The Operation of the NHS Internal Market:

Local Freedoms, National Responsibilities

NHS
Executive

THE OPERATION OF THE NHS INTERNAL MARKET:

Local Freedoms, National Responsibilities

FOREWORD

Since the NHS reforms were introduced four years ago, there has been a transformation in the health service. By encouraging efficiency and by giving health professionals and managers the freedom and the incentives to respond to patients' needs, the NHS internal market has shown itself to be a powerful tool for putting patients' interests first.

The introduction of this new system is a means to an end. It is a mechanism for achieving better health for the population, and quality health care for individuals. It provides sharper incentives for hospitals and community health services to improve both quality and efficiency. Health authorities and GP fundholders are increasingly using their purchasing power to ensure that services respond to the needs of their patients.

We must use these mechanisms ever more skilfully. By building on experience, we will be able to maximise benefits for the public, patients and the taxpayer. The internal market itself does not, and was not expected to, achieve all the goals of the National Health Service. It does, however, go a long way towards supporting them. A strategic perspective will always be important, especially where we are faced with continuing change as a result of medical and technological advance. We need constructive co-operation between different parts of the NHS as well as the beneficial impact of competition. Improving health care is not a question of choosing one or the other. We have to find the appropriate balance between the two.

In thinking about how we develop the internal market, we need to set it alongside the other means by which we manage the NHS. These include:

- the management relationship between the NHS Executive and purchasers, through which we pursue national health strategies and ensure adequate support of teaching and research, as well as upholding the fundamental NHS commitment to the principle of equity
- the requirement on NHS Trusts, like other NHS bodies to meet accepted standards of public accountability and probity
- the principles of professional self-regulation which govern the

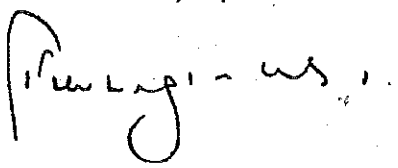
practice of those who provide health services directly to patients.

During the last four years we have built up a body of experience about how best to combine the incentives in the new system with strategic direction in order to provide the most effective outcomes for patients and the public. We have learned when to stand back, and when to intervene.

The purpose of this guide is to bring together that experience into a simple set of principles drawing on best practice. It provides a framework for operating the NHS internal market to improve still further efficiency, quality and the responsiveness of services to the needs of patients.

The guide lays down clear and practical ground rules for judging where the balance lies between local freedoms and national responsibilities. It sets out clearly the criteria the NHS Executive will use in deciding in individual cases whether or not to intervene. By reducing uncertainty, I believe the guide will encourage further innovation and initiative.

As the new system develops, so too will this guide. We will keep the principles under review, and develop them in the light of experience. We aim to provide the greatest possible freedom for those in the NHS to exercise their responsibilities on behalf of patients, while at the same time ensuring that the wider interests of the public - as patients and taxpayers - are always protected.



Alan Langlands

THE OPERATION OF THE NHS INTERNAL MARKET: LOCAL FREEDOMS, NATIONAL RESPONSIBILITIES

CONTENTS

OVERVIEW

THE OPERATION OF THE NHS INTERNAL MARKET:

Local Freedoms, National Responsibilities

OVERVIEW

INTRODUCTION

1. The purpose of the National Health Service is to improve health and to provide comprehensive and high quality health care on the basis of clinical need. This can only be achieved if the NHS is efficient and if it is able to respond to the changing needs of patients.

2. But efficiency does not occur by itself. The main factor in achieving efficiency and responsiveness has been the separation of responsibility for purchasing and providing NHS services. The introduction of competition has provided incentives to listen to what patients want, and to bring the service offered by all parts of the NHS up to the level of the best.

3. During this period we have learned a great deal about how to use these incentives to best effect, to the benefit of the public who use (and through their taxes pay for) the NHS. This guide draws on the lessons and achievements of the last four years. It sets out the main principles on which the internal health market is based, and provides a framework for its further development. These principles have been designed to give the greatest possible freedom to innovate while clarifying when and how the NHS Executive will intervene to ensure that the system is working in the public interest.

4. Establishing a purchaser/provider system has enabled the NHS both to improve further its efficiency and respond better to patients' needs. At the same time, that system, supported by other policies, continues to deliver the key objectives of the NHS:

   - **Equity of Access:** This is primarily achieved through national policies for the allocation of resources to health authorities and GP fundholders in different parts of the country. It is reinforced by actions at a local level.

   - **Quality:** By promoting efficiency, the system helps to free the resources to provide high quality care. Quality

and patient safety are also protected through the self-regulation of professionals, following standards set down by Royal Colleges and other bodies. Quality control is reinforced by clinical audit procedures, by the inclusion of quality thresholds in contracts and by other initiatives at a local level.

- **Strategic Goals:** National objectives - such as those defined in *The Health of the Nation* - are promoted through performance contracts with health authorities. The quality and effectiveness of teaching and research in the NHS are protected by various national policies, for example the SIFTR mechanism of allocating funds (which is being improved).

- **Public Accountability:** The public sector values expected of the NHS are spelled out in the Code of Conduct and the Code of Accountability which are mandatory on all health authority and Trust boards. A Code of Openness for the NHS, due early in 1995, will set out the public's right of access to information. The NHS Executive has to account to the Secretary of State for Health and to the Public Accounts Committee for the money spent in the NHS and the services provided.

- **Patients' Rights:** The Patient's Charter sets out patients' rights in the NHS, including guidance about patient participation and the rights of the public to a full investigation of complaints. The Charter also sets a number of national and local standards of service delivery which the public can expect from the NHS. An updated and expanded Charter is due in early 1995.

THE NATURE OF THE NHS INTERNAL MARKET

5. 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;

   - **responsive** - so that the needs of patients and communities are met.

6. In order to achieve these results, the new system needs to have certain characteristics:

A Competitive Structure

Competition provides the stimulus for hospitals and community health services to be efficient and to respond to the needs of patients and the public. Health authorities and GP fundholders, who purchase health services on behalf of patients in the new system, usually need to have a choice of providers to get the best possible service. For many services, it is therefore efficient to have competition between several providers. For other services (for example where there are economies of scale) it may be more efficient to have just one provider, whose behaviour is stimulated by the knowledge that another provider could replace it. In this case the system is contestable if not directly competitive.

To promote the benefits of competition, new providers must be able to introduce alternative services. By the same token, existing providers who do not respond to the needs of patients should risk losing patient and purchaser support and ultimately face change, including restructuring or closure. The new system is a powerful mechanism for identifying where such change is necessary so that patient care can be provided in the most modern and effective way. Competition also motivates purchasers. Thus GP Fundholders lose income if their patients choose to move to another practice. Public comparison, in the form of "league" tables for example, will challenge poor performing purchasers to improve.

Information on Price and Quality

The system will work best where purchasers and providers have access, at reasonable cost, to reliable data on price and quality. Providers need to be able to compare their performance with others and purchasers need information to make good choices about the services they buy on behalf of their population.

Increasingly, the people who **use** NHS services will also have access to information which can help inform the decisions they make. NHS performance tables are an excellent example of how information is being made available to the public in an accessible and useful form.

Incentives

If hospitals and community health services are to be efficient, there should be adequate incentives for service improvement and innovation. Similarly, health authorities and GP fundholders need to be motivated to be responsive to the needs of their population, and for being effective purchasers.

Price Structures

In any health care system, prices provide clear signals. Prices paid to providers must reflect the cost of providing the service, and allocations to purchasers must reflect the health care needs of users.

7. In many cases, the purchaser/provider system will operate effectively on its own, delivering improved services and outcomes. However, certain situations or behaviour can endanger efficiency and responsiveness. These could include:

- monopoly, especially where the costs of entry are high
- poor information
- barriers to the provision of alternative services by new or existing providers, especially where patients would benefit from a wide range of services in one location
- collusion, especially where this reduces the incentives for efficiency and responsiveness.

Where these factors do exist, a degree of intervention by the NHS Executive will be required to ensure that their impact is reduced, and to ensure that the system works at all times in the public interest.

THE PURPOSE OF THE GUIDE

8. This guide draws together the lessons that have been learned over the last few years about the effective operation of the new system, and the guidance material and "case law" issued by the NHS Executive and regional health authorities in response to requests for advice and arbitration. The guide provides - for the first time - a simple set of ground rules that everyone in the NHS can work by.

