Response to Department of Health discussion document

Comments on "Liberating the NHS: Regulating Healthcare Providers"†

by

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† The response to Q.17 is also relevant to the consultation on "Commissioning for Patients".

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Key issues in the proposed design of a competitive health system

A key idea behind the proposed reforms in 'Liberating the NHS' is that competition can be used constructively to promote better health outcomes and reduce the costs of bureaucracy. Patients are to be given more freedom to choose their GP and the information to allow them to choose between alternative providers of secondary care. Funding will follow those choices, so GPs and secondary providers have the incentive to deliver better services to attract patients. This 'bottom up' competitive process is intended to replace 'top down' targets as the means of improving quality.

There is now good evidence that an appropriately incentivised and well regulated system of competition in healthcare can be a powerful force for enhancing efficiency, improving health outcomes and, indeed, saving lives.[1] There is also evidence that an inappropriately incentivised and poorly regulated system can do the reverse.[2] All markets benefit from a degree of regulation to the extent of background competition law, including prohibitions on cartels, exclusionary behaviour by dominant firms and anticompetitive mergers. Some other markets with special features (e.g. water as a monopoly utility) require more direct intervention (e.g. on price setting).

Markets within the NHS framework will always need more regulation than background competition law if they are to be effective and beneficial. This is because the role of the customer in health markets is very different to, say, in retail or intermediate business markets. In 'normal' markets, the same person (i.e. the customer) does three things: chooses which product to buy from which provider; pays for the product out of their own budget; and 'consumes' the product (i.e. enjoys the benefits either directly as a consumer or indirectly as a firm from the profits it makes from onward sales). In this way, incentives for balancing cost and quality are aligned so customer choices between competitive providers drive the market to provide the right quality of product at the minimum appropriate price.[3] In a health market, however, the chooser may be a clinician, the payer is the NHS and the consumer is the patient. This creates problems for budgetary control and the balancing of various dimensions of quality, and is fundamentally why it is so difficult to design an effectively competitive NHS system.

'Liberating the NHS' expects patient choice to drive competition. In making their choices, patients will be aided by a 'revolution' in the amount of information they are provided (e.g. quality indicators). The particular design proposed in the consultation also places GPs in a pivotal position in commissioning the services that will provide local choice for patients and facilitate competition. However, the consultation on 'Regulating Healthcare Providers' conveys insufficient recognition of the problems this will create. There are two levels of patient choice: first they choose a provider of primary care (i.e. GP practice); second, if they

[1] See, for example, Gaynor, Martin, Rodrigo Moreno-Serra and Carol Propper, 2010, 'Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service', NBER working paper #16164; Gaynor, Martin, 2006, 'Competition and Quality in Health Care Markets' *Foundations and Trends in Microeconomics*, 2(6), 441-508; Bloom, Nicolas, Carol Propper, Stephan Seiler and John Van Reenen, 2010, 'The impact of competition on management quality: evidence from public hospitals' NBER working paper #16032.
[2] See, for example, Propper, Carol, Simon Burgess, and Denise Gossage, 2008, 'Competition and Quality: Evidence from the NHS Internal Market 1991-9', *The Economic Journal*, 118, 138-170; and Gaynor *op cit*.
[3] There are some difficulties in reaching full alignment even in 'normal' markets because providers are incentivised by the preferences of marginal consumers while overall welfare depends on the preferences of an average across all consumers. However, there is no general and systematic bias of the sort to be expected when the roles of chooser, payer and consumer are separated.

have a problem requiring further diagnosis or treatment, they choose a provider of secondary care (e.g. hospital).

On the first choice (between GPs) the evidence from behavioural economics suggests many people are likely to choose on the basis of immediate and easily understood indicators (e.g. location, waiting times, ease of making an appointment) and pay correspondingly little attention to other objectively important indicators that are less immediate or more difficult to understand (e.g. clinical indicators). Once signed on at a practice, few patients are likely to change GP except following a particularly bad experience or change of residence.[4] Choice between GPs can therefore be expected to provide an important discipline against the worst primary practices but may only be a limited competitive force beyond that.

On the subsequent choice between secondary healthcare providers, most patients will look to their GP for advice, particularly on clinical quality. He or she is the expert on their problem and patients will expect that they have the best knowledge of alternative providers. This influence may lead to conflicts of interest which have the potential to undermine the benefits envisaged in the reforms. GPs will be involved through commissioning in designing the market structure of secondary services in which they will be patient guides and may also have a commercial interest. Furthermore, GP Consortia provide a natural focus for coordinating the local quality of primary care. Such collusion would further undermine the benefits of competition between GP practices in driving quality improvements.

