National Health Service (Amended Duties and Powers) Bill [Bill 18 of 2014-15]

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Section Social Policy

On 2 July 2014 Clive Efford presented the *National Health Service (Amended Duties and Powers) Bill*, having come sixth in the Private Members' Bill ballot. The Bill received its Second Reading on Friday 21 November 2014; no date has yet been announced for its committal to committee. The Bill seeks to make changes to a number of provisions in the *Health and Social Care Act 2012* and the *National Health Service Act 2006*, including:

- Placing a statutory duty on the Secretary of State for Health to ensure the NHS in England operates on the basis of social solidarity; and to ensure that arrangements for the provision of health services provide for effective co-operation.
- Restoring the Secretary of State's responsibility for certain NHS services and his powers to issue directions to NHS bodies in England.
- Amending provisions relating to NHS contracts, repealing a number of Monitor's duties and powers relating to competition and procurement policy in the NHS, in order to remove any obligations on NHS bodies to put health services out to tender.
- Substituting provisions that currently allow NHS foundation trusts to generate up to half of their income from private sources with a new power for the Secretary of State to determine the appropriate limit on private income, subject to certain safeguards.
- Transferring the responsibility for approving mergers between NHS hospitals from Monitor and the competition authorities' to the Secretary of State.

The Bill also provides that the ratification of the proposed Transatlantic Trade and Investment Partnership (TTIP) Treaty must not cause procurement or competition obligations to be imposed on the NHS. This Library briefing provides information on the Bill and some background on competition policy in the English NHS, including recent changes under the *Health and Social Care Act 2012*. It also includes some recent data on independent sector provision of NHS-funded services. Most clauses in the Bill apply to England only although the section on TTIP and international agreements would apply across the UK.

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1 Introduction

The Bill would place a statutory duty on the Secretary of State for Health to ensure the NHS operates on the basis of social solidarity, and that arrangements for the provision of health services in England provide for effective co-operation. Measures in the Bill are intended to restore the Secretary of State's responsibility for certain NHS services and his powers to issue directions to NHS England, clinical commissioning groups, NHS trusts and Special Health Authorities.

The Bill would grant the Secretary of State greater discretion to set policy on procurement and competition and powers to limit independent sector involvement in the NHS; this is a response to concerns that the *Health and Social Care Act 2012* (*H&SC Act 2012*) placed additional obligations on commissioners of NHS services to put services out to tender.

Provisions in the Bill are designed to limit the use of competitive tendering for services, to remove Monitor's duties and powers to prevent anti-competitive behaviour, and to centrally determine the amount of private income that NHS hospitals are allowed to generate. The Bill would repeal or amend a number of provisions relating to competition policy in the *H&SC Act 2012* and the *National Health Service Act 2006*, including the following measures to remove obligations on NHS commissioner's to use competitive tendering for health services:

- amending provisions relating to NHS contracts, to allow the Secretary of State rather than Monitor to adjudicate in disputes about procurement;
- repealing a number of Monitor's duties and powers relating to competition and procurement policy in the NHS, including the repeal of section 75, under which NHS procurement and competition regulations are made; and
- exempting the NHS from the *Competition Act 1998* to try and prevent EU competition law being applied to the NHS.

The Bill would also transfer responsibility for approving mergers between NHS providers, from Monitor and the Competition and Markets Authority to the Secretary of State. This measure responds to concerns that mergers of NHS hospitals, intended to improve patient care and increase efficiency, can be blocked on competition grounds.

The *H&SC Act 2012* increased the private income cap for NHS foundation trust hospitals so that they could generate up to 49% of their income from private sources. The Bill would substitute the 2012 Act provisions with a new power for the Secretary of State to determine the cap on private income, subject to certain safeguards.

The Bill provides that the ratification of the proposed Transatlantic Trade and Investment Partnership (TTIP) Treaty must not cause procurement or competition obligations to be imposed on the NHS. There have been concerns that the TTIP deal being negotiated between the EU and US could make measures to open up the NHS to competition irreversible, although this has been disputed by the Government.

The following sections of this briefing provide information on the Bill and some background on competition policy in the English NHS, including recent changes under the *Health and Social Care Act 2012*. It also includes some recent data on independent sector provision of NHS-funded services. Further information can be found in the *Explanatory Notes to the Bill.*

Commenting on the Bill, Clive Efford said:

> "The NHS as we know it today will disappear if we continue to allow services to be forced out to private companies.
>
> "It will seriously undermine the capacity of the NHS to provide services in the future, leaving us at the mercy of the private sector. This Bill will halt the rush to privatisation and put patients rather than profits at the heart of our NHS.
>
> "My Bill will give Parliament sovereignty over the NHS and will protect it from the EU-US treaty."[1]

As well as having the strong backing of the Labour Front Bench, the Royal College of Nursing and the major trade unions representing NHS staff[2], the Bill also has the qualified support of the British Medical Association (BMA). The BMA and the organisation representing NHS foundation trusts and NHS trusts (The Foundation Trust Network) have particular concerns that the Bill will undermine the operational independence of the NHS.[3]

Most clauses in the Bill apply to England only although the section on TTIP and international agreements would apply across the UK.

The Second Reading of the Bill took place on 21 November 2014 and the full text of the debate in the Commons is available here.[4] The House agreed, on division (Ayes 241, Noes 18), to agree that the Bill be read a Second Time. No date has yet been announced for its committal to committee.

2 Changes to the Secretary of State's duties

Section 1 of the *NHS Act 2006* sets out the Secretary of State's duty to promote "a comprehensive health service".[5] The original duty, under Section 1 of the *NHS Act 2006* as introduced, is reproduced below:

> (1)The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—
>
> (a)in the physical and mental health of the people of England, and
>
> (b)in the prevention, diagnosis and treatment of illness.
>
> (2)The Secretary of State must for that purpose provide or secure the provision of services in accordance with this Act.
>
> (3)The services so provided must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.

Section 1 of the *H&SC Act 2012* substituted the duty under sub-section (2) "to provide or secure the provision of services in accordance with this Act" with a duty for the Secretary of State to "exercise the functions conferred by this Act so as to secure that services are

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1 Labour Party press release, *Labour publishes anti-privatisation NHS Bill*, 7 November 2014

2 See press notices from Unison and the TUC, for example.

3 See section 5 of this note for further detail of the BMA, FTN and RCN responses to the Bill.

4 HC Deb, 21 November 2014, cc539-603

5 Since the creation of the NHS in April 1948 the Secretary of State has always had the duty to promote a comprehensive health service but has never had a duty to provide a comprehensive health service.

provided in accordance with this Act". The new duty under sub-section (2) inserted by the *H&SC Act 2012*, no longer refers to a duty to provide.

