A fair playing field for the benefit of NHS patients

Supplementary paper

March 2013

Methodology

Methodology

Background

This section provides an overview of the framework used for the review. It begins by answering four questions that define the basis of our work:

1. What "**field**" is being discussed?
2. What is meant by "**fair**"?
3. What "**matters**" might affect that fairness on the playing field?
4. **Who** do those matters affect?

We discuss the first and second questions in the next section, and the third and fourth questions in the following section. Having established our approach to the fair playing field, we then discuss in more detail our approach to understanding the link between the impacts considered and patients.

What is a "fair playing field"?

There are two aspects to defining a "fair playing field":

1. What "field" are we discussing?
2. When is it "fair"?

The NHS in England currently spends about £86 billion a year on providing primary, secondary and specialist clinical care. This is the "**playing field**". It encompasses the delivery of clinical care to patients in the English NHS. This includes all types of clinical care across all sectors, from primary through secondary and into tertiary and specialist care. This scope stems from the Secretary of State's letter to Monitor setting up the review. The letter refers to the ability of different providers to "participate fully in the delivery of NHS care" and focuses attention particularly on whether there are matters which might prevent the best providers from serving patients.

In light of the Secretary of State's letter we also considered what was meant by "**fair**". To answer that question, we returned to the focus on patients. Each of the "matters" referred to by the Secretary of State are fair or unfair insofar as they affect patients' ability to access care from the "best providers". This is consistent with Monitor's primary duty to protect and promote the interests of patients.

We considered a number of different impacts on patients:

- access to services;
- their choice of services;
- patient outcomes (including the effectiveness and safety of services and the quality of the patient experience); and
- value for money.

Providers clearly play a central role in delivering these outcomes for patients. The review is not seeking to achieve fairness for providers but instead for patients. Nevertheless, care

is delivered by (a very wide range of) different providers. In many cases the "matters" referred to in the Secretary of State's letter act directly on providers. For example, the only "matter" mentioned in the Health and Social Care Act that is specific to this review relates to taxation. Taxation affects providers and taxes are applied differently to different types of providers. That may not be "fair". Our concern is whether those impacts on providers are likely to translate into an impact on patients. If it is likely to mean that patients cannot access care from the best provider then we conclude there is lack of fairness in the playing field.

The "matters" may affect providers in a number of different ways. We considered whether they had an impact on provider's willingness to invest, to innovate, to enter new areas of care or new geographies or to act as strong rivals in their current services and geographies. Providers will weigh up a very large range of issues in making these decisions. Therefore, we considered the evidence and formed a judgment (supported by stakeholder input, analysis, modelling and other tools discussed elsewhere in the review) about the likely impact on providers and whether that impact was likely to affect patients. Below we discuss in more detail how we considered the potential for an impact on patients.

Who plays on the field and what "matters" affect them?

The previous section considered what is meant by a "fair playing field". It covered clinical care for English NHS patients and the impact of "matters" on those patients. The route through which the "matters" affect patients is by their impact on providers. This raises two further elements in the framework:

- What are these "matters" that may affect providers and, through them, patients?
- Who are the different providers that are present on the playing field, or would like to be present on the playing field?

The Secretary of State's letter refers to **"matters"** that might affect providers and, through them, patients. We break these "matters" down into two categories: factors and distortions. Factors consist of any matter that has been raised (by stakeholders, in existing analysis or discussion) that may have an impact on providers and, through them, on patients. The main report discusses the long list of factors we have considered. A factor then becomes a distortion when the evidence suggests:

- it may have a differential impact on different types of providers (we discuss the different types of providers below); and
- that impact is beyond the control of the providers, or "extrinsic".

This means that factors such as the skills of a provider's employees, the ability to develop successful services and the ability to make good strategic decisions are not distortions by themselves unless other factors affect them. For example, the ability to offer equivalent pensions at equivalent costs may affect providers' ability to recruit similar-quality staff. In that case, the pension could constitute a distortion.

Distortions may be insignificant if providers' responses are unlikely to impact patients or significant where their responses are likely to impact patients. In the next section we elaborate on our framework for when provider impacts are likely to translate into patient impacts.

