NHS markets and privatisation

For details of privatised clinical services, see Privatisation 2.

For details of PFI and privatisation of NHS estates, see Privatisation 3.

Privatisation in the NHS takes many forms and impacts on the NHS and patients in a number of ways. This overview gives a brief history of NHS markets and privatisation and sets out the main issues. Further information can be found in the **Resources** section of the KONP website.

This article gives information about:

PRIVATISATION RED HERRINGS

The NHS is massive, complex and full of exceptions and anomalies. Attempts by campaigners to discuss privatisation are regularly met with diversion from the real issues. Here are the main red herrings:

There is no privatisation as the NHS remains free: Government talk often conflates 'privatisation' with 'private payment', and says the NHS is not being privatised as healthcare is available free at the point of use. This a deliberate deception: the fact that services are free to patients does not mean they are not run by private companies for profit, using NHS funding! The World Health Organization has defined privatisation in healthcare as "a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services". Clive Peedell has delivered a comprehensive rebuttal of government 'no privatisation' claims[1]

Patients don't mind who provides services so long as they remain free. Patients may well 'not care' that their services are run by private companies. However most people have no idea of the problems and risks this involves, which have not been spelled out.

GPs have always been private contractors: True. But there's a world of difference between a single self-employed GP or small group of GPs committed to their patients who work in close collaboration with local NHS hospitals and community services, and large companies managing dozens of GPs for whom profit is the sole reason for existence.

NHS Hospitals have always had private patients: true, but up until the 2012 Act, there was a ceiling of 2% of NHS Trust income raised from private sources. Most private patients were overseas visitors treated in major London hospitals, and most NHS hospitals had no private patients. The Act increased the limit to 49% of income – and several major hospitals are headed that way.

[1] Peedell, C. *BMJ* **2011;342:d2996 doi: 10.1136/bmj.d2996**

Only 7.6% of NHS services are run privately and this is a trivial portion of the NHS budget. This figure refers only to clinical services and does not include GPs or dentists. The proportion has risen sharply on the back of the 2012 Act. In the period from 2013/14 to 2015/16 the amount spent on Independent Sector Providers (ISPs) rose from £6.6bn to £8.7bn – a rise of 33%. (BMA 2017). The shift to STPs and a focus on collaboration paves the way to private procurement of massive ACS and ACO contracts .

Hospices and not-for-profit agencies have always provided specialist services and been a source of innovation. True. And most campaigners are happy to see a continued role, especially for small scale innovative projects including many in mental health care, and hospices. Voluntary sector services accounted for only £0.5bn in 2015-16. These not-for-profit services could be provided via grants and do not need to be the subject of competitive tender. They could continue to thrive in partnership with a re-nationalised NHS. Other voluntary sector contracts have acted as a Trojan Horse, with subsequent take-over by corporates wherever they see opportunities for profit.

'*Outsourcing is not the same as privatisation'*. 'Outsourcing' means putting a service out to tender with a commercial contract. Procurement Regulations require that all but the smallest contracts must be open to any bidder, including private companies and corporates, and must be advertised through the EU procurement channels. Strict competition rules outlaw prior selection of a 'preferred bidder' and demand selection of 'the Most Economically Advantageous Tender'.

Accountable Care Systems (ACSs) and Accountable Care Organisations (ACOs) are the solution to integrated care. Two major issues here:

i. We all want better *co-ordination*. But *Integration* of charged-for social care with free NHS provision risks more care being defined as social care and so becoming charged-for. To achieve *integration*, campaigners demand first that social care must be provided free (as it is in Scotland).
ii. ACSs and ACOs, by definition, involve services provided through commercial *contracts* rather than provided directly by the state. Procurements associated with ACSs and ACOs risk wholesale privatisation of the NHS. Integrated health and social care can and should be provided directly by the state, not through the market and commercial contracts.

BACKGROUND: PRIVATISATION AND THE MARKET IN NHS SERVICES

An element of private provision has existed since the NHS began, and remained relatively stable up until the Thatcher Government from 1997. Private elements included independently contracted GPs and dentists- who were nonetheless closely integrated into the NHS, a very small element of private beds, mostly in major NHS hospitals, supplies of medical and non-medical equipment and community pharmacy.

Prior to 1990s, NHS services were both arranged and provided by Health Authorities in collaboration with GPs as the main independent providers. Most GPs owned or rented their own premises, and NHS estates (buildings and grounds) were managed by trusts' in-house property services.

