CNC
COMISIÓN NACIONAL DE LA COMPETENCIA

APPLICATION OF THE GUIDE TO PUBLIC PROCUREMENT AND COMPETITION TO THE PROVISION OF PUBLIC HEALTHCARE IN SPAIN

CONTENTS

I. INTRODUCTION

(1) Healthcare in Spain is a public service whose provision, from the supply side, affects numerous sectors of the country's economic activity. Provision of the healthcare service, whether public or private, involves such varied sectors as land, construction, production of medical and pharmaceutical material, maintenance and cleaning services, hospital management and training and recruitment of healthcare personnel.

(2) From the demand side, it is a basic service in society. A service which, for overriding reasons of general interest, requires appropriate quality in its provision and, in practice, involves significant and increasing public expenditure.

(3) The administration providing healthcare must necessarily take these factors into account when choosing the best system for the provision of this public service, ensuring the required levels of quality at a sustainable cost.

(4) In Spain, the autonomous regional governments are responsible for organising healthcare resources in their respective regions, and therefore also for designing and implementing the outsourcing of these resources. The design selected will determine not only the effectiveness of the service but also its quality and cost.

(5) With the supposed objective of increasing levels of efficiency, one of the most commonly introduced instruments in the past few decades has been the outsourcing of the management of healthcare resources. This outsourcing constitutes the transition from a model of public provision managed by a public entity to one managed by private organisations.

(6) So far, outsourcing in Spain has been carried out by means of public procurement procedures. The subject of this report is the bidding processes for the provision of public healthcare services, from the construction of healthcare infrastructure to the outsourcing of the provision of the final service.

(7) For the bidding processes in relation to the bidding processes related to the outsourcing of healthcare management, , they must be optimally designed and monitored at every stage, so as to guarantee competition and to serve the pursued objective of improving efficiency without jeopardising quality. All this will, in turn, depend on the supply and demand characteristics of each of the services being provided.

(8) In 2011, the CNC, Spain's National Competition Authority, published a Guide to Public Procurement and Competition[1], which contains a list of

[1] The Guide can be accessed on the CNC's website (www.cncompetencia.es).

recommendations for favouring competition in bidding processes and detecting indications of anti-competitive conduct.

(9) In light of the outsourcing processes being undertaken, this study aims to apply the recommendations of the aforementioned Guide to the management of the provision of healthcare services[2], which range from the provision of the physical infrastructure to the outsourcing of the actual healthcare services management[3]. This does not imply a positioning of the CNC in favour of or against any model of public provision managed by private organisations, which falls outside the scope of this study. In this regard, the study merely aims to serve as a reminder that, if this model is chosen, the outsourcing processes must be carried out in such a way as to allow effective competition that genuinely favours the general interest.

(10) To achieve our objective, we study the necessary conditions for bidding processes for the provision of these public services to be carried out in a competitive context, in this way favouring those awards being made in the best general interest. We look at how these processes may affect the configuration and structure of the markets concerned, the level of competition in these markets and consequently their static and dynamic efficiency.

(11) For the preparation of this report the CNC requested information from the Ministry of Health, Social Services & Equality and the Autonomous Regions' departments with competence in the field of healthcare. We also maintained contact with healthcare professionals and academic experts. Additionally, we consulted official journals and publications and websites of the Ministry of Health, Social Services & Equality and Autonomous Regions' health departments, among other public documentary sources. All requests for information were complied with, with the sole exception of the Department of Health and Social Welfare of the Autonomous Region of Andalusia, which did not comply with the duty of collaboration with the public administrations contained in Article 4 of Law 30/1992, of 26 November, on the Legal Regime of the Public Administrations and Common Administrative Procedure or with the duty of collaboration with

[2] The field of healthcare management includes the following concepts: i) Healthcare Management, which refers to the provision of primary care and specialised healthcare services; ii) Social Healthcare management, which refers to therapeutic, social and educational assistance services for dependent groups such as the elderly, the chronically ill and persons with physical, psychological or sensorial disability; and iii) Non-Healthcare Management, concerning the financial, logistical and ancillary activities of hospitals and health centres.

[3] Consequently, agreements with private companies in the field of healthcare fall outside the scope of this study. Nor do we analyse on this occasion the procurement processes for these administrative arrangements.

the CNC contained in Article 39 of Law 15/2007, of 3 July, on the Defence of Competition[4].

(12) The report is structured as follows: section II studies the legal and economic context of the healthcare sector in Spain; section III examines in detail the content of healthcare bidding processes in various Autonomous Regions of Spain, applying the principles set out in the CNC's Guide to Public Procurement and Competition; the report ends with section IV, which sets out the main conclusions.

(13) This document was approved by the Board of the CNC in its meeting of 18 September 2013, in exercise of its powers to promote competition granted by Article 26.1 of Law 15/2007, of 3 July, on the Defence of Competition[5]. This Article establishes the CNC's duty to foster the existence of effective competition in the markets by means of actions such as promoting and carrying out studies and research work in the field of competition, making proposals for liberalisation, deregulation or legislative amendment and preparing reports on situations in which maintaining effective competition in the markets is hindered as a result of the application of the legal regulations.

II. THE HEALTHCARE SECTOR IN SPAIN

II.1. Regulatory framework

[4] On 10 May 2013, we sent the Health Departments of the 17 Autonomous Regions, including the Department of Health and Social Welfare of Andalusia, a request for information within a timeframe of ten days. On 14 June 2013, not having received a reply, we repeated the request for information to the Department of Health and Social Welfare of Andalusia, granting a further ten days. On 1 July 2013, we received a letter from the Department of Health and Social Welfare of Andalusia asking for a further extension and without providing the information requested, which was reported to the Andalusia Agency for the Defence of Competition. On 5 July 2013, we sent a letter to the Department of Health and Social Welfare of Andalusia (addressed to the Councillor for Health) declining to grant an additional extension and repeating the initial request for information within ten days. On 23 July 2013, past the last deadline granted, we received a letter from the Department of Health and Social Welfare of the Regional Government of Andalusia which did not provide the information requested. The reply contained no reference to any case of outsourcing of healthcare services in Andalusia and referred to a Register of Contracts of the Regional Government of Andalusia. Access to this register by the CNC's Promotion Division revealed no public information on these types of contracts. By other public means the CNC obtained information exclusively on the Functional Programme for the Public-Private Collaboration Contract for the provision, renewal and all-in maintenance of the clinical and general equipment of the Campus de la Salud Hospital in Granada, which is excluded from this report since it does not tie in with its subject matter.

[5] The CNC continues to exercise the powers granted it by Article 26.1 of Law 15/2007 as indicated in the third transitional provision of Law 3/2013 of 4 June creating Spain's National Authority for Markets and Competition (CNMC).

II.1.1. The National Health System (NHS)

(14) The Spanish Constitution (Article 43) enshrines citizens' right to health protection. Article 149.1.16 grants the State exclusive competence over the fields of foreign healthcare (which contains both legal and executive functions[6]), the bases and general coordination of healthcare (relating to domestic healthcare, specifically the determination of the basic legislation) and the legislation on pharmaceutical products (full legislative competence). Furthermore, in accordance with Article 149.1.17, the State has exclusive competence over the field of basic legislation and financial system for Social Security, without prejudice to the execution of the services by the Autonomous Regions.

(15) Law 14/1986, of 25 April, the General Health Act, gives effect to this right by establishing the National Health System (NHS)[7]. The NHS is the coordinated combination of the healthcare services of the State Administration and those of the Autonomous Regions, which encompasses all the healthcare functions and services for which the public authorities are legally responsible. The basic characteristics of the NHS, as per Article 46 of the General Health Act, are:

a. Extension of its services to the entire population.

b. Appropriate organisation for providing comprehensive healthcare, including the promotion of health and the prevention of illness as well as treatment and rehabilitation.

c. Coordination and, where appropriate, integration of all public healthcare resources in a single system.

d. Financing by means of resources of the public administrations, contributions and charges for certain services.

e. Provision of comprehensive healthcare with high levels of quality duly evaluated and controlled.

(16) In accordance with the **division of competences** established in the General Health Act:

- The State Administration, through the Ministry of Health, assumes responsibility for strategic areas such as foreign healthcare and international relations and healthcare agreements; general

6 Constitutional Court Ruling 329/1994 of 15 December.

7 The Beveridge model, an alternative to the Bismarck model, gave rise to the National Health System (NHS) of various countries such as the U.K., Sweden, Finland, Norway, Denmark, Italy, Spain and Portugal. Public healthcare is financed directly by the general State budget and is provided free of charge on the basis of universality and equality. In the case of Spain, starting in 1986 the Bismarck model Social Security system, in which healthcare services were financed by employers' and employees' contributions, was converted into a Beveridge model, with state financing and responsibility through taxation and general State budgets.

coordination and basic healthcare legislation; defining the basic portfolio of services of the NHS; pharmaceutical policy; pre- and post-graduate healthcare education; and establishing the legislative and regulatory framework for information systems and for cooperation among the various Autonomous Regions.[8]

- The Autonomous Regions, in turn, have planning powers and the ability to organise their healthcare services, conforming to the basic portfolio of services established by the State Administration. All the Autonomous Regions decide how to organise and deliver the healthcare services and draw up their healthcare maps divided into Healthcare Areas with responsibility for providing healthcare to their respective populations.
- Local authorities have a limited role, with functions in the areas of environmental health, hygiene and vaccinations.
- Within the Ministry of Health, Social Services & Equality and with the participation of all the Autonomous Regions, an Inter-regional Healthcare Council has been established, with aim of promoting the cohesion and quality of the system[9].

(17) The NHS is structured at two **levels of care**: Primary Care and Specialist Care, with citizens' spontaneous access being in inverse proportion to the degree of technological complexity.

(18) Primary Care makes a number of basic services available to the public (health promotion and disease prevention) within fifteen minutes' drive from any place of residence. The main points of delivery are the Health Centres, staffed by multi-discipline teams of family doctors, paediatricians, nursing staff and administrative personnel and, in many cases, social workers, midwives and/or physiotherapists.

(19) Specialist Care is provided in Specialists Centres and hospitals, on an out-patient or admission basis. Post-care, the patient and the corresponding clinical information return to the primary care doctor, who takes responsibility for the clinical view and overall treatment, since he has the whole medical history.

(20) Within this organisation, the location of the healthcare resources basically derives from planning based on demographically and geographically defined Health Areas, which are established by each Autonomous Region taking into account a variety of different factors but essentially the notion of

[8] The Government is also directly responsible for the planning, management and administration of healthcare for Ceuta and Melilla through the National Healthcare Management Institute (INGESA in the Spanish acronym). See Royal Decree 840/2002, of 2 August.

[9] Basic principles of Law 16/2003, of 28 May, on Cohesion and Quality of the NHS.

proximity of services to users. The Health Areas are in turn subdivided into "basic health zones" which are the geographical units in which the health centres operate. Each Area has a general hospital to which patients are referred for Specialist Care. In some healthcare services there are intermediate organisational structures between the Health Area and the "basic zone".

II.1.2. Private healthcare

(21) The General Health Act acknowledges "*the right to the free exercise of the healthcare professions, in accordance with the provisions of Articles 35 and 36 of the Constitution*" (Article 88) and "*the freedom of enterprise in the healthcare sector, in accordance with Article 38 of the Constitution.*" (Article 89).

II.1.3. Private management of public healthcare centres

(22) The organisational model for the NHS centres and services set by the General Health Act is characterised basically by direct, traditional management in the healthcare institutions of the social security system. The General Health Act also regulated special conventions and contracts with general hospitals in the private sector for the provision of healthcare services with third-party resources, giving priority to non-profit organisations.

(23) With a view to widening the range of organisational management models for healthcare centres, Royal Decree-Law 10/1996, of 17 June, on new management formulas of the Spanish NHS recognised "*indirect management of public healthcare centres by any entities allowed by law, and by means of consortia, foundations and other entities with legal personality, with the possibility of entering into agreements or conventions with public or private persons or entities, and establishing integrated or shared management formulas, thus generalising the provisions contained in various laws passed by the Autonomous Regions with competence in the matter.*"

(24) Law 15/1997, of 25 April, on the approval of new management models for the National Health System, which recasts the sole Article of Royal Decree-Law 10/1996, establishes in its recitals that "*management of health and social care centres and services may be carried out directly or indirectly by any public entities allowed by law; among other legal forms,* [Law 15/1997] *provides for management by intermediate entities with legal personality, such as public companies, consortia or foundations - on the same terms as those already created - or other entities of a public nature or publicly owned and recognised by law.*"

(25) Thus the main management models for healthcare services, apart from traditional direct management with the Administration's own resources, are the following:

a) Contracts and conventions: The General Health Act establishes that private health centres and establishments may be linked to the public healthcare network by means of contracts (Article 67 of the General Health Act, indirect management subject to contract law) and conventions (Article 90 of the General Health Act).

b) Forms of indirect management: Law 15/1997 provides new forms of management for the NHS: "*by means of agreements, conventions or contracts with public or private persons or entities*".

c) New forms of direct management: Royal Decree 29/2000 specifies forms of direct management of healthcare services:

- Private foundations established by public initiative (created by a non-profit public entity and normally subject to private law) and public healthcare foundations (foundations also subject to the Law on the Organisation and Functioning of the General State Administration (LOFAGE in the Spanish abbreviation), which are public entities considered as publicly owned companies and acting under private law).
- Consortia (groupings created by public entities but which may also include private entities).
- State owned enterprises (majority or wholly owned by the NHS).

(26) Autonomous regional legislation has mainly retained the principle of direct management in its various forms, but some Autonomous Regions have provided for and used indirect forms of management other than those contained in the General Health Act (contracts and conventions), specifically public service concession for the construction and operation of a hospital[10] and public works concession[11].

[10] Specifically:

- In the Autonomous Region of Valencia, Law 3/2003, of 6 February, of the Valencia Regional Government, on the organisation of healthcare in the Autonomous Region of Valencia. In this case, the first concession, of the Alzira hospital (La Ribera health area) in the Autonomous Region of Valencia (in 1997) was contested on the basis of the alleged illegality of administrative concession as a means of managing the public healthcare service. However, the Supreme Court of the Autonomous Region of Valencia (Ruling 1925/2000) confirmed the legality of the system, finding that there was no legal impediment to indirect management of healthcare services by means of a concession and that the public nature of the system was not called into question by the initiative of formulas of private management or responsibility.

(27) The public service management contract (in particular in the form of concession) is defined in Article 8 of the Redrafted Text of the Law on Public Sector Contracts (hereinafter referred to by its Spanish initials "TRLCSP")[12] as one whereby "*a Public Administration or a Mutual Insurance Society for Accidents at Work and Occupational Illnesses of the Social Security entrusts to a natural or legal person the management of a service for which the Administration or Mutual Society has accepted responsibility".*

(28) The public works concession contract is covered by Article 7 of the TRLCSP and defined as one "*the purpose of which is the performance by the concessionaire of any of the services referred to by Article 6*[13]*, including those of restoration and repair of existing constructions, as well as the conservation and maintenance of constructions, and where the consideration consists either solely of the right to operate the works or of such right plus the right to receive a price*".

(29) Another typical contract for healthcare outsourcing processes is the public-private cooperation contract. Article 11 of the TRLCSP defines it as one by virtue of which an Administration *commissions a private sector entity, for a period determined by reference to the time taken to depreciate the investments or to such financing formulas as may be provided, the performance of a global, integrated action which, as well as the financing of the intangible investments, works and supplies necessary for the attainment of certain objectives of public service or related to actions of general interest, comprises one or more of the following services:*

- *The construction, installation or transformation of works, equipment, systems and complex products or goods, as well as their maintenance, upgrade or renovation, exploitation or management.*
- *The complete management of complex installations.*
- *The manufacture of goods and the provision of services incorporating technology specifically developed with the purpose of providing more advanced and economically more advantageous solutions than those existing in the market.*
- *Other services linked to the Administration's delivery of such public service or such action of general interest as has been entrusted to it.*

- In the Autonomous Region of Madrid, Law 12/2001, of 21 December, on the organisation of healthcare in the Autonomous Region of Madrid and Law 8/2012, of 28 December, on Tax and Administrative Measures.

[11] It has been carried out in the Autonomous Regions of Madrid, Castilla y León and the Balearic Islands.

[12] Royal Legislative Decree 3/2011, of 14 November, approving the TRLCSP.

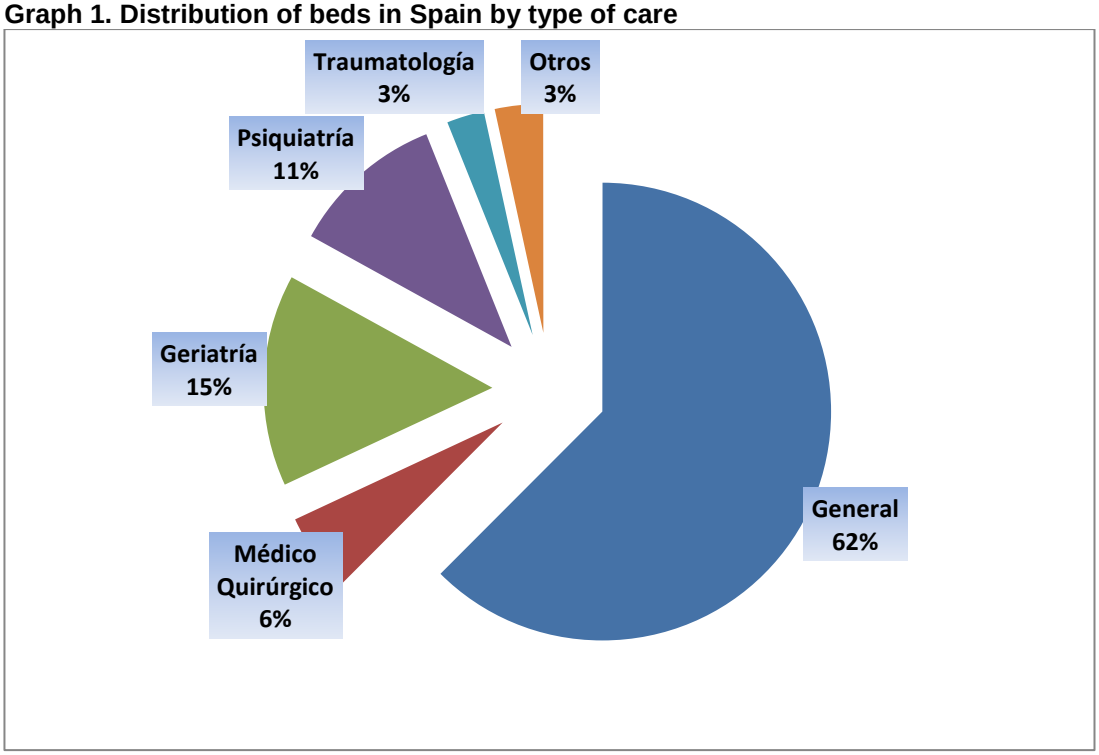
[13] Article 6 of the TRLCSP defines the works contract.

II.2. Economic structure of the Spanish healthcare sector

(30) According to data of the National Catalogue of Hospitals[14] for 2013, Spain has a total of 789 hospitals, with 162,070 beds[15], which implies 59,335 inhabitants per hospital and 289 per bed[16]. The average-sized Spanish hospital has 205 beds.

(31) By type of care, nationwide the majority of beds are in general hospitals (62.5% of the total). After general hospitals come geriatric and psychiatric hospitals with 15% and 10.9% respectively of the total, followed by medical-surgical centres with 5.6%.

