Liberating the NHS: Regulating healthcare providers

Summary

1. *Liberating the NHS* sets out proposals to develop further market-based incentives for NHS-funded health care across England. Market-based incentives in the NHS have the potential to deliver the goals of improved efficiency and quality. Key elements of market-based incentives in the NHS to date include competition among providers, choice for patients, and national prices (tariffs). The Nuffield Trust considers on the basis of its own and others' research that all these areas need further development in synergy with one another. This note concentrates on competition, price and the role of the economic regulator.
2. Early signs from research show that competition between hospitals in England on the basis of fixed prices is associated with increased quality in some dimensions of care (Cooper et al, 2010; Gaynor et al, 2010; Bloom et al, 2010). This is also consistent with international literature (Gaynor, 2006). We consider on the basis of this evidence that competition should be developed further. The economic regulator will need to consider competition between different organisational forms rather than simply the GP practice and the hospital if patient care is to improve and the taxpayer get better value. GPs and specialists may wish to come together to hold a risk adjusted capitated budget for provision of some or all care to a local population. Such an approach may hold more promise to achieve efficiency and quality gains that are urgently needed, in particular for care of older people and those with long term conditions (Commonwealth Fund, 2007; Rosen et al, forthcoming). The economic regulator will need to take a view on whether such vertical integration would be anti competitive, or, if it is likely to benefit

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patients and taxpayer, whether to permit it and encourage competition between such networks.

3. Furthermore, effective competition can only occur if entry, expansion and exit by providers are possible. But many potential barriers to this occur in practice (Frontier Economics, 2010), and economic regulation can work only if the regulator has the power and capacity to tackle these barriers.
4. Early signs from the main evaluation to date of *Payment by Results* showed that the introduction of a national tariff has been associated with reductions in the unit cost of care (Gaynor et al, 2010). The economic literature on competition between hospitals suggests that competition with regulated prices increases quality of care provided that the price is above marginal cost. Given the acute financial pressures on the NHS, and the policy over time to 'unbundle' tariffs, the task to ensure that the regulated price is at an appropriate level will become far more complex and politically fraught, requiring a great deal of accurate information on costs. The new economic regulator will need to be adequately resourced to carry out this task. Its feasibility should be regularly reviewed, The strategy for developing the policy on regulated prices in the NHS – which we understand is the role of the NHS Commissioning Board – thus needs much more development and should be done in close collaboration with the economic regulator.
5. The Nuffield Trust supports the establishment of an independent economic regulator with responsibility for regulating prices, promoting competition, and supporting service continuity. We particularly welcome the proposals which will give the regulator the duty to promote competition rather than just prevent anti-competitive practice, although this needs to be clearly in the context of securing more economic, efficient and effective healthcare. The legislation should make this clear. The Nuffield Trust supports the proposal for Monitor to become the new health and social care economic regulator, since Monitor has built considerable credibility and expertise which will be essential given the complexity and scale of this role.
6. Regulating the NHS proposes a twin system of regulation with CQC regulating quality and Monitor focusing on economic regulation. We support this – these forms of regulation require different, specialist skills and both are essential. However, for patients it is vital that the two regulators work closely together, share information and coordinate their work so that providers face clear and consistent incentives where improving quality and economic performance are not seen as competing goals but mutually reinforcing. But there may be conflict between on the one hand priorities such as improving equity of access to care, or quality of care, and on the other efficiency and the desire to increase choice and competition. In this case it will be important that CQC and Monitor early on make explicit these tensions and try to craft a set of principles they can both work to in the event of a conflict of objectives. There needs to be greater clarity

as to how differences will be reconciled and who may be the final arbiter.

