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**Regulating Competition in the NHS**  
*The Department of Health Guide on Mergers  
and Anti-Competitive Behaviour*

*Diane Dawson*

***DISCUSSION PAPER 131***



**REGULATING COMPETITION IN THE NHS**

**The Department of Health Guide on Mergers and Anti-competitive Behaviour**

**by**

**Diane Dawson**

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## **Abstract**

In December 1994 the Department of Health published guidelines intended to inform participants in the NHS internal market of current government policy with respect to mergers and anti-competitive behaviour. The Guide focused on four topics: provider mergers and joint ventures, providers in difficulty, purchaser mergers and collusion. The policies outlined in the Guide are drawn from traditional models of competition policy as applied to private sector firms except that it would appear the Department of Health is intended to act in place of the usual institutions of competition policy such as the Monopolies and Mergers Commission. This paper questions the Government's approach on two broad grounds. First, there is an inherent conflict of interest between the Department's role in rationalising capacity in the NHS and enforcement of competition policy. If there is to be a competition policy, it should not be internally administered. Second, private sector competition policy based on maintenance of excess capacity and new entry is an inappropriate and potentially inefficient framework for regulating competition between public sector firms. Treasury and Department of Health rules create financial constraints on the ways public sector firms (Trusts) are able to compete. These constraints have the effect of concentrating market power in the hands of purchasers not providers. A competition policy designed to regulate competition within the public sector is likely to be very different from the traditional models with which we are familiar.

## **I Introduction**

On 12 December 1994 the Department of Health published guidelines intended to inform participants in the NHS health care market of current Government policy with respect to mergers and anti-competitive behaviour (DoH 1994). In his forward to the Guide, Alan Langlands points out that the objective of publication is the reduction of uncertainty as to how the Government will react to changes in market conditions that might affect the degree of competition. The Government wants to encourage purchasers and suppliers to innovate and change the services available for patients. As not all changes desired by market participants are acceptable to the government, making the government's criteria generally known should avoid waste of resources by alerting the internal market to actions the government will not allow to proceed. A precis of the Guide appears as Appendix 1 to this paper.

The Guide discusses four general topics:

- Provider mergers and joint ventures;
- Providers in difficulty;
- Purchaser mergers and boundary adjustments;
- Collusion.

Two kinds of information are provided. There are quantitative trigger values for automatic intervention by the Department of Health and qualitative information on the kind of issue the Department will wish to consider when they do intervene. Predictably, very little can be quantified in the competition field. We are told that mergers where the resulting Trust has less than 50% of the market can ordinarily proceed without Departmental investigation. Trusts are defined as "in difficulty" and subject to Departmental intervention if they suffer an "unexpected" fall in real income of more than 2% or a forecast fall in real income of more

than 10%. Most of the Guide is devoted to explaining the subjective values that will guide Departmental decisions. "Where intervention is necessary, the presumption is in favour of a competitive solution..."(p.5). However if, in the opinion of the Department, there are benefits of mergers or collaborative agreements that outweigh the loss of competition, the changes in the market structure will be allowed to proceed (p.6). The clear message through every section of the Guide is that government action will reflect a preference for competitive structures and competitive behaviour except where they prefer a less competitive solution to a problem.

It might be thought a document advocating transparency and predictability but stating that policy will be based on factors that can only be defined and weighed in the mind of the minister is unlikely to achieve the objective of reducing uncertainty as to the degree and form of government intervention in the market. However it should be noted that the principles and approach set out in this Guide for the NHS are precisely those that have underpinned UK competition policy for the past thirty years. The essence of the UK approach to monopoly and anti-competitive practices has always been political discretion. The relevant primary legislation is the Fair Trading Act 1973 and the Competition Act 1980. Neither Act defines the kind of behaviour that will be treated as anti-competitive and proscribes it. Neither Act defines a particular market share that will be considered an unacceptable degree of monopoly power and prohibits mergers or growth that would exceed that limit. The management of a firm knows that the law prohibits actions against the public interest but as the definition of the public interest is whatever the current Minister says it is, the law is of no more help to private sector firms trying to anticipate what market "reconfigurations" will be acceptable to the Government of the day than the present Guide will be to NHS management in the internal

market.<sup>1</sup>

The dependence of the decision as to what is legal and illegal behaviour on ministerial discretion, and the moveability of that important dividing line with changes in ministers rather than changes in the law, was given its most recent public viewing in the Financial Times on 13 December 1994. "A Policy in Disarray" focused on the unpredictability of competition rulings due to differences in policy as between the present and previous Secretaries of State. The article also highlighted the necessarily subjective valuation of any measure of a reduction in competition by examining the very different views of the Director General of Fair Trading, the Monopolies and Mergers Commission and the Secretary of State for Trade and Industry. Appearing the day after publication of the NHS Guide, this lament for personality driven competition policy should have been a warning that in the UK, publication of a competition policy does not reduce uncertainty.

This paper is not concerned with a section by section analysis of the NHS Guide but with stimulating discussion of a basic set of questions prompted by publication of the Guide. First, to the extent that a competition policy is considered necessary for the efficient operation of the NHS internal market, should it be an internally administered policy? Second, competition policy as discussed in the Guide is dominated by two strategies: (1) a perceived need to maintain sufficient excess capacity to ensure purchasers always have the option of switching providers and (2) the need to minimise barriers to entry by new providers into any

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<sup>1</sup> A leading commentator on UK competition law has noted criticism of the Fair Trading Act that "as nothing is illegal, it is hard to advise clients on what they can and cannot do." (Whish 1993, p.92).



particular market. How far are these approaches to securing efficiency gains compatible with Treasury rules on the use of public funds? If the model of competitive supply by public sector "firms" is to be an important part of UK public services, we may need to develop regulatory regimes for the public sector that are different from those used in the private sector.