Graph 1. Distribution of beds in Spain by type of care



Source: National Catalogue of Hospitals 2013, Ministry of Health, Social Services & Equality (data as at 31 December 2012)

Table 1. Network of hospitals (public and private) by Autonomous Regions

	Hospitals	Beds	Average	Population	Inhabitants

[14] Publication of the Ministry of Health, Social Services & Equality containing descriptive data on the NHS.

[15] The number of beds is a commonly used indicator in the sector to study the size and capacity of specialist care centres (clinics and hospitals, mainly).

[16] According to the 2011 census of the National Statistics Institute (INE), the population of Spain was 46,815,916.

			size of hospitals		per bed
Andalusia	106	22,174	209	8,371,270	378
Aragón	29	5,404	186	1,344,509	249
Asturias	20	4,017	201	1,075,183	268
Balearic Islands	22	3,675	167	1,100,503	299
Canary Islands	37	7,694	208	2,082,655	271
Cantabria	8	1,999	250	592,542	296
C.-La Mancha	29	5,806	200	2,106,331	363
C. y León	37	9,698	262	2,540,188	262
Catalonia	211	34,437	163	7,519,843	218
Valencia	62	14,026	226	5,009,931	357
Extremadura	19	4,276	225	1,104,499	258
Galicia	38	9,945	262	2,772,928	279
Madrid	82	22,136	270	6,421,874	290
Murcia	26	4,689	180	1,462,128	312
Navarra	11	2,422	220	640,129	264
Basque Country	44	8,290	188	2,185,393	264
La Rioja	6	960	160	321,173	335
Ceuta	1	252	252	83,517	331
Melilla	1	170	170	81,323	478
Total Spain	**789**	**162,070**	**205**	**46,815,916**	**289**

Source: Ministry of Health, Social Services & Equality, *National Catalogue of Hospitals 2013* (data as at 31 December 2012) and INE, 2011 population census.

(32) From an economic point of view, publicly and privately owned healthcare services present some significant differences: (i) in the financing of the hospitals, in that private hospitals are financed by the patients (generally via insurance), whereas public hospitals are financed, in whole or in part, through budgets with no additional cost to the patient at the time the care is provided, and (ii) in other possible factors such as waiting lists and comfort[17].

[17] This distinction is within the decision-making scope of the competition authorities. *See:* European Commission, Cases M.4229 APHL/ L&R/Netcare/General Healthcare Group, M.4367 APW/APSA/Nordic Capital/Capio and M.5548 Barclays/RBS/Hillary. CNC, cases C-0447/12 DHC/FAMILIA CORDON MURO/USP HOSPITALES/GRUPO HOSPITALARIO QUIRON, C-0252/10 MAGNUM CAPITAL/TEKNON, C-0198/09 RECOLETAS/CENTRO MEDICO ZAMORA, C-0177/09 CAPIO/CLINICA COREYSA, C-0085/08 ADESLAS/GRUPO LINCE, C-0051/08 ADESLAS/POLICLINICA SAN JOSE, N-07080 CINVEN/EQUIPO GESTOR/USP, N-06069 ADESLAS/GLOBAL CONSULTING/LINCE SERVICIOS SANITARIOS (case C-101/06 of the former TDC (Tribunal for the Defence of Competition, the CNC's predecessor)) and N-05053 IGUALMEQUISA/ADESLAS/IMQ SEGUROS/IMEQUISA SEGUROS (case C-89/05 of the former TDC).

II.2.1. The public healthcare network

(33) The public healthcare system is designed to care for all members of the Social Security system plus public employees of MUFACE, ISFAS and MUGEJU who have opted for the system. The public hospitals are more than 90% financed by taxation, healthcare not being subject to separate contribution[18]. The personnel is mainly statutory, similar to civil servants, although there are also regular employees.

(34) Spain has 325 publicly owned hospitals (41.2% of the total), with 108,444 beds (66.9% of the total). This represents an average size of 334 beds per public hospital. The public network is divided into 157 health areas, which in turn are subdivided into 2,534 basic health zones.

(35) By region, Catalonia has 55 public hospitals with 14,369 beds, representing an average size of 261 beds per public hospital and 523 beds per inhabitant. Andalusia has 48 public hospitals, representing an average size of 348 beds per hospital and 501 beds per inhabitant. The Autonomous Regions of Madrid and Valencia each have 35 public hospitals, the average size being 428 and 329 beds per hospital respectively. Aragón has 19 public hospitals and 4,360 beds, representing 308 beds per inhabitant. Castilla y León has a network of 16 public hospitals with an average of 461 beds per hospital and 345 beds per inhabitant. Asturias has 9 public hospitals and 2,983 beds, representing 360 beds per inhabitant. Lastly, Ceuta has a single public hospital with 252 beds. This represents 331 beds per inhabitant.

Table 2. Public network of hospitals by Autonomous Regions

	Health Areas	Basic Health Zones	Hospitals*	Beds	Average size of hospitals	Inhabitants per bed
Andalusia	33	216	48	16,714	348	501
Aragón	8	125	19	4,360	229	308
Asturias	8	68	9	2,983	331	360
Balearic Islands	3	57	11	2,544	231	433
Canary Islands	7	111	14	4,838	346	430
Cantabria	4	42	4	1,332	333	445
C.-La Mancha	8	201	20	5,328	266	395
C. y León	11	251[19]	16	7,371	461	345
Catalonia	7	362	55	14,369	261	523

[18] An insignificant part of Healthcare is funded by social contributions, but this relates to Mutual Insurance Societies for Accidents at Work and Occupational Illnesses. There is also a small contribution from civil servants' mutual societies.

[19] Divided into urban basic health zones (77), semi-urban basic health zones (18) and rural basic health zones (156).

Valencia	24	240	35	11,499	329	436
Extremadura	8	113	8	2,968	371	372
Galicia	7	146	14	7,581	542	366
Madrid	7	310	35	14,982	428	429
Murcia	9	89	10	3,128	313	467
Navarra	3	55	4	1,435	359	446
Basque Country	7	122	18	5,782	321	378
La Rioja	1	19	3	808	269	397
Ceuta	1	7[20]	1	252	252	331
Melilla	1		1	170	170	478
Spain	**157**	**2,534**	**325**	**108,444**	**334**	**432**

* Hospitals functionally dependent on a Public Administration entity according to the National Catalogue of Hospitals.
Source: Ministry of Health, Social Services & Equality, *Catalogue of NHS primary care centres* and *National Catalogue of Hospitals 2013* (data as at 31 December 2012) and INE, population census 2011.

(36) Catalonia[21], Valencia[22], Madrid[23], Navarra[24] and La Rioja[25] have outsourced healthcare or social welfare management of public healthcare centres[26]. Various processes of construction of healthcare infrastructure and outsourcing of non-healthcare management of public healthcare centres have also been observed in several Autonomous Regions[27].

(37) As well as outsourcing healthcare, social welfare or non-healthcare management of public centres, the Autonomous Regions enter into contracts with private hospitals whereby the latter provide care on behalf of the public sector in certain geographical areas with their own resources.

[20] Combined data for Ceuta and Melilla.

[21] Social welfare management of the Jaume Nadal Meroles Hospital is outsourced through a public services concession contract.

[22] The entire management (healthcare and non-healthcare) of the health areas corresponding to the Ribera, Denia, Torrevieja, Manises and Vinalopó (Elche-Crevillente) hospitals has been outsourced.

[23] The entire management of the Infanta Elena, Rey Juan Carlos, Torrejón, Henares, Sureste, Infanta Leonor, Infanta Sofía, Infanta Cristina and Tajo hospitals and the non-healthcare management of Puerta de Hierro Hospital have been outsourced. Non-healthcare management of the Collado-Villalba Hospital, which remains closed and does not appear in the National Catalogue of Hospitals, has also been outsourced.

[24] Social welfare (mental health) management of the Burlada Mental Health Centre and Mental Health Day Hospital and Zuría Day Hospital has been outsourced.

[25] Social welfare management of the Virgen del Carmen Centre in Calahorra and of the Los Jazmines Centre in Haro has been outsourced. The latter is shown as privately owned in the National Catalogue of Hospitals.

[26] Andalusia is the only autonomous region that has not provided the CNC with data regarding outsourced management of hospitals.

[27] New Burgos Hospital and Son Espases and Can Misses Hospitals in the Balearic Islands.

The following table shows the number of conventions of this kind in existence.

Table 3. Number of hospitals with healthcare contracts by Autonomous Region

	Private hospitals	Private hospitals with contract (in parentheses, in %)	Number of beds of private hospitals with contracts*
Andalusia	58	17 (29%)	2,052
Aragón	10	8 (80%)	714
Asturias	11	6 (55%)	869
Balearic Islands	11	7 (64%)	778
Canary Islands	23	16 (70%)	2,426
Cantabria	4	3 (75%)	637
Castilla La Mancha	9	3 (33%)	182
Castilla y León	21	19 (90%)	1,925
Catalonia	156	34 (22%)	6,334
Autonomous Region of Valencia	27	16 (59%)	1,729
Extremadura	9	7 (78%)	456
Galicia	24	19 (79%)	2,149
Autonomous Region of Madrid	47	35 (74%)	5,904
Murcia	16	12 (75%)	1,356
Navarra	7	5 (71%)	953
Basque Country	26	18 (69%)	1,992
La Rioja	3	3 (100%)	152
TOTAL	**462**	**228 (49%)**	**30,608**

* The National Catalogue of Hospitals 2013 does not specify the number of beds contracted, so the table presents an approximation based on the total number of beds per hospital.
Source: Ministry of Health, Social Services & Equality, *National Catalogue of Hospitals 2013* (data as at 31 December 2012).

(38) The fact that there are economic agreements does not mean that all the private hospital's resources are dedicated to caring for public service patients; this depends on the scope of each agreement. In any case, the number of hospitals with agreements and the number of beds in these hospitals will provide a rough idea of the importance of the economic agreements: 49% of Spanish private hospitals have a contract to care for patients from the public network[28]. However, since the report focuses exclusively on bidding process for the outsourcing of healthcare and non-healthcare management, the specific implications of the existence of contracts with private companies in the field of healthcare have been

[28] One example is the case of the Jiménez Díaz Foundation, which has signed a special agreement with the autonomous region of Madrid, with 407 beds available, an assigned population of 286,582 and 14 associated primary care centres. Source: Court of Auditors of the Autonomous Region of Madrid (2010), *Audit Report on Budget Programme 750.- Specialist Care of the Madrid Health Department, fiscal year 2007*.

omitted from this study. Nor do we analyse the procurement processes for these agreements.

II.2.2. Private healthcare

(39) Demand for private healthcare services comes from private individuals, often holders or beneficiaries of individual health insurance or of a public or private sector group scheme[29]. Their financing comes mainly from contracts with insurers[30].

(40) Providers of private healthcare services include, as well as hospitals and health centres, physicians and specialist clinics. Because of its close vertical connection with the healthcare insurance market, competition in this market takes place at two levels:

- Competition for the insurer: hospitals and professionals practising in the private sector compete to form part of the catalogue of services offered by the insurance companies. In the absence of exclusivity clauses, providers of healthcare services may have relationships with several insurers.
- Competition for the patient/insured: private hospitals and healthcare professionals compete to attract patients to their own centre. In the case of insured patients, their choice is made from among the centres forming part of the insurer's catalogue.

(41) At present, significant competition in the field of private healthcare mainly takes place on a local or regional scale. In some competition decisions,[31] geographical markets have been defined at provincial level, due to the fact that consumers prefer healthcare to be close at hand, as low-priced and as little time-consuming as possible in terms of travel, plus the fact that there are differences in the cost of healthcare among various provinces and that in the contracted healthcare market, the mutual insurance

[29] Those belonging to the national mutual societies for public administration employees: MUFACE, ISFAS and MUGEJU. Article 17.1 of Royal Legislative Decree 4/2000, of 23 June, approving the redrafted text of the Law on Social Security of Civil Servants determines that "*healthcare will be provided by the General Mutual Society of Civil Servants, either directly or through contracts with other public or private entities or establishments. These contracts will be established preferably with Social Security institutions*".

[30] Private healthcare centres also obtain revenue from providing services to public patients. Healthcare services that depend on public administrations outsource the care of public insured persons to private hospitals in a number of different ways, such as specific services to reduce waiting lists or by having the centre join the public healthcare system. .

[31] Case TDC C89/05 Igualatorios Médicos; Case TDC C101/06 Adeslas/Global Consulting/Lince; Report of the SDC (the former *Servicio de Defensa de la Competencia* or Defence of Competition Service) N-06069 Adeslas/Global Consulting/Lince; Report of the SDC N-04064 Adeslas/Gestión Sanitaria Gallega; Case C-0177/09 Capio/Clínica Coreysa.

society's choice, unaffected by price, is guided by proximity to the place of residence, as shown by the provincial service catalogues containing each insurer's healthcare offering.

(42) Apart from this, there are a large number of activities closely related to the provision of healthcare services, which may affect or be affected by the conditions of competition in the provision of healthcare services: health insurance[32], the supply of healthcare material[33] and medical equipment[34] or services related to healthcare[35].

(43) Spain has 464 private hospitals (58.8% of the total), with 53,626 beds (33.1% of the total). The average size of the private hospitals (116 beds per hospital) is much smaller than that of the public hospitals (334 beds per hospital). Nearly half of the private hospitals (228 hospitals) have some type of contract with the Public Administration.

[32] The competition authorities have taken the view that health insurance constitutes a separate market from other insurance by reason of its object (it covers a risk on people), its utility (reducing the social burden for the insured), its purpose (provision of services instead of indemnification) and the premiums (which are geared to the cost of the healthcare services). Within this type of insurance, we can differentiate among individual health insurance, private sector group health insurance and public sector group health insurance, which would constitute a market distinct from the first two. Competition in the field of private health insurance has been considered on a provincial level. See: TDC resolution C89/05 Igualatorios Médicos and CNC resolutions C101/06 Adeslas/Global Consulting/Lince and C/0356/11 Mutua Madrileña/La Caixa/Vidacaixa Adeslas.

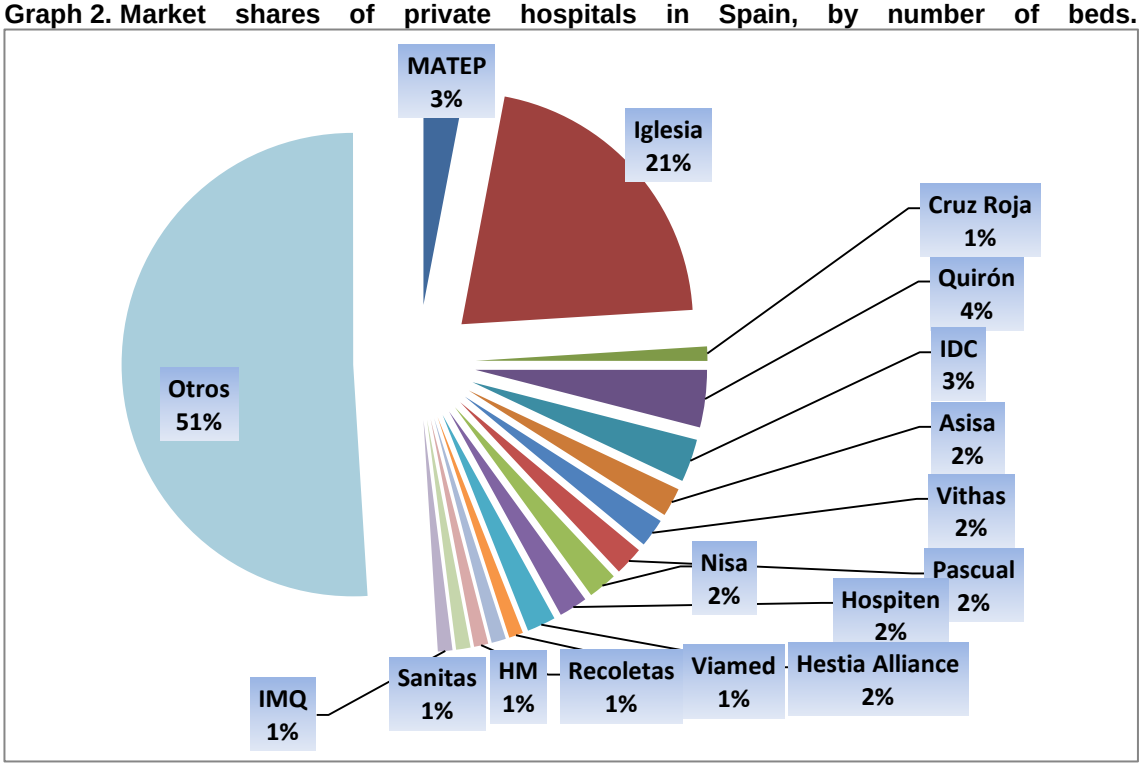
[33] There is a great variety of products relating to healthcare. The hospitals generally use bidding processes for the procurement of medical and healthcare products.

[34] Some healthcare equipment manufacturing and distribution markets have been studied in the past by the European Commission or the CNC, which have defined them as separate markets depending on the type of equipment and their functionality, the geographical dimension being nationwide. *See:* SDC, case N-03058 Dräger Medical/Hillenbrand; CE, case M.308 - GE/Instrumentarium.

[35] Laboratory services, specifically clinical analyses, were studied by the CNC in case C/0124/08 3i Gestion/Labco. A distinction is made between this market and image analyses (X-ray radiography, ultrasound, magnetic resonance imaging, computed tomography, etc.) which are normally carried out in health centres without requiring blood or tissue tests. Moreover, they do not require any chemical reaction to be able to examine them in the laboratory and the equipment is totally different from that used for clinical analyses. Within this market a distinction is made between ordinary (common, technically simple) analyses and specialised ones requiring more advanced technology and equipment. Due to the specific characteristics of these services, their handling does not depend on each particular hospital. In the Autonomous Region of Madrid, the Infanta Sofía Hospital's laboratory contract covers the diagnostic clinical laboratory tests for five other hospitals, and the performance of this contract was awarded to the temporary consortium formed by the Balagué Center laboratory and healthcare services company AMS. Subsequently Unilabs (IDC-Capio group) bought this participation. Among the main providers in this market are Unilabs (IDC-Capio Group) and the Balagué Center Laboratory.

(44) As regards the ownership of the private hospitals[36], the groups included under the heading "Church"[37] together have 21% of the beds in the private sector (54 hospitals, 11,083 beds). Of the private non-profit groups, Grupo Quirón is the biggest (19 hospitals and 2,146 beds, representing 4.1% of the total), followed by Grupo IDC Salud[38] (10 hospitals and 1,810 beds, representing 3.4% of the total). Nisa has 5 of its 7 hospitals in the Autonomous Region of Valencia (1,166 beds, 2.2% of the national total), and the José Manuel Pascual Pascual Group has 6 hospitals (1,148 beds, 2.2%), all of them in Andalusia. Other agents also concentrate their activity in a single region: Hospiten[39] concentrates its national activity in the Canary Islands, where it has 6 of the Islands' 8 hospitals (1.7% of the nation's beds). HM has all 5 of its hospitals in the Autonomous Region of Madrid (1.2% of the nation's beds).

Graph 2. Market shares of private hospitals in Spain, by number of beds.



Source: National Catalogue of Hospitals 2013, Ministry of Health, Social Services & Equality (data as at 31 December 2012)

[36] Hospitals functionally dependent on a Public Administration entity according to the National Catalogue of Hospitals.

