HEALTH AND SOCIAL CARE BILL: PUBLIC BILL COMMITTEE
SUBMISSION ON PART 3 OF THE BILL FROM THE KING'S FUND

1) The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

Introduction

2) The Health and Social Care Bill goes much further than previous reforms in applying market-based principles to the provision of health care. The aim is to increase diversity of supply, promote competition and increase choice for patients. This will be achieved by establishing Monitor as an economic regulator, extending choice of provider to a wider range of services and allowing providers from all sectors to compete on an equal footing.

3) This submission focuses on Part 3 of the Bill which sets out the legislative framework for the economic regulation of health and social care.

Monitor

4) The establishment of Monitor as a powerful economic regulator is very significant. From April 2012, it will be responsible for three key functions across health and social care: promoting competition; setting prices; and ensuring continuity of essential services. The Bill gives Monitor wide-ranging powers to impose licence conditions to prevent anti-competitive behaviour, apply sanctions to enforce competition law and refer malfunctioning markets to the Competition Commission.

5) The framework set out in the Bill appears to be modelled on the approach taken in the utilities sector and will open up the NHS to challenge by the Office of Fair Trading and the Competition Commission. It places a heavy onus on Monitor to deliver an optimal configuration of services that balances access, quality, efficiency and cost.

Monitor's principal duty

6) Monitor's principal duty is to 'protect and promote the interests of users of health care services by promoting competition where appropriate and through regulation where necessary'. Both competition and regulation are means, not ends. As the duty currently stands, it appears that competition and regulation are viewed as alternatives, with the inference that regulation should be used where competition is not deemed appropriate. In fact, as experience in other sectors has shown, regulation is a necessary pre-requisite if competition is to be beneficial to service users.

7) Given that the framework set out in the Bill appears to mirror the approach taken in the utilities sector, there may be lessons to be learned from previous experience. During the last parliament, Ofgem was widely criticised for interpreting its functions too narrowly and placing too much emphasis on promoting competition. Its principal duty was eventually amended by the Energy Act 2010 to make it clear that its main objective is to promote the interests of consumers and that competition should be used only in order to achieve this.

8) Recent government statements have stressed that competition should only be used in health care where it will deliver benefits to patients, and that it is not an end in itself. However, although it is qualified by the reference to using regulation where necessary, the way Monitor's duty is framed is strikingly similar to the original duty on Ofgem (as set out in Utilities Act 2000), in that the duty to promote competition is closely linked to the duty to protect and promote the interests of service users.

The Committee may wish to consider whether the principal duty on Monitor, as it is currently framed, will achieve the main objective of promoting the interests of users of health care or whether it tips the balance too far in favour of promoting competition as an end in itself.

9) If the clause remains as it stands, the definition of 'where appropriate' will be critical. Competition may be beneficial to patients in some areas, such as simpler elective services or small-scale community provision. In other areas, competition may make it more difficult to commission services that best serve patients' interests, for example, where partnerships are needed to ensure provision of seamless care between providers of hospital and community services, or where, as with stroke and trauma care, hospitals need to work together across wide geographical areas. In both these examples, competition *for* the market could be organised through a tendering process, but the result would be that the choice of individual patients would be limited to the chosen partners or specialist centres.

The Committee may wish to seek assurances that the exercise of competition powers by Monitor will enable partnership agreements to continue where these are in the interests of patients.

<u>Other duties and powers</u>

10) Monitor also has a duty to promote the economic, efficient and effective provision of services [section 52 (3)] and must have regard to safety, continuous improvement in quality and efficiency and fair access (section 54), as well as a number of other factors. These provisions do not make it clear how the balance between these various duties and considerations should be struck and how conflicts between Monitor's policies and those of the Care Quality Commission and NHS Commissioning Board, for example, should be resolved. The Bill does not adequately define the role of Monitor in relation to these bodies. For example, it does not make clear the circumstances determining whether the Secretary of State should turn to Monitor or the NHS Commissioning Board to deal with performance issues.

11) Under the framework set out in the Bill, no single organisation is responsible for overseeing the NHS as a whole, in terms of both provision and commissioning. In the case of the energy industry, this difficulty has been resolved in part by giving ministers powers to issue general directions relating to the policy framework within which the regulator should operate. However, these sectors have a much simpler governance structure and there are no equivalent bodies to the Care Quality Commission or the NHS Commissioning Board. In relation to specific trade-offs, such as cost or access versus quality, other regulators have commissioned research from service users to help define where the balance should be struck. In one case, the water regulator asked ministers for a decision as the cost implications of implementing higher standards were so considerable.

