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The Currie Lecture, Cass Business School

Economic regulation in healthcare

Good evening and thank you for inviting me to speak to you.

I will aim to speak for about forty minutes before we open the discussion up and I'm going to use that time, first of all, to set the scene in terms of where we are at the moment, and then, to give you an idea of Monitor's current thinking on some of the key issues associated with the health reforms.

As you will know, since I accepted the invitation to speak at this event, there have been a number of developments and changes. Not least of these is the fact that the Government has paused the passage of its reform Bill through Parliament for a period of listening and reflection. The health reforms and Monitor's proposed new role are therefore subject to change, depending on the outcome of the listening exercise. I'll touch on the implications of this in a moment.

Monitor background

However, let me begin with a brief summary of Monitor's current role. Monitor today is the sector regulator for NHS foundation trusts. We have two principal roles. The first is to set the standards for NHS organisations that wish to gain the earned autonomy associated with becoming a foundation trust and to authorise trusts as FTs when they have achieved those standards. Second, we ensure that

NHS foundation trusts comply with the terms of their authorisation – the detailed requirements covering how FTs must operate.

At the moment, there are 137 NHS foundation trusts. That represents 57% of all acute providers, 73% of all mental health providers and 18% of ambulance trusts. Overall, health expenditure represents around 7.5% of GDP and just over a quarter of this – almost 30 billion pounds – is currently spent on NHS services provided by FTs.

The Government has set a deadline of April 2014 for all of the remaining acute and mental health trusts, alongside all 11 ambulance trusts and around 15 community trusts, to become foundation trusts. At this point the FT provider sector will be spending approximately 70 billion pounds of public money.

Once a trust achieves FT status, we operate a compliance regime to ensure it complies with its terms of authorisation on an ongoing basis. If local governance arrangements fail and a trust gets into difficulty then we will step in to seek remedial action. Under the Bill's current proposals this compliance role will largely disappear over the next five years, leaving local governance as the back-stop should a trust get into difficulty.

Over the next few years we will have, therefore, to focus both on ensuring that we maintain the standards embedded in our assessment process as we assess the remaining trusts for FT status, and on ensuring that foundation trusts prepare effectively for a world of greater autonomy that they are going to move into, but

also for one in which they will face for sometime an increasingly demanding financial environment.

So that is our current role, but I want to focus this evening mostly on the Government's proposals to establish Monitor as a sector-specific regulator for health and adult social care in England - although I should say that initially the focus will be on healthcare and so I will limit myself to that sector tonight. We will, however, from the outset cover all public, private and voluntary providers, whether they're funded by taxation or privately. This role is often characterised as our economic regulator role, although in truth it is a broader role than this.

I will cover two main topics. First of all, some background on the Health and Social Care Bill. And secondly, some thoughts on how Monitor would approach its new role - assuming for the moment that the legislation stays broadly as it is currently drafted.

Now I should say at the outset, however, that it is not my assumption that the legislation will stay as it is. What I want to do is to comment on how we would approach our role as currently set out, to inform the debate. In this context I should also stress that the views I express today are personal views. Once the Bill is settled and Monitor's future role is clear I will, of course, say more, formally, on how exactly we will implement our role.

The Health and Social Care Bill

The Health and Social Care Bill was introduced into Parliament in January this year. It is a very substantial Bill which includes some 281 clauses and 21 schedules. I am told that it is the largest Bill for the NHS since “free at the point of use” healthcare was introduced in this country.

The Bill proposes a number of structural changes to the way in which the NHS in England operates. However, it maintains the vital elements that lie at the heart of today’s NHS: provision remains free at the point of use, is based on need rather than ability to pay, and is funded from general taxation.

The main structural changes that are currently proposed include:

- The establishing of the NHS Commissioning Board, whose job it will be to determine how the NHS budget should be spent to deliver the outcomes set out by the government of the day. To do this it would: performance manage GP commissioning consortia – one or two more words on those in a moment; hold - and therefore enforce - the consortia contracts with all GPs, dentists and pharmacists for the services they themselves provide; and commission specialist services, such as those for rare conditions, on behalf of GP commissioning consortia.