[37] The heading "Church" encompasses a variety of religious orders which in principle do not act under a single commercial management. We do not know the breakdown of the religious orders included under this headings.

[38] Until the second half of 2013, IDC Salud was called Grupo Capio Sanidad.

[39] Hospiten also has international activity, in Jamaica, Mexico and the Dominican Republic.

(45) Apart from this, given its close connection with the private provision of healthcare, the competitive structure of the health insurance market should be taken into account. According to data from ICEA (the research arm of the Spanish insurance industry) Adeslas is the company with the biggest share of Spain's health insurance market (22.6%), followed by Sanitas (16.6%) and Asisa (13.4%). The top five insurers in the ranking account for a combined market share of 62%[40].

II.2.3. Structure of healthcare in Autonomous Regions with outsourced healthcare or social welfare services.

(46) Having studied the characteristics of Spain's healthcare sector at national level, we go on to carry out a more detailed study of the structure of healthcare in Autonomous Regions that have outsourced the healthcare and social welfare management of public healthcare centres[41].

Catalonia

(47) Catalonia is the Autonomous Region with the most extensive network of hospitals. It has 211 hospitals, representing 26.7% of the total number of hospitals in Spain, with a total of 34,437 beds, which is 21.3% of the total number of beds in Spain. In Catalonia there are 218 inhabitants per bed, which is below the national average of 289. The average-sized Catalonian hospital has 163 beds.

(48) Of the total number of hospitals, 156 (73.9%) are private and 55 (26.1%) are public. As regards the number of beds, 14,369 are public (41.7%) and the remaining 20,068 (58.3%) private. Among public hospitals, the Jaume Nadal Meroles Hospital, which has 126 beds, has outsourced its social welfare management[42].

(49) As regards the private hospitals[43], apart from the groups forming the "Church" heading (14 hospitals and 3,233 beds), the main operator in Catalonia is the Hestia-Alliance Group, which has 7 hospitals and 893 beds (4.4% of the total). Next come Grup Pere Mata (1 hospital, 727

[40] Investigación Cooperativa entre Entidades Aseguradoras y Fondos de Pensiones (ICEA) Health Report. 2010.

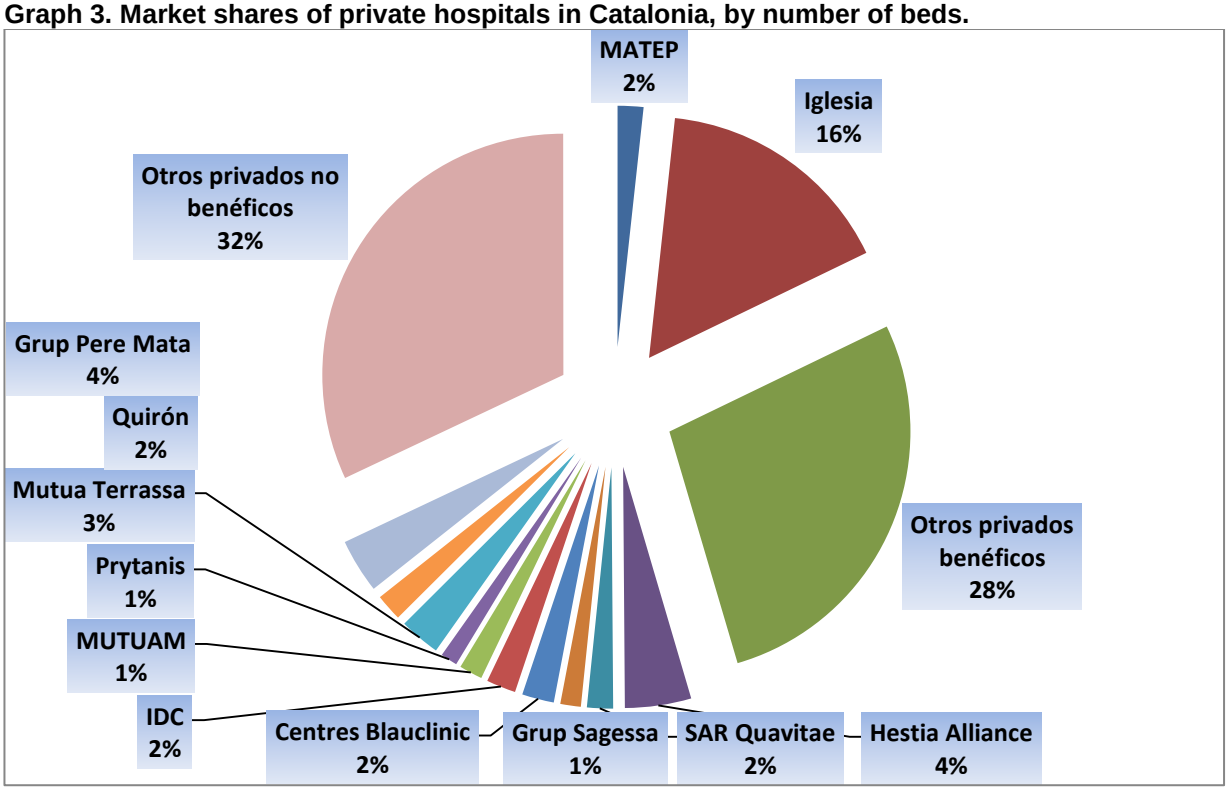
[41] According to information provided to the CNC by the Autonomous Regions. In the case of Andalusia, since it has provided no such information, we do not know whether this Autonomous Region has outsourced healthcare or social welfare management.

[42] The Durán i Reynals Hospital, which does not appear in the National Catalogue of Hospitals 2013, has also outsourced the construction and management of its social welfare service.

[43] These figures include the above-mentioned Jaume Nadal Meroles Hospital since, according to the National Catalogue of Hospitals 2013, it was functionally private (and functional reporting was the criterion used to classify hospitals as public or private in this section).

beds), Mutua Terrasa (2 hospitals, 553 beds), Centres Blauclinic (3 hospitals, 430 beds), Quirón (2 hospitals, 362 beds), the SAR Quavitae Group (5 hospitals, 351 beds), Grup Mutuam (4 hospitals, 311 beds) and Grup Sagessa (3 hospitals, 275 beds).

Graph 3. Market shares of private hospitals in Catalonia, by number of beds.



Source: National Catalogue of Hospitals 2013, Ministry of Health, Social Services & Equality (data as at 31 December 2012)

Autonomous Region of Madrid

(50) In the Autonomous Region of Madrid there are 82 hospitals in all (10.4% of the total number of hospitals in Spain), and 22,136 beds (13.7% of the total number of beds in Spain), representing 290 inhabitants per bed (for Spain as a whole the ratio is 289 inhabitants per bed). The average-sized Madrid hospital has 270 beds.

(51) 35 Madrid hospitals, with 14,982 beds (67.7% of the total) are publicly owned. Another 47 hospitals, with 7,154 beds (32.3%) are privately owned. In the past few years healthcare management outsourcing processes have been carried out affecting 10 public hospitals, which have 2,521 beds, as shown in table 4.

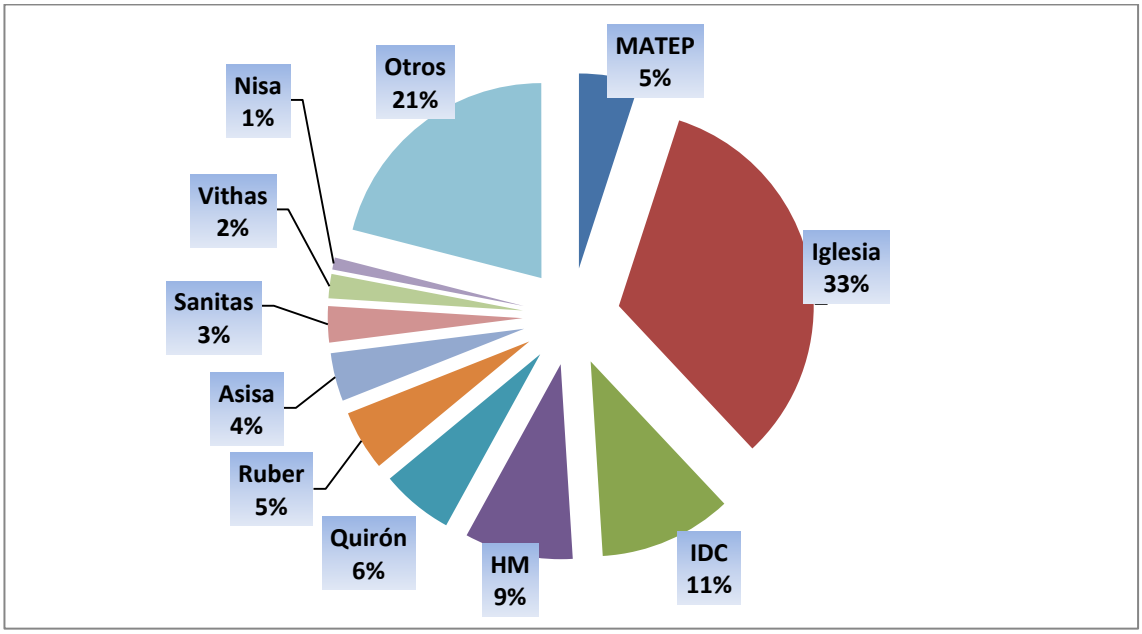
Table 4. Network of civil public hospitals in the Autonomous Region of Madrid, by type of management.

	Direct Management	Outsourced Management	Total
Number of hospitals	25	10[44]	35
Number of beds	12,461	2,521	14,982

Source: National Catalogue of Hospitals 2013. Ministry of Health, Social Services and Equality.

(52) As for privately owned hospitals, those held by the Church number 11, with 2,340 beds (33.2% of the total). Apart from the groups included under the "Church" heading, the main operator in the Autonomous Region of Madrid is the IDC-Capio Group, which has two 2 hospitals and 796 beds (11.3% of the total). Then come Grupo HM (5 hospitals, 634 beds), Grupo Quirón (3 hospitals, 441 beds), Ruber (2 hospitals, 322 beds), Asisa (1 hospital, 259 beds), Sanitas (2 hospitals, 234 beds), Vithas (1 hospital, 100 beds) and Nisa (1 hospital, 100 beds). The MATEP heading (5%) encompasses the Mutual Insurance Societies for Accidents at Work and Occupational Illnesses of the Social Security. In this last case, the breakdown by entities is unknown.

Graph 4. Market shares of private hospitals in the autonomous region of Madrid, by number of beds.



[44] The number of hospitals with outsourced management does not take account of the Collado-Villalba Hospital, which remains closed and does not appear in the National Catalogue of Hospitals.

Source: National Catalogue of Hospitals 2013, Ministry of Health, Social Services & Equality (data as at 31 December 2012)

Autonomous Region of Valencia

(53) In the Autonomous Region of Valencia there are 62 hospitals in all (7.9% of the total number of hospitals in Spain), and 14,026 beds (8.7% of the total number of beds in Spain), representing 357 inhabitants per bed (for Spain as a whole the ratio is 289 inhabitants per bed). The average-sized Valencia hospital has 223 beds.

(54) 35 hospitals, with 11,499 beds (82% of the total), are publicly owned. Another 27 hospitals, with 2,527 beds (18%) are privately owned. Moreover, both the healthcare and non-healthcare services of five health areas in the Autonomous Region of Valencia have been outsourced[45], together amounting to 1,423 beds, as shown in table 4.

Table 5. Network of civil public hospitals in the Autonomous Region of Valencia, by type of management.

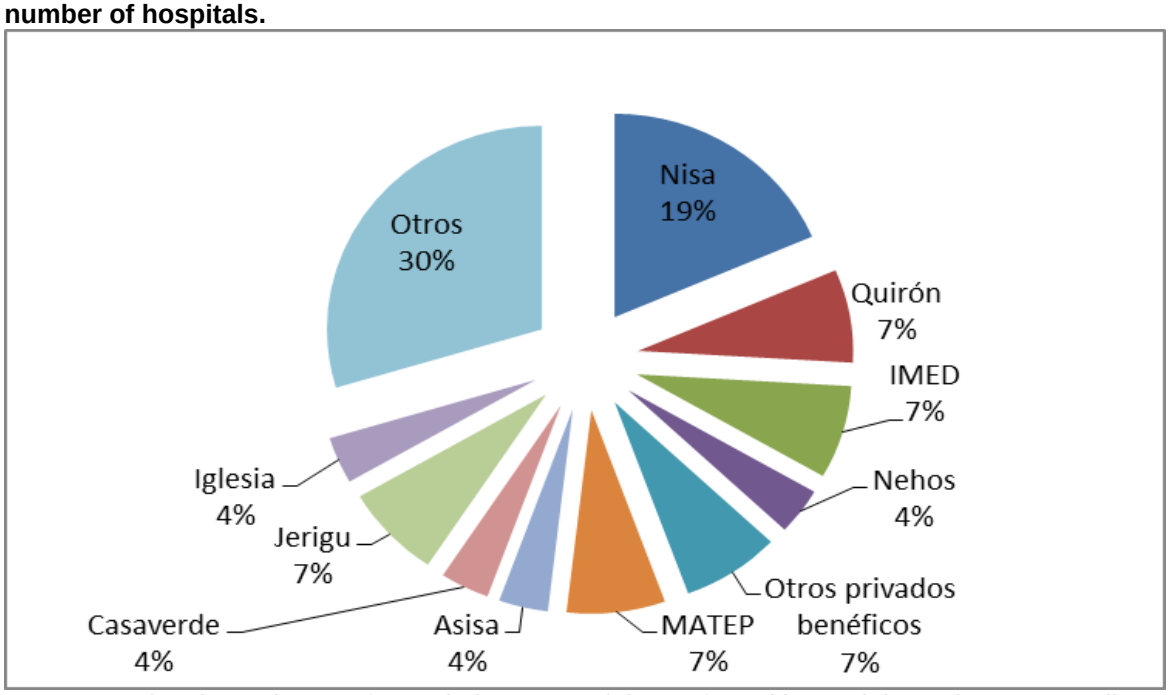
	Direct Management	Outsourced Management	Total
Number of hospitals	30	5	35
Number of beds	10,076	1,423	11,499

Source: National Catalogue of Hospitals 2013, Ministry of Health, Social Services & Equality.

(55) As regards the privately owned hospitals, apart from the groups forming the "Church" heading (1 hospitals and 192 beds), the main operator is the NISA Group, which has 5 hospitals and 739 beds (29% of the total). Next comes the Quirón group, with two hospitals and 179 beds, and IMED, with two 2 hospitals and 198 beds. Jerigu for its part has two 2 hospitals but only 21 beds. The MATEP heading (7%) encompasses the Mutual Insurance Societies for Accidents at Work and Occupational Illnesses of the Social Security. In this last case, the breakdown by entities is unknown.

[45] The health areas whose reference hospitals are Ribera, Manises, Torrevieja, Denia and Vinalopó (Elche-Crevillente) hospitals.

Graph 5. Market shares of private hospitals in the Autonomous Region of Valencia, by number of hospitals.



Source: National Catalogue of Hospitals 2013, Ministry of Health, Social Services & Equality (data as at 31 December 2012)

La Rioja:

(56) La Rioja has a total of six hospitals, with 960 beds, implying 335 inhabitants per bed (above the national average of 289) and an average size of 160 beds per hospital.

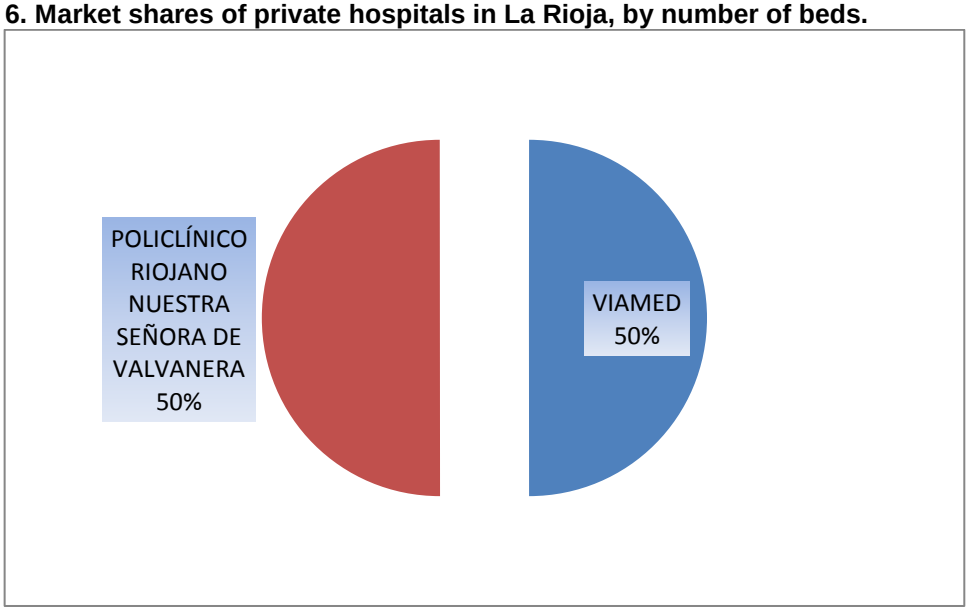
(57) The network of public hospitals has three centres, the number of beds being 808, whereas the number of beds in the three private hospitals is 152.

(58) The entire management of two hospitals has been outsourced: the Los Jazmines Social Welfare Convalescence Centre in Haro, which has 26 beds, and the Virgen del Carmen Social Welfare Convalescence Centre in Calahorra, which has 91.

(59) Two of the three private hospitals[46] belong to the Viamed Group (76 beds) and the other one belongs to the Policlínico Riojano Nuestra Señora de Valvanera (76 beds).

[46] These figures include the above-mentioned Los Jazmines Social Welfare Convalescence Centre in Haro, since according to the National Catalogue of Hospitals 2013, it was

Graph 6. Market shares of private hospitals in La Rioja, by number of beds.



Source: National Catalogue of Hospitals 2013, Ministry of Health, Social Services & Equality (data as at 31 December 2012)

Navarra:

(60) The Region of Navarra has a network of 11 hospitals with a total of 2,422 beds, representing 264 inhabitants per bed (somewhat less than the national average of 289 inhabitants per bed). The average-sized Navarra hospital has 220 beds.

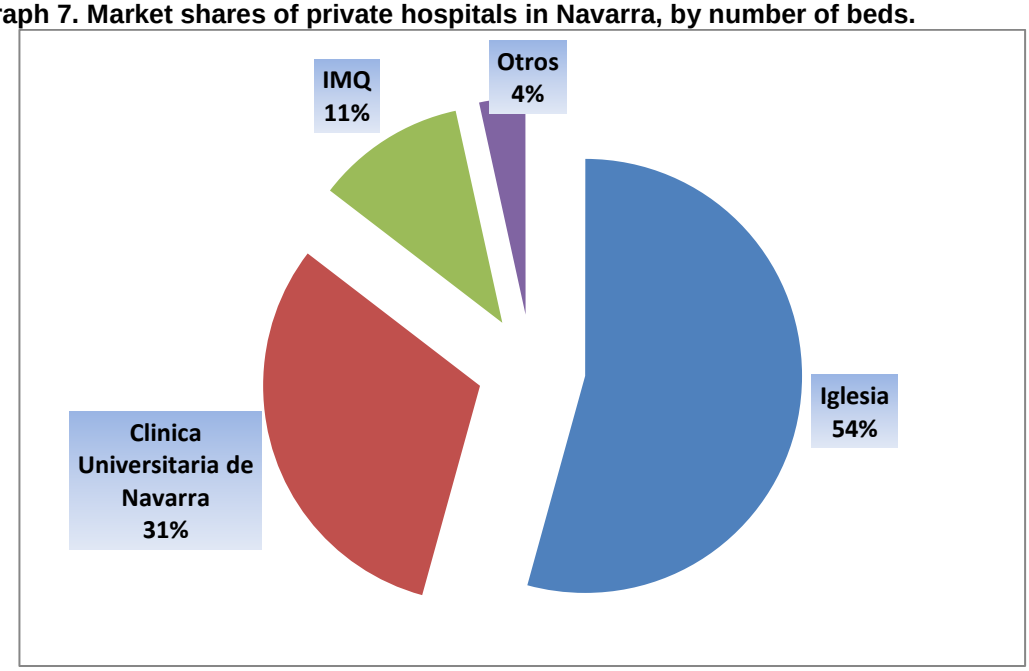
(61) Four of these hospitals are public (1,435 beds) and seven are private (987 beds). Apart from this, although they are not counted as public hospitals[47], two outsourcing processes of social welfare have been carried out, by the Burlada Day Health Centre and Mental Health Hospital and the Zuría Day Hospital.

