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**Citation** (please note it is advisable to refer to the publisher's version if you intend to cite from this work)

**Guy, M ORCID logoORCID: https://orcid.org/0000-0003-0242-6366 and Newcombe, L (2025) NHS patient choice policy in England: what mapping the private healthcare market for NHS patients can tell us. Liverpool Law Review. ISSN 0144-932X**

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Liverpool Law Review
https://doi.org/10.1007/s10991-025-09395-z

# NHS Patient Choice Policy in England: What Mapping the Private Healthcare Market for NHS Patients Can Tell Us

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Received: 14 August 2025 / Accepted: 29 September 2025
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## Abstract

This article examines how the private healthcare market supports successive governments' commitment in the English National Health Service (NHS) to patient choice of NHS or private provider. The Labour government's NHS Ten Year Health Plan in July 2025 reaffirms commitment to patient choice, and to working with the private healthcare market to improve healthcare access for NHS patients, alongside a focus on localism with the shaping of a "Neighbourhood Health Service". The article outlines the broader NHS-private healthcare interaction against the backdrop of concerns about a "two-tier" healthcare system. The legal and policy framework governing patient choice developed since New Labour is examined to identify where further attention is needed, not least on how and where differences may arise in implementing patient choice. A case study analyses publicly-available NHS referral data to map the private healthcare market for NHS patients across the various NHS commissioning regions of England. This yields unique insight into how NHS patients in different areas of England may have more or less choice of private provider, given that London is typically seen as the centre of the private healthcare market. With this country-wide perspective, combined with law and policy analysis, it becomes possible to start to identify aspects which can help enable patient choice, such as access to transport and the NHS App. It further identifies the need for further reforms, and raise questions about the roles which the Department of Health and Social Care and the Competition and Markets Authority may play.

**Keywords:** Patient choice · National Health Service (NHS) · Private healthcare · NHS England · Department of Health and Social Care (DHSC) · Ten Year Health Plan

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Published online: 11 October 2025

## Introduction

In July 2025, the UK Labour government's Department of Health and Social Care (DHSC) launched its Ten Year Health Plan (DHSC 2025a), with at least two notable developments. Firstly, reaffirmed commitment to patient choice of provider, and to working with the private healthcare market to improve healthcare access for patients in the National Health Service (NHS) (DHSC and and NHS England 2025; NHS England 2025a). Secondly, the launch of a "Neighbourhood Health Service", with a local focus to empower patients. This lends support to patient choice via NHS commissioning bodies, Integrated Care Boards (ICBs), being "…empowered to commission neighbourhood health services from a diverse range of providers, both within and beyond the NHS, drawing on different models of provision to develop effective contractual arrangements" (DHSC 2025a: 79). A further connection with patient choice can be inferred from the requirements on the "…Neighbourhood Health Service, providers and ICBs…to routinely publish information about quality of care and access to services using local authority boundaries" (DHSC 2025a: 87). Furthermore, these developments are taking place in a changing oversight landscape anticipated to involve a re-empowered DHSC following the announcement in March 2025 of the abolition of NHS England. This is an arm's-length body which has existed since 2013 (DHSC 2025b), and to varying degrees has overseen implementation of patient choice policies.

While NHS patients can exercise choice at various points in their treatment journey, the current legal requirement for patients to be offered choice is focused around scope for NHS patients to select an NHS or private provider, when accessing planned, non-emergency (elective) treatment under consultant supervision, notably in connection with a first hospital appointment (prior to surgery/treatment).[1] This aspect of patient choice has formed part of marketisation reforms in the NHS which have evolved since the early 1990 s at a national level with the Citizens' Charter, which influenced New Labour policy documents such as the NHS Constitution. Changes since then have seen the enshrinement of patient choice in law initially by the Health and Social Care Act 2012 (HSCA 2012) introduced by the Liberal Democrat-Conservative coalition government, and latterly by the Health and Care Act 2022 (HCA 2022) amid a fundamental shift in dominant NHS policy narratives from competition and marketisation to integration.

Patient choice has thus proven a persistent policy lever for successive UK governments across the political spectrum in reforming and modernising the NHS and reframing the interaction between the NHS and private healthcare market. It has also been used over time as a curious attempt to counter concerns about a "two-tier" healthcare system, as indicated by both Tony Blair while Prime Minister, and more recently by the current Secretary of State for Health and Social Care, Wes Streeting MP, in the following comments:

"The overriding principle is clear. We should give poorer patients…the same range of choice the rich have always enjoyed." (cited in Cooper 2012).

[1] Regulation 39, Part 8, National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended). SI 2012 No. 2996.

"Our ten-year plan will give all patients – rich and poor alike – the same information, the same choice, the same control." (The Labour Party 2024).

While the sentiments expressed appear to represent common ground, associated policy contexts are distinct: choice and competition reforms amid significant NHS spending for the former, and responding to years of austerity and the COVID-19 pandemic for the latter. The 2025 proposals furthermore show clear commitment to tackling health inequalities, with a new "patient choice charter" intended to start "in the areas of highest health need", and by the government entering into "discussions with private providers to expand NHS provision in the most disadvantaged areas" (DHSC 2025a: 13).

Key to the implementation of renewed commitments to patient choice is how the private healthcare market for NHS patients has developed across England. The Competition and Markets Authority (CMA) has previously indicated an important distinction between private providers who take on NHS work, and those who do not (CMA 2014: paragraph 2.15). Location is also a significant factor in a locally-focused NHS given that the CMA has previously considered that the private healthcare market is more active in London than elsewhere. This prompts questions of whether, and how, patient choice may vary across diverse places outside the capital, for example Blackpool and Norfolk.

Due, inter alia, to commercial sensitivity and data collection, it can be difficult to learn more about private provider delivery of NHS services, but further understanding and discussion is essential for the current reform proposals.

This article provides a timely insight into how the private healthcare market for NHS patients has developed across England alongside the evolution of national-level NHS patient choice policies. We sketch a geographical outline of a private healthcare market treating NHS patients by examining the publicly-available NHS Monthly Activity Return (MAR) (2008–2020) and Monthly Referrals Return (MRR) (2020–2024). These both relate to family doctor (General Practitioner, or GP) and other practitioner (e.g. optician) referrals for first consultant-led appointments for patients receiving planned (elective) treatment. This dataset offers a convenient connection with the aforementioned legal requirement for patients to be offered a choice of NHS or private provider in respect of such appointments. An original aspect of this article lies in its distinction from other analyses of NHS commissioning of private provider delivery for NHS patients. These have engaged with the questions of *what* (i.e. which treatments) and *why* (respectively, Kirkwood et al. 2024; and Goodair 2023), but not the complementary questions of *where* and *how*.

The article proceeds as follows. Section Overview of the Private Healthcare Market and its Interaction with the NHS in England examines in overview the private healthcare market in England with a particular focus on how it serves NHS patients. Section Patient Choice and the Patient Journey in England sets out the patient journey across the English NHS to understand where and how patient choice policies take effect, and the various actors involved in the process. Section The case study: Development of the private healthcare market for NHS patients across England comprises a case study based on the aforementioned datasets which offer insights into the development of the private healthcare market for NHS patients across the seven

NHS commissioning regions of England, and into referral patterns. Section 5 offers concluding remarks and policy-relevant recommendations.

## Overview of the Private Healthcare Market and its Interaction with the NHS in England

Coexistence of the NHS and private healthcare can be traced to the NHS' inception, with provision made for consultants to continue private practice alongside their NHS workloads and space being reserved in NHS hospitals for this.[2] A more clearly-defined private healthcare market operating independently can be linked to political campaigning to remove "pay-beds" from NHS hospitals in the 1970 s (Williamson 2015). Contemporaneously with the aforementioned marketisation reforms of the NHS in the early 1990 s, which included a separation of purchasing and providing functions (Klein 2013), the then UK competition authority noted the distinctive dynamic which had evolved between private healthcare and the NHS:

> "Healthcare in the UK is dominated by the NHS. Without it private healthcare would not exist in its present form. Private healthcare has evolved alongside the NHS […] It has flourished in areas where the NHS has been unable for one reason or another to meet the full range of demand for its services." (Monopolies and Mergers Commission 1994).

