CONTENTS

Clause 52, as amended, agreed to.
Clause 53 agreed to.
Clause 54 under consideration when the Committee adjourned till Thursday 17 March at Nine o’clock.
Members who wish to have copies of the Official Report of Proceedings in General Committees sent to them are requested to give notice to that effect at the Vote Office.

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not later than

Saturday 19 March 2011

STRICT ADHERENCE TO THIS ARRANGEMENT WILL GREATLY FACILITATE THE PROMPT PUBLICATION OF THE BOUND VOLUMES OF PROCEEDINGS IN GENERAL COMMITTEES
The Committee consisted of the following Members:

**Chairs:** † Mr Jim Hood, Mr Mike Hancock

† Abrahams, Debbie (Oldham East and Saddleworth) (Lab)
† Barron, Mr Kevin (Rother Valley) (Lab)
† Blenkinsop, Tom (Middlesbrough South and East Cleveland) (Lab)
† Brine, Mr Steve (Winchester) (Con)
† Burns, Mr Simon (Minister of State, Department of Health)
† Burstow, Paul (Minister of State, Department of Health)
† Byles, Dan (North Warwickshire) (Con)
† Crabb, Stephen (Preseli Pembrokeshire) (Con)
† de Bois, Nick (Enfield North) (Con)
† James, Margot (Stourbridge) (Con)
† Kendall, Liz (Leicester West) (Lab)
† Lefroy, Jeremy (Stafford) (Con)
† Morgan, Nicky (Loughborough) (Con)

† Morris, Grahame M. (Easington) (Lab)
† Poulter, Dr Daniel (Central Suffolk and North Ipswich) (Con)
† Pugh, John (Southport) (LD)
† Shannon, Jim (Strangford) (DUP)
† Smith, Owen (Pontypridd) (Lab)
† Soubry, Anna (Broxtowe) (Con)
† Sturdy, Julian (York Outer) (Con)
† Thornberry, Emily (Islington South and Finsbury) (Lab)
† Turner, Karl (Kingston upon Hull East) (Lab)
† Twigg, Derek (Halton) (Lab)
† Wilson, Phil (Sedgefield) (Lab)

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
Public Bill Committee

Tuesday 15 March 2011

(Afternoon)

[MR Jim Hood in the Chair]

Health and Social Care Bill

Clause 52

General duties

4 pm

Question (this day) again proposed. That the clause, as amended, stand part of the Bill.

Karl Turner (Kingston upon Hull East) (Lab): Before we adjourned this morning, I was about to explain more about clause 52, which places at the centre of Monitor’s role the obligation to promote competition where appropriate. In my view, the changes in the Bill, and the ideology on which they are based, pose a grave threat to the national health service. Placing a statutory obligation on Monitor to enforce competition creates a situation in which commissioners will not be able to act in the best interests of their patients because of a fear of costly legal challenges lurking in the shadows.

The Government’s approach to Monitor demonstrates how ill thought out the plans are. In a clamour to roll back the state and to woo private health care providers, the Government have set commissioners off on a long and treacherous journey, without providing them with a map. I am not alone in thinking that. David Owens, head of commercial law at Bevan Brittan, has said that “under these reforms, commissioners would face a much greater risk of challenge and potential tensions between what might be best practice from a healthcare perspective and what a competitive market might result in.”

If the Minister is not satisfied with a legal opinion, shall we take a medical one? The British Medical Association has stated:

“There is a risk that it will become difficult or impossible for commissioners and providers to operate in the best interests of patients, for fear of being open to frequent and costly legal challenges for anti-competitive practices”.

Monitor’s duty to enforce competition will lead us into a position in which attention is diverted away from achieving high-quality care so as to focus on competition. I am fundamentally opposed to taxpayers’ money being used for profiteering. Our emphasis should be on the promotion of increased quality of patient care. Commissioners and providers should compete on best quality, not on the best profit margin, and that view is shared by others.

It is particularly symbolic that Monitor’s first duty under the clause is to promote competition. That comes before any reference to quality of standards in the entire chapter, even though quality is the most important issue in the NHS. That sentiment is shared by many interested parties. The Royal College of Nursing stated in its written evidence to the Committee:

“This issue of promoting and regulating competition must not hinder Monitor from the most important issue of regulating a national health service which delivers integrated, collaborative and comprehensive care.”

Health care should not be treated in the same way as the privatised telecommunications and energy industries; the gamble is too great, and the outcomes far too important. Dr Hamish Meldrum, chairman of the BMA council, stated that the “consequences of failure in healthcare are far more serious than in other industries”—[Interruption.]

The Chair: Order. May I say to some Government Back Benchers that I can hear a humming noise when I should be hearing the hon. Gentleman’s speech?

Karl Turner: I am obliged, Mr Hood. It is difficult for Government Members to listen because some of the things that I have said have clearly caused them problems—[Interruption.] That is a fact. My remarks are based on oral and written evidence to the Committee, and they ought to listen. They should listen to the views of medical experts, and to the BMA, whose members are, as I speak, discussing the Bill’s provisions and the effect that, in their expert opinion, it will have on the national health service.

Dan Byes (North Warwickshire) (Con): I am curious to know whether the hon. Gentleman is aware of how many members of the BMA attended the meeting today and what the membership of the BMA is. The Committee would be interested to know those two things.

The Chair: Order. I am looking at the amendment paper, but I do not see the BMA conference on the agenda, so it is not in order to discuss that conference—unless you are a member of the BMA and are attending it, but not during my Committee.

Karl Turner: The hon. Gentleman knows that the BMA is a representative body. I understand that delegates will be attending that conference—[Interruption.]

The Chair: Order. I hope that Members heard my previous intervention.

Karl Turner: Mr Hood, I was about to explain the words of Dr Hamish Meldrum:

“The consequences of failure in healthcare are far more serious than in other industries… The role of the regulator should not be to enforce potentially damaging competition but to ensure comprehensive, high quality care and to protect patients.”

National Voices rightly said in its written evidence to the Committee:

“One of the strongest demands of patients, service users, their families and carers is for ‘joined-up’ services. Patients want continuous care, integrated around the patient—not, as now, to get lost in the gaps, or to have to fight their way from one service to another.”

That is yet another area in which the Government have over-promised and under-delivered. The Government talked about integration in the White Paper published last July, but they are failing to deliver, not slightly but on a monumental scale. There is a basic contradiction between competition and integration. The Bill does
more to fragment services than it does to connect them. The proposed regulatory framework will not support the delivery of more integrated care.

Effective relationships that have been built up over years through co-operation and trust will be swept away in an outbreak of litigation and European intervention. Litigation lawyers, as my hon. Friend the Member for Leicester West rightly said, will be rubbing their hands at the prospect of taking on this legislation. What happens when arrangements between local provider and commissioner, which have worked so well in the past, are subjected to anti-competition challenges? It is worth reminding the Committee and the Government of what the experts have said. Diabetes UK said that “duties to promote competition raise concerns about the impact this will have on the delivery of integrated services, and on commissioners and their ability to work collaboratively with other colleagues in the design and commissioning of services.”

I am sure that the Health Secretary’s news release yesterday has not escaped the Committee’s attention. In his desperate attempt the shore up support following the widespread condemnation of his plans at this weekend’s Lib Dem conference, the right hon. Gentleman claimed that the reforms are essential for helping the long-term ill. That is another spectacular contradiction. Integrated services are essential for effectively managing people with long-term conditions. The NHS-recommended model for long-term care is built on that evidence. He was right to highlight the concern, although his remedy is uninformed at best and disingenuous at worst.

If well established and effective clinical pathways are broken up, services and patient care will become fragmented and destabilised. Those who will be affected most are the long-term ill, who take up some 70% of in-patient hospital beds.

I agree with the King’s Fund when it says that “the Bill appears to move towards promoting competition at the expense of collaboration and integration”.

The Government’s plans to introduce competition into the NHS will work against the integrated networks needed to ensure that the long-term ill receive the services that they need and are entitled to.

The logic of the reforms becomes even more confused in the context of the Nicholson challenge. As we know, the NHS has the challenging task of finding £20 billion-worth of savings. Many have argued that such savings are impossible when implementing such a huge, top-down reorganisation of the NHS, especially given that the Bill will drive in a raft of new expenditures. As I understand it, giving Monitor the power to promote competition includes the power to issue fines to GP consortia and providers, including NHS providers.

Derek Twigg (Halton) (Lab): My hon. Friend makes a powerful argument. Can I ask his opinion? We have seen it reported in many forms that much of the detail of Monitor and the national commissioning board is just not available. We are being asked to make decisions today and in the coming days on a body whose role will be so important, but we will not have the details until much later in the process.

Karl Turner: My hon. Friend is absolutely right. One of the big problems is finding the detail.

William Sprigge, an expert on competition regulatory practice, said that “no trust board would want to have to close a ward or unit, with the consequent impact on the provision of care, to pay a multi million pound fine for price fixing.”

As Monitor stamps down its new economic regulatory regime, mistakes are bound to be made. Litigation will result and continue for some time afterwards. That means that budgets will be spent on paying fines for breaching competition law instead of improving quality of care. Public money will presumably be diverted away from spending on improving quality to enforcing a regime that will drive down patient care, fragment services and prevent commissioning in the interests of patients.

In order to deal with its new role, Monitor will need to massively expand its staff, resulting in another substantial cost to the public purse. That point is supported by Professor Chris Ham at the King’s Fund, who has said:

“Monitor will need to employ large numbers of economists, lawyers, accountants, and managers to deal with competition issues, providers who fail, price setting, licensing providers, and other work. Add to this the need for Monitor to work hand in hand with the Competition Commission and the Office of Fair Trading on competition, the Care Quality Commission on regulation of quality, and the NHS Commissioning Board on price setting, and the complexities of the proposed regulatory arrangements become apparent.”

The proposal makes the Prime Minister’s declaration of war on red tape another candidate to be added to a rapidly expanding list of broken promises. If members of the Committee are not convinced by Professor Ham, they need do no more than refer to the evidence submitted by Help the Hospices, which stated:

“The new role for Monitor as the economic regulator for healthcare runs the risk of creating an additional layer of bureaucracy for independent charitable hospices, and that there is potential for duplication of information required by Monitor and the Charity Commission.”

Another unnecessary cost is not far away. The level of training that staff will need is massive. William Sprigge made the point that “everybody, from the most senior to the front-line team will need to understand the new risks and staff must urgently be trained in competition law. The Directors of two NHS Foundation Trusts meeting to discuss the use of IT in health service management, doctors employed by different trusts meeting to discuss best clinical practice, and former administrative colleagues now with different service providers meeting socially, must all be made aware of the risks of discussing prices and how these prices might move, however harmless the discussion may seem at the time.”

That point was also helpfully made by the hon. Member for Stafford.

That is a pretty damning appraisal of the impact of the Government’s new regulatory regime, and that is even without mentioning the fact that price competition will also increase transaction costs, as commissioners and providers will spend substantial time on negotiating prices. I am grateful for the Committee’s indulgence in allowing me to make such remarks. I have spent a fair time outlining the objections of a host of professional bodies, but an appropriate statement was made by the hon. Member for St Ives (Andrew George), when he said:

“this is a dream come true for litigators, lawyers and management consultants.”

I agree entirely with that sentiment.
The Chair: Order. I did comment to the Government Back Benchers about whispering and I am duty bound to say the same to the Opposition Front Benchers who are whispering. When the Chairman can hear Front Benchers whispering, they are out of order.

Margot James: Thank you, Mr Hood. Having enshrined patient choice on a system of unfair competition to the NHS, the other point I was going to make is that, in addition to the price benefit that private providers had under the previous Government, they were allowed guaranteed volumes as well. The present Government are trying to create a regime where there is at least a level playing field between all potential licensed providers of health care services.

The hon. Member for Kingston upon Hull East talked about competition and integration as though the two are mutually exclusive. They most certainly are not—indeed, the Bill states that the tariff can comprise two or more services, which together constitute a form of treatment. That, by definition, means that there will be integration enshrined in the legislation, and that there is a possibility for providers to tender, for example, for a year of asthma care, rather than just single episodes of care. There is therefore no conflict between integration and co-operation.

Owen Smith (Pontypridd) (Lab): Yes, the ability for providers to tender for different aspects of a treatment pathway will be integrated, but that is not the same as the sort of integration that we see now, and which the Opposition are worried about seeing fragmented, between primary and secondary care, or between local GPs and their local hospital. That is a different sort of integration to that which is being discussed and which is, as you rightly point out, included in the Bill.

The Chair: Order. I was not pointing out anything.

Margot James: Thank you, Mr Hood, and thank you for the opportunity to go further on this point. There is nothing to stop a group of providers tendering together for—for example, in diabetes care—a collaboration between primary care, and hospital consultants inputting what they are required to input. In end-of-life care, there is nothing stopping the system of providing care that goes right through primary care, hospitals and into hospices.

Owen Smith: If I may be so bold, that is precisely what we are worried about, because there is something that might prohibit that sort of integration that we have seen hitherto—competition law and private providers turning to the hitherto integrated at local level primary and secondary care, saying that they want a piece of the action and attacking it in the courts.

Margot James: The hon. Gentleman seems oblivious to the fact that an awful lot of care in the current system is privately provided. May I draw his attention to the fact that of 475 acute care sites from which routine elective care is available, 175 are independent sector providers? That is something that the previous Government achieved in the face of resistance from quite a number of primary care trusts?
Grahame M. Morris (Easington) (Lab): Will the hon. Lady give way?

Owen Smith: Will the hon. Lady give way?

Margot James: No, I want to make a bit of progress and then I will give way. The previous Government achieved that in the face of a bias against private providers shown by many PCTs and strategic health authorities. The hon. Gentleman might be interested to—

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): Will my hon. Friend give way?

Margot James: Let me just finish this point and then I will give way to all three hon. Gentlemen in turn. The hon. Member for Pontypridd might be interested to review the contents of the latest report from the co-operation and competition panel—a name that was, I presume, assigned by the previous Government to a committee advising the Department of Health. The previous Government evidently did not think that there was a conflict between co-operation and competition, or they might have given that committee a different name.

The panel looked into commissioning and contracting practices and assessed PCT practices in relation to the patient’s right to choose—a right that was enshrined by the previous Government and that the current Government believe in. The panel found huge variations and the worst cases of practices that restricted the patient’s choice of provider via directives given to the general practitioners in their patch, inserting anti-competitive restrictions into provider contracts, activity caps, restrictions on procedures and—this is amazing—locally negotiated prices below the national tariff. I thought that Labour Members found that an anathema, but it was happening under their Government.