## II The NHS and the Law

While the NHS Guide mirrors the ultimately discretionary nature of competition policy elsewhere in the economy, there are two fundamental differences in the way discretionary policy can be expected to operate in the NHS. First, the Guide is written as if NHS Trusts are **not** subject to the existing law of the land as it regulates monopoly and anti-competitive behaviour<sup>2</sup>. Where the legal framework of the competition Acts applies, there are mediating institutions that provide a background of independent opinion, experience and expertise against which ministerial discretion is exercised and potentially curbed. The NHS Guide, considered along side the NHS and Community Care Act 1990, foresees a world where the Department of Health in effect acts as Administrator or Receiver where units are in difficulty, it acts as an Office of Fair Trading in deciding if practices are suspect, as a Monopolies and Mergers Commission in investigating the extent of the suspected abuse and then briefs the Minister who exercises her discretion.

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<sup>2</sup> The Guide points out that NHS contracts may bring DHAs and Trusts within the scope of the Restrictive Trade Practices Act (RTPA) 1976 and the Resale Prices Act (RPA) 1976. However it goes on to suggest that it is the Executive that will investigate and deal with any likely infringement. No mention is made that Trusts can be referred to the Monopolies and Mergers Commission under the Competition Act 1980.

The second important difference between NHS Trusts and private sector firms subject to discretionary competition policy is that ministerial discretion over the activities of private sector firms does not ordinarily extend to deciding on which firms will close and which will be allowed to remain open and active. Increased market concentration due to bankruptcy and consequent closure is outwith the control of the Secretary of State for Trade and Industry. The law only gives him the power to decide whether to allow increased concentration to occur as a consequence of two still functioning firms agreeing to merge or one taking over the other. The Secretary of State for Health is unique in her powers to "reconfigure" the market. She must decide which firms (Trusts) will be closed and which will be allowed to survive if they "reconfigure" as she sees fit. Where she decides on closure, the decision is highly visible. The Secretary of State must place an order before Parliament dissolving the Trust and transferring its assets to another organisation. She must take responsibility for the closure.

For the present and foreseeable future, a politically very difficult problem facing the Department of Health is that of removing excess capacity in the hospital sector. As the Secretary of State for Health must take very public responsibility for the outcome, where the choice is between closure of a Trust due to that hospital being the financially least successful Trust in a competitive market or a pre-emptive rationalisation of several Trusts that avoids embarrassing financial failure, we would expect political pressures to favour the latter. With the inherent tension between competition policy as outlined in the NHS Guide and industry rationalisation, making the same Department responsible for both policies can be expected to lead to lipservice paid to competition but little enforcement of competition policy.

Given these problems of implementation, it is reasonable to ask why the Department of Health felt it necessary to devise a competition policy that would be administered internally when anti-competitive behaviour by NHS Trusts can be investigated by the Monopolies and Mergers Commission (MMC) under existing legislation. Section 11 of the Competition Act 1980 allows the Secretary of State for Trade and Industry to refer a public corporation for investigation "of the efficiency and costs, services provided by and possible abuses of monopoly by public bodies." (Merkin p.2251). NHS Trusts are public corporations and clearly fall within the category of corporate public bodies for the purposes of this section of the Act. Previous references of public corporations under Section 11 have dealt with questions of predatory pricing and price discrimination, presumably examples of abuse of monopoly such as those to be discouraged in the NHS. The Secretary of State for Trade and Industry can place an Order before Parliament excluding Trusts from the 1980 Act<sup>3</sup> but why should he?

There is a positive advantage in allowing independent investigation of allegations of abuse of monopoly position. The understandable imperative to minimise political damage from discoveries of questionable behaviour in the NHS can lead to disbelief that complaints will be heard fairly and that relevant information will be made available for public scrutiny. It has been argued that one of the strengths of the legal position of the MMC is its independence of both the parties that refer a case for investigation and the parties who must decide whether to implement recommendations for action consequent on an investigation.

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<sup>3</sup> As of 19 December 1994 there is no record of amendment to primary NHS or Competition legislation to exclude NHS bodies and no Statutory Instrument excluding NHS Trusts under Section 11(4) of the 1980 Act. See Halsbury's Laws of England Vols 33 and 47.

"This distinguishes the role of the MMC from other regulatory agencies. The MMC is thus free from any internal conflicts of interest that may be generated by the decision to proceed or by a recommendation to adopt a particular 'remedy'. There is, therefore, separation of powers." (Lipworth,1993 p.41).

While Ministers are not bound by any definition of the public interest, the MMC is. In determining whether a particular matter operates against the public interest, the MMC must have regard to the desirability<sup>4</sup>:

- (1) of maintaining and promoting effective competition between persons supplying goods and services in the United Kingdom;
- (2) of promoting the interests of consumers, purchasers and other users of goods and services in the United Kingdom in respect of the prices charged for them, their quality and the variety supplied;
- (3) of promoting, through competition, the reduction of costs and the development and use of new techniques and new products and of facilitating the entry of new competitors into existing markets;
- (4) of maintaining and promoting the balanced distribution of industry and employment in the United Kingdom.

It is difficult to see the difference between the criteria laid down in the NHS Guide for determining the acceptability of an action and these twenty year old MMC guidelines. Should a question of conduct by an NHS Trust (or Trusts) be referred to the MMC and if the

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<sup>4</sup> For the legal meaning of the terms used and references to relevant acts and decisions see Halsburys Laws of England v.47 p.84.

MMC produced an adverse report, the Minister would of course still be free to reject it. Ministerial discretion is not compromised by the law but political accountability is enhanced as the background information and analysis assembled by an independent body is in the public domain.

