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The Uk Experience in Implementing an Economic Mechanism to Enhance the Competitiveness of the Private Healthcare Services Market

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Abstract: This article examines the economic mechanisms that shape the competitiveness of private and independent healthcare providers within the healthcare system of the United Kingdom, with particular emphasis on England. The analysis interprets the relationship between the National Health Service (NHS) and the independent sector not simply as competition between the public and private sectors, but as an interconnected system comprising publicly funded demand, patient choice, activity-based payments, transparency of quality and price information, provider regulation, and antitrust oversight. Based on the 2025 NHS–Independent Sector collaboration agreement, the 2026/27 NHS Payment Scheme, and mechanisms for ensuring transparency of information in the private healthcare market through the Private Healthcare Information Network (PHIN), the article identifies the key economic channels through which competition is fostered. For Uzbekistan, the study proposes the gradual establishment, within the state health insurance system, of a mechanism based on the following sequence: “accredited provider – unified base tariff – patient choice – payment for services delivered – quality coefficient – transparent rating.”

Keywords: United Kingdom, England, private healthcare services, NHS, competitiveness, NHS Payment Scheme, patient choice, PHIN, CMA, quality, public procurement.

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1. Introduction

The healthcare model of the United Kingdom is widely regarded in international practice as a classical example of a national healthcare system financed primarily through taxation. However, the dominant position of the National Health Service (NHS) does not imply the absence of a competitive environment for private and independent healthcare providers. On the contrary, recent reforms have placed increasing emphasis on utilizing the capacity of the independent sector to provide services to NHS patients, expand patient choice, and ensure greater transparency of information concerning provider performance.

In England, the concept of independent healthcare encompasses healthcare services provided by the private sector that fall outside NHS trusts or NHS general practitioner (GP) services. The Care Quality Commission includes private companies, charitable organizations, social enterprises, voluntary organizations, and individual providers within this sector [1]. Thus, the private healthcare market is not homogeneous in terms of ownership structure.

The academic significance of this system lies in the fact that the competitiveness of a private provider is shaped not only within the market for privately funded healthcare services, but also by its ability to access the market for NHS-funded services, operate

effectively under established payment rules, gain an advantage in patient choice, and provide transparent information on the quality of care.

On 6 January 2025, NHS England and the Independent Healthcare Providers Network announced a new collaboration agreement aimed at supporting the recovery of elective care. The agreement identified several priority areas, including taking the capacity of independent providers into account in local service planning, strengthening patient choice, utilizing transparent payment mechanisms, improving the quality of reporting and data, and jointly developing workforce capacity [2].

The agreement considers the independent sector not as an external competitor to the NHS, but as a provider capable of creating additional capacity and choice within the overall pathway of care. It states that Integrated Care Boards should take into account the capacities of both NHS and independent providers when planning to meet local healthcare needs [2]. This links the competitiveness of the private sector to its ability to participate in publicly commissioned healthcare services.

The 2026/27 NHS Payment Scheme came into effect on 1 April 2026 and establishes the payment rules and prices applicable to healthcare services funded by the NHS [3]. Under the scheme, NHS service providers other than NHS trusts and foundation trusts are classified as “non-NHS providers.” For services subject to NHSPS unit prices, almost all activity delivered by such providers is governed by activity-based payment rules [3].

At the same time, reducing information asymmetry in the privately funded healthcare market represents a distinct area of competition policy. The Competition and Markets Authority’s 2014 Private Healthcare Market Investigation Order requires private hospitals to publish performance data and consultants to disclose information on their fees through the Private Healthcare Information Network (PHIN). On 2 July 2026, the CMA confirmed that full compliance with these transparency requirements—the “gold milestone”—had been achieved [4].

The study of competition in the English healthcare system rests on a substantial empirical foundation that directly informs the present analysis. Gaynor, Moreno-Serra and Propper, examining reforms in England, identified positive effects of patient choice and hospital competition on clinical outcomes under conditions of regulated prices [5], while Cooper et al. showed that outcomes improved in more competitive markets during the period in which patient choice was expanded [6]. Subsequent work established that the removal of choice constraints made patients more responsive to clinical quality and increased the demand elasticity faced by hospitals [7], and that stronger competitive pressure was associated with higher managerial quality in public hospitals [8].

