Written evidence from Dr Abert Sanchez-Graells

Submitted 8 March 2019
By Dr Albert Sanchez-Graells
Reader in Economic Law
University of Bristol Law School

Executive Summary

1. The legislative proposals to support the implementation of the NHS Long-term Plan need to be assessed against the background of the ‘NHS internal market’, where some NHS entities act as purchasers and other NHS entities act as providers of healthcare services.
2. Given its nature of a market, the proper functioning of the ‘NHS internal market’ can only be fostered through enforcement of competition law and strict compliance with procurement rules.
3. The legislative proposals to support the implementation of the NHS Long-term Plan seek to effectively exempt the ‘NHS internal market’ from competition enforcement and oversight and to exempt the award of contracts between NHS entities from compliance with procurement law, which would be replaced by an unspecified new ‘best value’ test.
4. The proposal to suppress current competition enforcement and oversight mechanisms is not coupled with the formulation of an alternative regulatory mechanism, which could result in unfettered discretion for NHS Improvement.
5. The proposal to suppress procurement requirements is underpinned by unmerited arguments and all the advantages identified in the under-developed new “best value” test are achievable under the current rules. Moreover, the exclusion of the award of contracts between NHS entities from the Public Contracts Regulations 2015 is legally inviable.
6. The legislative proposals to support the implementation of the NHS Long-term Plan limit themselves to the de-regulation of the ‘NHS internal market’, without formulating an alternative governance architecture. This could result in NHS Improvement’s and NHS England’s unfettered discretion in the operation of the ‘NHS internal market’, with unforeseeable effects in terms of its performance and the adequate governance of the NHS.
7. A strategy that is solely de-regulatory such as that underpinning the NHS Long-term Plan should be opposed by the House of Commons Health and Social Care Select Committee.
Submission

This document provides the House of Commons Health and Social Care Select Committee with written evidence concerning the legislative proposals put forward by the NHS England Strategy & Innovation Directorate and the NHS Improvement Strategy Directorate to support the implementation of the NHS Long-term Plan (hereinafter ‘the document’). This submission concentrates on the proposals related to existing competition law and public procurement legislation.

This submission substantiates that the proposed legislative changes would not result in a dismantling or transformation of the ‘NHS internal market’, but in its almost complete de-regulation. This would remove important checks and balances and could result in NHS Improvement’s and NHS England’s unfettered discretion in the operation of the ‘NHS internal market’, with unforeseeable effects in terms of its performance and the adequate governance of the NHS. These would be undesirable changes to the existing legal framework, which the Committee should oppose.

1. Background

Before assessing the specific legislative proposals in the document, it is necessary to place them in the context of the ‘NHS internal market’ (section 1.1.), as well as in relation to the current rules on NHS procurement (section 1.2). This will stress the important governance functions that competition and public procurement law develop in the context of the ‘NHS internal market’, as checks and balances.

1.1. NHS internal market and competition law

Since the 1990s, in England, the activities of the NHS have been characterised by a peculiar purchaser-provider split that is absent in equivalent healthcare systems of other EU jurisdictions. In England, some branches of the NHS act as purchasers or commissioners of healthcare services (currently, clinical commissioning groups, or CCGs, within the broader context of the Sustainability and Transformation Plans, STPs), while other branches of the NHS (trusts and foundation trusts) act as providers of healthcare services and compete amongst themselves and, in some markets, also with private providers. These activities are overseen by NHS Improvement as sector regulator, with the Competition and Markets Authority (CMA) retaining important concurrent and oversight powers.

The NHS purchaser-provider split created an ‘NHS internal market’ to generate competition-based incentives for the improvement of service delivery and cost management. However, the system has been permanently evolving, and this has both created increased scope for public-private competition, and notable difficulties in keeping pace with the successive waves of re-regulation.

---

Given the organisation of the system as a mixed (quasi) market with public and private suppliers in different forms of competition for different types of healthcare services, a number of NHS activities are subject to competition law. On the whole, this results in a regulatory setting that is commonly criticised as imposing significant constraints on the way NHS activities are carried out.

Regardless of the accuracy of such criticisms, it is important to stress that competition-based constraints ultimately result from the existence of the purchaser-provider split and the establishment of a mixed (quasi) market for healthcare services. Unavoidably, the use of a market as a regulatory mechanism to foster the efficiency and quality of the NHS requires the application of competition law to the NHS. The proper functioning of the NHS internal market can only be ensured through competition law enforcement and oversight. Freeing the NHS internal market from competition law enforcement would not improve its governance in the absence of alternative regulatory mechanisms.

