

Evolution, revolution or confusion? Competition and privatisation in the NHS

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‘Health care and the NHS’ is now the most important issue for voters ahead of the election, with 38% saying it was a very important issue, up from 26% shortly before the last general election.¹

A key dividing line between the major political parties is the role of competition between providers of NHS-funded care (both NHS and non-NHS) and the extent to which non-NHS providers should play a role in the health system – often described as ‘privatisation’.

The Health Foundation is publishing a series of briefings and blogs in the run-up to the 2015 general election, to inform the ongoing public debate on health care policy. These materials will analyse and discuss key issues raised by political parties and others about health care policy and the NHS.

In this briefing we consider seven key questions relating to the role of competition and the role of non-NHS providers within the NHS. We mainly focus on England because, although the United Kingdom will elect a new parliament and government in May 2015, health has been a devolved matter since the late 1990s and each of the devolved administrations has taken a distinct approach to the NHS.²

This briefing draws on material from the Health Foundation’s briefing on NHS finances, which is available at www.health.org.uk/fundingbriefing

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Key points

- There has been a longstanding drive to increase competition between providers of clinical care in the NHS. From the early 1990s this focused on competition between NHS trusts, and from the early 2000s between NHS and non-NHS providers. The coalition government did not introduce competition to the NHS; however, the Health and Social Care Act 2012 did signal a shift in the development of competition within the NHS.
- The empirical evidence on a causative link between such competition and quality of care for patients is relatively weak. More evidence is needed before any definitive conclusions on its successes or failures can be made.
- The terms competition and ‘privatisation’ are often used interchangeably. However, they are not the same thing. There can be competition between NHS providers without privatisation, and privatisation without competition.
- ‘Privatisation in the NHS’ has become a catch-all term to mean many different things. During debate, there needs to be clarity as to which of three concepts the term ‘privatisation’ is being used to describe:
 1. **A greater role for non-NHS providers in providing NHS-funded services.** Since its inception, the NHS has purchased primary care and some other forms of clinical care from providers that are not owned by the NHS. Over time an increasing proportion of the NHS budget has been used to commission services from non-NHS providers. In 2013/14, £10.4bn was used to purchase care from non-NHS providers (excluding primary care), representing approximately 10.8% of total commissioner expenditure in England (based on 2014/15 prices).*
 2. **A greater role for non-public bodies or individuals in financing health services.** The global economic crisis since 2008 has had an impact on both public and private spending but so far the impact has been greater on private spending. In 2012, private spending made up 16.0% of overall health care spending – the lowest proportion in more than 15 years (equal with 2010). The Health and Social Care Act 2012 by design did not change the fundamental principle that the NHS operates as a comprehensive health service in England and that services must be free of charge (with very few exceptions such as prescription charges).
 3. **A transfer of assets from the NHS to the non-NHS sector.** There is little evidence that publicly-owned assets are being transferred *en masse* to the private sector. However, there are examples of state assets that are linked to the NHS having been sold to investors, such as the sale of Plasma Resources UK in 2013.
- While the role non-NHS providers should play in the NHS divides political parties, it appears this is reflected to a lesser degree by the public. The British Social Attitudes Survey 2014 found that less than half of the public (39%) reported a preference to receive their NHS-funded treatment from an NHS provider.

* Where financial figures are based on 2014/15 prices, they are based on the GDP deflator published on 12 January 2015. Accessed via: HM. Treasury. *GDP deflators at market prices, and money GDP*: December 2014 (Quarterly National Accounts). HM Treasury; 2015.

Introduction

The Conservatives, Labour and the Liberal Democrats have all introduced policies while in government that promote the ability of the public to choose who provides their NHS-funded health care, in part by encouraging non-NHS bodies (private or voluntary sector) to provide NHS-funded care.

In practice, the main political parties have been quite closely aligned on health policy since 2000. However, the passage of the Health and Social Care Act 2012³ saw the role of competition and the use of non-NHS providers in the delivery of clinical care re-emerge as a major dividing line between the parties.

A note about terms

The terms ‘competition’ and ‘privatisation’ are often used interchangeably, yet they actually describe two distinct issues. There can be competition between NHS providers without privatisation, and privatisation without competition.

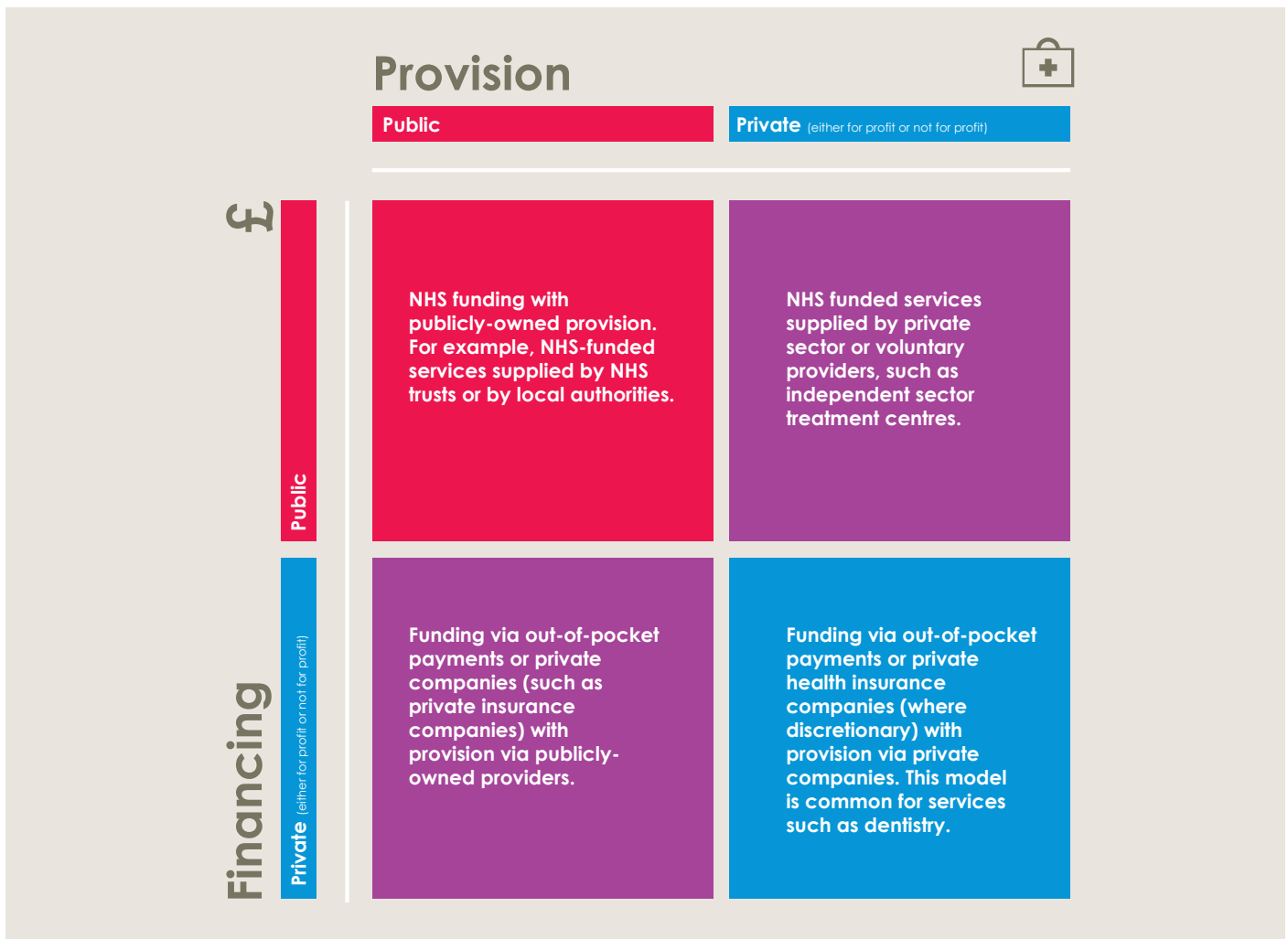
Table 1 gives definitions of some of the terminology around competition and privatisation used in this briefing.

Table 1: Terminology

Term	Definition
Commissioning	The process for determining which services a particular population needs and arranging these services. NHS England commissions specialised and primary care services at a national level and NHS clinical commissioning groups are responsible for securing NHS-funded services for their local population.
Competition based on choice	Patients and service users are able to choose between different providers of care services (whether NHS or non-NHS). ⁴
Competition for contracts	Providers compete for the right to provide a particular service to patients where a commissioner may only want to award a contract to a limited number of providers. ⁴
Independent sector	For the purposes of this briefing, we have avoided, wherever possible, the phrase ‘independent sector’ in favour of the term ‘non-NHS’ because there can be confusion over what/who ‘independent sector’ refers to. References to ‘independent sector providers’ in the financial data in this briefing generally refer to private sector providers.
Internal market	A system introduced in the 1990s whereby NHS commissioners bought health services from NHS providers.
Managed competition	A strategy to purchase the maximum value for patients and users of health care using rules for competition. ⁵
NHS provider	For the purposes of this briefing, NHS providers are statutory NHS bodies such as NHS foundation trusts, NHS trusts and care trusts.
Non-NHS provider	For the purposes of this briefing, non-NHS providers include all bodies that are not statutory NHS organisations. For example, local authorities, voluntary sector providers and private sector providers.
Privatisation	In the context of the NHS, the term ‘privatisation’ is used quite differently by diverse audiences. As such, this briefing considers ‘NHS privatisation’ with respect to three issues: <ul style="list-style-type: none">• A greater role for non-NHS providers in <i>providing</i> NHS-funded services.• A greater role for non-public bodies or individuals in <i>financing</i> health services.• The transfer of ownership and control of government or state assets, firms and operations to private investors (the OECD definition).⁶
Provider of NHS services	For the purposes of this briefing, a provider of NHS services includes NHS providers and non-NHS providers who provide NHS-funded care.

This briefing clearly signposts whether a policy change or proposal relates to greater non-NHS* involvement in financing or provision of clinical care, greater competition between providers of clinical care, or both. Figure 1 below gives a high-level framework for understanding the relationship between public and private funding and provision of NHS care. For example, NHS-funded care provided by an NHS trust would be publicly financed and publicly provided. However, NHS-funded palliative care provision delivered by Marie Curie would be publicly financed and privately provided.

Figure 1: Public sector and non-public sector functions within the NHS



* While local authority provision would be 'public' and 'public' in terms of the matrix in table 1, local authority providers of services would count as non-NHS providers.

1. Did the coalition government introduce competition into the NHS?

No. There has been a drive to increase competition for the provision of clinical care in the NHS from the early 1990s onwards. The NHS has made use of non-NHS providers such as general practitioners since its inception; however, it is only during the last 15 years that non-NHS providers have been able to compete directly with NHS providers to provide NHS-funded clinical services. NHS spending on non-NHS providers has increased during the current parliament.

Reform during the 1980s and 1990s

Increased competition (between NHS providers)

Widespread structural reform of the NHS was proposed following the publication of *Working for Patients*, the Conservative government's 1989 white paper, which introduced a separation between the purchasing and the provision of health care.⁷ The white paper also introduced GP fundholding, whereby large GP practices would be able to apply for their own budgets to procure services directly from hospitals.⁷ The intention was that GP fundholders would be able to select providers on the basis of price and quality, and providers would have incentives to improve the efficiency of their services. The white paper also proposed the creation of self-governing NHS hospital trusts. NHS hospital trusts would earn revenue from the services they provided, as well as having additional freedoms, such as the ability to employ their own staff.⁷ The resulting National Health Service and Community Care Act received royal assent on 29 June 1990.⁸

Increased private sector involvement

During the late 1980s, the NHS faced considerable financial pressure and low levels of quality and efficiency created dissatisfaction.⁹ For example, the British Social Attitudes Survey of 1983 found that 26% of the public were very/quite dissatisfied with the NHS overall; this had increased to 47% of respondents being very/quite dissatisfied in 1990.¹⁰

As part of a drive to extend the choice of providers available to patients, the Conservative government implemented policies that aimed to expand the provision of private medical insurance by providing tax relief to the over-60s.¹¹ In parallel with these efforts to expand private insurance coverage, the Conservative governments of the 1980s made efforts to encourage greater diversity among suppliers of ancillary services in the NHS, such as cleaning.¹² The Conservatives did not attempt to extend compulsory tendering to clinical NHS services. However, private provision of residential care began to grow during this period.

