KING'S FUND

RESPONSE TO CONSULTATION

WIDER REVIEW OF REGULATION IN HEALTH AND SOCIAL CARE

Introduction

This paper is a response by the King's Fund to the Department of Health's review of the regulatory framework for the health and social care sector. The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding. We are a major resource to people working in health and social care, offering leadership development programmes; seminars and workshops; publications; information and library services; and conference and meeting facilities.

General comments

We welcome this review. We believe it is very timely for two reasons: the strengthening of market incentives in the NHS in particular through the use of private providers competing with NHS providers; and the announcement of the Chancellor earlier in 2005 to reduce the number of public sector regulators from 11 to 4.

Much of our contribution to the Wider Review of Regulation is made in two accompanying documents: Contemporary reflections on regulation and health care; and How will we deal with hospital failure? In this document we aim to respond in brief to some of the specific questions posed in the invitation to respond to the consultation.

Brief responses to the specific questions posed.

1. What role can regulation play in achieving the Government's objectives for health and social care?

Classic roles of regulators include assuring safety (public assurance, including preventing abuses of consumers in a market), improving performance, providing information to the public, and reporting publicly on their findings.

Clearly as such the activities of regulators are but one strand in wider efforts to improve performance which in health and social are includes performance management against targets and other directives, and market-style incentives.

As noted above it is critical that the government outlines what role it wishes for itself with respect to improving care in state-owned and run institutions, and the role it expects of each

regulator. In particular the state needs to make explicit a policy framework in which it outlines the major objectives and how conflicts between them are to be resolved.

2. What are the key issues you believe need to be addressed through the review?

First, now more than ever it is important for the government to define what sees as its own role with respect to regulation, and also what it sees as the role of arm's length regulators, and indeed other regulators (such as professional bodies). This is not clear at present and there is the possibility of overlap and duplication. In particular it is necessary to define the role of the state with respect to 'economic' regulation of the emerging market in health care, and with respect to activities to improve performance (a) in NHS Trusts (b) in NHS Foundation Trusts (which are still NHS bodies but legally beyond the reach of direction by the Secretary of State) and (c) non-NHS providers, including both voluntary sector and private sector, which provide most of their care to NHS-funded patients (eg Independent Treatment Centres and general practices). Ideally the state should provide not just a statement as to its roles versus those of other regulators, but a clearly understood rationale for this, and ideally a vision for how these roles might appropriately change in future given the broad direction of travel of reform of the NHS.

Second, despite the developing efforts of the DH to assess the potential costs and benefits of new regulations on the health sector, in line with the recommendations for the Better Regulation Task Force and Better Regulation Executive, there is no attempt for the DH to assess the costs and potential impact of the total burden that it imposes on state-run institutions. For example regulatory impact assessments in the health sector do not include policies such as Payment by Results, Agenda for Change, or Commissioning a Patient-Led NHS - all of which impose large costs on the NHS. Clearly it is for the state to decide the burden it wishes to impose on state-run institutions but (a) it could be better informed as to the likely costs and benefits of its own actions and (b) if NHS bodies are meant to compete successfully with non-NHS bodies then the total volume of regulation (imposed by the state and the arm's length regulators) will need to be monitored.

Third, given the dynamic, and likely unpredictable, nature of reform in health care, regulation is likely to require changing roles of the state and other regulators, which in turn will need constant monitoring and evaluation and coordination between relevant bodies at a level which has not yet been seen. This is a significant challenge.

Fourth, in our view the area which needs the most thought is that relating to 'economic' regulation (as opposed to the linked activity of 'quality' regulation). A common view held, and outlined in a recent document by Monitor, is that the functions of economic regulation should be carried out largely by an independent arm's length regulator. But this is unlikely to be realistic or appropriate, and there is in our view a significant and appropriate role for the state, not least because of the challenging financial environment that is likely to persist at least in the medium term in the NHS. For example as the accompanying documents point out, it is within the ambit of the state to reduce the risks of avoidable financial failure in NHS bodies through a better management regime for dealing with financial distress, and the shape of the market is endogenous to the decisions made in the DH.

Fifth, again on economic regulation, it is clearly important that any new system developed should be congruent with the system of economic regulation for non-NHS providers as

regulated by the Office of Fair Trading. For example it is not clear at present whether or example the powers of OFT will apply to NHS Foundation Trusts.

Sixth, while most arm's length regulators have a mission (if not a statutory duty) to improve performance in regulated bodies, very few are able to quantify the contribution they have made eg in terms of cost-effectiveness. This is an area of potential 'regulatory creep' by regulators, which in health care is all the more problematic because of the dominant effect of the state (through investment, targets, performance management and financial incentives) to improve performance. It would be helpful if the state could spell out in more detail the expectations it has of arm's length regulators with respect to improvement (for example as opposed to safety/public assurance), and how the performance of the regulator will be assessed. A secondary but also important issue is the role of regulators in improving performance in non-NHS bodies including those that treat sizeable numbers of NHS-funded patients, and those that do not.

Seventh, there are important and related questions to resolve as to (a) whether economic and quality regulation should be merged into one organisation (b) the extent to which regulation of health and social care should be merged and when and (c) how conflicts between economic objectives (the optimal functioning of a market) and social objectives should be arbitrated.

