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Procurement, Competition and Choice in the new healthcare landscape

Monitor review - A fair playing field for the benefit of NHS patients

On 21 May 2012, the Secretary of State wrote to Monitor asking it to undertake "an independent review of matters that may be affecting the ability of different providers of NHS services to participate fully in improving patient care". His letter also set out the Government's aim that "NHS services are commissioned from the best providers, with competition based on quality".

Monitor considered the provision of NHS-funded care as a playing field on which the players are the wide variety of health care providers offering or seeking to offer services to NHS patients. If the playing field were fair, there would be nothing to prevent providers with the best services from reaching patients, regardless of the type of provider. Monitor sought to understand whether there are any systematic distortions in the playing field preventing this from happening. Throughout their work they treated all types of provider equally; with no assumption that certain types of provider might be better able to meet the needs of patients than other types. PSNC's response to the review is available on the website.

Playing field distortions

The review concentrated on distortions to the playing field that have, or potentially have, a significant impact on patients and are beyond the control of providers affected by them.

All of the providers that made comments to the review experience aspects of the playing field that they believe are unfair distortions. However, as Monitor's core duty is "to protect and promote the interests of people who use health care services", it weighed the evidence according to its impact on patients.

It found three types of distortion:

1. **Participation distortions**. Some providers are directly or indirectly excluded from offering their services to NHS patients for reasons other than quality or efficiency. Restrictions on participation disadvantage providers seeking to expand into new services or new areas, regardless of whether the providers are public, charitable or private. Participation distortions disadvantage non-incumbent providers of every type.
2. **Cost distortions**. Some types of provider face externally imposed costs that do not fall on other providers. On balance, cost distortions mostly disadvantage charitable and private health care providers compared to public providers.
3. **Flexibility distortions**. Some providers' ability to adapt their services to the changing needs of patients and commissioners is constrained by factors outside their control. These flexibility distortions mostly disadvantage public sector providers compared to other types. These are not relevant to pharmacy contractors and so are not discussed further in this briefing.

Participation distortions

Commissioners play a critical role in ensuring patients' care needs are met as well and as efficiently as possible. With limited resources to meet the population's growing health care needs, commissioners need to be increasingly rigorous in identifying the highest quality, most efficient and best coordinated care available.

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During the course of the Review, Monitor found widespread examples of commissioners failing to consider alternative providers where that might have been appropriate. Similarly, it found examples of commissioners running unnecessarily complex procurement processes. In such cases, commissioners give incumbents an advantage over alternative providers, whether public, private or charitable, and patients may finish up with a poorer service than they could have received. PSNC made comments to Monitor about such distortions to competition, faced by pharmacy contractors, and the concerns about commissioning by CCGs when their member practices have a competing interest.

Monitor's recommendations on participation distortions aim to complement current changes and support commissioners so that they can deliver benefits to patients without disrupting patient care. Specifically, the recommendations are intended to develop:

- a more stable and supportive commissioning environment, to help commissioners think and act strategically;
- better evidence, case studies and tools for commissioners, to help them identify the best solutions for patients; and
- better aligned incentives for commissioners, with a greater voice for patients.

Cost distortions

Monitor learned of many circumstances in which some types of provider face externally imposed costs that do not fall on others.

Monitor found two cost issues that affect patients and which are not currently being addressed: differences in access to rebates for VAT and the variation in cost of capital faced by different types of provider. PSNC commented on the effect of the cost of capital for pharmacy contractors but in relation to the VAT treatment of some services provided by pharmacies, there are advantages compared with other providers.

Several of the cost distortions raised by providers are already being tackled, and Monitor suggested complementary measures in some cases. The remaining cost issues that providers raised turned out, on examination, not to affect patient services, and they recommend making no changes in these areas.

Cost distortions not being addressed

VAT - Current VAT rules represent a material playing field distortion. Under the 'Contracted Out Services' scheme, public sector providers claim VAT rebates worth a substantial amount in total on contracted out services, such as legal or laundry services. However, it appears that they may no longer be eligible for all of this rebate because of changes in the healthcare sector. Private and charitable providers cannot claim VAT rebates on any of their contracted out services and this sometimes affects their decisions about supplying services. Monitor recommended that the Government reviews whether certain public providers remain eligible for VAT refunds and considers extending rebates to services provided by the charitable sector, where they would be eligible and that the Government re-invests any resulting net saving in the NHS.

Cost of capital - Many providers raised the differential cost of capital faced by different providers. Private and charitable providers borrow (and in the case of private providers, raise equity) at rates that reflect the lender's risk of not recovering the capital. Public providers, however, do not. It was helpful to pharmacy contractors that Monitor recommended that risk is priced into the cost of capital for all providers.

Cost distortions already being addressed

Pensions - Private and some charitable providers serving the NHS cannot generally offer continued access to the NHS Pension Scheme to staff transferring to them from a public provider. Instead, these providers must offer a broadly comparable private pension, which costs them more than the NHS Scheme costs public employers. These additional pension costs deter some providers from bidding for contracts. PSNC in its response to the review highlighted that pharmacy contractors and their staff cannot access the NHS pension scheme.