(62) As for the private hospitals, apart from the groups forming the "Church" heading (3 hospitals, 536 beds), which represent 54% of the private hospitals in Navarra, the biggest operator is the Clínica Universitaria de Navarra (1 hospital, 307 beds), followed by the IMQ Group (1 hospital, 110 beds).

functionally private (and functional reporting was the criterion used to classify hospitals as public or private in this section).

[47] Being outpatients hospitals, they are not included in the National Catalogue of Hospitals.

Graph 7. Market shares of private hospitals in Navarra, by number of beds.



Source: National Catalogue of Hospitals 2013, Ministry of Health, Social Services & Equality (data as at 31 December 2012)

III. ANALYSIS OF BIDDING PROCESSES FOR THE PROVISION OF PUBLIC HEALTHCARE SERVICES IN SPAIN

(63) In this section we examine the bidding processes for procuring healthcare infrastructure and outsourcing of management in the healthcare sector in Spain from the point of view of effective competition in the markets. For this we use as the basic reference the Guide to Public Procurement and Competition, which we apply to the healthcare sector taking account of the analysis of its competitive structure carried out in the preceding sections.

(64) In addition to the outsourcing of healthcare management, in this section we also look at certain processes where the object of the bidding process has included the construction of the healthcare centre and the management, for a certain time, of the associated non-healthcare services. The reason for including these processes in the study despite not having involved the outsourcing of healthcare management, is that they refer to healthcare centres and the manner of the bidding processes has many similarities with those for the outsourcing of healthcare. In this way, aspects of bidding processes for the construction of centres and management of non-healthcare services that are inappropriate from the point of view of competition may be extrapolated to outsourcing of healthcare management. It should be noted, however, that the kind of companies that enter bidding processes for managing healthcare services are not typically the same as those bidding for non-healthcare services. It is for this reason that, as regards the Autonomous Regions of Castilla y León and the Balearic Islands, where healthcare management has not been outsourced but the construction of centres and management of non-healthcare services have, we have not studied the competitive structure of their healthcare sectors in detail in section II.2.2 above. Taking this into account, the analysis focuses on a sample of terms of reference covering the three typical cases by object of outsourcing[48]:

- Outsourcing of healthcare management (second bidding process at Infanta Sofía, Infanta Leonor, Infanta Cristina, Henares, Sureste and Tajo Hospitals in the Autonomous Region of Madrid).
- Outsourcing of the entire management (healthcare and non-healthcare) and construction of the hospital and infrastructure (Infanta Elena, Torrejón and Rey Juan Carlos Hospitals in the

[48] As well as the bidding process for hospital management, we have analysed the process for outsourcing the clinical laboratory corresponding to the protected population of the Infanta Sofía, Infanta Cristina, Infanta Leonor, Sureste, Henares and Tajo Hospitals, given its close relationship with the management of these hospitals.

Autonomous Region of Madrid and Health Departments of La Ribera, Torrevieja, Denia, Manises and Elx-Crevillent in the Autonomous Region of Valencia).

- Outsourcing of non-healthcare management and construction of the hospital and infrastructure (Burgos Hospital and Son Espases and Can Misses Hospitals in the Balearic Islands).

(65) The analysis carried out is based on information obtained by means of requests for information to the health departments of the Autonomous Regions and to the Ministry of Health, Social Services & Equality. The Department of Health and Social Welfare of the Regional Government of Andalusia is the only one that did not provide the requested information, despite the fact that the initial request has been repeated twice.

(66) The following table summarises the information provided by the Autonomous Regions as regards their healthcare outsourcing processes[49]:

Table 6. Healthcare outsourcing processes carried out by each Autonomous Region

Autonomous region	Year	Centres	Service outsourced*
Andalusia	No information provided		
Aragón	No outsourcing has been carried out in the healthcare sector**		
Asturias	No outsourcing has been carried out in the healthcare sector**		
Balearic Islands	2006	Hospital Universitario Son Espases (former Hospital Son Dureta):	(1)
	2010	H. Can Misses, H. de Formentera, Eivissa Health Area, Andratx Primary Healthcare Centre, Ariany Primary Healthcare Centre, Es Molinar Primary Healthcare Centre, Esporles Primary Healthcare Centre, María de la Salut Primary Healthcare Centre, Muro Primary Healthcare Centre, Porreres Primary Healthcare Centre, Sa Pobla Primary Healthcare Centre, Ses Salines Primary Healthcare Centre and Son Servera Primary Healthcare Centre	(1)
Canary Islands	No outsourcing has been carried out in the healthcare sector**		
Cantabria	No outsourcing has been carried out in the healthcare sector**		
C.-La Mancha	No outsourcing has been carried out in the healthcare sector**		
C. y León	2006	Hospital Universitario de Burgos	(1)
Catalonia	2000	H. Jaume Nadal Meroles (formerly Lleida Military Hospital)	(3)
	2003	Hospital Duran I Reynals	(3)

[49] The reply of the health department of the Regional Government of Galicia of 12 July 2013 to the CNC's request for information makes no reference to any outsourcing process carried out in Galicia. However, we identified a concession of public service for the construction and operation of the new Vigo Hospital: http://www.xunta.es/dog/Publicados/2010/20100510/Anuncio139E6_es.html

	2006	Olesa de Montserrat Primary Healthcare Centre	(2)
Extremadura	No outsourcing has been carried out in the healthcare sector**		
Galicia	No outsourcing has been carried out in the healthcare sector**		
Madrid	2005	Hospital del Henares (Coslada), Hospital Infanta Cristina (Parla), Hospital del Tajo (Aranjuez), Hospital Infanta Leonor (Vallecas), Hospital Infanta Sofía (San Sebastián de los Reyes), Hospital del Sureste (Arganda) and Hospital Puerta de Hierro (Majadahonda)	(1)
	2005	Hospital Infanta Elena Valdemoro	(2)
	2009	Hospital de Torrejón	(2)
	2010	Hospital Rey Juan Carlos (Móstoles)	(2)
	2013	Hospital del Henares (Coslada), Infanta Cristina (Parla), del Tajo (Aranjuez), Infanta Leonor (Vallecas), Infanta Sofía (San Sebastián de los Reyes) and del Sureste (Arganda)	(4)
Murcia	No outsourcing has been carried out in the healthcare sector**		
Navarra	2010	Burlada Mental Health Centre and Mental Health Out-patients Hospital and Zuría Day Hospital.	(4)
Basque Country	No outsourcing has been carried out in the healthcare sector**		
La Rioja	2004	Los Jazmines Social Welfare Convalescence Centre, Haro	(2)
	2010	Virgen del Carmen Social Welfare Convalescence Centre, Calahorra	(2)
Valencia	1997	Health Area 10 (La Ribera)	(2)
	2003	Health Areas 10 (La Ribera) and Torrevieja	(2)
	2004	Health Area 12 (Denia)	(2)
	2006	Health Departments of Manises and Elx-Crevillent	(2)

* Key: (1) Construction of infrastructure and management of the non-healthcare type services; (2) Construction of infrastructure and comprehensive management (healthcare and non-healthcare services); (3) Construction of infrastructure and management of social welfare type services; (4) Management of healthcare services.

** According to information provided by these Autonomous Regions

Source: Information provided by the healthcare departments of the Autonomous Regions at the request of the CNC

Table 7. Outsourcing terms of reference studied in the Report[50]

Identification	Autonomous region	Year	Object of outsourcing		
			HS:	Non-HS	C
Hospital Infanta Elena Valdemoro	Madrid	2005	X	X	X
Clinical laboratory corresponding to the protected population of the Infanta Sofía, Infanta Cristina, Infanta Leonor, Sureste, Henares and Tajo Hospitals.	Madrid	2008	-	X	-

[50] Appendix 1 contains a list with the identification and origin of the outsourcing terms of reference studied.

Hospital de Torrejón	Madrid	2009	X	X	X
Hospital Rey Juan Carlos (Móstoles)	Madrid	2010	X	X	X
Hospital Infanta Sofía (San Sebastián de los Reyes)	Madrid	2013	X	-	-
Hospital Infanta Leonor (Vallecas)	Madrid	2013	X	-	-
Hospital del Henares (Coslada)	Madrid	2013	X	-	-
Hospital del Sureste (Arganda)	Madrid	2013	X	-	-
Hospital del Tajo (Aranjuez) and Hospital Infanta Cristina (Parla)	Madrid	2013	X	-	-
Health Area 10 of the Valencia Health Department: La Ribera	Valencia	2003	X	X	X
Health Department of Torrevieja	Valencia	2003	X	X	X
Health Department of Denia	Valencia	2004	X	X	X
Health Department of Manises	Valencia	2006	X	X	X
Health Department of Elx-Crevillent	Valencia	2006	X	X	X
Burgos Hospital	Castilla y León	2006	-	X	X
Hospital Universitario Son Espases	Balearic Islands	2006	-	X	X
Hospital Can Misses	Balearic Islands	2010	-	X	X

HS: Healthcare services; non-HS: Non-healthcare services; C: Construction of the centre.

Source: information provided by the Autonomous Regions and in-house.

(67) Healthcare services directly affect citizens' health and thus constitute an essential issue of general interest. They are characterised economically by the asymmetrical information associated with their provision[51], and by their intensive use of highly qualified human resources and high degree of sensitivity to technological innovation. Therefore, irrespective of the provider, a certain level of quality must be ensured (and this must be included in the terms of reference for the bidding process) by means of appropriate evaluation of the quality in the provision of services and appropriate monitoring.

(68) Following the Guide to Public Procurement and Competition, the analysis enabled us to identify a number of practical examples with potentially negative effects on competition in the area of bidding processes, which should be avoided by the responsible bodies. The results are structured in accordance with the various phases of the process that are most relevant from the point of view of competition:

- The general design of the outsourcing.
- The conditions of access to bidding procedures
- The criteria for selecting bidders

[51] Informational asymmetries between the contracting authority and bidders, between the hospital manger and healthcare personnel and between healthcare personnel and patients.

- The development of the contracts.

(69) From the point of view of competition, the **potential problems that may arise from public procurement of this kind** include:

- Firstly, **reduced competition *ex ante* for the service being outsourced**. An inappropriate design of the object or of the process of the bidding may facilitate collusion among potential awardees of the service concerned or severely reduce the number of companies able to bid. The less competition there is *ex ante*, the more likely it is that negative consequences will be seen for the final price of the agreement and/or the quality of the goods and services supplied.
- Secondly, **inefficiencies** may appear **during the execution of the agreements** as a result of the inappropriate design of the terms of reference, amendments thereto or oversight thereof. For example, a poor design of the remuneration formulas established in the terms of reference may act as a disincentive to productive efficiency or investment and result in their being far removed from their optimum levels. Similarly, insufficient or ineffective control by the contracting authority may emphasize the problems of asymmetric information between the contracting authority and the concessionaire and favour the latter's ability to obtain modifications to the initial terms of the concession which favour it. In the field of construction of infrastructure it may lead to subsequent revisions and modifications of the price resulting from the bidding process, and in the field of the provision of healthcare services it may lead to reduced quality of the service put out to tender. Apart from this, an inappropriate design of the relationship between the awardee and the rest of the centres of the healthcare system may reduce the quality of the services provided by the outsourced centre and by the rest of the centres.
- Thirdly, in the field of healthcare services, **future potential competition may be reduced because of the nature of the outsourced service.** The award may involve certain advantages for the awardee as regards renewal of the concession, for example in view of prolonged duration or of privileged access to information on the real profitability of the business. A bidding process lacking competition may facilitate the appearance of such advantages or their being unknown and unforeseeable at the time of the initial bidding process.
- Fourthly, a **reduction in effective competition in the market for the service being outsourced**. The award may give the bidder a substantial advantage over its rivals in the market for the service being outsourced, or facilitate an anticompetitive understanding among operators in such market, for example when several bidding

processes are held, which help to strengthen the geographical positions of the agents in the market.

- Fifthly, a **reduction in effective competition in markets related to the service outsourced**. Analogously with the foregoing case, the award may give the bidder a substantial advantage over its rivals in other markets related to the service being outsourced, or facilitate an understanding among operators in those markets. For example, the awardee of a healthcare bidding process may increase its purchasing power for supplies or equipment or, in the case of an insurance company, its portfolio of services.

III.1. General design of the bidding process

III.1.1. Outsourced services

(70) The first basic decision in the bidding processes is to determine the elements forming the object of the service put out to tender. Although this decision corresponds to the discretional sphere of the contracting authority, the delimitation of the object of public procurement can also affect competition among bidders and the efficiency of the supply or provision of the goods or services forming the object of the bidding process.

(71) In the specific field of outsourcing, if the contracting authority wishes to outsource the provision of goods or services, it may opt to contract them separately or put them out to tender together. In principle, the greater the complementarity of these goods or services from the point of view of supply, the greater the efficiency. This will be the more usual, the more closely the object of the bidding process resembles the offerings of existing companies in the market. On the other hand, the more the products included in the outsourcing differ among each other and relative to the market, the more likely it becomes that no company will be able to provide them on its own and that, in order to be able to bid, it will have to join forces with others or subcontract the provision of certain services. This may reduce the efficiency of the bidding processes in several ways. Firstly, because it may be that none of the groupings of bidders is as efficient as the set of contractors resulting from separate contracting of the services would be[52]. Secondly, because of the possibility of higher transaction

[52] For example, let us suppose that an Administration needs to put two services out to tender and that these services are non-complementary from the supply point of view, such that there is currently no company that provides them jointly. For each of these services, there is one company which would be the most efficient in meeting the Administration's needs. Therefore, if the services were put out to tender separately, an efficient allocation could be made to the most efficient company. However, if the Administration were to put these services out to tender jointly, it could be that groupings of companies formed to take part in

costs in private dealings than in public-private ones[53]. Thirdly, if there is a problem of competition in one of the services being outsourced, joint contracting may extend the problem to the rest of the services contracted.

Figure 1. Addition of services during the performance of the contract.

The outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste Hospitals in the Autonomous Region of Madrid includes the provision of various services, the bidding process for which might more appropriately be carried out separately instead of grouping them together in a single bidding process. The more so when the bidder cannot know when presenting his bid whether he will have to assume the provision of some of these services, or with effect from what date:

- The **image diagnostics** services in these hospitals are currently performed by Unidad Central Radiodiagnóstico (UCR). The concessionaire must respect their validity until 2014, when the contracts with this company expire. From that time on, if concessionaires agree unanimously, and with prior authorisation from the Administration, it is possible for the validity of this contract to be continued; otherwise, each concessionaire must manage this service with its own resources, in which case the Administration will assign it the equipment currently installed in the hospitals.
- The **laboratory services** in these hospitals have also been outsourced and are carried out by a temporary consortium formed by Ribera Salud and Unilabs (IDC-Capio group), with an initial duration of eight years (to November 2016), which could be extended for a further two years (to November 2018). According to the provisions of the Administrative and Particular Clauses, the healthcare management concessionaires of the six hospitals have to comply with this contract until its maturity and from then on provide the service themselves.

III.1.2. Design of the lots

(72) The Guide to Public Procurement and Competition acknowledges that the size and design of the lots forming the object of the bidding process have important implications for competition among the companies taking part in the bidding processes, especially in markets with characteristics that may facilitate collusion (uniform product, few bidders, barriers to entry, stable demand and technology).

(73) On the one hand, the subdivision of the object of the bidding process into a number of lots may facilitate their distribution among the companies participating in the market. Therefore, if it is decided to opt for division into

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the bidding process were not in all cases formed by the most efficient ones possible, and that therefore efficiency in the overall provision of the services would not be maximised.

[53] Transaction costs are inherent to transactions in the market and are due to information being incomplete. Coase (1960) explains that "*In order to carry out a market transaction it is necessary to discover who it is that one wishes to deal with, to conduct negotiations leading up to a bargain, to draw up the contract, to undertake the inspection needed to make sure that the terms of the contract are being observed, and so on*." The transaction costs may be higher in private relationships than in public-private ones for several reasons, notably the asymmetry of information between the contracting authority and the bidders and the contracting authority's ability contractually to reserve certain powers vis-à-vis the awardee.

lots, the number of lots must not be similar to the estimated number of participants, and care must be taken to avoid the lots being the same size. Apart from this, excessively large lots may make it difficult for small and medium-size companies to participate, so that although grouping several contracts with similar characteristics together in a single bidding process may be positive, care must be taken to avoid this making it difficult for bidders to emerge.

Figure 2. Design of lots in the Autonomous Region of Madrid

In the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste Hospitals in the Autonomous Region of Madrid, five lots, some of which are of fairly similar size, are auctioned in a single procedure:

- Lot 1 (H. del Norte): 283 beds, €132.9 million p.a.
- Lot 2 (H. Infanta Leonor -Vallecas-): 269 beds, €159.2 million p.a.
- Lot 3 (H. del Sur and H. del Tajo): 278 beds, €112.5 million p.a.
- Lot 4 (H. del Sureste): 132 beds, €75.7 million p.a.
- Lot 5 (H. del Henares): 187 beds, €81.5 million p.a.

In line with the recommendations of the Guide to Public Procurement and Competition, it would be preferable, in order to reduce the probabilities of collusion among bidders, to have separated the bidding processes temporarily and designed more asymmetric lots in each bidding process.

III.1.3. Duration of contracts

(74) One of the crucial aspects of the design of the terms of reference is the duration of the contract, since it is one of the elements affecting the existence of real competition in the market. In accordance with Article 23 of the TRLCSP[54], the duration of the contracts must be established taking account of the nature of the services, the characteristics of their financing and the need for their performance to be submitted periodically to competition.

(75) The duration of contracts requiring heavy investments must be sufficient to allow the investments to be depreciated and, at the same time, as short as possible so as to maximise the benefits deriving from the competition in successive bidding processes. Also, where substantial contracts are concerned, awardees can obtain through bidding processes a non-replicable and long-lasting advantage over its rivals to extend themselves to other related markets. It is therefore a matter of achieving a balance that facilitates greater competition for the market and, at the same time, enables the concessionaire's capital expenditure to be depreciated.

(76) The Guide to Public Procurement and Competition establishes a number of proposals for reducing both types of risks:

[54] Royal Legislative Decree 3/2011, of 14 November.