Further detail on our definition of a distortion

Our definition of a distortion focuses on extrinsic impacts. We considered a number of characteristics of providers to be intrinsic, and therefore not distortions. Intrinsic characteristics are:

- the type of provider itself (i.e. form of ownership);
- decisions that are made by the provider themselves; and
- a provider's endowments.

We considered whether the starting position of providers (what they are endowed with) could be considered a distortion. We concluded that endowments are not distortions because providers of all types may have (or may develop or acquire) endowments of any type. Providers of all types may have certain endowments: some may have financial endowments, others particularly good estate or locations, others a strong history of good management or the ability to access best practice from an international network, or many other endowments.

In order to examine the long list of factors, we considered a very wide range of different **types of providers** and ways of classifying providers. This includes classifications based on the form of ownership, size, geographic coverage, incumbency, type of specialisation, sector of health care covered. Among these different classifications, two emerged as particularly helpful for the Review: form of ownership and incumbency, meaning the distinction between incumbent providers in an area or service and those seeking to enter or expand into new areas or new services.[1]

Incumbency emerged as an important way to classify providers. A number of the factors raised – particularly those related to commissioning – result in different treatment of incumbents. The incumbents themselves may be public, private, voluntary, or other types of organisation. What matters for this classification is whether they are currently providing the service in question.

Ownership type is important in a number of other areas. A number of the factors treat providers with different ownership models differently. We consider three types ownership for NHS providers.

[1] We did also consider focusing on settings of care. For example: the impact of VAT on drugs or the impact of education and training on clinical care. Specific studies about how service delivery works and what factors affect outcomes in those settings may provide further insight into some of the same (and potentially other) issues to those considered in our review. Such studies would have to look at, amongst other things, provider types in each setting. Within the time available we chose to focus specifically on the types of provider, and draw out specific issues for particular settings, rather than analyse of all settings of care and all provider types.

First, there are providers that are owned by the **public**. We call these "public providers". They consist of all publicly owned and run providers, including foundation and non-foundation trusts in acute, mental health, ambulatory and community settings. They represent providers with different types and degrees of specialisation, different clinical focuses and different training and other responsibilities. For these providers, all revenue earned is used, to varying degrees of efficiency, for further patient care or recycled by Government.

Second, there are providers that are owned by **private** shareholders. This includes acute, mental health, community and primary care providers that are privately owned, owned by shareholders or partnerships. We call these "private providers". They also provide a very wide range of different services including acute, community and primary care services. For these providers revenue that is earned may be reinvested in services (to varying degrees of efficiency) or may be distributed to the owners in the form of profit or dividend.

Third, there are **voluntary and community sector** (VCS) **providers**. This includes providers that have an explicit (and regulated) purpose that includes the use of all or part of their revenue for wider social outcomes. In some cases these are charities with particular charitable purposes and a requirement to use all their revenue to those ends. In other cases these are forms of social enterprises, local voluntary or community organisations which have specific social objectives for which their revenue is used, alongside having the ability to distribute earnings to owners or for other uses.

Providers do not always fit into one category. For example, an NHS general practice, although formally a private provider, may be treated for some purposes as a public provider, for example, in relation to the NHS Pension Scheme. Similarly, while some social enterprises and mutuals may be charities, others are private sector providers. We take into account where relevant providers fall into more than one category of ownership type whenever this is relevant to the issue being considered.

The Review uses the term 'charitable sector' to refer to the different forms of organisation that comprise voluntary and community sector providers. However, we recognise that this group contains a wide and growing range of alternative organisational forms and funding structures, such as exempt charities (including) Industrial and Provident Societies (IPSs) for the benefit of the community, Charitable Incorporated Organisations, Companies Limited by Guarantee (CLGs) and Community Interest Companies. The impact of some playing field distortions identified by the Review on these different organisations and on the patients they serve or seek to serve may vary because of their differences in form. For distortions and recommendations where this may be the case the further work required in our recommendations will include assessing under what circumstances and for what providers any different forms of treatment apply.

