

**DIRECTORATE FOR FINANCIAL AND ENTERPRISE AFFAIRS
COMPETITION COMMITTEE****Working Party No. 2 on Competition and Regulation****Designing publicly funded healthcare markets – Note by the United Kingdom****26 November 2018**

This document reproduces a written contribution from the United Kingdom submitted for Item 4 of the 66th OECD Working Party 2 meeting on 26 November 2018.

More documents related to this discussion can be found at

<http://www.oecd.org/daf/competition/designing-publicly-funded-healthcare-markets.htm>

Please contact Mr Chris PIKE if you have any questions about this document

[Email: Chris.Pike@oecd.org]

JT03439615

United Kingdom

1. Introduction

1. For much of the last twenty-five years, the UK Government has sought through a series of reforms to reorganise the National Health Service (NHS) in order to increasingly embed market-based mechanisms as a way of providing incentives for improvement. In recent years, however, government policy concerning the means to achieve that objective has shifted, in light of the twin pressures of cost cuts and the increasing needs of an ageing population, to favour the use of collaborative approaches to delivering healthcare. This has impacted the role of regulators, commissioners, and providers, which must now attempt to adapt their behaviour accordingly in order to balance the delivery of multiple, sometimes varied, policy objectives.

2. This submission is structured as follows: first, sets out the background to the provision of healthcare in the UK, including an overview of recent market-based reforms and the current landscape of regulatory bodies for healthcare. It then considers competition within the NHS, in particular patient-driven competition and commissioner-driven competition, noting the NHS' role through its regulator in assessing anti-competitive behaviour and the recent introduction of new care models brought by the NHS' Five Year Forward View in 2014. Finally it highlights some of the work undertaken by the UK's competition agencies in the healthcare sector.

2. Background to the provision of healthcare in the UK

3. Healthcare in the UK is principally purchased and provided by the state, with private healthcare available but used by a small, albeit increasing, minority of consumers. The NHS is financed mainly by general taxation and is free to users at the point of use. NHS services are managed separately in England, Scotland, Wales and Northern Ireland.¹ This paper mainly discusses NHS services in England, as the UK's largest health system (covering ~85% of population).

4. 'Primary' care is provided by publicly funded physicians known as General Practitioners (GPs). GPs are mainly self-employed and work in practices which on average contain 4 to 5 GPs. GPs act as gatekeepers for hospital-based (known as 'secondary') care, sending patients who need treatment to one of the publicly-owned NHS hospitals. 'Tertiary' care is provided in specialist regional or national facilities run by the NHS. Patients may be referred to tertiary care from either primary care or secondary care.

5. Prior to 1992, local health authorities organised both the planning and delivery of healthcare services for their patients. NHS hospitals were centrally run and given annual budgets. There was no split between purchasers and providers. Hospitals were incentivised to run deficits because an overspend in one year often led to an increase in budget for the succeeding year; in addition, hospitals were not permitted to retain surpluses, as these were

¹ Those systems are similar in that they are funded through general taxation and based on a single payer model based on patient residence. There are however key differences in terms of health care delivery and autonomy of providers.

clawed back by the government to pay down the balance of hospitals in deficit. The system also essentially provided for payment upfront with no refunds, as there was no agreed basis for commissioners to withdraw funding if providers failed to deliver planned activity.

6. The majority of hospital contracts were annual block contracts, which were negotiated on an annual basis on the basis of price, service quality (that is to say, waiting times rather than clinical outcomes) and volumes. GPs were under no obligation to inform patients requiring secondary care that they had a choice in provider, and generally referred patients to the closest available hospital.

2.1. Overview of recent market-based reforms

7. During the 1990s, the Conservative government began to reform the commissioning of healthcare services by splitting the purchase and provision of such services, thereby creating an internal NHS market. To become 'providers' in that market, health organisations became 'NHS Trusts', which were in effect public sector corporations run by a board with a management relationship with the Secretary of State. In the first instance, NHS Trusts tended to focus on a particular area of hospital-based care such as acute care or mental health care. Since 2010, NHS Trusts have increasingly been providing community-based services and more integrated care along patient pathways. This change introduced a semblance of competition between hospitals. However, due to the payment system based around annual block contracts described above, hospitals had few incentives to improve their quality.