During the passage of the *Health and Social Care Bill* the Government explained the rationale for removing the Secretary of State's duty to provide from section 1 of the *NHS Act 2006*; Minister's said this reflected the fact that, even under the pre-2012 system, the duty did not "reflect the reality of a situation in which commissioning and provision rest with NHS bodies, not the Secretary of State", and that it would be even more of an anachronism after responsibility for commissioning and providing services was conferred to NHS England and clinical commissioning groups (CCGs).[6] However, there was some concern about the removal of the word "provide" from the Secretary of State's duties. As a result, the Government agreed to support amendments proposed by the House of Lords Constitution Committee during the final stages of the *Health and Social Care Bill*, to insert a new paragraph (para 1(3) above) clarifying that the Secretary of State retains Ministerial accountability for the NHS.[7]

Section 3(1) of the 2006 Act, as originally passed, contained a duty on the Secretary of State to provide secondary care services, namely that:

> (1)The Secretary of State must provide throughout England, to such extent as he considers necessary to meet all reasonable requirements—
>
> (a)hospital accommodation,
>
> (b)other accommodation for the purpose of any service provided under this Act,
>
> (c)medical, dental, ophthalmic, nursing and ambulance services,
>
> (d)such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service,
>
> (e)such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service,
>
> (f)such other services or facilities as are required for the diagnosis and treatment of illness"

The introductory words of Section 3(1) of the 2006 Act were changed by the 2012 Act and now reads as follows:

> "A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility …"

The range of services that the decision maker under section 3(1) has a duty to provide were unchanged but the duties are now owed by CCGs and not by the Secretary of State.

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6 The wider debate about the decision to remove the word "provide" from section 1 of the 2006 Act can be found in pages 8-10 of the Library Research Paper on the *Health and Social Care Bill* (RP 11/63, 30 August 2011).

7 HL Deb 8 February 2012 c298-307. A Library standard note (SN06252) set out the key amendments to the Secretary of State's duties during the House of Lords Committee and Report stages of the *Health and Social Care Bill* (see section 2.1, pages 6-8).

2.1 The Bill: the Secretary of State's duties regarding the health service

Clause 1 of the Bill would substitute the Secretary of State's current duty under section 1 of the *NHS Act 2006* (as amended by section 1 of the *H&SC Act 2012*), introducing two additional duties. Under clause 1(2) of the Bill the Secretary of State must, for the purpose of continuing the promotion in England of a comprehensive health service:

- "ensure that the health service is a public service which delivers services of general economic interest and operates on the basis of social solidarity" (clause 1(2)(b)); and
- "ensure that arrangements between commissioners and providers of health services require effective co-operation between different providers under this Act and between providers of health services and providers of community care services" (clause 1(2)(c)).

The reference to social solidarity in clause 1(2)(b) is, in conjunction with other measures in the Bill, an attempt to exempt the NHS from EU competition law.[8] Clause 1(2)(c) is intended to promote integration in health and social care services.

Clause 2 of the Bill would insert a new section 2 in the *NHS Act 2006*, giving the Secretary of State an additional duty "to exercise his powers under this Act to promote the health service as an efficient service based on mutual cooperation and social solidarity". It would require him to ensure that commissioners of health services (NHS England and clinical commissioning groups) follow guidance on procurement, promote patient choice and do not engage in anti-competitive behaviour:

> **"2C Duties and guidance in respect of cooperation and social solidarity**
>
> (1) The Secretary of State shall exercise his powers under this Act to promote the health service as an efficient service based on mutual cooperation and social solidarity and so as to ensure that that any person who is concerned in commissioning or providing health services for the purposes of the health service—
>
> (a) adheres to such practices in relation to procurement as the Secretary of State identifies as being appropriate for the purposes of the health service;
>
> (b) protects and promotes the right of patients to make choices with respect to treatment or other health care services provided for the purposes of the health service, in as much as the exercise of such choice is consistent with the overall interests of the health service;
>
> (c) does not engage in anti-competitive or any other behaviour which the Secretary of State considers is against the interests of people who use health services.

Clause 3 and 4 are intended to restore the Secretary of State's direct responsibility for local NHS services. It has been argued that a consequence of the changes introduced by the *H&SC Act 2012*, and in particular the responsibilities under section 3(1) of the *NHS Act 2006* being transferred to clinical commissioning groups (CCGs), that the Secretary of State has no power to intervene with local commissioning decisions and thus cannot be expected to

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[8] If it is established that a service is organized under principles of social solidarity then this is one factor that could be used to argue that an organisation is an undertaking engaged in a social rather than an economic activity – and therefore EU competition law could be held not to apply. However, this is a complex area and a more detailed discussion of EU competition law and health policy, including an account of relevant case law – can be found in chapter 8 of *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Edited by Mossialos E, et al., Cambridge University Press, 2010).

answer in parliament for those decisions. Clauses 3 and 4 would establish that the Secretary of State has a duty to arrange for the provision of certain health services, duties which are currently owed by CCGs and NHS England, under the *H&SC Act 2012* (clauses 3 and 4 make clear that these duties could be delegated by the Secretary of State).[9]

Clause 5 would re-establish the Secretary of State's powers to issue directions to NHS England, CCGs, NHS trusts and Special Health Authorities.

The BMA state that the Bill's measures to reinstate and enhance the Secretary of State's duties to promote and to provide are helpful measures to secure confidence in the Secretary of State's ultimate responsibility and accountability for the NHS. In particular, the BMA say that the Bill's reference to social solidarity helps to "clarify Government's lasting responsibility towards the NHS were there to be structural changes in the future."[10] However, the BMA's response to the Bill also says that care must be taken to ensure that the legislation does not risk bringing in inappropriate political interference in the day-to-day running of the NHS.[11]

3 NHS hospitals' private income

The *H&SC Act 2012* increased the limit on the amount that NHS foundation trusts could generate from private income. The previous cap on private income, which was introduced in 2003, had the effect that a foundation trust could not earn in any financial year a higher proportion of its total income from private charges than it derived from private charges in the financial year 2002-03 (the year before the first foundation trusts were authorised).[12] The *H&SC Act 2012* increased the private income cap for NHS foundation trust hospitals so that they could generate up to 49% of their total income from private sources. Currently NHS Trusts agree levels of private income with the NHS Trust Development Authority (NHS TDA) but this is not a matter set out in statute.