7. It is obviously essential for all hospitals to be financially viable and well-governed – unless they are, many providers will be unable to cope with the pressures of a tight financial settlement and effective commissioning. However, we are concerned about the requirement for all NHS Trusts to become Foundation Trusts within three years, if this means either that Monitor lowered the bar, or that individual hospitals concentrated on foundation trust status to the exclusion of all else as Mid Staffordshire NHS Foundation Trust demonstrated. Moreover there may be a disconnect between the timetable for achieving foundation trust status and the development of commissioning intentions by GP consortia. Previous foundation trust applications have been deferred because of uncertainty about local commissioning strategies. Changes in commissioning intentions can also destabilise a trust if it was configured on the basis of an earlier strategy.
8. We are also concerned that Monitor be given sufficient resources to discharge its large responsibilities adequately, in assessing applicant NHS Trusts for foundation status over the next three years, in monitoring access to essential services across the population, and in particular in setting appropriate prices,. Improving the efficiency of management and eliminating unnecessary waste is important especially when overall resources are being constrained but an underfunded regulator may well be a false economy as the inefficiency from a poorly functioning market and poor access to care would dwarf the running costs of the regulator.
9. The consultation document sets out proposals for the governance of Foundation Trusts but does not discuss the governance and accountability arrangements for the economic regulator. It is important to recognise that an effective economic regulator will be a very powerful force influencing the pattern and cost of health care across England. The Government needs to consider how accountability and public engagement are managed. The economic regulator needs to be seen by the public as legitimate particularly as it manages the challenges associated with the financial failure of some Foundation Trusts. The economic regulator also need to be seen to be independent of vested interests when setting national tariffs – an issue which in the US in part resulted in the abolishing of regulated prices across many states(Gaynor et al, 2010).

Details points on the proposals in the paper

10. The Nuffield Trust has a number of observations on the details in the consultation document. For obvious reasons, the consultation document is at quite a high level and the economic regulator will need to build an approach to regulation which evolves. We are keen to work with the Department of Health and the regulator to support this developing agenda. Our key points fall into 5 different areas which we outline below.

Determining the right unit of competition

11. The goal of competition in health care is to improve efficiency and increase, choice, access and quality. As we argue above, the moves towards greater competition in health care needs to carefully consider the right unit of competition. Research evidence (Rosen et al, forthcoming; Thorlby et al, forthcoming; Dixon et al, 2004) suggests that better, more efficient, care for older people and people with long term conditions requires greater coordination and integration between primary, community and secondary care services. Over the medium to long term, provider networks of clinicians may develop to deliver such care. The task of the regulator will be to ensure that such arrangements can flourish but that there is competition between them.

    It will also be important that the regulator recognises that hospitals provide multiple services (in the economics jargon they are multi-product organisations). Analysis of competition to date has tended to focus on the hospital but to be effective it needs to shift to look at competition at the service level. Not all hospitals will provide the full range of specialties and services and some hospitals provide services beyond direct patient care such as training and research. Moreover, quality and efficiency will vary within hospitals as well between hospitals which performs well on average may have some specialities which are relatively weak and vice versa.

12. This is also important because if market power is assessed purely at an institutional level it may mask pockets of monopoly. It also means that the regulator will need to understand and establish a regulatory position in relation to cross-product subsidy. Hospitals are complex organisations. Closing one set of services may impact on the cost and quality of others. For example, closing A&E may have an effect on the viability of anaesthetics and paediatrics.

13. The data and analytical needs required for judging competition and monitoring potential anti-competitive practices at the service level are considerable and beyond most of the research which has previously been undertaken. We believe it will be a priority for the regulator to establish a framework to determine the units of competition and establish transparent, consistent data at this level. We also believe that this is a area where it is vital that Monitor works closely with CQC as quality data should be available on the same basis – service level rather than just institutional.

Defining essential services

14. Paragraph 3.2 states that Monitor will be required to exercise its functions in a manner consistent with 'supporting commissioners in maintaining continuity of essential services and providing equitable access to essential health and adult social care services'. We support this objective; in using market mechanisms to

improve choice and efficiency in health care, quality and access must at least be maintained. Indeed, the goal is to improve them. However, defining essential services will be complex and contentious. If essential services are drawn too broadly they will limit exit, artificially constrain competition, raise inefficiency and ossify health care. Defined too narrowly, there could be problems of access and service discontinuity which are likely to affect A&E, children's services, maternity services, services for the elderly, and those with complex healthcare needs most. Work on essential services needs to link with the financing regime. A service may be essential in the short-term as it is neither efficient nor practical for another provider to hold spare capacity which can take over care immediately. But for most of the country geographical access to more than one provider is good. Work undertaken by the Competition and Cooperation Panel (Gaynor et al, 2010) found that 40% of the population lived within 20 kilometres of at least 2 hospitals and almost 80% lived within 40 kilometres of at least 3 hospitals.

