The Care Quality Commission (CQC) response to the Competition Commission Private Healthcare Market Investigation

1 Introduction

1.1 This is the CQC response to the Competition Commission investigation of the private healthcare market. It is based on:

- our knowledge of regulating NHS and private dentistry and the wider private healthcare (PH) industry,
- our involvement with the OFT roundtable discussions during 2012 which fed into their Private Healthcare Market Study,
- our understanding of the wider regulatory health reforms and changing landscape of private healthcare provision.

2 CQC as a Regulator of Healthcare

2.1 The Care Quality Commission is the independent regulator of health and adult social care services in England. Our aim is to make sure that better care is provided for everyone, whether it is in hospital, in care homes, in people's own homes, or anywhere else that care is provided. Providers' who carry on a `Regulated Activity',[1] are required by law, to register with the CQC. We also monitor the Mental Health Act 1983 to protect the interests of people whose rights are restricted under the Act.

2.2 CQC strategic aims focus on quality, and acting swiftly to eliminate poor quality care; and ensuring care is centered on people's needs and protects their rights. We have a wide range of enforcement powers to take action on their behalf if services are unacceptably poor.

2.3 CQC regulates NHS healthcare and much of the wider private healthcare industry, including NHS and private dentistry. The Scope of Private Healthcare Regulated by CQC includes the following:

- Acute independent hospitals and services
- Mental Health hospitals (including those who treat persons detained under the Mental Health Act or suffering from substance misuse)
- Hospices
- Termination of pregnancy providers
- Maternity services
- Hyperbaric oxygen services carried out by or under the supervision of a medical practitioner
- Services carried out by or under the supervision of a healthcare professional, including certain private doctor services
- Diagnostic and / or screening services

[1] Regulated Activity means the activities prescribed in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ("The Regulated Activities Regulations")

CQC does not regulate all private health care. For example, talking therapies, such as cognitive behavioural therapy or counselling.

2.4 Further information about CQC and the services we regulate can be found in our guidance about compliance and on our website: www.cqc.org.uk

3 Response to the Competition Commission investigation questions

3.1 CQC has an interest in the investigation insofar as these might impact the nature of the services we regulate or the people who receive them. For example, the recent report on the market study for private healthcare carried out by the Office of Fair trading (OFT) and their study to examine competition and consumer aspects of the market for NHS and private dentistry.

3.2 Both CQC and the public may also directly benefit from the outcomes of the investigation. For example, if subsequent developments provide access to publicly available, consistent information and data, which enables CQC to make comparisons about outcomes for patients across particular healthcare professionals and / or providers. Providers would also benefit in terms of being able to assess and monitor the quality of the services they provide in order to drive improvements. This would be of interest to CQC and particularly in relation to our regulatory role around monitoring compliance with regulations and outcomes for people (for example under Regulation 10 of the Regulated Activities regulations outcome 16[2]).

3.3 The Competition Commission (CC) is seeking views on the five questions below. CQC are pleased to contribute this response and has provided a response on the following:

Question a): the definition of the relevant market or market(s)
We note the CC definition and agree that it reflects the scope of the PH market and makes it clear that this does not include NHS funded healthcare in the private healthcare sector. However, does this mean that care funded by Personal Health Budgets is excluded as well? In practical terms how easy will it be to draw such clear distinctions? Also some private providers will also provide NHS funded care and therefore this is likely to have an impact on the privately funded care.
Question b): how easy it is to enter the relevant market(s)
CQC are required to register those private healthcare providers that

[2] Outcome 16 within the CQC Essential standards of quality and safety, March 2010

fall within the scope of the Health and Social Care Act 2008. Registration is based on the quality and safety of care that will be provided. Our processes for registration can be found on our website (http://www.cqc.org.uk/), but we aim to receive applications and process these quickly (usually within 8 weeks) as long as they are fully completed. Although we are continually improving the customer experience of registration we do not believe that our process impacts adversely on being able enter the market. We do not charge fees for registration although thereafter they pay and annual fee. For further information please see details of our fees scheme here: http://www.cqc.org.uk/organisations-we-regulate/registered-services/fees.

NHS trusts which develop private patient units (PPUs) are not required to register these separately, they form part of the overall registration. To enter the market may be slightly easier and has the benefit of 'shared' services/facilities, over wholly private facilities entering the market for example, with a new build facility and associated costs.

