

Cooperation and Competition Panel

Draft interim guidance on the assessment of conduct

January 2009

1. Introduction

- 1.1. There has been extensive Government investment in the NHS since 2000. During the same period, the NHS has moved from a system model based on control of the means of provision, towards a more open system with a defined division of roles between commissioners and service providers. The catalyst for change was the desire to make patient needs the main focus of the NHS.
- 1.2. For routine elective services, patients now have the right to choose¹ any willing and registered provider of these services regardless of the physical proximity or type of provider.² The NHS is also moving towards a more competitive (or contestable³) model in the procurement of health services as well as through patient choice. Competition, including through service contestability, encourages innovation, quality and responsiveness to patient needs.
- 1.3. Competition and choice are powerful levers to drive up service quality, deliver better value and reduce inequalities. Yet they can only be effective if there are clear, enforceable rules guiding and governing behaviour within the healthcare system.
- 1.4. To address this need, the Department of Health published the Principles and Rules of Cooperation and Competition as part of the NHS Operating Framework 2008/09 – 2010/11. Their purpose is to ensure fair and transparent cooperation and competition so as to make the best use of resources, enable innovation, and provide essential safeguards for the interests of patients, taxpayers, and the reputation of the NHS.
- 1.5. The Cooperation and Competition Panel (the Panel) helps ensure that the *Principles and Rules for Cooperation and Competition*⁴ (Principles and Rules) in the provision of NHS-funded services support the delivery of high quality care for patients and value for money for taxpayers. It investigates potential breaches of the Principles and Rules, and makes independent recommendations to the Strategic Health Authorities (SHAs), Department of Health and Monitor (Department of Health and Monitor together, the Sponsors) on how such breaches should be resolved. It also reviews proposed mergers, and advises on the wider development of cooperation and competition within the NHS. In carrying out its responsibilities, the Panel works with all parts of the NHS, the independent sector and others to drive improvements in service delivery.
- 1.6. These guidelines deal specifically with the Panel's responsibilities in relation to the competitive conduct of NHS-funded healthcare service providers or commissioners where that conduct may breach the provisions of the Principles and Rules. More detail on the Panel's wider responsibilities are provided on the Panel's website at www.ccpanel.org.uk.

¹Choice is exercised at the point at which a patient requires a referral for their first, consultant-led outpatient appointment.

²This right has now been enshrined within the NHS Constitution (Department of Health, January 2009).

³In economics a contestable market is one in which an incumbent faces strong competitive constraints from potential competitors because low barriers to entry and exit constrain an incumbent's ability to take advantage of their position. In the context of this document, however, we use the term 'contestability' to refer more generally to services where a commissioner may have the option of contracting with alternative service providers.

⁴The Principles and Rules are available at www.ccpanel.org.uk.

- 1.7. These guidelines supplement the Panel's Rules of Procedure regarding its consideration of conduct issues and are designed to provide information and advice to Primary Care Trusts (PCTs), NHS Trusts and Foundation Trusts and their advisers on the procedures and the analysis that the Panel will use in the assessment of such conduct. In the event of any conflict between the Rules of Procedure and the conduct guidelines, the Rules of Procedure will take precedence.
- 1.8. It is expected that the guidelines will be reviewed as required and that they will need to be reviewed following any review of the Principles and Rules. The guidelines have introduced new concepts and processes in relation to NHS-funded health services. The review will allow the Panel to consider the effectiveness of the current provisions in the guidelines and to incorporate the learning acquired through the initial conduct cases that it will investigate.
- 1.9. The remainder of this document is set out as follows:
 - Section 2 sets out the policy framework for the Panel's consideration of conduct issues;
 - Section 3 sets out the acceptance criteria that must be met before the Panel can consider complaints relating to conduct;
 - Section 4 describes the means by which parties may receive informal advice from the Panel;
 - Section 5 outlines the process by which the Panel will conduct investigations of alleged anti-competitive behaviour;
 - Section 6 addresses the means by which the Panel will assess conduct that may breach the Principles and Rules;
 - Section 7 outlines possible remedies that the Panel may recommend to Sponsors in cases of anti-competitive behaviour and other breaches of the Principles and Rules; and
 - Section 8 outlines the submission content required for complaints.

2. The policy framework

2.1. This section sets out the policy framework for the Panel's consideration of conduct issues. The first part sets out the rationale for choice and competition in the NHS and the associated need to prevent conduct that is anti-competitive and, more specifically, breaches the relevant provisions of the Principles and Rules. The second part sets out those provisions of the Principles and Rules that regulate conduct and which are addressed under these guidelines.

Choice and competition in the NHS

2.2. Choice and competition are key components of the government's strategy for reforming the NHS and delivering improved quality and more personalised care.⁵

2.3. For routine elective services, patients now have the right to choose any willing and registered provider of these services regardless of the physical proximity or type of provider. Providers may include, for example, NHS Trusts, Foundation Trusts and non-government healthcare providers. Patient choice is being expanded into additional areas. For example, choice of provider, treatment and setting is beginning to be offered to patients with long-term conditions. Patients' ability to choose between competing providers is supported by the provision of comparable information about providers through the NHS Choices website.⁶ Providers are also able to advertise or otherwise promote their services consistent with the NHS Code of Promotion.

2.4. For other services, PCTs are under an obligation to commission services from the providers that are best placed to deliver the needs of their patients and population. While choice for patients for these services may be limited, competition between providers will play an important role in ensuring that PCTs obtain the best possible offer of services for their patients.

2.5. In general terms, competition can be expected to have numerous beneficial effects: costs are driven down, and innovation and productivity increase, so increasing the quality and, more generally, the diversity of choice available as service providers respond to the preferences of their actual or potential patients. As set out in the *Framework for Managing Choice and Competition*⁷, choice and competition in the NHS can be expected to:

- improve quality and safety in service provision;
- improve health and well-being;
- improve standards and reduce inequalities in access and outcomes;
- lead to better informed patients;
- generate greater confidence in the NHS; and
- provide better value for money.

2.6. The benefits of competition for patients and taxpayers will only be realised, however, where there is effective competition between service providers for patients or contracts to provide services to patients. Where the process of competition is dampened, or otherwise hindered, by the conduct of a service

⁵See, for example, the interim report of The NHS Next Stage Review (*Our NHS, Our Future*).

