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Competition and Collaboration in the 'New NHS'

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Summary

1. The Health and Social Care Act 2012 has placed requirements on the NHS commissioners to engage in both collaboration and competition – but there has been no indication that the two are compatible. Competition has primacy over collaboration despite last minute changes to the procurement regulations. This is evident in the following ways:

2. The 'Sole Provider' Clause is very limited in practice. This clause says that there is no requirement to put contracts out to competitive tender 'where only a single provider is capable of providing the services'. Apart from rural and remote areas it is difficult to conceive of a situation where one provider can be the only source of supply, and to this extent the regulations imply that almost all services must be competitively sourced. This is at odds with the professed claim that commissioners will be free to decide which services to tender.

3. The procurement regulations leave Monitor to determine what freedom CCGs have in procurement. The regulations now state that CCGs: '...must not engage in anti-competitive behavior unless to do so is in the interests of people who use healthcare services.' However, it will be for Monitor (or the Office of Fair Trading or the Competition Commission) to assess whether the 'interests of people' are being served. It is assumed that choice of providers invariably benefits patients. Other than this assumption there is no definition in the regulations as to what constitutes 'patient interest'.

4. NHS trusts are losing the exemption they had from competition law to place a contract without a competition on the grounds that the activity serves a predominantly 'social' purpose. The UK Government is closing the loophole which NHS Trusts had (the Teckal exemption) by making it clear that competition must be the norm for placing NHS contracts. No NHS body will be able to depart from this even if it has a good reason to do so in the interests of patients. This competition law will trump any appeal that commissioners may have to Monitor for exemption from competitive tendering.

5. NHS providers (whether NHS Trusts or Foundation Trusts) are liable to full scrutiny under the 2002 Enterprise Act when seeking to merge. Mergers may be stopped for anti-competitive reasons even if they are in the interests of the providers and local health community.

6. Further guidance promotes competition over collaboration. Guidance from NHS England for CCGs on the use of competition when awarding

contracts for local services to GPs contains no opt-out to preserve the integration of services. At the same time Monitor has produced its new consultation on how it intends to turn the section 75 regulations into legal guidance in which it asserts that 'choice, competition and integrated care are not mutually exclusive' (p18).

7. Despite assurances by the Government that collaboration will trump competition if it is in patients' interests, it is up to Monitor (not the local commissioners) to decide if collaborative behaviour is anti-competitive and (in the absence of guidance) it is not even clear on what basis they would arrive at such a judgement. Where a decision has to be taken between collaboration for integrated care and competitive tendering, the default setting of the new system is competition with a view to increasing diversity of provider. The presumption is that conduct which serves to restrict competition is usually going to be against patients' interests.

8. The belated inclusion in the NHS Act of requirements in relation to integrated care will have little effect unless they are seen as a sub-set of procurement rooted within competition law. In coming years there is likely to be conflict as public sector commissioners and providers seek ways of working together more closely in the face of legislation and regulations that pull in the opposite direction.

Introduction

9. The twin policy imperatives of competition and collaboration in health and wellbeing have sat together uneasily since the 1980s. The first thrust towards marketisation – especially the split between 'purchasing' and provision – came with the twin white papers of 1989 on health[1] and community care[2], though the two failed to even cross-reference each other. Throughout the two succeeding decades, aspects of marketisation increased – a clearer separation of purchasing from provision and (in the case of social care) the wholesale privatisation of provision.

10. At the same time the commitment to some form of collaboration within the NHS and between the NHS and local government became a normal part of policy exhortation, though invariably to little effect[3]. It was possible to detect during the 1990s a sense of frustration amongst politicians that collaborative working seemed unable to produce quick results and in the later years of the last Labour Government there was a further thrust towards competition as an alternative model[4]. It is within this policy milieu that the Health and Social Care Act (HSCA) 2012 must be understood.

