House of Lords – Motion to Annul

NHS procurement, patient choice and competition: response to draft regulations

Key Points

- Increasing competition for the provision of care in the NHS was one of the key elements of the coalition government's Health and Social Care Act 2012. In February 2013 the government published draft regulations governing procurement practice (SI 2013/257) as required by the primary legislation, only to withdraw them shortly after. Substitute regulations have now been published (SI 2013/500).
- This briefing has been produced for peers ahead of a debate that is taking place in the HoL on Wed 24 April, following a motion by Lord Hunt of King's Heath to annul the revised regulations. It may also be of interest to other individuals interested and engaged in discussions surrounding the implementation of the Health and Social Care Act.
- Our view is that the confusion over the role that existing competition law will play in shaping procurement decisions has been compounded by an absence of formal guidance for commissioners on how to interpret and use the new regulations. Balanced guidance (see below) is needed urgently.
- Given the relative lack of case law in this area, practical examples are vital to avoid, at one extreme, risk averse commissioning policies that result in unnecessary, wasteful tendering, and at the other, unjustifiably anti-competitive behaviour promoted by providers and commissioners that works against the patient and taxpayer interest.
- Beyond the question of what level of competition for elective services should be permissible, the scope for competition law to apply to healthcare services

Parliamentary briefing

24th April 2013

has considerable strategic relevance. In the context of a financially stressed acute sector, commissioners need to be confident that any preferred solutions can withstand the robust scrutiny from competition authorities seeking to determine whether large scale changes are in the patient interest.

- We note that recent documents published by the Cooperation and Competition Panel between December 2012 and March 2013 are a helpful attempt to fill some of this gap, but their precise status in relation to the 'Choice and Competition' Framework recommended by the NHS Future Forum is still unclear at this time.
- More substantively we observe that these documents appear to place the burden of proof on those wishing to redesign services, and would caution that they potentially create a risk that commissioners perceive the scope for regulatory action as being so wide that it inhibits service redesign and innovation.
- We have previously pointed out that the evidence base in favour of integration (particularly in relation to generating savings) is still limited. Equally, however, the evidence base for the benefits of competition in the NHS is not especially well developed either, particularly in relation to specialised hospital services or community based services.
- Yet what seemingly emerges from the recent CCP documents is an automatic assumption that a reduction in competitive pressure will reduce the incentives to invest in quality improvement. This is an important assumption (that competition leads to investment in quality that might otherwise not take place) and has not been investigated empirically.
- In March 2013 NHS England and Monitor publicly reiterated their commitment to work with the system over the coming years in strengthening the evidence base to help commissioners decide if and when competition and choice are appropriate. We welcome this pledge and recommend that part of their forthcoming 'Choice and Competition' website include a section on the emerging evidence in relation to competition, as well as integration, so that clinical commissioners can weigh decisions about how to shape the local health economy against the available evidence base.

There is currently some confusion about the role that competition law and patient choice will play in shaping procurement decisions in the future. Critics argue that Section 5 of the Procurement, Patient Choice and Competition ('section 75')[1] regulations laid in February 2013 mean that commissioners will be forced to tender competitively for contracts under all but exceptional circumstances, thereby opening up the NHS to unrestricted competition. The substitute regulations do not appear to have allayed their concerns. This briefing places the debate within its wider strategic context, and recommends that the Government hold to its commitment to continue developing the evidence base around competition and integration so that commissioners and providers have accurate information when forming decisions.

Background

In response to concerns raised by the above the government revised the wording of Section 5 in order to clarify that the final decision on whether to use competition for contracts or not rests with commissioners, not with the regulator. Under the terms of the substitute regulations (SI 2013/500), a commissioner can award a new contract to a single provider without a competition, provided it is satisfied that the services in question 'are capable of being provided only by that provider.[2]

Beyond the question of what level of competition for elective services should be permissible, the scope of competition law to apply to healthcare services has considerable strategic relevance. Under the Health and Social Care Act 2012 commissioners are expected to play a much more influential role in shaping their local health economies. Arguably the development of the commissioner requested services (or failure) regime demands this. In the context of a financially stressed acute sector, commissioners will need to be confident that any preferred large scale solutions can withstand robust scrutiny from competition authorities seeking to determine whether changes are in the patients' interest.

