



Understanding ‘NHS privatisation’: from competition to integration and beyond in the English NHS

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ABSTRACT

References to National Health Service (NHS) ‘privatisation’ can be found in UK parliamentary debates since the early 1980s, but it remains not well understood as a concept and can certainly be distinguished from the standard definition of ‘privatisation’, meaning taking into private ownership. Nevertheless, it is possible to say that the characteristics of ‘NHS privatisation’ include clear links with the evolving interaction between the NHS and private healthcare, a relationship which can be traced back to the inception of the NHS in 1948.

By juxtaposing primarily the debates of the Health and Social Care Act 2012 (HSCA 2012) and the Health and Care Act 2022 (HCA 2022), it becomes possible to gain at least two insights into ‘NHS privatisation’ in the English NHS. Firstly, it enables us to understand whether, and if so, how, ‘NHS privatisation’ may be changing with the reversal of the controversial HSCA 2012 competition reforms by the shift to integration now enshrined by the HCA 2022. Secondly, we gain a greater understanding of how ‘NHS privatisation’ has developed as a criticism capable of being invoked by diverse political parties and thus able to shape the development and implementation of NHS reforms. Thirdly, ‘NHS privatisation’ may operate to inhibit more radical NHS reform in opposing directions by reference to the NHS Bill and the NHS (Co-funding and Co-payment) Bill. Finally, ‘NHS privatisation’ can be understood in terms of questions of accountability and the dynamic between market and state.

Keywords: NHS; privatisation; ‘NHS privatisation’; Health and Social Care Act 2012; Health and Care Act 2022; competition; integration; private healthcare.

INTRODUCTION

Debates of healthcare reform across the UK frequently include references to National Health Service (NHS) 'privatisation', particularly in England, where the relationship between the NHS and private healthcare has evolved with successive marketisation and competition reforms since the 1980s. As a term, 'NHS privatisation' is so politically charged that governments – and opposition parties – routinely deny categorically that proposed reforms would amount to privatisation,¹ since this is to make 'an ideological attack on the [NHS], an attack on the founding principle of free healthcare at point of need'.²

Despite its prevalence at the level of activism³ and its persistent use since the early 1980s in UK parliamentary debates, 'NHS privatisation' remains poorly understood. For example, it is often couched – crudely⁴ – in terms of 'Americanisation'⁵ which can overlook both clear differences between the two systems,⁶ and the difficulty of modifying

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- 1 A recent example being concerns attributed to the UK Prime Minister and former Chancellor of the Exchequer Rishi Sunak that more people seeking private treatment amounts to 'privatisation by the back door'. Isabel Hardman, 'Can Rishi Sunak heal the NHS?' *The Spectator* (London 23 July 2022). See also Labour's proposals in 2023 to make further use of private sector delivery of NHS services. Rachel Wearmouth, 'Wes Streeting: "NHS privatisation could not be further from my aims."' *New Statesman* (London 7 March 2023).
 - 2 Jill Mountford, 'The future of the NHS – irreversible privatisation? Interview with Dr Lucy Reynolds' (2013) 346 *British Medical Journal* f1848.
 - 3 See further, David I Benbow, 'Commentary: the Boy Who Cried Wolf or Cassandra? A consideration of the correct characterization of critics of neoliberal reforms to the English NHS' (2023) 53(2) *International Journal of Social Determinants of Health and Health Services* 239–242. For an interesting policy mobilities perspective on activism and the links with 'Americanisation', see Colin Lorne, 'Repoliticising national policy mobilities: resisting the Americanization of universal healthcare' (2022) 0(0) *Environment and Planning C: Politics and Space*.
 - 4 Colin Lorne and Michael Lambert, "'Protecting the NHS" – and its limits' (2023) 2022(82) *Soundings – A Journal of Politics and Culture*.
 - 5 On perceptions of US healthcare reform influence on the NHS marketisation reforms from the 1980s to the HSCA 2012 and the HCA 2022, see, respectively, L Reynolds and M McKee, 'Opening the oyster: the 2010–11 NHS reforms in England' (2012) 12(2) *Clinical Medicine* 128; and Peter Roderick and Allyson M Pollock, 'Dismantling the National Health Service in England' (2022) 52(4) *International Journal of Health Services* 470–479.
 - 6 For comparison of the differing approaches between the US and UK healthcare systems, see S K Germain, *Justice and Profit in Health Care Law: A Comparative Analysis of the United States and the United Kingdom* (Hart 2019).

a taxation-funded model.⁷ The increased prevalence of private-sector delivery of state-funded (NHS)⁸ (clinical and ancillary) services since the 1980s represents a narrow definition of 'NHS privatisation', but it is arguably the most common.⁹ Media coverage suggests that 'NHS privatisation' can encompass a diversity of issues, including increased interest in accessing private healthcare due to frustration with NHS waiting lists; charges for treatments not offered by the NHS; and a 'postcode lottery' for certain treatments being available in some parts of England but not others.¹⁰ While 'NHS privatisation' can thus be anchored primarily in questions of rationing and resource allocation, further complexity arises when this is linked – implicitly or explicitly – to wider questions about health outcomes¹¹ and patient safety.¹²

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- 7 It is widely considered that 'Beveridge'-style taxation-funded healthcare systems are notoriously difficult to reform in light of the 'compact' between government and taxpayers to provide healthcare. See, for example, Ewen Speed and Jonathan Gabe, 'The reform of the English National Health Service: professional dominance, countervailing powers and the buyers' revolt' (2020) 18 *Social Theory and Health* 33–49.
- 8 The phrasing 'state-funded (NHS)' is used at various points in this article to indicate the relevance of funding to the present discussion. It can be considered that the phrase 'NHS' elides funding and the wider system which may be unhelpful in some contexts. However, it is clear across the range of sources cited – from parliamentary debates to CMA reports – that 'NHS' is frequently used as shorthand for 'state-funded', with no clear distinction being drawn between funding and the wider healthcare system.
- 9 Mary Guy, 'Between "going private" and "NHS privatisation": patient choice, competition reforms and the relationship between the NHS and private healthcare in England' (2019) 39(3) *Legal Studies* 479–498.
- 10 See variously, Kat Lay, 'Young go private amid frustration at NHS care' *The Times* (London 9 October 2023); Sian Elvin, 'WW2 veteran denied medication by NHS which could stop him going blind' *Metro* (London 31 July 2020); and Ella Pickover, 'World's first IVF baby calls out "postcode lottery" of care' *The Independent* (London 22 June 2022).
- 11 Benjamin Goodair and Aaron Reeves, 'Outsourcing healthcare services to the private sector and treatable mortality rates in England, 2013–20: an observational study of NHS privatisation' (2022) 7(7) *The Lancet Public Health* e638–e646.
- 12 The Ian Paterson case highlighted different governance approaches in the NHS and private healthcare sector. Kieran Walsh and Naomi Chambers, 'Clinical governance and the role of NHS boards: learning lessons from the case of Ian Paterson' (2017) 357 *British Medical Journal* j2138; Patrick Leahy, 'A private matter: why have politicians ignored private surgical standards for so long?' (2018) 100(5) *The Bulletin of the Royal College of Surgeons of England* 197. More recently, a *Sunday Times* investigation has indicated a range of more general concerns: S Lintern, 'You can pay for private healthcare – but can you trust it?' *Sunday Times* (London 10 September 2023).