3.1 The Bill: powers for the Secretary of State to determine private income

Clauses 7 and 8 of the Bill would substitute section 43 of the *NHS Act 2006,* as amended the *H&SC Act 2012*, to replace the 49% private income cap for foundation trusts with a new power for the Secretary of State to determine a general cap on private income, subject to certain safeguards. The Bill would also allow the Secretary of State to set a higher cap for an individual foundation trust, and would require the Secretary of State to publish a statement of the principles for considering applications.

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9 Section 3(1) of the *NHS Act 2006*, as introduced, stated that the "Secretary of State must provide throughout England [certain health service] to such extent as he considers necessary to meet all reasonable requirements." The services listed in section 3(1) of the 2006 Act, and changes to the duty under the *H&SC Act 2012*, are covered in section 2 of this note (page 5). Clause 3 of the Bill covers the same list of services but the wording is as follows: "The Secretary of State must arrange for the provision [of the services listed], to such extent as he considers necessary to meet all reasonable requirements –". Advice from a QC, supplied to the Member in charge of the Bill, states that the wording of clause 3(1) reflects the reality that the Secretary of State had never performed the duties that had existed under section 3(1) himself and had always delegated the provision of these functions to NHS bodies. The QC's advice maintains that there is no legal difference between the duty to provide as originally stated in section 3(1) and the duty to "arrange for the provision" in clause 3(1), and that the Bill would restore the Secretary of State's direct legal and political responsibility for the NHS services listed in the clause.

10 BMA briefing on the Bill, November 2014

11 *Ibid.*

12 Figures from the Department of Health, deposited in the Library in response to a PQ (DEP2011-1580) showed that in 2011 the majority of NHS foundation trusts had private income caps of between 0.1% and 2%; only 3 FTs had caps set above 10%: The Royal Marsden NHS Foundation Trust (30.7%), the Royal Brompton and Harefield NHS Foundation Trust (14.4%), and Moorfields Eye Hospital NHS Foundation Trust (13.7%).

The Bill inserts two safeguards, which the BMA had previously called for during the passage of the *Health and Social Care Bill*, that NHS services and patients:

- should not be adversely affected by Foundation Trusts treating private patients; and
- should benefit from the Foundation Trust treating private patients (for example, by private income being re-invested into improving NHS service).

The Bill would extend these legislative provisions to NHS Trusts (as noted earlier, NHS Trusts agree levels of private income with the NHS Trust Development Authority (NHS TDA) but this is not currently a matter set out in statute).

While welcoming the insertion of safeguards intended to protect NHS services and patients, the BMA briefing on the Bill states that it is reasonable to ask why statutory provisions on private income have been extended to NHS Trusts; in particular, the BMA warns that there is the potential for this to encourage, albeit unintentionally, NHS trusts to seek private income:

> Were the Secretary of State to set the cap at a high percentage, this would send the message that trusts are being encouraged to behave more like commercial entities than NHS bodies.[13]

The Foundation Trust Network (FTN) states that the ability to receive non-NHS income is a critical component in foundation trusts' efforts to stabilise finances and maintain quality in NHS care. The FTN also argue that non-NHS income enables trusts to offer services to NHS patients which might not otherwise be available, as well as the benefits from investment in research and development. The FTN's response to the Bill says they would be very concerned to see the non-NHS income facility removed, made variable or decreased. They believe the current system offers an equitable, consistent approach with strong governance arrangements to ensure the benefit to NHS patients.[14]

3.2 Background to the cap on NHS hospitals' private income

The *Health and Social Care Bill* as introduced would have entirely repealed the restriction on the amount of income a foundation trust could earn from private charges, otherwise known as the 'private patient income cap'. The Government's proposals to lift the cap provoked strong views, with some respondents to the Government's consultation, such as Unison, saying it would lead to foundation trust's prioritising fee-paying patients and have a negative impact on NHS services. The Government and others in favour of lifting the cap argued that it would not alter the primary function of NHS foundation trusts, which is to provide goods and services for the NHS. Having listened to concerns about entirely removing the cap on private income, the Government introduced amendments to ensure that the majority of every NHS foundation trust's income must come from NHS service provision (in effect setting the cap on private income at 49%), and require every foundation trust to explain how its non-NHS income had benefited NHS services.

4 Competition policy

Competition law is a complex area but, in summary, organisations are subject to EU and UK competition rules if they are "undertakings" for the purposes of those rules. Whether or not an NHS body is an undertaking will depend on the circumstances and in particular on whether they are engaged in economic activity, offering goods or services on a given market.

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13 BMA briefing on the Bill, November 2014

14 FTN response to the Bill, November 2014 (not available online)

EU law prohibits anti-competitive agreements, concerted practices or abuses of a dominant position by undertakings that affect trade between member states. Anti-competitive practices are also prohibited by the *Competition Act 1998*.

4.1 The Bill: provisions relating to competition

The Bill would repeal or amend a number of provisions relating to competition policy in the *H&SC Act 2012* and the *NHS Act 2006*, including the following measures to remove obligations on NHS commissioners to use competitive tendering for health services:

- Clause 6 would amend provisions relating to NHS contracts, to allow the Secretary of State rather than Monitor to adjudicate in disputes about procurement[15];
- Clause 9 would try to exempt NHS commissioners from legally enforceable procurement obligations in relation to NHS contracts and would amend the procurement regulations, the *Public Contracts Regulations 2006,* to specify that they do not apply to the procurement of NHS funded services.[16]
- Clause 10 would repeal a number of Monitor's duties and powers relating to competition and procurement policy in the NHS, including the repeal of section 75, under which NHS procurement and competition regulations are made.
- Clause 11 would specify that the NHS is exempt from the *Competition Act 1998,* to try and prevent EU competition law being applied to the NHS.

