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Agenda

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Competition law and patient choice in the NHS Help or hindrance?

Mergers between National Health Service (NHS) Foundation Trusts have recently been brought fully into the competition assessment process that applies to the mainstream economy. But the outcomes from the first major cases have been contentious. Oxera Senior Adviser, Fod Barnes, asks whether the process has exposed significant differences between the dynamics of service provision in the NHS and how the rest of the economy behaves, and/or an inability of health service stakeholders and competition authorities to communicate in a common language

In the 'normal' economy, the process of customers choosing between suppliers allows the market to solve complex problems about what producers should produce, at what quality/price trade-off, and with what specific features. When the process works reasonably well, the outcome is that consumers get what they want (within reason), and producers at least recover their costs. Dynamically, producers are also incentivised to be more efficient (i.e. to produce more with fewer inputs) and to find out what consumers actually want.

Underlying the elegant mathematics and neat graphs in the textbooks, however, are assumptions that are rarely, if ever, fully met in the real world. Some parts of the economy will be quite close to these ideal conditions, but others will be a long way away. However, although it is all a bit of a mess compared with the (often not very realistic) outcomes described in the economics textbooks, the outcome is generally better than anything else that has been tried.

Most Western economies now have competition authorities and laws that seek to ensure that markets are moved closer to conditions where competition 'works', or are at least prevented from moving further away—the underlying assumption being that the more that consumers can make effective choices, the better the outcome. However, are there parts of the economy where the fundamental conditions are so far away from what is in the textbooks that trying to move them (at least in the conventional way) closer to the idealised competitive market will make matters worse, rather than better? Or, more practically, are there parts of the economy where the trade-off between the dynamics of consumer choice and the operation of the production process means that the straightforward application of normal competition policy leads to less than optimal outcomes, and 'special' rules or policies should be applied? The UK energy market is one area where this debate is being played out; another is the NHS in England.[1]

Mergers, choice, efficiency and patients' interests

In relation to the Health and Social Care Act 2012, Sir David Nicholson, outgoing chief executive of NHS England, commented:[2]

> All of [the politicians who drew up the Act] wanted competition as a tool to improve quality for patients [...] That's what they intended to happen, and we haven't got that…

Since 2012, mergers between NHS Foundation Trusts have been subject to the full scrutiny of the Office of Fair Trading (OFT)/Competition Commission (CC) (soon to be the Competition and Markets Authority, CMA). The same economic and legal tests have been applied as for the rest of the economy.[3] So far the OFT has found that one merger between Foundation Trusts risked leading to a substantial lessening of competition (SLC), and this was referred to the CC. The CC found that there was an SLC and that the claimed benefits to patients did not meet the CC's evidential threshold, or were not sufficiently linked to the merger to be relevant.[4] (Where NHS mergers have been approved by the OFT, this has been where it has found no SLC.)

In the words of Roger Witcomb, Chairman of the Bournemouth and Poole Inquiry Group and Chairman of the CC:[5]

> We've been acutely aware of the pressures facing NHS hospitals. However, while the broad aims

of the merger are desirable ones, there simply isn't enough detail in the hospitals' plans for us to conclude that any of the claimed benefits are likely to materialise.

This is a somewhat surprising result. Most, if not all, of the recent mergers (including this one) have been proposed in order to improve patient care and patient outcomes. For the CC not to find sufficiently robust evidence of patient benefits, even after an explicit request to the parties to provide such evidence, indicates that perhaps NHS mergers in general do not do what their proposers claim; that this merger is somehow different in delivering no patient benefits; or that something has gone wrong in the translation of how the clinicians and managers see the world to the way the competition authorities see it.

So we now have two types of bodies—the competition authorities and NHS Foundation Trusts—which are both charged with looking after patients' interests, coming to diametrically opposed views on the likely results of a merger. It would perhaps be expected that those charged with managing the provider institutions would have a somewhat different view to those charged with looking at the world through a competition lens. But, unlike the dynamics in most of the rest of the economy, there is no group in the NHS that has the shareholder interest in suppressing competition to earn excessive profits. These two groups may still not see eye to eye on the issues, but for the CC to arrive at a conclusion that there is insufficient evidence that the merger will deliver (relevant) patient benefits does suggest that this is more than just a slightly different version of the same shared view of the dynamics of the market.

Is the NHS different?

A number of characteristics of the provision of NHS services to patients are both very different from the mainstream economy and depart even further than normal from the textbook ideals of a competitive market, as follows:

- patients do not pay (at the point of delivery) for the services they receive—so there is no monetary price dynamic driving patient (customer) choice between NHS suppliers;
- individual institutions provide many services, but patients generally want a specific service (e.g. an appendectomy) and other services are not substitutes (e.g. a leg amputation), even if the same staff can supply both services;
- the supplying institutions may benefit from supplying services together and, as a result, the success (or failure) of the institution has a complex relationship with the quality of the individual services as experienced by the patient;
- most patients are accessing a service that they would rather not need, and may have limited (if not non-existent) prior information about the quality of the service and/or the quality of potential alternative suppliers;
- most patients are dependent on a GP to advise them both that they need the service and on where they could go to receive it;
- the outcome of the service is often uncertain and may depend on the (condition of the) patient, as well as the quality of the service provider;
- repeat 'purchase' by the same patient is relatively rare for many NHS hospital services;
- different institutions, which may compete in relation to many services, are encouraged to cooperate with each other where this is in the patients' interests;
- the actual purchase of services is undertaken by specialist commissioners;
- in return for supplying an additional unit of service, an institution may receive a reduced level of additional income or even no additional income, depending on the service and how the purchasers have negotiated the contract(s);
- there are mechanisms in place to ensure that certain services continue to be supplied at a particular location, even if the supplier fails financially.

