Understanding "NHS privatisation":

from competition to integration and beyond in the English NHS

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References to "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 what "NHS privatisation" means. 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. A further consideration is how "NHS privatisation" may operate to inhibit more radical NHS form in opposing directions by reference to the NHS Bill and the NHS (Co-funding and Co-payment) Bill.

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 "NHS privatisation", particularly in England, where the relationship between the National Health Service (NHS) and private healthcare has been more developed by 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 activism[3] and its persistent use since the early 1980s in UK parliamentary debates, "NHS privatisation" remains not well understood. For example, it is often couched – crudely[4] – in terms of "Americanisation"[5] which can overlook clear differences between the two systems,[6] as well as the difficulty of modifying a taxation-funded model.[7] The incremental expansion of private sector delivery of NHS (clinical and ancillary)

[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*, 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"', *The New Statesman*, 7 March 2023.

[2] Jill Mountford 'The Future of the NHS--Irreversible Privatisation? Interview with Dr Lucy Reynolds' 346 *BMJ* (2013), 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) *International Journal of Social Determinants of Health and Health Services*, Vol. 53(2), 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) *Environment and Planning C: Politics and Space*.

[4] Colin Lorne and Michael Lambert, 'Protecting the NHS' – and its limits (2023) *Soundings – A Journal of Politics and Culture* 2022(82).

[5] On perceptions of US healthcare reform influence on the NHS marketisation reforms from the 1980s to the Health and Social Care Act 2012 and the Health and Care Act 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) *International Journal of Health Services*, Vol. 52(4) 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.

[7] It is widely considered that "Beveridge"-style healthcare systems are notoriously difficult to reform in light of the "compact" between government and taxpayers to provide healthcare. See, for example, Ewen Speed, Jonathan

services since the 1980s represents a narrow definition of "NHS privatisation", but it is arguably the most common.[8] 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.[9] 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 outcomes[10] and patient safety.[11]

These myriad considerations contribute to views that "NHS privatisation" has become "a general "boo word"" and a "factoid".[12] This is particularly concerning as its invocation by diverse political parties[13] belies important implications for political debate and the shaping of legislation: "NHS privatisation" becomes key to questions concerning the extent to which

Gabe, 'The reform of the English National Health Service: professional dominance, countervailing powers and the buyers' revolt' (2020) *Social Theory & Health* 18:33–49.

[8] 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.

[9] See variously, Kat Lay, 'Young go private amid frustration at NHS care', *The Times*, 9 October 2023, Sian Elvin, 'WW2 veteran denied medication by NHS which could stop him going blind', *Metro*, 31 July 2020, and Ella Pickover, 'World's first IVF baby calls out 'postcode lottery' of care' *The Independent*, 22 June 2022.

[10] Benjamin Goodair, Aaron Reeves, 'Outsourcing healthcare services to the private sector and treatable mortality rates in England, 2013-20: an observational study of NHS privatisation' (2022) *The Lancet Public Health* 7(7), e638-e646.

[11] The Ian Paterson case highlighted different governance approaches in the NHS and private healthcare sector. Kieran Walsh, Naomi Chambers, 'Clinical governance and the role of NHS boards: learning lessons from the case of Ian Paterson', (2017) *BMJ*, 357, j2138. Patrick Leahy, 'A private matter: Why have politicians ignored private surgical standards for so long?' (2018) *The Bulletin of the Royal College of Surgeons of England*, 100(5). More recently, a Sunday Times investigation has indicated a range of more general concerns: "You can pay for private healthcare – but can you trust it?" 10 September 2023. https://www.thetimes.co.uk/article/you-can-pay-for-private-healthcare-but-can-you-trust-it-csd0rsm8d

[12] 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.

[13] An example beyond perhaps anticipated debates between Labour and Conservative MPs is found with the exchange between the former SNP leader and First Minister Nicola Sturgeon and Conservative MSP Douglas Ross during First Minister's Question Time on 24 November 2022, https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/meeting-of-parliament-24-11-2022?meeting=14007&iob=126907

decisions about resource allocation are to be juridified rather than politicised or resolved in the professional paradigm.[14]

This article makes an original contribution by examining "NHS privatisation" in the macro level context[15] 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 enshrined controversial competition reforms, thus offers a particularly fertile environment for concerns about "NHS privatisation", especially in light of the explicit link with 1980s utilities liberalisation reforms.[16] The HCA 2022 repealed these competition reforms and enshrined the intervening policy shift towards integration, but nevertheless invited comment that this would, and would not,[17] amount to "NHS privatisation".

By juxtaposing these two pieces of legislation, it becomes possible to consider not only whether the extent of "NHS privatisation" may be changing, and also whether different dimensions encapsulated within "NHS privatisation" take on more prominence outwith the policy focus of competition and integration.