Summary of overarching framework

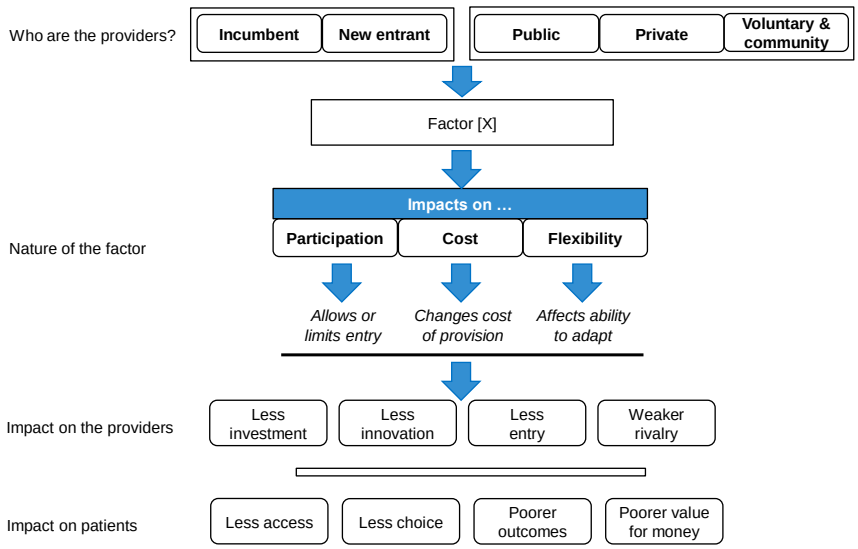
Figure 1 below summarises the overall framework as set out above. We considered different types of providers and the impact of factors on each. In doing so we found it useful to divide the factors into three categories:

- **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.
- **Cost distortions.** Some types of provider face externally imposed costs that do not fall on other providers.
- **Flexibility distortions.** Some providers' ability to adapt their services to the changing needs of patients and commissioners is constrained by factors outside their control.

The factors relating to participation (e.g. commissioning) have a different impact based on whether a provider is an incumbent or not. The factors relating to cost and flexibility have an impact based on whether a provider is public, private or from the voluntary or community sector.

If a factor has an impact on providers (either through its impact on participation, cost or flexibility) then it is a distortion. That impact may result in less investment, innovation, entry or weaker rivalry. The distortions themselves will have these impacts to a greater or lesser extent. Depending on the size of their impact and also on the position of the affected provider, the distortion may or may not have a significant impact on patients. It is only where there is an impact on patients that the distortion is of concern to us. The impacts on patients fall into four categories: less access, less choice, poorer outcomes and/or poorer value for money. The rest of this supplementary paper discusses in more detail how we link impact on providers to impacts on patients.

Figure 1 Overview of framework



How do provider impacts translate into patient impacts?

There is no established theoretical framework for determining how a distortion experienced by providers might have an impact on their decision-making NHS funded patient care. The relationship between distortions and patient care are complex and may differ in different circumstances. We sought to understand this issue by:

- listening closely to stakeholders and asking them about decision making and its impacts on patients, including asking for specific case studies; and
- examining carefully the existing theoretical and empirical evidence.

We use these two sources of evidence to understand how provider impacts translate into patient impacts.

In this section we provide an overview of both the theoretical and empirical evidence and examples of stakeholder views. In addition, the analysis and discussion of each factor in the report contains factor-specific evidence (in the form of stakeholder views, case studies and related evidence).

The theory

Below we develop a theoretical framework that we recognise is a considerable simplification of reality. The framework has specific elements – they are highlighted in bold. The simplification allows us to keep a manageable number of issues under consideration. We also find evidence that the simplified presentation provides a reasonable guide to understanding the impacts of the factors we have considered. However, simplifying some aspects means that we need to also consider where making simplifying assumptions might lead to misleading conclusions. We raise some of those areas below.

The framework starts from the premise that **all providers (whatever their ownership structure) need to cover their costs and want to offer services to patients**. From this follows that their ability to offer services is determined by whether the revenue they receive for a service is greater than or equal to their costs of provision, i.e. whether there is any margin between revenue and costs. If this margin is positive, then providers will be able to continue providing the service, or have incentives to enter or expand the service to new patients. If this margin is negative, then a provider may not be best placed to offer best value to patients and so might exit. We discuss this simplified characterisation of provider decisions in more detail below but it is worth noting that there is wider empirical support for this approach. Some of that is summarised in the box below.