On (a), clearly economic regulation and quality regulation are highly interlinked. It would make sense for one organisation to do both to avoid duplication. But pragmatically there is much to do, in the developing state of reform in the NHS, to develop both, in particular economic regulation by an arm's length regulator (currently Monitor for Foundation Trusts). It may make sense for both types of regulation to be developed separately in the short term, although there would need to be significant joint working between such bodies - far more than has been apparent to date. Keeping these bodies separate but linked would also avoid the inevitable distraction if the bodies merged, at a time when the NHS is under significant financial challenge and there is pressure for all NHS Trusts to become NHS Foundation Trusts by 2008. On (b), as things stand at present, the main quality regulator (the Healthcare Commission) is to merge with the main social care regulator (Commission for Social Care Inspection or CSCI) by 2008. CSCI is a quality regulator and is developing its functions as an economic regulator. If there is any flexibility in the decision to merge the Healthcare Commission and CSCI, it would be worth considering the pros and cons of delaying this merger, to allow the Healthcare Commission time to develop appropriate links with Monitor and to harmonise assessment regimes across NHS and non-NHS providers, and to allow CSCI the time to develop appropriate economic regulation. The Healthcare Commission is also due to subsume the Mental Health Act Commission - a quality regulator - although there have been concerns expressed that the loss of a separate mental health regulator might endanger the level of monitoring of mental health services, as mental health will have to compete with other priorities within the Healthcare Commission. On (c) whether or not economic and quality regulation are merged, there are likely to be significant conflicts between economic objectives and social objectives (for example achieving efficiency and promoting equity in access to care). This is not something that regulators can easily sort out, it is the role of government to make clear in a policy framework how such conflicts should be resolved. The policy framework is not clear at the moment in this respect.

Eighth, the term regulation most often refers to the activities of arm's length regulators, and often to the regulation of institutions. Clearly individual professionals have a very significant

role in assuring safety and improving performance. It will be important that this DH review also links to the reviews of professional self-regulation that are currently underway.

3. In your view, what should be the main purposes of regulation and inspection? What are the appropriate success criteria and critical factors to ensuring both effective and proportionate regulation?

Main purposes: as stated in 1. The success criteria and critical factors have been in the main outlined by the Better Regulation Task Force in its paper 'Principles of Good Regulation', which in our view is a good place to start. Success should in part be measured by feedback from consumers, from the bodies being regulated, from an assessment of risks prevented, and against government expectations of success of each regulator (which are hopefully explicit).

4. In your view what are the strengths and weaknesses of the current systems of regulation and inspection in health and social care? Are there lessons to be learned from regulation of other UK sectors or from other international health and social care sectors?

We think there is a danger of regulatory creep, in particular where the remit of an organisation is not tightly defined. This is a danger especially in organisations with a statutory duty or mission to improve performance, for example the Healthcare Commission, for the reasons outlined above. For lessons from other UK sectors and from abroad see accompanying paper 'Some contemporary reflections on regulation of health care'.

5. What steps can the DH and other regulators take to reduce the overall burden of regulation and inspection on organisations and staff providing frontline services?

The answer must be to assess the total burden of regulation (imposed by government and the regulators as noted above and in the accompanying paper 'Some contemporary reflections…') which currently is not done, and constantly seek to prune it. By far the largest burden on NHS organisations is that impose by government directly.

6. In light of the anticipated changes in the health and social care systems, what regulatory functions need to be undertaken? Which of these functions do you believe sit best with independent regulatory bodies?

This is covered in the accompanying paper 'Some contemporary reflections…' and in the response to question 2. above (with respect to economic regulation).

7. Which organisational model and what statutory powers do you believe would most effectively discharge those functions and achieve the best outcomes in terms of costs and benefits? How might stakeholders be involved in the regulatory process. How do we ensure that the regulatory system is able to cope with continuing change in the health and social care system?

This is covered in the accompanying paper 'Some contemporary reflections…' and in the response to question 2. above. On stakeholder involvement, it will be important to distinguish two linked activities: involving stakeholders essentially as 'consumers' in feeding back to regulators how their activities are impacting and how they might be modified (as, for examples, currently happens with Mental Health Act Commission visits to mental health

facilities and interviews with patients); and involving stakeholders essentially as 'citizens' (in particular the public) and for example having their direct input to shape strategic decisions at national level. Clearly the former is important (although must be cost-effective), but we question the latter, in particular how meaningful this activity is on decision-making as well as how appropriate this is given the accountability of the regulator.

8. How should the regulatory framework for health and social care best fit with others in the public sector, in particular, local government?

It is important that there is congruence, if not fit, between the activities of for example the Audit Commission, the Healthcare Commission and CSCI. Clearly the activities and performance of social services are critically important in reducing the risk of ill health and hospitalisation of some groups. And conversely, the performance of the health sector will have an important effect on the need for social care. In addition, there is much joint working across health and local government to improve public health, but also to reduce avoidable hospitalisation. There clearly could not be total harmonisation, for example between the Comprehensive Performance Assessment applying to local authorities (carried out by the Audit Commission) and the annual health check carried out by the Healthcare Commission, but joint scrutiny, as is taking place already with respect to services for older people is critical.