8. Between 1997-2010, the Labour government implemented a series of more fundamental reforms to the NHS. These were underpinned by an understanding that the objective of improving the performance of the NHS would be more efficiently achieved by strengthening market incentives for providers rather than relying on central management and the public service ethos.

9. In order to begin to introduce such incentives, the 2000 NHS Plan established a major shift in the way that providers were paid, with fixed annual block contracts being largely replaced by 'Payment by Results' (PbR), whereby providers were paid according to how many patients they treated and the types of services given. To support the transition towards PbR, government also introduced a national tariff system, which effectively capped the prices that could be paid by commissioners for most forms of NHS healthcare provided to individuals.²

10. The underlying principles of national tariff prices are that they should be reflective of efficient costs and that they should provide appropriate signals to encourage the efficient provision of services. There are a number of exceptions and qualifications to the standard approach to setting the national tariff.³ The NHS has recently introduced new payment

² The pricing provisions set out in the Health and Social Care Act 2012 cover healthcare services in the NHS in England only, with the devolved administrations being responsible for the NHS in Scotland, Wales and Northern Ireland. The principal categories of services not included within the tariff include certain primary care services and public health services commissioned by local authorities.

³ In some cases, the system allows for regional or 'national variations' to national prices, which aim to ensure that prices better reflect the complexity of care or location-specific costs. There are also NHS services for which there are no national prices. Some of these services have nationally specified

models such as best practice tariffs (BPTs)⁴ and pathway payments⁵ to support integrated care in clinical areas of particular importance.

11. Subsequent legislation also outlined proposals to give clinicians and managers greater freedom to run local services under organisations such as Foundation Trusts, which were introduced in 2003. These organisations were given greater operational autonomy than was previously afforded to NHS Trusts; most importantly, they were able to retain and reinvest any budgetary surpluses. The expectation was that such organisations would have increased incentives and ability to compete.

12. Primary Care Trusts (PCTs) were also introduced as organisations responsible for commissioning primary, community and secondary health services from providers. They were run by a board and were generally responsible for delivering care to a local population of around 100,000 (this number rose over time as the original number of PCTs decreased by around 50%). Until 2010, PCTs also directly provided community services.

13. Another key suite of reforms during this period aimed at increasing patient choice and provider capacity. These measures were initially intended to address waiting times, but after progress had been made towards that objective they were repurposed to drive an improvement in quality.⁶ In addition, these measures helped to ensure that NHS patients had both the formal right to choose a provider for elective care, and more options for treatment in practice.

14. In 2006, explicit patient choice was introduced through a policy requiring GPs to offer patients a choice of four to five hospitals for elective secondary or tertiary care. In 2008, the limitation of the number of providers offered to patients was removed and choice was extended to any eligible NHS or independent sector provider. In 2009, the parameters of patient choice were formally enshrined in the new NHS Constitution.⁷ Supplemental policies increased the number and capacity of private sector providers that could provide care to NHS patients.⁸ This was in full force from 2008 and, by 2013, 10.8% of total

currencies, but others do not. In both cases, commissioners and providers must work together to ensure that prices are in the best interests of patients and have been reached on the basis of transparent criteria following constructive engagement.

⁴ BPTs are tariffs tailored to the relevant clinical characteristics and standards of best practice. They apply to high impact service areas supported by a strong evidence base such as heart failure and major trauma.

⁵ Pathway payments cover a bundle of services which may be provided by several providers for an entire episode or whole pathway of care in the areas of maternity healthcare services and patients with cystic fibrosis. For example, in relation to maternity services, the commissioner makes a single payment to the lead provider of each of the three main stages of antenatal, delivery and postnatal care.

⁶ See <https://www.nuffieldtrust.org.uk/files/2017-01/choosing-place-of-care-web-final.pdf>

⁷ The purpose of the NHS Constitution was to provide in one place the details of what staff, patients and the public can expect from the NHS. For patients in particular, the constitution sets out their rights, how they can access health services, the quality of care they will receive, and the treatments and programmes available to them.

⁸ This first led to the creation of privately managed specialty centres and then to a more general programme allowing registered private providers in England to provide care to NHS-funded patients.

commissioner expenditure was used to purchase elective physical care from non-NHS providers (there is no patient choice in relation to mental health and ambulance-conveyed emergency services).