9. The purpose of the guide is to spell out clearly the circumstances in which the NHS Executive, working with the relevant regional Policy Board member, will act to ensure the correct balance between local freedoms and national responsibilities. It describes the criteria it will use in deciding what action is required. The aim is to provide an explicit framework within which individuals and organisations can act with certainty to deliver services which are of high quality and give value for money.

10. The guide reflects several important principles:

- Trusts, health authorities, GP Fundholders and GPs have primary responsibility for the delivery of health services. The ground rules are therefore designed not to restrain purchasers and providers, but rather to guide their actions, so that they and their patients can get the best out of the new system

- There should be a presumption **against** intervention, to ensure the maximum freedom of individuals and organisations in using the system to bring benefits to patients. However, the NHS Executive will intervene when it is necessary to protect the overall interests of patients or the taxpayer

- Where intervention **is** necessary, the presumption is in favour of a competitive solution; the ground rules aim to promote competition as the sharpest way of providing incentives to efficiency and responsiveness

- Where NHS Executive intervention is needed it will have clear aims, and be on the basis of explicit criteria, so that participants know where they stand, and so far as possible can predict the outcome.

- The regional Policy Board members have a vital role to play working with regional offices and advising Ministers in respect of the issues covered in the guide.

THE INITIAL SCOPE OF THE GUIDE

11. The guide outlines four situations where NHS Executive intervention might be required: provider mergers and joint ventures; purchaser mergers and boundary adjustments; providers in difficulty; and collusion. Further guidance may be added in future.

12. In each case, the guide outlines:

- **why** intervention is needed;
- **what** actions are expected of those who purchase and provide health care; and
- **what** actions the NHS Executive will take.

13. As the guide makes clear, it does not replace the requirement to follow statutory procedures on public consultation where appropriate.

Provider Mergers and Joint Ventures

14. If the benefits of a merger between providers outweigh the disadvantages, then it should go ahead. But it should not lead to the merged organisation abusing monopoly power.

15. The guide identifies a "local decision limit", defined by the proportion of services in a given area provided by one organisation. Mergers between providers or between specific services or specialties that do not exceed this limit will be allowed, unless there are extraordinary circumstances. Any merger which falls outside this limit will be assessed by the NHS Executive through its regional offices, working with the relevant Policy Board member, to determine its impact on the public interest. Mergers requiring trusts to be dissolved will always require ministerial approval. If the merger is unlikely to increase monopoly power, or if its benefits outweigh any possible reduction of purchaser choice, then it will be allowed to go ahead. Particular scrutiny will be given to proposed mergers between acute and community health Trusts to ensure that the full range of services are protected.

Purchaser Mergers and Boundary Adjustments

16. Health authorities and GP fundholders are the agents of patients in the new system. Their role is to assess local needs and purchase health care which responds to those needs and reflects the choices of those on whose behalf they act. While health authority mergers can have benefits, such as lower administration costs, they also have the potential to reduce this responsiveness and choice.

17. Such changes will be permitted where the benefits outweigh

the costs, taking into account the impact on patient choice and the likely financial and organisational fitness of the merged organisation.

18. Mergers and boundary adjustments will be assessed by the regional office to determine their impact on responsiveness and patient choice. The criteria and procedure for the assessment are outlined in the guide as are the actions required of Trusts and DHAs.

Managing Change where Providers are in Difficulty

19. The key incentive in the new system is that hospitals and community health services which can attract patients by the quality, responsiveness and efficiency of their services attract funding with them. Services which are not meeting the needs of patients have the stimulus to improve or face the risk of losing patient and purchaser support.

20. In some instances, the operation of this system will highlight areas where more fundamental change, including restructuring or closure, needs to take place. This may be, for example, because the advance of medical technology or changing population patterns are rendering a particular scale or type of service obsolete.

21. When these situations arise, any consequential re-organisation of health care provision needs to be planned and carried out with minimum disruption. High quality services which meet the needs of patients must be maintained at all times. Major service changes must of course be subject to statutory public consultation.

22. Small changes should be primarily the responsibility of provider management, taking the wishes of local health authorities, GP fundholders, GPs and patients into account. Larger scale change, however, will need support and guidance from the NHS Executive, through its regional offices and from the relevant regional Policy Board member. The guide explains when and what intervention from the NHS Executive is required.

Collusion

23. Co-operation between providers, health authorities and fundholders can be highly beneficial. It is important, however, that this does not lead to collusion, through such actions as

price-fixing which can reduce or eliminate incentives for efficiency. Collusion between providers can lead to lower quality services or higher prices (and hence less services for the money available). Collusion between providers and purchasers may prevent the entry of other organisations offering better quality services.

24. The guide shows how to prevent harmful collusion which protects the interests of purchasers and providers, while allowing beneficial collaboration to promote the interests of patients. Purchasers are encouraged to seek alternative providers wherever possible, using guidance from the NHS Executive. Any complaints of collusion will be investigated by the regional offices.

CONCLUSION

25. The purchaser/provider system has great potential to deliver effective, modern and innovative services which respond to the changing needs of NHS patients. A great deal of that potential has already been demonstrated.

26. By ensuring the effective operation of the new system, the NHS will be able to build on this progress. The ground rules set out in this guide will ensure that the public - as both patients and taxpayers - receive the maximum benefit from the new National Health Service which is now in place.

TECHNICAL PAPERS

THE OPERATION OF THE NHS INTERNAL MARKET:

LOCAL FREEDOMS, NATIONAL RESPONSIBILITIES

TECHNICAL PAPERS

1. The following chapters cover the technical issues arising in the four areas for which guidance has been prepared: Mergers and Joint Ventures between Providers; Purchaser Mergers and Boundary Adjustments; Managing Change where Providers are in Difficulty; and Collusion.

2. In each case, a set of general principles outlining the policy goal and rationale is followed by a more detailed set of operational guidance which sets out specific actions and responsibilities.

3. These are written for purchasers, providers and regional office staff who are involved closely with these issues. They will not need to be consulted on a regular basis but will need to be understood and used as appropriate when issues of merger, financial difficulty or potential collusion arise.

4. Some of the detail may need to be amended in the light of experience and for this reason they will be the subject of evaluation and review. In particular, experience will show whether the "local decision limits" specified in some of the documents are set at sensible levels or need to be adjusted upwards or downwards.

5. A glossary of terms used throughout the document is attached at the end of the technical papers.

PROVIDER MERGERS AND JOINT VENTURES: PRINCIPLES

PROVIDER MERGERS AND JOINT VENTURES: PRINCIPLES

1. The principles outlined in this paper cover merger activity and joint ventures in high technology equipment between providers in the internal market. They do not cover the issues related to the process of merger once decisions have been made. In addition, they do not replace the need for the business case process in cases involving capital investment.

2. In the context of this guidance, "mergers" and "merger activity" includes both formal mergers which require each trust to be dissolved and a new one created and also mergers between services or specialties from two or more providers.

POLICY GOALS

3. To allow mergers or joint ventures with net beneficial effects to go ahead, but to ensure that proposed mergers/joint ventures do not lead to the acquisition and abuse of monopoly power, with subsequent detrimental effects on patient welfare. Where proposed mergers between acute and community Trusts are proposed, the need to safeguard the full range of services must be a key consideration.

COSTS

4. Merger is the main route to the acquisition or enhancement of market power through a reduction in competition. Market power reduces incentives for providers to reduce the costs and/or to improve the quality of the service offered when compared with competitive services, and thus reduces patient welfare.

5. Not all mergers/joint ventures will reduce competition significantly. It will depend on the nature of the system in which the providers operate. Even where market power is enhanced by merger, if there is a real threat of competition in the form of new suppliers entering the market, detrimental effects may be limited.

BENEFITS

6. The main potential benefit from mergers/joint ventures is the production of efficiency and/or quality gains. This is likely to be the case where there are substantial economies of scale or scope in production of the service. This can mean lower costs and/or higher quality if services are provided by just a small number of providers rather than within many smaller units.

7. In some circumstances, given a particular level of demand and the existence of significant economies of scale, a monopoly provider will provide the most efficient outcome ("natural monopolies").