The evidence, however, is not uniform. Moscelli, Gravelle and Siciliani found that for several high-volume elective treatments public hospitals facing more rivals did not improve, and in some dimensions reduced, quality under fixed regulated prices [9]. Studies of independent-sector entry reveal a similar duality: competition from private surgical centres shortened pre-surgery length of stay in neighbouring NHS hospitals, yet the entrants treated a healthier case mix [10], and private hospital entry altered the composition of publicly funded elective activity [11]. Reviews of the English experience conclude that the effects of competition depend on whether prices are regulated, how quality is measured and published, and how referral and commissioning mechanisms function [12], [13], [14].

Two parallel domains of competition therefore need to be distinguished in the UK system: provider choice for patients and commissioners within NHS-funded services, and competition in the fully private market, where price, consultant, hospital and outcome information serve as the key competitive factors. Existing research concentrates mainly on the first domain and on the behaviour of public hospitals, whereas the economic mechanism shaping the competitiveness of private and independent providers

themselves, together with its applicability to countries introducing state health insurance, remains insufficiently examined. The present study is directed at this gap.

2. Materials and Methods

The study employed institutional and comparative analysis, functional grouping, cause-and-effect analysis, analysis and synthesis, and logical generalization. The experience of the United Kingdom was examined primarily through the case of England, with particular attention to the mechanisms of NHS financing and the regulation of private healthcare. The elements of the economic mechanism were systematized according to the following sequence: “demand financing – provider choice – payment – quality – information – competition oversight.”

3. Result and Discussion

The first distinctive feature of the UK experience is the impact of publicly funded demand on the competitiveness of private providers. When an NHS patient receives treatment from an independent-sector provider under specified conditions, the source of demand for the private organization is not the patient’s personal income but public funding. This expands the potential market for the private sector and prevents competition from being confined to segments of the population with higher purchasing power.

The second feature is the activity-based payment mechanism. Under the 2026/27 NHS Payment Scheme, where a non-NHS provider delivers a service for which an NHSPS unit price has been established, the commissioner pays the applicable NHSPS price for each unit of activity delivered [3]. This mechanism links the private provider’s revenue directly to the volume of services actually delivered.

The third feature is the financial support for patient choice through the alignment of unit prices for NHS and non-NHS providers in elective services. Documents relating to the 2026/27 payment policy indicate that non-NHS and NHS providers are paid at 100% of the applicable unit price for elective activity, thereby facilitating patient choice and enabling funding to follow the patient [15].

The fourth feature is the regulation of quality and safety alongside market access. The Care Quality Commission (CQC) oversees independent healthcare services as a distinct category of regulated providers [1]. Access to the market for NHS-funded services is in turn governed by the statutory framework introduced by the Health and Care Act 2022 [18] and by the provider selection rules applied by commissioners when awarding healthcare contracts [19]. Consequently, the competitiveness of a private clinic depends not only on price and marketing, but also on its ability to comply with regulatory requirements and provide safe healthcare services.

The fifth feature is the conversion of patient choice into an economic signal. The 2025 elective reform plan provides patients with greater choice and control over where and when they receive treatment [16]. When funding is directed to the provider selected by the patient, patient flows become a market signal for providers.

The sixth feature is the integration of independent-sector capacity into the NHS planning system. The 2025 collaboration agreement stipulates that Integrated Care Boards (ICBs) should take existing independent-sector capacity into account when planning local services and, particularly in specialties and areas with high waiting lists, involve the sector in relevant discussions [2]. As a result, private-sector capacity becomes not merely an excess or reserve resource within the system, but an instrument for meeting demand.