The article's starting-point is to outline where "NHS privatisation" features within English healthcare in general terms, and more specifically within parliamentary debates since the 1980s

[14] 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', *Social Science & Medicine* 75 (2012), pp. 2515–2521.

[15] 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* (Abingdon: Routledge, 2022), Chapter 3.

[16] Chris Smyth, "Gas and power markets are a model for the health service", *The Times*, 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.

[17] See, respectively, 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*, 7 December 2021, and Mark Dayan and Helen Buckingham, 'Will the new Health and Care Bill privatise the NHS?' *The Nuffield Trust Blog*, 15 July 2021 https://www.nuffieldtrust.org.uk/news-item/will-the-new-health-and-care-bill-privatise-the-nhs.

and including the opposing visions for NHS reforms presented by the NHS Bill and the National Health Service (Co-funding and Co-payment) Bill. The HSCA 2012 competition reform landscape is then examined, including the associated secondary legislation, the National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) 2013 ("the 2013 Regulations"). The apparent decoupling of "NHS privatisation" from competition by the policy shift to integration is analysed in the context of the HCA 2022 and the early stages of its implementation. 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" can be characterised broadly as comprising a "three dimensional" approach comprising ownership, finance, and regulation.[18] 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.[19] It also encompasses attempts to define "NHS privatisation" in narrow terms which relate broadly to the marketisation reforms,[20] and reinforces the obvious point that "NHS privatisation" is distinct from the general meaning of "taking into private ownership".[21]

[18] Powell and Miller, above n12.

[19] See, respectively, Rhys Andrews, George A. Boyne, Richard M. Walker, 'Dimensions of Publicness and Organizational Performance: A Review of the Evidence' (2011) Journal of Public Administration Research and Theory 21(3) 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' 47 *Journal of Management* (2021), 1596-1629.

[20] Benbow, n3 above, relies on a definition attributed to the World Health Organisation 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 Organisation; 1995, p3. 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.

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

However, in order 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.[22] While this has given rise to complex framings and political campaigns,[23] it also indicates 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 initial 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 this delicate inconsistency posed by the coexistence of NHS and private healthcare. This can be seen in two main ways. Firstly, by the levying of prescription and other charges ("co-payments") being permitted.[24] Secondly, and in contrast, by the prohibition on "co-funding" which has long circumscribed the scope for combining NHS and private healthcare to avoid

[22] See, specifically, Sections 5 and 6 National Health Service Act 1946.
[23] Notably the distinction between "NHS amenity beds" and "NHS pay-beds". See Aneurin Bevan, 'A Free Health Service', Chapter 5 in Aneurin Bevan, In Place of Fear, Quartet Books, 1978, and specifically on the latter, HC Deb 05 May 1975 vol 891 cc1084-149 HOSPITAL PAY BEDS (Hansard, 5 May 1975) (parliament.uk)
[24] 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).

(even perceptions of) the NHS subsidising private healthcare,[25] but has been reviewed over time to enable, for example, "top-up" payments for cancer drugs.[26]

Nevertheless, "NHS privatisation" – as a distinct phrase, even concept, is more recent. The first UK parliament record we find of the term "NHS privatisation" in England relates to the outsourcing of cleaning services in comments by the Labour MP Jeremy Corbyn in 1984.[27] This would seem to indicate a clear link with the wider privatisation reforms by the Conservative governments of the 1980s, although we also see references to "privatisation" of the NHS emerging in connection with charges being levied for specific services.[28]

Locating "NHS privatisation" within English healthcare

While it may seem intuitive to link "NHS privatisation" with the competition reforms from the NHS internal market 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:[29]

[25] Ibid.
[26] Notably in the change in approach taken regarding cancer treatment. Department of Health Guidance on Nhs Patients Who Wish to Pay for Additional Private Care (2009), 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) *MLR* 399; K Syrett 'Mixing private and public treatment in the UK's National Health Service: a challenge to core constitutional principles?' (2010) 17 *EJHL* 235.
[27] HC Deb 21 December 1984 vol 70 cc686-94 National Health Service (Privatisation) (Hansard, 21 December 1984) (parliament.uk). It appeared earlier with regard to Scotland in a question by Dennis Canavan while a Labour MP in 1983. HC Deb 13 May 1983 vol 42 c549W. NHS (Privatisation) (Hansard, 13 May 1983) (parliament.uk)
[28] For example, HC Deb National Health Service 21 October 1991 vol. 196 col. 662.
[29] See further, for example, Mary Guy, *Competition Policy in Healthcare – Frontiers in Insurance-Based and Taxation-Funded Systems*, Intersentia 2019.