⁶See <http://www.nhs.uk/ServiceDirectories/Pages/ServiceSearchTreatmentAtoZ.aspx>

⁷See http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084779

provider (or commissioner), competition may be lessened, and the benefits to patients and taxpayers from choice and competition may be weakened or lost. As a result, there is a need for the regulation of the competitive conduct of market participants to ensure this does not occur.

Framework for consideration of conduct issues by the Panel

- 2.7. The Panel is required to advise the Secretary of State or Monitor whether conduct that it investigates would breach certain provisions of the Principles and Rules for Cooperation and Competition. The relevant provisions of the Principles and Rules are set out in Table 2.1.
- 2.8. A number of the provisions in connection with conduct that are identified in Table 2.1 may also be covered by the provisions of UK and EU competition law. Where a service provider or commissioner may be considered to be an undertaking for the purposes of Chapters I and II of the Competition Act 1998 and Articles 81 and 82 of the EC Treaty, in particular non-government service providers, conduct that is in breach of the Principles and Rules may also be in breach of UK and EU competition law. In some cases, such conduct may constitute a criminal offence.
- 2.9. Responsibility for enforcing UK and EU competition law lies with the Office of Fair Trading and the European Commission. The Panel does not have jurisdiction to enforce the Competition Act or the EC Treaty and does not have any concurrent powers in this regard.

Table 2.1: Principles and Rules for Cooperation and Competition in relation to conduct

No.	Principle	Rules
1	To create world-class clinical services and a world-class NHS, commissioners must commission services from the best providers.	<ol style="list-style-type: none"> 1. [omitted – covered under Procurement disputes appeals guidance] 2. [relates to PCT contract enforcement, which of itself is not a matter for the Panel] 3. PCT provider services should be subject to these competition rules in the same manner as any other provider and be managed on equal terms to other providers. 4. [omitted - covered under Procurement dispute appeals guidance]
2	Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability.	<ol style="list-style-type: none"> 5. Consistent with the values of the NHS, patients' interests must be put first. 6. PCTs and providers must ensure appropriate cooperation and effective handover along pathways. 7. PCTs should use the relevant contracting mechanism as their primary performance management lever. 8. All providers must have regard for the Duty of Partnership legislation.
4	Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare. [This overarching principle, inter alia, covers procurement disputes and advertising disputes.]	<ol style="list-style-type: none"> 1. [covered under Procurement dispute appeals guidance] 2. Providers, referrers to and commissioners of NHS services must not restrict choice via collusive behaviour or any other action. 3. [relates to PCT contract enforcement, which of itself is not a matter for the Panel] 4. [relates to PCT contract enforcement, which of itself is not a matter for the Panel] 5. [relates to PCT contract enforcement, which of itself is not a matter for the Panel]
6	Providers must not discriminate against patients and must promote equality.	<ol style="list-style-type: none"> 1. [relates to PCT contract enforcement, which of itself is not a matter for the Panel] 2. [relates to broader legal obligations on service providers, which are not of themselves a matter for the Panel] 3. Providers should not discriminate against or disadvantage particular patients or commissioners (Payment by Results Code of Conduct, March 2007)
7	Payment regimes must be transparent and fair. [Cases under this overarching principle are dealt with under procurement disputes.]	<ol style="list-style-type: none"> 1. [covered under Procurement dispute appeals guidance] 2. Commissioners and providers must adhere to the provisions for determining a non-tariff price contained in the NHS Contract (Clause 7.2). 3. Commissioners must not contract with providers whose pricing strategy currently constitutes predatory pricing (i.e. deliberate action by an incumbent provider to constrain market entry by competitors through pricing strategy).
8	Financial intervention in the system must be transparent and fair.	<ol style="list-style-type: none"> 1. Rules on financial intervention are set out in the 2008/09 Operating Framework and are binding on all PCTs and SHAs.

NB. The full version of the Principles and Rules is available at www.ccp-panel.org.uk.

3. Acceptance criteria for conduct cases

- 3.1. Before the Panel will consider undertaking an inquiry⁸ into complaints regarding the conduct of service providers or commissioners under the Principles and Rules, the following acceptance criteria must be met:⁹
- (i) The subject matter of the complaint comes within the ambit of the Principles and Rules;
 - (ii) The Panel is the most appropriate body to consider or resolve the issue (i.e. over other bodies or regulators including the Office of Fair Trading (OFT) and the Advertising Standards Authority (ASA));
 - (iii) All relevant parties involved make available all relevant and applicable information on the case to the Panel, including that outlined below under Submission Content.¹⁰ This does not preclude the Panel from asking for further information as it requires. Furthermore, any individuals connected to the complaint are on hand to provide further evidence/testimony as required;
 - (iv) No legal proceedings have commenced in relation to the relevant appeal or reserved matter;
 - (v) The dispute is not trivial, vexatious or an abuse of the Panel's procedures; and
 - (vi) Where a complaint relates to potentially anti-competitive conduct, complainants should use all reasonable endeavours to engage with parties at a local level, including appropriate engagement with the relevant SHA, prior to referring the matter to the Panel. This does not apply in the case of complaints regarding potentially collusive behaviour which should be referred directly to the Panel.

⁸The conduct inquiry process is described in Section 5

⁹This acceptance criteria does not apply to the provision of informal advice as described in Section 4.

¹⁰See *Submission Content* in section 7 of this document.