15. The NHS Constitution also explained the right for patients to access certain services within maximum waiting times. For example, NHS patients can expect to be:

- treated after a referral for elective care within 18 weeks (the NHS aims to meet this in 92% of cases)
- admitted, transferred or discharged within 4 hours if using accident and emergency services (the NHS aims to meet this in 95% of cases).

16. NHS performance against these metrics was initially strong but has steadily decreased in recent years. This decline has been attributed to a funding gap created by demand increasing at a greater rate than funding. Greater demand in particular is difficult to address in the context of a system in which access is free at the point of use.

17. Government complemented the structural reforms to liberalise healthcare markets described above by setting new guiding principles for procurement, competition and mergers in 2007. To enforce these new rules, the Co-operation and Competition Panel (CCP) was established in 2009 to investigate potential breaches of the Principles and Rules of Co-operation and Competition. Additionally, the CCP made independent recommendations to strategic health authorities, the Department of Health and Monitor (in relation to NHS foundation trusts) on how such breaches should be resolved. Those rules were then explained by the Health and Social Care Act 2012 (HSCA 2012), which also brought about the following changes which further strengthened the legislative basis for choice and competition within the NHS:

- First, it established the Any Qualified Provider (AQP) system, meaning that when NHS patients are referred (normally by their GP) they should be able to choose from a list of all qualified providers. To become qualified, providers must sign up to NHS service quality requirements, accept NHS prices and normal NHS contractual obligations. Combined with the national tariff, the AQP system was intended to focus competition between providers on improving quality.
- Second, it introduced a new licencing system for providers of NHS healthcare services. Monitor was made responsible for licencing providers and enforcing licence conditions with a view to ensuring that it was able to regulate all providers under AQP. This system gave a regulatory underpinning to ensure sustainability when introducing wider choice of provider.
- The CCP also had the function of reviewing proposed mergers and advising on the wider development of cooperation, patient choice and competition within the NHS. In 2013, the CCP became a directorate of Monitor.
- Finally, it replaced PCTs with Clinical Commissioning Groups (CCGs) as the organisations responsible for the planning and commissioning of most secondary care services. CCGs differed from PCTs in two main respects: first, they were led by GPs as opposed to a board; and second, they were smaller in size. CCGs were placed under the mandate of NHS England, which retained responsibility for commissioning primary care services such as GP and dental services, as well as some specialised hospital services.

- It is worth noting that the 2012 reforms have been criticised by some groups, including practitioners. Common criticisms of competition with the NHS include that it:
- risks fragmentation of services;
- creates unnecessary transaction costs; and
- increases scope for legal challenge, making it harder for the NHS to deliver high-quality, cost-effective and integrated care to patients.

18. Some commentators also argue that the expansion of patient choice may widen inequality. For instance, the availability of choice may disadvantage those who are less able to take advantage of it, such as the elderly, those who are not highly numerate or health literate, and those who do not have their own means of transport.

2.2. Current landscape of regulatory bodies for healthcare

19. There is a complex framework of regulatory bodies that share responsibility for the oversight of healthcare within the NHS. This section provides a brief overview of the key bodies.⁹ It is worth noting that the current shift towards more integrated care models (on which further below) suggests that there may need to be some consolidation among these bodies in the future.¹⁰

20. The Department of Health and Social Care (DHSC), led by the Secretary of State for Health and Social Care, is responsible for the NHS, public health and social care in England. It is responsible for setting high-level policy and funding for the NHS, amongst other things.

21. NHS England is responsible for setting the priorities and direction of the NHS and improving health and social care outcomes for people in England. It is required by statute to exercise its functions with a view to securing continuous improvement in the quality of services and to promote autonomy and choice within the NHS. NHS England is also a commissioner of primary healthcare services (along with an increasing number of CCGs) and specialised services supporting people with a range of rare and complex conditions.