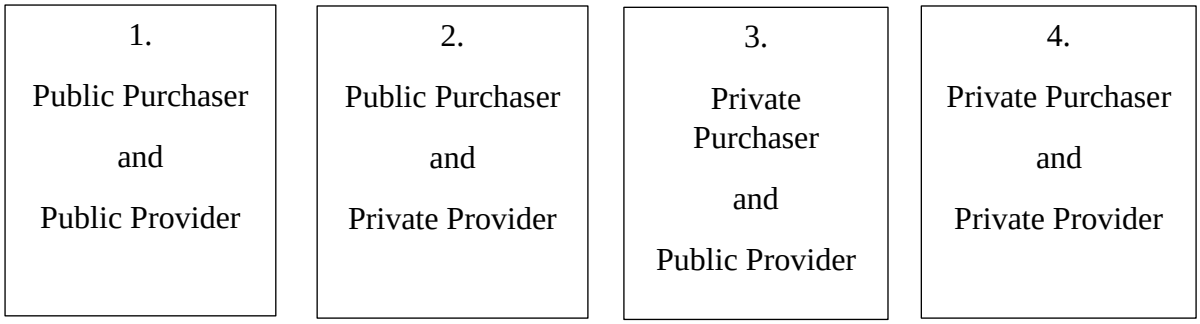

Figure 1: Relationship between the NHS and private healthcare sectors as demonstrated by the purchaser/provider separation.

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

A process of moving from a nationalised system to a privatised one would seem to entail a shift between categories 1 and 4, and a simplistic reading may lead to inferences that the intervening categories 2 and 3 are mid-points along a general direction of travel. Certainly categories 2 and 3 represent different understandings of "NHS privatisation", comprising respectively, the outsourcing of NHS services to private providers (category 2) and the private provision of services and treatments by the NHS, notably via private patient units (category 3). There has been particular development of these two categories in subsequent reforms – notably the New Labour choice and competition reforms which combined the expanding recourse to private providers with patient choice policies, and development of the private healthcare market contemporaneously[30] with the HSCA 2012 reforms which included removal of the private patient income cap.[31]

[30] Competition and Markets Authority, Private Healthcare Market Investigation Final Report, CMA25, 2 April 2014.
[31] Section 165 HSCA 2012. This was anticipated to enable an expansion of private patient units.

The idea of "NHS privatisation" as a process is given support by its collocation with "creeping".[32] Indeed, this contributes to a sense of "NHS privatisation" as being open-ended both in terms of definition and duration, given references persisting for 40 years. Whether "NHS privatisation" is an evolving process, or an inevitable process, appears moot as successive reforms have related to Category 2 or Category 3 activity, but with no clear sense that these link to each other, or necessarily point directly to an expansion of Category 4. Thus while there can be merit in examining reforms in succession to construct a narrative and to (rightly) highlight areas of concern, caution is advised: chronology does not necessary imply coherence, as can be demonstrated by close readings of parliamentary debates and the development of legislation underpinning NHS reform.

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 their approaches to it. Thus we have seen claims by Conservative 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

[32] See, for example, comments relating to concerns about accountability and the business interests of board members of the then new NHS Trusts by Margaret Beckett MP, HC Deb 25 October 1994 vol 248 cc775-865. The National Health Service (Hansard, 25 October 1994) (parliament.uk).

[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 National Health Service 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."

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 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. "Path dependency" provides theoretical explanations of actors being so 'hemmed in by existing institutions and structures that channel them along established policy paths'[36] and of 'how policy can become so institutionalised and historically embedded that it becomes nearly impossible to break free'.[37] While "path dependency" has been used, inter alia, to analyse the NHS internal market reforms,[38] it is also considered that these definitions 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.[39] Thus the stability of the New Labour government, particularly in 1997, could have heralded a decisive reformulation of the interaction between the NHS and private healthcare, and certainly a move away from the competition reforms of the previous Conservative governments, but did not. Path dependency may also serve to explain

[34] See, for example, debates on NHS pay. Vol. 628. 13 September 2017. 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, NHS (Co-operation/Competition) Vol. 488, 24.02.2009, Column 66WH.
[36] D. Wilsford, 'Path Dependency, or Why History Makes It Difficult, But Not Impossible to Reform Health Care Systems in a Big Way', *Journal of Public Policy* 14(3) (1994), pp. 251–283.
[37] I. Greener, 'Understanding NHS Reform: The Policy-Transfer, Social Learning, and Path-Dependency Perspectives', *Governance: An International Journal of Policy, Administration, and Institutions*, 15(2) (2002), pp. 161–183
[38] Ibid. See also G. Bevan and R. Robinson, 'The Interplay between Economic and Political Logics: Path Dependency in Health Care in England', *Journal of Health Politics, Policy and Law* 30(1–2) (2005), pp. 53– 78.
[39] M. Guy, '(How) is COVID-19 reframing interaction between the NHS and private healthcare?' (2023) *Medical Law International* 23(2), 138-158.

the current approaches being taken by the Sunak government and the Labour party under Sir Keir Starmer's leadership.

