Consultation response

The King's Fund's response to *Liberating the NHS: Regulating healthcare providers*

11 October 2010

The King's Fund 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 consultation paper, Equity and Excellence: *Liberating the NHS: Regulating healthcare providers*, sets out the government's proposals for some additional changes to the powers and freedoms of NHS foundation trusts and changes in the scale and scope of the role and functions of Monitor.

This note forms part of The King's Fund's response to the government's consultation on the White Paper (Department of Health 2010a). It first sets out our view about the need for regulation, the general scope and nature of that regulation and then responds to the direct questions asked in the consultation. Second, it addresses the changes to the powers and freedoms proposed for NHS trusts.

The need for regulation of the health care market

The thrust of the government's overall policy proposals is to achieve improved health outcomes '*that are among the best in the world',* in the main through competition and patient choice rather than performance management by regional authorities or the Department of Health. However, the nature of the structure and funding of the health care market, the potential for anti-competitive behaviour and not least the value society attaches to key NHS objectives (for example, access to care) mean that some form of market management or regulation is required to protect patients and the public interest in general. The question therefore is what form regulation should take and what balance needs to be struck between regulation, legislation, performance management and the actions and powers of market actors – in particular commissioners and patients (through choice) – in order to maximise benefits for patients and taxpayers.

The role and scope of regulation

There are a number of key questions that need to be addressed with regard to regulation (adapted from Palmer 2006):

- How many regulators should there be?
- Who should be subject to regulation?
- If prices are to be set, to what aim and who should do this?
- What role is there for regulators with respect to competition policy?
- To what extent should a regulator have a role in government health policy objectives?
- What is the regulator's role in dealing with provider/commissioner financial failure?

We address these issues in the course of our responses to the consultation's direct questions below.

The consultation's direct questions on Monitor's new roles

As part of its proposed economic regulation function, the consultation paper lays out four main roles for a revamped Monitor:

- licensing providers
- regulating prices
- promoting competition
- supporting service continuity.

Below we deal with the specific questions raised by the consultation in these areas as well as making some general observations.

Licensing providers

The consultation proposes that only providers of 'NHS services' should be subject to licensing by Monitor. It is not entirely clear which organisations this definition would cover. The consultation paper seems to suggest that private providers will not need a licence because unlike those providing NHS services '…there are already mature markets with a range of choice between alternative providers' (Department of Health 2010b, p12, para 4.5). However, it is clear from the consultation's proposals on Monitor's powers to deal with anti-competitive behaviour (Department of Health 2010b, p20/21 6.6) – where its scope is not limited to providers required to hold a licence – that it is *not* proposed that non-NHS providers (even though they may provide services to NHS commissioners) be similarly required to be licensed by Monitor.

This seems unnecessarily muddled, and the proposed licensing arrangements need much greater clarification in terms of the objectives of licensing, to which organisations they apply and how it is envisaged licensing arrangements might change over time.

Further, no mention is made of licensing in relation to general practice. There are potentially significant issues around competition and conflict of interest concerning GPs in their provider and commissioning roles which will need to be considered by Monitor in its new regulatory task.

There is also the complementary question as to whether Monitor's licensing should also extend to *commissioners* of NHS services and, if not, whether the proposed accountability, performance management arrangements and in particular the rules governing contracting and procurement, etc, are the best way to ensure Monitor's objectives for competition and patient protection are met.

Q8. Should there be exemptions to the requirement for providers of NHS services to be subject to the new licensing regime operated by Monitor, as economic regulator? If so, what circumstances or criteria would justify such exemptions?

No.

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

In general, yes. However, clarification is needed on the objectives of licensing, who will need to be licensed and how the licensing regime may need to change over time with changes in the nature of the health care market. There is also an open question as to whether commissioners of NHS services should also come within Monitor's licensing scheme.

Q10. Under what circumstances should providers have the right to appeal against proposed licence modifications?

It would be good practice for Monitor to have in place an agreed process for dealing with any complaint or appeal regarding its licensing decisions.

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?