1.2. NHS procurement

There are two separate dimensions of NHS procurement that need to be differentiated.

First, there is a dimension that concerns procurement within the ‘NHS internal market’. Given the purchaser-provider split, NHS contracts between entities on both sides of the NHS internal market (as well as between NHS purchasers and private providers) qualify as public contracts and their award is thus subjected to procurement law. In particular, this dimension is regulated by the *Health and Social Care Act 2012* and the *NHS (Procurement, Patient Choice & Competition) No 2 Regulations 2013*, as well as by the *Public Contracts Regulations 2015* (hereinafter the ‘PCR2015’). \(^5\)

Second, there is a separate dimension of NHS procurement that mainly concerns the acquisition of equipment and supplies needed for the provision of healthcare services from outside the ‘NHS internal market’. Here, the contracts are mostly awarded by NHS providers (i.e. trusts and foundation trusts) to non-NHS entities. This dimension is (primarily) subjected to the PCR2015. It is worth noting that there is a growing level of centralisation of this dimension of NHS procurement, and the ‘New Operating Model’ for the NHS supply chain that is being rolled out aims to double the level of NHS expenditure channelled through centralised procurement by 2022. \(^6\)

Concerning the first dimension of NHS public procurement, it is worth stressing that, while the existence of the NHS internal market formally triggers the applicability of procurement law, there are clear possibilities to exempt intra-NHS contracts from compliance with (all or most) procurement requirements derived from the PCR2015 on the basis of existing exemptions for public-public cooperation and *in-house* providing arrangements (see below section 3.2). Conversely, given that the second dimension of NHS procurement involves the award of contracts beyond the NHS remit, it is necessarily subjected to full compliance with procurement law. The document does consistently not include any proposals concerning this second dimension of NHS procurement.

It is worth stressing that the procurement rules applicable to NHS expenditure seek to ensure the integrity of the procedures for the award of contracts and the achievement of value for money in a manner consistent with the patients’ interest. Suppressing procurement-related requirements could thus result in an erosion of the integrity and the efficiency of the system and, ultimately, in risks of

---

\(^5\) However, the interaction between both sets of rules is not clear, as discussed in A Sanchez-Graells, ‘New Rules for Health Care Procurement in the UK. A Critical Assessment from the Perspective of EU Economic Law’ (2015) 24(1) *Public Procurement Law Review* 16-30.

maladministration of public funds. The substitution of existing mechanisms for largely equivalent mechanisms would not improve procurement governance and would create unnecessary costs.

2. Almost absolute exemption from competition law analysis

In part 1, under the heading ‘Promoting collaboration’, the document effectively proposes to create an extremely broad exemption from competition law enforcement for the NHS. The proposals seek to: (i) end the role of the CMA in the review of NHS mergers (point 4), (ii) suppress NHS Improvement’s competition law powers and duties (point 5) and (iii) suppress the need to involve the CMA in disputes concerning the National Tariff Payment System (NTPS) and, in particular, licensing and pricing decisions taken by NHS Improvement together with NHS England (point 7).

The connection between these proposals and the claimed goal of ‘promoting collaboration’ is unclear, even if one reads the NHS Long-term Plan alongside the more specific legislative proposals. What is clear, however, is that the combined effect of such changes would be to (almost) completely insulate the NHS from competition law enforcement. Ending the CMA’s role in the review of NHS mergers and contested modifications to the NTPS, and simultaneously freeing NHS Improvement of its competition law duties would suppress all practically relevant competition law-based checks and balances and would leave the management of the NHS internal market exclusively at the unfettered discretion of NHS Improvement and NHS England.

This could result in a practical impossibility to challenge—except in judicial review proceedings—decisions affecting both structural (mergers) and operational (NTPS) aspects of the functioning of the ‘NHS internal market’. Moreover, freeing NHS Improvement from its competition duties would remove competition as a relevant factor in the formulation and implementation of policies concerning the management of the ‘NHS internal market’. Functionally, this would devoid the latter of any meaning as a market-based mechanism of governance and would rather replace competition-based criteria and analysis with purely regulatory policy and decision-making procedures. However, by contrast with other regulated sectors, the activities of the regulator would be shielded from scrutiny by the CMA. The neutralisation of the current competition-based governance of the ‘NHS internal market’ would be compounded by the proposals on the establishment of joint CCG-NHS providers committees detailed in part 6 of the document. On the whole, this would result in significant risks to the proper functioning of the ‘NHS internal market’, which raise important questions as to the justification of its continuity within the new paradigm (this is further discussed in the conclusion).