22. NHS Improvement (NHSI) is an umbrella body which includes Monitor and the NHS Trust Development Authority. Monitor authorises and regulates NHS foundation Trusts, sets prices for NHS services (through the national tariff) and supports

⁹ Other relevant public bodies in the area of healthcare include: (i) Healthwatch England, which is responsible for representing the public's view on healthcare by gathering views on health and social care at both local and national levels and feeding these views into local health commissioning plans; (ii) the local Health and Wellbeing Boards, which were established under HSCA 2012 to promote cooperation from leaders across the health and social care system to improve outcomes for the local population and reduce health inequalities; and (iii) the National Institute for Health and Care Excellence, which develops quality standards and promotes best practice for the NHS in England and Wales.

¹⁰ To this end, NHS England and NHS Improvement have launched a joint working programme that increasingly integrates and aligns national programmes and activities, including joint appointments across both organisations' executive teams.

commissioners to maintain service continuity. Monitor oversees licensing, which gives it powers to intervene in private and publicly owned providers in financial difficulties. NHS Trust Development Authority oversees NHS Trusts in England and supports them as appropriate to ensure improvement in their services.¹¹

23. The Care Quality Commission (CQC) is responsible for regulating, auditing and inspecting providers of healthcare services to ensure that they meet common safety and quality standards. The CQC has enforcement powers including the imposition of fines, public warnings or closures if standards are not met. These powers cover all providers of care to NHS patients, including private providers.

3. Competition within the NHS

24. Following the reforms set out above, competition in the NHS typically takes one of two forms (although it can involve both):

- competition to attract patients (i.e. competition in the market); and
- competition to provide services (i.e. competition for the market).

3.1. Patient-driven competition

25. In well-functioning markets, customers can drive effective competition by making well-reasoned and well-informed decisions to purchase goods and services from firms which best satisfy their needs. Patient choice provides patients with a similar ability to drive effective competition as consumers of healthcare services (e.g. by choosing providers that offer better facilities or more integrated services). However, patients' ability to perform that role within the NHS is constrained to some extent by the boundaries of patient choice and the significant information asymmetries which can exist in healthcare.

3.1.1. The factors which constrain patients' ability to exercise choice and NHS countermeasures

26. While patients' right to choose has been expanded in recent years, that right is by no means universal. Patients have the right to choose their provider for routine elective services and, except where they arrive by ambulance, for non-elective services. Patients also have the right to choose in other circumstances affecting their pathway of care, such as the choice of a GP and GP practice and the right to move an appointment, including one involving the provision of treatment such as an operation, to a different provider if maximum waiting times are exceeded.

27. Patients mainly face information asymmetries due to their lack of understanding of healthcare but many are also unaware of their right to choose their healthcare provider in the first place. GPs, in their role as an informed adviser, have traditionally been the principal tool available to patients to overcome those asymmetries. That role was strengthened in 2006, when it became mandatory for GPs to inform patients about their right to choose. However, patient survey evidence shows that GPs do not always perform

¹¹ NHSI was created in 2015/16 but the constituent bodies under its umbrella (i.e. Monitor and the NHS Trust Development Authority) predate it.

that role effectively. The most recent NHS outpatient survey from July 2015 revealed that only 40% of people who had visited their GP in the last year recalled being offered a choice of hospital or clinic.¹² This indicates that many GPs are not promoting patient choice to the extent required, and that some GPs may be unaware of the extent of patient choice.

28. Following its commitment to open data and transparency, the NHS has developed several sources of information to assist patients in making treatment decisions.¹³ These include the NHS Choices website (launched in 2007), which provides information on both clinical indicators and non-clinical ones related to patient experience and the MyNHS website (launched in September 2014), which collates data from across the system to allow the public to compare the performance of health and care services (including at the consultant level for several high volume) over a range of measures. Despite the availability of these tools, survey results show relatively low usage of the NHS Choices website and that patients continue to rely on their GP as the principal source of information regarding the choice of a consultant.¹⁴ In light of that evidence, NHS England has launched a major project to achieve a significant improvement in the offer, awareness, uptake and operation of patient choice across the NHS by 2020.

3.1.2. Patient choice and outcomes

29. Overall, analysis of the impact of patient choice on competition and outcomes remains fairly mixed. There is some evidence that patients are more likely to choose based on quality following the introduction of choice policies.¹⁵ However, in many cases, analysis has revealed that travel time remains the key driver of patient choice despite the increased volume of information available regarding clinical outcomes and service quality. In general, it is difficult to reach definitive conclusions about the interaction between patient choice, competition and outcomes, partly due to the lack of data available for analysis. The impact on providers is also unclear as there has been little or no published data investigating the impact of patient choice on individual providers. These therefore represent critical areas for research in the future.