FRAMEWORK FOR ASSESSMENT

8. The framework is designed to allow the maximum freedom for providers, whilst ensuring that proposed mergers/joint ventures proceed only if they have net beneficial effects. The framework involves defining the limits for local decisions, assessing proposals for mergers/joint ventures falling outside these limits, making a decision and public consultation.

PUBLIC CONSULTATION AND DECISIONS

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

10. The final decision on mergers rests with ministers, advised by the NHS Executive and the relevant regional Policy Board member.

THE "LOCAL DECISION LIMIT"

11. Proposed mergers or joint ventures which fall within the local decision limit may proceed unchallenged by the NHS Executive unless there are extraordinary circumstances which warrant investigation. The purpose of defining the local decision limit is to allow changes to proceed freely in those situations where the effect on competition is unlikely to be significant.

12. For mergers, the local decision limit is based on the market share of the providers who wish to merge. Market share is defined in terms of the activity of the merging parties relative to the total activity carried out by all providers within a defined geographical area.

13. For joint ventures, the local decision limit is defined in terms of size. A joint venture will fall outside the local decision limit if the value of the equipment or technology that the providers wish to operate and purchase together is over £1m.

PROCEDURE FOR ASSESSMENT OF MERGERS FALLING OUTSIDE THE LOCAL DECISION LIMIT

14. Proposed mergers/joint ventures which fall outside the local decision limit will be assessed to determine the impact on competition and any additional economic and non-economic beneficial effects. Mergers/joint ventures which affect adversely the level of competition will be allowed only if there are sufficient offsetting benefits.

Measuring the impact on competition

15. This will require:

- Definition of the service and the relevant geographic market.
- Measurement of concentration.
- Assessment of the likelihood of entry of new suppliers i.e. the likely extent of contestability.

Details are given in *Provider Mergers and Joint Ventures: Operational Guidance*.

Estimation of other benefits from merger

16. If the proposed merger/joint venture is shown to reduce competition, it will not be allowed to proceed **unless** it can be shown that there are benefits which more than compensate for the effect on competition.

17. **Economic** benefits may arise due to the existence of significant economies of scale or scope which mean that:

- the unit costs of producing the service in the merged unit would be lower than they would be in separate smaller units; and/or
- the quality and outcomes of the services would be better in the merged unit than in separate smaller units.

18. **Non-economic** benefits should also be considered and could include:

- effects on employment;
- the implications of closing units with recent large investments;
- retaining units which are popular with the public;

19. Such non-economic benefits are an important consideration. However, in the overall assessment of the merger the greatest weight should be given to the impact on competition and hence on the efficiency and quality of services provided.

20. The onus of providing evidence of the additional benefits will be on the merging parties.

DECISIONS ON MERGER/JOINT VENTURE PROPOSALS

21. If the proposal falls outside the local decision limit and is subject to an assessment, it will be allowed to proceed:

- if it has no significant effect on competition

- if it is shown to have an adverse effect on competition, but the offsetting benefits are sufficiently large to produce an overall net benefit.

PROVIDER MERGERS AND JOINT VENTURES: OPERATIONAL GUIDANCE

PROVIDER MERGERS AND JOINT VENTURES: OPERATIONAL GUIDANCE

1. This guidance covers merger activity and joint ventures in high technology equipment between providers in the internal market.

2. It outlines:

   - the purpose of the guidance on mergers/joint ventures;
   - the definition of a "local decision limit" within which proposed changes will be allowed to proceed without investigation;
   - the procedures for assessing the costs and benefits of mergers/joint ventures which fall outside the local decision limit;
   - the parties responsible for each stage in the process.

3. 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.

THE PURPOSE OF GUIDANCE ON MERGERS/JOINT VENTURES

4. 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.

5. The purpose of this guidance is to ensure that, where appropriate, an assessment of costs and benefits of proposed mergers/joint ventures is made according to a set of defined procedures and a clear decision is made to allow or prevent the changes.

6. The guidance is designed to allow the maximum freedom for providers whilst ensuring that changes which do not result in net overall benefits do not proceed.

7. It 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.

- Assessment of other potential benefits from the merger or joint venture.

- A decision whether to allow the proposed changes to proceed which will take account of whether the merger/joint venture is net beneficial.

THE "LOCAL DECISION LIMIT"

8. 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. These will always be a matter for ministers.

(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. The definition of the market is given below in paragraph 9.

(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. The definition of the market is given below in paragraph 9.

(v) Collaborative agreements between providers to purchase and operate high technology or other expensive equipment with a value of over £1m. Such joint ventures of over £1m will not be challenged if it can be shown that **none** of the providers could support the equipment on their own. Evidence to support this claim should include details of the cost of purchasing and running the equipment, useful life, the workload necessary to break even on the costs and the likely demand for the service. 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.

9. 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 or 19 minute travel time zone (urban and rural areas respectively) for accident and emergency (consistent with the Patient's Charter standards for ambulance response times).

10. Activity will be defined in terms of Finished Consultant Episodes (FCEs) for those specialties in which FCEs are used to measure activity. For other services, activity will be measured in terms of the units currently used.

PROCEDURE FOR ASSESSMENT OF MERGERS/JOINT VENTURES FALLING OUTSIDE THE LOCAL DECISION LIMIT

11. If a proposed merger/joint venture falls outside the local decision limit, an investigation will be carried out by the NHS Executive, working with the relevant regional Policy Board member, to assess the impact of the proposed changes on competition and to consider any offsetting benefits. Mergers/joint ventures which do not reduce economic welfare will not be prevented on economic grounds.

MEASURING THE IMPACT ON COMPETITION

12. Proposed mergers/joint ventures which are shown to reduce competition significantly should not be allowed to proceed unless it can be shown that other benefits resulting from the merger will offset the disadvantages of reduced competition.

13. 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 by other suppliers (i.e. contestability).

Definition of the service and the market

14. Definition of the service should include consideration of:

- the availability of substitute forms of treatment or medical intervention or the availability of the treatment in different facilities (eg GP surgeries)
- whether the provider takes into account purchaser substitution between services when making business plans
- whether purchasers have considered switching services before in

response to relative price and other factors.

15. Definition of the **market** should include consideration of:

- the location of the services and the extent to which patients may be prepared to travel to receive these services. Ease of access is important and particularly so for some services such as A&E.

- the size of the geographical market will, therefore, vary according to the service considered. For non-accident and emergency services, a 30 minute travel zone will be taken as the starting point for definition of the market. For accident and emergency the definition will be based on a 14 or 19 minute travel time zone (urban and rural areas respectively).

- whether the provider takes into account purchaser substitution between services when making business plans

- whether purchasers have considered switching demand between locations in response to relative price or other factors

16. The **quality** of the service must be also be considered:

- a difference in the quality of a service offered by alternative suppliers could be sufficient to classify the services as two separate services rather than substitutes.

Assessment of the extent of concentration in the relevant market

17. The second stage is the measurement of market concentration. Initially a simple approach will be followed.

18. 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. The appropriate size of the geographical area and cut-off points will vary across types of service. For emergency care, the cut-off point will be a function of the maximum time recommended for travel to these facilities (based on Patient's Charter Standards for emergency cases). In other cases, a judgement of the size of the market will need to be made by the regional office.

Assessment of the probability of entry by new suppliers (i.e contestability)

19. Increased concentration may not pose a threat to competition if entry to the market for the service is relatively easy and is likely to occur, offsetting the anti-competitive effects of the merger/joint venture.

20. Entry is more likely to be high when:

- Sunk costs are low
- Time taken to enter is short

21. Factors to be considered in making this assessment include the possibility of entry by existing Trusts with excess capacity, the private sector, the voluntary sector and primary care providers.

ESTIMATION OF OTHER BENEFITS FROM MERGER/JOINT VENTURES

Economic Benefits

22. 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:

- Services which use expensive capital equipment that is highly specialised and requires a minimum throughput to be used most efficiently
- Low volume specialist services involving specialised labour, requiring a minimum throughput to be used efficiently
- Services which have large overhead costs, making them uneconomic at low levels of output (eg R&D, teaching)
- Services for which merger will allow rationalisation of management and organisational costs
- 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 (eg some specialist services)
- Services where there are links between specialities and sub-specialities, so making it beneficial for them to be located on one site

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

24. For more information on those services where economies of scale and scope exist see *Economies of Scale and Scope in Health Care Services: Summary of Evidence* (included as Annex 1).

