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DISCUSSION REPORT

Delivering choice and competition – operating a market in healthcare

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Public Policy Projects' Westminster Breakfast Discussions are an acknowledged leading forum examining issues and opportunities in health and care services policy, exploring and encouraging pathways to reform, and calibrating propositions for change. All the Breakfasts are conducted under the Chatham House Rule. This note provides our summary of the main points arising in discussion.

Context

In December last year the **Office of Fair Trading** and the **Cooperation and Competition Panel** made separate announcements of investigations into the operation of the market in healthcare. With differing perspectives – the OFT looking at the private market and whether it works well for consumers, and the CCP examining the operation of the 'any willing provider' model in elective NHS services – they will provide critical guidance to policymakers and regulators, commissioners and providers, managers and clinicians in the public and independent sectors.

The over-arching theme was the belief that choice and information were the key drivers of competition and innovation in healthcare markets, improving patient outcomes and efficiency in patient care. This Breakfast was positioned between the March **launch of the OFT study** and the mid July publication of the **final report of the CCP study**.

The immediate policy backdrop was the report of Professor Steve Field's Future Forum (on 13 June) and the government's response (on 20 June), accepting all the core recommendations. In the 'listening exercise' the role of choice and competition had been the most controversial area where the fear was of destabilising the NHS, fragmenting care and large-scale privatisation of delivery.

A big part of the difficulty was the illogical conflation in many minds of the fundamental principle of an NHS that is universal and free at point of delivery, with the operational aspects of who delivers the service. The Future Forum report talked about people being "genuinely worried" at the prospect of allowing the "private sector to get involved in large parts of the NHS", concluding that "the NHS should not be privatised".

The upshot of the government's response is a commitment to neutrality as to the dominance of the public or private sectors in service provision, an extended and phased timetable (from April 2012) for the start of Any Qualified Provider, and a re-orientation of Monitor's role away from competition and towards a level playing field, tackling anti-competitive behaviour, and the promotion of patients' interests. They have explicitly ruled out any question of privatisation.

Is this the “biggest car crash in history” feared by Alan Milburn with a constraint on independent sector partnerships, a patchwork in commissioning for years to come, and an inability to drive care out of hospitals, resulting in a failure to deliver the £20 billion efficiency savings and the inevitability of a bail-out from the Chancellor to an unreformed NHS? Or is it a careful re-presentation of the approach to fundamental reform? Time will tell.

The three bullets

- **Competition and choice** must be at the core of public services, delivering large benefits to consumers, taxpayers and staff, but a level playing field will be essential to both sides;
- **Information and health informatics** will expose performance, enable choice and allow service integration with a single view of the patient;
- **Issues to be resolved** are numerous and complex with difficult decisions ahead with the prospect that the NHS may be unable to raise its game.

The benefits of competition

Competition and choice in public services must be at the core with people able to vote with their feet, opting for a better offer. The facts were clear and consistent. Opening up public services delivers dramatically large benefits to consumers and taxpayers and workers in those services: lower prices, highly innovative and dynamic services, anticipating and responding to new consumer demands, with more and better jobs. Over time, as markets develop, a self-regulatory mechanism will also emerge. However, there were persistent and recurrent fears whenever tasks were transferred from the public sector and these fed public anxiety. Protection of vested interests and job loss was always well to the fore but the arguments were most often presented in terms of threats to public safety and loss of service quality. The reality was starkly different and what had seemed to be an impossible and unacceptable challenge delivers value to all the stakeholders.

You cannot achieve Olympic performance by protecting your athletes from competition!

The principles for competition

Competition is a means to an end. Moving service provision from state monopoly to a mixed economy is a decision for government, as is the level of competition and the boundary lines between the public and private sectors. The capital-intensive nature of healthcare is a particular factor in the viability of a competitive environment; the private sector providers will not invest without an assurance of equal terms. There are three core framework issues:

- **Level playing field** – both public and private providers enjoy a number of implicit subsidies and there needs to be clarity and transparency with a ‘competitive neutrality framework’ to balance these factors.
- **Information** – rich, reliable and multiple sources of information will be essential to expose provider performance and allow consumer choice between services and providers. Interestingly, NHS Choices had identified 8 private sector providers of NHS services in the Top 20.
- **Embedded competition** – for markets to work effectively they must have a currency and a failure regime to allow for an orderly exit of under-performers. Payment-by-Results is the beginning of the currency but it must be more dynamic. All such mechanisms must be alert to the potential for ‘gaming’ the system. The failure regime requires clarity and accountability: *who confirms failure*, the banks or CQC as the regulator?