The seventh feature is the relationship between data quality, payment, and competition. All providers working with the NHS are required to maintain accurate clinical coding in accordance with national standards [2]. Since inaccurate coding can

distort revenue and expenditure analysis under activity-based payment, data quality becomes an independent determinant of economic efficiency.

The eighth feature is information transparency in the privately funded healthcare market through PHIN. The CMA's 2014 Order is aimed at providing private patients with information on outcomes and fees to support their choice of hospitals and consultants [4], [17]. As information asymmetry decreases, clinics are required to compete not only through brand-based marketing but also through comparable outcome information.

The ninth feature is the existence of competition policy and antitrust oversight. The CMA's investigation of the private healthcare market was based on identifying market characteristics that could adversely affect competition and addressing them through measures such as greater information transparency [4]. This demonstrates that supporting competitiveness is not equivalent to granting preferential treatment to private clinics.

The tenth feature is the interdependence between the NHS and the private sector in the labour market. The 2025 agreement stipulates that the capacity offered by independent providers to the NHS should not have a significant adverse effect on the local NHS workforce, while opportunities for joint training should also be developed [2]. Accordingly, the competitiveness of the private sector should not be achieved at the expense of weakening the overall healthcare workforce base.

The eleventh feature is the differentiation of payment mechanisms according to the type of provider. Under the 2026/27 NHSPS, aligned payment and incentive arrangements and low-volume activity mechanisms are applied primarily to NHS providers, whereas activity-based payment is applied to non-NHS providers for services with an established unit price [3]. This distinction takes into account the contractual and cost characteristics of each sector, while common unit prices for elective activity support patient choice.

The twelfth feature is that the objective of competition is not the mechanical redistribution of market share in favour of the private sector. The NHS-Independent Sector collaboration agreement identifies high quality, patient interests, and value for the taxpayer as key objectives [2]. Therefore, the economic efficiency of private providers should be assessed simultaneously with the efficiency of public fund utilization.

Table 1. Economic Mechanisms Shaping the Competitiveness of Private Healthcare Services in the United Kingdom

Mechanism	Mode of operation	Channel of impact on competition	Outcome for private providers
NHS commissioning	Procurement of NHS services from the independent sector	Demand financed through public funds	Expansion of the patient base
Activity-based payment	NHSPS price paid for each unit of activity delivered	Links service volume with revenue	Incentive to utilize capacity
Patient choice	Choice between NHS and alternative providers	Patient flows become a market signal	Competition in service provision and quality
CQC regulation	Quality and safety oversight	Establishes a minimum quality threshold	Trust and regulatory compliance
PHIN transparency	Disclosure of outcomes and consultant fees	Reduces information asymmetry	Differentiation based on outcomes
CMA oversight	Legal measures addressing competition concerns	Limits barriers to competition	Fair competitive environment
ICB planning	Consideration of local independent-sector capacity	Alignment of demand and capacity	Contracting opportunities

Source: Developed by the author based on official and academic sources.

As shown in Table 1, the economic foundation of the competitiveness of private healthcare services in the United Kingdom is based not on direct state subsidies, but on the integration of private providers into the system for meeting overall healthcare demand. The state finances demand, establishes payment rules, and oversees quality, while providers compete through capacity, service quality, and outcomes.

Within this mechanism, a key advantage of activity-based payment is that reimbursement is directly linked to services actually delivered. However, strong incentives based on service volume may also create a risk of increasing the provision of services that are not necessarily required. Therefore, the payment system needs to operate in conjunction with clinical standards, commissioning arrangements, and data oversight.

Table 2.Functional Model of Economic Relations between the NHS and the Independent Sector

Stage	Key participant	Economic decision	Oversight / Information	Final impact
Needs assessment	ICB / NHS	Assessment of demand for capacity and services	Waiting lists, geographical area, specialty	Commissioning direction
Provider access	NHS + independent provider	Contract and service profile	Regulatory requirements	Market entry
Patient choice	Patient / referrer	Choice of treatment provider	Choice-related information	Patient flows
Service delivery	Provider	Utilization of capacity and resources	Clinical coding	Activity volume
Payment	Commissioner	NHSPS unit price	Activity data	Revenue
Quality assessment	CQC / NHS / PHIN	Compliance and outcomes	Quality / outcome data	Reputation
Competition oversight	CMA	Assessment of market conduct	Transparency and market information	Competitive environment

Source: Developed by the author based on official and academic sources.

