March 2019 Health Select Committee response

Submission by the Competition and Markets Authority

About the CMA

1. The Competition and Markets Authority (CMA) is the UK's lead competition and consumer enforcement authority which works to promote competition for the benefit of consumers, both within and outside the UK.1 It is an independent, non-ministerial government department.

2. In summary, the CMA's main powers are to:

   - conduct market studies and investigations in markets where there may be competition and consumer problems;[2]
   - investigate potential breaches of UK or EU prohibitions against anti-competitive agreements and abuses of dominant positions;
   - investigate mergers which could restrict competition; and
   - enforce consumer protection legislation, in particular to tackle practices and market conditions that make it difficult for consumers to exercise choice;
   - act as a regulatory appeal body in relation to certain decisions of other regulators.

3. The CMA strives for competitive, efficient and innovative markets where consumers are empowered and confident about making choices, and where businesses comply with competition and consumer laws without being overburdened by regulation.

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1 Further detail about the CMA can be found on the CMA's website.

2 Market studies enable the CMA to study markets to identify competition (and often also consumer protection concerns) and to take appropriate action in the form of, for example, recommendations to business or government or enforcement. A recent example is the market study into Digital Comparison Tools (see further paragraphs 23ff.below). A market or markets can also be referred for an in-depth market investigation to determine whether any remedial action should be taken in relation to features of the market which adversely affect competition. By way of example, the CMA has undertaken market investigations into the energy and retail banking sectors.

Questions posed by the Committee

Question 1: Would the CMA be happy to surrender its role in NHS mergers, as is being proposed?

Question 2: What added value does the CMA believe its role in NHS mergers offers to patients - as opposed to its wider role in health markets (eg in pharmaceuticals, or the operation of the private patient market) which the committee understands would be unaffected by these proposals?

The CMA's role in NHS mergers

The CMA's role in reviewing NHS mergers in England involving at least one NHS foundation trust was confirmed in the Health and Social Care Act 2012 (HSCA).[3] The CMA's role came after the gradual introduction in the NHS of patient choice and 'payment-by-results' funding, which aimed to encourage trusts to compete for patients. Changes in the NHS also delivered greater choice and competition for commissioners of specialised services. We do not have jurisdiction to review NHS mergers in Scotland, Northern Ireland or Wales.

The CMA has a statutory duty to refer relevant mergers for an in-depth phase 2 investigation if it believes that there is a realistic prospect that the merger would result in a substantial lessening of competition. After a phase 2 investigation the CMA has a statutory duty to decide whether or not the merger may be expected to result in a substantial lessening of competition and, if so, to remedy it. Therefore, as with mergers in the wider economy, the CMA's role in NHS mergers involving foundation trusts, is not discretionary. The CMA will have jurisdiction to review a merger where, amongst other things, there is a a 'relevant merger situation' which is where two or more 'enterprises' have ceased (or will cease) to be distinct. 'Enterprise' in the context of UK merger control may refer to an entire organisation or a part of it, whether or not it operates for profit. An 'enterprise' may comprise any number of components, most commonly including the employees working in the service and the assets and records needed to carry on that activity, together with the benefit of existing contracts and/or goodwill. In healthcare, entire organisations such as NHS foundation trusts controlling hospitals, ambulance services, mental health services, community services and individual services or specialities may be enterprises for the purpose of UK merger control.[4]

Two enterprises cease to be distinct if they are brought under common ownership or control. A merger between two NHS trusts is not deemed to create a relevant merger

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[3] However, the CMA's jurisdiction over NHS mergers does not derive from the HSCA. It is the Enterprise Act 2002 which gives is the jurisdiction to review these mergers and determines the CMA's statutory duties.
[4] CMA guidance on the review of NHS mergers, paragraph 5.3

situation because, under the existing legislation, both merging providers are already under the common control of the Secretary of State for Health.[5]

Foundation trusts however, have been granted increased operational autonomy to drive delivery of high-quality services to patients and therefore aspects of the system moved away from a centrally organised model. They are not under the control of the Secretary of State to the same extent as NHS trusts. It is this for this reason that the CMA's role in NHS mergers is restricted to mergers involving foundation trusts. Indeed, mergers between NHS trusts are not covered by the HSCA.

We note *The NHS Long Term Plan* proposes to remove the CMA's duties to intervene in NHS provider mergers, as well as the CMA's role in relation to NHS pricing and NHS provider licence condition decisions.[6] We do not oppose that. We would, however, like to make clear that with respect to mergers, our jurisdiction derives from the Enterprise Act 2002 not the HSCA. Although foundation trusts as 'distinct enterprises' appear to have become less autonomous over time and *The NHS Long Term Plan* appears to continue this trajectory (as we discuss below), our view is that if the desire is for the CMA to have no ability to review mergers of foundation trusts, then the HSCA should be amended to contain a positive statement that foundation trusts are not enterprises for the purposes of the merger control provisions of the Enterprise Act 2002.