In order to locate – and thus attempt to assess the 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 Bill[40] was initially introduced by the Green MP, Caroline Lucas during the 2014-15 and the 2015-16 Parliamentary Sessions before being re-introduced subsequently by Labour MPs during the Jeremy Corbyn leadership.[41] This 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 firmly situating the NHS as a public service completely exempt from EU law and WTO rules. As such, it 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 has been introduced by the Conservative MP Sir Christopher Chope in almost every parliamentary session since 2017. This proposal aims 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. While this might be seen primarily in terms of an expansion of Category 4, it would certainly be expected to invite criticisms of "NHS privatisation".

A striking common feature of both Bills is their failure to gain traction: to date, neither have 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

[40] Also known as the NHS (Reinstatement) Bill.
[41] Margaret Greenwood MP in the 2016-17 Parliamentary Session, and Eleanor Smith MP in the 2017-19 Parliamentary Session.

private members' bills. However this merely underscores the apparent unwillingness of government to engage with radical NHS reform – be this further towards, or away from, "NHS privatisation".

The HSCA 2012 and the HCA 2022 then start to assume a middle ground between the NHS Bill and the Chope Bill. This is because neither can be said to advocate for either a radical rejection, or embrace, of "NHS privatisation", but nevertheless involve aspects which, to varying degrees, are subsumed within definitions of "NHS privatisation". By juxtaposing the NHS and Chope 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

It is useful to note that the HSCA 2012 competition reforms comprised three convoluted dimensions: the reduction of ministerial oversight via the involvement of the Competition and Markets Authority and the establishment of NHS England and latterly NHS Improvement; an enshrinement of the New Labour choice and competition reforms; and an attempt to align competition regulation in the NHS with the experience of other sectors in a manner reminiscent of the 1980s utilities liberalisations via economic regulation and a licensing regime. 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 Paper[42] met with a range of sceptical responses.[43]

[42] Department of Health, 'Equity and Excellence: Liberating the NHS' (Cm 7881, July 2010).
[43] 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*, 20 September 2019.

Indeed, the introduction of primary legislation with the seeming intention of making the market in the NHS "more real"[44] further underscored scope for "NHS privatisation" to be seen as an inevitable process, a setting in train of an irreversible direction.[45]

Thus scope for a disruptive, detrimental influence might be inferred from the HSCA 2012 being subject to a lengthy passage through 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.[46] 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.[47] 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 the role for Monitor (subsequently NHS Improvement) as no longer "promoting competition", but rather "preventing anti-competitive behaviour", 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

[44] A.C.L. Davies, "This Time, It's For Real" (2013) 76(3) M.L.R. 564-588.
[45] 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 & Class* 293-313; Mary Guy, "Dealing with 'unworkable ideas in primary legislation': juridifying and dejuridifying competition in the English National Health Service", *Public Law*, January 2023.
[46] NHS Future Forum, *Choice and Competition – Delivering Real Choice*. A report from the NHS Future Forum, June 2011.
[47] Ibid, page 6. The report further notes that this network represented some 45,000 clinicians carrying out NHS work from the independent sector.

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.

Firstly, the general vagueness attached to "NHS privatisation" which continues to contribute to its representation as something to be avoided, and therefore something which is distinct from what the Health and Care Bill set out to do, in a manner reminiscent of the defensiveness surrounding New Labour reforms. Thus at various stages across the Bill's passage, we see distinctions such as "[e]xtending choice and increasing competition is not about privatisation".[50] 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.[51] 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.[52]

[48] Department of Health, 'Government response to the NHS Future Forum report', CM8113, 22.06.2011, paragraph 5.16, p. 44.
[49] For detailed examination of these, see Guy, above n30.
[50] See comments by Earl Howe, 12th Sitting, Lords Debates.
[51] See comments by Professor Chris Ham, 1st sitting, 8 February 2011.
[52] See comments in the 28th Sitting, 1st April 2011.

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…".[53] 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 financial interests of being a director or shareholder of a private company, and conducting clinical private practice.[54]

Secondly, there is continuing sense of "NHS privatisation" as a process, albeit with indistinct start and end points. For example, while the New Labour policies of developing NHS Foundation Trusts and expanding private sector delivery of NHS services had been accepted, this had not solidified as a particular direction of travel, leading to consideration by Labour MPs in the early stages of the Health and Social Care Bill that enshrinement of these policies would amount to "[holding] the door open for the vandals who are now marching through…", [and leading to] wholesale de facto privatisation.[55] 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.[56]

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

"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

[53] See comments by Grahame Morris MP in the 14th Sitting, 9th March 2011 at column 565.
[54] Initially published in 2013, then updated. NHS England, Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017. https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-conflict-of-interest-guidance-v7.pdf
[55] See comments by Owen Smith, 7th Sitting.
[56] See comments during the 23rd Sitting.