- Contracts should not be left to run for long periods without being subjected to competition.
- Extensions of the contractual term in exchange for the introduction of substantial modifications to the contract must be avoided, except where there are overriding reasons of necessity[55].
- In the event that the terms of reference envisage the possibility of extensions and such extensions are justified, they must be used only as an exceptional mechanism. This is aimed at avoiding the risk of successive extensions leading to a closure of the market for long and potentially indefinite periods.
- In the case of public works and public service concession contracts, the timeframe chosen must be justified in terms of objective parameters that are related to the depreciation period of the investments necessary for the execution of the object of the contract or of the assets associated with the contract.
- The legal provisions regarding contractual timeframes must be understood as maximum periods, which need not necessarily be fully used.

Figure 3. Excessively long duration of contracts.

In the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste Hospitals of the Autonomous Region of Madrid, the period of concession of the healthcare management of the hospitals is ten years. This term might be too long, bearing in mind that the awardees do not have to undertake major capital expenditure: the hospitals being practically new (they were commissioned in 2008), in principle the infrastructure, equipment and fittings do not require any investment other than that related to maintenance. A long period of ten years may give its rivals a competitive advantage in winning any possible new award of the management contract after 10 years.

There are also striking differences around the country as regards the initial terms of contracts for similar objects of outsourcing. The bidding processes of the health areas in the Autonomous Region of Valencia, which included the construction of a hospital in each health area and their comprehensive management (healthcare and non-healthcare), envisaged as a general rule initial periods of 15 years. In contrast, the bidding processes in Madrid for the Valdemoro, Torrejón and Móstoles Hospitals, which had similar objects (construction of a hospital and healthcare and non-healthcare management of same)[56] had an initial term of 30 years.

In some cases of bidding processes for non-healthcare management and public works construction, contract terms have been around 30 years:

- New Burgos Hospital: 30 years
- Son Espases Hospital, Balearic Islands: 31 years and 8 months (two years and eight months

[55] For example, the existence of an imminent risk of cessation of the service.

[56] Indeed the object of outsourcing might even be said to be more limited in these three hospitals than in the autonomous region of Valencia, since the Madrid ones cover only specialist healthcare whereas the Valencia ones included primary and specialist care.

of construction phase and 29 of operation phase).

- Can Misses Hospital, Balearic Islands: 32 years and seven months (two years and four months for the construction).
- Non-healthcare management outsourcing processes of the Autonomous Region of Madrid in the Henares, Infanta Cristina, Tajo, Infanta Leonor, Infanta Sofía, Sureste and Puerta de Hierro hospitals: 30 years.

Figure 4. Granting of extensions.

The Administrative and Particular Clauses of the Central Laboratory of the Autonomous Region of Madrid have an eight-year duration with the possibility of extension for two more years at contracting authority's option, acceptance of such extension being mandatory for the concessionaire. The terms of reference do not spell out the reasons that would make extension of the contract advisable, nor do they mention that it should apply only exceptionally. Therefore the inclusion of this extension does not appear to be sufficiently justified from the point of view of competition.

III.1.4. Procurement procedure

(77) According to the Guide to Public Procurement and Competition, the procedure that most favours competition in public procurement is the open procedure, since it is the one that best ensures the principle of equality among participants, allowing all companies that meet the capability and solvency requirements set out in the terms of reference to take part. The Guide recommends that use not be made of procedures that are *a priori* less favourable to competition, even if there is legal provision for them, since this would involve restricting access by potentially competing companies from the outset. In any case, if the Administration decides to make use of any other procedure allowed by law, it must evaluate its possible effect on competition, even though the alternative procedures present other kinds of advantages.

(78) In all the outsourcing processes studied in this report the contracting authority used the open procedure.

III.2. Access to bidding processes

(79) If the requirements for access to the bidding process are unnecessarily demanding, the number of participants in bidding processes will be reduced. The smaller the number of participants, the less intense competition in the bidding process is likely to be, and this will lead to worse results than those that could have been obtained in terms of price and quality in the concession.

(80) The following table shows the number of participants in bidding process of the various Autonomous Regions:

Table 8. Number of companies participating in bidding processes for hospitals.

Bidding	Object of outsourcing	Number of participants
AUTONOMOUS REGION OF VALENCIA		
Ribera health area (1997)	Construction and comprehensive management	1
Ribera health area (2002)	Construction and comprehensive management	1
Torrevieja health area	Construction and comprehensive management	1
Denia health area	Construction and comprehensive management	1
Manises health area	Construction and comprehensive management	2
Elche-Crevillente health area	Construction and comprehensive management	1
AUTONOMOUS REGION OF MADRID		
Hospital del Henares	Construction and non-healthcare management	8
Hospital Infanta Cristina	Construction and non-healthcare management	8
Hospital del Tajo	Construction and non-healthcare management	9
Hospital Infanta Leonor	Construction and non-healthcare management	9
Hospital Infanta Sofía	Construction and non-healthcare management	8
Hospital del Sureste	Construction and non-healthcare management	8
Hospital Puerta de Hierro	Construction and non-healthcare management	5
Hospital Infanta Elena Valdemoro	Construction and comprehensive management	5
Hospital de Torrejón	Construction and comprehensive management	1
Hospital Rey Juan Carlos	Construction and comprehensive management	1
Infanta Cristina and Tajo Hospitals[57]	Healthcare management	1
Hospital Infanta Leonor	Healthcare management	1
Hospital Infanta Sofía	Healthcare management	1
Hospital del Henares	Healthcare management	1
Hospital del Sureste	Healthcare management	1
CATALONIA		
Hospital Jaume Nadal Meroles	Construction and comprehensive management	2
Hospital Duran I Reynals	Construction and comprehensive management	1
Olesa de Montserrat Primary	Construction and comprehensive	1

[57] Awarded as a single lot.

Healthcare Centre	management	
BALEARIC ISLANDS		
Hospital Son Espases	Construction and non-healthcare management	6
Hospital Can Misses	Construction and non-healthcare management	2
Formentera Hospital	Construction and non-healthcare management	2
Eivissa health area	Construction and non-healthcare management	2
Andratx	Construction and non-healthcare management	2
Ariany	Construction and non-healthcare management	2
Es Molinar	Construction and non-healthcare management	2
Esporles	Construction and non-healthcare management	2
María de la Salut	Construction and non-healthcare management	2
Muro	Construction and non-healthcare management	2
Porreres	Construction and non-healthcare management	2
Sa Pobla	Construction and non-healthcare management	2
Ses Salines	Construction and non-healthcare management	2
Son Servera	Construction and non-healthcare management	2
CASTILLA Y LEÓN		
Hospital Universitario de Burgos	Construction and non-healthcare management	8
NAVARRA		
Burlada Mental Health Centre and Mental Health Day Hospital	Non-healthcare services	1
Zuría Day hospitals	Non-healthcare services	1
LA RIOJA		
Los Jazmines social welfare convalescence centre, Haro	Construction and comprehensive management	1
Virgen del Carmen social welfare convalescence centre, Calahorra	Construction and comprehensive management	2
NATIONAL TOTAL (in the last column, average participants)		
14 bidding processes	Construction and comprehensive management	1.5 companies
22 bidding processes	Construction and non-healthcare management	4.3 companies
5 bidding processes	Healthcare management	1.0 companies
2 bidding processes	Non-healthcare services	1.0 companies
TOTAL		**2.9 companies**

Source: In-house based on information provided by the health departments and the website of the health department of the Autonomous Region of Madrid.

(81) As can be seen in the foregoing table, the average number of companies participating in each of the 43 bidding processes covered is 2.9. In only ten bidding processes did more than two companies bid, and in 17 bidding processes there was only one bidder.

(82) Each of the 19 bidding processes that included healthcare management (the "Construction and comprehensive management" and "Healthcare management" types in the table) had on average fewer than two companies taking part (in only four of the 19 bidding processes was there more than one bidder), whereas in the other 24 bidding processes, which did not include healthcare management, the average number of companies taking part was more than four.

(83) From the foregoing analysis it might be concluded that either the number of potential competitors able to provide healthcare management services is particularly small, or that the small number of bidders is due to the design of the bidding procedure or the behaviour or incentives of the agents concerned in the procedure.

(84) Section II of this report shows that the number of companies competing in the provision of private healthcare services is high (graph 2), and that there are several private groups already present in the market, both profit and non-profit, managing networks of several hospitals. Consequently at first sight there could be a fairly large number of potential candidates, even if only from among existing operators, for managing public healthcare services. However, in a number of bidding processes the only bidding company has been the same one. For example, in five of the six bidding processes in the Autonomous Region of Valencia only one consortium tendered, and all six contracts were awarded to consortia in which Ribera Salud was a member[58].

(85) Nor is it easy to reconcile the idea of a robust competitive procedure with the low rate of participation seen in some of the outsourcing processes of the Autonomous Region of Madrid, specifically in the bidding process for the healthcare management of six hospitals in 2013. In this procedure five lots were put out to tender, with the provision that no single company or consortium could be awarded more than three hospitals (two lots). The fact is that only three companies tendered for the five lots, with no overlapping bids for any one lot[59], and as a result there were no significant

[58] In the case of Manises Hospital in the Autonomous Region of Valencia, Ribera Salud was a member of the temporary consortium until December 2012.

[59] In the case of the outsourcings of the Autonomous Region of Madrid of 2013, and assuming a common value auction, the probability of the result's being the same as that actually seen is remote, albeit dependent on the number of potential bidders. For example, if there were six possible bidders, the probability of only three candidates bidding for all five lots, no lot being without a bid and no lot being bid for by more than one bidder is 0.0002%; if the

reductions in the variable (per capita) price proposed by the respective bidders for any of them.

(86) In the case of the Balearic Islands, only for Hospital Universitario Son Espases were there more than two bidders (the total number of bidders being six).

(87) Similar results are obtained from an analysis of the procedures in Catalonia, Navarra and La Rioja, where there were no cases in which more than two companies took part.

(88) The CNC's Guide to Public Procurement and Competition establishes an unusually low number of bidders as one of the indicators for detecting possible cases of collusion among bidders. The Guide recommends that public administrations report suspicions of this kind of practice to the competition authority.

III.2.1. Economic and technical requirements for access to the bidding process

(89) The requirements regarding economic-financial solvency and technical and professional ability contained in the terms of reference for the bidding processes are designed to ensure a minimum quality in the provision of the services, such that participants meeting the requirements are qualified to provide the service in an appropriate manner. Therefore, these criteria must be linked to, and proportionate to, the object of the contract. Otherwise, unnecessary barriers to entry might arise, thus disproportionately reducing competition in the bidding process.

(90) The CNC's Guide to Public Procurement and Competition lists various types of requirement for access to bidding processes that may prove unnecessary or disproportionate for ensuring a minimum quality in the provision of the services forming the object of bidding processes.

- Solvency requirement and classification of bidders. The Guide to Public Procurement and Competition indicates that economic-financial solvency and technical-professional ability must be linked to, and proportionate to, the object of the contract. The means of evidencing solvency and ability must also be proportionate.

- Requirement of a certain legal form. The CNC's Guide to Public Procurement and Competition refers, by way of reminder, to the prohibition of making access to a public bidding process subject to a specific legal form, since to do so would be to exclude in advance a

number of possible bidders were greater, for example 50 companies, this probability would be practically zero ($9.8*10^{-68}$%).

number of companies that would otherwise be able to provide the service appropriately.

- Discrimination based on territory. Any provisions giving rise to differences in access by reason of territory, language, domicile or nationality, and the requirement for participants to be located in a particular territory, would constitute barriers to entry and would in principle be unjustified.
- Unnecessary or excessive technical and economic requirements. The Guide to Public Procurement and Competition also stresses the anti-competitive effects deriving from the establishment of references to particular types, brands or technical specifications defining access to the market, and requirements that may involve excessive economic burden for bidders, with the exception of those provided by law. This prohibition is based on the fact that they constitute an excessive and unjustified criterion which deprives other potential bidders of the possibility of accessing the bidding process.
- Requirements for quality certifications. Public Administrations may envisage in the terms of reference the requirement for certain quality certificates to be produced. This provision does not constitute a restriction of competition as long as certifications issued by any certification body approved by the National Accreditation Body are accepted. At the same time, this certification is one way of certifying quality, but other possible ways of accrediting it must not be excluded.

Figure 5. Solvency requirement for companies bidding as part of a temporary consortium.

In the case of companies bidding in consortia, as the CNC has stated before, the requirement for each company individually to meet the required criteria for technical ability and economic solvency may amount to an "*unnecessary and unwarranted restriction, since when a temporary consortium submits a tender the important thing is for it to be capable, as an economic unit, of fulfilling the requirements made of it. Precisely one of the reasons for which temporary consortia are established to take part in tender processes is to bring together the experience, technical ability and economic/financial solvency of different economic operators, thus making access to tender processes possible for companies that would not be able to compete individually. Imposing the requirements on each member of the temporary consortium involves unnecessarily restricting the ability of many companies to participate in the tender processes and thereby erecting unwarranted obstacles to competition*." (CNC, Res. S/0272/10, FJ 2º, underlining added).

There are **numerous examples** of companies bidding in a temporary consortium being required individually to meet solvency criteria:

- The Administrative and Particular Clauses for the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals in the Autonomous Region of Madrid provide certain solvency requirements for companies entering bidding process (positive turnover and profits in two of the past three financial years). In the case of companies bidding as part of a temporary

consortium, each member of the consortium is required to meet these requirements individually.

- The Administrative and Particular Clauses of the Son Espases and Can Misses hospitals in the Balearic Islands and the Torrejón, Infanta Elena and Rey Juan Carlos Hospitals in the Autonomous Region of Madrid[60] require the criterion of positive results of the annual accounts to be met by each bidder even though they are bidding as a consortium.
- The outsourcing terms of reference of the Ribera, Torrevieja, Denia, Manises and Elche-Crevillente health areas in the Autonomous Region of Valencia provide that when two or more companies present a joint bid "*each one shall show its personality, capability and solvency*".
- The Administrative and Particular Clauses for the outsourcing of the central laboratory service of the Autonomous Region of Madrid also requires compliance with the solvency criteria relating to annual accounts "*for the bidder or each one of the bidders*" in the case of bidding in a consortium.

In contrast, the bidding process for the construction and operation of the non-healthcare services of the new Burgos hospital provides, in a way that is more favourable to competition, for the characteristics of each company bidding as part of a temporary consortium to be agglomerated for purposes of meeting the solvency requirements.

Figure 6. Show profits in two of the past three years.

The terms of reference for the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals of the Autonomous Region of Madrid, the Can Misses Hospital in the Balearic Islands and the Hospital Rey Juan Carlos in Móstoles require bidders to have posted profits in two of the past three years.

The terms of reference for the outsourcing of the central laboratory of the Autonomous Region of Madrid, the new Burgos Hospital and the Hospital Infanta Elena in Valdemoro require the annual accounts of the past three years to show positive results in at least one of them.

This type of requirement penalises newly established companies, companies that have made recent investments, or that have opted for conservative criteria for the depreciation of their investments and recognition of their trade debtors' payment difficulties. Apart from this, the requirement does not adequately prove bidders' solvency, since for example there may be companies that are highly indebted and therefore cannot borrow to make the necessary investments for the contract, but that have posted profits in one or more of the past few years.

Figure 7. Seemingly disproportionate criteria as regards previous experience.

The Administrative and Particular Clauses for the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals in the autonomous region of Madrid establish as a criterion for technical ability the fact of having operated a number of beds equal to or greater than that of each hospital bid for. Although the requirement for a certain experience in management may be justified to ensure the appropriate provision of services to citizens, the fact that this requirement evidences technical ability does not mean it is the only possible way or the most appropriate way of doing so.

In the terms of reference of the Torrejón hospital and the Rey Juan Carlos hospital in Móstoles, technical ability must be shown by means of a formal declaration of having owned or managed at least two acute hospitals with a combined minimum of 150 beds during the past three years.

[60] For the financing requirement, on the other hand, the bidders are allowed to combine their accounts to show that they have a sufficiently sound financial situation.

In the terms of reference of the Hospital Infanta Elena in Valdemoro, technical ability is proven by ownership or management, during the past five years, of at least two acute hospitals with at least sixty beds. The number of hospitals managed or owned by the bidder should be irrelevant, since it seems reasonable for the requirement to apply to ownership or management of a complex with similar characteristics. Therefore the relevant datum should be the number of beds, irrespective of how many hospitals they relate to. The requirement to own or manage at least two hospitals might limit the entry of companies that own or manage a hospital with similar characteristics and which therefore could be qualified to administer the hospital[61].

The Administrative and Particular Clauses of Health Area 10 (Ribera) and the Health Area of Torrevieja in the Autonomous Region of Valencia include as one of the criteria for technical ability for the construction of the Ribera hospital, having previously been an awardee for the construction of public works of similar characteristics to the future hospital. Therefore, participation in public works is valued to the detriment of the performance of private sector projects, which may well have similar characteristics. The purpose of requiring a certain experience in the construction of similar complexes is to show that bidders have sufficient technical ability to perform the project with due diligence, irrespective of the nature of the project they have carried out. Otherwise, the participation of incumbents who have already carried out public projects would be favoured disproportionately, and this would amount to a de facto closure of the market to new companies wishing to contract in these markets with the Administration.

Figure 8. Discrimination in the requirements for proving technical ability.

The Administrative and Particular Clauses for outsourcing in the Autonomous Region of Valencia require bidders to be exercising their activity as providers of healthcare services or in the health insurance sector (in the case of temporary consortia, the temporary consortium must be led by a company of one of these kinds). However, the requirements provided in the terms of reference to ensure technical ability differ depending on the type of bidder:

- If the bidder operates mainly as a provider of healthcare services, the terms of reference of Health Area 12 (Denia), L'Horta-Manisses and Elx-Crevillent require proof of the activities carried out in that field, while the terms of reference of Torrevieja and Health Area 10 (La Ribera) require the bidder to own a hospital of similar characteristics to that which is the object of the bidding process.
- If, on the other hand, the bidder operates mainly in the health insurance sector, in all cases the sole requirement is to provide "*a report of the General Insurance Directorate on the sufficiency of the margin of solvency and own funds for the volume of contracting expected*".

The certificate justifying the bidder's financial capacity, as with health insurance companies, does not seem to bear any relation to technical ability. Thus, while health insurance companies are not required to demonstrate their technical ability, companies operating in the provision of healthcare services are required to do so.

Figure 9. Excessive technical ability requirements.

The Administrative and Particular Clauses for outsourcing of the Autonomous Region of Valencia allow providers of healthcare services or health insurers to bid in temporary consortia

[61] One example is the terms of reference of the Can Misses Hospital, which, to demonstrate solvency, require specific experience in the execution of two buildings of a similar volume and complexity to that which is the object of the contract and the provision of at least three services analogous to those indicated in the terms of reference, as well as experience of five years for its management personnel.

with other construction, financial or technological companies. The Administrative and Particular Clauses of Torrevieja and of Health Area 10 (La Ribera) establish as part of the technical ability requirements that the construction company must previously have been awarded the construction of public works of similar characteristics to those projected. However, this requirement is not imposed in the remaining Administrative and Particular Clauses of the Autonomous Region of Valencia where the object of outsourcing has similar characteristics, and it may restrict the access of potential candidates.

The Administrative and Particular Clauses of Torrevieja in the Autonomous Region of Valencia establish detailed requirements for the technical team drawing up the management project for the works: "It *must have recognised solvency and must include at least one senior architect, one senior industrial engineer and one quantity surveyor or technical architect* (…). *The senior architect must have been involved in drawing up the basic project and the execution and management project of at least two new hospitals in the past five years or of two hospital works with a budget of more than €30 million in that same period*". Both the degree of detail in the composition of the technical team and the requirements made of the senior architect seem excessive and disproportionate, and one may question the need for them given that they are not imposed by any of the other Administrative and Particular Clauses of the Autonomous Region of Valencia for outsourcing objects of similar characteristics. The excessive degree of detail in the composition of the technical team may limit bidders' ability to organise themselves, while the requirements made of the senior architect may severely restrict the number of possible candidates.

