Dear Sir/Madam

Policy options regarding competition – EU preliminary opinion consultation

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year.

The Association welcomes the opportunity to respond to the European Commission’s Expert Panel on Investing in Health (EXPH) public consultation on competition among healthcare providers in the European Union. We are broadly supportive of the opinion expressed by the panel, and we hope that our submission will compliment this opinion.

We hope that our submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely

Raj Jethwa

Head of the Health Policy and Economic Research Unit
BMA response to the policy options regarding competition – European Commission preliminary opinion consultation

1. Summary of the main points

- The BMA agrees with the panel’s assertion that neither economic theory nor empirical evidence support the conclusion that competition should be promoted in all health services.
- The BMA believes that competition has been detrimental to service integration within the NHS and between health and social care services.
- The BMA believes that the English NHS is lacking the necessary preconditions for the effective implementation of competition policy as outlined by the panel.
- We agree with the panel’s assertion that accurate information is necessary for effective competition. However, the attempted use of such information to underpin competition within England has proven inaccurate, unwieldy and ineffective.
- The panel asserted the necessity of an effective payment system to underpin competition. It is the experience of the BMA that the payment system that supports competition within the NHS is unsuccessful and has had many unintended and negative consequences.
- We agree with the panel’s assertion that easy entry and exit to the market is a necessary precondition for effective competition. In its current form, the NHS cannot deliver easy entrance and exit to the internal market without negative consequences such as failures of quality. It has been the experience of the BMA that attempts to create these market mechanisms have been disruptive and costly.
- The BMA believes that further fragmentation of the health market could cause significant problems relating to the disruption of coordinated care between health and social care providers.
- It has been the perception of the profession that the European procurement regulations place an onerous burden on commissioners in relation to competition.
- The BMA has raised concerns at the potential of TTIP to commercialise the NHS and to prevent future UK governments from legislating to bring commercialised services back under public ownership or control.
2. Introduction

This submission focuses on competition within the devolved nations of the UK. The panel’s opinion clearly differentiates between different types of competition\(^1\). This submission will focus on competition between providers through competitive bidding for tenders, as well as competition between providers for patients (through patient choice)\(^2\).

This submission will provide the panel with evidence to supplement the panel’s own research, based on doctor’s on-the-ground experience of how competition works in the UK’s National Health Service (NHS).

The UK provides a unique perspective for the study of competition in health systems. This is because of the devolved nature of healthcare and the resultant differing levels of competition operating in the devolved nations\(^2\). Competition within the UK is intrinsically linked to the healthcare delivery structures of the devolved nations\(^3\). Up until 1990, the purchasing and provider functions of the devolved nations were combined and there was no provider competition within the NHS. The creation of the internal market in 1990 introduced competition within the NHS. Since 1999 healthcare powers within the UK have been devolved to the respective nations, and since this time the levels of competition between the devolved nations has diverged. Both Scotland and Wales have moved away from the structural purchaser-provider split, abolishing the split in 2004 and 2009 respectively, whilst it has been retained within England and Northern Ireland. This has meant that competition has ceased to play a role within Scotland and Wales, whilst it plays an ever increasing role in England, and to a much lesser extent in Northern Ireland.

This response will therefore focus on the experience of competition in England. Over the last 25 years the internal market has been growing within the NHS in England. The Health and Social Care Act (HSCA) 2012 further entrenched competitive principles within the English NHS\(^4\). This response will provide the panel with doctors’ experiences and views on the use of competition within the English NHS over this time period.

The panel’s opinion clearly sets out the key perceptions of potential aims for using competition as a policy tool within public healthcare. The most commonly-cited aims are the efficient allocation of resources and using competition as a method of making health systems more responsive to patient needs\(^5\),\(^6\). These aims have not been achieved by using competition in the English NHS.

