

Response to the Co-operation and Competition Panel consultation on draft guidelines

The BMA welcomes the opportunity to respond to the consultation on the draft interim guidelines. The BMA is a voluntary, professional association that represents all doctors from all branches of medicine across the UK. Over 100,000 practising doctors are members, as are nearly 20,000 medical students. The BMA is an independent trade union, a scientific and educational body and a limited company, funded largely by its members.

This submission does not seek to comment in great depth on the detail of the guidelines but rather looks to outline a range of serious concerns pertaining to the underlying policy approach and philosophy which informs the Cooperation and Competition Panel's (CCP) role. Our most serious concern is that the rationale of CCP's work is too closely informed by the very same assumptions that underpin the broader reform agenda currently at play in the NHS. We contend that the development of a competitive market in the NHS, based on policy levers including patient choice, payment by results, and the purchaser-provider split, ignores the inherent problem of regarding health as a commodity. There is no recognition of the paradox that patients can never act as true consumers in the market sense or that demand and supply do not operate in a rational way where health is concerned.

We note that the process of drafting and revising the guidelines is likely to stretch over the next 12 months and beyond following further development of the Principles and Rules of Co-operation and Competition by the Department of Health in 2009. We hope that the CCP will respond constructively to our submission and we look forward to working with the Panel in addressing our concerns and those of other NHS stakeholders.

1.1 In representing its members' views, and in chorus with other groups allied to the NHS, the BMA has been a vocal critic of many elements of the ongoing NHS reform agenda that have been in evidence in recent years. Equally, our concern has been directed at the volume of reform to which the NHS in England has been subject and the pace of its introduction. We believe this has both destabilised the health service and alienated large sections of its dedicated staff.

1.2 Our response to these concerns has been to work constructively, engaging with stakeholders, to develop alternative perspectives that might better achieve the objective of an NHS fit for the 21st century. This effort to advance proposals for a way forward has been driven by a wish to ensure that the NHS can continue to deliver improving health to the population in an efficient and equitable manner, honouring a set of shared values and principles to which all those that are invested in the NHS can subscribe. In short, we remain committed to an NHS funded from general taxation providing care free at the point of delivery and advancing the social goal of providing health care fairly and transparently, wherein valuable resources are allocated in an accountable way.

1.3 Consequently, whilst supportive of the general concept of creating and improving guidance for the NHS in order to achieve fairness and transparency in its operation, our overriding concern is that the work of the Cooperation and Competition Panel, and therefore the draft interim guidance in question, both implicitly and explicitly, acts to support key elements of ongoing reform that have been the subject of our sustained criticism in recent years. Most pointedly, the work of the CCP may often act to legitimise and promote the market model in the NHS, driving forward a business-model approach to healthcare wherein cooperation amongst NHS actors, and the fostering of a collaborative ethos, is subordinated to competition and an extension of the plurality agenda.

1.4 Though the BMA recognises the benefits of ensuring efficiency and the pursuit of innovation and improvement in the NHS, we do not believe competition, articulated in the context of a market model, is the appropriate means to achieve these ends. On the contrary, we believe that the marketisation of healthcare is likely to lead in many instances to poorer health outcomes for patients, rising administrative costs and the erosion of key NHS founding principles concerning equity and universality. The BMA is entirely supportive of partnership working and the many valuable relationships the NHS has with a wide range of other organisations in delivering NHS services. However, the BMA is committed to an approach which would see these relationships based on genuine cooperation and integration rather than competitive pressures driven by a market philosophy.

1.5 It is a concern, therefore, that the CCP's anticipated role is predicated on taking forward its work in the context and spirit of the existing policy framework developed by the government. This policy framework is dominated by a belief in the assumed potential benefits of competition in healthcare and provides an increasing role for the commercial private sector and ultimately the commoditisation of NHS care. We believe that the government has failed to produce robust evidence to support this policy agenda and has ignored its potential to threaten the stability of the NHS and undermine the spirit of collaboration which is central to the success of the NHS. It would be somewhat of a paradox, therefore, if the CCP is being asked to monitor adherence to the Principles and Rules of Co-operation and Competition but did not intend to investigate further the claims underpinning the reforms in order to substantiate the claimed benefits of competition.

1.6 What is more, in its guidance the CCP appears to restate these claims uncritically,

6.3. Competition in markets has numerous beneficial effects: innovation and productivity may increase, so increasing the quality and, more generally, the diversity of choice available as service providers respond to the preferences of their patients and commissioners. As set out in the Framework for Managing Choice and Competition, choice and competition in the NHS can be expected to:

- *improve quality and safety in service provision;*
- *improve health and well being;*
- *improve standards and reduce inequalities in access and outcomes;*
- *lead to better informed patients;*
- *generate greater confidence in the NHS; and*
- *provide better value for money¹.*

Again, the BMA would be most keen for the CCP to develop as part of its role a mechanism to formally test the evidence-base for these claims in order to support its decisions. Moreover, in carrying out its role we hope that the CCP will seek appropriate input from the medical profession over and above that provided by the sole medical representative on the Panel, Dame Janet Husband. Significant expertise resides in the medical profession that might provide informed insight in respect of the considerations likely to face the Panel.