These conditions are a long way from the textbook incentive framework that leads to optimal prices and levels of output, and encourages suppliers to provide the services that patients (i.e. consumers) demand.

The choice dynamic in the NHS

Where normal competition operates, suppliers that meet consumer demands well will tend to be successful. Unsuccessful suppliers may exit the market, but even if they do not, their profitability will be depressed. For normal competition to work, consumers (or an agent acting on their behalf) must be able choose supplier, and to base that choice on the price and quality of the product/service being supplied; and suppliers must benefit from more sales and suffer if there are fewer sales. For choice to work in the NHS, patients (or their agents, in the form of NHS commissioners) must be able and willing to choose suppliers according to the quality of the service being offered, and suppliers must benefit from supplying more of the service, and suffer from supplying less.

The overall regulatory structure being developed and put in place at present is designed to achieve this dynamic. But this is only one aspect of the reforms being introduced; one of the major issues facing the NHS is control of the total expenditure, so rewarding institutions for undertaking more services may look counterproductive. In addition, providing the information ex ante that allows patients (or GPs/

commissioners acting as their agents) to prefer institution A over institution B along dimensions that foster high quality and efficient services is difficult—so the choice dynamic is partial and incomplete, at least at present. Given the fundamental differences that exist in the demand and supply characteristics, it seems unlikely that the choice dynamic would ever operate close to a normal market in the wider economy.

However, as the choice dynamic is fairly new, even in its present incomplete form, there are few, if any, specific analytical tools for analysing the likely impact of a reduction in the number of suppliers of specific services in the local health economy (i.e. a merger). Given the underlying differences, it may also be risky to simply apply the techniques that have been developed in other parts of the economy—for example, supermarkets—without ensuring that the causal links between the existence of multiple suppliers, customer choice and improved outcomes exist in the context of the Foundation Trusts.

Better patient outcomes versus SLC

In its final report from the Bournemouth and Poole merger investigation, the CC concluded that there was insufficient evidence of patient benefits from the merger to outweigh the SLC it had identified. The Trusts maintained that the merger was necessary in order to deliver improvements to patients, or at least to avoid an otherwise inevitable decline in quality.

The CC's frame of reference is one in which the competition dynamic plays an important part. The CC (quite rightly) questions claims that a merger is necessary to achieve economies of scale that are claimed to be passed on to customers (relevant customer benefits), or that a merger is benign because one or both of the merging parties would exit the market if the merger did not go ahead (the exiting-firm scenario). In other parts of the economy, the motivation to acquire market power in order to raise profitability is strong, and in some cases these arguments can provide a useful cloak under which to hide this motivation.

However, the current geographic and institutional disposition of NHS service providers has not developed in a world where the dynamics of choice and patient demand have shaped the detail of where suppliers are currently located, and/or determined precisely what services each institution supplies. Indeed, in other policies applying to the NHS, great store is placed on reconfiguration of the supply of health services to drive significant increases in efficiency and allow the NHS, at a global level, to meet increasing patient demands for services with relatively static total inputs. The scale of these efficiency gains is significant—in the order of £20bn (or around 20%) over a relatively short period of a few years. Clearly, not all these savings come from changing the geographic or institutional distribution of service provision, but many of those involved in the provision of health services put significant store in the ability (and necessity) of reconfigurations to deliver efficiency improvements.[6] The implication is that the current disposition of service delivery is significantly inefficient.

This leads to the rather unexpected outcome that, on one side, we have managers and clinical staff (and others) claiming that reconfiguration will deliver significant benefits to patients, while, on the other side, the competition authorities and some academics find little (or no) evidence that it will, at least in the case of institutional mergers.[7]

We also have an outcome where, if the current disposition of services really is inefficient and the choice process is capable of rationalising the disposition of services, the outcome might be rather similar to what could have been achieved by merger. As a result, merger control may not stop reconfiguration to an outcome with less competition. But if the choice process does not work as planned (and thus fails to achieve the more efficient reconfiguration), the blocking of mergers on the basis of an SLC runs the distinct risk of locking in the current inefficient disposition of services. Finally, if reconfiguration, no matter how it is achieved, cannot deliver the level of efficiency gains that is needed, it is not a solution to NHS funding difficulties.

Same issues, different languages, minimal communication?