The CMA's experience of the importance of patient choice and competition in NHS mergers

Since 2012, the CMA (and its predecessor bodies) have reviewed a relatively small number of NHS mergers, all bar one of which have been cleared to proceed without any intervention from the CMA.[7]

When reviewing NHS mergers, we have been mindful that much of what NHS providers do, and how they deliver services to patients, are not a direct result of competition. Rather, NHS providers face considerable regulation and regulatory oversight (whether from NHS England, NHS Improvement, commissioners or the Care Quality Commission) all of which has undoubtedly influenced to a very large degree the decisions made by them. The regulations and recommended standards that providers face cover many facets of their operations including the quality and safety of patient care, which services they can or must offer, which medicines are approved for use, the pricing of medicines and the salaries of some staff. Provider

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[5] CMA guidance on the review of NHS mergers, paragraph 5.7.

[6] Paragraph 7.14.

[7] In 2013 the Competition Commission, a predecessor body to the CMA, prohibited the proposed merger between Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust.

exit due to financial failure is uncommon and collaboration between providers to supply services is commonplace. Because of these and other factors, the CMA has been acutely aware that many of the normal conditions and dynamics of competition between suppliers that are seen in other industries are not present in the NHS.

Furthermore, the CMA has recognised the pressures on the NHS (in the context of an ageing population and rising demands for healthcare), capacity constraints, and the focus by national bodies on greater collaboration between providers and commissioners, have reduced the role of competition. For example, in recent decisions the CMA has had regard to the NHS '*Five Year Forward View'* and the Sustainability and Transformation Plans (STPs) which have emphasised the role of collaboration between providers in improving patient care.

Most importantly, with the support of NHS Improvement, the CMA has also placed considerable weight on the benefits to patients that some NHS mergers bring about. Our experience suggests that detailed identification and verification of likely benefits to patients of NHS mergers is a useful discipline for trusts going through a merger and would encourage NHS Improvement to consider continuing this work.

Although the CMA has found in recent cases that the role of competition in the provision of NHS hospital services has been reduced, we have also found that patient choice of first outpatient appointments in England for routine NHS elective treatments (supported by the payment mechanisms) incentivised NHS providers to compete for patients by improving their service levels and efficiency. The CMA also found that commissioners, in choosing which NHS providers to award specialised and community contracts to, can use competition between NHS providers to improve services. These two areas have been the main focus of recent CMA investigations.

In the past the CMA has used its powers to review NHS mergers to ensure that patient choice for elective treatments and the quality benefits that meaningful choice can deliver to patients will be preserved after a merger. The benefits that have been considered include the provider's incentive to improve waiting times, increase the ratio of nurses or doctors to patients, reduce infection rates, improve cleanliness, invest in new equipment or offer services valued by patients. The CMA has been conscious that NHS Improvement has also viewed patient choice as being a way to facilitate some improvements in the system (eg reducing waiting times).[8] Regarding preserving choice and competition for commissioners of specialised services, the CMA has investigated mergers to ensure that a loss of competition will not result in a

[8] See, for example, NHS England and NHS Improvement (2016), Securing meaningful choice for patients: CCG planning and improvement guide; and NHS Improvement (2014) Procurement, choice and competition in the NHS: documents and guidance; and Cooperation and Competition Panel (2012), Inside the black box: How competition between hospitals improves quality and integration of services.

reduction in the quality associated with the provision of specialised services, such as investment in equipment, developing staff expertise or some other factor of quality.

We are aware of some evidence that competition between NHS providers since 2012 has been beneficial to patients. For example, a working paper recently published by the CMA found a negative relationship between local hospital concentration and certain patient outcomes based on patient data collected between 2013 and 2015.[9] This is consistent with the findings of some academic studies, although other research has found, conversely, that competition may have had a negative effect on elective quality.[10]

However, competition within the system depends on the incentives in, and the structure of, the NHS system. Even in the period since the start of the CMA's involvement in 2012, the role of competition with respect to foundation trusts has evolved; including in ways not envisaged at the time of the 2012 reforms. For example, the CMA's decision in the *Manchester hospitals* case recognised that regulators and policy makers were encouraging greater levels of collaboration and collective responsibility in the provision of NHS services within local health economies, and they placed a reduced emphasis on competition.[11] The CMA found that recent policy developments (in particular, the *Five Year Forward View*, STPs and financial control totals) had constrained the operational autonomy of foundation trusts. The CMA went on to say in that case that the policy developments, increased regulatory oversight and agreements which linked funding to financial and quality targets "significantly constrained" any adverse effect resulting from a substantial lessening of competition.