Non-Economic Benefits

25. Non-economic benefits from proposed mergers/joint ventures are important, though the greatest weight should be given to the impact on competition and hence on the efficiency and quality of services provided.

26. 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.

CONSULTATION AND DECISIONS ON PROPOSALS

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

28. If the proposed merger/joint venture falls outside the local decision limit and is subject to an assessment, it 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.

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

30. Regional offices will inform providers of the decision and the reasons for the decision.

RESPONSIBILITIES

31. **Merging Parties**

- Notify the NHS Executive regional offices of proposals, providing detailed plans for proper consultation.

- Provide the NHS Executive regional offices with the information necessary (including evidence of benefits) for assessment of merger/joint venture if it falls outside the local decision limit.

- If the merger/joint venture is allowed, ensure that service delivery and quality are maintained and wherever possible enhanced during the process and handle any necessary staff and public communication.

- If the merger/joint venture is not allowed, handle any necessary staff and public communication and ensure normal services are maintained in each unit.

30. **Purchasers**

- Provide the NHS Executive regional offices with information on current and projected demand in response to potential changes in price and/or quality from the merged provider.

- Provide NHS Executive regional offices with information on actual and potential alternative sources of supply taking into account issues such as accessibility of alternatives.

31. **Regional offices**

Regional offices, working with the relevant regional Policy Board member, will:

- Decide whether the proposals fall outside the local decision limit.

- If so, obtain the information needed for the assessment from the merging providers and affected purchasers.

- Apply the assessment procedure to establish the net benefit of the changes under the guidance of the NHS Executive Headquarters.

- Ensure proper consultation procedures have been followed.

- Support providers in handling staff and public relations.

- Inform providers of the decision and reasons for the decision

32. **NHS Executive Headquarters**

- Provides guidance and information to regional offices to define the market, to estimate the effects on competition, and to assess the net benefits of the merger/joint venture.

- Keep ministers informed and advised and make recommendations to them on merger proposals with the support of the regional offices where appropriate.

- The final decision on mergers involving existing trusts dissolving rests with Ministers, advised by the NHS Executive and the relevant regional Policy Board member.

ANNEX 1

ECONOMIES OF SCALE AND SCOPE IN HEALTH CARE SERVICES: SUMMARY OF EVIDENCE

This paper provides a brief summary of the current evidence about the existence of :

Economies of **scale** with respect to costs and quality
Economies of **scope** with respect to costs and quality

ECONOMIES OF SCALE: COSTS

Definition: Reduction in average unit costs due to increase in scale of production (ie increased output).

1. Economies of scale can be classified in the following way:

- **Production** economies of scale - these relate mainly to **indivisibilities** in inputs and to division of labour.
- **Managerial** economies of scale - relate to specialisation of management.
- **Pecuniary** economies of scale - discounts on input prices, transport etc.

2. Focusing on those most relevant to health care, we would most expect to find economies of scale in relation to **costs** where:

- Services involve the use of expensive capital and equipment which is highly specialised, requiring a minimum throughput to be used most efficiently eg linear accelerators for radiotherapy treatment.
- Low volume specialist services involving specialised labour, requiring a minimum throughput to be used efficiently.
- The overhead costs associated with a function is large and is uneconomic at low levels of output eg R&D and teaching function.
- Where the merging of units will allow rationalisation of managerial and organisational costs.

In all such cases, services provided by one unit are expected to be less costly than the same level of provision at two or more smaller units.

Evidence:

Hospital size

3. In the US, the Federal Trade Commission assumes that if a hospital has less than 100 beds with an average daily inpatient census of 40 or below, then economies of scale can be gained through merger.

4. Econometric evidence from the UK is limited, mixed and fairly dated. U-shaped cost curves with minimum costs at the level of 903 beds and 430 beds have been suggested, but the methodology used in the former study may have exaggerated the economies of scale.

5. Econometric evidence from the USA and elsewhere is also mixed. Older studies have found no evidence of scale economies, whilst others were inconclusive. More recent evidence suggest economies of scale in acute hospitals in Canada up to a level of 581 beds and in the US, up to 900 beds and also some evidence of economies of scale in the outpatient sector.

6. It is difficult to draw conclusions from such mixed evidence especially as substantial methodological problems arise in some of the studies. Whilst the potential for economies of scale in relation to the size of an acute hospital may exist up to a fairly large scale, beyond which potential diseconomies of scale operate, it is difficult to be specific in terms of precise bed numbers. In 1990/91, only 131 hospitals (8%) in England had more than 500 beds, so some mergers affecting smaller hospitals could possibly reap the benefit of economies of scale with less danger of experiencing diseconomies. Given the uncertainty surrounding much of the evidence (and the fact that much of it originates in the USA), it would be unwise to base decisions on the organisation of hospital services on the basis of this literature alone.

Specific Services

Labour Intensive Services

7. For a large number of services where fixed costs are a relatively small proportion of total costs and variable costs increase in line with output, economies of scale are unlikely to exist. This might apply to many domiciliary based services. However, in the USA, several states have laws restricting the entry of free-standing home health agencies into the market in the belief that the existence of economies of scale means that additional home health agencies will result in higher unit costs. Previous research supported the existence of economies of scale, but more recent thorough analysis has found no evidence of economies of scale.

8. An increasing variety of procedures and services are now being shifted out of the hospital sector into GP surgeries, which may suggest the lack of significant scale economies in these areas (however, this should be treated with caution as the shift is not entirely attributable to relative cost differences but to factors such as improved responsiveness and accessibility to patients). GPs now undertake many minor surgical procedures in their surgeries (eg excisions, curettage, electrocautery, cryocautery) in addition to a range of diagnostic services and pathology. GPFHs have also initiated a shift in the location of care where health professionals provide their services within the GP practice (eg physiotherapy, counselling) again suggesting that economies of scale may not be a significant issue for these services.

9. Some services have become less "high-tech" over time and arguments for the existence of economies of scale may be less convincing than previously eg

maternity services.

Specialist services

10. For some specialist services, economies of scale would be expected due to the indivisibilities in inputs described earlier, but empirical evidence about optimal scale of provision is not available.

11. However, the desirability of improving efficiency by exploiting fully expensive equipment and specialist skills by ensuring a sufficient volume of cases, has been the rationale for recommendations about the configuration of specialist services in London.

12. In particular, for cardiac and cancer services, a move towards a smaller number of larger sites was recommended and experts proposed that economies of scale were possible in cancer units up to at least the level of 4,500 patients per year. Similarly, the forthcoming Review of Renal Services suggests that the appropriate number of procedures for renal transplant unit is 80 to 100 per year based on the provision of cost-effective staffing and infrastructure and training needs in that specialty. Currently a large proportion of the centres providing renal services are below this range, implying that concentration on fewer sites could potentially reduce unit costs.

13. Recent evidence suggests that economies of scale exist for neonatal intensive care, partly due to the need for specialised equipment and skills and also because higher average occupancy of cots can be achieved in larger units whilst still ensuring that cots are available to meet demand at short notice. Economies of scale are reaped up to the level of 4000 cot days (13-14 cots).

14. In summary, empirical evidence of economies of scale in costs for specific services is very limited and for many services, especially lower-tech and labour intensive services, significant economies of scale are unlikely. For a small number of specialist services involving expensive capital and highly specialised skills or relatively low volumes, economies of scale may exist and rationalisation of smaller centres into fewer larger ones can potentially reduce unit costs.

Research & Development, Teaching

15. Providing an R&D or teaching function involves incurring a relatively high overhead cost which may not be economical unless this cost can be spread over a large volume of students.

16. The more usual argument for requiring large volumes is related to the need to ensure a wide enough variety of caseload to facilitate training and research. However, the focus when considering economies of scale in **costs** is that larger units can "produce" R&D and teaching at lower unit costs.

17. Evidence from the US has examined the costs of "producing" residency training in teaching hospitals and concluded that there are indeed economies of scale associated with residency training.