4. Informal advice

- 4.1. This section sets out the process by which the Panel will provide informal advice to parties wishing to seek guidance regarding conduct under the Principles and Rules.
- 4.2. The Principles and Rules have introduced new concepts and processes in relation to NHS-funded health services. Consequently, providers, referrers and commissioners are currently involved in a learning process. During this stage of building knowledge and awareness, the Panel expects that relevant stakeholders will need guidance as to the application of the Principles and Rules in relation to specific types of conduct. Therefore, the Panel is looking to approach conduct issues from an educative perspective and encourages stakeholders to approach the Panel to discuss possible issues and concerns.
- 4.3. The Panel is willing to provide informal advice to parties as to the likely competition issues arising out of specific conduct to assist in the proper introduction and application of the Principles and Rules. Informal advice will generally be given orally and will represent the view of Panel staff, usually given by the Director of the Panel or other senior members of staff. The advice will be based on information provided by the parties seeking guidance and will not be binding on the Panel.
- 4.4. To provide informal advice that is as helpful as possible, the Panel will need information about the parties involved, the proposed (or current) conduct, the market(s) involved and the potential effects of the conduct, as described in the 'content of complaint submission' section below. Although submissions are not expected to be extensive, the quality and accuracy of the Panel's advice will, to a large extent, reflect the quality of the information provided. The Panel recommends parties provide clear, full and accurate information when preparing submissions for informal advice.
- 4.5. There is no administrative timetable for the provision of informal advice, but the Panel will endeavour to accommodate parties' timeframes as much as possible. The Panel will expect submissions to be provided at least 10 working days prior to the Panel providing its informal advice.
- 4.6. Given that informal advice is aimed at assisting parties to identify potential competition concerns and the Panel will not have tested the information provided by the parties externally, informal advice should be kept confidential (although not from the relevant Sponsor) and in no way be used by the parties as advice on which third parties can rely. In this respect, as noted above, it should be noted that informal advice is not binding on the Panel.
- 4.7. In the first instance, parties seeking informal advice (or simply wishing to discuss whether to request informal advice) should contact the Panel on the details provided on its website at www.ccpanel.org.uk.

5. Conduct inquiry processes

- 5.1. This section sets out the processes that the Panel will adopt for undertaking inquiries into complaints regarding the conduct of service providers or commissioners under the Principles and Rules.

Making a conduct-based complaint to the Panel

- 5.2. Complaints regarding the conduct of service providers or commissioners may be made to the Panel by anyone with an interest in either the conduct in question or the effects of that conduct. This may include, but is not limited to, other service providers, other commissioners, Strategic Health Authorities (SHA), trade associations and members of the public.
- 5.3. Any complaint to the Panel concerning a conduct issue should be supported by as much factual information as possible to allow the Panel can make a thorough and prompt assessment as to whether the matter meets its acceptance criteria for further investigation. All complaints should cover the information specified in the Submission Content section¹¹ of these guidelines, including details of the conduct that is alleged to be in breach of the Principles and Rules as well as an assessment of the effects of that conduct on patients and/or taxpayers. For example, an allegation of predatory pricing should be supported by analysis that supports that allegation. General allegations of undesirable conduct are unlikely to be sufficient to support the commencement of an inquiry by the Panel.
- 5.4. The Panel is generally unable to investigate complaints on a confidential basis. Service providers or commissioners that are the subject of a complaint must have the opportunity to respond to any allegations being made about their conduct. However, the Panel will consider requests to keep the identity of the complainant confidential where there is a strong reason for doing so, although in such circumstances the fact that an investigation is being conducted will be made public. Concerns about confidentiality should be raised with the Panel as soon as possible.
- 5.5. After receiving a complaint, the Panel will conduct an initial assessment of the complaint within 10 working days to determine whether it meets the Panel's acceptance criteria. Where the Panel decides that a complaint should be accepted, it will publish a Notice of Acceptance on its website. The Panel will, at the same time, notify the complainants as well as the parties that are the subject of the complaint (respondents) and invite submissions on the matter. Where the Panel does not accept a complaint as the subject for further inquiry, it will notify the complainant in writing (with a copy to the relevant Sponsor) setting out the reasons for its decision.

Decision making process

- 5.6. The Panel will adopt a two-phase approach to assessing conduct matters. The purpose of this two phase approach is to facilitate the efficient assessment of conduct cases, and in particular, to allow any conduct that does not raise any significant concerns to be dealt with promptly, while providing sufficient time for the Panel to consider more complex cases in a second phase where this is required.
- 5.7. In Phase One, the Panel will undertake an initial assessment to determine whether the conduct in question is potentially inconsistent with the Principles

¹¹See section 8.

and Rules. This may involve the collection and evaluation of further data and information from the complainant, the respondent(s), as well as third parties. Throughout Phase One, the Panel will generally consult with interested parties including via its website. During this phase, the Panel may request meetings or hearings with relevant parties.

- 5.8. Where the conduct in question does not raise potential concerns under the Principles and Rules, the Panel will advise the complainant, the respondent(s) and the relevant Sponsor that it considers that no further action should be taken.
- 5.9. In cases where the conduct in question raises potential concerns, the Panel will set out in a letter to the parties the issues it has identified and the relevant evidence. Following the response to that letter by the complainant and the respondent(s), the Panel will consider whether the complaint should be upheld, dismissed or subject to further investigation. The Phase One assessment will be completed within 30 working days following the publication of a Notice of Acceptance. If the Panel considers that further investigation is warranted, it will proceed to a Phase Two investigation.
- 5.10. During a Phase Two investigation, the Panel will undertake further analysis based on data, information and submissions provided by interested parties, including the the complainant and the respondent(s), and may request additional information to be provided by these parties. The Panel's analysis will then be provided to the complainant and the respondents for comment.
- 5.11. Once the Panel's analysis has been provided to the respondent(s), a hearing will be held with the respondent(s) to provide the Panel with the opportunity to ask questions and discuss the case as well as allowing the respondent(s) to respond to the Panel's analysis. During this second phase, the Panel may also hold hearings with the complainant and third parties having a sufficient degree of interest in the outcome of the investigation. Subsequent to the hearing(s), the complainant and the respondent(s) will have the opportunity to submit further and final comments to the Panel.
- 5.12. Final advice and recommendations will then be provided to the relevant Sponsor as well as to the complainant and respondent(s). The Phase 2 assessment will be completed within 70 working days subject to any extension that might be granted by the relevant Sponsor.
- 5.13. The Panel will publish on its website the text of its advice and recommendations, subject to the excision of business secrets and other confidential information.