These myriad considerations contribute to views that 'NHS privatisation' has become 'a general "boo word" and a 'factoid'.¹³ This is particularly concerning as its invocation by diverse political parties¹⁴ belies important implications for political debate and the shaping of legislation: 'NHS privatisation' becomes key to questions concerning the extent to which decisions about resource allocation are to be juridified rather than politicised or resolved in the professional paradigm.¹⁵

This article makes an original contribution by examining 'NHS privatisation' in the macro level context¹⁶ of the debates and implementation of the Health and Social Care Act 2012 (HSCA 2012) and the Health and Care Act 2022 (HCA 2022). The HSCA 2012 enacted controversial competition reforms, seen by some as a mechanism for 'NHS privatisation', especially in light of the explicit link with 1980s utilities liberalisation reforms.¹⁷ The HCA 2022 rescinded aspects of these competition reforms and enshrined the intervening policy shift

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- 13 Respectively, M Powell and R Miller, 'Privatizing the English National Health Service: an irregular verb?' (2013) 38(5) *Journal of Health Politics, Policy and Law* 1051; and S Iliffe and R Bourne, 'The myths of NHS privatisation: a commentary on factoids, policy zombies and category errors' (2021) 114(12) *Journal of the Royal Society of Medicine* 578.
- 14 An example beyond perhaps anticipated debates between Labour and Conservative MPs was found with the exchange between the former Scottish National Party leader and First Minister Nicola Sturgeon and Conservative Member of the Scottish Parliament Douglas Ross during 'First Minister's Question Time' on 24 November 2022.
- 15 Although beyond the scope of this article, much remains to be explored and understood about how 'NHS privatisation' and NHS-private healthcare interaction may affect the professional paradigm in a variety of senses, from distinctions between medical professionals who may, or may not, be in favour of working in the NHS, or engaging in 'dual practice' with both private and NHS patients. On the latter, see, for example, W Whittaker and S Birch, 'Provider incentives and access to dental care: evaluating NHS reforms in England' (2012) 75 *Social Science and Medicine* 2515–2521.
- 16 Implications of NHS-private healthcare interaction have also been identified with regard to the micro level of the doctor-patient relationship. See, for example, S Ost and H Biggs, *Exploitation, Ethics and Law: Violating the Ethos of the Doctor-Patient Relationship* (Routledge 2022) ch 3.
- 17 Chris Smyth, 'Gas and power markets are a model for the health service' *The Times* (London 25 February 2011). For more detailed interrogation of the influence of the utilities regulation model on the HSCA 2012 reforms, see Lindsay Stirton, 'Back to the future? Lessons on the pro-competitive regulation of health services' (2014) 22(2) *Medical Law Review* 180–199.

towards service integration. This posed the question of whether the changes would reverse or encourage 'NHS privatisation'.¹⁸

Juxtaposing these two pieces of legislation makes it possible to consider whether the extent of 'NHS privatisation' is changing, the mechanisms by which 'NHS privatisation' occurs, and whether this can also exist outwith the policy foci of competition and integration.

The article's starting point is to outline discussion of 'NHS privatisation' within English healthcare in general terms, and more specifically within parliamentary debates since the 1980s. This scene-setting is framed by reference to 'four categories of English healthcare' which span various aspects of the NHS and private healthcare interaction. Further context is given by the opposing visions for NHS reforms presented by the NHS Bill and the National Health Service (Co-funding and Co-payment) Bill, with the latter, but not the former, indicating connections with 'NHS privatisation'. The HSCA 2012 and the associated secondary legislation, the National Health Service (Procurement, Patient Choice and Competition) Regulations (No 2) 2013 (the 2013 Regulations) are then analysed. The apparent removal of competition law mechanisms by the policy shift to integration envisioned by the HCA 2022 and implications for 'NHS privatisation' are then examined. Finally, some concluding remarks are provided.

DEFINING AND LOCATING 'NHS PRIVATISATION' IN ENGLISH HEALTHCARE AND UK PARLIAMENTARY DEBATES OF NHS REFORMS

It is acknowledged that 'NHS privatisation' debates are at least 'three dimensional' and concern issues of ownership, finance and regulation.¹⁹ This would seem to situate 'NHS privatisation' within definitions found within distinct, but arguably related, strands of more general literature on public ownership and privatisation.²⁰ It also goes beyond the idea that 'NHS privatisation' is a debate about 'taking into private

18 See Allyson Pollock and Peter Roderick, 'If you believe in a public NHS, the new Health and Care Bill should set off alarm bells' *The Guardian* (London 7 December 2021); and Mark Dayan and Helen Buckingham, 'Will the new Health and Care Bill privatise the NHS?' (*Nuffield Trust Blog* 15 July 2021).

19 See Powell and Miller (n 13 above).

20 See, respectively, Rhys Andrews, George A Boyne and Richard M Walker, 'Dimensions of publicness and organizational performance: a review of the evidence' (2011) 21(3) *Journal of Public Administration Research and Theory: Special Issue: Dimensions of Publicness and Organizational Performance* 301–319; and Mislav Radic, Davide Ravasi and Kamal Munir, 'Privatization: implications of a shift from state to private ownership' (2021) 47 *Journal of Management* 1596–1629.

ownership'.²¹ Rather, the debate about 'NHS privatisation' is instead one about the mechanism of provision, and associated accountability, which is often focused in narrow terms relating to the marketisation reforms connected with the HSCA 2012.²²

To begin to understand 'NHS privatisation', it is necessary to consider the relationship between the NHS and private healthcare in existence since 1948. This relationship emerges as a result of a concession necessary to implement the NHS: namely, that consultants could continue private practice alongside their NHS workload, and that hospital provision would be made available for this.²³ While this has given rise to complex framings and political campaigns,²⁴ it also indicates a difficulty if 'NHS privatisation' is to be defined in apposition to 'nationalisation', because it prompts the question of the extent to which the NHS was ever fully nationalised.

A 'fully nationalised' health service might be considered to comprise three dimensions: state ownership of essential infrastructure; state-employed or contracted clinicians; and state determination of the scope (and price) of the services provided. Already at the inception of the NHS in 1948 each of these three dimensions appears challenged by the aforementioned underlying NHS–private healthcare interaction, as well as the independent status of general practitioners (GPs).

It would therefore follow that any development which did not serve to 'complete' the nationalisation of the health service could be criticised as 'privatisation' of the NHS. Indeed, far from 'completing' the nationalisation of the NHS, the focus has been instead on managing the contradiction and conflicts posed by the coexistence of state-funded (NHS) and private healthcare. This can be seen in two main ways.

21 The limited experiment with franchising may be the nearest development to this with the notable example being the short-lived private management of an NHS hospital in Cambridgeshire. 'Hinchingsbrooke Hospital asks for £9.6m bailout as Circle withdraws' (*BBC News* 10 February 2015). For further discussion, see Peter Scourfield, 'Squaring the Circle: what can be learned from the Hinchingsbrooke franchise fiasco?' (2015) 36(1) *Critical Social Policy* 142–152.

22 Benbow (n 3 above) relies on a definition of privatisation attributed to the World Health Organization in 1995: 'a process in which nongovernmental actors become increasingly involved in the financing and/or provision of healthcare services'. Jeff Muschell, *Health Economics Technical Briefing Note: Privatization in Health* (World Health Organization 1995) 3. However, it should be noted that the very next sentence of Muschell's text reads 'A distinction should be made between the process of privatization and the public/private mix in the health sector', thus underscoring the difficulty of adopting a narrow definition.

23 See, specifically, ss 5 and 6 National Health Service Act 1946.

24 Notably the distinction between 'NHS amenity beds' and 'NHS pay-beds'. See Aneurin Bevan, 'A free health service' in Aneurin Bevan, *In Place of Fear* (Quartet Books 1978) ch 5; and specifically on the latter, 'Hospital pay beds', HC Deb 5 May 1975, vol 891 cols 1084–1149.