From the inception of the internal market it was recognised that the purchaser provider split could lead to forms of behaviour that were undesirable. "...no District, doctor, or hospital will be allowed to exploit short term competitive advantages. Purchasers or provider cartels, or abuse of a monopoly position will not be tolerated." (DoH, 1989, p.13). Conciliation/arbitration arrangements were to be put in place by the Department of Health to deal with disputes arising from "unfair" practices. "Plainly it might be necessary to take strong management action in the case of any NHS body found to be acting unfairly in this way." (ibid.,p.14). The December 1994 NHS Guide reflects the policy that has developed from this initial assumption that anti-competitive behaviour is an internal management issue for the Department of Health. Perhaps one of the few examples of advantage flowing from the bestowing of corporate status on NHS Trusts by the NHS and Community Care Act 1990, is the opportunity to bring Trust behaviour within the more open purview of the competition Acts rather than the relatively closed environment of departmental dispute arbitration. If the NHS Guide is to serve its stated function of informing market participants of the "rules of the game", it should be amended to at least point out that a 25% market share or turnover of £5 million is sufficient to permit investigation by the MMC of accusations of anti-competitive behaviour under the Competition Act 1980.

### **III The Ground Rules for Government Intervention**

Failure of the NHS Guide to explain the position of NHS bodies relative to the law is politically important but easily rectified. Of much more importance for the development of the NHS is the failure of the Guide to address the issues that are in fact determining the competitive structure of supply of health care. If anything, it gives the misleading impression that traditional competition policy, as developed to control private sector firms, should be borrowed to regulate public sector firms. A few examples, outlined below, illustrate the need to reexamine this underlying assumption of the Guide.

#### **III.1. Mergers vs. shotgun marriages**

In industrial economics the term "merger" is ordinarily applied to situations where both parties want to join forces and form a single organisation. Hostile take-overs imply one unwilling party, still a legal entity, attempting to defend itself. A firm that is failing to survive in the market may simply go into liquidation. Competition policy for the private sector deals with the first two means of increasing concentration in a market. The NHS Guide mimics this emphasis in that it has a great deal to say (over half of the technical material) on the conditions under which two or more providers wishing to merge will be allowed to proceed. Because NHS Trusts are public corporations a hostile takeover is not possible and one would not expect analysis of this issue but an examination of the criteria for choosing between closure and merger certainly was expected. This is an area where public sector competition policy of necessity diverges from the private sector model.

By far the most important type of "market reconfiguration" of NHS providers since the introduction of the internal market has been the shotgun merger promoted by the government (as opposed to the parties concerned). London and Newcastle provide conspicuous examples as well as the current examination of how to reduce capacity in Leeds. The Guide on competition policy does not help much with this situation, the need to reduce capacity prior to defacto insolvency. The parties concerned usually do not want to merge. The Department of Health guidelines on merger, placing the onus of proof for the desirability of merger on the merging parties is clearly irrelevant. On p.40 we are told that where units are "in difficulty" and merger is the Executive's preferred solution, they must ensure "the relative benefits of merger exceed closure..." but no where do we find an indication of the factors relevant to establishing this trade-off. A year ago Ham and Maynard (1994) suggested that experience of the London Implementation Group might be of use to the rest of the NHS. Amendment of the Guide to include discussion of principles and evidence relevant to the closure/merger decision, perhaps based on recent NHS experience, may be a way of making the Guide of more relevance to the kind of merger activity actually taking place.

### III.2. The main potential benefit from merger: Economies of scale vs. short-run cash savings

The majority of provider mergers that have taken place have occurred to meet a need to reduce the scale of provision in particular geographic areas. It is highly likely that the redistribution of purchasing power through capitation and the need to reduce excess capacity will continue to be the prime motive for merger. It is positively misleading for the Guide to say "The main potential benefit from mergers/joint ventures is the production of efficiency and quality gains. This is likely to be the case where there are substantial economies of scale

or scope in production of the service." (p.10).

As Annex 1 of the Guide makes clear, we have virtually no useable evidence on economies of scale or scope ( long run concepts) but we do have some data on short-run average cost declining with throughput: the number of patients a Consultant on a full time contract can be expected to treat per week; the number of patients who can be given appointments for examination on a single scanner. In these cases, reducing capacity to increase throughput for remaining labour and capital will reduce costs. This gives the Department a clear choice: the resources that are to remain in a particular geographic area can either be used to maximise potential activity rates by increasing concentration or can be used to maintain some excess capacity (lower activity for the funds available) in order to maintain competitive pressure on providers<sup>5</sup>.

In health care systems with hard global budget constraints, any politician will choose to maintain short-run activity rates through increased concentration rather than purchase the excess capacity needed for competition. It may or may not be efficient to force providers to compete against each other but if that is the policy, the institutional structure of the guidelines is extremely unlikely to lead to implementation of that policy. If the Department of Health is to be responsible for rationalising the industry, acting as Administrators, avoiding the disruption of rapid closure and finding alternative markets or uses for inputs, some other organisation must be responsible for enforcing any rules of competition policy.

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<sup>5</sup> It is obviously true that if the rate at which excess capacity is emerging in an area is greater than the rate at which the Department of Health is able to reduce capacity there is no need to consider this policy trade-off. Concentration can be single mindedly pursued.