III.2.2. Publication and access to relevant information for preparing the bid

(91) The participation of bidders able to compete effectively for the provision of the outsourced service depends crucially on the announcement of the bidding process providing all the information necessary for preparing bids appropriately. This implies:

- That there is sufficient publication of the bidding processes. The more widely announcements of bidding processes are publicised, the greater the number of candidates likely to appear.
- That there is enough time to prepare the tenders, given that construction and services in the field of healthcare are complex and bidders must prepare complex technical solutions and value them appropriately.
- That the published information reduces possible uncertainties as to the future volume and development of the flow of revenues and costs of the contract to an absolute minimum for all participants.
- That there are no informational asymmetries among potentials bidders. If one company has an information advantage over its competitors, these will have less incentive to bid, since the financial problem known as the "winner's curse" that may arise in bidding processes will be exacerbated for them.

<u>Sufficient publication of the announcements of bidding process and time to prepare bids</u>

(92) To ensure the effectiveness of the tender process and allow a wide participation of companies, it is advisable to make the most extensive possible use of all the mechanisms that the contracting authority has at its disposal. This implies dissemination through official journals and, even beyond the cases provided by law, the use of the State Procurement Platform.

(93) Greater dissemination helps reduce companies' search costs, the direct effect of which is greater participation in the bidding process and therefore greater competition. Also, to the extent that companies need to devote fewer resources to seeking procedures, they will have a margin for greater efficiency, which may be reflected in lower bid prices or greater quality in the performance of the contract and therefore improvements from the point of view of public administrations and citizens.

Figure 10. Insufficient publication of bidding processes.

The bidding process for contracts subject to harmonised regulation, as is the case of works contracts or public works concession contracts exceeding certain quantitative thresholds (Article 14 of the TRLCSP), must be published in the Official Spanish State Gazette (BOE in the Spanish initials) and in the Official Journal of the European Union (OJEU)[62]. In this way, all the terms of reference studied which involve the execution of hospital or health centre works and are classified as public works concession contracts have been published in three different official journals: the official journal of the relevant Autonomous Region, the Official Spanish State Gazette and the OJEU, these contracts being given wide dissemination.

However, in the case of the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals of the Autonomous Region of Madrid, since it does not include building works, in principle there would be no obligation to publish other than in the regional official gazettes. In fact, the announcements of the bidding process were published only in the Official Gazette of the Madrid Autonomous Region. Bearing in mind the amount of the contract, which was more than €4 billion, a greater dissemination of the bidding process would have been recommendable, with a view to increasing the number of potential participants, a power which is vested in the contracting authority by law[63].

[62] Article 142.1. TRLCSP: "*Procedures for awarding contracts of public administrations, with the exception of negotiated contracts, which are followed in cases other than those envisaged in sections 1 and 2 of Article 177 must be announced in the Official Spanish State Gazette. However, in the case of contracts of the Autonomous Regions, or local entities or organisations or public entities depending on them, publication in Official Spanish State Gazette may be replaced by publication in the official journals or bulletins of the Autonomous Regions or provinces concerned.*

When contracts are subject to harmonised regulation, the bidding process must also be published in the Official Journal of the European Union and, in this case, publication in the official Autonomous Regional or provincial journals cannot replace publication which must be made in the Official Spanish State Gazette".

[63] Article 142.2 TRLCSP.

Figure 11. Tight timeframes for preparing bids[64].

Setting a short period for the presentation of bids may have the undesired effect of limiting the number of companies entering the bidding process, and may even give an advantage to some companies that initially have information, even if this is not private. For example, the announcement of the bidding process for the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals in the Autonomous Region of Madrid was published in the Official Gazette of the Madrid Autonomous Region on 7 May 2013, granting one month for presentation of tenders (until 7 June 2013). This timeframe may prove tight for preparing proposals, given the complexity of the requirements for participation and the evaluation criteria. For example, the detail required in the care plan seriously limits the number of companies able to provide it within one month of the publication of the terms of reference.

In the bidding processes of the Torrejón hospital and the Rey Juan Carlos hospital in Móstoles, a period of one and a half months was granted for the presentation of tenders, which had to contain the development of a healthcare plan, a draft tender for the construction of the hospital and an investment plan, among other things, in detail.

In the bidding processes of the Health Areas of the Autonomous Region of Valencia corresponding to the Ribera and Torrevieja hospitals, the deadline for submission of bids was barely a month and a half, with presentation of a quality management plan, technical pre-projects, an investment plan and information on the technical project team being required.

Figure 12. Modifications to the terms of the bidding process without extending deadlines.

During the period for submission of bids in the outsourcing process for the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals of the Autonomous Region of Madrid, two modifications were made to the terms of reference. The first correction of errors concerned a percentage in the formula for evaluating the financial offer. The second one took place on 3 June 2013, clarifying that the guarantee of the bidder with the best financial offer had to be for 5% of the *annual* amount of the contract, not of its *overall* amount.

This new interpretation of the amount might involve greater ease of access to the bidding process and be favourable to competition. However, this modification was made just four days before the deadline for presentation of bids, which, given the volume of information that companies had to present, made it difficult for any potentially interested companies to be able to present all the documentation required. In fact, there may have been cases of companies that originally decided not to participate because they did not find it profitable to do so, but which with the change in conditions might have reconsidered their decision if there had been time to prepare a bid. There might even have been companies that submitted their bids before the change in conditions, since the announcement of the change was within the presentation period.

Sufficient information for preparing bids

(94) The terms of reference must provide as much financial and technical information as possible on the future costs and revenues that the provider

[64] Article 159 of the TRLCSP establishes a period of not less than 52 days from the date of dispatch of the announcement of the contract to the European Commission for contracts subject to harmonised regulation, whereas for contracts not subject to harmonised regulation the deadline for submission of tenders cannot be less than 15 days from the publication of the announcement.

of the service will have, in order to minimise the risk incurred by the bidders when presenting their tenders. The greater the degree of uncertainty, the greater will be the risk perceived by the potential bidders, which may lead to some bidders withdrawing, and may have negative consequences for the contracting authority as regards the price and quality proposed by the bidders and increase the likelihood of awardees' subsequently being unable to assume the costs of the contract.

Figure 13. Uncertainty at the time of presenting bids as regards the costs to be assumed.

In the Administrative and Particular Clauses for the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals of the Autonomous Region of Madrid, the receipts and payments in respect of the contract are affected by a very high level of uncertainty, since they depend on external factors that are hard for bidders to foresee, and in some cases on administrative discretion. Specifically, the factors in which these problems are seen most markedly are:

- medical staff: bidders do not know the details of the medical staff that will eventually remain at the hospital (the Administrative and Particular Clauses provide that the personnel of the hospitals can choose whether or not to stay) and whose employment costs they will have to bear.
- Billing between centres: The Autonomous Region of Madrid has not made statistics available to possible awardees that would enable them to make reliable estimates of how much the billing will involve and the possibilities of improving it for the awardee, simply mentioning an overall amount of the average represented by net inter-centre billing in the two previous years at each hospital. Nor does it establish a method of calculation for the prices by type of service, merely saying that prices will be published periodically, such that agents may perceive a high regulatory risk in the event of possible adverse modifications of these prices. This same problem is seen in the terms of reference for the outsourcing of the management of Torrejón hospital, Infanta Elena hospital in Valdemoro and Rey Juan Carlos hospital in Móstoles and in the Administrative and Particular Clauses of the five health areas of the Autonomous Region of Valencia.

Equal access to information

(95) The terms of reference must provide all relevant technical information facilitating the preparation of bids by companies participating in the bidding process. However, there are circumstances in which certain companies can be presumed to have more information than other potential competitors. These cases arise, for example, when a company has been providing the service previously and thus has a more in-depth knowledge of the aspects relating to certain operating benefits and costs and the performance of the service.

(96) To ensure informational symmetry among all candidates, in these cases of renewal of contract or in similar circumstances, the contracting authority must make all the information necessary for the appropriate preparation of the bids public sufficiently far in advance.

Figure 14. Asymmetrical access to information.

The terms of reference for outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals of the Autonomous Region of Madrid require the healthcare plan to include aspects such as a forecast of the demand for healthcare services and an estimate of the need to expand the infrastructure of each hospital. This information may be impossible to gather for companies that are not already operating in the same zones, so companies managing non-healthcare services of these hospitals start out with a certain advantage, as do companies carrying out their activity in the field of private healthcare in the same zone as the hospital the management of which is being outsourced.

A similar situation arises with the inter-centre invoicing envisaged by the terms of reference for the outsourcing of the healthcare management of the Autonomous Regions of Valencia and Madrid, the calculation of which is provided as determining the awardees' remuneration in the terms of reference for hospitals with outsourced healthcare management. As has been remarked, it appears that there are no statistics enabling reliable estimates to be made or indications as to the method of calculation in either case. In the specific case of the six hospitals of the Autonomous Region of Madrid whose healthcare management was outsourced in 2013, non-healthcare management had previously been outsourced and, therefore, this lack of transparency in determining inter-centre invoicing may favour the companies that are managing these hospitals' non-healthcare, as they have greater knowledge of their management and operation.

The terms of reference for the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals of the Autonomous Region of Madrid oblige the awardee to contract the laboratory services of the company that won the laboratory contract in 2008 until 2016 and, thereafter, to provide the services with its own resources or contract them with a third party. Thus the company awarded these services (a temporary consortium composed of IDC-Capio and Ribera Salud), unlike other possible bidders, has detailed information relating to the real cost of these services.

III.3. Contract award criteria and procedure

(97) In accordance with the legislation in force, the bid evaluation criteria must be public, objective and related to the object of the contract. It is important for the award criteria to meet certain conditions, which we analyse hereunder.

III.3.1. Assurance of equal treatment and non-discrimination among bidders

(98) As established by the TRLCSP, contracting authorities must give bidders and candidates equal, non-discriminatory treatment. This implies, as explained in the Guide to Public Procurement and Competition that it is forbidden to favour companies that are already established in the sector by means of different mechanisms that effectively reward this circumstance.

- Valuation of experience. Spanish legislation and case law establish that solvency and ability are the metrics for the suitability of bidding companies, whereas evaluation criteria are for assessing the characteristics of the tender. It would therefore not be appropriate to consider bidders' experience as a scoring parameter in the award process. Consequently, all companies meeting the solvency and ability criteria contained in the terms of reference are understood to

be equally qualified to perform the contract, and the selection must be carried out based on other criteria.

- Valuation of satisfactory fulfilment of other contracts. Companies' participation in the performance of previous contracts with the Administration must not act as an award criterion for the contract since, if it did, this would close the market to new companies and lead to a very limited group of companies with which the Administrations could contract, with the consequent risk of possible anti-competitive market-sharing or price-fixing agreements among established companies. Therefore, account should be taken only of the provision contained in the legislation concerning the prohibition of public administrations' contracting with companies that have failed to comply with the special conditions of execution of the contract in previous processes.
- Pre-emptive right and right of first refusal. The Guide to Public Procurement and Competition recommends avoiding these two rights, since ultimately they translate into asymmetrical situations among companies that are candidates in the bidding process. Indeed, in the case of the pre-emptive right, in certain circumstances advantages accrue to the current holder merely by virtue of that status. The right of first refusal allows the beneficiary to subrogate itself in the position of the winning bidder and replace it in the contract. Thus we see that in both cases either the current holder of the concession or a third party is favoured, to the detriment of an open, transparent and public process allowing the presentation of bids and fostering competition in the market.

III.3.2. Correction of errors by the bidder

(99) There are a number of requirements in the administrative procedure aimed at assuring bidders of legal certainty. Nevertheless, this procedure can in turn involve a number of complex and costly processes that may pose obstacles to companies' participation in the bidding process, with a particularly marked effect on small companies which do not always have sufficient infrastructure to be able to cope with these processes. To avoid these processes acting as obstacles to companies' participation, the legislation provides a period for the correction of errors, so that formal aspects do not act as a hindrance to greater competition.

(100) As established by the Guide to Public Procurement and Competition, in general terms certification of data or elements relating to all the characteristics of the company at the time of the deadline for the presentation of bids may be corrected. However, the certification of elements that did not exist at the time of the deadline or that refer to the

content of the bidder's proposals is not considered to be capable of being corrected.

III.3.3. Appropriate weighting of basic variables

(101) The Guide to Public Procurement and Competition identifies a number of elements that may make the weighting of the basic variables difficult. The criteria for evaluating bids must be designed so as to reflect the priority and importance attributed to each of the competitive elements, and there must also be a margin for competition among such variables.

(102) If the design were not to conform to these principles, the end result could be an inappropriate provision of services or prices in excess of the competitive price, especially in the case of public services.

a. Inappropriate weight of the evaluation criteria. To ensure the correct execution of the contract, it is only reasonable that the evaluation criteria established, and their weighting, be related to the subject matter of the contract. Otherwise, an optimal provision of the service would not be ensured. In the case of healthcare services, the basic objective is to assure appropriate provision of the service to the patient, so a high weighting should be given to scores based on criteria relating to quality of service. Therefore, a balance should be struck between price competition and quality of service, and efforts should be made to avoid terms of reference being based on technical matters that do not ensure a given level of quality in the provision of the service, or incentivising greater revenues in the short term at the expense of quality. Nonetheless, in terms of reference for the outsourcing of construction and non-healthcare management, the component relating to public health is diluted, so the contract price must be given a greater weighting, since it is an objective and financially quantifiable variable giving an indication of the relative efficiency of the various operators. This reduces the risk of the Administration's assigning a greater weighting to criteria with a greater discretional component, which could lead to sub-optimal performance of the services.

Figure 15. Reduced valuation of the financial offer in non-healthcare management.

In the terms of reference of the Son Espases and Can Misses hospitals in the Balearic Islands, the price variable has a weighting of 30 points out of a possible 100. In these cases, the object of the contract does not cover healthcare management.

Figure 16. Evaluation of economic criteria with little relevance to invoicing.

The Administrative and Particular Clauses of L'Horta-Manises and Elx-Crevillent in the

Autonomous Region of Valencia establish that the contract price consists of three elements: the per capita part (charge per capita of protected population), inter-centre invoicing (of the difference between the cost of care provided by the concessionaire to patients not forming part of its protected population and that of care provided by third parties to patients that do form part of that population) and the saving on the pharmaceutical service.

However, the bid evaluation criteria contain only one economic criterion: the percentage reduction in the service transfer factor. The service transfer factor is a percentage applied to the concessionaire's invoices for care provided to patients not forming part of its protected population. Remuneration is determined by applying this service transfer factor - offered by the concessionaire - to the official prices for the various treatments in the Autonomous Region of Valencia.

In this way bidders' ability to compete on price is very limited, since it is confined to just one of the elements forming part of the contract price, and one that is unlikely to be the major one (the per capita part should be the biggest of the three by a significant margin).

b. Inadequate reflection of the impact of the price or tariff offered on the budget selected as the basis of the project. The weighting of the price variable must be in proportion to the reduction in the base budget that it makes possible, as pointed out in the Guide to Public Procurement and Competition. The objective is simply to avoid distorting the impact of the price on the overall evaluation of the contract.

Figure 17. Inappropriate valuation of the financial offer.

The majority of the terms of reference studied establish rules for identifying reckless bids (defined as those where the financial is a certain percentage less than the average of the financial offers submitted). This definition is usually accompanied by rules for determining each bidder's score by comparing its offer with the best offer, and a score of zero may be assigned if the financial offer is not sufficiently attractive.

However, in the Administrative and Particular Clauses of the central laboratory of the Autonomous Region of Madrid, in certain circumstances 50 points are awarded to the lowest financial offer and 20 to the highest. The Guide to Public Procurement and Competition studies a similar example and determines that this generalised increase of 20 points in the weighting of the price not only diminishes the effective weighting of the most efficient financial offer, but also acts as a disincentive to bidders' offering significant price reductions.

c. Limits on prices, tariffs or other basic characteristics of the service. The establishment of limits on bids is aimed at ensuring a minimum level of quality in the service provided, eliminating reckless bids and seeking to avoid the taking on of unnecessary risks that might affect the public. However, establishing a strict limit may reduce the leeway for bidders to present offers with viable prices. Therefore, it is a matter of establishing mechanisms that strike a balance between ensuring an appropriate level of quality in the provision of the service and leaving sufficient room for manoeuvre to encourage price competition. The Guide to Public Procurement and Competition recommends that "*the criterion for*

defining the reckless nature of bids be established in such a way as not to affect bidders' incentive to compete, with abnormal or disproportionate bids being weeded out by mechanisms not involving the scoring of the bid", providing an appropriate level of quality in the provision of the service is assured.

Figure 18. Limits on improvements of financial offers.

The Administrative and Particular Clauses for the outsourcing of healthcare in the Torrevieja zone and for the second bidding process of Health Area 10, La Ribera, both in the Autonomous Region of Valencia, establish that "*bids with percentage reductions of more than 12% of the amount of the premium will be deemed reckless*".

These terms of reference also award a maximum of 10 points to the reduction offered by bidders in the service transfer factor, but indicate that "*each percentage point of reduction will be awarded two points*". This means that, de facto, the maximum reduction is 5%, since this scores the maximum of 10 points in the evaluation. To continue offering additional reductions would not improve the bidder's evaluation, and this is to the detriment of effective competition.

It means that bidders have a lower limit on their offers relative to a value (the premium) calculated by the contracting authority itself, which moreover does not tie in with that envisaged in Article 85 of the General Regulations of the Law on Contracts of Public Administrations[65].

d. Excessive weighting of criteria which have little relevance to the performance of the service or which impose additional costs on bidders relative to incumbents. Public services contracts sometimes limit bidders' freedom of management and organisation with a view to guaranteeing existing conditions of employment or organisation linked to the performance of the service. This limitation may hinder the bidder's ability to obtain greater costs savings or improvements in the quality of the service. Therefore, if such guarantees are considered essential for the appropriate provision of the service, it would be preferable for them not to be included as criteria for scoring the bids but rather as a special condition of execution of the contract.

Figure 19. Criteria giving rise to extra costs for bidders

In the Administrative and Particular Clauses for the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals of the Autonomous Region of Madrid, up to 150 points (out of a maximum of 500 points for the technical offer) are awarded for the presentation of a plan offering shares to the hospital's professionals. The purpose of this is stated as being "*to involve the professionals in the management of the centre, to the benefit of the effective performance of the public service*". However, there are two considerations that could be borne in mind when establishing these kinds of criteria.

- Firstly, the hospital personnel who eventually acquire shares are not necessarily representative of the structure of the centre: for example, it may be that only executives buy shares, or only the professionals of a particular department. The interests of these

[65] Approved by Royal Decree 1098/2001, of 12 October.

shareholders will not necessarily be the same as those of the centre.

- Secondly, over the course of the 10 years of the contract term it may be that some of the professionals who have acquired shares will leave the centre, making the *raison d'être* of this shareholding obsolete.

In the terms of reference of the Infanta Elena Hospital in Valdemoro, the total evaluation is 1,000 points, with 400 points being assigned to the financial offer, 400 to the technical offer and 200 to criteria of employment stability and quality. This last criterion is more on the nature of a basic characteristic providing assurance of effective provision of the service than of a scoring criterion. Therefore, bearing in mind the previous recommendation, it should be included as a special condition of execution of the contract and as such required of all candidates, rather than as an evaluation criterion.