The panel’s opinion makes a clear and important distinction between patient choice and competition. Whilst some forms of competition inevitably require patient choice as an enabler\(^7\), they are distinct ideas and this response will focus solely on competition. The BMA believes that the panel is right to clearly differentiate between competition and privatisation. However, within the English context, competition

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\(^1\) Using table two of the panel’s opinion, this submission will focus on the provision of clinical services sub-market, on competition among health care providers in a market and competition for the market (e.g. competitive bidding).
and privatisation are inimically linked and it is often difficult to divorce discourse surrounding either subject within the context of the NHS.

Within the UK there are diverging views on the degree to which competition should be used within the NHS. Competition can thus be viewed within the English context as an end in itself, and conversely as an unacceptable ideologically-based intervention within the NHS. The BMA takes an evidence-based approach to our policies on competition. Whilst the aims of many policy makers may be good, the utilisation of competition in the NHS has had many detrimental impacts on the English NHS, such as an increased fragmentation of services, and should be abandoned as a policy tool. This submission will outline the evidence upon which we have based our policy position.

The panel has stated within its opinion the conditions that are seen as necessary for competition to be a useful policy instrument across countries, health systems, sub-sectors and time. The BMA is primarily concerned with the sub-market of clinical services, and we agree with the panel’s assertion that this sector is less favourable than others for the introduction of competition.

3. European procurement law and competition

European procurement law has had a direct impact on competition policy within the United Kingdom. The effect of the European legislation is similar to the Section 75 Regulations that were passed as a result of the Health and Social Care Act 2012. The obligations between the European and domestic legislation overlap in many aspects. The section 75 regulations derived from the Health and Social Care Act have an onerous and detrimental impact on the NHS.

Over recent years there has been considerable confusion in the NHS regarding the tendering process, with many commissioners and providers being unsure of the best way to proceed. This has led to a climate of instability within the health service, unnecessary tenders and increased litigation costs both from an advisory point of view and from increased legal challenges to decisions. This climate of instability would be countered if the NHS had the freedom to be the preferred provider of services, without worrying about commercial tendering. Some voluntary and not for profit services such as hospices seek to complement rather than supplant existing services and where they are successful they should work in an integrated fashion with NHS services within the local area. Where private or commercial-sector providers are already delivering services to NHS patients, commissioners must first ensure these services are coordinated with local GP, hospital and other NHS services and look at establishing the NHS as preferred provider in the future.

It is the perception of the profession that the European procurement regulations, combined with the section 75 regulations place a too onerous burden on commissioners. We believe that the procurement legislation should allow for greater freedom of commissioning and procurement within the English NHS and that competition should not be enforced upon NHS commissioners.
The adverse impacts of competition policies

4. Fragmentation of services

The BMA agrees fully with the panel’s assertion that neither economic theory nor empirical evidence support the conclusion that competition should be promoted in all health services. Competition is unlikely to achieve improvement in all aspects of health system performance at the same time, and can have unintended negative consequences that outweigh its usefulness as a policy instrument.

The expert panel advises against policy measures to introduce (or increase) competition without careful prior assessment of conditions for improvement in health system objectives and probable effects. We are broadly supportive of this assertion. Any policy intervention within the health system should have a sound evidence base. The panel clearly states that the introduction of competition policies can have unintended adverse effects when they are introduced without a rigorous assessment of conditions. This has certainly been the case in the NHS.

One of the main unintended consequences has been the impact that competition has had on service integration. There has been considerable debate about whether competition is harmful to the integration of services. There are staunch supporters on both sides of the argument, however, the experience and belief of doctors that competition within the English NHS has been detrimental to the integration of clinical services.

It is necessary to define what we mean by the term integration, as the term has many nebulous connotations and variations. The BMA take a patient-centric view of integration and has accepted the National Voices definition of integration:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me”
Whilst the absence of competition does not automatically mean that integration will occur and work well, the rigid enforcement of competitive principles does appear to have a negative impact on integration. Repeated surveys of member opinion undertaken by the BMA have demonstrated that the profession has interpreted the implementation of competitive principles within the NHS as harmful to service integration. Following the implementation of the Health and Social Care Act 2012 the BMA surveyed member opinion on the impacts of the Act:

Question: As a result of the introduction of the Health and Social Care Act 2012 have you experienced any changes that affect how you now plan or deliver care? If so what has the change been?  