In social care, there had been a growing trend from the 1960s onwards to shift local authority-funded care for older people away from institutions and into the community. However, during the 1980s, perverse financial incentives accelerated the growth of residential care homes, as opposed to care in the home. For example, under the benefits regime, the Department of Health and Social Security would cover care home fees for people on low incomes,

but not the costs of caring for them at home. This led to a rise in private care home provision.¹³ Then, in 1990, the National Health Service and Community Care Act transferred responsibility for funding, planning and means-testing community care services from the Department of Social Security to local authorities. This ended the previous regime of open-ended and demand-led expenditure as local authorities became responsible for allocating funding for places in residential homes, as well as domiciliary care services such as home assistance and care.¹⁴

Competition under the Labour government, 1997–2010

When the Labour government first came to power in 1997, it did not support the introduction of the internal market. The Labour Party manifesto made a specific commitment to end the Conservatives' internal market in health care, suggesting that:

*'Under the Tories, the administrative costs of purchasing care have undermined provision and the market system has distorted clinical priorities. Labour will cut costs by removing the bureaucratic processes of the internal market.'*¹⁵

Later that year, the new government set out how it intended to create a system based on partnership and driven by performance management in the white paper *The new NHS: modern and dependable* (although the split between purchasers and providers was retained).¹⁶

Increased competition (between NHS providers)

As the Labour government's plans for the NHS developed, the concept of patient choice was to become a major driver of health policy. While choice under the Conservatives had focused on increasing access to private insurance, under Labour the focus was on increasing the options available to NHS patients, so that choice became a catalyst for increasing provider diversity in the NHS. In September 1999, in his speech to the Labour Party conference, the Prime Minister Tony Blair stated that:

*'A predecessor of mine famously said she wanted to be able to go into the hospital of her choice, "on the day I want, at the time I want, with the doctor I want". That was Margaret Thatcher's argument for going private. I want to go to the hospital of my choice, on the day I want, at the time I want. And I want it on the NHS.'*¹⁷

One year later, the *NHS Plan*¹⁸ was published under Alan Milburn's tenure as Secretary of State for Health. The Plan outlined significant changes to how health care in England was to be organised, with the intention of 'modernising' the service. It aimed to strengthen the role of patient choice and included a commitment to ensure that patients could book any hospital or elective admission at a date and time that was a convenient for them. Running through the *NHS Plan* was the desire to wage a 'war on waiting'.¹⁹ Patient choice was gradually extended until 2008, when all patients registered with a GP in England were given the right to choose from any NHS-funded provider following a referral for a routine elective hospital service.²⁰

* 'Modernising' can be an ambiguous term but within the NHS plan there was a focus on redesigning the health service around the needs of patients with a focus on increasing accountability and performance.

Unlike in the internal market system in the 1990s, competition was designed to operate on quality, not on price. This is because in April 2002, the Department of Health introduced prospective payment with nationally set prices for acute, elective activity under 'payment by results' (PBR). The introduction of PBR coincided with the drive to decrease waiting times, as providers were rewarded for additional activity.²¹ Previously, block contracts had been widely used: hospitals were paid a fixed rate to provide a broad range of services and there was little financial incentive to increase activity.

The Labour government built on the Conservatives' 1989 reforms by further extending the powers and independence of self-governing NHS trusts. The new model of trust (NHS foundation trusts) was established under the Health and Social Care (Community Health and Standards) Act 2003. Unlike NHS trusts, NHS foundation trusts were autonomous organisations that were not subject to direction from the Secretary of State for Health. This resulted in more freedom for NHS foundation trusts taking them outside of the direct ownership of the Secretary of State. The legislation provided for an independent regulator (later known as Monitor) to oversee the performance of foundation trusts.²²

Increased private sector involvement

Significantly, the government suggested that the private and voluntary sectors would have a role to play in ensuring patients received the full benefit of the increased financial investment in the NHS which accompanied the reforms outlined in the NHS Plan.¹⁸ In a speech to the Social Market Foundation in 2003, the then Chancellor of the Exchequer, Gordon Brown, emphasised the need to move away from 'discredited dogmas' about how the public sector should operate. He stated that the private sector could play a valuable role in supporting the NHS, but that the sector shouldn't be able to 'exploit private power to the detriment of efficiency and equity'.²³

The *NHS Plan* led to the development of independent sector treatment centres (ISTCs) to provide fast, pre-booked surgery and diagnostic tests for NHS-funded patients by separating scheduled treatment from emergency care. Treatment centres were run both by the NHS and by non-NHS providers. Private sector involvement was intended to provide additional capacity, in part to reduce waiting times. In 2003, the first ISTC – the Birkdale Clinic – was opened in Daventry.²⁴

In its 2006 report on ISTCs, the Health Select Committee concluded that separating elective and emergency care in treatment centres where there was local agreement, and need, had been beneficial. However, the committee was not convinced that ISTCs provided better value for money than alternatives such as NHS treatment centres, partnership arrangements or greater use of NHS facilities out of hours. The report suggested that ISTC providers were paid, on average, 11.2% more than the equivalent cost to the NHS and were given financial guarantees of a certain income regardless of activity. However, it found that ISTCs did play a role in reducing the price paid for 'spot purchases'* with private providers. Previously, the NHS had made use of the independent sector on an ad hoc basis, often paying 40-100% more than the equivalent cost to the NHS.²⁵

* Purchasing arrangements that relate to a single service user or patient

Under Labour, the Department of Health introduced a number of initiatives in an attempt to increase the range of bodies providing NHS services. For example, the 2006 white paper *Our health, our care, our say: a new direction for community services* outlined the important role that the voluntary sector played in the NHS, but noted that the barriers for market entry were often too high. It outlined plans to establish a Third Sector Commissioning Task Force to address the key barriers to a sound commercial relationship between the public and the voluntary sectors. The white paper also focused strongly on supporting the development of social enterprises,^{*} and the Department of Health committed to establishing a Social Enterprise Unit which would provide funding (from April 2007) to support the development of new models of care provided by the voluntary sector.²⁶

In the 2004 *NHS Improvement Plan: Putting people at the heart of public services*, the Labour government set out an expectation that the independent sector would supply up to 15% of NHS services by 2008.²⁷ However, a later evaluation of the Labour government's market reforms concluded that there had not been a large expansion in the quantity of non-NHS activity by the time of the general election in 2010.²⁸

Transforming community services

The *NHS operating framework 2008/09* included a requirement that by April 2009 all primary care trusts (PCTs) would need to create an internal separation between their commissioning functions and their operational provider services and agree service level agreements for these services based on the same business and financial rules as applied to all other providers.²⁹ By October 2009, PCTs were expected to have developed detailed plans for transforming their community services and to consider models of service provision for the future. The 'transforming community services' programme was intended to support this transition. PCT providers were asked to consider governance models such as social enterprises or community foundation trusts. PCT Commissioners were asked to consider a range of contracting options for their community services.³⁰ A freedom of Information request response outlined that at 17 January 2011, PCTs planned to integrate the majority of services (by value) with acute, mental health or community NHS foundation trusts and care trusts (80%). Social enterprises would form 10% of community services by value with the remaining 10% being contracted out or being merged with existing community providers.³¹

Top-ups

The government also issued guidance in 2009 stating that patients could pay for additional private health care through 'top-ups', while continuing to receive care from the NHS, as long as the NHS was not subsidising private care and there was a clear separation between NHS and private care.³²

* A business with primarily social objectives whose surpluses are principally reinvested for that purpose.

A change in direction?

On 17 September 2009, the then Secretary of State for Health, Andy Burnham, announced that he would adopt an NHS 'preferred provider' approach, stating that:

“The time has come for us to set out a better way of pursuing reform in the NHS. Top-down reform was right for its time, but it can only go so far. It led to a feeling that reform was imposed; done to people, rather than with them. It gave unintended messages at ward level – “public bad, private good” and process targets implied a lack of trust.”³³

In October 2009, a letter from Sir David Nicholson, Chief Executive of the NHS, outlined the need for commissioners (at that time PCTs) to engage with new and existing services, enabling them to contribute to a service specification before a decision on whether to tender openly could take place. Existing providers would have the opportunity to improve their services before a tendering process was commenced. However, the letter also outlined that the government remained committed to the participation of non-NHS providers in circumstances that were quite broad. Specifically where:

- new service models were required
- there was a need to increase capacity
- participation of non-NHS providers would offer choice to patients, or participation of non-NHS providers could ‘stimulate innovation’.³⁴

2. Did the Health and Social Care Act 2012 increase privatisation?

The Health and Social Care Act 2012 made changes to the structures of the NHS in terms of how providers were regulated and how services were purchased. It sent a strong message that competition was perceived as a positive force for improving the quality of care.

The Act, as it was passed, had a different emphasis to the original bill, with a weaker focus on economic regulation than was originally envisioned. The Act did not change the fundamental principle that the NHS operates as a comprehensive health service in England and that services must be free of charge (with some exceptions, such as prescriptions).

The early days of the coalition government

In 2010, the then Secretary of State for Health, Andrew Lansley, outlined a vision for an NHS in which competition was maximised and promoted by Monitor, the foundation trust regulator.³⁵ The white paper *Equity and excellence: liberating the NHS* set out the government's vision for a reformed health service that gave patients and the public more choice and control, while giving providers and professionals more autonomy.³⁶ A key focus of the Lansley reforms was to measure success through outcomes of care for patients, rather than centrally set process measures, such as targets. The white paper also made it clear that increasing the diversity of providers of clinical care was a key objective.

The government aimed to allow 'any willing provider' to supply clinical services (as appropriate), thereby giving patients greater choice and stimulating innovation and improvement through greater competition. The white paper also outlined the government's intention to alter the role of Monitor, making it an economic regulator with responsibility for promoting competition, regulating prices and safeguarding the continuity of services.³⁶

Part three of the Health and Social Care Bill, as introduced on 19 January 2011, was dedicated to the economic regulation of health and adult social care services, and was to become one of the most controversial aspects of the bill during its parliamentary passage (see Annex A for more detail). The Health and Social Care Act 2012 marked a shift in the role of competition in the NHS, but it represented a progression of previous policies.

Competition

One of the main changes in the Act was to turn Monitor's role from regulator of NHS foundation trusts into a broader 'sector' regulator. Initially, one of Monitor's key responsibilities in the bill as first introduced had been to protect and promote the interests of people who use health care services by encouraging competition where appropriate. Following various amendments, the final Act changed this to ensure that the main duty of Monitor in exercising its functions was to protect and promote the interests of people who use health care services by promoting economic, efficient and effective provision that maintained or improved quality.³⁷

Sector regulation under the Health and Social Care Act 2012

The Health and Social Care Act 2012 set out provisions for the regulation of health and adult social care services in England and defined the role of the sector regulator, Monitor. The Act outlined that Monitor's overriding duty would be to protect and promote the interests of patients by promoting **economy, efficiency and effectiveness** in the provision of health care, while maintaining or improving quality.

With respect to competition, Monitor was given concurrent powers with the Office of Fair Trading (OFT) to apply the Competition Act 1998 (allowing Monitor to investigate anti-competitive practice) and the Enterprise Act 2002 (in relation to market investigations). The OFT has since merged with the Competition Commission to form the Competition and Markets Authority.