### III.3. The nature of the evidence on economies of scale/scope and implications for procedures of competition policy

The guidelines stress the need for clear objective criteria and procedures. Competition policy is to be seen to be concerned with economic impacts. For mergers to be investigated by the NHS Executive, we are to measure the impact on competition and then, because a merger will reduce competition below what it would otherwise be, we are to measure any economic benefits that might be acceptable compensation for the lost competition. Economic benefits are implied to be any reductions in average NHS cash costs per unit of activity.<sup>6</sup> However, as mentioned above, Annex 1 carefully explains that there is no research evidence on the basis of which we can make statements such as "one unit will enable us to treat a given number of patients at a lower average cost than three smaller units"<sup>7</sup>. Even more important, we do not have evidence on which to base predictions as to whether the quality of care will benefit or be adversely affected by increased concentration of health care delivery<sup>8</sup>. Instead of evidence that can be used as the Guide suggests, to estimate the benefits of increased concentration, we have "expert opinion" and committees of experts who advise the Minister that it would be much better to have renal units of a certain minimum size or

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<sup>6</sup> There is a low key allowance for "non-economic" benefits but "the greatest weight should be given to the impact on competition and hence on the efficiency and quality of services provided." (p.19)

<sup>7</sup> The cash saving from rationalisation discussed in the previous section is from the removal of excess capacity not from economies of scale where, to use the example above, closing three units that were "too small" and replacing with one unit would reduce average costs.

<sup>8</sup> In an important recent study Sowden et al (1995) examine the problems of interpretation of the existing research on quality and scale.

single site grouping of particular specialities. This has always been true in the NHS. The movement from more accessible community hospitals to large district general hospitals in the 60s and 70s was justified on economies of scale and quality of treatment. There was little evidence for this but expert opinion was sure of it. Research in York on treatment protocols suggests expert opinion can often be out of date, inconsistent with what research evidence does exist and reflect personal enthusiasm more than science (Sheldon 1994).

While the lack of data may mean there is no alternative to "expert opinion" in formulating a view on the consequences of structural change of NHS units, it is particularly unsuitable as the basis of a competition policy. The committees of experts tend to be interested parties in the outcome! For other industries, when the Monopolies and Mergers Commission needs evidence on the likely effects of a merger between say, two defense electronics suppliers, there may be little directly relevant data but it is possible to commission research and advice (opinion) from experts who have no interest in the outcome. It provides the Commission with an independent source of information. For medical matters, the expert committees tend to be drawn from the teaching hospitals, specialist units and other centres of excellence that are precisely the institutions likely to be affected by the "reconfigurations" being investigated. There are good reasons for this way of proceeding. If the Department of Health is to have the cooperation of medics in general, they must be seen to be taking the advice of the "most respected" medics.

If and when we have data bases that permit a generally acceptable analysis of likely consequences of structural change on the quality of patient outcomes, it may be possible to undertake a relatively objective analysis of possible trade-offs between quality, cost and

market concentration. Until then the nature of the evidence that will be available to the secretary of state makes it virtually impossible to judge the direction of change much less the magnitude of the economic benefits as required by the procedures outlined in the guide.

The Guide suggests a spurious objectivity will be the basis of decisions on merger/closure rather than the ordinary short term pressures on a Government department. The sentiment is laudable but the practice virtually impossible especially where the policy is internally administered.

#### III.4. Measures of Concentration: Ownership vs. location of services

The guidelines are precise on how we are to measure the impact of a merger on competition:

1. Define the market for the relevant service.
2. Measure concentration in that market.
3. Assess the probability of entry by other suppliers.

This is the standard approach used in most monopoly inquiries. How appropriate is it to the NHS internal market? There are two problems, the first can be remedied in time with data likely to be collected but the second is probably insoluble.

First, the definition of the market for the relevant service. The guidelines define the geographical extent of the market as being the population within a 30 minute travel time of the location of the "facilities" for non-A&E services. This will not define the relevant market unless people always go to the closest hospital. We need information on the addresses of

patients using a particular hospital in order to define the geographic market of that hospital. In the future such data will be available to the Department of Health. What will make the calculation of market concentration difficult (but again potentially manageable) is the increased frequency with which non-A&E services may be taken to the patients at centres away from the main hospital facilities. There may be only one acute hospital with its main buildings in a zone defined by 30 minute travel times but the population in that area may be served by several competing providers with main hospital facilities located outside the zone but offering clinics within the zone.

The more serious problem concerns the probability of entry and the dynamics of competition. If only one hospital is providing non-A&E services in an area but it is relatively easy for another supplier to enter the market, then the incentive to behave competitively exists even though concentration is high. According to the guidelines we are to consider the "possibility of entry by existing Trusts with excess capacity, the private sector, the voluntary sector and primary care providers." (p.18). Will the Department or the Treasury permit Trusts to borrow or raise capital to be used to take market share away from another Trust? Past experience of public expenditure controls makes this seem very unlikely.

The wording of the guidelines suggests a market can be contested by a Trust simply using "excess capacity". The implication is that no capital expenditure is necessary--- an underemployed consultant with a mileage allowance can start taking market share in a market where the Trust that employs him has not previously been a competitor. It is probably true that a Trust could use existing excess capacity to pick up some extra work from a Health Authority with a waiting list initiative but it is highly unlikely that purchasers who tend to

place great importance on continuity of supply would make any major change of provider on the basis of current and possibly temporary excess capacity. A capital commitment is ordinarily necessary to signal commitment to the new market. As the voluntary sector also tends to have limited access to new capital, the serious potential new entrants are GPs and the private sector because both have access to private capital markets. It is important to keep in mind that the ability of existing Trusts to play the constructive role in competition policy of potential entrants is further constrained by the break even rules on revenue account and expenditure targets. Experience elsewhere suggests successful entry into a new market requires more than one financial year before break-even is remotely possible (Milne and McGee, 1992). There can be no credible threat of entry from a firm not allowed to plan for losses.