The NHS Long Term Plan appears to continue this trajectory of placing increased emphasis on collaboration, greater levels of integration and regulatory oversight of foundation trusts. For example, we note in *The NHS Long Term Plan* that foundation trusts will be encouraged to set up joint committees to allow for decisions regarding integrated care systems to be taken jointly between foundation trusts and commissioners. Moreover, the plan sets out that every NHS trust, foundation trust and clinical commissioning group will be expected to agree single year organisational operating plans and contribute to a single year local health system-level plan. Under the vision of the plan, it appears that although patient choice will be preserved, the effectiveness of competition in driving incremental improvements in some aspects of service delivery may be further reduced.

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[9] 'Does hospital competition reduce rates of patient harm in the English NHS?', CMA Economics Working Paper, January 2019.

[10] For example, see Gaynor el al (2013) and Skellern (2018)

[11] Central Manchester University Hospitals NHS Foundation Trust/University Hospital of South Manchester NHS Foundation Trust (August 2017)

The NHS Long Term Plan rightly points out that the CMA undertakes critical investigations in tackling anti-competitive behaviour in health-related markets.12 For example, we have taken a number of cases regarding infringements of the Competition Act 1998 against pharmaceutical companies supplying drugs to the NHS. The NHS Long Term Plan does not change our powers and ability to continue to take such cases. We also note that the enforcement cases and market studies that we have taken in health-related markets have involved private providers, not NHS providers. NHS Improvement, as with other regulators (eg Ofcom and the Financial Conduct Authority), has concurrent powers to apply competition laws in its regulated industry. The CMA notes the benefits of concurrency, in particular facilitating cooperation between the CMA and concurrent regulators. We note that NHSI has never used its concurrent powers. We do not oppose NHS Improvement giving up its powers under the concurrency arrangements since the CMA itself can undertake relevant cases.13 In addition, we fully expect to continue our close working relationship with NHS Improvement and that any formal change in their role can be reflected in updated MoU and other processes. In this way, both organisations can ensure that their complementary skills, knowledge and technical understanding can continue to be brought to bear on competition enforcement in the health-related markets.

Question 3: The way the NHS tariff is used is designed to limit price competition for NHS services. Is there anything in these proposals that might lead to price competition for core NHS services?

As discussed in respect of the previous question, the CMA's work in the specific areas within the scope of the question has generally been in respect of mergers, where we have consistently found that competition between providers has focussed on quality and patient outcomes, rather than on price.

Although NHS Improvement determines the way that NHS tariffs are set, if the methodology applied is objected to by a sufficient proportion of the providers affected by these tariffs, NHS Improvement can refer the methodology for determining tariffs to the CMA for redetermination. Where such a reference is made, the CMA would have 30 days to complete the function. The *NHS Long-Term Plan* proposes that this role for the CMA is removed.

No such reference has ever been made to the CMA and, in our view, the specialist knowledge required to perform the redetermination function does not in any event, sit well within the CMA. We therefore support the proposal that NHS Improvement should be able to implement these changes directly, following consultation. We have

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[12] Paragraph 7.14.

[13] For example, as we did in Private ophthalmology: investigation into anti-competitive information exchange and pricing agreements

had some exploratory discussions with NHS Improvement about how it could design an internal review system. This could replicate some of the appeal processes that the CMA has in other sectors, without the need for a costly and complex process of an appeal to the CMA. Judicial review would also remain as an appeal route if NHS Improvement is not considered to have properly undertaken the consultation process indicated in the proposals for change.

The Committee has asked specifically about whether the proposals, as a whole, could lead to an increase in price competition. As discussed above, we have not been involved in cases where price competition has been a relevant consideration, and where the amount of competition could be changed by the proposals. We cannot therefore draw on specific experience in commenting on this question.

We have though considered whether the proposals to change the ways tariffs are set could have unintended consequences of increasing price competition. Our assessment is that there is no particular mechanism identified which would be likely to increase price competition. Price competition relies on there being competing providers with the freedom to set prices in a way which allows purchasing bodies to make decisions based, at least in part, on difference in price between those providers.

Our understanding of the legislative proposals is that there will remain, where appropriate, parameters which could change the price charged by different providers to reflect local circumstances, albeit that some of the existing ability to apply to change tariffs is being removed. If any local adjustments are on an objective and transparent basis, i.e. with any differences limited to factors which would result in providers in the same area offering the same service at the same price, then the proposals would not lead to increased price competition. This would be consistent with the proposals for the role of Integrated Care Systems to ensure greater consistency and collaboration.

We would also highlight to the Committee that the CMA is heavily involved in resolving issues relating to price competition for products – in particular pharmaceutical drugs - supplied to the NHS. We currently have a number of competition law enforcement investigations relating to suspected anti-competitive behaviour in respect of products supplied to the NHS. We are fully supportive of any changes which improve the workings of markets for these products which are supplied to the NHS, in some cases well above cost, and we have an ongoing relationship with DHSC on various projects, including their assisting us in providing evidence in our investigations and their taking measures to avoid excessive pricing for medicines. We also do not see any proposals which will adversely affect the CMA's ability to take forward these important competition enforcement investigations.