The Thatcher and Tory governments from 1979-97 introduced GP Fundholding and began a huge new wave of privatisation starting with Compulsory Competitive Tendering (CCT) of (especially) cleaning and catering services,. The strict CCT rules were later amended by the new Labour Government in 1997, but only to a requirement to obtain 'Best Value' though tenders.

The Thatcher government introduced the private finance initiative (PFI) as a way to raise money for crumbling hospitals and other public sector buildings. In opposition Labour castigated PFI, but went

on to greatly extend PFIs as part of New Labour's 'Third Way', leaving a massive legacy of unsustainable debt.

In 1990, the Tory government introduced NHS and Community Care Act 1990 which separated the NHS into Health Authority purchasers and providers. The purchasers were allocated budgets to buy care from provider trusts[2] creating the 'internal' NHS market, These changes resulted in a rapid expansion of privatised services, including in clinical services.

Thatcher's government also agreed a new contract with the BMA which, in effect, encouraged all NHS consultants to take on private work, and hence further encouraged development of the private sector[3].

Low levels of NHS funding under successive Tory governments resulted in lengthy waiting lists; from 1997 Blair's New Labour governments responded first with increased funding, aiming to bring funding back into line with the European average. However Labour went on to promote further marketisation and privatisation. Labour (advised by Simon Stevens), published the NHS Plan 2000 which brought a new wave of private Sector involvement. A drive to reduce waiting lists enabled independent sector treatment centres (ISTCs) to contract on very favourable terms for NHS elective procedures. NHS trusts were not allowed to compete for these contracts. In 2009 New Labour introduced the 'any willing provider' – later rebranded as 'any qualified provider' (AQP) - initiative, allowing private hospitals to undertake NHS work outside the ISTC programme at premium rates up to 40% over NHS rates. They also encouraged long-term contracts for low-risk diagnostics and surgery, on average at 11% above NHS rates. PCT commissioners were originally required to introduce at least three AQP services, but from 2013, this requirement was dropped.

NHS Foundation Trusts (FTs)

Foundation Trusts were established by Labour's Alan Milburn in 2003 and enthusiastically promoted by the coalition government from 2010. NHSE describes them as not-for-profit, public benefit corporations. The stated aim was to liberate FTs from central control so they could innovate and improve patient care. They would be free to determine their own pay, retain surpluses and decide how to use their assets, and would be accountable to local people. The original intention was for all NHS Trusts to attain FT status. In practice, local people have never been allowed any meaningful role in governing FTs, while scandals around clinical care standards exposed by the Francis enquiry[4] and the financial squeeze which led to dependence on central government covering overspends, have led to increased control by central government and eroded the distinction between FTs and other NHS Trusts[5].

THE MARKET AND NHS SERVICES IN 2017

The 2012 Health and Social Care Act

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[2] http://news.bbc.co.uk/1/hi/health/background_briefings/your_nhs/93732.stm).

[3] http://www.healthp.org/node/71

[4] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

[5] https://www.kingsfund.org.uk/blog/2016/02/foundation-trust-model

The Coalition Government's 2012 Health and Social Care Act was designed to bring about a step change in pace of privatisation. The main stated intention was to reduce expensive referrals to hospital by enabling GP-led Clinical Commissioning Groups (CCGs) to use their budgets to commission alternative services in the community. New NHS national bodies were put in place to support this aim, requiring CCGs to put more and more services out to tender.

A 2017 review of the reforms confirms (as many predicted) that the Act failed to reduce hospital admissions, with no significant change in trends in hospital admissions in years following the Act. At the same time, numbers of outpatient appointments increased nearly four times faster after the Act and there was also a 12.7% higher rate of referral to hospital specialists, resulting in 3.7million additional specialist appointments compared with the pre-Act trends and comparisons with Scotland where the Act did not apply.

In practice (again as predicted) the main impact of the 2012 *Health and Social Care Act* has been greatly increased privatisation and fragmentation of the NHS, with problems compounded by narrowly commercial UK and EU procurement rules which outlaw 'anti-competitive' approaches. Procurements must be widely advertised with bidding open to all and it is unlawful to impose clauses that give preference to one bidder or 'unfairly' disadvantage another. The procurement process inherently favours corporate bidders, as many local accounts testify[6]. The section on Commissioning and contracts below gives more detail on this.

Increase in privatisation

In 2006, under Labour, spending on ISPs amounted to 3% of total NHS spending, rising to 5% by 2010 and 7.6% in 2017. CHPI point out that spending on private adult social care was very small at first, but then grew exponentially – so government reassurances that 'only 8p in the pound' is spent on private services is no reassurance!