It is imperative that the clause stand part of the Bill, because it will correct many of those problems, create a level playing field and overcome the bias of some health service commissioners in the current system. I will give way to the hon. Gentleman.

The Chair: I call Grahame Morris—I assume that I chose the hon. Member whom the hon. Lady intended.

Margot James: It was more a collective decision.

Grahame M. Morris: I thank the hon. Lady for giving way. I return to private sector competition and the risk of legal challenge on the basis of European competition law. That will be a huge challenge for NHS providers and a huge cost to the NHS.

Margot James: I refer the hon. Gentleman to the answer that the Minister gave this morning: legal advice has been taken and considered in drafting the Bill.

Dr Poulter: I cannot follow the Opposition’s argument. They talk about joined-up thinking between primary and secondary care, but it does not exist. GPs cannot be involved or have relationships with secondary care because PCTs get in the way; that is true for the voluntary sector, as well. Does my hon. Friend agree that the Bill will put that right?

Margot James: I thank my hon. Friend for that excellent intervention. I agree that the provision opens up the possibilities of further and better integration beyond the status quo, which is a good thing.

Liz Kendall (Leicester West) (Lab): The debate on the clause will be one of the most important during the passage of the Bill. Hon. Members have referred to the recent article in the British Medical Journal by Chris Ham, the chief executive of the King’s Fund. He rightly states that, although most attention, including that of this Committee, has so far focused on the Government’s plans for general practice-led commissioning consortia, such changes are of secondary importance compared with the proposals set out in part 3.

Part 3 seeks to remove Monitor’s responsibility for regulating foundation trusts and to turn it into an economic regulator with three core functions: promoting competition, setting and regulating prices, and supporting the continuity of services. As part of those functions, Monitor will also have the power to license providers of NHS-funded care. Part 3 also explicitly adds UK and European competition law to the NHS—it will be in primary legislation—for the first time. That was confirmed by the new chairman of Monitor, David Bennett, and it will have significant implications, which I shall come to.

In attempting to explain the purpose of the changes, Chris Ham’s article rightly points to a speech that I have mentioned before. “The Future of Health and Public Service Regulation” was made in 2005 to the NHS Confederation by the then shadow Secretary of State for Health. In that, he specifically invoked his experience as a civil servant working with Norman Tebbit on opening up the telecoms sector. Chris Ham rightly says:

“The provisions in the Health and Social Care Bill derive directly from these principles and underline the government’s intention...in taking forward the reform of the NHS.”

The Government’s first and primary objective is to “maximise competition”. He says that that is not a means to an end; it is the primary objective.

4.30 pm

In an interview with The Times on 25 February, David Bennett confirmed that approach. He said that Monitor’s role will be comparable to that of “the regulators who opened up the gas, electricity and telecommunications markets”.

The explanatory notes on the Bill are also explicit: on page 85, they state that the clauses in part 3 are based “upon precedents from the utilities, rail and telecoms industries”.

The first fundamental question that I want to try to address is whether it is right to seek to remodel the NHS along the lines of the gas, electricity, rail and telecoms industries. The second is what the consequences might be for what I argue is a very different system. The goals of health care in the NHS are to save lives, reduce disability and improve health, both physical and mental. Those are fundamentally different from the goals of the utilities, which are to provide people with gas or electricity, so that they have heat and light: the goal of the railways, which is simply to get people from place to place; and
the goal of telecoms, which is to ensure that people have access to telephones, television, newspapers, the internet and so on.

I note the slightly amused look on the Minister’s face, but if he is seeking to base a regulatory system on one from a different sector, we have to ask whether there are fundamental differences between the two sectors. I argue that there is. The reason that health is so different from those other sectors is that people’s health needs and their ability to benefit from health services are far more complicated than their need for gas, electricity, railways or telecoms, and they are influenced by a much wider range of more complex factors.

People’s health is influenced by some factors that are beyond their control. The human genome project has increasingly shown that a person’s genetic inheritance can have a significant impact on the likelihood that they will develop a particular disease, and that it affects how they will respond to different treatments. People’s health is also influenced by factors within their control, such as their diet, how much exercise they take and other lifestyle factors, such as smoking. However, those lifestyle factors are in turn shaped by wider social factors. We all know that there is clear evidence about the links between health and poverty, levels of employment and equality of housing. There is also interesting evidence that social networks can influence health. Work by Robert Putnam on the amount of social capital within society shows that the quality and range of links within communities can affect the health of individuals and local populations.

The health needs of individuals and local populations are far more complicated than their need for utilities, telecoms or rail. Their ability to benefit from health care interventions, and the priorities that should be accorded to different groups, are far more complicated. I emphasise that point because—as flows from that—the nature of and the way services are provided in health are fundamentally different from those of the utilities.

I want to highlight five key differences. First, quality is far harder to judge in health care than it is in the utilities or rail industries. It is relatively easy to judge the quality of water, by testing for impurities, and of a particular rail service, by assessing how many trains arrive on time or whether there are enough seats on a journey. Let us compare that to the difficulty of judging the quality of care for someone with a mental health problem or a complex physical condition, such as heart disease. In those cases, we have to assess the effectiveness of a wide range of different interventions, including preventive measures, the effectiveness of drugs, operations or other treatments, and the amount and type of emotional and other support received by the patient and their carers.

Many different factors influence the outcomes of these services, which makes judging that quality of care extremely difficult. For example, different success rates for particular treatments and even different death rates between hospitals can be influenced not only by the direct quality of care being provided, but by the complexity of the case load, as well as the person’s ability to benefit from that health care intervention. In addition, judging the true quality of care may be possible only many years after the operation or treatment has taken place. This is completely different from judging the quality of the gas, electricity or water a person receives, or the quality of broadcasting or internet provision.

The second fundamental difference is that health services are far more interlinked than services in the gas, electricity or telecoms industries. Those industries can generally be broken up into quite discrete markets and products which can then be regulated and monitored to improve outcomes for consumers. For example, in telecoms, it is relatively easy to separate the provision of fixed phone lines from mobile lines. I have a different phone line provider for my mobile phone, occasionally used for tweeting. There are also different products for home internet provision and for digital TV channels.

In health care, separating different services and monitoring them is far more difficult. Patients need a more complicated range of services that should be tailored to their specific needs. That is very different from having a more standard set of products to choose for home telephone, internet, television and so on. In health care services need to work seamlessly together to deliver the best-quality care and to ensure that patients do not fall through the gap. I would be the first to say that in too many parts of the NHS we have not got that integrated care as yet. We need to develop much closer working between services, for example, by developing specialist cancer networks and integrating community, primary and social care services for our increasingly ageing population and patients with long-term conditions.

As the King’s Fund rightly says in its briefing on this part of the Bill:

“Competition may be beneficial to patients in some areas such as simpler elective services or small scale community provision.”

I would argue that those were the areas where the previous Government brought some competition into the system. That is simply a statement of fact. The briefing continues:

“In other areas, competition may make it more difficult to commission services that best serve patients’ interests, for example where partnerships are needed to ensure provision of seamless care between providers of hospital and community services, or where—as with stroke and trauma care—hospitals need to work together across wide geographical areas”.

There is little if any evidence that competition improves integration and collaboration of services.

Dr Poulter: Obviously the hon. Lady is concerned about integration. She says that competition and private providers have a problem with providing integrated care, but she is talking about elective services such as orthopaedics that were commissioned out by the previous Government. What about rehabilitation after orthopaedics?

Liz Kendall: The hon. Gentleman raises an important point. It is difficult to separate services entirely. Both the Nuffield Trust and the King’s Fund have stated that there is some evidence that in niche markets in discrete areas competition can help to improve quality. Many others would dispute that. A lively debate is going on about the impact of competition, but they have found no evidence that competition improves collaboration; in fact, the opposite. I am sure that we will discuss this on later clauses, but I believe that competition law could severely limit the potential for collaboration between the different health care providers.

On the point about health services being much more interdependent and interlinked, changing one aspect of the health care market can often have a significant knock-on effect in other areas. For example, deciding to
take a particular service, such as diagnostic services, out of a hospital can have a knock-on effect on what else that hospital is able to do. For example, the children’s heart surgery unit in Glenfield hospital, in my constituency, is currently under review. I am not mentioning that in relation to competition, but if that unit is moved to Birmingham, there will be a knock-on effect on adult heart surgery that is provided and on our fantastic extra corporeal membrane oxygenation service, which was used during the swine flu epidemic.

I am not saying that that is a result of competition, but I am arguing that health services within organisations are interlinked. Bringing in a model that seems to be based on the idea that services can easily be separated, which is exactly what happened in the utilities and other sectors, is the wrong approach.

Mr Burns: Would the hon. Lady care to reflect that it is probably unwise to mention her local hospital and the specialist service? It certainly puts me in a difficult position. As she knows, a consultation is being carried out by a joint committee of PCTs. It would be totally inappropriate of me to comment on the situation. I would not want to be seen in any way to be trying to influence, interfere or prejudge the consultation.

Liz Kendall: I am not asking the Minister any questions on that point, and I would not do so in the debate, although I might write to him separately. The crucial point is that there is a fundamental difference between regulating health services and regulating utilities.

Mr Burns: Of course there is.

Liz Kendall: Then why is he simply moving the model from the utilities sector into the NHS? I will come on to that in a moment. In health care, we need to think about the impact of decisions within organisations and the knock-on effects for the wider health economy.

Mr Burns: We are not doing that.

Liz Kendall: But that is precisely what the Bill will do. That is what David Bennett, the new chairman of Monitor, in his latest interview with The Times, has clearly said the Government are doing, what the explanatory notes to the Bill say and what many commentators think. In the Minister’s own words, he is trying to create a genuine market and turn Monitor into an economic regulator. I will not go over this point.

I want to move on to the third difference between health and other services, which is important because it determines how effectively an economic regulator can work. The difference is that there is a smaller number of providers in the utilities and telecoms industries. The providers tend to dominate the market and act on a national or regional level. It means that it is relatively easy for a national regulator to have good information on each provider and to understand and to predict much more easily the impact of a provider’s actions. In contrast, there will be thousands of different providers in the NHS and social care. A national regulator would somehow have to have detailed knowledge about each individual provider as well as the health needs of the local community to fully understand the impact of providers’ actions. It would be highly unlikely that Monitor could achieve that unless it became a huge organisation with thousands of staff working in every local community in the country.

The complexity and inter-related nature of services leads to the fourth key difference. It is far more difficult to set prices in health care than it is in the utilities, rail or telecoms industries. Anyone who has had the pleasure—perhaps that is not quite the best word—of being involved in discussions about determining the NHS tariff for different types of health care knows that it is a hugely complicated process, and far more complex than setting prices for gas, electricity or water. That is in part because of what I have mentioned about the inter-related nature of health services, the fact that services need to be tailored to particular individuals and the fact that an individual’s ability to benefit from those services differs widely.

4.45 pm

The final difference between the utilities and telecoms industries and health care is that the users of gas, electricity and telecoms are the purchasers, but in health care, the commissioners are the purchasers, and the Government want the commissioners to be GPs and, ultimately, the state. Many GPs are closely attuned to their patients’ needs, but some of them do not always know what is in their patients’ best interests. I have been a long-standing champion for empowering patients with more choice, more information and a greater say in their treatment and care, but even if the Government deliver their promise of an information revolution, there will always be what economists call asymmetries of information in health care. In other words, there will inevitably be aspects of health care about which providers know more than patients, meaning that patients must rely on the judgment, skills and expertise of doctors and other clinicians.

The Government say that if patients do not like the services commissioned by their consortium, they can move elsewhere, but that choice is simply a fallacy in many parts of the country. In Leicester, for example, one consortium will cover most of the city. Moving to a different consortium in the county, for example, might be possible for people who live on the edge of my constituency, but it would not be a choice for the vast majority of patients. Relying on markets and competition alone to drive up quality from the patient’s perspective is different in health care from telecoms and other industries.

John Pugh (Southport) (LD): May I take the hon. Lady back to an earlier point? She mentioned that it is difficult to be precise and accurate about tariffs in health as opposed to electricity and other sectors. Was that intended as a criticism of the legislation or of both the tariff system and the legislation?

Liz Kendall: The hon. Gentleman spies the issue immediately. There are difficulties with setting a tariff. Some organisations say clearly that we need to move to an entirely different approach. Rather than trying to specify and price each tiny, individual bit of the care pathway and then summing up the costs, they say, we should move to a pathway approach. That might be difficult under competition law, as different providers
would have to give one another information about what prices they are charging, which could be considered to be collaboration.

There are problems with both approaches, but if an economic regulator attempts to set the price, along with the national commissioning board and in consultation with commissioners, that is a complicated process, and it cannot be compared with what happens in telecoms or other sectors. It is far more complicated, which is another reason why the Government’s approach is wrong. I have explained in detail why I think health care is fundamentally different from utilities and telecoms, which is why the Government’s approach in basing Monitor’s powers along similar lines is not correct.

Moving to the consequences of applying a fundamentally incorrect model to the NHS, I do not want to stray beyond the scope of clause 52. We have already debated Monitor’s role and the effect of bringing UK and EU competition law into the NHS, so I shall simply touch on both those issues. The first concern, which has been mentioned, is that under the new system, GPs will be driven by Monitor’s duties and powers to promote competition and by competition law, not by patients’ needs. Organisations including the British Medical Association and the Royal College of General Practitioners are rightly worried that instead of referring patients to their local NHS hospital or community service, GPs could be forced to put most health services out to tender for fear of being accused of breaking competition law. As someone who knows many members of the medical profession, I know that that is what many GPs are saying publicly and privately.

The BMA’s latest briefing on the Bill says:

“The pressure to apply competition rules could divert providers and commissioners from their key task of designing and maintaining high-quality patient care. There is a risk that it will become difficult or impossible for commissioners and providers to operate in the best interests of patients, for fear of being open to frequent and costly legal challenges for anti-competitive practices”.

The Minister of State, Department of Health (Paul Burstow): If I heard the hon. Lady correctly, she suggested that one concern is that GP consortia will be fearful about their normal referral patterns being upheld in a situation in which the competition authorities require them to put services out to tender. However, she was just talking about the existence of tariffs and the need to ensure that those tariffs are robust and effective in terms of pricing health services. She understands, of course, that when there are tariffs and fixed prices, there is no need to tender, because there is a price that is paid when a service is provided.