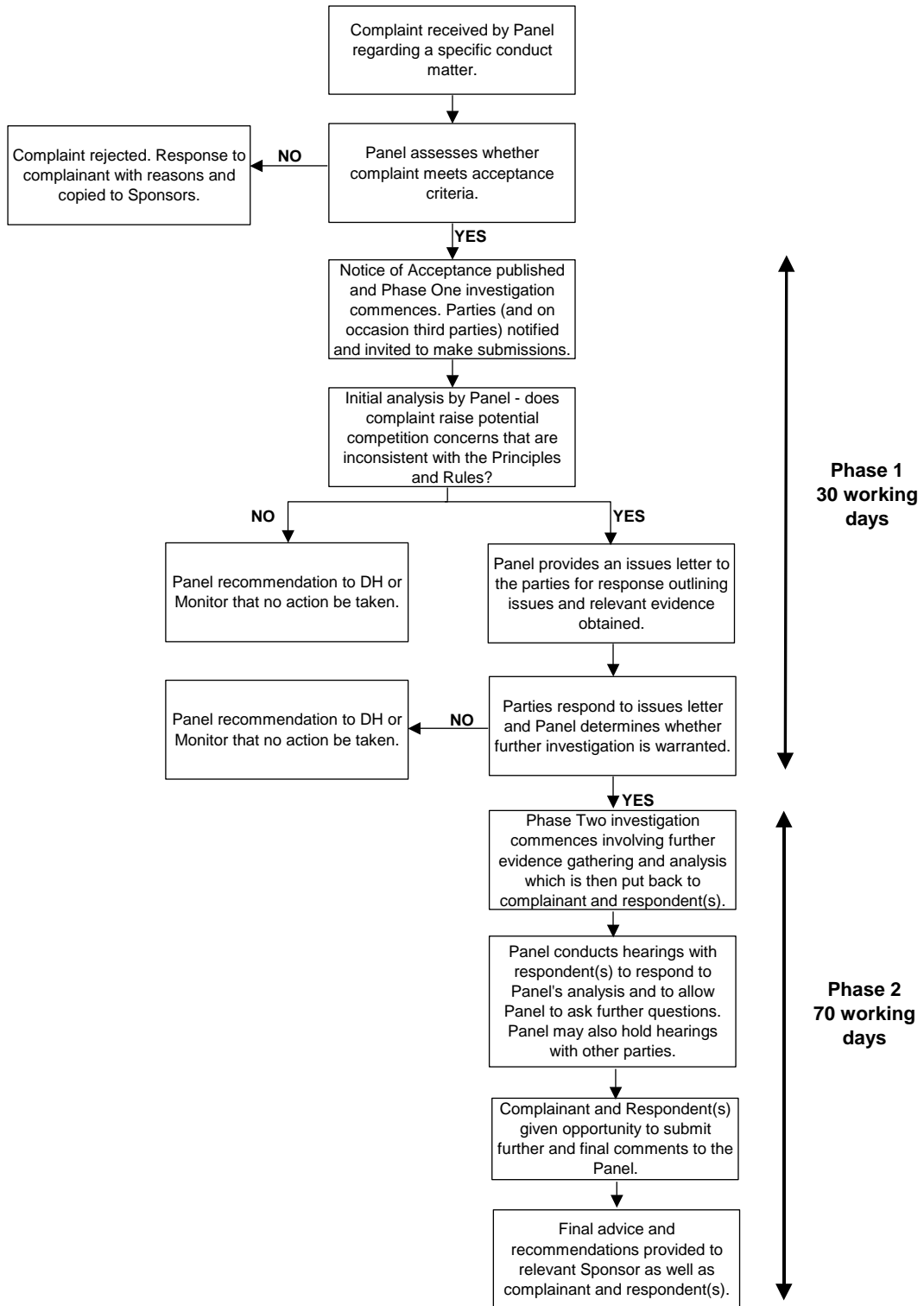
Third parties

- 5.14. The Panel will invite comments from third parties during a conduct inquiry by means of an invitation to comment published on the Panel's website at www.ccpanel.org.uk. The Panel may also actively seek information and submissions from customer representatives, competitors, suppliers, relevant government agencies and industry bodies.
- 5.15. The purpose of third party inquiries is to seek input from relevant stakeholders, confirm and clarify the information provided by the complainant(s) and respondent(s), and identify any additional issues. Where the submissions of third parties raise significant additional concerns or provide significant additional evidence, the respondent(s) will be given an opportunity to respond.

Publishing and confidentiality

- 5.16. The Panel will publish on its website non-confidential versions of submissions by the complainant(s), respondent(s) and others, the Statement of Objections and the Panel's advice. It will also publish summaries of any hearings held with parties.
- 5.17. Before any such publication, the relevant parties will be offered the opportunity to request the excision of business secrets or other confidential information from the public version of the document. The Panel may publish information where it is compelled by law or the Courts or where it is reasonably necessary to facilitate the Panel in the exercise of its functions and to allow transparency.
- 5.18. To the extent that the Panel's reasoning in any decision relies on confidential information, the Panel will make this information available to the relevant Sponsor, subject to the Sponsor confirming that it shall treat such information as confidential and that it shall use the relevant information only for the purposes of its decision.

Diagram 1: Panel decision making processes on specific conduct complaints



6. Assessment of conduct under the Principles and Rules

- 6.1. This section sets out how the Panel will assess whether service provider or commissioner conduct is in breach of the relevant provisions of the Principles and Rules. The relevant provisions are set out in Table [1] above.
- 6.2. For the purpose of assessing conduct that is alleged to be in breach of the Principles and Rules, the Panel has grouped the conduct provisions of the Principles and Rules into the following three categories:
 - (i) discriminatory conduct, which is addressed under Principle 6 of the Principles and Rules;
 - (ii) conduct related to financial interventions, which is addressed under Principle 8 of the Principles and Rules; and
 - (iii) conduct that may restrict cooperation, choice, or competition which is addressed under the remaining applicable conduct provisions of the Principles and Rules (see Table 2.1).

Overarching approach to assessing conduct

- 6.3. The Panel's overall approach to assessing whether the conduct of a service provider or commissioner is in breach of the relevant provisions of the Principles and Rules will, in most cases, go beyond a simple assessment of whether the relevant conduct breaches the relevant provisions. Rather, it will assess whether the conduct in question has or is likely to have an adverse effect on patients and/or taxpayers.
- 6.4. There are two main reasons for wishing to assess the effect on patients and taxpayers of conduct that might be in breach of the Principles and Rules:
 - first, it will provide a sense of the materiality of any breach that may be identified; and
 - second, it will facilitate the taking into account of any offsetting benefits to patients or taxpayers that may arise from the conduct in question.
- 6.5. Where conduct that would otherwise have been in breach of the Principles and Rules generates current or future benefits to patients and/or taxpayers as well as a detriment to patients and/or taxpayers, the Panel will conduct a balancing exercise that takes into account both benefits and detriments in assessing whether the Principles and Rules have been breached.