11. The Health and Social Care Bill had a stormy parliamentary passage during which the initial focus upon markets and competition appeared (belatedly) to be balanced by a range of obligations upon organisations to work in partnership to deliver 'integrated care'. Despite its large size the Act left uncovered much of the detail on how the new system would actually work. Only now is vital detail emerging, enabling a judgement to be formed on the respective positions of competition and collaboration. This analysis examines the two policy strands and considers the policy priority attached to each of them.

Collaboration: New Requirements on Local Government and the NHS

12. Many of the new collaborative requirements are set to be led by local government. Local authorities have responsibility for:

- The joint strategic needs assessment (JSNA) is a local analysis of current and future health and wellbeing needs of both adults and children produced by the local authority and clinical commissioning group(s).

- The joint health and wellbeing board (JHWB) consisting of representatives from the local authority, the NHS and elsewhere (eg HealthWatch) to set the local strategic direction for health and wellbeing.

- The joint health and wellbeing strategy (JHWBS) arising from the JSNA and the deliberations of the JHWB to offer the local vision and plan for health and wellbeing improvement.

13. This triad of collaboration requirements to be led by local authorities (though with no formal power to require wider engagement) is matched by new obligations upon the new NHS organisations:

- NHS England: Among the duties of NHS England, formerly the NHS Commissioning Board (which is mandated by the Secretary of State to run the NHS), is one to 'secure that health services are provided in an integrated way' and that the 'provision of health services is integrated with the provision of health-related services or social care services'. Both duties are subject to whether the NHS England considers this would improve quality or reduce inequalities.

- Monitor: The HSCA 2012 includes a duty on Monitor (the new regulatory and licensing body) to 'exercise its functions with a view to enabling the provision of healthcare services provided for the purposes of the NHS to be provided in an integrated way' where this would improve quality or efficiency and reduce inequalities with respect to either access or outcomes.

- Clinical Commissioning Groups (which hold the budget to arrange most secondary and community health care locally): The HSCA 2012 says that each CCG 'must exercise its functions with a view to securing that health services are provided in an integrated way' and further that a CCG 'must exercise its functions with a view to securing that the provision of health services is integrated with the provision of health-related or social care services'.

If these obligations constituted the only factors to be taken into consideration then commissioners would have a strong and clear steer on how they should work together to produce integrated care. However, the HSCA 2012 also imposes expectations and requirements in relation to the desirability of competition.

Competition and the HSCA 2012

14. The original Health and Social Care Bill gave Monitor, the task of 'promoting competition' in the NHS, but in the face of opposition this was changed to 'preventing anti-competitive behaviour'. The broad outline of the rules Monitor will enforce became clear in the 2012 Department of Health consultation on 'good' procurement practice[5]. The 'overarching principle' is that:

'commissioners should use the providers who are best capable of meeting patients' needs and delivering value for money, whether they are from the public, private or voluntary sectors' (para 2.21)

15. The consultation paper offered the prospect of flexibility and discretion:

'The proposals would require commissioners to use choice and competition where appropriate to improve quality and efficiency. This does not mean that commissioners should pursue competition as an end in itself or to seek to increase the market shares of particular providers, but rather that commissioners should be able to demonstrate that they have considered alternative options in determining which providers offer best value' (2.22)

The consultation document made it clear that 'if commissioners decide to make arrangements which materially restrict competition' they would need to demonstrate three 'trade-offs': (para 4.13)

- It is 'in patients' interests'
- It delivers tangible countervailing benefits such as improvements in quality or efficiency
- The benefits outweigh the disadvantages of restricting competition

Indeed, the consultation paper went further and referred to the need for commissioners to pass an 'indispensability test' such that the restrictions to competition are 'indispensable for the intended benefits' (para 4.1).

16. Following a perfunctory official response to the respondents to the Consultation Paper[6] the Government published in February 2013 its proposed procurement regulations[7] in the form of a statutory instrument. These usually obscure orders give effect to ministerial decisions and normally come into force within 40 days unless revoked (in either House) by 'negative procedure' – which is an almost unheard of occurrence. Although the proposed regulations claimed that 'the starting principle is for commissioners to decide how best to secure services for their populations', they then went on to hugely restrict the discretion of clinical commissioning groups. For example:

- All providers must be treated equally, 'particularly on the basis of ownership'.
- Commissioners 'must not engage in anti-competitive behaviour' and should 'not include any restrictions on competition that are not necessary'.
- A contract can only be awarded without competition 'for reasons of extreme urgency'.