18. Analysis undertaken on behalf of the NHS Executive for the SIFTR project suggests that there are economies of scale in research in a model containing the SHAs, but otherwise there is no evidence.

ECONOMIES OF SCALE: QUALITY

Definition: Increase in quality of outcomes due to increases in the scale of production

19. Economies of scale in relation to quality are due to a correlation between outcomes and the volume of work undertaken either per **unit** or per **clinician.** The existence of the former would support the case for larger units/hospitals more strongly than the latter.

20. Economies of scale in quality are most likely to occur where the opportunities for "practice makes perfect" are highest eg for complex technical procedures and for rare, low volume conditions where familiarity with the condition would be important. In addition, for routine procedure, an element of "practice makes perfect" may exist at large volumes.

21. One of the problems in establishing the existence of this relationship concerns the direction of causality: rather than practice makes perfect it may be the case that selective referral is the cause ie units with better outcomes attract more patients.

Evidence:

22. Evidence from the UK and US suggests that the positive relationship between outcome and volume is strongest for a small set of surgical procedures and a small number of other specialist services:

- In **surgery**, there is evidence that lower volumes are associated with poorer outcomes (usually measured by mortality rates) for the following operations: abdominal aortic aneurysm, appendicectomy, some types of biliary tract surgery, CABGs, hysterectomy, hernia care, intestinal surgery, total hip replacement and vascular surgery. Studies on stomach operations, fracture of the femur and cataract surgery have been inconclusive or shown no positive association.

- In **cardiac services**, the relationship seems strongest for CABG where it is reported to persist even at high volumes (600-700 per year for hospitals and 100-200 for individual surgeons). Thus it has been suggested that units need to be large enough to undertake 700-1000 CABGs annually. However, a recent analysis of the empirical evidence undertaken by the NHS Centre for Reviews and Dissemination at York University has shown that many of the studies looking at the relationship between volume and outcome do not adjust adequately for case-mix. When such

adjustments were made for CABG studies, the strength of the relationship between volume and mortality declines. Evidence to support the existence of a positive relationship in cardiac catheterisation is available, but is mixed for acute myocardial infarction (the association in the latter case may be at the level of physician rather than hospital).

- In **renal** services, the specialty reviews for Tomlinson Report/SHAs compared patient survival and graft survival rates of existing centres of different sizes, but no statistically significant differences due to size were found. However, expert opinion suggested a minimum size of 100 grafts per year for transplant centres.

- For **neuroscience** services, similar arguments were used to support the recommendation that each centre needs to serve a population of between 2 and 2.5 million people in order to ensure good quality of care, especially for less common disorders, but no empirical evidence is available.

- Recommendations for the reconfiguration of **cancer** services in London were made on similar grounds and units treating 3000-4500 people per year were considered to be optimal in terms of ensuring good outcomes.

- The specialty reviews suggested that **plastic surgery and burns** care services need to be located in acute hospitals with a minimum of 2,000 patients per year in order to achieve best outcomes. However, available research evidence (from the US only) shows no association between volume and outcome.

- The literature suggests that **trauma care** and **heart transplantation** in larger centres is associated with better outcomes, whilst the evidence for **perinatal care** is mixed and less convincing.

23. In summary, the existence of a positive relationship between volume and outcome is widely held but there is only a limited amount of empirical evidence from the UK and US to support this. The evidence is strongest for only a limited number of procedures and services and is complicated by the fact that the correlation is sometimes strongest not at a hospital level, but for individual clinicians. In addition, most studies have not adjusted for case-mix which casts some doubt on the strength of any reported relationship. It is therefore not advisable to use this evidence as the sole justification for decisions about the optimum way of organising services.

ECONOMIES OF SCOPE: COSTS

Definition: Joint production of two or more services has a lower cost than the production of the services, at the same level of output, by separate enterprises.

24. Economies of scope arise from the sharing or joint utilisation of inputs. In industry, the most obvious example is the multi-product firm. In health care services, economies of scope are most likely to be found when inputs such as capital can be used for more than one purpose eg operating theatres are used for many different specialties.

25. Where there are shared costs, the loss of one service will result in a rise in the costs of producing the other services For example, if a hospital loses one speciality, the costs of operating theatres will have to be spread over the remaining users and the unit costs of these services will rise.

Evidence:

26. There is extremely limited empirical evidence to support the existence of economies of scope. The US research on home health agencies found no evidence of substantial economies of scope for domiciliary services. Indeed, for some categories of care, diseconomies were found as the variable cost of adding services outweighed the savings in fixed costs.This is again likely to be the case for UK services of this type where fixed costs are a relatively small proportion of total costs.

27. In the hospital sector, economies of scope have not been widely addressed, but there is some US evidence that they exist, especially in relation to the joint production of patient care and medical training.

28. In the US, restructuring in the hospital market provides some indirect evidence of lack of economies of scope. Hospital services are being "unbundled" so that services once provided on a single site (or in a single management unit) are now provided on separate sites. In the UK, GPFH activity in terms of performing minor operations in the surgery rather than the hospital also provides some indirect evidence of lack of economies of scope in some parts of the hospital sector.

29. One service in which economies of scope may exist is in A & E services. If an A&E department shares overheads with other services, then loss of A&E may result in increases in costs of other services. Care must be taken however, to distinguish between the short and long run: in the short term, factors of production may be fixed and/or methods of producing services may be fixed. A loss in one service will therefore result in a rise in the unit cost of producing another service. Thus loss of an A&E facility will result in loss of business for a hospital as over 45% of FCEs are linked to emergency admissions. In the short term, unit costs of other services in the hospital will rise, but in the longer term an A&E unit may not be required for the hospital to remain financially viable.

ECONOMIES OF SCOPE: QUALITY

Definition: Joint production of two or more services produce higher level of quality, at the same level of cost, than production of the services at separate sites.

30. Economies of scope with respect to quality are most likely to be found where:

- There are links between specialties and sub-specialties which require them to be located at one hospital site in order that cross-consultation and referral may be made.
- Functions such as teaching and training require a broad range of specialties at one site in order to be effective.

Evidence:

31. The argument for needing linked specialties and sub-specialties on one site is strong for some specialties which rely on joint clinical management of patients but there can be a danger that every specialty is always seen as essential. In terms of economies of scope in quality, it is the ultimate effect on patient morbidity and mortality which should be the criterion for siting of specialties. Work by York Health Economics Consortium has started to explore the strengths of such links by creating "interspecialty links matrices" for DHAs.

32. These considerations also influenced the recommendations of the specialty reviews in London. For example, it was thought essential that general and orthopaedic surgery was on the same site for neuroscience services to function, but less essential (but desirable) for A&E department to be on site.

33. The need to ensure that the teaching function is adequately supported by a wide case-mix range heavily influenced the reconfiguration proposals in Newcastle. It was felt that postgraduate medical education could not be provided at all if the existing hospitals were scaled down rather than undertaking some sort of merger between two or more of them.

34. Whilst the teaching argument has some strengths, it is not obvious that it is an argument for providing services at one site. It may be sufficient to rotate trainees between hospitals in order to ensure they experience the range of case-mix required for their education. The association between individual hospitals and University Medical Schools militates against this at present.

PURCHASER MERGERS AND BOUNDARY ADJUSTMENTS: PRINCIPLES

PURCHASER MERGERS AND BOUNDARY ADJUSTMENTS: PRINCIPLES

1. The principles outlined in this paper apply to mergers between DHAs. They also apply to boundary adjustments which may not involve a formal merger. The responsibilities of GPFHs will be considered as part of the draft accountability framework to be issued for consultation shortly. The principles applying to the formation of new health authorities will be included in specific guidance expected in 1995 (subject to Parliamentary approval of the current Health Authorities Bill).

POLICY GOALS

2. Purchasers must be responsive and offer choice to those for whom they buy health care and transactions costs should be minimised. Proposed mergers should be assessed to ensure the resulting purchasing organisation is better able to offer these benefits.

COSTS

3. The costs from merger may be financial or non-financial.

Financial costs might include:

- Potential additional overhead costs associated with extra administration, travel costs over large area, 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;
- reduction in patient choice eg through standardisation, use of a single provider.

BENEFITS

4. 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

Non-financial benefits might include the ability of larger units to:

- adopt a strategic approach to service planning over a larger population, a larger geographical area and wider range of services and to forge alliances with other organisations which cover large geographical areas;

- increase patient choice by contracting with a wider range of providers.