Charging fees for its activities makes sense and aligns Monitor with other economic regulators. However, there needs to be oversight of the way fees are set and scrutiny of changes over time by, for example, the National Audit Office.

Price regulation and setting

A key role for economic regulators in other industries is the setting of prices for consumers in order to deal with potential abuse by natural monopolies and also to encourage greater provider efficiency. The health care market in England is different from other (natural monopoly) markets in a number of respects, however. For example, there is effectively a monopsonistic purchaser (the State) operating via a relatively large number of commissioners and a large number of providers with little national market power (although perhaps more local monopoly power locally for some types of service). And the whole system is effectively cash limited. This means that price controls directly determine volume and composition of supply and set limits on what commissioners can buy, and the incentives facing providers will not mirror those of natural monopolies in other sectors.

The consultation implicitly endorses the need for some form of price-setting or regulation and that this should move away from the current Payment by Results system (PbR), in which prices are fixed by the Department of Health at broadly the average cost of NHS provision and towards the setting of 'efficient or maximum' prices by Monitor but in close collaboration with the NCB.

More generally, we would support the proposal for Monitor to take on the price-setting task, but, as the consultation notes and as Palmer has pointed out (Palmer 2006), there is an important role for government to retain general policy on price-setting – eg, the objectives and aims Monitor needs to work to in developing prices – and to be able to work with (and challenge) Monitor in its task. The proposal that the National Commissioning Board determine the structure of prices needs to be reviewed and the relationship between the Board, Monitor and government carefully defined.

Regardless of who sets the tariff levels, these new pricing rules raise a number of issues, not least their potential impact on the supply of (volume, quality and efficiency of production), and demand for, health care as well as implications for affordability in a cash-limited system. We would therefore suggest that such changes need to be modelled as well as possible for their effects and then monitored closely as they are introduced. Given the proposal that Monitor develop the methodology for price-setting, the responsibility for engaging in research and modelling of the impact of alternative pricing strategies should be Monitor's also. Such analysis should not ignore some complicated financial issues involved – such as the way legacy debt, PFI and capital in general should or could be treated within a pricing system to ensure a level playing field between providers. This will require investment in Monitor's analytic and research skills. All such work needs to be available for public and expert scrutiny.

The suggestion is that there will be a degree of price competition introduced for some or all services subject to price regulation if a maximum price is set. For others an 'efficient price' will be set – that is, in economic terms, one equivalent to marginal cost.

Monitor will also have a key role in protecting the provision of 'essential' services in areas subject to higher costs by effectively subsidising providers for such unavoidable costs in a way that goes beyond the current PbR methodology, which already takes account of geographical differences in provider costs through the market forces factor (MFF). In general, however, we would support the potential power to use subsidies in this way as part of Monitor's role in ensuring continuity of provision and alongside the duty of commissioners and the NCB in ensuring equal access to those in equal need. Whether sustaining certain services is carried out through higher tariffs or direct subsidies leaves open the question of who pays. Higher prices will bear on commissioners' budgets; direct subsidies may do too, but could also be part of the risk-pooling scheme suggested by the consultation in respect of provider failure.

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

Monitor should have regard to overall affordability and as part of its 'road testing' and modelling of price schedules should demonstrate that general NHS objectives will not be jeopardised by the pricing system.

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

The NCB should be able to challenge Monitor's pricing methodology if it leads to unacceptable trade-offs between the NCB's objectives as defined by the Secretary of State.

Q14. How should Monitor and the Commissioning Board work together in developing the tariff? How can constructive behaviours be promoted?

It is not entirely clear what the consultation envisages for the role of the NCB in price-setting. Presumably it could be somewhat similar to the Chancellor's role with respect to the Monetary Policy Committee. That is, the NCB or Secretary of State would set the broad objectives of price-setting policy and Monitor would then have to devise an appropriate pricing methodology that met those objectives. There is, however, a question here as to how precisely these objectives can be framed; for example, those set for the MPC are very precise and easily measured. More specific (and measureable) objectives need to be set for Monitor's price-setting task rather than the general 'promotion of fair competition' and improvement in productivity as currently set out in the consultation paper.