Academic evidence on the motivation of health care providers

We examined the existing evidence about how providers with different forms of ownership actually behave in practice. Much of that evidence necessarily comes from the United States where there is the most systematic research and also a wide variety of different types of providers. The health care system in the United States is very different and provider behaviour may be affected by that. Nevertheless, the overall finding of this research is that:

- there is limited, statistically detectable, difference in behaviour between providers who might have profit as their primary motive (private providers) and those with other motives (various forms of not-for-profit providers); and
- where differences are observed, they may be linked to how many similar providers are competing – if lots of not-for-profits are competing, any particular not-for-profit provider may act differently than they would were they competing against a for-profit provider.

We discuss each of these in turn.

A number of papers (Abelson 2006, Fisher at al 2010) indicate that the significant variation in treatment options for particular conditions may reflect financial considerations (i.e. greater referrals or prescribing in some areas reflect revenue from such activity rather than underlying patient need). This is similar to the large literature about supplier-induced demand where there is a lot of evidence from the US that movement from a retrospective, fee-for-service system to a prospective system resulted in large reduction in time spent in hospital. In other words, when the financial rewards changed (with no underlying change in patient health), the pattern of treatments changed (e.g. see Chandra et al 2012). This evidence tends to indicate that all providers (and indeed individual physicians) respond to financial incentives and revenue opportunities, as well as seeking the best health outcome for patients.

Some studies have sought to explicitly compare “not-for-profit” with “for profit” hospital behaviour. They have failed to find any significant differences in pricing behaviour between the two different providers (see Gaynor et al 2012). Capps et al (2010) do not find any significant difference in how surpluses are used by not-for-profit hospitals in California (e.g. they do not engage in any more social activity than the for-profit comparators). Furthermore, Duggan (2000) finds both types of hospital respond equally to pricing incentives that signal which patients are profitable and which are likely to be loss making – both avoid the loss-making patients.

However, given pricing and a set of patients, other studies do find greater attempts to *become* profitable from the for-profit sector. For example, Dafny (2005) finds more evidence of “up-coding” by for-profit compared to not-for-profit providers.

Duggan (2002) finds that not-for-profits act much more like for-profit hospitals in areas where there are lots of for-profits, and respond less to changes in financial incentives in areas dominated by not-for-profit hospitals.

This simplified theoretical framework raises a number of specific issues. First, we recognise that provider decisions are determined (at least in the short to medium term) by a range of issues that are difficult to reduce purely to cost. Many of these are discussed, for example, under the "flexibility" category in the main part of the review. Second, even if we examine the cost trade-off as the basis for our theoretical framework, providers do not instantly change their offer when margins become negative. Instead they assess the medium- to longer-term outlook and adjust accordingly. This assessment may be affected by many very practical issues. One of those that has been widely investigated by Monitor is the link between their costs and what they are paid through the tariff. The fact that this link is currently very poor means that some providers may not react immediately to negative margins.

Notwithstanding these issues, **providers will try to win work where it does cover their costs and so offer the best-value proposition that is consistent with that result**. In most cases of NHS services, this means offering the highest quality that is compatible with commissioners' budget constraints or national tariffs.

Distortions may affect their ability to make the best possible offer. In some areas, they are prevented from making the offer. These are the participation distortions. In some circumstances (examined below) this will result in worse outcomes for patients. In other areas, there will be distortions that increase their cost and so decrease the quality they can offer in order to continue to cover higher costs. In these areas this could result in:

- reducing the scope they might have to invest in new and innovative services;
- reducing their ability to compete to raise the quality of service they can offer to patients; or
- forcing them to cross-subsidise between services, which could, amongst other things, have a negative impact on the services that are providing the cross-subsidy.

The impact of the distortions on patients depends on whether the provider that is disadvantaged by the distortion ("disadvantaged provider") is more or less efficient than the provider that is not affected by the distortions ("unaffected provider").

If the distortion only affects providers who deliver poorer overall value ("are less efficient"), for any level of quality, there may not be a concern in terms of patient impact. This is because we would not expect patients or commissioners to choose these providers even without the distortion as they would not be offering best value.

There is one specific circumstance where this scenario may still lead to a negative impact on patients. It relates to how the overall value of a service is determined. If the provider offering the best-value service need only offer a slightly better value than the next best alternative, then a distortion which makes the next best alternative worse also allows the unaffected provider to be worse without risking a loss of the service. This may manifest itself in different ways. The unaffected provider might earn more revenue in excess of cost than they would without the distortion, or they may deliver lower quality than they would without the distortion.