The Health and Social Care Act 2012 gives Monitor powers to:

- run a system of licensing of providers of NHS services
- set and enforce requirements to secure continued provision of NHS services
- regulate prices for NHS services through a national tariff (national prices and rules), in conjunction with NHS England
- secure continuity of NHS services that are provided by companies through a process of 'special administration'
- establish funding mechanisms to enable trust special administrators to secure continued access to NHS services.

The Health and Social Care Act 2012 also gave the Secretary of State powers to make regulations that could place requirements on commissioners with respect to good practice in procurement, patient choice, anti-competitive conduct and conflicts of interest. These regulations – known as 'Section 75 regulations' made it a general requirement that the purchasing of health care services should be carried out in a transparent manner and that all providers should be treated equally. As a result, where commissioners advertise an intention to seek offers from providers, they must publish a contract notice, unless they are satisfied that appropriate services can only be provided by one organisation. Commissioners are also prohibited from engaging in anti-competitive behaviour, except where it is in the interests of the people who use NHS services.

Role of non-NHS providers

The Act seeks to prevent any type of provider being preferred or promoted based on ownership status – whether NHS or non-NHS. It prohibits both the Secretary of State and Monitor from deliberately setting out to increase or decrease the market share of any type of provider.

On 21 May 2012, the Secretary of State wrote to Monitor asking it to carry out an independent review of the issues limiting the ability of new providers to supply NHS-funded services. The regulator found three potential areas in which the provider playing field may be being distorted, impacting on the care delivered to patients.

- **Participation distortions:** some providers were directly or indirectly excluded from offering their services to NHS patients for example because of poorly designed procurement processes.
- **Cost distortions:** some types of provider faced externally imposed costs that were not universally applied across all providers for example differences in access to rebates for Value Added Tax (VAT).

- **Flexibility distortions:** public sector providers faced different obligations to voluntary or private sector providers. For example, mandatory service obligations, rigidities in public sector workforce and the possibility of direct government intervention.³⁸

The Act did not do anything to change the way in which the NHS is financed and did not change the fundamental principle that the NHS operates as a comprehensive health service in England with services that must be free of charge (with some exceptions, such as prescriptions).

The Act increased the autonomy of NHS foundation trusts, including by repealing the private patient income 'cap', which had previously limited the amount of money that foundation trusts could earn from private sources.* The Act effectively allowed trusts to increase their private income to 49%. Where a foundation trust proposed to increase their private income by 5% or more in any financial year, the trust would require more than 50% of the council of governors to approve the proposal. The foundation trust would also be required in its annual report to explain the impact of private provision on its core NHS activity.

* The National Health Service Act 2006 limited the total income an NHS foundation trust could derive from private charges, so that it could not be greater than the proportion it received from such charges in its base year. The base year was taken as the first full financial year in which an organisation was an NHS trust. If the organisation had been an NHS trust throughout the financial year ending with 31st March 2003, the base year was taken as that year or, in the case of a mental health NHS foundation trust, that proportion or 1.5%, if greater.

3. Are NHS commissioners required to put all clinical services out for competitive tender?

No. Commissioners are not required to put all clinical services out for competitive tender. However, there remains confusion within the NHS about the extent to which competitive tendering applies.

The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 have their roots in previous guidance documents issued by Labour in 2007, updated by the coalition government in 2010. However, the regulations go further in imposing requirements on NHS commissioners to ensure good procurement practice and to prevent anti-competitive behaviour.

Commissioners are required to secure the services to meet the needs of their patients, improve the quality of services and improve efficiency (which could include integrated service provision). Competitive tendering may be a mechanism to achieve those objectives but is not an end in itself.

Background

The Health and Social Care Act 2012 gave the Secretary of State the power to make regulations that would place requirements on commissioners with respect to good practice in procurement, patient choice, anti-competitive conduct and conflicts of interest. These regulations – known as the ‘Section 75 regulations’ – generated considerable opposition.³⁹ However, many of the principles contained within them had their roots in existing guidance issued from 2007 onwards.

In December 2007, the Department of Health published the Principles and Rules for Co-operation and Competition (PRCC). The PRCC was intended to set out the expected behaviours and rules governing cooperation and competition. As well as announcing plans to develop an independent Competition Panel, the document set out ten principles that would apply from April 2008.

The PRCC stated that in order to make the system operate effectively in the interests of patients, more competition would sometimes need to be encouraged through the purchase of NHS-funded care from new (non-NHS) providers, but at other times enforced cooperation between providers would be necessary. Key provisions included a requirement that commissioners should contract with the provider best able to meet the needs of their local population, and both commissioners and providers were required to foster patient choice.⁴⁰

In July 2010, the Department of Health updated the PRCC to take into account the coalition government’s plans as outlined in *Equity and excellence: liberating the NHS*. While the ten principles remained similar to those published in 2007, the role of choice and competition within the NHS was strengthened. For example, in 2007, one of the principles related to fostering

choice. In the revised guidelines, commissioners and providers would be required to promote patient choice with specific reference to the policy of ‘any willing provider’ (later ‘any qualified provider’).

The updated PRCC contained a new requirement stating that commissioners and providers should not reach agreements that would restrict commissioner or patient choice of providers against the interests of patients or taxpayers. The document also outlined guidance that aimed to prevent individual providers from unreasonably refusing to supply services and cited circumstances where established providers had attempted to restrict choice or competition by refusing to accept or provide services.⁴⁰

The ‘Section 75’ Regulations

On 11 February 2013, the Secretary of State made the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013, otherwise known as the ‘Section 75 Regulations’ (see box).⁴¹ They replaced the PRCC but maintained many of the same principles.

The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

The regulations imposed requirements on the NHS Commissioning Board (now NHS England) and clinical commissioning groups (CCGs) in order to ensure good practice in relation to the procurement of NHS services, to ensure the protection of patients’ rights to make choices regarding their NHS treatment and to prevent anti-competitive behaviour by commissioners.

The regulations gave commissioners a general duty to secure the needs of the people who use their services, and improve the quality and efficiency of services, including through integrated provision.

The regulations also established:

- a general requirement for the procurement of health care services to be carried out in a transparent and proportionate manner, and for all providers to be treated equally. Commissioners should establish and apply proportionate and non-discriminatory criteria
- requirements in relation to transparency in the awarding of contracts for the provision of health care services. CCGs or the NHS Commissioning Board are required to publish a contract notice, unless they are satisfied that the services can only be provided by one provider
- that a contract can’t be awarded where actual or potential conflicts of interest between the provider and the commissioner affect the integrity of the contract. A conflict arises where an individual’s ability to exercise judgement or act in their commissioning role is impaired or influenced by their interests in the provision of those services
- that commissioners are prohibited from engaging in anti-competitive behaviour, except where it is in the interests of people who use NHS health care services
- that commissioners are required to offer a choice of alternative provider following a referral to a health service provider, in accordance with the *National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012*
- powers for Monitor to investigate and take enforcement action in relation to breaches of the regulations.

The Section 75 Regulations attracted parliamentary opposition:⁴² on 7 March 2013 the House of Lords Secondary Legislation Scrutiny Committee published a report which concluded that the regulations marked a significant change and would require commissioners to use competitive tendering for more services.⁴³ Four days later, the government laid amended regulations in parliament, against a background of opposition and the prospect of a Liberal Democrat revolt.

The amendments intended to make it clearer that: there would not be a requirement to put all contracts out to competitive tender; Monitor would not have the power to force competitive tendering; and commissioners should be free to use integration if it was in the interests of patients.⁴⁴ Labour peers attempted to annul the revised regulations during a debate on 24 April 2013. Lord Hunt of King's Heath, Shadow Spokesperson for Health, suggested that the regulations were part of a 'drive to shift the culture of the NHS from a public service into a public marketplace.'⁴⁵ Earl Howe, Parliamentary Under Secretary of State for Quality, countered, saying that:

'one area of the law that we have not changed one iota is the law relating to competitive tendering... these regulations usher in nothing new at all... there is no government agenda to privatise NHS services – quite the contrary'.⁴⁶*

While the regulations do not specify that all services have to be put out to tender, there remains confusion about how the legislation should be applied despite guidance from Monitor. For example, a recent report from the King's Fund on commissioning and contracting for integrated care outlined that CCGs are often uncertain about when a procurement process is necessary, to what extent it is obligatory and what is involved in the technical process itself.⁴⁷ The guidance from Monitor is clear that there are circumstances in which a decision to commission services without publishing a contract notice or running a competitive tendering process is appropriate. The circumstances where this would apply include:

- if there is only one provider capable of supplying services (for example, if it is not viable for providers to deliver one service without also providing another)
- if an NHS commissioner has carried out a detailed review of services and identified the most capable provider of those services
- where the benefits of publishing a contract notice would be outweighed by the costs of running a tender exercise.⁴

The picture has become slightly more complicated as new public sector procurement regulations, the Public Contracts Regulations 2015, have also been introduced. The Labour Party has expressed concern⁴⁸ about the effect the new Public Contracts Regulations 2015, which were laid before parliament on 5 February, will have on NHS procurement and whether the regulations would require compulsory tendering for large NHS contracts. The regulations and the explanatory notes suggest that the new procurement scheme '*necessitates advertising of relevant contracts above a threshold of €750,000*'. These regulations will sit alongside the NHS Procurement, Patient Choice and Competition Regulations 2013 and their implementation will be delayed until April 2016 to allow NHS commissioners time to adapt.⁴⁹

* It is not clear what definition of privatisation was being used in the debate.

The Department of Health has denied that NHS commissioners would be required to issue invitations to tender, instead suggesting that the publication of a notification would only be required once a decision has been made to go to market.⁴⁸ Further clarity is needed for the NHS on the interface between the two sets of regulations.

4. Does competition improve quality of clinical care?

The empirical evidence of a causal link between competition and quality of clinical care is still relatively weak. The evidence base for other complex health reforms, such as increasing integration of care, is also limited. As such, it can be difficult to separate the impact of the policy (that is, introducing competition) from the impact of how it is implemented. More evidence is needed before a definitive objective conclusion is possible about the impact of competition on patient care and on the performance of existing NHS providers.

Introduction

In many industries, it is accepted that competition is good for consumers. The rationale for this is that where it works, competition results in greater choice, better quality products and services and lower prices.⁵⁰ However, the picture is more challenging in health care, where specific factors contribute to the need to intervene in the market, such as:

- an imbalance of knowledge and information between consumers and health professionals
- the risk that some patients will use more services than they need to if they don't pay directly for them (moral hazard)
- the possibility that care providers or insurers driven by profit may select healthier patients with lower predicted costs (cream skimming)
- health care can be a distressed purchase, for example urgent and emergency care.

A significant challenge in relation to competition in health care is the ability of patients and users of health services to make truly informed decisions when choosing providers. While competition has existed within the NHS for some time, public awareness of a patient's right to choose is somewhat limited. A number of studies have shown that the role of the GP is critical in this decision-making process.^{51,52} A survey conducted by Monitor in 2014 suggested that of those who had seen a GP in the last 12 months and had been referred for an outpatient appointment:

- 51% were aware of their right to choose a hospital or clinic for an outpatient appointment before visiting the GP
- 53% had discussed where to have their treatment
- 38% were offered a choice of hospital or clinic.⁵³

Research suggests that patients do want to be offered a choice of provider, as well as choice of treatment. However, we know more about the impact of shared decision making* on patients' experience and outcomes than we do about the impact of choice of provider.⁵⁴

* A collaborative process that allows patients and their providers to make health care decisions together.