- Tendering can only be avoided ‘where the relevant body is satisfied that the service to which the contract relates are capable of being provided only by that provider’ – the so-called ‘sole provider’ clause and a formidable hurdle.

17. The proposed regulations aroused immense concern and opposition. Spurred on by a 250,000 signature petition organised by the lobbying group 38 Degrees, politicians and professional groups called for withdrawal of the regulations. Opposition came from the BMA, RCGPs, RCN, the UK Faculty of Public Health and an alliance of voluntary organisations – even the conservative Academy of Royal Colleges joined in, as did the normally loyal NHS Alliance. The obscure Lords Scrutiny Committee reeled under the weight of an unprecedented 2000 plus representations, and the crucial ‘prayer’ for annulment, the parliamentary procedure for rejecting the proposed regulations, was to be laid by Labour in the Lords on April 24th.

18. Taking refuge in claims of ‘poor drafting’ and ‘inadvertently created confusion’, the Coalition hastily redrafted the offending regulations[8]. In the new version[9] assurances are given that CCGs will be free to determine their own procurement decisions, and the option of collaboration (expressed as ‘integrated care’) seems to be belatedly rediscovered. Specifically the Department claims the changes make clear that:

- There is no requirement to put contracts out to competitive tender ‘where only a single provider is capable of providing the services’ – a simple repetition of the position in the original regulations.
- Monitor will have no duty to force the competitive tendering of services – again this is not a change from the previous situation.
- Competition should not trump integration – commissioners should be free to use integration where it is in the interests of patients.

These amended regulations were duly debated in the House of Lords on April 24th, 2013, where a three-line whip on Liberal Democrat peers to support the regulations resulted in a comfortable Government majority of 108. Despite bland assurances to the contrary, the primacy of competition seems as strong as ever. There are several reasons for this.

The ‘Sole Provider’ Clause

19. Apart from rural and remote areas it is difficult to conceive of a situation where one provider can be the only source of supply, and to this extent the regulations imply that almost all services must be competitively sourced. This is at odds with the professed claim that commissioners will be free to decide which services to tender. The transaction costs associated with such a duty would be crushing, especially since the regulations do not even specify a min-

imum financial level below which authorities would be free to award without tendering.

20. In a response to legal opinion from David Lock QC (for the lobbying group 38 Degrees)[10] the Department of Health[11] seemed to raise the possibility of taking into account the interests of the wider health economy as opposed to the specific contract under consideration. It said (para 16) that:
'If a commissioner can properly satisfy itself that the provider of the required services needs to maintain a caseload volume and a certain case-mix in order to provide a safe and effective service...that would be a legitimate justification for awarding a contract without a competition'.

This could be an important ground for seeking exemption, but the paragraph also adds that this wider consideration will only count – once again – where there is only one provider capable of delivering the service. This is an important limitation and, as Lock argues, means that a CCG would not be entitled to focus on the wider strategic needs for services across the local health economy. It therefore follows that a private provider will be free to cherry-pick services which are profitable to deliver by putting pressure on CCGs to divide out these services from other unprofitable activities. In such a situation the CCG would be effectively surrendering its strategic jurisdiction for the health and wellbeing of the population.

The Role of Monitor

21. Monitor is officially portrayed as a more appropriate 'specialist' alternative to the courts when dealing with anti-competitive behaviour and beaches of competition law[12]. In developing this 'supportive' role, Monitor and NHS England will jointly develop advice and guidance which, it is claimed, will reduce uncertainty for commissioners and give them greater confidence that decisions in patients' best interests should not lead to regulatory intervention. This guidance – to be called the Choice and Competition Framework - was not produced in advance of the issuing of the procurement regulations. To this extent peers were voting on matters on which there was still no detail or clarity.