3. Unnecessary replacement of the existing procurement regime

In part 2, under the heading ‘Getting better value for the NHS’, the document claims to present targeted amendments to primary legislation to free the NHS from overly rigid procurement requirements, which would be replaced by a ‘new “best value” test’ and stronger protection for patient choice. Effectively, the document proposes to: (i) repeal the NHS (Procurement, Patient Choice & Competition) No 2 Regulations 2013 and for the powers in the Health and Social Care Act 2012 under which they are made to be repealed and replaced by a ‘best value’ test (point 12), and (ii) remove arrangements between NHS commissioners and NHS providers from the scope of the PCR2015 and that NHS commissioners are instead subject to a new ‘best value’ test when making such arrangements, supported by statutory guidance (point 14).

Effectively, the combined effect of these two changes would be to eliminate all existing requirements applicable to procurement within the ‘NHS internal market’ and to replace them with a ‘new “best value” test’ that is not explained in any meaningful level of detail in the document.
Even at this level of abstraction, these proposals raise two sets of difficulties. First, the impossibility of exempting the award of any public contracts (not only intra-NHS contracts) from the scope of the PCR2015 (section 3.1). Second, the unmerited assessment (section 3.2) of the need for a replacement of the existing regime with a yet to be spelled-out ‘new “best value” test’ (section 3.3). On the whole, there is nothing in the proposals about NHS procurement that could not be achieved within the current legal framework, which raises questions as to the reasons behind the proposal (3.4).

3.1. Legal impossibility of exempting NHS procurement from the PCR2015

Subject only to any post-Brexit reform of the PCR2015 in a way that deviates from the EU public procurement rules that they transpose—which is largely dependent on the existence of a general framework for future UK-EU trade in procurement, but highly unlikely in view of the UK’s imminent accession to the World Trade Organisation Government Procurement Agreement as a member in its own right—the scope of the PCR2015 needs to match the scope of application of Directive 2014/24/EU, which clearly covers intra-NHS contracts.

Therefore, the proposal to remove arrangements between NHS commissioners and NHS providers from the scope of the PCR2015 is currently legally inviable. It is worth stressing, however, that there are ways in which subjection to the full requirements of the PCR2015 could be avoided, as discussed in the next section.

3.2. Unmerited proposal based on potential advantages that are achievable under current rules

The document seeks to justify the exemption of procurement within the ‘NHS internal market’ from the PCR2015 on the basis of three main arguments. For the reasons given below, all those arguments are unmerited and simply seem to reflect misunderstandings or an extremely restrictive and risk averse interpretation of the rules in the PCR2015.

(1) The change would ‘allow NHS commissioners to choose either to award a contract directly to an NHS provider or to undertake a procurement process, with the clear aim of ensuring good quality care and value for money when designing local healthcare services’ (point 15).

This is already possible. Reg.12(2) PCR2015 allows for the direct award of public contracts between entities within the public sector in situations where the contracting authority and the awardee of the contract are subject to control by the same (higher) contracting authority. Given the relationships of dependence of all NHS entities on the Department of Health and Social Care, the scope and application of this exemption seems to be misunderstood. Any potential doubts as to the possibility to resort to this exemption from full compliance with the competitive requirements of the PCR2015 would probably derive from a potential misunderstanding of the requirements for such exemption. The simple adoption of guidance as to the interpretation of the exemption under reg.12 would

---

7 In particular, Directive 2014/24/EU. For discussion, see A Sanchez-Graells, ‘The Implementation of Directive 2014/24/EU in the UK’, in S Treumer & M Comba (eds), Modernising Public Procurement: The Member States Approach, vol. 8 European Procurement Law Series (Edward Elgar, 2018) 277-306. Given that the UK followed a copy-out approach to the transposition, it is not possible to foresee as scenario where exclusion from the Public Contracts Regulations 2015 and subjection to an alternative procurement regime would be compliant with EU law.

suffice to dispel any such doubts without the need to exclude the applicability of the PCR2015 altogether.
(2) The change would ‘give commissioners freedom to engage widely with existing providers to design the model of care they want before awarding a contract, whether via a procurement process or otherwise’ (point 15).

This is already possible. Reg. 40 PCR2015 foresees that, before commencing a procurement procedure, contracting authorities may conduct market consultations with a view to preparing the procurement and informing economic operators of their procurement plans and requirements, and that, for this purpose, contracting authorities may, for example, seek or accept advice from independent experts or authorities or from market participants. Therefore, this is also not a valid argument to seek to exclude the applicability of the PCR2015.