Gravelle and others reviewed 12 studies focused on the influence of quality on patient choice of hospital. Most of the studies found that there is a positive association between demand for care and quality after controlling for other factors, including distance and waiting times. Three of the 12 papers focused on the English NHS. All three considered used mortality rates as a measure of quality with one using a range of measures including ratings by the Care Quality Commission and infection rates.⁵⁵

However, when patients or service users do actively choose providers, they may not do so for the reasons policy makers expect. The Nuffield Trust highlights that the evidence suggests that patients often pick providers on the basis of convenience rather than on the basis of quality indicators or ratings. This view is supported by a study focusing on the impact of high profile investigations between 2006 and 2009 on admission trends for discretionary care. In two out of three hospitals studied, the investigations had no impact on hospital use. Since one of these two hospitals was Mid Staffordshire NHS Foundation Trust, it appears that even when quality failures are significant and well-publicised, they do not always result in a change in patient behaviour.⁵⁶

Challenges in measuring the effects of competition

Bevan and Skellern produced a helpful summary for the British Medical Journal on the challenges of assessing whether competition between hospitals improves quality of care for patients. Their paper argues that the market conditions introduced under the Labour government of the early 2000s resulted in a better market structure than the Conservatives' internal market in the 1990s due to the elimination of price competition, and the provision of greater quality information and stronger incentives to increase market share. The article concludes that the impact of patient choice on outcomes in elective surgery remains an open question and the exact role of patient choice as a policy lever remains unclear.⁵⁷ It also summarises some of the methodological challenges in estimating the causal effects of competition on outcomes (see table 2).

Table 2: Methodological limitations in measuring the effects of competition on outcomes according to Bevan and Skellern, 2011⁵⁷

Issue	Limitations
Measuring the intensity of competition and defining the size of a hospital's market	However it is measured, market structure is not necessarily a good proxy measure for the intensity of competition.
Measuring quality	Hospital mortality rates after acute myocardial infarction (heart attack) have been used as a proxy for the quality of clinical care across organisations. However, patients do not choose hospitals on the basis of quality when they are having a heart attack – they are generally taken to the nearest hospital. The implicit assumption is that quality for emergency patients is highly correlated with quality for non-emergency patients. 'All cause' mortality measures are also used but deaths from elective surgery are rare and additional measures of quality such as outcome measures are needed.
Estimating the effect of competition between providers on quality	Researchers need to show that variation in the intensity of competition is independent of hospital quality. If this is the case, changes in quality could be attributed to competition through correlation. Effectively, the intensity of competition should affect quality, but not be affected by changes in quality. However, high quality organisations might attract patients from wider catchment areas, making quality a factor in determining the intensity of competition.

Competition based on price

As Bevan and Skellern suggest,⁵⁷ current evidence on the impact of competition within the NHS is mixed. Broadly speaking, the evidence suggests that competition based on price can have a negative impact on quality measures such as mortality rates. For example, in 2004 research by Propper and others found that competition under the internal market regime of the 1990s (where there was competition on price and quality) found that although the estimated impact of competition was small, greater competition was associated with higher death rates.⁵⁸ In 2008, Propper and others found that hospitals located in more competitive areas had higher death rates between 1991 and 1997, but that competition appeared to reduce waiting times. The authors concluded that competition led providers to focus more on measurable activities, such as waiting times, at the expense of less easily measured aspects of quality.⁵⁹

Competition on quality (where prices are regulated)

In contrast, a number of studies have suggested that where prices are regulated, competition could have a positive impact on quality. For example, Cooper and others investigated whether the expansion of patient choice in the NHS in England in 2006 led to a change in hospital quality, using acute myocardial infarction (AMI) mortality data. The researchers found that, after the reforms were implemented, higher levels of competition were associated with a faster decrease in 30-day AMI mortality (within hospitals only).⁶⁰ Similarly, over the same period, Gaynor and others found that competition saved lives without raising costs. A rise in competition measured as a 10% decrease in the Herfindahl–Hirschman Index (HHI, a measure of market concentration) was associated with a fall of 2.91% in the 30-day AMI mortality rate.⁶¹

Bloom and others have analysed the causal impact of competition on managerial quality and hospital performance using political marginality (that is, areas that are marginal parliamentary seats) as a variable for the number of hospitals in an area. The authors suggest that UK politicians rarely allow hospitals to close in marginal seats therefore leading to higher numbers of hospitals and higher rates of competition. They found that higher competition was associated with a higher quality of management and improved hospital performance. Adding a rival hospital was associated with increased management quality (based on survey data) by 0.4 standard deviations and increased 28-day survival rates after emergency AMI by 1.5 percentage points (9.7%).⁶²

A paper from the Centre for Health Economics at the University of York examined the effects of hospital market structure on the risk of mortality among hip fracture and stroke patients, in addition to AMI, between 2002/03 and 2010/11. The researchers also considered whether this effect changed after the introduction of the right for NHS patients to be offered a choice of at least four providers from 1 January 2006 onwards.

The study found that for AMI and hip fracture, hospitals with more rivals had higher mortality at the start of the period, but the effect became smaller over time, which is consistent with previous studies. Following the introduction of 'choice', the detrimental effect of rivals was smaller and statistically significant only for hip fracture. However, the decline in the apparently harmful effect of market structure seemed to pre-date the introduction of choice in 2006.

The authors suggest that this decline in apparently harmful effects may have been prompted by improved medical knowledge and also the introduction of 'payment by results' which increased a provider's income according to the number of patients that were treated. Market structure did not appear to have any effect on stroke mortality.⁶³

A recent study of the association between market concentration of hospitals and patient-reported gains used patient-reported outcome measures data, linked to NHS Hospital Episode Statistics in England 2011/12 after elective primary hip replacement surgery. It concluded that using hospital market concentration as a proxy for competition appears to show no significant association between competition and the outcome of elective primary hip replacement, but these findings cannot necessarily be broadly applied due to the limited nature of the data.⁶⁴

In 2014, the Office of Fair Trading (now part of the Competition and Markets Authority) published an analysis of the theoretical and empirical literature on the impact of competition on quality. The review noted that the empirical literature is '*recent and still relatively sparse*' and '*it is probably too early to draw any general lessons from this*'. However, the report also stated that for health care, empirical studies suggest that competition leads to improvements in some measures of quality when prices are regulated.⁶⁵ The review did not consider the impact of competition relative to a full range of extrinsic incentives that can affect quality in the NHS, such as targets, regulation, commissioning and payment mechanisms, or intrinsic incentives (for example, boosted by better availability of data on performance). It also did not explore whether the relationship between competition and quality outcomes in the literature was causative or merely associative.

The Office of Health Economics' 2012 report on competition in the NHS suggests that competition is feasible across a range of clinical services, but that the nature of the 'customer' (ie whether the customer is a patient or a commissioner of care) can affect some dimensions of competition (including demand factors, ease of acquiring information, short-term supply factors, political or institutional factors and cost factors). The customer could be individual patients (with or without access to a GP), a GP acting on behalf of their patient or a commissioner. The report again emphasised that competition based on quality and not price can be beneficial, but recognised that competition is not desirable or feasible for all NHS services in all locations.⁶⁶

One of the arguments in favour of introducing provider diversity is that private or voluntary sector providers might be more efficient. A World Health Organization (WHO) report suggests that the literature on the relative efficiency levels between private and public delivery of health care shows inconclusive evidence, and that the factors that could affect efficiency, such as demand, lack of resources or decision making powers, and payment mechanisms can cut across all types of provider ownership.⁶⁷ A study more specifically related to the NHS context observed that while competition between public providers promoted improvements in efficiency (measured using average length of stay for patients undergoing elective surgery), competition from private hospitals left incumbent public providers with a more costly case mix of patients with increased post-surgical lengths of stay.⁶⁸

5. What have the different political parties said?

Labour and the Conservatives have previously pursued similar policies regarding the separation of provision and purchasing of services, as well as promoting the role of the private and voluntary sectors in providing NHS-funded care. This position now appears to be changing, with the Labour Party arguing that the NHS should be the preferred provider of care. It is unclear at present whether Labour mean by this a policy similar to the 'preferred provider' stance they introduced in 2009 (which was reversed by the coalition government in 2010), or a different, potentially stricter, interpretation.

The table below gives some examples of statements that the major political parties* have made in relation to competition or the role of the private sector between providers for clinical care in the NHS. These statements give a flavour of views and are not intended to be comprehensive. These statements are likely to be superseded by the parties' manifesto commitments when they are published.

Table 3: Announcements by the major national political parties on competition between clinical care providers in the NHS

<p>Conservative Party</p> <p>Equity and excellence: liberating the NHS (2010)³⁶</p> <p>'Providers will no longer be part of a system of top-down management, subject to political interference. Instead, they will be governed by a stable, transparent and rules-based system of regulation. Our aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market.'</p> <p>Jeremy Hunt, Secretary of State for Health: Speech to Conservative Party conference (2014)⁶⁹</p> <p>'We mustn't stop new ideas that come from outside the NHS –whether from charities or, yes, the independent sector. Labour call this "privatisation". But using a charity like WhizzKids to supply wheelchairs to disabled children or using Specsavers to speed up the supply of glasses is not "privatisation". When the last Labour government used the independent sector to bring down waiting times that wasn't "privatisation" either. So stop scaremongering about "privatisation" that isn't happening.'</p>	<p>Ending the role of the Competition and Markets Authority (CMA) in health, making the rules clear that the needs of patients will always come ahead of competition and that services do not need to be put out to tender.</p> <p>Repealing any parts of the Health and Social Care Act 2012 that dealt with competition, if they had been shown to make NHS services vulnerable to increased 'privatisation' through international agreements on free markets in goods and services.</p> <p>Liberal Democrat website: Health⁷²</p> <p>'The Tories and Labour have put the NHS at risk. It was Liberal Democrats who stopped Conservative privatisation plans and reversed some of Labour's policies which meant private health companies got special favours. In fact, Labour paid private companies £250 million for operations they didn't even perform. Liberal Democrats have made sure that can never happen again.'</p>
<p>Labour Party</p> <p>Labour's 10-year plan for health and care (2015)⁷⁰</p> <p>'We will repeal the privatisation laws which force the NHS to waste millions on competition lawyers and tendering, strengthen democratic accountability, and bring in tougher controls on hospitals increasing their focus on private patients to ensure they always put NHS patients first.'</p> <p>'We will place tougher controls on trusts' ability to earn Private Patient Income in order to ensure NHS patients always get put first, and ensure proper safeguards on conflicts of interest.'</p> <p>'We will ensure the [Transatlantic Trade and Investment Partnership] TTIP Treaty cannot impose procurement or competition obligations on the NHS.'</p>	<p>UK Independence Party</p> <p>UKIP website: Policies for People⁷³</p> <p>'UKIP will stop further use of [private finance initiative] PFI in the NHS and encourage local authorities to buy out their PFI contracts early where this is affordable.'</p> <p>'We will ensure that visitors to the UK, and migrants until they have paid NI [National Insurance] for five years, have NHS-approved private health insurance as a condition of entry to the UK.'</p>
<p>Liberal Democrats</p> <p>Protecting public services and making them work for you (2014)⁷¹</p> <p>In October 2014, the Liberal Democrat conference endorsed Policy Paper 119: Protecting Public Services and Making them Work for you as a statement of Liberal Democrat policy. The following approaches to health were agreed.</p>	<p>Green Party</p> <p>Green Party website: Health⁷⁴</p> <p>'The National Health Service must provide healthcare, free at the point of need, funded through taxation. It must be a public service funded by, run by and accountable to local and national government and devoid of all privatisation, whether privatised administration, healthcare provision, support services or capital ownership. The NHS is concerned with healthcare provision and should not be subject to market forces either internal or external.'</p> <p>'The internal market has wasted badly needed resources on administration, and reduced the efficiency and morale of the whole system. The internal market opens the long-term possibility of further privatisation of the NHS. The internal market should be wound up and replaced with clear financial and service accountability of decentralised service units to regional assemblies within a single corporate whole.'</p>

* We have selected the five political parties with the highest projected share of votes: www.electoralcalculus.co.uk

6. Is the NHS being privatised?

‘Privatisation’ is often used to refer to three concepts, namely the extent to which 1) provision, 2) financing and 3) asset transfer, have occurred between the NHS and non-NHS organisations. When referring to ‘privatisation’ it is important to be clear which of these three concepts is meant.