Conduct that may restrict cooperation, choice or competition

- 6.6. The relevant provisions of the Principles and Rules that are dealt with under this section are as follows:
 - To create world-class clinical services and a world-class NHS, commissioners must commission services from the best providers (Principle 1 and the related rules).
 - Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability (Principle 2 and the related rules).
 - Providers, referrers to and commissioners (referrers and commissioners collectively referred to as, commissioners) of NHS services must not restrict choice via collusive behaviour or any other action (Principle 4, Rule 2).

- Commissioners must not contract with providers whose pricing strategy currently constitutes predatory pricing (i.e. deliberate action by an incumbent provider to constrain market entry by competitors through pricing strategy) (Principle 7, Rule 3).
- 6.7. A number of these provisions relate to anti-competitive conduct. The Panel does not consider itself bound by the Competition Act 1998, including section 60 of the Act, the Enterprise Act 2002 or the EC Treaty. However, to the extent that the Panel will undertake an analysis of alleged anti-competitive conduct in the NHS the provisions of Chapter I and Chapter II of the Competition Act and Article 81 and Article 82 of the EC Treaty can be a useful source of reference, particularly in understanding the type of conduct that might restrict, distort or prevent competition in the NHS.
- 6.8. In assessing conduct that may breach these provisions, the Panel will apply a two part test that, first, assesses the impact of that conduct on patients, and second, assesses the impact of that conduct on taxpayers.
- 6.9. In general terms, conduct that restricts choice, cooperation or competition may have an adverse effect on patients or taxpayers when, as a result of reducing the intensity of competition between service providers it reduces the quality and choice of services delivered to patients or it increases the prices paid by commissioners.
- 6.10. The following paragraphs discuss a number of specific types of conduct that restrict cooperation, choice or competition and are likely to breach the Principles and Rules in the absence of offsetting benefits.

In assessing the effect of the conduct on current and future patients, the Panel will consider the impact on service quality and choice as a result of reduced competition and balance any adverse effects against the clinical or other benefits to patients that may arise from the conduct.

Collusive behaviour

- 6.11. The Panel will consider collusive behaviour¹² that has or is likely to have an adverse effect on patients and/or taxpayers. Collusive behaviour having such an adverse effect can take many different forms including price fixing, bid rigging, market sharing, or the exchange of price or non-price information. Moreover, it is not limited to collusive behaviour between competing entities but it may also arise between parties operating at different levels along the patient pathway (e.g. between a commissioner of a service and providers). The following paragraphs discuss these different forms of collusive behaviour in further detail.

¹²Collusive behaviour includes any explicit or tacit agreement, arrangement or understanding between parties in whatever form and regardless of whether it is (or is intended to be) legally enforceable or not. Tacit collusion may arise where interdependence between parties leads them to anticipate competitors' responses to their own actions and take this into account in their own decisions.

6.12. Price fixing is a form of collusive behaviour which directly or indirectly fixes prices or (to the extent relevant) the resale prices of any service. Price fixing

In assessing the effect of conduct on current and future taxpayers, the Panel will consider the impact on commissioners, as purchasers of these services. In particular, the Panel will consider the impact on the price paid by commissioners and will balance any adverse effects arising from reduced

may involve fixing either the price itself or the components of a price, setting a minimum price below which prices are not to be reduced, establishing the amount or percentage by which prices are to be increased, or establishing a range outside which prices are not to move. Parties to collusion may also indirectly fix prices, for example, by covering the discounts or allowances to be granted, transport charges, payments for additional services, credit terms or the terms of guarantees. For example, providers may collude regarding the price charged to

commissioners for commissioned services. Price fixing issues are not limited to collusive behaviour between competing entities. They can also arise between parties operating at different levels along the patient pathway (e.g. a commissioner of a service and providers).

6.13. Bid rigging is another form of collusive behaviour. Tendering procedures are designed to provide competition between potential providers of a service. An essential element of the system is that prospective providers or suppliers prepare and submit tenders or bids independently. Bid rigging occurs when two or more competitors collude in order not to compete genuinely with each other for particular tenders either through collaborating on prices, non-price aspects of a tender or selective participation in a tender.

6.14. Limiting or controlling production or investment is another form of collusive behaviour. Competitive pressures may be reduced if competitors collude to, for example, limit the volume or type of a particular service available.

6.15. Market sharing is a form of collusive behaviour in which participants collude to share markets, whether by territory, type or size of customer or some other way.¹³ In the context of healthcare service providers, market sharing may take the form of providers allocating patients or patient groups between them; providers allocating between them commissioners to whom they provide commissioned services; or commissioners allocating between them providers to whom they will offer contracts. Service providers might also collude so as *not* to: provide the same services; provide

Assessments of conduct need to take into account the way in which 'prices' are set in the NHS. First, and foremost, provision of NHS-funded healthcare services to patients is free to the patient. The 'price' for these services is paid by the commissioner, in most cases a Primary Care Trust. For routine elective services, there is a uniform national tariff for each procedure. For other services, the 'price' that is paid by a Primary Care Trust may be determined through an annual negotiation or through a competitive tender.

¹³Such behaviour is not only prohibited under Principle 4, Rule 2, but also under Principle 1 which sets out that services must be commissioned from the best providers.

services in one another's geographic 'territories'; solicit or service one another's patients, providers or commissioners (in the case of contracts for the provision of services); or expand into a sector in which a competitor is an actual or potential rival.

- 6.16. The exchange of price and non-price information may be a form of collusive behaviour that is likely to have an adverse effect on competition and/or taxpayers. Competitors may exchange information on a variety of matters legitimately and with no risk to the competitive process. Indeed, competition may be enhanced by the sharing of information, for example, on new technologies or opportunities. The exchange of information may, however, have adverse effects where it serves to reduce or remove uncertainties inherent in the process of competition.¹⁴
- 6.17. Factors taken into consideration in assessing the likely effect of collusive behaviour may include the following:
- whether collusive behaviour is a result of explicit or tacit arrangements between providers or commissioners leading to conditions of competition which do not correspond to normal conditions of the market;
 - the structure of the market and the nature of the service under consideration; and
 - the number of providers or commissioners in the market and, where there are only a few, whether they have similar cost structures and outputs.