Difficulties surrounding the reconfiguring of the delivery of NHS services have been around for decades—this is not a new problem. Indeed, failure to reconfigure in the past (combined with new provision that is less than optimally located) is likely to underpin a significant part of the perceived current locational and institutional inefficiency. And here is a major distributional problem with much reconfiguration. In nearly all cases where institutions move, or change their service offering, even if most patients are generally better off, some patients will not be. Those who live close to a local hospital that is too small to be economically viable, or who use a current service that is due to move, would, quite rationally, not want the reconfiguration to take place.

Given the overall budgetary constraint on NHS spending, the distributional consequences of any gains from reconfiguration are also very different from those in the normal economy. So, if a unit cost reduction can be achieved in (say) cancer treatment by concentrating the supply in fewer institutions, the benefits are likely to be felt not in cancer treatment, but in the treatment of some other condition(s) that now have access to the money that has been 'saved'. (It is even possible that the money 'saved' would actually be transformed into lower taxes.)

In other cases, the benefits of reconfiguration may arise through lower patient mortality rates, and/or benefits to some patients through a change in the quality of their particular outcome. How is this benefit to be traded off against both a static disbenefit (some patients will have

to travel further) and a potential dynamic disbenefit, as the ability of patients to exercise choice of supplier gets worse? These complex distributional issues relating to reconfiguration (including mergers) are not new, and if competition authorities (and the sector regulator for health services in England, Monitor) are to improve the way they are addressed, it will be necessary to have a robust methodology that enables decisions to be based on complex trade-offs with large distributional components. This would raise complex ethical issues (e.g. how much is one additional saved life 'worth'?). The application of a methodology that is drawn largely from the normal economy (for example, the analysis of competition/choice between supermarkets), and which has an implicit assumption that choice really is a powerful mechanism to increase quality and efficiency, may need significant development before it can fulfil this role.

On the other hand, those proposing mergers or other reconfigurations also need to explain why the reconfigurations would, actually, deliver benefits to patients, in a way that goes beyond the professionals (or the managers of the institutions) merely claiming that they will. (The CC is unlikely to be wilfully ignoring evidence of patient benefits in concluding that the claimed benefits are unlikely to materialise.)

Unless this happens, it is hard to see how we will move beyond an outcome where, whenever there is an SLC, the merger (or other relevant reconfiguration) would be blocked by the CC. One such outcome is already causing some concern:

> [The CC's] refusal to sanction the merger has been viewed with alarm in the Department of Health and NHS England, where rationalisation of services is seen as central to hospitals' financial and clinical sustainability as the service copes with a £20bn savings target.[8]

This has even resulted in calls to remove NHS mergers from the purview of competition law.[9]

Conclusion

In general, applying competition and choice to parts of the economy that were previously immune to such considerations has delivered benefits in the past, but it is not all plain sailing. In the case of NHS services to patients there are very specific, and difficult, barriers to making this work. To evaluate how important this choice process is to patients, we really need better evidence of how it works, and the magnitude of the benefits it brings. The dynamic is so different from those in other sectors that applying analytical techniques designed for other parts of the economy may need to be very carefully assessed to ensure they are fit for purpose.

On the other side of the equation, if there are benefits to patients from reconfiguration, it should not be beyond clinicians and managers to provide evidence of this in a form that those concerned with market dynamics can understand and, where necessary, test. But it will need to be tested against the real stakeholder interactions of NHS institutions, and not against an assumed dynamic from the mainstream economy.

Monitor has a clear role here, just as the utility regulators have developed special rules on market structures and dynamics to reflect the peculiarities of their sectors. Failure here runs the risk of either reducing the scope of choice to work for patients where it can, or setting in stone the current (and likely to be inefficient) geographic and institutional disposition of service provision. Neither is likely to be good for citizens, either as patients or taxpayers.

So over to Monitor...

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[1] The NHS is run independently in England, Scotland, and Wales.

[2] Quoted in Cooper, C. (2013), 'Competition in NHS is harming efforts to improve patient care, says outgoing chief Sir David Nicholson', The Independent, 25 September.

[3] NHS Foundation Trusts are not-for-profit, public-benefit corporations. Part of the NHS, provide more than half of all NHS hospital, mental health and ambulance services. The Foundation Trusts were created to devolve decision-making from central government to local organisations and communities.

[4] See Competition Commission (2013), 'The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust: A report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust', 17 October.

[5] See Competition Commission (2013), 'CC makes final decision on hospitals merger', news release, 17 October.

[6] See, for example, the interview with the NHS England policy director in Williams, D. (2013), 'NHS England plans to lead "radical" service change', Health Service Journal, 17 April.

[7] See, for example, Gaynor, M., Laudicella, M. and Propper, C. (2012), 'Can governments do it better? Merger mania and hospital outcomes in the English NHS', Journal of Health Economics, 31:3, May, pp. 528–43.

[8] Neville, S. (2013), 'Prospect of more UK hospital mergers', Financial Times, 17 October.

[9] See the comments from Andy Burnham, Shadow Health Secretary, reported in PoliticsHome (2013), 'Labour: Competition Commission ruling on NHS trust mergers - response from Andy Burnham', Labour press release, 17 October.