- **A greater role for non-NHS providers in *providing* NHS-funded services:** There is no doubt that a greater proportion of NHS spending now goes on clinical services provided by non-NHS providers (approximately 10.8% of commissioner expenditure in England). What is more concerning is the lack of objective evaluative research showing what impact this may have on incumbent NHS providers, as well as the quality of services provided.
- **A greater role for non-public bodies or individuals in *financing* health services:** In 2012, private spending made up 16.0% of overall health care spending – the lowest proportion in more than 15 years (equal with 2010).
- **A transfer of assets from the NHS to the private sector:** There is little evidence to suggest that publicly-owned assets are being transferred *en masse* to the private sector. However, there are examples where state assets linked to the health service have been sold to investors, such as the sale of Plasma Resources UK in 2013.

The Labour party has made two claims in relation to increased ‘privatisation’:

- the Health and Social Care Act 2012 has resulted in increased privatisation
- five more years of a Conservative government would risk ever greater privatisation.⁷⁵

The Conservatives have denied these claims. The Liberal Democrats suggest that both Labour and the Conservatives have ‘put the NHS at risk’ through ‘privatisation’.

The debate on competition has become increasingly linked to ‘privatisation’, but what does this really mean? The OECD definition of privatisation refers to the transfer of ownership and control of government or state assets, firms and operations to private investors; it also suggests that these terms can be used more broadly to include other policies, such as contracting out, whereby publicly financed or organised functions are carried out by private sector companies.⁶ However, the WHO suggests that this categorisation of wider policies as ‘privatisation’ is not always accurate.⁷⁶

Throughout this chapter, we consider three definitions of ‘privatisation’:^{*}

- A greater role for non-NHS providers in *providing* NHS-funded services.
- A greater role for non-public bodies or individuals in *financing* health services.
- A transfer of assets from the NHS to the private sector (the OECD definition).

* For a further explanation of the relationship between public and private funding and provision within the NHS, see figure 1.

Provision: are non-NHS organisations providing more services?

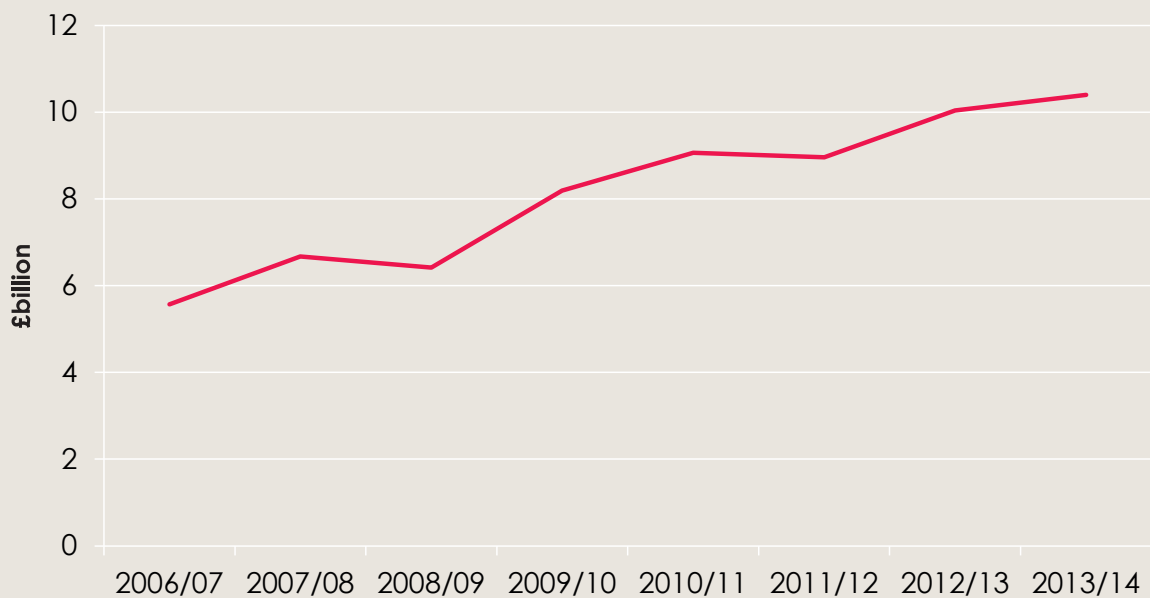
Increased private involvement in health care provision could occur when:

- the ownership of a provider organisation is changed from public to private
- clinical services or management functions are contracted out; or
- patients choose to be treated by private sector providers.⁷⁷

While there had been increasing efforts to open up ancillary services (such as cleaning and catering) to competition during the 1980s, it was not until the early 2000s that the government moved towards increasing non-NHS involvement in NHS clinical services.

In recent years, there has been a steady increase in the amount of care being purchased by NHS commissioners from non-NHS bodies (see figure 2).

Figure 2: Purchase of NHS-funded health care from non-NHS bodies from 2006/07 to 2013/14, excluding primary care (2014/15 prices)



Source: Primary care trusts' financial accounts from 2006/07 to 2012/13 and NHS England annual report & accounts 2013/14.

While most spending on clinical care by NHS commissioners goes to NHS providers, the sum of money spent outside of the NHS represents a significant investment. In 2013/14, £10.4bn was used to purchase care from non-NHS providers (excluding primary care), representing approximately 10.8% of total commissioner expenditure in England (based on 2014/15 prices^{*}).⁷⁸ In addition, NHS providers also purchase health care services from non-NHS bodies. In 2013/14 NHS providers spent approximately £653m buying clinical care from non-NHS providers.⁷⁹

^{*} Where financial figures are based on 2014/15 prices, they are based on the GDP deflator published on 12 January 2015 accessed via : HM. Treasury. *GDP deflators at market prices, and money GDP: December 2014 (Quarterly National Accounts)*. HM Treasury; 2015.

Analysis from the Nuffield Trust shows that between 2006/07 and 2011/12 there was a substantial rise in the proportion of NHS spending on secondary care delivered by independent sector* providers. However, NHS spending on care from voluntary sector providers as a proportion of total PCT spending remained fairly constant.⁸⁰

In 2012/13, the most rapid increase in spending on non-NHS providers was for the provision of community health services. From 2009/10 to 2012/13, spending on independent sector provision of NHS community health services increased from £0.9bn to £1.8bn in real terms (2014/15 prices), and accounted for 18% of the total expenditure on community health services.⁷⁸

Analysis of commissioner spending shows how the proportion of spending on non-NHS providers has increased since 2006/07 (see table 4). The data in table 4 underestimates total spending on non-NHS providers because it excludes spending on independent contractors of primary care services such as general practitioners, dentists, pharmacists and ophthalmologists.

While non-NHS providers have been successful in winning contracts, particularly in community services, overall expenditure on non-NHS providers as a percentage of total NHS revenue spend is relatively small. The Department of Health calculates that spending on independent providers in 2013/14 was 6.1% of total NHS revenue compared with 4.4% in 2009/10.⁸¹

Table 4: Total commissioner spending on the purchase of non-NHS services including general and acute services, accident and emergency services, community health services, maternity services, mental health services, learning disability services and primary care services†. (2014/15 prices)

Year	Independent sector (Independent sector treatment centres and other private providers)	Voluntary and others (including local authorities and NHS bodies outside of England)	Non-NHS	NHS bodies	% independent sector‡	% Non-NHS‡
2013/14§	NA		10,402,704	NA	NA	10.8%
2012/13	6,461,969	3,370,848	9,832,817	83,623,768	6.9%	10.5%
2011/12	5,605,648	3,352,915	8,958,562	86,911,499	5.8%	9.3%
2010/11	5,092,144	3,969,648	9,061,793	87,457,224	5.3%	9.4%
2009/10	4,550,536	3,636,564	8,187,099	89,602,749	4.7%	8.4%
2008/09	3,887,278	3,418,779	7,306,057	84,681,978	4.2%	7.9%
2007/08	3,394,056	3,272,783	6,666,839	83,848,087	3.7%	7.4%
2006/07	2,557,829	3,018,155	5,575,984	82,725,538	2.9%	6.3%

Source: Health Foundation analysis of primary care trusts' financial accounts from 2006/07 to 2012/13 and NHS England annual report and accounts 2013/14.

† It is not clear from accounts data what primary care services were included but in general it excludes GP, dentistry, ophthalmic and pharmaceutical services.

‡ For the 2013/14 financial year the spending on the independent sector and on non-NHS providers was compared against total commissioner operating costs. For other financial years spending against the total purchase of health care.

§ Data for 2013/14 was presented in a different format to previous years and it was not possible to break down spending on non-NHS providers.

* Independent sector treatment centres and other private sector providers.

The difference between the figures in table 4 and the Department of Health calculation may be the result of difference in the proportion of health spending which is used. The estimates in table 4 show spending as a share of the commissioning budget. But the Department of Health's total Departmental Expenditure Limit (DEL) includes other aspects of health spending. We believe that the Department is using a larger overall figure to calculate the percentage, which would account for differences in our figures.

Examples of independent providers

Independent contractors: GPs

The NHS commissions independent general practices to provide services for patients. This means that general practitioners are not generally employed directly by the NHS (although they do have access to the NHS pension scheme), but instead provide services through contracts with commissioners. Staff working in GP practices are employed by the contract owner rather than as direct NHS employees. Traditionally, GP surgeries have been small businesses and have been seen as high street family doctors. However, single-handed practices* made up 11.2% of all practices in 2013, down from 22.8% in 2004.⁸²

Approximately 95% of practices hold either a General Medical Service (GMS) national agreement, or a personal medical service (PMS) local agreement, and a small number of these contracts are held by limited companies. A small but growing number of practices (271 in 2013, compared with 173 in 2009) hold Alternative Provider Medical Services (APMS) contracts, which make up 3.4% of all contracts and can be used to commission primary care from traditional GP practices as well as commercial providers, NHS providers and voluntary organisations. Of the 271 APMS contracts in 2013, 98 were held by limited companies.⁸²

Marie Curie Cancer Care

Marie Curie provides care to people with terminal cancer and other illnesses in their own homes. During 2013/14, Marie Curie nurses provided over 1.3m hours of nursing to 31,558 terminally ill people and nine Marie Curie hospices cared for 8,931 people. During the 2013/14 financial year, Marie Curie received £22.4m in NHS funding for nurses, £19.1m for hospices, £0.34m in other NHS funding, and grants from the Department of Health totalling £1.05m.⁸³

Virgin Care: Award of Devon's integrated children's service to Virgin Care

Since April 2011, Devon County Council had been managing an integrated children's service on behalf of NHS Devon, following the requirement for NHS commissioners to fully separate from their community service providers. Following a procurement process, Virgin Care Ltd was contracted to provide a range of services on 12 September 2012. These include public health nursing, child and adolescent mental health services, and services for children with physical, sensory and learning disabilities.⁸⁴ The final value of the contract was £131m over three years.⁸⁵

Circle: operational control of Hinchingsbrooke Healthcare NHS Trust

Hinchingsbrooke Healthcare NHS Trust was the first NHS trust to be franchised to a private sector provider. Between 2006 and 2008 the Department of Health had needed to provide significant financial 'bailouts' to the trust and its position became unsustainable. In July 2009, East of England Strategic Health Authority received permission from the Department of Health to seek a partner to run the trust as an operating franchise.