In addition to registration with CQC, under the Health and Social Care Act 2012, in the future, providers of NHS funded care will also need to be licensed by Monitor, the market regulator. More information can be found here: http://www.monitor-nhsft.gov.uk/monitors-new-role

Under new powers, Monitor will also be responsible for ensuring that NHS services operate economically, efficiently and effectively and will regulate prices through setting the national tariff (with room for local flexibility). So pricing for NHS funded care will be explicit. We are not sure how this might influence or have implications for, the pricing of private care.

We are not sure if relevant to highlight but some private providers may also need to be registered with the Charity Commission.

Question c): the structure of the markets(s) for privately-funded healthcare

We are now seeing a variety of models and structures in the market which in some ways are opening up more opportunities for professionals working in them (for example, the Circle model). CQC has also been looking at innovative service models that are developing and trying to ensure that registration with CQC does not act as a barrier for these new service models entering the market (including working with other regulators and sharing information). We have developed streamlined scope guidance[3] so that providers can see whether they should be registered and to some degree this does give a broad picture of the range of service models currently operating.

[3] The scope of registration, CQC, July 2012

From time to time we may carry out some market analysis to inform how we feedback on future review of regulations. We might also gain insight to where there may be gaps where services might need to be regulated for safety reasons or conversely where services are low risk and may not need to be regulated. One of the areas where there is a growing increase in provision is in services such as telemedicine and internet based diagnostic services. Whilst some services can be more easily regulated where they are wholly provided in England, if for example some reporting is carried out outside of our sphere of regulation, it is not possible to regulate the quality. For example, a diagnostic procedure can be undertaken in London but reported on abroad. CQC has no remit for that and can only monitor the arrangements the provider has in place for monitoring the quality of that reporting.
Question d): the conduct of, and the extent of competition between, current providers (including hospitals/clinics and consultants) of privately-funded healthcare.
Our recent market study[4] detailed that we currently regulate 1,227 providers of independent healthcare across 2,764 locations[5]. Of those 862 that were inspected, the majority were meeting the government standards. CQC does not know the extent to which its findings might influence competition. However, we are aware that the independent sector has further developed its Hellenic project and a new organisation has recently been established (the Private Healthcare Information Network (PHIN) to take forward the work around information. Whilst many of the large providers may participate in submitting information, there may still be some that do not, for a variety of reasons.
Question e): the existence of consultant groups.
CQC do not feel it is sufficiently informed to comment on this question.
Question f): the role or conduct of private medical insurers.
CQC do not feel it is sufficiently informed to comment on this question.

3.4 To supplement our response we have also enclosed a copy of our comments to the OFT private healthcare market study scoping paper which provides some further background

[4] CQC Market Report, Issue 1, June 2012
[5] Note: A 'location' as defined in CQCs 'What is a 'location' guidance for providers, 2010

3.5 If appropriate, we would be pleased to discuss or clarify any aspect of our regulatory role or provide further supporting information. We hope these comments are helpful and if you would like to discuss any of the points raised please do not hesitate to contact us.

July 2012

Encls: The Care Quality Commission (CQC) response to the Office of Fair Trading (OFT) scoping paper on their proposed market study into private healthcare (PH), January 2011

The Care Quality Commission (CQC) response to the Office of Fair Trading (OFT) scoping paper on their proposed market study into private healthcare (PH)

1 Introduction

1.1 This response provides information about CQC as a regulator of private healthcare in England. It aims to provide the OFT scope of the market study with an introduction to our knowledge of regulating the industry, the wider UK regulatory systems and changing landscape of private healthcare provision. We will be happy to provide further information about the sector from a regulatory perspective if that would be helpful.

2 CQC as a Regulator of Private Healthcare

2.1 The Care Quality Commission is the independent regulator of health and adult social care services in England. Our aim is to make sure that better care is provided for everyone, whether it is in hospital, in care homes, in people's own homes, or anywhere else that care is provided. We also protect the interests of people whose rights are restricted under the Mental Health Act 1983. CQC strategic aims focus on quality, and acting swiftly to eliminate poor quality care; and ensuring care is centered on people's needs and protects their human rights. We have a wide range of enforcement powers to take action on their behalf if services are unacceptably poor.

2.2 The Health and Social Care Act 2008 introduced a new, single registration system that applies to all health and adult social care services. If a provider carries out a 'regulated activity' as defined by the Government in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, they are required to register with CQC.

2.3 The Government has also set out essential standards of quality and safety which apply across both health and adult social care. The registration system is based on our assessment and ongoing monitoring of providers compliance to ensure the care that people receive, meets the essential standards.

2.4 CQC have produced guidance about compliance[1]
which explains what providers need to do, to meet the standards and the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. If we find that a registered provider is not meeting the standards or complying with their statutory obligations under the Health and Social care Act 2008, we will take action quickly to ensure improvement and where appropriate use our enforcement powers.