- It is proposed that GP consortia themselves would be responsible for commissioning the care for most of the needs of their local populations. And

they would be accountable to the NHS Commissioning Board for expenditure within a local health economy.

- Also, as I have mentioned, all providers would become foundation trusts by April 2014, free from central government control and entitled to the greater freedoms that foundation trust status brings.
- Finally, Monitor would become the sector-specific regulator, responsible for aspects of economic regulation as found in other sectors, but with a broader role.

Importantly, one area that would not change as a result of the proposed legislation is the role that the Care Quality Commission plays in ensuring that safe, high quality care is provided for all patients. That stays the same.

Monitor's new role as is currently proposed is intended, like other similar regulators, to reflect a principal duty to protect and promote the interests of people who use healthcare services through the promotion of competition where appropriate and effective regulation where necessary. In carrying out this general duty Monitor would, in particular, need to have regard to the likely future demand for healthcare services. It would also need to have regard to a number of other factors, including the benefits of achieving continuous improvements in quality, promoting investment by providers, and the need for commissioners to ensure that access is fair.

In order to fulfil its role Monitor would have four core functions:

- First, licensing providers. There would be standard conditions that apply to all providers and special conditions that apply to particular providers, for example because the ownership of the provider means that there need to be additional requirements applied to it– so that would be the case for foundation trusts.

- Second pricing, where it is proposed that Monitor and the NHS Commissioning Board would have a shared responsibility. The NHS Commissioning Board would take the lead in designing the products, needing to reach agreement with Monitor. Then, Monitor would then take the lead in calculating the efficiency requirements for the sector and setting the individual price levels, again, with the NHS Commissioning Board needing to agree these. Overall it is hoped that through the NHS Commissioning Board and Monitor working together to set prices (and therefore allowing competition to take place on the basis of quality, where this is appropriate) the system would be both efficient and responsive to the changes that are needed to support the changing commissioning patterns, themselves reflecting changing demands from patients.

- The third function would be Continuity of Service where it is proposed that Monitor would have a key role in supporting commissioners to ensure that, in the event of the financial failure of a healthcare provider, patients can continue to access the care that they need.

- The fourth function would be competition policy, where it is proposed that Monitor would have concurrent powers under both the Competition Act and Enterprise Act, as well as having a sector-specific competition regime that would cover NHS commissioners as well as all providers.

The pause and listening exercise

So these are the core elements of the Bill in relation to Monitor, at least as it stands at the present. However, as I mentioned at the outset, the Health Bill is going through a consultation process at the moment. At the end of the Commons Committee phase the Government decided that it needed to respond to the concerns that were being voiced, particularly by clinicians and other staff within the NHS, about the extent and pace of the reforms, and about some of the specific proposals. The Government therefore decided that there should be a break in the progression of the Bill to enable a listening exercise to take place, and to take account of clinical input to reshape the proposals where necessary. The listening exercise reports to Government later this month and it is expected that the Government will respond shortly after this, before the Bill then continues with its parliamentary stages.

To provide a framework for the listening exercise, which is being led by Professor Steve Field, four different work streams have been set up. These are:

1. the role of choice and competition in improving quality;

2. how to ensure public accountability and patient involvement in the new system;
3. how new arrangements for education and training can support the modernisation process and;
4. how advice from across a range of healthcare professions can improve patient care.

The first of these is of course the one that's most relevant to Monitor and its proposed future role. As I said earlier, because there is the possibility of significant change I must caveat all that I'm about to say, but I still want to comment on how we would approach the role, as currently set out, to inform the debate on any potential changes.

One of the first observations that I would like to offer is that healthcare regulation has a very different starting point from the other sectors where economic regulation has been introduced. Indeed, much has been made about the extent to which regulation of healthcare can or should be based on the regulation of the utilities sector. To be very clear, healthcare is not the same as utilities. There are lessons that can be drawn, but there are significant differences that must be fully recognised and sensitively reflected.