Firstly, by the levying of prescription and other charges ('co-payments') being permitted.²⁵ Secondly, and in contrast, by the prohibition on 'co-funding', which has long circumscribed the scope for combining state-funded (NHS) and private healthcare to avoid (even perceptions of) the NHS subsidising private healthcare.²⁶ However, this approach has evolved over time to enable, for example, 'top-up' payments for cancer drugs.²⁷

Nevertheless, 'NHS privatisation' – as a distinct phrase, or even concept – is more recent. The first UK parliamentary record we find of the term 'NHS privatisation' in England relates to the outsourcing of cleaning services in 1984.²⁸ While this may seem to indicate a link with the wider privatisation reforms by the Conservative Governments of the 1980s, we also see references to 'privatisation' of the NHS emerging in connection with charges being levied for specific services.²⁹

Locating 'NHS privatisation' within English healthcare

While it may seem intuitive to link 'NHS privatisation' with the competition reforms from the NHS internal market of the late 1980s onwards, it is useful to recall how the fundamental separation of purchasing and providing functions makes this possible. The combination of NHS–private healthcare interaction and the separation of purchasing and providing functions can be illustrated by reference to 'four categories', thus:³⁰

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- 25 Department of Health, 'Guidance on NHS patients who wish to pay for additional private care' (23 March 2009); NHS Commissioning Board (now NHS England), 'Commissioning policy: defining the boundaries between NHS and private healthcare' (NHSCB/CP/12, April 2013).
- 26 Department of Health (n 25 above).
- 27 Ibid para 4.2; and Mike Richards, *Improving Access to Medicines for NHS Patients* (Department of Health 2008). For discussion, see E Jackson, 'Top-up payments for expensive cancer drugs: rationing, fairness and the NHS' (2010) 73(3) *Modern Law Review* 399; K Syrett, 'Mixing private and public treatment in the UK's National Health Service: a challenge to core constitutional principles?' (2010) 17 *European Journal of Health Law* 235.
- 28 In comments by the Labour MP Jeremy Corbyn, 'National Health Service (privatisation)', HC Deb 21 December 1984, vol 70, cols 686–694. It appeared earlier with regard to Scotland in a question by Dennis Canavan while a Labour MP in 1983: 'NHS (privatisation)', HC Deb 13 May 1983, vol 42, col 549W.
- 29 For example, 'National Health Service', HC Deb 21 October 1991, vol 196, col 662.
- 30 See further, for example, Mary Guy, *Competition Policy in Healthcare – Frontiers in Insurance-Based and Taxation-Funded Systems* (Intersentia 2019).

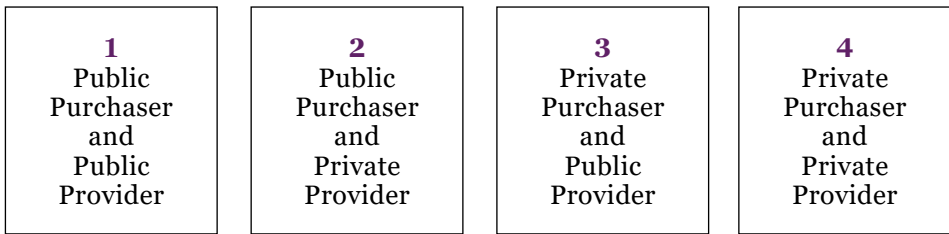


Figure 1: Relationship between the NHS and private healthcare sectors as demonstrated by the purchaser/provider separation.

As two extremes, category 1 encapsulates the situation where NHS patients are treated by NHS bodies (eg NHS Trusts or NHS Foundation Trusts), and category 4 the situation where private patients are treated by private providers.

A shift between categories 1 and 4 may seem to be properly described as ‘privatisation’, and the reverse as ‘nationalisation’. This language, however, does not well account for categories 2 and 3. Certainly categories 2 and 3 represent different understandings of ‘NHS privatisation’, comprising respectively, the outsourcing of state-funded (NHS) services to private providers (category 2) and the private provision of services and treatments by the NHS, most recently via private patient units (category 3). Thus the New Labour choice and competition reforms, which combined the expanding recourse to private providers with patient choice policies (category 2 activity), often underpins claims of ‘NHS privatisation’. In contrast, the development of the private healthcare market contemporaneously³¹ with the HSCA 2012 reforms which included removal of the private patient income cap³² (enabling more category 3 activity) appears to have received less attention. The ability to distinguish categories 2 and 3 in this way demonstrates that there is no clear sense that these link to each other, nor that they point directly towards an expansion of category 4.

Locating and defining ‘NHS privatisation’ within UK parliamentary debates of NHS reforms in England

While ‘NHS privatisation’ can be understood as a broadly open-ended criticism of various dimensions of NHS–private healthcare interaction, some attempt at clarification is evident in parliamentary debates. This is because, broadly speaking, the two main political parties – Labour and the Conservatives – have both had to contend with the underlying NHS–private healthcare relationship while needing to differentiate

31 CMA, *Private Healthcare Market Investigation Final Report* (CMA25 2 April 2014).

32 S 165 HSCA 2012. This was anticipated to enable an expansion of private patient units.

their approaches to it. Thus we have seen claims by Conservative Members of Parliament (MPs) that Aneurin Bevan, by introducing charges for prescription and dental services, may have been the father of 'NHS privatisation',³³ and that Labour introduced more 'NHS privatisation' than the Conservatives.³⁴ In contrast, New Labour MPs in particular have attempted more nuance: 'NHS privatisation' is not 'commercialisation' or 'market mechanisms', but it is the 'bad competition' found in connection with United States (US) healthcare.³⁵

An explanation for the sense of lack of inevitability in any process of 'NHS privatisation', and indeed arguably circular criticisms between the Labour and Conservative parties, may be attributed to theories of 'path dependency', which have been used to analyse the marketisation reforms from the mid-1980s, and more generally explain why healthcare system reform is so difficult.³⁶ Path dependency may also go a long way to explaining the limited evolution of the underlying NHS–private healthcare interaction in view of relatively stable governments, albeit with political shifts between Labour and the Conservatives.³⁷ Thus the stability of the New Labour Government, particularly in 1997, could in theory have heralded a decisive reformulation of the interaction between the NHS and private healthcare, and certainly a move away

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- 33 See comments by the Conservative MP William Waldegrave, indicating the heated debates between Labour and the Conservatives regarding nascent marketisation reforms in the 1980s, HC Deb 21 October 1991, vol, 196 col 662: 'Let us examine some of the new definitions [of "privatisation"]. One line is that having charges for some items of service in the NHS is privatisation. In that case, the very founder of the NHS invented privatisation. It was Aneurin Bevan who passed the legislation for prescription charges, and it was a Labour Government who introduced charges for teeth and spectacles.'
- 34 See, for example, debates on NHS pay: HC Deb 13 September 2017, vol 628. The then Conservative MP Anna Soubry asked for confirmation that Labour 'privatisation' amounted to 5%, whereas the 'privatisation' under the Conservatives was 1%. This was responded to with a discussion of the distinction between GPs and pharmacists (as private enterprises), and other kinds of private-sector involvement in delivering NHS services.
- 35 With the Labour MP Ben Bradshaw responding to connections drawn by the Independent MP Dr Richard Taylor between the New Labour reforms and those of the NHS internal market: HC Deb 24 February 2009, vol 488, col 66WH.
- 36 D Wilsford, 'Path dependency, or why history makes it difficult, but not impossible to reform health care systems in a big way' (1994) 14(3) *Journal of Public Policy* 251–283. I Greener, 'Understanding NHS reform: the policy-transfer, social learning, and path-dependency perspectives' (2002) 15(2) *Governance: An International Journal of Policy, Administration, and Institutions* 161–183. See also G Bevan and R Robinson, 'The interplay between economic and political logics: path dependency in health care in England' (2005) 30(1–2) *Journal of Health Politics, Policy and Law* 53–78.
- 37 M Guy, '(How) is COVID-19 reframing interaction between the NHS and private healthcare?' (2023) 23(2) *Medical Law International* 138–158.

from the market reforms of the previous Conservative Governments, but did not.³⁸

In order to locate – and thus attempt to assess the type and extent of – ‘NHS privatisation’ in the HSCA 2012 and HCA 2022, it is useful to briefly consider two Private Members’ Bills which offer wildly opposing visions for NHS reform.