Questions in 2025 include the extent to which this dynamic remains given the intervening NHS patient choice policy developments (which support recourse to private providers delivering NHS services, notably under New Labour since the early 2000 s), and expansion of the private healthcare market. Certainly in 2014 the CMA focused on London, where it has since been acknowledged that "[p]rivate patient work is also key to providing financial support for our NHS paediatric services." (Great Ormond Street Hospital for Children NHS Foundation Trust 2018). More recently, the private healthcare market more generally has clearly benefitted from pressures on the NHS impeding its ability to deliver adequate healthcare following austerity policies and the COVID-19 pandemic. A striking illustration of the current situation emerges not only from the record numbers of patients on NHS waiting lists in 2023 (Harker et al. 2025), but also with the first ever inclusion of budgeting for private healthcare in the Minimum Income Standard (Joseph Rowntree and Foundation 2024).

We know that the private healthcare market is sensitive to external changes, such as the economic downturn of 2008 and the initial national COVID-19 lockdown, both leading to acknowledgements by private providers that NHS work was welcome (Arora et al. 2013; Lintern 2020). Relaxation of the competition rules at various points during the pandemic permitted greater cooperation between the NHS and private healthcare companies, which revealed a "core" of private healthcare companies supporting the NHS across England (Guy 2023a), including Spire, Ramsay, and Circle. Over time, this "core" has evolved as providers enter, leave, or merge within

[2] See Sect. 5 National Health Service Act 1946.

the private healthcare market. A recent example is BMI being taken over by Circle in 2020,[3] which appears taken over since by PureHealth, a UAE company making its first move into the UK (Kerr 2023).

Nevertheless, the overall dynamic of NHS-private healthcare interaction involves a complex interdependency which relies on understanding and engaging with the private healthcare market as much as NHS reforms. This interaction can be illustrated in general terms by reference to four categories, a model developed from analysis of the competition and market reforms of the NHS (Guy 2019a) (Fig. 1):

Category 1 represents the situation where NHS patients access treatment from NHS providers (e.g. NHS Trusts or NHS Foundation Trusts), and payment for treatment is managed within the taxation-funded system of the NHS (via ICBs).

Category 2 represents a similar situation as regards payment for treatment from the patient's perspective, but treatment is delivered by a private healthcare provider and funded by the NHS (via ICBs). Examples include private provider groups such as Spire or Ramsay, who treat both NHS and private patients across England[4] - a dynamic which underpins the successive "patient choice" policies since New Labour. The case study in Sect. 4 below focuses on category 2 activity, to gain insights into where private provision for NHS patients has evolved not only in London, but across England. The development of this private healthcare market for NHS patients has been facilitated by general and "NHS-specific" procurement rules, notably in connection with the HSCA 2012 reforms (Smith, Heard, Bevan, 2013), which have been replaced by a new system under the HCA 2022 – the Provider Selection Regime. Private providers wishing to deliver services for the NHS need to hold a provider licence (which includes a patient choice condition) unless exempt (NHS England 2024a) and be designated "qualified providers", which indicates they meet certain minimum regulatory requirements,[5] such as being registered with the Care Qual-

| | |
|---|---|
| Category 1<br>NHS ICB (purchaser)<br>NHS Provider | Category 3<br>Patient (purchaser)<br>NHS Provider |
| Category 2<br>NHS ICB (purchaser)<br>Private Provider | Category 4<br>Patient (purchaser)<br>Private Provider |

**Fig. 1** The "four categories" of English healthcare

[3] Competition and Markets Authority, Circle Health/BMI Healthcare merger inquiry, https://www.gov.uk/cma-cases/circle-health-bmi-healthcare-merger-inquiry#:~:text=Competition%20and%20Markets%20Authority%20cases, equipment%20Closed:%208%20May%202024. Last accessed 12 August 2025.

[4] See, for example, https://www.spirehealthcare.com/how-to-book/nhs-patients/ and https://www.ramsayhealth.co.uk/patients/nhs-patients, both websites last accessed 12 August 2025.

[5] Regulation 42 C Qualification of providers: criteria, 2012 Regulations (nXX above).

ity Commission in respect of relevant services, demonstrating that they can comply with the terms and conditions of the NHS Standard Contract, and have indemnity arrangements in place. NHS bodies (including NHS England and ICBs) which award contracts must adhere to the procurement principles and relevant selection process which can have specific criteria[6] under the Provider Selection Regime (NHS England 2025b).[7] Providers aggrieved by the outcome of an NHS body's decision can make representations to the Independent Patient Choice and Procurement Panel for review of whether the Provider Selection Regime has been complied with (NHS England 2024b). Cases reviewed thus far indicate cases emerging across England, on diverse healthcare services, and that it is possible for the Panel to consider compliance with the Provider Selection Regime also in light of NHS England's patient choice redress procedures (NHS England 2025c)[8] discussed in Sect. 3 below.

Category 3 represents a kind of mirror image to Category 2 insofar as the NHS delivers the service, but payment is made by patients to receive treatment, with examples including medical tourism particularly in London (Lunt, Exworthy, Hanefield, Smith, 2015), and patients using Private Patient Units (PPUs) in NHS Foundation Trust hospitals. This activity can arguably be most readily understood in the context of wider "public sector entrepreneurialism" noted in the marketisation reforms of the NHS since the early 1990 s, considered intensified by the HSCA 2012 reforms (Exworthy, Lunt, Tuck, Mistry 2024). Calls to develop PPUs to support the NHS are made periodically (Risebrow 2019; Robertson 2024), and PPUs have been deemed a factor in concerns about consolidation of the private healthcare market in London following the HSCA 2012 reforms, leading the CMA to institute a separate review test (CMA 2014; CMA 2019). Nevertheless, PPUs have developed to varying degrees across England, and can offer a wide range of specialisms in rural areas such as Norfolk,[9] or wide-ranging or specific specialisms in deprived areas such as Blackpool.[10] PPUs raise various considerations (if not concerns) with regard to the NHS. This is because PPUs can be seen both as a way to "go private" and help the NHS,[11]

[6] For example, Direct Award Process B must be used where there is unrestricted patient choice of provider for a service, but patient choice is among the criteria which must be considered with regard to other Direct Award Processes.

[7] The Health Care Services (Provider Selection Regime) Regulations 2023, SI 2023 No.1348.

[8] See, for example, Case CR0001-24: review of a proposed contract award for online ADHD assessment, diagnostic and management services for North Cumbria.

https://www.england.nhs.uk/publication/independent-patient-choice-and-procurement-panel-review-of-a-proposed-contract-award-online-adhd-assessment-diagnostic-and-management-services-for-north-cumbria/.

[9] For example, the Charnwood Suite at the James Paget Hospital near Great Yarmouth https://www.jpaget.nhs.uk/departments/charnwood-suite-private-patients/ website last accessed 12 August 2025.

[10] For example, the Lancashire Suite at Blackpool Victoria Hospital is a cardiology and cardiothoracic unit - https://www.blackpoolteachinghospitals.nhs.uk/services/cardiac/departments/inpatient-wards-and-departments website last accessed 12 August 2025. See also the Rowan Suite of the Liverpool Chest and Heart Hospital, and the Sefton Suite of Liverpool University Hospitals NHS Foundation Trust).

[11] See, for example, information for private patients provided by the Norfolk and Norwich University Hospitals NHS Foundation Trust. https://www.nnuh.nhs.uk/departments/private-patients/#:~:text=Our%20Private%20Patients%20service%20enables, nhs.uk%20with%20your%20query. Website last accessed 12 August 2025.

and as posing a challenge to the allocation of NHS staffing as staff may treat both NHS and private patients.

Category 4 reflects the conventional understanding of a private healthcare market, whereby a private provider delivers treatment in return for payment from a patient. As noted above, some of these private providers will also deliver services for the NHS in Category 2, such as Spire.