¹² <https://www.england.nhs.uk/wp-content/uploads/2015/09/monitor-nhse-outpatient-appointments-summary.pdf>

¹³ Sources of patient information have also appeared outside of the NHS. For example, Dr Foster Intelligence provides league tables for services such as commissioning and weekend care.

¹⁴ The failure to use supplemental information sources has not necessarily led patients to poorer outcomes. Survey results show that, among those offered a choice for their first outpatient appointment, the vast majority felt that they had enough information to help them make their decision. <https://www.england.nhs.uk/wp-content/uploads/2015/09/monitor-nhse-outpatient-appointments-summary.pdf>

¹⁵ Patient information can drive outcomes positive for the NHS even when it does not directly inform patients' exercise of choice. For example, evidence shows that patients using NHS Choices and other patient choice websites have appropriately decreased their use of GP services, with an approximate total cost saving to the NHS of around £44 million per year. <https://www.nhs.uk/about-the-nhs-website/professionals/developments/documents/annual-report/primary-care-consultation-report.pdf>

3.2. Commissioner-driven competition

30. Government has legislated to provide a specific framework for procurement by NHS commissioners. Those rules require commissioners to act with a view to achieving the following objectives when procuring NHS health care services: (i) securing the needs of health care service users; (ii) improving the quality of services; and (iii) improving the efficiency with which services are provided. Notably, these objectives do not require commissioners to extend patient choice beyond patients' rights to choose (although they can), or to promote competition as an end in itself.

31. Those rules also contain general requirements that commissioners must comply with when procuring NHS services, including: (i) to act in a transparent, proportionate and non-discriminatory way; (ii) to obtain value for money; and (iii) to consider appropriate ways of improving services, including through services being provided in a more integrated way.¹⁶

32. Commissioners must also act in accordance with EU public procurement law,¹⁷ which has the broad purpose of liberalising EU public procurement markets, when tendering services with a value over the specified threshold amount. When those regulations apply commissioners must follow a number of procedural rules concerning when and how tendering for NHS services takes place.

33. Under the current rules, commissioners should primarily procure a range of services (including elective hospital care, most community health services and mental health and learning disability services) by means of a competitive tendering process or by publishing a contract notice, unless one of three specified exceptions applies. Those exceptions are: where there is only one provider capable of providing the services in question, where a commissioner has already performed a general review of service provision and has consequently identified the best provider, and where the costs of tender outweigh the benefits.¹⁸ The broad scope of those exceptions is revealed by research (which however predates CCGs) showing that less than 3% of the £46 billion budget that local commissioners spent on commissioning clinical services in 2010/11 involved the use of a competitive tender or local AQP to secure services.¹⁹ Nonetheless, there is a widespread perception that CCGs are putting too many contracts out to tender unnecessarily, driving expense and delay into the system.

34. Commissioners must consider competition against other potential methods of achieving policy objectives such as integrated care and service quality. This tension can

¹⁶ Further specific requirements applicable to commissioners include a requirement to maintain adequate records and prohibitions on awarding contracts where there is a conflict of interest and engaging in anti-competitive behaviour unless this is in the interests of people who use health care services.

¹⁷ This was implemented into UK law by the Public Contracts Regulations 2015.

¹⁸ There was previously an additional exception which applied when the activity serves a predominantly 'social' purpose which was removed.

¹⁹ See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284634/The_Fair_Playing_Field_Review_FINAL.pdf

cause difficulties in practice when commissioners are under an obligation to demonstrate compliance with the competition and procurement legislations. For example, qualitative evidence shows that commissioners may sometimes undermine patient choice by steering patients to ‘cheaper’ contracts in order to fill block contracts and fulfil certain financial objectives (as noted above, CCGs can justify not going out to tender if one of the specified exceptions applies). Commissioners also face challenges stemming from the current drive for cost cutting, which places pressure on their incentive to select bids primarily on the basis of quality.