The National Health Service Bill³⁹ was initially introduced by the Green MP Caroline Lucas, during the 2014–2015 and the 2015–2016 parliamentary sessions before being reintroduced subsequently by the Labour MPs Margaret Greenwood, in the 2016–2017 parliamentary session, and Eleanor Smith during the 2017–2019 parliamentary session. This Bill articulated a vision of the NHS reminiscent of how it existed prior to the 1980s, with a more centralised structure and greater ministerial oversight, and attempting to situate the NHS as a public service completely exempt from European Union (EU) law and World Trade Organization rules.⁴⁰ As such, the NHS Bill might be seen as firmly within category 1, and also the nearest attempt to ‘complete’ the nationalisation of the health service, thus, would be expected to avoid any suggestion of ‘NHS privatisation’.

In contrast, the National Health Service (Co-funding and Co-payment) Bill was introduced by the Conservative MP Sir Christopher Chope in almost every parliamentary session between 2017 and 2023. This Bill aimed to relax the prohibition on co-funding, and expand co-payment which would have the effect of facilitating access to private healthcare for NHS patients and enabling more out-of-pocket expenses to be levied. Whether this might be cast in terms of an expansion of category 4 is moot, but it might certainly be expected to invite criticisms of ‘NHS privatisation’.

A striking common feature of both Bills is their failure to gain traction: neither progressed to a second reading, let alone committee debates. Of course this may be explained in part by prioritising of parliamentary business and technicalities regarding the status of Private Members’ Bills. However, this merely underscores the apparent unwillingness of government to engage with radical NHS reform – be this seemingly further towards, or away from, claims of ‘NHS privatisation’.

The HSCA 2012 and the HCA 2022 then start to assume a middle ground between the NHS Bill and the National Health Service (Co-funding and Co-payment) Bill. This is because neither can be said to advocate for either a radical rejection, or embrace, of ‘NHS

38 Path dependency may also explain the current approaches being taken by the Sunak Government and the Labour Party under Sir Keir Starmer’s leadership.

39 Also known as the NHS (Reinstatement) Bill.

40 Although beyond the scope of this article, it can be noted here that even category 1 activity would not necessarily be considered so exempt.

privatisation', but nevertheless involve aspects which, to varying degrees, are subsumed within definitions of 'NHS privatisation'. By juxtaposing the NHS and National Health Service (Co-funding and Co-payment) Bills it thus becomes possible to frame and attempt to assess the extent and evolution of 'NHS privatisation' within the HSCA 2012 and HCA 2022 accordingly.

COMPETITION AND 'NHS PRIVATISATION': THE EXPERIENCE OF THE HSCA 2012

The HSCA 2012 competition reforms comprised three convoluted dimensions: the reduction of ministerial oversight via the involvement of the Competition and Markets Authority (CMA) and the establishment of NHS England and Monitor/NHS Improvement; enshrinement by the 2013 Regulations of the New Labour choice and competition reforms; and an attempt to align competition regulation in the NHS with the experience of other sectors. This was intended to reflect the 1980s utilities liberalisations via economic regulation and a licensing regime as enforcement mechanisms. All three – individually as well as in combination – indicate a fertile environment for claims of 'NHS privatisation', based on the wide-ranging definitions identified above, and unsurprisingly the ambition of the initial White Paper⁴¹ met with a range of sceptical responses.⁴² Furthermore, the introduction of primary legislation with the seeming intention of making the market in the NHS 'more real'⁴³ further underscored scope for 'NHS privatisation' to be seen as an inevitable process, a setting in train of an irreversible direction.⁴⁴

Thus, scope for a disruptive, detrimental influence might be inferred from the HSCA 2012 being subject to a lengthy passage through

41 Department of Health, 'Equity and excellence: liberating the NHS' (Cm 7881 July 2010).

42 Including from the former Prime Minister, David Cameron, who is quoted as saying: 'It was like an artist unveiling a piece he'd spent years on, and everyone wondering what on earth it was.' Alistair McLellan, 'The bedpan: David Cameron's autobiography' *Health Service Journal* (London 20 September 2019).

43 A C L Davies, 'This time, it's for real' (2013) 76(3) *Modern Law Review* 564–588.

44 Ibid and further on the 'juridification' of these reforms see the various subsequent responses to Davies' article. Dorota Osipovič, Pauline Allen, Marie Sanderson, Valerie Moran and Kath Checkland, 'The regulation of competition and procurement in the National Health Service 2015–2018: enduring hierarchical control and the limits of juridification' (2019) 15(3) *Health Economics, Policy and Law* 308–324; David Benbow, 'Juridification, new constitutionalism and market reforms to the English NHS' (2019) 43(2) *Capital and Class* 293–313; Mary Guy, 'Dealing with "unworkable ideas in primary legislation": juridifying and dejuridifying competition in the English National Health Service' (2023) *Public Law* 57–80.

Parliament (January 2011–March 2012), and the recollection that the Conservative/Liberal Democrat Coalition Government was obliged to pause the passage of the Health and Social Care Bill and conduct a 'listening exercise' in the spring and early summer of 2011 to engage with the concerns which arose, particularly in connection with the 'choice and competition' aspects.⁴⁵

Concerns about 'NHS privatisation' were dismissed in this context by the Clinical Forum of the NHS Confederation Partners Network taking the view that the proportion of NHS work carried out by private providers would be unlikely to change.⁴⁶ This 'listening exercise' concluded with a report by the specially constituted NHS Future Forum, which led to notable amendments and an apparent scaling-back of the Coalition Government's ambitions. Two examples are the reconfiguring of the role for Monitor (subsequently NHS Improvement) as no longer 'promoting competition', but rather 'preventing anti-competitive behaviour',⁴⁷ and the wider refocusing of competition away from price competition to competition on quality. In the Coalition Government's response to this report, a further important concession was made, namely to enshrine existing New Labour policy guidance on choice and competition rather than design new rules.⁴⁸ Further amendments were made to the competition provisions of the HSCA 2012 when debates reconvened, right up to enactment.⁴⁹ It is therefore possible to consider separately how 'NHS privatisation' featured in the debates of the Health and Social Care Bill, and how it was in evidence in the implementation of the HSCA 2012.

'NHS privatisation' and Health and Social Care Bill debates

We find references to 'NHS privatisation' featuring particularly in the Commons debates preceding the NHS Future Forum report, as well as in the Lords debates subsequently. At least three aspects of 'NHS privatisation' can be identified.

'NHS privatisation' as a general and vague concept

This framing contributes to the representation of 'NHS privatisation' as something to be avoided, and therefore something which is distinct from what the Health and Social Care Bill set out to do, in

45 NHS Future Forum, *Choice and Competition – Delivering Real Choice* (NHS Future Forum June 2011).

46 Ibid 6. The report further notes that this network represented some 45,000 clinicians carrying out NHS work from the independent sector.