Basically, we know how to do all this and exemplars include the European State Aid Regime and the Australian Productivity Commission. What the UK needs is a **competitive neutrality framework** across all of its mixed markets (including education, transport and health) to serve the broader debate on efficiency in public services. That framework will deliver pricing transparency in both the public and private sectors by teasing out subsidies, including:

- Public sector pension schemes
- Cheaper government capital borrowing
- Price adjustments – including the ‘bungs’ to protect services
- Public sector obligations for education, research and assured access

The Cooperation and Competition Panel

The CCP has undertaken 140 merger reviews and numerous conduct cases and advised in the resolution of a great many disputes. Disquieting points had emerged. In mergers – where many were dealing with a turnover in the range £500-£1 billion – the rationale and business case was appalling: badly argued, poorly designed, lacking taxpayer or user value, and yet fully supported by the Board and the non executive directors. What were they thinking of? In conduct cases the main complaint had been about PCT restrictions on choice of provider. The typical defence was budgetary constraint; none of them based their case on reasons of integration. Whilst there was some encouraging evidence that patients were exercising choice of provider, the disturbing counterpoint was a remarkable stability of market share among primary and acute providers.

As financial constraints bite deep, compounded by the Nicholson £20 billion Challenge, the necessity of opening the market to new providers with innovative and ingenious models must increase. The CCP was there to help (notwithstanding recent uncertainties in policy messages). New partnerships and relationships will be the key to a step change in performance, and some parts of the NHS will be bold and move fast. Planning and analysis for mergers and partnerships must improve to ensure delivery of real and significant benefit. As a rule-of-thumb on mergers 80% don't work, 50% can work, but only 20% do work – the ones that have got into the analysis and arithmetic and developed a 100 day plan!

A cautionary note was signalled around self-supply in primary care. The boundaries must be clear, we must guard against over-referral, and savings arising should end up in the public pot. Any structure which fundamentally restricts user choice is wrong. The implications of the shift in the government's language from Any *Willing* provider to Any *Qualified* Provider will need to be watched: there were Soviet overtones, dependent on who judges who is qualified.

The future of the Cooperation and Competition Panel had been assured. In the government's response to the Future Forum report it confirmed maintenance of the existing Principles and Rules for cooperation and competition and undertook to give the CCP statutory authority, retaining its identity and independence within Monitor. The “cooperation” component in the work of CCP was an essential part of the mix, as was sensitivity and full transparency, given the difficult decisions ahead.

What's left to resolve?

Actually, quite a number of challenges and issues have to be tackled over the coming months including:

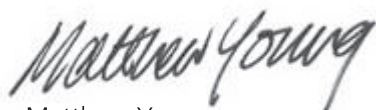
1. Competition in different services – there needs to be a mechanism that allows and stimulates consumer choice in completely new treatments, service offerings and settings for which there isn't a direct NHS comparator.
2. Personal budgets – potentially releasing several £100K to individuals will raise procurement, value-for-money and accountability issues, and the need for guidance to patients.
3. Status quo bias – we need to be wary of the resistance to innovation, particularly the stifling effects of a demand for proof of benefit. The greatest benefits are usually not foreseen.
4. Pathway constraint – integration is the future but safeguards will be needed. Competition may be exercised in choice of pathway or, if we're really clever, in pick'n'mix options.
5. New technologies – these will drive service transformation but the trick will be promotion, adoption and diffusion from the bottom up, not top down.
6. Health informatics – this will prove to be the essential enabler for the delivery of highly effective and integrated services from a multiplicity of providers and offering a single view of the patient. It's widely operated elsewhere – what's the problem?
7. Fragmentation versus Integration – yes there will be issues arising around maintaining comprehensive local/regional services, training, audit, research etc, but integration, coordination and competition are well established and stunningly effective across all other sectors. Moreover, new entrants hold the prospect of modernising traditional arrangements and delivering high value innovation.
8. Effective market operation – there are areas of constraint in price (a national tariff), in geographic monopoly (rural areas), or an absence of robust competition (perhaps a single qualified bidder) but transparency in process is an effective discipline.
9. Failure regime – this must be established with speed and determination, but we need to know who calls failure and to recognise the valuable signal of facilities' closure.

Calibrating the OFT and CCP reports

These parallel investigations were both subject to rigorous tests and to exchanges between the two organisations. There would be a comparison of positions and conclusions on the operation of the market in healthcare in advance of publication of the CCP report. The CCP ensures peer review oversight via a clinical and an economic reference group and with some of its work published in the prestigious Economic Journal.

Looking ahead

Some held the view that there is a real probability that the NHS will prove unable to raise its game. That would be bad for a mixed market. The effect would be to accelerate development of what is already a multi-tier health system. Aside from extraordinary variation in care and outcomes within the NHS, the sharp contrast is between NHS services and privately provided healthcare. Private suppliers will become increasingly efficient and the funding options and range of services will become more explicitly defined, effectively sitting seamlessly on top of an NHS-assured 'universal core service'. Unashamedly, people will make choices reflecting personal priorities about where and with what frills their core services are delivered and the result will be First, Second and Third Class services. It's inevitable.



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