The Act further entrenched competitive principles within the NHS, and the impacts as discerned by our members suggest that the use of competition within the NHS has further fragmented services. The creation of a payments system to support competitive principles has also been associated with the fragmentation of the delivery of services (see section 7).

The BMA runs quarterly surveys of doctor opinion on key issues through a dedicated research panel, we would be happy to work with the European Commission in undertaking further research of doctor opinion on competition policy.
5. Health and social care fragmentation

Users of social care services in England are almost always heavy users of NHS services. The two markets are interdependent, and problems can occur within either sector if there is a lack of coordinated working or capacity within either service. The further fragmentation of the health market could cause significant problems for coordinated care between the two markets. The impact on the relationship between health and social care providers should be at the forefront of policy makers’ minds when proposing and implementing competition policies. This section will outline the state of the social care market and the fragmentation of the relationships between health and social care providers as a result of competition.

In England health and social care are commissioned and provided separately. The social care market has, however, significant crossover with the health care market. There is an obvious synergy between services such as nursing and care homes, and NHS continuing care often blurs the boundaries between health and social care. There are areas where care crosses over, but is largely provided in the social care setting, the most prominent examples are care for dementia, Parkinsons disease and end of life care.

The King’s Fund has argued that the current split of care along these institutional lines results in an inequitable financial burden being placed on certain patients, depending upon which condition they have. The King’s Fund compares cancer and dementia; they argue that both conditions have similar burdens on the patient and their families from a healthcare perspective, however financially those suffering from dementia will pay a very large contribution to their care whilst cancer sufferers will not.

In recent decades the provision of social care has radically shifted from mostly being provided by the public sector, to mostly being provided by the private sector. Social care was never nationalised, but was previously provided in the main through the public sector. This has dramatically changed over the last three decades. In 1979 the proportion of residential and nursing care services provided publicly was 64%, by 2012 this was just 6%. Publicly provided home care services made up the majority of provision as recently as 1993 with the private sector providing only 5% of care; by 2012 private provision had risen to 89%.
Social care makes up a large proportion of local authority and government spending. A total of £17 billion was spent in the 2012/2013 financial year, providing support for 1.3 million people. The breakdown of social care spending by means of provision can be seen in the graph below:

There is significant variation in how social care is funded. Around 400,000 people are estimated to be paying for their own care; however, data on the exact number is currently lacking. A study from Leeds University for Carers UK has estimated that the value of informal care in England is the equivalent of £119 billion annually; this is based on the average cost for paid home care in England in 2009/10. If these figures are accepted, this is more than the annual budget for the NHS. There is often little recognition of this form of care, there is little research on the extent of the issue, and there is little support available for those providing such care.

The recently passed Care Act 2014 provides for a new failure regime specifically for adult social care services. This compares and contrasts with the failure regime outlined later within this submission for health-care services (see subsection 8.1). The panel should simply be aware of the separate mechanisms for exit from the market within these two interrelated markets within England.
The profession believes that the split between health and social care providers creates conflicting organisational priorities which can directly harm care coordination. The BMA has found through surveying our members opinion that competition can be a barrier to achieving joined-up care:

<table>
<thead>
<tr>
<th>Conflicting organisational priorities</th>
<th>82%</th>
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<tbody>
<tr>
<td>Lack of coherent information technology systems</td>
<td>63%</td>
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<tr>
<td>Lack of leadership (managerial)</td>
<td>54%</td>
</tr>
<tr>
<td>Competition between providers</td>
<td>49%</td>
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<tr>
<td>Ineffective commissioning</td>
<td>48%</td>
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<tr>
<td>Separation of purchasing and provision (England only)</td>
<td>47%</td>
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<tr>
<td>Concern over destabilising existing services/facilities</td>
<td>46%</td>
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<tr>
<td>Lack of leadership (clinical)</td>
<td>44%</td>
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<tr>
<td>Poor professional relationships</td>
<td>43%</td>
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<tr>
<td>Payment by results/national tariff</td>
<td>43%</td>
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<tr>
<td>Lack of capacity in primary care</td>
<td>35%</td>
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<tr>
<td>Resistance from secondary care</td>
<td>28%</td>
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<tr>
<td>Patient choice</td>
<td>26%</td>
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<tr>
<td>Other (unspecified)</td>
<td>5%</td>
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The profession believes that the benefits of achieving integrated care from the patient’s perspective outweighs any potential benefit from successfully implemented competition policies. Successful joined-up working between health and social care providers is essential to providing good care for many patients that have needs from both services. These patients are often the most vulnerable, and policies should focus on how to provide their care in the joined up fashion that their needs require.
Preconditions for the use of competition as a policy tool

It is the view of the BMA that the use of competition within the NHS has been based on misguided aims and objectives, and that the conditions within the NHS are not conducive to successful provider competition. The conditions under which competition can be useful within healthcare are well articulated by the panel. The English NHS lacks these preconditions and is structurally unsuitable for effective provider competition. In this section we hope that our submission can be of use to the panel in highlighting areas where competition is not an effective policy tool.

6. Quality indicators for enabling competition

Within England there is no accurate information available to enable effective competition. The complicated nature of the delivery of services within the English NHS prevents the creation of effective metrics to enable accurate comparisons of services, and attempts to produce such metrics have been policy failures in this respect. The panel has asserted in its opinion that accurate information is critical for effective competition. Under certain circumstances, adequate market information (namely about the quality of care) is a necessary prerequisite for the effective implementation of competition policies. The information requirements for different methods of competition are markedly different. This section will focus on the information requirements for competition among health care providers for patients within a market underpinned by patient choice.

The use of patient directed information to support competition policies within the context of England has highlighted systemic problems with the implementation of competition policies in England. This section will highlight several attempts that have been made within the English NHS to provide patient directed information to underpin patient choice and competition within the internal market.

6.1 Care Quality Commission (CQC) Ratings

In England the CQC now provides an overall rating for services provided by providers of NHS services. An overall performance rating is simplistic and cannot adequately capture the complexities of delivering healthcare services. For example, the list of core services that the CQC will ordinarily inspect in an acute hospital, or the key patient groups in a GP practice, does not cover the entire spectrum of care delivered by that provider. An overall ‘requires improvement’ or inadequate rating might conceal areas of excellent care within that provider. Of course, the converse would also apply, that an overall ‘good’ or ‘outstanding’ rating might conceal areas of poor care.

The Nuffield Trust’s report Rating providers for quality: a policy worth pursuing?, commissioned by the Government in 2012, advised that “unless there is a ‘health warning’ on a rating to clarify to the public what it can and cannot say about the quality of care, there is an inevitable risk that the rating (and the rating organisation) will be discredited...”.
The frequency of CQC inspections – ordinarily no more than every three years 42 - will mean that the CQC rating that is displayed by providers will not reflect ongoing service improvements or deteriorations. The Nuffield Trust also recommended that “ratings should be updated regularly and made available in a timely way”. This is another example of how the necessary prerequisites for competition between providers are not being, and likely cannot be, met within the English NHS. This experience demonstrates the difficulties in obtaining relevant data to enable effective comparison between providers and in collecting this data in a timely and cost-effective fashion.

There are further impacts resulting from this form of information gathering and ratings systems. A well-recognised consequence of the former star rating system introduced to the NHS in 2000 was the damaging effect it had on staff morale 43. The impact on staff morale that such ratings and similar forms of information can have should not be underestimated, especially given the concerns surrounding accuracy and frequency that are inherent with this form of supporting information.