3.2.1. Examples of regulatory intervention to address procurement issues

35. The National Audit Office (NAO) opened an investigation²⁰ in December 2015 after a five-year contract between UnitingCare Partnership and Cambridgeshire and Peterborough CCG, worth around £800 million, collapsed after only 8 months due to financial difficulties. The NAO found that the bidders faced significant difficulties in pricing their bids accurately due to limitations in the available data. This issue was caused in part by the complex group of services involved and the long contracting period, which increased the difficulty of estimating current costs and the scope for improvement. Commentators have noted that competitive procurements in these circumstances often favour the most optimistic bidders, those making the least accurate calculations, or those planning to renegotiate terms after the contract has been awarded.

36. NHSI (through Monitor) opened a case²¹ into the commissioning of elective services in July 2015 following the receipt of a complaint that certain CCGs in North London had not complied with their regulatory obligations (including to follow the national tariff) when contracting for the services at issue. This case raised important questions about how CCGs’ actions in commissioning the elective care services should promote the interests of patients. After conducting a year-long inquiry, involving detailed engagement with a number of stakeholders, NHSI ultimately closed the case after receiving undertakings from the CCGs under investigation that they would change their practices to remedy the alleged breach of the procurement rules and to prevent such issues arising in future.

3.2.2. NHSI’s role in assessing anti-competitive behaviour

37. As noted above, both licensed providers of NHS healthcare services and NHS commissioners are prohibited from engaging in anti-competitive behaviour. NHSI (through Monitor) together with the CMA, has concurrent powers to enforce competition law²² in

²⁰ <https://www.nao.org.uk/report/investigation-into-the-collapse-of-the-unitingcare-partnership-contract-in-cambridgeshire-and-peterborough/>

²¹ Specifically, this investigation considered whether the CCGs had breached their obligations under the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and section 116 of HSCA 2012. See <https://www.gov.uk/government/publications/case-investigation-into-the-commissioning-of-elective-services-in-north-east-london>

²² In the UK, nine sector regulators have concurrent powers with the CMA to apply UK and EU competition law. There is legislation setting out how the sector regulators and the CMA decide which is competent to handle a case, including the CMA’s power to allocate in case of disagreement and the transfer from one regulator to another. A specific provision means that the CMA cannot transfer a case away from NHSI.

relation to all healthcare services in England, with the CMA additionally having jurisdiction to enforce competition law in relation to healthcare services in the rest of the UK.

38. NHSI (through Monitor) has set out²³ that in assessing competition issues, it will consider the extent to which any restriction of competition is necessary to provide benefits not otherwise possible. It has stressed that this assessment is made qualitatively, not just quantitatively. NHSI has also flagged in its guidance that a number of common behaviours, such as information sharing within professional associations may in certain circumstances be considered a breach of competition law.²⁴ Similarly, NHSI (through Monitor) has noted that the fact that a commissioner initiates, encourages or participates in an arrangement does not protect participating providers or trade associations from the possibility of breaching competition law.

39. NHSI offers to provide informal advice to healthcare service providers with questions or concerns about the potential application of competition law. Parties however are ultimately responsible for their activities and cannot treat any such advice received as formal legal clearance.

4. A shift in approach: the five year forward view and the introduction of new care models

40. The NHS Five Year Forward View²⁵, published in October 2014, recognised that the traditional divides between primary care, community services and hospitals, between GPs and hospitals, and between social care and mental health services were increasingly becoming a barrier to the personalised and coordinated health services needed by an ageing population. The document signalled an important change in policy, proposing that the NHS shift its focus towards managing integrated networks of care focussed on patients rather than organisations.

41. On a more practical level, the Five Year Forward View announced, amongst other measures, two new care models to integrate care in local areas and deliver the proposed change in approach. Under the first model, the Multispecialty Community Provider (MCP), groups of GP practices would come together to offer a broader range of services, including community and outpatient services. Under the second model, the Primary and Acute Care System (PACS), a single entity would oversee the provision of the full range of primary, community, mental health and hospital services, to improve co-ordination and shift the burden of care away from hospitals. The defining feature of the MCP and PACS models is that they create more substantial opportunities for providers to innovate in relation to payments, contracting and organisational structure than was possible under the existing, more fragmented system. NHS bodies announced that they would provide support for commissioners and providers to develop these new care models at 23 different ‘vanguard’ sites.

