

Memorandum submitted by Dr Michael Lloyd (HSR 03)

My expertise is as an EU expert having spent 40 years working on EU economic and legal issues, including time spent as a European Commission official and as an economic adviser to the European Parliament.

Summary

The fundamental problem with the Bill is the underlying premise that *competitive markets* are the best way of cost-effectively delivering high quality health (and social care) services. Not only is this economic proposition challengeable, but the placing of such emphasis on competition involves economic and legal risks in a legally uncertain and complex EU-wide context.

General Competition Issues. The emphasis on competition and the establishment of autonomous sub-national health care markets in the Bill means that there is a high degree of uncertainty as to the impact of competition policy and law. There is a strong likelihood, given policy developments in the EU, that future competition rulings may adversely affect the delivery of health and social care services in the UK. The *Fenin* case does not offer the protection for health services that the Department of Health assumes. (N.B. It should be noted that UK national competition policy will itself move in this direction; including any rulings of the Monitor, as well as the OFT and the Competition Commission).

Procurement and Commissioning. Both existing and future procurement and commissioning will require the significant and increasing application of EU public procurement procedural rules (already under-going a substantial revision) to the delivery of health and social care services. Though, of itself, this development need not necessarily be detrimental to such delivery, it will require considerable sophistication of approach. The current expertise in PCTs will need to be drawn on (assuming it remains available) and extended. In particular there are likely to be problems where commissioning bodies and health service providing groups are the coterminous.

Mergers and Abuse of Dominant Positions. Here problems are already surfacing in relation to the merging of Hospital Foundation Trusts to secure economies of scale. The likelihood of successful challenge from smaller groupings – public, voluntary, and private – may be expected. The issues of the use of dominant positions, via predatory pricing, may also be the subject of adverse rulings. The danger is that sensible arrangements, in patients' interest, may well be prejudiced by developments in this area of competition policy.

State Aid Challenges. This is a complex area, but one that will give rise to concern if it is held that an undertaking providing health or social care services, in competition with a non-publicly funded undertaking, has been provided with funding from state resources on terms different from that available in a competitive market economy. and be likely to affect trade between Member States. It can readily be seen that a

key issue is whether specific health and social care services markets will be held to be markets which extend into other EU countries.

1. Introduction

1.1 This submission concentrates on the introduction, via the Bill, of an 'external NHS market' for the provision of health and ancillary services. It examines the key EU competition issues from economic and legal viewpoints. However, it should be stressed that subsequent, more detailed research and analysis will be required to positively identify the specific areas which will be likely to inhibit the efficient and equitable delivery of health and social care services in England.

2. General Competition Aspects

2.1 The introduction of competition and competitive markets, *on the scale envisaged in the Bill*, will change fundamentally the functioning of the NHS. It is naive and misleading to suggest that the Bill, even in its revised form, simply represents an evolution of the current marginal elements of existing competition in the NHS. Moreover, the emphasis on competition and the establishment of autonomous sub-national health care markets via the Bill – supported by the on-going evolution of national and EU competition impacts and influences in the health and social care sectors – means that there is a *high degree of uncertainty* as to the impact of competition policy and law on the new health services environment. It may be felt that this is a risk worth taking in the Bill improves the provision of health services. However, the main risks and uncertainties appear to lie in the direction of a weakening of the NHS underlying principles of solidarity and universality via the substantially increased application of competition policy and law.

2.2 The Bill contains an inherent conflict between its, apparent, desire to deliver greater integration and collaboration in providing health care services in the interests of patients (i.e. customers) and its focus on establishing competitive *markets*. Whatever may be stated about restricting competition if it interferes with collaboration or patient choice this will not prevent CAs in real situations from giving preference to competition over integration; this is their role and their *raison d'être*. Competition will be the *objective* and integration and collaboration will be *constraints*. Indeed, this essential irreconcilability (see below) suggests that *any* amendments in this fundamental area of the Bill will need to be radical. This problem may be seen in the context of the supposedly revised powers of Monitor in the new Bill.

2.3 The revised Bill indicates that "*the main duty of Monitor, in exercising its functions, is to protect and promote the interest of people who use health care services: (a) by promoting competition where appropriate, and (b) through regulation where necessary.*" It is clear that competition (the "where appropriate" is a meaningless qualification in practice and almost certainly in law) is seen as the principal way of "promoting and protecting" the customers of health services (i.e. "people who use health services"). This is a convoluted way of saying patient choice.