Liz Kendall: I hope that when the Minister’s right hon. Friend responds to the clause stand part debate he will confirm that GPs will not be forced to put every service out to tender under competition and procurement law. It is important for Ministers to understand that those are concerns that GPs have. I believe that it is entirely possible that if competition law is brought into the system more, they will feel obliged to put services out to tender, because they will be concerned that there could be a legal challenge.

Paul Burstow indicated dissent.

Liz Kendall: The Minister shakes his head. I hope that some legal assurance will be provided, possibly in the legal advice that his right hon. Friend is considering publishing on this point.

I shall give an example of why the provision will not necessarily increase patient choice. Let us take community services. If a commissioning consortium is required to put, for example, all the district nursing or health visiting services in a particular area out to tender, the likelihood is that the contract will be given to one provider, which will not necessarily increase patient choice. As I have already explained, if patients do not like the care on offer, they cannot choose to move to a different consortium. Certainly my constituents would not, because the Leicester consortium will cover the whole city.

The second major concern, to which several hon. Members have referred, is that the Government’s proposals could mean that health care becomes more fragmented, not less. I have already said that many people who work in the NHS and many users and patients know that the situation is difficult enough as it is. The hon. Member for Central Suffolk and North Ipswich made the point about the problems with fragmentation in the current system. In future, different parts of the patient pathway could be contracted out to different organisations, which would make it even harder for patients to navigate their way round the system.

Dr Poulter: In Suffolk, the needs of patients and the available support groups for patients in the voluntary sector are different in Lowestoft, Ipswich, Bury St Edmunds and Stowmarket. The needs of those patients are different and the support groups available are different. Is that not a reason to ensure that local health care providers and the voluntary sector in particular are better recognised and better used?

Liz Kendall: I agree that we could do far more to give voluntary sector organisations a role, particularly in respect of the support that they offer older people and those with long-term and chronic conditions. If individual contracts are issued separately across a patient pathway, that could make a situation that is not always perfect worse, and I hope that the hon. Gentleman would agree.

I shall go further and say that competition law could prevent collaboration between services and stop developments that would improve the quality of care. For example, many hospitals are considering how to provide integrated care across primary, secondary and community services—the terrible phrase in the policy jargon is “vertical integration”. There is, however, concern that they would have to put their plans on hold in case they were deemed to be behaving anti-competitively. Another example is that hospital doctors might be far less willing to get involved in redesigning services with commissioners, either because they feared such involvement and co-operation with their colleagues in primary care could be deemed anti-competitive, or because shifting services out into the community would risk their hospitals’ future revenue.

The third major concern is about the impact of Monitor’s duty to promote competition, and the proposal explicitly to add to primary legislation, for the first time, the application of UK and EU competition law to the NHS. There are concerns that commissioning consortia
simply will not have the necessary skills and experience effectively to hold a far greater number of providers to account. We know, and I think that this was mentioned by both the hon. Member for Stafford and my hon. Friend the Member for Oldham East and Saddleworth, that many NHS organisations have already struggled to strike effective deals, particularly with large private providers that have the resources and time to employ far greater numbers of lawyers, accountants and contract managers.

The point that I really want to emphasise is the significant and serious consequences of the Government’s plans to create a genuine market in the NHS and to apply UK and EU competition law for the first time. EU competition law applies to the behaviour of undertakings, which the European courts have confirmed as any entity engaged in economic activity. Currently, primary care trusts, in commissioning NHS services, are not undertakings and are therefore not subject to competition law. However, clause 6 clearly states: “There are to be bodies corporate known as commissioning consortia”, and the Minister confirmed this morning that as competition law is driven throughout the NHS, commissioning consortia will be considered undertakings. That is a fundamental change to the current situation, and it means that commissioning consortia will face the full force of EU competition law if become undertakings. Where competition law applies, there are severe penalties for non-compliance. The Office of Fair Trading, whose functions Monitor will take on in relation to health services, can fine undertakings up to 10% of their turnover if they are found to be in breach of competition law. Undertakings can also be sued by third parties.

Jeremy Lefroy (Stafford) (Con): This is a genuine question: given that pretty much every instance of a referral to the Competition Commission, or further, to Europe, that I have come across is based on collusion, or lack of competition, on price, why does the hon. Lady think that the Competition Commission would be able to investigate anti-competitive practice, as competition will not be based on price but on quality?

Liz Kendall: I would like to make two points in response, the first being a somewhat technical one. As the hon. Gentleman will know, the OFT and the Competition Commission will be merged by the Department for Business, Innovation and Skills, but the legislation does not appear to take that in account. It is not clear what that new body’s functions will be, and how the original bodies’ powers will change.

Secondly, as the hon. Gentleman says, one of the key ways in which referrals can take place is if there is collusion on pricing. The process by which Monitor will set prices is unclear. It will not only have to talk to the national commissioning board, but consult individual commissioning consortia. There might be some concern that the process in the legislation by which the tariff will be determined could itself be challenged, because information will have to be shared not only between Monitor and the national commissioning board but between Monitor and commissioners on the ground. That is a legal minefield. There are lawyers in the room; I am not a lawyer, but I have spent a great deal of time over the past few weeks talking to lawyers in this field, and there is a great deal of confusion over the plans and their implications.

5 pm

Mr Kevin Barron (Rother Valley) (Lab): My understanding is that the major issues in competition law are the anti-competitive agreements, collusion between organisations and the alleged abuse of a dominant monopoly position in a market. Surely it is the latter that we ought to be worried about in relation to the national health service.

Liz Kendall: My right hon. Friend is correct. Monitor is going to get the OFT’s powers to look at collusion between providers, and particularly whether there is a market that is not open to other providers when a provider has a dominant position. Many of us can think of an example in our own constituencies whereby a dominant provider has closed the local hospital. It will no longer be up to GP commissioners to determine what happens in future. It could be up to lawyers and the courts.

Jeremy Lefroy: I am genuinely trying to tease this out, because this is an important part of the Bill. In my constituency, an independent provider wanted to tender for services against the big incumbent trust, which did not make life easy for that provider. Eventually, the independent provider was able to take over and produced excellent results with huge cuts to waiting lists. Does the hon. Lady think that the clause might improve the chances of such an independent provider overcoming the kind of obstacles that were put in its way?

Liz Kendall: I believe that such decisions need to be effectively managed and planned. If the local hospital loses a chunk of its services to a different provider, that has consequences for the income of the trust and whether it remains financially viable. It has consequences for the remaining services within that trust. The hon. Gentleman will know why people are so passionate about defending their accident and emergency services. The A and E is linked to other services. If the diagnostics go, can they do the operations? I have always believed that there is a role for different providers in the NHS. Indeed, I have championed that in the past, but it needs to be done within a managed framework based on the best interests of patients, not because a legal challenge is issued by a private provider. Bearing in mind the impact that it can have on the hospital, my concern is that the Bill—this is perhaps not the best analogy in the world—lets the competition law cat out of the bag. When that happens, it will not be clinical needs and patients needs that will end up determining future decisions, but lawyers in court and legal precedent.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): My hon. Friend is making an excellent argument on a very important area for the NHS. Is she aware that the primary work was done prior to the Bill’s coming to Committee? The Office of Fair Trading published a paper on the subject in July 2010, which built on the 2006 Serco Institute and CBI paper “A fair field and no favours: Competitive neutrality in UK
public service markets”. That paper also indicates that the health sector is one of the sectors where the inherent advantages of a certain place in the market may lead to competitive distortions.

Liz Kendall: My hon. Friend is right to raise that point. I come back to my argument, which is not about the private sector and voluntary organisations not having a role but about competition law driving the system. A health service that is clinically led on the basis of patient need within a managed system, which is acutely aware of the consequences for different providers in the local health economy, is vital.

Dr Poulter: Let us consider an area that does have price competition: adult social care within county councils. Can the hon. Lady give some examples of where there have been legal challenges to county councils on the basis of decisions they have made about who provides adult social care, particularly for older people? Can she give us some tangible examples of that and tell us how that will impact on the Bill, under which there will not be any competition on price, just on quality?

Liz Kendall: I am not discussing the impact on adult social care; I am setting out the implications of the Bill following discussions with people who work in the NHS and with lawyers. The question about the possible implications should not be put to me, but to the Government, so that they can reassure the Committee and Members of Parliament that the matter will not end up being decided by competition law and the courts. The Minister should give us some guarantee, which is why I have asked for the legal advice to be published. It is very important that we should be aware of what the consequences could be according to the lawyers who may ultimately make these decisions.

Tom Blenkinsop: Further to my previous point, might we not be in the perverse situation of the Secretary of State for Business, Innovation and Skills having more say than the Secretary of State for Health in those to whom these services are potentially contracted out by Monitor?

Liz Kendall: My hon. Friend makes a very good point, which I am sure he will develop later in the debate.

I move on to the specific issue of EU competition law. The point also relates to later clauses, so I do not want to stray beyond the issue too far. UK competition law is obviously very closely modelled on EU competition law. One of the Bill’s implications could relate to what we have seen in the utilities sector, where foreign-owned companies, such as German-owned E.ON UK and French-owned EDF, have come in to provide gas and electricity. Those companies have been able to provide gas and electricity in the UK, but our companies have not been able to go into the European market to do so because they have not opened up those markets to competition in the same way. Has the Minister taken any legal advice on whether such a situation is possible in relation to the health service under his proposed changes?

Could the Minister also tell the Committee whether he can guarantee that commissioning consortia will have the skill and expertise necessary to hold private providers to account? If so, will he explain how? Can he also confirm whether commissioning consortia will be obliged to accept tenders for goods or services from any operators in any other EU member states, even those whose health care markets are closed to competition from UK suppliers?

Hon. Members will, I am sure, be glad to know that I am about to bring my comments to a close. My fourth concern about applying the proposals to the NHS is that driving competition through most parts of the NHS while removing primary care trusts and SHAs could risk the sustainability of many hospitals, particularly local district general hospitals. We have covered most of those points already. However, the hon. Member for Southport raised the issue about private providers cherry-picking profitable services and leaving NHS hospitals to run more expensive and complicated services, such as A and E. The BMA has raised that issue. Its latest briefing on the Bill states “Local health services…may become destabilised if arrangements between local providers and commissioners that have worked well in the past are deemed anti-competitive by Monitor. Existing NHS services could be at risk of closure, despite being popular with patients and delivering high quality care.”

As I said, primary care trusts and strategic health authorities currently manage the consequences of bringing different providers into the system and ensure that the impact of individual contracts and of having patients moved around the system does not threaten the financial future of individual hospitals, or the health economy as a whole. However, those bodies, of course, will be abolished by the Bill, which removes the ability to manage the often significant consequences of patient choice and diversity of provision.

As we have said before in this Committee, it is unclear who, if anyone, will be responsible for system management under Government plans. Will it be Monitor, the NHS commissioning board or the commissioning consortia? The Bill is unclear about how those different parts of the system will work together. When PCTs and SHAs are abolished, who will have overall responsibility for system management? If a service moves out of a particular hospital, leaving it with major financial consequences, who will be responsible for ensuring that that hospital is not destabilised?

Can the Minister guarantee that, if commissioning consortia work together, including with the NHS board—to reconfigure services, for example—they will not fall foul of competition law? The Secretary of State said on Sunday—and the Minister repeated it this morning—that the Bill prevents any private provider from cherry-picking services. That returns us to the point made by the hon. Member for Stafford. If providers cannot compete on price, where is the danger?

However, ensuring that providers cannot compete on price will not, on its own, prevent cherry-picking. In a competitive market, private providers can choose which services they bid for, and they may well choose not to bid for more complicated services, or for services for groups of patients with more complex needs, because, as I explained, it is difficult to guarantee the quality and care outcomes. Will the Minister tell us precisely which clauses guarantee that the cherry-picking of services will not happen under the legislation?
My final point centres on increased costs under the new system. I think that my hon. Friend the Member for Kingston upon Hull East has already quoted Chris Ham, who said that “the government’s proposals run the risk of replacing the bureaucracy of performance management with the red tape of economic regulation. Monitor will need to employ large numbers of economists, lawyers, accountants and managers to deal with competition issues”.

The Minister stated earlier that Monitor’s costs will increase by up to six times, from £20 million now up to a potential £130 million in future. I would argue that it is not just Monitor that will face increased costs. GPs and hospitals could also end up employing an army of lawyers, accountants and managers to deal with the Government’s NHS market. GPs and hospitals might also have to take out expensive insurance against the risk of being fined, taken to court or even sued because they fall foul of competition law. Far from reducing the costs of bureaucracy, as the Government claim, the costs of red tape will increase.

I am sure that the Minister will not deny this—perhaps he will—but if a model is to be applied to the NHS, an assessment should be made of the new system’s likely costs, so that the Minister can say what the likely costs are, not just for Monitor, but for commissioners and providers of the new system. Has the impact assessment looked at that and the costs of legal advice, insurance and so on?

I have spoken for a considerable time and I am grateful to hon. Members for their patience, if not their attention. These are serious issues. I raise them not in jest or for scaremongering, but because they are genuine concerns that have been raised with Opposition Members not only by professional bodies, but by patient groups. The questions have been raised in discussions that I have had with lawyers who are involved in both competition law and the NHS. I am sure that the Minister will wish to answer them as fully as possible.

The Government have not, so far, talked about the broad range of changes in anywhere near as much detail as their plans for GP commissioning. Ministers may feel that they have done so in this Committee, but I think it will be big news and a shock to members of the public that the plan is to turn the NHS into the same system as applies to gas, electricity, telecoms and rail. Government Members should understand the real concerns about the fact that competition law in the United Kingdom would be applied to the NHS. As a consequence, the Government contracted with the independent sector.

Some people did not agree with those arrangements. I did. I felt that some patient choices in my constituency a decade ago were unacceptable, such as when a consultant would say to someone, “You can wait two-and-a-half years for a new hip or a new knee or you can go to a hospital waiting for an operation, during which time you might have an accident on the motorway and so on.”

Mr Barron: My hon. Friend has made a very good contribution to the debate. We should reflect on the powers of Monitor when discussing the future of the national health service. My hon. Friend shone light on the reduction of the independent sector in the last decade and on how that was done within a managed framework. She also talked about how our once public utilities are now owned by companies from abroad.

I remember that you, Mr Hood, and I were members of a Committee in 1989 on the privatisation of electricity. We were told by the Government of the day not to worry because electricity would have third-party access throughout Europe and we would be in a position where our electricity would be able to go elsewhere, and we could buy in. In fact, my local electricity company is run by a French state industry, which operates several utilities in this country. The third-party access that was talked about for ideological purposes never happened in a lot of areas where our utilities were once public. All hon. Members should reflect on such issues.