The Government has made a commitment to allow NHS staff who are members of the NHS Pension Scheme to retain their membership if they are transferred to a non-public health care employer. However, to remove this distortion fully, all staff working in NHS-funded health care services should have access to the NHS pension scheme, not just those

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currently working for the public sector. Monitor recognises this presents practical challenges but recommended that the Government works to overcome them.

Clinical negligence indemnity - The Clinical Negligence Scheme for Trusts (CNST), overseen by the NHS Litigation Authority, is open only to public sector providers. Contributions for CNST indemnity do not fully reflect the risks of individual providers, which creates a distortion among providers in the Scheme that have different levels of risk but pay the same rate for their indemnities. There may also be distortions between public providers in the Scheme and other providers who cannot gain access to it. PSNC made the point that pharmacy contractors are unable to access the scheme.

The review indicates that the Government has already laid regulations to open the CNST to charitable and private providers. Monitor recommended that the Department of Health and the NHS Litigation Authority also improve the pricing of risk within the CNST and minimise barriers to joining and leaving the Scheme for all types of provider.

Education and training - Responses to Monitor's initial request for evidence suggested that the requirement to provide education and training for clinical staff disadvantaged public providers because independent sector providers are able to recruit trained staff without incurring the costs of training them. However, since the aggregate funding of provision of education and training appears to match the aggregate costs, this is not a distortion between types of provider. Nevertheless, the current system for funding undergraduate and postgraduate education and training does create a distortion amongst providers within the public sector. This system pays more per trainee to some large, established public sector hospitals than to other public sector hospitals.

Health Education England is responsible for reforming clinical training arrangements to ensure funding reflects the underlying costs, which should remove this distortion. PSNC made the point in its response that there is not always equitable access to training for clinical staff (although the development of LETBs may address this). We commented that LETBs may be swayed by large NHS employers. We also raised the point that there is little standardisation of training requirements across PCT areas, and this was undermining mobility of the pharmacy workforce.

Further Discussions

Following submission of PSNC's comments to the review, we were invited to attend, to discuss PSNC's concerns in more detail. We emphasised that there was real concern amongst pharmacy contractors that when CCGs are responsible for commissioning, pharmacy contractors may not be commissioned, where the CCGs GP practices are direct competitors. We were also able to share recent examples of direction of prescriptions, and other anti-competitive activity.

Procurement, Patient Choice and Competition Regulations

During the passage of the Health and Social Care Bill, the Government responded to concerns about the future application of choice and competition in the health service by committing to retain the existing non-statutory administrative rules (The Principles and Rules for Cooperation and Competition), that concern procurement for clinical services, and place them on a firmer, statutory footing. On 13 February 2013, as part of the arrangements the Government laid the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013.

The Regulations imposed requirements on NHS England and CCGs to ensure good practice in procurement of health care services; to ensure protection of patients' rights to make choices regarding their NHS treatment; and to prevent anti-competitive behaviour by commissioners.

Where a commissioner advertises an invitation to providers, it would be required to publish a notice on a website maintained by NHS England, but there was no requirement to advertise where the commissioner is satisfied that the services are capable of being provided only by a particular provider.

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There was a prohibition on anti-competitive behaviour which is against the interests of users of NHS services. There would also be a prohibition on the award of contracts where there are conflicts between the interests of commissioning and providing services, and commissioners would be required to establish and apply transparent, proportionate and non-discriminatory criteria for making commissioning decisions. There would be a requirement to publish a record of all contracts.

Monitor was provided with powers to investigate and take enforcement action in relation to breaches of the requirements imposed on commissioners, and this included the power to declare contracts that were in contravention of the requirements as ineffective. Monitor also had power to issue directions to commissioners.

These regulations were opposed, and particular concern was raised about the apparent power of Monitor to require commissioners to undertake competitive tendering, and the possibility that Monitor may interfere with contracts that had been agreed. As a result of the challenges, the Government hastily reviewed them and on 11 March, revised Regulations were laid which revoked the earlier set.

The changes to the regulations made clear that:

- there is no requirement to put all contracts out to competitive tender. Commissioners are able to offer contracts to a single provider where only that provider is capable of providing the services;
- Monitor has no power to force the competitive tendering of services; and
- Competition should not trump integration - commissioners are free to use integration where it is in the interest of patients.

The Regulations place requirements on commissioners to ensure accountability and transparency in their expenditure. In particular:

- to record the rationale for their decisions and how they have met their duties as to quality, effectiveness and the promotion of integration;
- to publish details of the contracts that they have awarded;
- to not award contracts where conflicts or potential conflicts of interest have, or appear, to affect the integrity of the decision; and
- not to engage in anti-competitive behaviour unless to do so is in the interest of patients. Behaviour in the interests of patients may include services being provided in an integrated way or co-operation between providers in order to improve the quality of services. Questions of anticompetitive terms or conditions would not be considered in isolation from the objective of improving quality and efficiency, and securing the needs of patients.