This scenario might not occur if there are many unaffected providers, such that they still have incentives to offer best value or else see commissioners and patients go elsewhere. However, it may not always be the case for all services that there are many unaffected providers who continue to want to provide the service in question.

There is likely to be greater cause for concern where the disadvantaged provider delivers better overall value prior to the distortion. There are two potential outcomes in this situation, the:

1) distortion means that disadvantaged providers cannot offer the same or better quality at the same price as unaffected providers – in this case, the disadvantaged providers are excluded from the playing field; or

2) disadvantaged providers are so much better than affected providers that they can continue to offer the same or better quality at the same price as unaffected providers, despite the distortion.

In scenario (1), patient value is most obviously damaged. Disadvantaged providers are not able to offer the same or better value to patients and commissioners, even though they are the better provider. Commissioners must therefore pay more for a service, or receive lower quality than if the distortion did not exist. Patient and commissioner choice is also restricted as is access to potential sources of innovation. These impacts will combine to damage patient value.

There may be some instances, however, where disadvantaged providers are sufficiently superior that they can still offer lower prices or higher quality, despite the distortion. In these cases, patients and commissioners may still have the same set of choices as they would without the distortion. This is a difficult situation because, at face value, we would conclude that distortions in these circumstances are not important – they do not translate into patient impacts. Crucial to reaching this conclusion would be how the disadvantaged provider reacts to the distortion while continuing to provide the service. This will depend on whether the impact of the distortion (e.g. additional costs) is fully absorbed by the disadvantaged providers or passed on (at least to some extent) to patients and commissioners in the form of lower quality (or higher prices) than would otherwise be offered.

By removing distortions that affect high-value providers we are more likely to ensure patients get the best quality care. This final statement follows from the logic set out above. We provide a summary below and in the next section we provide some specific examples of how distortions translate into worse patient outcomes.

Summary of theoretical framework

The discussion highlights the distinction between a distortion that has an impact on providers and one that has an impact on patients. We are only concerned with the latter. As such, we should be mainly concerned where distortions have an impact on high-value

providers (i.e. those that would be seeing patients absent the distortion), and particularly where the impact might result in a change in who provides the service.

Figure 2 summarises the scenarios considered within this framework. The box immediately underneath Figure 2 also considers one specific issue in the context of this framework.

Figure 2 Summary of scenarios

Scenario	Impact on patient value
Disadvantaged providers delivering poorer value even without the distortion	Unlikely to result in damage to patient value
Disadvantaged providers are at least as good or better value prior to distortion, but are poorer value due to distortion	Patient value is likely to be damaged as best value providers are excluded from provision
Disadvantaged providers are better value prior to the distortion and also following the imposition of the distortion	Patient value may be damaged; damage depends on the degree to which providers retain quality output at same price despite distortion

The circular flow of funds

One issue that has been raised in the context of this framework is that some of the cost distortions are not relevant, because if otherwise equally efficient public providers benefit from lower costs, that benefit is recycled within the public sector. Specific examples include the discussion about whether the cost of capital should reflect the rate at which Government borrows or the riskiness of particular providers, or whether certain taxes should apply equally to all providers.

We distinguish between two different aspects of this issue.

First, in seeking a fair playing field for patients, we are interested in ensuring the provider with the best outcomes (in relevant dimensions) is able to treat patients. For that to be the case, distortions (as defined above) should be eliminated where they are significant and reduce the services provided by otherwise efficient providers.

Second, where the cost base of public providers is affected by the elimination of the distortion, we are clear that any money is recycled within the NHS in a way that does not re-create the distortion, and avoids other distortions. This approach is discussed in the context of specific distortions (e.g. VAT, cost of capital, Corporation Tax) in the main report.

Each of these scenarios will play out in a different way for each of the distortions, and possibly also for different areas of health care services. In many cases, we did not have sufficient empirical evidence about who was providing services and whether they offered much better, slightly better or worse value than other existing or potential providers without the distortion. Therefore, we do not seek to replicate this analysis for each specific distortion. Instead, this framework serves as the basis for recognising that not all distortions need to affect patients. Since we are concerned with distortions only when they do affect patients, the framework serves to make clear that in each case we need to understand not just the impact on providers but whether that is likely to translate into an impact on patients. The framework does clarify that, in some (but not all) circumstances, if there is a material impact on providers, a patient impact would follow. For each factor, we considered the range of evidence (quantitative and qualitative) and reach a judgment based on this framework about the likely impacts.