(3) The change would allow commissioners ‘to choose how they oversee contracts with NHS providers and amend them as they see fit when healthcare needs change’ (point 15).

This is already possible. Reg. 72(1) PCR2015 allows for the inclusion of contract modification clauses in public contracts that would cover any changes, irrespective of their monetary value, if they stated the scope and nature of possible modifications or options as well as the conditions under which they may be used in clear, precise and unconditional terms. Therefore, unless the proposed modification sought to create a (commercially possibly unacceptable) unilateral and unlimited right to contractual modification for NHS purchasers, there is no reason to seek a deviation from the rules in the PCR2015.

3.3. Under-specified alternative test that seems to also fit within the current rules

The scant detail that the document provides about the proposed ‘new “best value” test’ also seems to reflect a misunderstanding of the rules controlling award criteria under the PCR2015. The document indicates that under the proposed new rules, ‘[t]he key tests would be whether NHS commissioners were obtaining “best value” from their resources in terms of the likely impact on quality of care and health outcomes, whether they were acting in the best interests of patients, and whether they were actively considering relevant issues in making any decisions, for example, the improvement progress a particular provider is making in tackling unwarranted lower outcomes than their peers’ (point 16).

Nothing in the PCR2015 prevents such an approach. Reg. 67 establishes that contracting authorities shall base the award of public contracts on the most economically advantageous tender—which surely reflects the same functional goal as the intended ‘best value’. Moreover, reg.67 indicates that such determination can be made on the basis of criteria such as, for example: quality, including technical merit … organisation, qualification and experience of staff assigned to performing the contract; or after-sales service and technical assistance, delivery conditions such as … delivery process, etc. Therefore, under the applicable rules, NHS commissioners can clearly seek to meet all the key tests mentioned in point 16 of the document.

3.4. Recapitulation on procurement matters

Given that the proposals on NHS procurement reform are currently undeliverable (exclusion of intra-NHS public contracts from the PCR2015) or unnecessary, as the current rules allow for all of the suggested benefits of the insufficiently detailed alternative system in the document, it would seem that the proposals largely derive from either a misunderstanding of the current rules, risk aversion for their practical interpretation or, else, a mere de-regulatory attempt for its own sake. Be it as it may, the proposals seem inapt to improve NHS procurement governance and much more detail
about the alternative ‘new “best value” test’ would be necessary to try to identify any practical advantages concerning the presumably different procedures through which it would be delivered.
Final remarks

Taken together, the proposals in sections 1 and 2 of the document would suppress or neutralise the competition and procurement-based checks and balances on the functioning of the ‘NHS internal market’ and NHS Improvement’s intervention in such market. The proposal does not identify an alternative regulatory framework but limits itself to the de-regulation of the ‘NHS internal market’, subject only to a vague requirement to benchmark the future behaviour of NHS commissioners against an unspecified ‘new “best value” test’.

On the whole, the proposed legislative changes would not result in a dismantling or transformation of the ‘NHS internal market’, but in its almost complete deregulation. This could result in NHS Improvement’s and NHS England’s unfettered discretion in the operation of the ‘NHS internal market’, with unforeseeable effects in terms of its performance and the adequate governance of the NHS. It is submitted that these would be undesirable changes to the existing legal framework.

If changes are sought, these should be underpinned by either a complete abandonment of the ‘NHS internal market’ through a proper and full suppression of the purchaser-provider split, or an improvement of the existing mechanisms for the governance of this (quasi) market. A strategy that is solely de-regulatory such as that underpinning the NHS Long-term Plan should be opposed by the House of Commons Health and Social Care Select Committee.

March 2019

Biographical information

Dr Albert Sanchez-Graells is a Reader in Economic Law at the University of Bristol Law School and Member of its Centre for Health, Law, and Society. He is also a former Member of the European Commission Stakeholder Expert Group on Public Procurement (2015-18), a Member of the European Procurement Law Group, and a Member of the Procurement Lawyers Association Brexit Working Group. He is a specialist in European economic law, with a focus on competition law and procurement.


His broader publications include the leading monograph Public Procurement and the EU Competition Rules, 2nd edn (Bloomsbury-Hart, 2015). He has recently co-authored Shaping EU Public Procurement Law: A Critical Analysis of the CJEU Case Law 2015–2017 (Wolters-Kluwer, 2018), edited Smart Public Procurement and Labour Standards. Pushing the Discussion after RegioPost (Hart, 2018), and also coedited Reformation or Deformation of the Public Procurement Rules (Edward