III.3.4. Precision in setting the criteria

(103) In the interests of greater legal certainty, the award criteria for bidding processes must be clear and precise and must reflect the objectives that it is proposed to score.

(104) Each criterion must clearly establish the content of the objective pursued and must leave each bidder free to choose the mechanism it sees fit to attain these objectives. To do otherwise would be to interfere in companies' ability freely to allocate their factors of production.

(105) Sometimes the award criteria chosen entail certain value judgements. In this case, with a view to reducing the contracting authority's discretionary margin, it is desirable for these criteria to be broken down into sub-criteria each with its own qualitative evaluation.

Figure 20. Excessive discretion of the contracting authority

The Administrative and Particular Clauses of Valencia do not specify how the quality plans, which account for 75%-80% of the total weighting depending on the case, are to be evaluated. The Court of Auditors of the Autonomous Region of Valencia has criticised this situation in several reports[66]. For example, as regards the outsourcing of the l'Horta-Manises Area it pointed out that "*With respect to the contract award criteria, which were included in Clause 11 of the Administrative and Particular Clauses, it is striking that the text lends itself to several different interpretations, which increases the evaluators' discretion. The contract price does not appear among these criteria*" (underlining added). The Court made an almost identical evaluation in respect of the outsourcing of the Elx-Crevillent Health Area.

III.3.5. Other aspects to be avoided

a. Insufficient transparency in the system for allocating scoring to evaluation criteria

[66] Court of Audit of the Autonomous Region of Valencia, *Accounts of the Administration of the Regional Government for financial year 2006* and *Accounts of the Administration of the Regional Government for financial year 2007*.

(106) To ensure appropriate application of the principle of transparency, the Guide to Public Procurement and Competition recommends that the contracting authority clarifies the mechanism and the parameters that determine the progressive nature of the scoring, avoiding possible excessive discretion. We also advise against having only two possible scores, maximum and minimum, which do not reflect the real differences existing among the various offers. The scoring must have a sufficient number of grades or ranges for there to be an adequate margin of incentive to stimulate this price competition while in all cases ensuring an appropriate level of quality in the provision of the service.

(107) Also, for evaluating the economic parameters, it is preferable to use a progressive system with linear progression between the score awarded to each offer and the degree of improvement it represents in this respect.

Figure 21. Declining evaluation of successive improvements to the financial offer.

The Administrative and Particular Clauses of Torrevieja and of Health Area 10 (La Ribera) in the Autonomous Region of Valencia establish as one of the economic evaluation criteria the percentage of reduction from the maximum per capita charge established in the terms of reference. The Administrative and Particular Clauses also specify the points obtained in the evaluation of the offer for each percentage of reduction. The problem is that the greater the percentage reduction offered by the bidder, the fewer additional points are awarded. For example, if the bidder offers a discount of 4%, he is awarded 10 points; if he offers al 7% discount, he is awarded 12 points; and if he offers a discount of 10%, he gets 13 points. Thus an extra 3% discount is worth two points if the discount is increased from 4% to 7%, but only one point if it is from 7% to 10%. This discourages bidders from making bids likely to lead to a competitive outcome, since they receive less and less credit in the evaluation.

b. Prior knowledge of the threshold for abnormally low tenders

(108) The risks deriving from bidders' prior knowledge of the threshold for abnormally low tenders has already been pointed out. Therefore, the Guide to Public Procurement and Competition recommends avoiding systems that indicate this maximum competition threshold in advance[67]. This is so, according to the Guide, because "*disclosing this information can severely restrict competition, especially if the threshold established excessively curtails the possible range of levels for the parameters.*"

(109) It also recommends that these parameters should not be established in absolute values, but should be determined on the basis of relative formulas so as to avoid affecting incentives as regards prices in bidders' offers, such as the definition of reckless bids according to the deviation from a given percentage of the average value of the bids submitted.

[67] The CNC's Guide to Public Procurement and Competition defines it as the level of the parameter in question at which the bid will start to be considered disproportionate.

(110) Finally, the TRLCSP envisages that in the case of bids that may be considered abnormal or disproportionate, the bidder concerned should be heard and invited to justify the valuation of the bid and explain the associated conditions[68].

Figure 22. Lack of definition of reckless bid.

The Administrative and Particular Clauses of the health areas corresponding to the Manises and Vinalopó (Elche-Crevillente) hospitals in the Autonomous Region of Valencia and the terms of reference of the Son Espases and Can Misses hospitals in the Balearic Islands do not define what is understood by reckless bid, and this introduces uncertainty as to whether this absence means that the concept will not be applied or simply that the definition of the criteria to be applied is missing, which would favour administrative discretion and the perception of regulatory risk *ex ante*. As has been indicated, the terms of reference must refrain from limiting bidders' ability to compete on price, to this end it is advisable for the definition of the threshold of reckless bids in the terms of reference not to set a limit on possible improvements to the financial offer. But this must be done while at the same time meeting the need for the terms of reference to define clearly the rules for assessing the threshold of recklessness in the bids, if applicable.

Similarly, in the interests of greater legal certainty, it would be desirable for the terms of reference themselves to include the provision established in the legislation on public contracts regarding the obligation to hear bidders that present reckless bids. Only the terms of reference of the Autonomous Region of Madrid explicitly refer to the legislation on this point.

c. Scoring of elements already taken into account when evaluating solvency

(111) We have already referred previously to the legal prohibition of this practice. The Guide to Public Procurement and Competition refers explicitly to quality evaluation[69], recommending that the criteria for evaluation, and therefore for scoring, be configured so as to reflect the existence of different degrees of quality in the bids. Therefore, in order to evaluate these aspects, care must be taken to avoid using criteria that have already been used, such as solvency and suitability of bidders.

(112) Consequently, these quality criteria for the evaluation of bids must be linked to aspects relating to the content of the bid and to the quality objectives pursued, and bidders must be left free to choose the means whereby they present the required quality accreditation.

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[68] The legislation establishes that, in particular, such bidder must specify "*the savings made possible by the contract execution procedure, the technical solutions adopted and the exceptionally favourable conditions available to it for executing the services, the originality of the services proposed, compliance with the provisions relating to the protection of employment and working conditions in force in the place where the services are to be provided, or the possible obtainment of state aid*" (Article 152.3 of the TRLCSP).

[69] For example, by means of accreditation of a particular certification.

III.4. Development of the contracts.

III.4.1. Quality of the services provided

(113) Outsourcing the management of public services entails the loss of direct control on the part of the contracting authority. The concessionaire has much more information on the quality of the services provided than the Administration does, and without control and appropriate incentives this situation may lead to users of public services seeing a reduced quality of services received.

(114) This is especially important in the case of healthcare services, where informational asymmetries are a characteristic feature, not only between the service provider and the contracting authority, but also between doctors and patients and between doctors and managers. Given these informational asymmetries, the appropriate design of means of ensuring appropriate quality of the services provided is fundamental.

(115) There are basically two ways of seeking to ensure appropriate quality of service: (i) control of the management company (ii) incentives for it to internalise the objective of quality care.

Control of quality of services provided

(116) A fundamental requirement is for the terms of reference for the outsourcing to establish measures for controlling the proper performance of the object of the contract. Here are some recommendations that can be put into practice to carry out appropriate quality control:

- **The terms of reference must appropriately specify the aspects to be monitored**. Without prejudice to such justified adjustments as may be made during the performance of contracts, it is important for both contracting authorities and bidders to know from the outset which aspects are to be subject to evaluation. This can facilitate both the bidder's preparing properly for the quality required and early detection of inappropriate aspects for measuring quality or carrying out the control. It is also important for the aspects to be controlled to be based on variables that are objective and measurable, as opposed to subjective estimates of the concessionaire, the Administration or the controlling entity.

- **The controlling entity must be selected on the basis of the principles of independence and competition (specialisation)**. The controlling entity must be entirely independent of the concessionaire, and it may be preferable for it also to be somewhat independent of the contracting authority, insofar as it might be inclined to apply the control less strictly on the basis that the outsourcing process has been carried out correctly.

- **Credible penalties for deviations from quality objectives**. In order to be effective, control and supervision must be credibly dissuasive, and this can best be achieved by having the terms of reference provide penalties in proportion to the cost of deviations from quality objectives and an automatic procedure for applying the penalties in the event of non-compliance.
- **Transparency in control, second evaluations and *ex post* evaluations**. It is also important for the control function to be seen to be subject in turn to comparison and public evaluation to make sure that it is carried out correctly.

Figure 23. Quality control measures.

The Administrative and Particular Clauses and the Technical Specifications for the outsourcing of healthcare of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals in the Autonomous Region of Madrid give a rather brief account of the quality controls and the effective penalisation of the awardees' remuneration to which non-compliance with standards can lead. This favours administrative discretion and heightens bidders' perception of regulatory risk. The penalties for non-compliance with certain indicators associated with the quality of the healthcare services may increase the incentive to provide better quality care. However, the information in the terms of reference on the penalties and how they are determined is scanty, and this makes them less credible. Apart from this, the terms of reference contain a 20% maximum limit on the amount that may be deducted from the per capita charge for non-compliance with levels of quality; therefore, even if the concessionaire were to fail to comply with any of the quality indicators, it would still receive 80% of the per capita rate. It would seem more appropriate to set minimum values for the quality indicators rather than for the concessionaire's revenues.

The Administrative and Particular Clauses of the Autonomous Region of Valencia refer to the development of a Quality Management Plan for the award of the contract, but do not regulate its subsequent implementation or how it is to be controlled by the Administration.

In the case of the outsourcing of the non-healthcare management of the Son Espases and Can Misses hospitals (Balearic Islands), the rules provide for monthly deductions for quality defects found in the provision of these services. However, the maximum deduction is 0.5% of the variable charge.

Quality incentives in the services provided

(117) The second way to encourage quality in the provision of the services is to establish incentives, so that the provider internalises or takes ownership of the quality objective and thus seeks to improve the quality of care. The provider's remuneration may thus introduce mechanisms to stimulate this quest for quality[70].

[70] The OECD (2012) acknowledges that remuneration for the provision of healthcare services is a fundamental factor for stimulating productivity, efficiency and quality in the healthcare sector. Its conclusions point to both fixed budgets and reimbursement schemes as generating inefficiencies. In the past few years, many countries have adopted the Diagnosis-Related Groups (DRG) method, which seems to be more efficient. This method assigns an

(118) These mechanisms are based on introducing competition into the provision of the public service, linking remuneration to the result of this competition. Competition can be introduced directly (public centres competing with each other to attract users) or by introducing mechanisms for competition by reference among public centres (linking their remuneration to their efficiency relative to other similar centres). In either case, if a single company runs all the outsourced public services of a particular Autonomous Region, it is unlikely that there will be much competition among public centres (assuming that there will be some degree of competition between outsourced and non-outsourced centres).

Figure 24. Billing between centres

In all the cases of outsourcing of healthcare services that we have studied, the provider's remuneration is based on a per capita payment, the amount of which depends solely on the population covered (it is the result of applying a per capita rate to the protected population). This model does not encourage quality in the provision of healthcare, since the remuneration is independent of the number of patients attended to and of the quality of the care they receive. Therefore, the outsourcing processes provide other remuneration mechanisms which seek to encourage quality in the provision of the services. Prominent among these is inter-centre billing.

Inter-centre billing can act as a stimulus for quality of healthcare, because if the provider delivers poor quality services, its patients will switch to other centres, which will lead to the concessionaire's inter-centre billing turning negative. However, the real extent to which inter-centre billing can stimulate the quality of care is limited, for several reasons:

- Firstly, in order for inter-centre billing to act as a real stimulus to quality improvement, there must be mechanisms for measuring it credibly[71].
- Secondly, the quality stimulus from inter-centre billing is based on the existence of competition in the market for attracting patients. The lower the level of competition among public centres, the less effective this variable will be. In this sense we must give a negative assessment to the effectiveness of inter-centre billing as a stimulus to quality in the Autonomous Region of Valencia, where all the outsourcing processes are managed by consortia that include the Ribera Salud group. This considerably weakens competition among centres.
- Thirdly, in the terms of reference providing for the outsourcing of the healthcare management in the Autonomous Regions of Madrid and Valencia, inter-centre billing is based on a number of prices for each type of care or healthcare intervention published in the official gazette of the Autonomous Region. To the extent that these prices might be incorrectly calculated and/or might not reflect healthcare costs correctly, this system may seriously distort the provision of healthcare by the outsourced centres, since they will have an incentive to focus their resources on capturing patients from other areas for the specialities that are comparatively better remunerated, to the detriment of care in the less well remunerated specialities.
- Lastly, inter-centre billing is directed only at stimulating competition in quality as perceived by patients, which is not necessarily the same thing as better quality healthcare. The patient

"efficient price" case by case, and these efficient prices may contribute to greater innovation and productivity gains.

[71] There has been criticism in certain circles of the lack of mechanisms for accurately measuring inter-centre billing among hospitals in the Autonomous Region of Madrid. See Asociación de Facultativos Especialistas de Madrid (AFEM) (2013).

does not usually have sufficient medical knowledge, and tends to evaluate only external indicators of the care received (such as whether he has recovered, the cleanliness of the facilities or waiting times) which are not necessarily in line with the best possible care (for example, the patient may recover despite having received deficient healthcare).

III.4.2. Use of elements of the concession

(119) Another important aspect that must be specified in the terms of reference is the ability of the public service provider to use the goods and services that it manages for its own ends.

(120) In the healthcare sector, given the heavy investment required in infrastructure and equipment, access to these assets via the provision of a public service can generate significant distortion in competitive processes. If the provider of a healthcare service can use, for example, the healthcare infrastructure or equipment that it manages on behalf of a Public Administration to provide or offer its own healthcare services, this may give it a strong advantage over its rivals. Thus, distortions may appear in the markets for the provision of healthcare services, health insurance or other related markets.

(121) Another source of advantages for the awardee which may distort competition is the ability to negotiate with its suppliers for the joint acquisition of equipment or supplies for the public service which it runs and for the provision of its own private services. For example, a company managing a public hospital and at the same time owning and operating its own hospitals may obtain a substantial advantage over its competitors in the provision of healthcare services thanks to the larger scale of its purchasing, which may boost its negotiating power with its suppliers.

Figure 25. Availability for own use of assets covered by the contract

The Administrative and Particular Clauses for the outsourcing of the healthcare management of the Infanta Leonor, Infanta Sofía, Infanta Cristina, Tajo, Henares and Sureste hospitals of the Autonomous Region of Madrid establish a limitation on the manager's use of the public services for purposes other than the object of the outsourcing ("*The awardee is expressly forbidden to use the infrastructure and resources made available to it for providing private healthcare services, except for emergency cases and cases deriving from the application of state legislation in force*.")

In contrast, this kind of provision is not included in the outsourcing processes of the Autonomous Region of Valencia, and this might give managers of outsourced health areas a competitive advantage in private healthcare, insofar as they can use the public infrastructure and resources to provide this kind of services.

III.4.3. Subcontracting

(122) Subcontracting is a process allowing greater speed and flexibility in the provision of services, with the consequent reduction in costs. Moreover, this system helps promote the participation of SMEs, which sometimes

find it difficult to access bidding processes due to the requirements for participating.

(123) Nevertheless, it is desirable to establish limits on subcontracting, because a lack of control of this process could lead to the contract's being executed by a company that does not meet the solvency and ability requirements of the bidding process, with the consequent relaxation of the competitive conditions of the bidding process.

Figure 26. Mandatory subcontracting in terms of reference.

A particularly striking provision in the terms of reference of the Son Espases and Can Misses Hospitals (Balearic Islands) establishes the mandatory subcontracting of 30% of the contract, with a maximum limit of 50% and 60% respectively. This means that half the contract may be executed by a company that has not been directly awarded the contract, and this might facilitate collusion among bidders.

Figure 27. Subcontracting not subject to evaluation by the contracting authority.

All the terms of reference studied include the possibility of subcontracting part of the contract that is the object of the bidding process. However, many terms of reference do not stipulate that subcontractors must meet the same solvency and ability criteria as those required for participating in the bidding procedure, so it is possible that they are not subject to evaluation by the contracting authority.

The terms of reference of the health areas corresponding to the Manises and Vinalopó hospitals in the Autonomous Region of Valencia establish that only ancillary services may be subcontracted and that the subcontractors must "*meet subjective requirements of solvency and ability ensuring the effective performance and fulfilment of the services*", without specifying whether these requirements must be equivalent to those contained in the terms of reference for the bidding process.

III.4.4. Subsequent unexpected modifications and complementary services

(124) The TRLCSP establishes that contracts may be modified only if this possibility is provided in the terms of reference or in the announcement of the bidding process, except in the cases provided in Article 107 of the TRLCSP[72]. This provision aims to avoid subsequent unexpected modifications that affect basic aspects of the contract and that might be used by some companies to carry out strategies such as presenting a low

[72] Article 107 of the TRLCSP establishes that, if they are not provided in the terms of reference, modifications may be made only when one of the following circumstances is shown to exist: i) inappropriateness of the contracted service due to errors or omissions in the drafting of the contract or the technical specifications; ii) inappropriateness of the project for objective reasons determining its unsuitability and coming to light after the award of the contract; iii) force majeure or act of God; iv) desirability of incorporating technical advances made since the award of the contract; v) need to adjust the services to technical, environmental, town planning, safety or accessibility specifications approved after the award of the contract.

price in the bidding in order to win the contract and subsequently modifying it to receive a higher price.

Subsequent unexpected modifications

(125) These modifications must conform to the general principle according to which modifications subsequent to the award may be made only if they are provided in the terms of reference, and always for reasons of general interest. Also, the modifications must not affect the essential terms of the contract.

(126) Although the possibility of subsequent unexpected modification is envisaged by Spanish legislation, it should not be abused, and we recommend making limited and prudent use of this device, in the interests of greater transparency for companies in the sector and greater certainty for the awardee.

(127) The following table shows the modifications to contracts that have taken place:

Table 9. Subsequent unexpected modifications to contracts.

Bidding	Number of modifications to the contract	Type of modification
AUTONOMOUS REGION OF VALENCIA		
Ribera health area (1997)	1	HS:
Ribera health area (2002)	0	
Torrevieja health area	0	
Denia health area	1	C
Manises health area	1	HS:
Elche-Crevillente health area	1	HS:
AUTONOMOUS REGION OF MADRID		
Hospital del Henares	2	C/Non-HS[73]
Hospital Infanta Cristina	2	C/Non-HS[74]
Hospital del Tajo	2	C/Non-HS[75]
Hospital Infanta Leonor	2	C/Non-HS[76]
Hospital Infanta Sofía	2	C/Non-HS[77]

[73] There is a first modification for increased investments in infrastructure during the construction phase, and a second modification for increased investments in infrastructure during the operational phase.

[74] There is a first modification for increased investments in infrastructure during the construction phase, and a second modification for increased investments in infrastructure during the operational phase.

[75] There is a first modification for increased investments in infrastructure during the construction phase, and a second modification for increased investments in infrastructure during the operational phase.

[76] There is a first modification for increased investments in infrastructure during the construction phase, and a second modification for increased investments in infrastructure during the operational phase.