6.2 Quality Accounts

Quality accounts are annual reports concerning the quality of services provided by publicly-funded healthcare providers. All providers “of relevant health services” that are publicly commissioned need to provide a quality account, and these include all publicly-provided health services excluding primary and continuing care along with small organisations whose contracts are less than £130,000 or employ less than 50 staff. The account includes reports against various mandatory and selected quality indicators such as ambulance response times and rates of C Difficile infection. Other information within quality accounts includes: research, clinical audits, targets adherence, future plans for quality improvement and a review of previous performance 44.

Quality accounts have detailed, and onerous, assurance processes. Quality accounts are now required to be externally audited and, alongside this, assurance statements are required from Clinical Commissioning Groups (CCGs), Monitor and CQC and are recommended from Overview and Scrutiny Committees and Health Watch organisations. Providers also have to include statements on data quality and provide breakdowns on specific indicators45. Quality accounts can be hundreds of pages long and are not easily digestible by patients; they contain complex reports and are neither easily accessible nor directly comparable, despite attempts to enforce uniformity between provider reports. Whilst quality accounts provide a fuller picture as to the quality of care within an organisation, the sheer volume of information, whilst still not providing enough service specific information, makes them unsuitable for use to enable competition.

6.3 Friends and Family Test

Another metric used to better support patient choice and, indirectly, competition between healthcare providers, is the Friends and Family Test (FFT).
The Friends and Family Test is being implemented across all NHS services in England and is seen as integral by NHS England to its business plan for 2013/14 – 2015/16. It was first announced by the Prime Minister in January 2012; it was rolled out in acute Trusts in April 2013 and is being rolled out across all NHS services over the coming months and years. It is a simple metric; the question simply asks “how likely are you to recommend our A&E department/ward/GP practice to friends and family if they needed similar treatment?” Patients score the service from 1 to 6 which represent extremely unlikely to extremely likely. These scores are calculated to produce a ‘net promoter score’.

The scores are collected by service providers and collated and published by CCGs. Because of the simplistic nature of the metric, the idea is that services are directly comparable. This has given rise to the publication of lists of ‘failing services’, for example, 36 wards were listed as failing the FFT which gained significant attention in the national press. In practice the methodology has been questioned; many of these wards, for instance, had less than 10 responses for the FFT, often only receiving one or two negative reviews which distorted the reporting.

The Friends and Family Test was developed to test consumer satisfaction with products and is overly simplistic as a rating system and information basis for effective competition policies within health services. The metric fails to provide the context in which care might be being delivered. It is also an unsuitable metric upon which to base competition policies. The simplistic nature of the metric fails to take into account the difference between the provision of health services compared to less complicated markets for which the test was developed.

6.4 Conclusions on competition metrics

The information that is currently used to underpin provider competition within the internal market of the NHS supported by patient choice is not, and cannot be, sufficient to support effective competition. One common theme across all of the metrics currently used within the NHS is that they are too simplistic. Understanding, measuring and providing appropriate information that supports the patient experience and accurately describes the quality of care within provider organisations is complicated, and cannot be disaggregated from the overall organizational performance, or be reduced to it.

Providers of NHS care offer multiple clinical services out of necessity. Attempts at creating provider level information metrics of performance for these organisations over-simplifies the complex nature of the delivery of healthcare services. Whilst this information can certainly be refined and improved upon, the complex nature of health care delivery means that meaningful comparisons between service providers are difficult to make. Whilst providing better and more accurate information for patients should of course be a priority for its own sake, using such information to underpin competition has been proven inaccurate, unwieldy and ineffective in England.
7. Payment systems and costing

The panel has made it clear within its opinion that a payment system based upon good and accurate information is essential for enabling a competitive market. Competition within the acute setting of the NHS in England is underpinned by the National Tariff Payment System. Prices within the tariff are refreshed annually by NHS England and Monitor and are subject to consultation with both providers and commissioners. There have been many problems associated with both the costing and implementation of the payment system.

Whilst the payment system has been credited in some quarters as contributing to a reduction in waiting times, there have been many negative unintended consequences associated with its implementation.

One of the principal concerns is that the tariff system encourages silo working among providers and is directly harmful to collaborative working. Doctors have repeatedly asserted that the tariff payment system can act as a barrier to integrated working:

August 2014 Omnibus survey – Question: In general what impact do you think the national tariff has had on collaborative working between secondary and primary care?