I want to pick up on a number of things that have been said about the past 10 years and the introduction of the independent sector into the national health service, known as “competition” to some people. It is certainly not the same competition as outlined in the Bill. I will have a couple of questions to ask the Minister about the Bill’s exact intention.

Many independent contractors were brought in to undertake screening and the immunisation against human papillomavirus under contracts with the national health service. Where there was a change—designed by the then Government, in my view, although I was not a member of the Government at that time—was when a measure was introduced to reduce waiting times inside the national health service and set targets on areas of orthopaedic surgery. As a consequence, the Government contracted with the independent sector.

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In many cases, such establishments had to be built. Ironically, when I was on the Health Committee in the previous Parliament, we visited a treatment centre that had been run by the national health service for many years. However, in most district general hospitals, that did not happen and the reason why we had long waiting times for orthopaedic surgery was that people were in hospital waiting for an operation, during which time there might have been an accident on the motorway and so on.

The surgeons would be taken away from such lists to deal with the emergencies and, as a consequence, our constituents were knocked back. Even some who were getting ready for surgery were sent back home and told to come in another day. Some parts of the NHS got rid of that practice by having designated areas in which people were guaranteed to have the operation on the day they went in. I visited them and during the last Parliament, the Health Committee took evidence on them.

It is true, as the hon. Member for Stourbridge said, that some were contracted by volume and were never met. I visited the one in north Derbyshire that serves my constituency, which is on the Yorkshire-Derbyshire border. One reason was that some GPs in the NHS were reluctant.
to refer their patients to an independent sector treatment centre. I accept that entirely. I think that they were wrong; the public purse paid for the centres, and they could have dealt with waiting times in other surgeries. However, I accept it.

Introducing the independent sector into the NHS in that way is, however, a lot different from introducing competition and competition law. Although I am not a lawyer, I will give my view. The first phase of independent sector treatment centres had some deficiencies, such as a lack of training for young doctors. The Government got a number of similar things wrong that they should have got right from day one. However, phase 2 in South Yorkshire never took place. I was lobbied by the owner of one of the two hospitals in Sheffield—I will not name which one—to prevent phase 2, because the hospital was at about 50% capacity at the time, and if the proposals went ahead, it would have been competing with a treatment centre in 10 years’ time. Phase 2 never happened. The initiative was meant to drive down waiting times. Phase 1 is still being used, and I think that it was the right and proper thing to do.

NHS patients use the hospitals in Sheffield as well, when local hospitals cannot deal with them in the time scales laid down. As a consequence, the independent sector has been used directly by NHS patients. Personally, I do not think that there is anything wrong with that. That managed framework for using the independent sector is right and proper. What worries me is what the future holds. We are introducing competition under Monitor, which will have a statutory responsibility to promote competition. I am deeply worried about what might happen under the Bill.

The White Paper published last July discussed Monitor’s scope and powers, which are wider than what is suggested in the explanatory notes and include competition. I hope that the Minister will listen to this. I have some questions about what the White Paper says. Page 39, paragraph 4.28 says:

“Like other sectoral regulators, we propose that Monitor should have proactive, ‘ex ante’ powers to protect essential services and help open the NHS social market up to competition, as well as being able to take ‘ex post’ enforcement action reactively. Ex ante powers would enable Monitor, for instance, to protect essential assets; require monopoly providers to grant access to their facilities to third parties”.

I will stop there. Every time I look through the window, I see what I would term—I am not a lawyer—a monopoly provider: St Thomas’ hospital. What are the implications of that paragraph in the White Paper for St Thomas’ hospital, my local hospital and many other hospitals throughout the land? I hope that the Minister can tell us exactly what the intent of that paragraph is, as it is not laid out clearly in the explanatory notes.

The White Paper goes on to say that Monitor may also conduct market studies and refer potential structural problems to the Competition Commission for investigation."

Again, what does that mean? What are the implications for referring potential structural problems to the Competition Commission for investigation? What does it mean in the context of the secondary sector of the national health service? I should like the Minister to tell us before we move on from the clause. That paragraph goes on to talk about the

“scope for purchasers to act anti-competitively, for example by failing to tender services or discriminating in favour of incumbent providers.”

The National Audit Office has published year-on-year figures for procurement in the NHS. That happens in other sectors, too. There have been one or two headlines in the past few weeks about how we have been paying far more for NHS goods than we should be. I remember, more than a decade ago, somebody buying syringe drivers in a hospital for about £36 a set in October, but a set cost about £73 in March. The hospital and the supplier were anonymised, but it was the same hospital and supplier because they were getting rid of the money at the end of the financial year. I agree with competition in such cases, but I am not too sure why competition law is better than driving better procurement in the NHS. I suspect that there are some cozy relationships between people who buy for the NHS and the people who supply it.

Paragraph 4.29 states:

“Monitor’s powers to regulate prices and license providers will only cover publicly-funded health services. However, its powers to apply competition law will extend to both publicly and privately funded healthcare, and to social care.”

Again, I pose a question to the Minister. What is the implication of that? What does it tell the Committee about whether competition law will be involved in every aspect of health and social care in this country?

I have a brief from the NHS Confederation, which talks about competition law. I briefly mentioned two aspects of competition law to my hon. Friend the Member for Leicester West during an earlier intervention. The brief states that it does not believe at this stage that PCTs are involved in competition law when commissioning NHS services and would not be subject to it. The paper rightly goes on to say that whether or not noncommissioning consortia would be covered by such competition law would depend on how things evolve in the future.

During an earlier intervention, I said that such competition law is not only UK-based, but EU and UK-based, which effectively means that any player could be involved. I do not know whether EDF would want to own my local hospital or have rights at my local hospital that it does not have now. I do not say that in a scaremongering way. Given the powers that are being given to Monitor, as outlined in the White Paper and the explanatory notes, the Committee has every right to ask, before we go any further with this aspect, about the implications for the NHS as we know it.

It is one thing to encourage the independent sector to improve the patient journey and to give patients more choice—I accept that entirely and support it—but it is another thing to say that Monitor will have the right to regulate competition throughout all health care in this country, although it will be dealing specifically with the NHS. There are major implications for the future of the NHS, and I want to know the answers to these questions.

Will third parties have the right to go to my local monopoly providers and use facilities? That has happened for a long time with private patients in NHS hospitals, but this provision goes far beyond that. I hope that, before we conclude this clause stand part debate, the Minister will answer some of these questions.

Before we go any further, it seems relevant that we should know the implications of the Competition Commission being brought into areas of health care
that people grumble about. In the end, this is not about people working in managed frameworks, as now. People can grumble about GPs, and I have grumbled about what some GPs are and are not doing in using the independent sector. We are talking about a publicly paid-for facility, never mind who owns it. That seems to be a relevant argument, and it is entirely different from turning around and saying that competition law will apply and that lawyers will come in and argue whether facilities should be used by individuals.

5.30 pm

I have deep concerns about that, and I hope that the Minister can satisfy the Committee that we will not see the end of the type of national health service that we have seen before. The previous Government—rightly so in my view—used the strength of the wider health care system in this country to improve the lot of patients. I do not necessarily think that a fully competitive market will do that. Indeed, while looking round the world at health care services during my time on the Health Committee, I realised that there was no better place for equitable health care than in this country. The 20% of people who could afford it might get better care in places such as America, but there is no more equitable health service than this country's—none is better funded and ours asks nothing of someone when an ambulance comes to pick them up on the street. I hope that powers will not be given to Monitor that will lead to people being asked whether they can afford health care when an ambulance comes to pick them up.

Grahame M. Morris: I support the arguments that have been forcefully and eloquently made by my right hon. and hon. Friends, and I will try not to repeat them. The key issue with clause 52, which goes to the heart of the Bill, is the change in the role of the independent regulator of NHS foundation trusts. It will, instead, carry out the duties and functions of an economic regulator for the markets funded by the NHS. As we have heard, its sphere of activity will be to promote competition, using Office of Fair Trading powers to apply competition law to the commissioning of both private and—while they last—public providers and, indeed, social care. There has been a well-reported, alleged U-turn on price competition within the health service. Opposition Members are eagerly waiting that being actually transcribed into the Bill. I will return to that point, and I hope that the Minister can clarify certain points about price competition.

Monitor will treat patients as consumers of health services. As clause 52 sets out, Monitor's role is to

"in our view the core of the Bill is part 3, concerning economic regulation, setting up Monitor and the powers that will be associated with it. That takes forward things that we have been doing in the health service for 20 years"—

as Government Members have pointed out, but he continues—

"but goes much further in creating the architecture of a market, and it is unknown how that will work in practice. Whatever the policy intentions, whatever the legislation says, there may well be a gap, once these arrangements are up and running, in how the regulator works in practice."—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 30, Q61.]

There must be serious concerns about how Monitor will carry out its duties and what it will decide that its duties are. As the Bill stands, we have only broad-brush responsibilities and Ministers' stated intentions to guide us. As with previous clauses, there is a lack of explicit detail. Much of the changes and the intent are implied, and we would like that detail incorporated into the Bill. However, we fundamentally disagree with the clause.

We have already discussed amendment 479, which would have expanded Monitor's main duty, which is to protect and promote the interests of people who use health care services, but would have removed its rather broad duty to promote competition where appropriate, through regulation where necessary, in relation to its main duties. My hon. Friend the Member for Leicester West quoted the new chair of Monitor, Mr David Bennett. In an interview in The Times, he said that there is competition in power, rail, water and telecoms and experience in tackling monopolistic and monolithic markets and providers and in using economic regulation, and that that is how it should work in the NHS. There is a clear conflict between what the new chair of Monitor is saying and what the Minister is saying. That point of view is utterly out of step not only with the Opposition's view, but with those of the BMA and the general public.

On 15 February, I put it to the Minister of State, Department of Health, the right hon. Member for Chelmsford that he could liken the new NHS to "running a mobile phone company or a gas supply company, in that the health service will be independent and market-oriented, and politicians will have no control over it".

The Minister responded in his usual sanguine manner:

"I am sorry, but I do not think the hon. Gentleman has quite got the plot behind the philosophy of...liberating the NHS. It is none of those things."—[Official Report, Health and Social Care Public Bill Committee, 15 February 2011; c. 188.]

The Minister should not worry. He is not the only one to be being contradicted by the new chair of Monitor. Speaking to the publication, GP earlier this month, David Bennett contradicted both the Secretary of State and Sir David Nicholson, the chief executive of the NHS, by saying that the Bill paves the way for providers to compete on price. He said:

"It is more likely to be at commodity level rather than specialist services."

and that

"Monitor and the NHS and the NHS Commissioning Board will be very careful about where we introduce it."

The fact that two arm's length, unelected bodies—Monitor and the Competition Commission—will use the powers in the Bill to introduce price competition in the NHS, whether it is done quickly or slowly, should ring alarm bells. Indeed, that should be a wake up call for us all. The Secretary of State has said time and again, and it
has been repeated by the Ministers, that that will not happen. We should be rid of any notion of Monitor promoting competition, especially when competition is undefined in the Bill. None of us knows how Monitor will interpret its responsibilities. It is disingenuous for Ministers to speculate about its intentions. Such speculation may turn out to be completely wide of the mark.

The most recent briefing note from the King’s Fund states:

“The approach set out in the Bill places a heavy onus on Monitor as the economic regulator to oversee a step change in competition in the health care market. The outcome will depend on how Monitor interprets its duties and invokes its powers.”

It goes on to state:

“In more complex areas of care, evidence suggests that the emphasis should be on collaboration and integration”.

I think that hon. Members agree about the value and importance of such a collaborative and integrated approach, not only between primary and secondary care, but between health and social care. Although Ministers have stressed the need for integration, Monitor will not have a duty to promote it. Surely, that is an incredible admission, given the debates that we have had.

Subsection (2) states:

“Monitor must have regard…to the likely future demand for health care services.”

That responsibility seems to contradict its other responsibilities to promote competition, which in turn will lead to the failure of some providers, including some NHS providers. The Health Secretary suggested that he could amend the reforms after the recent Liberal Democrat motion at their spring conference in Sheffield condemned them as “damaging and unjustified”. We are discussing some of the most contentious and controversial elements of the Bill, so I urge Members on both sides of the Committee to consider the issues that are at stake before they vote on clause 52.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): As many of my hon. Friends have said, the clause goes to the heart of a Bill that puts health on a systems level, competition does not happen. We should be rid of any notion of Monitor promoting competition, especially when competition is undefined in the Bill. None of us knows how Monitor will interpret its responsibilities. It is disingenuous for Ministers to speculate about its intentions. Such speculation may turn out to be completely wide of the mark.

The most recent briefing note from the King’s Fund states:

“The approach set out in the Bill places a heavy onus on Monitor as the economic regulator to oversee a step change in competition in the health care market. The outcome will depend on how Monitor interprets its duties and invokes its powers.”

It goes on to state:

“In more complex areas of care, evidence suggests that the emphasis should be on collaboration and integration”. We are discussing some of the most contentious and controversial elements of the Bill, so I urge Members on both sides of the Committee to consider the issues that are at stake before they vote on clause 52.

Owen Smith: We have had a curate’s egg of a performance from the Minister today, in respect of this crucial clause. It has been good in parts; my right hon. Friend the Member for Rother Valley had answers to some of his questions about the extent to which we will see unbridled competition in the NHS. We heard a very clear exposition from the Minister on how that will work, and I will come back to that in a moment. It was bad—rotten—in that we did not receive any greater clarity about price competition and the extent to which it is the driving force behind creating an economic regulator. We have heard lots of warm words about the fact that quality, rather than price, will drive competition. Truthfully, though, those warm words are leaving us, and people outside the Committee, more confused about the Government’s intentions.

5.45 pm

Nicky Morgan (Loughborough) (Con): I cannot listen to the hon. Gentleman without asking him whether the real reason for the confusion of Opposition Members is that they are not getting the answers they want. They have an agenda, and believe that the Bill is all about price competition and privatisation. Despite what the hon. Member for Leicester West said, they are scaremongering. The reason they are not happy and are talking so much this afternoon is that they hope to good people into saying, “The principle of the NHS, which is free at the point of need, is absolutely preserved in this Bill.”
Owen Smith: I am grateful for that intervention. The hon. Lady and other hon. Members should really listen to what the Minister is saying and set it against the previous statements of Ministers and the clear intentions set out in the White Paper and determine, as we are now doing, where the clarity of the narrative sits. Let me quote some remarks that the Secretary of State made in January—not months or even years ago—on the Department of Health website:

“Monitor will have a vital new role in ensuring effective competition and a level playing field, acting in the interests of patients and the taxpayer. They will also oversee the process of price competition”—

not quality but price competition—

“which is to be allowed only where it is deemed appropriate and where it will not harm quality of service.”