Nevertheless, this should not be taken as a message of despair – only that *it is of the utmost importance to get the detailed regulation right so that competition drives health outcomes in the right direction*. It is in this context that the following comments are offered to the consultation on Regulating Healthcare Providers. I focus on the consultation questions relating to the regulation of competition. I also emphasise the need to start the system with an appropriate market structure, and make some detailed comments on the institutional framework for regulating healthcare. My responses to the consultation questions are not ordered by importance, but are grouped under the chapter headings in 'Regulating Healthcare Providers' (RHP), beginning with chapter 2.

Ch.2 Freeing providers

Q5. What if any changes should be made to the NHS Act 2006 in relation to foundation trust governance?

Following the discussion in the consultation document [RHP #2.18], if the staff-only governance model is to be extended to certain categories of provider (e.g. small or community services), it would be desirable to retain majority public/patient representation on the board of governors where there is no effective choice between providers (e.g. as may be the case in some rural areas). Competitive constraints matter more than size per se because patient choice is the discipline and incentive for patient-focused quality.

[4] Evidence for this expectation comes from many other choices where the default is continuation (e.g. current account banking); see Chang, Yoonhee Tina and Catherine Waddams Price, 2008, 'Gain or Pain: Does Consumer Activity Reflect Utility Maximisation?' ESRC Centre for Competition Policy Working Paper 08-15. This reticence to switch will be compounded by healthcare being largely a 'credence good' (i.e. it is difficult for a patient to know if their current state of health is due to the treatment, or lack of it, provided by their GP). Also, patients may be concerned for their personal relationship with a GP and fear being viewed as a 'troublesome patient' if they switch.

Q6. Is there a continuing role for regulation to determine the form of the taxpayer's investment in foundation trusts and to protect this investment? If so, who should perform this role in future?

Someone has to oversee the public investment in Foundation Trusts (FTs), but it is important to separate the regulation of competition from any sort of financial interest (direct or indirect) in the parties being regulated. The alternative would be a very high risk of 'capture' with the regulator (i.e. Monitor) helping to bail out a distressed FT. Even the possibility that this might happen creates a moral hazard that a weak FT would take insufficient remedial action. Furthermore, the possibility of bailout softens incentives for a strong FT to compete vigorously to attract patients because it would expect the regulator to step in to limit its success. Thus, there would be a negative impact on good providers as well as a reduced incentive for the weak to become efficient, high quality providers. Monitor should stand at a distance and be free publicly to criticise any intervention by the Department of Health (or alternative 'protector' of taxpayer investment).

Ch.3 Economic regulation

Surprisingly, there are no consultation questions attached to chapter 3 of RHP on 'economic regulation'. My observations on this chapter are collected in my answer to Q20.

Ch.4 Licensing

Q9. Do you agree with the proposals set out in this document for Monitor's licensing role?

Pre-notification of the withdrawal of an essential service is entirely appropriate. However, more subtlety is required before setting out: 'requirements on providers to promote choice (for example requirements to provide certain services to competitors)' [RHP #4.8]. There is an important difference between required access to a) a standard or inherited facility that happens to be owned by a monopolist and which cannot efficiently be replicated due to economies of scale, and b) an innovative investment in provision that has been identified and developed by a new provider in response to a gap in the market. Even though b) may look like a monopoly, this is a necessary incentive to encourage innovation and is part of the way efficient markets work. For type a) cases, it is insufficient simply to require access. Great care is needed also to determine appropriate access prices that reflect the costs of provision and do not distort incentives between existing and new service providers.

Q11.Do you agree that Monitor should fund its regulatory activities through fees? What if any constraints should be imposed on Monitor's ability to charge fees?

Inasmuch as regulated providers derive their funding from the NHS, any requirement to pay fees to Monitor will have to be reflected in higher prices for the treatments provided (or reduced quality of provision). It would simply juggle the location of the cost from a central government budget for grant-in-aid to the NHS. It is different when most prices are not regulated (which is the case for most other specialist regulators except Ofwat).

Ch.5 Price regulation and setting

Q12. How should Monitor have regard to overall affordability constraints in regulating prices for NHS services?