For example, if we look back at the starting point of economic regulation in the utility sector, this was typically characterised by one or a few very large incumbent players. The job of the economic regulator under these circumstances was mainly

to address market failure arising from market power problems. The regulators in telecoms and energy worked over a period of years to distinguish between those areas of the supply chain where competition was possible and appropriate, and the areas where effective regulation was necessary. In some cases, markets were restructured and regulation modified several times to resolve market power problems and deliver outcomes in the best interests of consumers.

Similarly, the utility sector is characterised by its high capital intensity.

Infrastructure costs are a large part of consumers' bills, whether they are for telecoms networks or replacing power stations.

Furthermore, in the utility sector, the consumer has a direct relationship with their service provider.

Healthcare is quite different. There are currently 183 providers of acute care in England and 56 providers of mental health care. These providers, combined with ambulance trusts and community providers, mean that we expect over 260 NHS provider foundation trusts by 2014. This is a very different landscape to utilities, and the interface between the regulator and providers in the sector is, therefore, likely to be very different from the somewhat adversarial relationships that have sometimes existed between one incumbent monopoly and the economic regulator in other sectors.

Similarly, healthcare provision is largely about access to specialist knowledge and skills, not about expensive capital assets. For example, there might only be a

handful of neurosurgeons who can perform certain procedures. Access to this expert knowledge is the vital component of the 'supply chain', or care pathway.

The ownership of healthcare providers is also worth pausing on. In the utility sector, the starting point has generally been that an industry has been privatised and an economic regulator introduced at the same time. It has therefore been the combination of pressure from shareholders and the economic regulators that has resulted in the efficiency improvements that we have seen.

In health, the ownership model is different. The Government has clearly set out that NHS hospitals would not be sold to inject private capital into them, and the Bill makes clear that the assets of the organisations belong to the State.

This is not to say that there would not be any private sector involvement in the sector, but this is only small at the moment – it's about 5% of NHS spend at the moment - and is likely to grow, even under current proposals, only slowly.

It is made clear that we would not have shareholders or institutional investors in publicly-owned services. Instead we would see providers overseen by elected governors who are accountable to their local membership. This would bring with it different pressures and the regulator would need to consider carefully the nature of the incentives this creates for providers.

There are other distinctive features of healthcare that are worth mentioning. For example, there are significant asymmetries of information between the medical profession and patients. GPs often need to guide patients and offer information to

help them make decisions over both treatment options and the inherent risks. At the same time, these GPs would be responsible for commissioning budgets, and may have interests in providing some treatment themselves. The scale and complexity of these 'principal-agent' issues are considerable.

My overall message is, therefore, that although each sector says it's different, there are a number of compelling reasons as to why health really is.

Competition in healthcare

Now against this background, one of the most exercising and contentious issues we have seen as the Bill has progressed is the extent to which competition can and should be introduced into healthcare provision. Let me set out our thinking on this.

First, let us be clear. There is already competition in English healthcare, and there has been for many years.

As a sector regulator, we should be guided by the evidence, and there is evidence which shows that choice and the competition between providers that goes with it can be a valuable tool, alongside other levers and incentives, driving up quality, efficiency and effectiveness, and encouraging innovation.

For example, two studies published in June last year provide evidence that competition introduced so far into the NHS has led to improvements:

- LSE researchers looked at elective hip replacement and found that hospitals exposed to competition, after a wave of market-based reforms, took steps to shorten the time patients were in the hospital prior to their surgery. This resulted in a decrease in the overall length of stay, without compromising patient outcomes. This is better for patients and better value for the tax payer.
- Similarly, a study led by Carol Propper of Imperial College and Bristol University showed that greater competition results in better management, which in turn leads to improved clinical outcomes such as survival rates from emergency heart attack admissions.

There is international evidence as well, which shows that where there is effective competition, all producers are driven to raise their game, so that even those providers that are less successful improve, and it follows that those served by them also receive better care.