Nicky Morgan: Does it say anywhere on the website or in the Minister’s remarks that what is at stake and what will not happen after this Bill is passed is that there will be some sort of up-front charging of patients for their treatment? That is the point of principle that most constituents care about and that is not under threat from this Bill, whatever the hon. Gentleman might like to think.

Owen Smith: I notice that the hon. Lady did not come back to rebut the point that the words “price competition” were in the mouth of the Minister of State, the right hon. Member for Chelmsford, only a couple of months ago. We have also heard from the right hon. Gentleman that genuine competition was going to be the key driver of reform in the NHS.

We are not the only ones who are confused. Many organisations, such as the British Medical Association, which is representative of doctors’ opinions, and many lay readers are confused about what the Government intend. Were this straightforward, price-driven, commercial competition, red in tooth and claw, we would understand it. Instead it is morphing into a hybrid whereby competition law and its commercial underpinnings are the arbiter of performance in the NHS, with price competition somehow not being a part of it. As someone who has worked in the private and public sector, that seems to me to be a curious market.

Let me move on now to answer the hon. Lady’s second point. It is an extremely narrow definition of privatisation in the NHS to suggest that it is about the charging of individuals, consumers, for receipt of NHS services. No one is suggesting that the Bill will lead overnight to members of the public being charged for NHS services. Let me go even further. No one is suggesting that the Bill instantly leads to the privatisation of the NHS. What it does, however, is lay the foundations for performance in the NHS, with price competition somehow not being a part of it. As someone who has worked in the private and public sector, that seems to me to be a curious market.

What the Minister said this morning was so interesting that, sad individual that I am, I listened to it again at lunch time. Hansard, marvellous though it is, could not report it in time, and I know that the Minister sometimes worries that he is misrepresented, so I concede that this is my transcription of his words, not that of Hansard. However, I am sure that it is pretty accurate.

The Minister said, “Another hon. Member mentioned the whole question of EU and British competition law. Can I just say that the Bill does, with regard to this area, simply add ‘Monitor’ as an enforcement body? The OFT already has these powers in respect of the health care sector, and the Bill itself does not introduce any new competitive law or extend the applicability of current EU and UK competition legislation. However”—this is the key point—“as NHS providers develop and begin to compete actively with other NHS providers and private and voluntary providers, UK and EU competition laws will increasingly become applicable. The safeguards offered by these laws will therefore apply equally to all providers.” Yes, the safeguards will apply, but so too will the threat; so too will the prospect that decisions on commissioning and tendering will be challengeable under EU law. The Minister went on to say what had happened under the Labour Administration, when only 5% of the NHS budget was going to private providers. Why is it different?

The Minister said, “In the health-care sector currently, we have a situation where 90% of health care provision is being delivered by public providers fulfilling a largely social function. Organisations fulfilling a purely social function are not for profit and are not considered to fall within the definition of undertakings, and therefore are not subject to European competition rules. Markets have only been developed in certain limited sectors over the last decade. However, in a future where a large majority of providers are likely to be undertaking for the purposes of EU competition law, this law will apply.” That goes to the heart of the difference between what pertained under the Labour Administration in respect of the entry of private providers into the NHS and what will pertain under the new regulations.

Tom Blenkinsop: Is my hon. Friend aware of the Adjournment debate that took place today on the national blood transfusion service, during which I asked the Minister whether the current review of that service is subject to European competition law? The Minister confirmed that it already is.

Owen Smith: I am not surprised. As I said, the architecture being laid out by the Minister is clear. I for one am extremely grateful to him for that, and for answering many of the questions raised by my right hon. Friend the Member for Rother Valley. However, many questions remain, most of which are critical to price.

We are told, as I have outlined, that competition will bite on the NHS as it has not done before, but we are also told that such competition will be driven solely by quality. No one on the Government Benches and none of those who gave evidence have come up with a single area of NHS services where it would be appropriate—“appropriate” is the critical word—for Monitor to be given the duty to apply competition. No one has suggested a single area in which it might be appropriate to apply price competition.

Liz Kendall: Does my hon. Friend agree that saying that Monitor will promote competition “where appropriate” is a most opaque and ill-defined phrase? Should not the question of when competition is applied be based on evidence of its effectiveness and be determined not by
an economic regulator but by commissioners on behalf of patients. Does my hon. Friend agree that the Minister has yet to say who is to define “where appropriate”?

**Owen Smith:** I entirely concur with my hon. Friend. It is only a matter of time before she is a right honourable Friend.

**Mr Burns:** You’re in opposition.

**Owen Smith:** Not for too much longer. I hope. It depends when the Lib Dems peel off. Nowhere does the Bill state the terms under which Monitor will deem price competition, or competition on quality, to be an appropriate method for improving the delivery and efficiency of health services. That is a crucial point.

Why are we concerned about competition? As many Government Members have pointed out, we introduced some degree of competition to the NHS. We have pointed out that we did that within a managed framework to tackle specific problems and in a prescribed and proscribed manner, which is radically different from this Bill. The result of that was that only 5% of the NHS budget was ever in the hands of private providers. The difference here is that we are talking about opening up the whole of the NHS—all aspects of service provision—and having no-holds-barred competition being applied to the NHS.

**Liz Kendall:** No going back.

**Owen Smith:** As my hon. Friend says, there is no going back from that. Once it has been opened up, it is hard to imagine how lawyers will ever be able to unpick it. Competition will be completely disruptive. This is an NHS that is not built on commercial law, where doctors do not have experience of operating within a competition framework, and where the new consortia, let alone the existing PCTs, do not have the requisite expertise to make decisions on whether their commissioning decisions are in line with or at odds with EU competition law. At the very least, as the hon. Member for Stafford said earlier, it will create concern in the minds of GPs. We can go much further: it will inevitably lead to risk-averse decisions, to tendering for services on an open market and to advertising in the Official Journal of the European Union or elsewhere, for fear of falling foul of European competition law.

With that risk-averse behaviour, will come inordinate increases in costs—that is inevitable. There will also be inordinate increases in the training costs that will be borne by the NHS providers in order to insulate themselves. One of the big changes that anyone who works in the private sector will have seen in the past decade is the growth of compliance officers and lawyers around procurement, precisely to shield companies from falling foul of aggressive interventions by competitors under European competition law. That is precisely the sort of defensive behaviour that the NHS will have to undertake if it is operating in this sort of framework. Litigation costs, training costs and so on are all bound to increase.

Speaking of litigation, the hon. Member for Southport came up with an arresting phrase. He referred to the “cosy cartels of care”. The reason I thought it arresting is that I can absolutely imagine that phrase in the mouth of a competition lawyer operating on behalf of a private provider referring to a “cosy cartel of care” when seeking to break up a long-established, locally welcomed and arguably effective integrated care pathway. One man’s cosy cartel of care is another’s carefully calibrated, integrated, locally respected care pathway. That is precisely the sort of debate we can imagine occurring in the NHS.

**John Pugh:** The hon. Gentleman is right about goods and services and the costs under OJEC regulations that the health procurement process gets involved with. The Minister can correct him if it is different, but is he suggesting that ultimately, perhaps sooner rather than later, we will end up with the same competition framework for clinical services as we currently already have for some goods and services within the NHS—taxis and things like that? In one respect there is a certain amount of flexibility there, but is that what he is suggesting?

6 pm

**Owen Smith:** I am suggesting that that is my interpretation of what the Minister said earlier, and I think it is legitimate. In the past, and under the current rules, health and social services have been excluded from EU competition law and its UK legal framework, which I believe is the public services procurement regulations 2006, because they have been designated part B services. They have been state-protected, publicly provided services, so the bits for which the NHS has had to competitively tender have been things such as providing wastepaper baskets or other non-clinical services. However, the very clear implication of what Minister said was that once there are multiple providers in a system, that system is inevitably opened up to scrutiny under EU competition law, and that both NHS and private providers and will be subject to that. If I am wrong and the Minister was not implying that, I would welcome some clarity.

**Derek Twigg:** My hon. Friend is making a very powerful speech. The Minister must respond to the fact that he touched upon before, which is that once the system is open to EU competition regulations there is no going back, ever. That is the difference, and it is a massive change from where we are today.

**Owen Smith:** Absolutely. Lawyers are not circling this stuff naively; they have been engaged in testing the extent to which states can protect and proscribe health services from the full rigours of EU competition law. Our profound worry is that the Bill signals the end of that protection. The inevitable consequence will be the disaggregation and fragmentation of the NHS—the ending of a national service. It all militates against the sort of integration and collaboration that has been the underpinning ethos of the NHS since its inception.

**Liz Kendall:** Just in case Government Members think that Opposition are making up an argument without foundation, people have raised these issues with us. Indeed, the NHS Confederation has issued a joint briefing with one of the top 50 legal firms, Mills and Reeve, “An introduction to procurement and competition for GP commissioners”. The PCT network at the confederation understands that, after PCTs are abolished,
the commissioning function will move to GPs. It has issued a briefing making it clear that although PCTs, in commissioning NHS services, are not undertakings subject to competition law, that may well change under the new system. It says that “areas of law and policy continue to develop quickly” and warns of the implications. It is doing that are very grave concerns—

The Chair: Order. That intervention is too long.

Owen Smith: But a very relevant one if I may say so, Mr Hood.

I am conscious that I have been speaking for a long time, so I will conclude by returning briefly to the issue of price competition and making a plea for the Minister to clarify what is going on in that respect. Are we witnessing a volte face, a change of mind by the Government? Have they read Carol Propper’s paper and looked at the other evidence and decided that price competition is a bad idea because the evidence suggests that it drives down quality? Or are we witnessing sleight of hand—the Minister and others suggesting that there will not be competition on price when in reality there will, which is why an economic regulator is needed to deal with it?

If there is to be competition only on quality, I have two more questions. First, what competence does Monitor have to judge quality of health care provision? Monitor will be full of lawyers and accountants, not clinicians, so how can it be the arbiter of quality in the national health service?

Secondly, if quality is the principal driver of competition, why on earth are we going to subject the NHS to competition law? Why can we not continue with the status quo that protects the NHS? The Care Quality Commission’s various committees are peopled by doctors and clinicians, so why can it not act as the arbiter of quality in the national health service?

However, it is not Mr Bennett who makes the argument for competition in the NHS; it is in the Bill and, specifically, in the clause. Under clause 52(1)(a) and (b), it is absolutely clear that Monitor’s function is “promoting competition where appropriate, and...through regulation where necessary.”

By introducing a blanket imposition of a market philosophy, it is clear that competition will almost certainly reduce commissioning effectiveness. The privatisation of the utilities industry was based on the dynamic of supply and demand, with excess supply being key to regulating the market’s economics. In the health care system, especially considering the NHS’s limited resources and the complexity of patient care, that analogy becomes flawed, to say the least, and extremely dangerous to the future of the NHS.

Monitor will have a large role in the NHS under the changes that are outlined in the clause. Undoubtedly, competition is embedded within the clause and the entire Bill. When he took up his new role at the beginning of March, Dr Bennett wrote a letter to foundation trusts in which he said that he wanted Monitor to become “an exemplary economic regulator, building on lessons from other sectors and making sound decisions in an open and transparent way based on dialogue, widespread consultation and rigorous, fact-based analysis.”

The measures under the clause create the risk, however, that the Government will replace the perceived bureaucracy of performance management with the red tape of economic regulation. They will demand that Monitor employ undoubtedly large numbers of economists, lawyers, accountants and managers—whose numbers will grow over time—to deal with competition issues, providers who fail, price setting, licensing providers and other work.

The complexities of the regulatory arrangements become apparent when we consider that Monitor will also need to work hand in hand with the Competition Commission and the Office of Fair Trading on competition, the Care Quality Commission on regulation of quality, and the NHS commissioning board on price setting. It will be a hugely powerful empire within the NHS and a wholly new bureaucracy. It will spend public money with the sole purpose of ensuring a market, not of ensuring quality, nor of maintaining frontline services. It will necessitate huge amounts of power and personnel to police a competitive system that runs counter to all received wisdom within health economics since Arrow in 1963.

What could be more counter-intuitive to the Government’s hailed liberation of the NHS than an NHS reorchestrated for commercial purposes? Price competition in health care is not the route to take, even though it has brought gains in other sectors. Peter Smith, who is one of Britain’s most respected health economists, recently conducted a review for the OECD. He found that evidence on the benefits of competition is equivocal and underlined the challenges in applying market principles successfully. The review concluded that effective implementation of market-type mechanisms is likely to require considerable managerial skills and impose substantial transaction costs, particularly on purchasing and regulatory institutions. Links to markets have given rise to the argument that there should be increased collaboration between providers in many areas.
of care—including the provision of specialist cancer and cardiac services through networks and care for people with chronic diseases—through the integration of primary and secondary care.

Lessons from the experience of applying market principles in the NHS since the 1990s also need to be heeded. In a highly visible public service such as the NHS—the nearest thing we have to a national religion, according to Nigel Lawson—it will always be difficult for politicians to distance themselves from controversial matters such as reducing access to hospital services when providers fail to compete successfully, even if those decisions are taken by the regulator, Monitor.

In that respect, as in many others, health care is different from the former publicly owned utilities, underlining political and technical challenges and adapting lessons from one sector to another. Furthermore, competition in the health care sector is different to that in other regulated sectors. In most regulated sectors, consumer choice is now taken for granted, but it is a relatively new concept in the NHS. In other sectors, the consumer pays for the service they receive, but in the NHS the service is free at the point of delivery and paid for only indirectly via taxation. Therefore, the scope for price competition is more limited. The promotion of competition in health care and social care services may focus on those areas where patient choice can be viably introduced, and thus where there is competition—at least non-price competition—in the market. That includes an increasing range of elective, diagnostic and other services. Measures currently promoting competition in the NHS include the Primary Care Trusts (Choice of Secondary Care Provider) Directions 2009. Monitor will also set the objective of making best use of limited NHS and adult social care resources, and there will be a difficult balancing act between short-term austerity measures, and the longer-term perceived benefits of choice.

Liz Kendall: Does my hon. Friend agree that it is not clear who decides how to make the best use of finite NHS resources? He rightly quotes from Monitor’s responsibilities, but is it not the case that NICE is supposed to help make decisions about what drugs and treatments should be used, and that GP commissioners will have to make decisions about whether to give expensive drugs to patients? It is not clear who takes those ultimate decisions.