Market power

6.18. The Panel will also consider cases where, even though there is no collusive behaviour, the conduct is likely to give rise to an adverse effect on patients and/or taxpayers. In assessing the effect of non-collusive conduct, the market position of the provider or commissioner may be relevant. Market power arises where a provider or commissioner does not face sufficiently strong competitive pressure. It can be thought of as the ability profitably to sustain prices above competitive levels, or to sustain quality below competitive levels. For example, a provider with market power might also have the ability and incentive to harm the process of competition in other ways, for example by weakening existing competition, raising entry barriers or slowing innovation. A provider or commissioner has market power where it does not face strong competitive constraints on its ability to behave independently. The most important constraints are existing competition and potential competition. Other factors, such as the countervailing influence of powerful buyers, or regulation may also be relevant.

Inhibiting competitors through frustrating their access to patients

6.19. Vertically integrated service providers, which offer different services along the patient treatment pathway, may have incentives to pursue exclusionary strategies in order to encourage patients to remain within their integrated

¹⁴Generally, it is more likely that competition will be adversely affected the smaller the number of competitors operating in a sector, the more frequent the exchange and the more sensitive, detailed and confidential the nature of information being exchanged. Colluding to exchange information on prices may lead to price coordination and therefore diminish competition between competitors. This will be the case whether the information exchanged relates directly to the prices charged, or other elements of a pricing policy such as discounts, costs, terms of trade and rates and dates of change. The exchange of purely historical or aggregated information will generally be unlikely to breach the Principle. The exchange of non-price information such as output and sales may also have an adverse effect if the information is recent, or concerns future plans, is not aggregated and can be attributable to a particular party.

organisation for the totality of their treatment (including the different stages of such treatment) or for different treatments. Capturing patients at a particular point in the treatment pathway and retaining them may be a particularly effective strategy for frustrating the ability of other service providers to provide a competing service. An example of such a strategy might be denying patients information about other service providers or their ability to choose alternative service providers. Patient-based foreclosure of competitors of this type could take the form of explicit policies or more subtle forms of bias.

6.20. The Panel considers that this behaviour is, in particular, likely to be inconsistent with Principle 2 that providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability. This Principle is the core of the requirement that service providers and commissioners must, in certain circumstances, cooperate as well as compete with each other in order to ensure that, from a patient's perspective, patients receive a seamless service.¹⁵

6.21. Evidence relevant to any assessment of whether a service provider has engaged in conduct that breaches this provision may include:

- agreements between service providers related to the movement of patients and, where agreements have not been reached, negotiations or understandings between service providers related to this;
- internal guidance or instructions to staff regarding patient movement between service providers;
- financial and other incentives for the staff of service providers with the ability to make, or influence, decisions regarding patient movement between service providers;
- feedback from patients seeking to move between service providers; and
 - statistics on patient movements between service providers.

Few NHS-funded healthcare service providers have a profit maximisation objective. But, service providers generally need to earn enough revenue to cover their costs. Losing patients to other service providers will affect their ability to cover their costs. This increases their incentive to provide patients with high quality services and thus ensure that they are amongst

Inhibiting competitors through other forms of exclusionary conduct

6.22. The Panel considers that attempts to prevent successful entry by competitors through denial of essential inputs are likely to have an adverse effect on competition to the detriment of patients or taxpayers.

¹⁵Cooperation between service providers and commissioners under this Principle should not, however, have an adverse effect on patients and/or taxpayers under Principle 4, Rule 2.

6.23. The Panel considers that generally speaking, a provider or commissioner, regardless of its market power, should have the right to choose its trading partners and to dispose freely of its property. However, certain conduct may be problematic if a party that has market power is an integrated provider (for example, it offers different services along the patient pathway) and competes on a “downstream” service (that is, a service for which the refused input is needed in order to provide that service) with the buyer whom it refuses to supply. Exclusionary conduct having an adverse effect on patients and/or taxpayers is prohibited under Principle 1, which sets out that services must be commissioned from the best providers, as well as Principle 4, Rule 2, which sets out that providers and commissioners must not restrict choice.

6.24. Non-price exclusionary conduct could take many different forms, including refusal to supply and margin squeeze, exclusive dealing and tying and bundling. The following paragraphs set out some examples of exclusionary behaviour that may have an adverse effect on competition. This is not an exhaustive list.

6.25. Refusal to supply may be a form of non-price exclusionary conduct. The concept of refusal to supply covers a broad range of practices, such as refusal to supply products or services to existing or new customers, to license intellectual property rights, or to grant access to an essential facility or network.

6.26. Exclusive dealing may be another form of non-price exclusionary conduct. A party (e.g. a provider) with market power may try to foreclose its competitors by hindering them from selling to customers (e.g. commissioners) through use of exclusive purchasing obligations or rebates, together referred to as exclusive dealing. For example, a provider may require an exclusive purchasing obligation in order to ensure that the commissioner of a particular service will purchase exclusively or to a large extent from that provider. There may also be an exclusive purchasing obligation where a provider induces a commissioner to commit to purchase only from it. The restriction on competition is likely to be compounded where there a large number of commissioners (or other buyers, depending on the specific case) that enter into an exclusive contract with such a provider, thereby preventing the entry or expansion of rival providers. This type of contract increases the demand for the particular provider’s services and reduces the demand for the services of rival providers. Actual or potential foreclosure may also arise where a provider with market power offers conditional rebates based on quantity of a particular service or services that is commissioned from it. Such rebates may exhaust the commissioner’s requirements and reduce the demand faced by competing providers.

Competition between service providers may take the form of direct competition for patients under the Any Willing Provider model or other models of patient choice. It may alternatively, or additionally, take the form of competition between service providers for contracts let by Primary Care Trusts or other commissioners. Both types of competition, where present, will need to be taken into account in considering the effect of conduct.

6.27. Tying and bundling may be another form of non-price exclusionary conduct. “Tying” usually refers to situations where customers (e.g. commissioners) that purchase one service (the tying service) are required to also purchase another product from a provider that has market power (the tied service). Tying can take place on a technical or contractual basis. “Bundling” usually refers to the

way products are offered and priced by a provider with market power. In the case of pure bundling the services are sold jointly in fixed proportions. In the case of mixed bundling, the products are also made available separately, but the sum of the prices when sold separately is higher than the bundled price. A provider that has market power in one service (or more) of a tie or bundle (referred to as the tying service) can harm patients and taxpayers through tying or bundling by foreclosing the market for the other services that are part of the tie or bundle (referred to as the tied service) and, indirectly, the tying service.