47 S 62(3) HSCA 2012.

48 Department of Health, 'Government response to the NHS Future Forum report' (CM8113, 22 June 2011) 44, para 5.16 .

49 For detailed examination of these, see Guy (n 30 above).

a manner reminiscent of the defensiveness surrounding New Labour reforms.⁵⁰ Thus, at various stages across the Health and Social Care Bill's passage, we see distinctions such as '[e]xtending choice and increasing competition is not about privatisation'.⁵¹ We also see long-standing inconsistencies being highlighted – for example, that general practice has been essentially a privately run, profit-making activity since 1948 yet never seen as incompatible with NHS principles.⁵² In a similar vein, companies partly or wholly owned by the Secretary of State and established to provide services or facilities to persons exercising functions under the National Health Service Act 2006 (such as NHS Professionals or Dr Foster Intelligence) are not a 'prelude to privatisation', but a means of allowing private-sector investment and expertise to be brought in as required.⁵³

Attempts at further clarification are seen in consideration of conflicts of interest for the (then) new Clinical Commissioning Groups (CCGs), with the concern that:

the entire commissioning function will be contracted out over time to private companies and there will be no proper scrutiny or accountability.⁵⁴

This led to further discussion of the operation of private providers more generally, but also eventually to clarification of how to manage conflicts of interest within CCGs, for instance between financial interests of being a director or shareholder of a private company, and conducting clinical private practice.⁵⁵

'NHS privatisation' as a process

There is a continuing sense from parliamentary debates of 'NHS privatisation' being a process, albeit with indistinct start and end points. For example, the New Labour policies of developing NHS Foundation Trusts (to have greater autonomy from central government) and expanding private-sector delivery of state-funded (NHS) services had been accepted. In the early stages of the Health and Social Care Bill, however, once concern was that enshrinement of these policies would amount to '[holding] the door open for the vandals who are now

50 See n 35 above.

51 See comments by Earl Howe in the 12th Sitting: HL Deb 13 December 2011, col 1144.

52 See comments by Professor Chris Ham, PBC Deb (Bill 132) 9 February 2011, col 42.

53 See comments by Simon Burns MP, PBC Deb (Bill 132) 1 April 2011, col 1277.

54 See comments by Grahame Morris MP, PBC Deb (Bill 132) 9 March 2011, col 564.

55 Initially published in 2013, then updated: NHS England, 'Managing Conflicts of Interest: Revised Statutory Guidance for CCGs' (2017).

marching through [and leading to] wholesale de facto privatisation'.⁵⁶ Later stages of the Health and Social Care Bill saw additional facets of 'NHS privatisation' being elaborated, with the emphasis on NHS Foundation Trusts treated in essence as private entities, subject to failure regimes.⁵⁷

The idea of 'NHS privatisation' as a process gained further momentum, and even consolidation, with discussion of the applicability of 'competition law':⁵⁸

No-one is suggesting that the Bill instantly leads to the privatisation of the NHS. What it does, however, is lay the foundations for gradual, creeping erosion of the public provision of NHS services and allows a challenge to the NHS by private providers, through the opening up under competition law.⁵⁹

A further dimension to this was added by linking questions of applicability of *EU* (as distinct from *UK*) competition law:⁶⁰

If the full weight of EU competition law applied to the NHS, as if it were a standard service industry, the process of privatisation, which Opposition members are concerned about and the Government have indicated that they are opposed to, could not only be accelerated but might become entirely irreversible.⁶¹

While a range of general questions were asked about whether the proposals would expose the NHS to EU competition law, more concrete concerns were articulated in terms of cross-subsidy in the context of private patient units in NHS hospitals and the implications of this in connection with the EU state aid rules.⁶²

Writing in 2023, with the benefit of hindsight post-Brexit, it is striking how concerns about EU-level influence over the English NHS were manifest in the Health and Social Care Bill debates given these now appear overstated.⁶³

56 See comments by Owen Smith MP, PBC Deb (Bill 132) 15 February 2011, col 232.

57 See comments by Derek Twigg MP, PBC Deb (Bill 132) 24 March 2011, col 1009.

58 It can be noted that 'competition law' as used by MPs appears to conflate the distinct aspects of procurement and competition (if understood eg as the prohibitions on anti-competitive agreements and abuse of dominance).

59 See comments by Owen Smith MP, PBC Deb (Bill 132) 15 March 2011, col 755.

60 See further on the effects of EU competition law on the HSCA 2012 reforms more generally, Guy (n 44 above).

61 See comments by Grahame Morris MP, PBC Deb (Bill 132) 17 March 2011, col 864.

62 See comments by Grahame Morris MP, PBC Deb (Bill 132) 24 March 2011, col 1084.

63 See Guy (n 44 above).

'NHS privatisation': connections with utilities liberalisation?

These concerns were initially seen in Monitor/NHS Improvement being reconceptualised as an 'economic regulator' (akin to OFCOM or OFGEM) with a duty to 'promote competition',⁶⁴ and a shared competence with the CMA, *inter alia*, to apply competition law.⁶⁵ The connection between the two was highlighted by Monitor/NHS Improvement's role⁶⁶ and led to statements such as 'Healthcare should not be treated in the same way as the privatised utilities', with distinctions being drawn between the two.⁶⁷ Further examinations led to the suggestion that 'giving Monitor concurrent powers⁶⁸ to the Office of Fair Trading [now the CMA] opens the gateway to wholesale privatisation'.⁶⁹

It is also useful to note that these amendments did not mark the end of controversy surrounding the HSCA 2012 competition reforms, with further concerns emerging about the associated secondary legislation (the National Health Service (Procurement, Patient Choice and Competition) Regulations (No 2) 2013), which similarly reflected the sense of vagueness and process attaching to 'NHS privatisation'. These regulations raised claims of 'NHS privatisation' via the view that they required mandatory tendering of all services.⁷⁰ What emerges from the Lords debates of the 2013 Regulations appears to be that provision (whether by NHS or private providers) is a characteristic feature of 'NHS privatisation'. This may explain the divergence of opinion – among charities and professional associations, as well as parliamentarians – about whether the 2013 Regulations would lead

64 Following the NHS Future Forum report and the recommendations to refocus competition within the Health and Social Care Bill, Monitor's status was redesignated as a 'sectoral regulator', and, as noted previously, its focus confined to 'preventing anticompetitive behaviour'. See further on these changes, Guy (n 30 above).

65 Outside the scope of the parliamentary debates, it can further be seen in the development of a licensing regime for providers delivering state-funded (NHS) services – again, in reflection of other sectors. For a good overview of the comparisons and contrasts – and a suitable urging of caution – see Stirton (n 17 above).

66 See comments by Liz Kendall MP, PBC Deb (Bill 132) 15 March 2011, col 690.

67 See comments, *inter alia*, by Karl Turner MP, PBC Deb (Bill 132) 16 March, 2011 col 730.

68 In essence, a shared competence.

69 See comments by Karl Turner MP, PBC Deb (Bill 132) 17 March 2011, col 868. Although beyond the scope of the present discussion, such references to economic regulation and competition can again be interpreted as conflating distinctions which are drawn elsewhere regarding economic governance and law (eg between different aspects of competition, such as price-setting, and procurement activity).

70 See comments by Lord Clement-Jones, HL Deb 24 April 2013 vol 744, col 1483.

to 'NHS privatisation'.⁷¹ However, a strikingly different view of 'NHS privatisation' – based on funding, rather than provision – was found in the citing of Care Quality Commission feedback of 'the best NHS experience I have ever had in my life' being unpacked to clarify that the patient had been unaware that the NHS service had been delivered by a private provider.⁷² This led to the conclusion:

So privatisation is not about the provider; it is about reaching into your wallet to pay for the service for which the state should pay. That is the fundamental ethic of the NHS.⁷³

How did implementation of the HSCA 2012 reforms affect 'NHS privatisation'?