Tom Blenkinsop: I concur with my hon. Friend’s forensic examination of the consequences the new body will create, and I will speak specifically about how it must act as an agent in relation to competition law. Choice is surely not appropriate for services such as emergency ambulance admissions to A and E, where referral to a local provider is automatic. However, competition for the market may still be promoted, for example by requiring that transparent affair procurement procedures are followed before the A and E providers are commissioned in a particular area for a specified period. It is not yet clear how far the promotion of competition in the market will be considered appropriate within the NHS, and I hope that the Minister will provide an edifying response to my question on that.

The Government will give Monitor concurrent powers to enforce competition law in the UK health and social care sectors. The scope of those powers is therefore broader than its licensing powers, which are limited to the licensing of providers of NHS-funded services. Monitor will have the power to enforce the Competition Act 1998 against the full range of health care providers in relation to their NHS, private health care and social care activities. In addition, Monitor will have the power to carry out market studies and refer dysfunctional markets in the health and social care sector to the Competition Commission for investigation. That power has been used in other sectors by the Office of Fair Trading to refer the groceries sector, for example, or supermarkets to the Competition Commission.

Monitor will have the power under its general licensing powers to set not only general licence conditions applicable to all providers of NHS-funded services, but special conditions for some providers, incumbent on other providers having the ability to prevent choice and quality development as a result of their powerful position. The special conditions may include obligations to accept or provide services in certain circumstances.

6.15 pm

Historically, the Office of Fair Trading has been reluctant to get involved in investigating conduct relating to NHS-funded services, as health care provision has always been based on quality and not purely on price. The co-operation and competition panel was tasked with advising Monitor and the Department of Health on anti-competitive practices by NHS providers and commissioners, further to “The principles and rules for cooperation and competition”, the code of conduct drawn up by the Department of Health. Compliance with the PRCC is encouraged by the threat of directions imposed by the Secretary of State, against NHS acute trusts and PCTs, or of licence enforcement by Monitor, against NHS foundation trusts. The PRCC, therefore, currently exists in parallel with the competition law rule.

Conferring concurrent competition powers on Monitor marks a departure from the PRCC and a move towards embracing the application of a more coercive and independently enforced competition law in the NHS-funded health care sector. It seems likely that, in time, the clause will undermine the PRCC, and one can conclude only that the code will be disbanded in favour of guidance on the application of competition and procurement law in the sector.

Significant uncertainties remain. Competition law will apply only to the activities of undertakings, as defined in UK and EU case law. That definition encompasses the activities of bodies that operate on economic markets. Assuming patient choice expands and competition is promoted, there will be an increasing array of NHS markets and thus increased scope for the application of competition law to both primary and secondary care services. It seems likely that the move towards concurrency will simplify the UK rule framework by removing the need for the PRCC. It will safeguard the promotion of competition, given the severity of the potential sanctions for competition law breaches, which include fines of up to 10% of the turnover of the undertakings involved. Competition will have absolute primacy over quality.
Monitor will be able to consider factors that may put particular providers at a relative disadvantage, and make proposals to the Government or the NHS commissioning board to ensure that any differences are fair. One of the challenges faced by Monitor in promoting competition in the health care sector is that the types of provider that will be competing in the new markets have very different characteristics, and that might help or hinder their ability to compete fairly. A case in point is the current restriction on a foundation trust’s ability to provide services to private patients. That restriction is to be relaxed considerably under the reforms in the Bill, and foundation trusts will thus be encouraged to find new sources of income from private patients. That undermines the principle of “free at the point of use,” and might increase waiting times for non-private patients.

Mr Burns: I assume that the hon. Gentleman knows that when the legislation was first introduced to the House by Alan Milburn and Tony Blair back in 2002, the intention was not to have a cap, and the only reason the cap has been as it has, is that it was necessary to buy off rebels in the governing party to get the legislation through.

Tom Blenkinsop: Getting back to the Bill—[Interruption.]

At the same time, the independent sector might question some of the advantages enjoyed in the market by, for example, foundation trusts. Such advantages might include not only a position of incumbency but access to NHS staff pensions and NHS insurance cover. As a result of the clause, the need to ensure a level playing field will have to be viewed in the context of the debate on ensuring competitive neutrality in mixed public-private markets. The OFT published a paper on that subject in July 2010, building on a 2006 paper written by the CBI and the Serco Institute, entitled “A fair field and no favourites—competitive neutrality in UK public service markets.” The health care sector is one of the sectors in which the inherent advantages of certain players in the market might lead to competitive distortions.

The Bill notes that the Government are to introduce legal duties on the NHS commissioning board and on commissioners to promote choice, to act transparently and in a non-discriminatory manner in commissioning activities, and to prohibit agreements or other actions that restrict competition. Monitor will have the power to investigate and remedy complaints about procurement decisions or other anti-competitive conduct.

Commissioning and procurement is another area that is currently regulated by the PRCC and the CCP, as well as by strategic health authorities. Current CCP rules state that any providers unhappy with a tender process must pursue a complaint to the strategic health authority, with a right of appeal to the CCP. Under public procurement law, health care is a part B service, as my hon. Friend the Member for Pontypridd elucidated, and therefore is not subject to the full rigour of the Public Contracts Regulations 2006. Regulation 4 imposes a duty on contracting authorities to treat economic operators equally and in a non-discriminatory and transparent way, and EU law principles require an advertised tender process where there is a cross-border effect: for example, where a non-UK provider would be interested in the tender. Those legal principles are enforced by the courts, but their application to NHS health care services has not yet been tested. However, it will be if the clause passes into law.

As with competition law, the principles and rules for co-operation and competition relating to commissioning currently operate in parallel with public procurement law rules. There will therefore be a growth in new legal rules and duties to be enforced by Monitor. The Bill will cause Monitor to metamorphose into a leviathan. The possibility of bringing a direct action in the courts under the generic public procurement rules will remain.

The Minister must also be mindful that care is taken to ensure that the new commissioning rules are consistent with public procurement law, given the need to avoid confusion and given the supremacy of EU law. One key issue will be how market entry can be controlled fairly and transparently. How will private providers gain access to markets that have traditionally been the preserve of NHS trusts? How will foundation trusts with a national reputation secure out-of-area referrals if directed by Monitor, paying heed to EU competition law? How will such practices encourage collaborative relationships between primary and secondary care?

If Monitor wants to enable price competition below a regulated tariff cap, tenders will probably be needed, as the patient will not be influenced by price in making his or her choice. Again, that demonstrates the patient alienation at the heart of the clause and the Bill.

In other areas where competition for the local market is a possibility, open tender procedures may be needed before contracts are placed: for example, with a provider of A and E services. That might be subject to exemptions where, for example, only one capable provider is available.

The Government’s proposals on mergers are equally radical. It is envisaged that the Office of Fair Trading and the Competition Commission will have sole responsibility for investigating mergers in health and social care. Under current law, Monitor, in relation to foundation trust mergers, and the Secretary of State for Health, in relation to NHS trust mergers, investigate and approve mergers with the advice of the CCP on the competition implications, which has led the CCP to develop complex merger control analysis for NHS mergers, without any statutory basis for assessing the competition implications of mergers between NHS bodies.

Given that the Enterprise Act 2002 does not expressly take into account the specific characteristics of the health sector, the clause applies law unsuitable to health. Therefore, amendments to the Enterprise Act are needed before it can be applied to health. In particular, such amendments should seek to ensure that the full range of NHS providers are subject to the merger control rules and that the Secretary of State for Business, Innovation and Skills, not the Secretary of State for Health, will be able to intervene in health care mergers on public interest grounds.

Although the OFT has been involved in reviewing many mergers in social care and private health care, it has not yet considered mergers involving NHS health care trusts, which we will discuss in a later clause. That will change under the new rules in clause 60. My question to the Minister is this: will the definition of an enterprise under the Enterprise Act encompass NHS trusts and GP partnerships and consortia? If so, it will highlight the fact that GP practices are effectively small businesses,
and consideration must be given to the competition and other implications of consolidation in that area. It is another complication.

Given the current roles of Monitor and the Secretary of State in relation to mergers between NHS trusts and the need to take into consideration other factors than competition, it seems likely that a specific health care-related power of intervention will be introduced into the Enterprise Act as a consequence of the Bill.

Mr Burns: We have had a considerable debate on this clause. I fully understand that. Opposition Members’ numerous and lengthy contributions have expressed many issues. A number of questions have been raised by different hon. Members, and it would be helpful if I explain how I intend to make my contribution. I will seek to answer as many of the questions that hon. Members posed, without taking interventions, so that I keep to the point and do not start going down cul-de-sacs. The answers will be in order of contributions given by hon. Members, so they may not always be symmetrical. I beg indulgence in that respect.

It would not be useful or helpful for me to reiterate what the clause does. Opposition Members have a viewpoint considerably different from mine, and I suspect I will never convince them, because I do not think they want to be convinced. To be frank, I find some Opposition suggestions and views rather suspect vis-à-vis what is actually in the Bill. That is a point of argument or disagreement.

I would like to start by agreeing with the hon. Member for Leicester West. She went into considerable detail, saying basically—and then elaborating—that health is different from Ofgem, utilities and so on. I could not agree more: she is absolutely right. Health is very different from utilities. Quality is hard to judge in health, in the way that she mentioned. One cannot split up service providers; there are too many local providers; it is very difficult to set prices; and purchasers are not users but commissioners. In that respect, there is agreement. I have certainly never had any intention of treating the health service as if it were a utility. It just does not work like that. I hope the hon. Lady is reassured in that respect. However much it may pain her, we do agree that health is different. The details need to be different, and one size certainly does not fit all.

As the explanatory notes show, we have taken elements where appropriate from other regimes. Where it is not appropriate, we have customised the details, such as the special administration regime, to take fully into account the different situation, circumstances, mechanisms and mechanics of the NHS. It is true that quality is hard to judge in health, which is the first point that the hon. Lady made in illustrating the point. Our plans will radically increase transparency about outcomes, which is why there will be fixed prices, so competition is on quality.

Regarding the second point that the hon. Lady made, it is not true that regulation is harder with more providers. Competition works better with more providers and leads to less work for regulators to tackle anti-competitive behaviour. She also said that it is difficult to set prices. Again, I would agree that it is. Setting prices is an extremely complex issue. We already have a national tariff, and Monitor will have the specialised expertise to develop it further, independent of Government. I welcome that as a positive move forward.

Liz Kendall rose—

6.30 pm

Mr Burns: No. I said that I would answer the hon. Lady’s question because, if we are not careful, we will be here all night; one intervention will encourage others and we will not get any further forward. If she wants to hear the answers to the question, which I believe she sincerely does, let me give her them.

The hon. Lady said that competition law would prevent vertical integration by providers. If I cannot assure her, I tell her that that is not the case. Competition law does not prevent a provider from expanding its range of services. Indeed, patient choice and competition on quality would strengthen incentives for providers to work together in integrating services when that would improve quality.

The hon. Lady also said that commissioners—GP consortia—will become undertakings for the purposes of competition law. Commissioners, when purchasing services for the purpose of the NHS, will not be acting as undertakings. GP practices, when competing for services as providers, will be acting as undertakings and that is exactly the same position as now. She said that Monitor would be an economic regulator like telecoms and gas, but that health was different.

The underlying legal principles of economic regulation are the same, and we have drawn on them to help with the Bill. However, of course, as I said earlier, health is fundamentally different from telecoms and the utilities, and the way in which competition works will be different as a result. That is exactly why we have a dedicated regulator with the expertise to get the details right.

The right hon. Member for Rother Valley and the hon. Member for Pontypridd said that we should have competition within a managed framework.

Mr Barron indicated dissent.

Mr Burns: I am sorry for linking the right hon. Gentleman’s question to that of the hon. Member for Pontypridd. He has asked several questions that I will answer, but I understood him to be making the same point as the hon. Gentleman. If that is not the case, I ask him to accept my apologies.

The hon. Member for Pontypridd suggested that competition was acceptable in a managed framework, but not under the Bill. The Bill ensures that competition is always in a patient’s interest, bound by the values and principles of the NHS constitution. What is described as a “managed framework” is too often an excuse for unaccountable regional bureaucracies to subvert the choices of patients. “System management” is used to mean propping up poor quality providers and commissioners to give opaque cross-subsidies. Under the Bill, competition will be fair. It ensures that money follows the choices of patients transparently.
Grahame M. Morris: Will the right hon. Gentleman give way?

Mr Burns: I will not give way. The hon. Gentleman has misunderstood what I said. I will go through the answers to the specific questions that I have been asked, otherwise we will end up going up and down cul-de-sacs and never getting anywhere.

The hon. Member for Pontypridd asked me to clarify the Government’s proposals on price competition. Our policy is to promote competition on quality, driven by patient choice. Monitor will regulate prices through the national tariff, and we have tabled amendments to clauses under chapter 5 of the Bill which would clarify that the tariff will be a fixed price, not a maximum price. That approach would focus competition on quality, as I have been saying from the outset. Obviously, we shall be debating that in far greater detail when we come to the amendments under chapter 5, which begins at clause 103.

I was also asked who decides when matters are appropriate. The commissioners will decide how best to improve services and increase choice for their patients, including how best to utilise competition as a means to that end. Competition law and economic regulation will ensure that the regulated market operates in patients’ interests.

There have been allegations in some hon. Members’ contributions that commissioners will be forced by competition law to put everything out to tender. I hope that I will reassure Opposition Members—although, sadly, I do not think that I will, for reasons that we all understand—that procurement competition law will not require commissioners to put services out to tender. It provides that if services are put out to tender, commissioners must comply with relevant procedural rules. Moreover, we expect patients to have a choice in an increasing range of services and that there will be a much smaller role for competitive tendering.

The hon. Member for Leicester West believes that GPs will be driven by Monitor instead of their patients, but I do not accept that at all. The primary duty of GP consortia is to commission services that meet the needs of their populations and to secure continuous improvement in quality. I hope that she will accept that.

Mr Barron: Why didn’t you vote against then?

Mr Burns: The right hon. Gentleman shouts from a sedentary position, asking why I did not vote against the provision.

Grahame M. Morris: Will the right hon. Gentleman take an intervention on that?

Mr Burns: No, I will not. I am going to be consistent. If I give way to the hon. Gentleman—I would like to—his hon. Friends will start to tempt me to go down the same route, and we will then have the chaos that I am trying to avoid.