It is important to note that the CMA defines the private healthcare market in terms of categories 3 and 4 only, and separate from the NHS "market" of categories 1 and 2, which form the overriding focus of the present discussion. From a private provider perspective, the ability to expand from category 4 into category 2 has been facilitated by policies since New Labour,[12] and continued by the subsequent coalition and Conservative governments. A related development was the Independent Sector Treatment Centre (ISTC) programmes, introduced in 2003, which saw the development of clinics to assist with certain elective treatments and thereby reduce NHS waiting lists for planned operations and diagnostic tests. Two groupings of ISTCs were located across England, and often used the title "NHS Treatment Centre" even though they were operated by a private provider.[13]

The overlap between categories 2 and 4 can be further considered in the context of merger review by the CMA. Against this backdrop, private provider reconfiguration indicates potential implications for NHS patient choice policies, as seen with the 2020 BMI/Circle merger.[14] The CMA considered that this merger could lead to concerns, including increased prices for self-pay and NHS-funded patients regarding hospitals providing private hospital medical services in Bath and Birmingham. As a result, Circle undertook to divest two hospitals to enable merger approval. Such a capacity reduction may have implications for NHS patients, although the effect of this merger was limited to considerations of a potential detrimental effect on post-pandemic elective recovery. The CMA's assessment in such cases includes reference to the interaction between provision of private and NHS services, but the basis of the decision prioritises effects on the private healthcare market.

Before examining patient choice in the context of NHS policies in the next section, it is useful to note at this point the broader – separate – choice available for patients themselves to "go private", that is, to access treatment via the private healthcare market, effectively exiting the NHS for at least some of their treatment.

The "choice" implied in "going private" is thus a separate narrative (to NHS choice policies) and is based around a change in status from NHS to private patient, a mechanism which rightly underpins concerns about the existence of a "two-tier" healthcare system. There have been various policies underscoring the importance of

[12] Notably the NHS Concordat, signed in 2000, and the NHS Plan, also launched in 2000.

[13] See lists in HC Deb 10 February 2009, vol 487, col 1766WA. https://hansard.parliament.uk/commons/2009-02-10/debates/09021036000037/NHSTreatmentCentresPrivateSector#:~:text=The%20centrally%20procured%20Independent%20Sector,2%20ISTC%20schemes%20in%20mobilisation. website last accessed 12 August 2025.

[14] CMA, ME/6864/19 Completed acquisition by Circle Health Holdings Limited of GHG Healthcare Holdings Limited, a parent of BMI Healthcare Limited Decision on acceptance of undertakings in lieu of reference. 29 June 2020.

keeping private and NHS care (and corresponding patient statuses)[15] separate, largely to avoid even suggestions of the NHS cross-subsidising the private healthcare market. A distinction drawn in this policy documentation (Department of Health 2009) is between permitted co-payment (a classic example being the levying of prescription charges), and prohibited co-funding (which would see the combination of NHS and private healthcare). This prohibition has been refocused notably in cancer care, where it became possible to combine, for example, chemotherapy on the NHS with paying for drugs not licensed for use on the NHS (Jackson 2010; Syrett 2010). There have been various attempts by the Conservative MP, Sir Christopher Chope, to introduce a Private Member's Bill to allow co-funding,[16] which would involve a significant change in approach were this legislative proposal ever to gain traction.

## Patient Choice and the Patient Journey in England

The NHS has been described as a "ecosystem of care providers" (Digital 2022) comprising primary care (the first point of contact with, e.g., a GP, dentist, or optician), secondary care (planned care, emergency care, or mental health care), tertiary care (highly specialist services), and community care (which includes child health services and sexual health services). Patients entitled to receive NHS treatment in England are generally considered to be able to exercise choice at four junctures in their treatment journey: choice of GP; choice of hospital or consultant; choice of mental health service; and choice in respect of end-of-life care (NHS England 2023a). These choice dimensions may be constrained or enhanced by geographical location, with it being noted that patient access to the NHS is currently framed around seven NHS commissioning regions in England: London, South East, South West, East of England, Midlands, North West, and the North East and Yorkshire. Each of these regions comprises several Integrated Care Boards (ICBs) which have responsibility for planning NHS services via GPs and hospitals. From a patient's perspective, their GP may be associated with one ICB, but they may be able to choose an NHS or private provider within either the same, or a different ICB area or wider commissioning region depending on their clinical needs and the contractual arrangements in place.

As noted in the Introduction, "patient choice" in the context of the legal requirement for patients to be offered choice relates to the more specific aspect of referrals for planned, non-emergency (elective) treatment, in respect of a first outpatient appointment with a consultant (prior to surgery/treatment). This therefore can be seen as relating to the move between primary and secondary care, prompting questions as to the function of choice in this context, the actors involved, and limits on individual patients as exercisers of choice. The following examination of the legal and policy framework enabling choice for NHS patients can start to provide some answers.

[15] As "private patients" and "NHS patients".

[16] National Health Service Co-Funding and Co-Payment Bill. This was most recently introduced on 14 May 2025 and as at September 2025, is awaiting its second reading. This Bill has been introduced in almost every parliamentary session since 2017, and has yet to proceed further beyond a first reading.

## The Legal and Policy Framework Underpinning Patient Choice in the NHS

The current[17] legal framework[18] post-HCA 2022 is defined in terms of two duties (predominantly on ICBs and NHS England)[19]: to ensure persons are offered a choice of health service provider,[20] which can be an NHS or a private provider, and to publicise and promote information about choice.[21]

The first duty is limited to persons under the responsibility of the ICB, and requiring a referral for planned (elective) treatment. "Elective treatment" is now defined to mean a referral by "(a) a general medical practitioner, (b) a general dental practitioner, or (c) an optometrist".[22] These limitations are further supported by clarification of the exclusions to the choice duty. Thus excluded services[23] are those attaching to a separate duty to make arrangements to diagnose or rule out cancer, maternity services, and any service where it is necessary to provide urgent care. Persons excluded from the choice duty[24] include anyone who is detained in or on temporary release from prison, or is serving as a member of the armed forces.

The second duty – to publicise and promote choice[25] – requires ICBs to make arrangements for publicising, and promoting awareness of information about NHS and private providers ("health service providers") and consultant-led teams for the purposes of enabling a person to choose, respectively, a health service provider and a clinically appropriate team, and publicising details and promoting awareness of where that information may be found. The legal provision also refers to choice in the context of mental health care but it is important to note that the function, and operation, of choice in the context of mental health care functions in a different way (see Newbigging, Rees, Ince, Mohan and others 2020), so is beyond the scope of the present discussion. Indeed, the complexity and discrete nature of mental health services is perhaps indicated by the exclusion of persons detained under the Mental Health Act 1983 from the choice duty, juxtaposed with the inclusion of information about health care professionals providing mental health services.

It is noted that these two broad duties in the legal framework broadly reflect two previous arrangements, namely the policy-level 2009 Directions,[26] and enshrine-

[17] As at September 2025.

[18] Part 8 of The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. 2012 No. 2996 (as amended).

[19] Regulation 2 of The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2024 also includes NHS Trusts and NHS Foundation Trusts in certain instances.

[20] 2012 Regulations, Regulation 39 – Duty to ensure persons are offered a choice of health service provider.

[21] Ibid, Regulation 42 – Duty to publicise and promote information about choice.

[22] Regulation 2, The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No. 2) Regulations 2023. 2023 No. 1105.

[23] Ibid, Regulation 40 – Services to which the duties as to choice do not apply.

[24] Ibid, Regulation 41 – Persons to whom the duties as to choice do not apply.

[25] Ibid, Regulation 42 - Duty to publicise and promote information about choice.