However, I should say at this point that it is often inappropriate to compare the NHS and the US healthcare system.

The NHS is a single-payer system, funded through taxation and free at the point of use. In the US, much healthcare is linked to employment and funded through private insurers who compete for healthy patients and screen-out the less well.

In the NHS, more quality information and the support of GPs should help patients understand their choices. In the US, the proliferation of different prices and types of treatment make it difficult for patients to work out what suits them best.

US style competition introduced into the English system would reduce quality and increase costs. The reforms proposed for the English healthcare sector are different. They do not take us towards a US style healthcare system.

Nevertheless, we do need much more evidence about what works and what does not work in healthcare, and so a critical and early priority for any regulator of the sector must be to undertake, or to encourage others to undertake, further research. There is much more we need to know.

I do also want to be very clear that competition should always be seen as a means to an end and not an end in itself. We should not support competition for its own sake, but as a way to drive innovation, quality and efficiency. Only where it is appropriate, only where it is more likely to deliver benefits for patients and the public than other routes, should it be used. Indeed, the starting point in health will often not be competition per se but choice. Providing service users with choices about who provides their care, where and how, is a powerful tool. Empowering patients, aided by their GPs and others as appropriate, to shape the care they receive around their own needs is a benefit in its own right. Allowing different providers to compete to meet those needs is a powerful means to an important end.

Examples of services where choice and competition in the market should improve quality and efficiency include, for example, hip or knee replacement, where as long as a provider can deliver care safely, and is willing to be paid the NHS price, competition can be used to improve the patient experience.

There are also likely to be circumstances where competition for the market to run services is appropriate. A good example of this is hyper acute stroke care in London where NHS London ran a competition based on quality to select four specialist providers. Concentrating care in these four providers is designed to improve outcomes and there is clear evidence that this is working. However, if at the end of their contract a provider is found to be failing to deliver, an alternative provider can be sought. This is competition at work, delivering safer and better care in the English healthcare system.

Of note in these and many other examples of the use of choice and competition to improve outcomes and value for money is the fact that competition amongst alternative public sector providers can often be the key to realising beneficial improvements.

All of this, however, does not ignore that in some circumstances it will be inappropriate to attempt to introduce competition to service delivery. Where this is the case, Monitor as the sector regulator would need to make the best use of other tools. For example, making use of benchmarking to regulate rural and remote hospitals, ensuring that they deliver care to an equivalent quality and cost effectiveness as urban hospitals that are subject to more direct competitive pressure.

Specific competition issues

There are a number of specific issues that have taken centre stage in the debate about increasing competition in healthcare. One of these is 'competition versus co-operation'.

Our starting point is that competition and co-operation are not mutually exclusive – competition does not and should not have to come at the expense of beneficial collaboration and the integration of services. We believe that the two can co-exist as they do elsewhere, and that the aim should be to increase co-operation where this will increase the quality or efficiency of healthcare, whilst not allowing behaviours that are clearly not to the benefit of patients, such as arrangements that might exclude a service provider purely on the basis of its ownership.

Similarly, the wrong sort of integration - such as one player buying up many other players in a particular geographical area - runs the risk that patients do not have access to the best care. It would be critical, therefore, that while partnerships fostering innovation and clinical integration must be facilitated, the patient's ability to choose must also be protected wherever this is appropriate.

Consequently, it would be Monitor's job to seek to achieve a healthy combination of competition and collaboration through the approach we take. Allowing patients with long term conditions to choose the best care package for themselves, in consultation with their doctor, would also no doubt drive some further integration. GPs should be able to work with clinicians from hospitals, and hospitals should be able to work with other hospitals, to plan ways in which patient care can be

improved, provided this is done in ways that do not seek to exclude other qualified providers from participating in the provision of care as well.

Nevertheless, we understand that this is an important issue about which people have genuine concerns. Just to be clear. We believe that there are significant opportunities to promote the interests of patients through the integration of care. Where there is a net benefit to patients through greater integration of care we would not take any action that prevents it. Indeed, we would seek to promote it using whatever powers we have at our disposal.