Shifting services, or enabling others to take over carries a funding implication in the interim. There may also be capital cost implications. It is vital that the financing regime allows services to move over time in response to the market, where this is compatible with access and equity, and does not create artificial barriers to competition.

Provider networks of clinicians

15. Perhaps the biggest challenge now and into the future is caring for the older people and for people with long term conditions. As the Royal Colleges recognise(Gaynor et al, 2010, Bloom et al, 2010), GPs need to work together with specialists so that costly avoidable hospitalisation is reduced and care is integrated and coordinated along a pathway stretching from home to hospital. Already this is very well recognised across Europe and the US as countries strive to achieve better value from health care expenditures through integrated provider networks (Gaynor et al, 2010, Bloom et al, 2010). While competition is a feature between these networks, the primary drivers of quality and efficiency within these networks appear to be more closely related to peer review of performance using better data, coupled with professionalism, and aligned 'intra-network' incentives (Rosen et al, forthcoming; Thorlby et al, forthcoming; Dixon et al, 2004). The economic regulator will need to consider how it can use its powers, and what the unit of competition should be, to achieve improvements in a wide range of different services. It should draw upon international evidence of the success of integrated networks in unplanned care and for those with long term conditions as well as elective and community services. The Government could also consider stronger incentives to encourage the emerging coordination across primary and secondary care which can achieve better quality and value in health care. Across the NHS there are already many impressive initiatives in this direction, led by clinicians, that need understanding, nurturing and evaluating (Farrar et al, 2007; Haas Wilson, 2003; BMA,2010).

Payment By Results

16. The efficiency of markets depends on prices reflecting the costs and value of services to producers and consumers. In health care, pricing services is very complex. In common with many other countries the UK has introduced a fixed

tariff pricing system with prices grouped by HRG, this is known as *Payment by Results*. The evaluation of the early years of the PBR system suggests it has been associated with improved efficiency and providers have increased the volume of services they have provided (a goal of the system to tackle waiting times)(RCP, 2008).

17. The Government proposes to continue to develop the PBR system and the economic regulator will have a key role in setting price caps for services which are subject to national tariffs and will work with the commissioning board to decide the range of services to be covered by PBR, currencies for pricing and payment. The consultation document makes clear the need to ensure that methodologies are transparent and that there is public consultation. We welcome this. The Nuffield Trust also welcomes the proposal for close working between the regulator and commissioning board on the tariff given its centrality to the market system. We are unsure about the relative merits of splitting responsibility for price setting between the economic regulator and the Commissioning Board and believe there should be a more explicit debate about the pros and cons of different options. In other regulated industries such as water and gas the regulator controls both the structure of prices and their level.

18. However, we question whether the time has come for a more wholesale and fundamental review of PBR in light of the very different challenges facing the NHS Commissioning Board and providers. PBR was conceived in a period of very rapidly rising resources where the need to improve access made it right to incentivise acute providers to increase volumes. The challenge for the coming years is to maximise the efficiency and effectiveness of resource utilisation across the care pathway for those with long-term conditions and unplanned care, particularly for older people, especially as the population ages and complex co-morbidity become ever more common. This may include examining more closely the promise of annualised capitated payments for providers across a pathway (covering for example primary and secondary care).

Removing the cap on private income

19. The consultation document proposes removing the existing cap on the proportion of Foundation Trust income which can be earned from private income. The Nuffield Trust supports this change in the context of the establishment of a more comprehensive system of economic regulation for health care. The level of private income a Foundation Trust makes would be of concern only if providers began to reduce access to, or the quality of, NHS care. These would be examples of potential abuse of market power. If Foundation Trusts were to adopt such practices the current cap is an arbitrary and blunt instrument to deal with them. The more comprehensive framework for the economic regulator set out in the consultation document is a more effective tool to deal with this problem and in that context we agree that the cap should be removed, and the impact monitored.

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