Predatory pricing

- 6.28. The Panel considers that attempts by a provider with market power to prevent successful entry by competitors through pricing strategy (i.e. predatory pricing) is likely to have an adverse effect on competition to the detriment of patients or taxpayers. Predatory pricing is inconsistent with Principle 4, Rule 2. It is also inconsistent with Principle 7, Rule 3 that commissioners must not contract with providers whose pricing strategy currently constitutes predatory pricing (i.e. deliberate action by an incumbent to constrain market entry by competitors through pricing strategy).
- 6.29. Predatory pricing involves a provider with market power deliberately incurring losses or foregoing profits in the short-term (referred to as “sacrifice”) by temporarily selling services below cost, so as to foreclose or be likely to foreclose one or more of the provider’s actual or potential competing providers with a view to strengthening or maintaining market power (see also under Principle 4, Rule 2 above). Typically, the provider’s intention would be to raise prices above the competitive level (or reduce quality or choice) so as to recoup lost profits, or to otherwise benefit from the sacrifice, once rivals have exited the market or have been disciplined into following the infringing provider’s (higher) pricing, thereby causing harm to patients and taxpayers. The provider in question may also use profits gained in a monopoly service to cross-subsidise its activities in another service and thereby threaten to eliminate effective competition in that other service.
- 6.30. As noted above, while the application of predatory pricing under Chapter II of the Competition Act and Article 82 of the EC Treaty can be a useful source of reference, the Panel does not consider itself bound by the approach under those regimes. For example, the Panel does not consider that the existence of dominance is a necessary element to demonstrate predatory pricing and relies on market power of the relevant provider as an indicator of whether the relevant conduct is likely to restrict, distort or prevent competition.
- 6.31. The Panel notes that taxpayers and patients may benefit from service providers offering low prices (as commissioners will be able to afford to purchase more services than would otherwise be the case), and as a result, care needs to be taken to distinguish competitive prices that arise from effective competition from predatory pricing that may have adverse effects.
- 6.32. The Panel will view that pricing conduct entails a sacrifice if a provider, by charging a lower price for all or a particular part of its service over the relevant time period, or by expanding its service output over the relevant time period, incurred or is incurring losses that could have been avoided. The Panel will take average avoidable cost (AAC) as the starting point for assessing whether a provider incurred or incurs avoidable losses (in most cases the average variable cost (AVC) and AAC will be the same, as often only variable costs can

be avoided). If a provider charges a price below AAC for all or part of its services, it is not recovering the costs that could have been avoided by not providing that service, that is, it is incurring a loss that could have been avoided. Accordingly, in most cases, pricing below AAC will be viewed by the Panel as a clear indication of sacrifice.

6.33. Generally speaking, patients and taxpayers are likely to be harmed if the provider can reasonably expect its market power after the predatory conduct comes to an end to be greater than it would have been had the provider not engaged in that conduct in the first place, that is, if the provider is likely to be in a position to benefit from the sacrifice. This does not mean that the Panel will only intervene if the provider would be likely to be able to increase its prices above the level persisting before the conduct. It is sufficient, for instance, that the conduct would be likely to prevent or delay a decline in prices that would otherwise have occurred.

6.34. The Panel in assessing allegations of predatory pricing may consider evidence in the following areas:

- prices and their relationship to the costs of the service provider that is alleged to be engaged in predatory pricing;
- barriers to entry and expansion facing potential entrants or existing service providers; and
- internal documents related to the pricing strategy of service providers.

Exercise of market power by providers to the detriment of patients or taxpayers

Where a service provider has a strong position, and patients and taxpayers have few alternatives, a service provider may be in a position to take advantage of that position to the detriment of patients or taxpayers through offering higher prices or lower service quality than would otherwise prevail in more competitive conditions. Where a service provider takes advantage of its position in this way, the Panel will consider this to be a breach of the Principles and Rules (in particular, Principle 1 and Principle 4, Rule 2).

Factors taken into consideration

6.35. Depending on the type of conduct under review, relevant factors that the Panel will consider may include:

- the type of conduct;
- the content of any agreement;
- internal documents relating to the pricing or competitive strategy of service providers, referrers or commissioners;
- the extent of concentration in the market;
- market power;
- barriers to entry or expansion;
- the characteristics of the buyer/commissioner and the buyer/commissioner sector;
- transparency of prices and other competitive variables;

- the sustainability of any collusive behaviour and the incentives for participants to such collusive behaviour to deviate; and
- the sustainability of any unilateral conduct having an adverse effect and the ability of customers to resist such conduct or competitors to compete.

Offsetting benefits that may arise from restrictions on choice, cooperation or competition

- 6.36. In assessing whether conduct could be expected to give rise to an adverse effect on patients and/or taxpayers, the Panel will have regard to any benefits to patients or taxpayers arising from the conduct in question. These benefits may take the form of clinical or other considerations such as higher quality services, a greater choice of services, greater innovation in relation to such services or lower prices to commissioners.
- 6.37. Where providers or commissioners consider that the conduct in question gives rise to patient or taxpayer benefits, they will be expected to provide evidence regarding the nature and scale of these benefits and to show that they would be unlikely to accrue without the conduct in question. The Panel will, to the extent possible, seek to verify these claims, and where it has doubts about the extent of the claimed benefits arising from the conduct will include this in its advice to Sponsors.
- 6.38. Where the Panel identifies patient or taxpayer benefits arising from conduct, the Panel will consider whether these are sufficient to offset any adverse effect on patients or taxpayers that it has identified.