services and allows a challenge to the NHS by private providers, through the opening up under competition law."[57]

A further dimension to this was added by linking questions of applicability of *EU* (as distinct from UK) competition law:[58]

"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."[59] 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.[60]

Thirdly, an additional dimension to "NHS privatisation" is provided by the – arguably logical – connections drawn between the HSCA 2012 reforms and the experience of liberalising utilities. This was initially seen in Monitor being reconceptualised as an "economic regulator" (akin to OFCOM or OFGEM) with a duty to "promote competition",[61] and a shared competence with the Competition and Markets Authority, inter alia, to apply competition law.[62] The connection between the two was highlighted by Monitor's role,[63] and led to statements such as "Healthcare should not be treated in the same way as the privatised utilities", with

[57] See comments by Owen Smith MP, 18th sitting.
[58] See further on the effects of EU competition law on the HSCA 2012 reforms more generally, Guy, n46 above.
[59] See comments by Grahame Morris MP, 20th sitting, March 2011.
[60] See comments by Grahame Morris MP, 24th sitting, columns 1083/1084.
[61] 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, n30 above.
[62] Outside the scope of the parliamentary debates, it can further be seen in the development of a licensing regime for providers delivering NHS services – again, in reflection of with other sectors. For a good overview of the comparisons and contrasts – and a suitable urging of caution – see Stirton, above n16.
[63] See comments by Liz Kendall MP, 17th sitting.

distinctions being drawn between the two.[64] Further examinations led to the suggestion that "giving Monitor concurrent powers[65] to the Office of Fair Trading [now the Competition and Markets Authority] opens the gateway to wholesale privatisation".[66]

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 reflect the sense of vagueness and process attaching to "NHS privatisation". These Regulations in particular invited further linkages with "NHS privatisation" in light of misconceptions that they required mandatory tendering of all services thus went beyond the relevant EU law in operation at the time.[67] What emerges from the Lords debates of the 2013 Regulations is not only the characteristic Labour-Conservative distinction, but also further distinctions emerging between separate groups – for example, between charities which regarded the 2013 Regulations as leading to "NHS privatisation" and those which did not, and support for claims of "NHS privatisation" coming from the BMA and some Royal Colleges.[68] Further support for the separation of private sector delivery of NHS services from claims of "NHS privatisation" was found via 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. This led to the conclusion "So privatisation is not about the provider; it is about

[64] See comments during the 18th sitting, including by Tom Blenkinsop MP.
[65] In essence, a shared competence.
[66] See comments by Karl Turner MP, 20th sitting.
[67] See comments by Lord Clement-Jones in the Lords Debates of the National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) 2013. Vol. 744. 24 April 2013. National Health Service (Procurement, Patient Choice a - Hansard - UK Parliament
[68] See comments by the cross-bench life peer, Lord Walton of Detchant, National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013, Volume 744: debated on Wednesday 24 April 2013

reaching into your wallet to pay for the service for which the state should pay. That is the fundamental ethic of the NHS".[69]

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

The considerable controversy surrounding the HSCA 2012 reforms generates questions about the extent and way in which these could facilitate "NHS privatisation". The references to "NHS privatisation" in the debates seem to entrench common themes, such as the open-ended definition of "NHS privatisation" and that it involves a process. However, the link with utilities liberalisation and indeed the very enshrinement of New Labour competition policies in law might seem to provide *prima facie* evidence of an actual facilitation, and thus scope for an increase in "NHS privatisation". However, what emerged was either an ambivalence about, and even lack of, enforcement activity regarding the competition provisions, suggesting that the structural prerequisites to deliver expansion of "NHS privatisation" were impeded.

Thus with regard to the competition law provisions[70] we find plausible and persuasive arguments at the time of the Health and Social Care Bill for the logic that once competition law was found to be applicable, it would increasingly be applied.[71] The passage of time and non-enforcement led to considerations that applicability is a largely theoretical question distinct from actual *application*,[72] which might be inhibited by various factors, including prioritisation of Competition and Markets Authority workload, and possibly also the political sensitivities which could have attached to competition law cases involving the NHS. Writing in 2023, it is possible, with hindsight, to see the concerns about the reach of EU competition law as overstated in light of Brexit, but substantive arguments can also be made about the relative EU

[69] See comments by Baroness Cumberledge, Column 1503, National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013, Volume 744: debated on Wednesday 24 April 2013.
[70] That is, the prohibitions on anticompetitive agreements and abuse of dominance.
[71] 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 n45 to underscore concerns about accountability.
[72] See further, Guy, n30 above.

