THE KING'S FUND SUBMISSION TO THE CO-OPERATION AND COMPETITION PANEL

REVIEW OF THE OPERATION OF ANY WILLING PROVIDER FOR THE PROVISION OF ROUTINE ELECTIVE CARE: INTERIM ASSESSMENT

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

The King's Fund welcomes the opportunity to respond to this interim report, which recognises the complexities in the implementation of 'any willing provider' (AWP) for the provision of routine elective care. We are in agreement with the Co-operation and Competition Panel (CCP) that there are important lessons to be learned from the current experiences of primary care trusts (PCTs) ahead of the wider implementation of AWP.

We have recently published four reports that have significant implications for the government's approach to choice and AWP:

- *Choosing a high-quality hospital: The role of nudges, scorecard design and information* (Boyce *et al* 2010)
- *Patient choice: How patients choose and how providers respond* (Dixon *et al* 2010)
- *Referral management: Lessons for success* (Imison and Naylor 2010)
- *Improving the quality of general practice: Report of an independent inquiry commissioned by The King's Fund* (The King's Fund 2011a)

We refer to these reports in our response below but suggest that the CCP refer to the reports directly when completing its final report.

Choice of provider

Our work suggests that choice is valued by patients and enables more patients to be treated at the hospital they choose. Even if few patients use their ability to choose to go to a non-local provider, the ability to exit appears to be important to the majority of patients. This suggests that choice may have intrinsic value (Dixon *et al* 2010).

Policy to date in the NHS has largely focused on choice of provider – specifically, choice at the point of referral to specialist care. Patient choice of provider has been introduced to create competition among health service providers and thereby improve their efficiency and quality. While there is some evidence that competition between providers in some areas has increased (Gaynor *et al* 2010), the evidence indicates that choice of provider does not currently act as a strong driver for service improvement (Dixon *et al* 2010).

Our research found that while the threat of patients choosing a different hospital led some providers to focus on reputation and to ensure that patients attending the hospital had a good experience (through collecting and acting on patient feedback), there was little evidence of direct competition for individual patients' custom. There was some evidence of providers competing for GP referrals, particularly from practices on the periphery of their catchment areas.

Only about half of the patients involved in the study were offered a choice at the point of referral, and of those, 29 per cent chose to attend a non-local hospital (compared with 21 per cent among those who were not offered a choice). The main reason for not attending a local hospital was a previous poor experience of that hospital. Choice of provider seems particularly important to enable those who have had a poor experience of a local hospital to exercise choice to go elsewhere. Regardless of the effectiveness of choice as a driver for quality improvement, we therefore conclude that, given its intrinsic value, choice should continue to be offered to patients.

We also found that providers were quite sceptical about the extent to which patients were acting as informed consumers. Any observed changes in referral patterns were largely seen to be a result of GP decisions rather than the preferences of individual patients. Consequently, providers focused their promotional activities on GPs. Few providers were undertaking market research to understand the preferences that influenced the choice of hospital for 'potential' patients, but instead they were focusing on the experience of 'current' patients (that is, feedback and complaints) and the interests of GPs. Many providers were using this information to drive quality improvement.

Providers saw GPs as a significant barrier to developing patient choice and establishing a competitive market for health care services. They perceived GPs' referral patterns to be fairly stable and giving little attention to quality. Practice-based commissioning (PBC) and the development of community-based services run by GPs were also seen as a potential conflict of interest.

Referral Management Centres

Our recent research (Imison and Naylor 2010, Goodwin *et al* 2011) has demonstrated that there is wide, unexplained variation in the numbers, rates and quality of GP referrals. There is also good evidence that many GP referrals are either unnecessary or could be better managed by the GPs themselves or other out-of-hospital providers. Referral Management Centres (RMCs) or other services acting as referral gateways may attempt to address these issues by sending referrals back or redirecting referrals into out-of-hospital assessment and triage services. Advocates for RMCs argue that the capacity to triage and then divert, or even refuse, GP referrals into secondary care will be critical to helping GP consortia to contain demand and manage their budgets.

However, the research findings suggest that RMCs may not be an effective means to control expenditure. RMCs can exact a high overhead per referral, and if the cost of the alternative, out-of-hospital services are taken into account, the overall value for money is questionable. RMCs may also undertake clinical decisions in the absence of full clinical

information and thus present clinical risks, especially if based on a poor-quality referral. Finally, RMCs can be confusing for patients who may not understand what they are and how they relate to their GP and the hospital.

The case for RMCs is further undermined by the availability of alternatives. There is growing evidence from GP commissioning groups that peer review and audit provide a valuable means of reducing overall referral rates, but without the clinical risks and with the added benefit of peer review providing insight into an individual GP's training needs.

Choose and Book

Research by Dixon *et al* (2010) found that GPs had a number of reservations about the way the current choice policy was working in practice. Most of these reservations centred on the Choose and Book system itself. GPs, in particular, conflated patient choice with Choose and Book, in part because it is through this system of booking that the policy of patient choice is 'enacted'.