Are we to believe that the Department of Health genuinely intends to operate a competition policy where new entry or potential entry is expected to play an important role if that implies the selective competition that would come from GPs and the private sector? There is no evidence that either have shown interest in the whole range of activities provided by an acute unit. We would therefore have selective competition and the resultant unbundling of services not on the basis of economic efficiency but as a consequence of differential regulation. Day surgery units are likely early candidates to provide us with evidence as to whether Treasury controls will de facto limit the role of new entrants to suppliers with access to private sector capital. A member of the NHS Executive's day surgery taskforce has predicted that "...as we move towards carrying out 50 to 60 per cent of elective surgery as day cases, more of the average district general hospital will become empty" (David Ralphs quoted in Miller (1995)).

A company with private capital can provide a new purpose built facility in a particular location designed to compete with the local Trust hospital for elective surgery. Even relatively modest success of the new unit will have profound implications for the financial viability of the existing local Trust and necessitate steps to protect access to treatment for all the non-day case patients of the local financially threatened hospital. Would the Department of Health have permitted an NHS Trust located elsewhere to have borrowed the capital necessary to mount such a threat to the incumbent Trust?

### III.5. Collusion vs. cooperation

As collusion is an agreement to cooperate, why is it a pejorative term? The presumption is that it is an agreement to cooperate in securing an outcome that will be to the disadvantage of someone else. But this is precisely what we mean by "competitive behaviour", the kind of behaviour the reforms were intended to encourage in the NHS. Competition law has long reflected the fact that some forms of competitive behaviour that harm some market participants are thought beneficial and should be rewarded while other manifestations of competitive behaviour are considered detrimental and should be punished but that in practice it is often impossible to distinguish between the two. Adopting a structure that permits and encourages competitive behaviour is a risky but potentially beneficial strategy. The problem is similar to that of using a drug that can be highly toxic if not used on correctly indicated patients and in carefully regulated doses. Willingness to use the drug for the acknowledged good it can do depends on your faith in the rules and control procedures being highly effective in preventing the damage that can be caused by the misuse of the drug.

The guidelines acknowledge that it is virtually impossible to identify collusive practices that are detrimental to NHS objectives as opposed to those that can be expected to positively contribute to achievement of those objectives. The approach adopted is that common in UK competition law (but not in the US or Europe) of prohibiting certain consequences of collusive behaviour rather than collusion per se. The Department of Health will distinguish between agreements that protect patients (acceptable agreements) and agreements that protect purchasers or providers (unacceptable agreements). This again is consistent with practice elsewhere in the economy where agreements that protect consumers (and a few other interests) are acceptable. The problem is identifying when the collusion has been to the benefit of purchasers and/or providers as opposed to patients. Benefit to suppliers over and above what "acceptable" competitive behaviour would have delivered is difficult enough with private sector firms but the rules imposed on participants in the NHS market destroy or conceal most of the evidence. For example, identical or similar prices are taken as prima facie evidence of collusion (p.49 ).<sup>9</sup> To prove this is the result of anti-competitive as opposed to competitive pricing, competition authorities would ordinarily study data on costs and profits. If differences in costs and profits lead you to expect differences in prices, then the identical prices are inferred to be the result of collusion. In the NHS, profits in excess of the required 6% are not allowed therefore any potential profit would not be observed but would be converted into a cost. This means major price/cost differences would not be observed but that in at least one "firm" supplier costs will be higher than they might otherwise

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<sup>9</sup> There is some irony in the fact that only a year ago in press and academic discussion the lack of identical prices was taken as evidence that the market was not working properly. Now it appears that divergent prices are evidence that the market is working properly and if prices do converge that is evidence of collusion--i.e. the market is not working. This text soon to be set to the music of Mr. Sullivan.

have been. To apply this approach to the NHS requires counterfactual evidence of what costs would have been in the absence of collusion. Competition authorities throughout the world have found it extremely difficult to discover acceptable evidence of collusion and other anti-competitive practices. The guidelines acknowledge the likely ineffectiveness of identifying and curtailing collusion in the internal market.

The Department of Health puts forward a potentially more effective means of dealing with this problem, it announces a determination to undertake the "promotion of competition and contestability". (p.50 ). The guidelines give this sentiment more concrete form by specifying the need to encourage more contracts to be put out to competitive tendering and, to reduce the likelihood that long term contracts do not discourage new entry, the Executive should ensure there is an "adequate" number of bidders at the contract renewal stage. The argument is that competitive tendering is less vulnerable to collusive agreements than the negotiated contracts more common in the NHS. On p.16 above we pointed to the problems of Trusts being credible new entrants and the likely inefficiency of relying on new entry where potential entrants face very different forms of regulation. The new form of control raised in this section of the guidelines, an increased insistence on contracts being put out to competitive tender, is another example of a measure intended to contribute to efficient resource use but one that could easily be counterproductive.

One of the few things we do know about contracting for health care is that for all acute care and for a great deal of non-acute care, contracts will be incomplete. Competitive tendering for incomplete contracts is costly. It either leads to an increase in transactions costs, trying to increase contract specification, or it shifts all risks on to the purchaser as the



provider is only bound by the explicit terms of the contract (Chalkley and Malcomson, 1994). Collusive behaviour would have to be a serious problem to warrant this drastic remedy.

### III.6. Concentrated Purchasing

At no point do the guidelines highlight the importance of the monopoly position of providers due to asymmetric information and the inability of the patient or any third party to determine the quantity or type of care to be supplied and hence the cost of care. As evidence from the United States has made clear, competition in the presence of fragmented purchasing and a soft budget constraint fails to control supplier behaviour. Monopsony, increased power of purchasers relative to suppliers, combined with hard budget constraints appears to be far more effective in controlling supplier behaviour than any competition policy yet devised. Given the problems of third party enforcement of traditional supplier centred competition policy and the additional difficulties of applying that policy to public sector firms, we should consider the alternative of using purchasers to control provider behaviour.