1.7 Whilst not intending to elaborate at length ourselves on the evidence-base around the role of competition and those policy levers supporting it, such as patient choice, we would wish the CCP to note that a range of empirical literature has examined the impact of competition in markets for health care. This includes an exploration of both the consequences for prices and costs as well as the impact of competition on quality. Upon reviewing this work what appears is, at best, a rather mixed picture. In terms of competition, increasing quality and improving standards, a number of studies have shown that competition appears to be associated with lower quality (higher death rates)² and that on balance the relationship between competition and quality of care appears to be negative³. Commentators suggest that competition in health care too often works to the detriment of improving patient care with

¹ Cooperation and Competition Panel. Consultation Document (2009).

² Propper, C., Burgess, B., Green, K. (2002) Does Competition Between Hospitals Improve the Quality of Care? Hospital Death Rates and the NHS Internal Market, unpublished mimeo, University of Bristol, CEPR & CMPO

³ Propper, C., Burgess, B., Abraham, D. (2002) Competition and Quality: Evidence from the NHS Internal Market 1991-1999 CMPO

restrictions to the access of care, gaming, the shifting of costs on to fellow providers and the stifling of innovation⁴.

1.8 The current policy agenda which encourages a shift toward a market or business-driven model in the NHS, where competition is promoted to the detriment of cooperation and collaboration, will no doubt give rise to many of the same shortcomings experienced in other health systems in western industrialised nations where this same approach has been adopted. In particular we are concerned that the market model necessitates a growth in bureaucracy such that resources are increasingly devoted to managing the market and operating within it. (The CCP itself is evidence of this). The US experience is such that the proportion of health funds devoted to administration has risen by 50% in the past 30 years⁵ and now stands at 31% of total health spending. The US experience is not unique and the development of markets in other health systems shows a related sharp rise in administrative costs including earlier attempts in the UK⁶ and in New Zealand⁷. A counter-argument may be put that competition will in time drive down costs, improve quality and in so doing offset any rise in the administrative burden. However, no credible evidence has yet been put forward to support this supposition and the CCP should, in its considerations, strive to provide this evidence (and furnish existing policy with some much needed credibility).

1.9 As regards the policy of 'patient choice', we are concerned that this has developed in terms of a prerequisite for competition and marketisation rather than a means to empower patients, improving their experience of care in the NHS and creating a partnership approach between the patient and health professions. Introducing choice to health care is a complex process with potentially unpredictable results and the evidence suggests that choice is likely to increase costs, is probably more likely to increase than decrease inequalities and may or may not increase efficiency.⁸ The 'apparent disregard for the available evidence'⁹ in respect of the benefits of patient choice should be addressed by the CCP in considering its policy on competition and enabling a market in the NHS.

1.10 In sum, our most serious concern is that the rationale of CCP's work is too closely informed by the very same assumptions that underpin the broader reform agenda currently at play in the NHS. We contend that the development of a competitive market in the NHS, based on policy levers including patient choice, payment by results, and the purchaser-provider split, ignores the inherent problem of regarding health as a commodity. There is no recognition of the paradox that patients can never act as true consumers in the market sense or that demand and supply do not operate in a rational way where health is concerned¹⁰.

1.11 Therefore, notwithstanding our concerns in respect of an appropriate evidence-base, we strongly believe that as a result of the apparent acceptance of current policy the interim guidance does not fairly balance the principles of co-operation and competition. Instead primacy is given to competition such that we believe health economies will be at real risk of destabilisation as SHAs, PCTs and provider organisations struggle to meet the demands to ensure a 'competitive market place'. In particular, the guidance pertaining to both conduct and mergers do not adequately take into account the need to gauge concerns around the sustainability of local services in the context of service design. The threat of a charge of 'collusive behaviour' exists and as presently defined may inhibit the ability of clinicians and commissioners to enter into a meaningful dialogue thus circumscribing their ability to deliver a high quality, collaborative and integrated service.

1.12 The BMA looks forward to working constructively with the Panel in addressing our concerns and those of other NHS stakeholders as it develops its new role.

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⁴ Porter, M. E., Teisberg E. O. Redefining Competition in Healthcare. *Harvard Business Review*, June 2004.

⁵ Woolhandler S, Campbell T, Himmelstein DU. *Costs of care and administration in the United States and Canada. N Engl J Med* 2003;349:768-75

⁶ Health Policy Network of the NHS Consultants' Association. In Practice: The NHS market in the UK. *J Public Health Policy* 1995; 20(3):152-61

⁷ Coney S. Relentless unravelling of New Zealand's health-care system. *Lancet* 1996; 347:1825

⁸ Fotaki et al. What benefits will choice bring to patients? Literature review and assessment of implications *J Health Serv Res Policy* Vol 13 No 3 July 2008

⁹ Barr, D. A., Fenton, L., Blane, D. The claim for patient choice and equity. *J Med Ethics* 2008;34:271-274

¹⁰ Woolhandler S, Himmelstein DU. Competition in a publicly funded healthcare system. *BMJ* 2007;335;1126-1129