[1] Guidance about compliance: Essential standards of quality and safety, March 2010

3 The Scope of Private Healthcare Regulated by CQC

3.1 CQC regulates a spectrum of private healthcare under the Health and Social Care Act 2008. This includes the following examples of service provider type:

- Acute independent hospitals and services
- Mental Health hospitals (including those who treat persons detained under the Mental Health Act or suffering from substance misuse)
- Hospices
- Termination of pregnancy providers
- Maternity services
- Hyperbaric oxygen services carried out by or under the supervision of a medical practitioner
- Services carried out by or under the supervision of a healthcare professional, including certain private doctor services
- Diagnostic and / or screening services

3.2 CQC does not regulate all private health care. For example, talking therapies, such as cognitive behavioural therapy or counselling.

3.3 Further information about CQC and the services we regulate can be found in our guidance about compliance and on our website: www.cqc.org.uk

4 Feedback to OFT on the Proposals for the Study

4.1 CQC is pleased to comment on the proposals for this study. Consistent with a predecessor regulatory body[2], it has considerable experience of regulating a large part of the PH sector, including knowledge of the changes and developments that have shaped the PH market today.

4.2 Overall, CQC feels that the scope of the study is comprehensive and hope that its comments are helpful in clarifying definitions and the regulatory landscape of private healthcare.

4.3 Our comments:

1 Clarification on the term 'PH consumer'

In the scoping paper (para 1.6) the term PH consumer is defined. CQC would like to suggest that the last part of the sentence "NHS patients obtaining private treatment via the NHS" could be further clarified as it may be interpreted to include all of the three types of arrangements listed below or limited to only one:

- NHS private patient units
- NHS private amenity beds
- NHS funded care in the private sector
- NHS patients privately 'topping-up' care

[2] The Healthcare Commission

CQC has taken the definition to mean all arrangements within this response paper.

2 Clarification on the term 'acute medical treatment'

In the scoping paper (para 3.1) the term 'acute medical treatment' is defined. CQC would like to suggest that it may be helpful to avoid misinterpretation, that 'recovering from surgery' would mean the patient has been transferred to the PH facility for the purpose of recovering from surgery as opposed to having their surgery carried out in the same facility?
The phrase 'severe illness or injury' may also require further clarification as 'severe' may be widely interpreted, from a coronary event requiring specialised intensive care facilities to a fractured femur that usually can be managed within low dependency settings.
From the definition used, we interpret the overall definition as excluding, privately funded cosmetic surgery, the main purpose of which is to improve appearance. However, the latter may account for a significant element of private healthcare business.
Hospices (whose work is often grant aided by Strategic Health Authorities (SHAs) / Primary Care Trusts (PCTs)) may also be deemed as providing specialist palliative care for acute episodes of treatment and care during a patients' illness and it may be helpful to clarify that these services are out of scope.

3 Clarification on the term 'medical professional'

In the scoping paper (para 1.6) states that OFT proposes to limit the study scope is to PH which is provided by a 'medical professional'. CQC would like to suggest that it may be helpful to clarify this definition. For example, does it solely refer to a medical practitioner or is it wider, including professionals such as doctors, dentists or nurses? In the current PH market, treatment is often a combination of that provided by a medical practitioner alongside other healthcare professionals and referral routes may be from a nurse to a doctor or physiotherapist to a doctor and vice versa. The patient treatment pathway is often complex and may involve several providers. For example diagnostics being provided by the NHS and treatment by the private sector or vice versa.
In para 3.1 the term 'consultant' and 'other medical professional' are referred to. It is usual for private hospitals to only permit Consultants or medical practitioners whose name appears on the specialist register of the GMC and only once they have carried out a range of personal and professional checks on the person to use their facilities. These were standards that PH providers were required to meet under previous (now repealed) legislation[3] and which have likely influenced the market provision as it is today.