The Committee may wish to consider whether the framework set out in the Bill is sufficiently clear about the balance between Monitor's duties and its relationships with other key organisations. There may also be

case for specifying how decisions about difficult trade-offs should be supported in terms of analysis and the process for doing so.

Consumer voice

13) In other sectors strong bodies have been set up to represent consumers and ensure regulators take their preferences into account. Although it is being abolished, Consumer Focus is a good example of this. In contrast, HealthWatch, which is being established as an 'independent consumer champion' in health care, will be a sub-committee of the Care Quality Commission – it is hard to see it having much influence on a regulator as powerful as Monitor.

The Committee may wish to consider whether HealthWatch will have sufficient power to act as an effective consumer champion.

Procurement and competitive commissioning

14) The Bill gives the Secretary of State powers to allow Monitor to 'impose requirements' on the NHS Commissioning Board and consortia so that they adhere to good practice in relation to procurement, protect patients' right to choice and promote competition. Specifically, it refers to Monitor's ability to require competitive tendering. Under section 64 (3) it appears that Monitor could require a consortium or the NHS Commissioning Board to tender services.

15) The same risks arise here as with Monitor's principal duty – ie, whether promoting competition might be placed above other factors affecting the interests of patients, such as integration of services based on collaboration between providers. For example, a commissioning body may wish to procure an innovative community-based service where only one organisation is in a position to pioneer it. In this case, a less formal process such as market testing may be more appropriate.

The Committee may wish to seek assurances that the requirements on commissioners to competitively tender services will not prevent them from deciding not to use the full tendering process in specific circumstances.

16) A major benefit of GP involvement in commissioning is the potential for GPs to design innovative forms of primary care provision and new models of care in the community. This creates a potential conflict of interest for GPs as both commissioners and providers of services. An appropriate balance needs to be struck that does not stifle the potential for creativity under the burden of highly bureaucratic processes or complex procurement and tendering rules. However, it will be important that such decisions are made and reported transparently to avoid conflicts of interest.

The Committee may wish to seek assurances that the NHS Commissioning Board and Monitor will be able to develop a proportionate approach that allows GPs to develop and deliver innovative services, while providing reassurance that conflicts of interest will be managed effectively and transparently.

Designation of services

17) Under the more market-based approach outlined in the Bill, providers unable to compete will be allowed to 'fail' and exit the market. Monitor will be responsible for protecting the public interest in these circumstances by guaranteeing the

continuity of 'designated' services, for example, ensuring access to A&E and maternity services within safe travel times. The process must be flexible enough to challenge incumbent providers and allow new and innovative providers to enter the market.

18) Before a service can be designated, commissioners must consult 'relevant persons' and demonstrate to Monitor that there would be a 'significant adverse impact on the health of persons in need of the service'. The expectation is that the case would be made primarily by local professionals in GP consortia. The burden on commissioners making an application will be considerable if it is to be evidence-based. For example, the relationship between travel times and outcomes are not well established in many areas of care. They may also find it difficult to assess the interdependencies between different services. It is not clear therefore whether GP consortia will have the technical skills and evidence base to make the case for designation.

19) The Bill does not acknowledge that people (and professionals) outside the immediate local area may be affected by a loss of service. For example, tertiary and specialist services often serve wide catchment areas. It is not clear what happens if no local consortium chooses to designate such a service. There is provision for NHS Commissioning Board to step in and 'facilitate agreement between commissioning consortia' to decide whether to designate and who should apply, but it is not clear what should happen if that does not work.

The Committee may wish to seek further clarification about the regime for designating services.

20) It will also be difficult for GP commissioners to drive major reconfigurations within secondary care. The importance of the system leadership role currently provided principally by strategic health authorities is underlined by a new report published by The King's Fund on the reconfiguration of hospital services (Palmer 2011). The report shows that essential changes to improve quality and tackle financial deficits in some hospitals are unlikely to happen if left to market forces alone.

21) The Bill enables GP consortia to collaborate to address issues across consortia boundaries. However, they may not have the appetite or the skills to tackle large, complex and contentious service changes, with the result that the pressing need to reconfigure hospital provision in some areas may not be addressed quickly enough, if at all. A strong, strategic commissioning function able to look across large geographical areas is needed for these purposes. In a recent radio interview, the Secretary of State indicated that the NHS Commissioning Board may have a role in this, although he did not explain how this might work.