Experience in the US with "managed competition" has demonstrated how concentrated purchasing can change the pricing and supply behaviour of providers. The UK government introduced a system, Fundholding, that could have resulted in fragmented purchasing as more funding for secondary care was devolved to GPs. However Fundholders are forming purchasing consortia that create monopsonistic counters to local supplier monopoly. Departmental announcements suggest there is to be a move toward total fundholding and as this spreads, purchasing consortia based on GP practices will replace the District Health Authorities in terms of monopsony power. These new purchasing bodies will need to be large

relative to the size of suppliers to permit effective control of supplier behaviour. It is extraordinary that a document concerned with attempts to control market power in the public interest does not examine the role and potential effectiveness of countervailing power when discussing mergers of purchasing organisations<sup>10</sup>.

We are given a list of reasons why increased concentration of purchasing may have a "negative impact on responsiveness and choice" (p.30). Most of the problems outlined, such as the obvious fact that authorities covering both urban and rural areas may have different needs, are problems only if purchasers produce a single undifferentiated package of services for all patients. Is there any evidence of this? More important, the guidelines assume purchasers are District Health Authorities with their remoteness from patients. If as current policy initiatives indicate purchasing in future will be based on consortia of GPs, the important empirical issue is the extent to which GPs would remain in consortia that did not deliver services suited to their patients. The information flows, interests and incentives of individuals in GP based purchasing consortia are likely to be quite different from those of individuals in District Health Authorities. It is an understanding of their behaviour that is central to the development of appropriate market rules and guidelines.

The criteria offered by the Guide for assessing the possible gains from greater purchaser concentration have nothing to do with changes in concentration. On page 33 we are given a "check list" that the Executive will use to assess whether a proposed purchasing

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<sup>10</sup> On page 29 of the Guide there is one sentence relating to this issue: "Financial benefits [of purchaser mergers] might include better value for money obtained in contracting as a result of the increased purchasing power of a larger organisation".

merger will be beneficial in terms of enhanced "responsiveness to patients and patient choice."

It includes items such as:

"If there is a choice of consultants within a providing unit, is the patient involved in this choice?"

"Have purchasers shifted any specific services in response to patient wishes?"

Even a single fundholding practice should be expected to provide these services if the provider has made them available. This check list belongs not in a document on merger policy but in (does it exist?) a document on monitoring the acceptable discharge of the purchasing function. The real issue is whether an increased concentration of purchasing will be more likely than a less concentrated pattern of purchasing to secure the availability of a choice of consultants from providers in the first place.

#### **IV Conclusions**

The Department of Health guidelines try to apply to the NHS the rules of a competition policy that have evolved for the control of oligopolistic and monopolistic firms in the private sector. As such it represents a misconception of the nature and scope of competition in the NHS and the requirements of a policy designed to secure the benefits of competition within the public sector.

Traditional competition policy sees buyers as passive, fragmented and helpless. The policy exists to control the consequences of supplier driven competition for larger market share. The financial infra-structure for supplier driven competition does not exist in the public

sector. Treasury rules on use of public funds makes it virtually impossible for Trusts to credibly contest market share held by other Trusts. Given public expenditure constraints, the political pressure to show short-term improvements in service delivery will encourage reduction in excess capacity normally considered essential for competition. In publically financed systems holding excess capacity will be treated as a waste. For the foreseeable future merger activity in the NHS will be dominated by the Department of Health policy of attempting to reduce excess capacity in an orderly manner. Neither of the traditional means of enforcing a competition policy discussed in the Guide, restricting mergers to maintain excess capacity or encouraging new entry are likely to be observed.

The cheerful conclusion of this paper is that it probably does not matter that we are never likely to observe the Department of Health implementing the competition policy outlined in the guide. The main problem competition was supposed to address was reduction in x-inefficiency, in particular reduction of NHS cash costs per unit of activity. A second objective was that the purchaser / provider split in conjunction with competition between providers would reduce the influence of the medical establishment in provider units in determining priorities within the health service. Treasury and Department of Health rules that make contesting market share virtually impossible also have the effect of making Trusts highly vulnerable to fairly small changes in revenue (the guidelines suggest anything over 2% can be serious). Purchasers need only threaten to switch a small amount of activity, 2-3% to exert considerable pressure on providers to conform with respect to service mix, costs and conditions of delivery. The amount of excess capacity required to make such threats credible is correspondingly small. The financial rules of the internal market concentrates market power on purchasers.

The implication of this argument is that the units requiring monitoring and regulation, if the benefits of competition are to be realised, are the purchasers not the providers. If you have passive or incompetent purchasers, you have no mechanism to secure improvements in x-efficiency or impose preferences for service mix<sup>11</sup>. The Department of Health needs to produce a new and different paper; this one borrowed from the DTI via the United States<sup>12</sup> will not do. Competition policy for firms in the public sector will be different from competition policy for private sector firms. The objective remains the same but the means will be very different.

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<sup>11</sup> To date the Treasury/Department of Health have relied on the efficiency index to secure X-efficiency gains but as has been frequently pointed out (for example Clarke et al 1993) this mechanism discourages service innovation and makes no allowance for any effects on quality or appropriateness of treatment. Securing efficiency gains requires active purchasers not constrained by such an index.

<sup>12</sup> In a personal communication Professor Frances Miller of Boston University School of Law pointed out the heavy dependence of the NHS Guide on the US Department of Justice/ Federal Trade Commission guidelines for the health care industry. There are minor differences in terminology, the US guidelines refer to antitrust safety zones where as the UK guidelines refer to local decision limits, but the overall structure of the guidelines are remarkably close.

