Health Foundation parliamentary briefing

Issues raised by the National Health Service (Amended Duties and Powers) Bill

This briefing has been prepared by the Health Foundation, an independent charity working to improve the quality of health care, to inform the debate on the National Health Service (Amended Duties and Powers) Bill taking place in the House of Commons on Friday 21 November 2014.

This briefing aims to provide an explanation of the Bill's contents and policy implications in order to inform public debate around what are an important set of issues. This briefing is descriptive, it does not seek to set out the Health Foundation's policy position on these areas. Instead it seeks to highlight how the provisions might change the current legislative position to contribute to an informed debate on the issues raised by the Bill.

An accompanying set of briefing notes is available which discuss the key provisions of the Bill and the potential implications for the broader system. They are available from www.health.org.uk/publications/issues-raised-by-the-national-health-service-amended-duties-and-powers-bill/

About the National Health Service (Amended Duties and Powers) Bill

The Bill largely retains existing administrative structures but amends the way in which NHS organisations, or organisations providing NHS-funded services, are managed and regulated. The Bill seeks to:

- place a legal duty on the Secretary of State to secure the provision of national health services in England, replacing the equivalent duty that currently applies to NHS clinical commissioning groups (CCGs) or the NHS Commissioning Board where applicable
- amend provisions relating to Monitor, the sector regulator, and in particular its competition functions
- repeal the powers of the Secretary of State to make regulations on procurement, competition and choice under Section 75 of the Health and Social Care Act 2012
- exclude NHS services from public procurement legislation and competition legislation under the Competition Act 1998 and the Enterprise Act 2002
- reinstate direction-making powers over CCGs and the NHS Commissioning Board (NHS England) as well as revoking some powers of NHS foundation trusts (including freedoms in relation to generating private income).

Summary of key issues

- While the Bill does not represent widespread structural change, its potential impact on the health service should not be underestimated. It could significantly alter the relationship between the Secretary of State and NHS providers and commissioners. Such changes would need to be carefully managed to avoid creating any system instability.
- The NHS *Five Year Forward View* sets out a clear direction for the NHS to bridge the estimated £30 billion funding gap by 2020/21. It received cross party support, and any new initiatives should be viewed in the context as to whether they would support the aims of the Forward View.
- It is important to be clear about the policy issues behind the technical drafting of the clauses and the potential implications for the NHS in England. This briefing aims both to explain what the clauses of the Bill would do but also some issues to consider.

Introduction

The private members' bill – the National Health Service (Amended Duties and Powers) Bill – published by Clive Efford MP raises important questions on a range of issues such as the role of NHS providers and the role of competition. The Bill might not survive its second reading debate on 21 November 2014 but may give indications as to how the Labour Party might seek to amend NHS legislation in this area should they form the next government.

The issues behind the Bill's 15 clauses have been debated for a number of years, with some (such as the appropriate role of the Secretary of State for Health) stretching back to the original National Health Service Act 1946.

Why do these issues continue to reappear? Partly because they expose long-running contradictions that have not been substantially resolved. For example, under the Health and Social Care Act 2012, the Secretary of State has a duty to promote autonomy but he/she can choose to override this provision if they perceive it to be in the best interest of the NHS to do so.

This lack of clarity can be compounded by the fact that parliament has very different responsibilities with regard to its role in approving legislation versus its scrutiny role of broader government policy. Legislation is a means to implement policy ends; however, the exact policy issues at stake can often get lost amidst a thicket of clauses, sub-sections and legal language.

As such, this briefing aims to set out the Health Foundation's interpretation of the key policy issues which sit behind the clauses of the Bill. The Health Foundation is planning to publish a series of similar briefings in the run-up to the 2015 general election which aim to inform and support debate on critical NHS issues. This briefing does not seek to set out the Health Foundation's policy position on the Bill. Instead it seeks to highlight how the provisions might change the current status quo.