[3] The Care Standards Act 2000 and the National Minimum Standards for Independent Healthcare, Department of Health, 2002

5 The requirements of being regulated

5.1 All providers who carry on a 'Regulated Activity' are required by law to register with the CQC. In the first instance, this requires the provider to submit an application for registration. For the application to be granted, the provider is vetted to ensure they are able to provide the services and must be able to demonstrate that they meet essential standards of quality and safety and legal requirements of the Health and Social Care Act 2008. Additionally, the first time they apply for registration, they are required to pay a registration fee and once registered will be subject to annual fees. Further information about our fees and fee scheme can be found on our website; http://www.cqc.org.uk/guidanceforprofessionals/independenthealthcare/registration.cfm

5.2 Once registered, a service will be subject to ongoing monitoring, including where necessary, inspection by CQC, to make sure that it continues to meet essential standards and the provider complies with the law. We use our guidance about compliance and judgement framework[4] to decide whether services are continuing to meet the standards. CQC has powers to take enforcement action against a provider who does not make improvements in their services and can also prevent them from carrying on a regulated activity. Enforcement action may range from a warning, to placing a condition on a providers' registration which requires them to address a particular failing. Alternatively, a condition may place a restriction on the service being provided. Any breach of a condition is an offence for which CQC may take enforcement action. Enforcement may also be in the form of a fixed penalty offence fine. (A fixed penalty fine may be offered as an alternative to prosecution). In cases of a serious major concern enforcement action may be taken to close a provider's service. The outcome of our monitoring and enforcement action is published on our website.
As part of their legal obligations, registered providers are required to notify CQC of certain events. For example, certain changes in the provision of the service, absence of management and notification of death or serious injury of a person using the service.

5.3 In addition to being regulated by CQC, PH providers may be checked and inspected by other regulatory agencies[5] and also commissioners of their services and although these are not barriers to entry, providers may need to satisfy a range of other 'enactments' in addition to those within the specific remit of CQC.

6 Markets for consumers and choices

6.1 The OFT jurisdiction covers the UK, across which there are variations in the way the PH sector is:

- regulated,
- what PH is regulated

[4] Guidance about compliance Judgement Framework, March 2010
[5] For example, the Health and Safety Executive or Environmental Health

- how PH has changed or improved over the last decade and
- to what extent it is used for NHS funded healthcare

Until October 2010, the legislation governing PH in England and Wales was the same but this was replaced in England by the Health and Social Care Act 2008 which saw some more minor PH services[6] exempted from regulation but the bringing into regulation of NHS services.

6.2 The regulatory bodies and health departments of the four UK countries have collaborated closely over the regulation of private healthcare although all acute PH hospitals are required to be registered, there are some small but significant differences in the types of services regulated and the standards they are required to meet. For example, Wales continue to regulate the use of a laser or intense pulsed light source for non surgical cosmetic treatment whereas England and Scotland do not. Wales have specific national minimum standards for PH whereas England has generic standards for both the NHS, adult social care and PH sectors.

6.3 The introduction of a separate national regulatory regime across each of the UK countries means that there is now more information about the performance of PH providers through the publication of reports by regulators. Greater awareness of the need for sound governance and its role in ensuring the quality and safety of services (and ultimately in reducing costs for negligence and litigation claims) has helped to improve standards.

6.4 There remain different approaches to the use of the PH sector for NHS funded care which in England has continued to grow, whereas in Wales, the Welsh Assembly Government 'One Wales' document[7] sets an agenda for reducing the private sector role in NHS funded care. It is difficult to say whether lack of private competition for NHS funded care has had any impact / influence on local market entry or quality of services.

6.5 In England, NHS Choices has enabled PH providers to bid for services and patients to benefit from waiting list initiatives and being able to choose where they have their treatment. When these initiatives were first introduced by the Department of Health in the last decade, this had a significant impact for example, on orthopaedic and ophthalmic waiting lists which were long for procedures such as hip replacement or cataract removal. The introduction of waiting list initiatives by the PH sector also meant that patients who may have previously decided to pay for their surgery in order to get treated more quickly no longer needed to do that. In addition patients benefited from a right of redress through the NHS where things went wrong. However, there have been few PH providers who have provided tertiary level care and more complex acute care has remained the domain of NHS provision, although this may change with the advent of the new Health and Social care Bill 2011.

[6] For example, use of a Class 3b or 4 laser for non surgical cosmetic purposes
[7] One Wales, A progressive agenda for the government of Wales, June 2007

7 Nature of competition - the regulators' perspective

7.1 CQC have set out above, the requirements and impact of being regulated. In terms of regulatory compliance – which is of course different to any effects that competition may have for consumers or suppliers – we would probably highlight that competition in the acute hospital sector assists by incentivising compliance.

We have no evidence to say that market concentration by area impacts on competition but certainly the type of facilities available may impact on the level of acute services which can be offered. For example, if one hospital has an Intensive Care Unit whereas other hospitals in the area only have a high dependency unit this will limit the types of procedures that can be offered.