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## APPENDIX

The Department of Health Guide is 52 pages long but highly repetitive. The precis that follows uses, as far as practicable, the exact wording of the Guide or a paraphrase of that wording in order to convey the spirit as well as the content of the document. This summary concentrates on the principles and evidence rather than processes.

### **A GUIDE TO THE OPERATION OF THE NHS INTERNAL MARKET: LOCAL FREEDOMS, NATIONAL RESPONSIBILITIES**

#### Overview

Provision of a high quality of health care on the basis of clinical need can only be achieved if the NHS is efficient. But efficiency does not occur by itself. We have learned a great deal about how to use the incentives provided by the introduction of competition to the benefit of the public who use (and through their taxes pay for) the NHS.

Competition and the purchaser/provider system is supported by other policies to achieve the objectives of the NHS:

**equity of access:** achieved through national policies for the allocation of resources to health bodies.

**quality:** achieved through the self-regulation of professionals and clinical audit procedures.

**Strategic Goals:** achieved through performance contracts relating to objectives defined in The Health of the Nation and support for teaching and research in the NHS.

**Public Accountability:** achieved through the Code of Conduct, Code of Accountability and Code of Openness, all mandatory on health bodies, and Parliamentary accountability.

**Patients' Rights:** achieved through the Patient's Charter.

All of these mechanisms are necessary features of a managed NHS, but they will not by themselves ensure that the NHS delivers services which are efficient, so that the taxpayer's pound buys as much effective health care as possible, and responsive, so that the needs of patients and communities are met. In order to achieve these results, the new system needs to have certain characteristics: a competitive structure and access to reliable data on price and quality.

#### Provider Mergers and Joint Ventures

In the context of this guidance, "mergers" and "merger activity" includes both formal mergers requiring each trust to be dissolved and a new one to be created and also mergers between services or specialties from two or more providers. Merger activity can reduce patient welfare through the acquisition and abuse of monopoly power. In certain

circumstances, usually where substantial economies of scale or scope exist, mergers may be associated with increased efficiency and quality. Mergers/joint ventures will be allowed to go through only if they produce net beneficial effects. Evaluation of these effects involves the following stages:

- Definition of a "local decision limit" within which provider mergers/joint ventures will not be challenged.
- For mergers or joint ventures falling outside the local decision limit, assessment of the impact of any merger/joint venture on competition and assessment of other potential benefits from the merger or joint venture.

The following proposals for merger/joint ventures fall **outside** the local decision limit:

- i) All merger activity requiring trusts to be dissolved and a new one to be created.
- ii) All mergers between acute and community units because of issues related to the fair use of funds in the two types of units.
- iii) For any specialty which accounts for more than 5 percent of any of the merging providers' total activity: all mergers in which the joint activities of the providers will account for more than a 50 percent share of total market activity.
- iv) For accident and emergency activity: all mergers in which the joint activity in accident and emergency services of the providers will account for more than 50 percent of the market activity.
- v) Collaborative agreements between providers to purchase and operate high technology or other expensive equipment with a value of over £1 million. Such joint venture of over £1m will not be challenged if it can be shown that **none** of the providers could support the equipment on their own. Providers entering into such ventures must not enter into additional agreements covering price or other aspects of the service, except practical issues such as operating hours.

Where mergers/joint ventures fall outside the local decision limit, there are 3 stages involved in measuring the impact on competition:

- definition of the service and the market
- measurement of the extent of concentration in that market
- assessment of the probability of entry into the market

For proposed mergers in categories (iii) and (iv) the market will be defined in terms of a geographical distance around each provider. Initially this geographical distance will be defined as a 30 minute travel time around each provider for all services except accident and emergency and a 14 (urban) or 19 (rural) minute travel time zone for accident and emergency.

Definitions of both the service and the market should include consideration of availability of substitute forms of treatment, whether the provider takes into account purchaser substitution between services when making business plans and whether purchasers have considered switching between locations or services in response to relative price and other factors. The quality of the service must also be considered in defining substitute products.



Market concentration will be defined in terms of the number of providers and the proportion of activity that they account for in a given geographical area. Cut-off points will be used to define areas of low, medium and high competition. For emergency care, the cut-off point will be a function of the maximum time recommended for travel to these facilities. In other cases, a judgement of the size of the market will need to be made by the regional office.

Factors to be considered in making an assessment of the probability of entry by new suppliers include the possibility of entry by existing Trusts with excess capacity, the private sector, the voluntary sector and primary care providers. Entry is more likely to be high when sunk costs are low and time taken to enter is short.

In some circumstances the proposed merger/joint venture may also enhance efficiency. This is most likely to occur where one or both of the parties supplies:

- Expensive capital equipment that requires a minimum throughput to be used most efficiently
- Low volume specialist services involving specialised labour
- Services which have large overhead costs
- Services for which merger will allow rationalisation of management
- Services where there is joint utilisation of inputs in the production of two or more services
- Services where there is a positive correlation between volume and outcomes
- Services where there are links between specialities and subspecialities, so making it beneficial for them to be located on one site.

In all cases the onus of proof of these benefits will rest with the merging parties.

Non-economic benefits which should be considered include:

- the creation of additional employment opportunities;
- the implications of closing a unit which has undergone recent new investment;
- the implications of closing a unit which is popular with the public.

Public consultation will proceed at the appropriate time, in line with statutory requirements.

The proposed merger/joint venture will be allowed to go ahead only if:

- It is shown to have no significant adverse effects on competition, using the measures outlined above; or
- It is shown to affect competition adversely, but the offsetting economic and non-economic benefits are sufficiently large to outweigh these effects, producing an overall net benefit.

The final decision on formal mergers involving existing trusts dissolving rests with Ministers.

## Purchaser Mergers and Boundary Adjustments

The guidance emphasises the potential impact of larger purchasers on responsiveness and patient choice. However, the Executive also considers other factors relating to organisational and financial fitness and this will continue as usual.