This survey, undertaken by the BMA, demonstrated that 61.4% of our member respondents believed that the tariff has made collaborative working more difficult, whilst only 2.7% believed that it made collaborative working easier.

It has also been the experience of the BMA that the payments system is frequently used as a policy tool to affect provider and commissioner behaviour within the NHS. This has led to great uncertainty, particularly for healthcare providers. The payment system has been used to achieve specific policy goals. The enforcement of efficiency savings through the use of a blunt “efficiency factor” reduction in payments is one of the principal reasons for a significant downturn in financial performance within the provider sector. From a position of a surplus of £1.6 billion in 2012/13, the sector has had a
dramatic reversal in its financial position, with the FT sector reporting deficits totalling £396 million, and the NHS trust sector reporting deficits of £247 million\(^61\). This is over eight times higher than the figure of £79 million cited as the worst case scenario in the tariffs 2014/15 impact assessment\(^62\). In total, 107 NHS acute and foundation trusts may end the year in deficit; this is close to half of the entire sector. At the time of writing 77% of acute FTs are in deficit, with more likely to enter deficit in the near future.

The provider sector also remains unconvinced as to the quality of data used within the tariff. In early 2015 the provider sector rejected the national tariff due to disagreements concerning the methodology underpinning the tariff\(^63\). Many concerns were raised about the quality of the data\(^64\), as well as the use of the payments system to push certain policy goals. The payment system is viewed as a policy tool, decisions made within the tariff can frequently distort the market, and the annual nature of its review also leads to uncertainty and inhibits long-term strategic planning\(^65\).

The development of a payments system to support competition within the NHS has been unsuccessful and has had many unintended and negative consequences.

8. Easy entry and exit into the market

The panel has made it clear within its opinion that easy entry to the market is necessary for successful utilisation of competition policies. The nature of the English NHS and the necessity of strategic planning of large-scale health economies means that there is no easy entrance or exit from the market for such providers\(^66\).

8.1 The failure regime and exit from the market

Within England a single failure regime has been developed over recent years for public providers of secondary care, namely NHS Trusts and Foundation Trusts, based on either financial or quality of care failure\(^67\). The failure regime is underpinned by a process of risk assessment run by the financial and governance regulator, Monitor\(^68\), and quality regulation through the CQC. In theory these regulators monitor providers’ performance and attempt to intervene at an early stage to prevent any severe governance, financial and quality failings within the English NHS. In practice, such regulation has not always been successful in averting failure, particularly on quality\(^69\).

Independent providers of NHS services have their financial and governance risk monitored in a different way from public providers. Credit agency risk ratings are used in place of establishing Monitor’s own independent risk assessment ratings. Concerns have been raised that using credit agency risk ratings as an alternative to applying Monitor’s risk assessment framework removes accountability for financial risk assessment\(^70\). Concerns have also been raised that credit agency assessments do not take into account the complex requirements mandated for providers of core NHS services, neither do they take into account the unique nature of these providers, including a focus on patient safety. This disparity of regulation between different types of providers further distorts the market, placing greater regulatory burdens on public providers of NHS care relative to private providers.
The failure regime is used as a last resort for when such interventions fail, and to date has only been implemented twice\textsuperscript{71,72}. Implementing the failure regime has also proved costly, with the process in Mid Staffordshire costing an estimated £19.5 million over 18 months\textsuperscript{73}. The failure regime is expensive and time consuming. It is, however, necessary given the current structure of the NHS to ensure the continuity of services for patients\textsuperscript{74}. There is thus no effective, equitable or easy exit of secondary care providers from within the English NHS.

8.2 Entry into the market

It is often viewed as challenging for new providers to enter into the market and to provide NHS services\textsuperscript{75}, although in recent decades it has been considerably easier for new providers to enter the market. Since the enactment of the 2012 Act, for example, a significant number of new providers have entered the market\textsuperscript{76}.

