient treated. Termed Payment by Results (PbR), the policy rewards hospitals for volumes of work adjusted for differences in casemix. Casemix is defined by the Healthcare Resource Groups (HRG) to which each patient is allocated [2].

Along with the change in the form of contracting, NHS patients are being given a choice of hospital. By and large, in the past NHS patients requiring elective (non-urgent) care simply had to wait until their local hospital admitted them. Now patients are offered a choice about where and when they receive treatment and the options include both NHS (public) and independent sector (private) hospitals [3].

The overhaul of contractual relations is intended to provide stronger incentives for NHS hospitals to

* Corresponding author. Tel.: +44 1904 321445; fax: +44 1904 321454.
E-mail address: ads6@york.ac.uk (A. Street).

0168-8510/$ – see front matter © 2006 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2006.11.007

increase activity and/or lower costs. PbR links hospital income and activity much more closely than previously has been the case. If they receive a fixed payment, hospitals should be encouraged to find ways to cut costs and reduce length of stay in order to find capacity to accommodate more patients. Access should improve because hospitals have a direct financial incentive to do more work—they receive extra funds for each additional patient they treat. In the past purchasers may have been reluctant to refer patients and hospitals reluctant to accept patients not included in their formal contracting arrangements because of the difficulties of dealing with one-off financial matters. The new system is intended to remove these financial obstacles, and therefore to allow patients greater choice of hospital.

However, it may not be costless to realise the benefits that might arise from the changed contracting regime. The Audit Commission, an independent body established to monitor public spending, reported that "payment by results has been time consuming and costly to implement. The additional burden on senior management, particularly where formal disputes arose, was often significant" [4].

This paper applies a transaction costs approach to quantify and analyse the nature of how contracting costs have changed as a result of the contracting reform. Section 2 presents a description of the analytical framework and of the nature of contracting arrangements in the NHS. Section 3 describes the empirical approach and source of data. Results are presented in Section 4 and concluding comments offered in Section 5.

2. Contracting arrangements

The theoretical framework for identifying and quantifying transaction costs is that of New Institutional Economics (NIE), originated by Coase [5] and developed by Williamson [6,7]. This framework has been applied to analyse the costs associated with changing contractual arrangements in a number of health care contexts [8–13]. Essentially, the approach provides insight into organisational structure in terms of the contractual relationships required to support it, defining the associated costs as transaction costs.

Transaction costs arise in any situation of imperfect agency, where bounded rationality and opportunism give rise to incomplete contracts between the principal and agent [14,15]. Bounded rationality describes the limitations of either party to act as fully informed rational agents, because of the complexity of the decision-making process and uncertainty about future events. Opportunism refers to the pursuit of individual self-interest, where the goals of the agent do not coincide with those of the principal. It is costly to manage the impact of bounded rationality and opportunism, and the level of costs varies according to the governance arrangements between principal and agent. Most of the NIE literature compares the choice of governance structure between hierarchical arrangements and market-type arrangements [7,16,17].

Market-type arrangements between a payer (principal) and provider (agent) rely on detailed specification of the contract between the two parties in order to limit the possibility of opportunistic behaviour. But, under conditions of uncertainty, bounded rationality may make it costly to arrive at a precise contractual specification. Less formal contracts are required in a hierarchical system where a manager (principal) can tell a subordinate (agent) what to do as circumstances arise. But subordinates usually face low powered incentives and lack detailed specification of their role, which allows them greater scope to act opportunistically, particularly with respect to the effort they apply to furthering the principal's objectives. To counter this tendency, the principal in a hierarchical governance structure has to monitor more closely whether the subordinate actually does as instructed.

The level of transaction costs and optimal governance structure also depend on the nature of the exchange that constitutes the basis of the relationship between principal and agent. Frequent and repeated exchanges are likely to entail lower transaction costs, because the parties are able to learn more about the circumstances of the exchange and about each other's behaviour and are less likely to wish to jeopardise a potentially long-term relationship by behaving opportunistically in the current situation. Costs will also be lower in contexts where assets are highly specific to the particular agreement, meaning that they cannot be diverted easily to other tasks. Each party has more at stake, and is less likely to risk undermining the relationship by opportunistic behaviour.

As well as describing the factors that drive transaction costs, the NIE literature classifies costs in terms of the time at which they occur during the contractual