Derek Twigg: This is very unusual.

Mr Burns: It is not unusual. We have had a considerably long debate on the clause, and several of the hon. Gentleman’s hon. Friends asked a series of questions that they—particularly the right hon. Member for Rother Valley—want answers to. It is only fair to hon. Members to give them the answers to their questions.

The hon. Member for Leicester West asked why we are proposing a system where legal arguments on competition would trump patients’ interests. We are not. It is actually the contrary. Monitor will seek to protect patients’ interests, which is consistent with the role of the OFT and the competition authorities in protecting consumer interests. Competition law would not trump patients’ interests. Rather, as I said earlier, Monitor would apply competition law to protect those interests.

Mr Barron: Why didn’t you vote against then?
[Mr Simon Burns]

The hon. Lady also asked why Monitor had a principal duty to promote competition. That is actually not what the Bill states. Monitor’s duty would not be to promote competition as an end in itself, but to protect and promote patients’ interests, as clause 52(1) makes clear.

The hon. Lady asked why we need Monitor if competition is on quality, and how Monitor would improve quality. Monitor’s role in promoting competition is about strengthening incentives to improve quality and efficiency through setting the tariff and intervening where necessary to address restrictions on competition that could undermine improvements in quality. As a regulator, therefore, Monitor’s role is about creating the conditions for commissioners and providers to improve quality, with patient choice as the key driver.

I think it was also the hon. Lady—if it was one of her hon. Friends, she must forgive me—who asked why Monitor should have powers to fine GP consortia as commissioners. That is not what the Bill states, and I hope that she accepts that.

The Chair: Order. There is a Division in the House, and there will be a suspension for 15 minutes. It was my intention to have a suspension for dinner from 7 pm until 8 pm, so I will add that dinner suspension on to this Division. We will reconvene at 8 pm. If there is another Division during dinner, add 15 minutes on to that.

6.43 pm
Sitting suspended.

8.15 pm
On resuming—

Mr Burns rose—

Liz Kendall: Can we have a vote?

Mr Burns: We cannot have a vote yet, because I promised the right hon. Member for Rother Valley some answers to his questions and I intend to honour that promise.

Let me briefly recap where we were when the sitting was suspended. Many of the questions that arose in the debate are based on a fundamental misconception of the Government’s policy—that we are promoting competition for its own sake. That is not the case, as the clause makes abundantly clear. We are talking about competition only in the interests of patients. If competition does not promote or protect the interests of people who use health services, it will not be the role of Monitor to promote it. I hope that that clarifies the basic premise within the context of the debate.

Another question that has featured repeatedly during the debate has been whether competition will undermine co-operation between clinicians across organisational boundaries. Again, I do not believe that that is the case because both co-operation and competition have important roles to play. The Government do not accept that co-operation and competition are mutually exclusive. In other sectors, and in health care systems throughout the world, providers compete with each other and work in partnership. Our reforms would simply ensure that opportunities improve NHS services and are open to providers from all sectors, and that, wherever possible, patients are given a free choice of any willing provider that has demonstrated that it can deliver to NHS standards at NHS prices.

One of the first questions posed by the right hon. Gentleman was whether the ISTC programme was different from applying competition. It is true that our proposals are different from the last Government’s independent sector treatment centre programme. They are different because we want fair competition on a level playing field and not the rigging of contracts and prices to favour the private sector. Our Bill would prevent any future policies to expand the private sector. It would be patients and commissioners who chose which providers to use, not, as previously, because Ministers wanted a bigger role for private providers.

The right hon. Gentleman also raised the issue of Monitor’s express duty to promote competition. As the clause makes clear, that is only to protect and provide for the interests of people who use health care services. Competition is a means and not an end in itself. He also asked about the meaning of Monitor’s powers to protect essential assets and require monopoly providers to grant access to their facilities to third parties. First, Monitor may need powers to protect essential assets to ensure continuity of essential services. Secondly, the powers to grant access by third parties to a monopoly provider’s facilities would be used only in limited circumstances, when it was in patients’ interests, which could in the form of extended hours, more flexible access or more innovative services; the provider giving access would receive payment for doing so.

The right hon. Gentleman also asked what was meant by regulation to address abuses by monopoly providers. First, our proposals explicitly recognise the role of monopoly providers in the NHS, which, to my mind, are not always a bad thing. In the NHS, there are both natural monopolies, such as providers of specialist neurosurgery, and local hospitals that provide essential services where there are no alternative providers. We have recognised that through our proposals for additional regulation of designated services.

Secondly, monopoly providers would, in some cases, have the power to abuse their dominant position, and Monitor would have the power to deal with that. For example, where a provider refused to co-operate with GPs to provide integration of primary care within A and E, Monitor would be able to intervene. However, Monitor would grant GPs the licence to require access to the monopoly providers’ facilities only if it was in patients’ interests and on condition that the provider received payment for granting such access.

The right hon. Gentleman asked about the implications for the NHS of the Government’s proposed role for market investigations by the Competition Commission. The proposal is that Monitor would have the power to conduct studies of the health care market and to refer issues to the Competition Commission for investigation. For example, if Monitor identified problems with block contracts preventing patients from following their choices, it could refer the matter for further investigation. If the Competition Commission’s investigation concluded, on balance, that such arrangements acted against the
patient and public interest, it would be able to intervene and direct any appropriate remedy. The OFT already has such powers in relation to the health care sector.

If the right hon. Gentleman is not altogether reassured by that, I hope that he at least accepts that he has had answers to his questions—whether or not he likes them is another matter. None the less, I hope that my answers have been illuminating to both Opposition Members and my hon. Friends and that they agree to the clause standing part of the Bill.

Liz Kendall: I have three points to make in response to the Minister’s comments. First, I am glad that he agreed that health is different from utilities, telecoms and rail and that we therefore need a different approach from that provided by the regulatory bodies in those sectors. That, however, is not what the Government propose.

As stated quite clearly in the King’s Fund briefing on the Bill, Monitor’s main duty in clause 52 is virtually identical to that of Ofgem—when it was first established, not after its remit was amended in 2010 to ensure that it did not promote competition over the needs of users. It is interesting that the senior economist at Monitor used to be the director of wholesale markets at Ofgem; there may be an interesting link to be made there.

Additionally, under both UK and EU competition law, Monitor is given virtually identical powers to those of the OFT. It gets the same powers as the OFT under part 1 of the Competition Act 1998 and it gets the same powers as the OFT under the Enterprise Act 2002. The Minister asserts that the Government are using a different approach, but he has not spelt out any of the differences between the legal framework that applies to the utilities, telecoms and rail sectors and the regulatory approach set out in the Bill. He has not specified the differences, and that is why the clause is fundamentally wrong.

Secondly, it is interesting that the Minister gave such assurances in his speech. For example, he clarified that, at this stage, GP commissioners would not be undertakings. I thought that I clearly heard him say that GP commissioners are different from what he told us this morning. I thought that that is acting against the patient interest. The burden of proof will be on Monitor, and it cannot intervene without demonstrating its case. The short answer, therefore, is no. Monitor will not have an overriding power to intervene. I hope that that has been helpful for both the hon. Gentleman and the hon. Lady.

Liz Kendall: I am interested to hear that. That was not the point that I was making at the time, but I am grateful to him for explaining it. Lawyers that I have spoken to, however, say that if GP commissioners are considered to be undertakings, the burden of proof will be on them to prove that they should not be subject to competition law. This is a legal minefield, so it is important that we have clarity. These are not simply thoughts that I have developed over the many joyous hours spent studying the Bill; my arguments arise from briefings from organisations such as the NHS Confederation, which has had legal advice from Mills and Reeve, and which says that it is quite clear that GP commissioners could become undertakings and therefore be subject to EU competition law. That is why we need to see the legal advice and to have it published.

My final point, which relates to the point that the Minister clarified for my hon. Friend the Member for Halton, is about who decides. Under the new system, who has the power to make final decisions? The Minister says that it is GP commissioners, so why have Monitor? What is the point of having Monitor, with its role to drive competition, if it will not look at a particular market? As David Bennett said in his interview with The Times on 25 February, there may be some parts of the country that have only one provider of diabetes care, and those are the sorts of areas that Monitor could look at to see if they can be opened up to the market. It is Monitor, not GP commissioners, that will be driving changes, and if the Minister thinks differently, perhaps his Secretary of State should not have appointed David Bennett.

8.30 pm

John Pugh: I have just discovered a paradox. Presumably, if Monitor overrules GP consortia in the interest of patients, which is what the Minister has just said, that is slightly cross-grained with the assumption that GPs understand patients’ interests best, which is the premise of the legislation.

Liz Kendall: At 8.30 pm on this Tuesday evening, for the hon. Gentleman to spot a paradox when the rest of us are merely chugging through the Bill is extremely helpful. Following on from his comments and particularly
those of my right hon. Friend the Member for Rother Valley, I would say that the changes are huge; their implications are at best unclear, and at worst extremely risky for patients, the public and the NHS as a whole. It is not clear who will decide. Organisations such as the King’s Fund have rightly asked where decision making lies. Is it with Monitor, the national board or with Ministers?

8.31 pm
Sitting suspended for a Division in the House.

8.46 pm
On resuming—

Liz Kendall: I have not been convinced by the Minister’s arguments; we need greater clarity and certainty.

Question put, That the clause, as amended, stand part of the Bill.

The Committee divided: Ayes 11, Noes 9.

AYES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick

Tories

James, Margot
Lefroy, Jeremy
Pouler, Dr Daniel
Souby, Anna
Sturdy, Julian

NOES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Smith, Owen

Labour

Thornberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

Question accordingly agreed to.

Clause 52, as amended, ordered to stand part of the Bill.

Clause 53

POWER TO GIVE MONITOR FUNCTIONS RELATING TO ADULT SOCIAL CARE SERVICES

Question proposed, That the clause stand part of the Bill.

Emily Thornberry (Islington South and Finsbury) (Lab): This skeletal clause is a bit like a Trojan horse—who knows what will be put in it? It leaves regulations to fill in all the gaps and it will allow Monitor, in some form and at some stage, to take charge of adult social care and introduce competition into it.

I have some questions for the Minister because this is potentially an important clause for those involved in adult social care. At this stage, it is important to get some idea about the extent of the clause’s remit and its time frame. The clause seems to introduce the powers of Monitor to adult social care when we have yet to see how it can be brought into force in relation to health care. There are more questions about this matter than there are answers.

The explanatory notes anticipate that “these regulations would be limited to potential anti-competitive practice and/or provider failure.”

I am particularly interested in provider failure, given the terrible cuts that local authorities have to implement as a result of the Government’s reckless economic policy. During recent negotiations on the price of beds for people in long-term care, the only discussions were about how much the amount that local authorities pay for long-term care beds was going to be cut by—whether it was going to be 0% or up to 21%. That is what is going on at the moment.

Providers of long-term care—old people’s homes—are having to have their money cut. Those who have an interest in the issue worry hugely about what the future of Southern Cross will be. Its shares were worth more than £600 before Christmas and, this week, they have gone down to £5. Southern Cross has unsustainable debts and we do not know what will happen to a large number of elderly people who are staying in old people’s homes provided by that organisation.

I have been approached by the families of people with dementia who live at Oakleigh home in the London borough of Sutton, where a Conservative-Liberal coalition council is closing dementia beds. Given that we are talking about certain services being effectively guaranteed by Monitor in the health service—designated services—is that what is anticipated in relation to social care? Are the Government considering having an equivalent of designated services in relation to long-term care? If someone with dementia has been living in one place for a long time and they are moved out, it has an extraordinarily tragic effect on them, as I am sure Ministers know.

Although administrators currently have a duty to creditors when winding up things such as old people’s homes, what is their duty in relation to the individuals who live there? If Monitor is to take responsibility for adult social services, particularly for those in long-term care—I shall use this example to highlight my point—it would be interesting to hear whether the Government are considering whether there might be some designated social care.

We know that it will be a while before Monitor takes responsibility for adult social care, but those of us in the field also know that social care will be changing a great deal in the next few years. Whatever it is, the social care that Monitor will be taking responsibility for in a few years’ time will look very different from how it looks now.

However, people will still need some kind of guarantee. I would be interested to know what the right hon. Gentleman has to say about that. Age UK in particular is, of course, very concerned and would be interested to hear the Minister’s answers to the questions I have posed this evening.

Mr Burns: Clause 53 enables the Secretary of State to provide, through regulation, for specified functions of Monitor to be exercisable in relation to adult social care. The proposals that we set out in last year’s White Paper included that Monitor should become an independent regulator for the health and social care sectors.
The consultation highlighted the complexities of applying competition law to the NHS. In the light of that, the Government announced that initially they intended to bring Monitor’s powers into force only for health care. Provision to extend that to adult social care would be brought into force later. There was support for taking that phased approach in the consultation responses. What I mean by the consultation responses is the consultations that flowed from the publication of the White Paper last July.

As I said in an earlier debate when the subject was briefly discussed, we received a number of responses from local authorities and others that were supportive in broad principle of taking this course of action at some point.

Emily Thornberry: That is quite clear. In the interim period, I have read the consultation and appreciate the result. That is why I had those questions, and I would be interested to hear the answers.

Mr Burns: Marvellous. I am delighted that the hon. Lady has had a chance to read the consultation. The clause enables that phased approach. It does not provide that Monitor’s functions will be extended to adult social care, only that they could be. A joint review by the Department of Health and the Department for Communities and Local Government is considering proposals for a role for Monitor in regulating adult social care services. We anticipate that any such role would be limited to anti-competitive behaviour and/or provider failure.

The hon. Lady has raised specifically the question of whether designation would be used for social care. I have to, up to a point, disappoint the hon. Lady, partly because I am not going to fall for that trick. I am afraid that I am not going to fall for that trick.

Emily Thornberry: The Minister misheard me. I do not want any suggestions or anything hypothetical; I just want to know the answers to the questions that I have asked—answers that the Minister will be happy to stand by.

Mr Burns: Exactly. That is precisely what the hon. Lady is going to get, even if she is not happy with the response. What I am going to say to the hon. Lady, which is, I suspect, what she would say in the unlikely event that she was in my place and I in hers, is that we have yet to bring forward detailed proposals on whether, when and how Monitor’s functions would apply to social care. In that context, I am unable and not prepared to give her a specific answer, because there are too many ifs, hows and whens, and I am not going to get tripped up.

Grahame M. Morris: Will the Minister give way?