Sustainability and Transformation Partnerships (STPs)

In 2014, Simon Stevens (previously advisor to the Blair Government, followed by a decade at major US health insurer United Health), now the new head of NHS England, published the NHS Five Year Forward View (5YFV), setting out a completely different direction for the NHS.

Since 2016, the NHS has been reorganised into 44 locality-based STPs. This has been achieved with full support from Government but in the absence of any new legislation or debate in parliament. For the time being, the rhetoric has switched from a focus on procurement to the need to achieve 'integration' between health and social care services in each area, with the aim of STPs 'evolving' first into Accountable Care Systems (ACSs) and then to Accountable Care Organisations (ACOs) – both of which involve services being outsourced through commercial contracts.

Accountable Care Systems (ACSs) and Accountable Care Organisations (ACOs)

A detailed analysis of ACSs and ACOs is available in the KONP Resource Cabinet.

In an ACS, hospitals, GPs and community services retain (at least initially) their separate organisations. A commercial contract is issued for an 'ACS care integrator' (or similar title) responsible for 'integrating' all the hospitals, GPs and community services in the area, possibly together with social care. The ACS has collective responsibility, through the integrator, for resources and population health.

[6] https://www.newstatesman.com/politics/health/2017/07/putting-nhs-out-corporate-tender-isnt-working

An ACO is an evolved version of an ACS, in that there is a commercial contract with a single organisation which includes the majority of hospitals, GPs, community NHS and care services in an area, and this organisation is responsible for population health in the area.

'Integration' vs 'co-ordination': The move to ACOs and ACSs has been deftly portrayed by Government and NHS England as the only possible solution to the fragmentation and lack of coordination that bedevils NHS and social care organisations (greatly worsened by the *Health and Social Care Act 2012*). No one doubts the need for better *co-ordination*. But *integration* of charged-for social care with free NHS provision will inevitably result in more care becoming charged-for. To achieve *integration*, campaigners demand, first, that social care must be provided free (as it is in Scotland).

Commercial contracts: ACSs and ACOs, by definition, involve services being outsourced and provided through commercial *contracts* rather than provided directly by the state. Procurements associated with ACSs and ACOs risk wholesale privatisation of the NHS, with a major healthcare corporate responsible for all the healthcare in a local area. Integrated health and social care can and should be provided directly by the state, not through the market and commercial contracts.

ACSs and ACOs will be open to bids from corporates (possibly in partnership with an NHS Foundation Trust) which can secure capital funding to build new hospitals and 'community hubs', leased back to the NHS at exorbitant rates, and freeing up former NHS sites for lucrative sale.

In spring 2018, there are two judicial reviews pending of the Government's ACS / ACO programme.

COMMISSIONING, PROCUREMENT AND CONTRACT MANAGEMENT

Commissioning is fundamental to NHS privatisation and it's increasingly passing into corporate hands – with dire consequences. Dr Jacky Davis has likened private companies responsible for commissioning to '*Dracula in charge of the blood bank'*. This process is complex, so most people don't bother trying to understand it – but it's well worth persisting if you can for an insight into just how the corporate cards are stacked.

EU procurements require specialist legal and technical expertise which CCGs don't have in-house. So responsibility for handling major procurements is outsourced to commercial commissioning support agencies. These, in turn, must first be procured through a potentially lengthy and complex competitive process. NHS England has simplified this process for local commissioners by running its own procurement to create a '*Lead Provider Framework'* (LPF) of commissioning support agencies deemed to have the skills to provide commissioning support[7].

In lay person speak, NHSE have created a ready-made shortlist of commissioning support agencies, so CCGs don't have to manage this time-consuming and costly process themselves[8]. CCGs can simply invite the agencies on NHSE's LPF to compete in a '*mini competition'* for the contract to manage the CCG's procurements. Under procurement regulations, *all the eligible organisations* listed on the

[7] https://www.england.nhs.uk/2015/02/lpf-launch/;

[8] https://www.england.nhs.uk/lpf/how-to-use/

Framework must be invited to compete, and the contest must be judged solely on price, with the winner being the 'Most Economically Advantageous Tender' (MEAT)[9]

Of the ten agencies on NHSEs LPF, judged by NHSE to be capable of providing 'end to end commissioning support', four are private companies: Capita, eMBED Health Consortium, Arden-GEM partnership and Optum (a subsidiary of United Health).

To keep procurement costs as low as possible and win the 'mini-competition', companies on NHSE's LPF can establish their own Lead Provider Frameworks of organisations deemed capable of delivering a wide range of services.

