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Challenges of EU competition law for general practice commissioning

Rupert Dunbar-Rees and **Robert McGough** explore the choice and competition issues facing general practice commissioners

The health white paper¹ has generated considerable debate, but there has been little discussion about the practical implementation of the processes underpinning its requirements. Many commentators have drawn parallels between some features of general practice commissioning and previous commissioning incarnations, such as fundholding and total purchasing pilots. However, the regulatory landscape has changed beyond all measure since then,²⁻⁴ and this fundamentally affects the way consortiums purchase support services and healthcare.

The National Health Service has moved from a position 20 years ago where most healthcare spending was essentially the state purchasing care from itself, to the current proposals to extend the “any willing provider” (or any qualified provider) model and further distance NHS hospitals from the state.⁵ All providers of care, including the independent sector, are set to be able to compete for NHS funded services on an equal footing.¹ Since the state is increasingly less a direct provider of care, it could be argued that EU competition law should apply to the allocation of public spending with providers. Surprisingly, the Department of Health’s impact assessment on the reforms does not consider the effect of EU competition law, even in the sections covering economic regulation.⁶ We examine the effect of EU and UK regulations concerning the spending of public money on general practice commissioning and the wider NHS.²⁻⁴

General practice consortiums as contracting authorities

The first issue to establish is whether general practice consortiums will be bound by procurement regulations concerning the spending of public money and EU competition law in general. This depends on whether they will be deemed “contracting authorities governed by public law,” and therefore bound by the regulations.⁷ Our view is that consortiums will be bound by the regulations

since they appear to fulfil the three requirements of contracting authorities—that is, they will be set up for a specific purpose (commissioning healthcare), have a “legal personality” (groups of general practices working in consortiums), and either receive more than half of their funding from state sources or be set up as statutory bodies.

It seems that the current proposals would require consortiums to obey the public contracts regulations in much the same way as primary care trusts (PCTs) currently do, which is sensible, given that consortiums will be responsible for spending up to £80bn (€90bn; \$130bn) of public money.

Consequences of being contracting authorities

The regulations set out that where contracting authorities (or consortiums) are seeking to enter into publicly funded contracts for part A services (box) or supplies with a contract value above £156 442⁸ they must advertise the tender in the EU official journal and competitively tender (or procure) for those services following one of the four procedures set out in the public contract regulations.⁴ Even smaller contracts would not entirely be exempt from these requirements because case law supports potential application of the general EU principles of non-discrimination, transparency, proportionality, equal treatment, and mutual recognition.²

In addition, the coalition government has committed to transparency, including the disclosure of contracts, and this may apply to these types of public contracts.⁹ The new information strategy mentioned in the operating framework for the NHS in England 2011/12 will also need to be considered when it is published.¹⁰

Procurement challenges for consortiums

Challenges to procurement decisions have steadily increased over recent years, and this is unlikely to change in the current climate with more competition and greater rights for disgruntled bidders.

High value part B services (which include health services) must comply with regulations regarding obligations of equal treatment and transparency (which reflect the general EU principles).⁴ These are especially important when the contract is likely to interest bidders from other EU countries.

Therefore, general practice commissioners should consider the extent to which an opportunity to provide health services may be of interest to the EU market. Even if the regulations do not formally apply because the contract value is below the threshold, EU principles could still potentially apply.

However, it is unclear how much cross border interest many small value medical services contracts would have, and the use of any qualified provider on an individual patient basis could have a significant effect on the application of EU competition law by consortiums through the inherent uncertainty in the volume of patients involved, and removal of

the requirement for a formal competitive process for individual patients.¹¹

Sanctions for not complying

The consequences for consortiums of not following appropriate procedures could be serious. Ultimately, for part A services, a recent EU directive has widened the potential remedies open to unsuccessful bidders who are treated unfairly and potential bidders who are excluded from tendering.¹²

Examples of part A and part B services (as set out in EU regulations)

Part A services

- Management or procurement consultancy services
- Computer and related services
- Telecommunications services

Part B services

- Health and social services
- Education and vocational health services
- Legal services



If a court decides a contract for part A services has been awarded unfairly it can now cancel the contract and levy a fine (which could be on the consortium) as well as award damages. The contractor who was awarded the contract might also bring a claim for breach of contract by the consortium. So what can consortiums and providers do to ensure that they comply? We will examine three key areas: consortium members wishing to provide new services, commissioning support, and commissioning of secondary and tertiary care.