The extent to which the HSCA 2012 reforms can be said to have facilitated 'NHS privatisation' is moot. Claims of 'NHS privatisation' could, for example, attach to concerns about conflicts of interest within the membership of CCG boards. These conflicts emerge in view of the procurement functions of CCGs and the involvement of private companies delivering CCG-commissioned care, such as community services.⁷⁴ Other concerns about 'NHS privatisation' relate to the structural changes to the NHS oversight landscape with the incorporation of bodies such as the CMA and Monitor/NHS Improvement in view of questions of applicability of competition law and the UK general merger control regime. Certainly, what emerged was either an ambivalence about, or even lack of, enforcement activity regarding the competition provisions, which suggested that the fear of putting in place structural prerequisites to deliver expansion of 'NHS privatisation' have proven unfounded.

With regard to the competition law provisions⁷⁵ it was thought at the time of the Health and Social Care Bill that, once competition law

71 See comments by the cross-bench life peer, Lord Walton of Detchant, HL Deb 24 April 2013, vol 744, col 1495.

72 See comments by Baroness Cumberledge, HL Deb 24 April 2013, vol 744, col 1503.

73 Ibid.

74 This has been considered in various literature. See, for example, National Audit Office, 'Managing conflicts of interest in NHS clinical commissioning groups' (11 September 2015); Valerie Moran et al, 'How are clinical commissioning groups managing conflicts of interest under primary care co-commissioning in England? A qualitative analysis' (2017) 7 *British Medical Journal Open* e018422.

75 That is, the prohibitions on anticompetitive agreements and abuse of dominance, as distinct from the public procurement rules.

was confirmed to be applicable, it would increasingly be applied.⁷⁶ The passage of time and non-enforcement led to considerations that applicability is a largely theoretical question distinct from actual *application*, which might be inhibited by various factors, including prioritisation of CMA workload, and the political sensitivities which could have attached to competition law cases involving the NHS.⁷⁷ Ongoing controversy and sensitivity about the HSCA 2012 reforms also offer an explanation for the institutional enforcement void left by the *de facto* reclassification of Monitor/NHS Improvement as separate from regulators such as OFCOM and OFGEM,⁷⁸ and the removal of CMA oversight⁷⁹ amid wider review of the UK competition landscape.⁸⁰ Ongoing controversy can also explain limited recourse to the 2013 Regulations, together with the consideration that these did not add anything to the general procurement regime.⁸¹

Arguably, the most visible activity to emerge from the HSCA 2012 reforms was assessment of NHS Trust and Foundation Trust mergers between 2013 and 2020. If a merger was felt to substantially lessen competition, it could proceed only if 'relevant patient benefits' were identified by Monitor/NHS Improvement before determination by the CMA. This merger assessment approach of section 79 HSCA 2012 received surprisingly little attention in the Health and Social Care Bill debates, but was intended primarily to facilitate NHS Trusts establishing themselves as NHS Foundation Trusts with greater autonomy from central government. This suggests primarily concerns regarding accountability which feature less amid claims of 'NHS privatisation'. These NHS Foundation Trust mergers were assessed

76 O Odudu, 'Are state-owned healthcare providers undertakings subject to competition law?' (2011) 32(5) *European Competition Law Review* 231. This article was cited by Davies (n 43 above) to underscore concerns about accountability with regard to the involvement of bodies such as the CMA. However, it can be noted that the possibility of private enforcement of competition law via the courts did not receive much attention at this point.

77 See further Guy (n 30 above).

78 Ibid 135–139.

79 While theoretically this modification did not affect the conducting of market investigations under s 83 HSCA 2012, the lack of recourse to this can arguably be attributed to the ongoing controversy.

80 Via the Enterprise and Regulatory Reform Act 2013 and the associated Competition Act 1998 (Concurrency) Regulations 2014.

81 S Smith, E Heard and D Bevan, 'New procurement legislation for English healthcare bodies – the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013' (2013) 4 *Public Procurement Law Review* 109.

between 2013 and 2020,⁸² although the shift in policy towards integration might explain the CMA questioning the role ascribed to it in the 2017 Manchester Hospitals merger:⁸³

Competition in the NHS is only one of a number of factors which influence the quality of services for patients and we have found in this inquiry that it is not the basic organising principle for the provision of NHS services. More important are considerations such as the increasing demand for NHS services and greater degree of clinical specialisation being sought, and the regulatory, policy, and financial context within which such services are provided.

Taking together the varying implementation of the competition law and merger control provisions of the HSCA 2012, it might be considered that the structural prerequisites for expanding 'NHS privatisation' did not materialise as had been feared. This also highlights a notable disconnect between legislative frameworks and policy shifts which may offer insights for current and future implementation of the HCA 2022.

INTEGRATION AND 'NHS PRIVATISATION': THE EXPERIENCE OF THE HCA 2022

The shift in NHS policy focus away from competition and towards integration can be traced to approximately 2015, and solidified with the 2019 NHS Long-Term Plan (NHS LTP), which outlined legislative proposals for repealing the HSCA 2012 reforms since these were seen as inhibiting the policy shift. Presenting competition and integration as opposites is a false dichotomy,⁸⁴ but emphasis on more collaborative

82 A period bookended by mergers involving the same hospital, with the first merger being banned, and the second approved. Competition Commission, *Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Merger Inquiry* (Competition Commission 17 October 2013); *Anticipated Merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust Decision on Relevant Merger Situation and Substantial Lessening of Competition* (CMA, ME/6875-19 27 April 2020).

83 CMA, *Central Manchester University Hospitals/University Hospital of South Manchester Merger Inquiry Final Report* (1 August 2017) 2, para 7.

84 Reforms in Dutch healthcare indicate that it is possible to incorporate aspects of both competition and integration, and the Dutch competition authority has produced guidance on how and why competition law may not be applicable to partnerships and collaborations: The Netherlands Authority for Consumers and Markets (ACM), ACM Policy Rule on arrangements as part of the movement called 'The right care in the right place' Case no ACM/19/034968, Document no ACM/UIT/524798. See further, Mary Guy, 'Rethinking competition in healthcare – reflections from a small island' (2021) (*Competition Policy International Antitrust Chronicle* May 2021).

forms of working has been welcomed.⁸⁵ The 2019 NHS LTP thus consolidated the shift in NHS policy towards 'triple integration' between primary and secondary care, the NHS and social care, and mental and physical health, which has evolved into the enshrinement of integrated care systems (ICS) across England by the HCA 2022.⁸⁶

While neither the 2019 NHS LTP, nor the subsequent policy documents relating to its implementation⁸⁷ explicitly reference 'NHS privatisation' as a motivation, we see some related features. For example, the NHS LTP seemed to reaffirm a previous distinction between 'bad' and 'good' competition insofar as it envisaged, respectively, the removal of the 'counterproductive effect' of the HSCA 2012 reforms (specifically the CMA's oversight role and NHS Improvement's competition powers) on the one hand, but on the other hand, the retention of the CMA's 'critical investigations work in tackling abuses and anti-competitive behaviour in health-related markets such as the supply of drugs to the NHS'.⁸⁸

In contrast, the outlining of legislative proposals to support the move towards ICS in the 2019 NHS LTP generated concerns in parliamentary debates about 'NHS privatisation' regarding the scope for integrated care provider (ICP) contracts to be awarded to private providers.⁸⁹ The concerns reflected apparent inconsistencies between concessions made to the Health and Social Care Committee, that '[t]o privatise in the sense of handing over the assets and staff to a private contractor is a theoretical possibility',⁹⁰ and the Secretary of State's denial of 'NHS privatisation' taking place. This was further complicated by the inhibiting effect of the HSCA 2012 competition framework on this transition to a very different system of care models, with acknowledgment that the combined effects of the HSCA 2012, the 2013 Regulations and procurement rules meant that it was not effectively within the Secretary of State's gift to categorically rule out

85 Marie Sanderson, Pauline Allen, Dorota Osipovič, Christina Petsoulas, Olga Boiko and Colin Lorne, 'Developing architecture of system management in the English NHS: evidence from a qualitative study of three integrated care systems' (2023) 13(2) *British Medical Journal Open* e06599.