Circle was awarded a ten-year franchise in November 2011. Under the franchise model, the trust's staff and assets remained within the NHS, but Circle took full operational control on 1 February 2012. Under the terms of the agreement, if the trust generated a deficit, Circle must cover up to £5m of the shortfall from its own resources. If Circle met the £311m efficiency savings predicted over 10 years, it would receive a franchise fee of around £31m, but no fee would be payable unless a surplus was achieved.⁸⁶

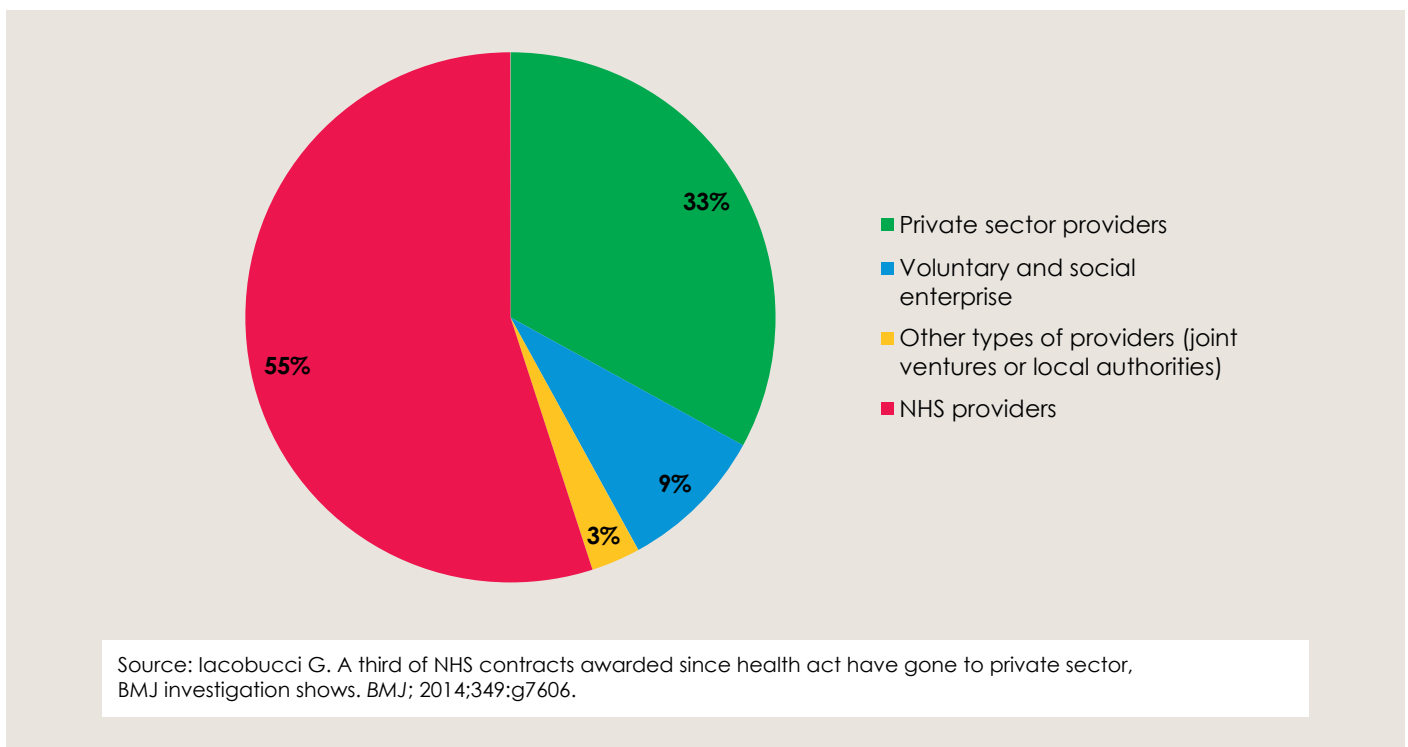
On 9 January 2015, Circle announced that it would be seeking to withdraw from the contract on the basis that funding pressures meant it was unsustainable to continue the arrangement.⁸⁷ On the same day, the Care Quality Commission published a report rating the trust 'inadequate'.⁸⁸

* A 'single-handed' GP practice is a practice which has only one working GP, although a GP registrar or GP retainer may also work in the practice.

There has been concern about the proportion of contracts being awarded to non-NHS providers since the Health and Social Care Act 2012 came into effect. The British Medical Journal analysed 3,494 contracts awarded between April 2013 and August 2014 that had been disclosed under Freedom of Information requests to 211 clinical commissioning groups (192 responded). In total, non-NHS providers had been awarded 45% of contracts with 55% being awarded to NHS providers (including general practices). In the case of contract awards, a contract with one organisation to provide a service does not necessarily preclude another from providing the same service. The situation would be different for competitive tenders where a contract for one provider might preclude others from providing care.

Of the 195 contracts that were awarded by competitive tender, private sector providers won 41%, NHS providers won 30%, the voluntary sector won 25% and other types of provider won 4%. CCGs only disclosed the full financial value of 1,349 of the contracts, representing approximately £10bn. Of this amount, NHS providers were awarded contracts worth £8.5bn (85%) while the private sector was awarded contracts worth £490m (5%).⁸⁹

Figure 3: Analysis of 3,494 contracts awarded by NHS clinical commissioning groups between April 2013 and August 2014⁸⁹



As well as concerns over the number of contracts, there has been unease⁹⁰ about the size of some non-NHS contracts. For example, in March 2015 it was announced that NHS Supply Chain* had signed a deal worth up to £780m (across five national contracts) with 11 private firms to provide a range of services, such as diagnostics and some surgical procedures.⁹¹ In addition, media coverage questioned proposals to procure £1.2bn of cancer and end-of-life care services in Staffordshire.⁹²

* NHS Supply Chain provides health care products and supply chain services to the NHS.

Do the plans to procure £1.2bn of services in Staffordshire represent the biggest 'privatisation' of services in the history of the NHS?

In March 2014, the *Financial Times* reported that a consortium of NHS commissioners in the Staffordshire area had invited companies to bid for contracts worth over £1.2bn over ten years to provide cancer and end-of-life care services. The offer consisted of a £687m contract for cancer services and a £535m contract for end-of-life care and older people's care in the county.⁹³ The stated objective behind the procurement programme is to appoint one organisation to be responsible for managing the provision of the two services, in order to reduce the complexity of commissioning arrangements and provide integrated care for patients and service users.⁹⁴

In March 2015, the plans again attracted press coverage with an opinion piece in *The Guardian* entitled 'the biggest privatisation in NHS history: why we had to blow the whistle'.⁹² The article suggests that: 'Staffordshire commissioners want to hand the management of all care for cancer and end-of-life patients to a private company, a "prime provider" that will take responsibility for the delivery of care, subcontracting and performance management.'

In response, a spokesman for Stafford and Surrounds Clinical Commissioning Group stated that: 'the only purpose of the transforming cancer and end-of-life care programme is to improve the services which patients and their families receive... The Memorandum of Information referred to is not secret and has not been "leaked". It has been in the public domain since November 2014 and available to view on the programme's website.'

Pre-qualified bidders for both service contracts included several private providers. The Royal Wolverhampton NHS Trust and the University Hospitals of North Midlands NHS Trust were pre-selected for both service contracts.⁹⁵ As of 26 March 2015, the contract had not been awarded.

Privately funded provision by NHS providers

The Health and Social Care (Community Health and Standards) Act 2003 required Monitor to impose a cap on the total level of income derived by NHS foundation trusts from the provision of services to private patients. Foundation trusts that were NHS trusts in the financial year ending 31 March 2003 would be restricted, going forward, to the proportion of their total income received from private patients in that year.²² There was no equivalent cap imposed on NHS trusts.

The Health and Social Care Act 2012 removed the cap and instead required NHS foundation trusts to receive the majority of their income from providing NHS-funded services. The Act effectively provides for a maximum income of 49% from providing private services. However, any proposal by directors to increase the proportion of total income earned from non-NHS services by five percentage points requires agreement by more than 50% of the governors. NHS foundation trusts are required to explain in their annual report the impact that non-NHS income has had on their NHS service provision.

For the 2012/13 financial year,^{*} trusts' total revenue from the provision of care to privately funded patients was approximately £500m and 51.8% of this was generated by just ten NHS trusts. £500 million is an extremely small percentage of overall NHS expenditure. The Royal Marsden NHS Foundation Trust earned the most private income, generating £59.8m in 2012/2013 (11.9% of the total NHS private patient revenue).⁹⁶ The trust's private income rose to £67.8m in 2013/14 and it has outlined plans to increase this to £100m.

* The abolition of the private patient cap came into force on 1 October 2012.

Private income plays a role in supporting the provision of NHS services and profit margins from private provision have subsidised the cost of delivering specialist NHS services.⁹⁷

Transatlantic Trade and Investment Partnership

The proposed Transatlantic Trade and Investment Partnership (TTIP), a trade agreement between the European Union (EU) and the United States (US), has provoked widespread media coverage around the extent to which it might threaten national autonomy over public services such as the NHS. In addition, concerns have been expressed 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 as a result of its decision making. There are already some international examples of policy change resulting in legal action by foreign investors, including in the health sector.⁹⁸

In October 2014, the Council of the European Union published the negotiating directives for talks on the EU-US agreement. With regard to 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.⁹⁹ However, the wording of the TTIP has not yet been agreed, so it is not possible to identify the precise impact on the NHS.

In January 2015, the European Commission published the results of a consultation on TTIP held during 2014. Over 52,000 responses were received from the UK, making up 34.8% of responses overall. The collective submissions reflected widespread opposition to ISDS and TTIP in general. Respondents expressed concern that ISDS would have a negative impact on social policy areas such as the NHS.¹⁰⁰ The Commission will now organise follow-up consultation meetings with member states and stakeholders to discuss investment protection and ISDS.¹⁰¹

Increased role of non-NHS organisations in commissioning

Alongside concerns about the increasing involvement of non-NHS providers in the provision of frontline services to patients and service users, there has been concern at the prospect of outsourcing the provision of commissioning functions on a large scale. It is to be expected that commissioners will, at times, need to draw on advice from external experts (for example, when obtaining legal advice) but, in recent years, the ability of commissioners to obtain external advice on a greater scale has prompted concerns about accountability arrangements.

It should be emphasised that while CCGs can outsource a range of commissioning support functions, they cannot legally delegate commissioning decisions to an external organisation.¹⁰² Concerns have been expressed about the possibility of conflicts of interest.

Towards the end of the decade, the Department of Health introduced the Framework for Procuring External Support for Commissioners (FESC). This was a procurement tool that allowed PCTs to procure services from 13 independent sector providers to address gaps in commissioning capability or capacity across a range of functions, including health needs assessments, contracting and performance management and patient and public engagement.¹⁰³ The Health Select Committee's 2010 report on commissioning was critical about the use of FESC, suggesting that while PCTs were clearly lacking some of the skills, they needed to be effective commissioners: FESC was 'an expensive way of addressing PCTs' shortcomings'. The committee also doubted whether PCTs had the ability to use consultants effectively.¹⁰⁴

Following the Health and Social Care Act 2012, the capability and capacity of commissioning organisations to undertake functions such as contract negotiation, monitoring and service redesign continued to be an issue. A more radical alternative to FESC was proposed, whereby NHS commissioning support units (CSUs) were formed from existing PCT staff, with the intention of these bodies becoming independent entities that would compete for services by April 2016. CCGs were given the opportunity to undertake some functions in-house, or to buy in services from the CSUs or other bodies.¹⁰⁵

In January 2014, NHS England finalised options for the models that CSUs would follow as independent bodies. The option of selling CSUs to the private sector was ruled out on the basis that 'there would be significant risk that the NHS would be giving away value to the private sector buyer' and because CCGs were not supportive of that approach. Instead, the preferred model would be for CSUs to take the form of a social enterprise, staff mutual (owned equally by members) or a company limited by shares (where adequate safeguards were in place to protect the taxpayer).¹⁰²

In February 2015, NHS England announced which organisations had been successful in joining its new Commissioning Support Lead Provider Framework, which allows CCGs to procure commissioning support from a pre-approved list of providers. The organisations accredited to provide 'end-to-end commissioning'* included existing NHS CSUs as well as three private sector providers.¹⁰⁶

Financing: is public spending being reduced in favour of private financing?