Provision of new services by consortium members

Consortiums may wish to commission services from one or more of their constituent practices, and those individual practices may want to have the opportunity to provide new services (over and above the primary care services they already have a duty to provide). Consortiums will be free to use their resources in ways that achieve the best and most cost efficient outcomes for patients, but the economic regulator, Monitor, and the NHS Commissioning Board will seek to “ensure transparency and fairness in spending decisions.”¹³ Safeguards will be needed to ensure that these objectives are met, particularly when consortiums commission services from general practice. One of the few areas specifically required to be covered in the constitution for a general practice consortium is how conflicts of interest will be managed.

We understand that a “framework” will be developed to allow the commissioning of serv-

ices while guarding against any real or perceived conflicts of interest, but the actual detail has yet to be published. When services are commissioned on any qualified provider basis, the new framework may need to draw on protocols to report and audit the pattern of referrals from general practices that are also part of the commissioning consortiums. Certainly, practices will need to become more aware of the possibility of these types of conflict and the structures needed to identify and manage them appropriately. One suggestion is that a third party such as the NHS Commissioning Board or local authority could manage major procurements when member practices want to bid.

Consortiums securing commissioning support

Consortiums have several options when securing commissioning support, including direct employment of staff, transfer of staff from PCTs, or contracting for commissioning support with one or more commissioning support organisations. The 2011-12 operating framework for the NHS in England envisages that PCT clusters will offer developmental support to the consortiums in the transitional phase through a commissioning expert to assess the activities that they may need to buy in support for, in addition to direct support.

Procuring commissioning support would fall under the definition of part A services. Consortiums considering contracting for commissioning support with a total contract value above the threshold value would need to run a competi-

tive tender using one of the four routes outlined in the regulations. If the contract value comes under the threshold, consortiums would still be advised to run a proportional competitive process in order to reduce the chance of a challenge and ensure transparency and value for money.

Many emerging consortiums are already receiving support from PCT and PCT cluster staff without any formal contract, since services are being offered without charge. This is satisfactory while the consortiums do not exist as separate entities, but consortiums do need to be careful when they take on their statutory functions and roles. They will need to consider whether any such support services need to be tendered and ensure that any procurement is not unfairly biased in favour of any incumbent support.

Other models of support to the consortiums may be available, including direct employment of relevant support staff, which would not require a tender under the regulations. Consortiums will still need to be mindful of the automatic transfer of staff under the Transfer of Undertakings (Protection of Employment) regulations (TUPE) (which provides that existing employees providing a service can in many circumstances transfer to a new organisation providing the same service with all their rights, liabilities, and obligations).¹⁴ These regulations may result in an enforced transfer of staff from PCTs to consortiums, although this will not become clear until the status of consortiums is specified in secondary legislation.

Consortiums commissioning secondary care

Most secondary (and tertiary) care services fall under the category of part B regulations, since they are clinical services. This exempts them from some of the detailed requirements of the advertisement and tendering routes; however, case law supports a legal requirement to follow the general EU principles outlined above.

Also it seems essential that contracts are not awarded to any qualified provider without a fair and transparent process to assess the adequacy of the providers. However, recent statements from the Department of Health suggest that there are circumstances (“service integration and continuity of care”) where general practice commissioners would be able to offer a tender to only one contractor.¹⁵ It is not clear what the legislative basis for these exemptions would be, since service integration and continuity of care would not fall within the scope of any current exemptions from full competitive tender under EU law.