The costs from merger may be financial or non-financial. Financial costs might include additional overhead costs associated with extra administration, travel costs over large areas, locality arrangements etc. Non-financial costs might include lack of responsiveness to patients and loss of local "identity", lack of attention to wishes of local GPs in purchasing strategies and reduction in patient choice.

The benefits from merger may be financial and non-financial. Financial benefits might include the potential reduction in management and administrative overheads, better value for money obtained in contracting as a result of the increased purchasing power of a larger organisation, use of scarce skills in a cost effective manner.

The evidence relating to the **processes** used to ensure responsiveness to patients and GPs might include:

- The extent to which the principles outlined in "Local Voices" have been incorporated into purchasing.
- Is there an ongoing mechanism which incorporates patient views into the purchasing process?
- Are there links with localities where appropriate?
- Does the purchaser have good links with the voluntary sector and local interest groups?
- Has the purchaser a good relationship with the CHC?
- What is the mechanism for involving GPs and incorporating their views into the local purchasing strategy?

The evidence relating to the **outcome** of the process of choice involves examination of the actual choices offered to the patient. Such evidence might include:

- What alternatives are offered to patients who wait over a defined time for treatment?
- If there are many alternative providers within travelling distance, are patients offered a choice?
- If there is a choice of consultants within a providing unit, is the patient involved in this choice?
- Have purchasers shifted any specific services in response to patient wishes?

Public consultation will proceed at the appropriate time, in line with legal requirements.

The final decision rests with Ministers, advised by the relevant regional policy Board member.

## Managing Change Where Providers are in Difficulty

Market intervention should not replace decentralised decision making by health authorities, GP fundholders and NHS Trusts. Interventions undertaken by the NHS Executive should be characterised by maximum transparency. Actions taken by the NHS Executive regional office and Headquarters will depend on whether the reconfiguration lies within or outside 'the local decision limit'. The local decision limit is defined as any reconfiguration instituted by the current Trust management that is the result of an unplanned fall in real revenue which accounts for less than 2% of a Trust's total revenue or a planned fall in real revenue with 12 months' notice which accounts for less than 10% of the Trust's total revenue and where there is written agreement of all the major purchasers. All other reconfigurations arising from real revenue loss lie outside the limit.

For reconfigurations falling outside the local decision limit, the regional office will assess financial viability using the check-list for financial viability and its local knowledge of the management of the Trust, the plans of other Trusts in the same area and the purchasing and commissioning intentions of purchasers in the relevant market. On the basis of this assessment the regional office may undertake a number of actions:

- approve the Trust's own reconfiguration plan;
- ask the Trust to draw up new plans;
- advise the Trust chairman where management appears to be poor but the Trust appears to be viable in the long term;
- draw up proposals for larger scale reconfiguration including major rationalisation, merger or closure of Trusts.
- ensure that, where proposals for such major change are drawn up, it is clear that comprehensive services to patients can and will be maintained at an acceptable level.

Where mergers are proposed as part of the reconfiguration these should be assessed to ensure that:

- the merger will sufficiently improve the efficiency of the unit to offset any negative effects on competition;
- the relative benefits of merger exceed closure or other reconfiguration of one or more of the providers concerned.

In cases involving major reconfiguration or closure, the NHS Executive will keep ministers informed and advised, making recommendations on the basis of which ministers will make the final decision. Statutory consultation procedures will be followed at all times.

## Collusive Behaviour

Collusion can be a way to acquire, maintain and exploit market power. When providers and/or purchasers collude in order to protect their own interests in this way, the interests of the public-as either patients or taxpayers or both- may be harmed. However, in some cases cooperation between providers and/or purchasers is undertaken in order to promote the

interests of patients. Intervention will focus on preventing the former type of behaviour rather than discouraging the latter. It is often difficult to detect collusion as overt collusion is not needed for suppliers to behave in a collusive way. They may collude tacitly. Conversely, suppliers may react similarly when they are not in fact colluding, because they have similar cost structures.

Collusive behaviour between providers includes:

- price-fixing
- market sharing
- collusive tendering for contracts
- formation of groups to negotiate jointly prices with buyers
- joint provision of services by suppliers.

Collusion between purchasers and providers includes:

- lack of search for new suppliers at contract renewal date
- provision of unjustifiable financial support for inefficient units.

Collusion can be limited through the promotion of competition and contestability. Purchasers for services where alternative suppliers exist will consider alternative suppliers in other locations particularly for services where waiting lists are long and consider the use of competitive tendering for services where there is no supplier who is obviously the 'first choice'. Purchasers, for services where there is only one supplier, will encourage as many bidders as possible at contract renewal stage. Ways of doing this include sharing the risk with a provider, breaking contracts into smaller components so that specialist providers may bid and reducing unnecessary bureaucracy in the bidding process. If existing suppliers appear to be winning long term contracts most of the time, the NHS Executive will check that adequate competition at contract renewal stage exists.

Where existing EC and UK competition legislation covers the NHS, NHS Executive Headquarters will be responsible for issuing general guidance to purchasers and providers on relevant competition legislation. Regional offices will:

- act as collectors of information to be sent to NHS Executive Headquarters in cases where allegations of collusion (such as price-fixing, unfair pricing, market sharing) are made by providers or purchasers;
- liaise with counsel and the DGFT as appropriate;
- inform the purchasers and providers involved of the outcome of a case.

Purchasers and providers wishing to bring cases should send these to regional offices with supporting material.

## Annexes

The Guide contains two annexes:

Annex 1: Economies of Scale and Scope in Health Care Services: Summary of Evidence.

Annex 2: Check-list to Assess Financial Viability.