8 Healthcare professionals who operate in the PH sector (including those with Practicing Privileges)

8.1 Doctors working in hospitals are usually self-employed but subject to an agreement on the grant of practising privileges (admitting rights) by a registered provider. This agreement enables CQC to hold the hospital accountable for compliance with requirements for safety and quality, rather than expecting each self-employed doctor to register individually, in addition. 'Practising privileges' is a term that is used in legislation and defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as: '*the grant, by a person managing a hospital, to a medical practitioner of permission to practise as a medical practitioner in that hospital*'. The independent sector itself has taken steps to develop model policies and procedures (notably through the BMA, GMC and larger provider companies with their representative organisation, IHAS[8]). This currently works well from our perspective, although no equivalent exists for other clinical staff.

8.2 We have noted changes in recent years, such as increases in the employment of overseas doctors and dentists from other EU countries, particularly central and eastern European countries, and particularly by corporate groups. We are aware of concerns that this causes within the sector about competition but there is no noticeable effect on compliance with our requirements for quality and safety of care. Similarly, we are aware of the partnership model developed by the Circle Health Group[9], and the questions that this has raised for neighbouring hospitals using a more traditional model but it has not affected their ability to register with us and obtain a licence to operate.

8.3 It is for professionals working outside of hospitals in private practice (or in private contractors to the NHS), that regulation creates the most significant structural barriers to market entry. This part of the sector is often the most innovative and quick to respond to patients' needs. But as it is characterised by small enterprises without the resources or resilience of large companies, it

[8] The Independent Healthcare Advisory Service
[9] http://circlehealth.co.uk/

is also potentially more vulnerable to structural barriers. We include primary medical care in this grouping.

- Our legislation is complex in this area. That complexity, combined with a high rate of innovative service models, makes this by far the area in which we receive the most complex queries about whether a provider must register. This may potentially discourage or delay market entry, especially when combined with complex requirements and differential treatment by PCTs under NHS regulations for general or personal medical or dental services.
- Our legislation imposes different requirements on different situations, depending on whether a private doctor also works for the NHS. A wholly private doctor must register, but a doctor who has a single NHS patient will be exempt (unless they are captured by a further complex set of rules depending on which procedures are carried out). This creates an uneven playing field and potentially discourages proper growth of this market.

8.4 The Department of Health is aware that this situation is unsatisfactory and has committed itself to keeping this legislation under review. CQC are actively looking at what we need to do to ensure that we are not inhibiting innovation and developing markets across the sectors we regulate.

9 Information sharing

9.1 From a regulatory perspective, the ability to compare performance through standardised data reduces the need for physical inspection and therefore costs. At present, independent sector providers do not all have standardised data definitions and cycles, with the result that their frequency of inspection and their regulatory fees may be higher than for an NHS trust. Although there are national projects initiated by the sector to collaborate and improve this situation, the ability to compare data also significantly affects providers' ability to compete on the basis of quality, and consumers' ability to make informed choices.

9.2 The main independent acute providers made a good start to agreeing an approach to standardising information related to quality, so as to enable comparisons. This is known within the sector as the Hellenic Project[10], and was developed in partnership with the former Healthcare Commission and the NHS Information Centre. Mandatory information required by NHS commissioners, PMI insurers and CQC often largely determines what information will be collected above and beyond the essentials. Some NHS systems which could enable comparison are closed to non-NHS providers (for example, incident reporting, some national audits), but equally some non-NHS providers pick and choose which they will cooperate with. It is often short-term competition considerations which inhibit longer-term development of information that might benefit consumer choice and public assurance.

[10] http://www.independenthealthcare.org.uk/index.php?/the-hellenic-project.html

9.3 We are not aware of any developments of this kind in the mental health sector, where competitive dynamics are quite different and sometimes less transparent.

10 Future regulatory developments

10.1 The Health and Social Care Bill 2011 has now been introduced to take forward the range of proposals for the NHS set out in the white paper[11], including the establishment of Healthwatch England which will feed information to CQC through local intelligence networks about the quality of local services (LINks). However, this does not include the PH sector and it is not yet clear if LINks will have a role in relation to NHS funded healthcare in PH facilities.

10.2 The economic regulator, Monitor, as part of its new role in promoting competition, overseeing cooperation and setting price tariffs', will also look at barriers to competition. This will also help ensure that the implementation of 'Any Willing Provider' can be effectively monitored and we suggest that the OFT need to be aware of this in its' scoping work. Further comment on future regulatory developments may be possible as CQC become aware of the likely impact for PH providers.

11 Summary

11.1 CQC hopes that this response can contribute to the proposed OFT market study and if appropriate, would be pleased to discuss or clarify any aspect of its regulatory role or provide further supporting information.

January 2011

[11] NHS White Paper – Equity and excellence: Liberating the NHS, Department of Health, 2010