Choose and Book is not being used as widely as anticipated to support patient choice. The financial incentives for GPs to use Choose and Book improved their willingness to engage with the system, and we believe that an associated payment system may prove to be an effective method to encourage greater use of Choose and Book. The system must become more timely, accurate, flexible and able to manage increased demand on booking slots. In addition, there is a need to develop Choose and Book support aids and translated information about available services, to facilitate more effective consultant–patient discussions and decision-making.

The research also showed that GPs wanted to be able to refer direct to named consultants, so the introduction of this function as part of the new proposals may serve to encourage greater use of Choose and Book among health professionals.

Extension of AWP

We recognise the benefit of offering greater choice to patients in elective care and would like to see greater choices being offered to patients with long-term conditions, as well as in mental health, maternity and end-of-life care services. We would recommend that the extension of choice in these areas is managed carefully by the NHS Commissioning Board and Monitor, and have suggested ways that this could be achieved in our response to the *Greater choice and control* consultation (The King's Fund 2011b). It will be important, in developing an AWP market, to pay attention to lessons learned from implementing the policy of choice at point of referral to secondary care.

We understand AWP to mean that any provider (public or private) that is registered by the Care Quality Commission (CQC) would be able to deliver services, with the expectation that they will be reimbursed by NHS commissioners at an agreed price (usually a nationally set tariff) as long as they deliver care in line with agreed standards (again, these would usually need to be defined in a national contract).

We have recently submitted evidence to the Health Select Committee's inquiry into commissioning (The King's Fund 2011c), highlighting further tensions between patient choice and GP commissioning. Giving patients the choice of AWP has the potential to weaken commissioners' hands in negotiations with service providers. A commissioner's power is based to some extent on their ability to negotiate and selectively contract with certain providers to deliver services under defined terms. Under the any willing provider model, a provider's income is determined by the sum of individual patients' choices rather than by agreements with commissioners (which could not specify contract volume or expected income).

There is some risk that this could weaken commissioners' ability to influence provider behaviour or specify innovative service models. Patient choice could also compromise the commissioner's ability to control their budget if the options available to patients vary in cost. There is, therefore, a need to strike a balance between commissioning and patient choice as two alternative means of driving service improvement. These benefits of restricting choice to patients through selective, preferred or exclusive provider contracts must be considered.

We also stress that complex services, such as those for trauma or cancer, need a co-ordinated approach across providers. Quality has been demonstrably improved by focusing care within centres of excellence and creating networks of providers – an approach which necessarily reduces the extent of choice for patients. A market that encouraged multiple new entrants to offer such services would not be good for patients, or financially beneficial for commissioners. GP consortia should be supported to develop integrated care networks with acute and community providers. Patients could then be offered choice between integrated delivery systems – although this scenario may take some years to develop (Curry and Ham 2010).

It is unclear what scope will remain for GP commissioning consortia at the local level for flexibility to make decisions about how and where they want to commission services. A more integrated service provision will depend largely on the scope set by the NHS Commissioning Board about the extent to which AWP will apply. What will be important is setting the rules there will be for the NHS Commissioning Board to govern if local commissioning consortia would like to commission, for example, an integrated diabetes service, but the NHS Commissioning Board has specified an 'any willing provider' service for podiatry. Podiatry services could well lend themselves to a competitive market, including competition on price. But if a local consortium would like to commission an integrated diabetes service, including a podiatry service, will they be able to work outside of the AWP market? We think these specifications and distinctions are critically important to understanding AWP, and predicting the impacts of introducing and extending this policy in the NHS.

AWP, competition and integration

The dual objectives of the reforms of promoting competition and integration are not incompatible, but the balance between them will be determined by the ways the health care market is set out to work in practice. Commissioners need to be able to specify products, and the NHS Commissioning Board and Monitor need to specify tariffs, in a

way that can promote collaboration to deliver an integrated package of care for complex patients, or to deliver a pathway of care. This is likely to involve multiple providers.

The arrangements in the Health and Social Care Bill allowing tariffs to comprise more than one service do allow the possibility that commissioners could use this to commission integrated pathways of care. The scope and structure of the AWP market will be fundamental to whether these arrangements for collaboration will be taken forward.

Monitor will then have a critical role in analysing the commissioning and provision practices and outcomes under each of these models. We have set out evidence on Part 3 of the Health and Social Care Bill in our submission to the Public Bill Committee (The King's Fund 2011d) on economic regulation and competition; this considers how Monitor might effectively regulate a more competitive provider market. For those services, and/or pathways of care, that are left to selective tendering, Monitor must ensure that commissioners are tendering in line with procurement guidance set down by the Department of Health.

Closing comment

The real question is not whether competition is good or bad for health, but where and how it should be applied. The challenge is to ensure that competition does not lead to fragmentation of services or a reduction in quality. Competition works well in some types of health care markets, but less well in others. Given the benefits of more integrated services, particularly for those with chronic conditions and complex needs, it is important that choice of provider does not result in greater fragmentation of care.

The Co-operation and Competition Panel must carefully consider the benefits and risks of where and how competition should apply in realising a judgement on whether parts of the NHS are in breach of the Principles and Rules of Co-operation and Competition.

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