and national competence in healthcare to support this sense of overstatement.[73] Ongoing controversy and sensitivity about the HSCA 2012 reforms also offer an explanation for institutional enforcement void left by the de facto reclassification of Monitor/NHS Improvement as separate from regulators such as OFCOM and OFGEM,[74] and the removal of Competition and Markets Authority oversight[75] amid wider review of the UK competition landscape.[76] 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.[77]

The most active area of implementation of the HSCA 2012 reforms has been assessment of NHS Trust and Foundation Trust mergers. This involved determination by the Competition and Markets Authority drawing on advisory opinions identifying "relevant patient benefits" from Monitor/NHS Improvement under section 79 HSCA 2012. Perhaps surprisingly, this merger assessment regime received surprisingly little attention in the Health and Social Care Bill debates. The section 79 merger control regime appeared intended primarily to facilitate the policy in place between approximately 2004 and 2014 to "upgrade" NHS Trusts to have greater autonomy from central government and achieve NHS Foundation Trust status, thus suggests a lesser-considered aspect of "NHS privatisation". The shift away from competition and towards integration as the predominant NHS policy focus from approximately 2015, led the

[73] Guy, n46 above.
[74] See Guy, n30 above, 135-139.
[75] While theoretically this modification did not affect the conducting of market investigations under section 83 HSCA 2012, the lack of recourse to this can arguably be attributed to the ongoing controversy.
[76] Via the Enterprise and Regulatory Reform Act 2013 and the associated Competition Act 1998 (Concurrency) Regulations 2014.
[77] 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.

Competition and Markets Authority to question its own role in merger approval in the 2017 Manchester hospitals merger thus:[78]

> "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."[79]

Despite this, NHS Foundation Trust mergers continued to be assessed until April 2020, which saw the clearance of the second Dorset Hospitals merger:[80] the original one was not only the first to be assessed under the HSCA 2012 framework in 2013, but was also blocked.[81] This necessitated a widespread review of how these mergers would be assessed and an expansion of NHS Improvement's role, with the implication that the Competition and Markets Authority's approval function became increasingly a "rubber-stamping" exercise.[82] More concerning from the perspective of "NHS privatisation" was the formal scope for assessing mergers between NHS and private providers within section 79 HSCA 2012, but this appears not to have been used. A further concern may be the lack of requirement to establish "relevant patient benefits" in mergers involving private providers who treat NHS patients, as these are merely subject to review under the competition test in the Enterprise Act 2002.[83]

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[78] Competition and Markets Authority (CMA), *Central Manchester University Hospitals/ University Hospital of South Manchester merger inquiry*. *Final Report*, 01.08.2017.
[79] Ibid, para 7, page 2.
[80] CMA, ME/6875-19 - 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. 27 April 2020.
[81] Competition Commission, *Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Merger Inquiry* (CC), 17.10.2013
[82] Guy above n30, page 227.
[83] Ibid, Chapter 4.

These considerations indicate that the competition regime which resulted from the HSCA 2012 and 2013 Regulations was not implemented in the way originally envisioned. This might be taken to suggest that it could not facilitate an expansion of "NHS privatisation" as had been feared: indeed it can be considered to represent a kind of impasse, and the worst of all worlds: a system which is both found wanting by those actively in favour of competition as a principle in itself, and which does little to allay the worst suspicions of those more sceptical about the competition reforms in healthcare.[84]

A final consideration regarding the possible expansion of "NHS privatisation" by the HSCA 2012 reforms emerges from the concerns about conflicts of interest in membership of CCGs. This is not considered part of the competition reforms[85] (in contrast to, e.g. merger control or the 2013 Regulations), but nevertheless involves the interaction between the NHS and private healthcare, outside the scope of GPs' status as independent contractors, but including the involvement of private companies in delivering CCG-commissioned care, such as community services. The HSCA 2012 obligations for conflicts of interest to be managed by CCGs has received varied attention,[86] with the delegation of this from NHS England to the CCG level attracting particular concern.[87]

INTEGRATION AND "NHS PRIVATISATION": THE EXPERIENCE OF THE HEALTH AND CARE ACT 2022

As noted above, 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

[84] Ibid, page 222.
[85] It is recognised that CCGs are, however, successors to the GP Fundholding Initiative of the 1980s, and this was deemed one aspect of competition reforms alongside the development of the NHS internal market. For an overview of these different conceptions of competition, see D. Baines, 'Improvements suggested by Enthoven and Maynard' (2014) 25(12) *Prescriber* 33.
[86] National Audit Office, 'Managing conflicts of interest in NHS clinical commissioning groups', 11 September 2015. https://www.nao.org.uk/reports/managing-conflicts-of-interest-in-nhs-clinical-commissioning-groups/
[87] Valerie Moran et al., 'How are clinical commissioning groups managing conflicts of interest under primary care co-commissioning in England? A qualitative analysis' (2017) BMJ Open;7:e018422.