Please note

- NHS England is referred to as the NHS Commissioning Board – its legal name.
- The National Health Service (amended duties and powers) Bill is referred to as 'the Bill'
- The Health and Social Care Act 2012 is referred to as 'the 2012 Act'

Key issues raised by the Bill

- **What role should the Secretary of State have in the operational control of the NHS?**
- **What is the role of commissioners of NHS-funded services?**
- **Does it matter who owns providers of NHS-funded services?**
- **How much independence should NHS foundation trusts and NHS trusts have?**
- **How would legislative change support the NHS to meet its challenges?**

What role should the Secretary of State have in the operational control of the NHS? [Clauses 1-5]

To what extent should the Secretary of State for Health be involved in operational as well as strategic NHS issues? What are the potential advantages and disadvantages of different degrees of involvement?

It is widely accepted that the Secretary of State for Health should be accountable to parliament for the NHS. The issue is **how** that accountability should be exercised. On the one hand you have the model articulated by Bevan of direct control where a dropped bedpan in Tredegar would 'resound in the Palace of Westminster'.[1] But those who believe that the NHS should be operationally independent of politicians criticise this model as risking political micro-management, lack of autonomy and fear of innovation for those working in the NHS.

During the passage of the 2012 Act, the appropriate role of the Secretary of State provoked considerable debate. The intention behind the Act was to create a legislative framework in which health service functions were directly conferred on the bodies that would be responsible for exercising them such as the NHS Commissioning Board (now known as NHS England) or clinical commissioning groups (CCGs). One of the major objectives of the 2010 NHS white paper, *Equity and excellence: liberating the NHS*,[2] was to 'liberate' front-line organisations from political interference and control. The 2012 Act sought to minimise the powers of the Secretary of State to become involved in day-to-day operational matters.

The Bill would replace the duty on CCGs (or the NHS Commissioning Board where it has a duty to do so) to secure the provision of certain services with a duty for the Secretary of State to do so, albeit with the ability for part or all of this duty to be delegated to CCGs or the NHS Commissioning Board. It would also give the Secretary of State broad direction-making powers over NHS England and CCGs and potentially give limited direction-making powers over NHS foundation trusts (which would be a new power rather than reinstating the position prior to the 2012 Act). It would also give the Secretary of State broad powers to make decisions about procurement, choice and aspects of anti-competitive behaviour.

The tension here is that a greater political role in operational matters implies less independence for providers and local and national commissioners of NHS services. Even if the Secretary of State were only to use the powers exceptionally rarely, it is possible that the behaviour of health service bodies would be affected by the knowledge that they could be overruled.

[1] Ross, M (2011) Cutting the reporting lines. *Civil Service World*. 11 March 2011.

[2] Department of Health (2010) *Equity and Excellence: liberating the NHS*. The Stationery Office.

What is the role of commissioners of NHS-funded services? [Clauses 3-6 and 10-11]

Commissioners in the NHS have the responsibility to spend NHS resources on health services to meet the needs of their patients.

The Bill aims to remove the commissioning of NHS services from broader procurement legislation (both EU and domestic). The Bill would also remove the Secretary of State's regulation-making powers in relation to competition, choice and procurement. It would instead give him or her direction-making powers over health service bodies in these areas.

Aside from potential legal issues as to the feasibility of this approach, there is a broader issue as to why robust procurement processes might be seen as a barrier to NHS commissioners. The current legislation contains key principles relating to fair, transparent and non-discriminatory procurement. If the NHS is to be exempted from good practice procurement requirements which apply to other public services, what is it that makes NHS services special? What rules or principles would replace the repealed regulations made under Section 75? In addition, it is not clear whether it would actually be possible to exempt health from European legislation in this field.

As discussed above, the Bill would also seek to increase the Secretary of State's operational powers over NHS commissioners by introducing broad powers of direction.

Taking both those provisions together, what would be the role of NHS commissioners going forward? If public procurement processes may not need to be quite as stringent and NHS organisations would have a 'preferred providers' status, how much power would commissioners really have? In addition, if the Secretary of State was able to be involved in day-to-day operational issues, does that negate the role of clinical commissioners more specifically? How would local commissioners be protected from political interference and instability?