Discriminatory treatment of patients

- 6.39. Principle 6 states that providers must not discriminate against patients and must promote equality. The Panel will investigate complaints that selective treatment of patients is unjustified.
- 6.40. Under UK legislation, it is unlawful for a public authority exercising a function of a public nature, including NHS organisations, to perform any act which constitutes discrimination. Public authorities, including NHS organisations, also have a legal duty to promote equality.
- 6.41. The Panel, in interpreting Principle 6 and assessing allegations of discriminatory conduct, is not seeking to simply reinforce or duplicate the existing legal obligations on NHS organisations in terms of discrimination based on disability, age, gender, religion or belief, sexual orientation or race. Consistent with the Panel's overall role in terms of aiding cooperation, choice and competition in the provision and commissioning of NHS-funded services, the Panel will particularly assess whether discriminatory conduct by providers confers a competitive or economic advantage on them.
- 6.42. However, in addition to this, the *Payment by Results Code of Conduct*¹⁶ expressly requires that 'providers will not discriminate or disadvantage particular patients or commissioners when operating Payment by Results, including when accepting or declining to treat individual patients and in the provision of services generally'. The aim of the *Payment by Results* system is to reward efficiency, support patient choice and diversity and encourage activity

¹⁶*Payment by Results Code of Conduct* (February 2008)

for sustainable waiting time reductions. This is achieved by linking payments to activity and adjusting for casemix.

- 6.43. In assessing whether a service provider has breached this principle, the Panel will consider any objective justification (such as clinical, medical, capacity or other considerations) as well as any patient and/or taxpayer benefits arising from any discrimination in which a service provider may engage. The Panel will seek evidence that these considerations have influenced the service provider's decision to discriminate, and will consider the weight of these considerations relative to any other considerations in the provider's decision making process. The Panel will also take into account any action that a service provider has taken, or is taking, to reduce the need for such discrimination in the future. The Panel will not generally accept an argument that refusal to treat a patient because the relevant treatment is too costly amounts to such an objective justification.

Transparent and fair intervention in the system

- 6.44. Principle 8 states that intervention in the system must be transparent and fair. The Panel will investigate complaints that intervention in the system is not transparent and fair.
- 6.45. Financial intervention in the provision of NHS-funded health services has the potential to distort competition between providers in the NHS. Consequently, any financial intervention in the provision of NHS-funded health services must not interfere with a level playing field for providers or afford particular providers or commissioners in the NHS an unfair competitive advantage.
- 6.46. However, there may be instances where financial intervention is necessary in order to prevent a provider from being unable to properly service patients. In particular, the NHS Operating Framework 2008/09 recognises the existence of NHS trusts which are considered 'financially challenged' under the relevant certain criteria.
- 6.47. Financial intervention in the NHS is not prohibited outright but, ultimately, such intervention in the NHS system must be transparent and fair.
- 6.48. In the Panel's view, financial intervention is fair where it does not afford any undue competitive advantage to the recipient. Financial intervention will be considered fair where the amounts are restricted to those which are necessary and efficient:
- "Necessary" financial intervention is assistance that is indispensable to the provision of NHS-funded healthcare services and that cannot be funded through any other means.
 - "Efficient" financial intervention is the lowest reasonably achievable cost associated with necessary intervention.
- 6.49. Additionally, transparency requires that:
- all financial assistance is clearly and accurately accounted for;
 - all financial assistance is clearly documented; and
 - information regarding financial intervention is openly available for scrutiny by the relevant overseers.

6.50. The Panel, in assessing whether such financial intervention is transparent and fair, will consider the following evidence:

- the financial status of the recipient of the funds;
- any existing or potential relationships between the financier and the recipient of the funds;
- the amount of the financial intervention and calculations for arriving at the sum;
- whether funding is available through any other means; and
- whether and how the funds being provided have been accounted for.

7. Panel advice and recommendations to the relevant sponsor

- 7.1. Following an assessment of a conduct complaint, the Panel must provide advice and recommendations to the relevant Sponsor. In summary, the Panel will recommend action to be taken by the relevant Sponsor which it considers to be reasonable and practicable:
 - to remedy, mitigate or prevent the conduct concerned; and
 - to remedy, mitigate or prevent any detrimental effects on patients or taxpayers so far as they have resulted from, or may be expected to result from, the conduct concerned.
- 7.2. When the Panel has completed a conduct inquiry, the Panel will advise the relevant Sponsor as to whether any action should be taken, and if so, the nature of the action recommended by the Panel.
- 7.3. The Panel will recommend that conduct be allowed to proceed and no further action be taken where the conduct is consistent with the Principles and Rules or where it finds that such conduct does not have an adverse effect on patients or taxpayers. Where the Panel finds that the conduct does not have an adverse effect on patients or taxpayers due to the presence of offsetting benefits, the Panel may include in its advice recommendations to secure those offsetting benefits to patients or taxpayers.
- 7.4. Where conduct is in breach of the Principles and Rules and has an adverse effect on patients and/or taxpayers, the Panel will make recommendations as to whether the conduct should not be allowed to proceed or should only be allowed to proceed under certain conditions.
- 7.5. Any recommendations to the Sponsors will be proportionate. At all times, the Panel may only recommend or advise the relevant Sponsor on appropriate remedies and ultimate decision making power will rest with the relevant Sponsor.
- 7.6. Recommendations by the Panel may include the following:
 - requiring the relevant party or parties to adopt certain behaviour;
 - requiring the relevant party or parties to modify or bring the relevant conduct to an end and to refrain from repeating the conduct in future;
 - requiring the divestment or otherwise transfer of a function, such as the provision of a service, to another commissioner or provider;
 - requiring the relevant party or parties to participate in a competition law compliance education program;
 - instructing the relevant party or parties to issue an apology or corrective notice;
 - issuing warning notices to the relevant party or parties to deter future breaches;
 - withdrawing from the relevant party or parties any financial intervention;
 - accepting undertakings from the relevant party or parties as to future conduct; or
 - any other remedy it deems fit in relation to the particular case.

8. Submission content for complaints

8.1. In order to investigate a complaint, the Panel requires that complainants provide a detailed submission which includes the following details at minimum:

- The business name, address, telephone number, fax number and email address of the complainant as well as the relevant contact details of a representative who can discuss the detail of the complaint;
- Business details of the respondent;
- An explanation of the reason for the complaint including the alleged anti-competitive conduct and any evidence in support as well as the Principles and Rules which have been breached;
- The products and services involved;
- Relevant dates and incidents;
- Details of a relevant contact with the respondent;
- A chronology of events;
- The relationship between the complainant and the respondent/s; and
- How the complainant's business has been affected by the alleged activity and/or how patients or taxpayers have been adversely affected by the alleged activity.