FRAMEWORK FOR ASSESSMENT

5. Potential mergers between DHAs are already subject to scrutiny by the Executive in terms of the organisational and financial "fitness" of the partners. This guidance does not replace this process but emphasises the additional issues of responsiveness to patients and patient choice which are important parts of the process and should be assessed in detail.

PUBLIC CONSULTATION AND DECISIONS

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

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

ASSESSMENT OF PROPOSED MERGERS

8. Proposals for merger will be assessed to determine the impact on patient choice and responsiveness.

Factors which suggest that size may have a negative impact on responsiveness and choice include:

- Larger authorities may serve populations which differ in terms of demographic characteristics such as social class and unemployment rates which may affect the health care needs of each constituent population.

- Larger authorities may cover a mixture of urban or rural areas which have different needs.

- A merged authority may be dominated by one of the original organisations, so the purchasing strategy may be biased in favour of one set of needs.

- The views of GPs may be more diverse over a wider geographical area and it may be difficult to aggregate them into a single purchasing strategy.

- Those living long distances away from the headquarters of the newly formed authority may feel less able to approach and influence their purchaser (for example, difficulty in attending public meetings etc).

- A large organisation may be less able to forge strong links with local agencies representing patient views in particular areas of the authority (such as local voluntary bodies and pressure groups).

9. Large purchasers may be able to show that they incorporate features which can offset these potentially adverse effects and be even more responsive to patients:

- Provision of a better forum for liaison with agencies representing patient views (eg CHCs).

- Use of a variety of methods for consultation with the public.

- Provision for GPs' views to be assessed via a variety of formal arrangements such as GP panels.

- Organisation of purchasing on a locality basis to reflect variation in needs and to build a local identity.

- The ability to put in place mechanisms which offer patients a degree of choice about the services received (eg the location at which treatment is given).

10. Details of the type of evidence required to measure patient responsiveness is given in *Purchaser Mergers and Boundary Adjustments: Operational Guidance.*

Decisions on mergers

11. Proposals for mergers will be allowed to proceed only if they are judged to produce overall net benefits where benefits and costs include both the effects on responsiveness and choice, and the organisational and financial factors the NHS Executive considers important.

12. The Secretary of State retains the power to determine health authority boundaries and this is unaffected by this guidance.

PURCHASER MERGERS AND BOUNDARY ADJUSTMENTS: OPERATIONAL GUIDANCE

PURCHASER MERGERS AND BOUNDARY ADJUSTMENTS: OPERATIONAL GUIDANCE

1. This guidance covers mergers between DHAs and boundary adjustments. It does not apply to GPFHs whose responsibilities will be considered as part of the draft accountability framework to be issued for consultation shortly. Guidance on the formation of new health authorities will also follow in 1995 (subject to Parliamentary approval of the current Health Authorities Bill).

   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.

2. The guidance outlines:

   - The procedures for assessing the impact on patient choice and responsiveness of proposed mergers.

   - Who should be responsible for each stage in the process.

PROCEDURE FOR ASSESSMENT

3. Proposals for merger will be assessed for evidence of the existence of mechanisms which promote patient responsiveness and choice.

Evidence

4. The focus of the assessment will be:

   - To examine the evidence that there are mechanisms in place which allow the new purchaser to be responsive to patients. This also includes consideration of how responsive they are to GPs as agents of the patient. This concerns the **processes** used to ensure responsiveness.

   - To examine the evidence that the new purchaser offers the patient a degree of choice in terms of the location of services. This concerns the **outcome** of the process of choice.

5. It is possible that a purchaser could be **responsive** but yet not offer the patient **choice.** A responsive purchaser might have mechanisms for assessing the views of the local population and take action to satisfy the majority of them, but still not allow for a degree of choice for the individual patient. For example, by placing a contract with a popular local provider unit, the purchaser might satisfy the local population, but if waiting lists for a specific treatment at this unit lengthen and patients

on this list are not offered an alternative location for treatment where lists are shorter (even if this means they are required to travel further for treatment), the purchaser is offering limited choice.

6. The assessment will consider the arrangements already in place and also the plans the merging parties have to **strengthen** these once they have merged.

(i) 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" (NHSME, 1992) have been incorporated into purchasing. For example, what means are employed to inform the public about the work of the purchaser?

- Is there an ongoing mechanism which incorporates patient views into the purchasing process (eg patient panel or systematic surveys and consultation) rather than just an *ad hoc* approach on specific topics?

- 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?

(ii) 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? For example, are they offered a referral to another unit at a different location?

- 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

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

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

DECISIONS ON MERGERS

9. Mergers will be allowed to go ahead only if they produce overall net beneficial effects, where the benefits and costs include both the effects on choice responsiveness (covered in this guidance) and the organisational and financial factors considered important by the Executive.

RESPONSIBILITIES

10. **Purchasers involved in merger**

- Notification of proposals to regional offices
- Provision of information to regional offices to allow assessment to take place.

11. **Regional offices**

Regional offices, working with the relevant regional Policy Board member, will:

- Collect information and make assessment of proposals
- Communicate this assessment to NHS Executive Headquarters

12. **NHS Executive Headquarters**

- Keep ministers informed and make the final recommendation to them with support from regional offices.

MANAGING CHANGE WHERE PROVIDERS ARE IN DIFFICULTY: PRINCIPLES

MANAGING CHANGE WHERE PROVIDERS ARE IN DIFFICULTY: PRINCIPLES

POLICY GOALS

1. 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.

COSTS OF CENTRAL INTERVENTION

2. Intervention reduces the scope for purchasers and providers to determine the best outcomes for patients.

3. Funds used to smooth market transition are diverted from other uses and users.

BENEFITS OF CENTRAL INTERVENTION

4. There will, however, remain an important role for market management as a result of:

- the need to balance local freedoms in the new system with national responsibilities;
- the current lack of a **single indicator** of long term viability of a provider;
- the need to ensure that, where market mechanisms point to the need for change, it takes place in a manner which enhances services to patients;
- the indirect role for final users of the service in expressing demand;

FRAMEWORK FOR INTERVENTION

5. A 'local decision limit' is defined with the aim of giving maximum weight to the views of market participants and to the information the market provides.

This limit defines those cases in which the NHS Executive will not intervene, unless specifically requested to do so by a Trust management.

The definition of the local decision limit needs to be known by all Trusts, purchasers and CHCs.

The precise definition of the local decision limit takes into account the

extent of change occurring in a particular market and the development of market participants. Over time, the level of the local decision limit may be extended.

6. Outside the local decision limit the actions to be taken by the NHS Executive may include some or all of the following:

- assessment of the financial viability of Trusts;
- assisting in drawing up plans for reconfiguration for one or more Trusts in the area;
- liaison between providers, purchasers and patients in the case of disputes over service relocation and closure;
- provision of advice to chairpersons of Trusts where the Trust is judged to be viable under a different management;
- helping trusts to dispose of surplus assets arising from the process of change;
- operation of funds which permit Trusts to make service reconfiguration without severely increasing prices or disrupting services within year.

7. In undertaking these actions, the NHS Executive will:

- collect information on a regular basis so it is well informed about local services;
- give as much weight as possible to the views of those involved and affected by change, especially patients;
- employ a common set of criteria in all regional offices to assess the financial viability of a Trust and apply sensitivity analysis of crucial assumptions when applying the criteria;
- follow clearly defined, published procedures for intervention;
- ensure that statutory consultation procedures are followed.

MANAGING CHANGE WHERE PROVIDERS ARE IN DIFFICULTY: OPERATIONAL GUIDANCE

MANAGING CHANGE WHERE PROVIDERS ARE IN DIFFICULTY: OPERATIONAL GUIDANCE

1. This guidance outlines:

   - the procedures to follow and the organisations responsible for taking action;

   - the factors to be considered in making decisions.

   where a provider or group of providers is experiencing financial difficulties.

2. The 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

3. 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.