[26] National Health Service England The Primary Care Trusts (Choice of Secondary Care Provider) Directions 2009.

ment in law following the HSCA 2012 via the related 2013 Regulations[27] and underpinned by the associated 2012 Standing Rules.[28] The broad consistency in approach of the policy and legal frameworks is notable when juxtaposed with the significant reorganisations of NHS managing bodies which have taken place in connection with the HSCA 2012 and HCA 2022 in particular. Thus the 2009 Directions (under New Labour) specify Primary Care Trusts, and the 2012 Regulations (as originally enacted) specify the then newly-constituted NHS England and Clinical Commissioning Groups (CCGs) with the HSCA 2012. The current version of the 2012 Regulations, as noted above, are understood to relate to ICBs as successors to CCGs, following the HCA 2022. Wider evolution of NHS managing bodies, particularly from the early 1990 s until New Labour (Paton 2006; Ham 2009), is however beyond the scope of the present discussion.

It was noted above how patient choice has re-emerged in recent times with related policies and reforms regarding marketisation and competition, as well as the oversight architecture for implementing these. Thus the 2009 Directions were overseen by the then Department of Health,[29] and include reference to contracts with Independent Sector Treatment Centres (ISTCs). These were an important aspect of New Labour's choice and competition focus, and comprised private clinics treating NHS patients (Gregory and Naylor 2009). The 2013 Regulations continued the controversy which attached to the HSCA 2012 and were overseen by Monitor, which had been refocused as a sectoral regulator akin to OFGEM by the HSCA 2012 (Guy 2019b), but was eventually subsumed into NHS England.

The 2013 Regulations and 2012 Standing Rules formed the basis for a patient choice test case involving an allegation by Spire that the Blackpool CCG and Fylde and Wyre CCG had taken steps to refer NHS patients away from its hospital, based on previous patient referral trends. NHS Improvement upheld part of the complaint, accepting undertakings from the CCGs to ensure that GPs reported the number of patients offered choice at their practice, and to promote patient choice on GPs' and CCGs' websites, and in GP premises, as well as producing promotional materials.[30] It was notable that Spire acknowledged that it could not be certain that patients would have chosen its hospital, as this raises interesting questions about incorporating private providers in delivering NHS services and patient switching behaviour (Guy 2019a).

Aside from this case, the 2013 Regulations have for the most part been considered disregarded with the intervening shift in policy focus towards integration, and particularly the removal of the purchaser/provider split which had underpinned the competition reforms since the early 1990 s (Public Accounts and Committee 2017). This can be attributed to the wider political failure of the HSCA 2012 competition

[27] National Health Service (Procurement, Patient Choice, and Competition) Regulations (No.2) 2013, SI 2013 No. 500.

[28] Part 8 of The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. 2012 No. 2996.

[29] Renamed the Department of Health and Social Care in 2018.

[30] Monitor, Case CCD 05/13 *Commissioning of elective services in Blackpool and Fylde and Wyre Final Report*, 20 March 2015.

reforms and the workarounds instituted pending the enshrinement of integration by the HCA 2022 (Guy 2023b).

Following the HCA 2022, the current oversight architecture encompasses two discrete aspects: oversight within NHS England, and the Independent Patient Choice and Procurement Panel. Overall, NHS England is empowered to investigate whether an ICB has failed, or is likely to fail to comply with patient choice requirements (NHS England 2023b). More specifically, the National Choice Team within NHS England has been established to respond to complaints from providers about the qualification of providers by commissioners using the post-HCA 2022 Provider Selection Regime. If the Choice Team is unable to resolve the complaint, it will be escalated to the Independent Patient Choice and Procurement Panel (NHS England 2023c; NHS England 2023d).

This current framework is reminiscent of the 2013 Regulations insofar as the focus is on providers challenging commissioning and referral decisions, rather than providing recourse for individual patients to question whether their right to choice has been complied with. Given the current changes afoot with the abolition of NHS England, it remains to be seen whether and how the National Choice Team and the Independent Patient Choice and Procurement Panel may feature within the new landscape overseen by the DHSC.

### Considerations Surrounding the 2025 Patient Choice Proposals

The extensiveness of the above framework encompasses scope for action to be taken against both providers (via the NHS Provider Licence noted in Sect. 2) and ICBs for non-compliance with patient choice requirements.

The foregoing analysis of the law and policy framework underpinning patient choice gives rise to at least three insights.

Firstly, that despite "patient choice" being very much at the heart of this aspect of NHS-private healthcare interaction, the actual role accorded to individual patients appears minimal, in seeming contradiction of "patient empowerment" or "patients-as-consumers" narratives which typically accompany marketisation reforms. This is particularly evident in the fact that standing to challenge commissioning and referral decisions lies with providers, not patients. Thus a patient who, perhaps having had their awareness of their entitlement to choose raised via the aforementioned publicity and promotion requirements, may feel aggrieved if they are not offered a choice of provider due to their location, and are left with no clear recourse. The aforementioned Spire case gives an indication of the kind of situation which may give rise to patient choice complaints within the current legal framework – by private providers challenging referral practices within the NHS. In addition the case demonstrates the difficulty of bringing a successful challenge given the necessarily varied nature of referrals over time and the difficulty of predicting how many patients may be directed to a particular provider and why at a given point, but not at another time.

This according of such importance to providers in facilitating the patient choice mechanism might be interpreted as providers acting on behalf of patients. However, such understanding should be challenged as NHS patients enjoy a "dual identity" of being patients on the one hand, and taxpayers on the other. This recognition acknowl-

edges the link with marketisation reforms, but also reinforces the need to pay attention to wider considerations both with regard to patient identity, and the multifaceted nature of choice (Whiteman 2013; Fotaki 2014).

It is useful to recall that healthcare systems can be seen as comprising three levels: micro (equating to the doctor-patient relationship), meso (regarding decisions by ICBs or other NHS bodies), and macro (in connection with government policy). With the above legal and policy framework what has emerged is the idea of patient choice as a policy lever and a disruption mechanism which can have effects on a wider scale than benefitting an individual, and can encourage change and reform in healthcare practices and NHS institutions (Sheppard 2016). The pairing of patient choice with use of the NHS App in the 2025 reforms appears to take this insight further.

Secondly, it is notable that the continued focus on the two duties – of offering choice and publicising and promoting choice – across three "generations" (namely the 2009 Directions under New Labour, the HSCA 2012 approach of the coalition government, and now the post-HCA 2022 approach) has nevertheless yielded a consistent concern that patients appear to lack awareness of their entitlement to choose: "Overall, a slim majority (53%) said they knew that there was a legal right to choose a hospital or clinic for a first NHS outpatient appointment. […] Just 37% of the public knew that they can choose to receive their first NHS outpatient appointment in an independent/private sector provider with no additional cost to the NHS." (Patients' Association/Independent Healthcare Provider Network, 2022). The Patients' Association and IHPN identify a role for GPs in raising awareness of patient choice, but other considerations also emerge. It would be interesting to gain insights into the demographics of patients polled in the aforementioned data to identify whether any correlations exist between, for instance, a patient's age or professional status, and level of awareness of their entitlement to choose. Furthermore, in view of the aforementioned noted focus of the private healthcare market on London, and the symbiosis between private providers treating both NHS and private patients (as discussed in Sect. 2), it would also be useful to understand whether, and if so, how, location plays a part in levels of awareness of patient choice. In other words, is there greater awareness of patient choice in (perhaps more affluent) locations where the private healthcare market (i.e. category 4) is known to be active? Conversely, may there be less awareness of patient choice in deprived or rural areas if there are fewer private providers active?

Thirdly, the framework appears one-sided in that it appears to focus exclusively on creating the conditions necessary for *offering* choice, but not to look far beyond this to the complementary practical considerations which emerge in *facilitating* (the acceptance of) choice, such as considerations of transport, and, in the context of the 2025 proposals, access to the NHS App.