These regulations also establish the framework under which Monitor will exercise its duty to protect and promote the interests of people who use health care services. The regulations provide the following powers:

Powers of investigation - Monitor may investigate a complaint received by it that a commissioner has failed to comply with a requirement imposed by the above regulations or by specified regulations in The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

An important feature is that Monitor may on its own initiative investigate whether a commissioner has failed to comply the regulatory prohibition on anti-competitive behaviour. This means that a complaint from a patient is not required to trigger an investigation.

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Commissioners are required to provide Monitor with such information in its possession as Monitor may specify for the purposes of an investigation.
The power of Monitor includes:

(a) power to require the commissioner to provide an explanation of such information as it provides; and
(b) in relation to information kept by means of a computer, power to require the information in legible form.

Declaration of ineffectiveness - Monitor may declare that an arrangement for the provision of health care services for the purposes of the NHS is ineffective where it is satisfied that in relation to that arrangement, a commissioner has failed to comply with some of the requirements imposed by the regulations, where the failure is sufficiently serious.

Power to give directions - Monitor may direct a commissioner:

(a) to put in place measures to prevent failures to comply with a requirement imposed by the regulations;
(b) to put in place measures for the purpose of mitigating the effect of such failures;
(c) to vary or withdraw an invitation to tender to prevent or remedy a failure to comply with specified requirements;
(d) to vary an arrangement for the provision of health care services made in consequence of putting the provision of services out to tender to remedy a failure to comply with a requirement imposed by the regulations;
(e) to vary an arrangement for the provision of healthcare services to remedy a failure to comply with specified regulations;
(f) to otherwise remedy a failure to comply with a specified requirement.

However, Monitor may not direct a commissioner to hold a competitive tender for a contract.

Undertakings - Monitor may accept an undertaking from a commissioner to take action of a kind mentioned in its powers to give directions, and within such period as is specified.

Guidance - Monitor has a duty to publish guidance for commissioners on compliance with the Regulations and how it intends to exercise its enforcement powers. Monitor must consult and must obtain the approval of the Secretary of State before the guidance is published.

NHS England will also publish guidance in early 2013 to help CCGs understand and work within the Regulations, including in relation to conflicts of interest. NHS England and Monitor are working closely together so that their guidance is consistent and will bring the guidance together through a resource for the NHS called the Choice and Competition Framework.

The regulations can be accessed at www.legislation.gov.uk/uksi/2013/500/made.

In a recent HSJ interview with David Bennett, chief executive of Monitor, he rejected claims that the new competition regulations could lead to a sharp increase in competitive tendering for NHS services. He said “Fortunately for the patients of England, we have a duty to do whatever we do with a focus on what’s in their best interests. We would be mad to enforce those rules in a way that leaves commissioners spending all their time running competitive processes because they’re terrified they’re going to get into trouble if they don’t”.

Mr Bennett noted that there were 211 CCGs, each with an estimated 60 to 600 contracts, while Monitor would have only around 40 employees investigating competition issues. “We’re going to have to prioritise and we’re going to be extremely clear about how we will prioritise what we do. We will be focusing on areas where we think opportunities to improve the service delivered to patients have been missed in a serious way”.

David Bennett and Catherine Davies (Monitor Cooperation and Competition director) told HSJ competition regulation would be largely "complaints driven", and its assessment of complaints would hinge on whether the commissioner had acted in a reasonable way. They suggested this would begin by looking at the commissioning plan the CCG had developed with its HWB.

Monitor's steps would be to ask, have they gone through a process? Have they established a commissioning plan that sets out what they want to do? Is the conclusion they've reached a reasonable conclusion given the steps they've followed?

Mr Bennett also indicated that in some cases it might be reasonable for commissioners not to run a competitive process for a service, because they did not feel they were able to accurately measure the quality of their existing provider. "It's fair to say that the quality metrics in community and mental healthcare are poorer than they are in acute services. So if a commissioner says my focus in the next year is on getting a much better grip on the quality of care my patients are being provided by the current provider, we would say that sounds like quite a sensible thing to do".

Since the publication of the report of the Fair Playing Field Review, and the Regulations, DH has accepted Monitor's proposal, set out in its Fair Playing Field review, to undertake more work on commissioning of GP services. Monitor's report says questions were raised during the course of the Review about the extent to which the commissioning of general practice and associated services in particular is operating in the best interest of patients.

Issues raised included:

- the rules for setting up a general practice;
- the different contractual terms under which practices operate;
- the perceived reluctance of PCTs to commission new services against the wishes of existing local practices and Local Medical Committees;
- perceived conflicts of interest that may in future prevent clinical commissioning groups from commissioning services from new entrants; and
- concerns about a lack of choice of general practitioners for patients.

The report proposed that 'Monitor should issue a call for evidence by June 2013 to help determine the extent to which the commissioning and provision of general practice and associated services is operating in the best interests of patients'.

Whilst this review is primarily about patients accessing medical services, there is a reference to perceived conflicts of interest that may in future prevent CCGs from commissioning services from new entrants – and Earl Howe said: "We are committed to making sure that patients can access services delivered by the best possible providers. We are constantly working to improve the quality of care that patients receive and creating a fairer playing field will help to do this".

PSNC will continue to input into any reviews that may be relevant to the commissioning of pharmacy contractors by CCGs.

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