22. Monitor will hold very significant powers. Although it will not be able to insist that a CCG invites competition for a contract it will have the power to:

- conduct an investigation in relation to anti-competitive behaviour on its own initiative rather than only when it receives a complaint.
- cancel any contract that is 'non-competitive'.
- put in place 'measures for the purpose of preventing failures to comply with a requirement'.
- vary or withdraw an invitation to tender.

In a strange interview for the Health Service Journal[13] the CEO of Monitor (David Bennett) appeared to introduce a new ground for exemption from tendering – where a commissioner 'did not feel they were able to accurately measure the quality of their existing provider'. However this, he warned, could not be 'an excuse for doing nothing year after year'.

23. Whilst the 2012 consultation paper proposed to introduce the idea that competition in health care was to be used unless the award of a contract without tendering was considered 'indispensable' for the intended benefits, the first set of procurement regulations had moved from 'indispensable' to 'necessary'. The subsequent revised regulations seem to represent a major concession by stating that CCGs: '...must not engage in anti-competitive behaviour unless to do so is in the interests of people who use healthcare services' (Section 10). However it will be for Monitor (or the Office of Fair Trading or the Competition Commission) to assess whether the 'interests of people' are being served, and the discipline of competition assumes that choice of providers invariably benefits patients. Other than this assumption there is no definition in the regulations of what constitutes 'patient interest'.

Competition Law

24. NHS provision is losing the so-called Teckal exemption under EU Law whereby contracts could be placed with an NHS Trust without a competition on the grounds that the activity serves a predominantly 'social' purpose. It has been the policy of both the last and the present government to phase out NHS Trusts in favour of more free-standing Foundation Trusts and it is unlikely that the Teckal exemption will continue to apply given the intention to eliminate NHS Trust status entirely. However, even if the exemption continued the UK Government is itself closing the loophole by removing the option from the Regulations and making it clear that competition must be the norm for placing NHS contracts.

25. Although the Department of Health likes to claim that the new regulations simply put onto a statutory footing the existing Rules for Cooperation and Competition (introduced by the last Labour Government), this does constitute a significant status shift. The move has been introduced precisely because the Department of Health cannot enforce these rules against the new commissioners created by the 2012 Act given that the Secretary of State no longer has extensive powers to intervene in the NHS. In effect what has been largely treated as a voluntary code has been elevated to the status of law – no NHS body will be able to depart from it even if it has a good reason to do so in the interests of patients.

26. In its 'fair playing field' review,[14] Monitor appears to suggest that it will be within its gift to determine the nature of procurement challenges from an aggrieved alternative provider – effectively to vet them. The review said that: 'Monitor will be mindful of the risk of trivial or inappropriate challenges to

commissioners by alternative providers and will work with commissioners and providers to minimise this risk' (p23). However, even in the unlikely event of a CCG managing to justify to Monitor grounds for exemption from competitive tendering, there remains the issue of competition law trumping commissioner discretion.

27. Faced with the potential threat of legal action, the only safe decision would be for a CCG to tender competitively and the likelihood is that only a handful of courageous CCGs will disregard this advice. CCGs are new organisations largely run by GPs with no experience of large-scale procurement and contracting with large private companies. Faced with rising demand, fixed budgets that can simply be top-sliced by NHS England Local Area Teams and a requirement to contribute to the £20b 'efficiency savings' demanded by the Department of Health, it is hard to see CCGs risking high legal costs by resisting competition regulations.

28. It is not simply commissioners getting entangled with procurement policy that is problematic; providers are now similarly entangled. This is clear from the case of the potential merger of the Royal Bournemouth and Christchurch Hospitals and Poole Foundation Trust which attracted the interest of Monitor and the Office of Fair Trading. The position of the trusts is that they do not compete significantly in any specialties but rather offer complementary services, but the working assumption of the competition authorities is that merger might restrict competition and choice and is therefore not beneficial.