Another issue that has come to the fore relating to competition is 'cherry picking'. There is concern that private providers could 'cherry pick' routine and less complex healthcare services and interventions that are cheaper to provide and therefore more profitable. This in turn leads to the concern that this would leave the NHS to deal with higher-cost, more complex and long-term conditions with insufficient funding to cover the higher costs, causing the destabilisation of local hospitals or, even worse, leaving the most frail and vulnerable unable to get proper care.

This does require careful examination. Most important, we take the view that to a large degree this problem is a consequence of the current Payment by Results mechanism which is not sufficiently fine-tuned to distinguish between different case mixes and does not reflect the full costs to providers of making use of other providers' 'back up services' - such as trauma services or critical care. Until issues relating to pricing can be adequately addressed, this is a market distortion that we will need to consider. We would look to bring forward measures as soon

as practicable to address the problems created by the current pricing regime so as to prevent the inappropriate destabilisation of incumbent providers whether they are public, private or voluntary sector providers. In the longer term of course, we should seek to make sure tariffs are fully cost reflective, insofar as possible. Put simply, we need to make sure there are no cherries to pick.

Nevertheless, it is very important that providers do remain able to select patients on the basis of their specific capabilities. The alternative – forcing all providers to cater for all types of patient and to provide all possible back-up services - would lead to the duplication of expensive critical care facilities and generally be inefficient.

Of course, one of the important effects of competition is that it puts pressure on poor quality or inefficient providers to ‘shape up’. If they fail to do so, if patients or their GPs don’t want to use the service, and an alternative service is readily available nearby, then they should be allowed to withdraw from providing that service. However, if this is an essential service – say chemotherapy treatment for a cancer patient where it would be highly undesirable for the continuity of service to the patient to be disturbed, or where no appropriate alternative is available - then the service must be protected.

To do this, the Health Bill allows for commissioners to designate services which need protection. In the event of the failure of a designated service provider, the consequences for the management team could be profound, with the appointment of a Health Special Administrator. However, importantly for the patient, the nature of the special administration means that essential services would continue to be

delivered. These proposals, or something equivalent, are important. Whilst we must ensure that patients have access to the care they need, we cannot allow patients to be served by poor quality and inefficient providers. Not all care offered today is good enough. Some providers have unnecessarily high costs. This wastes money that could be spent on providing more and better care.

So, to summarise on the issue of competition in healthcare. I know that there are some who worry about increasing competition; who are concerned about backdoor privatisation and the end of the NHS; and that there are some who say that encouraging non-NHS providers to offer their services would lead to poorer levels of patient care. Based on the evidence that exists, this need not and should not be the case. And it would be our job to make sure it is not the case.

Just by way of illustration, let me take you back a few years to the last significant round of reforms when foundation trusts were introduced. There were also those at that point who were concerned that the creation of foundation trusts would lead to privatisation of the NHS. Yet foundation trusts today are still fully part of the NHS, providing care free at the point of delivery and delivering significant benefits for patients and taxpayers. For example, a 2009 report found that, across the acute care sector, foundation trusts rank the highest in terms of clinical performance and sustainability; and every year that Annual Health Check ratings were given, they showed that foundation trusts performed better than other trusts.

Overall then, what this means is that the market would not just be allowed to take over and get on with it. Healthcare requires strong and independent regulation. This would be Monitor's role – to ensure effective competition where it's

appropriate, to ensure a level playing field, and to use levers other than competition – most obviously price regulation – where these are most likely to deliver the greatest benefits for patients and for the tax payer. And all the while, the Care Quality Commission would be there to ensure that the standards of safety and quality that we expect from the NHS are consistently delivered no matter who provides the care.

How would Monitor regulate?

So, finally, I want to conclude by explaining how we might carry out this new role were it to be implemented broadly as currently proposed.

The Health and Social Care Bill is very clear that Monitor's primary role would be to protect and promote the interests of current and future service users. It would be this principle that guides our approach as a regulator.

