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Decoding the Efficiency Domain in VBP guidance from a Health Economics and Market Access Perspective

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The following is part of a series of short articles developed by SWART Evaluation for members of the Association of British HealthTech Industries in response to the June 2026 release of UK Department of Health and Social Care's Guidance on Value Based Procurement standards.

If you would like to discuss our approach to VBP and how we can support you, you can reach us at info@swartevaluation.com

VBP Domain: Efficiency

This is Article 1 of 5 on each of the 5 domains outlined by DHSC to assess value in VBP.

To support the shift of NHS procurement decisions from acquisition cost to value, efficiency is a central component in how technologies can be measured and assessed. But efficiency is not a single concept. Productive, allocative, technical, and dynamic efficiency each pose a different question, require different levels of scrutiny within the framework, and require fundamentally different kind of evidence.

NHS VALUE-BASED PROCUREMENT

Minimum scoring weight* = 60%

**VBP National Standard Guidance*

"Efficiency" isn't just one scored question. It's four perspectives, measured and scrutinised in very different ways.

Productive efficiency

Were resources released?

VBP COVERAGE

Explicitly scored across pathway, hospital and community productivity questions.

THE CHALLENGE

Releasing time is not the same as using it. Most submissions evidence the saving, not the redeployment.

Allocative efficiency

Were the resources used well?

VBP COVERAGE

Implied but not scored. Released capacity is tracked; its destination is not.

THE CHALLENGE

Suppliers cannot prove what a trust does with freed resource. Released capacity ≠ value created.

Technical efficiency

How close to best achievable?

VBP COVERAGE

Limited. Evidence requirements rely on single-site, before-and-after studies by design.

THE CHALLENGE

Single-site designs cannot separate real gains from regression to the mean or secular trends.

Dynamic efficiency

Does today's spend pay off later?

VBP COVERAGE

Outside the framework. Whole-life cost covers spend, not forward efficiency claims.

THE CHALLENGE

Future payoffs are unfalsifiable at procurement. Unstated assumptions carry the argument.

Make sure you are demonstrating the right kind of efficiency for your audience, and that you are speaking to the expectations and criteria of the stakeholders who will be affected. Impact their decision by speaking to their metrics.

The word ‘efficiency’ is often used as though it were singular. Yet productive, allocative, technical, and dynamic efficiency each pose a different question, sit at a different level of scrutiny within the NHS Value-Based Procurement framework, and carry different weights with different stakeholders. This article is not a detailed description of those concepts - the diagram above handles that. It is an account of what responding to each one properly requires, and what a rigorous economic approach changes in practice.

Productive efficiency: close the gap between time saved and time used

The VBP framework scores productive efficiency directly for pathway simplification, reduced length of stay, fewer follow-ups, increased throughput. Most submissions will produce a headline number and stop there. Harder to demonstrate but much more important is demonstrating what happened to the freed resource. The NHS's value and savings methodology distinguishes between cost avoidance, added value, and released capacity: three different claims requiring three different evidence approaches. Closing the gap means agreeing the baseline before implementation, specifying what redeployment looks like, and running a post-implementation check against both.

Allocative efficiency: build the evidence the scoring doesn't require, but buyers increasingly want

The framework asks whether capacity was released. It does not ask where it went. The economic tool is opportunity cost analysis: instead of asserting that released capacity could be redirected to higher-value uses, build a structured comparison between the actual use of released resource and the next-best alternative foregone. Use a post-implementation audit to ask where the freed capacity went vs the baseline. This is evidence almost no competitor currently provides, because nothing in the scoring obliges it, but this will be a key factor for commissioners.

Technical efficiency: use multi-site data to validate what single-site studies cannot

The framework's single-site before-and-after standard cannot separate a genuine productivity gain from regression to the mean – don't fall into this trap and commission an incomplete analysis. Methods like stochastic frontier analysis and data envelopment analysis use panel data across several providers to estimate what best achievable performance looks like, and measure each site's distance from that frontier before and after deployment. For systems considering multi-trust rollout, this benchmarked evidence can be the difference between a pilot that stays a pilot and a deployment that gets commissioned.

Dynamic efficiency: make the assumptions visible and realistic

The framework may not require a dynamic efficiency case for the understandable reason that future payoffs cannot be verified at the time of procurement. However, without clear and justifiable assumptions and a coherent logic model, a long-term benefit claim cannot be properly evaluated. Be realistic and transparent: show the adoption curve against realistic NHS uptake rather than best-case projections, and run sensitivity analysis showing how the case holds up when things go slower than planned.

What this adds up to – avoiding the pitfall

Each of the four efficiency types has a specific evidence gap, and each gap has a specific response. But taken together, they point to a structural problem in how efficiency is evidenced under current VBP guidance: the framework is strong on measuring capacity release and largely silent on capacity utilisation.

Crucially, VBP submissions can successfully claim 'freed capacity' on paper without ever demonstrating that those resources yield real-world systemic improvements. A trust can release a hundred bed days, absorb them as slack, and still satisfy the framework's evidence requirements. A supplier can demonstrate a fifteen-minute

procedure saving, map it to the released capacity category, and score well without ever showing that a single additional patient was treated. The gap between what is evidenced and what actually constitutes value is not a flaw in individual submissions. It is a structural feature of what the framework currently asks for.

The smart response is to close that gap voluntarily, not because the scoring requires it but because the argument is more defensible and more compelling to commissioners when it does. That means tracking redeployment alongside release for productive efficiency; building an opportunity cost case that names what the freed resource actually went to for allocative efficiency; using multi-site frontier analysis to show that a productivity gain is real and not a baseline artefact for technical efficiency; and presenting long-term benefit claims with assumptions visible enough that a buyer can stress-test rather than simply accept them.

None of this is required by the VBP framework but will be required to convince NHS decision makers to use the VBP framework for their commission decisions. It requires treating evidence design as a core part of what is being sold and the actual decisions that will be made, not a retrospective justification for a decision already made. The VBP framework creates space for suppliers with stronger evidence that speaks to commissioner priorities to distinguish themselves. In a market where most submissions stop at the headline figure, that space is not yet crowded.

How can we help?

In our work we help our clients close that gap. We look beyond the limits of what is required by guidance, and we ensure that the evidence we generate and evaluate speaks directly to NHS priorities and stakeholders, and moves the dial on their decision-making.