Repeal of Monitor's duties and powers to prevent anti-competitive behaviour

Clause 10 of the Bill would repeal a number of sections of the *H&SC Act 2012* relating to Monitor's duties to prevent anti-competitive behaviour, and its powers to enforce competition rules. In particular, it would repeal sections 62(2), 62(3), 62(10), 67(3)(a) and 72 to 80 of the *H&SC Act 2012*.

The Labour Party, the BMA and the major trade unions representing NHS staff argue that integration must be given clear prominence over competition and that the NHS should always be the preferred provider of patient care. By removing Monitor's responsibilities in terms of competition the intention is to remove the prioritisation of competition as a policy goal. The Bill instead puts decision-making powers back in the hands of the Secretary of State. While the BMA's response to the Bill acknowledges that this is better than the present situation, it is concerned that the Secretary of State's powers in relation to procurement and contracts are too widely drafted and that the intention to limit competition rests upon a sympathetic Secretary of State:

> "These are not sufficient safeguards if a Secretary of State wants to continue to promote competition. However, if statutory checks and balances were introduced,

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15 The *Explanatory Notes to the Bill* (19 November 2014) state that: "The clause also enables the NHS to take advantage of exemptions to procurement obligations as set out in the European Union Directive 2014/24/EU." This Directive still has to be transposed into UK law – see the gov.uk page on *Transposing EU procurement directives* for more on this process. An earlier European Directive on procurement (Directive 2004/18/EC) were implements in the UK by the *Public Contracts Regulations 2006.*

16 As noted in the footnote above, the *Public Contracts Regulations 2006* implement European Directive 2004/18/EC, on procurement. A new set of procurement directives (2014/24/EU) was agreed in Europe earlier this year.

these provisions could provide a welcome limitation on the use of competition and promote integrated services."[17]

A statement on the Bill from the Foundation Trust Network gives its view that competition is one of many drivers of quality and service improvement in the health service. While the FTN states that the use of competition should not prevent NHS providers and their local health economy partners from moving towards new patterns of service delivery[18] they do not believe that it is appropriate for Monitor's key functions to be transferred to the Secretary of State. The FTN believe that it is crucial that regulators are able to act independently from political influence and take a proportionate, risk-based approach, to support the patient interest.[19]

4.2 Background to competition policy in the NHS in England

This section provides some background to the development of competition policy and independent sector involvement in the NHS from 2002, while the following section covers the changes introduced under the *H&SC Act 2012*.

There had been some contracting out of support services, such as cleaning and catering, during the 1980s but the first major reforms to introduce competition to the NHS came in 1991 with the first internal market reforms and the introduction of NHS trusts and the "purchaser-provider split" (the term commissioner is now preferred to purchaser). From 2002, a number of policies were introduced to strengthen the role of competition and patient choice within the NHS. As a result, NHS spending on independent sector treatment in England grew from 3.3% in 2002/03 to 9.5% in 2012/13 (see section 6 of this note for data on independent sector activity in the NHS). The Office of Health Economics' report on competition in the NHS (January 2012) provided a useful summary of NHS competition from 2000, and references to further reading.[20]

The Health and Social Care Act 2012

There have been claims that more NHS contracts are being awarded to private companies now than was previously the case.[21] In particular, it has been alleged that the *H&SC Act 2012* has extended competition law to the NHS and led to greater private sector involvement.[22] However, Ministers have responded that their reforms do not extend existing rules but rather create a framework within which competition can operate on the basis of quality, not price.[23]

Part 3 of the *H&SC Act 2012* creates a framework for choice and competition in the provision of NHS services. In particular, the 2012 Act allows the Department of Health to set regulations giving Monitor, as the new sector regulator for health services, the power to investigate and remedy anti-competitive behaviour by CCGs or NHS England. The key provisions of the 2012 Act are set out in a Department of Health factsheet on choice and competition. In particular this notes that:

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17 BMA briefing on the Bill, November 2014

18 The FTN is currently working with Monitor and the Competition and Markets Authority to ensure their frameworks enable innovation, service reconfiguration and cooperation.

19 FTN response to the Bill, November 2014 (not available online)

20 Office of Health Economics report on competition in the NHS (January 2012), para 3.2

21 "NHS contracts 'going to private firms'", *Health Service Journal*, 16 January 2014

22 "Labour calls for freeze on NHS contracts with the private sector until after general election", *BMJ,* 30 July 2014

23 The key provisions of the 2012 Act are set out in a Department of Health factsheet on choice and competition.

> "Monitor will be able to address abuses and restrictions that prevent competition and could lead to poorer care for patients. The Act does not change EU or UK competition [under the Competition Act 1998] and procurement legislation [Public Contract Regulations 2006]. What the Act does do is create a framework in which competition (on quality, not price) can operate, including appropriate safeguards."

The Department of Health publication *Sector regulation: update on plans for consultation and implementation* (July 2012) provides some further background. This explains that the 2012 Act creates a framework in which competition can operate, with safeguards, and repeats the assurance (noted earlier) that the Act does not change EU or UK competition and procurement legislation. In particular it sets out the Government's view that Monitor is able to address abuses and restrictions that prevent competition and could lead to poorer care for patients.[24]

However, there have been some concerns that following recent reforms, particularly the new role of Monitor as a sector regulator and the introduction of the section 75 regulations, more NHS contracts are being put out to open tender.[25] The BMA believes that the *H&SC Act 2012* places too much emphasis on commercialisation and competition, which threatens to undermine the ethos of the NHS and make both integrated care and collaboration between primary and secondary care harder to achieve.[26] While there is little consensus about the direct impact of the 2012 Act a recent survey found that more than a quarter of clinical commissioning leaders who responded said they had put services out to tender because they feared they would fall foul of competition rules if they did not. A fifth of respondents to *a Health Service Journal* survey, carried out with PwC, said their groups' decisions had been formally challenged under controversial NHS competition regulations.[27]

The role of Monitor

The *H&SC Act 2012* established Monitor, previously the independent regulator of Foundation Trusts, as the "sector regulator" for NHS-funded services in England. Monitor has the power to set and enforce a framework of rules for providers and commissioners; implemented in part through licences issued to NHS-funded providers. In addition to tackling anti-competitive practices, Monitor is also responsible for: setting prices for NHS-funded services alongside NHS England; helping commissioners to ensure that essential services continue if providers get into financial difficulty; and enabling better integration of care.[28]

Monitor review of barriers to integration

Monitor commissioned a consortium led by Frontier Economics (including the King's Fund, the Nuffield Trust and Ernst & Young) to undertake research into the integration of health services; drawing on existing literature and discussions with stakeholder their report identified a number of barriers to integrated care. The report, *Enablers and barriers to integrated care and the implications for Monitor*, was published in June 2012.