For a great many Trusts seeking solutions to entrenched financial problems, the preference has been to plan reconfigurations with commissioners across an area, which may include mergers of hospitals into bigger units. The Herfindahl-Hirschman Index (HHI) measures potential provider competition. An HHI score of 10,000 means that all patients are treated at the same provider. An HHI score of 2.500 is equivalent to four providers each sharing patients equally, and is considered a relatively concentrated market. Research carried out by the Nuffield Trust indicates that in 2006/7 the average HHI score for acute providers was 5,371, meaning the acute landscape is considerably monopolistic.[3]

For future mergers to be approved, the benefits arising from consolidation (such as potential economies of scale), must outweigh the potential negative effects of dampened competition. On economies of scale, the research evidence shows that benefits exist – for both quality and cost – but these may not be continuous. A Nuffield Trust evidence review concluded that cost per case falls as a hospital's size increases to 200 beds and remains roughly constant until about 600 beds, above which

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[1] Procurement, Patient Choice and Competition regulations SI 2013/257. http://www.legislation.gov.uk/uksi/2013/257/pdfs/uksi_20130257_en.pdf (Accessed 20th April 2013)
[2] Procurement, Patient Choice and Competition regulations SI 2013/500. http://www.legislation.gov.uk/uksi/2013/500/pdfs/uksi_20130500_en.pdf (Accessed 20th April 2013)
[3] Jones N & Charlesworth C (2013) *The anatomy of health spending 2011/12: A review of NHS expenditure and labour productivity*. London: Nuffield Trust. http://www.nuffieldtrust.org.uk/publications/anatomy-health-spending-201112-review-nhs-expenditure-and-labour-productivity (Accessed 22nd April 2013)

diseconomies begin to appear.[4] Many of mergers contemplated by NHS Trusts would result in organisations with 600 plus beds. The evidence base for other aspects of service redesign, for example Trusts 'swapping' entire service lines, needs to be built up. There is no reason why this evidence cannot be built up over time, especially in a data rich system like the NHS – the need for this should be recognized as important and analysis performed.

Although the government contends that guidance has been made available to commissioners since September 2012 these are in effect short, high level documents.[5] They explain that the "law in this regard is complex and carries an inherent risk of challenge" and warn of the importance of commissioners recording the rationale for their procurement decisions. Ministers have promised that more detailed guidance will be produced by Monitor and NHS England in the near future (originally due in March).[6]

A lack of evidence

Until such formal guidance is produced it will be difficult for commissioners to predict what the scope of potential regulatory action in the area of competition and choice might be in the future, or how vigorously, in the absence of substantial case law, it will be policed. This could lead, at one extreme a risk-averse stance that results in unnecessary, wasteful tendering, and at the other extreme to unjustifiably anti-competitive behaviour that works against the interests of patients and the taxpayer.

Judging by a series of papers published by the Cooperation and Competition Panel between December 2012 and March 2013 which explore how the rules on choice and competition are likely to be applied to different aspects of health care services, the scope of the regulator's duty to prevent anti-competitive behaviour could be quite wide.[7][8][9][10] The papers published so far cover clinical networks; agreements between providers; unilateral conduct of providers; and integrated care. They use case studies to illustrate whether a whole range of hypothetical activities (including integrated care initiatives, cancer networks, data-sharing initiatives between hospitals or professional bodies, specialised commissioning of stroke services), are likely to fall foul of the competition rules,

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[4] Hurst J & Williams S (2012) *Can NHS hospitals do more with less?* London: Nuffield Trust: http://www.nuffieldtrust.org.uk/sites/files/nuffield/can-nhs-hospitals-do-more-with-less_full-report-120112.pdf (Accessed 22nd April 2013)

[5] NHS Commissioning Board (A special health authority) 'Procurement of healthcare (clinical) services: Briefing 2, What are the procurement options', (2012). http://www.england.nhs.uk/wp-content/uploads/2012/09/procure-brief-2.pdf (Accessed 20th April 2013)

[6] Secondary Legislation Committee, '33rd Report of Session 2012-13' HL (2012-13), p23 http://www.publications.parliament.uk/pa/ld201213/ldselect/ldsecleg/153/153.pdf (Accessed 20th April 2013)