As illustrated in table 2, the formation of competitiveness within the functional model begins not when the patient enters a clinic, but with the planning of local healthcare needs and available capacity. In this context, the competitive position of a private provider within the NHS system is reflected in the combined ability to gain access to contracts, maintain accurate clinical coding, provide the required capacity, comply with quality standards, and remain attractive to patients.

Table 3. Matrix for Adapting the UK Experience to the Context of Uzbekistan

UK Element	Advantage	Potential risk	Adaptation for Uzbekistan	Outcome indicator
Activity-based payment	Funding follows the service	Artificial inflation of service volume	Base tariff + clinical oversight	Service volume / expenditure
Patient choice	Strengthens competition on quality	Choice based on insufficient information	Electronic provider catalogue	Share of patient choice / satisfaction
Independent capacity planning	Utilization of existing capacity	Regional concentration	Regional healthcare needs mapping	Coverage / waiting time
PHIN mode	Reduces information asymmetry	Inaccurate comparisons	Open quality and price dashboard	Share of publicly available indicators
CQC approach	Establishes a uniform quality threshold	Excessive regulatory burden	Risk-based accreditation	Compliance / complications
CMA oversight	Protects competition	Insufficient information	Monitoring of regional concentration	Concentration index
NHS-sector partnership	Mobilizes additional capacity	Attraction of personnel from the public sector	Joint workforce planning	Vacancies / staff turnover

Source: Developed by the author based on official and academic sources.

For Uzbekistan, the most important aspect of the UK experience is the principle of directing public funding to a private clinic not because of its ownership status, but for a service that has been selected by a patient and delivered in accordance with established standards. This approach makes it possible, within the state health insurance system, to shift competition between public and non-state providers towards quality and efficiency. However, the direct transfer of the activity-based payment mechanism would not be appropriate. When payment is closely linked to service volume, incentives for the provision of unnecessary services may arise. Therefore, in the national model, it is necessary to link the base tariff to quality indicators such as clinical appropriateness, repeat visits, complications, patient satisfaction, and accreditation status.

The PHIN experience is also important for the national market. Publishing not only licensing and address information on private clinics, but also information on types of services, accreditation status, key quality indicators, patient satisfaction, and price ranges on a unified digital platform would increase the economic effectiveness of patient choice. On this basis, the establishment in Uzbekistan of the following chain is proposed as a nationally adapted transformation of the UK experience: “state health insurance – accredited public and private providers – informed patient choice – unified base tariff –

payment for services delivered – quality coefficient – transparent provider rating – competition monitoring.”

4. Conclusion

The findings of the study demonstrate that the economic mechanism for enhancing the competitiveness of the private healthcare services market in the United Kingdom is based on integrating the private sector not as an alternative system to the NHS, but as a participant that creates choice and additional capacity in meeting publicly funded healthcare demand.

First, NHS commissioning and activity-based payment partially decouple private providers’ revenues from patients’ individual purchasing power and link them to the volume of services actually delivered.

Second, patient choice and the application of unit prices create the economic conditions for shifting competition away from price and towards quality, service, waiting times, and reputation.

Third, the disclosure of outcome and fee information through PHIN, together with CMA competition oversight, reduces information asymmetry in private healthcare and contributes to the formation of the institutional infrastructure of competition.

Fourth, joint planning of NHS and independent-sector capacity enables the private sector to be utilized not only in response to market demand, but also to meet system-level needs in areas characterized by high waiting times and insufficient capacity.

For Uzbekistan, when applying this experience, it is advisable to establish transparent criteria for integrating private providers into the state health insurance system, link public funding to patient choice, align part of provider payments with quality outcomes, and establish an open information platform providing comparable information on healthcare providers.

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