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24 DH, *Sector regulation: update on plans for consultation and implementation* (July 2012)

25 "£5.8bn of NHS work being advertised to private sector", *Financial Times*, 29 July 2014

26 BMA briefing on the Bill, November 2014

27 "CCGs open services to competition out of fear of rules", *HSJ,* 4 April 2014 The survey asked CCG leaders if they had invited, or were currently inviting, competition for services in cases where they would not have done so if not for competition rules or concerns about the rules, 29.1 per cent said they had; two thirds said they had not, and the remainder did not know. There were 103 respondents across 93 CCGs, 96 of whom were chairs or accountable officers. The remainder were other governing body members. There are 211 CCGs in total.

28 Further background can be found in Library Standard Note, *The reformed health service, and commissioning arrangements in England* (SN06749). The Monitor website provides more detailed information on its responsibilities.

While competition rules were not identified as a major barrier to integration, the Frontier Economics report also referred to other recent reports into integration from the NHS Future Forum, the King's Fund/Nuffield Trust, and the Health Select Committee. In terms of the impact of competition rules on integration, the Future Forum had called for Monitor and the NHS Commissioning Board (NHS England) to urgently support commissioners and providers to understand how competition, choice and integrated care can work together to improve services for users and communities. Similarly to what was said in the Future Forum report, the King's Fund and Nuffield Trust said Monitor must adopt a proportionate approach that encourages both competition and integration where this benefits patients and service users.

Procurement, choice and competition (Section 75) Regulations

A framework of regulations on competition and procurement have been introduced under Section 75 of the 2012 Act (known as the section 75 regulations). The Government has said CCGs will decide when to use competitive tendering as a means of improving NHS services, within this framework:

> We do not intend that regulations under Section 75 would prescribe when commissioners should use competitive tendering. Instead, our preferred approach is to require that commissioners must act transparently and be able to demonstrate the rationale for their decisions in patients' best interests. A provider could complain to Monitor where it considered that a commissioner had acted in breach of Section 75 regulations and the commissioner may be required to justify its decisions.

Section 75 of the *H&SC Act 2012* provides for regulations to place requirements on commissioners with respect to procurement, choice and competition. The Department of Health has stated that these requirements are: "...designed to protect the interests of patients by establishing health sector-specific rules to ensure transparency and accountability in the decisions that commissioners take, so that commissioners are able to demonstrate the rationale for their decisions in terms of quality and value for patients." And that: "...regulations will build on the existing PCT Procurement Guide and the Principles and Rules for Cooperation and Competition, but will give them a firmer legislative footing".[29]

A Department of Health consultation on its proposed procurement and competition regulations, published in August 2012, said that Monitor's powers would include "the power to direct a commissioner to remedy a breach of the regulations", and "the power to direct a commissioner to withdraw or vary a tender for the provision of services". Monitor will only investigate breaches of rules on procurement, choice or conflict of interests where it receives a formal complaint, but it also has the power to investigate potential anti-competitive conduct "on its own initiative".[30]

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[29] DH, *Sector regulation: update on plans for consultation and implementation* (July 2012). The consultation on the Department's procurement, choice and competition proposals ran from August to October 2012. See: http://consultations.dh.gov.uk/sector-regulation/pccrconsultation

[30] The *NHS (Procurement, Patient Choice and Competition) Regulations 2013* were laid before Parliament on 13 February 2013 (as statutory instrument SI 2013/257), to come into force on 1 April 2013. On 5 March 2013 the Health Minister Norman Lamb announced in the House that the Government would amend the draft regulations and revised regulations were laid on 11 March (SI 2013/500). The *Health Service Journal's* commentary on the new regulations noted some disagreement over the effect of the amendments to the rules ("Government's competition rowback 'doesn't address fundamentals'", *HSJ*, 13 March 2013). The House of Lords Secondary Legislation Scrutiny Committee considered the revised regulations and reported on these Regulations in its 33rd Report, published on 21 March 2013. The report and evidence can be found on the Committee's publications webpage.

NHS England has published procurement guidance for CCGs on meeting the requirements of the s75 regulations.[31] In addition, commissioners will receive guidance from Monitor on investigations and enforcement to ensure compliance with the regulations.[32]

Pre April 2013 principles and rules for cooperation and competition
The Department of Health, under the previous and current Government, issued *Principles and rules for cooperation and competition* (PRCC).[33] The PRCC set out the rules that the Department expected commissioners and providers of NHS services to follow to ensure co-operation and competition before the new competition regulations came into force on 1 April 2013. The PRCC principles and rules were not legally binding provisions and were not enforceable by the courts.

4.3 The Bill: mergers between NHS providers

Clause 10 of the Bill would repeal provisions under the *H&SC Act 2012* that gave Monitor a role in referring mergers to the competition regulators. Clauses 12 and 13 specify that the Secretary of State would have the discretion to approve significant mergers between NHS organisations.

The Bill's intention is to transfer responsibility for approving mergers between NHS providers, from Monitor and the Competition and Markets Authority to the Secretary of State. This measure responds to concerns that mergers of NHS hospitals, intended to improve patient care and increase efficiency, can be blocked on competition grounds (see below). The BMA has warned that this would lead to greater scope for the politicisation of health service decisions and the Foundation Trust Network has raised similar concerns.[34]

Background to mergers policy for NHS providers

The *H&SC Act 2012* did not alter existing statutory requirements regarding mergers under the *Enterprise Act 2002*. However, a decision by the Competition Commission to block a proposed merger of two Dorset NHS foundation trusts led to concerns that the competition regulators (the Competition Commission and the Office for Fair Trading were merged to form the Competition and Markets Authority in April 2014) are taking a more active role in scrutinising mergers in the NHS.[35]

In November 2011 the boards of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) and Poole Hospital NHS Foundation Trust (PH) announced their intention to merge. At that time financial problems had left PH in breach of the terms of its authorisation with Monitor (in its role as the regulator of Foundation Trusts) and the trusts argued the merger was necessary to ensure the sustainability of services.