The payment by results tariff¹⁶ will help satisfy part of the competition requirements (as long as it is available to all providers and across all specialties) because it facilitates free choice among several accredited providers without guaranteeing contract activity to any one provider. However, the tariff’s usefulness remains limited by the following factors:

Lack of service coverage—Large sections of care remain outside the tariff, and even service areas with tariff have major exclusions, including most expensive drugs and devices. The remaining services that sit outside the tariff are subject to local negotiation, which necessitates some form of fair competition on the price of services to show value for money and offset potential challenges against the process.

Price pressures—One of the future imperatives for the health system is to deliver much more activity for the same, or less, cost. Commissioners, encouraged by a provision in the 2011/12 operating framework, will be seeking to commission locally at prices below the tariff. Somewhat confusingly, there has been a recent statement that this option was intended for use only in “exceptional circumstances”¹⁵ and the government has laid an amendment to the bill to remove reference to tariff being the maximum price. From a regulatory perspective this is acceptable up to a point, but if commissioners agree to commit to large volumes of activity as a means of reducing the price, all providers will want an opportunity to bid, which necessitates some type of competitive tender. Similar considerations may apply if consortiums wish to seek to use local incentives or “claw backs” to help manage contracts.

Pathway redesign—If the clinical gains that the white paper proposes are to be realised, clinicians will need to alter clinical pathways, which have been priced according to a historical national tariff. They may wish to “unbundle” some parts of the

pathway beyond that which is currently possible within the present payment by results framework, and they will need to move some of the budget for care from the acute setting into initiatives that prevent patients requiring care. The tariff as currently constructed, does not facilitate either of these actions. As local clinicians seek to create alternative pathways more suited to their patient and provider profile, the nationally agreed tariff for a given pathway will become less useful. Any move away from using the tariff locally would require some type of local negotiation, which would need to include the transparent and fair requirements mentioned above.

Although use of the payment by results framework may be satisfactory while consortiums are getting established, it is likely to deliver only marginal financial and outcome gains and replicate the current system that exists within PCTs. Use of local competitive frameworks may solve some of the problems, but joint procurement of services may be needed to benefit from economies of scale and access to resources.

Conclusion

It seems overall that the technical argument reinforces the logical argument that the reforms further open up the NHS to EU competition law. Although there are other elements of the competition regime (such as mergers and acquisitions rules) that may affect commissioning, it is the rules for procurement of goods and services that will have the greatest effect. In all of the situations outlined above, the exact process to be followed depends on the nature and value of the services in question. However, procurement skills will remain a key requirement for commissioners. Procurements will need to be run exceptionally carefully when consortiums have bidders for a service from within their constituent member practices. Involvement of secondary care colleagues in the commissioning process is vital to ensure best outcomes, but commissioners will have to be careful not to prejudice the principles of transparency and fairness by favouring a provider whose staff have given advice.

From the patients’ perspective, any moves away from using tariffs and standard pathways at a local level must not result in compromises on service quality. Such compromises would threaten to undermine the desired quality outcomes and impair patients’ experience of NHS funded care.

Rupert Dunbar-Rees is a general practitioner and healthcare management adviser, Healthcare Advisory Practice, BDO, London W1U 7EU, UK

Robert McGough is a solicitor, Beachcroft, Leeds LS1 2LW, UK

Correspondence to: Rupert Dunbar-Rees

Rupert.Dunbar-Rees@bdo.co.uk

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Contributors and sources: RD-R is a general practitioner and associate director in the healthcare advisory practice of BDO. He was previously the clinical lead on a national clinical services procurement of 265 health centres and secondary care services and worked as clinical lead on the commercial team at the

Department of Health for three years. He has just completed an MBA at Cass Business School. RMcG is a partner in the commercial services-health division of Beachcroft. He specialises in commercial application of the public contracts regulations and EU directives and has wide experience of advising NHS bodies and private sector clients on procurement, commissioning, and contractual issues spanning primary and secondary care. RD-R had the idea for the article and was responsible for the clinical and commercial perspective. He is the guarantor. RMcG was responsible for the content from a commercial and legal perspective.

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