Evidence on the impact of competition via entry of new providers is lacking. There are currently no quantitative studies comparing the efficiency of Independent Sector Treatment Centres (ISTCs) relative to existing providers with which they were introduced to compete.

The only evidence on quality of outcomes shows no significant differences for three types of routine day case surgery, after adjusting for case-mix\textsuperscript{77}. New providers seeking to enter the system (largely from the private sector) often “cherry pick” profitable services, leaving public providers to provide less profitable services\textsuperscript{78}. We have found that this can destabilise public providers of healthcare and can have potential knock-on effects to other clinical services\textsuperscript{78,80}.

Other studies have found that patients treated in ISTCs are more likely to need further care, often in NHS hospitals, and that ISTCs could damage the local health economy, profiting from NHS funding by explicitly choosing to treat only less risky patients, while being paid the same rate as publicly funded hospitals\textsuperscript{81}.

It has also been found that ISTCs present weaker learning environments than NHS trusts and do not reproduce cooperation across organisational boundaries to the same extent as incumbent NHS providers\textsuperscript{82}.

It is evident that new entrants to the internal market of the NHS can underbid (only with services outside the tariff) to secure tenders and contracts. The drive to find new efficiencies within the NHS and the use of price competition in an attempt to achieve this has led to many policy failures within the NHS. Outlined below are two case studies of where the use of competition have been attributed to severe service failure within the NHS.
Case study NHS 111

NHS 111 is a non-emergency number medical helpline operating within the NHS. This service is available 24 hours a day every day and is intended for urgent but not life-threatening health issues.\(^{83}\)

NHS 111 replaced a long-existing nationally procured service in the form of NHS Direct.\(^{84}\) The creation of NHS 111 opened up the provision of this service to competition, both between public providers and new private sector entrants to the market.\(^{85}\) What ensued has been dubbed as a “race to the bottom” with quality concerns being ignored in favour of providing a cheaper service, with tenders being won and lost on this basis.\(^{86}\)

The most obvious example of a quality reduction as a result of the introduction of NHS 111 was the removal of the link between out-of-hours services from call handling. Another example is the lack of clinically-trained call handlers within the service.

During the tendering process for NHS 111, commissioners were asked to select successful contract bids despite not yet taking on full responsibility for the commissioning of services. Many commissioners had not been authorised or did not have fully-formed Boards when the procurement processes for NHS 111 was completed. It is unlikely that those commissioners would have been able to consider the planning, procurement or implementation of any service to a sufficient degree.\(^{88}\)

Serious problems were encountered with NHS 111 when the system was launched in a number of areas, which included Greater Manchester, parts of London, the West Midlands and the North East of England. There were a considerable number of calls abandoned in the initial stages of the project.\(^{89}\) There were also a considerable increase in the number of calls referred to GP services, and a considerable increase in the number of calls referred to A&E services.\(^{90}\)

Media coverage, including the Dispatches programme Undercover in NHS 111, demonstrated understaffing, both by ‘Healthcare Assistants’ and clinicians, and patients were left waiting an unacceptably long time to receive advice.\(^{91}\)

Another development was the announcement that every 111 contract held by NHS Direct would have to be re-tendered, at great expense, less than a year after the tenders were awarded.\(^{92}\)

There are multiple lessons relating to competition that can be learnt from the creation and failures of NHS 111. It would be inaccurate to blame all the failings of NHS 111 on competition, however competitive principles were an integral part of this failure. The focus on cost reduction led to
under-bidding and resulted in services which did not meet the required clinical standard. The separation of the service from out-of-hours providers has also introduced an artificial split within NHS services, making coordinated working harder for NHS staff.

Case study Hinchingbrooke Hospital

Hinchingbrooke Hospital is a small district general hospital in Cambridgeshire. It covers a wide range of services including an accident and emergency department. It was formally administered by an NHS Trust which had long-standing financial problems. In 2010 a franchise for Hinchingbrooke Hospital was put out to commercial tender, this tender was won by Circle Health. Circle began administration of the hospital in 2012.