Hospital del Sureste	2	C/Non-HS[78]
Hospital Puerta de Hierro	0	
Hospital Infanta Elena Valdemoro	0	
Hospital de Torrejón	0	
Hospital Rey Juan Carlos	0	
CATALONIA		
Hospital Jaume Nadal Meroles	0	
Hospital Duran I Reynals	0	
Olesa de Montserrat Primary Healthcare Centre	0	
BALEARIC ISLANDS		
Hospital Son Espases	1	n.a.[79]
Hospital Can Misses	1	n.a.
Formentera Hospital	0	
Eivissa health area	0	
Andratx	1	n.a.
Ariany	1	n.a.
Es Molinar	1	n.a.
Esporles	1	n.a.
María de la Salut	1	n.a.
Muro	1	n.a.
Porreres	1	n.a.
Sa Pobla	1	n.a.
Ses Salines	1	n.a.
Son Servera	1	n.a.
CASTILLA Y LEÓN		
Hospital Universitario de Burgos	2	C
NAVARRA		
Burlada Mental Health Centre and Mental Health Day Hospital	0	
Zuría Day hospitals	0	
LA RIOJA		
Los Jazmines social welfare convalescence centre, Haro	1	Non-HS[80]
Virgen del Carmen social welfare convalescence centre, Calahorra	0	

HS: Healthcare services; non-HS: Non-healthcare services; C: Construction of the centre.

Source: In-house based on data from the health Departments of the autonomous regions Data updated as at 31 August 2013

[77] There is a first modification for increased investments in infrastructure during the construction phase, and a second modification for increased investments in infrastructure during the operational phase.

[78] There is a first modification for increased investments in infrastructure during the construction phase, and a second modification for increased investments in infrastructure during the operational phase.

[79] The Health Department of the Balearic Islands has not provided detailed information on the modifications made.

[80] Contract modified in order to maintain the economic-financial equilibrium (regulating the price of unoccupied guaranteed stays).

(128) Of the 38 contracts on which we have information, modifications have been made to 24 of them (64%). In the case of seven of the 24 modified contracts, two modifications were made to each.

(129) The Guide to Public Procurement and Competition indicates some measures for limiting the possible negative effects of subsequent unexpected modification on the market in terms of competition, these effects being similar to those deriving from direct award:

- To include in all terms of reference a list of the circumstances in which subsequent unexpected modification of the contract is possible in the case of unexpected circumstances of an unforeseeable nature.
- Clear, detailed specification of the unforeseen circumstances, so as to avoid excessively broad interpretation that might unduly dilute the content of the provision.
- In the case of a significant change in prices, it is advisable to compare the new prices agreed between the parties with market prices, with a view to ensuring reasonable contract terms.
- The modification must relate exclusively to those aspects that derive from the unforeseen circumstance, and the introduction of modifications to elements not related to that circumstance must be avoided.
- Monitor contracts awarded by the contracting authority in order to identify the percentage of them that are subject to modification and publish these data.
- We also recommend that the contracting authority establish average price change percentages as a consequence of the modifications. If the results of the analysis show that the percentages are systematically high in relative terms, this may be an indicator of an excessively loose interpretation of the “unforeseen circumstances”.
- Moreover, in the interest of greater transparency in the procedure, the publication of modifications to contracts by public authorities would be desirable.

Figure 28. Modifications to contracts.

In the contracts for construction of infrastructure and non-healthcare management of the Infanta Leonor, Infanta Cristina, Infanta Sofía, Tajo, Sureste and Henares Hospitals in the Autonomous Region of Madrid, there have been two modifications: the first relating to increased investment in infrastructure during the construction phase and the second concerning increased investment in infrastructure in the operational phase. In neither case was the modification subject to a new tender process, the awardee temporary consortium carrying out the agreed modifications.

In the Autonomous Region of Valencia, the modifications have been of a different kind: the modifications in the health areas of Manises and Elche-Crevillente are due to the incorporation of a new basic health zone. In the Denia health area however, the modification concerns the construction of centres. Thus, the refurbishment of the old Denia Hospital envisaged in the

terms of reference is replaced by the construction of three new health centres. In these three cases, the modification was carried out by the temporary consortium that had been awarded the contract in the initial bidding process. In the case of the Ribera health area, the first bidding process, in 1997, had as its object the management of the specialist healthcare services. The contract was modified to extend the healthcare management so as to take in primary care as well, for which a new bidding process was called in 2002.

Other Autonomous Regions have also made modifications to their contracts: in La Rioja, there was a modification to the contract for the Los Jazmines Centre to ensure maintenance of the economic equilibrium. The modifications to the Burgos Hospital contract involved a technical modification of the works execution project (without altering the economic-financial plan) and a second modification to the execution project consisting of an increase in the amount of investment. In the case of the Balearic Islands the causes giving rise to the modifications are not specified.

Thus, except in the aforementioned case of the bidding process for the Ribera health area in the Autonomous Region of Valencia, in all the processes analysed the execution of the modification was awarded directly to the original awardee. While it is true that the legislation allows such direct awards, there is nothing to prevent new tenders being called for in certain cases, which would make for greater transparency in the procedure and promote equal opportunities for companies in the sector.

Lastly, from the detailed analysis of the terms of reference, we identified a number of them that do not explicitly provide for modification to the contracts. Such is the case of the terms of reference of the Denia, la Ribera and Torrevieja health areas in the Autonomous Region of Valencia. All the other terms of reference studied do make express mention of modification in the case of general interest. Only the terms of reference of the Infanta Elena Hospital in Valdemoro and of the six hospitals of the Autonomous Region of Madrid set out the circumstances in which such modification may be made.

Complementary services

(130) In practice these services involve the drawing up of a new contract which is awarded using the negotiated procedure[81]. Due to its exceptional nature, it must be used only for justified reasons and on the basis of unforeseen circumstances. To avoid its inappropriate use, the Guide to Public Procurement and Competition recommends that "*its use be justified clearly and explicitly, identifying precisely the reason giving rise to the need to resort to this mechanism*".

(131) As in the case of modifications, if an analysis of the processes reveals that these types of practices are used repeatedly by the administrative bodies or that a high proportion of them are close to the maximum permitted by the law, this may be indicative of an inappropriate interpretation of unforeseeability.

Price modifications

[81] By way of reminder, the negotiated procedure involves the contracting authority's selecting one bidder following negotiations with one or more candidates. This is an exceptional procedure.

(132) The prices established in contracts to determine the awardees' remuneration must be based on the reference of the real market value. In cases where there is provision for prices to be determined in accordance with certain parameters, these parameters should be clear, simple and objective, avoiding these price review mechanisms becoming mechanisms for additional remuneration of the awardee. Therefore, we recommend that these parameters be easy to monitor and control.

(133) As for the formulas for price revisions, they must act as guidelines contributing to the objective of maintaining the economic and financial equilibrium of the contract, without involving major payments to awardees.

Figure 29. Non-determination of contract price.

The terms of reference of Torrejón Hospitals, Rey Juan Carlos Hospital in Móstoles and Infanta Elena Hospital in Valdemoro establish an indeterminate budget for the contract, the price of which is established after the bid of the proposed awardee has been determined. There is a risk of candidates presenting relatively high bids, in excess of the market price, leading to an inefficient contract. In particular, this effect can be seen in processes for which there is a small number of bidders and therefore no competitive pressure in terms of price, as is the case of the Torrejón and Rey Juan Carlos hospitals, in which only one and two companies took part respectively.

Figure 30. Lack of definition of future services.

In several cases, the Administrative and Particular Clauses recognise the future revision of the remuneration established for the concessionaire but do not determine its method of calculation, thus giving the contracting authority a degree of discretionality that may be excessive.

For example, in respect of the outsourcing processes of Health Area 10 (La Ribera) and Torrevieja in the Autonomous Tegion of Valencia, the Regional Court of Auditors criticises this imprecision[82]:

> "*For determining the per capita rate, the initial budgets of the Regional Government of Valencia have been used as the basis. The revision of prices is established in clause 19, which sets as the reference for updating the per capita charge the increase in the healthcare budget of the Valencia Regional Government.*
>
> *The updating of the price in accordance with the clause referred to in the foregoing paragraph is limited in two ways: by the CPI, as the lower limit, and by the annual percentage increase in consolidated public healthcare expenditure of the State for the financial year, as the upper limit.*
>
> *We consider this criterion for updating tariffs questionable, since it does not correspond to movements in real prices or costs*."

Figure 31. Excessive price review rule

The Administrative and Particular Clauses of the Infanta Elena Hospital in Valdemoro provide a rule for the revision of prices consisting in the automatic updating of prices in accordance with the lower of the State CPI and that of the Autonomous Tegion of Madrid, plus two points.

[82] Court of Auditors of the Autonomous Region of Valencia, *Audit of the General Accounts of the Regional Government of Valencia for financial year 2003*.

Practically all the remaining terms of reference establish a rule for revision based on 0.85 of a price indicator. By not completely adjusting prices in line with the economy, they aim to incentivise the company to operate more efficiently. This is not the case with the rule provided for the Infanta Elena Hospital, which by revising remuneration by more than the CPI risks not incentivising the company sufficiently to conduct itself efficiently over time.

IV. CONCLUSIONS

(134) This report analyses recent bidding processes for the provision of public healthcare, ranging from the construction of healthcare infrastructure to the outsourcing of the provision of the final service. It is not a matter of assessing the need for or appropriateness of a direct or an indirect system for providing healthcare services, but of analysing the public healthcare outsourcing procedures carried out so far, seeing whether they have been carried out appropriately in accordance with the basic principles of competition and making recommendations for the future. To this end, we apply the recommendations contained in the Guide to Public Procurement and Competition published by the CNC in 2011 to the bidding processes carried out in the healthcare sector, taking account of certain essential elements of the sector's competitive structure.

(135) Healthcare is a service of the greatest possible interest for citizens' direct welfare and a basic element for ensuring equality and regional cohesion. Healthcare expenditure in 2011 amounted to €1,923 per head of the population (just under 9% of GDP), of which €1,434 related to public healthcare (source: Ministry of Health, Social Services & Equality). Healthcare and social services employed 1.5 million people in 2011 (7.9% of the country's workforce). This is a sector that can be a source of innovation, dynamism and competitiveness for the Spanish economy. For all these reasons, it is essential to make sure that it is organised efficiently and that the services provided are of an appropriate quality.

(136) An inappropriate design of public procurement processes for the provision of healthcare services from the point of view of competition may have highly negative consequences, given that it may unnecessarily increase the cost of the provision of the service for public administrations or lead to inadequate quality of services received by users, all of which have a negative effect on the general interest. Similarly, inappropriate procurement of public services may worsen competitive conditions in other related activities or connected markets, such as the private provision of healthcare services or health insurance.

(137) The report shows in particular that the healthcare outsourcing procedures carried out by the Autonomous Regions have generally had alarmingly low participation rates. In the majority of the procedures studied there was only one bidder. In some other non-healthcare outsourcing processes, there have been a very small number of participants too. Causes of this phenomenon might include overly restrictive requirements for participation in bidding processes, potential bidders perceiving excessive risk in respect of the future revenue and expenditure associated with running the centre, or of some competitor possibly having advantages in terms of information, or the existence of problems of competition in the market. In any case, when the number of bidders is small, it is quite possible that the potential

benefits of competition are not being obtained. The Guide to Public Procurement and Competition recommended that public administrations inform the competition authorities of any indications of collusion among bidders, and an unusually small number of bidders may be such an indication.

(138) The report also shows various examples of situations that are potentially harmful to the existence of sufficient effective competition in the markets, which need to be corrected insofar as possible or taken into account by contracting authorities in future. These examples relate both to healthcare and non-healthcare management awarded jointly with the construction of the healthcare centre. We analyse the main phases of the procurement process from the point of view of competition: i) the general design of the outsourcing, ii) companies' access to bidding processes, iii) evaluation of bids and execution of contracts. The examples given show different situations with negative consequences for competition, in some cases with suggested alternative ways of designing bidding processes so as to take advantage of the static and dynamic benefits offered by competition in public procurement.

(139) For all these reasons, the CNC urges all public administrations with competences in the area of healthcare and public procurement to take extra care with the design, implementation, awarding and monitoring of healthcare outsourcing processes and to take into consideration the examples given and recommendations made in this report.

(140) In particular, in light of the cases studied, and with a view to promoting effective competition in procurement processes in the healthcare sector, the CNC considers it appropriate to recall and emphasise the main recommendations made in the Guide to Public Procurement and Competition to public administrations:

a) <u>As regards the design of bidding processes:</u>

- Whenever possible, opt for the open procedure in bidding processes, since it is the one most favourable to competition.
- Make sure that seeking tenders for several services under a single contract does not reduce the number of possible awardees.
- Avoid the number of lots being the same as or close to the number of potential participants, and avoid the lots being of the same size.
- Adjust the duration of contracts to the time needed to depreciate such investments as may be needed to perform the contract, taking care to avoid excessively long durations reducing competition for the market.

b) <u>As regards participants' access to bidding processes:</u>

- Adjust the economic and technical requirements for participating in bidding processes to the object of the contract, along with the means of proving that they have been met. And in particular, in the case of temporary consortia, require all the companies forming the temporary consortium to meet the solvency and ability criteria.
- Publicise bidding processes sufficiently, even when there is no legal obligation to do so.
- Establish deadlines that give enough time for tenders to be prepared, facilitating maximum participation of companies in the process.
- Include all relevant information in the terms of reference so that potential bidders can make accurate forecasts of future flows of revenue and expenditure.
- Make sure that no candidate can have advantages over the others deriving from privileged access to relevant information.

c) Regarding the weighting of the criteria and the contract award procedure:

- Weight the variables appropriately so that the contracting authority is not given excessive discretion. In the case of healthcare services, the basic objective is to assure quality in the provision of the service to the patient, so a high weighting should be given to scores based on criteria relating to quality of service. Accordingly, a balance should be struck between price competition and quality of service. Reduce the weighting in the evaluation of economic criteria that are of limited or no relevance to invoicing.
- Avoid setting strict limits on prices or other basic variables of the contract that restrict the margin for presenting bids with viable prices, ensuring in any case a certain level of quality in the provision of the service.
- Make sure that the terms of reference provide a clear and precise description of the evaluation criteria, including prior knowledge of the threshold for abnormally low tenders.

d) As regards the development of the contracts:

- Specify in the terms of reference the elements determining the quality of execution of the contract and provide credible, robust control mechanisms and penalties for non-compliance.
- Establish remuneration mechanisms that incentivise the awardee to develop an appropriate level of quality in the provision of the services. In the field of healthcare, in particular, we recommend improving the transparency of inter-centre billing and the mechanisms for measuring and controlling it, so as to allow bidders

access to information which is fundamental for drawing up tenders and to make it a real stimulus to quality and efficiency.

- Avoid possible competitive advantages accruing to certain companies through public resources covered by the contract being available for use for purposes other than those of the contract.
- Establish limits on subcontracting to avoid relaxation of solvency and ability requirements for subcontractors.
- Strengthen the exceptional nature of subsequent unexpected modifications to contracts, which implies listing in the terms of reference the possible exceptional situations that might give rise to modifications and limiting their scope, especially when they affect the basic elements of the contract.
- Avoid establishing formulas for price revision that involve payments over and above the economic and financial maintenance of the contract.

ANNEX I. DESCRIPTION AND SOURCE OF THE DOCUMENTATION ANALYSED IN SECTION III

- Burgos Hospital: Announcement of bidding process for the concession of public works for the construction and operation of the new Burgos Hospital, published in the Official Spanish State Gazette of 24 August 2005.
- Hospital Infanta Sofía, Hospital Infanta Leonor, Hospital Infanta Cristina, Hospital del Henares, Hospital del Sureste and Hospital del Tajo, in the Autonomous Region of Madrid: Resolution of 30 April 2013 of the Vice-council for Healthcare of the Health Department of the Autonomous Region of Madrid, publishing the call for tenders for the service contract referred to as: "Management under concession of the public service of specialist healthcare for the Infanta Sofía, Infanta Leonor, Infanta Cristina, Henares, Sureste and Tajo university hospitals", published in the Official Gazette of the Madrid Autonomous Region of 7 May 2013.
- Hospital Infanta Elena Valdemoro Resolution of 3 August 2005 of the General Directorate of the Madrid Health Department, publishing the call for tenders by open procedure for the award of the public service concession contract for specialist healthcare of the Valdemoro Hospital, published in the Official Spanish State Gazette of 10 August 2005.
- Hospital de Torrejón: Resolution of 2 March 2009 of the Technical Secretary General of the Regional Health Department publishing the bidding process for the public service concession contract known as "Specialist healthcare in the municipalities of Torrejón de Ardoz, Ajalvir, Daganzo de Arriba, Ribatejada and Fresno del Torote" to be awarded by open procedure on a number of criteria, published in the Official Spanish State Gazette of 11 March 2009.
- Hospital Rey Juan Carlos (Móstoles) Resolution of 27 October 2009 of the Technical Secretary General of the Regional Health Department publishing the bidding process for the Public Service Management contract by way of concession, referred to as: "Specialist healthcare corresponding to the municipalities of Móstoles (Sabio, La Princesa and Barcelona basic zones), Navalcarnero, Cadalso de los Vidrios, San Martín de Valdeiglesias, Villa del Prado, Navas del Rey, Villaviciosa de Odón, Cenicientos, Rozas de Puerto Real, Pelayos de la Presa, Aldea del Fresno, Sevilla la Nueva, Villamanta, Villamantilla, Villanueva de Perales, Chapinería, Colmenar de Arroyo and El Álamo" to be awarded by open procedure on a number of criteria, published in the Official Spanish State Gazette of 19 November 2009.
- Health Areas and Departments of the Autonomous Region of Valencia: Documentation provided by the Health Department of the Autonomous Region of Valencia.

- Health Area 10 of the Valencia Health Department (La Ribera): Announcement of bidding process for the management of specialist healthcare of Health Area 10, published in the Official Gazette of the Valencia Autonomous Region of 25 February 1997.
- Health Area 10 of the Valencia Health Department (La Ribera II): Announcement of bidding process for the management of public service by means of concession of the entire healthcare of Health Area 10, published in the Official Gazette of the Valencia Autonomous Region of 11 December 2002.
- Health Department of Torrevieja: Resolution of the Under-secretary for Health Resources publishing the tender process for the management of public service by means of concession of Comprehensive Healthcare in the Torrevieja zone, published in the Official Spanish State Gazette of 13 December 2002.
- Health Department of Denia: Announcement of tender process for the public service management concession of Comprehensive Healthcare in Health Area 12, published in the Official Gazette of the Valencia Autonomous Region of 29 July 2004.
- Health Department of Manises: Resolution of the Valencia Health Agency of the Healthcare Department publishing the tender process for the management of public service by means of concession of Comprehensive Healthcare in the future l'Horta-Manises health department of the Autonomous Region of Valencia, published in the Official Spanish State Gazette of 25 April 2006.
- Health Department of Elche-Crevillente: Resolution of the Valencia Health Agency of the Healthcare Department publishing the tender process for the management of public service by means of concession of Comprehensive Healthcare in the future l'Horta-Manises health department of the Autonomous Region of Valencia, published in the Official Spanish State Gazette of 08 August 2006.

- Hospital Universitario Son Espases (formerly Hospital Son Dureta): Resolution of the Managing Director of the Health Department of the Balearic Islands announcing the tender process for the public works concession contract for the construction, maintenance and operation of the new Son Dureta University Hospital, published in the Official Spanish State Gazette of 18 November 2005.
- Hospital Can Misses: Announcement by the General Secretariat of the Health Department of the Balearic Islands of a bidding process for the construction, maintenance and operation of the new Can Misses healthcare complex in Ibiza and two associated Health Centres, published in the Official Spanish State Gazette of 20 August 2009.

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