The merger was referred to the Office of Fair Trading (OFT) in May 2012, in line with clause 79 of the *H&SC Act 2012*, which confirmed that mergers between FTs come under the

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31 NHS England website

32 On 27 March 2013 the Department of Health also issued a response to 38 Degrees' legal analysis of the *NHS (Procurement, Patient Choice and Competition) Regulations 2013*.

33 Following the Government's NHS White Paper in July 2010, the Department issued a revised PRCC to reflect the commitment that, wherever relevant, patients should have a choice of any willing provider and the greater range of commissioners. The two versions of the PRCC, for March 2010 and July 2010, are available on the DH website.

34 BMA and FTN briefings on the Bill, November 2014

35 The competition authorities have only reviewed NHS mergers from January 2012; prior to this the Cooperation and Competition Panel reviewed mergers between NHS provides under the Cooperation and Competition Rules and advising the Secretary of State: https://www.gov.uk/government/speeches/nhs-trusts-mergers-where-have-we-got-to

jurisdiction of the OFT. In January 2013 the OFT announced it was referring the proposals to the Competition Commission (CC) for investigation under the *Enterprise Act 2002*, after concluding the merger would leave patients and commissioners with "few realistic alternative providers". RBCH and PH are both NHS foundation trusts, independent NHS organisations that have a significant degree of autonomy in managing their affairs, and this was the first merger between two such trusts to be referred to the CC. The CC announced it was blocking the merger on 17 October 2013, having previously indicated it was minded to block the merger when it announced its provisional findings in July 2013.[36]

On 31 July 2014 the Competition and Markets Authority (CMA) and Monitor published guidance on NHS mergers to help merging providers navigate the review process and explained how they are working together to try to reduce the number of mergers requiring notification and lengthy merger reviews. The guidance covers the respective roles of the CMA and Monitor, whether and when to notify them about a merger, the stages of review, how the merger review assesses competition and where patient benefits are considered.[37] Monitor has stated that, as a result of its joint working the CMA was able to clear a recent merger at an early stage, of Frimley Park and Heatherwood and Wrexham Park NHS Foundation Trusts.

4.4 Evidence for the impact of competition

The Report of the Office of Health Economics Commission on competition in the NHS (January 2012) provided a useful summary of the evidence on the impact of competition in healthcare provision (see chapter 4). Summaries of some of the debates about research in this area can also be found on the Lancet website (December 2011).

Researchers at LSE have considered the impacts of hospital competition on performance, extending some earlier analysis conducted by the same team.[38] The study measured efficiency using hospitals' average length of stay (LOS) for patients undergoing elective surgery. Its results, published in February 2012, confirmed earlier results that suggested competition between public providers prompted public hospitals to improve their productivity. However, in contrast, the results suggested that competition from private hospitals did not spur public providers to improve their performance and instead left incumbent public providers with a more costly case mix of patients and led to increases in post-surgical LOS.[39]

With the advent of devolution there has been substantial divergence in health policy between the different parts of the UK, with Wales and Scotland abandoning internal market reforms and the role of competition increasing in England. These diverging paths create a laboratory for policy comparison[40] but the evidence for how the NHS in each home nation has performed is contested, with each model having their own champions and critics. Recent

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[36] Further information can be found in the CC's final report. See also King's Fund "NHS mergers: learning the lessons of Bournemouth and Poole", and Response regarding CC decision, October 2013

[37] CMA and Monitor guidance on the competition review of NHS mergers, 31 July 2014

[38] Zack Cooper, Stephen Gibbons, Simon Jones and Alistair McGuire, "Does Competition Improve Public Hospitals' Efficiency? Evidence from a Quasi-Experiment in the English National Health Service", CEP Discussion Paper 1125, February 2012

[39] This research was reported in *the Guardian* on 20 February 2012.

[40] See for example, National Audit Office report *Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland*, (June 2012). Overall, the report found that the limited availability and consistency of data across the four nations limited the extent to which meaningful comparisons can be made between the health services of the UK. For this reason the NAO was unable to draw conclusions about which health service is achieving the best value for money. Where comparative data are available, the NAO found that no one nation has been consistently more economic, efficient or effective across the indicators it considered. (page 10 para 23).

research suggests services are improving across the UK, despite very different health policies, and Health Foundation Chief Executive Jennifer Dixon has commented "no one policy cocktail seems to be more effective than another on NHS performance."

5 Transatlantic Trade and Investment Partnership (TTIP) and the NHS

Clause 14 of the Bill provides that the ratification of the proposed Transatlantic Trade and Investment Partnership (TTIP) Treaty must not cause procurement or competition obligations to be imposed on the NHS. There have been concerns that the TTIP deal being negotiated between the EU and US could make measures to open up the NHS to competition irreversible, although this has been disputed by the Government.

5.1 Background to TTIP

Concerns have been raised that TTIP, and specifically the investor-state dispute settlement (ISDS) provisions, could make measures to open up the NHS to competition irreversible by requiring US companies to be compensated in the event of a change of policy.

The ISDS provisions are highly controversial because of concerns that they will undermine the power of national governments to act in the interest of their citizens.[41] In particular, some commentators have claimed that, as a result of ISDS proposals in the TTIP, measures to open up the NHS to competition could be made irreversible if the provisions required US companies to be compensated in the event of a change of policy.[42]

The European Commission has stated that any EU-negotiated ISDS arrangements will "reaffirm the right of the Parties to regulate to pursue legitimate public policy objectives" and allow states to "protect… the public interest in a non-discriminatory way" (non-discrimination in this context means treating domestic and foreign companies in the same way).

However, in response to concerns, negotiations over ISDS were suspended while the European Commission ran a public consultation. This took place between 27 March and 13 July 2014.[43] 149,000 responses were received with over a third (52,000) coming from the UK. The Commission will analyse the responses and report on the outcome, although it has said it is unlikely to report before the end of November. Once the analysis is completed, the Commission will indicate what the next steps are likely to be.[44] However, in a letter to John Healey MP in July 2014, the European Commission explained that it was confident in its view that "…any ISDS provisions in TTIP could have no impact on the UK's sovereign right to make changes to the NHS." The Commission's letter also made the point that Member States are already required to respect applicable domestic and EU law regarding the conditions for early termination of contracts.[45]

Ministers have noted that overseas suppliers are already able to offer hospital services and health-related professional services in the UK[46] and will not affect the way competition policy

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[41] See, for instance, George Monbiot *This Transatlantic trade deal is a full-frontal assault on democracy*, Guardian, 4 Nov 2013

[42] See, for instance, Davies, P. (2013) *Trade secrets: will an EU-US treaty enable big business to gain a foothold?* BMJ 2013;346:f3574

[43] Details of the consultation are here.