Promoting competition

A key tenet of the government's reform of health policy is that competition will be the primary spur to improve the quality of health care and reduce inefficiency. An important qualifier noted by the consultation is competition 'where appropriate' (Department of Health 2010b, p19, 6.3). This rightly recognises that unfettered competition has limits and potentially unacceptable trade-offs with respect to the broader objectives of the NHS. However, this also makes Monitor's task in promoting competition a difficult one.

The nature of the health care market also suggests that the conventional reasons for an economic regulator to take an interest in promoting competition (and, for example, having powers to intervene over merger activities) may not necessarily apply. For example, the way monopolists abuse their market power to generate 'excess profits' is usually through restricting supply to push up prices. In the NHS, prices will be set by Monitor either at an efficient level or at a maximum. Reducing supply in these circumstances merely leads to a loss of income on the part of a dominant provider. Similar issues apply to mergers.

However, there are other good reasons for an economic regulator to take an active role in competition policy – for example, to ensure adequate (local) choice for patients and in doing so to ensure providers face incentives to improve service quality. Such a role needs to fit well with the responsibilities of commissioners in this area, of course, as well as the responsibilities of the NCB. Through the rules governing the contracting and tendering process for services, purchasers also have an active interest in promoting choice for patients as well as competition (where appropriate) as a means to incentivise higher quality. The extent to which commissioners fail to do so – up to and including positive anti-competitive behaviour – will be of interest to Monitor, and in the absence of licensing for commissioners, Monitor will presumably need to work closely with the NCB to ensure adequate regulation in this respect.

Notwithstanding the consultation's proposal that the OFT and the Competition Commission take sole responsibility for assessing mergers under the Enterprise Act 2002 (with Monitor providing assistance and information as required), for Monitor the regulatory role with regard to mergers would be more one of ensuring that the merged organisation had as likely a chance of meeting its licence conditions as the pre-merged organisations. For the OFT and the Competition Commission, again due to the nature and structure of the health care market, the main focus in any merger investigation would be on the potential loss of patient/commissioner choice (versus, for example, greater productive efficiency, perhaps) rather than the abuse of market powers through restriction of supply etc.

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

It is difficult to be prescriptive about particular circumstances under which Monitor should have the power to impose licence conditions in order to protect choice and competition as any particular case is likely to involve trade-offs with other desirable objectives. Therefore, we would suggest that Monitor have general powers to impose special licence conditions and that in doing so it needs to provide clear justification for its decisions (decisions which also need to be open to appeal by those affected).

Q16. What more should be done to support a level playing field for providers?

[no response]

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?

Monitor needs to take an interest in commissioners' behaviour vis-à-vis their roles in promoting choice and, where appropriate, competition as one means to incentivise service quality. The Department should consider whether it would be beneficial to Monitor in pursuing this interest if commissioners, like providers, should also come within Monitor's licensing scheme. Clarity is, however, also needed on the role of the NCB with respect to commissioners.

Supporting continuity of services

Ensuring consumers retain access to a service or commodity in the event of a provider failing (financially or otherwise) is not always the job of economic regulators. However, it would clearly be a gross failure if, in the event of a provider failing, the NHS did not ensure patients and the public continued to have access to health care services. Currently, it is generally the responsibility of commissioners to ensure continuity of supply, or, where a service is closed on safety grounds by the CQC, it is the Commission's responsibility to ensure, for example, the transfer of patients to another facility and then to ensure changes are made to deal with the safety problem. Monitor also has current powers to mandate the provision of certain services within the terms of authorisation for foundation trusts. We support the continuation of these responsibilities. Attention would need to be given to how this would be dealt with for a non-NHS provider (social enterprise, other independent sector, private agencies).

The consultation proposes, however, potential additional powers and responsibilities for Monitor to regulate for the provision of services to ensure access to 'essential' services. The consultation suggests that these powers would operate through special licence conditions for providers where there may be only one or 'very few' main providers in an area. If the current definition under which Monitor describes 'essential' is used then this will cover all contracted services. We agree that it would be useful for Monitor to have access to powers to impose special licence conditions to help commissioners to guarantee access. By definition, however, such powers could not be used for providers which do not have a licence – that is, all non-NHS providers. While Monitor will, with the OFT and current competition law, have powers over non-NHS providers with respect to competition issues, it is much less clear how 'essential' services are to be protected (or what Monitor's role in this would be) where such services are provided by non-NHS organisations.