It is noted that a "selling point" of patient choice is that shorter waiting times are juxtaposed with short journey times, in claims such as "90% of people live within a 30-minute drive of an independent [private] provider" (Patients' Association/Independent Healthcare Provider Network, 2022). Here transport is key and while juxtaposing reduced waiting times with drive times indicates benefits to selecting private providers, it presupposes ready access to private transport. Schemes exist to provide transport support, such as the Non-Emergency Patient Transport Service (NEPTS)

and the Healthcare Travel Costs Scheme (HTCS), but concerns have previously been raised about the awareness and efficacy of these (Healthwatch Islington 2015), and data collection for further investigation may prove challenging (NHS Business Services Authority 2024). Further research has indicated that accessing the NHS App has also revealed both positive and negative patient experience (Reidy et al. 2025), and NHS access has been highlighted in the context of digital poverty in the UK (Institute of Development Studies, 2022).

Whether it is the function of the legal and policy framework underpinning patient choice to engage with these practical considerations is moot, but arguably should be reviewed in light of the commitment of the 2025 proposals to engage with health inequalities. This is because concerns arise about patients being excluded duty to a lack of access to private transport and/or the NHS App.

A final significant insight, which draws on the foregoing, relates to the framing of patient choice seemingly being used by both Tony Blair and Wes Streeting to counter head on inferences of a "two-tier" healthcare system. With patient choice benefits being framed by juxtaposing reduced waiting times with limited drive/journey times (Patients' Association/IHPN 2022; DHSC 2025a:84), and in addition now by recourse to the NHS App, there is a real risk that three tiers may develop. The first tier remains the original point of distinction, with patients "going private" and paying for treatment, thus opting out of the NHS. The second tier may relieve pressure on the NHS by certain patients selecting a private provider on their smartphones and driving for treatment. It therefore favours those patients with access to private transport and a smartphone. A third tier then emerges for those NHS patients who depend on the NHS because they may not have access to either smartphones or to private transport, so may be relying on opaque transport support initiatives such as the HTCS alongside difficult-to-access benefits. This third tier needs most attention in implementing the new "patient choice charter" and related reforms since this is where the government's commitments to addressing health inequalities seem likely to be tested.

## The Case Study: Development of the Private Healthcare Market for NHS Patients across England

### Materials and methods

The following sections examine how referrals of NHS patients to private providers for a first consultant-led outpatient appointment have evolved across England between June 2008 and March 2024. The case study draws on two publicly-available NHS data sources, the Monthly Activity Return (MAR)[31] and Monthly Referrals Return

[31] NHS England. 2025. Monthly Hospital Activity (MAR) data https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/.

(MRR).[32][33] These were selected as a starting-point for sketching a private healthcare market for NHS patients given acknowledgements that information about this NHS-private healthcare interaction is difficult to access, and also limited due to problems with routine data collection and commercial sensitivity (Gregory and Naylor 2009).

Both the MAR and MRR data specifically address the provision of NHS-funded care for NHS patients by NHS or private providers, thus are directly relevant for the present discussion of category 2 activity. The time periods of MAR and MRR data collection enable insights into how the private healthcare market for NHS patients evolved alongside the aforementioned three chronological sets of policy and law developments, by New Labour, the HSCA 2012, and the HCA 2022. Data from both sources has been drawn on a quarterly basis (i.e. where available across March, June, September and December) to allow for potential variations across a calendar year (for example, in response to NHS winter crises).

Provider codes in the MAR and MRR enabled the extraction of data relating to NHS and private providers. This facilitated identification of specific private provider groups such as Spire and Ramsay (and their evolution) across different regions of England. Analysis of commissioning region codes required familiarity with the convoluted post-HSCA 2012 redefinitions of NHS commissioning bodies and regions, from 10 Strategic Health Authorities (SHAs), via 25 area teams (between 2013 and 2015) and 5 broad NHS commissioning regions, before settling into the current 7 NHS commissioning regions from approximately 2018. To support the present focus on evolution of the private healthcare market, we simplify these region definitions as far as possible[34] to the 10 SHAs, 4 broad NHS commissioning regions of London, the Midlands and the East of England, the North of England, and the South of England, and the current 7 commissioning regions, namely London, the Midlands and the East of England, the North East and Yorkshire, the North West, the South West, and the South East.

## Discussion

The aim of this case study is to track the development of the private healthcare market for NHS patients (i.e. category 2 activity) in terms of private provider numbers across the various regions of England in line with the aforementioned three sets of reforms. This is complemented by consideration of referral patterns, as referrals denote positive, active, category 2 activity (as distinct from the coincidental presence of a private provider in a given region). Both aspects are defined in terms of the dataset periods (2008–2024). The term "private healthcare market for NHS patients" is understood to encompass primarily the separate groups of private providers which may run small

[32] NHS England. 2025. NHS Digital, Monthly Referrals Return, https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notices/data-provision-notices-dpns/monthly-referrals-return.

[33] The data underpinning the present analysis of this discussion is accessible at Guy, Mary and Newcombe, Lee (2025) *Mapping NHS patient choice policies across England: Referral data to NHS and private providers*, *June 2008 – March 2024.* [Data Collection]. https://opendata.ljmu.ac.uk/id/eprint/242/ website last accessed 12 August 2025.

[34] For more information, see the relevant aspects of Guy and Newcombe (2025).

hospitals, as well as a separate "other" group (noted below) which may incorporate apparently independent private or voluntary sector providers. Further disaggregation of the "other" group is beyond the scope of the present discussion, as the present examination is intended to offer a starting point for further analysis of private and other non-NHS providers.

The period of June 2008 – December 2012 builds on the nascent choice and competition reforms under New Labour, with it being noted that a particular emphasis on patient choice and expanding private sector delivery of NHS services can be inferred from policy documents at the turn of the 21 st century (building in turn on the 1990 s marketisation reforms of the previous Conservative government). More specifically, this period spans a range of aspects, from the effects of implementing the ISTC programme around 2006/2007, via publication of the 2009 Directions and the 2010 launch of the NHS Constitution. In addition, the 2010 change of government (from New Labour to the Conservative/Liberal Democrat coalition government) should be noted, and the development of wide-ranging HSCA 2012 reforms.

This evolutionary period enables us to start to outline the contours of a private healthcare market for NHS patients by reference to the number of providers and identification of provider groups. Figure 2 demonstrates the emergence of private providers receiving referrals alongside NHS providers across the ten SHA regions. From the June 2008 data starting-point we can see a clear North-South divide, with an identifiable majority of private providers being located in London and across the South of England, with some activity emerging in the Midlands and Yorkshire. The absence of private providers in the East of England at the outset is perhaps surprising given the relative geographical proximity to both the Midlands on the one hand, and London and the South East on the other, although the largely rural aspect of the East of England may also provide an explanation for this. We note a sudden increase in the numbers of private providers in some regions being included in the data in the sum-

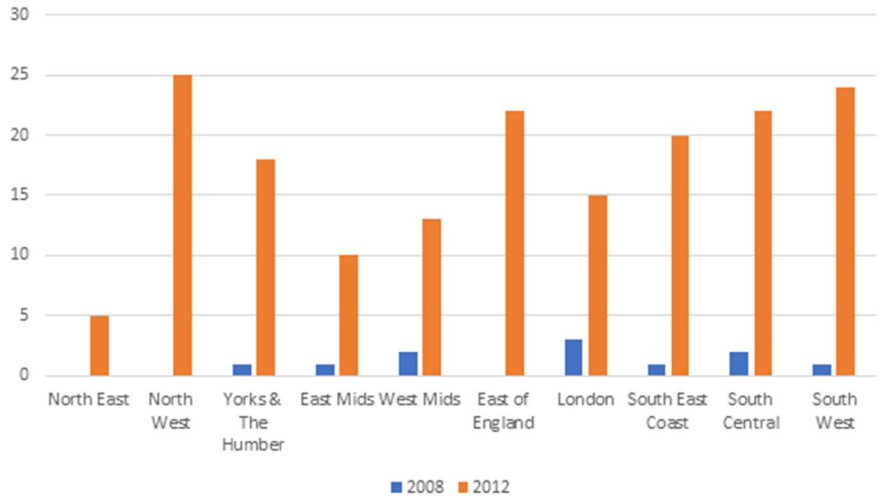


**Fig. 2** Private Provider Numbers across England, 2008 and 2012

mer of 2011. It may thus be inferred that perhaps a particular data reporting threshold was met, or that data reporting priorities shifted, rather than a widespread expansion of private provider physical presence at this point. In any case, renewed commitment to including private provider referrals appears evident at this point in time, perhaps in parallel to the development of the HSCA 2012.