LTP), which outlined legislative proposals for repealing the HSCA 2012 reforms since these were seen as inhibiting the policy shift. While it can be considered that presenting competition and integration as opposites is a false dichotomy,[88] the shift towards more collaborative forms of working has been welcomed.[89] 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.[90]

While neither the 2019 NHS LTP, nor the subsequent policy documents relating to its implementation[91] 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 Competition and Markets Authority's duties relating to mergers, NHS pricing and NHS provider licence condition decisions, and NHS Improvement's competition powers) on the one hand, but on the other hand, the retention of the Competition and Markets Authority's "critical investigations work in tackling abuses and anti-competitive behaviour in health-related markets such as the supply of drugs to the NHS."[92]

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[88] 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.

[89] Marie Sanderson, Pauline Allen, Dorota Osipovic, 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) *BMJ Open*, 13(2), e06599.

[90] For a brief overview, see NHS England, 'The journey to integrated care systems in every area'. NHS England » The journey to integrated care systems in every area

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

[92] NHS England, The NHS Long Term Plan, January 2019. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf Page 113.

In contrast, the outlining of legislative proposals to support the move towards ICS in the 2019 NHS Long Term Plan generated concerns about "NHS privatisation" regarding the scope for integrated care provider (ICP) contracts to be awarded to private providers.[93] 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",[94] 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 acknowledgement 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 "NHS privatisation" in light of long-term and high-value contracts.[95]

In the move from the NHS Long Term Plan to the White Paper[96] preceding the HCA 2022, the proposals were characterised as amounting to "deregulation, not demarketisation".[97] Where "demarketisation" might suggest a removal of markets[98] and thus a lessening of concerns about "NHS privatisation", "deregulation" can simply imply a lack of clear oversight mechanisms, but the underlying market aspects (thus the interaction between the NHS and private

[93] See comments, inter alia, by the MPs Stephen Hammond, Jonathan Ashworth. NHS 10-Year Plan, Vol. 654. 19 February 2019. NHS 10-Year Plan - Hansard - UK Parliament

[94] By Nigel Edwards of the Nuffield Trust, cited by Sarah Wollaston MP (then Chair of the Health and Social Care Committee) in Integrated Care Regulations, Vol. 656, 18 March 2019. Integrated Care Regulations - Hansard - UK Parliament

[95] See comments by Jonathan Ashworth MP in Integrated Care Regulations, Vol. 656, 18 March 2019. Integrated Care Regulations - Hansard - UK Parliament.

[96] Department of Health and Social Care, 'Integration and Innovation: working together to improve health and social care for all'. 11 February 2021. Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)

[97] Health and Social Care Committee *NHS Long-Term Plan: Legislative Proposals* (HC 2017-19, 15), page 16, citing written evidence by Andrew Taylor, former Director of the Cooperation and Competition Panel for NHS-funded Services.

[98] 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' (2021) Lancaster University Law School Working Paper, September 2021. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3915776

healthcare) remain intact. This has led to concerns being raised both with regard to competition[99] and procurement[100] frameworks.

A further point to note about the NHS Long Term Plan 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 Competition and Markets Authority oversight and refocusing of NHS Improvement's role.[101] This appeared to be 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 (so far) of the legislation.

"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,[102] and the effects of significant changes in England on Welsh healthcare.[103] "NHS privatisation" is further identified in aspects as diverse as private

[99] Ibid. See also Okeoghene Odudu and Catherine Davies, 'Enforcing competition law in the English Healthcare System', (2021) Competition Policy International Antitrust Chronicle, May 2021.
[100] 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. https://legalresearch.blogs.bris.ac.uk/2021/08/are-there-any-gains-to-be-had-from-the-proposed-new-provider-selection-model-for-nhs-commissioning/
[101] NHS Improvement has subsequently merged with NHS England. Section 33 HCA 2022 provides for the abolition of Monitor and the incorporation of its functions into NHS England.
[102] See comments during the 17th Sitting in the Commons debates and, at the Lords Report Stage, Health and Care Bill vol. 819, 7 March 2022.
[103] See comments by Hywel Williams MP during the 8th sitting (cols. 319 and 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. https://senedd.wales/media/nplhofww/cr-ld15809-e.pdf

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),[104] and questions of accountability and "who runs the NHS". Thus 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")[105] to avoid suggestions of price competition.[106] The former concern has received limited acknowledgement 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."[107]

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

[104] See comments by Dr Chaand Nagpaul during the 3rd sitting (cols. 89, 95).
[105] Section 77, HCA 2022.
[106] See comments by Edward Argar MP during the 11th sitting (col. 452).
[107] See Schedule 2 HCA 2022 section 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".

the reality of increasing numbers of US-owned private companies delivering services for the NHS:[108]

> "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".