86 For a brief overview, see NHS England, 'The journey to integrated care systems in every area'.

87 Health and Social Care Committee, *NHS Long-Term Plan: Legislative Proposals* (HC 2017-19, 15).

88 NHS England, *The NHS Long Term Plan*, January 2019.

89 See comments, *inter alia*, by the MPs Stephen Hammond and Jonathan Ashworth. 'NHS 10-Year Plan', HC Deb 19 February 2019, vol 654.

90 By Nigel Edwards (then Chief Executive of the Nuffield Trust), cited by Jonathan Ashworth MP in a debate on 'Integrated Care Regulations': HC Deb 18 March 2019, vol 656, col 871.

concerns about 'NHS privatisation' in light of long-term and high-value contracts.⁹¹

In the move from the NHS LTP to the White Paper⁹² preceding the HCA 2022, the proposals were characterised as amounting to 'deregulation, not demarketisation'.⁹³ Where 'demarketisation' might suggest a removal of markets⁹⁴ and thus a lessening of concerns about 'NHS privatisation', 'deregulation' seemed to imply removal of clear oversight mechanisms, while the underlying market aspects (such as the recasting of the purchaser/provider separation in combination with the interaction between the NHS and private healthcare) remain intact. This has led to concerns being raised both with regard to competition⁹⁵ and procurement⁹⁶ frameworks.

A further point to note about the NHS LTP proposals is that these were drafted by NHS England, and made no mention of plans to reincorporate Secretary of State oversight, merely the amendment of CMA oversight and refocusing of NHS Improvement's role.⁹⁷ Reincorporation of ministerial oversight – including with regard to mergers and procurement – was added to the White Paper by the then Secretary of State for Health Matt Hancock MP, and was retained by his successor Sajid Javid MP during the passage of the Health and Care Bill.

As with the HSCA 2012 reforms, it is possible to consider how 'NHS privatisation' featured in the debates preceding the Health and Care Act 2022 and in the implementation to date of the legislation.

91 Ibid col 872.

92 Department of Health and Social Care, '[Integration and innovation: working together to improve health and social care for all](#)' (11 February 2021).

93 Health and Social Care Committee (n 87 above) 16, citing written evidence by Andrew Taylor, former Director of the Cooperation and Competition Panel for NHS-funded Services.

94 Which had been implicit in earlier attempts to repeal the HSCA 2012 competition reforms, notably the National Health Service (Amended Duties and Powers) Bill, as well as the aforementioned NHS Bill. See further, Mary Guy, '[Demarketisation, deregulation, dejuridification: removing competition from the English NHS with the Health and Care Bill](#)' (Lancaster University Law School Working Paper September 2021).

95 Ibid. See also Okeoghene Odudu and Catherine Davies, 'Enforcing competition law in the English Healthcare System' (2021) (*Competition Policy International Antitrust Chronicle* May 2021).

96 Albert Sánchez Graells, '[Are there any gains to be had from the proposed new provider selection model for NHS commissioning?](#)' (*University of Bristol Law School Blog* 23 August 2021).

97 S 33 HCA 2022 provides for the abolition of Monitor/NHS Improvement and the incorporation of its functions into NHS England.

'NHS privatisation' and the debates of the Health and Care Bill

In the debates of the Health and Care Bill, we saw consideration of the current wider-ranging nature of concerns, such as the scope for 'privatisation' to be extended via reciprocal healthcare access agreements post-Brexit,⁹⁸ and the effects of significant changes in England on Welsh healthcare.⁹⁹ 'NHS privatisation' is further identified in aspects as diverse as private equity companies in the care sector and the NHS paying twice (for research and for procurement).

With regard specifically to the development of integrated care, the narratives surrounding 'NHS privatisation' might be seen primarily in terms of concerns about the effects of private activity (including on reduced scope for training of future clinicians, as well as on the ability of private providers to exit NHS service delivery after two years with limited accountability),¹⁰⁰ and questions of accountability and 'who runs the NHS'. Significant discussion focused on attempted amendments to restrict private provider representation on the new integrated care boards (ICBs) in view of the inherent conflict of interest this can generate, and the need for private providers to be paid at the NHS tariff (now re-cast as the 'NHS payment scheme')¹⁰¹ to avoid suggestions of price competition.¹⁰² The former concern has received limited acknowledgment in instructions about the constitution of ICBs:

The constitution must prohibit a person from appointing someone as a member ('the candidate') if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.¹⁰³

98 See comments by Dr Phillippa Whitford during PBC Deb (Bill 140) 26 October 2021, col 642, and by Lord Sharkey during HL Deb 7 March 2022, vol 819, col 1164.

99 See comments by Hywel Williams MP during PBC Deb (Bill 140) 21 September 2021, cols 319–320. These concerns have been given more concrete form recently by the Minister for Health and Social Services, Eluned Morgan MS, proposing new legislation regarding procurement in connection with the Welsh NHS. See the Senedd Health and Social Care Committee, [Health Service Procurement \(Wales\) Bill: Stage 1 Report](#), April 2023.

100 See comments by Dr Chaand Nagpaul during PBC Deb (Bill 140) 9 September 2021, cols 89, 95.

101 S 77 HCA 2022.

102 See comments by Edward Argar MP during PBC Deb (Bill 140) 23 September 2021, col 452.

103 See sch 2 HCA 2022, s 1 amendments to the NHS Act 2006 relating to 'Membership' and also identical wording to prohibit appointment to the ICB under 'Arrangements for discharging functions'.

It is striking that the growing attention paid to the complexity of governance and regulatory arrangements may in itself provide a further dimension to what is understood by 'NHS privatisation'. This might be inferred from comments by Lord Davies of Brixton in highlighting the disconnect between governmental promises to avoid 'NHS privatisation' and concerns about increasing numbers of US-owned private companies¹⁰⁴ delivering services for the NHS:

Even with the amendments to limit private companies being represented on integrated care boards, there is absolutely nothing here to stop private companies playing a part in other ways – for instance, clearly at the sub-system level via place-based partnerships and provider collaboratives. There is this whole word salad of different ways of describing these organisations operating at that level below, for or with the integrated care boards in providing services. This is the Trojan horse that will bring private provision within the walls of our publicly-provided NHS.¹⁰⁵

This additional dimension to concerns about 'NHS privatisation' is exacerbated by the lack of certainty offered by the HCA 2022 changes regarding the new Secretary of State oversight powers, as noted by Lord Hunt:

It seems rather extraordinary that we are taking out the marketisation sections from current legislation only to replace them with an open-ended power and a procurement regime when we simply do not know what it will be.¹⁰⁶

Outside the focus of integrated care, there are ongoing developments regarding wider aspects of 'NHS privatisation'. A notable example is longer-standing concerns about availability of state-funded (NHS) services, particularly dentistry, and how markets are created as more people 'go private' and take out dental insurance: 'This is what privatisation looks like.'¹⁰⁷ While this latter example appears not to find express recognition in the HCA 2022, there has been notable discussion relating to patient movement between the NHS and private healthcare – which is arguably less commonly acknowledged as 'NHS privatisation'. This occurred in the context of developing provisions regarding information standards and parity of information disclosure between NHS and private providers¹⁰⁸ – acknowledged as a response

104 Thus reinvoking misunderstood claims that 'NHS privatisation' contains an 'Americanisation' element.

105 HL Deb 11 January 2022, vol 817, col 1062.

106 HL Deb 24 January 2022, vol 818, col 107.

107 See comments by Alex Norris MP during PBC Deb (Bill 140) 2 November 2021, col 900.

108 See in particular ss 98 and 100 HCA 2022.

to the Ian Paterson inquiry which affected both NHS and private patients.¹⁰⁹

'NHS privatisation' and the implementation of the HCA 2022

Writing in 2023, it is possible to start to reflect on the implementation of the HCA 2022 and tentatively identify where further concerns about 'NHS privatisation' may arise following repeal of the HSCA 2012 competition reforms. At least three observations arise.