In addition, there needs to be agreement as to what constitutes 'essential services' and whether these should remain those as defined by Monitor through its current terms and authorisation process for foundation trusts – that is, essentially all services contracted or intended to be contracted by commissioners. Even under the implicit (market concentration) definition used in the consultation (ie, where there may be only one or very few providers) this would mean that most providers' services would be deemed 'essential'. Striking a balance between the freedom of providers to manage their business efficiently and the needs of patients and local populations is difficult. One option could be to define essential services in a more general way and from the perspective of local commissioners. For example, an essential service could be any whose withdrawal by a provider is opposed by commissioners. There is a danger this might give commissioners veto over the closure of local services even where there are alternatives within a reasonable distance. Another more complex task, but one which could be undertaken over time, would be to define essential services as those where market failure in a particular local market could not be tolerated, eg, in areas of the country where alternative providers of accident and emergency or

maternity services are not within 'safe' travel times. Monitor will need to ensure it has a strong case for subsidising services in order to avoid being seen to subsidise inefficient providers.

While imposing special licensing conditions can support commissioners in ensuring the continuity of services, a key issue to be addressed is how to deal with significant or catastrophic failure of a provider, such as insolvency. We agree with the consultation's proposal to establish a process of special administration, run by Monitor as part of the performance monitoring and intervention process that it has developed to date. As we have noted on this (Palmer 2005), there is a need to develop a clear financial distress regime which recognises the need to avoid catastrophic failure through early interventions (as, for example, developed by Monitor) but that in such an event involves the appointment of a special administrator. The task should be the preservation of essential services and choice for patients and the restoration of financial balance through actions such as the restructuring of the trust, or transfer of the trust to another organisation. One option would be to allow the closure of a provider as a business without merger or takeover and hence the consequent loss of services. This would be extremely unlikely, however. Another option is the break-up of providers (by the special administrator) where different services would be taken over by different providers, thus ensuring that some aspects of the services would continue (in the interests of patients) even if the business as a whole was wound up.

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?

Yes. We would suggest that 'essential services' could be defined as any whose withdrawal by a provider is opposed by a commissioner.

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

The consultation suggests that all 'providers of regulated services' – presumably *any* provider, public or private, supplying services to NHS commissioners – should be required to contribute to a risk-pooling scheme based on their size and likelihood of failure. This fund could then be drawn on to fund services in the event of a special administrator being appointed. Presumably such funds would cover the difference between ongoing income from current contracts and the actual running costs of the organisation. Depending on the details of such an insurance scheme, it could additionally act as an incentive on providers to minimise their likelihood of failure – although this may be relatively weak given other incentives not to fail. As a way of temporarily bridging the financial gap for a failed provider, this approach may have benefits, though more detailed work would need to be carried out to develop such a scheme. For example, there will be legal issues which may limit state subsidy of private providers.

NHS trust freedoms

The assumption underlying the consultation's proposals to liberalise some of the regulatory and statutory obligations and limits governing trusts is that these are the key barriers holding them back from making significant improvements in quality and efficiency. However, while there *are* issues about current arrangements, there appears to be no evidence to suggest this assumption is correct. A question to answer on this is why foundation trusts are

not fully exploiting their existing freedoms with respect to, for example, capital borrowing and local pay bargaining.

However, greater flexibility in the foundation trust model may allow trusts to develop a framework that is more able to engage patients, the community and staff in the operation and strategic vision of the organisation. The White Paper proposes greater opportunity for plurality in the foundation trust model (such as social enterprises). These could potentially work to achieve some of the originally espoused objectives of the foundation trust model that have not been realised in practice.

The move to ensure all trusts become foundation trusts is correct – but one that has always been the intention. The significant questions here relate to who, in future, deals with the authorisation of foundation trusts? And what arrangements will there be for dealing with the 20 to 30 trusts that are likely to find it extremely difficult if not impossible in the short/medium term to satisfy Monitor's current foundation trust requirements?