One of the features of Monitor today, of which I can be proud but for which I can claim no credit as I inherited it from my predecessor, Bill Moyes, is the professional, independent and rigorous, evidence-based approach that Monitor takes. I understand that it is for this reason that the Government, in recognition of this, has decided to build upon the foundations of Monitor to create the new sector regulator in healthcare.

My goal would be to ensure that in this new role we continue with the same approach. I want Monitor to become an exemplary regulator for healthcare, whatever the final definition of our role, building on appropriate lessons from other

sectors and healthcare in other countries, and making sound decisions in an open and transparent way based on dialogue, widespread consultation and rigorous, fact-based analysis. The role of sector regulator would be challenging and requires an organisation with technical expertise, health sector knowledge, and credible independence. We would be open about our aims and would set out our thinking as carefully and as clearly as possible so that all stakeholders can contribute to the design of the new regulatory regime. We see the move to an evidence based approach, with transparent decision making and direct accountability, as the key to how Monitor would add value. Monitor's current strengths and successes give us, I think, an excellent platform to build on.

Of course, we wouldn't be operating unilaterally. Strong and effective relationships would be key to the success of this next phase of health service reform. Partnership working with the NHS Commissioning Board, CQC and other regulators would be a key priority for Monitor, and we would have to work hard to build these relationships right from the start.

We would also need to ensure that we take a measured approach in carrying out our new role, recognising that even beneficial change needs to take place over time and in a managed way. So, we would need to take a long-term approach to foster stability so as to allow public or private providers to make long term investment decisions. As you will know, evidence from other markets shows that the longer you can provide price stability, the better sector participants can plan, invest and recover costs.

Similarly, reaching the stage where we have a fully level playing field isn't going to be a quick process as it isn't a straightforward task. While there are some quantifiable distortions which work in favour of NHS organisations, for example in the areas of tax, the cost of capital and pensions, there are others which work in favour of the private sector, such as the fact that NHS organisations tend to treat more complex cases and have responsibility for professional training of clinical staff. We would need to take the time to ensure that we gain a complete picture, and we would need to ensure that we have a long-term strategy in place.

Conclusion

So I'd like to conclude with some personal comments, but bearing in mind that everything I've said is subject to the outcome of both the listening process and the remaining parliamentary process.

I strongly believe in the NHS – a taxpayer funded system that is available to everyone equally, regardless of ability to pay.

As I learned in my previous job as Head of Policy at Number 10 – defending these values in the long term means, amongst other things, raising productivity in the NHS.

I see my role in Monitor very much as continuing the work I started under the last Government: to promote patient choice, to promote improvements in productivity, to allow local hospitals to make their own decisions, and above all to promote better outcomes for people.

I see the introduction of a new sector-specific regulator, independent of direct political influence and accountable to Parliament, as a key step in that journey towards a more productive and more devolved NHS.

So I would like to leave you with just three key points.

1. Firstly, there is evidence to show that choice and competition have delivered benefits within healthcare systems both here and in other countries. There are some areas in healthcare where I believe that choice and competition could usefully continue to be used to drive innovation, quality and efficiency in a way that will deliver benefits for patients and the public. The issue is how we ensure that this is what happens.
2. Secondly, the Health and Social Care Bill makes it very clear that in everything we do, we would be legally obliged to put the interests of patients first. This means that Monitor would, for example, promote competition only where it is clearly in the interest of patients.
3. Thirdly, the role of sector regulator would be challenging and require an organisation with technical expertise, health sector knowledge, and credible independence. Monitor already has a track record as a regulator in setting up and operating a framework of rules which work well. Our style is rigorous, evidence based and balanced, and I hope and believe that we would build on this in setting up the new sector regulator.

Thank you very much for your attention. I'm aware that there is a lot of expertise and experience in the room much of which will be greater than mine, so I'm keen to hear your views on how you think these areas of regulation in healthcare could work.

Thank you

ENDS