The practice

A very wide range of practical evidence was also collected as part of the review, which corroborates the theoretical findings set out above. In particular, in a number of areas it is clear that high-value providers have been affected by distortions that translate into impacts on patients. In many of these cases we seem to be in the second scenario above: where a high-quality provider risks being excluded (or having to make very significant quality adjustments) because of the impact of the distortion. The significant difference in pension costs was commented on in a number of cases as translating into impacts on patients. A case study considering this case is provided in the following box.

Differential pension costs risk community service improvement

Different types of providers face different costs for equivalent pensions. This may reduce the ability of otherwise high-quality providers to offer services to patients. In one particular example, a private provider bid for a 3-year contract to provide services for £17 million per annum. The total pensionable pay per annum in this case was £7.2 million. NHS pension contributions for provision of this service would be £1 million, reflecting an employer contribution of 14%.

In contrast, the private provider's contributions in this case were £1.94 million (reflecting 27% of employer contributions). That was the payment required to offer an equivalent pension to staff transferring from the previous provider.

The increase of £940,000 per annum represents 5.5% of the annual contract value - a substantial cost disadvantage for the provider when considering bidding for the contract. A provider already offering good quality would have to be a further 5% more efficient to be able to offer this service to patients. In this case, the high-quality provider was faced with two choices: do not bid, and deny patients the option of a new service, or bid but decrease costs in other areas (lowering quality from what it otherwise would be) in order to make up the differences in pension costs.

This is a specific example provided to us that links to our theoretical framework: in cases where differential cost pressures arise, the need to ensure cost and revenue match means that spending in other areas, and quality output in particular, may have to be reduced.

Another prominent cost distortion relates to VAT and its differential impact on public, private and VCS providers. A number of stakeholders emphasised that its impact can be the difference between providing or not providing a service for otherwise high-value providers. One such case is illustrated below.

VAT threatens better palliative care

In April 2011, Berkshire West Primary Care Trust (PCT) transferred all specialist palliative care services to Sue Ryder. This was the first time an NHS-run hospice was transferred to a voluntary organisation.

Sue Ryder increased nursing support by recruiting additional Community Nurse Specialists (CNS), established a single a 24 hour contact number for health or social care professionals to refer patients to Sue Ryder services and provided two specialist palliative care consultants.

Almost two years since the transfer of services, access to end of life care has greatly improved with the number of patients seen by the CNS team has increased by approximately 10% and the number of patient contacts increasing by over 30%. The combination of the transfer of services to Sue Ryder and other initiatives has achieved a 50% reduction in annual emergency hospital admissions, a 50% reduction in excess bed days and the prevention of 7 emergency admissions per month.

This and other successful projects to deliver high quality care are threatened by the existing VAT rules. Despite Sue Ryder being awarded the NHS Berkshire West contract in order to provide improved efficiency and quality for patients, the tax rules meant that the service would cost the NHS more to commission. Had the commissioner operated the services directly or with another public provider they would have been eligible to reclaim a significant proportion of the VAT.

Under existing rules Sue Ryder would have incurred additional VAT business costs from operating the building and the services within it, for example maintenance, cleaning and providing food. These additional business costs would have made the service more expensive to operate. As a charity provider Sue Ryder doesn't have the same advantages as the NHS if they contract out services. The NHS has the ability to reclaim VAT on contracted out services.

In order to meet the challenge in Berkshire West we had to find ways of working with the PCT to overcome the additional VAT costs in order to make the transfer of the service viable.

Overall summary

The review covers all English NHS clinical care and is concerned with distortions when they have an impact on patients. It considers the impact of distortions on different types of providers. The first step is to assess the impacts on providers. We then consider the impact on patients. In many cases the specific impact on patients is more difficult to determine analytically. Our methodological approach emphasises the need to consider the position of the providers affected by the distortions: would they be providing the service without the distortion? If so, to what extent is the distortion material enough to affect how, or even whether, the service is provided? We use a range of qualitative and quantitative evidence to judge, in the case of each distortion, its potential impact on patients.