The Health and Social Care Act 2012, like previous legislation before it, requires the Secretary of State to promote a comprehensive health service and states that services provided as part of the health service in England must be free of charge (bar a few exceptions, such as prescription charges).³⁷ Furthermore, the NHS constitution specifies that access to NHS services is based on clinical need and not an individual's ability to pay.¹⁰⁷ There is no evidence to suggest that the Conservatives, Labour, or the Liberal Democrats wish to change this position. The introduction of competition among providers of NHS-funded clinical care does nothing to change the principles above.

* 'End-to-end commissioning' includes provider management, healthcare procurement, transformation and service design, as well as patient and public engagement.

‘Privatisation’ of health care financing could occur if:

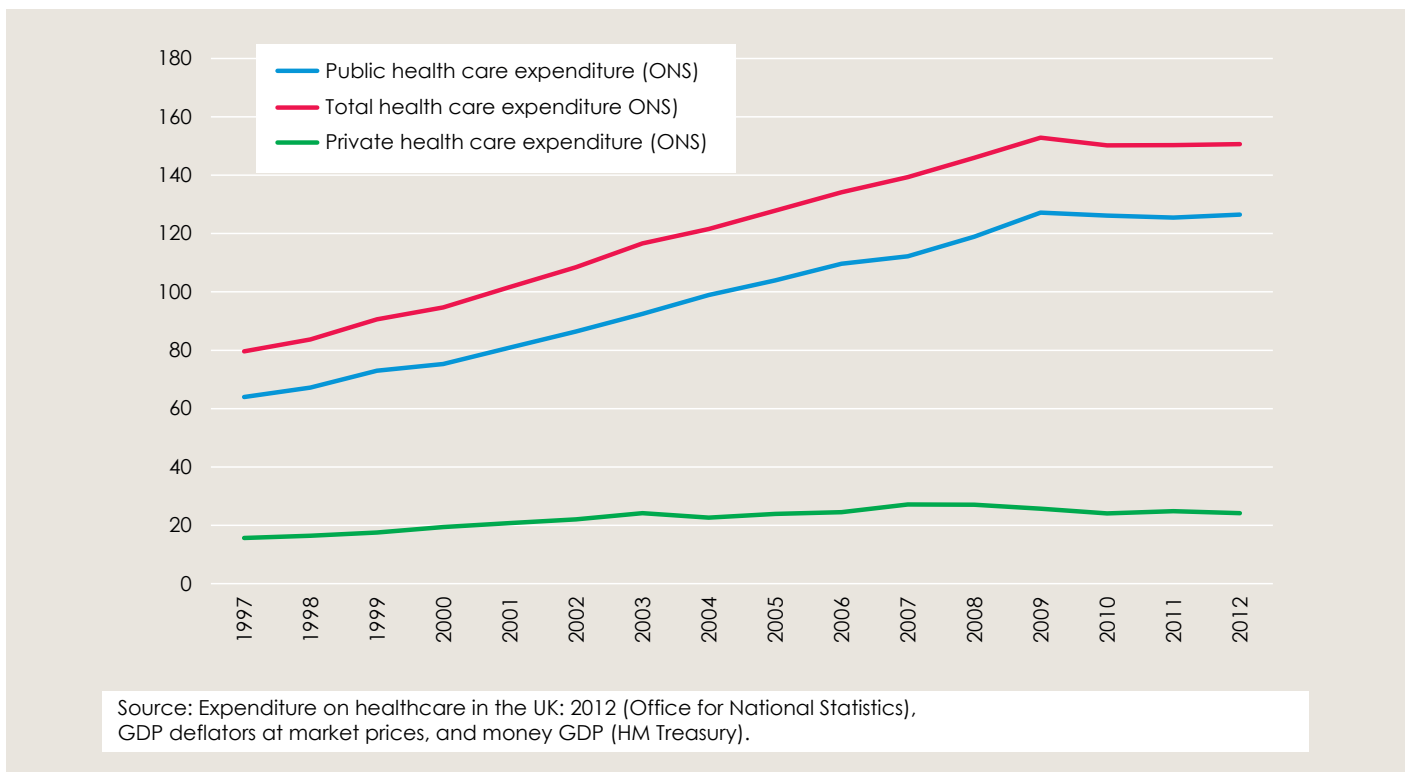
- there is a shift from public to private spending. For example, a decrease in the public proportion of total health care spending; or
- a growth of private investment in health care for example through investment in the building of hospitals.⁷⁷

Public and private spending on health care

Private health care expenditure is defined as private household spend on medical goods and services such as dental services and over the counter pharmaceuticals, private health care insurance, expenditure by not-for-profit institutions serving households (includes charities and other non-profit organisations) and private sector capital. Private household spending on medical goods and services includes goods such as over the counter pharmaceuticals and services such as dental services and private hospital services.¹⁰⁸ While the data can give us an indication as to the split between public/private spending, it can only offer a high level overview.

Private spending on health care in the UK rose from £15.6bn in 1997 to £24.1bn in 2012 in real terms. However, private spending reached a peak in 2007 at £27.2bn (all based on 2014/15 prices). As a proportion of total health expenditure, private health care spending represented 16.0% in 2012 – the lowest proportion in more than 15 years (equal with 2010). This figure was 19.6% in 1997, reaching 20.7% in 2003 (see figure 4). The drop in private expenditure is likely to be partly attributable to weak economic growth as private health care is seen as a luxury good in the UK and private health insurance is often linked to employment benefit packages.

Figure 4: Public and private health care spending in the UK, 1997 to 2012 (2014/15 prices)



Private capital investment

In 1992, the Conservative government introduced a policy to increase the scope of private financing for capital projects. This became known as the private finance initiative (PFI), whereby groups of investors manage the design, building and operation of public buildings, such as hospitals. This policy was expanded under the Labour government and continues today under the coalition government.¹⁰⁹ In 2010, the National Audit Office (NAO) found that most PFI hospital contracts were well managed, but that there were risks associated with long-term value for money from these contracts. The NAO also highlighted incidents in which investor profits had been maximised at the expense of the NHS organisation managing the contracts.¹¹⁰

In 2011, the Treasury Select Committee issued a critical report suggesting that PFI projects represented a significant cost to taxpayers because private finance is more expensive than government finance, and this higher cost is not sufficiently offset by any savings and benefits.¹⁰⁹ In February 2012, the Department of Health announced that seven NHS hospital trusts would have access to a £1.5bn fund because they had demonstrated serious structural financial difficulties as a result of PFI plans.¹¹¹

Transferring assets between public and private bodies

The transfer of publicly owned organisations to the private sector came to the fore as a policy objective in the 1980s. The driving objective behind privatisation was the Conservatives' belief that goods were produced more efficiently through competition in the private sector than under 'the monopoly protection of the public sector'.¹¹²

Companies that were privatised under the 1979–97 Conservative governments included British Petroleum, British Telecom and British Rail. More recently, in October 2013, the Shareholder Executive (part of the Department for Business Innovation and Skills) sold 60% of the government's shares in Royal Mail Plc to private investors, generating proceeds of £1.98bn.¹¹³ In addition, National Air Traffic Services (NATS) was part-privatised by the Labour government in 2001.¹¹⁴

It is harder to apply the traditional definition of privatisation to the NHS. However, there are examples of state assets linked to the health service that have been sold to investors. For example, in July 2013, the Department of Health announced that Bain Capital had bought 80% of Plasma Resources UK (PRUK), which manufactures blood plasma products for the NHS.¹¹⁵ A subsidiary of PRUK, Bio Products Laboratory (BPL), had previously been part of NHS Blood and Transplant Special Health Authority (NHSBT) and was transferred to the Secretary of State for Health in December 2010 to give BPL greater commercial freedom and closer integration with its plasma supply chain.¹¹⁶ When the government sold its stake in PRUK, public sector control was removed and the company was reclassified from a public to a private non-financial corporation.¹¹⁷

* Non-financial corporations produce goods and services for the market and do not, as a primary activity, deal in financial assets and liabilities for example retailers, manufacturers or farms.

More broadly, there are circumstances in which NHS estates have been sold to private investors. For example, following the Health and Social Care Act 2012, NHS Property Services (100% owned by the Secretary of State) was established to manage the estates of primary care trusts and strategic health authorities, following their abolition. One of the objectives of the company is to implement a strategy for disposal of assets to support the government's strategy of using surplus public sector land to provide new homes.¹¹⁸ Between 1 April 2013 and 31 December 2014, NHS Property Services completed the sale of 124 surplus properties, generating £58.3m and over £6.3m in operating costs. All sales were at or above market value and income from the sales will be reinvested in the NHS.¹¹⁹

7. What next?

The mainstream political parties are essentially providing a choice between maintaining the status quo (that is, competition based on quality, retaining the current system structures) or moving to a model with the NHS as a preferred provider. The latter option is outlined by the Labour Party in its 10-year vision for the NHS.⁷⁰ Clive Efford MP's private members' bill – the National Health Service (Amended Duties and Powers) Bill 2014 – in theory shows how Labour might seek to amend the Health and Social Act 2012's measures on competition.

A third, more radical option would be to abolish the purchaser/provider split and take the NHS back to the structures of the early 1980s. The Green Party, as well as a range of parliamentary candidates from across the political spectrum, have given their support to the proposed NHS Reinstatement Bill, which has been developed as part of a campaign to change the NHS's legislative framework in the next parliament.¹²⁰ The bill would re-establish district health authorities, abolish marketised bodies such as NHS trusts and NHS foundation trusts, abolish Monitor and CCGs, and would end virtually all commissioning.¹²¹ It has been suggested that the costs of the market could be spent on frontline services if competition policy was abolished.¹²²

Table 5: Potential options for competition and private or voluntary sector involvement

<p>Option 1: The status quo</p>	<p>A system where the provision and purchasing of care are split.</p>	<p>Competition Competition between NHS and non-NHS providers is hardwired into the system. There are specific roles for Monitor and the Competition and Markets Authority as regulators in relation to anti-competitive practices.</p> <p>Private or voluntary sector involvement There is, in theory, a fair playing field for providers (whatever their form) to compete on the basis of quality (and not price) to provide NHS-funded services.</p> <p>As the system stands currently, there is not a strong central drive to increase the market share of the private sector (indeed this would go against the Health and Social Care Act 2012). A system in which there was an active push to increase private or voluntary sector provision as an end in itself would be quite different.</p>
<p>Option 2: The NHS as a preferred provider</p>	<p>A system where the provision and purchasing of care are split.</p>	<p>Competition Competition between NHS providers would remain, but other types of providers would offer supplementary services rather than competing directly with the NHS for contracts. The role of Monitor and the Competition and Markets Authority in relation to competition would be reduced.</p> <p>Private or voluntary sector involvement The NHS would be the preferred provider, with the private and voluntary sectors providing support if the NHS is unable to deliver services. It has been suggested that voluntary organisations would be given some form of 'preferred provider' status under a Labour government.¹²³ In addition, on 27 March 2015, it was announced that, under a Labour government, profits would be capped on all private sector contracts to provide NHS-funded services worth more than £500,000.¹²⁴</p> <p>This option presents a number of legal challenges.</p>
<p>Option 3: Abolish the purchaser/provider split</p>	<p>A system where the provision and purchasing of care are not separated.</p>	<p>Competition The 'purchasing' function would be removed at a local level, with the abolition of commissioning and market-orientated practices, and replaced by a return to centralised planning and command and control structures. NHS trusts and NHS foundation trusts would be abolished alongside CCGs and Monitor. NHS providers would no longer compete with each other.</p> <p>Private and voluntary sector involvement The options would allow commercial organisations to provide services only if the NHS could not do so, thereby causing patients to suffer. Terms and conditions would be harmonised to require all providers of NHS-funded care to adhere to Agenda for Change terms and conditions (these are national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff).</p>