Insofar as 2012 may offer a more robust benchmark (or starting-point) for reviewing the presence of private providers, there are two findings of note.

Firstly, the relatively high number of private providers in the North West dispels any previous sense of a clear North-South divide. It also prompts questions about the identity of the providers, and these appear to be hospitals belonging to groups such as Spire and BMI at this stage. This in turn paves the way for more structural considerations to play a part in understanding the development of the private healthcare market for NHS patients. By "structural considerations" may be understood the wide-ranging, multifaceted nature of the NHS hospitals in a given region, and how private providers complement this, and may be facilitated in doing so by the aforementioned longstanding ability of consultants to continue private practice alongside their NHS workloads (West 2015).

Secondly, the prevalence of private providers in London appears average when presented alongside other regions. This is perhaps surprising in view of the more active nature of the private healthcare market in London acknowledged by the CMA in 2014. However, it may simply serve to reinforce the CMA's distinction between private providers electing to treat NHS patients, and those who focus solely on private patients.

Already at this point in time it is possible to observe the emergence of particular groups (notably Spire, Nuffield Health, and BMI) of differing sizes as indicated in Fig. 3, alongside the development of NHS Treatment Centres, or ISTCs, as well as the aforementioned "other" group comprising individual and specialist providers in the private and voluntary sectors. At this stage, BMI indicated the largest number of providers (46) in a single group, while the "other" group amounted to 41 providers. In particular we observe several regional distinctions: for example, while Spire and BMI developed varying sizes of presence across each of the SHAs, no Nuffield Health providers were noted in either the Midlands, or London. While the ISTC programme clearly included a national focus as indicated above, no ISTC was noted in the East of England in the MAR.

Examining referral data of the June 2013-June 2018 period involves awareness of significant reorganisations of NHS commissioning bodies in connection with the implementation of the HSCA 2012 reforms as indicated above. Thus for ease of presentation, data from the period June 2013 – June 2018 are encompassed by the following four broad groupings: North of England, the Midlands and East of England, London, and South of England.

Private provider numbers per region do not show significant variation during this period in Fig. 4. The variation of referrals month-by-month would seem sufficient to explain why a provider may appear in some months, but not others. In other words, unless there were to be no reference whatsoever to a specific provider beyond a certain point, it would be difficult to talk of a provider "exiting" the market completely. Rather, given relatively small referrals of NHS patients to private providers, a more

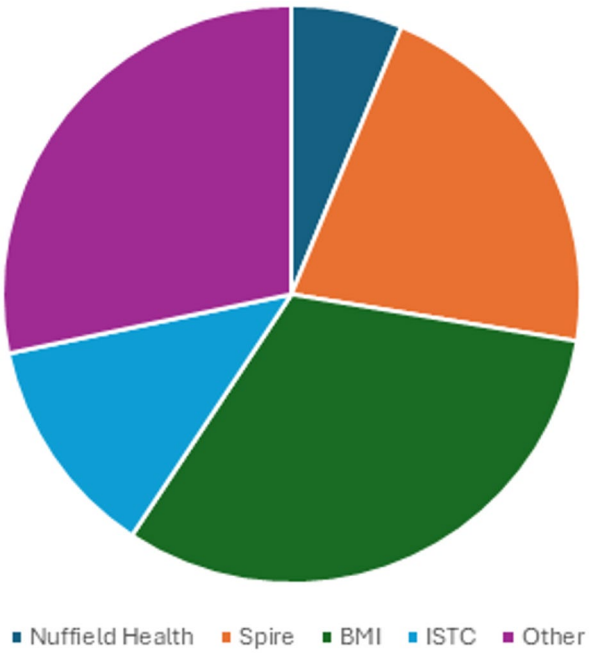


**Fig. 3** Overview of private provider groupings across England as at June 2012

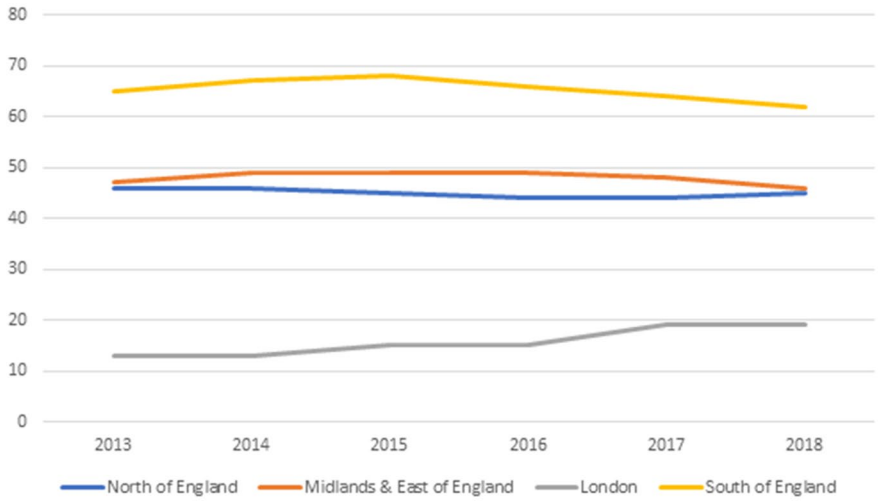


**Fig. 4** Private Provider Numbers across England, June 2013 – June 2018

logical explanation may be that the private provider either did not receive, or turned down, referrals of NHS patients. In other words, private providers could opt to treat private, rather than NHS, patients.

Nevertheless, we may infer a gradual consolidation of a private healthcare "market" for NHS patients with defined participants (provider groups) across England

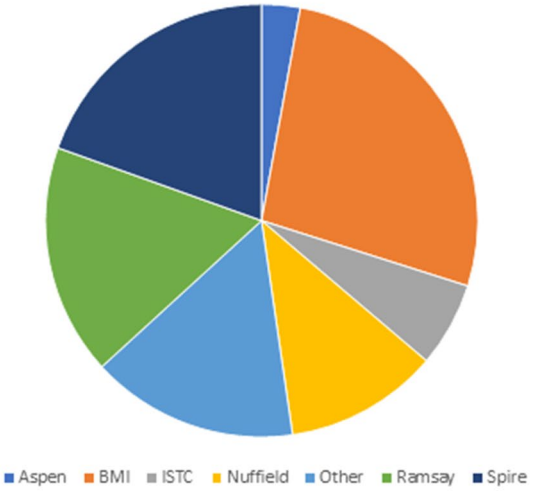


**Fig. 5** Overview of private provider groupings as at June 2019

between 2013 and 2019, when we see a further consolidation of private provider groups with BMI presenting as the strongest in terms of provider numbers (47), followed by Spire (34) and Ramsay (30).[35] From this MAR data, we were able to identify that the South East reported the highest total number of private providers (41) and London the lowest (19) in the Fig. 5 overview.

In using the MRR data between June 2020 (which marked the end of the first national lockdown) and March 2024, we are able to note that the COVID-19 pandemic appears to have had limited effect overall on the data presented. Indeed, it may indicate that the arrangements which had developed prior to the pandemic (if not the "historic deal" between NHS England and the Independent Healthcare Provider Network (IHPN) for the private healthcare market to support the NHS (England 2020) were sufficiently robust to enable support to the re-start of elective treatments. So what we observe is that numbers of private providers have increased across all regions as shown in Fig. 6.

Figure 7 suggests that previous findings remain constant, such as a seeming predominance in terms of provider numbers of certain private provider groups (notably SpaMedica and Circle), and a reach for almost all groups across the seven commissioning regions.[36] We note that SpaMedica data is included only from late 2022, despite this provider being active since 2008, and the largest provider of NHS cataract surgery since 2018 (SpaMedica 2025a). A further observation from the 2020–2024 time window is how ISTCs have evolved – from provider codes within the

[35] It is noted that the provider code in the June 2019 MAR data indicates the Ramsay Healthcare group. While Ramsay has been operating in the UK since 2007, its inclusion in, or reporting to, the MAR data appears to follow later.