A first consideration is the re-incorporation of Secretary of State oversight powers.¹¹⁰ The incorporation of the CMA in particular by the HSCA 2012 reforms highlighted a tension between accountability to the market, and political accountability regarding matters of public policy including recourse to private providers delivering state-funded (NHS) services.¹¹¹ The NHS Bill had proposed strengthening ministerial oversight in a manner which appeared to reinforce political accountability, and, as noted previously, this Bill would appear to be less likely to attract criticisms of 'NHS privatisation'. In contrast, the reincorporation of ministerial oversight by the Health and Care Act 2022 leaves open questions about how this can be understood in light, *inter alia*, of ministerial conduct in managing the Covid-19 pandemic.¹¹² This more complex oversight landscape¹¹³ arising with the HCA 2022 – involving both NHS England and ministerial oversight – ought to reinvigorate discussions of what political accountability now means *vis-à-vis* the NHS in England. Certainly it seems not to be a simple reversion to ministerial oversight as it would have been understood in 2011, prior to the HSCA 2012.¹¹⁴

109 See comments by Edward Argar MP during PBC Deb (Bill 140) 19 October 2021, col 522.

110 Including a power of direction: investigation functions (s 44 HCA 2022); a general power to direct NHS England (s 45 HCA 2022); and intervention powers regarding reconfiguration of services (s 46 HCA 2022).

111 See Davies (n 43 above).

112 Further clarity of understanding this new style of ministerial oversight has thus far been impeded by the presence of no fewer than five Secretaries of State for Health and Social Care holding office since April 2022, when the HCA 2022 received royal assent, and the time of writing in late 2023. The office holders are, in chronological order: Sajid Javid MP, Steve Barclay MP, Thérèse Coffey MP, Steve Barclay MP, and currently Victoria Atkins MP.

113 Already flagged in connection with NHS England and CCGs and the residual role of the Secretary of State for Health by cases such as *R (Hutchinson) v Secretary of State for Health and Social Care* [2018] EWHC 1698 (Admin), 21 CCL Rep 446 and *Khurana v North Central London Clinical Commissioning Group & Another* [2022] EWHC 384 (Admin) (23 February 2022).

114 See Guy (n 44 above).

Secondly, there are two provisions in the HCA 2022 which have relevance to considerations of 'NHS privatisation', which appear to have passed under the radar, but may actually suggest a refocusing of competition, rather than a removal.¹¹⁵

Section 83 HCA 2022 stipulates that mergers involving 'NHS enterprises' (defined as NHS Trusts and NHS Foundation Trusts) and private providers are subject to the general UK merger control regime.¹¹⁶ While this merely reframes part of the merger control regime of section 79 HSCA 2012,¹¹⁷ it remains unclear what kind of interaction may be intended to be captured here. The express exclusion of this from the new test for 'NHS mergers' might, however, suggest further expansion of NHS providers in the private healthcare market, for example via private patient units, thus category 3 activity.

Section 82 HCA 2022 imposes an apparently new duty for NHS England to provide assistance to the CMA with its activities under the Competition Act 1998 and the Enterprise Act 2002. This provision would seem to target NHS activity in the private healthcare sector (thus category 3 activity), but may also relate to assessments of private activity within the private healthcare market (given that some private providers also undertake NHS work). Some action has been taken by the CMA against NHS providers in this regard following the CMA's 2014 Private Healthcare Market Investigation.¹¹⁸

Thirdly, concerns about conflicts of interest in ICBs in connection with the combining of NHS and private roles are thought to extend beyond those articulated in connection with CCGs in light of the still more complex governance frameworks which have evolved.¹¹⁹ While this may be considered a fundamentally new concern which feeds into a wider picture of 'NHS privatisation', at its core, arguably, is the unresolved tension evidenced by the concession of permitting NHS clinicians to continue private work which was necessary to implement the NHS in 1948.

115 See Guy (n 94 above).

116 Pt 4 Enterprise Act 2002.

117 This interaction would have been covered by s 79(3) HSCA 2012.

118 CMA, 'Private Healthcare Market Investigation Order (as amended)' (28 February 2017), pt 4, 'Information', para 21.1. CMA, 'Directions to Royal Devon and Exeter NHS Foundation Trust issued under the Private Healthcare Market Investigation Order' (31 August 2017).

119 See further on this point, Roderick and Pollock (n 5 above) and Benbow (n 3 above).

CONCLUDING REMARKS

While the shift in NHS policy focus from competition as reflected in the HSCA 2012 towards integration as reflected in the HCA 2022 marks a key moment in NHS reform, both have taken place against the backdrop of claims of 'NHS privatisation', a phrase used persistently in UK parliamentary debates for the past 40 years. While competition/marketisation and integrated provision may be seen as antithetical, the development of both relies on the underlying interaction between the NHS and private healthcare which has evolved, but can nevertheless be traced to the inception of the NHS in 1948. The broad definition of 'NHS privatisation', which goes beyond the marketisation reforms from the 1980s and culminating in the HSCA 2012, illustrates the sheer range and flexibility of the concept in light of the distinctions which can be drawn with more general understandings of 'privatisation'. Thus 'NHS privatisation' has been shown to embody a sense of vagueness and an open-ended process, with the implication that this may never be complete. The HSCA 2012 and HCA 2022 enable claims of 'NHS privatisation' to be made concrete, and questions of accountability within the resulting system emerge as paramount. Secretary of State oversight and governance of CCGs, and now ICSs, show that there are no easy answers to questions of whether the HSCA 2012 or the HCA 2022 generated more or less 'NHS privatisation'. These factors also reveal that the real concern is one of accountability, as the nature, rather than the quantity, of 'NHS privatisation' may change.

By anchoring an examination of 'NHS privatisation' in UK parliamentary debates including and beyond the HSCA 2012 and HCA 2022, it becomes possible to see how 'NHS privatisation' has a curious power. Insofar as 'NHS privatisation' forms an inevitable backdrop to NHS reform, then it may also underscore overall governmental preference for a more central ground, as indicated by the failure of the opposing visions of the NHS Bill and the National Health Service (Co-funding and Co-payment) Bill to gain traction. In this regard, 'NHS privatisation' may seem to provide an important check on how the direction for NHS reform can be shaped. This is a vital consideration given the NHS's taxation-funded status. Furthermore, claims of 'NHS privatisation' highlight questions of who is accountable for whether and how treatment is provided or denied, and how that accountability is manifested. In this regard, 'NHS privatisation' reflects a dimension of wider tensions between market and state.

Ultimately, however, 'NHS privatisation' as a criticism can be seen as fundamentally problematic for at least two reasons. Firstly, its broad nature means that significant, and conceptually distinct, issues become conflated in a kind of 'white noise' where more specific, even individual attention may be needed. Thus a claim of 'NHS privatisation'

may conflate concerns about, for example, access to NHS dentistry and conflicts of interest within the new integrated care boards. Both generate justifiable concern, but the possible policy levers needed to address these issues may differ considerably. Secondly, the ability of 'NHS privatisation' to operate as an effective warning against undesirable reform becomes impeded at the level of parliamentary debate¹²⁰ by the need for opposing parties to differentiate themselves while developing NHS reform within the same landscape of NHS and private healthcare interaction. This leads to a curious situation in which 'NHS privatisation' might – counterintuitively – be seen to inhibit discussion of more radical questions of healthcare reform, be these who should pay for healthcare, or whether a fully funded public healthcare system can be implemented.

120 This is distinct from the ability of 'NHS privatisation' to operate effectively at the level of activism.