The consultation documents suggest that NICE will set quality standards and Monitor will set prices (with the NHS Commissioning Board providing an intermediation role). It is not explicitly stated that GP Consortia (GPCs) will not be able to negotiate price discounts. However, it seems probable that they will not if only because such price discounts would not be compatible with patient choice of provider. Price negotiation also compromises the quality of provision.[5] On the assumption of fixed prices, competition between providers will be channelled into quality competition, with any gap between price and the cost of meeting minimum quality standards providing the incentive to enhance quality. In this way, fixed prices can drive quality. If the price is fixed too low, quality will be too low and the service may even be withdrawn; and if it is fixed too high, competition will result in inefficient 'gold-plating' of treatments.[6] Monitor will therefore have to balance prices against both affordability and its judgement of where quality improvements are most likely to be forthcoming and desirable if a price incentive is given. While these observations do not directly answer Q12, they are intended to highlight the quality dimension of complexity in reaching an answer.

Q13. Under what circumstances and on what grounds should the NHS Commissioning Board or providers be able to appeal regarding Monitor's pricing methodology?

If the appeal is over national prices, then there could be a collective action problem. For example, each FT may try to 'free ride' on the legal and administrative costs incurred by others even in a justified appeal – and the appeal may not happen if everyone acts the same. It would be better for the NHS Commissioning Board to coordinate such an appeal which would also save on costs. For other matters more specific to one or a few providers, then these providers should be responsible for taking action. Legal and administrative costs will act as a restraint on parties, but an appropriate fee structure could be applied if experience results in frivolous appeals being made.

Ch.6 Promoting competition

Q15.Under what circumstances should Monitor be able to impose special licence conditions on individual providers to protect choice and competition?

Protection of competition is not the same as protecting competitors. Providers with inherited monopoly positions that are not easily challenged by new providers should certainly face special licence conditions. These conditions should provide both a greater control of quality and restraints on using their privileged position to disadvantage actual or potential providers

[5] See references in footnotes 1 and 2.

[6] This contrasts with, for example, water pricing where both investment plans and prices sufficient to fund them are fixed at the beginning of the planning period. It would not be feasible (or desirable) to scrutinise and agree quality-enhancement plans for every healthcare provider.

in related markets. The same does not apply to those who achieve dominance by creating an innovative niche, or whose skill, quality, efficiency and enterprise make them the preferred provider of most patients. They should be left to experiment and thrive as long as they do not directly hinder rivals (i.e. other than by providing a better service to patients).

An important example in health provision is that individual doctors and teams become more skilled with practice at a specific clinical diagnosis or intervention.[7] This leads to advantages of scale both in cost and quality of care. For some clinical interventions and geographic areas, this may mean a single provider would result in the highest quality and most efficient provision. This may still allow, for example, different hospitals to specialise in different therapies. It may also result in what is sometimes known as 'tipping'. Suppose a certain area has two good hospitals with equivalently good medical teams. If one arbitrarily gets more patients for a particular operation and volume impacts positively on clinical success, its quality will improve relative to the other hospital. Informed free choice will then feed the imbalance of patients and so further widen the relative quality gap (i.e. 'tipping'). This is, of course, a desirable outcome of competition as long as everyone can choose the high quality hospital. However, for regulatory purposes it is important to realise that this is more like the 'inherited monopoly' case I discuss in answer to Q9, than it is a reward for inherent skills. Nevertheless, it would harm patients if 'choice' were to be enforced by reducing volume in each provider below that necessary to generate high quality healthcare.

Q17. How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anticompetitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?

In addressing these questions, it is necessary to refer to the companion consultation on Commissioning for Patients (CP). I focus on three issues:

a) 'Buyer power' for GP consortia

Buyer power exercised sensitively on behalf of patients is generally beneficial. Sensitivity means that it must not undermine long term provision, innovation and investment in quality enhancement by providers. This sensitivity is in a commissioner's own interest but some may fall down on standards and others may seek to gain by pursuing their own short-term interests at the expense of other commissioners with a longer-term view. An appropriate code of conduct to reinforce appropriate and non-disruptive commissioning behaviour could be extended to all commissioners and enforced by Monitor.

b) The triple role of GPs as commissioners, providers and guiders

A more serious issue is that members of GPCs are well positioned to become providers. This is actively encouraged in 'Commissioning for Patients': 'It is essential… that individual practices or groups of practices have the opportunity to provide new services (over and

[7] The volume of similar procedures is positively correlated with the quality of outcomes. See for example, Birkmeyer, John D., Justin B. Dimick and Douglas O. Staiger, 2006, 'Operative Mortality and Procedure Volume as Predictors of Subsequent Hospital Performance', *Annals of Surgery*, 243(3), 411–417; and Halm, Ethan A., Clara Lee and Mark R. Chassin, 2002, 'Is Volume Related to Outcome in Health Care? A Systematic Review and Methodological Critique of the Literature', *Annals of Internal Medicine*, 137, 511-520.