[36] The exceptions we note at March 2024 are the absence of Ramsay providers in London, and the absence of Practice Plus Group in the East of England and the North East.

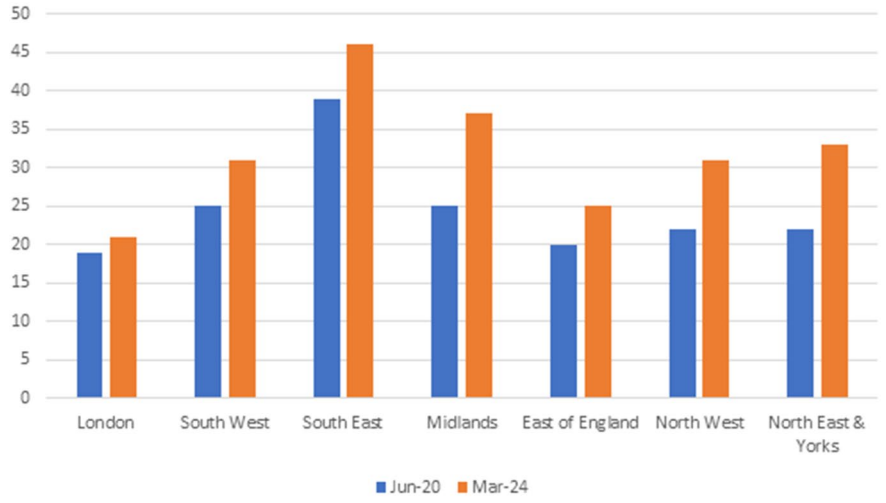


**Fig. 6** Private Provider Numbers across England, June 2020 and March 2024

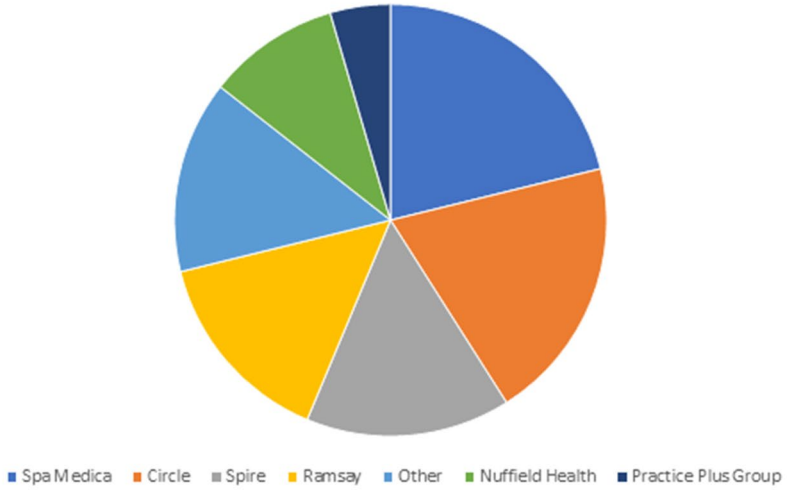


**Fig. 7** Overview of private provider groupings as at March 2024

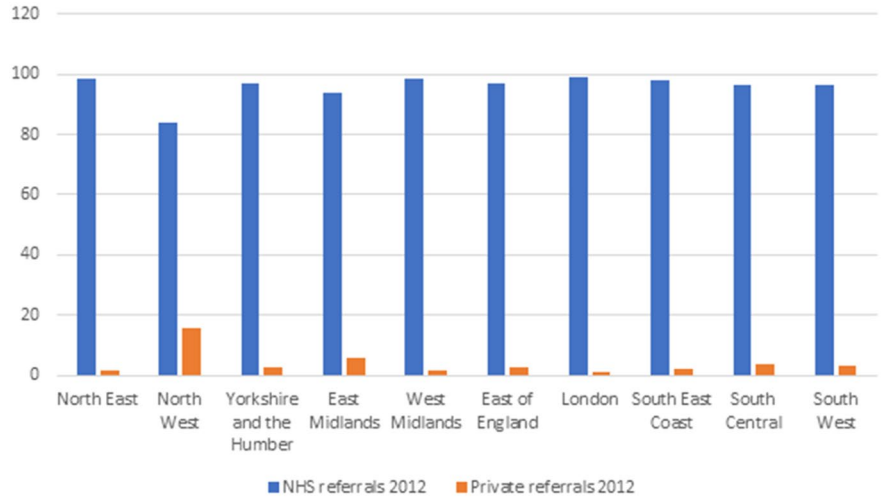


**Fig. 8** Percentage of referrals to NHS and private providers June 2008 and June 2012

MRR datasets it is possible to infer that several ISTCs may have been absorbed into the Practice Plus Group, notably in the South West and London.[37]

Having gained insights into the private healthcare market for NHS patients with regard to the number of non-NHS providers, it is now useful to consider how referral patterns provide further context.

Given the small but growing number of private providers across the initial period of June 2008-June 2012, we may anticipate a low level of referrals to private providers. This appears borne out by Fig. 8, where the overwhelming majority of referrals remained to NHS providers across all areas of England in June 2012. Prima facie, this may lend weight to arguments that awareness among patients needed to be raised of their entitlement to choose an NHS or private provider. A further observation is that private provider referrals across all SHAs at this stage were mostly made by GPs, rather than other practitioners, which may support the view that entrenched commissioning behaviour in the NHS could explain the relatively low level of referrals at this point.

To give a sense of scale, referrals to private providers at this stage are typically in the tens and hundreds, whereas referrals to NHS providers are comfortably in the hundreds and thousands. Nevertheless, it is possible to discern a small but consistent private healthcare market, particularly via the exceptions – for instance, that the InHealth Group Limited in the South already in 2008 and 2009 were receiving referrals in the thousands, as were BMI and Spire in London in 2009 and 2010. We also note that the Southampton NHS Treatment Centre received referrals in the thou-

[37] For example, the Shepton Mallet NHS Treatment Centre had the provider code NTPH1 in 2018, and this code was used for Practice Plus Group Hospital – Shepton Mallet in March 2024. Similarly, the North East London Treatment Centre had the provider code NTP15 in 2012, and this provider code was used for Practice Plus Group Hospital – Ilford by March 2024.

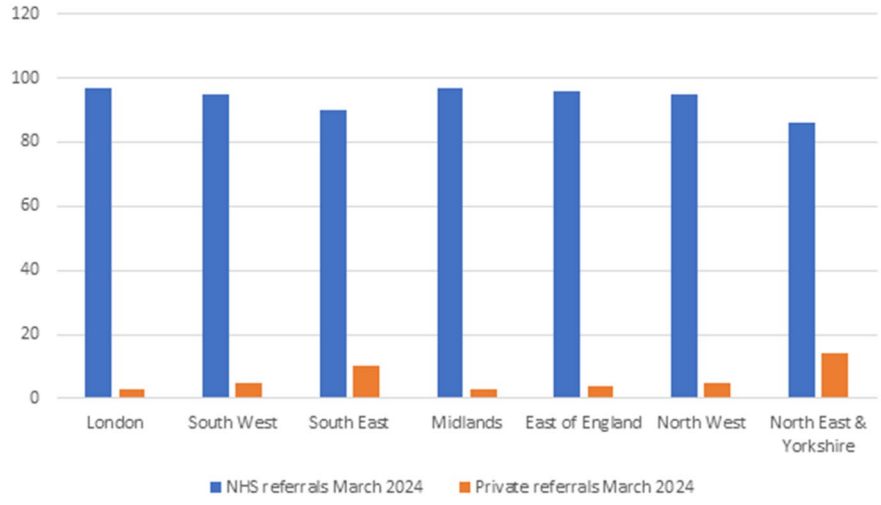


**Fig. 9** Referrals overview, March 2024

sands across 2010, and that the Circle/Nottingham NHS Treatment Centre received a similarly high level of referrals across the 2008–2012 period. This appears testament to the implementation and development of the ISTC programme prior to the MAR dataset.