2.4 However, the notion that this in any way establishes *twin* objectives for Monitor, one being competition and the other being patient choice, is naive for two reasons:

- In *mathematical/logical* terms there can be only one maximand; the other 'objective' will be a constraint
- In *legal* terms, insofar as the establishment of competitive markets remain the key objective then competition policy and competition law, UK and EU, *will* override other objectives such as integration, collaboration, patient choice.

2.5 The above introduction of 'patient choice' as an 'objective' for Monitor simply adds confusion. It is suggested that competition *implements* patient choice. In fact, the notion that competitive markets will empower patients (viewed essentially as customers for health services) is vacuous. Competition in this context is not the competition between runners in a race, nor is it the, sensible, emulation of best practice which goes on the NHS at present; it is *competition for market shares* (The eminent economist Joan Robinson once observed that competition, in this economic market sense, was like placing "barracuda in a goldfish bowl"). Moreover, the competition for market shares will be across the range of providers: public, private, and voluntary groups.

2.6 The claim that such competitive markets will empower patients (viewed essentially as *customers* for health services) is misleading. Patients wish, essentially, to be *guided* by health service professionals as to which clinical procedure they require, either to cure or to ameliorate the condition with which they present. (Price, as NHS patients, is irrelevant to them; though not to the commissioner or provider). This is completely different from their position as customers deciding which mobile phone to purchase from which store and to which phone network to be connected. No-one is suggesting that patients' views on their treatment should be ignored, particularly in the area where health care and social care meet. But it is disingenuous to argue that citizens as patients will ever be in the same position as citizens as supermarket customers. However, this vision of patients as customers is not limited to the UK; other European countries, notably the Dutch, have already ventured down this route. This Bill will influence how health and social care services will be viewed in the EU and in the development of an EU-wide health and social care services market.

2.7 There appears not to be any strong appetite among EU countries (buttressed by the 'subsidiarity' principle as indicated in the Lisbon Treaty) to indulge the Commission's desire to establish a *de jure* EU-wide health care market. Nonetheless, successive European Court of Justice (ECJ) rulings (see below on the *Fenin* case), and their interpretation by the Commission, will continue to lead to the gradual 'widening' of national systems into a *de facto* EU health care and social care system.

2.8 Hence, the notion that the use of the Monitor as a health sector regulator (see below) to *insulate* the modified NHS from the application of EU competition law (or for that matter general UK competition law), and that this will be sufficient protection is, to say the least, disingenuous. The Field Forum report accepted at face value the assertion by the Department of Health that the Bill does not alter the application of competition law (national or EU law) in the NHS. That the bill does not change the situation is trivially true. However, as far as EU (and, therefore, national) competition law applicability to the health services sector is concerned there are a number of points to observe.

2.9 *Commissioning Bodies*. In relation to competition law overall the Department of Health is relying on the *Fenin* case to suggest that *commissioning bodies* are not to be regarded as undertakings and hence are not subject to EU competition law. However, and particularly as the position in relation to health and social care in a developing EU-wide market is concerned such reliance may prove unsound. The *Fenin* case did confirm that the purchasing activity of a commissioning body could not be dissociated from the consumption of the procured services in the market. But the European Court of Justice (ECJ) did *not* rule on the other key issue raised by *Fenin*; as to whether health services were to be judged to be an *economic market* activity as opposed to a social activity based on solidarity. It avoided the issue by ruling the argument of the plaintiff as inadmissible on a technicality, i.e. it has not been raised with Court of First Instance (CFI) initially. This lacuna is worrying.

2.10 The Bill is clearly focused on establishing a competitive market for health and social care services. Moreover, the fact that the Dutch have already moved in this direction and other countries are following (partly because of pressure on public budgets) means that parts of the EU are moving in a manner which will lead to the *de facto* establishment of an EU health and social care market, with a mixture of public and private providers. This situation increases significantly the likelihood of a new ECJ ruling which may well remove whatever protection appears to be provided by *Fenin* (which affords by no means comprehensive cover as specific circumstances could mean competition law may still apply, in the absence of a new ruling).

2.11 *Providers*. As indicated above there is, as yet, no definitive EU case law on whether health services, in a competitive market context, are economic or social. In general, private and public providers of all services may be regarded as undertakings if they are engaged in an economic activity (any provider may, of course, engage in economic activity for some of its functions but not others). It is this key issue for the health (and social care) services which will sooner rather than latter be ruled on by the ECJ. It is not unreasonable to suppose – partly based on the opinion of the Advocate-General in the *Fenin* case – that health and social care services will, generally, be defined, *in health systems that are based on competitive market structures*, as economic activities. The question is do we want to take the, very real, risk of this happening?