The Committee may wish to clarify how major service reconfigurations will be overseen in future.

Price setting

22) The NHS currently operates a system of national tariffs, where providers are paid a fixed amount for providing a particular service and compete on quality. The Bill will make Monitor responsible for publishing a national tariff setting out the prices of health care services, doing so in agreement with the NHS Commissioning Board. Currently, responsibility for publishing the tariff rests with the Department of Health, so this part of the Bill builds on current practice, although it also introduces some new elements.

23) First, it provides for a higher tariff where a provider of a designated service cannot cover its costs even if operating efficiently. This is important as it will enable providers to maintain provision, for example, in rural areas where costs may be high or where, if they lose some services to other hospitals, they cannot reduce their fixed costs. However, it may mean that commissioners in areas with a large number of designated services will have to pay levies to Monitor for designating services and higher tariffs. This seems unfair. A solution would be to take these factors into account through the allocation formula, but the Bill makes no mention of this.

24) Second, the tariff can 'comprise two or more services which together constitute a form of treatment'. This possibility seems to open the way for tariffs that cover more than simply an episode of care. This is a welcome development as it should help to support integration of care by, for example, allowing a tariff for a course of treatment such as 'a year of diabetes care', allowing the successful contractor to combine the elements required for the whole package of care without negotiating separate deals for each one.

25) Evidence from the United States and from the NHS in the early 1990s suggests that price competition may reduce quality as providers seek to lower costs and lead to higher transaction costs, as commissioners and providers spend significant amounts of time negotiating prices. We therefore welcome the amendments tabled by the government to remove the provisions allowing Monitor to set maximum prices. However, given statements made by the Secretary of State and the new Chair of Monitor, David Bennett, indicating that price competition could be permitted in some circumstances, the position is still not entirely clear.

The Committee may wish to seek further assurances that the framework established by the Bill will deliver the government's stated intention of preventing general price competition and about the circumstances, if any, it might be allowed on an occasional basis.

26) Experience in other regulated sectors suggests that important elements of price setting have been omitted from the Bill. First, experience has shown that the level of the tariff has important implications for the level of new investment. The Bill requires Monitor to consider future health care needs but it does not explicitly refer to the link between price and new investment. In other industries, the regulator has taken a view on future investment needs as part of tariff setting to ensure that revenue is sufficient to improve and expand the capital stock. It is not clear which organisation will be responsible for setting out what these investment needs might be. Within the NHS, the capital budget has been persistently underspent. There is a case for allowing commissioners to pay a supplement, for a limited period, above the current capital allowance implicit in the tariff to encourage new investment.

27) Second, the Bill does not address the use of the tariff to promote specific objectives. The current NHS tariff embodies incentives set by the Department of Health to promote quality and reductions in emergency re-admissions. While it is clear that Monitor and the NHS Commissioning Board will be required to work together to set specific prices, it is not clear which organisation will be responsible for requiring that such 'incentive' tariffs should be introduced in future. The Bill gives the Secretary of State powers to direct the NHS Commissioning Board but these are intended to be rarely used leaving it open as to where decisions will lie on a day-to-day basis.

The Committee may wish to seek clarification about whether the new tariff regime will allow flexibility for encouraging new investment and promoting specific policy objectives.

Licensing

28) Licensing allows the regulator to impose conditions on providers, for example, requiring information about costs of services to inform price setting or to adhere to specific standards. The regime set out in the Bill is similar to the approach taken in other regulated sectors.

29) A key element of the licence is the requirement that providers should allow other providers to use their services. This will allow Monitor to require a provider such as a large foundation trust to make some of its facilities available to a competitor. Currently, private sector providers usually have access to NHS intensive care facilities in the event of a major incident in their own facilities. If they were denied this, the scope of their activity would be severely limited. Similarly, a new provider may wish to access the diagnostic services of an established larger provider to allow it to enter a market without major investment. But if there is no spare capacity available, then to do so would disadvantage the larger provider. The terms on which access of this kind is provided will have to be carefully worked out to ensure that such arrangements are limited to circumstances where the required capacity exists.

The Committee may wish to seek further clarification about the detail of the licensing regime.

References

Palmer K (2011). *Reconfiguring hospital services: Lessons from South East London*. London: The King's Fund. Available at: www.kingsfund.org/publications/reconfiguring.html