Overall, however, (and dealing with issues such as Monitor's new economic regulation and price-setting roles addressed elsewhere by the consultation) and short of outright privatisation, it is hard to see the consultation's proposed changes making a significant contribution to what is the ultimate goal – improved services for patients.

Q1. Do you agree that the Government should remove the cap on private income of foundation trusts? If not, why; and on what practical basis would such control operate?

Yes, but processes need to be in place to ensure no conflict with or compromising of quality of care for NHS patients or efficient use of taxpayers' money (see Appleby 2009).

Q2. Should statutory controls on borrowing by foundation trusts be retained or removed in the future?

Foundation trusts already have freedoms to borrow (within limits). A key point is not so much the lack of freedom, but the apparent reluctance of trusts to borrow (and possibly the unwillingness of lenders to lend). The reasons for this situation probably include the fact that it is more costly for trusts to borrow through the NHS Foundation Trust Financing Facility than from private lenders, lack of demand based on assessments of future income within a cash-limited system, as well as some potential uncertainty on the part of the private sector with respect to the risks of lending. Before removing or amending current statutory controls on borrowing, the Department should clarify the current barriers to trusts using their current freedoms, and base any changes on an analysis of the key impediments trusts face in accessing capital for the ultimate benefits of patients.

Q3. Do you agree that foundation trusts should be able to change their constitution without the consent of Monitor?

Yes – this was the intention laid out in Monitor's original guide for foundation trust applicants in 2002. However, trusts should still be required to inform Monitor of any changes and Monitor should review these to ensure they are consistent with legislation regarding the role and functions of foundation trusts.

Q4. What changes should be made to legislation to make it easier for foundation trusts to merge with or acquire another foundation trust or NHS trust? Should they also be able to de-merge?

While the requirements demanded by Monitor, including the statutory need for consultation and the need to engage in a full re-authorisation process with a newly merged trust (including dissolution of the former trusts, the election of new governors etc), may seem somewhat bureaucratic, Monitor, in its role as economic regulator needs to retain an interest in the merger activities of providers for reasons noted above – primarily with respect to its role in helping to ensure patient choice, the protection of essential services, etc. However, over and above this, as well as being satisfied that a merged organisation satisfies its licence conditions, Monitor's role should be minimal and it should be up to boards in conjunction with commissioners to make merger decisions.

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?

This question represents a bigger issue associated with foundation trusts: how they fit within the established NHS marketplace of providers and what organisational form they will take. The nature of the regulatory framework will be dictated by greater developments in this area. If foundation trusts become akin to private providers of care, then they should be regulated and licensed in the same manner that other non-NHS providers are (as discussed above). If foundation trusts are to fundamentally remain public benefit organisations, then they should be regulated in the same manner as other NHS providers.

Q7. Do you have any additional comments or proposals in relation to increasing foundation trust freedoms?

Foundation trusts have not shown much interest in borrowing or in exercising some of the other freedoms that have been available to them. Therefore, policy-makers need to focus on what support, encouragement and incentives are needed for foundation trusts to take advantage of these privileges. Greater flexibility in the development of the model may allow for institutions locally to meet these objectives according to their individual preferences and objectives.

References

Appleby J (2009). 'Capping earnings from private patients in NHS foundation trusts'. Editorial. *British Medical Journal*, vol 339, b4698. Available at: www.bmj.com/content/339/bmj.b4698.extract?papetoc (accessed on 6 October 2010).

Department of Health (2010a) *Equity and Excellence: Liberating the NHS*. Cm 7881. London: The Stationery Office.
Department of Health (2010b) *Liberating the NHS: Regulating healthcare providers*, London: Department of Health.

Palmer K (2006).*Regulation and System Management of the new NHS - Proposed Architecture*. Submission to the Currie review of healthcare regulation in England, 2005. Available at: www.keithpalmer.org/paperhealth2.php (accessed on 6 October 2010).
Palmer K (2005) *How should we deal with hospital failure?* London: The King's Fund.