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".[109]

Outside the focus of integrated care, there are ongoing developments regarding wider aspects of "NHS privatisation". This can be seen in concerns from the need to "tidy up" changes to the HSCA 2012 reforms, including the removal of the private patient income cap, to wider, and longer-standing concerns about increasing restriction of NHS dentistry, and how markets are created as more people "go private" and take out dental insurance: "This is what privatisation looks like".[110] 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

[108] Health and Care Bill, Lords Committee Stage, 11 January 2022, Part 2.
[109] Health and Care Bill, Lords Committee Stage, 24 January 2022, Part 2, col. 107.
[110] See comments by Alex Norris MP, 22nd Sitting, col. 900.

private healthcare – which is arguably less commonly acknowledged as "NHS privatisation". This occurred in the context of developing provisions[111] regarding information standards and parity of information disclosure between NHS and private providers – acknowledged as a response to the Ian Paterson inquiry which affected both NHS and private patients.[112]

"NHS privatisation" and the implementation of the Health and Care Act 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. As noted above, this was not envisioned as part of the NHS Long Term Plan, but introduced by Matt Hancock subsequently. This indicates a curious lack of coherence with regard to the repeal of the HSCA 2012 reforms. Concerns about the latter appeared to imply that more "NHS privatisation" and certainly less accountability could result from the relative independence from government of bodies such as the Competition and Markets Authority coupled with the seemingly objective, "functional" tests of competition law applicability. Notwithstanding the aforementioned patchy implementation of the HSCA 2012 competition reforms, the enactment of the HCA 2022 has taken place against the backdrop of allegations of cronyism arising out of how the COVID-19 crisis was handled. This ought to reinvigorate discussions of accountability in the now more complex landscape[113] which seeks to combine the existence of NHS England with ministerial oversight of procurement and mergers. In other words,

[111] See in particular sections 98 and 100 HCA 2022.
[112] See discussions in the 13th Sitting.
[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 & Anor* [2022] EWHC 384 (Admin) (23 February 2022).

this is not a simple reversion to ministerial oversight as it would have been understood in 2011.[114]

Secondly, beyond the refocusing of procurement and merger tests, there are two further provisions in the HCA 2022 which have relevance to considerations of "NHS privatisation". These 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 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 with its activities under the Competition Act 1998 and the Enterprise Act 2002. As the overall intention of the HCA 2022 changes seems to imply that competition law would not be applied to the NHS, 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 Competition and Markets Authority against NHS providers in this

[114] Guy, n 46 above.
[115] Mary Guy, 'Demarketisation, deregulation, dejuridification: removing competition from the English NHS with the Health and Care Bill' (2021) Lancaster University Law School Working Paper.
[116] Part 4, Enterprise Act 2002.
[117] This interaction would have been covered by section 79(3) HSCA 2012.

regard following the Competition and Markets Authority's 2014 Private Healthcare Market Investigation.[118] This new provision may serve to enshrine this.

Thirdly, concerns about conflicts of interest in Integrated Care Boards 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, 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.

CONCLUDING REMARKS

While the shift in NHS policy focus from competition towards integration – and the enshrinement of this by, respectively, the HSCA 2012 and 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 and integration 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. This article has purposely adopted a broad definition of "NHS privatisation" which goes beyond the marketisation reforms from the 1980s and culminating in the HSCA 2012 to illustrate 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 – including in the debates preceding both the HSCA 2012 and the HCA 2022 – to embody a sense of vagueness and an open-ended process, with the implication that this may never be complete, in a parallel

[118] CMA 'Private Healthcare Market Investigation Order (as amended)' (28 February 2017), part 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, n4, and Benbow, n3, above.

consideration to the interpretation of "NHS privatisation" as a corollary to the "incomplete nationalisation" of the NHS. "NHS privatisation" can also highlight more concrete aspects – and the various frameworks of the HSCA 2012 and HCA 2022 indicate this, particularly questions of accountability regarding the former's removal, and the latter's reinstatement of, Secretary of State for Health oversight. Other important aspects relate to governance of CCGs and now ICSs. These myriad concerns show that there are no easy answers to questions of whether the HSCA 2012 or the HCA 2022 generated more or less "NHS privatisation". That said, a tentative response may be that the degree of "NHS privatisation" between the two sets of reforms differs primarily in its nature rather than its quantity.

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. For example, while it demonstrably failed to halt the HSCA 2012 reforms, concerns about "NHS privatisation" nevertheless can help explain some of the modifications made which inhibited full implementation. Whether it will ultimately have the same effect on implementing the HCA 2022 reforms remains to be seen. If "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 and Chope Bills to (yet) 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 its taxation-funded status.

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 we see concerns about, for example, access to NHS dentistry being conflated with 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 debate[120] by the need for opposing parties to differentiate themselves while operating and 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.