4. All other reconfigurations arising from real revenue loss lie outside the limit.

ACTIONS FOR CHANGES WHICH FALL WITHIN THE LOCAL DECISION LIMIT

5. The Trust management is expected to:

   - assess the Trust financial viability using the *Checklist for Financial Viability* (Annex 2), bringing other information to bear as appropriate;

   - ensure that they have taken the most up-to-date purchaser plans into account

   - inform all purchasers who are affected by proposed changes so that they may undertake any statutory consultation required.

- follow current guidance on the use of funds from sale of assets in drawing up reconfiguration plans;

- handle staff and public relations arising from the change;

6. The regional office/regional Policy Board member will not be involved with reconfiguration associated with changes falling within the local decision limit except to:

- provide advice and support if requested to do so by Trust management;

- assess the business case arising from the reconfiguration where this falls within the delegated limits defined in current guidance *(Approval and Monitoring Procedures for Capital Investments - FDL(94)55).*

- act as arbitrator in any contract disputes associated with the reconfiguration;

- keep itself informed about the extent of likely reconfiguration in services.

ACTIONS FOR CHANGES FALLING OUTSIDE THE LOCAL DECISION LIMIT

7. Management in a Trust which is experiencing change that falls outside the local decision limit will be expected to:

- assess their financial viability using the check-list and provide a summary in the form of a projected cash flow over a 3-5 year period;

- draw up a strategy which addresses the problems, which may in some cases include an outline of a reconfiguration plan, identifying staff and capital changes where appropriate;

- notify the regional office.

8. 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;

- the purchasing and commissioning intentions of purchasers in the relevant market.

9. On the basis of this assessment the regional office, working with the relevant regional Policy Board member, may undertake a number of actions and will take the minimum action consistent with dealing with the problem:

- 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.

The relevant section below should be consulted for details of action in each case.

Regional office approval of Trusts' own reconfiguration plans/request for further plans

10. The plan should include:

- a precise timetable for reconfiguration.
- mechanisms for handling staff and public communication.
- a business plan that meets the needs of local purchasers.
- a timetable for disposal of surplus assets.
- means to ensure that the delivery and quality of services to patients is maintained while reconfiguration takes place.

Advice to Chairmen where the Trust management appear to be poor

11. The regional office, working with the relevant regional Policy Board member will aid the Trust Chairman and Non-Executives to secure the assistance of additional senior management support to the Trust in order to:

- ensure that the delivery and quality of services to patients is maintained while reconfiguration and handover take place.
- draw up a precise timetable for reconfiguration;

- handle staff and public communication;

- draw up a business plan that meets the needs of local purchasers;

- dispose of surplus assets;

Action where market reconfiguration is necessary

12. The regional office will draw up a service reconfiguration plan based on discussion with both purchasers and providers and appropriate public consultation.

13. 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;

14. *Provider Mergers and Joint Ventures: Principles* and *Provider Mergers and Joint Ventures: Operational Guidance* should be consulted and advice sought from NHS Executive Headquarters if required.

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

DECISION SUPPORT TOOLS

16. **Checklist to assess financial viability**

The check-list (appended as Annex 2 to this paper) is a management tool. Its function is to ensure that key economic factors are included in any analysis of viability. There is no single indicator of viability. The check-list takes into account both demand and supply conditions. A summary of these factors should be provided in the form of a cashflow projection over a 3-5 year period.

17. The Trust and/or the regional office as appropriate should make every effort to secure data on each of the criteria in the check-list. It is particularly important that estimates of demand and the views of purchasers are sought.

18. The broad criteria in the check-list are applicable to both small and large service changes and market reconfiguration. The weight put on the

criteria will differ across situations. In the case of large scale reconfigurations, key data will need to be subject to sensitivity analyses.

19. Other factors may need to be taken into account when a Trust and/or the regional office initiates service changes.

20. Every attempt should be made to increase transparency of the factors underlying reconfiguration and closure decisions.

Operational guidance on mergers

21. See documents *Provider Mergers and Joint Ventures: Operational Guidelines* and *Provider Mergers and Joint Ventures: Principles*.

ANNEX 2

CHECK-LIST TO ASSESS FINANCIAL VIABILITY

CRITERIA AND MEASURES OF THESE CRITERIA	DATA SOURCES	COMMENTS ON CRITERIA OR DATA SOURCES
Deficit on I/E account over a number of years or persistent failure to meet other financial duties	From provider accounts	May be too aggregated a measure since providers supply a range of services
Demand for services		Assess demand for each service provided by unit
- Projected purchasing power of local buyers	Projected resources of local buyers	Needs information on speed of move to weighted capitation and shifts in purchasing priorities
- Projected purchasing power of non-local buyers	Projected resources of non-local buyers	Needs information on speed of move to weighted capitation and shifts in purchasing priorities
- Likely alternative suppliers of services and purchaser preferences	Travel times to alternative suppliers, quality and prices of alternative suppliers, shifts in market share and patient/GP preferences	Make assessment for each service; give greater weight if supported by evidence collected directly from patients or from local GPs
- Assessment of changes in medical practice and technology that will affect demand	Issues include further moves to day surgery, movement of care into primary settings	Need to make similar assumptions across whole of NHS

Current and projected costs		
- Costs relative to other providers in same market	Information should be collected by purchasers and from provider accounts	Take into account possible changes in other providers' level of provision and costs
- Relative efficiency in future production	Capital improvements which will shortly come on stream	Whilst improvements which are in the pipeline should be taken into account, costs which cannot be recovered following reconfiguration or closure ("sunk costs") should not prevent such changes from occurring
	Extent to which efficiency target met	May be too aggregated; note possible distortions in efficiency index
	Costs relative to similar providers	
- Effect of change in size on costs: *economies of scale in costs* *economies of scale in quality* *economies of scope*	See *Guidance on research on economies of scale (Annex 1)*	Need to make similar assumptions across whole of NHS

CRITERIA WHICH ARE NOT APPROPRIATE SIGNALS OF FINANCIAL VIABILITY		
- Deficit on current I/E account or short term inability to meet other financial duties		May be a warning sign but can be misleading because only takes into account current years activity, thus need to take account of track record of Trust.
- Recent high investment in provider		Sunk costs should not be part of the assessment of future financial viability. However, such costs may be important when considering <u>where</u> services of merged units should be provided, or when considering alternative sources of supply which may be about to come on stream.

COLLUSIVE BEHAVIOUR: PRINCIPLES

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POLICY GOALS

1. To establish the extent to which collusion between providers or between provider and purchaser is inefficient, to limit the negative effects through the promotion of competition and contestability and to take robust action where collusion is identified.

COSTS OF COLLUSION

2. Collusive behaviour may allow providers to acquire, maintain and exploit market power. This exploitation may take a number of forms, for example, the provision of low quality services, the charging of prices significantly higher than cost or lack of responsiveness to purchaser and patient choices. Such actions are undertaken in order to enhance the interests of providers and may harm the interests of patients, taxpayers, or both. They are wholly contrary to the spirit of the new system.

3. Collusion between providers and purchasers should not occur if purchasers are seeking best value for money for their patients/ populations. But where this does not happen, collusion may be attractive and may, by preventing the entry of other organisations offering better quality services, act against the interests of patients and taxpayers.

BENEFITS OF CO-OPERATION

4. In certain circumstances, co-operation between providers may be undertaken in order to promote the interests of patients and such actions may then be beneficial:

- Where investment occurs in large discrete segments, it may be better for providers to take turns in making the investment. In such cases, providers may co-operate in bidding for contracts.

- Where investments are large, co-operation between providers may be the only way that the service will be provided.

- Where a minimum throughput of patients is needed in order to achieve a high quality service, co-operation between providers in order to offer a viable service may be beneficial.

- Contract negotiation costs may be reduced if buyers can negotiate jointly with a number of suppliers rather than each negotiating separately.

- Sharing of information may increase the ability of providers to meet purchasers and patients needs.

In certain circumstances, joint provider-purchaser actions may be undertaken in the interests of patients and may be beneficial:

- Where service provision requires the build up of specialist human and capital resources, providers and purchasers may enter into long term contracts. These types of relationships may appear to be collusive, but if there is adequate competition for provision of these services at the contract renewal stage, such long term relationships may be more efficient than short term ones.

FOCUS OF THE POLICY ON COLLUSION

5. In the interests of patients, purchasers and providers should report cases of suspected collusive behaviour to regional offices for investigation, who in turn should also inform the relevant regional Policy Board member.