Mr Burns: In a moment; let me finish this point. What I can tell the hon. Lady, and I hope she will find it reassuring, is that before the Government do anything there will be a proper and full consultation process. Whatever flows from that consultation process will lead to regulations that would be done by affirmative resolution, which, as I suspect the hon. Lady would agree, is far more appropriate than the negative procedure; with regard to this policy matter, it is the more appropriate way of using secondary legislation. I will now give way to the hon. Member for Easington.

Grahame M. Morris: Notwithstanding the problems currently being experienced by Southern Cross Healthcare, will the Minister give a general indication of whether the Department has made any assessment about private and public sector provider failure in the adult social care sector as a consequence of Monitor’s application of the competition rules?

Mr Burns: I certainly do not want to mislead the hon. Gentleman, so I say in all honesty—and, I believe, correctness—that the answer to his question is no, because it is premature. If it is proved, however, that I am incorrect—I do not think I am—he will be the first to know after the civil servants have told me. For that reason, I urge that the clause should stand part of the Bill.

Question put and agreed to.
Clause 53 ordered to stand part of the Bill.

Clause 54
MATTERS TO HAVE REGARD TO IN EXERCISE OF FUNCTIONS

9 pm

Liz Kendall: I beg to move amendment 481, in clause 54, page 63, line 40, at end insert—

‘(ca) the need for enhancing collaboration and integration between health and social care services,

(b) the impact that its actions affecting one service could have on related services and the local health economy as a whole’,.

Clause 54 sets out the matters to which Monitor must have regard when exercising its functions. Those include the need to maintain safety for people who use health services, the desirability of securing continuous improvement in both the quality and efficiency of health services, the need for commissioners to ensure access to services, best use of resources, the desirability to promote investment and research in the NHS, and a couple of others. When we have the possibly brief stand part debate on clause 54, I shall go into some of the difficulties of how to balance and reconcile all those different issues when promoting competition, and how they relate to functions of other bodies set up by the Bill.

The amendment would ensure that, alongside those different matters, Monitor must also have regard to the need for enhancing collaboration and integration between health and social care services, and the impact that its actions affecting one service could have on related services of the local health economy as a whole.

The reason for the amendment is clear from the stand part debate on clause 52. I think all Members would agree that there is a need for services to work more closely together, both within the health service and...
between health and social care. Members of my party think the Bill will make that challenge worse; I am sure Government parties will disagree. Having a clear requirement on Monitor to have a particular regard to the need to support integration and collaboration would help allay some concerns people have that competition will lead to greater fragmentation. That is why I hope the Minister will accept the amendment.

The second part of the amendment would require Monitor to think carefully about the impact that its decisions on one service could have on others. That is the point I raised earlier. Take the example of diabetes services raised by David Bennett. If the diabetes part of care were removed from a hospital, what would be the knock-on effect? The amendment would explicitly require Monitor to take those issues into consideration. It would give great reassurance to many people who are worried about the impact of competition if the Government were to accept the amendment. I look forward to hearing the Minister’s comments.

Mr Burns: I would like to start my response to amendment 481 in what the hon. Lady might consider a slightly unusual way. I actually agree with her, in so far as I believe that these are important issues. However, I am afraid that, although I understand and appreciate the sentiment of the amendment, I believe it is not necessary.

We have already spoken at length about the need for and benefits of co-operation and integration between different bodies in the health and care system. Co-operation between providers is an essential part of delivering high-quality, seamless care over organisational boundaries, and it is necessary for patients to be able to choose their preferred provider. As we have discussed, there is already a comprehensive range of duties under the National Health Service Act 2006, as well as new duties proposed by the Bill, which cover co-operation and integrated working. For example, under section 72 of the 2006 Act, NHS bodies have a duty to co-operate with each other in the exercise of their functions. Under section 82 of the same Act, they have a duty to co-operate with local authorities to secure and advance the health and welfare of the people of England and Wales.

Clause 19 would reinforce those provisions by placing a duty on the commissioning board to encourage integrated working between GP consortia and local authorities, and a duty on health and well-being boards to encourage integrated working, as laid out in clause 179. However, our approach to clause 54 is to set out the range of matters that Monitor must have regard to in carrying out its duties, by focusing on outcomes.

For example, Monitor would have to have regard to the need to maintain patient safety, to improve quality and to ensure patients had access to the services that they needed. It would also have to have regard to the need for high standards of education and training and the need to make best use of limited NHS resources. Co-operation between providers and the integration of services, including of health and social care, would be important means of achieving those outcomes, but not the only important ones. Other important issues would include high standards of professionalism, clinical governance and financial management, and there would be others that I have not mentioned.

Similarly, in relation to the second part of the amendment, Monitor would need to develop a robust understanding of provider economics and the interdependency between clinical services, not as an end in itself, but to inform the exercise of its functions and make its contribution to improve outcomes. That demonstrates the advantages of our proposed approach, which is to ensure that Monitor must have regard to the outcomes to be achieved, rather than attempting to produce an exhaustive list of the issues that would be important in achieving those outcomes. Having explained the rationale behind the clause, I hope that the hon. Lady will consider withdrawing her amendment.

Liz Kendall: I am glad that we agree about the need for services to work together, and I hope that the Minister would also agree that decisions on one part of the service—for example, in our hospitals—can have an important knock-on effect on other services. He did not specifically make that point, but I am sure he will agree that that is important.

The Minister says that this area of the Bill is about outcomes, not processes. I am not sure that that is strictly correct, because it refers to the need to promote research, which is not an outcome. It also mentions the need to promote investment, which is supposed to lead to high-quality, continuously improving care. There are some outcomes and some processes in the clause—it includes both—which is why the amendment is relevant. He used a snazzy way of saying that he did not want the amendment when he said that this area of the Bill is about outcomes and not inputs, but that is not the case.

Monitor needs a specific requirement to pay attention to such issues. It is not just about putting duties on other bodies to work together; it is saying that Monitor, in promoting competition, has to bear those matters in mind. This is another example of where the Minister and I will agree to disagree, and I will press the amendment to a vote.

Question put. That the amendment be made.

The Committee divided: Ayes 10, Noes 12.

Division No. 45]

AYES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Pugh, John

Smith, Owen
Thornberry, Emily
Turner, Karl
Tigg, Derek
Wilson, Phil

NOES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick

James, Margot
Lefroy, Jeremy
Morgan, Nicky
Poultter, Dr Daniel
Soubry, Anna
Sturdy, Julian

Question accordingly negatived.

Emily Thornberry: I beg to move amendment 166, in clause 54, page 64, line 22, at end insert—

‘(m) the future workforce needs to staff health services for the purposes of the NHS, and the necessity to train and ensure the continual professional development of that workforce.’.
The Chair: With this it will be convenient to discuss amendment 167, in clause 90, page 84, line 47, at end insert—

“(ia) requiring the licence holder, with respect to Monitor’s duty under section 54(m)—
(i) to make such provision as Monitor deems necessary for staff training, and
(ii) to allow the easy transfer of staff between the licence holder and other licence holders for the purposes of staff training.”

Emily Thornberry: We have discussed clause 52 on Monitor’s general duty, and in particular its duty to have regard to the future demand for health care services, and clause 54 covers its duty in the exercise of its functions to have regard to “the desirability of securing continuous improvement in the quality of health care”.

One way we have to secure improvement in the quality of health care in future is, of course, by looking after our work force and ensuring that it is properly developed. That is the purpose of the amendments.

Amendment 166 relates to matters to which Monitor must have regard. They should include the NHS’s future work force needs, including need for continuing professional development. Amendment 167 relates to clause 90, which is about the conditions that Monitor may place on providers when it is licensing them to provide health care. The amendment would enable Monitor to require licence holders to make provision for staff training, and to allow staff to transfer between different providers for the purpose of staff training.

The question of staff training has been raised several times in earlier debates and remains unresolved. It is important that there is proper strategic development of the work force, and particular concern has been expressed about the lack of that in the Bill. Currently, there is no requirement for private providers to train staff—I recall the hon. Member for Stafford voicing concern about that. If there is to be an increasing number of private providers, they must pull their weight when it comes to developing and training staff.

Concern about the issue was raised with us by the Chartered Society of Physiotherapy, which is particularly worried that it would be difficult to ensure that new physiotherapists receive the proper training if the Bill is passed and there is an increase in private provision. Concern was also raised by Unison. Although I realise, from what I have read in the newspaper today, that the BMA may not be the Minister’s favourite organisation—he has been doing a Gaddafi for most of the day and claiming that the BMA does not represent doctors and that all doctors love him—but at its extraordinary general meeting today, it passed a resolution stating how concerned it is about education and training.

Mr Burns: Would the hon. Lady like to point out to the Committee that, rather contradictorily, bearing in mind its first motion today, the BMA also voted to support GP commissioning?

Emily Thornberry: I am so pleased that the Minister raised that, and I am happy to respond. There has been much speculation about when he would claim again that the BMA is representative of doctors, now that it has decided to oppose the Bill in the same way as the loyal Opposition. We are fundamentally against it, but if we have to accept it, we will attempt to amend it. We have been open about that. We will try to amend it where it is amendable, but fundamentally we are against it. It seems that we are in full agreement with the BMA.

In any event, I am so pleased that—

The Chair: Order. I allowed that little bit of indulgence, because it has been a long day, I said earlier that it might not be a good idea to discuss the BMA conference and its decisions today. That advice holds.

Emily Thornberry: Thank you, Mr Hood. I have nothing useful to add.

Mr Burns: I am sure you could.

Emily Thornberry: I could, but it is late.

Mr Burns: As the hon. Lady said, we touched on these issues during earlier debates, and my remarks lead on from those discussions. I begin by reiterating the importance of ensuring that staff training is appropriately allocated within the NHS system. I fully appreciate that that is also an issue of great concern to my hon. Friend the Member for Stafford.

The consultation on liberating the NHS and developing the health care work force sets out proposals for a new system driven by patient need, led by health care providers and underpinned by strong clinical leadership and effective partnerships with the higher education sector. Individual health care providers will be responsible for developing their current work force by promoting staff engagement and partnership working, ensuring continued professional development and providing support to improve staff health and well-being.

9.15 pm

In training and development activity, providers of health care services will have a major role to play as employers and, in many cases, as providers of training. We want to ensure that providers fulfil those responsibilities and receive appropriate support to offer high-quality training to staff. However, we have no plans to expand the remit of Monitor to include regulation of providers in relation to work force matters. Monitor will be the economic regulator. It is not part of the role of other economic regulators to ensure that providers carry out appropriate training and development of their staff and we do not think that it should be part of Monitor’s role. Assessing that activity requires specialist knowledge and expertise that will not be available to Monitor.

Subject to the outcome of the consultation, which is still going on, as the hon. Lady is well aware, that role will be carried out by Health Education England, which will support health care providers and provide national oversight of work force planning, education and training. HEE will provide leadership for effective work force planning and the provision of high-quality education and training. It will also bring together the interests of health care providers, the professions, patients and staff. We believe that that is the most appropriate way to ensure sufficient and targeted investment in developing the work force of the future. The deadline for responses to the consultation is 31 March.
Derek Twigg: What will be the benchmark for quality of training? Will it be current NHS provision or something different?

Mr Burns: Although the hon. Gentleman will probably find my response less helpful than he hoped, I think he will understand why I give it. We are consulting because the Government, as much as any member of this Committee on either side, want to get this crucial issue right. We have to wait to see what flows from the consultation process—what responses, ideas and recommendations we get from those who take part—before we make any decisions. While that consultation process is ongoing, it would be wrong to anticipate, prejudge or seek to influence what will flow from it. That is the purpose of the consultation process—to get ideas about how to move forward in the most positive and relevant way, so that we can get the best training and education for the next generation of staff, as well as maintain the present levels of training.

For those reasons, I urge my hon. Friends to oppose the amendment if the Opposition decide to put it to a vote.

Emily Thornberry: The Minister attempts to have it both ways. On the one hand, he is abolishing strategic health authorities, the deaneries and the way that we plan the future development of our health workers. However, he also says that he wants to be able to consult—

Mr Burns: We are consulting.

Emily Thornberry: The Minister is consulting. He is also establishing a new quango and he says that the closing date of the consultation is some time in the future. I stand to be corrected, but no attempt is made in the Bill to establish an alternative to the structure that the Bill is getting rid of, so we are getting rid of what we have without establishing anything else in the interim, even though, of all things, work force planning is the sort of thing for which a long run-up is needed.

There is genuine concern among those who have dedicated their lives to the health service that there will not be sufficient work force planning for our NHS. Our NHS rests on our staff. It seems that, if we are not going to educate them properly with proper forward development, there is an hiatus in the Bill. If I am wrong, on behalf of a large number of organisations which are genuinely concerned about such matters, I seek reassurance from the Minister.

Mr Burns: I am more than happy to reassure the hon. Lady because, if my memory is correct, she made the same point and asked the same question in an earlier debate. I gave her a commitment then, which I am more than happy to give her now. There will be no hiatus. There will be no interruption. It will be a seamless service.

Emily Thornberry: As I understand it, the basis of that assertion is that everything will be okay. There is nothing in the Bill that we can point to, but we are to take it in good faith. There is not even a clause, like the earlier Trojan horse clause about letting Monitor in to regulate adult social care, about what will replace the current structure. That is our worry. Although the right hon. Gentleman makes his representations in good faith, I am sure he understands that there may be some who do not necessarily take it on the chin.

Dr Poulter: The hon. Lady makes a good point about the need to look at training, but given that she mentioned deaneries, does she agree that one of the main problems was that the time to look at training was when the European working time directive was introduced under the previous Government? That was when training really suffered. It is right that the Government are addressing the problem now in a comprehensive, but not rushed, way.

Emily Thornberry: To coin a phrase, back to the Bill. The Foundation Trust Network is among the organisations that have expressed considerable concern about the issue, and their anxiety should not simply be brushed aside. One of the FTN’s legitimate worries is that, if we are to increase the number of private providers, those in the private sector should really pull their weight. In a Bill that encourages the private sector and gets rid of what we have already, such as the structures of workplace developments, we need to have something more than the Minister’s assurance that everything will be okay—because it might not be. I urge the Committee to accept the amendment.

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 13.

Division No. 46]

AYES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Smith, Owen

Thornberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

NOES

Brine, Mr Steve
Burns, rh Mr Simon
Burrows, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
James, Margot

Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Soubry, Anna
Sturdy, Julian

Question accordingly negatived.

Ordered, That further consideration be now adjourned.

—(Stephen Crabb.)

9.24 pm

Adjourned till Thursday 17 March at Nine o’clock.