29. In the case of these two Foundation Trusts this resulted in a demand that they sign an undertaking restricting how they can communicate with each other, and to having an 'independent observer' present at all meetings while the case is reviewed[15]. Similar action has also been taken in the case of long-standing plans to centralise some acute services in Bristol[16]. What these case demonstrates is that NHS providers (whether NHS Trusts or Foundation Trusts) are liable to full scrutiny under the 2002 Enterprise Act when seeking to merge[17] Whatever the merits of working together might be, it is the Competition Commission that will have the final say and in this respect it will be treating mergers between NHS organisations in the same way as any other 'enterprise'[18].

30. Following the passage of the section 75 regulations little time was wasted in issuing further guidance. Guidance from NHS England for CCGs[19] on the use of competition when awarding contracts for local services to GPs contains no opt-out to preserve the integration of services. At the same time Monitor has produced its new consultation on how it intends to turn the section 75 regulations into legal guidance[20] in which it asserts (without any evidence) that 'choice, competition and integrated care are not mutually exclusive' (p18).

Conclusion

Where Does This Leave Collaboration?

31. Last year in the final stages of the NHS Bill in the House of Lords, there was a move to add the prevention of anti-collaborative behaviour to the duties of Monitor, to ensure this had equal status with its duty to prevent anti-competitive behaviour. Health Minister Earl Howe said this would be unnecessary, arguing that 'where collaboration was in the interests of patients it would be regarded by Monitor as trumping the need for competition'. The new regulations seemed to repeat this possibility, stating that they:

'...provide additional comfort to NHS commissioners that they would not be required to divide up or fragment services against the interests of their patients'. (para 27)

32. However it is up to Monitor (not the local commissioners) to decide if collaborative behaviour is anti-competitive and (in the absence of guidance) it is not even clear on what basis they would arrive at such a judgement. And overshadowing their judgement will be the requirement under Section 5 of the regulations that the only key test is that of sole provider capability. In these circumstances the only safe option for a CCG which wants to secure integrated care is to specify an integrated service and run a tender to secure a provider or providers to deliver it. All of the provisions outlined earlier around a joint health and wellbeing strategy for a locality determined by the health and wellbeing board will have to conform to an undefined concept of 'patient interest' that seems to rest upon the assumption that provider competition and choice are the predominant drivers.

33. Where a decision has to be taken (normally at local or sub-regional level) between collaboration for integrated care and competitive tendering (for integrated or fragmented care) the default setting of the new system is competition with a view to increasing diversity of provider. In short the presumption – in the face of the balance of evidence – is that conduct which serves to restrict competition is usually going to be against patients' interests. The regulations – albeit revised – constitute the most explicit description we have had of the role and requirements of competition in the NHS.

34. As things stand we have no clear idea how receptive the competition authorities will be to a collaborative alternative, nor do we know how strident large corporations will be on making – or threatening to make - use of competition law. We are slowly discovering more on the provider side with

the pending judgements of the OFT and Competition Commission in respect of the Bournemouth and Poole merger, and once again the assumption is that competition law principles devised with commercial markets in mind are equally applicable to the NHS[21].

35. Overall it is hard to escape the conclusion that the belated inclusion in the NHS Act of requirements in relation to integrated care will have little effect unless they are seen as a sub-set of procurement rooted within competition law. In the face of increased demands for 'integrated care' the Department of Health is now setting up 'integration pioneers'[22] – the latest incarnation of 'pilots' and 'trailblazers'. It is stated that national support will be provided to help selected sites to 'understand the framework of choice, competition and procurement' and to 'clarify how integrated solutions can comply'. The subjugation of collaboration to competition seems clear.

36. Collaboration through the market mode is not impossible but it is unlikely. The most likely outcome is that as providers proliferate and competitive tendering becomes the norm, integration will become more difficult. Partnership working is a delicate plant based upon shared vision and high trust relationships[23] and it is difficult to see large private companies focused on short-term profit, working in productive long-term relationships with the NHS and other public sector organisations. The alternative modes of collaboration – through hierarchies and networks[24] – seem totally neglected in the Act. What we may witness – at best - in coming years will be guerrilla warfare as public sector commissioners and providers seek ways of working together more closely in the face of legislation and regulations that pull in the opposite direction.

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