While the Bill's provisions would not abolish or create new bodies, there would be a significant change to the balance of power and autonomy between different levels of the system. The Bill could also potentially expose the NHS to increased political involvement in operational matters and may increase the risk of decisions being made following media or political pressure rather than on service priorities at a local level.[3] This could become particularly challenging as the financial climate becomes tighter with the possibility that the basket of services covered by the NHS becomes smaller. Making an individual CCG the focus of lobbying or intervention from politicians (either local or national) could be a distraction and might risk clinical disengagement.

Any significant changes risk system instability and any debate on the relative benefits of a command and control system versus a system of managed regulation would need full engagement with stakeholders in the system.

Does it matter who owns providers of NHS-funded services? [Clauses 7-11]

Currently, patients and service users are entitled to receive health care free at the point of use regardless of who owns providers of NHS-funded services (whether social enterprises, charities, private companies or NHS bodies – the concept of the 'fair playing field').

---

[3] Newdick, C and Smith, J. (2010) *The Structure and organisation of the NHS – A report for the Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust: January 2005-March 2009*. The Mid Staffordshire NHS Foundation Trust Public Inquiry.

It is legitimate to consider the extent to which NHS trusts (providers owned by the NHS) should be treated as 'special' for the purposes of management and regulation. There are provisions in the Bill which would exempt NHS providers and commissioners from public procurement legislation and it could be inferred that the Bill is designed to give NHS organisations preferential status (ie, viewing an NHS provider as a 'preferred provider').

The 'preferred provider' approach appears to assume that NHS bodies will be in the best position to provide the best services for patients with the role of other sectors being to provide services where there are gaps in NHS provision, or to supplement it. One of the original aims of the *Equity and excellence* white paper was to free up provision of NHS-funded health care to allow any qualified provider to provide services in most sectors of care on the basis that this would give patients greater choice.[4] However, in practice, adopting a policy of 'NHS-preferred providers' might limit commissioner choice more than patient choice and could stifle commissioners' ability to innovate in the delivery of services.

The role of competition and choice

Assuming that an 'NHS preferred provider' model is intended, there is a question about the role of alternative providers and the role of patient choice. If NHS providers were the preferred providers, what would happen to existing services provided by social enterprise, voluntary or independent sector providers? Would there still be a role for voluntary sector providers and social enterprises? Would there still be competition between NHS providers?

It is important to emphasise that competition among providers for NHS-funded services does not necessarily need to affect the principles at the heart of universal health coverage which relate to financial risk protection and equitable access to services based on need.[5] However, there is a clash between the view that the NHS should be protected as a public sector monopoly versus the broader market-based approach which sees competition and supplier diversity as being advantageous for patients as consumers.

There is some evidence to suggest that when prices are regulated, competition can lead to improvements in some measures of quality.[6] However, there is a need for more robust empirical evidence on the causative link between competition and quality in the NHS.

The Bill seeks to remove NHS providers and commissioners from their obligations under the Competition Act 1998 and the Enterprise Act 2002. One of the implications for NHS foundation trusts would be to amend the merger control regime and give decision-making powers to the Secretary of State for Health instead of the independent Competition and Markets Authority.

The extent to which competition should play a role in the health service is not unique to the NHS in England and at European level it has been suggested that the European Union is '*at a legal crossroads, where economic policy and social policy collide*'.[7] The Bill seeks to exempt NHS providers and

[4] Department of Health (2010) *Equity and Excellence: liberating the NHS*. The Stationery Office.
[5] WHO (2014) *The global push for universal health coverage*. WHO. Accessed via: http://www.who.int/health_financing/universal_coverage_definition/en/
[6] Office of Fair Trading (2014) *Competing on Quality – Literature Review*. Office of Fair Trading.
[7] Mossialos, E, Permand, G, Baten, R and Hervey, T (2010) Chapter 1: Health systems governance in Europe: the role of European Union law and policy in Mossialos, E, Permand, G, Baten, R and Hervey, T (2010) *Health Systems Governance in Europe: The Role of EU Law and Policy*. European Observatory on Health Systems and Policies. Accessed via: http://www.euro.who.int/en/about-us/partners/observatory/studies/health-systems-governance-in-europe-the-role-of-eu-law-and-policy

commissioners from European public procurement directives (and the associated domestic regulation) but also considers the implications of the proposed Transatlantic Trade and Investment Partnership.