[44] European Commission Preliminary report (statistical overview), *Online public consultation on investment protection and investor-to-state dispute settlement (ISDS) in the Transatlantic Trade and Investment Partnership Agreement (TTIP)*, July 2014

[45] Letter to Rt Hon John Healey MP, from the European Commission Directorate-General for Trade, dated 8 July 2014

[46] HC Deb 25 February 2014 c213-4

currently operates in the NHS.[47] The UK has already undertaken some long-standing multilateral level commitments through the general agreement on trade in services (GATS, 1995) on health services, and the UK Government's position during the TTIP negotiations has been to go no further than existing obligations:

> Hugh Bayley: To ask the Secretary of State for Business, Innovation and Skills, what safeguards for (a) the NHS and (b) other UK public services the Government is seeking to secure within the Transatlantic Trade and Investment Partnership.
>
> Matthew Hancock: The Transatlantic Trade and Investment Partnership (TTIP) will not change the fact that it is up to UK Governments alone to decide how UK public services, including the NHS, are run. The UK has insisted on maintaining the same safeguards for the NHS in TTIP as it has in all recent trade agreements.[48]

The Government has not sought to exclude health services from the scope of the Transatlantic Trade and Investment Partnership (TTIP) negotiations and has pushed for a broad agreement with all issues on the table. In response to questions about whether ISDS will make private sector involvement in the NHS irreversible, recently Ministers have highlighted that national government's will remain free to decide where services are provided by the private sector:

> Caroline Lucas: (...) Will the Minister confirm that under the investor-state dispute mechanism, US corporations will be able to challenge our national health policy decisions for ad hoc arbitration tribunals and potentially sue us for millions of dollars in damages for loss of profit in the event of any moves to reverse the coalition's privatisation agenda and bring the NHS back fully into public hands?
>
> George Freeman: No, I will not confirm that, but the hon. Lady does not have to take it from me. She can take it from the people who are doing the negotiations.
>
> The US chief negotiator confirms that the United States has no provision in its trade agreements on health. The EU chief negotiator says:
>
> > "I wish… to stress that our approach to services negotiations excludes any commitment on public services, and the governments remain at any time free to decide that certain services should be provided by the public sector."[49]

The BMA shares concerns that TTIP could tip the balance of power further towards private corporations and away from the public sector. Whilst the BMA says it has received commitments that the further liberalisation of the procurement of health services is not a focus of the TTIP negotiations, the BMA has concerns that TTIP threatens the fundamental principles of the NHS, by:

- facilitating the further commercialisation of the NHS via the inclusion of health services within the agreement's scope; and
- permitting proposed investor protection and ISDS mechanisms to be used to "attack" public services. (For example, providing companies with the legal means – backed by the threat of compensatory payments - to prevent the reversal of the outsourcing of NHS resources to the private sector.)

The BMA's response to the Bill states that:

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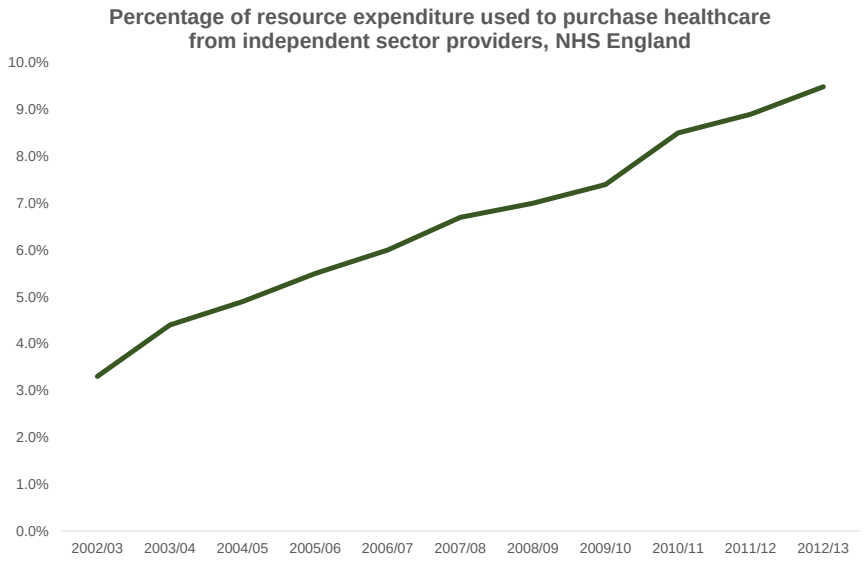
47 HC Deb 12 Nov 2013 c598W
48 PQ 905326 11 September 2014 (EU External Trade: USA)
49 HC Deb 21 October 2014 cc739-740

> "We... remain concerned at the failure to include legal provisions to prevent corporations from challenging public policy decisions, for example preventing US corporate interests from contesting any future UK Government legislation which sought to repeal the Health and Social Care Act 2012."[50]

The Library Standard Note on the Transatlantic Trade and Investment Partnership (TTIP) provides a section on ISDS.

6 Independent sector activity in the NHS

The chart below shows that the proportion of NHS resource expenditure used to purchase healthcare services from the independent sector (which includes private, voluntary sector and local authority providers) increased from 3.3% in 2002/03 to 9.5% in 2012/13 (see also Annex Table for monetary amounts.)



The chart below shows that the monetary amounts for NHS resource expenditure used to purchase independent sector treatment:

[50] BMA briefing on the Bill, November 2014

NHS England resource spending on purchase of healthcare from independent sector providers, 2002/03 to 2012/13

	Expenditure on independent sector providers (£millions)	% of total NHS resource expenditure
2002/03	1,889	3.3%
2003/04	2,848	4.4%
2004/05	3,353	4.9%
2005/06	4,092	5.5%
2006/07	4,685	6.0%
2007/08	5,717	6.7%
2008/09	6,421	7.0%
2009/10	7,448	7.4%
2010/11	8,400	8.5%
2011/12	8,426	8.9%
2012/13	9,522	9.5%

Sources:

Expenditure on non NHS providers

2002/03 to 2010/11 Summarised Accounts of the Strategic Health Authorities, Primary Care Trusts and NHS Trusts

2011/12 and 2012/13 Department of Health data presented in Nuffield Trust *Into The Red* report

Total resource expenditure

HMT Public Expenditure Statistical Analyses Table 1.3 (various years)

The Nuffield Trust report, *In to the Red* (July 2014) reveals that the overall percentages mask big variations in non-NHS involvement by sector and by region and, in particular, significant recent increases in independent sector involvement in community and mental health services.