Nottingham and Nottinghamshire STP provides an illustration – and a dire warning - of how this works in practice and how the system hugely preferences major corporates:

In 2017, Nottingham and Nottinghamshire STP were selected by NHSE as a 'Vanguard', to pilot an Accountable Care System (ACS), which would integrate health and social care across the STP area.

Nottingham and Nottinghamshire STP needed to run a tender to procure the organisation that would integrate all the local health and social care services. To do this, the STP first needed to select their commissioning support, so they used NHSE's Lead Provider Framework to hold a mini competition between all the companies on the framework. Capita's bid proved the Most Economically Advantageous Tender, and was awarded the contract for commissioning support – much to the outrage of local GPs and others.

Capita then set about commissioning the next stage of this £2.7m contract to integrate health and social care across the Nottingham and Nottinghamshire STP.

Capita had previously run a separate procurement to develop its own Lead Provider Framework of 'Supply Chain Partners'. These are organisations that Capita itself has deemed fit to (among other things) manage NHS and social care integration. Capita were able simply to hold a mini competition between their own 'Supply Chain Partner' companies to a select the 'care integrator', and in late August 2017, the STP announced that Centene had won the bid. A full list of Capita's Supply Chain Partners is available on their website[10]. None has any prior experience of integrating health and social care services in England since it's never been done before.

Although Centene is a major US healthcare corporate, the Centene UK which won this £2.7m contract barely exists in the UK, apart from as a shareholder in other companies. Centene UK's registered office is a single room rented at the Kings Fund. This registered office has no phone, and the three directors listed on the Companies House records are all listed with addresses in the US.

This process for this procurement which resulted in Centene UK, winning the £2.7m contract to integrate health and social care across the whole of the Nottingham & Nottingham STP is typical. It illustrates the power of corporates and the powerlessness of individual CCGs or local councils involved in the STP, let alone local people, to have any meaningful influence over the procurement or selection of provider.

Legal challenges following procurements

[9] https://www.uk.insight.com/content/dam/insight-web/en_GB/solve/public-sector/frameworks/Insight-Framework-Guide-for-Customers-March-2017.pdf

[10] http://www.capitahealthpartners.co.uk/media/478105/leaderproviderframeworkpartners.pdf

Providers unhappy with the outcome of procurements may consider challenging the outcome. Even minor breaches of procurement rules can result in the procurement having to be re-run at great cost and disruption to services. Whatever the outcome, legal challenges place a huge burden on commissioners and this has the effect of making them extremely cautious in seeking to avoid potential for any legal challenge.

In 2016, Virgin Care filed procedings against NHS, Surrey Council and its six CCGs after a failing to win an £82m 3-year contract to provide health visitors, school nurses, speech and occupational therapy was awarded to a consortium formed by in-house NHS providers and a social enterprise.[11] Although the CCGs said they had confidence in their procurement process, a legal challenge is extremely costly. In November 2017, the parties reached a settlement involving an undisclosed sum (but estimated at around £2 million) being paid to Virgin[12].

No need to outsource!

Although the *Public Services (Social Value) Act 2012*[13] allows a degree of flexibility in public procurement, it's unlikely commercial commissioning support agents will pay any heed to this.

However, the UK government could exempt the NHS from any requirement to outsource NHS services if it chose to do that – it does not!

The opening provisions of the European Union Public Procurement Directive state: *It should be recalled that nothing in this Directive obliges Member States to contract out or externalise the provision of services that they wish to provide themselves or to organise by means other than public contracts within the meaning of this Directive. However, where a contracting authority does choose to put a service out to tender, the authority must comply with the UK's regulations in conducting its procurement process.*

Despite huge pressure from NHS England, there remains legal scope for commissioners not to tender services, and campaigners can have an important influence on this. In addition, commissioners always have the option to procure not-for-profit services through a grant rather than via competitive tender.

THE ALTERNATIVE to markets: The NHS Reinstatment Bill

Campaigners' main aim is to force Government to abolish the NHS market entirely and reinstate to an NHS that is directly publicly planned and provided, with no market or contracts involved – as set out in the NHS (Reinstatement) Bill[14].

[11] https://www.ft.com/content/297e7714-089f-11e7-97d1-5e720a26771b

[12] https://www.thesun.co.uk/news/5022569/bransons-health-firm-wins-high-court-battle-with-nhs/

[13] http://www.legislation.gov.uk/ukpga/2012/3/enacted; See also https://knowhownonprofit.org/funding/commissioning/procurement/importance-of-social-value-to-commissioning-and-procurement#

[14] http://www.nhsbillnow.org/