The aim of the tendering exercise was that the trust’s financial problems could be reversed through savings proposals, whilst improving the quality of care.

Soon after Circle took control of the franchise it was found by the National Audit Office that the relative risks had not been considered fully by NHS East of England (the procurer of the services), and that the process had encouraged overly-optimistic bids.

Circle appeared to have some initial success with Hinchingbrooke, however this success was short lived. In 2015 a CQC report into the hospital discovered substantial quality failings and recommended that the hospital be placed in special measures after it was rated ‘inadequate’. The hospital’s finances also deteriorated rapidly. The head of hospital inspection was quoted as saying:

“It was one of the worst inspections that I had ever been to. I drove home and wanted to drive back again with my nurse’s uniform on to sort it out”.

In early 2015 Circle announced its intention to pull out of Hinchingbrooke Hospital. The franchising of Hinchingbrooke Hospital has been a failure of quality as demonstrated by the CQC report as well as encouraging a deteriorating financial position. There is also uncertainty about the future direction of the hospital and continuing concerns about the quality of care.

With the example of Hinchingbrooke the distinction between competition and privatisation needs to be made. It is clear however that the tendering process encouraged overly optimistic bidding based on solving the hospital’s financial problems. The winning proposal from Circle was not capable of delivering the required reductions in expenditure whilst maintaining the service at the required standard.
8.3 Conclusion on easy entry and exit to the internal market

The NHS has no process for an easy exit from the market. The current process is disruptive and very expensive but it is necessary within the current architecture of the NHS to ensure the continuity of services. The failure regime demonstrates the problems of applying competition within the NHS. As the panel has clearly stated, effective competition requires easy entry and exit for providers. However the complexity of NHS healthcare economies precludes any easy exit from the system due to concerns around continuity of services. The English ‘experiment’ in attempting to provide an internal market in which providers can exit the system has highlighted this incongruence, and has consequently delivered an internal market where there is no easy exit.

Easy entry to the market has provided different problems. The use of competition and the desire to introduce new entrants into the market based on lowering the cost of provision has led to several instances of failures of quality and worsened financial situations.

The NHS cannot deliver easy entry to and exit from the internal market without negative consequences. Attempts to create an artificial market in this fashion have been disruptive and costly.

9. International treaties and competition

Many concerns have been raised concerning the applicability of international trade treaties to the provision of healthcare services within the United Kingdom. Many of the concerns relate to competition, and the potential for the increased use of competition within the NHS.

The BMA has lobbied the European Union and argued that the substantive standards of protection should clearly exclude the provision of healthcare services from the scope of application of the TTIP, in the same way as there is already a carve-out in the TTIP for the audio-visual sector. This would reflect the existing carve-out of healthcare services from the Services Directive (see recital 22 and Article 2(f) of Directive 2006/123/EC of the European Parliament and the Council). It would also be consistent with the case law of the Court of Justice of the European Union which has held that entities engaging in public healthcare services provision are not to be regarded as engaged in economic activity and thus are not subject to the EU competition rules (Case C-205/03 P FENIN v Commission [2006] ECR I-6295).

One of the chief concerns behind the agreement is the potential to open up the NHS to further competition, and to prevent potential health reforms within the UK designed to restrict the use of competition. The BMA has therefore raised concerns at the potential of the TTIP or other free trade agreements to commercialise the NHS and to prevent future UK governments from legislating to bring commercialised services back under public ownership or control.
10. Conclusion

The use of competition within the NHS in England is a failed policy experiment. The necessary preconditions for the effective implementation of competition policies, as outlined by the panel, do not exist within England. These preconditions cannot exist without fundamentally changing the way the NHS operates and is structured, which would in itself undermine the founding principles of the NHS by threatening the publicly provided nature of the health service.

We believe the panel’s review is of vital importance and we hope that the evidence we have submitted is useful for the panel’s deliberations. The BMA would be happy to work with the panel further if we could be of assistance.

References