²³ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/354078/cc_Guidance_on_application_of_CA98.pdf

²⁴ In 2015, the CMA fined CESP Limited, a membership organisation of private consultant ophthalmologists, £500,000 for sharing confidential pricing and other commercial information in breach of competition law. See <https://www.gov.uk/cma-cases/conduct-in-the-healthcare-sector>

²⁵ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

42. These models (and the policy behind them) continue to evolve, in particular as regards issues of contracting, how to work on whole population budgets, and system design. To date, most of the MCP and PACS vanguards have focused on building partnerships between organisations, with some starting to put in place more formal governance systems so that they can work together more effectively. It has been acknowledged by commentators that for these models to produce improved outcomes they will need further time to mature and that, given the scale of the innovation involved, it may be three to five years before there is evidence of improvement. It is also worth noting that these new models raise tricky questions about the application of procurement law and the role of commissioners. It remains to be seen whether commissioners can contract for the new care models in a way that supports rather than frustrates their intended objective of promoting integrated care. Integration and greater coordination can also raise issues under competition law, meaning that design of the new care models at the ‘vanguards’ must be treated with sensitivity.

4.1. Sustainability and Transformation Partnerships

43. Pursuant to the Five Year Forward View, in 2016 the NHS and local councils came together in 44 areas covering all of England to form Sustainability and Transformation Partnerships (STPs) to develop proposals to improve health and social care. STPs were intended to facilitate the agreement of system-wide priorities, and to help stakeholders plan collectively how to improve local health outcomes. The intention was that, over time, some STPs would become Integrated Care Systems (ICS), in which NHS providers and commissioners take collective responsibility for resources and population health, often in partnership with local authorities. It is the intention that STPs and ICSs will lead to:

- less confrontational relationships between CCGs and NHS providers (thereby reducing some of the transactional costs currently associated with these contracts); and
- more joined up care (by encouraging separate organisations/teams to work together in the best interests of their population) by forming closer working relationships between organisations (e.g. alliance agreements) even if they do not involve changes to organisational form (e.g. the constituent organisations do not fully merge).

44. It is likely that the shift towards such systems reduces competition; for instance, the use of such systems could involve some areas having only a single vertically integrated provider.

45. Since publishing their initial proposals in 2016, the 44 STPs have evolved at widely varying rates and in different directions in line with local priorities. One challenge currently facing STPs in the delivery of new care models is that they do not have any legal standing and therefore cannot independently make decisions or compel other NHS organisations to act in a certain way. Legislation may therefore be required to bolster STPs to enable them to reach their objective of integrating care.

4.2. Recent competition agency casework in the healthcare sector

46. NHSI (through Monitor) has undertaken a number of market reviews in the last five years which have attempted to explore the link between choice, competition and patient

outcomes, particularly in the light of the recent suite of market-based reforms.²⁶ This section summarises those reviews and also sets out certain relevant findings from the UK Competition Commission's (one of the predecessor bodies to the CMA) market investigation into private healthcare.

4.2.1. Competition Commission – Private healthcare market investigation (2012)

47. The Competition Commission conducted a market investigation into the private healthcare sector,²⁷ following a reference from the Office of Fair Trading finding issues relating to information asymmetries, concentration and barriers to entry. Though the Commission's investigation is largely outside the scope of this paper, it is worth noting certain observations which it made in establishing the wider context for its investigation into those specific areas.

48. In particular, the Commission broadly observed that policy reforms aimed at increasing patient choice had increased the level of interaction between the private sector and the NHS. While the NHS was already funding the treatment of NHS patients at private hospitals prior to those reforms, NHS spending with private hospitals had grown so much since the reforms that the NHS had become the second largest customer of private hospitals and the fastest-growing source of revenue for private healthcare services. Overall, the Commission found that the NHS's spending with private hospitals had more than quadrupled in real terms since 2004 and accounted for over a quarter of private hospitals' revenue, on average.

49. The Commission noted that the direction of payments between the NHS and private sector was not all one way. For instance, in the 2012/13 financial year, NHS England generated approximately £500 million in revenue from the provision of privately-funded healthcare services (contributing 8 per cent of total private healthcare industry revenue), either in dedicated private patient units or in private beds in NHS hospitals.