3. Procurement/Commissioning Issues

- 3.1 Potential problems may initially arise in this area. Obviously within the NHS, and particularly within PCTs, there is valuable experience in using appropriate public procurement procedures – including the use of EU procedures (e.g. NHS Manchester have provided a useful reference handbook on the various procedures and their practical and legal implications) – and in being aware of the need to seek value for money and where competition may be beneficial in this regard. However, the position is continuously developing, including in particular the EU public procurement rules as they apply to the provision of health and social care services. The European Commission is part way through a wide consultation exercise prior to a major reform of the rules.
- 3.2 Not all the changes which may be expected will be adverse as far as health service commissioning and procurement are concerned. The introduction of the “competitive dialogue” procedure (see below) in 2006 is an example of such a positive change. However, this change was introduced to avoid the improper use of the “negotiated procedure” (see also below) to ensure that this latter procedure was used only exceptionally, as it was supposed to be used.
- 3.3 Currently, health and social care services proper (as opposed to ancillary activities, e.g. the building of a clinic) are classified as Type B Services and are not subject to the full public procurement procedures. These services have nonetheless to be procured in a fair and transparent manner (i.e. not anti-competitively) and the contract award notices have to be published in the OJEC. One of the possible reforms being considered by the European Commission is to abolish the distinction between these Type B services and the Type A Services that are subject to the full public procurement procedures.
- 3.4 The underlying thrust of the European Commission’s position, buttressed by case law from the ECJ, is to establish a genuine EU-wide health and social care services procurement market. In itself this may perhaps to be welcome; though there are issues concerning the allocation of resources. However, the prevailing orthodoxy – if the health and social care services markets are to be subject to competition in the manner prescribed by the Bill – this will lead to competitive market structures and functioning prevailing over issues of health services’ patient interests.
- 3.5 In relation to the application of the EU public procurement rules, though GP Commissioning bodies, as with GPs themselves, are likely to be private undertakings they will, nonetheless, be regarded as bodies governed by public law, and hence subject to the public procurement rules. Other NHS commissioning bodies will be similarly defined.
- 3.6 As indicated above, it is likely that, *for the time being*, perhaps the majority of ‘pure’ health services may be defined as Type B services and hence not subject to the full rigours of the formal public procurement procedures. If this were to

change, as it could, then a far greater proportion of health service expenditure would be covered by the rules, and exposed to potential challenges

4. Mergers and Abuse of Dominant Positions

4.1 Problems with *mergers* are already arising from informal advice from the CCP (the precursor of Monitor's role in the Bill) to hospital foundation trusts in areas where hospitals wish to combine to form larger groupings to deliver more efficient health services.

4.2 The issues surrounding the potential for the *abuse of a dominant position* are obviously linked with the issue of mergers. It may be that the merger itself – entailing a large undertaking – may not itself be the problem, but its pricing or commissioning/procurement policies may be.

4.3 Competition policy in this area is critically dependent on the definition of markets, always a difficult and contentious issue surrounding the issue of whether or not substitute products or services exist and are available. Initially, the European Commission was accused, correctly, of defining markets in such a manner as to validate *a priori* the existence of dominance and abuse. The Commission now uses a methodology which relies on a definition which pays greater attention to whether or not there is substitutability between products/services to define the market. This is particularly complex where health services are concerned as there are many alternative procedures. Again it is the possibility for uncertainty in future potential EU rulings which gives rise to concerns.

4.4 For instance a possible, though not unrealistic, scenario might be

Scenario A. A large conurbation has two hospitals, one large and the other a District General Hospital (DGH), and a community clinic. The clinic – which has viability problems – provides a variety of health and social care services, including, among other services, family planning, substance abuse advice, and physiotherapy. The clinic uses the services of local GPs with special interests

The Commissioning Consortium decide to integrate all of the services provided by all three organisations into one single network and encourage the local consortia to consider a tender to provide the combined services.

Will this be possible without infringing competition law?

The problem that arises in this scenario surrounds the creation of a dominant, combined service provider which might be challenged as excluding other potential providers of some of the services.

5. State Aid Issues

5.1 State aid problems are likely to arise where the provision of public funds – which may in specific circumstances be construed as providing state aid to the recipient organisation/undertaking – is made in a full competitive market for health care and

social care. The definition of state aid is not straightforward as it relates not simply to the fact of state funding being made available, but to the *terms* on which the aid is provided and affects trade across the EU. It can readily be seen that a key issue is whether specific health and social care services markets will be held to be markets which extend into other EU countries.

5.2 The issues here are complex but this does mean that the involvement of public funds in an economic area where there is a mix of competitive markets with both economic and social services delivery may give rise to state aid challenges.

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