above the primary care services that they already have a duty to provide), where this will provide best value in terms of quality and cost' [CP #5.12].[8] Furthermore, the intention is that a GP's income will essentially be separated from the commissioning budget of the GPC to which they belong [CP #3.16], other than 'a proportion… linked to the outcomes that they achieve collaboratively through commissioning consortia and the effectiveness with which they manage financial resources' [CP #5.17]. The implication appears to be that this 'proportion' will be relatively small and GPs will be rewarded mainly for the number of patients they attract and through a revised system of measured health outcomes [CP #3.17]. This system distorts GP incentives as they can increase their personal incomes by indirectly or directly guiding patients to use secondary provision in which they have a private interest. This can happen even if they do not directly discourage alternative NHS provision through their GPC.[9]

Only limited safeguards seem to be envisaged: 'Where services are commissioned on an 'any willing provider' basis, there are established protocols that can be used or adapted to report and audit the pattern of referrals from GP practices that are also themselves a provider or part of a provider consortium. We would also anticipate that, where GP practices wish to bid in a major procurement, the procurement could be managed by another party' [CP #5.13]. The NHS Commissioning Board is given the role of 'holding consortia to account for delivering outcomes and financial performance' [CP p.32 box] but this will be difficult to implement except in the worst cases of abuse. Furthermore, GPs may encourage their more straightforward patients to choose their own provision while guiding more complex cases to alternative providers. The incentive is that this would both lower the costs of their own provision and likely improve its outcomes as measured by quality indicators that are unable to differentiate according to individual case complexity.[10]

Vertical separation between primary and secondary care (i.e. independence of GP practices from ownership interests in secondary care to which they may guide their patients) is the natural way to ensure that the roles of guider and provider for the patient are not distorted.

c) 'Gold-plating' to attract patients

Inasmuch as patient choice of GP is sensitive to clinical indicators and local reputation for 'thoroughness', there is an incentive for 'gold-plating' provision to entice a longer list of patients (e.g. sending patients for costly tests of insufficient likely benefit). While this 'service risk' is recognised [CP #5.7], the proposed solution of peer pressure within GPCs [CP #3.19] will be hard to make effective without encouraging the collusion problem identified in my introduction (p.2). The gold-plating problem arises in exactly the situation where patient choice between GPs is effective and sensitive to word-of-mouth reputation and clinical information. This is because a practice could gain significant income from

[8] 'CP' paragraph references refer to the companion consultation 'Liberating the NHS: Commissioning for Patients'.

[9] In 'normal' markets (i.e. those with free price setting and motivated by profits), there is a powerful argument that vertical integration (e.g. between primary and secondary provision) can be beneficial in creating efficiencies without enhancing market power. This is known as the 'Chicago view'. The basic idea is that if a potentially integrated firm can outsource from a more efficient provider, it makes more profit by outsourcing than by using its own subsidiary. The market in Liberating the NHS is very different. Consider a GP with an ownership interest in a specialist secondary provider. She has no personal gain in guiding patients to more efficient providers (other than a probably very diffuse potential bonus through the GPC) but personal profits can be gleaned directly through a share of a private secondary provider even if that provider is not the most efficient or highest quality.

[10] Economists refer to this sort of distortion as 'adverse selection'.

capitation fees. The problem is exacerbated if GPs respond to what they think others are doing, and seek to avoid losing patients by indulging in gold-plating of their own. Needless to say, inasmuch as patients turn out to be reluctant to switch and are insensitive to perceived GP quality, gold-plating pressures are reduced, but so too are the incentives for GPs to drive quality forward. A solution may be found in enhanced independent monitoring of GP practices.

Ch.7 Supporting continuity of services

Q18. Do you agree that Monitor needs powers to impose additional regulation to help commissioners maintain access to essential public services? If so, in what circumstances, and under what criteria, should it be able to exercise such powers?

The proposed focus for intervention is on 'identifying where a provider is the only provider or one of very few providers of services in a local area' [RHP #7.4]. However, the focus should be on the consequences if one provider were to withdraw provision. For example, if there are four providers each working at full capacity and unable to expand, then there would be a serious continuity problem if one were to withdraw. Equally, if the service is currently provided by a monopolist but others could and would rapidly enter the gap following withdrawal (on suitable notice; see Q9) there would be no need for additional regulation. Safeguards are necessary for cases where there is a monopoly provider and no likely immediate entry; but they are also necessary where there are several providers with insufficient collective capacity to satisfy demand if one were to withdraw from the market.

Q19. What may be the optimal approach for funding continued provision of services in the event of special administration?

Similar issues arise as in my answer to Q.11 above (on fees).