Option two could significantly alter the relationship between NHS providers and commissioners by strengthening the position of NHS providers. For example, would the power of commissioners be weaker compared to NHS providers? Such changes would need to be carefully managed to limit system instability as commissioners got to grips with changing processes and the roles of regulators changed. It would also raise a number of key questions, for example:

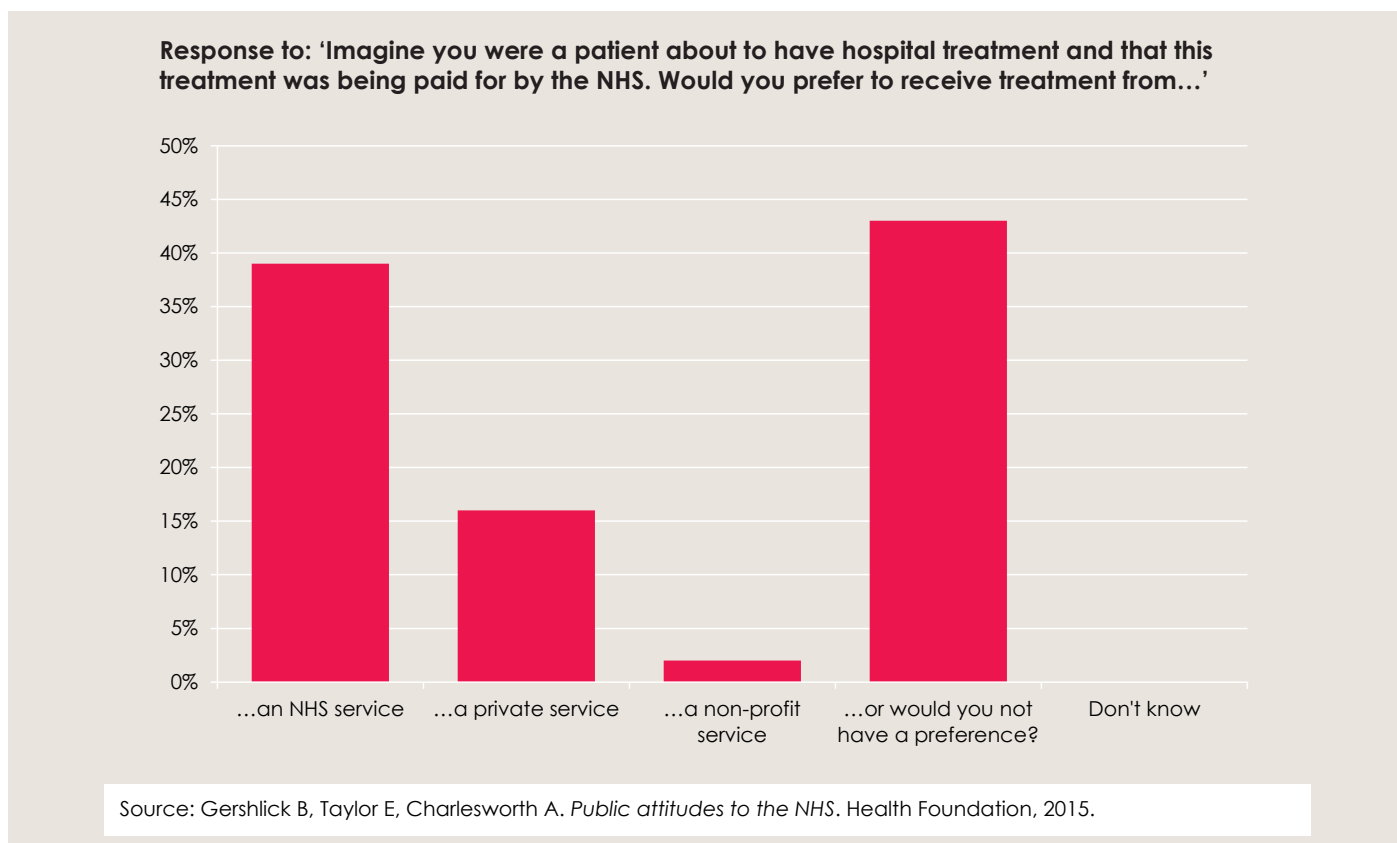
- Would the power of commissioners be diminished?
- What flexibilities would they have to transfer or change contracts?
- Would competition still exist between NHS providers?

Clarity is also needed around the legal feasibility of changing the role of competition now it has been established. The Health Foundation outlined some of these challenges in its briefing on Clive Efford's private members' bill¹²⁵ and the King's Fund has recently published an analysis of whether a new government could remove the NHS from European competition and procurement rules. This research concludes that it would not be possible to exempt the NHS, but the aim could be achieved by making broader changes to policy which would include bringing foundation trusts back under direct central control.¹²⁶

Option three would represent significant structural change and risk major system instability. It would involve change to nearly every NHS organisation within the system and would make the top-down reorganisation of the Health and Social Care Act 2012 look insignificant by comparison.

While policies that limit the role of private provision of clinical care are being emphasised by a number of parties during the election campaign, it is not clear that there would be universal support for such a move. The British Social Attitudes Survey 2014 polled 2,878 adults from across Great Britain. Survey data showed that less than half (39%) of the public would prefer to receive their NHS-funded treatment from an NHS provider, while 43% had no preference and 16% would opt for a private service (see figure 5 overleaf). Loyalty to the NHS as a provider also correlates with age and by political affiliation. Among Labour supporters, 48% would choose an NHS provider, compared with 30% of Conservative supporters. Of people born before 1945, 50% would pick the NHS as a preferred provider compared to 32% of those born between 1980 and 2000.¹²⁷

Figure 5: Health care provider preferences among respondents to the British Social Attitudes Survey 2014*



Competition and privatisation will remain 'hot topics' in relation to health policy. As the election draws nearer, more detail will emerge about the different parties' plans for the NHS. The question to be answered by any policy proposals is whether they will better equip the NHS to meet the challenges it will face in the coming years. Despite divergence in policy between the four UK countries around the role of competition and increased provider diversity in the NHS, there is no obvious divergence of performance using very broad indicators. However, England performs marginally better in relation to life expectancy and amenable mortality rates.²

The Health and Social Care Act 2012 met with significant criticism for incurring costs to organisational stability without sufficient clarity as to the benefits it would realise. The *Five year forward view* has since set out a clear direction for the NHS, with significant consensus among a range of stakeholders.¹²⁸ Any new initiatives (either policy or legislative changes) should be considered in the context of whether they would support the aims of the *Five year forward view*. The Health Foundation's *Three tests for a credible health policy*¹²⁹ highlights that it should be a political priority to avoid upheaval of administrative structures.

* For the full results, see the Health Foundation's analysis of public attitudes to the NHS, available at: www.health.org.uk/publications/public-attitudes-to-the-nhs

Annex A: The Health and Social Care Act 2012 and its parliamentary passage

The Health and Social Care Bill, as introduced on 19 January 2011, gave effect to the policies set out in *Equity and excellence: Liberating the NHS*.³⁶ Part three of the bill was dedicated to the economic regulation of health and adult social care services and was to become one of its most controversial elements. It set out Monitor's overarching duties and responsibilities, giving the regulator powers to:

- ensure competition and patient choice would operate effectively
- run a system of licensing
- define designated services (the bill set out mechanisms to ensure the continuity of such services in the event of failure)
- set pricing in conjunction with the NHS Commissioning Board (NHS England)
- introduce failure arrangements.

With respect to competition, Monitor was to be given concurrent powers with the Office of Fair Trading (OFT) to apply the Competition Act 1998 (allowing Monitor to investigate anti-competitive practice) and the Enterprise Act 2002 (in relation to market investigation references).¹³⁰

As opposition to the Health and Social Care Bill grew, delegates at the Liberal Democrat conference passed a motion on 12 March 2011 that demanded significant amendments and criticised the government's 'damaging and unjustified market-based approach to reform'.¹³¹ Opposition amendments were not successful during the Commons Committee Stage, but the government put forward an amendment that would remove the ability of Monitor to set maximum prices and clarified that Monitor would not be able to vary prices by reference to whether a provider was in public or private ownership. The amendment was meant to clarify the government's position that competition in the NHS should be based on quality and not on price.¹³²

On 6 April 2011, the government launched the NHS Future Forum to consider further the implications of the Health and Social Care Bill and announced that the passage of the bill would be 'paused'. Choice and competition was one of four themes to be considered, with the Secretary of State suggesting that:

*'First, we need to make sure that we have the right sort of competition in the Health Service. Not competition for its own sake, not cherry picking the lowest hanging fruit, not giving preference to the private sector over and above [the] NHS or charities.'*¹³³

In June 2011, the NHS Future Forum published its recommendations, proposing changes to Monitor's duty to promote competition and stronger safeguards against the unintended effects of competition. The Future Forum also recommended there should be safeguards in place to prevent providers from 'cherry picking' more straightforward cases where it could distort the market or undermine quality.¹³⁴

In response, the government committed to amending the bill with regard to competition and choice in a number of areas:

- The bill would rule out any deliberate policy to increase or maintain the market share of any particular sector.
- Monitor's core duties would be focused on protecting and promoting patients' interests and not on the promotion of competition as an end in itself.
- The bill would include additional safeguards against cherry picking and price competition.
- Monitor's powers would be limited with regard to its ability to take action against commissioners.
- Monitor would be required to enable integration of services for patients.
- The duties on commissioners to promote integrated services would be strengthened.¹³⁵

After extensive debate on the bill in the House of Lords, in February 2012 the government outlined amendments that would be made at Lords Report Stage. A number of these were relevant to the development of competition in the NHS. The amendments would:

- allow Monitor to use its licensing powers to support integration and cooperation where it was in the interest of patients
- amend the existing provisions in the bill in relation to the Competition Commission's powers to conduct seven-yearly reviews of the health sector to focus on the 'effectiveness', not the 'development', of competition; peers had expressed concern that the original wording would have provided a disproportionate incentive on Monitor to develop competition
- amend the existing provisions in the bill to require Monitor to consult on how it would enforce regulations concerned with procurement, patient choice and anti-competitive behaviour.¹³⁶

During the Lords Report Stage, the government also accepted a number of significant amendments relating to the application of competition law. The first amendment required Monitor to provide advice to the OFT on benefits resulting from NHS provider mergers involving an NHS foundation trust.¹³⁷ The second amendment removed the (earlier amended) requirement for the Competition Commission (CC) to review the development of competition in the provision of health care services for the purposes of the NHS entirely. It was felt that prescribed reviews would have placed too great an emphasis on the pursuit of competition itself.¹³⁸

The Health and Social Care Act 2012 finally received Royal Assent on 27 March 2012. Part three of the Act (which set out provisions relating to the regulation of health and adult care services) had been subject to a number of amendments and had changed compared to the version of the bill as introduced on 19 January 2011. There were no longer references to 'economic regulation' and the focus was on 'sector regulation'.

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Emma Spencelayh joined the Health Foundation in October 2013 as Senior Policy Advisor.

Prior to joining the Health Foundation, Emma supported Dr Jennifer Dixon on a range of strategic projects at the Nuffield Trust and transferred with Jennifer when she moved to the Health Foundation.

While at the Nuffield Trust, Emma led the secretariat for the Ratings Review commissioned by the Secretary of State for Health. She joined the Trust from the Department of Health where she was a Senior Policy Advisor in the NHS Policy and Strategy Unit. Prior to this, she worked on a variety of high-profile policy areas as part of the Civil Service Fast Stream Programme including integrated care. Emma also worked on the development of the new public health system including responsibility for the public health provisions in the Health and Social Care Act 2012.

Emma started her career on the NHS Management Graduate scheme with placements at Poole Hospital NHS Foundation Trust and NHS Bournemouth and Poole.

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