Transatlantic Trade and Investment Partnership (TTIP)

The proposed TTIP between the European Union and the United States has provoked widespread media coverage on the extent to which national autonomy over public services such as the NHS might be threatened. This is in addition to concern over the possibility of litigation by investors with regard to unfavourable public policy decisions. One of the major concerns about TTIP has been related to investor state dispute settlements (ISDS). These settlements allow foreign investors to bring proceedings against a government that is party to the treaty when an investor has been harmed. There are some international examples of policy change resulting in legal action by foreign investors, including in the health sector.[8] In October 2014, the Council of the European Union published the negotiating directives for talks on the EU-US agreement. With regards investment protection, the current draft suggests that the agreement should be without prejudice to the right of the EU or Member States to adopt and enforce measures necessary to pursue legitimate public policy objectives, such as social, public health and environmental objectives, in a non-discriminatory manner.[9]

The wording of the TTIP has not yet been agreed, so it is not possible to identify the precise impact on the NHS. The Bill expresses a clear intention towards TTIP negotiations but for an issue that is of critical importance to the UK more broadly, it would be helpful to have cross-party consensus on the general approach to negotiations and more transparency about the potential benefits and risks.

How much independence should NHS providers have? [Clauses 2, 6-10]

A number of provisions in the Bill would limit some of the existing powers and freedoms of NHS foundation trusts. Namely, the Bill creates new powers for the Secretary of State to limit the percentage of a foundation trust's income that could be generated from private sources. The Bill would also make contracts between CCGs and NHS foundation trusts non-enforceable in a court of law (replicating the position of contracts between CCGs and NHS trusts). The Bill also potentially introduces a direction-making power over NHS foundation trusts. The Bill does not contain any provisions to deal with the transition from the current freedoms available to foundation trusts to a new landscape of what are unclear controls (as the Bill is currently drafted) over private income and non-enforceable contracts.

If the Bill was enacted, there would be broader questions as to whether there is a tangible difference between the powers of NHS trusts and NHS foundation trusts, and whether all NHS providers should be viewed as part of a single organisation with more clear accountability mechanisms back to the Secretary of State. Currently the system can feel incoherent and inconsistent in its approach to NHS providers and more specifically NHS foundation trusts. At times, they are expected to act for the 'greater good' of the NHS as a whole but at other times they are treated as independent entities that compete for activity and must 'break even' financially. Is the NHS a single organisation or a system of semi-autonomous organisations? Until that question is answered there is a risk that the systems of management and regulation will be inconsistent and misaligned.

---

[8] Webb, D (2014) *The Transatlantic Trade and Investment Partnership (TTIP)*. House of Commons Library

[9] Council of the European Union (2014*) Directives for the negotiation on the Transatlantic Trade and Investment Partnership between the European Union and the United States of America*. Dated 17 June 2013. Accessed via: http://data.consilium.europa.eu/doc/document/ST-11103-2013-DCL-1/en/pdf

How would legislative change support the NHS to meet its challenges?

The Bill does not introduce widespread structural change per se but would significantly alter the relationship between the Secretary of State and NHS providers and commissioners. Such changes would need to be carefully managed to limit system instability.

The question which needs to be answered by any set of changes, including those set out in the Bill, is whether they better equip the NHS to meet the challenges it will face in coming years. The 2012 Act met with significant criticism for incurring costs to organisational stability without sufficient clarity as to the benefits it would realise.

The NHS Five Year Forward View set out a clear direction for the NHS, based on significant consensus among a range of stakeholders for the NHS to bridge the estimated £30 billion funding gap by 2020/21.[10] Any new initiatives (either policy or legislative changes) should be considered in the context of whether they would support the aims of the Forward View.

For further information, please contact:

Emma Spencelayh, Senior Policy Fellow
020 7257 8000
emma.spencelayh@health.org.uk

www.health.org.uk

See also the accompanying briefing notes, available at: www.health.org.uk/publications/issues-raised-by-the-national-health-service-amended-duties-and-powers-bill/

[10] NHS England (2014) *Five Year Forward Year*. NHS England.