[7] Cooperation and Competition Panel, 'The Implications of Competition Rules for the Delivery of Integrated Care' (14 December 2012). http://www.ccpanel.org.uk/content/publication_documents/121218_Implications_of_Competition_Rules_for%20the_Delivery_of_Integrated_Care.pdf (Accessed 20th April 2013)

[8] Cooperation and Competition Panel, 'The Implications of Competition Rules for the Unilateral Conduct of Providers of NHS-funded Services' (22 March 2013). http://www.ccpanel.org.uk/content/publication_documents/130321_Application_of_the_competition_rules_to_unilateral%20conduct.pdf (Accessed 20th April 2013).

[9] Cooperation and Competition Panel, 'The Implications of Competition Rules for Clinical Networks' (22 March 2013). http://www.ccpanel.org.uk/content/publication_documents/130321_Implications_of_competition_rules_for_clinical_networks.pdf (Accessed 20th April 2013)

[10] Cooperation and Competition Panel, 'The Implications of Competition Rules for Agreements Involving Providers of NHS-Funded Healthcare Services' (22 March 2013). http://www.ccpanel.org.uk/content/publication_documents/130321_Application_of_the_competition_rules_for_agreements.pdf (Accessed 20th April 2013)

specifically whether they would be seen as examples of collusion, market sharing, price fixing, bid rigging, collective boycott, exchange of information or anti-competitive foreclosure by the regulator.

Many of the hypothetical case studies are typical of the types of service redesign and quality improvement initiatives taking place in the NHS. We draw several conclusions from this material. Firstly, there is a risk that the scope for regulatory action is perceived by commissioners as potentially being so wide and far reaching that it inhibits service redesign and innovation. Second, those commissioners wanting to redesign services appear to be faced with the burden of proof. The guidance makes clear that commissioners and providers will have to show that their actions produce benefits that are 'significant, quantifiable and evidence based' to set against the theoretical costs of any reductions in competition and patient choice.[11]

Currently the evidence base in favour of integration (particularly in relation to generating savings), for example, is still limited.[12] Yet conversely, the guidance does not seem to concede that the evidence base for the benefits of competition in the NHS is not particularly well developed either, particularly in relation to specialised hospital services or community based services.[13] Indeed what seemingly emerges particularly from the recent CCP documents is an automatic assumption that a reduction in competitive pressure will reduce the incentives to invest in quality improvement. This is an important assumption (that competition leads to investment in quality that might otherwise not take place), and has not been investigated empirically.

On the 20th of March 2013 the NHS Commissioning Board (as it then was) and Monitor published an explanatory note setting out how their forthcoming *Choice and Competition* website will help commissioners and providers understand where competition may deliver improved outcomes for patients, in line with the recommendation from the NHS Future Forum for the development of a 'Choice and Competition Framework'.[14] This is intended to be a 'one-stop' web-based resource to help commissioners, providers and patients understand and use choice and competition in the health care system.

The explanatory note also reiterates the commitment of both organisations to work with the system over the coming years to strengthen the evidence base to help commissioners decide if and when choice and competition are appropriate for the services they would like to commission for their local communities. We welcome this pledge and recommend that part of their forthcoming 'Choice and Competition' website include a section on the emerging evidence in relation to competition and choice, as well as integration and mergers, so that clinical commissioners can weigh their procurement and reconfiguration decisions against the available evidence base.

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[11] Op cit 8 p5

[12] Shaw S, Rosen R, and Rumbold B (2011) *What is integrated care?* London: The Nuffield Trust. http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/what_is_integrated_care_research_report_june11_0.pdf (Accessed 20th April 2013)

[13] The Nuffield Trust (2012) *Competition and Integration: Event report*. London. http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/event_report_competition_integration_jan12.pdf (Accessed 20th April 2013)

[14] NHS Commissioning Board & Monitor, 'Choice and competition in commissioning clinical services in the NHS in England (Unclassified) (20 March 2013). http://www.england.nhs.uk/wp-content/uploads/2013/03/choice-comp-note.pdf (Accessed 20th April 2013)

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Published by the Nuffield Trust.