Following on from this initial period between 2008 and 2012, we have noted above a sense of stability emerging in the private healthcare market for NHS patients in terms of provider numbers. It is notable, however, that the referral pattern observed above remains constant not only over the 2013–2019 period, when the HSCA 2012 reforms enshrined in law the duties to offer choice, and to publicise and promote choice, but also subsequently, as indicated by the following overview (Fig. 9).

A striking finding from March 2024 is how the largest percentage of private provider referrals is in the North East and Yorkshire at 14%, in contrast to 10% in the South East, and between 3% and 5% in the other regions. This may be explained by the emergence of SpaMedica as (one of) the largest providers (in terms of numbers) by March 2024.

Unusually for the MRR, SpaMedica offers an example of a provider which can be identified clearly with certain treatments (optometry). However, SpaMedica's inclusion provides useful insights in two ways. Firstly, regarding referral patterns: the vast majority of referrals are from other practitioners, which could logically include optometrists such as Boots Opticians or Specsavers, rather than GPs. Typically there may be hundreds of referrals from an "other" practitioner, and fewer than ten from a GP in a given month. Secondly, perhaps a more generalisable insight for developing patient choice policies, is how patient transport is facilitated by SpaMedica patient buses, which provide a "door-to-door" service between the patient's home and the SpaMedica clinic (SpaMedica 2025b). This would lend support to the view indicated above that there is a need not simply to create an infrastructure for offering choice, but also to support the facilitation of patients accepting choice.

With the final March 2024 MRR data, we observed that NHS provider and private provider referrals had essentially reverted to pre-pandemic levels, aside from the aforementioned divergence between the North East and Yorkshire, and the South East.

### Limitations of the Study and Possible Future Research Avenues

Our aim was to gain a geographical overview of the private healthcare market for NHS patients as this can provide useful insights which have received less attention in equivalent literature which tends to focus on specific treatments, and to do so at a time when reforms of patient choice are developing. To obtain a picture which does full justice to all the possible components, including, for example, the interaction of private providers with NHS structures in different regions, would clearly be beyond the scope of a single article. This study therefore has some limitations.

By relying on the MAR and MRR datasets, this overview is necessarily constrained by data collection and reporting limitations. This appears to be the case with the aforementioned acknowledgements of sudden "spikes" in data relating to non-NHS providers being included during the summer of 2011, and specifically regarding the inclusion of SpaMedica data only from late 2022. Whether or not this reflects the broadly contemporaneous change in the patient choice legal framework specifying optometrists and dentists alongside GPs as referrers is a possibility, An alternative explanation lies in the acknowledged specific focus on cataract surgery as part of the wider post-pandemic elective recovery plans and dramatic rise in outsourcing of this surgery at this point in time (Royal College of Ophthalmologists 2022; Rowland and Ryan 2024).

The MAR and MRR datasets were selected because of the useful general proxy they provide to consider patients exercising choice in view of the aforementioned legal requirement to offer choice for such appointments, although it is acknowledged that choice in the context of clinical referral does not equate to demand in other markets. The requirement to offer NHS patients an alternative provider for elective treatment where the waiting list target has been exceeded can be similarly linked with a dataset, namely the Referral to Treatment Time (RTT) dataset, which relates specifically to hospital waiting lists (Wood 2021). Indeed, RTT data has enabled the development of narratives in related literature (e.g. Goodair 2023). This could enable a focus on treatment (and potentially also location) at a different point in the patient journey, which could offer a complementary analysis to the findings of the present case study.

## Concluding Remarks

Amid the renewed attention on patient choice in the "NHS 10 Year Health Plan" published in July 2025, this article has examined the development of NHS patient choice policies and concurrent evolution of a private healthcare market for NHS patients in England. It has done so by examining the relevant law and policy, and also conducting a case study based on publicly-available NHS referral data.

Our case study affords three specific insights, and our wider law and policy analysis raises two broader considerations which can inform the development of the new "patient choice charter" and related reforms.

Firstly, the case study indicates a clear emergence and consolidation of a consistent private healthcare market for NHS patients across each NHS commissioning region of England: this forms a significant basis for developing current and future reforms.

Secondly, *who* makes the referral may play a part in the "uptake" of patient choice (whether a GP or an "other" practitioner), as demonstrated in particular by the experience of SpaMedica, although the nature of the treatment may also prove determinative. The identity of the referral-maker, and indeed the nature of the treatment could also have implications for the wording of any future policy or legislation, as will the renewed commitment to waiting list targets (Health Foundation 2025).

Thirdly, data collection consistency, priorities, and principles complicate research in this area and may only tell part of the story – the seeming expansion of the private healthcare market in summer 2011 and inclusion of SpaMedica data from 2022 are testament to this.

### Risk of a "three-tier" Healthcare System

The risk of a "three-tier" healthcare system outlined above arises from the focus thus far of the law and policy framework on offering patients choice. It might be considered that a complementary, response focus can now emerge whereby due attention is paid (or clarified) in law and policy on supporting and facilitating the acceptance of patient choice. It was noted above that transport support initiatives exist, but that it may be difficult to either find out about, or even access, these. Insofar as the SpaMedica model of providing transport to NHS patients may be generalisable to other treatments, there may be scope for private providers to play a role here. Further attention needs also to be paid to ensuring that patients unable or unwilling to access the NHS App are also supported in their entitlement to exercise choice.

It was also noted above that, effectively within the middle (second) tier, if patients with the means to avail of shorter drive times and the NHS App were to exercise choice, this could play a useful role in reducing pressure on the NHS. This should not be underestimated, but may be difficult to reconcile with existing narratives about patient choice as a counter to a "two-tier" healthcare system whereby rich and poor patients are offered the same choice.

### "Patient choice" Does not Just Involve a Responsibilisation of Patients, but Roles for a Diversity of Actors

It is recognised that "patient choice" has potential as an important dimension of patient empowerment, as well as being linked with narratives of patients as consumers. However, the analysis of this article has highlighted the absence of an actionable right for individual patients, as well as the law and policy frameworks defining the NHS-public healthcare dynamic. These indicate that there are not only a variety of parties involved, but also that their interactions may now change amid the wider changes instituted by Labour in 2025.

For example, the Independent Patient Choice and Procurement Panel could continue its role if the DHSC takes over the NHS England oversight function of patient choice, and more explicit attention can be paid at both levels of investigation to whether and how transport considerations are factored in, and how health and digital inequalities are considered in assessments.

Also, despite the post-HSCA 2012 reframing of competition vis-à-vis the NHS, the CMA has continued to incorporate consideration of NHS patients – as noted in its assessment of the BMA/Circle merger discussed above. Further clarity as to whether category 2 activity (private providers treating NHS patients) may generate competition distortions within category 4 activity on the private healthcare market would be welcome. In any case, it is suggested that the private healthcare market for NHS patients identified by the analysis of this article be given more recognition in subsequent merger assessments, and even within an updated private healthcare market investigation, given the significant changes since 2014.

**Acknowledgements** The authors thank Helen Buckingham, David Furness, and Rachel Power for initial project discussions which shaped the development of this research. We are also grateful to Rob Gandy for insightful discussions, and to Lisa Knight for comments on research presentation, and to two anonymous reviewers for comments on an earlier draft.

**Author Contributions** MG wrote the main manuscript text and LN analysed data and prepared figures in the case study. All authors reviewed manuscript drafts.

**Data Availability** Data underpinning the case studies in this article is available here: https://opendata.ljmu.ac.uk/id/eprint/242/Citation information: Guy, Mary and Newcombe, Lee (2025) Mapping NHS patient choice policies across England: Referral data to NHS and private providers, June 2008 – March 2024. [Data Collection]

## Declarations

**Competing Interests** The authors declare no competing interests.

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