4.2.2. Monitor – a fair playing field (2013)

50. In 2012, the Secretary of State asked Monitor to undertake an independent review of matters that may be affecting the ability of different providers of NHS services to compete. In March 2013, Monitor published its findings,²⁸ noting in particular that there were three potential distortions to the provider playing field that might impact on patients:

1. First, some providers were directly or indirectly excluded from offering their services to NHS patients for reasons other than quality or efficiency, disadvantaging those seeking to expand into new services or new areas.
2. Second, some types of provider faced externally imposed costs which were not universally applied across all providers.
3. Third, public sector providers faced less flexible statutory obligations to voluntary or private sector providers.

²⁶ NHSI has not however launched any new competition enforcement cases since 2015.

²⁷ <https://www.gov.uk/cma-cases/private-healthcare-market-investigation>

²⁸ <https://www.gov.uk/government/publications/a-fair-playing-field-for-the-benefit-of-nhs-patients>

51. Monitor subsequently published a series of recommendations to government intended to address these potential distortions, including recommendations that the guidance for commissioning services be amended and that the tariff system be made more cost-reflective.

4.2.3. Monitor review of adult hearing services (2015)

52. Monitor conducted a review of the adult hearing services market²⁹ to assess the impact of increased patient choice following the introduction of AQP in that area in 2012.

53. Monitor found that where choice had been introduced, patients benefited from an increased diversity of providers and improvements in some aspects of service quality such as wait times and appointment flexibility. Monitor's survey results revealed that patients liked choosing who provided their care, with seven in ten patients who were offered a choice responding that they found it useful to have a choice. However, most patients were not placed in a position to exercise a meaningful choice, with only one in twenty patients indicating that they had been offered a choice of hearing service provider and sufficient information to help them choose.

54. Monitor also found that the introduction of choice and the resulting increase in providers had strengthened the opportunity for commissioners to achieve better value for money. For example, commissioners had been able to require higher service specifications and, in some cases, had also achieved savings of 20–25% compared to the national tariff. Patient choice did have some negative resource implications for commissioners as they were required more often to unpick old block contracts, qualify old and new providers, and put in place and manage a larger number of contracts.

55. In light of those findings, Monitor put in place a range of policies to support commissioners to ensure that choice works in the best interests of patients. For example, Monitor provided a number of recommendations on how to run an open and transparent provider qualification process, how to promote a level playing field and how to manage spending on services.

4.2.4. Monitor review – improving GP services: commissioners and patient choice (2015)

56. Monitor conducted a wide-ranging review of GP services in 2015,³⁰ with a specific focus on how competition and patient choice can drive improvements in such services. Monitor's evidence base consisted of survey results relating to 3,200 patients, interviews with 25 GP providers, and information collected from NHS England, the CQC and other stakeholders.

57. Monitor's main conclusion in relation to patient outcomes was that a substantial majority of patients were satisfied with their GP practice and that the large majority of GP practices perform well against NHS England's and the CQC's quality indicators. However, it qualified that conclusion slightly by acknowledging there were material variations in patients' access to GP services and in the quality of services provided. While patients were

²⁹ <https://www.gov.uk/government/publications/nhs-adult-hearing-services-in-england-exploring-how-choice-is-working-for-patients>

³⁰ <https://www.gov.uk/government/publications/improving-gp-services-commissioners-and-patient-choice>

aware of and valued their ability to choose their GP practice, most did not access information that would enable them to make an informed decision about their GP practice. Patients typically chose their GP practice because it was close to their home, and not because of other things that they reported were important when surveyed.

58. In relation to providers, Monitor found that resource constraints were a principal factor preventing providers' ability to respond to patients' needs. This was mainly due to an increase in volume and the complexity of consultations, particularly in economically deprived areas with challenging health needs. Monitor noted that in some areas providers had taken advantage of opportunities to respond to patients needs by introducing new services or expanding existing ones. Finally, in relation to commissioners, Monitor found that they could be more transparent and flexible in assisting providers seeking to establish new GP services and expand existing ones.

59. Following its report Monitor committed to address resource constraints facing GPs together with a number of other national organisations. It also committed to continue sharing its findings with NHS England and CCGs and to support CCGs and patient groups to disseminate information to patients.