Ch.8 Conclusion

Q20. Do you have any further comments or proposals on freeing foundation trusts and introducing a system of economic regulation?

The following comments mainly relate to underdeveloped issues and proposals in chapters 3 and 6 of RHP.

a) Monitor's objectives

Monitor is given the crucial role of regulating competition with an apparently focused mandate: 'Monitor's principal duty will be to protect the interests of patients and the public in relation to health and adult social care services, by promoting competition where appropriate, and through regulation where necessary' [RHP #3.2]. However, it is also given a list of seven separate 'objectives'. Most of these are consistent with promoting competition but some would more appropriately be governed by another regulator (e.g. 'maintaining the safety of patients' by the Care Quality Commission) or with explicit political input (e.g. interpreting what precisely is meant by 'equitable access').

b) Getting the initial structure right

Competition will work better, and less regulation will be necessary, if the structure of the market is correctly established in the first place. However, the RHP consultation focuses on longer-term issues and is almost silent on the key transitional task of getting the initial structure right. There will be considerable short-term change and reorganisation at both primary and secondary levels as the proposals in 'Liberating the NHS' take hold. The structure and organisation of existing providers (including foundation trusts and GPCs) needs careful thought. Too many, and they will lose economies of scale. Too few, and competition will be insufficient to provide potential benefits. It is important to get the initial structure right or the reforms may fail (as they have failed in the past when poorly designed). It is also very much harder to correct an over-concentrated or over-integrated market at a later date, than it is to begin cautiously then allow mergers when a genuine efficiency logic can be identified.[11]

c) The standard by which mergers are judged

Having established a good starting point, it is necessary to allow competition to work its course, protected by competition law including merger control. It is unclear why a reversion to the old 'public interest' test is being considered over the modern 'competition test' for mergers: 'We are considering the need for modifications to the Enterprise Act 2001 to take account of the specific characteristics of mergers in healthcare, including whether there is a case for…; and powers for the Secretary of State for Business, Innovation and Skills to intervene in mergers on public interest grounds' [RHP #6.14]. This would be an uncomfortably vague power and, *if* implemented, should be made more specific to reflect the potential concern. For example, in media mergers the specific concern is plurality of views, in defence it is national security and in banking it is stability of the UK financial system.[12] It is not clear what specifically is intended for healthcare that would not already be covered by a modern consumer welfare interpretation of the competition test. It would be better not to create a new source of uncertainty by reverting to 'public interest'.

d) Institutional structure for merger control

RHP proposes that mergers should not be appraised by Monitor but left to the OFT and Competition Commission (CC). This follows the model for other economic regulators (e.g. Ofgem, Ofwat). However, there are few firms and few mergers in these other regulated markets, so their regulators would never develop a critical mass of expertise in merger analysis. In contrast, there are dozens of mainly small-scale mergers between health providers currently being reviewed by the Co-operation and Competition Panel for NHS services. It is not clear from the consultation document what will be the future of this Panel,[13] but if its staff were brought into Monitor, they would provide a strong specialist expertise in understanding mergers in such markets. Rather than burdening the OFT with a substantial number of locally-important mergers subject to idiosyncratic competitive

[11] e.g. London airports.

[12] The latter was legislated in the furnace of the financial crisis specifically to allow the LloydsTSB/HBOS merger that turned out to be a huge failure. There is also a special provision for water mergers to preserve sufficient operators for the regulator to be able to use 'yardstick competition' between monopoly areas.

[13] RHP #6.15 says only that: 'The Panel will continue to provide expert advice on these mergers during the transition to the new system'.

constraints (as identified in my introduction), it could then be more efficient for Monitor to take on the 'OFT role' of first filter to decide on whether referral to the CC is necessary.[14] This would still preserve an attractive feature of the UK regime – that mergers are decided by a different body to the one responsible for proposing that there is a potential problem.[15]

Q21. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public, and where appropriate, staff?

It must be appreciated that competition typically operates in an unbalanced way, with innovations succeeding in one area and failing in another. Health outcomes will not be improved equally in all geographic areas at the same time. Only after a lag can successful innovation and new forms of organisation be copied as best practice. Meanwhile, minimum quality standards are an essential backstop to provide the minimum acceptable threshold of care.

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[14] Research on early settlement of merger cases by the European Commission shows that cases are less likely to be referred for costly Phase II investigation if DG Competition has more experience of the particular industry (as measured by the number of previous cases). This does not imply they are necessarily a 'softer touch' because the sample included only on mergers that were allowed subject to remedies. See Garrod and Lyons (2010).

[15] The final decision should be taken outside Monitor also to limit the danger of regulatory capture.