6. Regional offices will also carry out random checks and where collusion is suspected they will examine contracts in detail.

7. Intervention will be most actively pursued when the market is not competitive. The existence of competition will limit any gains that can be made from collusive behaviour.

8. In seeking proof of collusion, the focus should be on the effect of the agreements rather than the form i.e. the focus should be on outcomes and not conduct, as absence of overt collusive conduct does not mean that tacit collusion has not taken place.

9. In all cases, co-operation which is undertaken in the interests of patients will be distinguished from action which serves to protect the interests of purchasers and/or providers. Intervention will be targeted only at the latter.

LEGISLATIVE CONSTRAINTS

10. The Restrictive Trade Practices Act (RTPA), 1976 and the Resale Prices Act (RPA), 1976, are designed to prevent collusion.

11. Under the RTPA, all agreements between companies which contain restrictions of a kind likely to inhibit competition (eg agreements to do business with a restricted number of purchasers), should be registered with the Director General of Fair Trading (DGFT), and are assumed to be against the public interest unless they can pass through one of the "gateways" provided in the Act. These gateways are rather broad.

12. Contracts between DHAs and Trusts may contain features which bring them within the scope of this legislation, as may contracts between DHAs and the private sector and contracts between GP Fund Holders

and Trusts.

13. The RPA bans minimum resale price maintenance, with certain exemptions. Books and pharmaceuticals are currently exempted.

14. To avoid duplication of effort and the creation of a non-level playing field between public and private providers, the NHS Executive will:

- take into account compliance with the RTPA when investigating complaints of collusion;
- encourage purchasers to seek alternative providers wherever possible and to set up tendering arrangements to minimise the likelihood of collusion;
- collect information on the extent of collusion;
- undertake random checks of contracts;
- regularly assess guidance on market openness in pricing and costing;
- prevent the development of monopoly by disallowing inappropriate mergers.

COLLUSIVE BEHAVIOUR: OPERATIONAL GUIDANCE

COLLUSIVE BEHAVIOUR: OPERATIONAL GUIDANCE

1. 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 co-operation 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.

FORMS OF COLLUSIVE BEHAVIOUR

2. Collusive behaviour between providers includes:

- price-fixing (keeping prices significantly above cost by agreeing not to compete);
- market sharing (agreeing not to compete in certain localities or in certain services);
- collusive tendering for contracts (agreeing not to bid against each other when purchasers put contracts out to tender, either within the NHS or in cases of market testing);
- formation of groups to negotiate jointly prices with buyers;
- joint provision of services by suppliers;

3. Collusion between purchasers and providers includes:

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

THE PROBLEM OF DETECTION

4. 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. For example, if one supplier changes prices in a market and then all others always follow suit, the suppliers will almost certainly have colluded. However, there may be no firm evidence of collusion (eg talks about prices) that could be detected.

5. Conversely, suppliers may react similarly when they are not in fact colluding, because they have similar cost structures. A change which affects one firm will affect all others in the same way, so the responses to this change will be similar in all the providers.

COSTS OF INTERVENTION

6. Intervention has administrative and information gathering costs.

7. Excessive intervention will limit the advantages of decentralisation of decision making to purchasers and providers.

8. The difficulty of detecting collusion may mean collusion goes unregulated while in other cases providers are artificially restrained when not colluding.

IMPLICATIONS FOR POLICY

9. At present, the focus of policy will be on establishing whether collusion is taking place and if so, what impact it has.

10. The emphasis will be on discouraging collusion which has negative effects on patient welfare by encouraging purchasers to seek alternative providers. Co-operation which is undertaken to provide better services and/or better value for money will not be discouraged.

Establishing the extent of collusion

Purchasers and providers who have evidence of:

- price-fixing (two or more suppliers charging the same price);
- market sharing (providers sharing the available business amongst themselves);
- lack of competition at contract renewal stage;

will bring such evidence to the attention of the regional office;

will cease collusion if found to have been colluding.

Regional offices will:

- randomly sample contracts to check for evidence of collusion;
- investigate allegations of collusion, examining contracts in detail (treating all comments in confidence) and informing affected purchasers and providers;
- provide documentation to NHS Executive Headquarters of the extent of collusion;

- monitor those providers and purchasers found to have been colluding to establish that collusion has ceased;

- inform the relevant regional Policy Board member where collusion is suspected.

Penalties for collusion

11. Colluders will be told to cancel all contracts or arrangements found to be collusive. Management action may also be taken.

Limiting collusion through the promotion of competition and contestability

12. Purchasers, for services where alternative suppliers exist, will:

- consider alternative suppliers in other locations particularly for services where waiting lists are long;

- consider the use of competitive tendering for services where there is no supplier who is obviously the 'first choice'.

13. 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;

- reducing unnecessary bureaucracy in the bidding process;

14. Regional offices, working with the relevant regional Policy Board member, will:

- support purchasers in seeking alternative suppliers;

- disseminate NHS Executive guidance on the promotion of competition in contracting to purchasers;

- monitor all tendering for long term contracts (those over 3 years) at contract renewal stage;

- assess mergers for their impact on competition through the application of *Provider Mergers and Joint Ventures: Operational Guidance* ;

- sample cases where merger has been allowed one year after the merger. Collect purchasers' views on service improvement plus other evidence of price and quality change and send to NHS

Executive Headquarters for assessment of net benefits of the merger.

15. NHS Executive Headquarters will:

- keep itself informed about the extent of collusion in the market. In the light of this it will review actions and guidance in this area at regular intervals;

- draw up guidance on methods of promoting competition for contracts;

- co-ordinate policy action to ensure competition is promoted and collusion minimised;

- if existing suppliers appear to be winning long term contracts most of the time, check that adequate competition at contract renewal stage exists;

- ensure that other policies do not support the existence of collusion. In particular, policy on price dissemination should balance the potential negative effects on competition (eg facilitation of price fixing) with positive benefits from openness in pricing;

- use data supplied by regional offices to undertake periodic review of NHS Executive actions on mergers to ensure that the net economic effect of allowed mergers is positive;

- advise ministers where appropriate.

Compliance with UK and EC legislation

16. 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.

17. Regional offices will:

- be responsible for reminding purchasers and providers that relevant legislation must be followed when drawing up contracts;

- 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.

18. Purchasers and providers

- wishing to bring cases should send these to regional offices with supporting material.

GLOSSARY

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Anti-Competitive Features

Market features or behaviour which limit the amount of competition. These include monopoly, collusion, obstacles to entry and exit.

Collusion

Joint action by two or more providers or by providers and purchasers operating together to acquire or exploit a monopoly. Such joint action may include price-fixing and sharing of markets so that the amount of direct competition is reduced.

Contestable

A market into which a new supplier can enter quickly and with few costs which cannot be recovered if they subsequently left the market.

Economies of Scale/Scope

Economies of scale mean the unit cost of production falls as the volume of a service provided increases. Economies of scope mean that it is cheaper for one provider to supply two services than for two separate firms to provide one service each.

Efficient/Efficiency

Production is efficient where resources are used in a way so that maximum output and/or quality are derived from the resources used in production.

Entry Barriers

Something that makes entry more difficult or costly. The existence of an entry barrier may allow existing providers to charge prices above the competitive level without attracting others to enter the market.

Local Decision Limit

This defines the circumstances in which market participants will be responsible for their actions and the NHS Executive will not intervene unless there are extraordinary circumstances.

Market Entrant

A provider who provides services which it has not previously sold.

Market Participants

Trusts, DMUs or independent sector hospitals, GPs, Health Authorities and General Practice Fundholders.

Merger

Where two or more providers are dissolved and reconstituted into a single provider. In the context of this guidance, merger activity also includes circumstances in which particular services or specialties currently offered by two or more providers are brought together and offered by a single provider.

Monopoly

A situation in which there is only one provider of services.

Providers

All those who provide health care services. These include Trusts, DMUs, independent sector hospitals, General Practitioners.

Purchasers

Those who secure services for their populations or patients. These are Health Authorities and GPFHs.

Sunk Costs

Costs which cannot be recovered when providers reorganise or close down

Transparent

A term describing a set of rules or regulations which are clear and understood by all those to whom they apply.