Independent sector involvement as a proportion of total planned hospital admissions was only around 6 per cent in 2012/13 and growth actually appears to have slowed, whereas recent analysis from the Nuffield Trust reveals that one pound in every five spent by commissioners on community health services in 2012/13 was spent on care provided by private sector providers, an increase of 34 per cent in one year alone.

Along with the money spent on voluntary and other providers of community services, this means that nearly one third of the £9.75 billion the NHS spends on community health services is now with non-NHS providers. The Nuffield Trust's analysis also shows that non-NHS provision in mental health services has increased by 15 per cent in real terms between 2011/12 and 2012/13.

As noted above, in the hospital sector (which accounted for the single largest portion of NHS spending, at over £40 billion in 2012/13) the growth in spending on NHS funded care delivered by independent providers slowed. In 2012/13 commissioners spent £14 million less on independent sector providers in real terms compared with 2011/12 (£1.582 billion in 2012/13 compared to £1.596 billion in 2011/12).

Commenting on the analysis, Nigel Edwards, Chief Executive of the Nuffield Trust said:

> "This analysis shows that there has been a real shift in the makeup of organisations providing community and mental health services over the past three years, with a third of spending on community services now flowing to the private or voluntary sector.
>
> "While spending on non-NHS providers of hospital care has slowed, this plateau is probably a short term phenomenon – changes in procurement rules may well see this accelerate in future".[51]

It is important to note that the shift in the provision of community and mental health services, which the Nuffield Trust reported on, took place before the main provisions of the *H&SC Act 2012* relating to competition and procurement were introduced.

7 Reactions to the Bill

The BMA describes the Bill as a step in the right direction to address concerns about ministerial responsibility for the NHS in England, as well as what it believes is the over-emphasis on the use of competition in the NHS in recent years. However, the BMA also warn that the Bill gives potentially wide powers to the Secretary of State in a number of areas.

The BMA's response to the Bill states that care must be taken to ensure that the legislation does not risk introducing political interference in the day-to-day running of the NHS. The operational autonomy granted to the NHS in the *H&SC Act 2012* was, in many respects, a move which the BMA welcomed. Furthermore, the BMA says it is unclear how the Bill relates to a number of important bodies and structures created by the *H&SC Act 2012*, such as health and wellbeing boards.

While acknowledging concerns about the operation of competition, the Foundation Trust Network highlights the benefits that the Bill can bring to the NHS. They also note the importance of operational independence, including the freedom to generate private income, for foundation trusts seeking to improve services for NHS patients. The FTN also urges considerable caution in making any further far-reaching changes to the NHS:

> The reforms of the Health and Social Care Act 2012 are still bedding in, and at the same time the NHS is working to meet evolving patient needs while under severe financial pressure. The FTN believes that it is crucial that the system is allowed time to adapt to recent changes before any further, potentially disruptive, changes are made.[52]

The BMA also states that it would be extremely concerned if the Bill were a precursor for further top-down structural change.

Responding to the publication of the Bill, Dr Peter Carter, Chief Executive & General Secretary of the RCN said:

> "The Health and Social Care Act caused an unnecessary and chaotic reorganisation. It also introduced a level of enforced competition, and a lack of clear strategic coordination, which has been an unnecessary distraction from patient care. Since 2012, the RCN has been calling for the legislation to be scrapped.
>
> "Even a senior Conservative minister has admitted it was a mistake, and this Bill shows that it is not too late to undo the damage.

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51 Nuffield Trust website

52 FTN response to the Bill, November 2014 (not available online)

> "Reinstating limits around private income generation would ensure NHS patients are not being shoved to the back of the queue by trusts looking to profit from private patients.
>
> "This Bill also looks to protect the NHS from the Transatlantic Trade and Investment Partnership (TTIP), which will remove trade barriers between the EU and the US. The RCN has warned repeatedly that unless health services are exempt, the NHS could be vulnerable to privatisation through the backdoor. The Government must provide a cast-iron guarantee that this will not happen.
>
> "This bill highlights the ongoing concerns that staff, patients and politicians share about the effects of the Health and Social Care Act. Whilst there are many areas of ambiguity which need clarifying, particularly around the increased role for the Secretary of State, this Bill would remove the unnecessary focus on competition and allow trusts and health care staff to once more focus instead on caring for their patients."[53]

Links to further comments on the Bill can be found below:

- The NHS Confederation and NHS Clinical Commissioners (NHSCC represents CCGs) have produced a joint briefing to inform MPs ahead of the Second Reading of the Bill (19 November 2014). This briefing states the NHS Confederation's general position that it supports the use of competition in the NHS where it is in the interests of patients and the taxpayer.[54]

- In a letter to the Telegraph, reported on 21 November 2014, Dr Michael Dixon, chairman of the NHS Alliance, and eleven other doctors, said that reversing the changes would be a "backwards step for patients" which would force a needless reorganisation of the health service.[55]

- Professor Allyson Pollock, Peter Roderick and David Price, of the Centre for Primary Care and Public Health, Queen Mary, University of London have issued a response to the Bill. They describe it as a "step in the right direction of reducing procurement and tendering procedures", subject to the need for clarification. However, they also note a number of concerns, including that the Bill would not re-establish the Secretary of State's duty to provide the NHS, despite the long title of the Bill saying that it would.[56]

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53 RCN response to the Bill, November 2014 (not available online).

54 NHS Confederation and NHS Commissioners' response to the Bill (19 November 2014).

55 "Labour NHS bill is 'misguided and disruptive", *Telegraph*, 21 November 2014

56 Professor Allyson Pollock, Peter Roderick and David Price, response to the Bill (11 November 2014). See the website of the Campaign for the NHS Reinstatement Bill (www.nhsbill2015.org) for details of this groups' draft Bill, which intends to reinstate the founding vision of the NHS.